ANNUAL REPORT 2025/26

1 April 2025 to

31 March 2026

Contents

PERFORMANCE REPORT

JONATHAN HIGMAN
Accountable Officer
NHS Somerset Integrated Care Board

15 June 2026

Performance Overview

The past year has been the most significant period of change since the establishment of integrated care boards. For NHS Somerset, 2025-26 has been 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, NHS Somerset has worked closely with neighbouring ICBs, including NHS Dorset and NHS Bath and North East Somerset, Swindon and Wiltshire, to develop clustering arrangements that enable 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 want to wholeheartedly thank all my colleagues at NHS Somerset – including those who have now left the organisation as part of our restructure – for their incredible professionalism, flexibility and commitment throughout the year. Many have continued to deliver critical work during a period when the future of the organisation and their place within it have been uncertain. Supporting our people through this change has been a priority, and it remains clear that our colleagues are central to our ability to lead the system effectively, now and in the future.

Alongside this organisational reform, 2025-26 has also been a year in which the national direction of travel for the NHS has become clearer. The publication of the NHS 10 Year Health Plan sets 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. At its core are three key shifts: moving more care into the community, moving from analogue to digital, and shifting the focus from treating sickness to preventing ill health.

For integrated care boards, including NHS Somerset, the 10 Year Health Plan reinforces the importance of our role as strategic commissioners – a role for which we are equipping ourselves through the clustering and merger process. While many of the ambitions set out in the 10 Year Health Plan will take time to realise, the direction is clear, and the work described in this annual report reflects how we are already contributing to these shifts at a local and system level.

Operating sustainably

Financial sustainability has remained a central challenge throughout 2025-26. The cost-reduction requirements placed on ICBs sit within a wider context of system pressure and rising demand. Through sound financial discipline and responsibility, we have worked with partners to support value, productivity and the effective use of public resources and I am very pleased to report that the Somerset Integrated Care System and NHS Somerset ICB achieved financial balance this year. This has required difficult decisions, underpinned by transparency and strong governance and would like to pay tribute to all those who have worked so hard to achieve this.

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 Somerset continues to have a clear local voice within wider structures.

Highlights and achievements from the year

Despite the pressures of organisational change and financial constraint, the past year has also seen meaningful progress across Somerset's health and care system. Operationally, ambulance and urgent and emergency care colleagues have worked hard to bring about improvements key areas and, although there is still work to do, Somerset has among the best ambulance handover times in the South West.

In general practice, Mendip and Frome are currently participating in the national Primary Care Network (PCN) Test Site Programme, which is a targeted partnership between seven ICBs, NHS England, and 22 PCNs across the country. The programme aims to enhance the understanding of challenges faced by PCNs and inform improved policies to address these needs. The initial outcomes from the pilot are encouraging and the pilot is a promising step towards enabling investment in areas with clear evidence of improved patient care and support and ensuring that we are creating a more resilient healthcare system.

Also in primary care, I am pleased to say that three new dental practices are opening across the county. Wellington Dental Care (run by Dentistry For You) began treating patients in October 2025, while One Smile Dental – Chard saw its first patients in December. A further practice is planned to open in Crewkerne in spring 2026 and, together, it is expected that these new practices will provide care for up to 20,000 people each year. We know from our engagement work that improving access to NHS dental care is a key priority for local people it has therefore been central to our plans since we took on responsibility for commissioning dental care. Thank you to all those who have worked hard on these new practices, which are one of the measures we are putting in place to improve access.

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, NHS Somerset 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 Somerset 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. NHS Somerset has played a key role in convening partners, supporting joint decision-making and maintaining focus on shared priorities.

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 NHS Somerset and our new cluster partners continue to meet statutory duties.

We continue to work with our partners on high profile projects. After a period of closure due to safety issues, Somerset NHS Foundation Trust (Somerset FT) is on track to reopen inpatient maternity services and the Special Care Baby Unit (SCBU) at Yeovil District Hospital in April 2026, so women, birthing people, babies and families can once again receive care closer to home.

Work to launch reconfigured stroke services at Musgrove Park Hospital in Taunton, Yeovil District Hospital and Dorset County Hospital in Dorchester continues. The new services, which will mean better emergency treatment and better recovery for stroke patients, are due to start in 2026-27 and we continue to engage with local stakeholders about the new services.

We are also working with Somerset FT and local communities on ‘test and learn’ projects aiming to enable more people to recover at home after a hospital stay. Initial findings show how temporary changes to how reablement is provided are yielding improvements in some areas, with further work to do in others.

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 Somerset.

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, NHS Somerset 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. NHS Somerset'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 alone. Through our work with local government, communities and partners, NHS Somerset 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.

Instrumental in shaping our plans for the future have been the outputs from Somerset's Big Conversation 2025 (SBC). This major engagement programme was an important opportunity to engage directly with thousands of local people, communities and partners about their experiences of health and care and their priorities for the future. Through a wide-ranging programme of in-person and digital engagement, we heard clearly about what matters most to people in Somerset: timely access to services, care delivered closer to home, better coordination between services, and a stronger focus on prevention and wellbeing.

Not only did we take to the streets of Somerset and seek feedback online, we were proud to work with voluntary, community, faith and social enterprise sector partners to fund bespoke work with communities people whose voices are often missing from mainstream NHS engagement – including those facing poverty, disability, rural isolation, neurodivergence, bereavement, mental health challenges and social exclusion. The insights gathered through SBC have strengthened our understanding of local need and are already informing system priorities, commissioning decisions and longer-term planning.

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 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 Somerset. 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
NHS Somerset Integrated Care Board

15 June 2026

The following sections provide an **overview of the purpose** of NHS Somerset Integrated Care Board (ICB), **how we have performed** during 2025/26 in achieving our objectives, and the **key risks and challenges** we have faced.

Statement of Purpose and Activities of the Organisation

NHS Somerset ICB is a statutory body responsible for planning and commissioning local health services, managing the NHS budget, and improving population health

NHS Somerset ICB oversees how money is spent and ensures health services function effectively and are of high quality. We are conveners of the system so there is collaboration between our system partners to foster innovation, shared delivery of strategic aims and addressing complex issues. In doing so we seek to:

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

Our vision is for all people who live and work in Somerset to have healthy and fulfilling lives, living well for longer than they do now. This vision is clearly outlined in our Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28) which also seeks to support the purpose of the ICS.

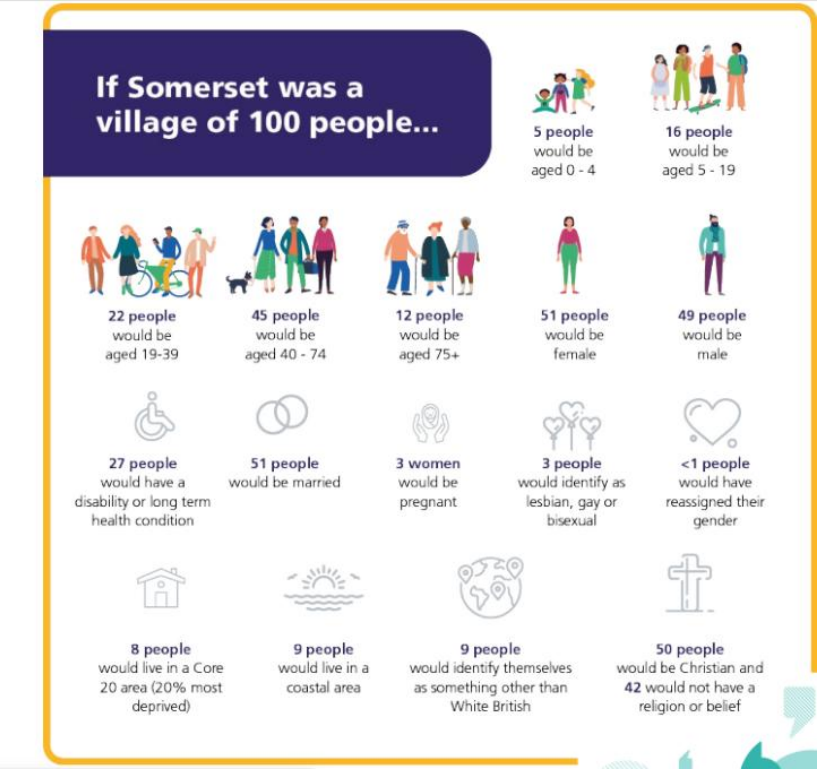
The Profile of Somerset

In Somerset we serve a population of approximately c.588,329 (ONS mid-year 2024). Data from the 2021 mid-year census indicate that Somerset has a much older average age than found in England with 1 in 4 of the population being over 65. Similar to the England picture, birth rates are declining. Key drivers for population age patterns are a net inward migration of those in the early retirement age group and outward migration of younger adults seeking work and education opportunities.

Somerset covers 3,452 square kilometres (1,333 square miles), one of the largest counties in England. The county is rich in environmental assets including 64Km of coastline, the Somerset Levels, Exmoor National Park, four designated national landscape areas and 39 national and local nature reserves.

Our residents are spread out across a large and varied area, which includes the densely populated towns of Taunton, Yeovil and Bridgwater. However, much of Somerset's distinctiveness comes from its rurality, with 48% of the population living in areas described as 'rural' by the Office for National Statistics (ONS) compared to 18% in England. The rural population has a slightly older profile than seen in the rest of Somerset. In rural areas, lack of mains gas and poorer public transport bring challenges of fuel poverty and barriers to access services.

The table below shows in more detail the demographics of Somerset.



Within the NHS Somerset ICB geographical footprint, the system covers:

- Somerset Council
- Somerset NHS Foundation Trust (including all Somerset's acute, community, mental health and learning disability services and around a fifth of General Practice provision under a single organisational umbrella).
- 59 GP practices which come together in 13 primary care networks (PCNs), located within 12 neighbourhoods and a single GP Support Unit.
- Strong working relationships and a Memorandum of Understanding with the local voluntary, community, faith and social enterprise sector (VCFSE).

Ambulance services in Somerset are provided by South Western Ambulance Service NHS Foundation Trust.

Somerset Board

In Somerset we have one Health and Wellbeing Board (HWB) which operates as a committee in common with the Somerset Integrated Care Partnership (ICP), known as the 'Somerset Board'. Its aim is to achieve greater integration across health, care, public health, and the VCFSE, together with other public sector partners and public voices to facilitate cooperation and collaboration, to improve health and care across the population of Somerset. This is underpinned by the HWB's Improving Lives Strategy (which has four priorities) and the ICP's Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28) (which seeks to deliver priority four of the Improving Lives Strategy).

4 Priorities

- A county infrastructure that drives productivity, supports economic prosperity and sustainable public services
- Safe Vibrant and well-balanced communities
- Fairer life chances and opportunity for all
- **Improved health and wellbeing and people living healthy and independent lives for longer**

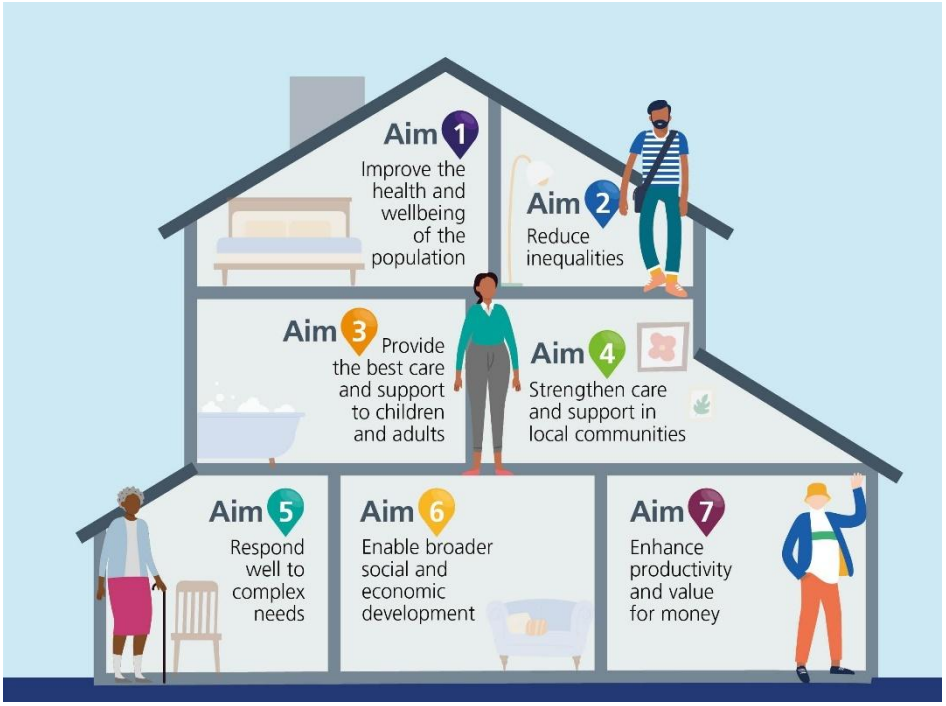
The Somerset Health and Wellbeing Strategy

Improving lives is the Somerset Health and Wellbeing Strategy. The strategy is owned by the Somerset Board, at which NHS Somerset ICB is a key consultative contributor. We take the Somerset Joint Strategic Needs Assessment (JSNA) into account when defining our strategy.

Our Strategy and Plans

We have set out how we will achieve our vision through Our Integrated Health and Care Strategy for Somerset and Somerset Five Year Joint Forward Plan Refresh 2025-2030. The strategy details our ambition for working collaboratively with partners from health, social care and the VCFSE, whilst outlining our vision to support all people who live and work in Somerset to have healthy and fulfilling lives. We want people to live well for longer than they do now. It is however worth noting that moving forward the Joint Forward Plan will be superseded by the Somerset Five Year Commissioning Plan.

Working together, Somerset will deliver this vision by prioritising seven key strategic aims, focused on achieving the ambition of enabling people to live healthier lives, as demonstrated in the diagram below.



Since publication of the strategy, there have been several changes which have taken place within the system:

- NHS services in Somerset continue to experience increasingly challenging financial and operational challenges.
- Announcement of the requirement to cluster with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, with the intention to formally merge in April 2027.

In 2023, as part of the new requirements set out for ICB's (Heath and Care Act 2022), Somerset produced its first Joint Forward Plan, which was refreshed annually. However, following guidance from NHSE during 2025/26, the Joint Forward plan (Somerset Five Year Joint Forward Plan Refresh 2025-2030) has been superseded by the development of the Five Year Strategic Commissioning Plan. The plan not only outlines how Somerset proposes to exercise its functions over the next five years, as we move towards becoming a strategic commissioning organisation, it also specifically covers the 17 legislative requirements mandated of ICBs.

The plan describes the commissioning priorities for the NHS in Somerset and articulates the steps that we will take over the next five years to deliver the actions required to achieve our vision and meet the requirements of the national NHS 10 Year Plan. As a system we have undertaken specific engagement and in particular the outputs from the Somerset 'Big Conversation' have been analysed and used to help develop our strategy for services to support our local population.

Our Operating Model

Working alongside NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, we are fundamentally transforming to become one single ICB. We are 'clustering' as an interim step but anticipate the three organisations will formally come together through a 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.

By coming together as a single ICB, covering a population of about 2.6 million people and with a total commissioning budget of just under £8bn, we believe we will be in the best place to be able to deliver the ambitions of the NHS 10-year plan, radically reforming how the NHS operates and delivers services.

Three radical shifts are necessary to transform the NHS: hospital to community; analogue to digital; and sickness to prevention. As strategic commissioners, we are expected to take bold and ambitious commissioning decisions to enable providers to deliver these shifts. We also retain accountability for a range of statutory functions, although the current way these accountabilities are delivered varies across our three ICBs, and will need to change.

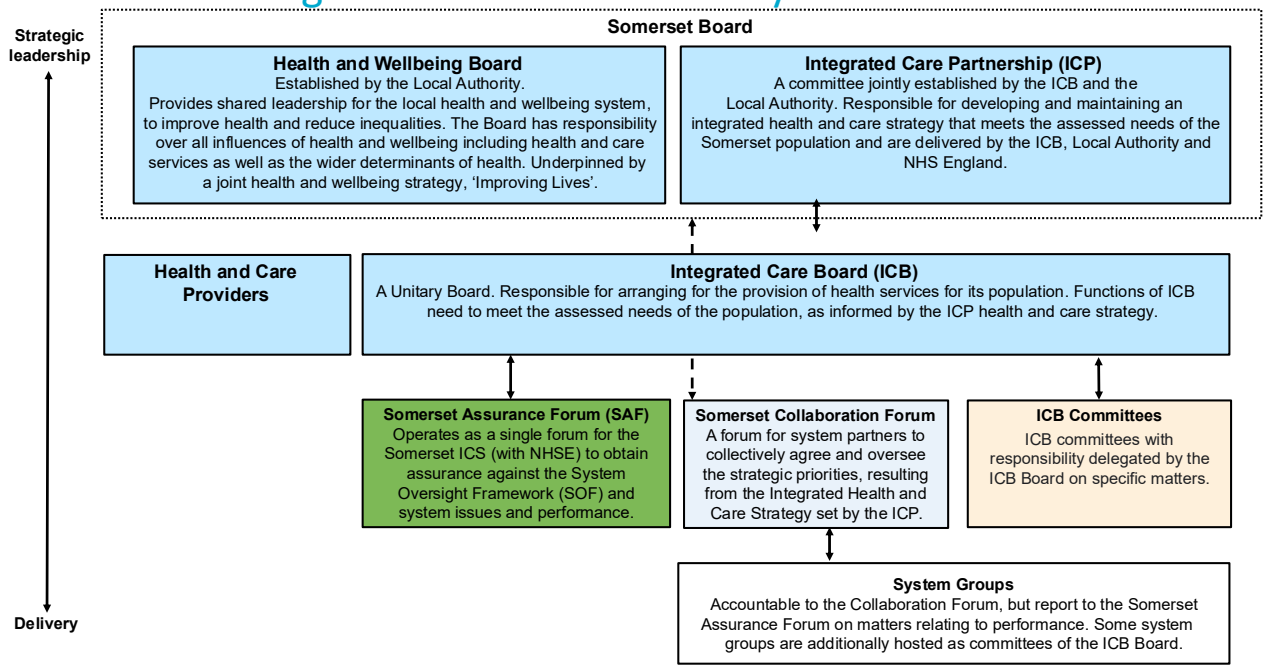
To achieve the transformation of our ICBs into a strategic commissioning organisation, we need to be clear about our core purpose and how we expect it to operate. We call this our operating model, which we been redesigning during 2025/26. It describes, at a high level, the vision, ambitions, functions and model of delivery of our new organisation, including how we balance the need to work across the cluster and at place (defined for this purpose as the six local authority areas within our geography). It does not define detailed organisational structures, instead it sets out our intended approach and direction of travel.

In 2023 we assumed delegated responsibility for commissioning of community pharmacy, ophthalmic and dental services. During 2025, the ICB took on additional commissioning of specialised services via delegation of functions from NHS England. NHS Somerset ICB aims to drive collaboration, promote innovation and support good health. We will listen to our residents and work with our communities to develop innovative ways to prevent people from becoming unwell, whilst also delivering high quality services. Our operating model allows us to be agile; to 'pivot' ourselves to work as a 'team of teams', breaking down traditional organisational silos.

How We Make Decisions

In making decisions about the provision of healthcare, we must consider the effects on the health and wellbeing of the people we serve (including by reducing inequalities with respect to health and wellbeing) the quality of services provided or arranged by both us and other relevant bodies and the sustainable and efficient use of resources.
This is known as the 'triple aim'. Our governance structure has been set up to ensure that we make decisions and work in this way in collaboration with our partners.

Integrated Health and Care System Overview



The following assurance and statutory committees have been established by the Board, chaired by a non-executive director:

- Audit Committee
- Quality Committee
- Finance Committee
- Strategic Commissioning Committee
- Remuneration Committee

We also have two Joint Committees currently in operation: Joint Committee (Specialised Services) and the Transition Committee (clustered with BSW and Dorset ICBs). In addition, the Management Board was established as an executive arm of the Board responsible for operational delivery of the organisation.

During the year, we have reviewed our governance structure and committee arrangements, to ensure they are fit for purpose, help us achieve both our statutory requirement and strategic objectives, and in particular in readiness for clustering with BSW and Dorset ICBs. Our governance handbook, and more information on our constitution and governance can be found here: Our Constitution and Governance - NHS Somerset ICB

Our Key Risks

In conjunction with our system partners, a series of system strategic risks have been identified which are key to impacting the delivery our overarching strategic aims and objectives. These risks are managed by ICB executive leads and overseen by ICB assurance committees and by the ICB Board through its Board Assurance Framework.

The ICB clustering arrangements and future anticipated formal merger by April 2027 (referenced earlier in this report) have impacted the Somerset risk profile. To reflect likely impact, a new strategic risk was agreed during the year relating to the transition. Risks associated with the transition work have been identified and overseen by a Cluster Transition Board.

Current key strategic risks are:

Workforce – that we do not have a workforce with the right skills and diversity in the right places at the right time to effectively meet the health and care needs of our population.

Finance – that if we do not improve and maintain the financial health of the Somerset system, we will be subject to restrictions which will impact on our ability to deliver sustainable, continually improving services, resulting in worse outcomes for the people of Somerset

Culture / Partnership Working – that if system partners lack a set of shared values and behaviours then the agreed operating model and ways of working will not prove effective, resulting in limited delivery of strategic aims and poorer outcomes for the people of Somerset

Innovation – that if we fail to identify and maximise the opportunities presented through innovation, we may miss chances to improve services, resulting in poorer outcomes for the people of Somerset.

Population Health – that if we fail to improve the health and wellbeing of the people of Somerset, then existing service delivery models will be further stretched resulting in exacerbating inequalities and worsening healthy life expectancy.

Outcomes – that if the Somerset system fails to transform delivery of health and care services, then current models of care will become unsustainable, with poorer outcomes for the people of Somerset.

Population Demographics – that if service transformation does not meet the future needs of the Somerset population, then there is a risk of exacerbating inequalities, resulting in poorer outcomes for the people of Somerset.

Reducing Inequalities – that if we fail to reduce inequalities for the population of Somerset, then there will be a worsening of healthy life chances and outcomes for disadvantaged groups among the people of Somerset.

Transition – There is a risk that the national ICB cost reduction programme and transition to ICB cluster arrangement will adversely impact the delivery of Somerset ICS strategic aims resulting in limited progress and a failure to deliver improvements in health and care for the population of Somerset.

Risks have been managed during the year as part of development of priority programmes and key enablers of work linked to the Strategic Commissioning Plan, namely:

- Clinical pathways
- System flow
- Neighbourhoods
- Population health
- Finance

There has been a strong focus on managing and mitigating financial risk during the year to enable the Somerset system including the ICB to achieve a balanced end of year position for 2025/26. The ICB Finance Committee has taken a leading role in ensuring robust control of the financial position.

The ICB has managed a wide range of risk during the past year across all functional areas. Key risk areas include:

Risk Profile

Workforce

Ensuring we have a workforce that is sufficient and equipped to deliver the system strategic aims and objectives for the people of Somerset remains a significant risk.

The People Board, one of our system groups, has continued to monitor workforce development and programmes across healthcare services. Work has continued to support mitigation of longer-term workforce risks, such as general practice, longstanding workforce shortfalls in high demand professions in clinical settings and sectors (including mental health assessments) and improving retention initiatives.

Due to the cluster transition work, the priority programme linked to workforce was reset midway through the year. These organisational change people risks have been well documented and are overseen through a Cluster Transition Board.

Finance

Financial risks have continued to form a significant component of our risk portfolio. We have collaborated with our system partners to manage risk to achieve a balanced end

of year financial position for 2025/26. However, for 2026/27 the financial outlook remains challenging and presents risk.

At a system level across Somerset there has been a deterioration in the underlying position due to higher delivery of non-recurrent savings in-year than planned. This will mean the underlying deficit starting point for 2026/27 will be higher than planned, which impacts on the level of cost improvement plans needing to be included to submit a balanced plan, increasing its risk of delivery.

Performance and Standards

As commissioner of health services for Somerset, we have a key role in overseeing performance across service providers delivering care for Somerset patients. There are a range of risks linked to performance and service standards, which in turn are closely linked to ensuring patient safety, service quality and patient experience are optimised for the Somerset population.

Progress has been made with improving access to NHS dental services, particularly for urgent and complex care and support for vulnerable groups, with more work underway and to come. Whilst progress has been made in reducing longer waits than NHS constitutional standards, there remains a continuing challenge to reduce waits across sectors throughout the system and no criteria to reside in inpatient wards. There are a range of mitigations documented on our risk register, and the ICB continues to support improved service pathway development to ensure delivery in the most effective and efficient way possible. Key areas of focus are urgent and emergency care and primary care models for paediatrics, women's health services, ophthalmology and ADHD adults service redesign.

Cyber Security / Digital

With increasing use of technology, a focus on cyber security is essential. An internal audit of cyber security was undertaken during the year which provided positive assurance on the controls and mechanisms in place to manage cyber security.

Next Steps

In the coming year it is expected that the risk themes outlined above will continue to dominate the landscape. This will require a renewed focus on ensuring services are optimised to deliver patient care in the most effective way. The transition to a cluster arrangement and development of the ICB as a strategic commissioner will provide greater opportunity to address and mitigate these risks.

Performance Analysis – Key Standards

NHS Oversight Framework

The updated NHS Oversight Framework for 2025/26 describes a consistent and transparent approach to assessing ICBs and NHS Trusts/Foundation Trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. Within this framework a range of metrics (including those included in the 2025/26 operational plan, together with other contextual metrics) are used in the oversight of ICB and Trust performance, resulting a segmentation score and identifying areas where improvement is required. However, ICBs have not been formally assessed in this way during 2025/26 recognising that this is a year of significant change and disruption due to clustering arrangements and transition and instead will be assessed via the statutory annual assessment which reviews how well the ICB is performing its statutory duties.

During 2025/26 several performance indicators have improved moving towards or exceeding the national average and an overview of performance is included in the analysis section of this report.

SPC Chart Key

A large proportion of the graphs used to illustrate performance in this section use Statistical Process Control (SPC) charts. The icons and colours are related to the mean, process limits and target featured on an SPC chart denoted as follows:

Mean

Target / Plan

Process (Upper/Lower Control) Limit

An SPC chart will have an **SPC Variation icon** which shows the kind of variation occurring within the data:

Orange indicates **concerning** special cause variation, requiring action

Blue indicates **improving** special cause variation, where no action is required

Purple indicates special cause variation where it is **hard to define** whether up is "good" (improving) or "bad" (concerning)

Grey indicates no significant change due to **common cause variation**

Alongside the variation icon, SPC charts will have an **SPC Assurance Icon** where a target/plan is stated:

Blue indicates an expectation to consistently **achieve** a target/plan

Grey tells you that sometimes the target/plan will be met and sometimes missed due to **random variation**

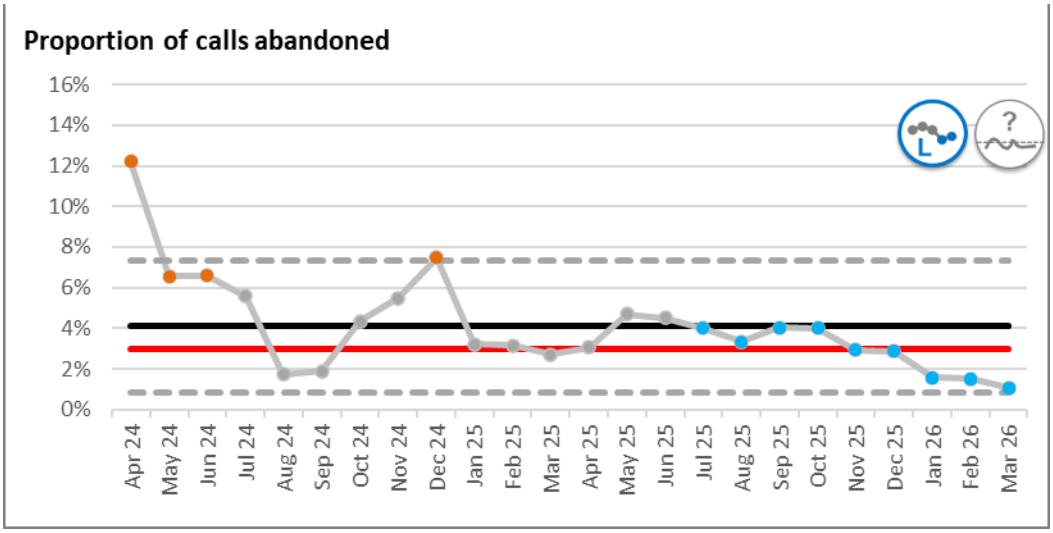
Orange indicates that you would consistently expect **to miss** the target/plan

Urgent Care

Measure	Standard	24-25 Full Year	25-26 YTD			
		Somerset ICB	Somerset ICB	Change to 24/25	National Avg	Change to National Avg
NHS 111 Call Abandonment	≤3%	3.4%	3.1%	↓	3.2%	↓
Category 1 Response (Mean)	7 Minutes	9.7	10.4	↑	7.6	↑
Category 2 Response (Mean)	18 Minutes	45.4	36.4	↓	30.0	↑
Average Handover Time	30 Minutes	00:34:56	00:36:36	↓	00:29:55	↓
% Handovers >15 Minutes	35%	79.9%	70.9%	↓	65.3%	↑
% Handovers >30 Minutes	5%	33.0%	24.2%	↓	25.70%	↓
% Handovers >45 Minutes	0%	14.1%	9.2%	↓		
% Handovers >60 Minutes	0%	3.90%	4.40%	↑	7.70%	↓
A&E 4-hour (All Types)	76%	74.4%	71.9%	↓	74.9%	↓
A&E 4-hour (Type 1)	76%	56.7%	52.2%	↓	60.9%	↓
Number of patients with NCTR	Plan	226	226	↔		
% of acute beds occupied by NCTR patients	Plan	25.0%	27.8%	↑		
All G&A Bed Occupancy	92%	93.4%	94.9%	↑		
Virtual Wards	Plan	53.3%	46.1%	↑		-

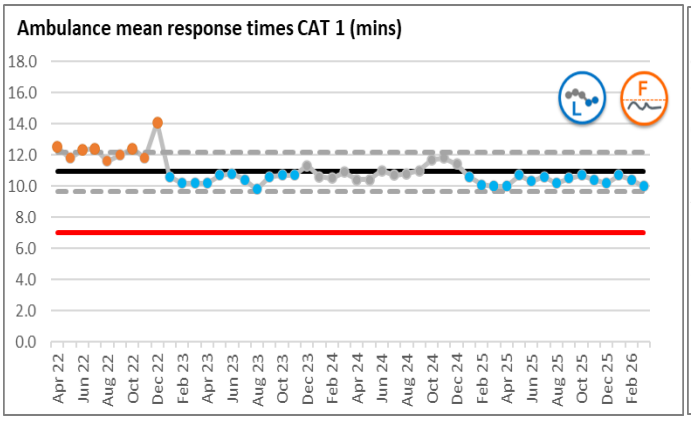
NHS 111

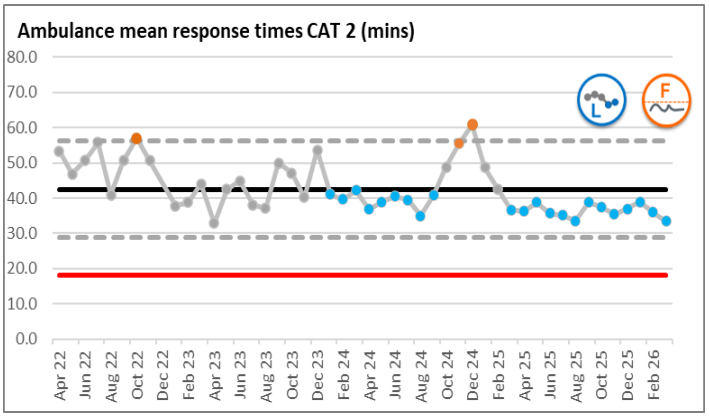
During 2025/26 209,596 people called the NHS111 service and 3.1% of these were abandoned which is a slight improvement on the previous year and is above the 3% operational standard and average national performance.

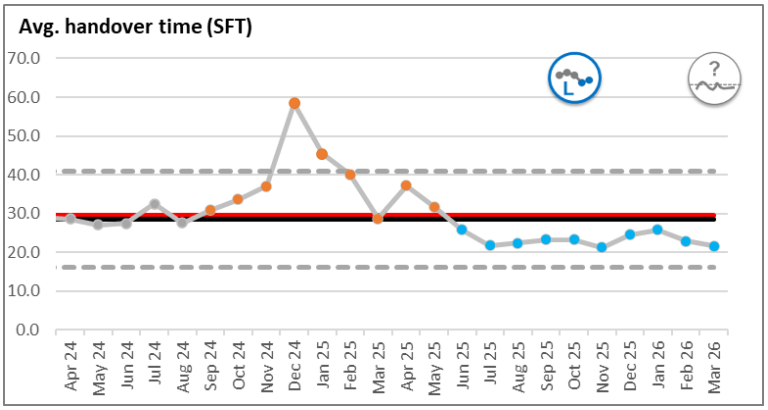


Ambulance Response Times

During 2025/26 Category 1 mean ambulance response times for life threatening injuries or illness (including cardiac arrest) was 10.4 minutes, which is a slight decline on the previous year, but behind the national standard of 7 minutes and South Western Ambulance Service NHS Foundation Trust (SWASFT) average of 9 minutes. For Category 2 ambulance calls (those classed as an emergency or a potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport and performance) response times performance was 36.4 minutes against the 18-minute standard which is an improvement on the previous year but higher than the SWASFT average of 34.3 minutes.



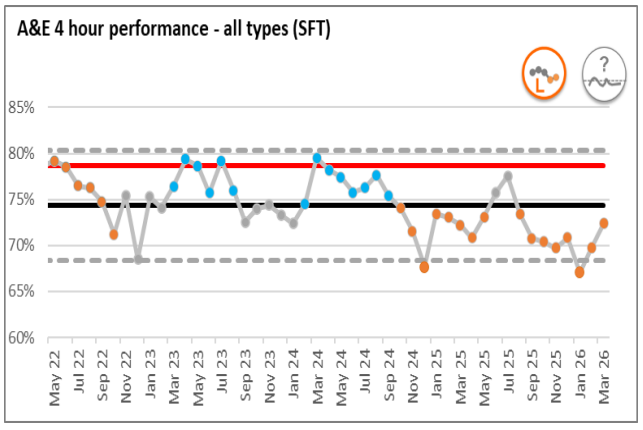


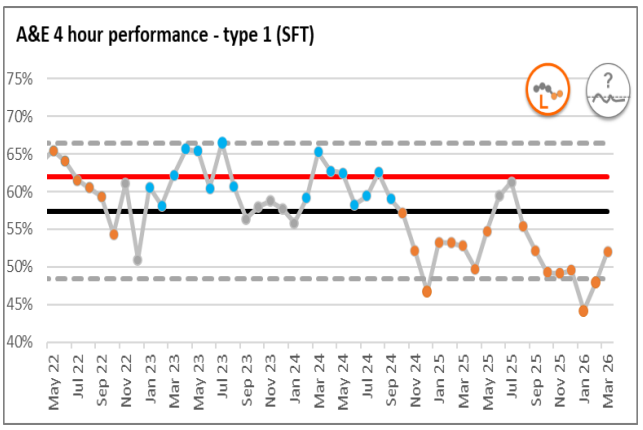


Accident and Emergency (A&E)

Demand for front door services in Somerset (Emergency Department and Urgent Treatment Centres) has reduced by 3.6% in 2025/26. However, there has been a 3.8% increase in ambulance arrivals. Somerset has the second lowest ambulance handover lost hours and average handover time in the SWASFT footprint, although performance has been more challenged and declined over the winter period. The average handover time in 2025/26 was 25.2 minutes compared to the SWASFT average of 36.4 minutes.

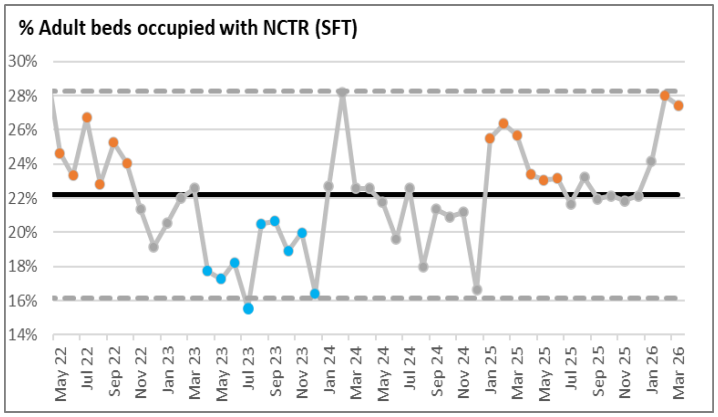
There has been a 3.76% reduction in A&E attendances, including Urgent Treatment Centres when compared to the previous year. During 2025/26 52.2% of A&E attendances to Type 1 Emergency Departments in Somerset were seen, treated and either discharged or admitted within 4-hours and across all A&E Departments (which includes Urgent Treatment Centres) performance was 71.9% compared to the 78% national improvement standard.

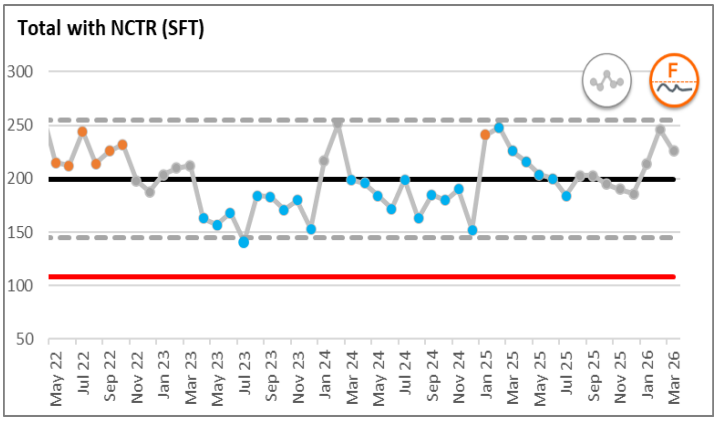




Beds, Discharge and Flow

Demand on hospital beds has remained high during 2025/26 with the average occupancy on adult wards exceeding 96%. Whilst there has been a 2.7% reduction in emergency admissions staying more than 1 day in hospital (to January 2026) the average length of stay has increased. In March 2026 in our acute hospitals (on average) 28% of our adult general and acute beds were occupied by patients who have no criteria to reside and this is leading to an extended length of stay and impacting on flow across the hospital site.





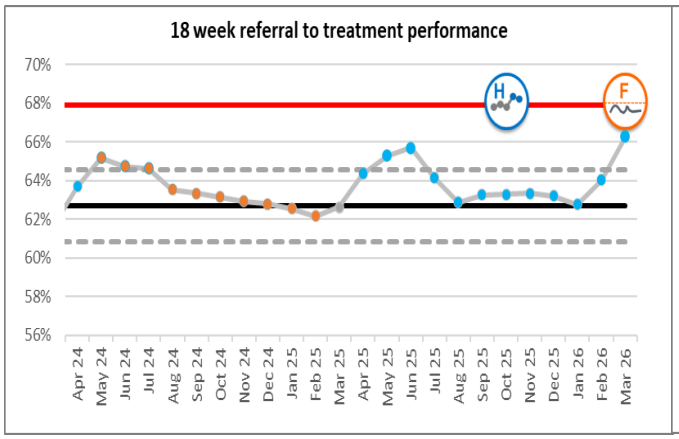
Elective Care

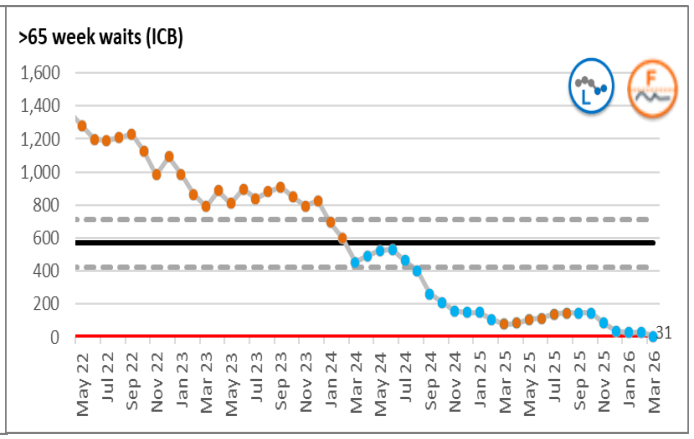
Measure	Standard	24-25 Full Year	25-26 YTD			
		Somerset ICB	Somerset ICB	Change to 24/25	National Avg	Change to National Avg
<18 Week Wait Performance	68%	62.6%	66.3%	↑	65.3%	↑
65 Week Waits - All	0	77	20	↓	4,302	
65 Week Waits - Children Services	0	6	3	↓		
52 Week Waits - All	0 by March 27	1,253	1,036	↓	92,609	
52 Week Waits - Children Services	0 by March 27	134	149	↑		
Diagnostics <6 Week Wait Performance	95%	78.4%	82.9%	↑	78.8%	↑
Cancer 28 Day Faster Diagnosis Standard	80%	74.6%	68.9%	↓	76.3%	↓
Cancer 31 Day Combined Standard	92%	92.1%	91.9%	↓	91.8%	↔
Cancer 62 Day Combined Standard	85%	68.4%	70.6%	↑	69.4%	↑

Referral To Treatment Waiting Times

During 2025/26 there was a 1.1% reduction in people referred into our hospitals for treatment. This is largely due to the implementation of a demand management system, 'Advice and Refer' at Somerset NHS Foundation Trust. Elective activity volumes have increased against the previous year, alongside a 8.7% reduction in the total waiting list size. Latest performance against the 18-week constitutional standard was 66.3% against the Somerset operational plan of 67.9%, which is an improvement to the previous year. Moving forward into 2026/27, there is a requirement for the ICB to make a 7% point increase in the 18-week performance. The focus in 2025/26 has continued to be upon reducing our longest waits. As at March 2026 there were 20 patients waiting longer than 65 weeks (compared to 77 as at March 2025) and 1,036 patients waiting longer than 52 weeks (compared to 1,253 in March 2025).

In 2025/26 the number of patients waiting longer than 52 weeks, under the age of 18, decreased by 11.2% when comparing March 2026 to March 2025.

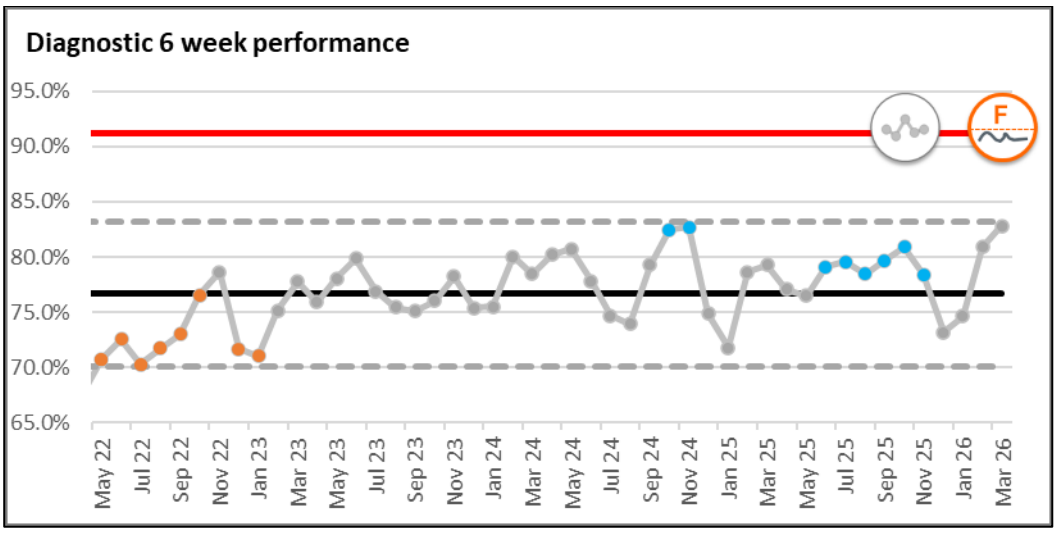




Diagnostic Waiting Times

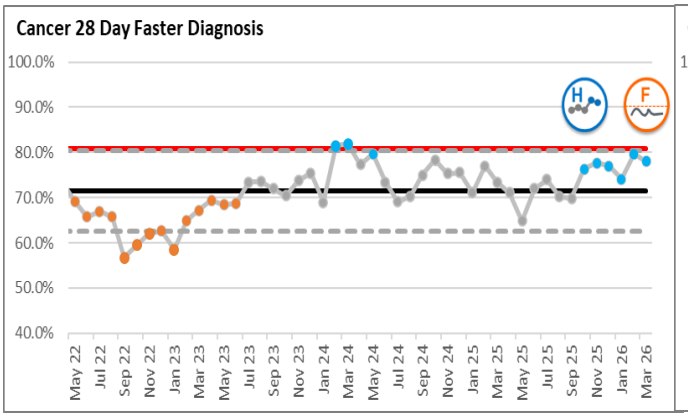
Somerset's latest 6-week wait performance to March 2026 was 82.8% against the year-end recovery ambition of 95%. The volume of diagnostic activity has increased by 5.9% when compared 2024/25, underpinned by additional activity delivered through Community Diagnostic Centres (CDC) in Somerset with the Yeovil CDC opening in 2025 and increasing in-house capacity. In 2026/27 Bridgwater Diagnostic Centre is expected to open in the summer.

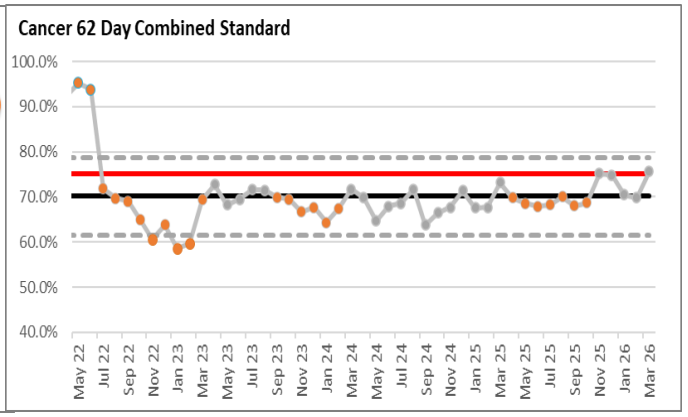
There have been some challenges across selected diagnostic modalities due to periods of very high demand, seasonal pressures and other isolated issues impacting upon capacity, but also there have been improvements throughout the year.



Cancer Waiting Times

During 2025/26 we saw a minor 0.2% reduction in the number of patients referred by their GP into the 28-day faster diagnosis pathway. The 28-day faster diagnosis standard (FDS) performance was 68.9% against the ambition to achieve the 80% standard by March 2026. 91.9% of patients received their first definitive or subsequent cancer treatment within 31 days against the 96% standard and 71.9% of patients received treatment within 62 days of referral from either a GP, consultant upgrade or from the screening service with the ambition to reach 75% by March 2026.





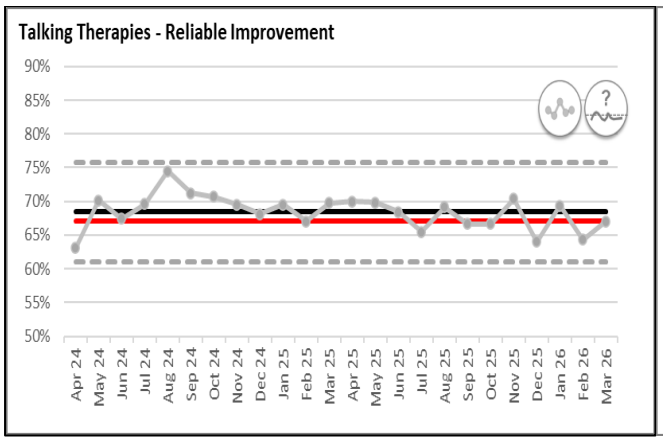
Mental Health

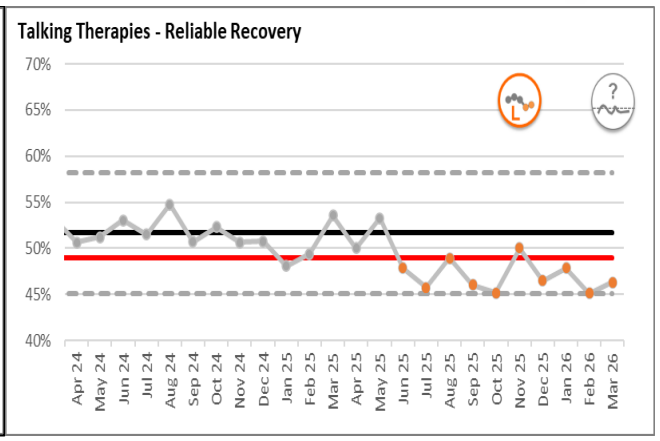
Measure	Standard	24-25 Full Year	25-26 YTD			
		Somerset ICB	Somerset ICB	Change to 24/25	National Avg	Change to National Avg
Talking Therapies Reliable Improvement	68%	69.2%	67.7%	↓	67.8%	↑
Talking Therapies Reliable Recovery	50%	51.5%	47.7%	↓	47.2%	↑
Indivdual Placement Support		582	575	↓		
CYP Access	7768	7935	9295	↑		
Perinatal & Maternal Mental Health Access	640	660	695	↑		
Community Mental Health Services Access	-	10,515	11,280	↑		
Dementia Diagnosis	67.7%	54.8%	56.0%	↑	66.10%	↓
PHSMI	60%	58.3%	56.9%	↓	65.0%	↓
LD Annual Health Checks	75%	80.7%	76.7%	↓	79.8%	↓
Out of Area Placements	0	3	4	↑	276	
Children on MH Adult Ward	0	0	0	↔		

Talking Therapies (formerly IAPT)
Reliable recovery performance (which indicates a person's symptoms have significantly improved from the start to the end of the treatment) reached the 50% national ambition in April, May and November 2025. Reliable improvement performance (which indicates a person's scores have improved from the start to the end of their treatment) has been variable throughout 2025/26, mirroring a national trend which is attributed to the increase in complexity of cases.

6-week waiting times performance declined in the first half of 2025/26 but has since recovered in the latter half of the year, as at March 2026 is 71% against the 75% national ambition with 18-week performance remaining above the 95% national standard.

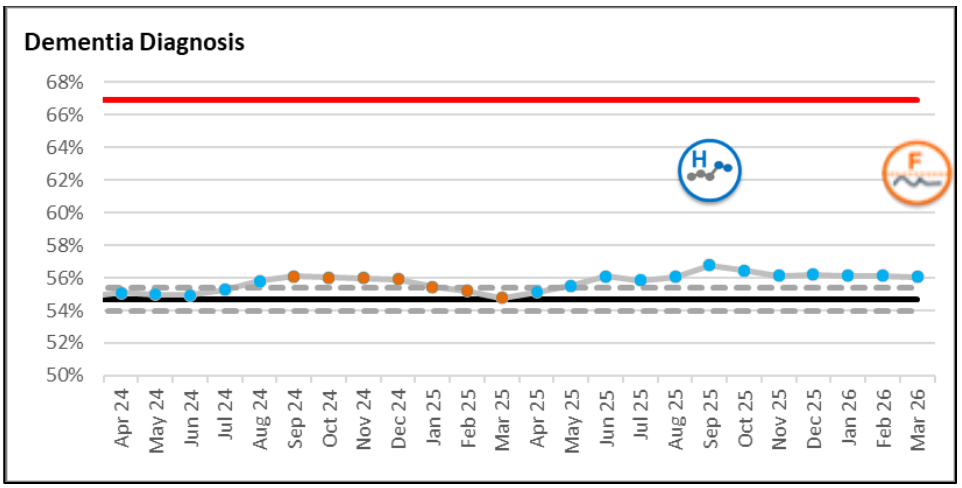
First to second treatment waits (which expects no more than 10% of people to be waiting over 90 days) has declined throughout 2025/26 which is largely due to the complex demand into the service. Somerset are increasing workforce who can treat the most complex individuals.





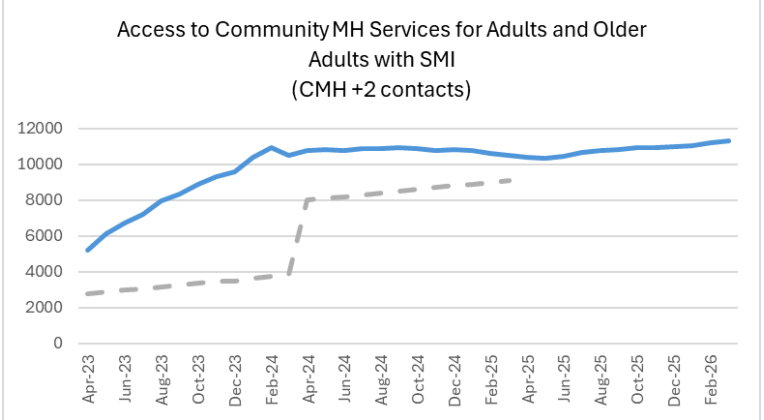
Dementia

Work continues to improve our dementia diagnosis rate, but in 2025/26 we were behind plan with performance of 56.0% (March 2026) against a 67.7% national ambition.



Community Mental Health for Adults

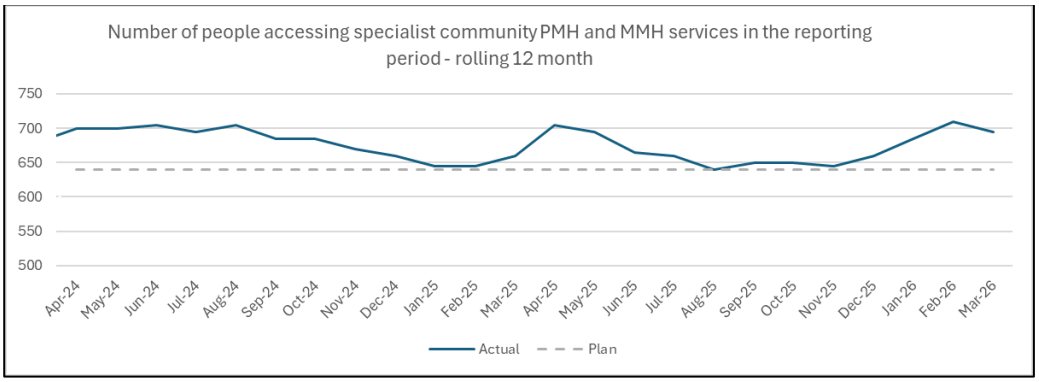
Following the significant improvement in 2023/24, the number of people accessing community mental health teams for adults and older adults has remained stable throughout 2025/26. The chart below is reported on a 12-month rolling basis.



CYP Access and CYP Community Eating Disorder Services
On a rolling 12-month basis to March 2026, performance for children and young people (CYP) accessing mental health services delivered 9,295 contacts, exceeding a plan of 7,768 contacts (112% achieved) and represents a significant year on year improvement. 2026/27 plans to continue to increase this number with a focus on expanding mental health support teams across Somerset.

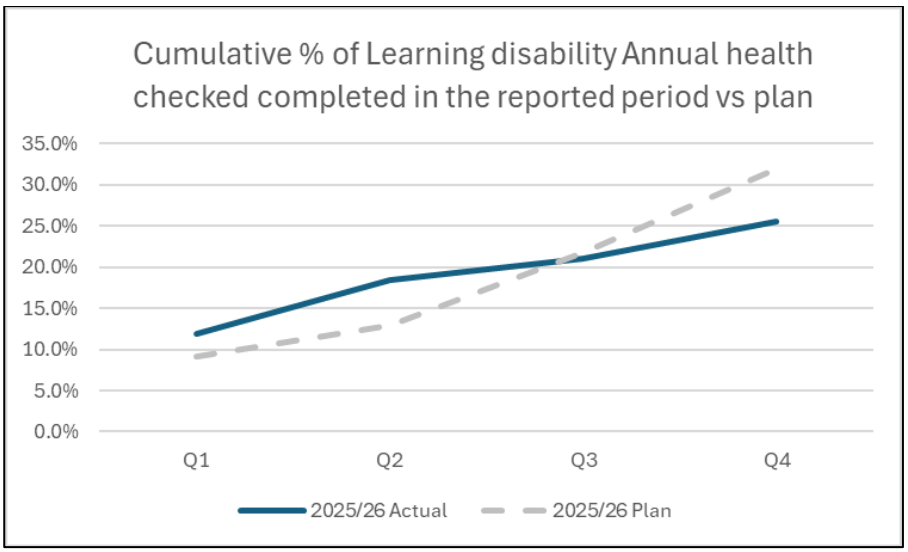
In respect of the eating disorder service, on a rolling 3-month basis to March 2026, performance for routine appointments was 92%, whilst for urgent patients, performance was 80%, against the national standards of 83%

Perinatal & Maternal Mental Health
695 women accessed the perinatal and maternal mental health services in the 12-month period to March 2026, exceeding an annual target of 640.



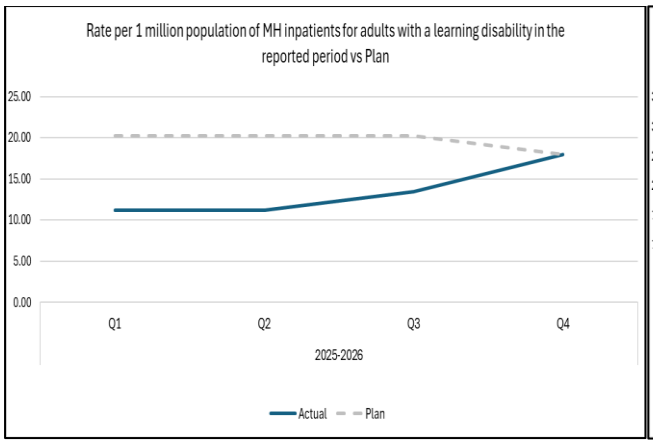
Learning Disabilities Annual Health Checks (LD AHCs)

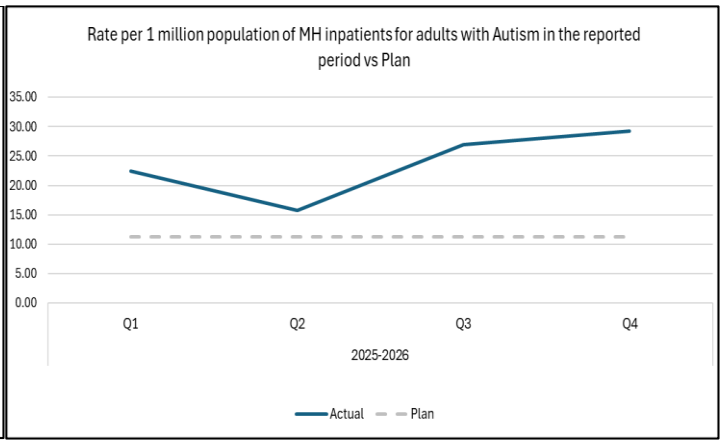
LD AHCs are a key part of promoting access to health care and reducing health inequalities for people with learning disabilities. LD AHCs are largely delivered by GP practices. In 2025/26 2,273 (or 76.7% of the LD register size) health checks have been completed, which is a decline on the previous year but in line with the 75% standard.



Learning Disability Reliance on Inpatient Care

During 2025/26 there have been a maximum of 21 adult inpatients with a learning disability and/or autism who have a mental health disorder and in a specialist hospital bed; this is above a plan of 13. Somerset achieve low admissions for children and young people and any admissions tend to be shorter stays. Current performance in Somerset is zero children and young people inpatients.





Primary Care and Community

Measure	Standard	24-25 Full Year	25-26 YTD			
		Somerset ICB	Somerset ICB	Change to 24/25	National Avg	Change to National Avg
Community Waiting List - Adult	-	8,162	12,565	↑		
Community Waiting List - Children	-	1,724	1,686	↓		
Community Waiting List > 52 weeks - Adult	0	5	0	↓		
Community Waiting List > 52 weeks - Children	0	4	0	↓		
Primary Care Appointments ≤14 Days	85%	84.2%	82.8%	↓		
Virtual Wards - Capacity	Plan	167	167	↔		
Virtual Wards - Occupancy	Plan	53.3%	46.1%	↓	90.2%	↓
Urgent Crisis Response Services Rate per 100,000	200	180	200	↑		
Pharmacy First Consultations	Fair shares	52,312	67,469	↑		
Units of Dental Activity Undertaken	Plan	44.8%	49.3%	↑		

Community Services Waiting List

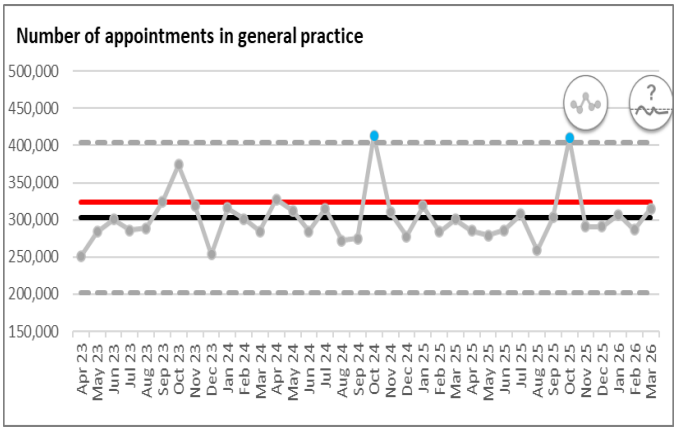
Community health services are made up of adult and children's services delivered in the community by Somerset NHS Foundation Trust. When comparing the overall waiting list size as at March 2025 to March 2026, it has increased by 48.0%, from 9,886 to 14,631 across both adult and children's services. This increase is due to additional services being reported as part of the data quality and assurance programme led by NHS England (South West Region) which saw further service lines added during 2025/26 align with national guidance.

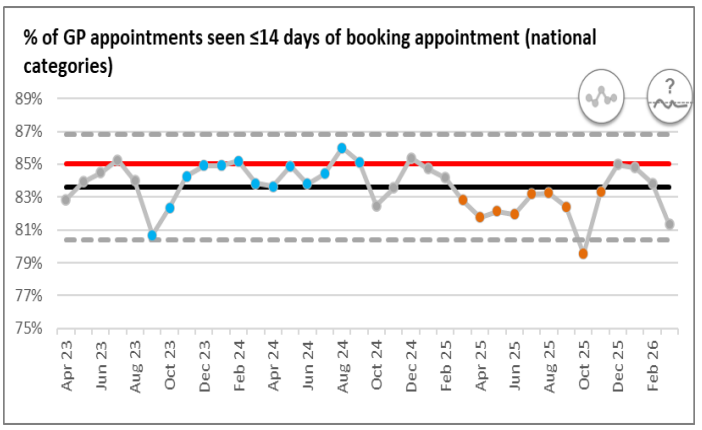
The number of patients waiting longer than 18-weeks has improved significantly due to the improvements made in the podiatry service, and across the children's services (specifically speech and language therapy and community paediatrics).

During 2025/26 Somerset FT have eradicated 52-week waits, with 0.2% of the overall waiting list waiting over 40 weeks. Neurodevelopmental services are not included in our community waiting list, due to these patients being recorded in the mental health services minimum dataset.

Appointments in General Practice

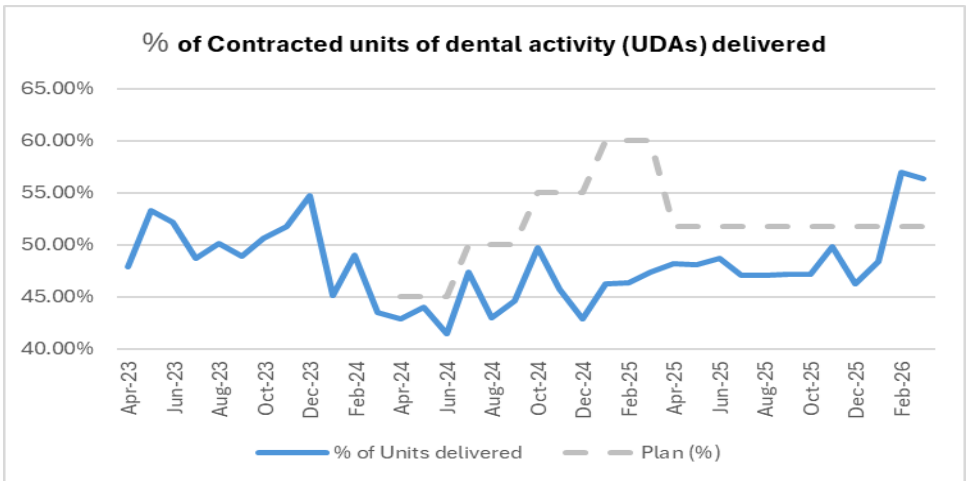
The number of appointments in General Practice when comparing 2025/26 to the previous year has decreased by 1.9%. When looking at the proportion of appointments booked within 14 days (specific appointment categories) performance has declined against the previous year, 82.8% (year-to-date 2025/26) vs 84.3% in 2024/25. Decline in performance across both metrics may be due to a decline in the registered workforce in Somerset over recent months. Somerset has also had one practice closure in 2025/26 and two practice mergers, which can impact on GP appointments due to merging practice clinical systems.





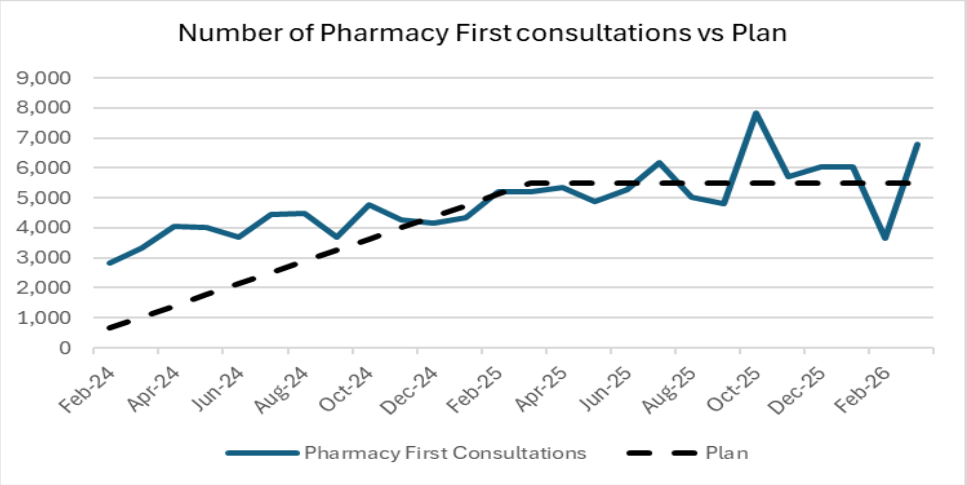
Dental Access

Access to dental care in Somerset remains challenged in 2025/26. A recovery plan is in place and actions to increase access to NHS dental treatment are underway which will improve the level of activity. In 2025/26 year to date Somerset has delivered 49.25% of contracted units of dental activity, which is a 4.1% increase on 2024/25. This is largely down to improved performance in Q4 2025/26



Pharmacy First

The Pharmacy First service launched in January 2024. It enables community pharmacies to complete episodes of care for seven common conditions following defined clinical pathways as well as emergency contraception and blood pressure checks. During 2025/26 Somerset pharmacies have delivered 67,469 consultations against a regionally set target of 65,856



Performance Overview – Statutory Duties Overview as Required Under the Annual Report

Mental Health

NHS England requires all ICBs in England to deliver the mental health investment standard (MHIS), which requires an increase in planned spending on mental health services by a greater proportion than the overall increase in budget allocations each financial year. The aim of this standard is to support the ambitions within the NHS Long Term Plan to ensure that essential investment is made into developing the provision of mental health services.

NHS Somerset ICB have reported full compliance with our obligations for the required levels of investment in mental health services for the 2025/26 financial year.

The table below demonstrates the amount of reported mental health expenditure incurred by NHS Somerset ICB during the financial years 2024/25 and 2025/26, and the proportion of this expenditure against the total of the organisation's programme resource allocation.

Financial Years	**2025/26 £'000**	**2024/25 £'000**
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England (£000)	130,301	115,323
Eligible Mental Health Expenditure (£000)	130,312	115,409
Mental health expenditure above/(below) minimum investment required (£000)	11	86
Mental Health expenditure as a proportion of total expenditure (%)**	4.1%	7.9%

** From 1 April 2025, NHS Somerset Integrated Care Board assumed the role of Principal Commissioner for Specialist Commissioning for the South West, acting on behalf of seven South West ICBs (including NHS Somerset ICB). As a result, expenditure relating to specialist commissioning services is now recorded within NHS Somerset ICB's accounts, leading to a significant increase in reported expenditure in 2025-26 compared with the prior year.

Statutory responsibilities in relation to safeguarding children, adults and children looked after and care leavers

For the purposes of this report safeguarding includes but is not limited to: Safeguarding Children, Safeguarding Adults, Children Looked After, Care Leavers, Domestic Abuse, Prevent, Exploitation, Serious Violence, Mental Capacity, Child Death Reviews

including the Child Death Overview Panel (CDOP) process, Female Genital Mutilation (FGM), Anti-Social Behaviour, and Deprivation of Liberty.

The Somerset Integrated Care Board (ICB) Chief Executive is the executive lead for Safeguarding, with the Chief Nursing Officer having delegated responsibility.

As set out in legislation the three safeguarding partners in Somerset (Local Authority, ICBs and Avon and Somerset Police) continue to work together with other agencies to safeguard and promote the welfare of children, adults at risk, children looked after and care leavers in our local area; through the work of the following Boards and Partnerships:

- Safer Somerset Partnership (SSP), which includes the Somerset Violence Reduction Partnership.
- Somerset Safeguarding Adult Board (SSAB).
- Somerset Safeguarding Children Partnership (SSCP), which includes the Corporate Parenting Board.
- Avon and Somerset Violence Reduction Partnership.

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.

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 Somerset.” The Somerset ICB Safeguarding Assurance Meeting (SAM) 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. Further detail in relation to child deaths and the Child Death Overview Panel (CDOP) process is available within the ICB safeguarding annual reports for 2024–2025.

Escalation to the Quality Committee or the Board is by exception. The SAM is now well attended by representatives from all Directorates within the ICB, who also provide a report on the following:

- Workstreams and priorities
- Safeguarding challenges and risks
- Safeguarding achievements

The safeguarding contribution to the Somerset’s Joint Forward Plan for 2026 to 2027 has been updated and details how the Integrated Care System (ICS) will ensure that all statutory safeguarding duties are discharged.

The ICB publish annual safeguarding assurance and human trafficking and modern slavery statements on their website.

The ICB safeguarding schedules are updated annually to include statutory and mandatory safeguarding responsibilities for short and long form contracts held by the ICB, as well as providing clear expectations of the services we commission in relation to safeguarding unborn babies, children, adults at risk, children looked after and care leavers. The annual review of schedules incorporates any changes made to the NHS Standard Contract.

Throughout 2025 to 2026 the ICB strategic safeguarding team have worked with partner agencies locally, regionally and nationally in relation to:

- Enhancing the system-wide approach to implementing the Domestic Abuse Act (2021) by improving the management of high-risk domestic abuse cases and working towards the standardisation of processes for supporting victims of non-fatal strangulation.
- Development of the Somerset Adoption Strategy 2026 to 2028, which outlines how Somerset's health system meets its statutory responsibilities within the Adoption Pathway.
- Design and implementation of significant system reform through the Families First Partnership Programme, including development of Somerset Multi-Agency Child Protection Teams.
- Ensuring children looked after and care leavers have timely, equitable access to high-quality, trauma-informed health services.
- The implementation and roll out of the Child Protection Information Sharing (CP-IS) system, to support timely safeguarding information across health settings.

Further demonstration of how Somerset ICB have performed against statutory safeguarding duties are outlined within the following annual reports for 2024 to 2025:

- SSAB annual report.
- SSCP 12 monthly report.
- SSP annual report.
- Somerset ICB safeguarding children annual report.
- Somerset ICB children looked after and care leaver's annual report.
- Somerset ICB safeguarding adults annual report.

Environmental Matters

Task force on climate-related financial disclosures (TCFD)

Our ICS Green Plan is underpinned by the UNs 17 Sustainable Development Goals. The SDGs provide a clear framework for the wider delivery of the Green Plan and enables the ICB to be more outward looking.

Being clearer and more transparent about ambitions and progress and how it supports organisational objectives is key. Where progress is reported it should be frequent and consistent. This will demonstrate commitment to targets set out in the plan which could attract further investment and/ or collaborative partnerships. The Green Plan should be recognised as an enabler. Each of the 9 headline targets supports the broader strategic direction and is closely linked to the missions and values of the NHS in Somerset. Using the 17 SDGs will help provide an opportunity to identify progress being made in areas that might not have otherwise had exposure, tackling inequalities for example.

The ICB Board recognises that policy needs to be joined up across the cluster and system. Fragmentation of policies can lead to silo working, duplication, and inefficient practices. It is important to understand the interdependencies across all strategies and to recognise synergies.

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

1. **Governance** – The governance pillar is shown in the KPI report Green Plan, target indicators (GT2; GT3). Climate related issues and Green Plan delivery progress is reported into the Collaboration Forum and annually through the Annual Report process. Bi-annual board updates are planned for 26/27 to ensure broader accountability.

2. **Risk Management**

   Climate change poses significant health risks, including increased heat-related illnesses, the spread of infectious diseases, and mental health impacts. Extreme weather events, like heatwaves and floods, can cause direct injuries and deaths, while also disrupting food and water supplies, leading to malnutrition and illness. Furthermore, climate change can exacerbate air pollution and create conditions for the proliferation of disease-carrying vectors, such as mosquitoes and ticks.

   In future years and decades climate change will mean we will see more frequent and intense heatwaves, more droughts, and more rain including more heavy downpour events and storms.

Somerset had the second wettest January on record with more than double the average rainfall. A third of this rain fell during Storm Chandra, which saw around 1.2 million cubic metres of water per hour moving though the Parrett and Tone catchments. Most of this water spilled into the floodplain of the Levels and Moors.

Wet weather continued into February, which had almost double the average rainfall by mid-month. Across the county, there have been widespread impacts from flooding.

Somerset Council declared a major incident on 27 January, with the support of the Environment Agency and Local Resilience Partners, including NHS Somerset ICB. Adapting to reduce the impact of these events on public health and the healthcare system will be one of the biggest challenges in the decades to come.

Whilst Climate Change isn't recorded as a specific risk in the ICB risk register, it is described in our ICB Green Plan and Climate Adaptation Plan, both of which are on the ICB website. Enc-H-Our-Green-Plan-2025-2028.pdf, Microsoft Word - Somerset ICS Adaptation Plan 2025 Final. A comprehensive climate change risk assessment is included in our Adaptation Plan that is published on the ICB website. The risk assessment addresses short, medium and long term risks, including a climate future at 2 and 4 degrees.

The focus on adapting to climate change in the ICS Adaptation Report is welcomed and will help achieve other priorities and objectives of Somerset ICB, Somerset Foundation Trust and Somerset Council. Adaptation must be done collaboratively; a Community of Practice has been established with partners across VCFSE, SWAST, Somerset Council, and NHS Somerset ICB and Trust to manage and mitigate climate risks across our Somerset system.

Several exercises were carried out to inform the development of the adaptation plan to understand three features of risk in Somerset, along with key sites and features within the ICS. These include:

- **Climate change projections** providing an overview of the current climate and how the climate may change in Somerset in the short-, medium- and long-term future.
- **Flood risk mapping** for key sites within the ICS.
- An initial look at the **vulnerability** of the population contextualised with mapping of key climate impacts in Somerset.

In the UK, the Climate Change Committee (CCC) provides advice to the Government on the risks the UK faces from climate change damage. The Department for Environment, Food and Rural Affairs (Defra) has overall ownership of the UK's adaptation strategy to address these risks, with responsibility for addressing the various risks and enacting the plans lying across multiple departments. The CCC published a report in March 2024 on the Governments National Adaptation Programme (NAP)[1] and found that whilst progress had been made on past NAPs, significant work was needed across its lifetime to address long-standing issues holding back adaptation in the UK. Stagnated approaches from central government fundamentally impact the progress we can make in the NHS and local government. The Office for Budget Responsibility OBR warns in their *Fiscal risks and sustainability* reports (July 2025) that in the central 3°C scenario, the combined fiscal impact of climate change adds 74 per cent of GDP to government debt by the early 2070s, relative to their latest long-term projection.[2]

The Greener Digital Project, now in its third phase seeks to unpack the knotty problem of '**How can we ensure our digital service is less likely to fail + quicker to recover when climate risks (heatwave) occur?'** The project adopts a systems mapping approach supported by desk research, public datasets and interviews with experts across the complex supply chain to move from a conceptual diagram of connected factors in the system to a dynamic, interrogatable Proof of Concept model enabling projection of complex systemic effects and prioritised interventions**. The** focus on Digital resilience provides a broader overview covering all functions to help us prioritise where we need to target investment, to ensure we are prepared and resilient to the challenges posed by climate change. For example, surges in energy demand that can lead to blackouts and power failures across the economy, impacting the delivery of public services.

3. Metrics and targets

The DHSC group accounting manual (GAM) sets out how TCFD requirements are being applied to NHS bodies, including explicitly stating that disclosure of Scope 1, 2 and 3 emissions is not required for NHS bodies as this is reported by NHS England. (Greener NHS » Organisations) All other climate related data for the ICB is reported in the KPI report.

Our first Green Plan, launched in April 2022, sought to rapidly embed nine foundational cornerstones at our ICB. These were workforce and system leadership; sustainable models of care; estates and facilities; digital

transformation; travel and transport; supply chain and procurement; medicines management; food and nutrition; climate adaptation. These cornerstones have now all been established. The refreshed Green Plan summarises ambition in the tables in each chapter and contains a delivery plan to support each ambition. The progress against the delivery plan can be viewed in the supporting KPI Report.

4. Strategy

Impact of climate related risks

Climate change is not a future problem; it is happening now. It is affecting all our lives, but particularly people from the most vulnerable populations. Even when the NHS achieves net zero, there will still be a changing climate to adapt to. Climate change adaptation seeks to manage this risk to services, adapting or designing buildings and processes to ensure continuity of care.

To inform the climate change risk assessment and the actions in the adaptation plan, we addressed the risks posed by climate change at a local level. Risk was made up of three main features:

- **Likelihood**: How likely a hazard is to occur. Hazards include events such as flooding, heatwaves, heavy rainfall and extreme weather. Climate change has increased the likelihood of these hazards occurring and thus potential impacts resulting from them.
- **Exposure**: This includes one's physical location relative to a hazard, e.g. being in close proximity to a river that could flood and whether you have features physically protecting you from hazards, such as a flood barrier or shading from trees.
- **Vulnerability**: How severe a hazard would affect an individual, community, organisation, asset or system. For people, vulnerabilities include features of socioeconomic deprivation and pre-existing health vulnerabilities. Systems and physical assets may be more vulnerable if they have single points of failure or are already under significant stress.

Changes in climate can result in hazards including heatwaves, droughts, storms, heavy rainfall and subsequent flooding and overall climatic variations. By building a picture of the change expected in Somerset, we can better predict the likelihood and severity of impacts, thus feeding into the Climate Change Risk Assessment.

The three big shifts described in the 10 Year Health Plan, provides a significant opportunity to change how the NHS works, enabling us to deliver better care for all patients, shifting care focus from hospitals to communities, from analogue to digital, and from sickness to prevention. As such, the 3 big shifts will be a key enabler to effectively achieving our carbon reduction goals. We will need to follow a systematic approach that consists of several key components including environmental policy development, planning, implementation and operation, monitoring, and measurement, then review and improvement. This is known as an Environmental Management System (EMS). It provides a comprehensive framework for managing emissions ensuring compliance with regulations and fostering a culture of continuous improvement.

As the ICB transitions in to the next phase of change, including redundancies that can be disruptive to progress, it is important to recognise that all NHS bodies will be expected to decarbonise, reduce environmental impact and increase resilience to climate risks in line with the climate change duties set out in the Health and Care Act 2022 and that commitment should not be lost. It is a collaborative effort and must continue.

Improving Quality

In line with section 14R of the Health and Social Care Act 2012, NHS Somerset Integrated Care Board (ICB) worked with our partners to discharge our responsibilities for improving the quality of commissioned services. The NHS Somerset Quality Committee provides governance and compliance, with established escalation routes to the ICB Board and to regional and national quality and safety forums. The Quality Assurance and Improvement Framework (2025–2027) outlined quality monitoring, risk identification, and escalation in line with national standards.

We continued to develop and embed processes that strengthen equity and inclusion across commissioning. As part of this work, Equality and Quality Impact Assessments (EQIAs) were increasingly integrated into service redesign, supported by a dedicated EQIA Panel with executive clinical oversight. This enabled more systematic assessment of impacts on equity, quality, clinical risks, access and helped identify and mitigate risks for underserved communities.

Quality and safety insights inform commissioning and contracting activities. This included progression of work to clarify our quality oversight and assurance methodology in line with National Quality Board guidance, supporting a proportionate, risk-based approach to the escalation and management of emerging concerns.

Patient Safety
Patient safety remained a core priority during the year. We sustained weekly insight review meetings to enable timely action on patient safety events and any new or emerging concerns. Our approach continued to mature under the Patient Safety Incident Response Framework (PSIRF), strengthening system learning and supporting a just and transparent culture. Engagement with our ICS Patient Safety Oversight Group further enhanced this by providing a system-wide forum for shared reflection and thematic discussion.

A priority for the year was support for primary care as it began to adopt PSIRF. Dedicated tools and resources were developed for practices, including tailored guidance, templates for proportionate learning responses, and practice-level support to strengthen early safety governance and reporting.

- **General Practice Patient Safety Pilot (Apr–Sep 2025):** Four practices identified local improvement needs and received targeted support (governance reviews, training, and improvement models) aligned to the National Primary Care Patient Safety Strategy. The pilot also facilitated early discussions on Learning from Patient Safety Events (LfPSE) and its transition into the GP contract.

- **General Practice Patient Safety Forum (launched Oct 2025):** A bi-monthly network for practices and Primary Care Networks (PCN) to share learning, explore practical application of PSIRF, and review themes from LfPSE submissions, aiming for representation from every PCN.

- **Rapid Reads and Training:** One-page rapid reads were shared following incidents to disseminate learning. Additional training supported early capability and confidence across primary care.

Mental Health and Learning Disability
We strengthened oversight of Care (Education) and Treatment Reviews (C(E)TRs) by establishing a system-wide oversight panel, a single mechanism to identify risks earlier, monitor placement quality, and support consistent, person-centred care planning. The panel also coordinated support for individuals placed out of county to return closer to home where appropriate, in line with least-restrictive, community-based care.

Following NHS England's Practical Quality Oversight Guide for Host and Placing ICBs, we enhanced our host commissioner framework for specialist inpatient services, with stronger surveillance, coordinated visits, routine provider engagement, and clearer escalation. Somerset was selected for NHS England's national pilot of a new host/home commissioning framework, recognising our approach as good practice and enabling us to contribute to national learning.

We also progressed work to address health inequalities, including a digital test-and-learn project to improve the quality, accessibility, and uptake of annual health checks for people with a learning disability, aiming to reduce unwarranted variation and support more personalised care (with academic evaluation planned).

Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

We continued to implement LeDeR reviews to improve care, reduce health inequalities, and prevent premature mortality for people with learning disabilities and autism. Alongside ongoing annual health checks, we strengthened implementation of the Mental Capacity Act (MCA), including making permanent the MCA assessor post within acute services to support timely access to two-week-wait cancer pathways. This has led to more timely diagnostics and increased referrals to advocacy.

We also worked with services across the system to improve access to healthcare for people with learning disabilities. A particularly positive example was in audiology, where a pilot project, developed in collaboration with LeDeR learning disability champions, focused on improving the accessibility of appointments. The initiative increased awareness among staff, improved patient experience, and resulted in a rise in referrals and outpatient activity.

Learning from Deaths

We strengthened our approach to learning from deaths through improved oversight, clearer governance, and enhanced use of data. Formal oversight of Medical Examiner services is established across providers to ensure independent scrutiny of all eligible deaths. Key performance indicators (including timeliness of review, Medical Certificate of Cause of Death (MCCD) completion, scrutiny rates, family engagement, and referral activity) were routinely monitored. Concerns raised by bereaved families were supported and escalated through provider governance structures and the ICB's Quality Committee. Medical Examiner insights were incorporated into system mortality dashboards to provide assurance and guide improvement.

Our Regulation 28 (Prevention of Future Deaths) process provided additional oversight. Through systematic logging, tracking, and monitoring, we ensured that coroner-identified risks were addressed, learning was shared, and required actions were completed, reducing the likelihood of recurrence. Regular communication with the coroner also supported wider system learning where issues fell below the Regulation 28 threshold but were nonetheless important for system awareness.

The mortality dashboard continued to translate raw mortality data into actionable insight, enabling the system to identify risks, improve pathways, and strengthen patient safety. Work also began to make this intelligence accessible to Primary Care Networks to support local improvement and reduce inequities across the population.

Maternity, Neonatal and Paediatric Services
During the reporting period, progress has been made to strengthen the quality, safety, and governance of maternity, neonatal and paediatric services.

Following a Care Quality Commission (CQC) visit in 2023, and report publication in 2024, the corresponding action plan was fully completed and formally closed, with any remaining actions incorporated into an overarching Maternity and Neonatal Improvement Plan (MNIP) for delivery.

A CQC inspection of paediatric services in January 2025 rated services at Yeovil District Hospital (YDH), operated by Somerset NHS Foundation Trust (SFT), as inadequate and a Section 29A Warning Notice was issued.

In May 2025, inpatient maternity services and the Special Care baby Unity (SCBU) at YDH were temporarily closed. A Contract Performance Notice was issued by the ICB in response to the closure. To strengthen oversight and assurance, a Maternity Enhanced Oversight Group, chaired by the ICB Chief Nursing Officer and aligned with the National Quality Board Framework, was established. This group has monitored the impact of the closure, the continuity of care pathways for women and birthing people, and the Trust's preparations for the safe relaunch of inpatient services at YDH.

Over the past year, work has been undertaken to strengthen services and meet essential safety criteria. This has included improved staffing, leadership, training and governance. The Trust has recruited additional senior paediatric consultants, increased senior cover during evenings and weekends, strengthened maternity and neonatal teams, and put clearer safety monitoring and escalation arrangements in place. This has resulted in inpatient maternity services and the Special Care Baby Unit (SCBU) being reopened on 21 April 2026 so women, birthing people, babies and families can once again receive care closer to home.

The ICB has been supporting SFT with improvements required in paediatric services over the last year. The ICB Chief Nurse chairs the Paediatric Quality Improvement Group (established under National Quality Board Framework).

In March 2026, SFT reported full compliance with Year 7 of the Maternity Incentive Scheme (MIS), achieving all 10 safety actions. Compliance with the Saving Babies' Lives Care Bundle also continued to improve, reaching 83% at the most recent review.

Progress against the Equity and Equality Three-Year Delivery Plan has slowed, reflecting competing operational and strategic priorities for system partners.

Audiology
NHS England's (NHSE) newborn hearing screening programme completed an analysis of data for every baby born in England from 2018-2021. This analysis found issues in a small number of NHS providers who had diagnosed significantly fewer babies with

permeant hearing loss compared with the national average A peer review of these providers highlighted some common and systemic problems across the patient care pathway resulting in a series of recommendations.

In 2023, NHSE established a national paediatric hearing services improvement programme, to understand the potential scale across England. In August 2023, ICBs were asked to work with paediatric hearing services to provide information against each of the 10 recommendations to support a review of the quality of services and to determine any risk of harm.

A paediatric audiology peer review visit was undertaken in Somerset in January 2025. This was a positive visit, which identified that there was no requirement to undertake a harm review. The service in Somerset was rated as high assurance and therefore the quality assurance and oversight functions was passed back to the ICB. The final report made some recommendations for service improvement and these have been formulated into an action with ICB quality lead oversight.

Infection Prevention and Management (IPM)
A major focus this year was strengthening education, workforce development, and support for providers across the system. The team delivered two primary care IPM lead nurse development days and launched a new care home education programme and network forum. As part of this work, 25 infection prevention and management champions were trained to build skills and confidence within residential and nursing homes. Work also began to convert the programme into an online resource to ensure long-term sustainability and wider reach.

Healthcare-associated infections (HCAIs) continued to rise, particularly those acquired in the community, and current projections indicate that 2025/26 thresholds may be exceeded. In response, the team adopted a system-wide approach focused on reducing HCAIs, moving beyond individual organism pathways. Key initiatives included developing new resource packs for Candida auris and Carbapenemase-Producing Organisms (CPOs), with the CPO pack adopted by the UK Health Security Agency for regional use, contributing to NHS England's Methicillin-Sensitive Staphylococcus Aureus (MSSA) Collaborative, and delivering training with the LeDeR team to support early recognition of sepsis in learning-disability settings.

Preventative programmes also expanded. The Hydration Project, delivered with the GP Support Unit, was rolled out to all residents aged over 60 to promote hydration awareness. Targeted infection-reduction work progressed, including a Clostridioides difficile project exploring potential links with hepatobiliary and prostate waiting lists, and hotspot analysis for Escherichia coli (E.coli) to guide focused prevention efforts. The mouth care programme continued to grow following a successful care-home pilot, supported by the listening and responding to care home (LARCH+) team for wider

implementation. In addition, the new county-wide Tuberculosis (TB) service was launched.

The team also began developing a more data-driven approach to infection prevention, using population health intelligence, large datasets, and emerging technologies such as machine learning to better identify trends and target interventions.

Overall, the IPM Team continued to play a vital role in supporting providers, strengthening infection-prevention practice, and driving innovative approaches to reducing infection risk across the Somerset system.

Intermediate Care
We strengthened oversight through clear outcome markers (recovery, independence, readmissions, length of stay, and “no criteria to reside”), with increasing focus on patient experience. Indicators were reviewed through system governance to identify variation, address risks, and target improvement, with data used proactively to support measurable gains in quality, safety, and effectiveness.

Care Sector
Insights from the Care Sector Quality Assurance Framework has informed targeted improvement this year. This included two prevention programmes delivered with the LARCH+ team, aiming for a 20% reduction in falls and tissue damage. The programmes focussed on training 80% of staff and developing tailored improvement plans.

A new key performance indicator (KPI) for 2025/26 was introduced to help identify residents with a BMI over 30. Working closely with Public Health, the team rolled out MORE training to support providers in improving nutrition and promoting better long-term health outcomes.

Dysphagia essentials training, which became mandatory in 2022, was set as a KPI with an 85% compliance target. By Quarter 3, average compliance had reached 88.5%, demonstrating strong collective leadership in ensuring safer eating and drinking support.

Somerset ICB and Somerset Council also piloted Nobi AI lighting technology, installing 40 lights across four residential homes, with plans to expand into older persons mental health settings. The pilot aims to reduce falls, improve post-fall planning, shorten long-lie times, and, where appropriate, offer an alternative to night-time 1:1 supervision. A three-year evaluation is now underway.

Gender-Affirming Care Pathway
In response to reduced access to cross-sex hormone treatments through GP practices, a pilot was commenced with the WellBN clinic in Brighton to provide remote monitoring

and prescribing for adults in Somerset experiencing gender dysphoria or gender incongruence. Through WellBN, people can also access referrals to local services such as speech and language therapy, fertility preservation, and sexual health services. Feedback from those using the service has been positive, particularly regarding improved access to gender-affirming care.

Patient Experience
During 2025/26, NHS Somerset received patient and stakeholder feedback through PALS and the NHS complaints process, providing valuable insight into experiences of care across commissioned services. Common themes included challenges accessing services, prolonged waiting times, communication and coordination difficulties, and concerns about the quality and safety of care, particularly across multi-provider pathways. Feedback frequently related to general practice access, ongoing difficulties accessing NHS dental services, and issues arranging Covid vaccinations for housebound patients. Primary care complaints were managed on behalf of South West Integrated Care Boards by the Collaborative Commissioning Hub, hosted by NHS Somerset. Learning from feedback and complaints informed service improvements across areas such as All Age Continuing Care, Section 117 aftercare, evidence-based interventions, data protection, wheelchair services and non-emergency transport. Further detail is provided in the NHS Somerset Annual Complaints Report 2025/26.

Engaging People and Communities

Working with people and communities
By listening to, involving and empowering people and communities, NHS Somerset ICB ensures the needs, experiences and priorities of our population are embedded in commissioning decisions. This supports our statutory duty to involve the public in planning, developing and making decisions about health services. Our Working with People and Communities Engagement Strategy sets out how we meet our statutory responsibilities and apply NHS England's 10 national principles of partnership involvement. It describes how engagement is embedded throughout the commissioning cycle, from early design and planning through to evaluation, and aligns with NHS England's published guidance and our legal duties.

We want the people of Somerset to work with us to help develop their local health and care services and have meaningful involvement and influence in decision-making. We continue to develop inclusive approaches to reach people who experience health inequalities or barriers to accessing services, including priority groups identified through engagement insight and population health data, ensuring that those whose voices are less often heard are actively included in shaping local health and care.

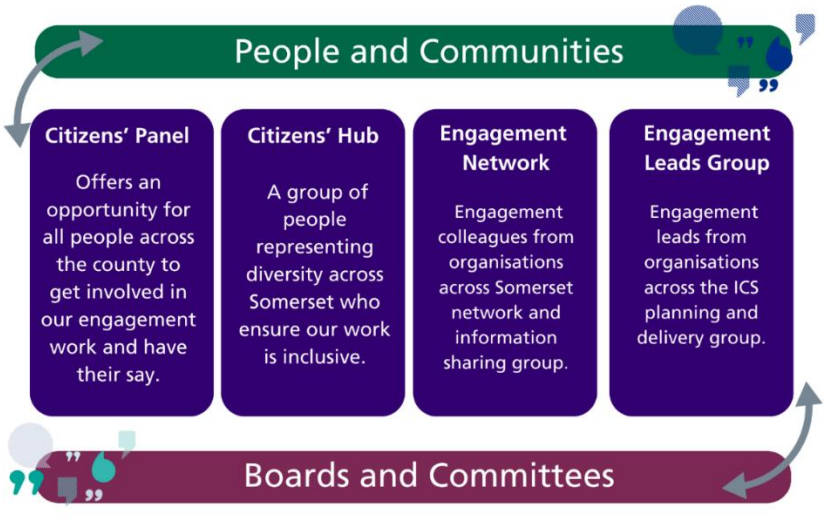
We assess the impact of engagement not only through participation numbers and reach, but by reviewing how insight has influenced decisions and by seeking feedback from participants on whether they feel heard and informed about outcomes. Engagement insight is considered alongside population health data, service activity data and inequalities analysis to help identify priority groups and inform targeted improvement actions.

Governance structures to support involvement and engagement
Our NHS Somerset constitution details how we involve the public in our governance. Our ICB Board meetings are open for the public to attend. Members of the public can raise public questions prior to the meeting. Papers are published on the NHS Somerset website here: NHS Somerset ICB Board Papers. Engagement findings relevant to Board decisions are summarised within Board papers where proposals may affect patients or communities. This ensures that public voice is visible within formal decision-making processes.

Our engagement networks and mechanisms
During 2025/26, we continued to maintain and strengthen our engagement structures to support delivery of our strategic priorities, enable diverse communities to be heard, and facilitate collaborative working across partners to improve health and care in Somerset.

The Engagement Leads Coordination Group provides system-wide oversight and coordination of engagement activity . This supports consistency, reduces duplication, and ensures insight is shared across organisational boundaries, including Healthwatch and voluntary sector partners.

Read about our engagement structures and how we involve people and communities.



The voluntary sector assembly, called the Somerset VCSFE Collaborative, is led by Spark Somerset. The assembly is open to all VCFSE organisations, and is a place where partners can come together to influence system priorities and contribute to engagement approaches, particularly in reaching communities experiencing inequality.

Working with people and communities
We continue to produce our spotlight reports which highlight key themes and are shared with commissioning teams and partners to inform ongoing service development.

Our process for public involvement in service change ensures we meet our legal duties under the NHS Act 2006. Engagement begins at an early developmental stage and is proportionate to the scale and impact of the proposed change.

We are committed to making our public engagement activities and involvement opportunities as accessible as possible and we want to make sure that people with differing needs can take part. For example, we use wheelchair accessible venues, we can access language and British Sign Language (BSL) interpreters and have a portable hearing loop. We also work with trusted community partners to deliver engagement in familiar, community-based settings where appropriate.

We have supported and led several engagement programmes and examples of these can be found on our website: Our work with people and communities and for more information about our work with our Citizens' Panel - NHS Somerset ICB.

Feedback received from public engagement and consultation is reported and heard at multiple levels of NHS Somerset ICB's governance structure, from the Board itself through all tiers of the organisation. This helps to promote discussion, ensuring public voices influence decisions about the development of services.

The following two areas are examples of our engagement work in 2025/26:

Somerset's Big Conversation 2025
From May to October 2025, NHS Somerset delivered Somerset's Big Conversation 2025 (also referred to as 'SBC2025'), a large-scale programme of engagement designed to hear directly from people across the county about their experiences of health and care services and their priorities for the future.

The programme combined an interactive roadshow, in-person events, online engagement and targeted outreach with communities more likely to experience health inequalities, including CORE20PLUS5 groups. Engagement took place in over 50 locations across Somerset, ensuring representation from rural, coastal and urban communities.

In total, we engaged with 3,947 people through nine different engagement approaches, capturing over 8,339 individual pieces of qualitative feedback. This included structured conversations, written comments, interactive exercises and digital responses. An online survey was promoted alongside in-person engagement to ensure people could contribute in ways that suited them.

Somerset's Big Conversation 2025 explored themes including access to primary care, the role of community hospitals, discharge and home-based care, workforce pressures, digital inclusion, prevention, mental health and NHS dentistry. Feedback demonstrated strong appreciation for NHS staff and local services, alongside consistent concerns about access, waiting times, transport barriers and inequalities in provision.

Findings have been analysed thematically, shared with the ICB Board and commissioning teams, and are informing key system priorities including the development of the current ICB strategy, community services planning and development, the Somerset Research Strategy, and the refresh of Somerset Council's Adult Social Care Strategy. Recurring feedback has highlighted health inequalities linked to rurality, transport barriers and digital exclusion. This insight is informing ongoing discussions about neighbourhood service development and reinforcing the need to maintain hybrid access models as digital services expand.

Feedback from SBC2025 has also been incorporated into a wider system insight report, bringing together engagement findings from across partners during 2025 to identify recurring themes and shared priorities. This collective analysis strengthens the evidence base for commissioning decisions and service development proposals, ensuring they reflect what matters most to people locally and supporting our statutory duty to involve. This analysis also helps identify communities experiencing barriers to access and informs targeted improvement work to reduce health inequalities.

In 2025, greater emphasis has been placed on demonstrating the impact of engagement. "You Said, We Did" summaries are being developed to show how public feedback is shaping priorities and influencing decisions. By strengthening partnerships with local organisations, community leaders and voluntary sector partners, Somerset's Big Conversation continues to evolve as a transparent, inclusive and ongoing dialogue with the population we serve.

During 2026, insight from Somerset's Big Conversation 2025 will be embedded into strategic planning, commissioning intentions and priority workstreams. Recurring themes – including primary care access, community-based services, prevention, digital inclusion and inequalities – will be used to inform service design and resource prioritisation.

Findings will continue to be shared with programme leads and system partners to support neighbourhood development, workforce planning and improvements in discharge and community pathways. The engagement team will monitor how insight is applied and provide "You Said, We Did" updates to demonstrate how public feedback has shaped decisions and service improvements.

Change NHS - 10-Year Health Plan
During 2025–26, NHS Somerset has continued to engage people and communities around the three key shifts set out in the Government's 10-Year Health Plan.

The three shifts have been embedded within wider system engagement activity, including Somerset's Big Conversation 2025, neighbourhood discussions, workforce engagement and partnership work with the voluntary, community, faith and social enterprise (VCFSE) sector.

Working in partnership with Healthwatch Somerset, Somerset NHS Foundation Trust, Spark Somerset and other system partners, we have continued to:

- Promote opportunities for people to share their views on how care should be delivered in the future.
- Hold in-person and online engagement sessions in community venues, libraries, Talking Cafés and local events.
- Facilitate discussions with NHS teams and system leaders to reflect on how the shifts translate into local service design.
- Engage with targeted communities experiencing health inequalities, including rural communities, armed forces and veterans, children and young people, and VCFSE partners.
- Share accessible communications materials to enable colleagues and partners to raise awareness and support participation.

Feedback consistently highlights support for care being delivered closer to home, provided this is accompanied by sufficient workforce, reliable transport and clear communication. People value digital innovation where it improves convenience and access but emphasise the need for non-digital options to avoid exclusion. There is strong support for prevention and early intervention, alongside concerns about ensuring urgent and acute care remains responsive and safe.

Insight gathered through this ongoing engagement is being used locally to inform strategic planning and commissioning priorities aligned to the three shifts. Feedback contributes to regional analysis across the South West and supports Somerset's development of community-based services, digital inclusion approaches and prevention-focused workstreams.

By continuing to engage openly and transparently around these shifts, NHS Somerset is ensuring that implementation of national policy reflects local context, lived experience and the needs of our population.

Social listening
Social listening helps NHS Somerset understand what matters most to our communities in real time, identifying concerns early, improving the way we communicate, and shaping services based on genuine patient insight. We have used some of the latest techniques in social listening to provide real-time updates for operational and commissioning teams.

Engagement support to GP Practices
Our engagement team continues to support GP practices and patient participation groups (PPGs) to engage with their practice population about changes and developments such as branch closures, staff changes and premises developments.

In addition to our weekly GP bulletin, we provide communications' resources for our practices to support them in their communications to their patients. In Somerset, we have a county-wide network of active PPG chairs who meet on a bi-monthly basis. NHS Somerset ICB has continued to support and work with our PPG Chairs Network.

Engagement to reduce inequalities
Reducing health inequalities remains a core principle of our engagement approach. We take deliberate steps to ensure that people who experience barriers to accessing services, or whose voices are less often heard, are actively included in shaping local health and care.

During 2025/26, this has included targeted outreach as part of Somerset's Big Conversation 2025 and ongoing engagement around the three key shifts of the 10 Year Health Plan. We worked with communities more likely to experience health inequalities, including rural communities, people living in areas of deprivation, armed forces and veterans, carers, children and young people, and communities supported by the VCFSE sector. Engagement took place in accessible, community-based settings such as Talking Cafés, rural hubs, youth forums and local support groups, helping to reduce practical and confidence barriers to participation.

We continue to build on trusted relationships with VCFSE partners, recognising their critical role in reaching communities through culturally sensitive and locally grounded approaches. Through partnership working, we have been able to hear directly about barriers relating to transport, digital exclusion, workforce capacity, access to dentistry and mental health services, and the impact of rurality and deprivation on health outcomes.

Our Equality Impact Assessment (EIA) process and use of the Health Equity Assessment Tool (HEAT) inform the design of engagement activity and commissioning decisions. These processes help ensure that information about health inequalities, including engagement insight and population data, is routinely considered when developing strategies, service changes and commissioning decisions. These tools help identify where targeted engagement or service adjustments may be required to avoid widening inequalities.

Through funding for the health campaigns and projects that we support, we maintain a participation fund to enable community and voluntary organisations to undertake engagement with groups we may not be able to reach directly. This approach supports proportionate, community-led insight gathering and strengthens our ability to understand lived experience in depth.

Insight gathered through these approaches is used by commissioning and programme leads to inform targeted interventions, neighbourhood development and prevention-focused workstreams, ensuring that action to reduce health inequalities is shaped by those most affected.

Communications
Opportunities to get involved in shaping local health and care are promoted through a range of established and accessible channels, including our Citizens' Panel, VCFSE partners, the Our Somerset newsletter, the NHS Somerset website, social media platforms and local media outlets. We aim to promote the work of NHS Somerset ICB in an open and transparent way and share information about our work and how people can get involved, for example our approach includes:

- We have an ICS (Our Somerset) newsletter with a wide audience and more opportunities to get involved.

- We work with key communities to ensure our website meets their needs and is accessible. We have launched a working group to progress this work further.

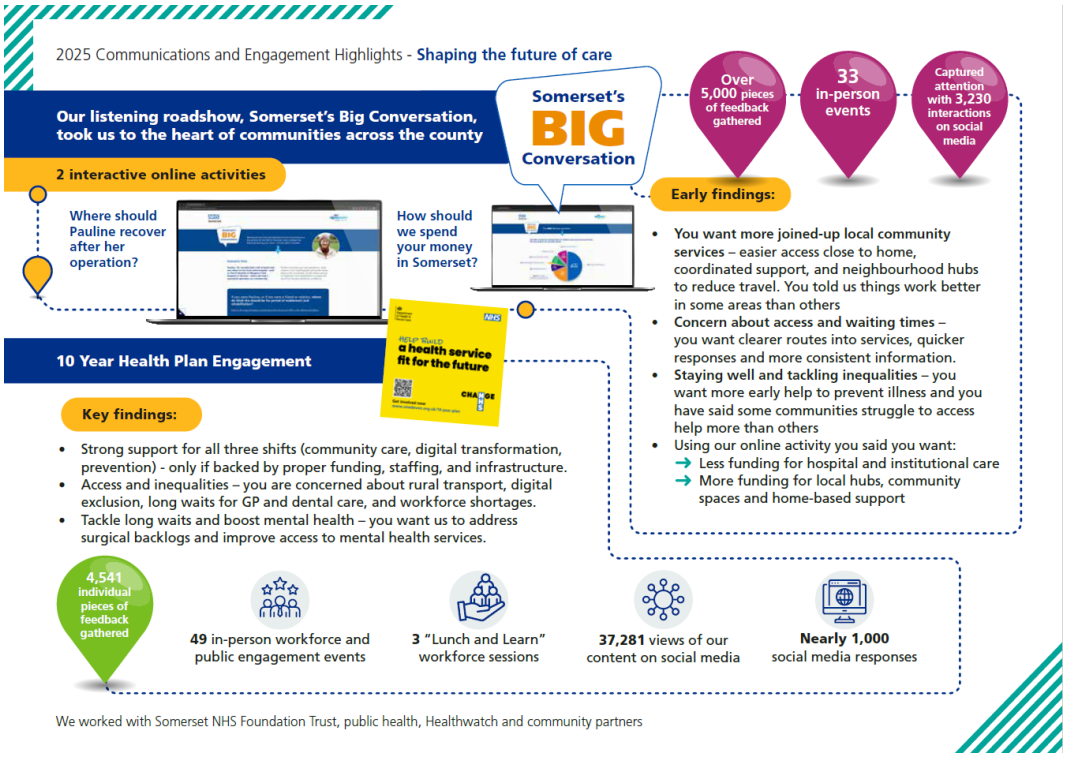
- We use social media and other digital platforms to provide opportunities for open and honest engagement. Information is presented in ways that are easy to digest via infographics, short videos and animations, case studies, and pictures. Our presence on platforms such as Nextdoor has enabled us to reach community-based audiences and generate localised discussion.

- Press releases are posted on our websites, shared on our social media channels and sent to our media distribution contacts.

- We run local multi-channel campaigns. These have included: live well this winter, Covid-19 vaccination, flu vaccination, sloppy slippers and hypertension.

We are committed to closing the feedback loop. "You Said, We Did" updates are used to demonstrate how engagement has influenced decisions and service development. Findings from major engagement programmes are published in accessible formats and shared with participants and partners. Information about health inequalities and the actions taken to address them is also reported through Board papers, insight reports and this annual report to support transparency and accountability.

Communications and Engagement impact infographic



2025 Communications and Engagement Highlights - **Communications priorities helping you to live healthier lives**

Promoting life-saving vaccinations

Mums -to-be in Bridgwater shared why they got the jab

Lina reached 47,750 people on Facebook

Working with mumsnet to reach local families

Lina, aged 3, our new social media influencer, showed preschoolers how easy it is to get a flu vaccine. She went viral and was shared by NHS England and other ICBs.

Our simple checklist cut through the confusion around eligibility changes, reaching 64,760 people and was shared by other ICBs across the country.

We are currently smashing our targets for flu vaccination rates, helping protect our communities and shield busy hospitals.

Player ready?

We took to gaming platform twitch to target 18-25-year-olds for an HPV catch-up vaccination campaign, reaching 40,000 users.

Supporting the opening of three new dental practices

Wellington

1st new dental practice in **Somerset for 10 years**

Targeted communications delivered: 90% of new patients from Somerset, 53% from Wellington

Achieved: Aim of avoiding people from outside Somerset queueing to register

Next: 2 more practices opening in Chard (December) and Crewkerne (2026).

Smokefree Somerset

Our Smokefree Somerset campaign – in partnership with public health – targets the leading cause of preventable disease. *What's Your Why?* uses personal case studies and positive messaging to help support people to quit for good.

Our social media posts led 14,000 people to 'quit smoking' pages

Our inspiring stories have been seen 158,000 times

813 referred smokers have set a quit date since April 2025

We have the highest quit rate in the region.

2025 Communications and Engagement Highlights - **Navigating times of challenge together**

Our networks and social listening bring real-time insight on public opinion to the top table to influence how teams respond in times of challenge. Trust in the NHS is at all-time low, meaning effective communication is key to restoring confidence

Digital Focus

Human-centred digital content that makes complex messages simple.

Short videos, human-centred stories, and clear infographics make information accessible, while localised posts and partner collaborations ensure key messages are delivered in engaging ways that resonate with audiences.

Top performing post:
Do I need to keep my child off school?

Reached over 620,000 people

68,000 engagements

Attracted 500 comments

Surfaced parents' concerns and worries – insight now being used to shape future communications

Luson Surgery closure, Wellington

Stakeholder engagement with practices, town council, patient group, MP and media

Listening to your concerns and sharing practical information

Communications to 6,500 patients moved to new practice

Sharing your views and concerns at times of challenge

Using online opinion and feedback from stakeholders to work with system partners on communications supporting:

- Temporary changes at Yeovil Hospital's paediatric and maternity units
- Reimagining community services
- Reconfiguring stroke services

Access to pharmacy and dental services

Managing public and stakeholder concerns around access to NHS dentistry and community pharmacies

Collaboration

We know you want us to collaborate and join up our services so we bring health and care partners together through **10 groups and newsletters** to ensure consistent messaging and access to the right information when you need it.

Personalised Care and Patient Choice

"Our connected Somerset system will enable individuals to be equal partners in decision-making, based on what matters to them — making this the golden thread that runs through everything we do."

Across Somerset, personalised care is becoming more than a programme of work, it is a fundamental shift in how we think, work, and partner with people and communities. We are moving from a system that does things *to* people, to one that works with people, recognising them as experts in their own lives.

NHS Somerset ICB, working with partners across health, care, and the voluntary sector, is developing a culture where conversations start with "what matters to you?" rather than "what's the matter?". This shift will shape both frontline practice and system leadership, ensuring that personalised care is not an add-on, but the foundation of how care is designed and delivered.

At the heart of this approach is a commitment to shared decision-making, enabling people, their carers, and professionals to work together as equal partners. We are supporting teams across Somerset to build the skills, confidence, and environments needed for this to happen consistently, while learning from exemplar teams who have already embedded these approaches into everyday practice and team culture.

We are working with our Somerset system colleagues to develop a standard approach to personalised care and support planning (PCSP) in order to be able to capture personalised conversations, patient choice and support people to be able to tell their story once, to the right person at the right time in the right place. This ensures that care is coordinated around the whole person, across their life course, joining up services, reducing fragmentation, and enabling people to navigate support more easily, particularly for those with multiple or complex needs

A key part of this transformation is the continued development of community-based support and social prescribing, creating stronger connections between statutory services and the rich assets within our communities. By investing in these approaches, we are enabling people to access practical, emotional, and social support that improves wellbeing and reduces reliance on traditional health services.

Alongside this, we are expanding opportunities for prevention and supported self-management, helping people to build the knowledge, skills, and confidence to manage their health and wellbeing in ways that work for them. This is complemented by increasing access to personal health budgets and integrated personal budgets, giving people greater choice and control over how their care is delivered.

Underpinning all of this is a focus on engagement and culture change-working with both the public and our workforce to build a shared understanding of personalised care and

what it means in practice. We are creating the conditions for staff to work differently, supported by clear frameworks, coaching and training, practical tools and strong system leadership.

Together, these changes are enabling a more coordinated, compassionate and person-centred system, one that supports individuals, families, and communities in Somerset to live the best and most fulfilling lives possible.

Somerset ICB remains committed to upholding and supporting patient's right to choice, having previously developed our choice plan with NHS England. We regularly communicate with GPs and other referrers to ensure all relevant options for patients are understood and referral systems are up to date, while patients are provided with information on services including waiting times at the point of receipt of referral. Somerset's Advice and Refer system integrates patient choice to ensure that patients continue to be offered the full range of providers even when a referral is not immediately made.

We have published our provider accreditation process Our Constitution and Governance - NHS Somerset ICB to increase the offer for our patients in Somerset.

Our hospital at home programme enables patients to improve the choice they have about how and where their care is delivered. We have multiple examples of the service enabling patients to go home from hospital earlier. Our respiratory at home service works closely with all chronic obstructive pulmonary disease (COPD) exacerbations to help patients understand their condition and medications much better giving them a greater chance of avoiding many of the hospital stays they would previously have experienced. Patients will often self-refer to the service at the early stages of an exacerbation for support, helping them to remain at home in line with their wishes.

Frailty hospital at home services works with individuals, their carers and families to provide hospital level care at home, avoiding an admission altogether. We have multiple examples of the team supporting a patient in line with their treatment escalation plan (TEP) or advanced care plan where the patient has specifically stated they do not wish to be admitted to hospital. This has included supporting patients to die in the place they call home.

Non-Financial Information – Staff Diversity and Inclusion Policy, Initiatives and Longer-Term Ambition

Social Matters

Community Engagement and Workforce Wellbeing

Commitment to equality and inclusion: The equality and equity improvement action plan outlines efforts to improve workforce diversity, equity, and inclusion. This aligns with the NHS Equality, Diversity, and Inclusion Plan (2023) and addresses inequalities in staff and patient experiences.

Health and wellbeing initiatives: Somerset is actively engaging with voluntary sector organisations to support staff wellbeing and address workforce health inequalities. Other initiatives include a focus on psychological support, well-being conversations, and staff engagement programs to improve staff experience.

Freedom to Speak Up (FTSU): NHS Somerset has been rated highly for its FTSU programme, ensuring staff can raise concerns in a safe and supportive environment. Significant work has been undertaken to support primary care in implementing a robust FTSU program, fostering a positive workplace culture and system-wide collaboration.

Sustainability and Ethical Business Practices

Equality, diversity and inclusion reporting and transparency: Regular Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Equality Delivery System (EDS22**)** reports ensure compliance with the Public Sector Equality Duty (PSED).

Flexible working and talent development: Flexible working policies are in place and being continually improved to promote work-life balance.

Respect for Human Rights

Legal and Ethical Commitments

NHS Somerset ICB upholds NHS and UK legal obligations under the Equality Act 2010, including:

- Eliminating discrimination across race, disability, gender, and other protected characteristics.
- Addressing workplace bullying, harassment, and discrimination with clear policies and reporting mechanisms.

Pay Equity and Fair Labour Practices

The gender pay gap report based on snapshot date 31 March 2025 identifies an average pay gap of 23.7% between male and female colleagues within the ICB. This represents a 7.5% reduction since March 2024 and a 13.3% reduction since reporting began in 2022. This demonstrates measurable progress and the positive impact of the organisation's ongoing initiatives to reduce pay inequality, such as using Executive Jobs pages for specific board-level opportunities which have a wide audience, with flexible working options offered if appropriate.

NHS Somerset has signed up to the NHS Sexual Safety Charter, committing to a zero-tolerance approach to harmful workplace behaviours.

Equality, Diversity and Inclusion (EDI)

Disability Confident Scheme
NHS Somerset ICB is a member of the Disability Confident Scheme, which helps employers attract, recruit, and retain disabled talent while fostering an inclusive workplace.

The programme is being strengthened to support:

- Inclusive recruitment practices: ensuring that hiring processes are accessible, barrier-free, and encourage applications from disabled candidates.
- Development of targeted support programmes: expanding learning and development opportunities to empower staff to engage with their specific needs.
- Personalised reasonable adjustments: Enhancing the onboarding process to proactively discuss and implement tailored adjustments from day one, ensuring employees have the support they need to thrive.
- Introduction of a Reasonable Adjustment policy and process, to improve colleagues experience at work
- Manager and peer training: Providing training to hiring managers and colleagues on best practices for workplace accessibility and supporting colleagues with neurodiversity and/or a disability.

Inclusive Workforce and Leadership Accountability
Board commitment: ICB leaders and executives have specific, measurable EDI objectives. In addition, recruitment and leadership diversity are key areas for improvement.

Staff training and cultural awareness: Regular EDI and cultural competency training, including lunch and learn sessions on allyship, LGBTQ+ care, and anti-discrimination policies.

Progress and challenges: Good progress has been made in workforce inclusion, though resource constraints remain a challenge in fully rolling out national EDI initiatives.

Governance and Next Steps

Governance and Reporting Structure
Regular regional and system-level reporting on EDI progress to the People and Culture Committee, Safeguarding Committee and Quality Committee and HR leadership teams. Regional assurance reports help track key performance indicators.

Future Actions (2025-2026)

1. Strengthen partnerships with community organisations to address health inequalities.
2. Continue gender and ethnicity pay gap analysis and implement targeted actions.
3. Continue workforce race equality standard reporting and workforce disability equality standard reporting and implement targeted actions
4. Expand leadership diversity initiatives by implementing a talent pipeline strategy.
5. Further develop data integration processes to better measure and track EDI outcomes.

Reducing Health Inequalities

Health inequalities refer to the avoidable and unfair differences in health outcomes and access to healthcare experienced by different groups within a population. These disparities are influenced by various factors, including socioeconomic status, geographical location, ethnicity, education, gender and employment. They manifest in differences in life expectancy, prevalence of certain health conditions and the quality of care received. These inequalities are often rooted in broader social, economic, and environmental conditions, known as the wider determinants of health.

The Annual Report and Health Inequalities appendix sets out delivery against national and local priorities, including Core20PLUS5 (adults and children services), operational performance standards, legal statement suggested metrices and key clinical programmes updates demonstrating measurable progress in improving access, outcomes and patient safety across a wide range of services during 2025/26.

This report (and Health Inequalities appendix) provides a clear and evidence-based account of how the ICB has discharged its statutory duty under section 14Z35 of the Health and Care Act 2022 to exercise its functions with a view to securing continuous improvement in the quality of services, including their effectiveness, safety and the experience of people who use those services. Somerset ICB demonstrates that quality improvement is embedded as a core principle across commissioning, service delivery and system oversight throughout this report; it is evidenced through the systematic use of population health and inequalities data (see specific programme updates within the Health Inequalities appendix) to inform decision-making, ensuring that resources and interventions are targeted towards areas of greatest need and unwarranted variation.

Robust governance and assurance arrangements are in place to oversee this work, including Board-level scrutiny and the role of system groups such as the Population Health Transformation Board, ensuring that quality improvement is monitored, evaluated and continuously strengthened. This group during 2025/26 was chaired by the ICB's Director of Population Health and Inequalities.

The Board has reviewed the evidence presented within this Annual Report and is satisfied that the ICB has discharged its duty under section 14Z35 of the Health and Care Act 2022 and is assured that Somerset ICB has exercised its functions with a clear and consistent focus on securing continuous improvement in the quality of services, including their effectiveness, safety and the experience of people who use them. This assurance is supported by comprehensive evidence demonstrating that quality improvement is

systematically embedded within commissioning, service delivery and performance oversight.

The Board recognises the strength of the ICB's approach in:

- The routine use of population health and health inequalities data to inform decision-making and prioritisation.
- Delivery of targeted improvement programmes aligned to national priorities, including Core20PLUS5 and key clinical pathways.
- A clear focus on reducing unwarranted variation in access, experience and outcomes for underserved populations.
- Robust governance and assurance arrangements that provide effective oversight of quality and continuous improvement.

In summary, Board has a high level of confidence that Somerset ICB is meeting its statutory duty to improve quality and is delivering measurable and sustained improvements for the population it serves. There is a breadth of evidence presented within this report and the Health Inequalities appendix and demonstrates a systematic and continuous approach to improving quality, and provides assurance that the ICB has effectively discharged its duty under section 14Z35 during 2025/26.

The Board will continue to monitor this duty closely and is satisfied that appropriate arrangements (under the proposed new Cluster structure) will be in place to sustain and further strengthen quality improvement in future years.

To read more key messages from the data that has been collected in line with our legal requirements, along with work currently being undertaken to address health inequalities see: Annual Reports - NHS Somerset ICB

Innovation and Research

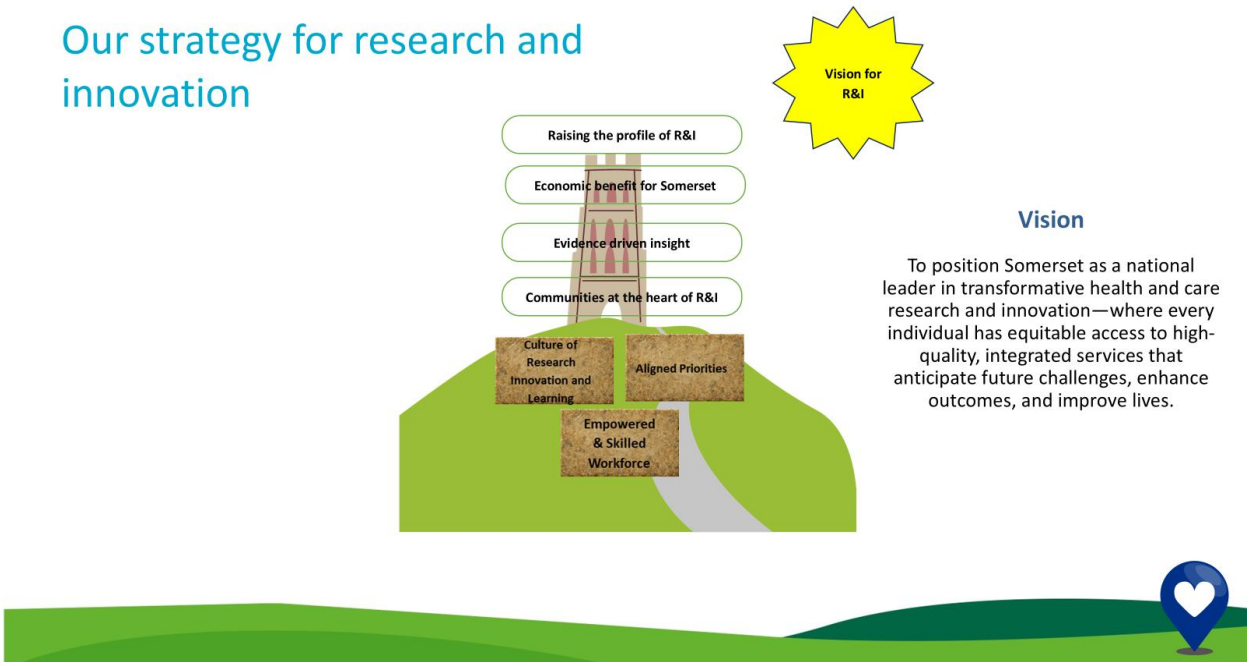
Research and innovation help improve health and care services for people in Somerset. By learning from research and testing new approaches, we can design services that are safer, more effective and better meet the needs of our communities.
Under the Health and Care Act 2022, NHS Somerset Integrated Care Board (ICB) has statutory duties to:

- Support and promote research.
- Promote the use of evidence obtained from research within the health service. Ensure research is reflected in system plans and reports.

During 2025/26, NHS Somerset worked with partners across the health and care system to strengthen research activity and ensure that evidence from research is used to improve services for residents.

Somerset's Approach to Research and Innovation

NHS Somerset has developed a system-wide approach to research and innovation that brings together workforce capability, research infrastructure, community engagement and evidence-informed decision making. This approach aligns research activity with the Somerset Health and Care Strategy and supports improvements in population health, service delivery and health inequalities.



Working in Partnership

Research and innovation rely on strong partnerships across the health and care system. NHS Somerset works closely with Somerset NHS Foundation Trust, which provides research delivery across hospital, community and mental health services, and the Somerset General Practice Support Unit (GPSU), which supports general practice across the county. This enables Somerset residents to participate in national research studies and benefit from advances in treatment and care.

The ICB also works with national research infrastructure including the NIHR South West Peninsula Research Delivery Network, the NIHR Applied Research Collaboration South West Peninsula (PenARC) and NIHR Biomedical Research Centres, ensuring Somerset benefits from national research programmes.

Somerset does not have its own university, so partnerships with universities across the South West are particularly important. NHS Somerset works with the Universities of Plymouth and Exeter and participates in the Leadership Group of the Integrated Care Academy at the University of the West of England (UWE Bristol). These partnerships support research collaboration, workforce development and knowledge sharing.

NHS Somerset ICB also works with Somerset Council's Health Determinants Research Collaborative (HDRC) to strengthen population health research and align research activity with work to improve health outcomes and reduce inequalities.

Regionally, NHS Somerset is part of the Peninsula Research and Innovation Partnership, which brings together ICBs across Devon, Cornwall and Somerset with universities, research organisations and Health Innovation South West. Collaborative work includes improving heart failure care and a community-based early detection programme delivered in rural and workplace settings, supporting earlier identification and treatment of lung conditions.

Increasing Public Involvement in Research
The Somerset Research Engagement Network (REN) works with voluntary and community organisations, researchers and system partners to increase diversity in research participation and ensure more people have opportunities to take part in research.

During the year, REN activity focused on embedding research engagement within the health and care system. Key developments included:

- Developing and testing the Somerset Research Engagement and Involvement Framework.
- Applying the framework within dementia pathway redesign and primary care research activity.
- Developing community conversation toolkits to support engagement with communities underrepresented in research.
- Gathering residents' views through county-wide engagement activity such as the Somerset Big Conversation.

Insights from this work are helping shape how research opportunities are offered across Somerset so that participation is more inclusive and reflects the diversity of local communities.

Strengthening Research in Primary Care
Primary care provides important opportunities for people to participate in research close to home.

During the year, partners across Somerset began developing a primary care research delivery alliance, bringing together general practice, research infrastructure partners and system leaders to strengthen research participation in primary care. The alliance aims to increase the number of research-active GP practices and make it easier for patients to take part in research through their local practice.

Community insight gathered through the REN programme is helping shape how research opportunities are offered through primary care so that participation is accessible and relevant to communities currently underrepresented in research.

A small grants scheme for clinical research in General Practice was launched to support practices and Primary Care Networks in developing their research capability and hosting research that benefits their communities.

Using Research Evidence to Improve Services
Supporting staff to access and use research evidence is another important part of strengthening research across Somerset.

A knowledge and evidence specialist role supported both primary care and NHS Somerset ICB by providing literature searches, evidence reviews and training on how to access and use research evidence.

Between April and December 2025 the service:

- Delivered training to 113 staff across primary care and the ICB.
- Completed 19 evidence searches supporting service improvement and programme development.
- Saved an estimated 178 hours of clinician and manager time.

Research evidence has also informed improvements in clinical practice, including supporting GP practices to introduce patient self-administration of Vitamin B12 injections and informing the development of Somerset hypertension guidance.

Strengthening Data and Evidence for Research
NHS Somerset is also working with partners to strengthen the data and evidence infrastructure needed to support research and service improvement.
This includes collaboration with the Secure Data Environment (SDE) to develop new datasets to support research and evaluation, including work focused on obesity and weight management services.

Impact
Research and innovation help ensure that health and care services continue to improve for people in Somerset. This work means:

- More opportunities for people to take part in research close to home.
- Research shaped by the experiences and priorities of local communities.
- Better use of evidence to improve services.
- Stronger partnerships bringing new knowledge and innovation into Somerset's health and care system.

Through these activities NHS Somerset is helping ensure that services are informed by the best available evidence and that residents benefit from new knowledge, treatments and improved models of care.

Education and Training

We have extensive and collaborative relationships with a wide number of education providers. We are currently working in partnership with universities across England to support and develop future healthcare professionals in training. Within the county we are working directly with Bournemouth University (Yeovil campus) and University Centre Somerset (Taunton campus) to continue to grow the local provision of degree nursing education. We also partner with all our local further education providers to support local training opportunities including T Level placements, work experience, careers promotion activities and opportunities to widen access into healthcare careers.

We are using the vision developed from our 'workforce 2035 scenario planning' programme to support the development of our longer-term education and skills strategy aligned to the Government's three shifts for healthcare, and we are continuing plans for the redevelopment of the Grade 2 listed old Bridgwater Hospital and satellite centre in Minehead as a future training Academy for health and social care to develop the skills and capabilities our workforce will need now and in the future.

We are developing our approach to supporting learners effectively and inclusively at all levels and across all sectors, responding to the national safer learning environment charter, and we will continue to support expansions in education pipelines to meet the needs of the NHS Long Term Plan, and develop new local apprenticeship and degree routes for other professions building on our success with nursing education.

To ensure that we are an inclusive employer and encourage socio economic regeneration we have continued to develop our programmes of work in relation to barriers to employment, including our care leavers, volunteer to care, workwell and sector based academy programmes.

Financial Review

Finances
NHS England has directed, under the National Health Service Act 2006 (as amended), that ICBs prepare financial statements in accordance with the 'Group Accounting Manual (GAM)' issued by the Department of Health. The GAM is drafted to meet the requirements of the Government Financial Reporting Manual (FReM). The financial information included in this section of our Annual Report is taken from the financial statements for the period 1 April 2025 to 31 March 2026.

Overview
NHS financial arrangements for 2025/26 continued to support a Somerset system-based approach to planning and delivery. NHS England published one year revenue and capital allocations with systems instructed to live within the budget allocated, reducing waste and improving productivity by:

- Reducing spend on temporary staffing and support functions.
- Improving procurement, contract management and prescribing.
- Driving improvements in operational and clinical productivity.

ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other partners.
As part of the financial reset:

- Systems must develop plans that are affordable within the allocations set, exhausting all the opportunities to improve productivity and tackle waste (and take decisions on how to prioritise resources to best meet the health needs of their local population).

- Most ringfenced budgets were released. Service Development Funding (SDF) was rolled into core allocations.

- Providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity before taking account of any new local pressures or dealing with non-recurrent savings from 2024/25. This represents a step change across all services.

- ICBs and providers must demonstrate that all productivity and efficiency opportunities have been exhausted before considering where it is necessary to reduce or stop services, taking account of each organisation's own legal duties.

- In deciding how to prioritise resources to best meet the health needs of their local population, ICB and provider boards are expected to explicitly consider both the in-year and medium-term quality, financial and population health impacts of different options using the Principles for Local Prioritisation. Plans should reflect the needs of all age groups and explicitly children.

In March 2025 the Somerset system submitted a financial plan for 2025/26, demonstrating a break-even position against financial resource for the year.
Monthly finance reports presented throughout 2025/26 have reported progress against these plans, with analysis of any variances.

ICBs have a duty to deliver financial balance independently of the ICS (section 223GC of the 2006 Act). This promotes careful financial management and reflects legislation

that requires NHS England and ICBs to manage within a fixed budget. Additionally, NHS Somerset ICB were required to ensure that we do not exceed our running cost allocation limit, which is published as part of ICB allocations.

NHS Somerset ICB has delivered a balanced financial position against its allocated revenue resource for the period 1 April 2025 to 31 March 2026.

Financial Duties

During the financial period 1 April 2025 to 31 March 2026, our performance against our financial duties is demonstrated in the table below:

Target Performance	Achieved
Expenditure not to exceed income	✓
Capital resource use does not exceed the amount specified in Directions	✓
Revenue resource use does not exceed the amount specified in Directions	✓
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	N/A
Revenue administration resource use does not exceed the amount specified in Directions	✓

Analysis of Financial Performance

NHS Somerset ICB has a statutory duty to maintain expenditure within the resource limits set by NHS England.

Revenue expenditure covers general day-to-day running costs and other areas of ongoing expenditure. As demonstrated in the table below, NHS Somerset ICB has met its statutory duty to operate within its revenue resource limits for the period 1 April 2025 to 31 March 2026.

Analysis of Financial Performance 1 April 2025 to 31 March 2026	Programme Costs £'000	Running Costs £'000	Total Revenue Resource £'000
Total net operating cost for the financial year	3,127,579	16,467	3,144,046
Final in year revenue resource limit for the year	3,122,836	21,216	3,144,052
Surplus/(deficit) in year	**(4,743)**	**4,749**	**6**

Capital resource is made available for long-term spend such as new buildings, equipment, and technology. We have been directly allocated capital resource of £40,000 for corporate information technology and have met our statutory duty to not exceed this resource for 2025/26, as demonstrated in the table below.

Analysis of Financial Performance 1 April 2025 to 31 March 2026	Total Capital Resource £'000
Total net capital cost for the financial year	39
Final in year capital resource limit for the year	40

Surplus/(deficit) in year	**1**

Here is a link to our joint capital resource plan

Running Costs
NHS Somerset ICB was funded a total of £21.216 million for the period 1 April 2025 to 31 March 2026 to support headquarters and administration costs. ICB running cost allocations (RCAs) are subject to a 30% real terms reduction per ICB by 2025/26. Our RCA included:

- Funds totalling £2.459m transferred from NHS England in relation to staffing and administration costs associated with the South West collaborative commissioning hub. This function has been hosted by NHS Somerset ICB since 1 July 2023.
- Cost of change funding of £8.675m transferred to support the ICB restructuring programme.
- Additional funding of £1.505m released in-year to support an increase in employers' pension contributions.

Total expenditure recorded against running costs for the period 1 April 2025 to 31 March 2026 was £16.467 million, ensuring that we delivered against our financial duty to ensure that revenue administration resource use does not exceed the amount specified in Directions.

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

Financial Governance
NHS Somerset ICB's Finance Committee and Board receive regular reports on the financial performance of the ICB and the wider Somerset health system, which provide considerable assurance and documentary evidence of financial performance. Other reports include risk register reviews, financial plans and ad-hoc reports and information as required. We also submit monthly and quarterly information to NHS England as part of the ICB and wider Somerset health system assurance process.

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

We have an established Audit Committee whose role is centred on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee is an assurance committee of the ICB Board and comprises non-executive members. Grahame Paine chairs the ICB Audit Committee. Four meetings were held between 1 April 2025 and 31 March 2026, and the committee members considered:

- Internal audit

- Governance, risk management and internal control
- External audit
- Counter fraud
- Other assurance functions

Through the work of the Audit Committee, the ICB Board has been assured that effective internal control arrangements are in place.

A full set of NHS Somerset ICB's Annual Accounts for the reporting period 1 April 2025 to 31 March 2026 are included in Appendix 1 of this report and describe how we have used our resources to deliver health services to residents of Somerset during the period. An explanation of the key financial terms can be found at the end of the Annual Accounts.

A full copy of the set of audited accounts is available upon request, without charge, from:

Alison Henly
Chief Finance Officer and Director of Performance and Contracting
Wynford House
Lufton Way
Yeovil
Somerset
BA22 8HR

E-mail: alison.henly@nhs.net

Alternatively, the full document can be viewed on our website at:
www.nhssomerset.nhs.uk

Cash Flow
NHS Somerset ICB's cash position is reported monthly to the Finance Committee. In addition, detailed monthly cash flow monitoring and forecasting is in place with NHS England.

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

Our performance for the period 1 April 2025 to 31 March 2026 is summarised below:

Measure of compliance	1 April 2025 to 31 March 2026 Number	1 April 2025 to 31 March 2026 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	24,436	423,479
Total Non-NHS Trade Invoices paid within target	24,424	423,388
Percentage of Non-NHS Trade invoices paid within target	**99.95%**	**99.98%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,740	2,571,953
Total NHS Trade Invoices Paid within target	1,736	2,571,793
Percentage of NHS Trade Invoices paid within target	**99.77%**	**99.99%**

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

Contingent Liabilities

A contingent liability is a possible obligation depending on whether some uncertain future event occurs or a present obligation where payment is not probable, or the amount cannot be measured reliably.

We have contingent liabilities for the period 1 April 2025 to 31 March 2026 relating to:

- Continuing healthcare (CHC) cases - to reflect a risk associated with the provisions estimate made for pending CHC eligibility assessments and appeals.
- ICB compulsory redundancy costs that will be incurred as part of the ICB clustering and restructuring programme.

The financial value of this contingent liability is not considered to be material.

Services
The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is important evidence of going concern. We are not aware of any plans that would fundamentally affect the services provided to an extent that the organisation would not continue to be a going concern

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

ICB Board Members
Full details of the remuneration paid to Board members and senior employees are provided within the Remuneration and Staff Report section of this report, together with their pension entitlements and declarations of interest.

External Audit
Grant Thornton UK LLP is the appointed external auditor for NHS Somerset ICB. The total fees payable to Grant Thornton UK LLP by the ICB for 2025/26 were:

- £474,000 including VAT to cover the cost of the statutory audit, value for money audit requirements and associated services for the ICB.
- £44,400 including VAT to cover the cost of assurance work carried out on the Mental Health Investment Standard (MHIS) compliance statement for 2024/25.

Governance Statement
The Chief Executive, as Accountable Officer, publishes an Annual Governance Statement, confirming the systems for managing risk within NHS Somerset ICB. This statement is supported by the Head of Internal Audit who provides an opinion on the overall arrangement for gaining assurance through the Assurance Framework and on the effectiveness of the controls in place to mitigate risks.

A copy of the full Governance Statement is included in the Governance Statement section of this Annual Report and is also available on request or can be viewed on the ICB's website

Medium-Term Planning Framework 2026/27 - 2028/29
On 24 October 2025 NHS England published the Medium-Term Planning Framework - Delivering Change Together 2026/27 to 2028/29, which introduced a shift away from short-term operational focus toward long-term, locally led improvement across the NHS. The framework underpinned the ambitions of the 10-Year Health Plan, seeking to empower local innovation through a revised operating model and financial regime, supporting major improvements in neighbourhood health services, digital transformation, and quality of care.

Medium-Term Planning Framework - 2026/27 to 2028/29

- The Medium-Term Planning Framework sets out performance targets and requirements for NHS organisations over the next three and five years, unlike previous annual planning rounds. ICBs and providers must develop robust and realistic three- and five-year plans to deliver these priorities

- The financial framework set out next steps to deliver on the 10-Year Health Plan for England, to move away from short-term planning to a system that empowers local leaders to plan over the medium-to-long term, and which supports innovation to deliver long-term sustainability.

- The framework helps to bridge the gap between immediate pressure for recovery with deeper, but longer-term, reform. It offers a path to recovery, but with risks to navigate along the way, including a challenging financial position.

- Alongside the framework, NHS England is to publish at least 20 additional guidance and resource documents for ICBs and providers over the coming months, for areas from neighbourhood health to integrated health organisations, setting significant central direction.

- It has 15 headline success measures over a three year-period, down from 18 in 2025/26 and 133 in 2022/23.

- Released five months before the next financial year, it also provided more time for local leaders to build its expectations into realistic plans.

Medium Planning Framework – summary of the requirements for both providers and commissioners

- **Financial discipline and incentives**

The multi-year funding settlement at the spending review provides 3% real-terms increase in revenue and 3.2% in capital funding; providing the foundation to move away from annual financial and delivery planning cycle. Capital allocations alongside updated delegated limit guidance and technical guidance will be released later this autumn.

All ICBs and providers are expected to deliver financial balance or surplus each year (without deficit support by 2029). A 2% productivity gains per year for 3 years as a minimum to be delivered through getting the basics right in productivity improvements and harnessing the opportunities of digital and service transformation in urgent and emergency care and outpatients.

ICB revenue allocations will move to 'fair sharing of resources' alongside a review of the broader NHS funding formulae. Alongside, the capital regime will be reformed to get better value from public and private capital.

Block contracts will be dismantled, with a new urgent and emergency care (UEC) payment model for 2026/27, comprising a fixed element of the UEC payment model and a 20% variable payment and an incentive element of the UEC payment model to left shift with clinical, financial and operational groups. The reformed payment mechanisms and models will be set out in the 2026/27 NHS payment scheme, including proposed best practice tariffs to incentives transformation and new ways of working.

A financial model/incentive model for neighbourhood health as demand for acute service reduces is currently being developed with pilot sites, available for adoption in 2026/27.

- **Productivity**

The operating framework continues the focus on improving the productivity of the NHS. It highlights focuses on the following areas:

- **Technical efficiency** – reducing inpatient length of stay, improve theatre productivity and return to pre-COVID levels of activity per whole-time equivalent (WTE). This means delivering at a minimum the 2% annual productivity target.
- **Analogue to digital** – accelerate the shift to a digital-by-default across acute, community, mental health, learning disabilities and autism services and primary care.
- **Metrices** – NHS England will publish trust-level productivity measures and incorporate these into the NHS Oversight Framework. This will include dedicated measures for community health services, addressing previously unwarranted variation.

- **Urgent and Emergency Care (UEC)** – shift to digital-first UEC model, using clinical prioritisation and scheduling to improve reducing available demand. Move away from traditional walk-in demand to models that support patients' access to the right care, in the right setting, at the right time, based on clinical urgency and individual needs. This includes expanding digital and telephony-based triage and booking mechanisms and increasing access to same-day or next-data scheduled care where clinically appropriate.
- **Outpatients** – shift to digitally enabled care by expending use of advice and guidance and digital triage and expanding patient initiated follow-up (PIFU), remote consultations and digital monitoring. This should deliver a reduction in outpatients follow-up activity (OPFU). Rather than a uniform national target, each ICB must model required OPFU reduction to accelerate delivery of referral to treatment (RTT) and long-way targets, and then submit bespoke plans.

- **Operating Model**

The refreshed NHS operating model enables delivery of the10 Year Health Plan; focussing on empowering integrated local care to improve access and reduce hospital demand, while prioritising prevention, tackling health inequalities and enhancing patient experience. It focusses on eight areas as follows:

- **Providing clarity on system roles –**every part of the system has a different role:

- **The centre –** sets national outcomes, codifies standards, builds shared platforms once and well and removes barriers.
- **Regions –** leadership interface, with a single line of sight across performance, finance, workforce and quality, responsible for both grip and for support.
- **ICBs –** strategic commissioners, moving resources into prevention and community capacity, tackling inequalities and commissioning for value (quality of care and optimal efficient cost).
- **Providers –** through a revitalised foundation trust process, are responsible for collaboration, productivity and quality, with earned freedoms for those who deliver and proportionate intervention where standards slip.
- **Integrated health organisations –** contracts will enable end-to-end redesigning of pathways, with efficiencies reinvested into better and more effective ways of working.
- **Neighbourhood teams –** will support communities and deliver proactivity support for people with facility and long-term conditions. They will provide urgent and acute community services, rehabilitation and prevention and support improved access to care,

especially general practice. Their work will be enabled by digital tools and shared care records.

- **Unleashing local potential to deliver integrated care** - setting out plans for ICBs to be strategic commissioners and taking an outcomes-based approach. With integrated health organisations (who will not be new organisations) they will work with the wider provider landscape to deliver high-quality care efficiently, including through sub-contracting arrangements and, where appropriate, delegation of commissioning. Blueprints for these are being developed which include the contractual frameworks to support them with success being rewarded with greater local control.

- **Neighbourhood health at pace** - taking immediate action on improving access and reducing unwarranted variation, reducing unnecessary non-elective admissions and bed days from priority cohorts (frail, care home residents and end of live) and shifting planned specialised care closer to home. Systems need to understand the current and projected total service utilisation and costs for high priority cohorts of those with moderate to severe frailty, living in care homes, housebound or at the end of life. Creating an overall plan to more effectively manage the needs of these high priority cohorts and significantly reduce avoidable unplanned admissions.

- **Sickness to prevention** - ICBs need to ensure that their five-year commissioning plan is focussed on prevention and early intervention. Specifically tackling obesity, rates of premature mortality linked to CVD, tobacco dependency and reduce exposure to antibiotics to meet thresholds set in recent guidance and addressing problematic polypharmacy to reduce avoidable harm.

- **Doing digital differently** - the health service must become one that is digital by-default; a core element of this is through the NHS App including using AI triage and data drive pathways to guide patients to bookings through My NHS GP, giving patients one place to manage all appointments, referrals and interactions and facilitating access to targeted prevention services and expanding point-of-care testing in the community. Establish NHS Online, a new 'online hospital' to connect patients to expert clinicians from 2027.

- **Transform approach to quality –** NHS England has developed a new purpose and scope for the National Quality Board and are currently undertaking stakeholder engagement to inform the vision and strategy. This strategy (March 2026) will inform local improvement priorities.

Preparation for the Single National Formulary will continue, focusing on priority medicines savings. All-age continuing care (AACC) services will transition to the AACC Data Set v2.0 by March 2027. Workflows will be redesigned to maximise use of digital systems and the NHS Federated Data Platform, eliminating duplicate paper processes.

- **Understanding and improving the patient experience** - by the end of 2025/26, all providers will complete a patient survey cycle for waiting patients and collect near real-time feedback from at least five wards or departments before discharge.

- **Reconnecting with our workforce and renewing and strengthening leadership and management** - NHS England will publish a new Management and Leadership Framework during autumn 2025, setting a code of practice of standards and competencies for clinical and nonclinical leaders and managers at five levels from entry level to board. ICBs and providers should use these in recruitment and approval. A national curriculum and interactive online modules will be published in 2026/27. Continuing to tackle discrimination, racism and sexual misconduct, including regularly assessing progress on the Sexual Safety Charter.

- **Embed Genomics, life sciences and research into care delivery** - All providers should meet the site-specific timeframes of the government's 150-day clinical trial set-up target. Progress should be reported to boards six-monthly. From April 2026, ICBs should proactively support clinical trials by following standards and guidance set out in Managing Research Finance in the NHS. Providers must deliver services in line with the NHS Genomic Medicine Service Specification from April 2026.

Guidance and Allocations
In mid-November 2025, NHS England published the following guidance and allocations to launch the next phase of medium-term planning:

- Revenue and Contracting Guidance
- ICB revenue allocations for 2026/27 to 2027/28 and supporting guidance
- Capital guidance and allocations for 2026/27 to 2029/30
- NHS Payment Scheme 2026/27 consultation
- NHS Standard Contract 2026/27 consultation

The guidance included an initial timetable, noting a draft submission of operational plans (activity, workforce, finance) due in December and a final submission (including narrative) submission due in February. It was noted that the third-year revenue settlement was to follow, with the draft submission only including 2026/27 and 2027/28.

Key Messages - Financial Plans 2026/27 – 2028/29

Context
We have a three-year revenue settlement and four-year capital settlement, allowing us to now publish two years of allocations, with a third year to follow shortly, in support of the medium-term planning process.

We will need to make improvements to elective and urgent and emergency care services, alongside the other shifts set out in the 10-Year Health Plan, whilst delivering 2% annual productivity and eradicating deficit funding.

Funding and allocations

- ICB core programme allocation growth in 2026/27 is 2.7% based on cost uplift factor (CUF) of 2.03%, a general efficiency requirement of 2.0%, and activity/other cost growth. Convergence of up to +/-0.5%. CUF and allocations subject to change depending on pay decisions.

- Target allocations made fairer with £2.3bn increase to target quantum's (not actual). Deficit Support Funding (DSF) moved into recurrent allocations for >2.5% under target systems. Annual convergence based on this revised Distance from Target. No system is more than 2.5% underfunded on ICB core programme by 28/29. All ICBs within +/-2.5% of overall fair share by 2028/29 excluding specialised commissioning.

- £6.3bn elective recovery funding has been moved into recurrent baseline allocations (ICB core and specialised) on a fair share basis. Further non-recurrent funding is allocated over the 3 years on a differential basis to enable delivery of diagnostic and elective performance standards.

- 2% general efficiency requirement in the NHS payment scheme consultation and allocations. In addition, DSF will be withdrawn over time, and ICB funding based on successful delivery of £19/head cost of commissioning target (not reflected in 2.7% base growth figure above).

- Operational capital allocations are made at provider rather than system level. Different methodologies are used to calculate strategic capital allocations. Organisations in NHS oversight framework (NOF) segments 1 and 2 may reinvest prior-year surpluses as additional capital departmental expenditure limits (CDEL).

NHS Payment Scheme

- Move to blended payment approaches for urgent and emergency care, including same day emergency care (SDEC) and other same day pathways, comprising a fixed payment, based on price x planned activity and a variable payment of 20% of prices for activity above or below the planned level.

- Continue work on deconstructing fixed payments. Recommended maximum contract value change of 2.5% to manage change at commissioner/provider level.

- Elective payments remain on variable basis. Best practice tariffs to encourage shift to day case, outpatient procedures and support elective delivery.

- Helping "left shift" through urgent and emergency care blended payment, working groups on neighbourhood payment models and urgent and emergency care, development of mental health and community currency models.

- Introduction of some non-mandatory guide prices for some ADHD and autism services.

- Set prices by updating the 2025/26 pay award prices by applying the cost uplift (2.03%) and efficiency (2.0%) factors and an adjustment reflecting the change in Market Forces Factor (MFF) values (0.42%).

- Ophthalmology services – reduce the prices for simple cataracts by 20% and use the funding to increase the prices of other ophthalmology services, focusing on more complex procedures.

- Low volume activity (LVA) – continue to use LVA arrangements for almost all NHS provider/commissioner relationships with an annual value of less than £1.5m.

Financial framework and business rules

- System financial balance requirement replaced with ICB and NHS trust/foundation trust breakeven requirements.
- Deficit Support Funding (DSF) is issued to organisations with deficit plan limits. No national provider surplus plan limits but surpluses will enable access to capital drawdown regime.
- Mental Health Investment Standard (MHIS) is set at flat real for ICB core programme allocations.

Planning approach

- ICB and NHS trust boards must ensure they have a robust approach to risk management in place. Plans must have assessed risk and identified robust mitigations that are actionable within the control of the organisation.
- ICBs and NHS trusts will be expected to submit plans that show a mutual alignment of contract information and planning assumptions. NHS England will reject plan submissions that are not aligned, requiring local resolution and re-submission.

Business Rules
As part of the new NHS operating model, ICBs and NHS trusts are required to deliver financial balance as individual bodies.

NHS England have published updated NHS finance business rules guidance which will apply from 1 April 2026.The system financial balance requirement is replaced by ICB and NHS trusts financial balance requirements. The system cumulative position is replaced by ICB cumulative position, with associated drawdown/repayment.

ICBs and NHS trusts will continue to be required to collaborate including when setting plans, as set out in the NHS Planning Framework shared in the summer.

System cumulative positions at 2025/26 year-end will be carried forward to form new ICB cumulative positions from 2026/27. Deficit repayments will be paused for two years with the opportunity for system cumulative deficits to be forgiven where the ICB maintains balance in each year alongside a history of strong financial management in recent years. Cumulative system surpluses will be carried forward to new ICB cumulative positions.

NHS Somerset Integrated Care Board submitted a balanced financial plan for 2026/27, 2027/28 and 2028/29 on 12 February 2026. The plan had been presented to the ICB Finance Committee and was approved by the ICB Board.

Going Concern
Within our accounts, we are required to make a clear disclosure that the individuals responsible for financial governance for NHS Somerset ICB have considered this

position, and that given the facts at their disposal, the ICB is a going concern. Where there are material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the ICB, these are disclosed as part of the disclosure notes supporting the annual accounts.

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, although Somerset ICB is 'clustering' with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) 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.

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 as they will continue to provide the services in the future.

Having considered the going concern guidelines, the financial reporting and governance arrangements of NHS Somerset ICB, approach to the development of operating plans for 2026/27, as set out above, and the continued focus by the ICB and Somerset system partners to drive improvements to the financial position, NHS Somerset ICB considers that it remains a going concern.

The statement of financial position has therefore been drawn up at 31 March 2026, on a going concern basis.

ANNEX 1 (PERFORMANCE ANALYSIS). Green Plan Metrics.

The Somerset ICS Green Plan Metrics

Key

Red <84%
Amber 85-94%
Green 95%+

▲ Activity increased
— No change
▼ Activity decreased

Workforce and system leadership

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
GT1	Conduct a resource audit	Determine clear outcomes from the evaluation to produce action plan for NZ alignment	Evaluation in progress	New indicator	—	Rolling programme of work
GT2	Implement Environmental Management System	Produce critical analysis to support a business case for introducing the standard, or clear reasoning to demonstrate why it is not applicable.	Critical analysis in progress	New indicator	—	Rolling programme of work

GT3	Greater transparency on delivery and accountability	Aim to reporting progress at least twice-a-year to our Executive and Board. Existing structure is light touch which could distance accountability.	In progress	Clustering of ICBs - Somerset, Dorset and BSW has led to board restructure	–	Rolling programme of work
SET1	We want our staff to become more aware of the importance and urgency of climate change	Develop job descriptions to ensure they include appropriate sustainability responsibilities	Activity paused	Clustering of ICBs - Somerset, Dorset and BSW has led to staffing restructure and recruitment freeze	▼	Paused
SET2	Continuous 'green' learning and innovation as a driving force for change	Understand what training programmes are already in place and how they can be replicated	Activity paused	Clustering of ICBs - Somerset, Dorset and BSW has led to staffing restructure and recruitment freeze	▼	Paused
SET3	Develop engagement programme and actions through the Internal Sustainability Group	Audit of existing engagement programmes across the cluster.	In progress	Currently analysing where there might be an opportunity to develop aligned campaigns.	–	Rolling programme of work
PWT1	Develop sustainability partnerships across our cluster with BSW and Dorset ICBs and Trusts	Liaise with each of the leads for the chapters of the Green Plan, align targets and opportunities to drive delivery	In progress	New indicator	–	Rolling programme of work
PWT2	Develop EV infrastructure map	Develop communities of practice to drive delivery	In progress	New indicator	–	Rolling programme of work

Estates & facilities

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
EFT1	Prioritise energy efficiency measures to avoid increasing costs unnecessarily and consider the interventions which address the NHS' net zero targets.	Work with NHSPS to understand tarrifs and opportunities to save energy. Support general practice to work with the Energy Cooperative.	Evaluation in progress	New indicator	–	Rolling programme of work
EFT2	Look to incorporate net zero and carbon emissions into ICB risk assessment matrix to increase prioritisation of capital investment in these areas	Develop clear plan for investment across the estate, understanding quick wins and supporting more efficient prioritisation and to highlight risk of underinvestment (dilaps, building efficiency etc.)	Critical analysis in progress	New indicator	–	Rolling programme of work
EFT4	Ensure a minimum of 10% Biodiversity Net Gain for all new build projects	Work with Natural England, Somerset Wildlife Trust and Somerset Local Nature Partnership to establish a framework for accurate habitat measurement. Q4 25/26	In progress	New indicator	–	Rolling programme of work
EFT5	Reduce waste and implement the principles of the circular economy across our ICS estate and supply chain	Working with clinical waste providers and through the Green Impact for Health Toolkit metric for general waste	In progress	New indicator	–	Rolling programme of work

EFT6	Determine how to best measure building performance during and after refurbishment works	Understand how construction waste will be managed, reported, and tracked.	Activity paused	Clustering of ICBs - Somerset, Dorset and BSW has led to staffing restructure and recruitment freeze	▼	Paused
NBT1	Thriving plants and wildlife across our estate.	As a starting point, we will link this work to the travel and Transport workstream to aim to achieve clean air	In progress	New indicator	–	Rolling programme of work
NBT2	Identify where poor access to green spaces exist across our estate	Develop green infrastructure mapping linked to the LNRS	In progress	New indicator	–	Rolling programme of work
NBT3	Understanding how we can leverage BNG on refurbishment projects across primary care	Working closely with S106 team and primary care estates teams we can establish a clear process to leverage the greatest benefit.	In progress	New indicator	–	Rolling programme of work

Travel and Transport

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
TTT1	Electric Vehicle Charging points	Develop collaborative map with partners for shared infrastructure to support our zero-emission vehicle mandate.	Community of Practice established	New indicator	▲	Rolling programme of work

TTT2	All new vehicle purchases and lease arrangements across NHS Somerset ICB are solely ULEV, or ZEV cars.	Refresh travel plan aligned to cluster partners travel plans to socialise the salary sacrifice EV lease scheme	In progress	New indicator	–	Rolling programme of work
TTT3	Promote active travel	Work with system partners to provide information, facilities, processes and infrastructure to facilitate and incentivise sustainable and active travel.	In progress	New indicator	–	Rolling programme of work
TTT4	Reduce patient travel	Aligned to the 10 Year Health Plan and the 3 big shifts. Enablers are moving care closer to home, telemedicine, virtual wards and NHS app	In progress	New indicator	–	Rolling programme of work

Medicines

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
MT1	Achieve medicines optimisation reducing unnecessary prescribing	Structured medicine reviews, embedding Show me your meds, please?	In progress -Open prescribing data March 2026: *19 measures doing well *9 opportunities for possible improvement *4 measures where there could be potential cost savings	New indicator	▲	Rolling programme of work

MT2	Continue shift towards lower carbon inhalers	MM team support pharmacy and primary care to move to DPI and SMIs. Low carbon MDIs have also been Introduced	Continuing to support our PCNs, Pharmacies and General Practice to move away from high carbon Metered Dose Inhalers	Metrics reported quarterly from Open Prescribing. Somerset is in the best 10% on 14 of 22 indicators.	▲	Rolling programme of work

Food and nutrition

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
FNT1	Prevention – underpinned by healthy diets. Reducing carbon intensive demand on healthcare services	Partnership working to raise awareness of health gains, removing the focus from weight	In progress	New indicator	▲	Rolling programme of work
FNT2	Support our workforce and wider population to be 'healthier'	Identify public health programmes that can be linked to wider determinants of health. Continued partnership working with Somerset Council	Continued 'MORE' training workshops being delivered to employees	New indicator	▲	Rolling programme of work
FNT3	Developing a population health ambassador programme	Develop comms programme that demonstrates the inextricable link between food, nutrition and the environment.	In progress	New indicator	–	Rolling programme of work

Sustainable Models of Care

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
SMCT1	Equitable social prescribing model	Development of a delivery model/platform to ensure equitable access to social and green prescribing	Case for change prepared to support funding bid	Activity paused during clustering process	▼	Paused
SMCT2	Support nature-based interventions	Work collaboratively with partners, Somerset Council, Local Nature Partnership to develop nature mapping across the county with initial emphasis on areas of deprivation.	In progress	New indicator	–	Rolling programme of work
SMCT3	Consider sustainability requirements for future commissioning	Recognise the ICBs role as strategic commissioners and the broader impact of how, where and who services are commissioned with. Sustainability needs to be a key consideration	In progress	New indicator	–	Rolling programme of work

Digital Transformation

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
DTT1	Reduce patient travel with shift towards digital delivery	Enabling patients to live healthy independent lives, supported by thriving communities (10-year health plan)	Digital delivery of care models being expanded	Digital cafes have delivered in partnership with Spark Somerset but is now no longer funded.	–	Rolling programme of work
DTT2	Using AI to analyse population needs	Building on the existing support programme being rolled out across Somerset	Activity paused	New indicator due to clustering and DDaT team changes	▲	Paused
DTT3	Develop digital inclusion programme	A Digital People's Champion Group has been established, which is made up of members of the public who are interested in our work	In progress	New indicator	–	Rolling programme of work
DTT4	Work towards digital climate resilience	Continue to develop and deliver actions set out in the digital climate resilience chapter of the climate adaptation plan supported by appropriate governance routes	Greener Digital climate resilience project in progress	New indicator	▲	Rolling programme of work

DTT5	Establish a clear and robust process for asset disposal	Ensure appropriate accreditations that provide independent verification of a product's circular, environmental product declaration	In progress. Primary care asset circularity process implemented, including certification of recycled assets.	New indicator	▲	Rolling programme of work

Supply Chain and Procurement

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
PSCT1	Strengthening procurement guidance to consider sustainability more robustly	Building on the work already in development around digital procurement and the GP IT operating model and commissioning framework. Understand how this is currently managed across the cluster.	In progress	New indicator	–	Rolling programme of work
PSCT2	Diversify supply chains and secure against geopolitical risks	Clearer 'Before you buy' specification guidance. Explore shorter supply chain opportunities. Establish a comms channel to share the existing guidance	In progress	New indicator	–	Rolling programme of work
PSCT3	Strengthen environmental and Social Value commitments and monitoring in new and existing procurements	Building on the existing collaborative pilot of Loop, the SV monitoring and measuring tool.	In progress	New indicator	–	Rolling programme of work

Adaptation

Green Plan Ref No.	Performance Target	Target	Current performance	Previous performance	Direction of travel	Comments
AT1	Commitment to publish Adaptation Plan	Working in partnership across our Somerset system. Adaptation is planned for all critical infrastructure, not just those where issues have been known in the past.	Adaptation Plan published on ICB website, March 2026. Community of Practice established to take work forward across the system	Plan in development.	▲	Rolling programme of work
AT2	Embed risk and resilience into NHS Somerset ICB specific policy	Building on the work with IG, EPRR and Risk teams informed by the climate adaptation plan	In progress. Linking with cluster partners to understand group approach	New indicator	–	Rolling programme of work

ACCOUNTABILITY REPORT

JONATHAN HIGMAN
Accountable Officer
NHS Somerset Integrated Care Board

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

Members Report

Member Profiles/Composition of Board and Committees

The membership of NHS Somerset ICB Board and leadership team is set out in the table below detailing names, roles and membership of the key committees within NHS Somerset ICB. A detailed breakdown of attendance at each of the committees is also provided below.

Board members are selected and appointed per the processes that are stipulated in NHS Somerset ICB's constitution.

In line with our duty to keep the knowledge and experience of members under review, the ICB ensures we undertake regular 360 review and appraisal using the NHS Board Member Appraisal Framework and NHS Leadership and Competency Framework. Board members undergo a rigorous fit and proper person test per the NHS England Fit and Proper Person Test Framework for board members. The constitution of the ICB sets out the measures that are in place for removal or disqualification.

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 vacancies arise, skills, requirements, and diversity of representation on the Board are taken into consideration.

Breakdown of NHS Somerset ICB Board and Executive Leadership (2025/26*)

Role	Name	Committee Membership M(V) = (Voting) Member A = Attendee, (P) = (Non-Voting) Participant M(NV) = (Non-Voting) Member						
		Board	Management Board	Audit Committee	Remuneration Committee	Quality Committee	Strategic Commissioning Committee	Finance Committee
ICB Executive Leadership								
Chief Executive	Jonathan Higman	M(V)	M(V)					M(V)
Chief Finance Officer and Director of Performance and Contracting	Alison Henly	M(V)	M(V)	A			M(V)	M(V)
Chief Nursing Officer	Shelagh Meldrum	M(V)	M(V)			M(V)	M(V)	M(NV)
Chief Medical Officer	Dr Bernie Marden	M(V)	M(V)			M(V)	M(V)	M(NV)
Chief People Officer	Graham Atkins (Until January 2026)	P	M(V)					
Chief Officer for Strategy, Digital and Integration	David McClay	P	M(V)				M(V)	
Executive Director of Communications, Engagement and Marketing	Charlotte Callen	P	M(V)					
Executive Director of Corporate Services and Affairs	Jade Renville	P	M(V)					

Non-Executive Members**								
Chair	Rob Whiteman (From September 2025)	M(V)			M(V)			
	Paul von der Heyde (Until September 2025)							
Non-Executive and Deputy Chair	Paul von der Heyde (From September 2025)	M(V)			M(V)		M(V)	M(V)
Non-Executive	Dr Caroline Gamlin (Deputy Chair Until September 2025)	M(V)		M(V)	M(V)	M(V) Chair	M(V)	
Non-Executive	Grahame Paine	M(V)		M(V) Chair	M(V)	M(V)		M(NV)
Non-Executive	Suresh Ariaratnam	M(V)			M(V)	M(V)	M(V) Chair	
Non-Executive and Senior Independent Member	Christopher Foster	M(V)		M(V)	M(V) Chair			M(V) Chair
Partner Members								
NHS Trusts/Foundation Trusts	Peter Lewis	M(V)						
Local Authority	Duncan Sharkey	M(V)						
Primary Care	Dr Berge Balian (Until July 2025)	M(V)						
	Dr Rebecca Duffy (From September 2025)	M(V)						

Participants								
Healthwatch	Judtih Goodchild	P						
Voluntary, Community, Faith, Social Enterprise Sector	Katherine Nolan	P						
Public Health Expert	Alison Bell	P					M(V)	

* We are ‘clustering’ with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) 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 is reflective of the NHS Somerset ICB Board and executive team during the reporting period, notwithstanding a Very Senior Managers appointment process whereby some executives have been appointed into roles covering the wider cluster.

** Non-Executive Members have membership to a set of assigned committees, but in addition, may also attend other committees on an ad hoc basis should they wish to do so.

Register of Interests
Our ICB register of interests, which includes details of company directorships and other significant interests held by senior ICB leaders, is available on our NHS Somerset ICB website at: Lists and Registers - NHS Somerset.

Provider Selection Regime and Register of Procurement Decisions
A summary is available on our website at: Lists and Registers - NHS Somerset.

Personal Data Related Incidents
There were two personal data related incidents which met the threshold for formally reporting to the Information Commissioner's Office (ICO) during the year.

- NHS Somerset ICB was alerted that information sent to an individual them by NHS Somerset ICB included information relating to another patient. The incident was investigated and reported to the ICO. A set of actions were taken to respond to the data breach, assess and learn from the incident. All impacted data subjects were written to with an apology and with details of investigation outcomes. Following their consideration of the incident, the ICO closed the case and provided the ICB with advice.

- Following an upgrade to software by a supplier commissioned by the ICB, it came to light that a small number of patient records had been misfiled such that patients were able to see information of other patients in their own online record. The initial assessment with the supplier and GP practices led to reporting of the incident to the ICO. A significant piece of work was undertaken across GP practices to support them in identifying any errors and ensuring they were safely corrected. Where appropriate, letters of apology were sent by GP practices to their patients. Working with the supplier, a fix was made to the software and root cause analysis undertaken to ensure lessons were learned. Following their consideration of the incident, the ICO closed the case and provide the ICB with advice.

Modern Slavery Act
NHS Somerset ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2026 is published on our website at Modern Slavery and Human Trafficking Statement.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Somerset Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.
In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Somerset Integrated Care Board. 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 NHS Somerset Integrated Care Board'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 NHS Somerset Integrated Care Board'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
NHS Somerset Integrated Care Board

15 June 2026

Governance Statement

Introduction and Context

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

NHS Somerset 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 NHS Somerset ICB's 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 NHS Somerset ICB's Accountable Officer Appointment Letter.

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

Governance Arrangements and Effectiveness

The main function of NHS Somerset ICB's Board is to ensure 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.

Within the NHS Somerset ICB geographical footprint, the system covers:

- Somerset Council
- Somerset NHS Foundation Trust (including all Somerset's acute, community, mental health and learning disability services and around a fifth of General Practice provision under a single organisational umbrella).
- 59 GP practices which come together in 13 primary care networks (PCNs), located within 12 neighbourhoods and a single GP Support Unit.
- Strong working relationships and a Memorandum of Understanding with the local voluntary, community, faith and social enterprise sector (VCFSE).

Ambulance services in Somerset are provided by South Western Ambulance Service NHS Foundation Trust.

NHS Somerset ICB has established a properly constituted Board with the appropriate clinical, professional, executive and non-executive skill-mix. Details of the membership and the attendance of those members are set out in the Governance Statement.

Our organisational structure and accountabilities are clear and well defined. We have set out how we will achieve our vision through Our Integrated Health and Care Strategy for Somerset and Somerset Five Year Joint Forward Plan Refresh 2025-2030. The strategy details our ambition for working collaboratively with partners from health, social care and voluntary sector partners, whilst outlining our vision to support all people who live and work in Somerset to have healthy and fulfilling lives. Moving forward the Joint Forward Plan will be superseded by the Somerset Five Year Commissioning Plan.

Working alongside NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, we are fundamentally transforming to become one single ICB. We are 'clustering' as an interim step but anticipate the three organisations will formally come together through a 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. To achieve the transformation of our ICBs into a single strategic commissioning organisation, we need to be clear about our core purpose and how we expect it to operate. We call this our operating model, which we been redesigning during 2025/26.

The following assurance and statutory committees have been established by the Board, chaired by a non-executive director:

- Audit Committee
- Quality Committee
- Finance Committee

- Strategic Commissioning Committee
- Remuneration Committee

We also have two Joint Committees currently in operation: Joint Committee (Specialised Services) and the Transition Committee (clustered with BSW and Dorset ICBs). In addition, the Management Board was established as an executive arm of the Board responsible for operational delivery of the organisation.

In addition, although not Board committees, there are a range of system groups that have been convened as a way of facilitating collaboration across health and care and voluntary sector bodies in Somerset. Individuals that form part of these groups act within the level of authority and the powers granted to them by way of their constituent bodies' policies and make decisions only on that basis. Organisational governance arrangements and financial limits and decision-making still apply.

The remit of each statutory/assurance committee of the Board is as follows:

COMMITTEES - KEY ROLES AND RESPONSIBILITIES
Audit Committee
Non-Executive Chair: Grahame Paine **Executive Lead: Alison Henly** To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB. The duties of the Committee will be driven by the organisation's objectives and the associated risks. To provide assurance to the ICB Board about the appropriateness and effectiveness of the ICB's risk assurance framework and of the processes for its implementation. To assure the Board on the appropriateness and effectiveness of the external audit, internal audit and counter fraud services, its fees, findings and co-ordination with audit providers. This will include overseeing the procurement for external, internal and counter fraud service provision.
Remuneration Committee
Non-Executive Chair: Christopher Foster **(executive leads only attend upon invitation)** To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board that the ICB is discharging its statutory responsibilities in relation to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) but excluding Non-Executive Directors[1] and the Chair.

The Board has also delegated the following functions to the Committee:

- Oversight of the nominations and appointments process for Board members
- Oversight of executive board member performance

For the Chief Executive, Executive Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars.
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).
- Oversee any exceptional contractual arrangements.
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

Strategic Commissioning Committee

Non-Executive Chair: Suresh Ariaratnam
Executive Lead: David McClay

To contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board that the ICB is discharging its statutory responsibility for commissioning services that meet the needs of its population. The commissioning of services by the ICB is driven by the need to meet its core purpose defined by the four aims:

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

The Board, through this Committee, has a role in ensuring that its commissioning strategies and plans are aligned and support the delivery of these aims, the systems integrated care strategy and the 'three shifts' defined in the 10-year health plan

[1] Non-executive Board member remuneration will be determined by the national framework with the Chair exercising limited discretion for any additional allowances.

(moving care from hospitals to the community, embracing digital transformation, and shifting from treatment to prevention). The Committee will also assure the Board the commissioning decisions are underpinned by data and evidence.

Finance Committee

Non-Executive Chair: Christopher Foster
Executive Lead: Alison Henly

To provide assurance on the overall financial position of the ICB and wider Somerset system. As an assurance Committee of the Board, it will hold to account the ICB executive for delivery of the ICB's financial plan and recommend further areas for financial scrutiny. This will be done through:

- Reviewing the financial performance of the ICB against statutory financial targets, financial control targets and the annual commissioning plan.
- Reviewing cost improvement plans, identifying areas for further improvement or commissioner actions.
- Supporting the development and onward monitoring of the overall process of financial planning across the system.
- Where finance issues are raised then these will be highlighted to the ICB Management Board and relevant delivery boards to agree actions and mitigations.
- Ensuring that the Committee agenda and papers take into account the risks on the Board Assurance Framework (BAF) and risk registers. The Committee will wish to be assured that matters of risk, with a financial impact, are being effectively managed.

Quality Committee

Non-Executive Chair: Dr Caroline Gamlin
Executive Lead: Shelagh Meldrum

To provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB Board, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, effective, safe high-quality care. With regards to safety and quality improvement, the Committee will:

- Promote a culture focused on safety, experience, safeguarding, quality improvement and clinical effectiveness and outcomes.
- Provide assurance on all NHS provider services governance arrangements, patient safety and performance, through the receipt of timely insight and intelligence reports.
- Report areas of risk, concerns, mitigations and opportunities for improvement to the NHS Somerset Integrated Care Board.
- Have strong links with externally facilitated quality groups.

NHS Somerset ICB's performance of effectiveness and capability is subject to continuous assessment including with NHS England.

The internal audit work programme has been reviewed via the Audit Committee and supports our review of internal control processes such as risk management procedures, conflicts of interest and hospitality reporting procedures, data security and business continuity. The audit programme, together with the subsequent work to improve systems where appropriate, and scrutiny by our committees, supports my assurance that we have a sound system of governance and internal control in place.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance and therefore, NHS Somerset ICB is not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the ICB. For the financial year ended 31 March 2026, and up to the date of signing this statement, we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

NHS Somerset ICB has reviewed all of the statutory duties and powers conferred on it during 2024/25 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 to undertake the ICB's statutory duties, this has been further strengthened by restructuring the organisation to meet our Operating Model.

Risk Management Arrangements and Effectiveness

NHS Somerset ICB is committed to corporate governance, with risk management being an integral part of the organisation's operations. Risk assessments, along with equality impact assessments, are a key element of our decision-making, service changes, and assurance processes. These assessments are consistently reflected in the reports that are presented to committees and the Board.

The Risk Management Strategy of NHS Somerset ICB outlines the framework for managing risk. This strategy encourages a proactive risk management culture, where individuals are empowered to address risks, ensuring that the ICB and the services it

commissions are protected from events that could have a negative impact on the achievement of its objectives. The strategy also outlines:

- The responsibilities of governance forums within NHS Somerset ICB.
- Key definitions and terminology.
- The process for identifying, reporting and managing risks.
- Procedures for monitoring risks.
- Compliance expectations.

Risk management is embedded in the core activities of NHS Somerset ICB, with a strong emphasis on proactive risk identification and mitigation. Equality impact assessments are consistently integrated into decision-making processes, ensuring that service changes and new initiatives align with our commitment to fairness and inclusivity. Additionally, incident reporting is actively encouraged across the organisation, with a transparent and supportive approach to handling and investigating incidents reported. This open culture enables continuous learning, ensuring that risks are effectively managed, lessons are learned, and improvements are made to enhance the quality and safety of services delivered to people in our communities.

A system-oriented board assurance framework has been developed by the risk team in conjunction with stakeholders and implemented during 2025/26. This framework offers the Board clearer insight into the risks we face in achieving our strategic objectives together with a high-level view of key priority programmes.

NHS Somerset ICB acknowledges the importance of defining and maintaining a 'risk appetite.' This refers to the amount and type of risk that an organisation is prepared to pursue, retain or take, against an optimal and tolerable risk position. The organisation has a defined risk appetite which helps inform our risk registers and the board assurance framework. This is a vital tool for decision-making, risk assurance, and achieving our strategic aims and objectives. The risk appetite is reviewed regularly to ensure it remains aligned with the organisation's evolving needs.

As the ICB moves to cluster NHS Dorset, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) ICBs during 2026/27, a review of risk management will take place to align the three existing risk systems to achieve a single approach that meets the future needs of the three merged ICBs.

Capacity to Handle Risk

NHS Somerset ICB has a strong commitment to managing risk, with a clear focus on both risk capability and risk capacity to ensure effective handling of risks.

Leadership in risk management is provided through a robust governance structure, with directors, assurance committees, and subcommittees holding defined responsibilities to oversee, assess and mitigate risks. Organisational change during 2025/26 and 2026/27 will result in a change of governance arrangements. Proposals are being developed to plan and implement a single risk management framework for the clustered ICB.

The risk team offers central support, providing training on risk management to all staff and ensuring that teams are equipped with the necessary skills and knowledge manage risk in a manner that aligns with their roles and responsibilities, This includes comprehensive risk management training, with additional guidance provided through clear policies and procedures. The ICB encourages a culture of continuous learning, actively seeking to incorporate best practices and lessons from external sources and internal experiences to improve risk management processes. Colleagues are requested to update risks on our organisation's risk management system on a regular basis to ensure any risk reporting is accurate and up to date. By learning from good practice, we ensure that staff remain informed and capable of responding to risks in a proactive and effective way.

Risk capacity is assessed through available resources, financial, human, equipment, and estate, allowing the ICB to manage both materialised and potential risks. The ICB's risk management process is supported by clear reporting lines, ensuring timely and accurate information is submitted to assess compliance with statutory obligations. The Board maintains rigorous oversight over the ICB's performance, regularly monitoring risk exposure and ensuring that risks are appropriately managed through statutory and non-statutory forums. This comprehensive approach ensures that the ICB has the capacity and capability to handle risks while striving to meet its objectives.

Risk Assessment

Risk assessment within the ICB is a continuous process of identification of possible events that, if they were to occur, may impact achievement of the ICBs strategic aims and objectives, and/or cause harm. Each team and functional area is responsible for regular review of their risk profile and horizon scanning to ensure the portfolio of risk they are managing is reflective of the potential events that could impact delivery of their service areas. Executive directors receive a regular summary of their risk portfolio to ensure they have oversight of the profile of risks their teams are managing.
The risk team manage risks related to governance, risk management, and internal control. The risk team leads management and mitigation of these risks. Progress is measured by the team through the risk cycle of treating, monitoring, and reporting, alongside the internal and external audit programmes. Reporting and oversight of this activity is made to assurance committees where outcomes are assessed.

Other Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the NHS Somerset 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.

To strengthen internal control and to ensure the effectiveness of risk management, the ICB has encompassed the 'three lines of defence' model, being:

- First line of defence: The ICB Management Board, chaired by the ICB Chief Executive and membership of directors and senior managers which includes internal risk scrutiny within its terms of reference
- Second line of defence: ICB statutory and non-statutory committees that specialise in risk management for clinical and/non-clinical functions in the overseeing and monitoring of risk and/or compliance
- Third line of defence: The ICB Audit Committee and Board, internal and external audit providers, and external assurance providers.

All reports presented to the ICB Board include identified risks. All strategic documents are reviewed to ensure risks to delivery are considered.

The effectiveness of our governance structure is subject to review and best practice learning. We commissioned an internal audit review of the ICB governance arrangements, including a self-assessment. This identified a number of areas of strength in our arrangements although it was acknowledged that improvements could be made, in particular to improving strategic focus and monitoring of strategic objectives. An action plan was created following this review and assessment to address the findings and recommendations.

The Board's performance, effectiveness and capability is subject to continuous assessment. During the year, we reviewed our governance structure and committee arrangements, to ensure they are fit for purpose and help us achieve both our statutory requirement and strategic objectives. In year, governance handbook was fully reviewed and updated, and more information on our constitution and governance can be found here: Our Constitution and Governance - NHS Somerset ICB

During 2025/26, the ICB Board has continued to oversee and monitor the delivery of the Somerset ICS Health and Care strategic aims through the Board Assurance Framework and Priority Programme reports

Attendance at the Board is recorded in the minutes and full membership of the Board has been present at the majority of the Board meetings and seminars during 2024/25.

Regular reports are presented to the Board on ICB business and include:

- Strategic planning/priorities
- Financial management
- Patient safety and quality of clinical care
- Performance management and the achievement of national and local NHS targets
- Emergency planning
- Compliance with the NHS constitution
- Identified risks and actions to address or mitigate the risks.

NHS Somerset ICB meets regularly with NHS England to provide assurance and the Chief Executive has had regular meetings with the NHS England Regional Director.

Conflicts of Interest Management
While the Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own policy, which should be included in ICB's governance handbook, NHS England's engagement with local stakeholders recognised that nationally-commissioned basic training is of value to avoid unnecessary duplication across systems. NHS England therefore provided national e-learning modules on managing conflicts of interest in the context of ICB arrangements; this included introducing additional guidance on conflicts of interest for ICB Chairs.

Data Quality
NHS Somerset ICB recognises the fundamental importance of reliable information and meets its responsibility in ensuring that good quality data is collated and appropriately used. All decisions, need to be based on information which is of the highest quality. During the financial year we have continued to focus upon data quality in conjunction with our principal business analytics partner, South Central and West Commissioning Support Unit (SCW CSU). The data used by the Board and delegated committees is obtained through various sources, the majority of which are national systems and official NHS data sets. The provider data is quality assured through contract and performance monitoring and against the secondary user service (SUS).

There is collaborative agreement across the ICS that data collected is appropriately sought and recorded, complete, accurate, timely and accessible, and that appropriate mechanisms are in place to support service delivery and continuity. Any identified data quality issues are addressed and resolved through the operational or contractual routes

to ensure the accuracy of the performance reports provided to the ICB Board and its delegated committees and the Somerset System Assurance Forum (SAF).

2025/26 has seen the development of a Somerset Linked Data Platform which is anticipated to play a significant future role in providing population health insights through data use. Data quality has been a central theme through the discovery and building of the platform architecture to ensure an accurate dataset is created to inform future insights for decision-making.

Information Governance

The NHS information governance framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The framework is supported by a data security and protection toolkit (DSPT) toolkit and the annual submission process provides assurances to the NHS Somerset ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The ICB published its DSPT submission for 2024/25 at the end of June 2025, with well documented evidence providing overall assurance, although we did have an improvement plan with a status of 'standards not met'. The improvement plan focused solely on supply chain and an assessment by the ICB that it did not meet the required standards of oversight and control of digital service providers.

Since June 2025 a significant amount of work took place to assure ourselves on supplier data security and protection risk. The Atamis contract database was used as a key component of developing a single point of assurance about suppliers. Following an audit of relevant contracts recorded in Atamis, the ICB was able to satisfactorily complete and submit its improvement plan by the end of 2025 and moved to 'standards met' for 2024/25 from January 2026.

NHS Somerset ICB places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have information governance processes and procedures in line with the DSPT. NHS Somerset ICB staff are required to undertake annual information governance training relevant to their role and we have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation of serious incidents.

We have a strong focus on information security and cyber risk management with a people, process and technology approach in identification of risk and its mitigation.

Business Critical Models

Within NHS Somerset ICB there is an appropriate framework and environment in place to provide quality assurance of business-critical models, in line with the recommendations of the 2013 MacPherson review into the quality assurance of such models.

Third Party Assurances

NHS Somerset ICB contracts with a range of third-party providers in order to deliver healthcare services to the population of Somerset and to support the corporate functions of the ICB, for example, through SCW CSU and external payroll services: further details can be found in the Delegation of ICB functions section.

An assessment of control issues associated with third party providers is detailed below. No further control weaknesses have been identified.

Control Issues

No significant internal control failures have been identified throughout the financial year 2025/26. However, internal audit have identified recommendations for learning and improvement, which are fully accepted by the organisation, particularly regarding cyber security, with the ICB needing to focus on having up-to-date antivirus installed on some devices. Further details of these audit recommendations are provided within the Head of Internal Audit Opinion section.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

NHS Somerset ICB has standing financial instructions and a scheme of delegation which ensures that financial controls are in place across the organisation.

The Audit Committee is responsible for seeking assurance and overseeing internal and external audit and counter fraud services, reviewing financial and information systems and monitoring the integrity of the financial statements, and reviewing significant financial reporting judgements. The Audit Committee reviews the system of governance, risk management and internal control, across the whole of the ICB's activities.

The Audit Committee supports the view that fraud against the NHS will not be tolerated. All genuine suspicions of fraud are investigated and if proven, the strongest sanctions are sought against the perpetrators.

NHS Somerset ICB has adopted the National Freedom to Speak Up (FTSU) policy and reporting processes are well publicised to staff. The organisation has a FTSU guardian and champions with dedicated protected time to support speaking up and colleague wellbeing. NHS Somerset ICB is confident these processes are effective. Ten cases have been reported in 2025/2026, all managed and supported without the need to proceed to a formal HR process.

In 2025/26 efficiency savings were delivered in-year in relation to continuing healthcare Services (CHC), GP prescribing and ICB running costs. Through system meetings, local leaders continue to discuss quality, innovation and prevention programme/cost improvement programme (QIPP/CIP) assumptions to inform future planning decisions and ensure that a robust peer challenge is in place across Somerset using benchmarking information, which also confirm that clear assumptions and monitoring are in place to ensure no double-counting across organisations.

NHS Somerset ICB looks at all opportunities for cost savings through demand management schemes and agree these with system partners.

To support this, our Finance Committee, which looks at the financial position and the system savings programme, ensure a framework for contract reviews to happen in a timely manner and identify and ensure delivery of QIPP/CIP across the range of services commissioned. This Committee meets monthly and has an active work programme.

As part of the developing and continued working towards a single system of finance, activity and workforce, the individual operational and financial, workforce and performance plans of the Somerset health partners are developed, cross-checked and triangulated as one, through established joint working and strengthened governance, as a collective partnership, including Somerset Council. This is part of the Somerset system's ongoing 'open book' approach to managing itself, through planning and delivery. This approach continues to be developed to ensure alignment and delivery of the aims for the system as a whole. This forward strategy will build on and refresh the already approved estates programme, capital plans, and digital plans. Future plans will continue to focus on managing demand and reducing cost across the system.

Commissioning of delegated services (Primary Care Services and Specialised Services)

NHS Somerset 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. NHS Somerset ICB is the Principal Commissioner for South West Specialist Commissioning services on behalf of other South West ICBs.

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.

Delegation of ICB Functions

It is implicit through the work of the NHS Somerset ICB Board and its committees that members have responsibility for ensuring appropriate use of resources. Where there are concerns about budget management, these are documented in our risk register.

Through our committee structure, regular reports are received about the performance of contracted service providers. Areas of under or over performance are addressed through contract meetings and reported through finance, performance and quality papers presented to ICB groups and committees.

The Audit Committee monitors the financial stewardship of the organisation and is responsible for scrutinising and signing off the financial accounts.

NHS Somerset ICB commissions support services from the South, Central and West Commissioning Support Unit (SCW CSU), as described here. The contract provides the framework under which assurance about their performance can be monitored and managed. In addition, to deliver assurance about the procedures operated by all CSUs, NHS England engages a reporting accountant to prepare a report on internal controls. The objective of this is to provide assurance in a cost effective manner for the NHS, through reducing the duplication which would likely arise from multiple ICB internal and external auditors separately assessing CSU controls. The scope of the Service Auditor Report (SAR) covers payroll, financial ledger, accounts payable, accounts receivable, financial reporting, Treasury and cash management and non-Clinical procurement. Of these services, NHS Somerset ICB only commissions the non-clinical procurement service through the SCW CSU. No control exceptions were identified within the SAR for the non-clinical procurement service for 2025/26.

Type II ISAE 3000/3402 service auditor reports, which assess the state of the control environment for the period 1 April 2025 to 31 March 2026 have been received and reviewed for the following services commissioned in the ICB:

NHS Shared Business Services Limited provide finance and accounting services to NHS Somerset ICB. The 2025/26 SAR presented an opinion, in all material respects, based on the criteria described in the service organisation's management statement that:

- The controls related to control objectives were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period 1 April 2025 to 31 March 2026 and the user entities applied the complementary controls and,
- The controls tested, which, together with the complementary user entity controls, if operating effectively, were those necessary to provide reasonable assurance that the control objectives were achieved, operated effectively throughout the period 1 April 2025 to 31 March 2026.

Capita Primary Care Support England (PCSE) provide administrative and support services as part of the delegated commissioning function for primary care medical services. The 2025/26 SAR presented a qualified opinion for the payments and pensions administration services provided by Capita PCSE, with exceptions identified relating to two out of 14 control objectives during the period. This exception resulted in the non-achievement of the following control objectives;

- Controls provide reasonable assurance that changes to data on Pensions Online (POL) and PCSE Online are accurate and are supported by valid / authorised requests.
- Controls provide reasonable assurance that payments are only made after changes to bank details are validated.

No significant impacts have been identified as a result of these exceptions in respect of the service provided to the ICB.

NHS Business Services Authority provide and maintain the electronic staff record system (ESR system) and the prescriptions and dental payment processes on behalf of NHS Somerset ICB.

The 2025/26 SAR covering the ESR system presented an opinion that reasonable assurance could be given that the controls tested, relating to delivery of the control objectives, were operated effectively throughout the period 1 April 2025 to 31 March 2026.

The 2025/26 SAR covering the prescriptions payment system presented an opinion that reasonable assurance could be given that the controls tested, relating to delivery of the control objectives, were operated effectively throughout the period 1 April 2025 to 31 March 2026.

The 2025/26 SAR covering the dental payment system presented an opinion that reasonable assurance could be given that the controls tested, relating to delivery of the control objectives, were operated effectively throughout the period 1 April 2025 to 31 March 2026.

The Better Care Fund (BCF)

The Better Care Fund (BCF) was established by the Government to encourage the integration of health and social care and to achieve specific national conditions and local objectives. These relate to supporting people to live as independently as possible in their own homes and avoid unnecessary admissions to hospital, long-term care placements or avoidably long stays in a treatment or care setting.

It was a requirement of the BCF that NHS Somerset ICB and Somerset Council establish a pooled fund for this purpose. This is in place covered by a signed agreement under Section 75 of the National Health Service Act 2006.

The BCF has evolved since its inception and now incorporates three budgetary components:

- The disabled facilities grant
- Mandated NHS (ICB) contributions (inc. ICB discharge fund)
- The local authority better care grant (contributions via Somerset Council, inc. adult social care discharge fund).

There is a one-year BCF framework for 2025/26. Each year, local systems are required to provide a plan and progress reports on the use of the BCF. BCF plans are required to have oversight and sign-off by Health and Wellbeing Boards and this is the case for Somerset.

During 2025/26 the Somerset BCF continued to help drive forward our person-centred integration agenda and the 2025/26 plan secured and stabilised investment in:

- Social prescribing and community-based support.
- Carers support services.
- Core social care services.
- Intermediate care services (including rapid response and home first).
- Adult social care discharge fund.
- ICB discharge fund.

Counter Fraud Arrangements

As well as overseeing the anti-fraud, bribery and corruption arrangements in place at providers, NHS Somerset ICB must also ensure that its own counter fraud measures remain robust. NHS Somerset ICB has well-established counter fraud arrangements to achieve the standards set out by the NHS Counter Fraud Authority (CFA). We engage an Accredited Counter Fraud Specialist to implement an ongoing programme of anti-fraud, bribery and corruption work. During 2025/26 work has involved the delivery of an annual work plan which follows the NHS Counter Fraud Authority standards to ensure our resources are protected from fraud, bribery and corruption, as well as addressing all

four key areas of the national counter fraud strategy: namely, strategic governance; inform and involve; prevent and deter; and hold to account.

NHS Somerset ICB's Counter Fraud Strategy and Annual Plan for 2025/26 aligns with the Government Functional Standard as a series of 12 'NHS Requirements' for Counter Fraud. These have been introduced to ensure a consistent approach across the public sector to protecting services against the risk of fraud, bribery, and corruption. The plan also supports the four main pillars of the NHS Counter Fraud Authority's (NHSCFA) strategic plan 2023-26. The 2025/26 strategy and work plan was produced taking into account:

- Discussions with the Chief Finance Officer and members of the Audit Committee.
- Local proactive work, risk measurement exercises and evaluation of previous work conducted by the Local Counter Fraud Specialist (LCFS) and staff within the organisation.
- Risks identified from referrals received and investigations conducted at the ICB by the LCFS.
- Risks identified at other clients either locally or nationally by the NHS Counter Fraud Authority (NHSCFA).
- Any national programme of proactive work by the NHSCFA.
- The NHSCFA's strategic aims, including implementation of the functional standards and increasing engagement with NHS organisations.

The counter fraud service is provided by BDO LLP, which includes a local accredited Counter Fraud Specialist who ensures that the annual work plan is delivered. Regular progress reports are provided at each Audit Committee meeting detailing progress against the work plan and highlighting any emerging fraud risks or allegations as they arise. In addition, an annual report is produced showing an assessment against the functional standards, including any actions which need to be taken to ensure the standards are achieved.

The LCFS has developed key relationships with the key ICB teams/directorates. These relationships, coupled with the significant work done by the LCFS to develop an anti-fraud culture, provides the foundation to enable good quality referrals being made to the LCFS and National Counter Fraud Specialist (NCFS), if needed. This in turn has resulted in a good proportion of cases concluding in civil, criminal and/or disciplinary sanctions.

The LCFS shares briefings with all staff through the ICB staff bulletin, '60 seconds', which covers key areas of learning from within the sector. The 2025/26 Counter Fraud Strategy and Annual Plan was developed to support NHS Somerset ICB in implementing appropriate measures to counter fraud, bribery and corruption. Having appropriate measures in place helps to protect NHS resources against fraud and ensures they are used for their intended purpose, the delivery of patient care.

The executive lead for counter fraud is Alison Henly, Chief Finance Officer and Director of Performance and Contracting, who is responsible for proactively tackling fraud, bribery, and corruption.

Head of Internal Audit Opinion
Internal audit is required to provide an opinion to the ICB, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by us as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period.

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 are satisfied that sufficient internal audit work has been undertaken to allow us to draw a reasonable conclusion as to the adequacy and effectiveness of NHS Somerset Integrated Care Board's risk management, control and governance processes.

Our opinion is as follows:

Generally satisfactory with improvements required in some areas.
The controls in the areas which we examined were found to be suitably designed and operating effectively to achieve the specific risk management, control and governance arrangements. However, there are some areas where weaknesses and/or non-compliance were identified and therefore may put the achievement of objectives at risk. Where weaknesses have been identified, improvements are required to enhance the design and/or effectiveness of risk management, control and governance arrangements. High significance findings raised during the year related to the cyber security controls.

In forming our view we have taken into account that:

- Our assessment of the design and operation of the underpinning risk management framework and supporting processes, including whether risk appetite has been established and embedded within the activities, limits and reporting of the organisation,

- The range of individual opinions arising from risk-based audit assignments that have been reported throughout the year; including the relative materiality of these areas,
- Any reliance that is being placed upon third party assurances.

- So far, we have completed a total of six assurance reviews, one audit is work in progress and one advisory review has been completed.

- For the assurance audits, the key financial systems audit rating is split, with ISFE1 assurance substantial and ISFE2 assurance moderate for both the design of controls and their operational effectiveness. The remaining four audits were all rated moderate for both design controls and their operational effectiveness. This is similar to the prior year. (Further comparison will be provided in the final version of this Annual Report).

- Our five reports for the year resulted in a total of 16 recommendations (high: 1, medium: 13 and low: 2), compared to 17 recommendations the year before (high: 1, medium: 13 and low: 3). (Further comparison will be provided in the final version of this Annual Report).

- The ICB has displayed strong controls in relation to its financial processes within ISFE1, although the implementation of ISFE2 has seen some teething problems nationally. The ICB continues to put in place workarounds to support areas of weakness.

- The ICB has performed satisfactorily in implementing our audit recommendations within the specified timeframes. As at the end of March 2026, there are 7 recommendations in progress (all medium), 4 medium rated recommendations are overdue (due to implications of the ICB clustering arrangements) and 4 recommendations have not fallen due (all medium).

- As is the case across the NHS, the ICB has faced financial challenges during the year. However, the ICB plans to deliver (subject to external audit) a break-even income and expenditure financial position for the year April 2025 to March 2026.

- We have considered the results of the service auditor reports that had been provided in May 2025. There were no matters which required us to undertake additional testing or change the scope of our work.

During the period, internal audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Key Financial Systems	**Design – Substantial (ISFE1), Moderate (ISFE2)** **Operational Effectiveness – Substantial (ISFE1), Moderate (ISFE2)** The purpose of the audit was to provide assurance over the local financial controls, general ledgers (ISFE1 and ISFE2), including access controls, control account reconciliations, journal preparation and entry, budget management, Better Payment Practice Code calculations, reporting, feeder systems and controls for ready to pay files. **ISFE1 – months 1 to 6** We have provided substantial assurance over the design and operational effectiveness of controls in relation to the general ledger processes operated under ISFE1. Control Design The control design is substantial because the ICB has a sound system of internal control in place over key processes. Financial reporting at all levels of the ICB is clear and a robust governance structure has been established to ensure that there is effective oversight of the financial position. Control Effectiveness The control effectiveness is substantial because the controls that are in place are being consistently applied. Our sample testing on user access, journals and control account reconciliations found that there was sufficient supporting documentation in place and controls had been applied effectively. **ISFE2 – months 7 to 9**

	We have provided moderate assurance over the design of the local controls and implementation of the ISFE2 ledger and moderate assurance of the operational effectiveness of controls. Control Design The ICB has taken steps to design local controls to mitigate the issues arising from the national implementation of the ISFE2 system. These include the establishment of manual workarounds to ensure timely and accurate reporting, and mitigations as far as possible to minimise inappropriate access to the financial ledger. However, due to the number of unresolved issues nationally, the ICB's ability to fully mitigate the risks has been limited we have provided Moderate assurance over the design of local controls. Control Effectiveness The effectiveness is moderate because of the additional time and effort required to implement the workarounds and the potential for increased risk of errors (although none were identified through our testing), due to the national system restrictions. Limitation in Scope Our opinion is limited to the areas that we have tested and the information that is in the ledger. There are on-going unresolved national issues in relation to ISFE2, resulting in a lack of confidence in the reports / output as there are inconsistencies and problems that other ICBs are facing which may impact this ICB. Efficiencies of ISFE2 are not being realised, significant time is being spent by the finance team to report, follow-up and try and resolve issues.
Better Care Fund (BCF)	**Design – Moderate** **Operational Effectiveness – Moderate**

	The purpose of the audit was to provide assurance that funds within the BCF are being utilised in line with the BCF plan and in accordance with national guidelines, and to understand to what extent funds are achieving the intended outcomes of the national BCF objectives and the priorities of the Somerset ICS. Overall we have concluded on moderate assurance for control design and moderate assurance for control effectiveness. BDO and SWAP (Somerset Council Internal Audit) worked in collaboration to carry out this audit. We found that there are positive working relationships in place between those charged with managing the BCF within the ICB and the Council, with communication taking place regularly. We identified gaps in the governance systems in place, such as a lack of regular reporting on progress toward achieving the objectives of the BCF narrative plan to senior executive committees such as the Finance Committee or Strategic Commissioning Committee. Also, we found that key financial management staff from the Council do not attend meetings of the Joint Commissioning Steering Group but instead receive reports from other attendees retrospectively. Our audit work found that four key performance indicators and expenditure against schemes within the BCF are recorded on the quarterly submissions that are mandated as part of the BCF management. While this was being completed each quarter, we found that there was a lack of detailed recording and review of how care providers were utilising the funds they were allocated and what was being achieved through this use of funds. This lack of in-depth monitoring impacts the ICB's and Council's ability to monitor the overall performance of the BCF and determine whether funds could be utilised better with alternative schemes. We noted that the metrics currently used to monitor the BCF performance are heavily health focused and do not provide sufficient social care insights. It is

	acknowledged that the BCF metrics are nationally defined.
Cyber Security	**Design – Moderate** **Operational Effectiveness – Moderate** The purpose of the audit was to appraise the design and effectiveness of the ICB's procedures for identifying and protecting information assets and managing its cyber security risks on an ongoing basis. This was to provide management with an independent assessment of the effectiveness of the information security and cybercrime prevention arrangements. We conclude that the ICB is moderate in both the design and effectiveness of controls for cyber security. Control Design We have concluded moderate assurance for control design as there is generally a sound system of internal control designed to achieve system objectives with some exceptions. This can be seen with the lack of wired network access controls and visibility of firewall and penetration testing visibility for the ICB. Control Effectiveness We have concluded moderate assurance for control effectiveness as there is evidence of non-compliance with some controls, that may put some of the system objectives at risk. This can be seen with the number of domain administrators which are part of the ICB's network as well as the outstanding devices relating to antivirus coverage.
Continuing Healthcare / Learning Disabilities (LD)	**Design – Moderate** **Operational Effectiveness – Moderate** The purpose of the audit was to: -Provide assurance on whether the ICB has robust procedures in place for contract monitoring,

	assessment, funding and reviews of LD care packages. -Offer advice on the planned process and information requested for the pooled budget review. We provided moderate over both the design and effectiveness of the controls in place for contract monitoring, assessment, funding and reviews of LD care packages. The process for contract monitoring is sufficiently documented within the ICB's CHC operational policy and the contract templates. Furthermore, for a sample of three contracts, we confirmed that monitoring had occurred in the last year in line with ICB policy. However, this policy has passed its review date. The policy also details the requirement for the ICB's financial contribution to jointly funded cases be based on unmet health needs, and we confirmed that the rationale for a sample of three jointly funded packages was in line with policy. Furthermore, the ICB's CHC operational policy detailed the review requirements for care packages which is in line with national guidance. Our sample of six package holders confirmed that all have had a review in line with ICB policy / national guidance. However, the commissioning care plan for three of these six care packages was not approved in line with ICB policy and one of six care packages did not have a documented outcome letter. We consider the project initiation document a good starting point for the pooled budget review, especially in areas such as governance, where a project team who will meet weekly will report into a monthly project board where the progress of delivery will be discussed with monthly highlight reports.

Population Health Inequalities	**Design – Moderate** **Operational Effectiveness – Moderate** A core objective for the Integrated Care Board is improving population health. This means improving health outcomes, promoting wellbeing, and reducing inequalities across the local population. This review will assess the ICB's effectiveness of embedding how data on health and healthcare inequality inform commissioning decisions and whether the concepts are part of business as usual processes. We have provided moderate assurance on both the design and operational effectiveness of the controls in place around health and healthcare inequalities. The content and review process for EQIAs is robust and there are sufficient governance arrangements set up to oversee and monitor health and healthcare inequalities. The ICB's draft commissioning intentions outline a clear focus on addressing health inequalities. However, we raised findings relating to embedding health inequalities into business as usual through training and commissioning processes. Furthermore, the health inequalities budget is used to fund schemes that do not clearly target health inequalities and/or are ongoing rather than transformative, and key performance indicators did not include health inequality metrics for two out of three initiatives in our sample.

Review of the Effectiveness of Governance, Risk Management and Internal Control

My review of the effectiveness of the system of internal control and its implications is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our risk assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

As Accountable Officer, I have received assurance of the effectiveness of the ICB's internal controls as discharged through the committees described in the Governance Arrangements and Effectiveness section.

We have also described the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including the role and outputs of the:

- NHS Somerset ICB Board
- Audit Committee
- Finance Committee
- Quality Committee
- Remuneration Committee
- Strategic Commissioning Committee
- Management Board

Conclusion

I can confirm that no significant internal control issues have been identified.

Jonathan Higman
Accountable Officer
NHS Somerset Integrated Care Board

15 June 2026

Attendance Records

NHS SOMERSET: ICB BOARD Attendance Record 2025/26								
Name and Role **(V) = Voting Member** **(P) = Non-Voting Participant**	**✓ = Present** **X = Apologies Given**							
	24/04/25	**22/05/25**	**19/06/25**	**24/07/25**	**25/09/25**	**27/11/25**	**29/01/26**	**26/03/26**
Rob Whiteman, Chair (From September 2025) (V)					✓	X	X	X
Paul von der Heyde, Chair (Until September 2025), Deputy Chair (From September 2025) (V)	✓	✓	✓	✓	✓	✓	✓	✓
Dr Caroline Gamlin, Non-Executive Member Deputy Chair (Until September 2025) (V)	✓	✓	✓	✓	✓	✓	✓	✓
Suresh Ariaratnam, Non-Executive Member (V)	X	✓	X	✓	✓	✓	X	✓
Grahame Paine, Non-Executive Member (V)	✓	✓	✓	X	✓	✓	✓	✓
Christopher Foster, Non-Executive Member and Senior Independent Member (V)	✓	✓	✓	✓	✓	✓	X	✓
Jonathan Higman, Chief Executive (V)	✓	✓	✓	X	✓	✓	✓	✓
Alison Henly, Chief Finance Officer and Director of Performance and Contracting (V)	✓	X	X	✓	✓	✓	✓	✓
Shelagh Meldrum, Chief Nursing Officer (V)	✓	✓	✓	X	✓	✓	✓	✓
Dr Bernie Marden, Chief Medical Officer (V)	✓	✓	X	✓	✓	✓	✓	✓
Peter Lewis, Chief Executive, Somerset Foundation Trust (Trust Partner Member) (V)	✓	X	✓	✓	X	✓	✓	✓
Duncan Sharkey, Chief Executive, Somerset County Council (Local Authority Partner Member) (V)	✓	✓	✓	X	X	✓	✓	✓
Dr Berge Balian, Primary Care Partner Member (V) (Until July 2025)	✓	X	✓					
Dr Rebecca Duffy, Primary Care Partner Member (V) (From September 2025)					X	✓	✓	✓

Alison Bell, Director of Public Health (P)	✓·	✓	✓·	✓	✓	✓	✓	✓
David McClay, Chief Officer for Strategy, Digital and Integration (P)	✓	✓	✓	X	✓	✓	✓	✓
Graham Atkins, Chief People Officer (Until January 2026) (P)	✓	X	✓·		✓	✓	✓	
Charlotte Callen, Executive Director of Communications, Engagement and Marketing (P)	✓	✓	✓	✓	✓	✓	✓	✓
Jade Renville, Executive Director of Corporate Services and Affairs (P)	✓	✓	✓	✓	✓	✓	✓	✓
Judith Goodchild, Healthwatch (P)	✓	X	✓	✓	✓	X	✓	✓
Tony Robinson, Healthwatch (On Behalf of Judith Goodchild) (P)		✓				✓		
Katherine Nolan, SPARK Somerset, VCFSE (P)	✓	✓	X	X	✓	✓	✓	✓
Hester McLain, NHS England, South West Representative							✓	✓

We are 'clustering' with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) 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 is reflective of the NHS Somerset 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.

Non-Executive Members have membership to a set of assigned committees, but in addition, may also attend other committees on an ad hoc basis should they wish to do so.

NHS SOMERSET: AUDIT COMMITTEE Attendance Record 2025/26				
Name and Role **(V) = Voting Member** **(NV) = Non-Voting Member**	**✓ = Present** **X = Apologies Given**			
	06/25	**09/25**	**12/25**	**03/26**
Grahame Paine, Non-Executive Member and Chair of Audit Committee (V)	✓	✓	✓	✓
Christopher Foster, Non-Executive Member (V)	✓	✓	✓	✓
Caroline Gamlin, Non-Executive Member (V)	✓	✓	✓	✓
Alison Henly, Chief Finance Officer and Director of Performance and Contracting (NV Attendee)	✓	✓	✓	✓

The Chief Executive is also invited to attend the meeting at least annually

NHS SOMERSET: QUALITY COMMITTEE Attendance Record 2025/26						
Name and Role **(V) = Voting Member** **(NV) = Non-Voting Member**	**✓ = Present** **X = Apologies Given**					
	04/25	**06/25**	**09/25**	**10/25**	**12/25**	**02/26**
Caroline Gamlin, Non-executive Member and Chair of Quality Committee (V)	✓	✓	✓	✓	✓	✓
Suresh Ariaratnam, Non-executive Member (V)	X	✓	X	✓	✓	✓
Grahame Paine, Non-executive Member (V)	✓	X	✓	✓	✓	X
Shelagh Meldrum, Chief Nursing Officer (V)	✓	X	✓	✓	X	X
Bernie Marden, Chief Medical Officer (V)	✓	X	✓	X	X	✓
Glen Salisbury, Patient Safety Partner (V)	X	✓	X	X	✓	X
Wendy Coward, Patient Safety Partner (V)	✓	X	✓	✓	X	✓
Bernice Cooke, Director of Nursing and Deputy Chief Nursing Officer (NV)	✓	X	✓	✓	✓	✓
Lynette Emsley, Associate Director of Continuing Health Services (NV)	✓	✓	✓	✓	✓	✓
Sarah Ashe, Associate Director of Safeguarding, Mental Health, Learning Disability and Autism (NV)	✓	✓	X	X	✓	X
Tom MacConnell, Deputy Chief Medical Officer	X	X	X	X	X	X
Robert Weaver, Deputy Chief Medical Officer	X	✓	X	X	X	X

NHS SOMERSET: REMUNERATION COMMITTEE Attendance Record 2025/26										
Name and Role **(V) = Voting Member** **(NV) = Non-Voting Member**	**Y = Present** **X = Apologies Given**									
	06/25	**08/5**	**09/25**	**17/10/25**	**29/10/25**	**11/25**	**12/25**	**01/26**	**02/26**	**03/26**
Paul von der Heyde, Non-Executive Member and Deputy Chair of ICB (V)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Suresh Ariaratnam, Non-Executive Member (V)	Y	Y	Y	N	N	N	N	N	N	N
Christopher Foster, Non-Executive Member and Chair of Remuneration Committee (V)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dr Caroline Gamlin, Non-Executive Member (V)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Grahame Paine, Non-Executive Member (V)	Y	Y	Y	Y	Y	Y	Y	Y	N	N

NHS SOMERSET: STRATEGIC COMMISSIONING COMMITTEE
Attendance Record 2025/2026

Name, Role, Organisation (V) = Voting Member (NV) = Non-Voting Member	✓ = Present X = Apologies given			
	06/25	09/25	11/25	01/26
Suresh Ariaratnam, Non-executive Member and Chair of Strategic Commissioning Committee (V)	✓	✓	✓	✓
Caroline Gamlin, Non-executive Member (V)	X	X	✓	✓
Paul Von der Heyde, Non-executive Member and Deputy Chair of ICB (V)	X	✓	✓	X
Grahame Paine, Non-executive Member (V)	X	X	X	X
Christopher Foster, Non-executive Member (V)	X	X	X	X
Alison Henly, Chief Finance Officer and Director of Performance and Contracting (V)	✓	X	✓	X
David McClay, Chief Officer for Strategy, Digital and Integration (V)	✓	✓	✓	✓
Dr Bernie Marden, Chief Medical Officer (V)	X	✓	✓	✓
Shelagh Meldrum, Chief Nursing Officer (V)	✓	✓	✓	✓
Mel Lock, Lead Commissioner Adults & Health, Somerset Council (V)	X	X	X	✓
Alison Bell, Director of Public Health, Somerset Council (V)	✓	✓	✓	✓
Trudi Grant, Director of Population Health and Inequalities (V)	✓	X	✓	✓
Lucie Laker, Chief Data Officer (NV)	✓	✓	✓	✓
Sukeina Kassam, Director of Primary Care (NV)	X	X	X	✓
Alison Rowswell, Director of Localities and Strategic Commissioning (NV)	✓	X	✓	✓

NHS SOMERSET: FINANCE COMMITTEE Attendance Record 2024/25												
Name and Role **(V) = Voting Member** **(NV) = Non-Voting Member**											**✓ = Present** **X = Apologies Given**	
	15/04/25	**14/05/25**	**17/06/25**	**16/07/25**	**20/08/25**	**16/09/25**	**15/10/25**	**12/11/25**	**15/12/25**	**23/01/26**	**10/02/26**	**09/03/26**
Paul von der Heyde (V) Chair	✓	✓	X	X	✓	✓	X	✓	✓	✓	✓	X
Grahame Paine Non-Executive Director	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Christopher Foster (V) Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alison Henly (V) Chief Finance Officer and Director of Performance and Contracting	✓	X	✓	✓	✓	✓	X	✓	✓	X	✓	✓
Jonathan Higman (V) Chief Executive	X	✓	X	X	X	X	X	X	✓	X	X	X
Shelagh Meldrum (NV) Chief Nursing Officer	✓	✓	✓	X	✓	✓	X	X	X	✓	X	✓
Bernie Marden (NV) Chief Medical Officer	X	X	X	✓	✓	✓	✓	✓	✓	X	✓	X

NHS SOMERSET: MANAGEMENT BOARD Attendance Record 2025/26							
Name and Role **(V) = Voting Member** **(NV) = Non-Voting Member**	**✓ = Present** **X = Apologies Given**						
	09/06/25	**14/07/25**	**08/09/25**	**13/10/25**	**10/11/25**	**08/12/25**	**12/01/26**
Jonathan Higman, Chief Executive (Chair) (V)	✓	✓	✓	✓	✓	✓	X
Graham Atkins, Chief People Officer (Until January 2026)	✓	✓	✓	✓	✓	X	X
Charlotte Callen, Executive Director of Communications, Engagement and Marketing (V)	✓	✓	✓	✓	✓	✓	✓
Bernice Cooke, Deputy Chief Nursing Officer (V)	✓	✓	X	X	✓	✓	✓
Ben Edgar-Attwell, Deputy Director of Corporate Services (working across SFT and Somerset ICB) (Until December 2025)	✓	X	X	✓	✓	✓	
Shaun Green, Chief Pharmacist (V)	✓	✓	✓	✓	✓	✓	X
Alison Henly, Chief Finance Officer and Director of Performance and Contracting (V)	✓	X	✓	X	✓	✓	X
Sukeina Kassam, Director of Primary Care (V)	✓	X	X	✓	X	✓	X
Lucie Laker, Chief Data Officer	✓	✓	✓	X	✓	✓	✓
Bernie Marden, Chief Medical Officer (Management Board Vice Chair) (V)	X	✓	✓	✓	✓	✓	X
Dr Tom MacConnell, Deputy Chief Medical Officer	✓	X	✓	X	✓	✓	✓
David McClay, Chief Officer for Strategy, Digital and Integration (V)	✓	X	✓	✓	✓	✓	✓
Shelagh Meldrum, Chief Nursing Officer/Chief Operating Officer (V)	✓	X	✓	✓	✓	✓	✓
Jade Renville, Executive Director of Corporate Affairs (V)	✓	✓	✓	✓		X	X
Alison Rowswell, Director of Localities and Strategic Commissioning (V)	✓	✓	X	✓	✓	✓	✓
Leanne Field, Deputy Director of Strategy and Transformation	X	✓	✓	✓	✓	✓	✓
Scott Sealey, Deputy Chief Finance Officer and Deputy Director of Performance and Contracting (V)	X	✓	X	✓	✓	✓	✓
Steve Sylvester, Director of Collaborative Commissioning, NHSE	X	X	X	X	X	X	✓
Mandy Black, Associate Director HR & OD	X	X	X	X	✓	✓	X
Helen Stapleton, Associate Director of Strategic Workforce Transformation – Somerset ICS	✓	✓	✓	✓	✓	✓	✓
Alex Cameron, Associate Director, Communications, Engagement and Marketing	X	✓	X	✓	✓	✓	✓
Trudi Grant, Director of Population Health & Inequalities				✓	✓	✓	✓

Remuneration and Staff Report

Remuneration Report

This section of the report contains details of remuneration and pension entitlements for senior managers of NHS Somerset ICB in line with Chapter 5 of Part 15 of the Companies Act 2006.

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, not only the decisions of individual departments. In defining the scope, the ICB has included members of the decision-making body, which the ICB has defined as the ICB Board, excluding those members not directly employed by the ICB. Senior managers are generally employed on permanent contracts with a six-month period of notice.

The remuneration report and other disclosures referenced as 'subject to audit' in the Accountability Report will be audited by Grant Thornton UK LLP, NHS Somerset ICB's external auditors.

- Single total figure of remuneration for each director
- CETV disclosures for each director
- Payments to past directors
- Payments for loss of office
- Fair pay disclosures
- Pay ratio information
- Exit packages

Remuneration Committee

Details regarding the Remuneration Committee membership can be found here.

Fair Pay Disclosure (subject to audit)

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 (subject to audit)

	Salary and allowances Increase / (Decrease) (25-26) %	Performance pay and bonuses Increase / (Decrease) (25-26) %	Salary and allowances Increase / (Decrease) (24-25) %	Performance pay and bonuses Increase / (Decrease) (24-25) %
The percentage change from the previous financial year in respect of the highest paid director	2.30%	0%	4.82%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.47%	0%	5.88%	0%

Staff remuneration increases for the period include Agenda for Change pay uplifts awarded for 2025/26. Agenda for Change guidelines also are taken into consideration when assessing inflationary increases awarded to Very Senior Managers. The Chief Executive Officer is shared across three NHS organisations due to 'cluster arrangements', with two-thirds of the remuneration recharged to partner bodies. In line with the FReM requirement, the fair pay disclosure is based on the cost to the organisation of remunerating directors. As a result, the Chief Medical Officer was the highest paid director of the organisation during the year

There have also been changes to executive director structures during 2025/26 due to 'clustering' with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) 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.

Pay Ratio Information (subject to audit)

NHS Somerset ICB is required to disclose:

- The 25th percentile, median and 75th percentile of remuneration of the ICB's staff (based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date).
- The 25th percentile, median and 75th percentile of the salary component of remuneration of the ICB's staff (based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date).
- The range of staff remuneration.

- The relationship between the remuneration of the highest-paid person in the organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The table below illustrates:

- Remuneration of NHS Somerset ICB staff.
- The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director.
- The ratios of the salary component of staff remuneration against the mid-point of the banded remuneration of the highest paid director.

2025/26	**25th percentile**	**Median**	**75th percentile**
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	38,278	52,774	64,455
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	38,278	52,774	64,455
Ratio of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	5.81 : 1	4.22 : 1	3.45 : 1
Ratio of the salary component of remuneration of all staff to the mid-point of the banded salary of the highest paid director	5.81 : 1	4.22 : 1	3.45 : 1
2024/25	**25th percentile**	**Median**	**75th percentile**
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	36,483	48,526	62,215
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	62,215

Ratio of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	5.96 : 1	4.48 : 1	3.5 : 1
Ratio of the salary component of remuneration of all staff to the mid-point of the banded salary of the highest paid director	5.96 : 1	4.48 : 1	3.5 : 1

The banded remuneration of the highest paid director / member in NHS Somerset ICB in the reporting period 1 April 2025 to 31 March 2026 was £220,000 to £225,000 (2024/25: £215,000 to £220,000 for 1 April 2024 to 31 March 2025)

During the reporting period from 1 April 2025 to 31 March 2026, no employees received remuneration in excess of the highest-paid director/member (2024/25: zero from 1 April 2024 to 31 March 2025). Remuneration ranged from £15,000 to £225,000 (2024/25: £17,500 to £217,500 from 1 April 2024 to 31 March 2025) 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 remuneration of the Chief Executive and Directors within NHS Somerset ICB is the responsibility of the Remuneration Committee. It is the Remuneration Committee that determines the reward packages of Executive Directors, whilst taking account of the Pay Framework for Very Senior Managers (VSM) published by the Department of Health. NHS Somerset ICB has complied with the NHS Very Senior Managers Pay Framework.

NHS Somerset ICB also has an established committee to oversee the appointments and remuneration for non-executive members. This Committee makes determinations about the appointment, pay and remuneration for non-executive members of the ICB.

National guidance was followed with regards to the remuneration of mandatory very senior manager posts within NHS Somerset ICB: Chief Medical Officer, Chief Nursing Officer and Chief Finance Officer, along with the Chief Executive Officer. Other very senior manager remuneration levels are agreed by NHS Somerset ICB's Remuneration Committee. Benchmarking was carried out to establish that rates of pay were comparable across the South West and are reviewed to ensure that pay scales remain competitive, but also take into consideration the financial position of the organisation.

Agenda for Change guidelines are taken into consideration when assessing whether to award an inflationary increase to very senior managers.

Remuneration of Very Senior Managers (VSMs)

NHS Somerset ICB has four VSMs in post with remuneration levels that exceed £150,000 per annum. For one post, national guidance was followed for the level of remuneration awarded and this was approved regionally and centrally. For the other VSM posts the approvals process was followed centrally with NHS England. The NHS ICB's Remuneration Committee have approved the levels awarded to each post.

Total 1 April 2025 to 31 March 2026							
		Salary (a)	Expense payments (taxable) (b)	Performance Pay and Bonuses (c)	Long Term Performance Pay and Bonuses (d)	All Pension Related Benefits (e)	Total (a to e)
Name	Title	(bands of £5,000)	(rounded to the nearest £100*)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Jonathan Higman	Chief Executive	145-150	0	0	0	75-77.5	220-225
Alison Henly	Chief Finance Officer and Director of Performance and Contracting	95-100	0	0	0	100-102.5	195-200
David McClay	Chief Officer of Strategy, Digital and Integration	130-135	0	0	0	60-62.5	195-200
Shelagh Meldrum	Chief Nursing Officer and Director of Operations	160-165	0	0	0	0	160-165
Rob Whiteman	Cluster Chair (from 01/09/2025)	10-15	0	0	0	0	10-15
Paul von der Heyde	Chair (to 31/08/2025)/ Deputy Cluster Chair (from 01/09/2025)	40-45	0	0	0	0	40-45
Bernie Marden	Chief Medical Officer	220-225	0	0	0	0	220-225
Graham Atkins	Chief People Officer (to 30/01/2026)	115-120	0	0	0	72.5-75	190-195
Charlotte Callen	Director of Communications, Engagement and Marketing	115-120	0	0	0	30-32.5	150-155
Jade Renville	Director of Corporate Affairs	75-80	0	0	0	67.5-70	145-150
Caroline Gamlin	Non-Executive Director	10-15	0	0	0	0	10-15
Suresh Ariaratnam	Non-Executive Director	10-15	0	0	0	0	10-15

Total 1 April 2025 to 31 March 2026							
		Salary (a)	Expense payments (taxable) (b)	Performance Pay and Bonuses (c)	Long Term Performance Pay and Bonuses (d)	All Pension Related Benefits (e)	Total (a to e)
Name	Title	(bands of £5,000)	(rounded to the nearest £100*)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Grahame Paine	Non-Executive Director	10-15	0	0	0	0	10-15
Christopher Foster	Non-Executive Director	10-15	0	0	0	0	10-15

Senior Manager Remuneration (Including Salary and Pension Entitlements) (subject to audit)

The table details the remuneration levels for all senior managers in NHS Somerset ICB.

*Note: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual.

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.

Officer Holder Changes notes:

We are 'clustering' with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) 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 is reflective of the NHS Somerset ICB Board and executive team during the reporting period, notwithstanding a Very Senior Managers appointment process 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 Rob Whiteman being appointed as Chair on 1st September 2025. This report includes one third of his salary costs from this date. Paul von der Heyde was NHS Somerset ICB Chair until 31st August 2025. He 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. His salary costs have been recharged three ways from this date, in equal shares to NHS BSW ICB and NHS Dorset ICB, whilst his full pension information is disclosed within the NHS Somerset ICB report. Full salary costs are within the 235-240 band (£'000s), resulting in the total remuneration within the 310 – 315 band (£'000s).

Alison Henly was seconded to NHS Dorset ICB as Chief Financial Officer, in a joint role, from the 1st April 2025. As part of this arrangement, 40% of her salary costs have been recharged to NHS Dorset ICB. Her full pension information is disclosed within the NHS Somerset ICB report. Full salary costs are within the 160-165 band (£'000s), resulting in the total remuneration within the 260 – 265 band (£'000s).

David McClay, Shelagh Meldrum and Bernie Marden were appointed to Cluster ICB executive roles from 1st January 2026. The full costs of their salary and pension information remain within the NHS Somerset ICB report.

Graham Atkins resigned from the Chief People Officer post on 30 January 2026.

Jade Renville has been seconded to a Joint Executive Director of Corporate Affairs post across both NHS Somerset ICB and Somerset NHS Foundation Trust since 6 July 2024. This recharge arrangement finished on 31 December 2025. From April to December, only 50% of her salary was charged to NHS Somerset ICB, which is reflected in the above table. Full salary costs are within the 120-125 band (£'000s), resulting in the total remuneration within the 190 – 195 band (£'000s).

Dr. Amanda Webb was appointed as Chief Office for Population Health Improvement for the cluster ICB on 1st January 2026. Her salary and pension information is shown within the annual report of NHS BSW ICB.

David Freeman was appointed as Chief Officer for Commissioning and Place for the cluster ICB on 1st January 2026. His salary and pension information is shown within the annual report of NHS Dorset ICB.

Other Notes:

- No senior manager waived his/her remuneration.
- No annual or long-term performance related bonus payments were made to any senior managers during the reporting period 1 April 2025 to 31 March 2026.
- Peter Lewis, Dr. Berge Balian, Dr. Rebecca Duffy and Duncan Sharkey are Partner Members of the ICB Board. Partner Members are not seconded to the ICB and, whilst regular Board members, are not considered Senior Managers of the ICB. During the year, Dr Berge Balian retired in July 2025 and Dr Rebecca Duffy was elected to the ICB Board as the Primary Care Partner Member.

Prior Year Comparator		Total 1 April 2024 to 31 March 2025					
		Salary	Expense payments (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total
Name	Title	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Jonathan Higman	Chief Executive	195-200	0	0	0	105-107.5	300-305
Alison Henly	Chief Finance Officer and Director of Performance and Contracting	150-155	0	0	0	130-132.5	280-285
David McClay	Chief Officer of Strategy, Digital and Integration	125-130	0	0	0	27.5-30	155-160
Shelagh Meldrum	Chief Nursing Officer and Director of Operations	155-160	0	0	0	0	155-160
Paul von der Heyde	Chair	55-60	0	0	0	0	55-60
Bernie Marden	Chief Medical Officer	215-220	0	0	0	0	215-220
Victoria Downing-Burn	Chief People Officer (to 31/08/2024)	50-55	0	0	0	25-27.5	75-80
Graham Atkins	Chief People Officer (from 30/09/2024)	70-75	0	0	0	15-17.5	85-90
Charlotte Callen	Director of Communications, Engagement and Marketing	110-115	0	0	0	27.5-30	140-145
Jade Renville	Director of Corporate Affairs	65-70	0	0	0	55-57.5	125-130
Trudi Grant	Executive Director of Public and Population Health	50-55	0	0	0	0	50-55
Caroline Gamlin	Non-Executive Director	15-20	0	0	0	0	15-20
Suresh Ariaratnam	Non-Executive Director	15-20	0	0	0	0	15-20
Grahame Paine	Non-Executive Director	15-20	0	0	0	0	15-20
Christopher Foster	Non-Executive Director	15-20	0	0	0	0	15-20

- **Officer Holder Changes notes:**
  - Jade Renville was seconded to a Joint Executive Director of Corporate Affairs post across both NHS Somerset ICB and Somerset NHS Foundation Trust on 6 July 2024. From this date, only 50% on her salary was charged to NHS Somerset ICB, which is reflected in the above table.
  - Victoria Downing-Burn resigned from the Chief People Officer post on 31 August 2024.
  - Graham Atkins was appointed as Chief People Officer on 30 September 2024.

- Trudi Grant resigned as Executive Director of Public and Population Health on 31 December 2024. Trudi Grant was awarded an honorary appointment with NHS Somerset ICB as Executive Director of Public and Population Health, Somerset Council & NHS Somerset from 1 April 2023. Her contract of employment was held by Somerset Council and NHS Somerset ICB make a 50% contribution to her salary cost. Trudi Grant's total salary for the 9 months to 31 December 2024 across both Somerset Council and NHS Somerset ICB was £100,000 - £110,000.

- **Other Notes:**

- No senior manager waived his/her remuneration.

- No annual or long-term performance related bonus payments were made to any senior managers during the reporting period 1 April 2024 to 31 March 2025.

- Peter Lewis, Dr. Berge Balian and Duncan Sharkey are Partner Members of the ICB Board. Partner Members are not seconded to the ICB and, whilst regular Board members, are not considered Senior Managers of the ICB.

Pension Benefits as at 31 March 2026 (subject to audit)

The following table details the pension entitlements for each of the senior managers who received pensionable remuneration through the NHS pension scheme.

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at Pension age at 31 March 2026	Lump sum at pension age related to accrued pension at 31 March 2026	Cash equivalent transfer value at 1 April 2025	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2026	Employer's contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Jonathan Higman	Chief Executive	2.5-5	2.5-5	80-85	195-200	1,723	89	1,867	0
Alison Henly	Chief Finance Officer and Director of Performance and Contracting	5-7.5	7.5-10	70-75	180-185	1,495	115	1,655	0
David McClay	Chief Officer of Strategy, Digital and Integration	2.5-5	2.5-5	35-40	85-90	656	52	735	0
Charlotte Callen	Director of Communications, Engagement and Marketing	0-2.5	0	5-10	0	69	17	102	0

Jade Renville	Director of Corporate Affairs	2.5-5	0	35-40	0	415	43	480	0
Graham Atkins	Chief People Officer (to 30/01/2026)	2.5-5	0	5-10	0	19	52	86	0

Notes:

1. Non-Executive Members do not receive pensionable remuneration.
2. Pensionable contributions may include more than just those from ICB employment. Where a GP is under a contract of service with the ICB and pays pension contributions then they are classed as 'NHS staff (Officer)' for pension purposes. The figures provided by NHS Pensions cover only the 'Officer' element of the GP's pension entitlement.
3. Cash Equivalent Transfer Value (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.
4. Bernie Marden and Shelagh Meldrum chose not to be covered by the pension arrangements during the reporting year.
5. 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.

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on Early Retirement or for Loss of Office (subject to audit)

NHS England has set restrictions on the payment of any compensation within NHS Somerset ICB. There have been no compensation terms agreed for 2025/26.

Payments to Past Directors (subject to audit)

NHS Somerset ICB has made no payments to past directors during the period 1 April 2025 to 31 March 2026.

Explanation of Key Terms used in Remuneration and Pension Reports

Term	Definition
Annual Performance Related Bonuses	Money or other assets received or receivable for the financial year as a result of achieving performance measures and targets for the period.
Cash Equivalent Transfer Value (CETV)	A 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 pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations.
Employer's contribution to stakeholder pension	The amount that the ICB has contributed to individual's stakeholder pension schemes.
Lump sum at pension age related to real increase in pension	The amount by which the lump sum to which an individual will be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 31 March 2026	The amount of lump sum pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2026
Real increase in CETV	This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including

Term	Definition
	the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Real increase in pensions at pension age	The amount by which the pension to which an individual will be entitled at pension age has increased during the year
Total accrued pension at pension age at 31 March 2026	The amount of annual pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2026

Staff Report

Number of Senior Managers

The number of senior managers within NHS Somerset ICB is set out below in the 'staff composition' table below.

Staff Numbers and Costs (subject to audit)

NHS Somerset ICB's total staff costs for the period 1 April 2025 to 31 March 2026 are summarised in the following table. These figures are consistent with information provided within the financial statements:

	Total		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
	N4G	N4H	N4I
Salaries and wages	16,945	1,402	18,347
Social security costs	2,367	49	2,415
Employer contributions to the NHS Pension Scheme	3,790	84	3,874
Other pension costs	1	0	1
Apprenticeship levy	71	0	71
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	3,468	0	3,468
Gross Employee Benefits Expenditure	**26,642**	**1,535**	**28,176**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(734)	(67)	(801)
Net employee benefits expenditure incl. capitalised costs	**25,907**	**1,468**	**27,375**
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excl. capitalised costs	**25,907**	**1,468**	**27,375**

Average Number of Persons Employed (subject to audit)

The average number of ICB staff employed by staff grouping is as follows:

Average number of people employed	2025/26 figures cover 1st April 2025 to 31st March 2026			2024/25
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	3	0	3	4
Administration and estates	231	14	245	251
Healthcare assistants and other support staff	8	0	8	1
Nursing, midwifery and health visiting staff	49	0	49	52
Scientific, therapeutic and technical staff	10	0	10	11
Social Care Staff	3	0	3	0
Total	**304**	**14**	**318**	**320**
Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

The majority of employees are members of the NHS defined benefit pension scheme. Details of the scheme and its accounting treatment may be found within the accounting policies disclosed in the full audited annual accounts.

Staff Composition

The breakdown of the gender profile for NHS Somerset ICB as at 31 March 2026 is set out below:

Category	% Male	% Female	Total Number
Board Voting Members	66.7%	33.3%	9
Executive Directors	60.0%	40.0%	5
All substantive ICB Staff	18.9%	81.11%	304

Sickness Absence Data

The absence full time equivalent (FTE) % for NHS Somerset ICB was 3.2%. This is based on data available for the period 1 April 2025 to 31 March 2026.

Figures Converted by DH to Best Estimates of Required Data Items				Statistics Published by NHS Digital from ESR Data Warehouse	
Months 12	Average FTE for 2025	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
	310	2,063	7	113,296	3,347

Notes:

Period covered: January to December 2025

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

Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

The ICB has a clear and robust Management of Sickness Absence Policy.

Sickness absence data for NHS Somerset ICB is available via the following link: NHS Sickness Absence Rates - NHS Digital

No ill health retirements took place during the period 1 April 2025 to 31 March 2026.

Staff Turnover Percentages

Staff turnover for NHS Somerset ICB during the period 1 April 2025 to 31 March 2026 was 11.7 %, which is a reduction from the previous year by 5.2%.

Staff turnover information for NHS Somerset ICB is captured as part of NHS Digital's NHS workforce statistics and is available via the following link:
NHS workforce statistics - NHS Digital

This data series is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

Staff Engagement Percentages

NHS Somerset ICB did not participate in the annual staff survey in October 2025, as the ICB was about to embark on a substantial period of organisational change. Instead, the ICB worked as a cluster to deliver a monthly Pulse Survey for staff, covering issues such as health and wellbeing, organisational change, equality, diversity and inclusion, allowing for targeted activities to be put in place to address highlighted issues.

The ICB was also effectively able to engage with colleagues by providing/developing:

- An in-person away day seeking feedback from colleagues.
- Developing a cluster wide staff intranet.
- Developing a cluster wide Colleague Engagement Network.
- Weekly updates from the Chief Executive Officer.
- Regular all staff Teams briefings.
- A weekly communications and engagement update for executive directors and on-call teams.
- Regular directorate and team meetings.
- A Mental Health First Aid Network consisting of ICB colleagues.
- Provision of weekly all colleague HR drop-in sessions on key workforce areas.
- All colleagues to get involved in the development of key policies, such as the Appraisal Policy, where colleagues joined focus groups, and provided feedback.

Staff Policies

During the year, NHS Somerset continued the implementation of its transition to adopting national NHS HR policies. The move away from locally written HR policies supports greater consistency across NHS organisations, enhances staff mobility, and strengthens partnership working within the Integrated Care System (ICS) and with our cluster partners.

In parallel, NHS Somerset ICB worked collaboratively with cluster partners to meet the National Principles for Creating a Common Cross Organisational Change Framework to Support the Clustering and Merging of ICBs. This joint work has contributed to the development of a shared, principled approach to workforce change, supporting consistency, transparency and meaningful engagement as organisations move through periods of transformation.

NHS Somerset ICB applied the following new or updated staff policies in the period 1 April 2025 to 31 March 2026:

- Annual Leave Policy
- Fixed Term Contracts
- Cluster Organisational Change Policy

Staff Diversity and Inclusion Policy, Initiatives and Longer-Term Ambitions
There are a number of programmes within the organisation which support our aims.

These include:

Measure	Detail
Disability Confident Scheme	NHS Somerset ICB is a member of the Disability Confident Employer Scheme level 2, ensuring we respond to the potential needs of new applicants and current workforce needs. Details of the scheme can be found here - Disability Confident employer scheme - GOV.UK (www.gov.uk)
Recruitment practices	NHS Somerset ICB continues to make progress in embedding equality, diversity and inclusion representatives into the recruitment programme. These individuals would offer expertise to professionals involved in the onboarding process from a legal and ethical perspective to help drive a wider diverse pool of staff, whilst supporting anti-racism practices and encouraging allyship. This is a system-wide programme.
Equality training	NHS Somerset ICB wants to embed lived experiences into training delivered to staff, as this offers a more impactful learning experience. This will be done through various formats including lunch and learns, workshops and delivery on specific awareness days.

NHS Somerset ICB has a long-term ambition to embed inclusion and equity into the core processes and policies which impact staff experience and will work closely with partners to develop, implement, and measure programmes and projects that are designed to improve staff experience across Somerset.

We have not identified any barriers to improving the diversity and inclusiveness of our workforce.

As described within the other employee matters section, NHS Somerset began an organisational wide change process in March 2026 when staff consultation commenced, which is anticipated to reduce running costs by 50%. Full equality impact assessment considerations are being made in respect of these anticipated changes.

There are no specific key performance indicators (KPIs) set in respect of inclusion and diversity, however plans in respect of specific points can be seen in their appropriate documentation, i.e. the gender pay gap action plan and the workforce race equality standard action plan.

Other Employee Matters

Organisational Change
Following the completion of the previous organisational restructure change process which enabled the organisation to align its form to the new operating model, whilst also meeting the challenge of reducing running costs by 30%, 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, although Somerset ICB is 'clustering' with NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) 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.

Trade Union Relationships
NHS Somerset ICB have been meeting regularly with Trade Union colleagues as part of the ICB Trade Union Partnership Forum, to maintain partnership working with recognised trade unions and strengthening employee voice within the organisation.

Pay Policy
In September 2025, NHS Somerset ICB undertook a review of localised pay rates agreed for medical colleagues on sessional pay rates. As part of this review, a commitment was made to award clinical colleagues with an annual award in line with the Doctors and Dentists Pay Review Body.

Expenditure on Consultancy

The ICB consultancy expenditure in the period 1 April 2025 to 31 March 2026 was £1,075, as per note 5 in the annual accounts. This related to services such as strategic advice, organisational and change management consultancy, technical consultancy and marketing and communications consultancy.

Off-Payroll Engagements

Table 1: 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	15
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	10
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax, and, where necessary, that assurance has been sought.

Table 2: 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	18
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]	0

No. subject to off-payroll legislation and determined as out of scope of IR35[2]	18
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period[1]	-
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. [2]	14

During the period there have been no incidences where a senior officer position has been held by an off-payroll member of staff.

Exit Packages, Including Special (Non-Contractual) Payments (subject to audit)

Table 1: 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	-	-	3	21,008	3	21,008	-	-
£10,000 - £25,000	1	11,484	6	105,158	7	116,642	-	-
£25,001 - £50,000	1	47,818	3	124,758	4	172,576	-	-
£50,001 - £100,000	-	-	16	1,196,785	16	1,196,785	-	-
£100,001 - £150,000	-	-	6	780,188	6	780,188	-	-
£150,001 – £200,000	-	-	7	1,181,172	7	1,181,172	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	**2**	**59,302**	**41**	**3,409,069**	**43**	**3,468,371**	**-**	**-**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service and are in line with statutory requirements. Exit costs in this note are accounted for in full in the year of departure.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	41	3,409,069
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
TOTAL	**41**	**3,409,069**

Parliamentary Accountability and Audit Report

NHS Somerset ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at Appendix 1. An audit report is also included in this Annual Report. An Audit Certificate will be published separately on the NHS Somerset ICB website.

ANNUAL ACCOUNTS

JONATHAN HIGMAN
Accountable Officer
NHS Somerset Integrated Care Board

15 June 2026

Appendix 1

NHS Somerset Integrated Care Board
Annual Accounts 2025/26

CONTENTS

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

	Note	**2025-26 £'000**	2024-25 £'000
Income from sale of goods and services	2	(15,253)	(13,216)
Other operating income	2	(1,457)	(2,422)
Total operating income		**(16,710)**	(15,638)
Staff costs	4	27,375	23,189
Purchase of goods and services	5	3,125,337	1,460,563
Depreciation and impairment charges	5	436	508
Provision expense	5	7,364	556
Other operating expenditure	5	242	269
Total operating expenditure		**3,160,754**	1,485,085
Net Operating Expenditure		**3,144,044**	1,469,447
Finance expense	7	2	6
Comprehensive Net Expenditure for the year		**3,144,046**	1,469,453

The notes on pages 1 to 25 form part of this statement

Statement of Financial Position as at 31 March 2026

	Note	**2025-26** **£'000**	2024-25 £'000
Non-current assets:			
Property, plant and equipment	8	227	262
Right-of-use assets	9	0	362
Total non-current assets		**227**	624
Current assets:			
Trade and other receivables	10	13,091	15,387
Cash and cash equivalents	11	270	73
Total current assets		**13,361**	15,460
Total assets		**13,588**	16,084
Current liabilities			
Trade and other payables	12	(74,949)	(61,880)
Lease liabilities	9	0	(422)
Provisions	13	(7,403)	(609)
Total current liabilities		**(82,352)**	(62,911)
Assets less Liabilities		**(68,764)**	(46,827)
Financed by Taxpayers' Equity			
General fund		(68,764)	(46,827)
Total taxpayers' equity:		**(68,764)**	(46,827)

The notes on pages 1 to 25 form part of this statement

The financial statements on pages 1 to 4 were approved by the Board on 15 June 2026 and signed on its behalf by:

Jonathan Higman
Chief Executive
NHS Somerset ICB

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	**(46,827)**	**(46,827)**
Net expenditure for the financial year	(3,144,046)	**(3,144,046)**
Net funding	3,122,109	**3,122,109**
Balance at 31 March 2026	**(68,764)**	**(68,764)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(55,495)	(55,495)
Net expenditure for the financial year	(1,469,453)	(1,469,453)
Net funding	1,478,121	1,478,121
Balance at 31 March 2025	(46,827)	(46,827)

The General Fund represents the cumulative net expenditure of NHS Somerset ICB since inception, financed through grant-in-aid from NHS England. The General Fund is not a distributable reserve and reflects the application of parliamentary funding to meet the ICB's statutory functions.

As the ICB does not operate to generate surpluses or accumulate profits, the General Fund balance represents the residual funding position and corresponds to the ICB's net liabilities at the reporting date.

The notes on pages 1 to 25 form part of this statement

Statement of Cash Flows for the year ended 31 March 2026

	Note	**2025-26 £'000**	2024-25 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(3,144,046)	(1,469,453)
Depreciation and amortisation	5	436	508
Interest paid / received	7	2	6
(Increase)/decrease in trade & other receivables	10	2,296	(1,686)
Increase/(decrease) in trade & other payables	12	13,069	(5,997)
Provisions utilised	13	(570)	(1,520)
Increase/(decrease) in provisions	13	7,364	556
Net Cash Inflow (Outflow) from Operating Activities		**(3,121,449)**	(1,477,586)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(39)	(85)
Net Cash Inflow (Outflow) from Investing Activities		**(39)**	(85)
Net Cash Inflow (Outflow) before Financing		**(3,121,488)**	(1,477,671)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		3,122,109	1,478,121
Repayment of lease liabilities		(424)	(423)
Net Cash Inflow (Outflow) from Financing Activities		**3,121,685**	1,477,698
Net Increase (Decrease) in Cash & Cash Equivalents	11	**197**	27
Cash & Cash Equivalents at the Beginning of the Financial Year		**73**	46
Cash & Cash Equivalents at the End of the Financial Year		**270**	73

The notes on pages 1 to 25 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 Somerset ICB, NHS Dorset ICB, and NHS Bath and North East Somerset, Swindon and Wiltshire 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 NHS Somerset 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 ICBs are prepared on a Going Concern basis as they 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. Joint arrangements

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.
The pooled budget agreements that NHS Somerset ICB holds with Somerset Council (as mentioned in Note 1.4) are joint operations, with the exception of the Better Care Fund.

1.4. Pooled Budgets

The ICB has entered into a pooled budget arrangement with Somerset Council [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for learning disability services, community equipment and wheelchair provision, carers services and the Better Care Fund and a memorandum note to the accounts provides details of the income and expenditure.
The pool is hosted by Somerset Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget

1.5. Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.6. Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

Notes to the financial statements

• 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. Payment terms are within 30 days of invoice
The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7. **Employee Benefits**

1.7.1. **Short-term Employee Benefits**
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2. **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the
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.

1.8. **Other Expenses**
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9. **Grants Payable**
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10. **Property, Plant & Equipment**

1.10.1. **Recognition**
Property, plant and equipment is capitalised if:
• It is held for use in delivering services or for administrative purposes;
• It is probable that future economic benefits will flow to, or operational capacity will be supplied to the ICB;
• It is expected to be used for more than one financial year;
• The cost of the item can be measured reliably; and,
• The item has a cost of at least £5,000; or,
• Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,

Notes to the financial statements

• Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2. **Measurement**
All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their operational capacity and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their operational capacity but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use having regards to RICS Professional Standard "Existing Use Value (EUV) Valuations for UK Public Sector Financial Statements" published in July 2023 and UKVPGA6.
• Specialised buildings – depreciated replacement cost, modern equivalent asset basis as set out in RICS Depreciated Replacement Cost Method of Valuation for Financial Reporting Guidance Note 2018IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational capacity are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or operational capacity is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

1.10.3. **Subsequent Expenditure**
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11. **Government grant funded assets**
Government grant funded assets are capitalised at current value in existing use, if they will be held for their operational capacity, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.12. **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.

1.13. **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.

Notes to the financial statements

• 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.

1.14. **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

1.15. **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.

1.16. **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.

1.17. **Insurance contracts**
IFRS 17 Insurance Contracts replaces IFRS 4 Insurance Contracts and is effective for periods beginning on or after 1 April 2025, 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.

1.18. **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.
All Financial Assets for Somerset ICB are measured at Amortised cost.

Notes to the financial statements

1.18.1. **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.18.2. **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the 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.

1.19. **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.

1.20. **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.

1.21. **Foreign Currencies**

The ICB’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. NHS Somerset ICB does not have any exposure to foreign

1.22. **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.23. **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.

Notes to the financial statements

1.23.1. **Critical accounting judgements in applying accounting policies**
No critical judgments with a significant effect on the amounts recognised in the financial statements were required.

1.23.2. **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
The ICB holds £7.4m in provisions at 31 March 2026, including a first-time £6.6m redundancy provision. Measurement of redundancy provisions involves judgements about probability and quantum of settlement. The continuing care provision methodology is based on estimated costs and historical success rates (Note 13).

1.24. **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.25. **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.
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 £'000	2024-25 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	227	418
Non-patient care services to other bodies	2,698	1,200
Prescription fees and charges	6,001	6,171
Dental fees and charges	5,137	5,007
Other Contract income	1,190	420
Total Income from sale of goods and services	**15,253**	13,216
Other operating income		
Non cash apprenticeship training grants revenue	46	51
Other non contract revenue	1,411	2,371
Total Other operating income	**1,457**	2,422
Total Operating Income	**16,710**	15,638

3. Disaggregation of revenue

2025-26	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	227	885	0	0	0
Non NHS	0	1,813	6,001	5,137	1,190
Total	**227**	**2,698**	**6,001**	**5,137**	**1,190**
Timing of Revenue					
Point in time	227	2,698	6,001	5,137	1,190
Over time	0	0	0	0	0
Total	**227**	**2,698**	**6,001**	**5,137**	**1,190**

2024-25	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	418	562	0	0	240
Non NHS	0	638	6,171	5,007	180
Total	418	1,200	6,171	5,007	420
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	418	1,200	6,171	5,007	420
Over time	0	0	0	0	0
Total	418	1,200	6,171	5,007	420

4. Employee benefits and staff numbers

4.1.1. Employee benefits

	Total		2025-26
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	16,945	1,402	**18,347**
Social security costs	2,366	49	**2,415**
Employer Contributions to NHS Pension scheme	3,790	84	**3,874**
Other pension costs	1	0	**1**
Apprenticeship Levy	71	0	**71**
Termination benefits	3,468	0	**3,468**
Gross employee benefits expenditure	**26,641**	**1,535**	**28,176**
Less recoveries in respect of employee benefits (note 4.1.2)	(734)	(67)	**(801)**
Net employee benefits expenditure	**25,907**	**1,468**	**27,375**

	Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	15,043	1,132	16,175
Social security costs	1,911	47	1,958
Employer Contributions to NHS Pension scheme	3,589	62	3,651
Other pension costs	1	0	1
Apprenticeship Levy	68	0	68
Termination benefits	1,336	0	1,336
Gross employee benefits expenditure	21,948	1,241	23,189
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Net employee benefits expenditure	21,948	1,241	23,189

4.1.2. Recoveries in respect of employee benefits

	2025-26			2024-25
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(574)	(67)	(641)	0
Social security costs	(81)	0	(81)	0
Employer contributions to the NHS Pension Scheme	(79)	0	(79)	0
Total recoveries in respect of employee benefits	**(734)**	**(67)**	**(801)**	0

4.2. Average number of people employed

	2025-26			2024-25		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**304**	**14**	**318**	305	15	320

4.3. Exit packages agreed in the financial year

	2025-26 Compulsory redundancies		**2025-26 Other agreed departures**		**2025-26 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	3	21,008	3	21,008
£10,001 to £25,000	1	11,484	6	105,158	7	116,642
£25,001 to £50,000	1	47,818	3	124,758	4	172,576
£50,001 to £100,000	0	0	16	1,196,785	16	1,196,785
£100,001 to £150,000	0	0	6	780,188	6	780,188
£150,001 to £200,000	0	0	7	1,181,172	7	1,181,172
Over £200,001	0	0	0	0	0	0
Total	**2**	**59,302**	**41**	**3,409,069**	**43**	**3,468,371**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	4	20,928	13	57,958	17	78,886
£10,001 to £25,000	2	27,609	11	179,079	13	206,688
£25,001 to £50,000	2	86,667	3	98,135	5	184,802
£50,001 to £100,000	1	80,000	5	283,642	6	363,642
£100,001 to £150,000	1	106,667	2	241,560	3	348,227
£150,001 to £200,000	0	0	1	154,221	1	154,221
Over £200,001	0	0	0	0	0	0
Total	10	321,871	35	1,014,595	45	1,336,466

Analysis of Other Agreed Departures

	2025-26 Other agreed departures		2024-25 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	41	3,409,069	13	799,069
Contractual payments in lieu of notice	0	0	22	215,526
Total	**41**	**3,409,069**	35	1,014,595

These tables report the number and value of exit packages agreed in the financial year.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook and are in line with statutory requirements.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

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.

4.4.3. Defined Contribution Pension Scheme (NEST)

NHS Somerset ICB also participates in the National Employment Savings Trust (NEST), a defined contribution pension scheme which was open to retired members of the NHS Pension scheme who were previously not allowed to rejoin the NHS Payment Scheme. The rules have now been changed and previously retired NHS Pension Scheme members are now allowed to rejoin the NHS Pension Scheme under the 2015 Membership Scheme.

Under the NEST scheme, NHS Somerset ICB pays 3% employer contributions to the Nest Scheme Administrators and has no legal or constructive obligation to pay further amounts beyond these contributions. The assets of the scheme are held by the NEST Scheme administrators in an independently administered fund.

For the year ended 31st March 2026, the total employer contributions payable by NHS Somerset ICB in relation to NEST Pension Scheme members amounted to £1,147.60. These contributions are recognised as an expense in period in which they have been incurred.

5. Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	5,460	4,158
Services from foundation trusts	1,911,529	953,828
Services from other NHS trusts	661,729	13,395
Services from Other WGA bodies	2,850	25
Purchase of healthcare from non-NHS bodies	184,491	150,016
Purchase of social care	51,817	52,669
General Dental services and personal dental services	20,001	17,461
Prescribing costs	104,259	102,202
Pharmaceutical services	19,558	18,223
General Ophthalmic services	6,546	6,307
GPMS/APMS and PCTMS	145,245	131,575
Supplies and services – clinical	1,220	56
Supplies and services – general	943	712
Consultancy services	1	3
Establishment	2,000	1,929
Transport	5,730	5,503
Premises	820	841
Audit fees	474	234
Other non statutory audit expenditure - Other services	0	47
Other professional fees	233	403
Legal fees	217	191
Education, training and conferences	168	734
Non cash apprenticeship training grants	46	51
Total Purchase of goods and services	**3,125,337**	1,460,563
Depreciation and impairment charges		
Depreciation	436	508
Total Depreciation and impairment charges	**436**	508
Provision expense		
Provisions	7,364	556
Total Provision expense	**7,364**	556
Other Operating Expenditure		
Chair and Non Executive Members	129	134
Clinical negligence	6	5
Research and development (excluding staff costs)	107	129
Other expenditure	0	1
Total Other Operating Expenditure	**242**	269
Total operating expenditure, excluding staff costs	**3,133,379**	1,461,896

1. External Audit Fees net of VAT total £395,000 for the period 1 April 2025 to 31 March 2026.
2. The auditor's liability for external audit work carried out for the financial year 2025/26 is limited to £1,000,000.
3. Internal Audit - As Internal Audit is carried out by a different organisation to our Statutory Audit, the Department of Health guidance is to show Internal Audit costs in 'Other professional fees'.
4. Other non-statutory audit expenditure for 2024/25 includes £44,400 which was accrued in 24/25 which paid for the 2024/25 Mental Health Investment Standard (MHIS) review work completed and paid in 2025/26.
5. From 1 April 2025, NHS Somerset Integrated Care Board assumed the role of Principal Commissioner for Specialised Commissioning for the South West, acting on behalf of seven South West ICBs (including NHS Somerset ICB). As a result, expenditure relating to specialised commissioning services is now recorded within NHS Somerset ICB's accounts, leading to a significant increase in reported expenditure in 2025-26 compared with the prior year.

6. Better Payment Practice Code

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	24,436	423,479	19,947	378,451
Total Non-NHS Trade Invoices paid within target	24,424	423,388	19,937	378,384
Percentage of Non-NHS Trade invoices paid within target	**99.95%**	**99.98%**	**99.95%**	**99.98%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,740	2,571,953	887	972,571
Total NHS Trade Invoices Paid within target	1,736	2,571,793	883	972,566
Percentage of NHS Trade Invoices paid within target	**99.77%**	**99.99%**	**99.55%**	**100.00%**

7. Finance costs

	2025-26 £'000	2024-25 £'000
Interest on lease liabilities	2	6
	2	6

8. Property, plant and equipment

2025-26	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2025	564	114	678
Additions purchased	39	0	39
Disposals other than by sale	(159)	(114)	(273)
Cost / Valuation at 31 March 2026	**444**	**0**	**444**
Depreciation 01 April 2025	302	114	416
Disposals other than by sale	(159)	(114)	(273)
Charged during the year	74	0	74
Depreciation at 31 March 2026	**217**	**(0)**	**217**
Net Book Value at 31 March 2026	**227**	**0**	**227**
Purchased	227	0	227
Total at 31 March 2026	**227**	**0**	**227**
Asset financing:			
Owned	227	0	227
Total at 31 March 2026	**227**	**0**	**227**

Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	5	7
Furniture & fittings	7	10

9. Leases

9.1. Right-of-use assets

2025-26	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2025	1,663	1,663
Cost / Valuation at 31 March 2026	**1,663**	**1,663**
Depreciation 01 April 2025	1,301	1,301
Charged during the year	362	362
Depreciation at 31 March 2026	**1,663**	**1,663**
Net Book Value at 31 March 2026	**0**	**0**
Net Book Value by counterparty		
Leased from NHS Property Services	0	0
Net Book Value at 31 March 2026	**0**	**0**

9.2. Lease liabilities

2025-26	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(422)	(839)
Interest expense relating to lease liabilities	(2)	(6)
Repayment of lease liabilities (including interest)	424	423
Lease liabilities at 31 March 2026	**(0)**	(422)

9.3. Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 £'000	2024-25 £'000
Within one year	0	(423)

9.4. Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	362	434
Interest expense on lease liabilities	2	6

9.5. Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	424	423

10.1. Trade and other receivables	Current 2025-26 £'000	Non-current 2025-26 £'000	Current 2024-25 £'000	Non-current 2024-25 £'000
NHS receivables: Revenue	635	0	2,080	0
NHS accrued income	1,999	0	2,237	0
Non-NHS and Other WGA receivables: Revenue	189	0	339	0
Non-NHS and Other WGA prepayments	1,638	0	655	0
Non-NHS and Other WGA accrued income	1,012	0	731	0
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	7,302	0	8,877	0
VAT	309	0	468	0
Other receivables and accruals	7	0	0	0
Total Trade & other receivables	**13,091**	**0**	15,387	0
Total current and non current	**13,091**		15,387	

10.2. Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	2025-26 Non DHSC Group Bodies £'000	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000
By up to three months	0	91	17	11
By three to six months	0	(1)	0	15
By more than six months	251	3	0	5
Total	**251**	**93**	17	31

11. Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	73	46
Net change in year	197	27
Balance at 31 March 2026	**270**	73
Made up of:		
Cash with the Government Banking Service	270	73
Cash and cash equivalents as in statement of financial position	**270**	73

12. Trade and other payables	Current 2025-26 £'000	Non-current 2025-26 £'000	Current 2024-25 £'000	Non-current 2024-25 £'000
NHS payables: Revenue	1,248	0	885	0
NHS accruals	13,428	0	2,689	0
Non-NHS and Other WGA payables: Revenue	8,114	0	11,711	0
Non-NHS and Other WGA accruals	41,193	0	37,619	0
Social security costs	264	0	225	0
Tax	266	0	241	0
Other payables and accruals	10,436	0	8,510	0
Total Trade & Other Payables	**74,949**	**0**	61,880	0
Total current and non-current	**74,949**		61,880	

Other payables include £1,328,067 outstanding pension contributions at 31 March 2026 (£1,284,089 at 31 March 2025)

13. Provisions

	Current 2025-26 £'000	**Non-current 2025-26 £'000**	Current 2024-25 £'000	Non-current 2024-25 £'000
Redundancy	6,616	0	0	0
Continuing care	543	0	609	0
Other	244	0	0	0
Total	**7,403**	**0**	**609**	**0**
Total current and non-current	**7,403**		**609**	

	Redundancy £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2025	**0**	**609**	**0**	**609**
Arising during the year	6,616	543	244	**7,403**
Utilised during the year	0	(570)	0	**(570)**
Reversed unused	0	(39)	0	**(39)**
Balance at 31 March 2026	**6,616**	**543**	**244**	**7,403**
Expected timing of cash flows:				
Within one year	6,616	543	244	**7,403**
Balance at 31 March 2026	**6,616**	**543**	**244**	**7,403**

The above is based on information currently held by NHS Somerset ICB.
The 'Redundancy' provision included in 25/26 was an assessment of potential cost commitments for ICB Staff at risk of redundancy as at 31st March 2026 due to organisational restructure.
The 'Continuing Care' provision is an assessment of continuing care cases which are currently being reviewed by the Integrated Care Board's assessment panel. This has been based on the best professional judgement in line with IAS37. All of the cases awaiting panel have been provided for and the calculation has been based on estimated cost and the probability of success. The probability factor applied is based on success rates in the current financial year. A contingent liability in respect of this provision is shown in note 14.
The 'Other' provision is in relation to dilapidations in relation to work required at Wynford House prior to exit of the lease.

14. Contingencies

	2025-26 £'000	2024-25 £'000
Contingent liabilities		
Redundancy	331	0
Continuing Healthcare	174	315
Net value of contingent liabilities	**505**	315

15. Financial instruments

15.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Somerset Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. NHS Somerset Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHS Somerset Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Somerset Integrated Care Board standing financial instructions and policies agreed by the ICB Board. Treasury activity is subject to review by the NHS Somerset Integrated Care Board and internal auditors.

15.1.1. Currency risk

The NHS Somerset Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. NHS Somerset Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2. Interest rate risk

NHS Somerset Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. NHS Somerset Integrated Care Board therefore has low exposure to interest rate fluctuations.

15.1.3. Credit risk

Because the majority of NHS Somerset Integrated Care Board revenue comes from parliamentary funding, NHS Somerset Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4. Liquidity risk

NHS Somerset Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. NHS Somerset Integrated Care Board draws down cash to cover expenditure, as the need arises. NHS Somerset Integrated Care Board is not, therefore, exposed to significant liquidity risks.

15.1.5. Financial Instruments

As the cash requirements of NHS Somerset Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS Somerset Integrated Care Board's expected purchase and usage requirements and NHS Somerset Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

15. Financial instruments cont'd

15.2. Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	**Total 2025-26 £'000**
Trade and other receivables with NHSE bodies	2,634	**2,634**
Trade and other receivables with other DHSC group bodies	0	**0**
Trade and other receivables with external bodies	8,510	**8,510**
Cash and cash equivalents	270	**270**
Total at 31 March 2026	**11,414**	**11,414**

	Financial Assets measured at amortised cost 2024-25 £'000	Total 2024-25 £'000
Trade and other receivables with NHSE bodies	4,296	4,296
Trade and other receivables with other DHSC group bodies	21	21
Trade and other receivables with external bodies	9,947	9,947
Cash and cash equivalents	73	73
Total at 31 March 2025	14,337	14,337

15.3. Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	**Total 2025-26 £'000**
Trade and other payables with NHSE bodies	3,284	**3,284**
Trade and other payables with other DHSC group bodies	11,392	**11,392**
Trade and other payables with external bodies	59,743	**59,743**
Lease Liabilities	0	**0**
Total at 31 March 2026	**74,419**	**74,419**

	Financial Liabilities measured at amortised cost 2024-25 £'000	Total 2024-25 £'000
Trade and other payables with NHSE bodies	85	85
Trade and other payables with other DHSC group bodies	3,490	3,490
Trade and other payables with external bodies	57,839	57,839
Lease liabilities	422	422
Total at 31 March 2025	61,836	61,836

16. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Somerset ICB	3,160,756	(16,710)	**3,144,046**	13,588	(82,352)	**(68,764)**
Total	**3,160,756**	**(16,710)**	**3,144,046**	**13,588**	**(82,352)**	**(68,764)**

17. Joint arrangements - interests in joint operations

NHS Somerset Integrated Care Board is party to a number of pooled budget agreements with Somerset Council. Under these arrangements funds are pooled under S75 of the Health Act 2006 for the provision of the following services;

- Community Equipment and Wheelchair Services
- Carers Services
- Learning Disability Services
- The Better Care Fund (not treated as a Joint Operation)

			Amounts recognised in Entities books ONLY	
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**2025-26 Expenditure £'000**	**2024-25 Expenditure £'000**
Integrated Community Equipment and Wheelchair Service Pooled Fund	NHS Somerset Integrated Care Board and Somerset Council	Purchase healthcare equipment services	3,856	3,810
Carers Services Pooled Fund	NHS Somerset Integrated Care Board and Somerset Council	Purchase Carers services	165	249
Learning Disability Service Pooled Fund	NHS Somerset Integrated Care Board and Somerset Council	Purchase Learning Disability services	32,407	32,463
Better Care Fund	NHS Somerset Integrated Care Board and Somerset Council	Purchase health and social care services	56,732*	55,866*

* Better Care Fund excludes £203,500 which is included within Carers Pooled Budget

18. Related party transactions

Details of related party transactions with individuals are as follows:

2025/26 - 1 April 2025 to 31 March 2026	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
Rebecca Duffy, GP Partner / Former Senior Partner exercising control over Mendip Country Practice operations. (transactions disclosed for Mendip Country Practice)	1,887	0	106	0
Christopher Foster, Non-Executive Director and Trustee of Royal Hospital for Neuro-disability, exercising significant influence. (transactions disclosed for Royal Hospital for Neuro-disability)	77	0	77	0
Grahame Paine, Chair of SPARK Somerset's Trustee Board with strategic and financial oversight (transactions disclosed for SPARK Somerset)	113	0	0	0
Berge Balian, GP Partner exercising control over Crewkerne Health Centre. (transactions disclosed for Crewkerne Health Centre)	2,372	0	70	0

Note
In formulating this note the Integrated Care Board has considered all declarations of interest for Board Members.
Under IAS24, related party transactions have only been disclosed where they meet the following criteria:
(i) have 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
The Register of Interests can be found on our website https://nhssomerset.nhs.uk/lists-and-registers/

Members of the board and/or key management personnel are considered related parties of the ICB. As disclosed in the table above, no material transactions were undertaken with these individuals during the reporting period.

To enhance transparency and uphold the integrity of related party reporting, the table also includes entities with which key individuals are associated, but which do not meet the definition of a related party to the ICB under IAS 24. These have been disclosed for information purposes only.

The Department of Health and Social Care is the parent department of NHS Somerset ICB. During the year the Integrated Care Board has had a significant number of material transactions with other entities for which the Department is regarded as the parent Department.

NHS England
South, Central and West Commissioning Support Unit
NHS Bristol, North Somerset and South Gloucestershire ICB

NHS FOUNDATION TRUSTS
Dorset County Hospital NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Gloucestershire Health and Care NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
Guy's & St Thomas' Hospital NHS Foundation Trust
Hampshire and Isle Of Wight Healthcare NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
Oxford Health NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Devon University Healthcare NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust, and its subsidiary Sulis Hospital Bath Ltd
Salisbury NHS Foundation Trust
Somerset NHS Foundation Trust, and its subsidiaries Symphony Healthcare Services Ltd & Simply Serve Ltd

NHS FOUNDATION TRUSTS
South Warwickshire University NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Dorset NHS Foundation Trust

NHS TRUSTS
Barts Health NHS Trust
Devon Partnership NHS Trust
North Bristol NHS Trust
Portsmouth Hospitals University NHS Trust
Royal Cornwall Hospitals NHS Trust
University Hospitals Plymouth NHS Trust
Worcestershire Acute Hospitals NHS Trust
Wye Valley NHS Trust

In addition, the Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Somerset Council, NHS Property Services Limited, National Insurance Fund, NHS Pension Scheme and His Majesty's Revenue and Customs.

19. Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	2025-26 Target £'000	**2025-26 Performance £'000**	2024-25 Target £'000	2024-25 Performance £'000
Expenditure not to exceed income	3,160,802	3,160,795	1,485,198	1,485,176
Capital resource use does not exceed the amount specified in Directions	40	39	85	85
Revenue resource use does not exceed the amount specified in Directions	3,144,052	3,144,046	1,469,475	1,469,453
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	21,216	16,467	12,907	11,940

20. Losses and special payments

Losses

The total number of NHS Somerset ICB losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Administrative write-offs	0	0	2	0
Total	**0**	**0**	2	0

Special payments

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Compensation payments	1	0	1	1
Total	**1**	**0**	1	1

21. Mental health expenditure

NHS England requires all ICBs in England to deliver the mental health investment standard (MHIS), which requires an increase in planned spending on mental health services by a greater proportion than the overall increase in budget allocations each financial year. The aim of this standard is to support the ambitions within the NHS Long Term Plan to ensure that essential investment is made into developing the provision of mental health services.

NHS Somerset ICB have reported full compliance with our obligations for the required levels of investment in mental health services for the 2025/26 financial year.

The table below demonstrates the amount of reported mental health expenditure incurred by NHS Somerset ICB during the financial years 2024/25 and 2025/26, and the proportion of this expenditure against the total of the organisation's programme resource allocation.

	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England (£000)	130,301	115,323
Eligible Mental Health Expenditure (£000)	130,312	115,409
Mental health expenditure above/(below) minimum investment required (£000)	11	86
Mental Health expenditure as a proportion of total expenditure (%)	4.1%	7.9%

From 1 April 2025, NHS Somerset Integrated Care Board assumed the role of Principal Commissioner for Specialised Commissioning for the South West, acting on behalf of seven South West ICBs (including NHS Somerset ICB). As a result, expenditure relating to specialised commissioning services is now recorded within NHS Somerset ICB's accounts, leading to a significant increase in reported expenditure in 2025-26 compared with the prior year.

Independent auditor's report to the members of the Board of NHS Somerset Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Somerset 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 Somerset Integrated Care Board, NHS Bath and North East Somerset, Swindon and Wiltshire 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 control and cut-off risk in the ICB's non-block, specialised commissioning expenditure and other operating expenditure. We determined that the principal risks were in relation to:
  - large and unusual journals 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 Somerset 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.

Barrie Morris

Barrie Morris, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
16 June 2026