NHS
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 2025 – 31 March 2026

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Jonathan Higman
Accountable Officer
15 June 2026

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The past year was the most significant period of change since the establishment of integrated care boards. For Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB), 2025-26 was defined by the need to respond to national reform, financial constraint and organisational change while maintaining a clear and consistent focus on improving health and care outcomes for the people we serve. This annual report reflects how we have continued to achieve despite a very challenging environment.

The Government's announcement of a 50% reduction in integrated care board running costs marked a fundamental shift in expectations of how ICBs operate. Responding to this required pace, collaboration and careful judgment to ensure that statutory responsibilities continued to be met and that system leadership remained strong. As part of this response, BSW ICB worked closely with neighbouring ICBs, including NHS Dorset and NHS Somerset, to develop clustering arrangements that enabled shared capability, increased resilience and greater efficiency, while preserving local leadership and accountability.

Change of this scale inevitably brings uncertainty, particularly for our workforce. I wholeheartedly thank colleagues – including those who have left the organisation – for their incredible professionalism, flexibility and commitment throughout the year.

Alongside organisational reform, 2025-26 was also a year where the national direction of travel for the NHS became clearer. The publication of the NHS 10 Year Health Plan set out an ambitious long-term vision for how health and care in England must evolve in response to changing population needs, workforce challenges and technological opportunity. Three key pillars provide the focus: from hospital to community, from analogue to digital and from sickness to prevention.

The 10 Year Health Plan reinforces the importance of our role as strategic commissioners and the work described in this annual report reflects how we are already contributing to these shifts at a local and system level.

Highlights and achievements from the year

Hospital to community

Innovative new integrated community-based care partnership

From 1 April 2025 HCRG Care Group lead an innovative new community-based care partnership with the NHS, local authorities and charities to transform the care and support that people get to help them with their health and wellbeing at every stage of their lives.

Traditional community services such as nursing, therapy and personal care will be enhanced as they become part of new integrated neighbourhood teams, working across homes, care homes, clinics, schools and community centres to bring more personalised support to local people.

Providing a single point of contact for people across BSW, the new 'front door' is accessible to all, and available in a face-to-face location, as well as online and over the phone.

Engagement with people and communities on neighbourhood health
Neighbourhood Health focuses on:

- working closer to where people tell us would be of greatest help
- joining up services around neighbourhood populations
- supporting people earlier, better and more consistently
- using shared foundations to work as one system, not separate parts

We're talking with our people and communities across BSW to capture their ideas, suggestions and feedback to inform decisions about future neighbourhood health.

New endoscopy unit in Swindon
A brand-new, state-of-the-art endoscopy unit at West Swindon Health Centre opened in November 2025, offering thousands of patients the opportunity to receive vital care sooner and closer to home, while helping to relieve pressure on Swindon's Great Western Hospital.

New dental practice opened in Swindon
In January 2026, a new dental practice opened at Abbey Meads in Swindon, providing local people with a brand new facility and access to thousands of extra dental appointments.

Trowbridge Integrated Care Centre
A new state-of-the-art health and care facility opened to patients on Thursday 30 April 2026. The £16 million centre represents significant investment in state of the art facilities, designed to be fully self-sufficient and carbon net zero, delivering real benefits to people living in the town and its surrounding areas.

The centre will become a hub for multiple health and care services, with teams from different organisations working together under one roof to help provide local people with a seamless, more joined-up NHS experience.

Sickness to prevention

Big A&E survey
Between April and August 2025, we worked with Healthwatch and hospitals in Bath, Swindon and Salisbury to find out from patients why A&E was their walk-in choice of service. This was prompted by an unprecedented rise in people choosing to go to A&E during 2024.

BSW ICB launched an engagement project and spoke to over 1,600 people to understand why more people are going to A&Es instead of using other NHS services, such as minor injury units (MIUs), urgent treatment centres (UTCs) and community pharmacies.

This information helped to inform 'right service, right time' and sickness prevention campaign activities.

Stay Well campaigns
Our Stay Well campaigns continue to raise awareness of preventative health measures and support national campaign activity. Vaccination uptake rates remained high for 2025-26, contributing to the South West having the highest uptake of all regions in England.

We continued delivering blood pressure testing in the community as part of our Know Your Numbers campaign, in a quest to help find and treat undiagnosed instances of hypertension.

Analogue to digital

NHS App

Use of the app continues to grow among people in BSW, particularly for ordering repeat prescriptions.

Place-based working and system collaboration

The year has also seen continued progress in place-based working, recognising that improving outcomes and reducing inequalities is most effective when action is rooted in local communities. Working with local authorities, providers and the voluntary, community and social enterprise sector, BSW ICB has supported approaches that bring services together around people and place, rather than organisational boundaries. This aligns closely with the national ambition to shift more care into community settings and build stronger neighbourhood-level provision over time.

Throughout the year, partners across BSW ICB have continued to demonstrate strong system collaboration, particularly in response to ongoing operational pressures. While demand across services has remained high, collective working to support quality, safety and patient flow has been a defining strength of the system. BSW ICB has played a key role in convening partners, supporting joint decision-making and maintaining focus on shared priorities.

ICB governance, assurance and leadership

We have also continued to strengthen governance, assurance and leadership arrangements during a period of change. Maintaining robust oversight and clear accountability has been essential as we adapt to new operating models and prepare for further reform. The Board has undergone its own transition, but members have remained focused on core responsibilities, providing appropriate challenge and support and ensuring that BSW ICB and our new cluster partners continue to meet statutory duties.

Operating sustainably

Financial sustainability remained a challenge throughout 2025-26. The cost-reduction requirements placed on ICBs sat within a wider context of system pressure and rising demand for access to health and care services. Through sound financial discipline and responsibility, we worked with partners to support value, productivity and the effective use of public resources.

The development of clustering arrangements with neighbouring ICBs forms an important part of this response. By sharing expertise, capacity and corporate functions, we are building greater resilience while ensuring that BSW ICB continues to have a clear local voice within wider structures.

Contributing to the NHS 10 Year Health Plan

The ambitions set out in the NHS 10 Year Health Plan resonate strongly with the direction of travel across BSW.

The shift from hospital-centred care to care delivered closer to home reflects work already underway through place-based partnerships, integrated teams and community-focused approaches. As an ICB, BSW plays a critical role in enabling this shift by working with providers and local authorities to align commissioning intentions, support new models of care, and ensure that resources are used in ways that best meet local need.

The shift from analogue to digital is equally significant. While much of the national focus is on new technology and innovation, there is also a clear recognition of the importance of improving the basics: better data flows, more efficient administrative processes, and digital tools that genuinely support both patients and staff. BSW's role is to create the conditions for digital progress across the system, supporting consistency, interoperability and shared learning, while remaining realistic about capacity and capability.

The shift from treating sickness to preventing ill health remains one of the most challenging and important ambitions of the plan. Reducing inequalities, improving healthy life expectancy and supporting wellbeing require sustained effort across the whole system and beyond the NHS. Through our work with local government, communities and partners, BSW ICB continues to prioritise prevention, early intervention and targeted support for those most at risk. While progress is incremental, this remains fundamental to our purpose as an integrated care board.

Looking ahead

The year ahead will continue to require flexibility, collaboration and clear leadership. There are challenges and opportunities in realising the ambitions of the 10 Year Health Plan as they begin to translate into action. Among the priorities for the newly clustered ICB will be to establish itself, embed new ways of working and settle and support a dedicated workforce who have been through a period of huge upheaval.

I would like to thank our system partners for their continued constructive engagement throughout a challenging year, as well as my Board colleagues for their continued focus. Most importantly, I want to reiterate my thanks to our staff, whose dedication and professionalism underpin everything we do.

This annual report tells the story of a year of transition, but it is also a reflection of our collective determination to continue improving health and care for the people of Bath and North East Somerset, Swindon and Wiltshire. By listening to our communities, working in partnership and embracing change with clarity and care, we remain confident in our ability to meet the challenges ahead and contribute meaningfully to the future direction of the NHS.

Jonathan Higman
Chief Executive
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board
15 June 2026

About BSW ICB in 2025/26

Our Executive Team

The following roles comprised the BSW ICB Executive Team up until March 2026:

- Chief Executive Officer
- Chief Finance Officer
- Chief Nurse Officer
- Chief Medical Officer
- Chief Delivery Officer
- Chief People Officer
- Place Director – BaNES
- Place Director – Swindon
- Place Director – Wiltshire

Bath and North East Somerset, Swindon and Wiltshire, Dorset and Somerset Integrated Care Boards were to formally work together as a cluster from 1 April 2026. The cluster executive team comprises:

- Chief Executive Officer
- Chief Officer for Strategic Finance and Resources
- Chief Medical Officer
- Chief Nursing Officer
- Chief Officer for Population Health Improvement
- Chief Officer for Commissioning and Place
- Place Director – Bath and North East Somerset
- Place Director – Swindon
- Place Director – Wiltshire
- Place Director – Bournemouth, Christchurch and Poole
- Place Director – Dorset
- Place Director – Somerset

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, faith and social enterprise (VCFSE) 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

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

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.

Place-based working, partnership and neighbourhood health

Each locality has a Place Director from the ICB who works alongside local authority partners, provider partners, primary care, the voluntary, community, faith and social enterprise sector and other local organisations to address the specific health and care needs of their population. This place-based model is central to how the ICB translates system-level strategy developed through population health insights into co-developed locally relevant plans and decisions.

During 2025/26, the ICB continued to develop its Integrated Care Alliance (ICA) arrangements across the three localities. ICAs provide the governance and partnership infrastructure at place level, bringing together all partners. Each ICA reflects the distinct character and priorities of its locality while contributing to the shared ambitions of the BSW Integrated Care Strategy, Cluster ICB priorities and the national direction towards neighbourhood health and prevention. BSW has developed trusted partnership between ICAs and Health and Wellbeing Boards. Each ICA has prioritised three key programme areas, aligned with the goals of prevention, reducing inequalities, and excellent care.

BaNES priorities include:

- Emotional health and wellbeing of children and young people (CYP)
- Integrated Neighbourhood Teams (INTs)
- NEETs (addressing the needs of 18-25 year olds who are not in education, training or employment)

Swindon priorities include:

- Developing neighbourhood health

- Children’s oral health (prevention of avoidable dental extractions in CYP)
- CYP emotional health and wellbeing

Wiltshire Priorities include:

- CYP emotional health and wellbeing
- INTs
- Children's oral health (a multi-agency approach to improving CYP oral health)

A significant area of work during the year has been the commissioning and governance of jointly funded services through the Better Care Fund (BCF) and Section 75 pooled budget arrangements. These arrangements cover a substantial proportion of integrated health and social care services across BSW, supporting areas including intermediate care, reablement, community equipment, discharge support and services for people with long-term conditions. During 2025/26, the ICB worked closely with its three local authority partners to review performance against national BCF metrics, strengthen assurance arrangements, and prepare for 2026/27 BCF planning in line with revised national guidance published in February 2026.

Neighbourhood health has been a major strategic focus during 2025/26, building on the established strategies across BSW and the subsequent national Neighbourhood Health Framework published by the Department of Health and Social Care (DHSC) and NHS England in March 2026. BSW ICB's approach is grounded in a layered model of care: community assets and prevention at the foundation, first contact services, integrated neighbourhood teams operating at a population of 30,000 to 50,000, specialist community services, and shared enabling infrastructure. This is a whole-system model, not simply a new team structure, and reflects the national ambition to shift care closer to home and address health inequalities in the communities that need it most.

A foundational step during the year was the development and agreement of a shared BSW-wide vision for neighbourhood health, developed across all three localities and through system partnership. Building on that shared foundation, partners in each locality subsequently worked with their Health and Wellbeing Boards to develop locality-specific visions that reflect local population needs, priorities and assets. These locality visions are now forming the basis of neighbourhood health plans that are currently being written, with the first in a planned series of thematic workshops, held in April 2026, delivering locality-level strategic steers and areas of focus to inform that work. Further workshops are planned through May 2026 to continue building the content and partnership consensus needed to finalise the plans.

The ICB's Integrated Community Based Care contract, delivered by HCRG Care Group, is central to the delivery model underpinning this work. To accelerate the establishment of integrated neighbourhood teams across BSW, the ICB has approved a further investment to fund the mobilisation of the integrated neighbourhood team model across all three localities. This investment, which is aimed at supporting key partners including Primary Care and VCSFE sector colleagues to engage in a fully facilitated development programme, will support the establishment of the operational infrastructure, workforce capacity and partnership working arrangements needed to implement the 'team of teams' approach at neighbourhood-level. Further work is planned to ensure parity of discussion in relation to neighbourhood co-design for children, young people and families aligning work across SEND reform, Best Start in Life, Families First Partnership programme and neighbourhood health.

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 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. This will develop to become the five year strategic commissioning plan and will meet the requirements of the NHS 10 Year Health Plan.

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 chief executive officers 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.

BSW operational plan

The 2025/26 operational plan met the overall requirement to deliver a breakeven financial position. However, delivery of the aggregate plan and individual plans is deemed extremely challenging, and we have worked at pace to turn them into detailed implementation plans. We have been addressing some key operational challenges, including the reduction in acute length of stay and acute 'no criteria to reside' to enable the required reduction in beds and associated workforce.

Further mitigating actions have included additional support in the form of a System Recovery and Delivery Director, enhanced operational support within BSW Hospitals Group, and additional programme delivery support.

We submitted a breakeven plan, which included deficit funding of £23.4m (deficit funding is conditional on a break-even plan). The system efficiency requirement totalled £125m, which is c.6.5% once we include productivity improvements.

The system challenge has grown due to the deficit run rate having increased by c.£50m since the Medium Term Financial Plan and 2024/25 plan. The underlying deficit now being estimated at c.£145m in 2025/26 planning.

Efficiencies within all organisations require rapid further development, with a high level of unidentified efficiency still remaining. This has meant there has been limited revenue for investment available in this financial year. The operational plan prioritised investment of £2.4m in the Electronic Patient Record (EPR) programme, and additional ambulance funding of £2m.

BSW capital plan

BSW submitted its 2025/26 capital planning submission for a total investment of £108m, aiming to best deploy operational and national capital funding to support strategic priorities. However, the level of capital resource available to BSW does not allow all strategic priorities to be delivered and has required us to take a strategic approach to investment, working together as a system to prioritise our available capital, and to ensure we maximise opportunities to align resources and investment.

The plan builds on the system successes of 2024/25, including how the funding can support the delivery of operational and national capital, which is needed to support strategic priorities and local system priorities, such as:

- Primary and Community Care and to support prevention initiatives
- Elective recovery
- Electronic patient records
- Integrated front door
- Diagnostic schemes

The strategic drivers underpinning the plan include:

- Tackling health inequalities
- Addressing an ageing population
- Increasing pressure on existing services

Our first objective reflects our shared commitment to ensuring people are able to stay healthier for longer. It unites all partners across BSW and is a key part of our rationale for working together. It is our first objective because the most effective way to improve healthy life expectancy is to create the right conditions, communities and environments for children and adults to remain healthy, regardless of where they live.

Capital investment plays a crucial role in acquiring, expanding and integrating care through new estates and upgrading older estates, providing new clinical equipment, driving forward new technologies, such as the electronic patient record system, and delivering diagnostic hubs. However, accessing sufficient capital funding through the NHS remains a challenge. The availability of funds is limited, and the bidding processes often have short notice periods, which makes it difficult to plan strategically for capital expenditure. Additionally, obtaining approval for business cases can be lengthy.

It is imperative that we secure adequate capital funding to support the strategic transformation of our services and have the flexibility to allocate it to agreed system infrastructure priorities. We continue to work with partners to explore all opportunities to maximise assets and capital funding streams, as well as blending investment opportunities to achieve best outcomes against shared priorities. This requires a matrix and developing partnership approach, as it is not in the gift of any one organisation.

Key Risks and Issues

During 2025/26, the highest scoring risks for the ICB were:

HR leadership and operational capacity during organisational change and merger with ICB's

The national mandate to ICBs, issued in March 2025, to reduce their running costs by 50% has over the course of the business year led to the depletion of the ICB's specialist HR capacity and capability, both of which are needed to deliver organisational change safely.

Mitigations and controls included:

- External legal and HR consultancy support commissioned
- Co-operation and resource sharing with neighbouring ICBs
- Regular engagement with staff side representatives and unions

Ambulance to hospital 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 Urgent and Emergency Care tactical urgent care meetings
- Waiting patients closely monitored and offered refreshments

Non-delivery of the ICS NHS finance and operating plan

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

Mitigations and controls included:

- Regular meetings of local Directors of Finance

- 3-year financial plan, common set off system planning assumptions
- Financial recovery board
- Workforce vacancy control protocols, recruitment freeze
- 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

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.

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, albeit that the NHS BSW ICB is moving towards very close collaboration with NHS Dorset ICB and NHS Somerset ICB (‘the cluster’).

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 2026, on a going concern basis.

Performance analysis

Between April 2025 and March 2026, 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.

While plans were developed to deliver this target, there were some risks that could not be mitigated, such as the national bone cement shortage, and, at the end of March 2026, there were 10 BSW patients waiting longer than 65 weeks for elective treatment.

Demand for urgent and emergency care remained high throughout 2025/26, 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 Coordination 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

The NHS Oversight Framework 2025/26 was published in July 2025 to provide a consistent and transparent approach to assessing Integrated Care Boards (ICBs), NHS trusts, and foundation trusts. It was developed with input from NHS leadership, staff, representative bodies, and think tanks through two public consultations.

It was designed to be a 1-year framework, to be reviewed in 2026/27 to incorporate work to implement the new ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan, and focuses on public accountability, performance improvement, and support for providers.

ICBs were not segmented in 2025/26 given the significant changes they are undertaking during the year. This means these metrics were not scored to inform segmentation, but they were reported as contextual information to be used in strategic planning and improvement conversations.

NHS Provider Oversight Framework methodology

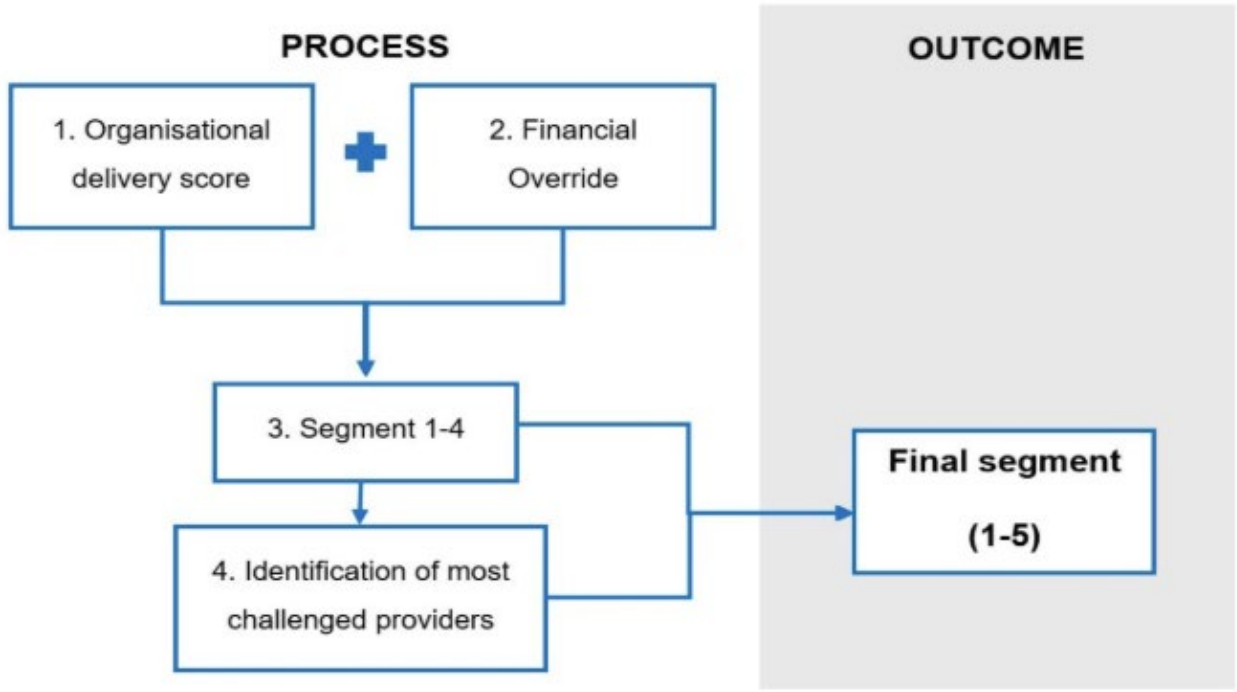
2025/26 was considered a transitional year, and each provider was scored against a focused set of metrics that targeted the priorities set out in the 2025/26 NHS priorities and operational planning guidance and allocated to a segment based on their performance against these metrics, from segment 1 (no support) to segment 5 (intensive support through the Provider Improvement Programme). The performance assessment process measures each provider's delivery on key metrics across 6 domains.

Where providers are part of a provider collaborative or group model, they were measured as a trust and not as a wider group.

Primary care providers, primary care networks and other non-trust providers or partnerships, such as provider collaboratives, will not be allocated their own segments. However, we will continue to keep under review our arrangements for accountability of primary care providers as we move towards the planned shift to neighbourhood health.

For independent providers of NHS services, ICBs were expected to continue to ensure quality and performance through contractual levers and escalate concerns to NHS England regions. All underlying data used to derive a segment is available to NHS staff through the Model Health System as well as a publicly accessible dashboard.

Process for determining a segment



Step 1 – Organisational delivery score

Each provider received an individual organisational delivery score derived from its performance against the metrics. Each metric has an individual set of scoring rules and based on these a provider will receive a score between 1 and 4 for each metric. To calculate the overall organisational delivery score, the individual metric scores are averaged according to the number of metrics the organisation will be measured against. The scores are then benchmarked against those for the rest of the country and divided into 4. These quartiles are numbered 1 to 4 with the highest performance scoring quartile numbered 1 and these numbers become each organisation's overall organisational delivery score.

Step 2 – Financial override

As part of the scoring methodology an override relating to organisational, not system-wide, financial performance was applied. The override means all organisations in deficit or in receipt of deficit support will be limited to an organisational delivery score of no greater than 3.

Step 3 – Segmentation

Based on the process, every provider was placed into a segment. This indicated its level of delivery from 1 (high performing) to 4 (low performing) and informs its support or intervention needs.

Assessment domains

The 25/26 assessment process measured each provider's delivery across six domains. Each domain has a range of appropriate metrics for each type of organisation (ICB, acute, mental health, community, and ambulance trusts):

- Access to Services
- Effectiveness and Experience of Care

- Patient Safety
- People and Workforce
- Finance and Productivity
- Improving Health and Reducing Inequality -Not to be scored in 25/26.

For this transitional year, the scoring metrics (28) reflect the 2025/26 NHS priorities and operational planning guidance. The other contextual metrics (36) did not influence the segmentation score.

BSW domain scores and rank

While ICBs were not scored this year, it was agreed that the results would still be shared with ICBs as contextual information to be used in strategic planning and improvement conversations. These metrics relate to tests applied at a whole system level for ICBs. The table below shows our quarterly performance for Quarter-1 to Quarter-3. It also shows how the other ICBs scored for each test in Quarter-3.

System Performance Q1-Q3					
2025/26 National Oversights Framework Summary BSW					
		Q1 2025/26	Q2 2025/26	Q3 2025/26	Q3 ICB Comparison
Urgent & Emergency care	Has the system been in the lowest quartile for four hour urgent and emergency care performance for each month of the last quarter?	No	YES	No	8 ICBs - YES 34 ICBs - NO
Elective care	Has the system been in the lowest quartile for 18-week elective perfromance for each month of the last quarter?	No	No	No	9 ICBs- YES 33 ICBs - NO
Cancer Care	Has the system been in the lowest quartile for 62-day cancer performance for each month of the last quarter?	No	No	Yes	7 ICBs - YES 35 ICBs - NO
Primary care	Is the system in the lowest quartile for overall primary care patient satisfaction?	No	No	No	9 ICBs - YES 33 ICBs - NO
Mental Health	Is the proportion of health checks for patients with severe menal illness completed in the last year below 60%?	No	YES	Yes	23 ICBs - YES 19 ICBs - NO
Finance	Is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan?	No	YES	No	12 ICBs - YES 30 ICBs - NO

The latest national oversight framework data was published in April 2026 and highlighted performance at the end of the third quarter of 2025/26. The table below shows the performance for each of the three acute providers within BSW with the overall Framework segment score and the overall rank, along with scores and ranks for each of the domains.

National Oversight Framework Summary BSW Acute Trusts													
		GWH Q1	GWH Q2	GWH Q3	Improved/ Declined from previous Quarter	RUH Q1	RUH Q2	RUH Q3	Improved/Declined from previous Quarter	SFT Q1	SFT Q2	SFT Q3	Improved/ Declined from previous Quarter
Oversight Framework Segment	Score	3	3	3	←→	4	4	4	←→	3	3	3	←→
	Rank	76 out of 134	82 out of 134	85 out of 134	↓	112 out of 134	105 out of 134	102 out of 134	↑	57 out of 134	70 out of 134	67 out of 134	↑
Average Score	Score	2.43	2.47	2.5	↓	2.70	2.68	2.73	↓	2.26	2.36	2.37	↓
Pre-Adjusted	Score	3	3	3	←→	4	4	4	←→	2	3	3	←→
Is segment downgraded due to financial deficit?		YES	YES	YES	←→	YES	YES	YES	←→	YES	YES	YES	←→
Is the organisation in the Recovery Support Programme?		NO	NO	NO	←→	NO	NO	NO	←→	NO	NO	NO	←→
Domain Scores													
Access to Services Domain	Score	2.42	2.69	2.77	↓	3.14	3.06	2.97	↑	2.22	2.19	2.25	↓
	Rank	73 out of 131	92 out of 131	95 out of 131	↓	121 out of 131	112 out of 131	106 out of 131	↑	53 out of 131	54 out of 131	52 out of 131	↑
Effectiveness and Experience of Care Domain	Score	2.23	2.37	2.3	↑	2.11	2.11	2.13	↓	2.67	2.66	2.67	↓
	Rank	82 out of 134	90 out of 134	82 out of 134	↑	58 out of 134	60 out of 134	56 out of 134	↑	126 out of 134	121 out of 134	123 out of 134	↓
Patient Safety Domain	Score	2.09	2.12	1.88	↑	2.94	2.8	2.86	↓	2.08	2.45	2.53	↓
	Rank	24 out of 134	26 out of 134	14 out of 134	↑	95 out of 134	87 out of 134	95 out of 134	↓	23 out of 134	62 out of 134	66 out of 134	↓
People and Workforce Domain	Score	2.38	2.16	2.08	↑	2.08	2.16	2.35	↓	1.43	1.39	1.39	←→
	Rank	63 out of 134	51 out of 134	47 out of 134	↑	46 out of 134	51 out of 134	61 out of 134	↓	12 out of 134	11 out of 134	12 out of 134	↓
Finance and Productivity Domain	Score	3.18	2.53	2.92	↓	2.38	2.6	3.06	↓	2.8	3.38	3.13	↑
	Rank	121 out of 134	76 out of 134	91 out of 134	↓	71 out of 134	79 out of 134	99 out of 134	↓	110 out of 134	122 out of 134	105 out of 134	↑
Improving Health and Reducing Inequality DomainMetrics													

South-West Acute Trust League Table

	NOF AVERAGE SCORE	National Rank (Out of 134)	Overall Segment (1 highest performing, 4 lowest)	Trust in Financial Deficit	Regional Rank (Out of 13)
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	1.99	17	1	NO	1
ROYAL CORNWALL HOSPITALS NHS TRUST	2.01	18	1	NO	2
SOMERSET NHS FOUNDATION TRUST	2.2	24	2	NO	3
NORTH BRISTOL NHS TRUST	2.3	25	2	NO	4
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	2.07	38	3	YES	5
ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	2.28	54	3	YES	6
SALISBURY NHS FOUNDATION TRUST	**2.37**	**67**	**3**	**YES**	**7**
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	2.39	68	3	YES	8
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	2.49	83	3	YES	9
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	**2.5**	**85**	**3**	**YES**	**10**
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	2.51	87	3	NO	11
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	**2.73**	**102**	**4**	**YES**	**12**
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	2.93	119	4	YES	13

Rankings

It should be noted that the overall rankings system on the public facing website has been created by using all 134 acute trusts in England including specialist hospitals and does not consider the size of the trust, locality or any other demographic factors that could provide further context when comparing performance. The top 8 ranked trusts are all classed as specialist hospitals which may not offer the full range of acute services such as A&E.

The domain ranks are based on all 205 NHS organisations which have been assessed and include acutes, mental health trusts and ambulance trusts.

The NHSE public facing site use more appropriate ranking when drilling down and looking at individual metrics within the framework. For example, 4-hour A&E performance is ranked out of 123, RTT 18-week performance is ranked out of 131 and cancer metrics are ranked out of 118 reflecting the actual number of acutes trusts providing that service.

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 2025/26 to include the updated operational plan deliverables and other emerging priorities.

The ICB integrated performance dashboard was further developed in 2025/26 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.

Performance and effectiveness monitoring

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 and effectiveness are 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 effectiveness, and expected recovery.

Escalation reports are shared at the following meetings, typically to agree courses of action to support improvement and effectiveness:

- ICB Executive Management Meeting
- System Planning and Delivery Executive
- System Recovery Board

The System Recovery Board oversaw the planning and execution of Implementation and Operating Plans of transformational, operational and financial strategies and overall sustainability within the BSW NHS organisations, and across the BSW health and care system. As such, the Recovery Board supported financial and performance recovery, improvement and effectiveness in the system through:

- Monitoring performance against operational and recovery targets, objectives and key performance indicators
- Reviewing reports on any material breaches of performance milestones (KPIs) and the adequacy of proposed action
- Assuring provider and ICB boards on Delivery Groups' and their programmes' progress with achieving objectives and outcomes as defined in Implementation and Operating Plans
- Advising the ICB Board on risk exposures with regard to the short- and long-term recovery plans and associated recovery strategies
- Prioritising delivery, unblocking issues and facilitating solutions

- Setting parameters and expectations for delivery within NHS organisations, drive and monitor in year delivery against these parameters and expectations, and hold responsible officers to account for delivery
- Monitoring of delivery of efficiencies across all NHS organisations

The Recovery Board oversaw actions to support performance improvement, effectiveness, and progress towards targets, for example:

- ICB and Provider Recovery Plans developed and implemented
- Non-criteria to reside (NCTR) daily review and escalation protocol developed and implemented
- Bed reduction plan developed and implemented
- Elective Recovery Plan developed and implemented
- Demand management initiatives developed and implemented
- Review of primary and mental health schemes
- Multi-agency discharge events (MADE), bringing partners together to support improved patient flow across the system, recognise and unblock delays, and challenge and improve discharge processes
- Urgent and Emergency Care Reset Programme commenced
- SWAST and BSW ICB working together to implement hospital ambulance liaison officers at acute hospitals led to a drop in ambulance handover times
- The Winter Plan implementation reduced operational performance issues and risks
- Demand management initiatives succeeded in an increase of hospital admission avoidance

Performance reports to the ICB Commissioning Committee, ICB Quality and Outcomes Committee and ICB Board provide assurance that arrangements and mechanisms are in place to address performance and effectiveness where these do not meet targets or expectations and allow for scrutiny of these mechanisms and arrangements' effectiveness themselves.

There is a range of more detailed and subject-specific reporting that goes to other key meetings, in which performance and effectiveness of programmes are 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 effectiveness, and key risks and mitigations.

The sections below describe in more detail how these arrangements supported improvements in performance and effectiveness, recognising that the system continued to operate in a challenging environment and struggled to meet targets.

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 January 2025.

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 four-hour target measures the time a patient spends in an emergency department (ED), urgent treatment centre (UTC) or minor injuries unit (MIU) 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 these waiting times can be affected by changing activity and system flow pressures in other areas, such as the ambulance service, primary care, community-based care and social services.

For example, patients cannot be admitted into the hospital 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 2025/26, 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)

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)

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 26	78.0%	77.1%	77.3%	64.9%	R	R
Ambulance – Average handover delays > 15 mins	Mar 26	25	-	-	41	n/a	n/a
No criteria to reside (NCTR) % occupancy	Mar 26	9.6%	-	-	19.5%	n/a	n/a
Ambulance response times (minutes) Cat 2 mean	Mar 26	00:30:00	00:26:18	00:30:15	00:33:00	R	R
NHS 111 answered in 60 seconds	Mar 26	95%	-	-	68%	n/a	n/a
Proportion of calls assessed by a clinician or clinical advisor	Mar 26	50%	45.3%	52.8%	61%	G	G

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

In 2025/26, urgent care performance continued to be challenging, with the system struggling to deliver the 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.

All BSW trusts monitor their individual performance on an ongoing basis. Each trust identified contributing factors to individual performance and made UEC recovery plans, supporting improvement in four-hour performance, ambulance handover times, etc. The ICB convenes daily operational meetings, with escalation to both tactical and strategic meetings, in which system partners can work together on delivering urgent care pathways, including patient flow.

Demand remains high for emergency services, with significant pressure affecting both ambulances and emergency departments. The Care Co-ordination Centre was fully established to enable providers to work together, offering alternative pathways and services within the community and primary care, instead of conveyance to an emergency department.

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 for the majority of 2025/26. 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 2025/26, and various mitigations and controls have since been put in place, with additional system-wide plans started in April 2025 to reduce the overall handover delays, which saw performance significantly improve between September and December.

Due to the ongoing Think 111 campaign, the number of calls to NHS 111 remained high throughout 2025/26. 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 (RTT) access targets have remained the key measures of the NHS for planned care in 2025/26, with the aim to return to the 18-week referral to treatment standard and cancer waiting times detailed in the NHS Constitution.

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Patients waiting over 52 weeks for treatment	Mar 26	n/a	94,400	10,800	1,029	n/a	n/a
Patients waiting over 65 weeks for treatment	Mar 26	0	7,380	301	10	n/a	n/a
Patients waiting six weeks or more for Diagnostics	Mar 26	5.0%	21.2%	16.0%	12.5%	G	G

People with urgent GP referral being told of cancer diagnosis outcome within 28 days of referral (FDS)	Mar 26	77.0%	80.0%	79.1%	80.4%	G	G
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral - combined standard	Mar 26	70.0%	71.0%	69.9%	67.8%	R	R

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 106,625 patients in March 2025 to 110,983 patients in March 2026. However, for the same period, the number of people waiting more than 52 weeks reduced from 1,976 to 1,029.

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 2025/26 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.

At the end of January 2026, there were 10 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.

Local diagnostic waiting times are better than the England average and overall South West performance in March 2026, with 12.5% 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 nonobstructive ultrasound and endoscopy. The challenged performance for diagnostics has also had an impact on waiting lists, particularly those relating to cancer.

There have been improvements across 2025/26 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 2026, BSW performance is below the national target and is below 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 for certain aspects of health services. 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 2025/26:

- 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 12 months	Mar-26	13,830	879,955	81,535	11,340	n/a	n/a
Estimated diagnosis rate for people with dementia (diagnoses as % of prevalence)	Mar-26	66.7%	66.3%	61.8%	63.0%	R	G
Inappropriate acute mental health out of area placements (beds)	Mar-26	0	276	20	<5	n/a	n/a
Severe mental illness (SMI) health checks %	Dec-25	60%	59%	57%	57%	R	A
Specialist community perinatal mental health access (YTD)	Mar-26	1,100	67,146	7,030	1,150	n/a	n/a
Talking therapies – number of adults receiving a course of treatment (rolling 12 months)	Mar-26	10,340	674,497	60,440	8,650	n/a	n/a
Talking therapies reliable improvement rate (month actual)	Mar-26	67%	68.7%	71%	73%	G	G
Talking therapies reliable recovery rate (month actual)	Mar-26	48%	48.4%	51%	51%	G	G

Note:

- Most Mental Health data published is rounded to the nearest 5 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 are at the same level as the South West region and below England as a whole but has improved in 2025/26 in line with the BSW operational plan.

Community talking therapies for adults has a nationally set target for growth in courses of treatment delivered, which is based on an estimated population need. The number of people who completed a course of treatment in 2025/26 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. Throughout 25/26 BSW ICB have utilised contractual levers to work with the provider to agree a recovery plan to meet the BSW target for 2025/26. Significant improvement across talking therapies metrics has been achieved, and during Quarter-4 25/26 the usage of contractual levers was formally closed.

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 2025/26.

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-26	75%	79.8%	76.4%	72.3%	R	R
Learning disability inpatients per million (adult)	Jan-26	28	45	-	42	G	n/a

Note:

- Numbers less than 5 cannot be reported as the patients may be identifiable.
- Children and young people's numbers 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 2025/26, and several 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 2025/26, 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.

Mental health expenditure

During this year, the ICB has embarked on pursuing and progressing the identified year one priorities of the BSW ICB Mental Health Strategy 2025-2030. Key areas of progress made include making significant strides in children and young people (CYP) trauma informed care; with Oxford Health NHS Foundation Trust leading a trauma conference resulting in a request for attendance and presentation at the Houses of Parliament. This good work has been furthered with the commission of further trauma informed support into CYP services, working collaboratively with our local authority colleagues. The ICB has also upheld its commitment to further expand the CYP Mental Health [school] Support Teams, with two additional teams launching in BaNES during January.

In addition to progress made for CYP, work has also been initiated to review the current memory assessment pathways across BSW. It is anticipated that the review will form the ICBs future commissioning intentions and work will continue into 2026/27 to ensure assessment and diagnosis pathways are fit for the future needs of our population.

The publication of NHS 10 Year Health Plan has also enabled the ICB to remain confident in its strategic priorities, furthering the commitments towards parity of esteem.

During 2025/26, the ICB mental health programme has undertaken competitive procurements in postvention services, individual placement support (IPS) as well as being a partner in the South West Regional procurement for crisis text services. Following the conclusion of each procurement, the ICB will welcome each of the new providers in to BSW, supporting them to ensure services are accessible and of high quality.

Whilst great strides have been made in a number of areas, improvement has been required in talking therapy services. Owing to the improvements required, the ICB utilised contractual levers to ensure the required level of senior oversight was involved in supporting service improvement, and we are pleased to confirm that significant positive change has been made in key metrics including access, waiting times, courses of treatment, as well as improvement and recovery.

In addition to talking therapy services, the ICB continues to work with providers to improve CYP access and will continue to hold enhanced oversight as system partners work to achieve national metrics.

Moving into 2026/27, a women's only crisis house will open in BSW, offering an additional bespoke service to the current crisis house provision. Added to this is the development of Neighbourhood Mental Health Centres through the NHSE four-year capital scheme.

During 2026/27 the ICB will work closely with strategic delivery partners and experts by experience to design the environments and new model of care, ensuring the provision is well planned to meet the needs of our population, offering wrap around mental health support in the community.

Close scrutiny of performance against national metrics will continue into 2026/27 to ensure improvements across both access, impact and outcomes.

Expenditure on mental health services and performance against the Mental Health Investment Standard can be seen in note 23 of the accounts on page 188 of this report.

Children and young people (CYP) safeguarding

BSW ICB, as a statutory safeguarding partner, is committed to working in collaboration with police and local authorities to ensure the people across our area are safeguarded. Safeguarding means protecting people's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. This is achieved through partnership working with all statutory and VCFSE 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 (2025), 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.

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

Throughout 2025–2026, the ICB Strategic Safeguarding Team has worked with partner agencies locally, regionally, and nationally to deliver the following:

- The implementation and rollout of the Child Protection Information Sharing System (CP-IS) to support timely safeguarding information sharing across health settings
- The implementation of ICON across the three Safeguarding Partnerships
- Collaboration with Safeguarding Partnerships, midwifery, and health visiting services to trial the GCP2 Home Conditions Tool. This initiative aims to assess the tool's effectiveness in supporting complex, vulnerable families after delivery and during the antenatal period
- The implementation of non-fatal strangulation guidance in emergency and radiology departments within acute trusts
- The safeguarding team has continued to strengthen its leadership and system-wide oversight of the Mental Capacity Act (MCA), ensuring that MCA principles are embedded across all relevant workstreams and that practice is continuously improved through collaborative efforts

The ICB continues to promote the voice and lived experience of children, adults at risk and their families within safeguarding arrangements, ensuring this informs service design, commissioning, contracts and evaluation.

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:

- 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 with governance arrangements. The NHS England Safeguarding Accountability and Assurance Framework states that Designated Professionals "must be consulted and able to influence at all points in the commissioning cycle from procurement to quality assurance. This will ensure that all services commissioned meet the statutory requirement to safeguard and promote the welfare of children, looked after children and adults requiring health services in BSW." The BSW ICB Safeguarding Transformation and Assurance Group (STAG) continues to provide oversight and scrutiny of the ICB's compliance with all aspects of safeguarding duties and responsibilities. Learning from local and national safeguarding reviews (including safeguarding adult reviews, child safeguarding practice reviews and domestic homicide reviews) is systematically captured and used to inform commissioning, quality assurance and service improvement. Further detail is provided within the ICB safeguarding annual reports for 2024–2025
- 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 Act.

As safeguarding practice evolves, in line with changes to both statutory and legislative developments, we continue our ongoing system-wide work to focus on self-neglect. We continue to work with partners in in Community Safeguarding Partnerships and influence future commissioning to support victims of violence.

BSW ICB has been working with local authorities and partners to align responses to new children and young peoples' reforms including Families First Partnership Programme, neighbourhood, and special educational needs and disability (SEND). The aim of this work is to ensure that we work collaboratively to address reform asks in the most efficient way.

Environmental matters

Introduction

The NHS produces around 5% of the UK's carbon emissions and about 3.5% of all road travel. This gives us a responsibility – and an opportunity – to lead on sustainable healthcare. Across Bath and North East Somerset, Swindon and Wiltshire (BSW), our partners have refreshed the BSW Green Plan (2025–2028) to set out what we will do next.

This section of our annual report explains our goals, the progress we've made, how we govern and manage climate-related risks, and how we measure our performance.

Our Green Plan (2025–2028)

Our refreshed plan sets out how we will deliver sustainable healthcare and support the NHS Net Zero ambition. It builds on the 2022–2025 Green Plan and ensures our sustainability priorities are embedded in how we plan, buy and manage NHS services, alongside wider system strategies shaped with patients and partners.

You can read the full Green Plan on our website Greener BSW - BSW Together. This Green Plan is part of the NHS England requirement for every ICB and trust to have a board-approved plan to support statutory emissions and environmental targets.

Targets and strategic objectives

We have aligned our targets for emissions we control as a system with national NHS Net Zero timelines:

- Emissions we control directly (scope 1 and 2): Net Zero by 2040, with an 80% reduction between 2028–2032.
- Emissions we can influence (scope 3): Net Zero by 2045, with an 80% reduction between 2036–2039.

These targets follow NHS-wide Net Zero commitments and the public sector approach to climate-related reporting in annual reports.

Progress to date

Working collaboratively with our system partners, we have made significant progress in delivering environmental sustainability initiatives across BSW. A selection of achievements to date include:

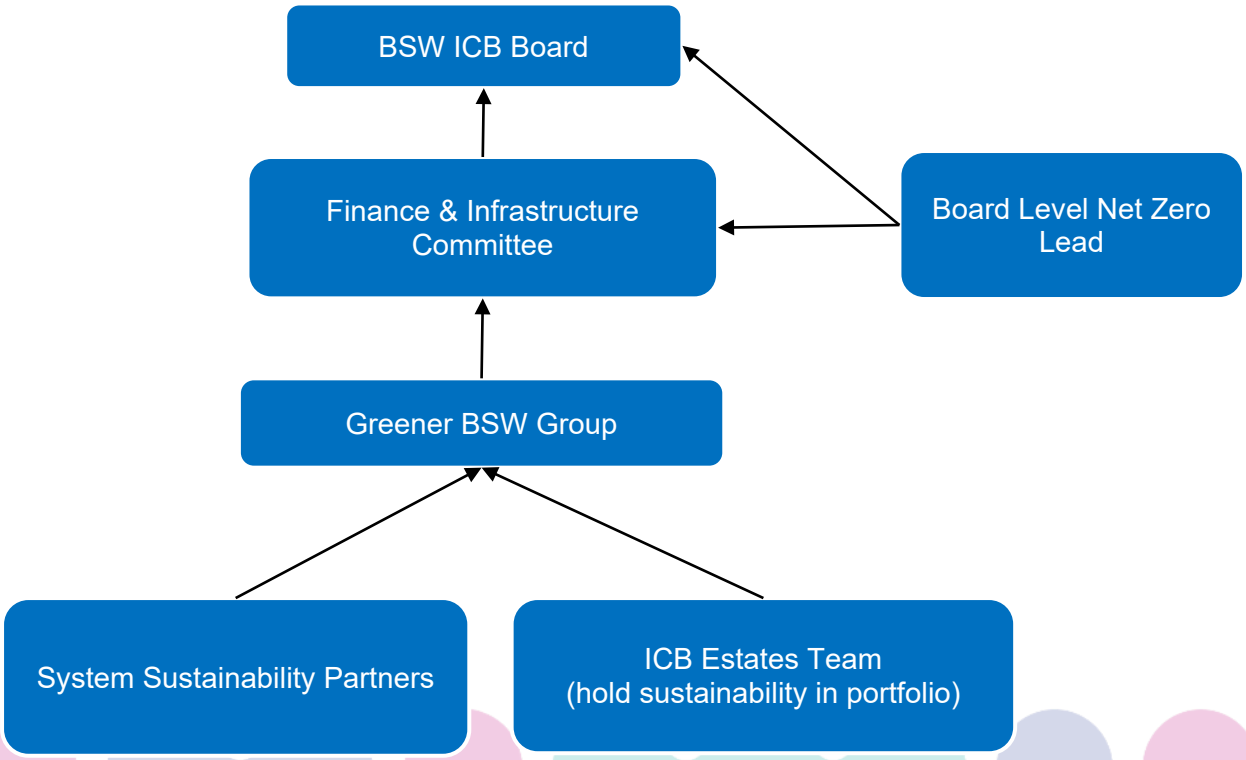
Delivery Area	Progress
Workforce and leadership	Hundreds of healthcare colleagues form part of green networks and working groups across BSW. NHS organisations have net zero board level leads.
Travel and transport	Air quality monitoring installed at SFT and RUH to improve on-site air quality.

Delivery Area	Progress
Supply chain and procurement	10% social value weighting is now mandatory in all NHS procurement tenders and suppliers are required to provide evidence to show they are aligned to our net zero goals.
Estates	Devizes Integrated Care Centre is the first net zero building with energy EPC rating of a+, which utilises green technology, such as heat pumps and solar panels, to generate energy and heat to serve the building, which opened in February 2023, and will soon be opening our next net zero Integrated Care Centre in Trowbridge in April 2026.
Digital transformation	Virtual outpatient appointments successfully rolled out where clinically appropriate. 21-23% outpatient appointments at SFT are delivered remotely.
Medicines management	Trusts have successfully stopped using desflurane across BSW. Achieved target of benchmarking in the lowest 10% for metered dose inhaler prescriptions compared to other regions.
Adaptation	BSW Hospitals Group have undertaken a climate risk assessment and are developing longer-term climate adaptation plans to increase climate resilience.

We will publish a short annual 'progress dashboard' alongside the Green Plan so the public can track change over time.

Governance

The refresh of our BSW Green Plan provided an opportunity to review our governance processes. As a result, we have strengthened our governance so there is clear accountability and regular oversight:



Individual / Committee	Function
ICB Chief Finance Officer	Board Level Net Zero Lead
ICB Board	Holds ICB to account for delivery
ICB Finance & Infrastructure Committee	Provides strategic oversight and escalation point
Greener BSW Group	Subject matter experts supporting delivery

Risk management

We use the ICB's Risk Management Framework to identify and manage strategic and operational risks for the organisation, including climate-related risks. Risk leads log a risk in our Decision Time system; the Executive Management Team and ICB Board review significant risks monthly.

At the time of drafting, there are no principal climate-related risks on the corporate risk register for the ICB, but this will be kept under review.

In 2026/27, we will perform an updated climate-risk review to consider whether specific climate risks should be promoted to the principal risk register, and we will explain any changes in the next Annual Report.

Taskforce Climate-Related Financial Disclosures (TCFD) reporting

Compliance requirement

The Department of Health and Social Care Group Accounting Manual set out a phased approach to incorporating the recommended Task Force on Climate-Related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

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

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

The Department of Health and Social Care requires NHS bodies to incorporate TCFD into their Annual Reports on a phased 'comply or explain' basis.

Our disclosures are structured under the four TCFD pillars: Governance, Strategy, Risk Management, and Metrics and Targets.

Graphic showing the 4 pillars of recommended climate related financial disclosures *Taskforce on Climate Related Disclosures*

ICB compliance statement

We comply with TCFD recommendations for:

- Governance: (a) Board oversight; (b) management's role
- Risk management: (a)–(c) processes to identify, assess and manage climate-related risks
- Metrics & targets: (b) reporting of relevant metrics. Scope 1 and 2

We partially comply with the TCFD recommendations for:

- Strategy disclosures (a) and (b) and will expand on our work in this area further in 2026/27 as described below

Our approach aligns with NHS sustainability reporting expectations for 2024/25 onwards, which expand the depth of TCFD reporting in NHS annual reports.

TCFD climate-related risk and opportunity reporting expectations

TCFD expects organisations to describe:

- Climate-related risks and opportunities over different time horizons,
- Their potential impacts on the organisation, and
- The resilience of the organisation's strategy, including scenario analysis

Time horizons (how we assess 'short/medium/long-term')

- **Short term (0–3 years):** operational impacts and quick-win decarbonisation (e.g., travel, office energy, care pathway changes)
- **Medium term (3–10 years):** estates investment cycles, procurement requirements, digital transformation at scale, adaptation works at priority sites
- **Long-term (10+ years):** major estates lifecycle decisions including site disposals, regional infrastructure dependencies (energy, transport), and structural supply-chain change

Key climate-related risks and opportunities

Transition risks (policy, legal, technology, market, reputation)
Policy and compliance: tighter national standards for public sector emissions and reporting could increase compliance workload and expose gaps if not addressed early.

- **Supply chain:** new supplier requirements (e.g., Net Zero Supplier Roadmap and carbon reduction plans) may constrain choice or increase costs in the short term but improve resilience over time
- **Reputation and engagement:** public expectation for visible progress; failure to deliver could affect confidence

Physical risks (acute and chronic)
Heat and extreme weather: hotter summers and more frequent heatwaves can disrupt care, reduce staff comfort and productivity, and affect IT and medical equipment performance.

- **Flooding and storms:** risks to access, business continuity and site operations; potential damage to buildings and equipment; impacts on community services and travel
- **Air quality:** ongoing risks to population health, with demand implications for services

Opportunities
Better care and efficiency: virtual care where clinically appropriate, lower-carbon pathways (e.g., inhaler optimisation), estates energy upgrades, and workforce travel changes.

- **Financial benefits:** reduced utility costs over time, better procurement value from low-carbon products, and access to targeted decarbonisation funding when available
- **Health and inequalities:** cleaner air, more active travel, and healthier homes improve outcomes – especially for deprived groups

Scenario analysis (how resilient is our strategy?)
We use a qualitative scenario screen and will progress to a more quantified analysis as data matures. We assess the resilience of our plans against two illustrative scenarios:

- **Scenario A:** Paris-aligned (≈1.5–2°C) – faster policy action; stronger transition pressures; physical risks moderate but manageable with adaptation
- **Scenario B:** High-warming (≈3–4°C) – slower transition; greater chronic heat and acute weather events; higher disruption and resilience costs

Preliminary findings
- Our estates strategy (new builds to Net Zero standards; heat pumps, solar PV) is resilient in both scenarios, with stronger benefits in Scenario A
- Care model changes (virtual clinics, pathway optimisation) remain beneficial in both scenarios – reducing travel emissions and improving access during disruption
- Supply chain dependencies are more exposed in Scenario B; we will increase engagement with key suppliers on resilience and low-carbon alternatives.

Potential financial and operational impacts
Operating costs: energy prices remain a volatility risk; energy efficiency and on-site generation mitigate this over the medium term.

- **Capital planning:** adaptation (cooling, shading, flood resilience) needs to be factored into lifecycle and business cases
- **Service delivery:** extreme weather may increase unplanned care demand and disrupt outpatient activity; our digital offer improves resilience

Strategic response (what we will do next)

Embed climate criteria in business cases and policies (e.g., carbon and climate-resilience checks).

- **Strengthen adaptation plans** across priority sites, aligned with estates investment cycles
- **Supplier engagement:** align with the NHS Net Zero Supplier Roadmap; monitor supplier transition plans
- **Improve data quality** for travel, energy and waste; develop a standard internal "sustainability dashboard"
- **Build capability:** targeted training for commissioners, finance, procurement and estates teams on climate risk and Net Zero delivery
- Report progress: provide clearer year-on-year commentary and cross-references in future Annual Reports

Metrics and targets

Alongside the Green Plan targets above, we publish the following operational metrics annually.

Mileage (staff claims)

Mileage has increased year-on-year, though zero-emission miles are also rising. We will aim to reduce overall miles by supporting virtual working and promoting active and public transport.

Category	Unit	2023/24	2024/25	2025/26
Petrol	Miles	83,485	108,331	105,367
	tCO^2e	22.0	26.4	27.6
Diesel	Miles	39,727	39,389	25,940
	tCO^2e	10.9	10.3	7.2
Zero-emission	Miles	7,811	11,622	9,406
	tCO^2e	0.7	0.9	0.6

Totals	2023/24	2024/25	2025/26
Mileage	131,023	159,342	140,713
tCO^2e	33.6	37.5	35.4
Cost (£)	77,373	86,359	80,897

Methodology: tCO^2e uses UK Government conversion factors for 2023–2026.

Other travel costs

Rail remains our main non-car travel cost. We will monitor taxi usage and promote lower-carbon options where practical.

Category	2023/24 costs (£)	2024/25 costs (£)	2025/26 costs (£)
Air	0	360	0
Bus	148	168	181
Taxi	598	451	362
Train	13,917	8,228	6,109
Total	**14,662**	**9,206**	**6,653**

Sustainable transport schemes

BSW ICB encourages staff to use sustainable travel, including an electric car lease scheme. In 2025/26, staff leased 14 electric cars. Since the scheme began in 2023, staff have leased 58 electric cars. Note that this scheme is currently paused due to the organisational change taking place within the ICB.

Paper use

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 increase recycling. In 2025/26, the ICB purchased 79 boxes of A4 paper at a cost of £1,574. This is a 43% reduction in the number of boxes purchased since 2023/24. A3 paper is not purchased.

ICT recycling

As part of the General Practice IT contract, we use Concept Management to recycle ICT waste.

Between 01/01/2025 and 22/12/2025 0.45 tonnes were recycled (66 items).

Note: this sits within a wider contract; separate costs are not identifiable.

Energy, water and waste (office sites)

The below figures relate to our office sites of Beacon House, Jenner House and St Martins. For 2025/26, the utilities information relating to Pierre Simonet has also been included, which has resulted in an increase in figures.

Category	Unit	2023/24 (Q1 – 4)	2024/25 (Q1 – 4)	2025/26 (Q1-4)
Electricity	KWh	293,791	67,687	171,003
	tCO^2e	61	14	27
	Cost (£)	76,942	21,084	50,417
Gas	KWh	284,694	162,434	195,538
	tCO^2e	50	29	36
	Cost (£)	22,338	12,557	13,885
Water	m3	2,401	3,549	879
	Cost (£)	7,069	10,452	4,871

Category	Unit	2023/24 (Q1 – 4)	2024/25 (Q1 – 4)	2025/26 (Q1-4)
Recovered waste	Kilograms	1,764	1,510	2,664
Recycled waste	Kilograms	3,087	1,765	3,838
Confidential waste	Kilograms	1,725	925	2,934
	Cost (£)	215	135	737

How this meets public sector reporting requirements

Our TCFD reporting has been expanded in line with HM Treasury's phased public sector guidance (governance, risk, strategy including scenario analysis, and metrics/targets), and with NHS sustainability reporting expectations for 2024/25 and beyond.

It also reflects NHS England Green Plan guidance, which sets the framework for ICB-level Net Zero planning and delivery.

Estates and infrastructure governance

The ICB recognises that safe, sustainable and well managed infrastructure is a critical enabler of high quality care delivery and system financial sustainability. The Board therefore maintains clear governance arrangements to oversee estates, sustainability and health and safety risks as part of its overall system of internal control.

Responsibility for estates and infrastructure oversight sits within the Board's established governance framework and managed through the Finance and Infrastructure Committee. ICB and Strategic system estates matters, including estate condition, capacity, utilisation and capital prioritisation, are considered through the ICB's system estates and capital governance arrangements, with escalation to the Board where risks are material or system-wide in nature.

The Finance and Infrastructure Committee receives assurance through exception reporting on:

- Estate performance, condition, and utilisation
- Progress against agreed capital and backlog maintenance priorities
- Significant infrastructure risks that may impact service delivery, safety or value for money

Where appropriate, estates related risks are reflected within the Board Assurance Framework and are subject to scrutiny through Audit Committee oversight.

Sustainability and net zero governance

In line with its statutory duties, the ICB has established governance arrangements to oversee delivery of its sustainability and net zero commitments. Accountability for environmental sustainability sits at executive level with the Chief Finance Officer and is supported by defined programme and reporting structures.

Progress against the ICB's Green Plan, including delivery of emissions reduction initiatives and management of climate-related risks, is monitored through the Board's governance framework through the Finance and Infrastructure Committee. Climate and sustainability considerations are incorporated into strategic decision-making, investment planning and risk management processes, and are reported publicly through formal sustainability and climate disclosures within the Annual Report.

Improve quality

Improving quality and safety

Under section 14Z34 of the Health and Care Act 2022, BSW ICB must act with a view to securing continuous improvement in the quality of services provided to its population. Throughout 2025–26, this duty has been discharged through strengthened quality governance, enhanced clinical insight, and targeted improvement programmes across the system.

The ICB continued to oversee quality across a wide range of services, including acute, community, mental health, primary care, and children's services. Quality and safety metrics aligned to contractual monitoring, provider quality reports, patient experience feedback, complaints, and regulatory intelligence informed continuous quality surveillance. Targeted interventions were initiated where identified, including enhanced monitoring via quality visits, deep-dive reviews, and development of collaborative multi-agency improvement plans.

Through the BSW system Learning and Improvement Group, the ICB and commissioned provider services identified learning from patient safety incidents, inquests, and national reports and used this learning to support quality improvement. The rollout of PSIRF (Patient Safety Incident Response Framework) also supported a more proportionate, compassionate, and learning-focused approach to incident management.

Quality Assurance and Improvement Framework

In April 2025, the BSW Integrated Care Board (ICB) approved a new Quality Assurance and Improvement Framework (QAIF), aligning fully with National Quality Board (NQB) guidance on quality governance and system quality functions. The framework strengthens system-wide oversight through a clear governance structure incorporating the System Quality Group, the Quality Outcomes Committee, and a suite of specialist subcommittees overseeing quality and patient safety. A central priority within the QAIF is the continued implementation of the Patient Safety Incident Response Framework (PSIRF), introduced across the system in early 2024.

To assess the effectiveness of these arrangements, an independent audit was carried out between September and October 2025. The review examined the design and operating effectiveness of BSW ICB's quality and patient safety governance, including alignment with the QAIF and NQB expectations. The audit concluded with an overall rating of significant assurance with minor improvement opportunities (amber - green), recognising strong governance structures, broad stakeholder engagement, and clearly defined system-wide metrics. The findings also highlighted areas for development, particularly in strengthening oversight of provider Patient Safety Incident Response Plans and monitoring the impact of improvement actions.

The audit identified several areas of good practice, including a well-defined tiered governance model with clear roles and accountability, broad representation across system groups supporting collaborative decision making, and targeted engagement by the Quality Team to gather frontline intelligence. Infection prevention and control (IPC) governance was noted as mature and well-established, supported by the BSW IPC and Microbiology Collaborative. The Integrated Patient Safety Learning and Improvement Group was recognised for effectively coordinating learning from incident investigations and monitoring resulting improvement work.

BSW ICB has now progressed all agreed actions arising from the audit and remains committed to sustaining improvements over the coming months. A full progress update will be provided as part of the refreshed governance structure, as BSW ICB formally clusters with Dorset and Somerset ICBs in 2026/27.

Using data to drive quality improvement

During 2025/26, we have enhanced our internal reporting capabilities by developing a bespoke quality-focused reporting product, to allow for targeted monitoring against the metrics within the quality framework. In collaboration with system partners, we have established a working process of data sharing across partners to enable a consistent and aligned mechanism for reporting and assurance. Alongside internal reporting, data is also reviewed and triangulated with the national NHS England Statistics.

Achievements and improvements

During the last year, we have worked collaboratively with stakeholders to support and monitor key improvement initiatives, including:

Working with Health Innovation England and a corporate partner to design and implement a standardised, evidence-based lower limb wound care pathway across Acute Hospitals, Community Services, and Primary Care within BSW, ensuring equitable and high-quality care regardless of patient location

Delivering safe care

Patient Safety Incident Response Framework (PSIRF)

The ICB has a statutory responsibility to ensure that the services it commissions are safe, effective, and focused on continuous learning and improvement in patient safety.

All healthcare organisations strive to ensure that people are not harmed while receiving care. However, it is recognised that patient safety incidents can occur. When they do, it is essential that there are robust, compassionate, and proportionate arrangements in place to support learning, improvement, and meaningful engagement with patients, families, and staff, as well as transparency across the wider health and care system.

In September 2022, the Patient Safety Incident Response Framework (PSIRF) was published, marking the transition away from the Serious Incident Framework. PSIRF represents a significant cultural shift, moving from a reactive, incident-focused approach towards one that prioritises systems thinking, learning, and improvement.

PSIRF sets out how NHS organisations should develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Under PSIRF, providers are required to develop and maintain a Patient Safety Incident Response Plan (PSIRP), which sets out how they will identify priorities for learning and respond proportionately to patient safety incidents.

ICB oversight and system support

The ICB plays a key role in providing oversight, assurance, and support for the implementation of PSIRF and provider Patient Safety Incident Response Plans across all commissioned services. This includes:

- Reviewing and assuring provider Patient Safety Incident Response Plans to ensure alignment with national guidance and system priorities
- Supporting providers to embed a learning-focused, just, and compassionate patient safety culture
- Maintaining system-level oversight of patient safety risks, emerging themes, and learning.
- Facilitating shared learning and improvement across the Integrated Care System (ICS)

Patient safety priorities

Analysis of local providers' patient safety response plans has highlighted the following key themes as system-wide safety priorities:

- Falls reduction
- Medication safety
- Management of the deteriorating patient
- Transfer of care
- Suicide prevention

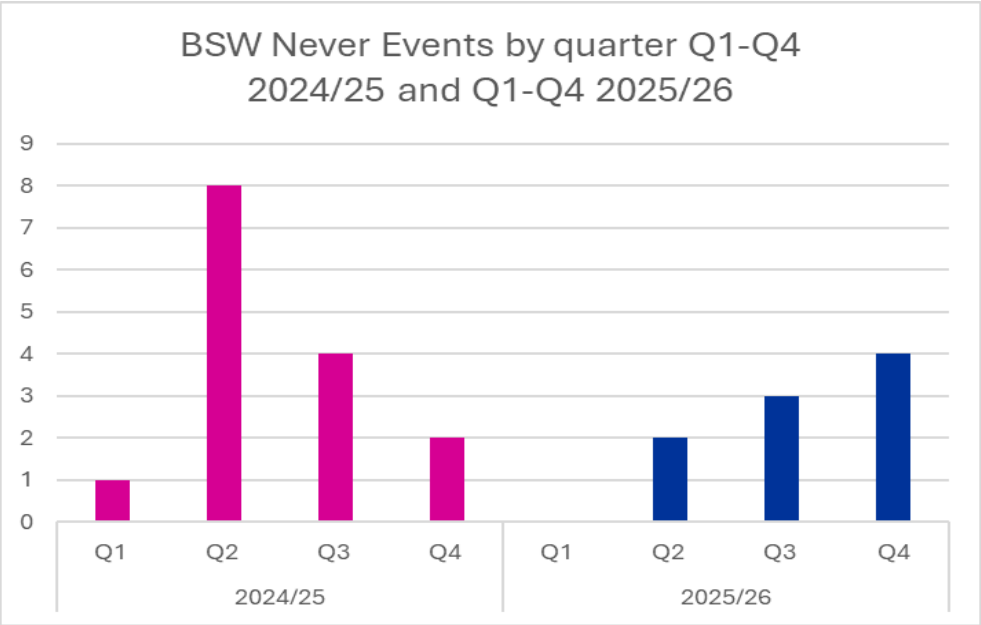
Reported patient safety incidents

Throughout 2025/26, BSW providers have continued to report Patient Safety Incident Investigations (PSIIs) to the Strategic Executive Information System (StEIS) as per NHS England National guidance. Work remains ongoing to ensure local risk management systems can support the latest 'Learn From Patient Safety Events' (LFPSE) software, which will enable incident reporting in line with Patient Safety Incident Response Framework (PSIRF) principles.

A total of 50 PSIIs were reported between April 2025 and March 2026.

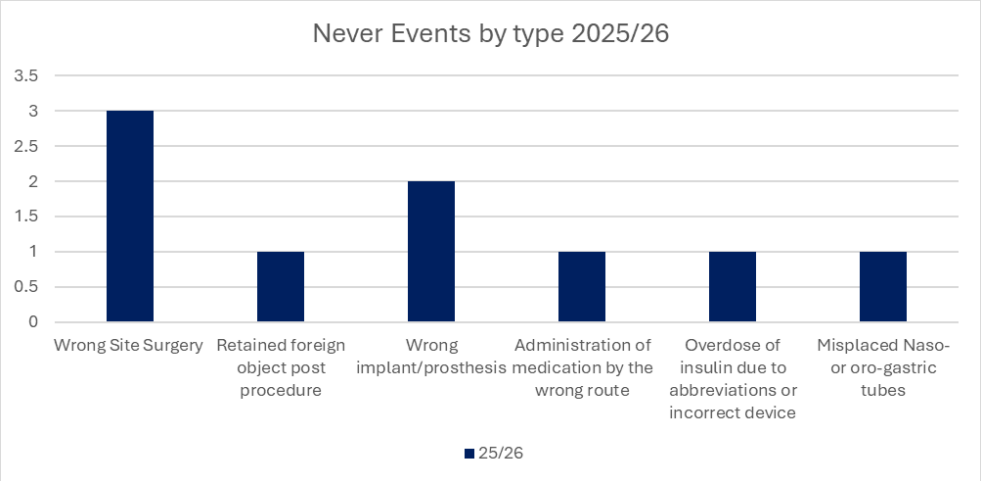
The total number of Never Events reported for the financial year 2025/26 was nine, which is a notable decrease compared to 2024/25 figures (15). (Graph 1)

A Never Event is defined by NHS England as "wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers."



Graph 1

Graph 2 shows the Never Events logged by type across BSW for 2025/26. Wrong site surgery is noted as the most logged Never Event type, followed by wrong implant/prosthesis.



Graph 2

BSW ICB has established robust system-wide governance and oversight arrangements to ensure Never Events are effectively identified, investigated, and acted upon. All incidents are subject to rigorous Patient Safety Incident Investigations (PSIIs), with clear action plans that are monitored to ensure learning is embedded and translated into sustained improvement. Systematic analysis of contributory factors such as communication failures, human factors, and non-compliance with safety protocols has informed targeted interventions, including strengthened monitoring of World Health Organisation (WHO) surgical safety checklist compliance and medication safety.

A cluster of Never Events identified in July 2024 was escalated through executive governance, with a formal post-event review completed and resulting actions being implemented collaboratively across providers. Ongoing assurance throughout 2025–26 continues to be maintained through robust monthly reporting, structured engagement with provider Quality Leads, and oversight via ICB governance forums.

In addition, the ICB has facilitated a coordinated, system-wide approach to learning, including the development of a joint submission and presentation from the three acute trusts to the South West regional Patient Safety 'Learning from Never Events' event in January 2025. This event aimed to bring together patient safety specialists to support shared learning, collaboration, and improvement across the region. Providers are also actively promoting training and engagement opportunities to strengthen safety culture within their organisations.

Following the 2024 national consultation on the future of the Never Events framework, and the publication of findings in September 2025, NHS England has signalled a shift toward a revised approach that places greater emphasis on system learning rather than the classification of incidents as wholly preventable. While the current framework remains in place, this direction aligns with BSW's focus on strengthening safety systems, embedding learning, and promoting a just culture.

Overall, these arrangements provide strong assurance that Never Events are subject to robust oversight, with learning consistently shared and coordinated action taken across the system to reduce variation, mitigate risk, and improve patient safety outcomes.

System-wide learning and improvement

To strengthen collaboration and system learning, the ICB established the BSW Integrated Patient Safety Learning and Improvement Group in May 2025. The group provides a system-wide forum for continuous learning, shared improvement, and the development of a consistent approach to patient safety across the ICS.

The group aligns with the NHS Patient Safety Strategy, the Patient Safety Incident Response Framework, and the BSW Quality Assurance and Improvement Framework, ensuring a coordinated and consistent approach to patient safety learning and improvement.

Since its first meeting in May 2025, the group has met bi-monthly and operates as a subgroup of the BSW System Quality Group, reporting into the ICB's Quality and Outcomes Committee and the BSW Partnership Board, providing assurance and visibility at system leadership level.

Membership has expanded to strengthen system integration, with South Western Ambulance Service NHS Foundation Trust (SWAST) and Health Hero joining the group.

System learning themes

System-wide learning discussed through the BSW Integrated Patient Safety Learning and Improvement Group has provided the ICB with valuable assurance regarding both areas of good practice and opportunities for further strengthening patient safety across commissioned services.

Key themes identified to date include:

Communication and coordination across care interfaces

Learning has highlighted the importance of effective communication and handover between organisations and professional groups. Providers are actively reviewing and strengthening their processes to support continuity of care and reduce the risk of fragmentation.

Recognition and escalation of clinical deterioration
The system has identified the need for consistent approaches to the timely recognition and escalation of patient deterioration. This has informed provider-level improvement work and system discussions to support clarity of roles, responsibilities, and escalation pathways.

Workforce capacity and resilience
Themes relating to workforce pressures and service capacity have been noted, with assurance gained that providers are identifying mitigations and incorporating these risks into their quality improvement and workforce plans.

Consistency in incident response and application of PSIRF
Variation in how organisations apply the Patient Safety Incident Response Framework has been recognised. The ICB is using this insight to provide targeted support, promote shared learning, and strengthen consistency in the application of proportionate, learning-focused responses to patient safety incidents.

Involvement of patients, families, and staff in learning
The importance of meaningful, compassionate engagement with patients, families, and staff following patient safety incidents has been reinforced. Providers are being supported to further embed these principles within their Patient Safety Incident Response Plans.

These themes are routinely reviewed through the ICB's quality governance arrangements and are being used to inform system priorities, provider oversight, and targeted improvement activity. This approach provides assurance that learning from patient safety incidents is being translated into tangible actions to reduce harm and improve patient outcomes across the Integrated Care System.

Patient safety in primary care

Quality assurance for primary care, pharmacy, optometry and dental services continues to be supported through collaborative monitoring arrangements between the ICB's Quality Team and the Quality and Patient Experience Team within the South West Collaborative Commissioning Hub.

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

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

Across BSW, there are 83 GP practices. One practice is currently rated as Inadequate, and all remaining practices are rated as Good or Outstanding.

The Quality Team continues to work closely with practices requiring additional support to meet the expected standards, providing oversight of individual action plans and evidence of improvement.

Mortality

In 2024 BSW ICB established a System Mortality Group. The BSW Mortality Group provides system-wide oversight of mortality trends by bringing together information from multiple

sources, including mortality metrics, Structured Judgement Reviews, incident reporting, legal and coroner feedback, and national clinical audits. This triangulated approach supports early identification of emerging themes and helps ensure that patterns in mortality are monitored consistently across all providers.

During the year, a temporary coding backlog at one acute provider affected the completeness of some data. This has since been addressed, and the group has used the experience to strengthen wider system learning particularly around shared coding processes and the value of using alternative data sources when coding information is less reliable. Strong engagement from clinical leaders, public health teams and regional colleagues continues to support a mature and collaborative approach to assurance across the system.

A range of workstreams are in place to enhance mortality oversight and drive improvement. These include strengthening how mortality intelligence is combined across national audits, incidents, safeguarding, maternity services and Structured Judgement Reviews, ensuring a fuller understanding of developing themes. The group is also refining its approach to thematic learning in areas such as cardiovascular, respiratory and neurological care, moving toward more focused priorities that can support meaningful change. In maternity and neonatal care, improvement activity continues through strengthened reporting, early warning tools and initiatives such as pre-term optimisation and smoking reduction. Work also continues to explore how analytical tools, including Artificial Intelligence (AI), might support better identification of mortality trends where existing data structures are limited.

All acute trusts contribute regularly through the Summary Hospital-level Mortality Indicator (SHMI) updates, triangulated intelligence and active participation in improvement discussions, demonstrating strengthened engagement across the system.

BSW, Somerset and Dorset are also exploring the development of a shared Cluster Mortality Group to create a more consistent and collaborative model across the three systems. The intention is to balance governance with a stronger focus on improvement, concentrating on shared priorities such as reducing premature mortality and strengthening learning across organisational boundaries. A cluster-wide approach is expected to support more aligned reporting and information sharing, particularly with public health, Medical Examiner offices and primary care, while helping to reduce duplication and establish a clearer regional framework for mortality oversight.

Medical Examiner Service

The Medical Examiner (ME) service plays an important role in supporting mortality assurance across BSW. The statutory phase of the ME system has now been in place for over a year, with high scrutiny rates and positive engagement from families and clinicians. Although ME data currently focuses mainly on activity such as numbers of cases reviewed or referred to the coroner the group acknowledges that the absence of a national case management system limits the ability to extract richer learning from reviews.

Challenges also exist around the sharing of thematic insights and ‘soft’ intelligence, particularly for community deaths, where information may go back to individual GP practices rather than feeding into a system-wide learning process. The mortality group is exploring local solutions to strengthen the flow of ME learning, including meeting directly with ME offices to establish more consistent mechanisms for sharing themes and enhancing system-level oversight. Future

national developments, including the appointment of a new National Medical Examiner, may also support improved data quality and reporting over time.

Patient Experience

The NHS Patient Experience Framework defines the essential elements of what patients should expect from NHS services by emphasising respect, dignity and personal values, alongside the importance of effective communication, emotional support, involvement in decision-making, and continuity within the care environment. This nationally recognised framework provides a consistent foundation for evaluating patient experience across England and supports organisations in assessing how effectively services deliver high-quality, person-centred care.

This framework underpins how BSW ICB evaluates, monitors and improves patient experience across all care settings, ensuring that the voices, needs and lived experiences of local people remain integral to quality improvement and system development.

Friends and Family Test

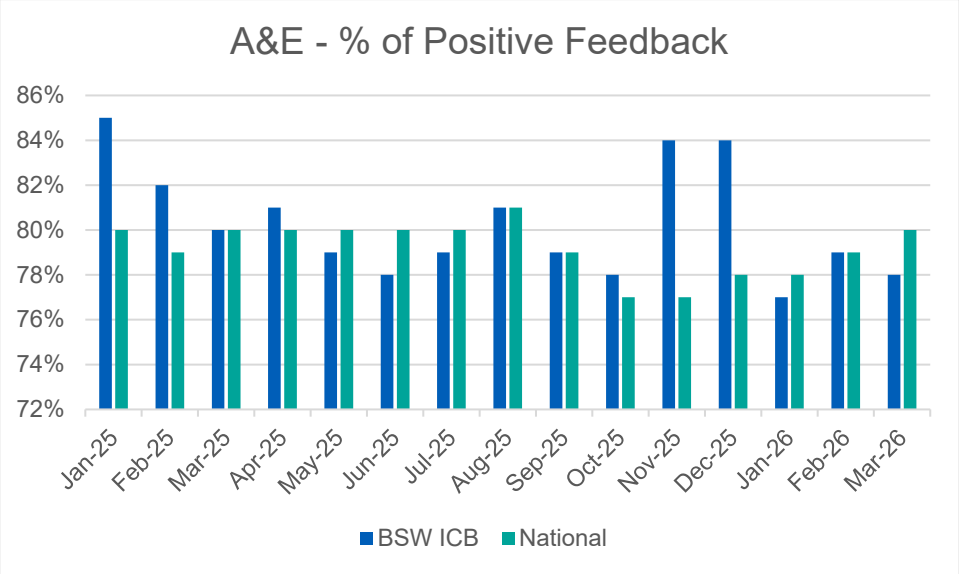
The Friends and Family Test (FFT) is an important tool that ensures people using NHS services have the opportunity to share their views about their care. By listening to the experiences of patients and staff, the NHS can better understand what is working well and where improvements may be needed.

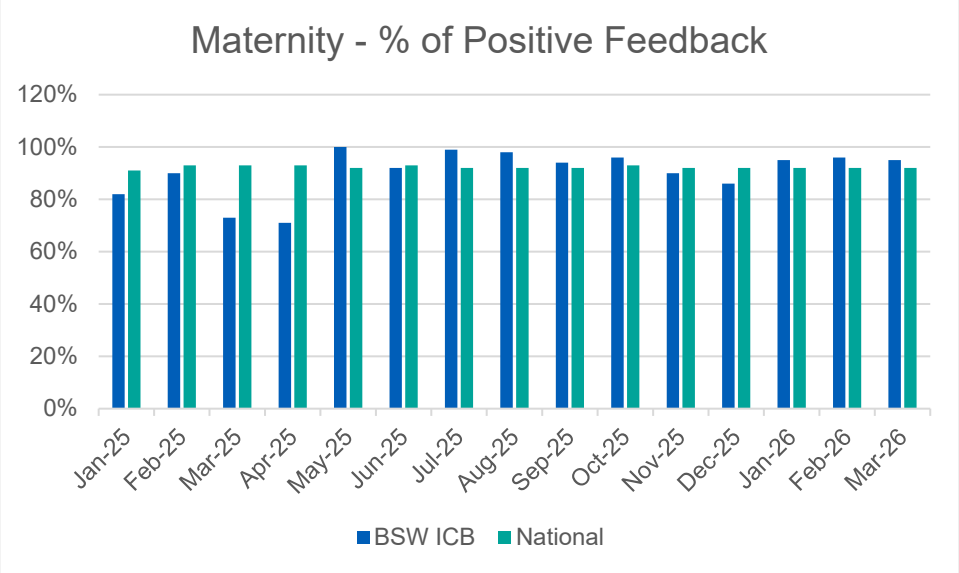
All providers across BSW use the Friends and Family Test as part of their commitment to continuous improvement.

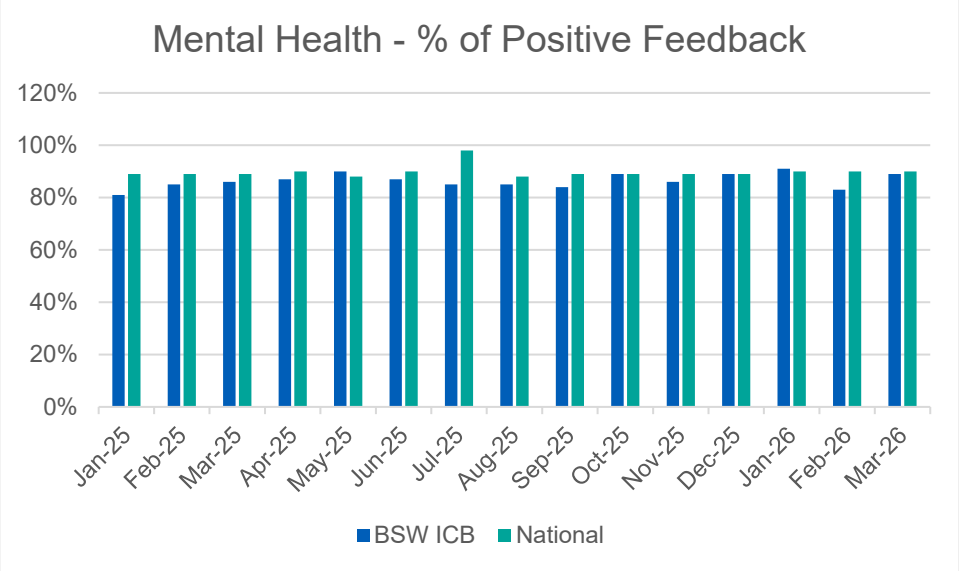
Overall, the ICB's response rates are broadly in line with national figures. Notably, maternity services, A&E departments, and outpatient areas all continue to perform above national averages. During 2026/27, the ICB will maintain a particular focus on improving response rates in local inpatient settings.

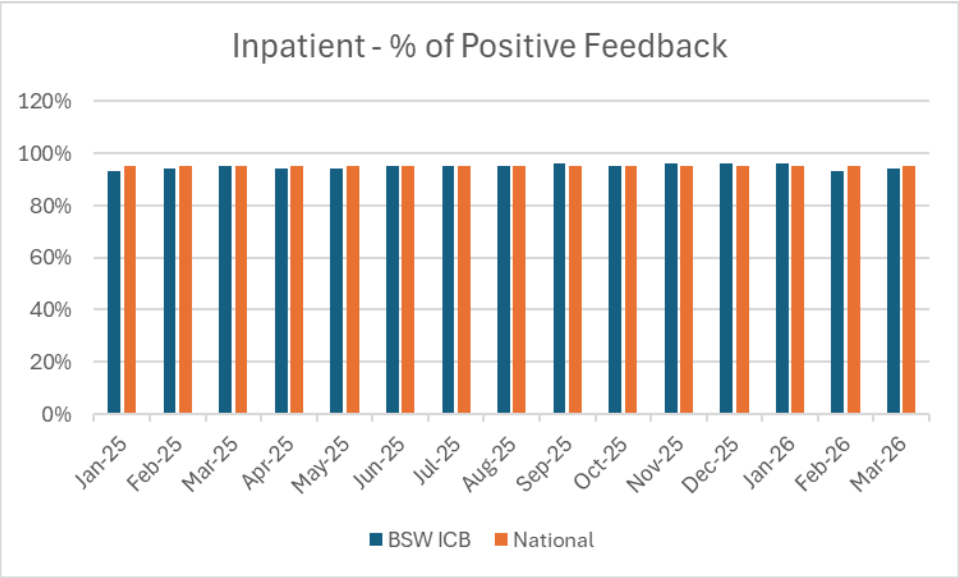
The ICB remains committed to understanding and responding to patient needs. We actively promote a culture that seeks feedback and uses people's experiences to shape the commissioning and delivery of services.

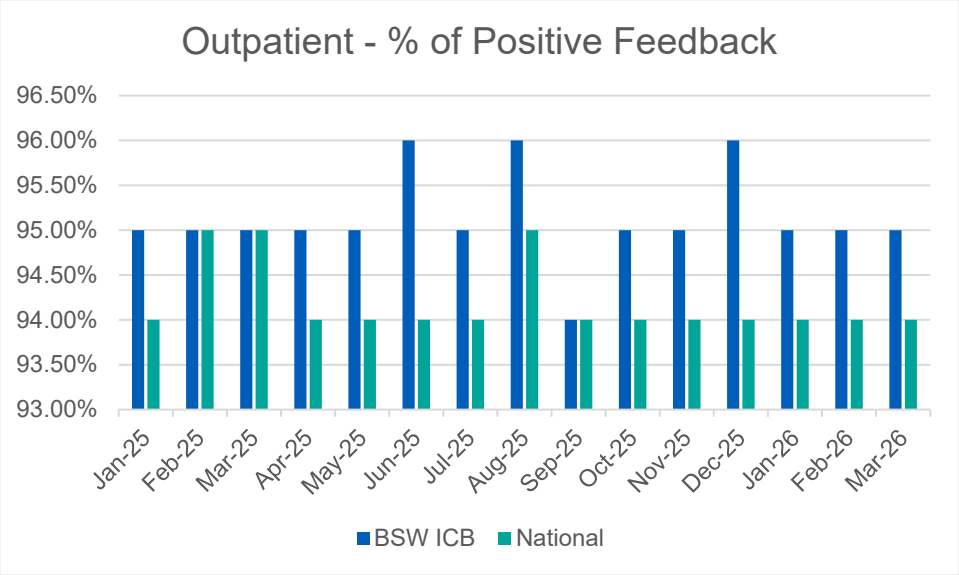
The graphs below summarise the responses received from local providers and illustrate the percentage of respondents who would recommend the service to their family or friends.


A&E - % of Positive Feedback
86%
84%
82%
80%
78%
76%
74%
72%
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
BSW ICB
National


Maternity - % of Positive Feedback
120%
100%
80%
60%
40%
20%
0%
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
BSW ICB
National


Mental Health - % of Positive Feedback
120%
100%
80%
60%
40%
20%
0%
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
BSW ICB
National


Inpatient - % of Positive Feedback
120%
100%
80%
60%
40%
20%
0%
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
BSW ICB
National


Outpatient - % of Positive Feedback
96.50%
96.00%
95.50%
95.00%
94.50%
94.00%
93.50%
93.00%
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
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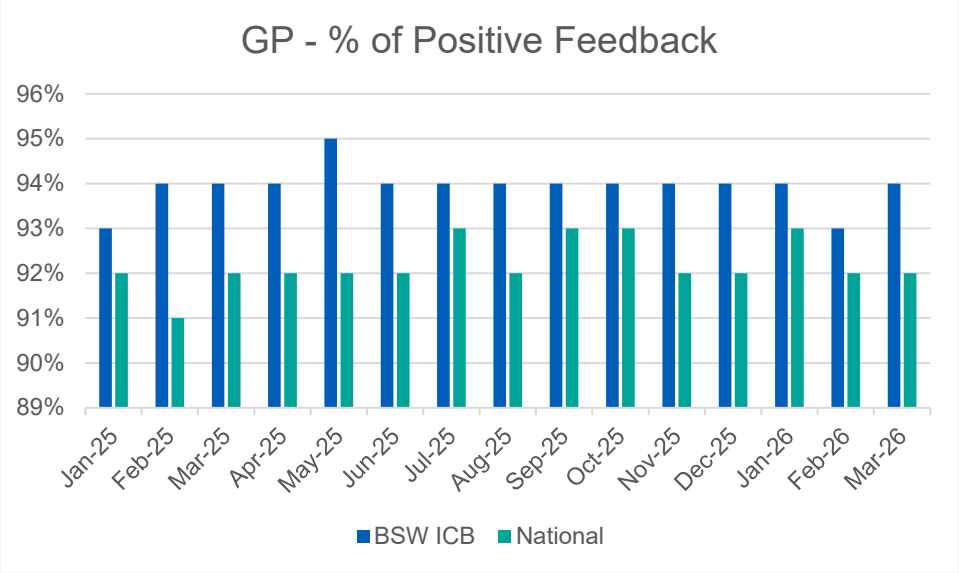
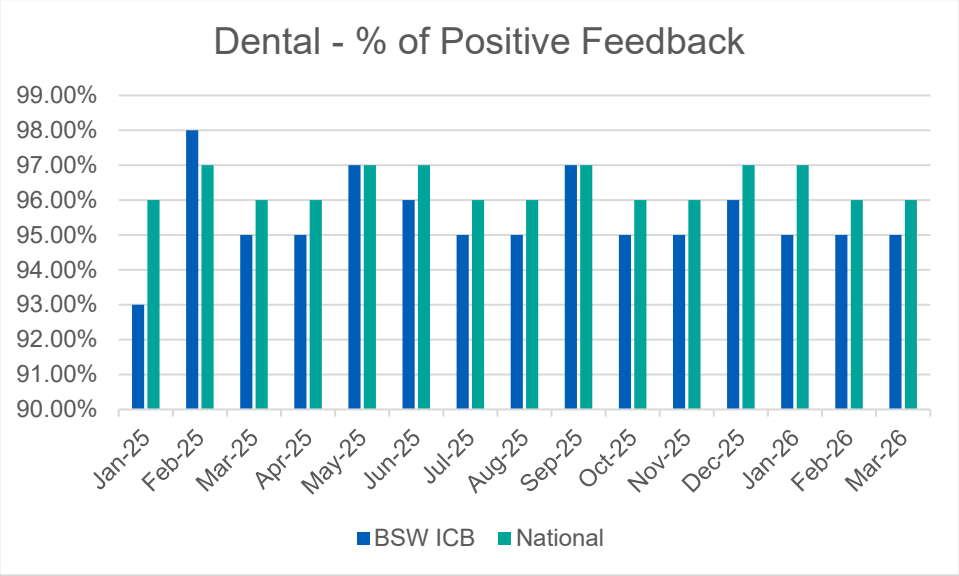
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
BSW ICB
National


GP - % of Positive Feedback
96%
95%
94%
93%
92%
91%
90%
89%
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
BSW ICB
National



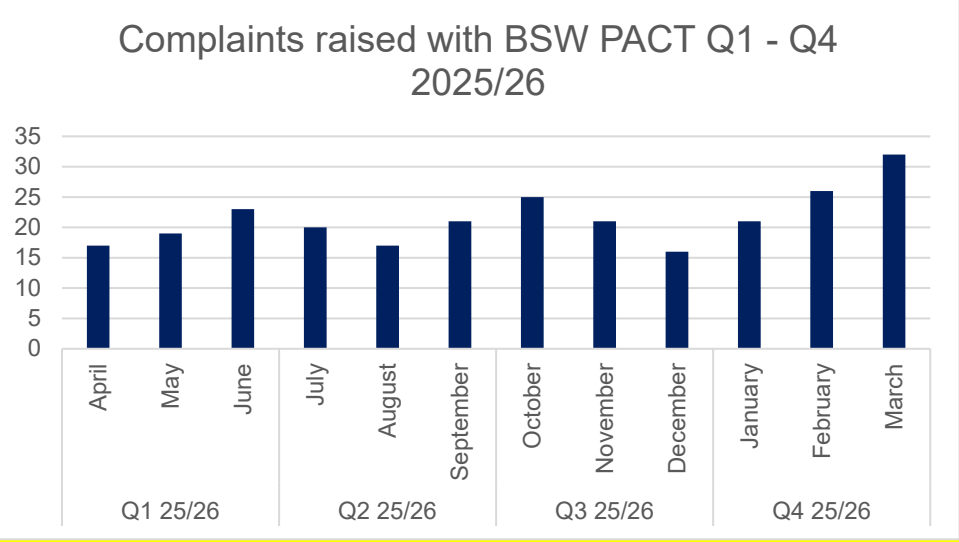
The Friends and Family Test is one of a number of feedback mechanisms that helps by providing a helpful picture of how people feel about the care they have received within health services. Services such as GP practices and outpatient clinics receive consistently good levels of positive feedback. Feedback for A&E and inpatient services also remains encouraging overall, with A&E improving towards the end of the year. Some areas, including maternity, mental health and dental services show lack of consistency, with periods of very positive feedback alongside times where patients felt less satisfied. These patterns help highlight where services are already doing well and where more focused improvements can make a difference, which will remain a focus for 2026/27.

Complaints and concerns raised with PACT

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

Complaints

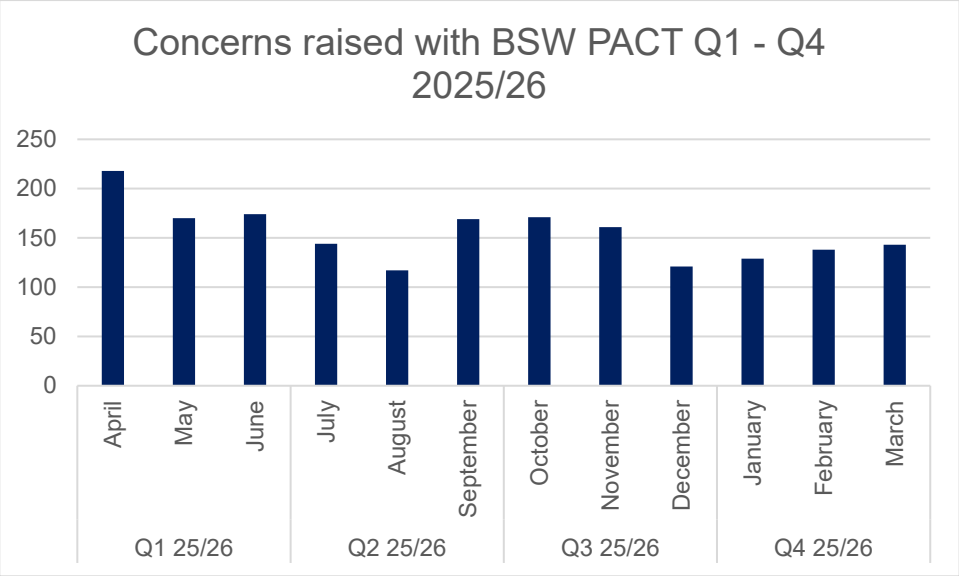
The table below shows the total number of formal complaints received during the period April 2025 to March 2026.



The top complaint themes identified for 2025/26 were waiting times and quality of care provided, specifically from acute hospital settings across BSW. Complaints relating to GP (primary care) closely followed, with themes noted as clinical care and access, and waiting.

Concerns

The table below shows the total number of concerns received during the period April 2025 to March 2026.



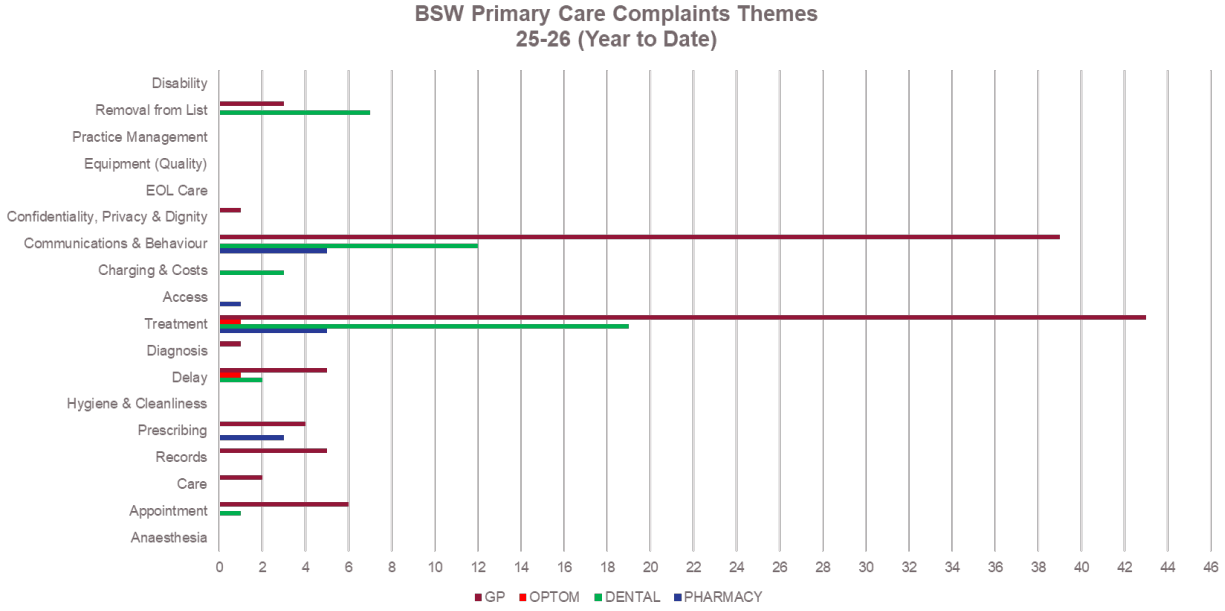
The top concern themes identified for 2025/26 were in relation to learning disability, autism and neurodivergent (LDAN) and attention deficit hyperactivity disorder (ADHD) letters, the Spring COVID-19 booster programme with the vaccination service, and access to NHS dental treatment.

BSW ICB and SCW PACT have strong working relationships and meet monthly to discuss themes and trends, which are onward shared through the appropriate quality governance channels.

Complaints in primary care, pharmacy, optometry and dental (POD)

KO41 data for 2025/26 is not currently available; however, quarterly reported data indicates that complaint numbers across primary care services have remained broadly stable.

Primary care and POD complaint themes



The top themes for complaints related to primary care services are communications and behaviours, and treatment. BSW ICB continues to work with the South West Central Commissioning Hub to address identified themes with a view to this work being progressed at system level.

Clinical effectiveness

Clinical effectiveness remains a core component of the Integrated Care Board's statutory duty to secure continuous improvement in the quality of services commissioned for the Bath and North East Somerset, Swindon and Wiltshire population. The ICB is committed to ensuring that care provided across the system is evidence-based, outcome-focused, equitable and represents best value for patients and the wider system.

Clinical effectiveness is underpinned by the systematic application of evidence, clinical guidelines and robust governance processes, alongside active clinical engagement, audit and benchmarking. This approach supports improved patient outcomes, reduces unwarranted variation, avoids ineffective or low-value interventions and promotes the best use of finite NHS resources.

Clinical policies and evidence-based decision-making

During 2025/26, the ICB continued to use clinical policies as a key mechanism for embedding evidence-based practice across care pathways. Clinical policies set clear thresholds and criteria for access to interventions where there is known variation in practice, evolving evidence or significant cost impact. Policies are developed collaboratively with clinical experts and stakeholders and are supported by equality and quality impact assessments (EQIAs).

Key policy updates during the year included:

- Clarification of access thresholds for abdominoplasty/body contouring, reflecting increased demand associated with weight loss medications

- Amendments to botulinum toxin for anal fissure to allow a second injection, supporting conservative management and reducing surgical risk
- Updates to grommet insertion to reduce repeat general anaesthesia in children
- Alignment of hernia repair policy to emerging evidence, particularly to reduce emergency presentations in women
- Development of a new rhinophyma policy following identification of a defined cohort

All revised policies were approved through the established governance process, including the Clinical Policies Working Group and Policy Review Group, and formally signed off at executive level. Policies were subject to 30-day contractual notification prior to implementation and were communicated to providers and primary care.

Standardised governance and policy development

The ICB continued to apply a robust standard operating procedure (SOP) for policy development and review. This includes systematic evidence review, activity and financial analysis, provider engagement, assurance through equality impact assessment, and formal sign-off processes. Criteria-based access policies are routinely added to the audit programme to support ongoing monitoring of effectiveness and compliance.

Clinical policies are published transparently via the ICB website and communicated through GP newsletters and contracting routes, supporting system-wide understanding and adherence.

Prior approval, audit and compliance

Prior approval processes remain central to ensuring that interventions are delivered in line with agreed clinical thresholds. During 2025/26, enhanced scrutiny of policy compliance continued, recognising the significant financial and clinical risk associated with unwarranted variation and non-adherence.

Benchmarking data and provider-level compliance intelligence are routinely reviewed to identify outliers and emerging risks. Where variation is identified, this is investigated with clinical input and addressed through audit, targeted engagement or contractual mechanisms.

Vaccination programme

BSW has continued to deliver consistently high levels of vaccination with more than 480,000 vaccinations delivered as part of the seasonal winter vaccination campaign in 2025, with a combined approach from GP practices, community pharmacies as well as community and hospital providers.

During the last 12 months, the vaccination delivery model has evolved further, with a sustained core offer from GP practices and community pharmacies, as well as a new outreach delivery contract provider. The three local acute trusts, along with community trusts, continue to deliver vaccinations to their staff, long-stay inpatients and pregnant women.

Seasonal vaccination programme

Covid-19, flu and respiratory syncytial virus (RSV) vaccinations have been consistently delivered across BSW through GP practices, community pharmacies, acute trusts and community trusts, with support from the community outreach vaccination provider. Prioritisation as always is to the most vulnerable population in care homes and those who are housebound.

Flu vaccinations for two and three-year-olds were again delivered early in the season to reduce the risk of transmission to more vulnerable relatives, and for the first time offered in community pharmacies. 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 all eligible cohorts.

Reducing inequalities

The outreach vaccination team has strengthened partnership working with local authorities and voluntary, community, faith and social enterprise (VCFSE) organisations to proactively reduce inequalities in access to vaccination. Delivery has been increasingly targeted, with tailored clinics and engagement designed around the needs of specific communities and supported by a broader Making Every Contact Count (MECC) offer.

The service has expanded its reach and range of settings, improving access for underserved groups, including those in substance misuse services and women's refuges. Innovative approaches, such as family clinics in libraries and nurseries, have supported improved vaccine confidence and uptake, with positive feedback and improved uptake and there are plans to expand this work further still.

The team also demonstrated flexibility by extending flu vaccination to care home staff and domiciliary care workers in workplace settings, engaging around 40% of care homes and delivering 292 vaccinations across BSW.

Working in partnership with current hypertension project workstreams to broaden vaccination delivery and associated education across wider CORE20PLUS5 population groups as well as VCFSE and local authority initiatives/project work across BSW.

Outbreak response and community engagement

The Outreach Vaccination Service has continued to deliver community engagement activities to a wide range of groups across BSW over the past year. This work focuses on building relationships with VCFSE organisations, provider organisations, and with communities who experience health inequalities and have lower rates of vaccine uptake. The team offers engagement conversations at all events that it attends and shares literature, links and other information to promote factual, accessible vaccine information across the lifespan.

Over the past 12 months the team has had a particular focus on engagement with the parents of pre-school aged children and childcare providers, substance misuse service-users and service providers, care home staff, homeless population and foodbanks and community pantries and the people who access them. The Outreach Vaccination Service also routinely attends community events such as Uniformed Service Day, celebration events arranged by faith groups and global majority communities, community events in lower Index of Multiple Deprivation (IMD) areas and health events.

Infection prevention and management

The ICB continued to lead and coordinate systemwide work to prevent and control infections across local health services during 2025/26. The ICB's role is to ensure that strong processes are in place to protect patients, reduce the risk of healthcare associated infections and support safe, high-quality care.

Throughout the year, the ICB's infection prevention and control (IPC) specialists provided oversight of IPC arrangements across the system. This included reviewing national guidance, ensuring consistent implementation, and monitoring emerging risks. Regular assurance activity helped maintain safe standards and supported early identification of issues.

The ICB's IPC specialists continued to monitor national infection indicators and local intelligence to identify trends and guide improvement. Information from UK Health Security Agency epidemiology services strengthened planning and highlighted potential risks, enabling timely system responses. As part of this work, the ICB also monitored performance against infection control thresholds set out within the NHS England Standard Contract and the National Oversight Framework, ensuring system performance remained aligned with national expectations.

UKHSA has published the 2025/26 end-of-year figures for reportable healthcare associated infections (HCAI) for BSW ICB. The data indicate that, at system level, BSW has breached the five HCAI thresholds set by NHS England. However, the overall position shows a stable or improving trend in four of the six reportable HCAI metrics (noting that thresholds are only set for five of the six infections). Despite threshold breaches, BSW continues to perform strongly in both regional and national benchmarking. Further detail and a full breakdown of all mandatory reportable infections will be provided in the Infection Prevention and Control 2025/2026 Annual Report. Learning from post infection reviews and incident investigations supported a shared understanding of where improvements were needed and informed future actions.

The ICB's IPC specialists supported primary care through quarterly educational webinars and monthly drop-in sessions, helping to promote consistent infection prevention practice across general practice. Work during 2025/26 also included a focus on reducing inequalities, with targeted IPC engagement to improve awareness and promote safe infection prevention practices within rural communities.

During periods of increased seasonal pressure, including outbreaks of norovirus and respiratory infections, the ICB worked with system partners to maintain patient safety and minimise disruption. This included supporting risk assessments to manage infection risks while maintaining patient flow.

The systemwide Infection Prevention and Management Collaborative continued to drive improvements during 2025/26. Collaboration with provider organisations and wider system stakeholders remained central to this work, enabling shared learning, consistent approaches and coordinated action across the health and care system.

More effective ways of working
The CHC team has introduced improved booking, scheduling and workflow processes, enabling assessments to be planned more effectively and capacity to be used more efficiently.

Maternity and neonatal

Throughout 2025-2026 BSW Local Maternity and Neonatal System (LMNS) have continued to ensure that the ICB has oversight of safety and quality outcomes and continued improvements within local maternity and neonatal services.

Maternity and neonatal providers within BSW continue to focus on quality improvements to reduce inequalities in care and to improve outcomes for pregnant women and babies within our area.

Perinatal quality and safety surveillance

The ICB Local Maternity and Neonatal system within BSW has continued to bring together all key stakeholders including Maternity and Neonatal Voices Partners (MNVP) Leads, who represent service users, to work collaboratively to implement the mandated and recommended changes that were set out in the national three year plan for maternity and neonatal services in 2023, in addition to other locally-identified actions.

All maternity and neonatal providers have continued to implement best practice care in line with NHS England Saving Babies' Lives Care Bundle and the NHS Resolution Maternity Incentive Scheme for Trusts. Achievement of these standards support safer outcomes for mothers and babies to reduce the risk of stillbirths, neonatal baby deaths and deaths of mothers. Assurance on progress with compliance is provided by the ICB and Local Maternity and Neonatal system.

Recognising that premature births contribute significantly to the national neonatal death rate, providers have continued to focus on reducing premature births through evidence-based pathways in line with national guidance that identify women at risk of early birth and provide additional surveillance during pregnancy.

The latest report (2021-23) shows a maternal death rate nationally of 12.82 per 100,000 maternities. In 2025 there were four maternity deaths reported in BSW.

BSW Maternity and neonatal teams have continued to focus on providing premature babies with 10 evidence-based interventions that improve their neurological development and health. This increases their chance of a healthy future life and reduces the risk of neurodevelopmental delay and physical health problems.

Babies that require additional care after birth are supported to remain with their parents wherever possible, with increased provision of transitional care in maternity and neonatal units over the past year in line with the national ambition to reduce separation of mothers, partners and babies. BSW has continued to maintain reduced admission to neonatal units and is below the 5% regional target.

Neonatal Units in BSW have continued to support family integrated care (FICare) which is a model that actively involves parents as integral members of the care team in neonatal intensive care units promoting better outcomes for both infants and families.

There has continued to be a focus on ensuring safe and timely access to maternity services throughout the pathway of care including electronic self-referrals and improvement of triage services which support early identification of pregnancy concerns or complications.

Listening to pregnant women, partners and families and making improvements

BSW ICB, Local Maternity and Neonatal System and maternity and neonatal providers in BSW continue to listen to women and families supported by the Maternity and Neonatal Voices Partnership Leads who are pivotal strategic partners with services. The MNVP leads continue to work closely with maternity and neonatal teams and are embedded within maternity services governance and strategic leadership teams to ensure that service user and families voices are driving service changes to meet the needs of the service users. The MNVP leads ensure that

engagement with a diverse range of service users takes place, including with military families within BSW, young parents, boating communities, migrants and asylum seekers.

Improvements to services have included clear signage within hospitals ensuring ease of access to maternity services, parents' hospital information packs, updated information resources for parents, and service user experience included in all maternity and neonatal training.

During 2025/26 BSW continued to participate in the national pilot of the Maternity and Neonatal Independent Senior Advocate (MNISA) role. This role provided independent advocacy support for families who had experienced an adverse outcome during their pregnancy or birth and was piloted in response to a recommendation from the Ockenden Report. The role supported families to navigate NHS investigation processes and, when required Coroners Inquests, providing information, support and advocacy. A national evaluation of this pilot has been completed with families positively recognising the value and impact of this role. The national pilot closed in March 2026, awaiting the recommendations from the National Maternity Independent Investigation that is currently taking place led by Baroness Amos and subsequent actions that will be identified by the planned future Maternity and Neonatal Taskforce.

Maternity and neonatal outcomes

	National ambition	BSW residents stabilised and adjusted rate	Notes
Stillbirth rate	2.5 per 1,000 births	3.10 per 1,000 births (2023*)	Within 5% of UK average of 3.22 per 1,000
Neonatal death rate	1 per 1,000 live births	1.41 per 1,000 births (2023*)	3-15% lower than UK average
Severe brain injury	No agreed national benchmark	Data not available at time of publishing	
Preterm birth rate	6%	Data not available at time of publishing	England average 6.3%

CQC maternity survey

	Maternity provider	Royal United Hospital, Bath	Great Western Hospital, Swindon	Salisbury Hospital
	Response rate	156 (51% response)	124 (41% response)	130 (45% response)
Comparison to other trusts	**Start of care in pregnancy**	Better than expected	About the same	About the same
	During pregnancy	Better than expected	About the same	About the same
	Labour and birth	About the same	About the same	About the same
	Staff caring for you	Better than expected	About the same	About the same
	Care in hospital after the birth	About the same	About the same	About the same
	Feeding baby Triage			

All maternity services have reviewed their results with the Maternity and Neonatal Voices Partnership Leads and co-produced actions for continued improvements during 2026/2027. In line with national results the area that is identified for improvement is care provided after birth (postnatal care). This will be supported by the recently published NHS England Postnatal Improvement Toolkit throughout 2026/27.

Preventing ill health and reducing inequalities in healthcare outcomes

Maternity services have continued to improve data collection relating to inequalities in outcomes in maternity care to support targeted actions to reduce inequalities in care and outcomes. This has included trials of the use of translation devices that support real time communication between staff and service users, implementation of a 'Passport' that supports service users who do not speak English as a first language to immediately access face to face services for any concerns, and a translation toolbar on all three maternity provider websites supporting translation of available information.

Smoking in pregnancy

Smoking in pregnancy increases the risk of pre-term births, stillbirths, neonatal deaths and low birthweights of babies.

BSW has seen a continued reduction in the number of women who smoke during pregnancy with the rate of smoking at the time of birth having halved since 2017 to below 5%.

This has been supported by the specialist maternity smoke-free teams, provision of maternity incentive voucher schemes, NHS England Treating Tobacco Dependency funding and implementation of all interventions in Element 1: Smoking in pregnancy of the NHS England Saving Babies' Lives Care Bundle.

Digital

A single maternity electronic patient record system has been implemented across all three maternity providers within BSW. This system provides an electronic portal for maternity service users to access their electronic records, access information and receive notifications. This also supports improved data collection for maternity services and easier transition of maternity records when service users move to other providers.

Perinatal pelvic health

The perinatal pelvic health services continue to receive positive feedback on patient experience of the service across BSW. Early interventions support the ongoing quality improvement work within maternity services to prevent pelvic health problems associated with pregnancy and birth and facilitate identification of problems to speed up access to specialist care in a timely way to prevent long term incontinence issues.

Maternal mental health

Service users continue to be able to access maternal mental health services which provide psychological interventions for women who experience trauma, grief or anxiety during pregnancy and birth, with very positive outcomes reported following treatment.

NHS Continuing Healthcare (CHC)

The Integrated Care Board (ICB) has a statutory responsibility to assess eligibility for, and fund, NHS Continuing Healthcare (CHC) for adults with the highest levels of health need. CHC ensures that individuals receive the right care, at the right time, in a way that supports their dignity, independence and quality of life.

Our responsibilities are delivered in accordance with the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (2022), which sets out how ICBs, working closely with local authority partners, should assess need and commission care using best practice that is fair, consistent and person centred.

Performance and delivery during 2025/26

During 2025/26, delivery of CHC assessments against national timescales remained a significant challenge. While the national expectation is that assessments are completed within 28 days, performance fell below this standard, with 60% of assessments completed within the required time.

We recognise that delays can be worrying and frustrating for individuals, families and carers at times of vulnerability. Addressing these delays has therefore been a key priority, alongside ensuring decisions remain robust, compassionate and clinically appropriate.

Performance summary

	28 day KPI			
	Q1	**Q2**	**Q3**	**Q4**
Achieved (%)	48%	48%	53%	60%
Target (%)	80%	80%	80%	80%
Variance (%)	-32%	-32%	-27%	-20%

Service improvement and transformation

Alongside recovery activity, the ICB has continued a comprehensive programme of CHC transformation with executive monthly oversight. Despite the operational pressures experienced during the year, meaningful progress has been made to strengthen systems, improve experiences and build sustainability for the future. Key developments during 2025/26 include:

Modernised care management systems

Continued mobilisation of a new end-to-end care management system has supported greater efficiency, improved visibility of care pathways and strengthened oversight. Most providers are now actively using the system, enabling more timely and improved coordination of care.

Targeted investment in brokerage capacity

We have invested in a brokerage service to better support individuals with complex needs who require bespoke care arrangements. This has improved access to appropriate placements and care packages that are tailored to individual circumstances.

Supporting our workforce
Organisational development has remained a priority, with the introduction of Culture and Values Advocates to promote staff wellbeing, foster a supportive team environment and sustain compassionate practice. A resilient and valued workforce is essential to delivering high quality CHC services.

Looking ahead to 2026/27
In 2026/27, BSW ICB will come together with Somerset and Dorset ICBs to operate as a cluster. While statutory responsibilities for Continuing Healthcare remain unchanged, this new way of working presents important opportunities to share learning, create further efficiencies and accelerate innovation, including improved use of digital technology.

Our focus remains clear: to continue improving timeliness, consistency and experience, while delivering a person centred CHC service that places individuals, carers and families at the heart of every decision. Through partnership, compassion and continuous improvement, we remain committed to ensuring people receive the care and support they need, when they need it most.

Stroke services – Hyper-acute Pathway

Stroke care across Bath and North East Somerset, Swindon and Wiltshire (BSW) is currently an area of focused improvement. National audit results (SSNAP) show variation in performance between hospitals, with some services performing below expected standards. While this indicates that care is not yet consistently meeting national expectations, it is important to emphasise that comprehensive improvement work is already underway across the system.

All three local hospitals: Royal United Hospital Bath (RUH), Great Western Hospital (GWH) and Salisbury Foundation Trust (SFT), continue to provide essential, round-the-clock stroke care. They are being actively supported by NHS England and national improvement programmes to strengthen services, improve consistency, and ensure patients receive the best possible care. Early signs of progress are expected to be reflected in future national audit results.

National guidance sets clear expectations for rapid assessment, timely brain imaging, and access to specialist treatments such as clot-busting drugs (thrombolysis) and clot removal procedures (thrombectomy). Across BSW, some aspects of this care are working well, for example, strong thrombectomy services at RUH and good thrombolysis performance at RUH and SFT. However, there are areas where improvements are needed, including ensuring patients are reviewed quickly by a stroke specialist and admitted promptly to a dedicated stroke unit.

Workforce capacity remains a challenge nationally and locally, particularly in recruiting specialist stroke doctors and therapists. Despite this, services continue to operate safely, supported by temporary staff where needed. Recruitment and workforce development are a key priority, with active efforts underway to build more sustainable teams.

There are also wider pressures affecting services, including demand on hospital beds and the need to maintain safe care overnight and at weekends. These pressures are being actively managed, and contingency arrangements are in place to maintain patient safety.

A coordinated programme of improvement is now in place across all organisations. This includes:

- Joint reviews with NHS England to identify and address gaps
- Dedicated stroke improvement groups within hospitals
- Plans to strengthen workforce, clinical leadership and service models
- Closer collaboration across the region to share expertise and reduce variation

Overall, while stroke services in BSW face challenges, clear plans are in place, and progress is already being made. Strengthened partnership working across the system and region will support more consistent, high-quality care for all patients.

Mixed sex accommodation breaches (MSAB)

Overview

Maintaining patients' dignity and privacy is a key priority for all NHS organisations. In BSW, the number of mixed sex accommodation breaches, where patients are cared for in shared areas with the opposite sex without a clinical reason, has been higher than expected.

These breaches are closely linked to wider pressures on the health system, such as high demand for hospital beds and delays in discharge. Importantly, all breaches are reported transparently and are taken seriously, with a clear commitment to improvement.

Review findings

A recent system-wide review confirmed that all organisations have appropriate policies in place. However, it also identified opportunities to improve consistency in how breaches are recorded and managed, as well as challenges related to hospital environments and capacity.

In particular:

- High demand and busy emergency departments can make it more difficult to maintain single-sex accommodation.
- Some older facilities are not ideally designed for modern standards of privacy.
- Delays in moving patients through the system can increase pressure on available beds.

Impact and response

While no formal complaints were recorded, it is recognised that these situations can affect patient comfort and experience. Staff continue to work hard to minimise breaches, often balancing competing priorities in very busy settings.

A clear improvement plan is now in place across all organisations, focusing on:

- Consistent reporting and better use of data
- Improving patient flow and reducing delays
- Optimising how beds are allocated
- Enhancing ward environments to improve privacy
- Strengthening oversight and accountability

Summary

Although challenges remain, a shared system-wide approach is now in place, with practical actions to reduce breaches and protect patient dignity.

Venous thromboembolism (VTE)

Preventing blood clots (VTE) is an important part of keeping patients safe in hospital, and overall performance across BSW is encouraging, with ongoing improvements in place.

- Great Western Hospital continues to perform strongly, with consistently high levels of risk assessment
- Royal United Hospitals, Bath has identified some variation in how quickly patients are assessed and treated, and a comprehensive improvement programme is already underway
- At Salisbury Foundation Trust, national reporting currently underestimates performance due to technical system limitations. Local audits provide reassurance, showing that most patients receive appropriate assessments and preventative treatment in a timely way

All hospitals closely monitor VTE cases and review any concerns to ensure continuous learning and improvement.

At Salisbury, new digital systems have introduced better real-time monitoring, although some technical challenges remain. Additional checks, including regular reviews of patient records, provide further assurance that care is being delivered safely while system improvements continue.

Summary

Across BSW, VTE prevention remains a priority with generally strong performance and clear plans to address areas for improvement. Ongoing monitoring, audit and system upgrades will continue to strengthen patient safety.

Engaging people and communities

Our approach to meaningful engagement 2025-2026

BSW ICB has a statutory duty (Section 14Z45, NHS Act 2006) to involve patients and the public in planning, development and decisions about commissioning arrangements. This section of the Annual Report sets out how we have discharged this duty in 2025/26.

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 area is 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 people it serves.

We know that local people have 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 new services or support or proposing changes to existing ones.

Throughout 2025/26, we have created and delivered a diverse programme of opportunities for our public to have their voices heard, listened to and, most importantly, acted upon. This approach to meaningful engagement is based on our local knowledge, valued relationships with partner groups and networks and 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, faith and social enterprise (VCFSE) 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 and build on the assets of all health and care partners – networks, relationships and activity in local places.

We are grateful to everyone who has taken the time to engage with us over the last year.

Examples of bespoke engagement and the subsequent outcomes

Throughout 2025/26, BSW ICB has continued to strengthen its approach to meaningful engagement with people and communities, ensuring that patient voice and lived experience informed service delivery and improvement activity across the system.

We have strengthened relationships with our system partners, voluntary, community, faith and social enterprise (VCFSE) organisations, Healthwatch and community groups. Engagement activity has been shaped to reach those who face the greatest barriers to accessing health and care, ensuring that insights from diverse communities are informing decision-making.

Involving the public throughout the development of Trowbridge Integrated Care Centre

During 2025 and 2026, BSW ICB delivered a comprehensive community engagement programme to keep local people informed about the progress of our new £16 million Trowbridge Integrated Care Centre and the closure of the old Trowbridge Community Hospital. We held over 255 face-to-face conversations with local people to ensure they knew about the development of the centre, its proposed opening schedule and the services on offer.

Between May and December 2025, 13 drop-in information sessions were held in a wide range of community locations across Trowbridge in areas of high footfall. These sessions were an opportunity for local people to inspect plans, view photographs, hear about services in the new centre and ask questions.

We also held a community evening information event in a local church for those who could not attend our daytime sessions. This was attended by local councillors, senior ICB staff and residents.

We also specifically sought out the views of patient groups to gather feedback on the design and development of key public areas of the new building including waiting rooms, receptions, entrances, interiors, signage and colour palettes.

We spoke with beneficiaries of West Wiltshire Alzheimer's Support Carers' Group, Hilperton Autism Support Group, Wiltshire Parent Carers Council and BSW Maternity Voices to gather views.

You said, we did

The feedback we collected at the sessions has been used to address specific issues highlighted by the groups in terms of design features and led to design changes to the entrance of the centre, seating and a joint process to select colour palettes for waiting rooms and reception areas.

Our engagement also highlighted local dissatisfaction with existing opening hours of the minor injuries unit (MIU) at Trowbridge Community Hospital. As a result of highlighting this feedback, opening hours at the new Integrated Care Centre MIU have been extended.

Integrated Community-Based Care (ICBC)

The ICB has worked with the ICBC contract provider, HCRG Care Group, to ensure that engagement requirements within the contract were fully met and continue to mature. Over 2025/26, the ICBC contract supported coordinated, insights-driven engagement across BSW, to shape delivery and development of community services. HCRG Care Group delivered targeted

engagement programmes in priority areas such as the overall branding as well as the new Single Point of Access and Integrated Neighbourhood Teams.

Collaboration between the ICB and HCRG Care Group ensured that engagement activity remained compliant, contributing to a more responsive and person-centred integrated care system.

Using public feedback from our 10 year plan engagement to inform our Strategic Commissioning Intentions

During early 2025 we held engagement sessions to inform the national NHS 10 year Health Plan with over 100 participants drawn mainly from members of BAME and Core20PLUS5 communities.

Our sessions focused on the three shifts featured in the plan: hospital to community, analogue to digital and sickness to prevention. Feedback on these themes was as follows:

- **Making better use of technology:** Technology was generally welcomed, particularly AI to manage waiting lists and shared patient records to reduce repetition for patients. However, there were concerns about losing human interaction if technology is overused. Digital exclusion was a key issue, especially for older people, and there remained a strong preference for face-to-face care for complex health needs.
- **Moving care from hospitals to communities:** Care delivered closer to home was viewed positively, with accessible community diagnostic centres strongly supported. Pharmacy First was seen as a good way to ease GP pressures, although poor pharmacy availability remains a challenge. The VCFSE sector was recognised as essential in delivering community services and supporting prevention.
- **Preventing sickness, not just treating it:** Prevention was seen as a priority, with strong support for lifestyle and nutrition education, alongside physical activity and weight management initiatives. Participants emphasised the need for preventive services to be inclusive and accessible to all communities. Adequate staffing, resources, and infrastructure were seen as critical to making prevention effective.

You said, we did

The views and comments we collected fed into the national plan and have also been used to inform our own future developments, including our recently published Strategic Commissioning Intentions 2026/27.

Reaching out to mobile and Gypsy, Roma, Boater and Traveller (GRBT) communities about Neighbourhood Health

In January 2026 BSW ICB started a programme of engagement to listen to the views of local people about how to develop communication and engagement approaches that will help Integrated Neighbourhood Teams communicate effectively about local services and gauge understanding and needs as our plans for Neighbourhood Health develop.

The first phase of this project, supported by funding from NHS England, has been to meet with Gypsy, Roma, Boater and Traveller (GRBT) and Veteran communities who may struggle to access health services and test aspects of our emerging Neighbourhood Health model.

During February and March, we worked with local authority outreach teams and VCFSE groups to meet residents at five traveller sites in Bath, Swindon and across Wiltshire. We also met

members of the boating community at parent and toddler and afterschool clubs hosted by VCFSE organisation Open Blue at the Kennet and Avon Canal.

We engaged with more than 30 members of the traveller community, alongside eight members of the boating community. Given the depth and specificity of the insights shared, we presented our findings in a standalone report. This report provides a snapshot of GRBT perspectives on local health and care services, highlighting key themes including access to care, experiences of discrimination, communication challenges and difficulties with continuity of care.

The second phase of the project is broadening the scope of the engagement to seek the views of wider communities through further outreach meetings and an online survey.

At the time of writing, over 400 people across Bath and North East Somerset, Swindon and Wiltshire (BSW) have shared their views on what neighbourhood health means to them and how they would like to see it develop. Alongside online engagement, we have heard directly from more than 40 people through a series of face-to-face sessions delivered in partnership with VCFSE organisations, including Bath Community Kitchen in Radstock and the BaNES Older People's Voice group.

We have also made a concerted effort to engage with local service veterans. This has included attending breakfast clubs across BSW, as well as hearing from over 70 Gurkha veterans and representatives of the Swindon Nepalese community at an event delivered in collaboration with Voluntary Action Swindon.

All feedback gathered through these activities will play a key role in shaping the development of neighbourhood health plans across Bath and North East Somerset, Swindon and Wiltshire.

You said, we did

Feedback collected will help us understand more about the needs and aspirations of our communities in terms of neighbourhood health and develop the best ways of communicating change with them as our plans develop.

Understanding Accident and Emergency attendance in BSW

During 2024 accident and emergency departments (A&Es) in hospitals in BSW experienced a 5.6 per cent increase in patient visits, mainly due to a rise in the number of 'walk-in' patients.

In order to find out what was behind this rise, BSW ICB launched an engagement project to help us understand why more people were visiting A&Es instead of using other NHS services, such as minor injury units, urgent treatment centres and community pharmacies.

Between April and August 2025, we worked with Healthwatch and hospitals in Bath, Swindon and Salisbury to find out more through the Big A&E Survey.

Almost 1,600 people took part through completing an online survey or face-to-face interviews in A&E departments to help us explore why patients choose A&E and their awareness of other treatment options.

The survey provided valuable insights into patient decision-making and awareness of alternative care options.

You said, we did
The feedback we received from patients and members of the public has informed our Commissioning Intentions for 2026/27, the messaging for our communications approach across BSW during winter 2025/26 and operational arrangements across our A&Es.

Involving the public in the development of our Ageing Well strategy

BSW ICB has created a new ageing well strategy to improve care, reduce inequalities, and ensure that people living with frailty receive the right support at the right time.

During July and August 2025, we carried out a programme of engagement with patient groups and the public to gather views on frailty and to ensure the voices of those with lived experience were included in the strategy.

Engagement was carried out via an online survey which was promoted though BSW social media channels and newsletters and through dissemination via ICB partner communications channels, parish council websites, newsletters and through VCFSE organisations.

We also arranged four face-to-face sessions with community and patient groups.

You said, we did
These voices helped us to shape a strategy that reflects real experiences and leads to better outcomes for everyone. The feedback collected is also being used by a South West Working Group to develop a people's definition of frailty and has been shared across ICBs in the region

Working with Patient Participation Groups (PPGs)

There is a strong network of Patient Participation Groups (PPGs) operating across BSW. These volunteer-led groups are made up of patients, carers and GP practice staff who collaborate to improve local health services, strengthen the doctor-patient relationship, and ensure the patient voice is heard. They act as a bridge between patients and the practice, focusing on enhancing service quality, patient experience, and health education.

During 2025 and 2026 we continued to work with PPGs to involve them in our engagement work, seek their views and ensure their voices are taken into account.

To ensure our relationships with PPGs is up to date, we surveyed practice managers across BSW to find out more about the status of their PPGs, their structure, role, frequency of meetings, strengths and challenges.

You said, we did
As a result of this, we have started a new programme of visiting PPG meetings to ask how we can support their work and help with the development of the PPG network.

We also worked with a number of Patient Participation Groups to gather views on the development of two patient facing leaflets explaining the Advice and Guidance service. As a result of the feedback provided, changes were made to make the leaflets easier to understand and follow.

Talking to local people about weight management services

We are currently engaging with local people to better understand their experiences of weight management services.

Current weight management services were designed at a time when rates of obesity were lower and before the introduction of new treatments. Over recent years increasing numbers of patients have been referred to the specialist weight management services, provided by hospitals.

In light of the growing waiting list and the availability of new drug treatments, a review of current services is underway to ensure they meet the needs of patients and reflect recent developments in treatments.

In order to support this and ensure future service offerings take into account the views of local people, BSW ICB is undertaking engagement.

Working with local authority wellness programmes, the Man Vs Fat football initiative, HCRG diabetes management groups and Slimming World, we have attended meetings and events to collect the views of local people on weight loss journeys. Additionally, almost 200 people have passed on their views through an online survey.

You said, we did

These valuable experiences, opinions and ideas will be taken into account as BSW ICB reviews current services to ensure they meet the needs of patients now and in the future and reflect recent developments in treatments.

Empowering patients in Asian communities and deprived areas through increasing understanding and testing of high blood pressure

As part of BSW ICB's work to address health inequalities in our communities we worked with Healthwatch during 2025 to find out why people, especially those from Asian heritage and socioeconomically disadvantaged communities, face systemic barriers to accessing blood pressure care.

Between May and September 2025, Healthwatch worked with local communities to understand more about this issue, hearing from nearly 500 people across the area who shared their experiences. Healthwatch focused on deprived areas and Asian communities, as these groups are less likely to have their blood pressure tested - despite being more at risk of high blood pressure.

Through focus groups and an online survey, Healthwatch found that most people they spoke to don't ask healthcare professionals about their blood pressure, and even when they get checked, many don't understand what their readings mean or what to do next.

Recommendations included in the evaluation report include the importance of making blood-pressure information short, clear, and available in multiple languages, offering convenient checks in community spaces and workplaces, providing personal follow-up so people can understand their result, and training community champions to share key messages and support local awareness.

You said, we did

These recommendations have been taken into account as we plan our work on hypertension and have informed our approach to a series of public blood pressure checking sessions underway across BSW during March 2026.

Working with our local authorities

The BSW ICB Engagement Team supports the ICB's statutory duties to involve and consult local people through our relationships with local authority oversight, scrutiny and health and wellbeing structures in Bath and North East Somerset, Swindon and Wiltshire.

This work includes coordinating timely information, reports and updates for Bath and North East Somerset Council's Children, Adults, Health and Wellbeing Policy Development and Scrutiny Panel and the Health and Wellbeing Board; Swindon Borough Council's Children and Adults Overview and Scrutiny Committee and Health and Wellbeing Board and Wiltshire Council's Health and Wellbeing Board and Health Select Committee.

Through proactive engagement, clear communication and early involvement in service change and development, the team ensures that each committee is appropriately briefed, that statutory consultation requirements are met, and that the views of residents and partners meaningfully inform ICB decision-making.

Supporting regular engagement

The ICB is fully committed to holding meaningful conversations with local people on a regular basis, as detailed in our communications and engagement strategy, which sets out a commitment to ensuring local communities have the opportunity to input into how services are developed and provided.

Our BaNES-based Your Health Your Voice patient and public engagement forum meets on a regular basis and is chaired by the ICB's Place Director for BaNES. This group has a strong and engaged membership, with attendants made up of interested members of the public, carers, people working in local voluntary organisations and representatives from local 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. More information on the patient and public engagement forums can be found on the ICB website.

Other engagement activity during 2024/25 includes:

- We worked with local Maternity and Neonatal Voices Partnership members to gather views on draft marketing materials to encourage pregnant women and parents to access winter flu and covid vaccinations**.** As a result of feedback, changes were made to materials used in the BSW area
- Our fortnightly engagement-focused newsletter – BSW ICB People and Communities Bulletin – is circulated to over 170 people and offers a roundup of engagement opportunities and news on health and care focused engagement projects underway in BSW
- We worked to gather views from people living with severe mental illness about their experiences of services to help them find paid employment or volunteer work
- We regularly attend meetings organised by VCFSE groups including 3SG in BaNES, Wiltshire and Swindon Community Foundation, Wiltshire Faith Communities Network and

Swindon VCFSE Leadership Alliance to share and seek support for our engagement work and identify engagement opportunities and networking connections

- We provided support for the BSW Health Inequalities Grant Funding workstream, advising grant recipients in the VCFSE sector on communications strategy and building important relationships for future engagement activities

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
- Engagement and public involvement has been a key function of the BSW ICB Commissioning Committee, which recognises the ICB's duties and responsibilities for involving the public in the development of services
- 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.

Reducing health inequalities

Reducing health inequalities is a core statutory responsibility of Integrated Care Boards. Under the Health and Care Act 2022, ICBs must have regard to the need to reduce inequalities in access to health services and in the outcomes achieved for different populations.

During 2025/26 Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) has strengthened its system approach to reducing health inequalities. This has focussed on improving the use of data and insight to understand inequalities, establishing clear system priorities, embedding inequalities within governance and decision-making processes and targeting investment and action towards populations experiencing the poorest outcomes.

Understanding health inequalities in BSW

A strong understanding of inequalities is essential to prioritising action.

During 2025/26 BSW developed a system Health Inequalities Statement aligned with the NHS statement on information relating to health inequalities. This brings together the latest available data across a wide range of indicators covering operational priorities and the national Core20PLUS5 clinical areas.

The analysis summarises inequalities across multiple service areas and, where available, presents the data by age, gender, deprivation and ethnicity. This enables the system to identify where the largest inequality gaps exist and where targeted action is required.

Insights from this analysis have informed the system's strategic priorities, the focus of inequalities investment, and delivery group transformation programmes.

The full BSW Health Inequalities Statement can be found here:
https://bsw.icb.nhs.uk/document/item-09b_bsw-statement-on-health-inequalities/

Alongside this work, BSW has developed a system Outcomes Framework, which provides a structured approach to monitoring population health and inequalities across the system and tracking progress against the system's population health ambitions. The framework brings together national and local indicators to track progress against key questions including whether people are living longer and healthier lives, whether patients are supported to manage their conditions, and whether inequalities in outcomes are reducing.

The Outcomes Framework is supported by a system dashboard, which allows variation in outcomes to be examined across population groups and geographic areas. This enables system leaders and programme teams to identify where the largest inequalities exist and where targeted action may be required.

The framework is increasingly being used to guide system planning and oversight. It has informed the priorities within the Health Inequalities Strategy, the focus of Population Health Board deep dives and the targeting of inequalities investment.

Inequalities analysis is also increasingly incorporated into dashboards developed through the BSW Intelligence Hub, enabling routine monitoring of variation in access, experience and outcomes across different population groups.

Together, these approaches are strengthening the system's ability to use data and insight to identify inequalities and inform action.

These insights provide the evidence base for the system's health inequalities strategy and help guide where action and investment should be focused.

Strategy and priorities for reducing health inequalities

During 2025/26 BSW refreshed its Health Inequalities Strategy (2025–2028), which sets out a system-wide commitment to reducing unfair differences in access, experience and outcomes.

The strategy focuses on the national Core20PLUS5 approach, identifying both the most deprived 20% of the population and locally identified groups who experience poorer health outcomes or barriers to accessing services.

Each place within BSW has identified its own priority PLUS groups, recognising that different communities experience inequalities in different ways. This place-based approach enables targeted action that reflects local need while maintaining a shared system focus on the most significant inequality gaps.

The strategy prioritises outcomes where data shows the greatest disparities, including areas such as cardiovascular disease, respiratory disease, alcohol-related harm, self-harm and oral health.

The strategy was developed during 2025/26 through engagement with system partners and will be published following completion of the ICB's governance processes.

Delivery of these priorities is supported through the system's governance arrangements, which ensure that inequalities are considered routinely in programme planning and decision-making.

Embedding health inequalities in system governance

Reducing health inequalities requires coordinated action across the system.

Within BSW, the Population Health Board provides strategic oversight of prevention and health inequalities and supports the identification of priority areas for action.

The Population Health Board membership comprises:

- Chief Medical Officer, BSW ICB (Co-Chair)
- Director of Public Health, Swindon Council (Co-Chair)
- Director of Public Health, Wiltshire Council
- Director of Public Health, B&NES Council
- Place Director (BaNES), BSW ICB
- Place Director (Swindon), BSW ICB
- Place Director (Wiltshire), BSW ICB

- VCFSE Strategic Lead for Integrated Care, Voluntary Action Swindon
- Director of Improvement and Partnerships, GWH
- Health Inequalities Lead, RUH
- Chief Medical Officer, SFT
- Physical Health Lead for BSW, Avon and Wiltshire Partnership
- Director Education, Inclusion and Skills, Swindon Council
- Head of Service Quality Assurance P&SL Improvement, Wiltshire Council
- Assistant Director Children and Young People, B&NES Council
- Primary Care representative
- Community Care representative
- Healthwatch representative

Delivery groups across the system are expected to identify and address inequalities within their transformation programmes. During the 2025/26 planning round, delivery groups were supported to articulate clear inequalities priorities which were incorporated into the system implementation plan.

Progress against these priorities is monitored through regular reporting and structured Action Learning Reviews, which provide a forum for delivery groups to reflect on progress, review available data and identify where further action or support may be required.

This approach helps ensure that inequalities considerations are embedded within programme delivery and system oversight.

The Population Health Board also undertakes outcomes deep dives to examine areas where data suggests improvement is required and where inequalities in outcomes may exist. These reviews draw on the BSW Outcomes Framework and wider system intelligence to explore variation in outcomes, understand the drivers of inequality and assess whether current system action is sufficient to achieve improvement.

Deep dives are conducted across two Population Health Board meetings, allowing time for initial analysis, system discussion and the development of recommended actions.

During 2025/26 deep dives were undertaken on dementia diagnosis rates and alcohol-specific admissions. A further deep dive on emergency admissions for intentional self-harm commenced during the year and will continue into 2026/27.

Insights from these reviews help inform system priorities, delivery group programmes and targeted prevention and inequalities activity.

Alongside these governance arrangements, the ICB also uses formal equality assurance mechanisms to assess how effectively services are addressing inequalities.

Equality assurance

The ICB uses equality impact assessments (EQIAs) when developing policies, programmes and commissioning decisions. These assessments help identify the potential impact of

proposals on different population groups and support the ICB in meeting its Public Sector Equality Duty. The use of EQIAs provides an important mechanism for considering whether proposals may reduce or inadvertently widen inequalities.

The ICB recognises there is an opportunity to further strengthen how EQIAs are used across the system to ensure that insights from these assessments more consistently inform decision-making and programme design.

During 2025/26 the ICB undertook the Equality Delivery System (EDS) review. The EDS is a national framework that supports NHS organisations to assess how effectively they are advancing equality across services, workforce and leadership.

Responsibility for different elements of the review sits across the organisation. The ICB Inequalities Team leads the assessment of Domain 1 (commissioned and provided services), while other domains are led by relevant teams across the organisation, including the People Team for workforce-related domains.

For the 2025/26 review, three commissioned service areas were selected for assessment within Domain 1:

- Use of the NHS App
- Flu and COVID-19 vaccination programmes
- Development of Integrated Neighbourhood Teams

The review was undertaken through the Inequalities Strategy Group's Action Learning Review process, enabling delivery groups to explore inequalities within services and identify areas for improvement.

The assessment highlighted areas of good practice, including strong vaccination uptake relative to regional and national averages, alongside areas where further development is needed. These include improving insight into NHS App usage and ensuring that emerging service models such as Integrated Neighbourhood Teams address barriers experienced by underserved communities.

The full EDS review will be published separately once the assessment across all domains has been completed.

Alongside these governance and assurance processes, the ICB continues to target investment towards initiatives designed to address the inequalities identified through system data and intelligence.

Targeted action to address health inequalities

Alongside system-wide approaches, BSW has continued to target investment and programmes towards reducing inequalities in access, experience and outcomes. Priorities for targeted investment during 2025/26 were informed by analysis from the 2024/25 Health Inequalities Statement, which identified areas where inequalities in outcomes were most pronounced.

During 2025/26 the Health Inequalities Fund supported a range of initiatives focused on improving access to services and addressing barriers faced by underserved communities.

Projects supported through the programme have included:

- Targeted outreach to increase cancer screening uptake
- Improving engagement with severe mental illness physical health checks
- Strengthening support for children and young people's mental health

Many of these initiatives are delivered in partnership with voluntary, community, faith and social enterprise (VCFSE) organisations and focus on communities identified through the Core20PLUS5 framework and locally identified PLUS groups.

Early evidence from these programmes shows increased engagement with communities who may previously have had limited contact with services, improved awareness of health services and increased uptake of screening and preventative support.

The programme has also strengthened partnerships between NHS organisations, local authorities and VCFSE partners, supporting more coordinated approaches to addressing health inequalities.

Learning from these programmes is used to inform future investment decisions and strengthen the system's overall approach to reducing health inequalities.

Strengthening system capability

BSW continues to strengthen its capability to identify and address inequalities across the system.

This includes improving the quality and completeness of data, particularly ethnicity recording, expanding the use of population health intelligence to understand inequalities across services and population groups, and embedding inequalities considerations within commissioning and investment decisions.

Alongside this, the system is strengthening its approach to evaluation so that the impact of inequalities programmes and investments can be better understood.

Looking ahead

During 2026/27 BSW will focus on implementing the refreshed Health Inequalities Strategy and further embedding inequalities considerations within commissioning, transformation programmes and system decision-making.

Future priorities include strengthening the use of inequalities data within routine performance management, continuing targeted investment to address priority inequalities, and building stronger partnerships with communities and VCFSE organisations.

Together these actions aim to accelerate progress towards reducing unfair differences in health outcomes and ensuring that improvements in health are experienced more equitably across communities in Bath and North East Somerset, Swindon and Wiltshire.

Prevention and population health

Improving population health and preventing avoidable illness is a key priority for Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB). Prevention plays a critical role in improving health outcomes, reducing pressure on health and care services and addressing the wider determinants that contribute to inequalities in health.

During 2025/26 BSW has continued to strengthen its system approach to prevention, working with partners across the integrated care system to align programmes, use population health intelligence to target action and embed prevention within service design.

BSW Prevention Strategy

During 2025/26 BSW developed its Prevention Strategy (2025–2028), which sets out a shared system approach to improving health outcomes by shifting the focus from treatment to prevention.

The strategy adopts a prevent–reduce–delay framework:

- Prevent the development of ill health through action on risk factors and wider determinants
- Reduce the impact of existing conditions through early detection and intervention
- Delay progression of disease and avoidable deterioration through improved management and support.

The strategy prioritises areas where prevention can have the greatest impact on improving outcomes and reducing demand on services. These priorities are informed by the BSW Outcomes Framework and wider population health intelligence.

Delivery of the strategy relies on collaboration between NHS organisations, local authorities, the voluntary, community, faith and social enterprise (VCFSE) sector and other system partners.

Targeted prevention programmes

A number of targeted programmes are supporting the system's prevention priorities.

Treating Tobacco Dependence

Smoking remains one of the leading causes of preventable illness and premature death and is a major driver of health inequalities.

BSW has continued to implement the Treating Tobacco Dependence (TTD) programme across acute, maternity and mental health services. The programme identifies smokers during healthcare interactions and offers evidence-based support to help them quit.

During 2025/26 the ICB approved recurrent funding to support the continuation of this programme and agreed a move to a host trust delivery model to improve resilience and consistency across the system.

Implementation of the host trust model is planned to begin in September 2026. The new model will provide a coordinated workforce, shared governance and strengthened data collection to support delivery across the system.

The programme plays an important role in reducing inequalities, as smoking prevalence remains significantly higher among more deprived communities and among people with long-term conditions.

Cardiovascular disease prevention

Preventing cardiovascular disease (CVD) remains a key priority for the BSW system. During 2025/26 the system focused particularly on improving the identification and management of hypertension, a major risk factor for heart attacks and strokes.

A system improvement programme supported primary care networks (PCNs) to review and strengthen their hypertension pathways. This work was delivered through the CLEAR programme, with additional support from system transformation associates. Participation by PCNs was supported through a locally commissioned service (LCS), enabling practices to review their hypertension registers, strengthen pathways for diagnosis and treatment, and improve the management of cardiovascular risk.

Alongside pathway improvement, the system worked with VCFSE partners to increase case finding for undiagnosed hypertension. This included community engagement activities to encourage people to have their blood pressure checked, with checks delivered through community pharmacy and general practice.

Community pharmacy providers were also supported to expand delivery and improve the quality of the national blood pressure case finding service, increasing access to opportunistic blood pressure checks across the community.

Innovative approaches to detection were also explored, including a pilot with dental services to identify previously undiagnosed hypertension in people attending routine dental appointments.

During 2025/26 the ICB also completed the planning and procurement of an expanded health coaching service, designed to support people to address modifiable risk factors such as smoking, physical inactivity and diet. Delivery of the expanded service began towards the end of the year through primary care networks and local authority services, with further delivery planned during 2026/27.

The ICB also developed plans to deliver outreach NHS Health Checks in community settings, with delivery expected to begin during 2026/27.

To support locally tailored approaches to prevention, each place within BSW was provided with a small community development fund to support asset-based community development initiatives aimed at improving engagement with prevention services and supporting healthier communities.

Together these initiatives aim to improve the early detection and management of hypertension, support people to reduce cardiovascular risk factors and contribute to reducing avoidable illness across the BSW population.

Population health intelligence

Prevention activity is increasingly informed by population health intelligence.

The BSW Outcomes Framework and wider system dashboards provide insight into health outcomes, risk factors and inequalities across the population. These insights support the identification of priority areas where preventative action can have the greatest impact.

This approach enables partners across the system to align prevention activity and focus resources on areas where improvements in population health are most needed.

Working with communities and partners

Prevention activity across BSW relies on strong partnership working.

Local authorities, NHS organisations and VCFSE partners work together to deliver programmes that support healthier communities. VCFSE organisations play a particularly important role in engaging communities, improving health literacy and helping people access preventative services.

This partnership approach supports the development of locally tailored initiatives that respond to the needs of different communities across the system.

Looking ahead

A number of further prevention initiatives are currently progressing through the ICB's governance processes. These proposals focus on expanding programmes that support earlier identification of risk factors, improving treatment of long-term conditions and strengthening preventative support across health and care services.

Planned developments include expansion of NHS Health Checks and health coaching services, which aim to support people to identify and address modifiable risk factors earlier.

Additional work is being developed to address cardiovascular disease treatment gaps, with a focus on improving the identification and optimisation of treatment for conditions such as hypertension and high cholesterol.

Further proposals aim to strengthen system responses to behavioural risk factors, including the development of Alcohol Care Teams and the introduction of risk identification and very brief advice approaches within acute and primary care settings.

Alongside this, the system is exploring targeted early intervention approaches to support people at risk of crisis, including the introduction of youth workers in emergency departments to support young people presenting with self-harm and related mental health needs.

Together these initiatives aim to strengthen the system's ability to identify risk earlier, provide timely support and prevent avoidable illness across the BSW population.

Health and wellbeing strategy

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

Throughout 2025/26, the ICB has worked alongside local authority partners to deepen joint planning and delivery against the strategies, with a particular focus on translating shared priorities into the system's response to the national Neighbourhood Health Framework published in March 2026.

Building on the Joint Local Health and Wellbeing Strategies agreed in 2023, and the locality delivery plans that form the place-based contributions to the ICS Implementation Plan, the ICB has worked with each Health and Wellbeing Board to align neighbourhood health planning with existing strategic priorities. This has ensured that the development of Integrated Neighbourhood Teams and the wider neighbourhood health programme is anchored in the priorities each Board has already set, rather than running in parallel to them.

To support meaningful progress and alignment, the ICB has:

- Participated in Health and Wellbeing Board discussions, strategy steering groups and Integrated Care Alliance meetings across all three local authority areas, including bringing forward the BSW Neighbourhood Health Vision for Board consideration and endorsement
- Worked with local authority colleagues to monitor joint delivery plans through shared reporting mechanisms, and to ensure that neighbourhood health planning, the Better Care Fund and Section 75 arrangements operate as a coherent whole rather than as separate workstreams
- Contributed expertise and resources to shared priorities including prevention and early intervention, reducing health inequalities, and improving outcomes for population groups experiencing the poorest health
- Supported each locality in confirming neighbourhood footprints, with 20 footprints now agreed across BSW, and in developing the local arrangements through which Integrated Neighbourhood Teams will operate
- Aligned joint efforts with each Integrated Care Alliance's locality priorities for 2025/26, which have included improving children's emotional health and wellbeing, reducing avoidable dental extractions in children from inequality groups, developing Integrated Neighbourhood Teams, and targeted support for young people not in education, employment or training
- Secured approval through the BSW, Dorset and Somerset Cluster governance for a £1.5m neighbourhood health enabling and mobilisation programme to support partner-led design across the 20 neighbourhoods during 2026/27

The ICB's contribution has been shaped by the principle of full participation in Health and Wellbeing Boards, with Integrated Care Alliances, partner-led forums which the ICB facilitates and administers, key to partnership and development. This has been particularly important as the system has moved into a more active phase of joint planning under the Neighbourhood Health Framework.

Financial review

The ICB receives a funding allocation from NHS England which is used to commission services for the BSW population. An annual operating plan is produced which incorporates the requirements set out within nationally published priorities and operational planning guidance.

For 2025/26 the ICB produced an organisational plan as part of a wider system plan with the BSW Hospitals Group. This Integrated Care System (ICS) plan expected to deliver a breakeven result for the year across the four organisations.

This was a challenging plan with high levels of efficiency combined with the additional need to make improvements in urgent and emergency care performance, elective recovery, primary care resilience, and improvements in mental health and community services. The system has also been operating with an underlying deficit.

The system has been unable to fully mitigate the impacts during 2025/26 from a highly challenging financial environment, increasing non elective service demand, system workforce pressures and market inflation. A recovery programme was implemented in year but despite this the system has failed to deliver on its system control total and has ended the year with a £25m deficit. The operational deficit was £19m but as the system has not delivered on its agreed system control total and in-year financial recovery plan the deficit has increased by £6m. NHS England withdrew a quarter of the deficit support funding the system had expected to receive.

The system deficit will become repayable in future years if all organisations don't deliver their 2026/27 and 2027/28 plans.

The ICB has made an in year financial surplus of £22.9m as part of the agreed in year system recovery plan, this has not been sufficient to fully offset deficits within system provider positions.

Despite the wider system financial position, the ICB has met its organisational statutory financial performance targets and continued to focus on delivering value for money for the population it serves. Operational performance metrics have not been fully delivered in 2025/26 and continue to be subject to operational recovery plans.

The ICB over-delivered its required efficiency programme as part of agreed system financial recovery actions. No services have been decommissioned as part of the ICB financial position improvement, but resources were reprioritised to protect services and offset the financial pressures within the BSW Hospital Groups. As a result of the recovery response, a significant proportion of the ICB savings were delivered non-recurrently, highlighting the need for continued focus on recurrent sustainability.

Although the ICS continues to face operational and financial pressures, partners remain committed to achieving greater financial sustainability over the medium term through shared transformation programmes and service redesign to help reduce the system underlying deficit. The ICB has included within commissioning intentions over the next five years to invest up to 3% of its funding each year non-recurrently to support system transformation initiatives.

The financial outlook for the coming year remains challenging. The ICB will continue to:

- Work with partners to strengthen system-wide financial disciplines

- Focus on recurrent efficiency delivery
- Prioritise investment that supports prevention, early intervention, and long-term sustainability
- Support elective recovery and improvements in access and performance
- Work collaboratively with partners to deliver integrated care models and improved population health outcomes

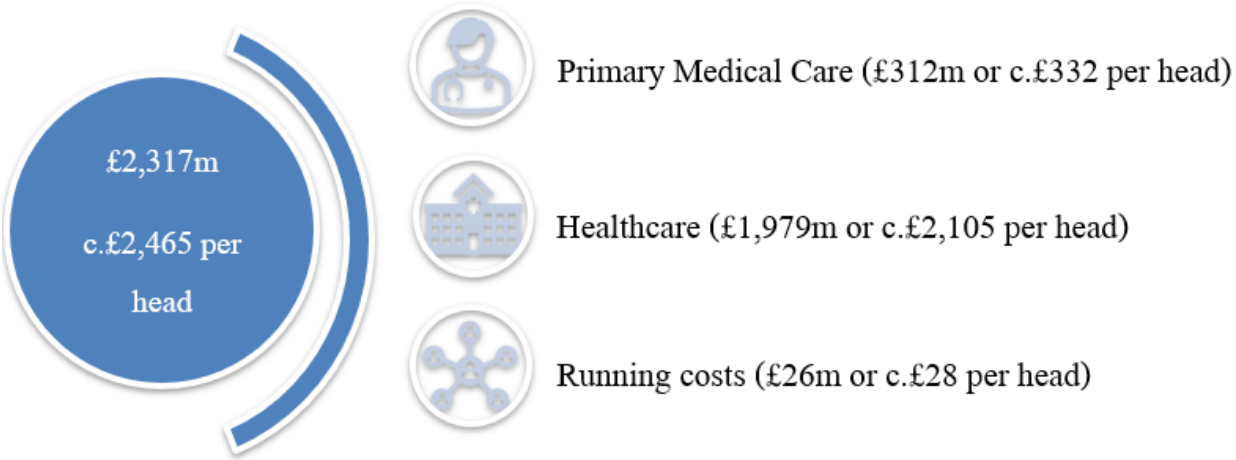
It is likely that demand growth on services will continue to be a pressure, but we are expecting community transformation initiatives to start to have an impact as the integrated community services provider contract enters its second year. If the non-elective demand is not successfully managed, then this will put pressure on the deliverability of expected efficiencies in 2026/27 as it will lead to the reopening of escalation beds and associated workforce pressures.

In 2026/27, the role of ICBs will shift decisively toward strategic commissioning, reflecting NHS England's reforms that consolidate ICB footprints, reduce their number nationally, and redefine their purpose. The ICB has clustered with Dorset ICB and Somerset ICB and plans to merge formally from April 2027. ICBs will move away from operational oversight and instead focus on long-term population health planning, allocating resources, and evaluating system-wide outcomes, supported by a new four-stage commissioning cycle and strengthened partnership requirements. They will also take on expanded responsibilities for neighbourhood-level integration under the reformed Better Care Fund, aligning health and social care plans more closely while managing non-elective admissions, delayed discharges, and reablement goals.

These changes will be enabled by structural and funding reforms and as part of this there will be a significant reduction in the ICB workforce in 2026/27.

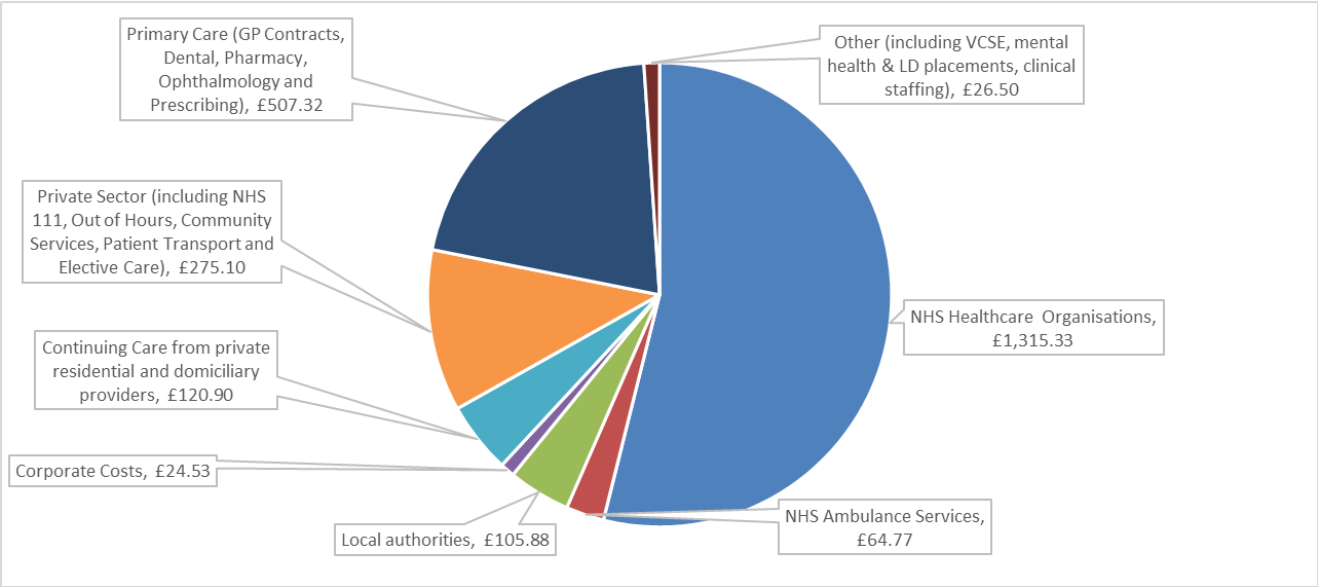
Funding

The funding that the ICB has received in 2025/26 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:



Promoting and facilitating research

BSW Integrated Care Board (ICB) continues to have a statutory responsibility to promote and facilitate research and over the last year has continued to work in partnership with the National Institute for Health and Care (NIHR), South West Central Regional Research Delivery Network (SWC RRDN) and local partners to support research delivery across the region.

As part of this, the BSW Research Hub exists to support health and care research in the wider care settings, as well as collaborations between academics, health and care commissioners and primary care providers to design and deliver research that aligns with health priorities and the communities with the greatest needs. The Hub's services are 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.

Research performance

In terms of overall research participation, SWC RRDN continues to contribute to national research delivery, with opportunities identified to increase recruitment and maximise impact across the region. While recruitment levels are currently below last year, this provides a clear focus for targeted improvement and renewed growth in 2026.

General practice remains a key area of strength, with SWC RRDN ranked 4th nationally for recruitment relative to population size. Although slightly below last year's position, performance remains consistently high and within the top tier nationally, demonstrating strong capability in primary care research delivery.

BSW has good engagement with GP practices for research activity. 35% of GP practices are actively involved in research, each recruiting participants into national studies. This reflects strong and sustained engagement across primary care, providing a solid platform to further expand participation and increase research impact.

Local research performance

Between April 2025 and February 2026, primary care sites across BSW ICB recruited 1,808 participants to research, this accounts for 23% of the recruitment in primary care across the SWC RRDN. Primary care sites across BSW ICB have experienced a 95% drop in recruitment to commercial studies in 2025/26 when compared to 2024/25. This reflects the regional and national picture. However, there has been a significant increase in recruitment to non-commercial studies in 2025/26 when compared to 2024/25, with BSW ICB having 54% increase in recruitment. Our top recruiting GP changes month to month, but in 2025/26, 33% of GPs across BSW ICB recruited at least one patient to a RDN portfolio study, an increase on 28% in the previous year.

NIHR research capability funding

The ICB was awarded £49,500 of research capability funding (RCF) based on the recruitment of participants to research studies in primary care and wider settings. RCF is received on behalf of partner organisations within our integrated care system and is offered to system partners to support research. These funds are used to improve local primary and community health and social care research infrastructure, to support the development of co-designed research projects, and to ultimately contribute to the health of our population through evidence generation within our health system. Awards in this year have included a grant to improve research workforce capability in BSW Research Hub and to the Brunel Health Group who will be piloting a new model of research delivery in primary care through a single principle investigator, with the aim of branching into commercial research in primary care settings.

The BSW Research Engagement Network (REN)

Our BSW Research Engagement Network received continuity funding from NHS England in 2025/26, and this funding was used to support the continuation of a number of projects.

BSW REN funded a project to increase understanding of how to leverage community pharmacies to recruit underserved populations into research studies. The money was used to offer a grant to a research secondment post for a primary care community pharmacist to undertake a scoping exercise to establish how best to increase research capacity in community pharmacies and how to engage communities that are underserved by research.

The final report highlighted an opportunity for widening participation in research and bringing research closer to communities on a more local level. The findings are being shared nationally, and proposals have been developed to help translate this understanding into impact for 2026/27.

The BSW Diversity in Health Research network has more than 130 people from 35 different organisations/sectors, and has continued to grow, moving towards a more sustainable model in a very deliberate way. The network continues to be a vibrant community for innovative solutions and valuing lived experiences for increasing diversity in research participation. BSW ICB has been successful in its application for REN funding for 2026/27 to further mature this enabler.

Health system innovation

BSW ICB continues to work closely with Health Innovation West of England (HIWE), who support innovation activity across the integrated care system (ICS). Engagement is particularly

strong with individual NHS trusts, particularly for a number of projects focusing on maternity and neonatal services, such as Black Maternity Matters, real-world evaluation of the Hegenberger retractor and HOME, an evidence-based, remote monitoring pathway designed to enhance care for those at high risk of developing hypertension during pregnancy, empowering them to stay healthy at home.

The ICS is connecting with several projects across all elements of the Health Innovation Network portfolio, with five projects within the Patient Safety Collaborative, three projects for individual innovators and/or real-world evaluation and three HIN National Programmes including the MedTech Funding Mandate. In 2026/27, BSW ICB will work with HIWE to deliver innovation aligned to the NHS 10 Year Plan, including closer collaboration with voluntary, community, faith and social enterprise (VCFSE) organisations, and local authorities.

Innovative use of technology

The ICB recognises the importance digital has in future transformation as the NHS continues to move from analogue to digital in line with the NHS 10 Year Health Plan.

Key areas of progress over the past 12 months are summarised below.

Artificial intelligence and automation

Artificial Intelligence (AI) and other new digital tools have the ability to both improve patient care and create efficiency, however we must ensure new technology is used safely. We have put in place a digital tools assurance process for GP practices to assist them in reviewing new solutions and to create sharing between practices, reducing duplication when implementing.

The ICB has put in place a generative AI policy and all staff now have secure access to Microsoft Copilot chat, allowing them to use this to summarise emails, draft documents, and turn data into insights.

Integrated care record

The integrated care record (ICR) 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. Use of the record saves the BSW health system over £13m a year through more efficient ways of working.

The ICR also provides a care planning solution for patients nearing the end of their lives, which includes the ReSPECT process. Over the past year we have also started sharing advanced care plans to ensure all the most useful information about these patients is available to paramedics should ambulance care be required. Views of this information has tripled over the past 12 months.

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.

Across BSW at any one time the equivalent of two wards worth of patients are supported with this technology whilst staying in their own homes.

NHS App

BSW residents now use the NHS App a combined 1.3 million times a month, double the level seen only two years ago.

Around 122,000 repeat prescriptions a month within BSW are now requested via the NHS App, again doubling over the past two years.

Practices across BSW send 400,000 messages via the NHS App each month making messaging more convenient and secure for patients while saving the NHS expensive SMS costs. We expect this to significantly increase over the coming year as more primary care systems gain the ability to message via the NHS App.

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 than cannot.

Single electronic patient record for primary and community care

In September 2025, the final GP practice in BSW migrated clinical system, and as a result all of primary care and community care now use a single system. This makes patient care safer as records can be securely shared. ICB reporting and data is more consistent as we only have one system to report on. Training, IT support, and software deployment are easier as staff only have to learn, create guides and operating procedures for one system.

Online GP registrations

BSW GP practices are now using the new national online register with a GP service, with over half practices also having the capability automatically register directly into their clinical systems within a few clicks. This has revolutionised how patients can register with practices.

People can check nearby surgeries, see which are accepting new patients, and make informed choices without paperwork. This makes it easier than ever for patients to register or change practice. NHS England has published a case study working with one of our practices: From paper forms to quick clicks: how online GP registration is reducing admin burden - NHS England Digital

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 now completed a significant full fibre connectivity upgrade programme across our GP practices to ensure each site has the connectivity required for the future.

Advanced analytics

Having established teams with expertise in modelling, data science and evaluation we are now deploying those analytical skills to support with making better decisions. We have supported the development of our Winter Plan using our more advanced forecasting methods to help predict when our services might be busier. We have been able to help make better investment decisions through robust evaluations of services like Hospital@Home and Care Co-ordination, highlighting how they help avoid demand on our hospitals.

Cyber security

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

The ICS Cyber Security Strategy has now been updated and approved by the ICB Board.

A digital strategy for BSW

Partner organisations across BSW have come together to agree a shared strategy to maximise the benefits of digital, data and technology. The NHS in England has identified the shift from analogue to digital as a key priority within its 10 Year Health Plan, alongside moving care from hospitals into the community and focusing on prevention rather than sickness.

Our strategy sets out how digital, data and technology will be used to empower our population, support our workforce, and enable better decision-making, underpinned by continued improvements to our digital infrastructure and cyber security.

Automation

Across BSW, organisations have released staff time through the use of robotic process automation (RPA). This software automates routine and repetitive tasks within clearly defined rules, enabling our workforce to focus on more complex tasks, while also reducing the risk of human error.

Anchor Institution

Within the work, health and skills environment, there are two main funding streams:

- Connect to Work is held by local authorities, and provides high fidelity supported employment. In Swindon and Wiltshire, part of this funding has recently been awarded to Shaw Trust to deliver individualised placement support to people facing health or disability barriers to employment. In Bath and North East Somerset, Connect to Work is commissioned by the combined authority, although effort is being made to tailor support to the different needs of the City of Bath and rural North East Somerset
- Workwell provides early intervention for people facing health barriers to employment. It is being managed centrally by the ICB cluster, with a separate allocation for each constituent ICB. The government expects delivery to start in November 2026. We are working through procurement timelines and reviewing existing services which could be scaled in order to develop a Workwell service which meets the different needs of each place

We are also beginning to explore community learning and tailored learning to support health barriers to employment and social determinants of health. This includes working with B&NES Council to use the West of England Combined Authority-funded Future Bright and Skills Connect programmes. Wiltshire Council especially is historically underfunded by government for community learning relative to other local authorities in the cluster. We have held initial conversations between the ICB, Council and Wiltshire College about accessing their tailored learning fund to deliver support which addresses health barriers to employment.

ACCOUNTABILITY REPORT

Jonathan Higman
Accountable Officer
15 June 2026

Accountability report

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

It comprises three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives
- The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate

Corporate governance report

The 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.

A list of the current BSW ICB Board members can be found on the ICB website and the full membership during 2025-26 is shown under the Board Composition section below.

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, faith and social enterprise (VCFSE) sector, NHS trusts and primary care.

In March 2025, the Government and NHS England committed to reducing the running costs of ICBs and to redirect this funding to frontline services. To deliver a reduction in running costs in this financial year, a number of ICBs clustered together to share leadership and functions; clustering ICBs remain legally separate organisations with their own financial allocations. NHS BSW ICB is in the tranche of 'clustering' ICBs (i.e. very close collaboration between ICBs and 'running as one' where permitted), and throughout 2025/26 has moved into close collaboration

arrangements with NHS Dorset ICB and NHS Somerset ICB. It is expected that the three ICBs merge in April 2027, subject to DHSC direction and approval of the merger.

During 2025/26, BSW ICB's Board was constituted per the ICB's Constitution. Constitutional amends were made, and approved by NHSE, in December 2025 to enable the appointments of joint chief officers for BSW ICB, NHS Dorset ICB and NHS Somerset ICB.

As the ICB moves into cluster governance arrangements from 1 April 2026, all committees other than the Risk and Audit Committee, will be run as joint committees between NHS Dorset, NHS BSW and NHS Somerset. Full details of these committees, including their terms of reference will be published as part of the Governance Handbook on the ICB website.

The membership of the BSW ICB Board between 1 April 2025 and 31 March 2026 was as follows:

Position on the ICB Board*	Name
Chair (until 31 August 2025)	Stephanie Elsy
Cluster Chair (from 1 September 2025)	Robert Whiteman
Chief Executive Officer (until 3 October 2025)	Sue Harriman
Cluster Chief Executive Officer (from 1 October 2025)	Jonathan Higman
Chief Finance Officer (until 18 March 2026)	Gary Heneage
Chief Officer Strategic Finance and Resources (from 18 March 2026)	Alison Henly
Chief Nurse (until 18 March 2026)	Gill May
Chief Nursing Officer (from 18 March 2026)	Shelagh Meldrum
Chief Medical Officer (until 18 March 2026)	Dr Amanda Webb
Cluster Chief Medical Officer (from 18 March 2026)	Bernie Marden
Chief Officer for Population Health Improvement (from 18 March 2026)	Dr Amanda Webb
Cluster Chief Officer for Commissioning and Place (from 18 March 2026)	David Freeman
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	Paul Fox
Non-Executive Director for Quality	Ade Williams
NHS Trusts & NHS Foundation Trusts Partner Member – acute sector	Cara Charles-Barks
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector (until August 2025; the position has remained vacant since then)	Alison Smith

Position on the ICB Board*	Name
Community Provider Partner Member	<vacant>
Local Authority Partner Member B&NES (until 31 December 2025; the position has remained vacant since then)	Will Godfrey
Local Authority Partner Member Swindon	Samantha Mowbray
Local Authority Partner Member Wiltshire	Lucy Townsend
Partner Member Voluntary, Community, Faith and Social Enterprise (VCFSE) (until 11 February 2026; the position has remained vacant since then)	Pam Webb
Partner Member Primary Care	Dr Francis Campbell

** We are 'clustering' with NHS Dorset ICB, and NHS Somerset ICB as an interim step ahead of a proposed merger by April 2027. Clustering means that we will operate as far as we can as a single organisation but remain as three statutory bodies until we formally merge. The leadership presented here reflects the leadership of the NHS BSW ICB Board and executive team during the reporting period, notwithstanding the completion of a consultation for Very Senior Managers whereby some executives have been appointed into roles covering the wider cluster.*

Board members are selected and appointed per the processes that are stipulated in the BSW ICBs Constitution. Board members undergo a rigorous fit and proper person test per the NHS England Fit and Proper Person Test Framework for board members before formal confirmation in their role. The Chair appraises non-executive Board members per the NHS Board Member Appraisal Framework and vis-à-vis the NHS Leadership and Competency Framework.

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.

Committee(s), including Audit Committee

The Board is supported in its work by its Board committees. All current committee terms of reference are published in the ICB's Governance Handbook. Among these Board committees are the mandated Audit Committee, and Remuneration and People Committee.

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

Role	Name
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, taxpayers, 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 2025 and March 2026, there were 79 incidents and near misses concerning personal data reported by ICB colleagues.

28 of these have been attributed to acts or omissions by ICB colleagues. This shows a marked improvement on the previous year.

Other organisations and individuals were wholly accountable for the remaining 51 identified incidents and near misses.

Of the 28 ICB incidents and near misses, the common theme was the accidental sharing of information about an identifiable data subject with the wrong organisation or additional recipients. In most cases this was a trusted partner organisation or another ICB colleague.

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

The ICB has not had any personal data related incidents deemed to be serious untoward incidents, or of a level that would require reporting to the Information Commissioner's Office (ICO).

The ICB has not been asked to investigate 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 Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of BSW ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

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

NHS England appointed Sue Harriman, and on her departure, Jonathan Higman 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 Integrated Care Board and enable 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 ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Jonathan Higman
Accountable Officer
15 June 2026

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).

BSW ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 April 2025 and 31 March 2026 the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

I am responsible for ensuring that BSW 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 2025 to 31 March 2026.

The main function of the Board is to ensure that the ICB 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

- Commissioning Committee

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.

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, setting out 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 four times during the reporting period.

Highlights of work undertaken during the period:

- Review of the Annual Report and Accounts for 2024/25
- Receipt and review of the internal audit reviews including core financial controls, risk management, quality and patient safety, and fit and proper persons test

- Review of the ICB corporate registers and corporate documents
- Review and assurance of the ICB's risk management arrangements and the ICB's Board Assurance Framework (BAF)
- 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 also includes seeking assurance regarding ICB workforce matters, including organisational change processes.

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

The Committee has overseen the assurance of:

- The ICB people agenda with regards the closure of the Evolve organisational change process and the commencement of the NHS-wide change programme
- BSW Equality Delivery System Report
- BSW ICB Equalities, Diversity and Inclusion Annual Employer Report 2024-25
- NHS Staff Survey results
- Internal workforce report
- Freedom to Speak Up quarterly report
- The fit and proper persons test annual return

To aid cluster collaboration and collective, timely decision-making, the BSW ICB, Dorset ICB, and Somerset ICB Remuneration Committees have met in-common since August 2025. Nine meetings were held during this reporting period, considering business such as:

- The BSW, Dorset, and Somerset Cluster ICB Chief Executive appointment and remuneration
- Executive team consultation and Chief Officer appointment process
- The cluster-adopted voluntary redundancy scheme and associated redundancy business cases for each ICB
- The cluster organisational change policy

- The proposed draft Joint Remuneration Committee terms of reference (to come into effect after Board approval)

Finance and Infrastructure Committee

The Finance and Infrastructure 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.

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 Committee received regular performance reports, to obtain assurance on the development, implementation and effectiveness of plans to support system recovery, performance improvement and effectiveness.

The Finance and Infrastructure Committee met 14 times during the reporting period. It oversaw the development of the Medium Term Plan and the financial plan submissions, and considered:

- Financial performance, risks and position reports
- System-wide recovery programme
- BSW Green Plan
- BSW Cyber Strategy

This also included two meetings held jointly with the ICB Commissioning Committee to review and sign off the BSW Medium Terms Plan ahead of submission, as delegated by the BSW ICB Board.

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 met seven times during the reporting period, and considered the:

- BSW Safeguarding Annual Report
- BSW Children Looked After Annual Report
- Patient safety and operational reports
- BSW Infection Prevention and Management Annual Report
- BSW Population Health Board updates

An extraordinary meeting was also held to enable the Committee to seek assurance that a robust process had been followed as part of the development of the equality quality impact assessment (EQIA) in support of the Medium Term Plan. The Committee received regular performance reports, to obtain assurance on the development, implementation and effectiveness of plans to support system recovery, performance improvement and effectiveness.

Commissioning Committee

The Commissioning 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 also concerns public engagement and involvement duties regarding service design, planning and change.

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 eight times during this reporting period receiving regular overarching commissioning assurance reports. It considered:

- BSW Medium Term Plan and Commissioning Intentions for 2025-26
- Neighbourhood Health Plan
- Emerging contract business cases
- The associated risk register
- BSW Better Care Fund Plan

This also included two meetings held jointly with the ICB Finance and Infrastructure Committee to review and sign off the BSW Medium Terms Plan ahead of submission, as delegated by the BSW ICB Board.

Transition Committee

The core purpose of the Transition Committee is to oversee the safe and coherent transition of the three ICBs into their future operating model in line with national guidance.

The Committee has met nine times during the reporting period and is currently chaired by Rob Whiteman, Cluster Chair.

During the reporting period, the key highlights of the work of the Committee included:

- providing oversight and assurance on the work of the transition programme and its workstreams, including reviewing the risks on the transition risk register
- recommending to the ICB Boards arrangements for Board and Cluster Board composition and arrangements for cluster governance
- consideration of the cost of change for the ICBs
- reviewing the Target Operating Model and the alignment of strategic commissioning intentions for the cluster.

Integrated Care Partnership

The Integrated Care Partnership is a statutory committee formed by the ICB, and brings together the NHS, local government, the voluntary, community, faith and social enterprise (VCFSE) 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.

BSW System Quality Group

The BSW System Quality Group (SQG) is a strategic forum at which partners from across health, social care, public health and wider organisations within the ICS can join up around common priorities linked to the ICP strategy, routinely and systematically share insight and intelligence, identify opportunities for improvement and concerns/risks to quality, and develop system responses to enable ongoing improvement in the quality of care and services across the ICS.

Members of the Group include B&NES, Swindon and Wiltshire local authorities, South West NHS England team, CQC, Health Education England, public health, primary care, Local Maternity and Neonatal System Board, and lay members with lived experience, including Healthwatch.

South West Ambulance Partnership Board

The South West ICBs agreed a principal commissioner model for the commissioning of ambulance services across the South West region. The key governance forum within this arrangement is 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 principal 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
- Cornwall and Isles of Scilly
- Devon
- Dorset
- Gloucestershire
- Somerset

South West Joint Specialised Services Committee

The commissioning of specialised services was delegated by NHS England to each of the seven South West ICBs from 1 April 2025, in seven separate portfolios by seven separate delegation agreements. The ICBs and NHS England entered into an ICB collaboration agreement under which six of the ICBs further delegated their portfolio to Somerset ICB designated as the principal commissioner, which became responsible for the combined portfolio.

The ICBs covered by these joint commissioning arrangements are:

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

The South West Joint Specialised Services Committee has continued 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.

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 Board received regular performance, quality and finance reports, to obtain assurance on the development, implementation and effectiveness of plans to support system recovery, performance improvement and effectiveness.

The business items covered included:

- BSW Operational Plan 2025-26
- ICB Review of Intensive and Assertive Community Treatment for People with Severe Mental Health Challenges (Psychosis) – Update report
- BSW ICS Winter Planning 2025/26 Board Assurance Statement and Winter Plan
- ICB governance review and corporate documents
- Update on the Health Inequalities Programme
- BSW Medium Term Plan and Commissioning Intentions
- BSW Green Plan
- BSW Cyber Strategy

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.

Board attendance at meetings

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

Note: Figures shown in orange indicate attendance as a non-voter.

Total number of meetings 1 April 2025 to 31 March 2026:		6	4	13 (9 in-common)	7	13	7	9
Position on the ICB Board	**Name**	**ICB Board (Meetings held in public)**	**Audit Committee**	**Remuneration and People Committee**	**Quality and Outcomes Committee**	**Finance and Infrastructure Committee**	**Commissioning Committee**	**Transition Committee**
Chair (until 31 August 2025)	Stephanie Elsy	2	0	5		2	3	2
Cluster Chair (from 1 September 2026)	Rob Whiteman	4	0	9		0	0	9
Chief Executive Officer (until 3 October 2025)	Sue Harriman	3	1	4	1	3	3	2
Cluster Chief Executive (from 1 October 2026)	Jonathan Higman	4 (1 as observer)	0	8				9
Chief Finance Officer (until 18 March 2026)	Gary Heneage	5	4			12	5	
Chief Nurse (until 18 March 2026)	Gill May	6			6		7	
Chief Medical Officer / Cluster Chief Officer for Population Health Improvement (from 18 March 2026)	Dr Amanda Webb	5			4	8		
Cluster Chief Officer Strategic Finance and Resources (from 18 March 2026)	Alison Henly	2 (1 as observer)	1	2		1		
Cluster Chief Medical Officer (from 18 March 2026)	Bernie Marden	2 (1 as observer)						

Total number of meetings 1 April 2025 to 31 March 2026:		6	4	13 (9 in-common)	7	13	7	9
Position on the ICB Board	**Name**	**ICB Board (Meetings held in public)**	**Audit Committee**	**Remuneration and People Committee**	**Quality and Outcomes Committee**	**Finance and Infrastructure Committee**	**Commissioning Committee**	**Transition Committee**
Cluster Chief Nursing Officer (from 18 March 2026)	Shelagh Meldrum	2 (1 as observer)						
Cluster Chief Officer for Commissioning and Place (from 18 March 2026)	David Freeman	1 as observer						
Non-Executive Director for Audit and Governance	Dr Claire Feehily	4	4					
Non-Executive Director for Patient and Community Engagement	Julian Kirby	6	4	13	6	12	7	8
Non-Executive Director for Remuneration and People	Suzannah Power	4	3	11	4			
Non-Executive Director for Finance	Paul Fox	6		12		12	5	
Non-Executive Director for Quality	Ade Williams	5		8	6	8	4	
NHS Trusts & NHS Foundation Trusts Partner Member – acute sector	Cara Charles-Barks	6			2			
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector (until August 2025) (the position has remained vacant)	Alison Smit	2						

Total number of meetings 1 April 2025 to 31 March 2026:		6	4	13 (9 in-common)	7	13	7	9
Position on the ICB Board	**Name**	**ICB Board (Meetings held in public)**	**Audit Committee**	**Remuneration and People Committee**	**Quality and Outcomes Committee**	**Finance and Infrastructure Committee**	**Commissioning Committee**	**Transition Committee**
Local Authority Partner Member B&NES (until 31 December 2025) (the position has remained vacant)	Will Godfrey	2					1	
Local Authority Partner Member Swindon	Samantha Mowbray	3				4		
Local Authority Partner Member Wiltshire	Lucy Townsend	5			3			
Partner Member Voluntary Community and Social Enterprise (VCFSE) (until 11 February 2026) (the position has remained vacant)	Pam Webb	5					7	
Partner Member Primary Care	Dr Francis Campbell	6						
Community Provider Partner Member	the position has remained vacant	0						

Health and safety and internal control

The Board is responsible for maintaining a sound system of internal control that supports the achievement of the ICB's objectives, while safeguarding public resources and ensuring compliance with statutory and regulatory requirements. The Chief Finance Officer is accountable for ICB Health and Safety management and oversight on behalf of the Board and Chief Executive.

Health and safety risks are managed through established policies, controls, and reporting arrangements, including oversight of ICB estates related safety risks where relevant. During the year, no significant health and safety internal control issues requiring disclosure were identified. Where risks arise, they are assessed, managed, and escalated in accordance with the ICB's risk management framework. The ICB has an agreement in place with Salisbury NHS Trust to provide 'component person' advice for health and safety matters.

Assurance

The Board has reviewed the effectiveness of the system of internal control in respect of infrastructure, sustainability and health and safety matters through appropriate committees, informed by reporting on management assurance, and relevant internal and external sources of assurance. On this basis, the Board is satisfied that appropriate governance and oversight arrangements are in place

Provider Selection Regime: Required reporting – Regulations 25 and 26

In relation to the period 1 April 2025 to the end of March 2026, the ICB has directly awarded 12 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
0	1	11

- The number of contracts awarded under the Most Suitable Provider (MSP) process: 3
- The number of contracts awarded under the Competitive Process: 2
- The ICB has not concluded any framework agreements and has not awarded any contracts based on a framework agreement
- The number of urgent contracts awarded/modifications: 2
- New providers awarded a contract in this period: 1
- The number of providers who ceased to hold a contract with BSW ICB: 3
- Representations received in writing and during standstill period in accordance with Regulation 12(3): 2. The first of these followed a PSR Competitive Process. The representation was closed once the ICB panel response was accepted by the provider. The second was received during March 2026 in relation to a Direct Award Process C and the ICB panel response is currently in process

The ICB is currently contracted with 50 healthcare providers.

There have been no requests for consideration received by the Independent Patient Choice and Procurement Panel.

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.

UK Corporate Governance Code

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

BSW ICB does however look to the UK Code for good practice.

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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

As ICBs finalise their future new operating structure in line with the revised running cost allowance and the direction set out in the Model ICB Blueprint, NHS England asked each ICB to provide an assurance statement. BSW, Dorset and Somerset ICBs each considered the functions for which they are accountable under current legislation, under formal delegation from NHSE, and as described in the Model ICB Blueprint, with specific regard to the current national position on functions identified as 'review for transfer', and the good practice guides shared on Continuing Healthcare, infection prevention and control, safeguarding, special educational needs, and medicines optimisation. Each ICB confirmed it was confident that the proposed 'to be' cluster structure enables the effective and efficient discharge of these functions within the £19 per head running cost allowance.

Risk management arrangements and effectiveness

The ICB's risk management approach is informed by and follows The Orange Book – Management of Risk – Principles and Concepts. The ICB's risk management processes to identify, assess, treat, monitor and report risks align with those described in the Orange Book.

The ICB's Board approves the ICB's approach to risk, which includes determination of the organisation's risk appetite. Quarterly risk reports keep the Board informed of both the top operational risks that the organisation faces, and of the risks to the organisation's ability to achieve its strategic objectives. The Audit Committee regularly scrutinises the appropriateness of the ICB's risk management arrangements and assures the Board thereof; and internal audit regularly probes and assesses in depth the ICB's risk capabilities.

The ICB's approach to risk and risk management is integrated into the organisation's activities. Responsibilities for identifying, assessing, monitoring and reporting risks sits with departmental leads.

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, for assurance, by the Audit Committee.

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

In May 2025, the Board approved the ICB's fully revised Board Assurance Framework (BAF). In its new format, the BAF contextualises the risks to achieving the ICB's strategic aims and objectives within analysis of the ICB's local, regional and national operating environment.

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.

The Performance Analysis section describes the top risks that the ICB and the system faced in 2025/26 and summarises respective main controls and key mitigations to contain and manage the risk.

As described in the Performance Analysis, the ICB and the system had arrangements and mechanisms in place to collectively support the improvement of performance and effectiveness. This included the regular consideration of risks to the Delivery Groups' delivery of agreed plans and KPIs. The Recovery Board oversaw and advised the ICB Board on the contemporary risk exposure with regard to the short- and long-term recovery plans and associated recovery strategies.

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 maintained 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.

An audit for the ICB's BAF was undertaken by KPMG in quarter four, with findings reported to the Audit Committee in March 2025. KPMG issued a rating of "significant assurance with minor improvement opportunities."

The Board's assurance committees – Finance and Infrastructure, People, Quality and Outcomes, Public and Community Engagement, Commissioning – 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. It 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 has 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 2025/26.

The highest scoring risks identified during the reporting period are referenced in the Performance Report section on page 14 of this document.

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 VCFSE Alliance brings together the voices of the voluntary, community, faith and social enterprise (VCFSE) 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 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.

Conflicts of interest management

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own conflicts of interest policy. The ICB published its Standards of Business Conduct policy and the register of interest for key decision-makers on its website. The policy describes how the ICB identifies, records and manages perceived and actual conflicts of interest. Compliance with the policy is closely monitored, and both mandatory national e-learning modules on managing conflicts of interest and internal guidance have supported all individuals in scope of the policy to comply with and apply the policy.

Data quality

The Board, in addition to its committees and sub-committees, receives information provided by the ICB Analytics Teams that is sourced from national mandatory returns, from local providers, and NHS England information.

This data is subject to data quality checks from providers prior to submission, from NHS England as part of the national collation process, and from the ICB as part of its data management and reporting processes. Information is also sourced directly from local providers, and this is validated by the ICB Team, as well as against national information and guidance, wherever available. The ICB works to ensure an appropriate balance between providing timely, caveated information, and information which is delayed but has been thoroughly validated.

During 2025/26 the ICB has again broadened the data it collects and processes to ensure the Board has effective oversight of system performance, as well as the needs of the BSW population and how well these are being met by the spectrum of services we commission. Where gaps are identified, the ICB works collaboratively with providers and relevant agencies to resolve these.

The Board has previously 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 (DSPT), 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 DSPT.

The ICB submitted a completed DSPT on 20 June 2025. The submission provided a status of 'Standards Met.'

There is a suite of UK 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 reflecting a strong incident 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 ensures that root causes are determined with lessons learned and mitigation to prevent reoccurrence put in place.

ICB colleagues understand the importance of privacy by design and default completing data protection impact assessments (DPIA) to identify and analyse information risk. The legal sharing of information between integrated care system 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 also relies on national services and systems provided by the NHS Business Services Authority and Primary Care Support England (PCSE). These systems and processes support dental, prescription and primary care payment and administration processes along with the Electronic Staff Record system (ESR). Annual Internal auditor assurance letters are shared with the Chief Financial Officer by the organisations

- 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 formally reported the following control issues to NHSE:

Continuing Healthcare assessment target

At the end of Quarter-3 BSW had achieved 53% completion of assessments within the expected 28 days compared to the Quality Standard of 80%. This is a recognised risk on the risk register scoring more than 15. The current mitigations, with the expectation of achieving the target at the end of Quarter-4 is employment of agency admin and clinical staff, review of allocation processes, closer collaboration with cluster colleagues to support border working and enhancing training and development opportunities. Oversight of the Quality Standards is through the Continuing Healthcare efficiency group chaired by the Chief Nursing Officer and Chief Finance Officer.

Accident and emergency target

The target performance levels have not been achieved. The following mitigations have been put in place:

1. A system coordination centre is in place which monitors urgent and emergency care (UEC) performance daily
2. Monthly BSW Urgent Care and Flow Delivery Group meetings held, chaired by the Acute Group lead for UEC, with all system partners which includes quality representatives. Weekly system overview meetings with all system partners, as well as quality representatives
3. UEC Quality and Safety Group in place, chaired by Deputy Chief Nurse at RUH, with acute and community partners represented including quality representatives
4. UEC performance and quality metrics monitored regularly via a number of different forums and groups
5. UEC demand and capacity review with actions identified to support increase in demand planned
6. Assurance monitoring and quality improvement is aligned to BSW Quality and Improvement Framework (QAIF), which describes the agreed process for system governance and principles for oversight of patient safety, experience and effectiveness of services
7. Identified UEC quality metrics are monitored, as set out in this framework, and reported to both the Quality and Outcomes Committee and BSW System Quality Group
8. UEC improvement plans in place across the acute trusts, as well as over-arching UEC project plan for the system

Ambulance services targets
The target performance levels have not been achieved. The following mitigations have been put in place:

1. Wait 45 live from 6th October to support timely handovers
2. Timely Handover Process SOP in place
3. Ambulance handover delays and ambulance response times are monitored daily and via the BSW operational system calls led by the System Coordination Centre
4. Acute providers have internal escalation plans around ambulance handovers
5. Acute providers have SOPs in place around the use of escalation spaces to support offloading ambulances
6. Weekly BSW Ambulance Improvement Group with system partner attendees as well quality representatives
7. Assurance monitoring and quality improvement is aligned to BSW Quality and Improvement Framework (QAIF), which describes the agreed process for system governance and principles for oversight of patient safety, experience and effectiveness of services
8. Identified UEC quality metrics are monitored, as set out in this framework, and reported to both the Quality & Outcomes Committee and BSW System Quality Group
9. BSW Care Coordination Centre in place and reporting through to HCRG. Service provides clinical advice and redirection on appropriate patients to alternative clinical pathways including community services and pathways. Supported by South Western Ambulance Service NHS Foundation Trust (SWAST) Specialist Paramedic to identify potential patients from 999 ambulance stack to prevent need for ambulance response
10. Hospital handover delays risk on ICB Risk Register is updated and reviewed regularly
11. Quality and Outcome Committee has direct oversight of performance, including patient harm

Cancer targets
Performance for the three BSW Acute providers (GWH, SFT and RUH) remains very challenging, the most challenged tumour sites being haematology, breast, colorectal, lung, gynaecology, and skin (dermatology and plastics). The key challenges relate to workforce, both clinical and non-clinical. A number of action plans are in place to improve performance including digital dictation, insourcing and outsourcing, review of PTL processes, use of AI and RPA tools, development of tele-dermatology, new diagnostic test rollout within CDC's. All providers have been involved in the cancer 360 roll-out. Ongoing performance is likely to be challenging going forward.

Elective targets
RUH Bath remains in Tier 1 for performance delivery. Progress is being made in reducing the volume of patients exceeding a 52 week wait. Use of Sulis continues as a mechanism to support long waiting patients. Use of inter-provider transfers take place to level waits as much as possible. Fortnightly tiering meetings with NHS England continue.

All trusts have achieved significant reduction in patients waiting more than 65 weeks (3.5% of total waiting list at the start of the financial year) however challenges remain within plastics at

both SFT and GWH. Ongoing reviews of long waiting patients on a weekly basis support continued reduction in waiting times.

The following mitigations have been put in place:

1. Regular interface and data sharing with all three providers takes place to ensure consistent application of GIRFT standards, particularly in respect of outpatients
2. Elective Delivery Group oversees delivery of programmes as set out in the operational plan for 2025/26
3. Local Trust performance meetings are in place to support oversight and review of patient tracking lists (PTLs)
4. Clinical pathways redesign programme being developed for 2026/27 - focus on ENT, cardiology, respiratory, urology, general surgery and dermatology
5. Assurance monitoring and quality improvement is aligned to the BSW Quality and Improvement Framework (QAIF), which describes an agreed process for system governance and the principles for oversight of patient safety, experience and effectiveness of services
6. Identified Planned Care quality metrics and standards, including safety and experience metrics, clinical audit and outcomes from Getting it Right First Time (GIRFT) visits are being aligned to performance reporting (as set out in this framework) and will be reported to both the Quality and Outcomes Committee and BSW System Quality group in Quarter-1 2026/27

Diagnostics targets
Delivery of 6 weeks diagnostics standard has proved challenging in-year.

The following mitigations have been put in place:

1. Continued focus on making best use of community diagnostic centre (CDC) capacity to support reduction in waiting times pan-system. Improvement starting to be seen but must be sustained
2. Diagnostics Strategy developed pan-system. Engagement with system partners underway to ensure rapid access and pre-appointment diagnostics where clinically appropriate
3. Overarching diagnostics workforce plan in development to ensure that long waits as a result of staffing challenge are mitigated (particularly non-obstetrics ultrasound).
4. Capital investment plan for diagnostics developed to support further expansion of CDCs and replacement of equipment where required. Alignment with Neighbourhood Health underway to ensure focus on local service provision of high volume low complex diagnostics (e.g. echo, non-obs ultrasound).
5. Diagnostics Delivery Group being established as sub-group of Elective Delivery Group to oversee both strategic development and operational delivery

System financial control total
The ICB has met all of its statutory financial metrics but the wider NHS system including the BSW Hospitals Group has not delivered on the expected system financial control total.

Review of economy, efficiency & 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 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 statutory financial targets for the period are set out within the notes of the Financial Statements. Further detail on efficiency is set out within the financial review section. Performance against central management costs (running costs) is part of monthly budget monitoring routines.

Further information on performance is set out within the Performance Analysis section. With regards to quality of leadership, this is assessed against three areas but only one of these is measured at ICB level.

Commissioning of delegated services (primary care services and specialised services)

BSW ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

The ICB has had a delegation memorandum of understanding and service level agreement with Somerset ICB for the provision of Collaborative Commissioning Hub activities connected to the delegated commissioning of community pharmacy, and primary care eye care and dental services. Assurance in relation to these services is supported through collaborative monitoring arrangements between the ICB and the South West Collaborative Commissioning Hub. The national Commissioning Assurance Framework sets out how NHS England will be assured across four domains (compliance with mandated guidance, service provision and planning, contracting and contractor / provider compliance and performance) that ICBs are exercising the delegated functions safely, effectively, and in line with legal requirements. NHSE recorded an assessment of “substantial” across all four areas of primary care commissioning in the most recent assessment for the ICB. Regular meetings are held, including the Customer Management 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.

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.

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 2025/26 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 2025 to 31 March 2026 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

We provide an annual conclusion over four components; governance, risk management and control; defined as financial reporting and management and data captured and used by the organisation. These are aligned with the requirements of the Global Internal Audit Standards (GIAS) as applied to the public sector by the application note for Global Internal Audit Standards in the UK Public Sector by relevant standard setters. During 2025/26 KPMG completed a total of nine reviews; based on the controls reviewed the following conclusions have been drawn.

- Governance: *Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed the need to improve the operating effectiveness of controls.*

- Risk management: *Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed some controls to be operating effectively and others could be more consistently applied.*

- Financial reporting and management: *Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed some controls to be operating effectively and others could be more consistently applied.*

- Data captured and used by the organisation: *Overall findings on design show some controls to be effectively designed with some exceptions. Our testing showed some controls to be operating effectively and others could be more consistently applied.*

During the period, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Data Security Protection Toolkit 2024/25 (September 2025)	Significant assurance with minor improvement opportunities
Fit and Proper Persons Test (December 2025)	Partial assurance with improvements required
Quality and Patient Safety Governance (December 2025)	Significant assurance with minor improvement opportunities
Prescribing (March 2026)	Significant assurance with minor improvement opportunities
Risk Management - Board Assurance Framework (March 2026)	Significant assurance with minor improvement opportunities
IEG4 Care Package Payments (February 2026)	Significant assurance with minor improvement opportunities
Efficiency Planning (April 2026)	Significant assurance with minor improvement opportunities
Data Security Protection Toolkit 2025/26 (May 2026)	Significant assurance with minor improvement opportunities

The Fit and Proper Person Test (FPPT) review signalled a requirement for the ICB to make improvements to its process and framework to ensure there is consistent completion of FPPT checks, and assurance gained over the completion of FPPT for partner members by their employing organisation. In response to this the ICB has a process improvement action plan in place. A FPPT Standard Operating Procedure has been produced in support of the process and implementation of these improvements. The FPPT check template has been revised to facilitate all check requirements and improve records. Full FPPT checks are to be undertaken for all Board members during March in readiness for the transition to cluster arrangements.

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.

Conclusion

Noting the control issues and mitigations identified and reported to NHS England, 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.

Jonathan Higman
Accountable Officer
15 June 2026

Remuneration and staff report

This report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the ICB. This means those who influence the decisions of the ICB. Such persons will include advisory and lay members. In defining this, the ICB has determined its senior managers to the ICB Board, excluding those members not directly employed by the ICB, and the executive leadership team.

Remuneration report

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:

Role	Name
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)	Paul Fox
BSW ICB Non-Executive Director (Quality)	Ade Williams
BSW ICB Chair (until 31 August 2025)	Stephanie Elsy

Fair pay disclosure (AUDITED)

Reporting bodies are required to disclose separately, for salary and allowances, and performance pay and bonuses:

- the percentage change from the previous financial year in respect of the highest paid director, and
- the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
2025-26		
The percentage change from the previous financial year in respect of the highest paid director	-13.79%	0%

	Salary and allowances	Performance pay and bonuses
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	7.79%	0%
2024-25		
The percentage change from the previous financial year in respect of the highest paid director	7.4%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	7.6%	0%

The percentage change stated in the table above for the highest paid director reflects the movement in the mid-point of their banded remuneration. The decrease is due to the ICB clustering process – compared to the previous year, the ICB did not have a full time chief executive in post at 31st March 2026. As outlined in this report, BSW ICB is clustering with NHS Dorset ICB and NHS Somerset ICB and guidance states that for this calculation, only the cost to the ICB should form part of the calculation for this disclosure.

The percentage change for employees as a whole is due to the impact of the pay award for NHS employees in 2025/26, added to a reduction in whole time equivalent staff during the year.

Pay ratio information

The ICB is required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in BSW ICB in the reporting period 1 April 2025 to 31 March 2026 was £265,000 to £270,000 (2024/25; £215,000 to £220,000).

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

2025/26	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	£37,865	£50,281	£68,720
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	£37,796	£50,273	£68,331

2025/26	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Ratio of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	5.0 :1	3.7 :1	2.7 :1
Ratio of the salary component of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	5.0 :1	3.7 :1	2.7 :1

2024/25	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	£36,487	£48,544	£66,249
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) (£)	£36,483	£48,526	£66,246
Ratio of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	6:1	4.5:1	3.3:1
Ratio of the salary component of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	6:1	4.5:1	3.3:1

During the reporting period 2025/26, 0 employees received remuneration in excess of the highest-paid director/member (2024/25: 0).

Remuneration ranged from £24,937 to £188,623 (2024/25 £24,071 to £215,163), 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 termination payments in accordance with existing Agenda for Change and very senior manager (VSM) arrangements, as well as the NHS provider and ICB pay ranges for the financial year 2025/2026. The ICB

executives notice periods were increased during this financial year to align with executive notice periods across the BSW, Dorset and Somerset cluster and NHS England.

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.

The remuneration takes 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 their own remuneration.

NHS England published an updated pay range for the financial year 2025/2026 for ICB executives on 18 June 2025 but it was effective from 1 April 2025. The updated pay ranges detail the minimum and maximum operational salary ranges for ICB CEOs and ICB Executive Directors and the salaries in the exception zone. All appointment and salary data is to be reported annually moving forward to allow any equity issues to be identified.

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 3.25 per cent in line with the recommendation made by the Senior Salaries Review Body for Very Senior Managers, which was applicable from 1 April 2025.

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.

The Remuneration Committee does not consider the remuneration or terms and conditions for non-executive members of the Board, due to the material conflicts of interest that the Committee members would have. When considering and setting the remuneration of appointed non-executive members of the Board, the Remuneration Committee and the Board, the Chair takes into account available NHS guidance, and comparative data from other ICBs and NHS organisations.

During December 2025, a consultation was undertaken with the BSW VSMs to form one Executive Board across the cluster. Following the consultation and associated selection processes two BSW VSMs secured roles.

Remuneration of very senior managers

The ICB has taken robust steps to ensure the remuneration of all very senior managers (VSMs) 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 and 2025/2026 ICB pay ranges.

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 3.25 per cent, which was applicable from 1 April 2025.

The new VSM pay range framework for 2025/2026 set out the thresholds and the process for when a pay case would need to be submitted to NHS England if the VSM proposed pay exceeded the agreed levels within the framework. BSW ICB did not need to submit any pay cases to NHS England during 2025/2026 as the sole reason for any VSM salaries going above the threshold was due to implementing the SSRB's pay recommendations for 2025/2026.

Senior manager remuneration (including salary and pension entitlements) 2025/26 (AUDITED)

Name	Title	Note	Salary (bands of £5,000) *6*	Expense payments (taxable) to nearest £100 *3*	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
Suzanne Harriman	Chief Executive Officer, BSW ICB (to 5th October 2025)	2	105-110	-	-	27.5 - 30	135 - 140
Jonathan Higman	Chief Executive Officer, Cluster ICB (from 1st October 2025)	1	40 - 45	100	-	-	40 - 45
Dr Amanda Webb	ICB Medical Director / Chief Officer for Population Health Improvement		180 - 185	100	-	65 - 67.5	245 - 250
Gary Heneage	ICB Chief Finance Officer (to 31st March 2026)	1	180 - 185	100	-	60 - 62.5	240 - 245
Rachael Backler	ICB Chief Delivery Officer (to 31st March 2026)	1	150 - 155	-	100 - 105	45 - 47.5	300 - 305
Gillian May	ICB Chief Nurse		155 - 160	200	-	67.5 - 70	225 - 230
Gordon Muvuti	ICB Place Director / Place Director, Swindon		145 - 150	-	-	-	145 - 150
Sarah Mair (previously Sarah Green)	ICB Chief People Officer (to 7th January 2026)	1	105 - 110	-	-	20 - 22.5	300 - 305
Laura Ambler	ICB Place Director (to 4th January 2026)	1	95 - 100	200	-	42.5 - 45	140 - 145
Caroline Holmes	ICB Place Director	1	130 - 135	400	-	32.5 - 35	165 - 170
Lucy Baker	ICB Place Director (from 1st February 2026)	1	20 - 25	200	-	0 - 2.5	20 - 25
Stephanie Elsy	ICB Independent Chair (to 31st August 2025)	1, 4	20 - 25	300	-	-	25 - 30
Rob Whiteman	Chair, Cluster ICB (from 1st September 2025)	2	10 - 15	100	-	-	10 - 15
Dr Francis Campbell	Partner Member Primary Care	6	35 - 40	-	-	30 - 32.5	65 - 70
Suzannah Power	Non-Executive Director (Remuneration & People)	4	15 - 20	-	-	-	15 - 20
Claire Feehily	Non-Executive Director Audit	4	15 - 20	-	-	-	15 - 20
Julian Kirby	Non-Executive Director Public & Community Engagement	4	15 - 20	100	-	-	15 - 20
Paul Fox	Non-Executive Director (Finance)	4	10 - 15	100	-	-	10 - 15
Adeyemi Williams	Non-Executive Director (Quality)	4	15 - 20	-	-	-	15 - 20

Notes

1. Where senior managers were in the NHS Pension Scheme for the whole year, but 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. This applies to:
   Sue Harriman who left the ICB on 5th October 2025
   Lucy Baker was appointed as a senior manager from 1st February 2026.
   Where senior managers were in post for part of the financial year, but not in the NHS Pension Scheme for the whole year, figures relating to all pension related benefits have not been pro-rated. This applies to:
   Sarah Green, who left the ICB on 7th January 2026.
   Laura Ambler, who left the ICB on 4th January 2026.
   Rachael Backler left the ICB on 31st March 2026.
   Stephanie Elsy left the ICB on 31st August 2025.
   Gary Heneage was no longer a senior manager from 31st March 2026, although remains an ICB employee.
2. The salary figures shown for senior managers above include recharges in from other NHS organisations.
   Jonathan Higman was appointed as Chief Executive of the NHS BSW ICB, NHS Dorset ICB and NHS Somerset ICB cluster from 1st October 2025. He is employed by NHS Somerset ICB and his costs are recharged on a proportionate basis to the cluster ICBs (one third to each ICB). His full salary costs for 2025-26 are within the band, £235,000 to £240,000.
   Rob Whiteman was appointed to the Chair of the NHS BSW ICB, NHS Dorset ICB and NHS Somerset ICB cluster from 1st September 2025. He is employed by NHS Dorset ICB and his costs are recharged on a proportionate basis to the cluster ICBs (one third to each ICB). His full salary costs for 2025-26 are within the band, £70,000 to £75,000.
   Their full salary and pension information can be reviewed in the annual reports of their employing ICBs.
3. 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.
4. The Chair and 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.
   Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The

Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

5. Salary includes any salary sacrifice arrangements under the ICBs lease car scheme.
6. Dr Francis Campbell holds a second remunerated position in the ICB as a clinical lead. The salary for this role is in the band £5,000 - £7,500.
7. The ICB Board includes attendees that receive no remuneration and are not considered to be senior managers:
   Cara Charles-Barks, Partner Member NHS Trusts and Foundation Trusts - Acute sector
   Alison Smith, Partner Member NHS Trusts and Foundation Trusts - Mental Health sector (to August 2025)
   Will Godfrey, Partner Member Bath & North East Somerset Council (to 31st December 2025)
   Samantha Mowbray, Partner Member Swindon Borough Council
   Lucy Townsend, Partner Member Wiltshire Council
   Pam Webb, Partner Member Voluntary, Community, Faith and Social Enterprise sector (to 11 February 2026)

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

1. 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.

2. The salary figures shown for senior managers above include recharges out to, and recharges in from other NHS organisations.

3. 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.

4. 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.

5. 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.

6. Salary includes any salary sacrifice arrangements under the ICBs lease car scheme.

7. Fiona Slevin-Brown left the ICB Place Director role on the 30th September 2024

8. On 2nd September 2024, Caroline Holmes took on the role of ICB Place Director

9. Paul Miller left the ICB at end of October 2024.

10. Dr Francis Campbell held a second remunerated position in the ICB as a clinical lead. The salary for this role is the band £5,000 - £7,500.

11. The ICB Board includes attendees that are not considered senior managers and receive no remuneration. Please refer to note 22 of the 2024/25 accounts for further information.

Office Holder changes notes:
NHS Bath and North East Somerset, Swindon and Wiltshire ICB (BSW ICB) is 'clustering' with NHS Dorset ICB and NHS Somerset ICB as an interim step ahead of a proposed merger by April 2027. Clustering means that the ICBs will operate as far as possible as a single organisation but remain as three statutory bodies until a formal merger. The leadership presented in the table for 2025/26 above reflects the BSW ICB Board and executive team during the reporting period, notwithstanding the completion of a consultation for very senior managers whereby some executives have been appointed into roles covering the wider cluster.

Due to the clustering arrangements noted above, there was a recruitment process for the role of Cluster Chair, resulting in the appointment of Rob Whiteman on 1st October 2025. Paul von der Heyde was appointed as Deputy Cluster ICB Chair on 1st September 2025.

Jonathan Higman was appointed as Chief Executive Officer of the Cluster ICB on 1st October 2025. He is employed by NHS Somerset ICB, and his salary costs have been recharged three ways from this date, in equal shares to NHS BSW ICB and NHS Dorset ICB. The remuneration table above shows the cost charged to BSW ICB. His full pension information is disclosed within the NHS Somerset ICB annual report.

The following individuals have been appointed to Cluster ICB executive roles from 1st January 2026.

- Alison Henly, Chief Officer for Strategic Finance and Resources
- Dr Bernie Marden, Chief Medical Officer
- Shelagh Meldrum, Chief Nursing Officer

Their salary and pension information can be seen within the NHS Somerset ICB annual report.

- David Freeman, Chief Officer for Strategic Commissioning and Place

His salary and pension information can be seen within the NHS Dorset ICB annual report.

- Dr Amanda Webb, Chief Officer for Population Health Improvement

Her salary and pension information is shown in the tables within this report.

Pension benefits

Pensions Disclosure - 2025/26 (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 2026 (Bands of £5,000)	Lump sum at retirement age related to accrued pension at 31 March 2026 (bands of £5,000) ❷	Cash equivalent transfer value at 1 April 2025	Real increase in Cash equivalent transfer value	Cash equivalent transfer value at 31 March 2026 ❸	Employers contribution to stakeholder pension
			£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Sue Harriman	BSW ICB CEO	❶	2-2.5	0	65 - 70	145 - 150	1428	39	1541	0
Gary Heneage	ICB Chief Finance Officer		2.5 - 5	0	35 - 40	0	461	46	538	0
Gill May	ICB Chief Nurse	❹	2.5 - 5	2.5 - 5	90 - 95	230 - 235	151	36	209	0
Dr Amanda Webb	ICB Medical Director		2.5 - 5	0 - 2.5	30 - 35	45 - 50	436	44	510	0
Laura Ambler	ICB Place Director	❶	2.5 - 5	0	10 - 12.5	0	81	38	133	0
Rachael Backler	ICB Chief Delivery Officer		2.5 - 5	0	25 - 30	0	300	24	349	0
Lucy Baker	Place Director, Bath and North East Somerse	❶	0 - 2.5	0	45-50	105-110	931	1	972	0
Sarah Mair (previously Sarah Green)	ICB Chief People Officer	❶	0 - 2.5	0 - 2.5	20 - 25	20 - 25	413	28	461	0
Caroline Holmes	ICB Place Director		2.5 - 5	0	10 - 15	5 - 10	183	23	226	0
Dr Francis Campbell	Partner Member		0 - 2.5	0	15 - 20	35 - 40	269	21	297	0

Notes

1. Where senior managers were in post for part of the financial year and were in the NHS pension scheme for the remaining part, 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.
   The following senior managers were in post for part of the financial year, were in the NHS Pension Scheme for the remainder of the year and the disclosures have been pro-rated:
   Sue Harriman was the CEO until 5th October 2025
   Lucy Baker was appointed as ICB Place Director from 1st February 2026
   The following senior managers were in post for part of the financial year, were not in the NHS Pension Scheme for the remainder of the year and their disclosures have not been pro-rated:
   Laura Ambler was Place Director until 4th January 2026
   Sarah Green was the ICB Chief People Officer until 7th January 2026
2. There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.
   The CETV values included in the table above have been prepared by NHS Pensions as at 31st March 2026.
   Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.
3. 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.
4. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2026.
5. Gordon Muvuti was not a member of the NHS Pension Scheme in 2025/26 and therefore there are no disclosures for him.
6. The Chair and Non-Executive Directors are not members of the NHS Pension Scheme.

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) ❷	Cash equivalent transfer value at 1 April 2024	Real increase in Cash equivalent transfer value	Cash equivalent transfer value at 31 March 2025 ❸	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	❹	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	❶,❺	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	❶	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

❶ *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.*

❷ *There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.*

❸ *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.

❹ *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.*

❺ *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.*

❻ *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.*

❼ *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.*

❽ *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 (AUDITED)
The ICB has awarded redundancy to one senior manager during 2025/26. Rachael Backler, ICB Chief Delivery Officer, was made redundant on 31st March 2026. The redundancy package totalled £100,670. This is made up of £60,000 redundancy and £40,670 of post employment notice pay, and this was in line with contractual terms.

Payments to past directors (AUDITED)
There have been no payments to past directors in 2025/26.

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 2026, the number of senior managers were:

Agenda for Change band	Number of senior managers
Very senior managers (VSM)	8

The Board of the ICB has an independent Chair, a partner member representing primary care and five non-executive directors who have non-Agenda for Change remuneration arrangements.

Staff numbers and costs (AUDITED)

Staff costs	2025-26			2024-25		
	Permanent Employees £m	Other £m	Total £m	Permanent Employees £m	Other £m	Total £m
Employee Benefits						
Salaries and wages	18.8	0.6	**19.4**	20.5	0.6	**21.1**
Social security costs	2.6	-	**2.6**	2.4	-	**2.4**
Employer Contributions to NHS Pension scheme	4.3	-	**4.3**	4.5	-	**4.5**
Apprenticeship Levy	0.1	-	**0.1**	0.1	-	**0.1**
Termination benefits	4.6	-	**4.6**	0.7	-	**0.7**
Gross employee benefits expenditure	**30.4**	**0.6**	**31.0**	**28.2**	**0.6**	**28.8**

The ICB has recognised £4.6 million of expenditure associated with termination benefits during 2025/26.

The average number of people employed by the ICB during the reporting period on a whole-time equivalent (WTE) basis was 340.64.

The permanent WTE average was 313.63, and the Other WTE average was 27.01.

Permanently employed	Other
313.63	27.01

Analysed as:	Permanent	Other
Scientific, therapeutic and technical staff	16.88	1.88
Admin and estates staff	237.74	16.80
Medical and dental staff	2.99	1.69
Nursing, midwifery and health visiting	56.02	6.64
Other healthcare	0	0

Staff composition

The table below shows the gender breakdown of staff working at the ICB as of 31 March 2026:

	Female headcount	Male headcount	Total
ICB Board Members	7	6	13
All other senior managers (excluding Board Members)	6	5	11
All other ICB staff	257	69	326
Total	**270**	**80**	**350**

Sickness absence data

The absence FTE % for NHS BSW ICB was 2.78%, based on data available for the period 1 January 2025 to 31 December 2025. Overall, the rolling staff sickness absence figure for the 12-month period was 2.86 per cent. This was a reduction of 0.14 per cent from the previous 12-month period.

The overall rolling sickness absence figure is as a result of 1.11 per cent short-term sickness absence and 1.75 per cent long-term sickness absence.

Sickness absence for short-term absence has slightly increased in 2025/26, as compared to 2024/25, however this may be reflective of the uncertainty associated with organisational change. Long-term absence has reduced in 2025/26 as compared to 2024/25. There were 2 ill-health retirements during the period 1 April 2025 to 31 March 2026.

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. It is acknowledged that since March 2025 when the Government made the announcements that ICBs needed to reduce running costs by 50% the ICB has been in a state of flux as the blueprint was worked through and target operating models, within the cost envelope, were developed. This has led to colleagues having to navigate an uncertain and challenging time for over a year. Additional support has been put in place to support colleagues in terms of navigating change and encouraging colleagues to focus on the factual information that the ICB had available. Colleague briefings were also increased during the time period to share with colleagues timely and factually accurate information.

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. Two sessions have been offered to all colleagues run by Macmillan. Individuals who attended the sessions found them extremely useful and felt the courses led to an increase in their confidence to support colleagues who are experiencing cancer themselves or supporting family members.

The menopause resources available to colleagues continue to be updated and include a menopause awareness toolkit, an employer guide to menopause and a wellness action plan.

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 1.51 per cent.

A number of colleagues took voluntary redundancy during the reporting period, with March 2026 recording a particularly high turnover rate. This is due to a voluntary redundancy scheme operating which supported colleagues to exit the organisation ahead of formal organisational change to meet the requirement for ICBs to reduce their running costs by 50%.

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 March 2026.

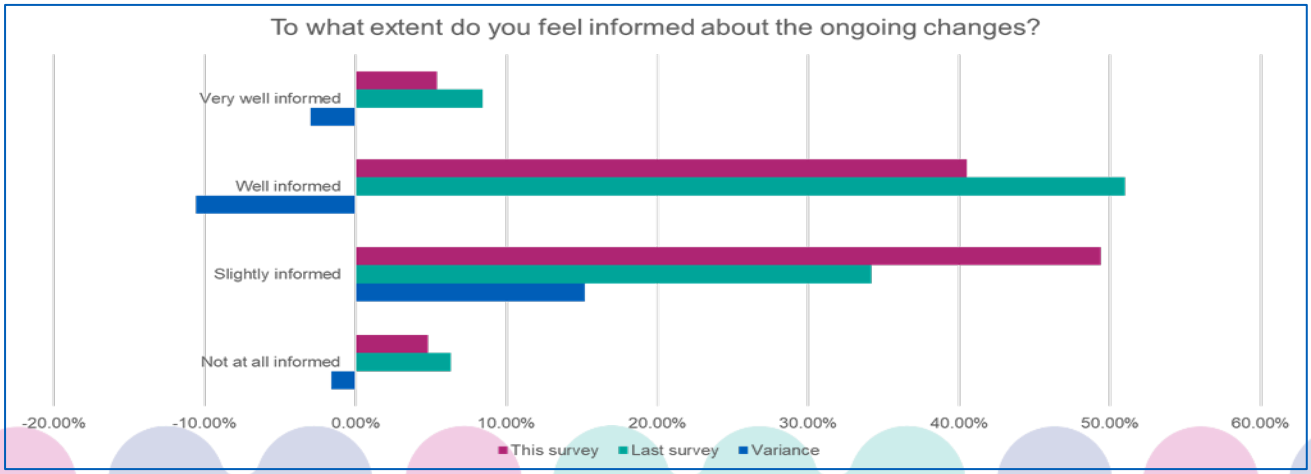
Month	Turnover Rate (FTE)
Apr-25	1.50%
May-25	0.78%
Jun-25	1.32%
Jul-25	1.05%
Aug-25	2.32%
Sep-25	1.87%
Oct-25	2.04%
Nov-25	1.05%
Dec-25	0.48%
Jan-26	1.80%
Feb-26	0.57%
Mar-26	3.32%

Staff engagement percentages

The ICB opted not to participate in the national NHS Staff Survey in 2025 due to the uncertain futures for many colleagues and the need to carry out bespoke surveys across the BSW, Dorset and Somerset cluster. This allowed the ICB to get timely information and be in a position to provide the best possible support to colleagues based on the feedback received.

A bespoke survey was carried out in October 2025 that focused on health and wellbeing. In total across the cluster 474 colleagues took part, providing a response rate of 43%. In December, a further bespoke survey was undertaken that focused on inform, involve and engage. There was a 13% response rate across the cluster with 148 colleagues completing the survey. In February 2026, the bespoke survey focused on equality, diversity and inclusion and obtained a response rate of 15% from across the cluster.

The following infographic from the February 2026 survey highlights how informed colleagues across the cluster feel about the ongoing changes and the difference between how colleagues felt when answering this question in December and then in February.



Following analysis of the bespoke survey responses, actions have been developed focusing on supporting colleagues' health and wellbeing and how best to inform, involve and engage colleagues during this period of uncertainty and change. The responses relating to EDI will also help inform the annual EDI plan and ensure colleagues are supported appropriately through the change process.

The themes from the bespoke surveys will also underpin and support the planned OD cultural programme and help to build the foundations of the new organisation and endeavour to be responsive to the further changes facing the future of ICBs.

Staff policies

Over the course of 2025/2026 the ICB has continued to review, update and develop policies to ensure legal compliance and alignment to the Agenda for Change terms and conditions.

Standard user-friendly policies continue to be developed and released by NHS England for organisations to adopt and utilise. As standardised policies have been released, reviews of the ICB policies are taking place, and if appropriate the policies are being updated based on the 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 during the reporting period:

- Annual Leave Policy
- Grievance Policy and Procedure
- Maternity, Paternity, Adoption and Shared Parental Leave Policy
- Ways of Working Policy
- Parental Leave Policy

The Cluster Organisational Change Policy has also been reviewed by cluster colleagues to ensure the ICBs are in a unified position moving into the change process. The policy will be revisited again following the conclusion of the change process and ahead of any formal merger.

This has been necessary to ensure that policies have been updated in line with recent legislative changes, learning from the application of the policies and also new guidance from NHS England.

The Sexual Safety Policy has also been embedded within the organisation, through regular communications and mandatory training for all colleagues about understanding sexual misconduct in the workplace. Colleagues can also report any concerns regarding sexual safety anonymously. A self-assessment was carried out by BSW ICB against the NHS Sexual Safety Charter Assurance Framework in September 2025. The actions identified by the self-assessment have continued to be taken forward and implemented where necessary.

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 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/specialist consultants 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 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.

BSW ICB has been reviewing the Equality Delivery System (EDS) for 2025/2026 and the activity to date has focused on collating organisational evidence ahead of the formal review and EDS reporting. The outcome of the EDS review and scores will be published inline with national requirements.

BSW ICB remains committed to meeting its statutory and national obligations in relation to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Ethnicity Pay Gap (EPG), Disability Pay Gap (DPG) and Gender Pay Gap (GPG) reporting. However, recognising that the organisation will undergo a significant period of change, with substantial and ongoing shifts in workforce composition anticipated on a month-by-month basis between March and July 2026, a full review and refreshed approach to these standards will be undertaken following the completion of the organisational change process in late summer/ early

autumn 2026. This will ensure that future actions and analysis accurately reflect the post-change workforce profile and provide a robust baseline for improvement.

During the interim period, cluster-wide equality objectives are being designed and delivered to ensure that the impact of organisational change on colleagues with protected characteristics is actively mitigated. This approach will prioritise a small number of high-impact actions, enabling focused and meaningful intervention while maintaining oversight of equality risks as the workforce continues to evolve.

Colleague Engagement Group

BSW 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. It also welcomes suggestions over a variety of themes to enhance the working environment or experience.

The regular meetings are structured to ensure effective communication and engagement of colleagues. The group are recognised as having an important role in helping to inform change and represent wider colleagues in the ICB. The aim is that the group will continue to thrive and help build an organisation that actively listens to its colleagues and creates a sense of belonging.

The Colleague Engagement Group members have continued to support the organisation and its colleagues throughout a challenging 2025/2026 year in relation to multiple policy reviews, and whole system-wide change programmes including the very senior manager (VSM) cluster consultation and engagement, and more latterly the voluntary redundancy programme and initial work in preparation for an organisational change programme.

Development has commenced on a cluster-wide colleague engagement group, intended to provide a consistent and inclusive forum for staff voice across the emerging clustered organisational form. This work is being undertaken in collaboration with the existing BSW ICB colleague engagement group, with joint discussions planned to determine how the group would wish to continue, adapt, or conclude during the interim period ahead of formal merger, expected in April 2027. This approach will ensure continuity of engagement while respecting existing arrangements and supporting colleagues through transition.

Other employee matters

BSW ICB emerged from a year of significant change in February 2025 where Project Evolve had been concluded which resulted in 30 per cent reduction in running costs and redesign to improve its services. The Government announced on 13 March 2025 that ICBs should reduce their running and programme costs by 50 per cent be more efficient and reduce duplication. As a result of the required cost reductions BSW ICB will cluster with Dorset and Somerset ICB. The announcements have led to uncertainty for individuals regarding their futures whilst cluster structures have been developed in line with the blueprint and NHS 10 Year Health Plan.

To help achieve the 50 per cent reductions a voluntary redundancy programme has been offered to all BSW colleagues and colleagues approved for voluntary redundancy will leave the organisation between 19th March 2026 and 31st July 2026. Following this a consultation regarding structures across the cluster and potential compulsory redundancies will be launched in late March 2026.

BSW VSMs were consulted with during December 2025 as the Executive Management Teams across the three ICBs that are clustering formed one Executive Management Team for the cluster.

To support colleagues throughout the challenging last year, a number of support mechanisms were implemented including voluntary redundancy drop in sessions, a cluster intranet site, increased colleague communications and bespoke surveys to temperature check the organisation and to seek feedback.

Colleagues who have opted to take voluntary redundancy have been provided with the opportunity to attend pension and financial planning workshops to help them make informed decisions as they consider exiting from the organisation.

It is acknowledged that it has been a time of uncertainty and anxiety for all of our colleagues and will continue to be for a period of time, as the organisational consultation regarding structures take place and the new structures and ways of working are embedded across the cluster. It is envisaged that on completion of the cluster change process, stability for colleagues will be achieved and the cluster can focus on its purpose as strategic commissioners and delivering the 10 Year Plan.

It continues to be 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 across the cluster.

Following the conclusion of the cluster structure consultation, time will be invested in designing the organisational development programme with colleagues to help embed, sustain and support new ways of working across the cluster.

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 especially at a time of significant change.

Colleagues can access our mental health first aiders, occupational health services and self-referral counselling services.

The Wellbeing Group consists of a small number of ICB colleagues with a special interest in wellbeing. They meet on a bi-monthly basis to make suggestions on what they feel could be useful to wider colleagues based on their own experience or from conversations with colleagues.

Throughout 2025/26, there has been a weekly wellbeing feature created for the ICB news feed on the intranet (Seven Days) covering a wide range of themes. In addition, features have been published including building resilience, physical wellbeing and healthy recipes.

Well established intranet resources have been checked, updated, and EDI related additions (including neurodiversity) have been made.

Financial wellbeing resources via webinars have been made available to assist with financial wellbeing.

Wellbeing Champions have been regularly advertised as contacts for supportive conversations for colleagues in the wider organisation.

The ICB took the decision to not renew its membership with Carers UK due to lack of update in utilisation. This decision was made with the intention of reviewing the situation once a cluster ICB is formed and a new merged carers policy is in place. Following merger and completion of organisational re-structure work, a scoping and engagement exercise is envisaged to determine the number of carers in the new organisation and a review of needs.

The ICB ran a very successful away day for all colleagues and workshops were available throughout the day. These included a mindfulness mini retreat, career development workshop with Hays Recruitment, pension support workshop, wellbeing and psychological safety workshop focusing on leading without authority and the game changers and express coaching skills.

Investment has been made in training and development for colleagues throughout the reporting period and has included interview techniques and CV writing workshops, a series of workshops about navigating organisational change from a neurodivergent perspective, line managers training workshops on supporting neurodivergent team members through consultation periods, how to have difficult conversations during change, leading without authority and inclusion with humanity workshops, techniques for personal and collective wellbeing workshops, and radical candour and psychological safety in change. A number of individual training applications have also been supported and apprenticeships.

Expenditure on consultancy

The ICB has spent £123,000 on consultancy services during 2025/26.

Off-payroll engagements

Length of all highly paid off-payroll engagements

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

	Number
Number of existing engagements as of 31 March 2026	
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
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.*

The ICB has reviewed the existing off-payroll engagement to obtain assurance that the individual is paying the right amount of tax.

Off-payroll workers engaged at any point during the financial year
For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	3
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	3
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
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.

Off-payroll engagements / senior official engagements
For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	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.	19

Exit packages, including special (non-contractual) payments (AUDITED)

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Agenda for Change terms and conditions, and very senior manager contracts. Exit costs in this note are accounted for in full in the year of departure. Where the ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table below.

Exit packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	2	12,862	2	14,366	4	27,228	0	0
£10,000 - £25,000	2	27,086	11	203,516	13	230,602	0	0
£25,001 - £50,000	0	0	11	363,116	11	363,116	0	0
£50,001 - £100,000	2	114,437	13	807,813	15	922,250	0	0
£100,001 - £150,000	1	100,670	9	1,131,374	10	1,232,044	0	0
£150,001 – £200,000	0	0	11	1,917,308	11	1,917,308	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**7**	**255,055**	**57**	**4,437,493**	**64**	**4,692,548**	**0**	**0**

Analysis of other departures

	Agreements number	Total Value of agreements £000s
Voluntary redundancies including early retirement contractual costs	57	4,432,422
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	1	5,071
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
TOTAL	**58**	**4,437,493**

**Any non-contractual payments in lieu of notice are disclosed under "non-contracted payments requiring HMT approval".*

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in the 'Exit package' table, which will be the number of individuals.

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

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 Board 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 2026, 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 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its 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 2025-26; 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.

Emphasis of matter – Integrated Care Board proposed merger

We draw attention to Note 1 to the financial statements, which describes the planned merger of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board, NHS Somerset Integrated Care Board and NHS Dorset Integrated Care Board into a single organisation, currently expected to take effect in April 2027. Our opinion is not modified in this respect of this matter.

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 2025-26 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 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 2025-26 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 2025-26; 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 2025-26).
- 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 controls and cut-off risk in the ICB's non-block and other operating expenditure and its associated payables. We determined that the principal risks were in relation to:
  - large and unusual entries outside the normal course of business;
  - self-approved journals;
  - manipulation of expenditure recognition using journals to close after year-end; and
  - deliberate manipulation of expenditure in order to meet agreed year-end targets.

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus with a focus on principal risks detailed above; and
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of recognition of year end manual expenditure accruals and related payable balances.
- 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 2026.

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 March 2026. 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 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the members of the Board 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 Board 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 Board 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

15 June 2026

ANNUAL ACCOUNTS

Jonathan Higman
Accountable Officer
15 June 2026

NHS Bath and North East Somerset, Swindon and Wiltshire ICB

Financial Accounts for the year ending 31st March 2026

The figures presented within these accounts have been prepared in millions (£m) rather than thousands (£k).
Where appropriate, disclosure notes may include figures in thousands.

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The Primary Statements:

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

	Note	2025-26 £m	2024-25 £m
Income from sale of goods and services	2	(31.7)	(30.6)
Other operating income	2	(0.8)	(0.0)
Total operating income		**(32.5)**	**(30.6)**
Staff costs	4	31.0	28.8
Purchase of goods and services	5	2,285.2	2,175.6
Depreciation and impairment charges	5	0.4	0.5
Provision expense	5	7.4	4.3
Other operating expenditure	5	2.4	6.3
Total operating expenditure		**2,326.4**	**2,215.5**
Net Operating Expenditure		**2,293.9**	**2,184.9**
Comprehensive Net Expenditure for the year		**2,293.9**	**2,184.9**

The notes on pages 173 to 177 form part of this statement.

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £m	2024-25 £m
Non-current assets:			
Property, plant and equipment		0.2	0.1
Right-of-use assets	7	5.9	0.7
Intangible assets		0.0	0.2
Total non-current assets		**6.1**	**1.0**
Current assets:			
Inventories	8	2.4	3.0
Trade and other receivables	9	15.3	13.3
Cash and cash equivalents	10	-	1.5
Total current assets		**17.7**	**17.8**
Total current assets		**17.7**	**17.8**
Total assets		**23.8**	**18.8**
Current liabilities			
Trade and other payables	12	(92.8)	(130.6)
Lease liabilities	7	(0.4)	(0.3)
Borrowings	11	(0.7)	-
Provisions	13	(14.4)	(9.1)
Total current liabilities		**(108.3)**	**(140.0)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(84.5)**	**(121.2)**
Non-current liabilities			
Lease liabilities	7	(5.6)	(0.5)
Total non-current liabilities		**(5.6)**	**(0.5)**
Assets less Liabilities		**(90.1)**	**(121.7)**
Financed by Taxpayers' Equity			
General fund		(90.1)	(121.7)
Total taxpayers' equity:		**(90.1)**	**(121.7)**

The notes on pages 178 to 181 form part of this statement.

The financial statements on pages 166 to 188 were approved by the Board on 15th June 2026 and signed on its behalf by:

Chief Executive Officer
Jonathan Higman

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £m
Changes in taxpayers' equity for 2025-26	
Balance at 01 April 2025	(121.7)
Changes in NHS BSW ICB taxpayers' equity for 2025-26	
Net expenditure for the financial year	(2,293.9)
Net Recognised NHS Integrated Care Board Expenditure for the financial year	**(2,293.9)**
Net funding	2,325.5
Balance at 31 March 2026	**(90.1)**

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 NHS BSW ICB taxpayers' equity for 2024-25	
Net expenditure for the financial year	(2,184.9)
Net Recognised NHS Integrated Care Board Expenditure for the financial year	**(2,184.9)**
Net funding	2,180.5
Balance at 31 March 2025	**(121.7)**

Statement of Cash Flows for the year ended 31 March 2026

	Note	2025-26 £m	2024-25 £m
Cash Flows from Operating Activities			
Net expenditure for the financial year		(2,293.9)	(2,184.9)
Depreciation and amortisation	5	0.4	0.5
(Increase)/decrease in inventories	8	0.6	0.9
(Increase)/decrease in trade & other receivables	9	(2.0)	26.8
Increase/(decrease) in trade & other payables	12	(37.8)	(21.1)
Provisions utilised	13	(2.1)	(3.8)
Increase/(decrease) in provisions	13	7.4	5.0
Net Cash Inflow (Outflow) from Operating Activities		**(2,327.4)**	**(2,176.6)**
Cash Flows from Investing Activities			
(Payments) for intangible assets		-	(0.1)
Net Cash Inflow (Outflow) from Investing Activities		**-**	**(0.1)**
Net Cash Inflow (Outflow) before Financing		**(2,327.4)**	**(2,176.7)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,325.4	2,180.5
Repayment of lease liabilities		(0.2)	(0.3)
Net Cash Inflow (Outflow) from Financing Activities		**2,325.2**	**2,180.2**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(2.2)**	**3.5**
Cash & Cash Equivalents at the beginning of the financial year		1.5	(2.0)
Cash & Cash Equivalents (including bank overdrafts) at the end of the financial year		**(0.7)**	**1.5**

The notes on pages 176 to 181 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 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards 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.

In March 2025, the Government announced significant changes affecting the Department of Health and Social Care, NHS England and a number of other NHS organisations. In response, NHS England and ministers formally approved, in June 2025, the grouping of NHS Dorset ICB, NHS Bath and North East Somerset, Swindon and Wiltshire ICB, and NHS Somerset ICB into a new cluster. These ICBs will continue to operate while progressing towards a single merged organisation over the next 12 months, with the merger expected to take effect in April 2027. Although the ICB will cease to exist at that point, its functions will continue to be delivered by the successor organisation.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for NHS BSW ICB are prepared on a Going Concern basis as it remains a separate legal entity and will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

1.3 **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 18 provides further details on the arrangements.

1.4 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.5 **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 to date.
• 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.

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **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.

1.7 **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.

Notes to the financial statements

1.8 **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.

1.9 **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.

1.10 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.11 **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 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 4.22% (2024-25: 4.07%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 5.32% (2024-25: 4.81%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the 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.

1.12 **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.

1.13 **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 the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 **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.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.15 **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.

1.15.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Notes to the financial statements

1.15.2 **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.

1.16 **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.

1.16.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.17 **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.

1.18 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in millions of pounds unless expressly stated otherwise. 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.

1.19 **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 2025-26, the ICB has made no critical accounting judgements nor identified any areas of material estimation uncertainty.

1.20 **Insurance Contracts**

IFRS 17 Insurance Contracts replaces IFRS 4 and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts. The organisation has reviewed the requirements of IFRS 17 and concluded that it does not have any contracts within the scope of the standard. Accordingly, IFRS 17 has no impact on the financial statements, and no additional disclosures are required.

1.21 **New and revised IFRS Standards in issue but not yet effective**

- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
- 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.

2 Other Operating Revenue

	2025-26 Total £m	2024-25 Total £m
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	7.9	7.0
Prescription fees and charges	11.0	11.0
Dental fees and charges	11.8	11.5
Other Contract income	1.0	1.1
Total Income from sale of goods and services	**31.7**	**30.6**
Other operating income		
Other non contract revenue	0.8	0.0
Total Other operating income	**0.8**	**0.0**
Total Operating Income	**32.5**	**30.6**

3 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
2025-26	**£m**	**£m**	**£m**	**£m**
Source of Revenue				
NHS	2.7	-	-	0.6
Non NHS	5.2	11.0	11.8	0.4
Total	**7.9**	**11.0**	**11.8**	**1.0**
2024-25	**£m**	**£m**	**£m**	**£m**
Source of Revenue				
NHS	4.9	-	-	0.0
Non NHS	2.1	11.0	11.5	1.1
Total	**7.0**	**11.0**	**11.5**	**1.1**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
2025-26	**£m**	**£m**	**£m**	**£m**
Timing of Revenue				
Point in time	-	11.0	-	-
Over time	7.9	-	11.8	1.0
Total	**7.9**	**11.0**	**11.8**	**1.0**
2024-25	**£m**	**£m**	**£m**	**£m**
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

2025-26	Total Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	18.8	0.6	**19.4**
Social security costs	2.6	-	**2.6**
Employer Contributions to NHS Pension scheme	4.3	-	**4.3**
Apprenticeship Levy	0.1	-	**0.1**
Termination benefits	4.6	-	**4.6**
Gross employee benefits expenditure	**30.4**	**0.6**	**31.0**

The ICB paid £0.25m in termination benefits during 2025/26. The reported value of £4.6m also includes the estimated cost of redundancies agreed in this financial year, but payable in a later financial period.

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. This expenditure was covered by a provision raised in 2023/24 which was released in the financial period.

4.2 Average number of people employed

	2025-26 Permanently employed Number	Other Number	Total Number	2024-25 Permanently employed Number	Other Number	Total Number
Total	313.6	27.0	**340.6**	338.9	30.8	**369.7**

4.3 Exit packages agreed in the financial year

	2025-26 Compulsory redundancies Number	£	2025-26 Other agreed departures Number	£	2025-26 Total Number	£
Less than £10,000	2	12,862	2	14,366	4	27,228
£10,001 to £25,000	2	27,086	11	203,516	13	230,602
£25,001 to £50,000	-	-	11	363,116	11	363,116
£50,001 to £100,000	2	114,437	13	807,813	15	922,250
£100,001 to £150,000	1	100,670	9	1,131,374	10	1,232,044
£150,001 to £200,000	-	-	11	1,917,308	11	1,917,308
Over £200,001	-	-	-	-	-	-
Total	**7**	**255,055**	**57**	**4,437,493**	**64**	**4,692,548**

	2024-25 Compulsory redundancies Number	£	2024-25 Other agreed departures Number	£	2024-25 Total Number	£
Less than £10,000	16	113,480	2	18,399	18	131,879
£10,001 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 £200,001	-	-	-	-	-	-
Total	**46**	**977,814**	**32**	**1,885,373**	**78**	**2,863,187**

Analysis of Other Agreed Departures

	2025-26 Other agreed Number	£	2024-25 Other Number	£
Voluntary redundancies including early retirement contractual cost	57	4,432,422	32	1,771,708
Contractual payments in lieu of notice	1	5,071	21	113,665
Total	**58**	**4,437,493**	**53**	**1,885,373**

* 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 2024/25 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These 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.

5. Operating expenses

	2025-26 Total £m	2024-25 Total £m
Purchase of goods and services		
Services from other ICBs and NHS England	3.4	3.2
Services from foundation trusts	1,148.3	1,112.6
Services from other NHS trusts	149.0	142.3
Services from Other WGA bodies	(0.0)	69.6
Purchase of healthcare from non-NHS bodies	438.9	327.2
Purchase of social care	46.6	40.1
General Dental services and personal dental services	40.9	43.0
Prescribing costs	164.9	165.1
Pharmaceutical services	37.2	32.8
General Ophthalmic services	14.9	17.8
GPMS/APMS and PCTMS	217.6	203.4
Supplies and services – clinical	4.8	4.1
Supplies and services – general	0.2	(0.3)
Consultancy services	0.1	0.3
Establishment	3.4	3.8
Transport	6.4	6.0
Premises	6.3	2.4
Audit fees	0.2	0.2
Other non statutory audit expenditure		
· Internal audit services	0.1	0.1
· Other services	0.1	0.0
Other professional fees	0.7	0.5
Legal fees	0.5	0.7
Education, training and conferences	0.7	0.7
Total Purchase of goods and services	**2,285.2**	**2,175.6**
Depreciation and impairment charges		
Depreciation	0.3	0.4
Amortisation	0.1	0.1
Total Depreciation and impairment charges	**0.4**	**0.5**
Provision expense		
Provisions	7.4	4.3
Total Provision expense	**7.4**	**4.3**
Other Operating Expenditure		
Chair and Non Executive Members	0.2	0.2
Grants to Other bodies	-	0.2
Expected credit loss on receivables	(0.4)	0.4
Inventories consumed	2.7	5.4
Other expenditure	(0.1)	0.1
Total Other Operating Expenditure	**2.4**	**6.3**
Total operating expenditure	**2,295.4**	**2,186.7**

The external audit fee for 2025/26 was £201,411 excluding VAT of £40,282.

The external auditor's liability for external audit work carried out for the financial period 2025/26 is limited to £1,000,000.

From 1st April 2025, the commissioning of Specialised Services was delegated from NHS England to south west ICBs. NHS Somerset ICB became the principal commissioner of services on behalf of BSW ICB, and received the funding to administer specialised service contracts.

However, BSW ICB was responsible for paying non-contract specialised services and this expenditure is reflected in the table above. £3.5m was paid to NHS Foundation Trusts, and £1.2m was paid to NHS Trusts.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2025-26 Number	2025-26 £m	2024-25 Number	2024-25 £m
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	45,865	837.6	42,031	798.9
Total Non-NHS Trade Invoices paid within target	45,232	832.3	41,324	784.3
Percentage of Non-NHS Trade invoices paid within target	**98.62%**	**99.36%**	**98.32%**	**98.18%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,548	1,424.0	1,355	1,308.0
Total NHS Trade Invoices Paid within target	1,525	1,422.9	1,342	1,306.5
Percentage of NHS Trade Invoices paid within target	**98.51%**	**99.93%**	**99.04%**	**99.88%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The ICB had no Late Payment of Commercial Debts (Interest) to report in 2025-26 or 2024-25.

7 Leases

7.1 Right-of-use assets

2025-26	Buildings excluding dwellings £m	Total £m	Of which: leased from DHSC group bodies £m
Cost or valuation at 01 April 2025	1.2	1.2	1.2
Additions	5.5	5.5	5.5
Cost/Valuation at 31 March 2026	**6.7**	**6.7**	**6.7**
Depreciation 01 April 2025	0.5	0.5	0.5
Charged during the year	0.3	0.3	0.3
Depreciation at 31 March 2026	**0.8**	**0.8**	**0.8**
Net Book Value at 31 March 2026	**5.9**	**5.9**	**5.9**
Net Book Value by counterparty			
Leased from other group bodies (NHS Property Services Ltd)			5.9
Net Book Value at 31 March 2026			**5.9**

2024-25	Buildings excluding dwellings £m	Total £m	Of which: leased from DHSC group bodies £m
Cost or valuation at 01 April 2024	2.0	2.0	2.0
Additions	0.3	0.3	0.3
Derecognition for early terminations	(1.1)	(1.1)	(1.1)
Cost/Valuation at 31 March 2025	**1.2**	**1.2**	**1.2**
Depreciation 01 April 2024	0.6	0.6	0.6
			-
Charged during the year	0.3	0.3	0.3
Derecognition for early terminations	(0.4)	(0.4)	(0.4)
Depreciation at 31 March 2025	**0.5**	**0.5**	**0.5**
Net Book Value at 31 March 2025	**0.7**	**0.7**	**0.7**
Net Book Value by counterparty			
Leased from other group bodies (NHS Property Services Ltd)			0.7
Net Book Value at 31 March 2026			**0.7**

7 Leases cont'd

7.2 Lease liabilities

2025-26	2025-26 £m	2024-25 £m
Lease liabilities at 01 April 2025	(0.7)	(1.5)
Additions purchased	(5.5)	(0.2)
Interest expense relating to lease liabilities	(0.0)	(0.0)
Repayment of lease liabilities (including interest)	0.2	0.3
Derecognition for early terminations	-	0.7
Lease liabilities at 31 March 2026	**(6.0)**	**(0.7)**

The addition reflects the ICB taking on the lease of the new Trowbridge Integrated Care Centre.
The lease liability balance of £6m is analysed as £0.4m due within 1 year, and £5.6m due in later periods.

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 £m	Of which: leased from DHSC group bodies £m	2024-25 £m	Of which: leased from DHSC group bodies £m
Within one year	(0.7)	(0.7)	(0.3)	(0.3)
Between one and five years	(1.8)	(1.8)	(0.5)	(0.5)
After five years	(7.8)	(7.8)	-	-
Balance at 31 March 2026	**(10.3)**	**(10.3)**	**(0.8)**	**(0.8)**
Balance by counterparty				
Leased from other group bodies		10.3		0.8
Balance as at 31 March 2026		**10.3**		**0.8**

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26 £m	2024-25 £m
Depreciation expense on right-of-use assets	0.3	0.3

7.5 Amounts recognised in Statement of Cash Flows

	2025-26 £m	2024-25 £m
Total cash outflow on leases under IFRS 16	0.3	0.3

8 Inventories

	Loan Equipment £m	Total £m
Balance at 01 April 2025	3.0	3.0
Additions	2.1	2.1
Inventories recognised as an expense in the period	(2.7)	(2.7)
Balance at 31 March 2026	**2.4**	**2.4**

	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**

9.1 Trade and other receivables

	Current 2025-26 £m	Current 2024-25 £m
NHS receivables: Revenue	3.1	2.8
NHS accrued income	0.5	2.3
Non-NHS and Other WGA receivables: Revenue	2.3	3.0
Non-NHS and Other WGA prepayments	1.6	1.2
Non-NHS and Other WGA accrued income	3.8	0.9
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	3.9	4.7
Expected credit loss allowance-receivables	(1.6)	(2.0)
VAT	0.6	0.4
Other receivables and accruals	1.1	0.0
Total Trade & other receivables	**15.3**	**13.3**
Total current and non current	**15.3**	**13.3**

9.2 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £m	2025-26 Non DHSC Group Bodies £m	2024-25 DHSC Group Bodies £m	2024-25 Non DHSC Group Bodies £m
By up to three months	-	0.7	0.6	0.9
By three to six months	0.0	0.0	-	0.0
By more than six months	0.1	0.9	(0.1)	1.3
Total	**0.1**	**1.6**	**0.5**	**2.2**

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Total
	£m	£m
Balance at 01 April 2025	(2.0)	(2.0)
Lifetime expected credit losses on trade and other receivables-Stage 2	0.4	0.4
Balance at 31 March 2026	**(1.6)**	**(1.6)**

	£m	£m
Balance at 01 April 2024	(1.6)	(1.6)
Lifetime expected credit losses on trade and other receivables-Stage 2	(0.4)	(0.4)
Balance at 31 March 2025	**(2.0)**	**(2.0)**

10 Cash and cash equivalents

	2025-26 £m	2024-25 £m
Balance at 01 April 2025	1.5	(2.0)
Net change in year	(2.2)	3.6
Balance at 31 March 2026	**(0.7)**	**1.5**
Made up of:		
Cash with the Government Banking Service	-	1.5
Cash and cash equivalents as in statement of financial position	**-**	**1.5**
Bank overdraft: Government Banking Service	(0.7)	-
Total bank overdrafts	**(0.7)**	**-**
Balance at 31 March 2026	**(0.7)**	**1.5**

11 Borrowings

At 31st March 2026, the ICB had a technical overdraft of £0.7m which would clear in 2026/27. This was due to a payment file released on the 31st March 2026, which would not clear from the bank until 2nd April 2026.

The ICB had no borrowings at 31st March 2025.

12 Trade and other payables	Current 2025-26 £m	Current 2024-25 £m
NHS payables: Revenue	3.1	4.5
NHS accruals	6.1	11.0
Non-NHS and Other WGA payables: Revenue	8.2	17.4
Non-NHS and Other WGA accruals	65.1	93.3
Non-NHS and Other WGA deferred income	0.4	0.7
Social security costs	0.3	0.3
Tax	0.3	0.3
Other payables and accruals	9.3	3.2
Total Trade & Other Payables	**92.8**	**130.6**
Total current and non-current payables	**92.8**	**130.6**

Other payables include £1.7m outstanding pension contributions at 31 March 2026

13 Provisions

	Current 2025-26 £m	Current 2024-25 £m
Restructuring	(0.0)	0.1
Redundancy	5.2	0.8
Legal claims	-	0.0
Continuing care	2.5	1.7
Other	6.7	6.5
Total	**14.4**	**9.1**
Total current and non-current	**14.4**	**9.1**

	Restructuring £m	Redundancy £m	Continuing Care £m	Other £m	Total
Balance at 01 April 2025	**0.1**	**0.8**	**1.7**	**6.5**	**9.1**
Arising during the year	-	5.2	2.5	2.9	**10.6**
Utilised during the year	(0.1)	(0.8)	(0.5)	(0.7)	**(2.1)**
Reversed unused	(0.0)	(0.0)	(1.2)	(2.0)	**(3.2)**
Balance at 31 March 2026	**0.0**	**5.2**	**2.5**	**6.7**	**14.4**
Expected timing of cash flows:					
Within one year	0.0	5.2	2.5	6.7	**14.4**
Balance at 31 March 2026	**0.0**	**5.2**	**2.5**	**6.7**	**14.4**

A redundancy provision has been recognised to reflect costs associated with organisational change. The ICB is clustering with NHS Dorset ICB and NHS Somerset ICB with a view to merge from 1st April 2027. The provision recognised relates to the possible impact on BSW ICB staffing and organisational arrangements

Continuing Care - This category relates to existing Continuing Healthcare retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the ICB.

Other provisions reflect provisions for legal claims, undertakings associated with healthcare buildings in the BSW area, and unfulfilled healthcare assessments.

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 2026.

The provision for LTPS (Liabilities to Third Parties Scheme) claims is £0, and for CNST claims is £59,175.

14 Contingencies

	2025-26 £m	2024-25 £m
Contingent liabilities		
Continuing Healthcare	5.5	6.7
Net value of contingent liabilities	**5.5**	**6.7**

This represents an estimate of the cost that would be incurred if all outstanding retrospective claims for Continuing Healthcare were found to be eligible for funding.

The ICB held no contingent assets at 31st March 2026.

15 Commitments

15.1 Capital commitments

The ICB had no capital commitments in 2025-26 or 2024-25

15.2 Other financial commitments

The ICB has financial commitments relating to the notice period included within multi-year contracts (should the contract be cancelled), and these are detailed below:

	2025-26 £m	2024-25 £m (restated)
In not more than one year	220.2	217.6
In more than one year but not more than five years	155.6	155.6
In more than five years	-	-
Total	**375.8**	**373.3**

The material commitments at 31 March 2026 relate to the following arrangements:
HCRG Care Services Ltd - this is the community services provider, and there is a notice period of 24 months
Healthhero Integrated Care Ltd - this is the provider of the integrated urgent care and out of hours service, and there is a notice period of 12 months.
E-Zec Medical Transport Services Ltd - this is the provider of non emergency patient transport services, and there is a notice period of 12 months.
Circle Health Group - this is an independent healthcare provider, and there is a notice period of 12 months.
Ramsay Healthcare UK Ltd - this is an independent healthcare provider, and there is a notice period of 12 months.
Practice Plus Group - this is an independent healthcare provider, and there is a notice period of 12 months.

The prior period disclosure has been restated to reflect the actual commitments as outlined in the multi-year contracts in place at 31 March 2025. Previously, the disclosure reflected the number of years a contract had been awarded for, without fully taking into account the cancellation arrangements. The level of commitment at 31 March 2025 has therefore reduced by £760m.

16 Financial instruments

16.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The 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.

ICB's standing financial instructions and policies agreed by the ICB Board. Treasury activity is subject to review by the ICB and internal auditors.

16.1.1 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.

16.1.2 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.

16.1.3 Credit risk

Because the majority of the ICB's revenue comes from parliamentary funding, there is low exposure to credit risk. The maximum exposure as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 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.

16.1.5 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 the ICB's expected purchase and usage requirements and the ICB is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £m	Total 2025-26 £m	Financial Assets measured at amortised cost 2024-25 £m	Total 2024-25 £m
Trade and other receivables with NHSE bodies	0.7	0.7	2.5	2.5
Trade and other receivables with other DHSC group bodies	2.8	2.8	2.5	2.5
Trade and other receivables with external bodies	11.1	11.1	8.6	8.6
Cash and cash equivalents	-	-	1.5	1.5
Total at 31 March 2026	**14.6**	**14.6**	**15.1**	**15.1**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £m	Total 2025-26 £m	Financial Liabilities measured at amortised cost 2024-25 £m	Total 2024-25 £m
Trade and other payables with NHSE bodies	1.0	**1.0**	1.5	**1.5**
Trade and other payables with other DHSC group bodies	8.2	**8.2**	14.6	**14.6**
Trade and other payables with external bodies	82.6	**82.6**	113.3	**113.3**
Other financial liabilities	0.7	**0.7**	-	**-**
Private Finance Initiative and finance lease obligations	6.0	**6.0**	0.7	**0.7**
Total at 31 March 2026	**98.5**	**98.5**	**130.1**	**130.1**

17 Operating Segments

	BSW Commissioning 2025-26 £m	Total 2025-26 £m
Gross Expenditure £m	2,326.4	2,326.4
Income £m	(32.5)	(32.5)
Net Expenditure £m	2,293.9	2,293.9
Total Assets £m	23.8	23.8
Total Liabilities £m	(113.9)	(113.9)
Net Assets £m	(90.1)	(90.1)

18 Joint arrangements

		Better Care Fund		
BaNES Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**	**Children's Services**
	£m	**£m**	**£m**	**£m**
Contribution				
Bath & North East Somerset Council	12.0	9.2	0.2	2.6
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	19.1	18.0	0.6	0.5
Total Funding	**31.1**	**27.2**	**0.8**	**3.1**
Expenditure				
Bath & North East Somerset Council	14.5	9.2	0.3	5.0
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	19.9	18.0	0.7	1.2
Total Expenditure	**34.4**	**27.2**	**1.0**	**6.2**
Net overspend/(underspend) as detailed below				
Bath & North East Somerset Council	2.5	-	0.1	2.4
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	0.8	-	0.1	0.7
Total Overspend/(Underspend)	**3.3**	**-**	**0.2**	**3.1**

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 community equipment are shared according to fixed percentages.

The ICB has contributed £19.1m to the joint arrangements. These arrangements have overspent by £0.8m during 2025/26.

18. Joint arrangements cont'd

Swindon Locality arrangement	Total	Better Care Fund			
		Better Care Fund	Community Equipment	Other Adult Services	Children's Services
	£m	£m	£m	£m	£m
Contribution					
Swindon Borough Council	11.5	8.3	0.0	2.1	1.1
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	21.1	18.9	0.9	0.4	0.9
Total Funding	**32.6**	**27.2**	**0.9**	**2.5**	**2.0**
Expenditure					
Swindon Borough Council	11.6	8.2	0.0	2.3	1.1
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	21.3	18.9	1.0	0.6	0.8
Total Expenditure	**32.9**	**27.1**	**1.0**	**2.9**	**1.9**
Net overspend/(underspend) as detailed below					
Swindon Borough Council	0.1	-0.1	0.0	0.2	0.0
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	0.2	0.0	0.1	0.2	-0.1
Total Overspend/(Underspend)	**0.3**	**-0.1**	**0.1**	**0.4**	**-0.1**

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 ICB has contributed £21.1m to the joint arrangements. These arrangements have overspent by £0.2m during 2025/26.

18. Joint arrangements cont'd

Wiltshire Locality arrangement	Total £m	Better Care Fund	
		Better Care Fund £m	Community Equipment £m
Contribution			
Wiltshire Council	17.7	15.8	1.9
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	47.1	43.5	3.6
Income from client contributions	-	-	-
Grant Funding	4.6	4.6	-
Total Funding	**69.4**	**63.9**	**5.5**
Expenditure			
Wiltshire Council	22.1	20.4	1.7
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	47.1	43.5	3.6
Total Expenditure	**69.2**	**63.9**	**5.3**
Net overspend/(underspend) as detailed below			
Wiltshire Council	(0.2)	-	(0.2)
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	-	-	-
Total Overspend/(Underspend)	**(0.2)**	**-**	**(0.2)**

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 ICB has contributed £47.1m to the joint arrangements. These arrangements have broken even in 2025/26.

19 Related party transactions

Details of related party transactions with individuals 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 the following:
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
NHS Pension Scheme

The ICB has had a number of material transactions with other public sector organisations. Most of these transactions have been with the following:
Bath and North East Somerset Council
Swindon Borough Council
Wiltshire Council
His Majesty's Revenue and Customs (HMRC).

For this note, the ICB has considered all declarations of interest for Board Members. Under IAS24, 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 and key management personnel to be related parties. No material transations were undertaken with these individuals during the reporting period.

For the purposes of transparency, the table below includes entities with which key individuals are associated, and with which the ICB has transacted during the reporting period, but which do not meet the definition of a related party under IAS 24. These have been disclosed for information purposes only.

Transaction details are as follows:

	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.	8.9	0.0	0.3	0.0
Elm Tree Surgery - Dr Francis Campbell, Board GP Representative, is a partner at this practice.	1.9	0.0	0.1	0.0

20 Events after the end of the reporting period

The accounts were authorised for issue by the Chief Officer Strategic Finance and Resources on 15th June 2026.

21 Financial performance targets

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
NHS BANES, Swindon and Wiltshire ICB's performance against those duties was as follows:

	2025-26 Target £m	2025-26 Performance £m	2024-25 Target £m	2024-25 Performance £m
Expenditure not to exceed income	2,354.8	2,331.9	2,224.0	2,215.5
Capital resource use does not exceed the amount specified in Directions	5.5	5.5	0.2	0.1
Revenue resource use does not exceed the amount specified in Directions	2,316.8	2,293.9	2,193.3	2,184.8
Revenue administration resource use does not exceed the amount specified in Directions	25.9	23.0	17.2	15.1

In 2025-26, the ICB has recorded a surplus of £22.9m - this reflects an underspend against the Revenue Resource Limit (RRL). This compares to 2024-25, when the ICB exceeded its RRL by £8.6m.
The ICB also underspent against its administration resource by £2.9m. In 2024-25, an underspend of £2.1m was reported.
The ICB has fully utilised its capital allocation in 2025-26. In 2024-25, the capital resource limit was underspent by £169k.

22 Mental Health expenditure

	2025-26 £m	2024-25 £m
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	177.3	155.6
Eligible mental health expenditure	177.3	155.8
Mental health expenditure above/(below) minimum investment required	0.03	0.22
Mental health expenditure as a proprortion of total expenditure	7%	7%

In 2025/26, the ICB is reporting that eligible mental health expenditure exceeded the minimum by £30,000. This spend equated to 7% of the ICB’s total expenditure.

In 2024/25, eligible mental health expenditure exceeded the Mental Health Investment Standard (MHIS) by £221,000. Expenditure was 7% of the ICB’s total expenditure.