

Annual Report

A review of our year



2025/26



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A message from

This has been a really challenging year with recovery and improvement ambitions, industrial action and the requirements of organisational change all placing significant pressure on our staff across the system.

Despite this, our local health and care professionals, supported by our fantastic partners, including local councils and other public and community and voluntary sector colleagues, have continued to work with determination, true professionalism and dedication.

The power of partnership (highlighted in our Annual Report) at neighbourhood, locality and county level has helped us to make real strides in improving health and wellbeing, care and services for local citizens and tackling long standing health inequalities.

Our Annual Report shows that working alongside local people and communities has been integral to this, listening hard to ensure their priorities are at the heart of One Gloucestershire plans.

Our Joint Forward Plan for healthcare (refreshed for 2025/2026) continued to guide our work and created the blueprint for action and transformational change.

Both the strategy and the plan were underpinned by three key pillars for priority action:

- ▶ **Making Gloucestershire a better place for the future** - improving the health, wellbeing and care of our citizens over the longer term. Focus on early prevention and the wider impacts on health
- ▶ **Transforming what we do** - integrated working in neighbourhoods and communities supporting the needs of the local population, achieving equity - reducing unfair and avoidable differences in health, developing our workforce, improving quality and outcomes across the whole person journey and making the most of digital technology to support care
- ▶ **Improving health and care services today** - improving access to care, reducing waiting times and providing services that are sustainable and safe.

These strategic areas closely aligned to the themes within the national 10 Year Health Plan which we fully support, including a focus on the shift from sickness to prevention, further development of neighbourhood health services and the shift from analogue to digital.

We have also now published our 5-year Population Health and Strategic Commissioning Plan, which sets out the next steps in improving health and wellbeing and transforming local services to meet the needs of local people.

In line with national reforms to the health service, work continues to bring NHS Gloucestershire and NHS Bristol, North Somerset and South Gloucestershire ICBs together to focus on our role as strategic commissioners - our work underpinned by a deep understanding of population health needs - to deliver for local people and communities.

This cluster arrangement between the two ICBs, which formally came into being on 1 April 2026, is being developed to support our shared priorities, reduce duplication and support implementation of the 10-year Health Plan.

Looking ahead to this year, we will be taking a system wide approach to service transformation to ensure care is provided in the right place at the right time. This includes making sure that the care and services people might need often are provided as close to home as possible.

We will also continue our relentless focus on reducing waiting times, ensuring quality and safety across our services, tackling health inequalities and achieving financial health.

We know that we have an important responsibility to support our staff through this difficult period of organisational change, meet the priorities of local people in 2026/2027, whilst putting the building blocks in place for a health and care system that can meet the needs of future generations.

Thank you for your continuing support.

Top 20

Highlights of the year

Making Gloucestershire a better place for the future

1

8 Young Minds Matter teams are now providing mental health support to children and young people **across 158 educational settings**, with each team covering a population of 8,000 pupils.

2

Up to 175 people with cold-sensitive health conditions who are at risk of fuel poverty received support to pay their energy bills through winter.

3

30 GP practices backed a greener asthma inhaler swap, with 448 patients changing to lower-carbon options.

4



Across 113 Gloucestershire schools, more than 6,000 children aged three to five are learning good tooth brushing habits through the **NHS backed Big Brush Club**.

5



An additional **4,000 people** with high blood pressure were diagnosed over a 12-month period, allowing **healthy lifestyles support** and treatment to begin.

6



55 student nurses were given the opportunity to gain first-hand experience of community nursing while 'on tour' with our information bus, performing health checks on more than 1,000 people.

Transforming what we do

7

86% of people with a serious mental illness have completed or been offered an annual physical health check, noticeably improving the physical health of those with SMI.

8

More than 50 staff including senior leaders across maternity services have completed **Black Maternity Matters training** to improve their cultural knowledge and understanding.

9

More than **1,700 people** at risk of developing Type 2 Diabetes have taken positive steps to improve their health and wellbeing by completing the 9-month National Diabetes Prevention Programme.

10

More than 220 people with low vision received specialist eye care at home, bringing hospital level assessments and practical support directly to vulnerable residents.

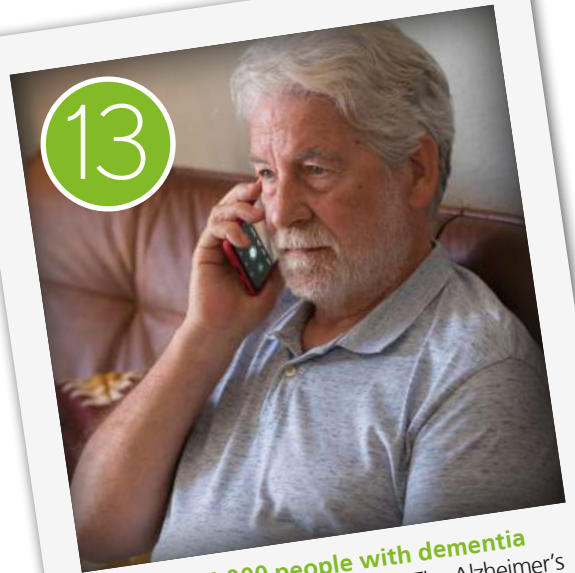
11

Our Gloucestershire Primary Care Training Hub's '**Be a GP Partner**' programme has supported a total of **36 GPs**, with many more attending elements of the bespoke programme.

12

94 people living with dementia and their carers have been supported with personalised music therapy at home to support their wellbeing.

13



More than 1,000 people with dementia and their families were referred to The Alzheimer's Society Dementia Advisors for advice, support and signposting to services.

14



Almost 70% of those eligible for a COVID vaccine in autumn/winter 2025 took up the offer, making Gloucestershire the second highest for vaccine uptake in England.

Improving health and care services today

15

More people are starting cancer treatment **within 62 days of an urgent GP referral**, with performance rising from just under 70% to over 80% and remaining above the national average.

16

The Integrated Urgent Care Service answered more than **200,000 calls** to NHS 111 and provided more than **22,000** out of hours appointments.

17

In 2026 almost **50% of GP practice appointments** took place on either the same or following day.

18

More than 4,700 referrals were made to the community Rapid Response service which operates 24 hours a day, 7 days a week. Over 87% of these people have been treated at home, avoiding an unnecessary hospital stay.

19

Around 25% more diagnostic tests are taking place than the previous year, reaching an all-time high three times, most recently in January 2025 where almost 26,000 tests took place in a single month.

20

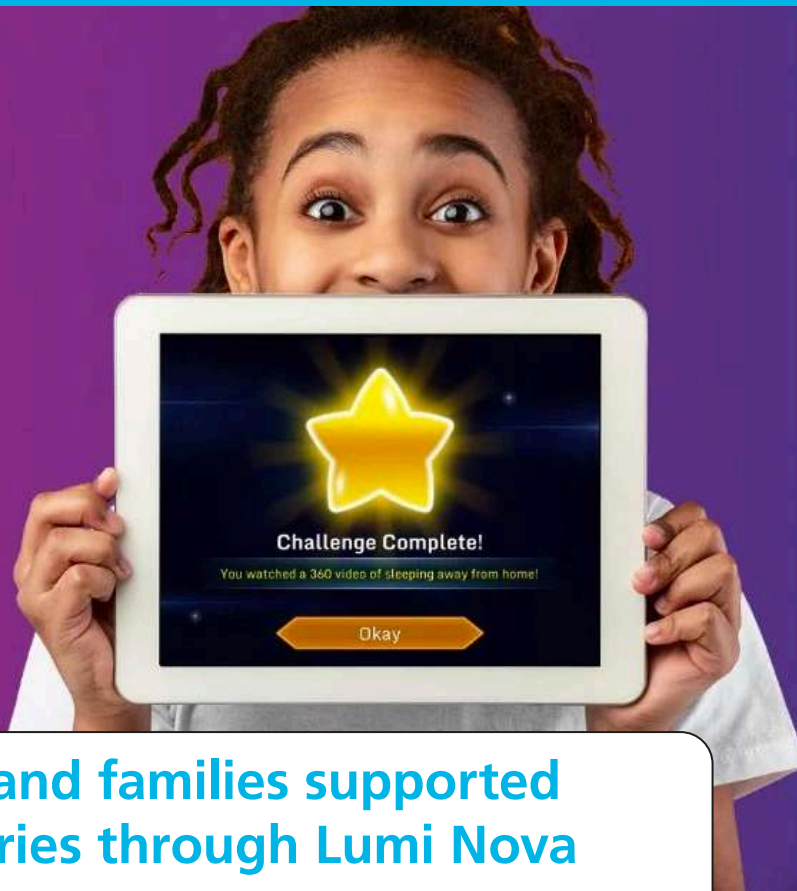


Each month the **NHS App** was used to book more than **4,500 GP practice appointments** and order around 75,000 repeat prescriptions.

News Digest

Stories from around the county

Making
Gloucestershire
a better place
for the future



Children and families supported with worries through Lumi Nova

More than 3,000 children across Gloucestershire have used the Lumi Nova app since it launched, giving families a new way to help children manage worries and anxiety. The free app uses simple games and challenges to teach coping skills in a fun, safe way.

Early feedback from parents shows strong results, with over 70% reporting improvements or no decline in their child's wellbeing after using the app. Lumi Nova is recommended by NICE and is available at no cost to families across the county, making support easier to access when it's needed most.

Increase prevention
and tackle the wider
determinants of
health and care

Young people in Cinderford thrive through creative health support

108 young people have been supported this year by Cinderford Artspace. Journeys, now in its fifth year, helps children and young people build confidence and resilience through arts, circus and pottery activities, contributing to a 14.2% reduction in NHS service use over 12 months.

Working with The Music Works and Art Shape, the Xpres! programme also supported 30 young people with long term conditions like diabetes or epilepsy, helping them manage their health, avoid hospital visits, and achieve personal goals. Across the county, around 7,000 people have benefited from creative health programmes in the last five years.





Dementia films shine a light on dementia care for families and professionals

Ten new dementia education films have been created to help families and care staff better support people living with dementia across Gloucestershire. The film series was launched at a local event and developed with people who have lived experience of dementia, ensuring real voices and practical situations shape the content.

The films cover key topics such as responding to distress, supporting eating and drinking, and helping families and friends understand dementia.

Created in partnership with the University of Gloucestershire and local health and care organisations, the films aim to improve understanding, confidence and the quality of dementia care locally and beyond.

Building stronger communities through local VCSE partnerships

We continued to invest in local VCSE partners to expand cookery, fitness and wellbeing activities and provide early support for people facing mental, financial or physical health challenges. This work helped strengthen community resilience and reduce social isolation.

ITSA Digital Trust supported 3,800 people to access digital technology and gain workplace experience, while 46 volunteers contributed 3,900 hours, building confidence and employability skills. Fair Shares Gloucestershire supported 1,595 people through time banking, where people earn time credits for helping others and can use them to receive support in return. Many reported feeling happier and more connected.

Partnership improves housing choices for disabled residents across Gloucestershire

A joined-up approach to matching people with suitable social housing through a new Accessible Housing Register is making it easier for disabled people to find homes that truly meet their needs.

The partnership between the NHS, Gloucestershire County Council and local housing partners is reducing delays and helping residents live more independently. Housing decisions are also quicker and more accurate thanks to better and more consistent information sharing.





Transforming
what we do

Encouraging farmers to seek help early for health issues

Farmers in Gloucestershire are being encouraged to come forward with health concerns as part of a project supporting people who often delay seeking help.

Around 200 farmers have already had free confidential health checks at livestock markets and community venues, making it easier for them to talk about physical or mental health worries. Many participants said they would not otherwise have approached a GP.

The project is helping spot issues early, offering advice on staying well and signposting people to further support when needed.

Take a community
& locality focused
approach to the
delivery of care



Person centred support helping over 1,000 carers get the help they need

GP practices in Stroud and Berkeley Vale have identified more than 1,000 previously unregistered unpaid carers after census data showed far fewer carers than expected in the district.

By reaching out proactively, practices connected people with the Gloucestershire Carers Hub, giving carers access to free advice, emotional support and opportunities to meet others in similar situations. The project is helping reduce isolation and ensures carers receive the tailored support they need to stay well while looking after someone else.

Joined up support for people experiencing complex homelessness

Around 50–60 adults at any one time are supported by the Complex Homelessness Partnership Support team. The team supports people who are rough sleeping or living in temporary accommodation, and who are not engaged with mainstream services, to access the health and care support they need. Funded by the Department for Levelling Up, Housing and Communities, the team brings together staff from GHC, Gloucestershire County Council and VIA to support people with mental health, physical health and substance misuse needs.

The team's work was recognised this year with the Health Equity Award at the South West Integrated Personalised Care Awards.

Community lung checks driving earlier diagnosis and better health

Since January 2025, around 12,000 smokers and ex smokers have been invited for a lung health check, with more than 2,800 people having a scan.

Over 40 people were referred to hospital for further tests and almost 800 received extra checks in their GP practice for lung or heart problems. So far, 24 cancers have been found, with three quarters identified at an early stage, giving people a better chance of successful treatment.

By bringing checks into communities with higher smoking rates and deprivation, the programme is helping reduce health inequalities and supporting earlier diagnosis for those most at risk. The programme will continue to be rolled out across the county in a phased way.



Lung
Cancer
Screening



Stay Well this Winter (SWTW) campaign supported people to have a healthy winter

Fifteen health, social care, voluntary and community sector partners played a central role in delivering the Stay Well This Winter campaign, using their expertise to encourage practical actions to support health and wellbeing during the colder months.

Working collaboratively with local partners, we expanded our video library to cover topics including eating well, staying warm, supporting others, mental wellbeing and managing cost of living pressures.

This year also saw the introduction of upright video content on YouTube Shorts, generating an additional 64,700 views. The campaign achieved strong engagement across social media channels and maintained consistent traffic to the campaign hub page.



Ensure that care is accessible when it is needed most

Acute Respiratory Infection (ARI) Hubs benefit local patients

ARI hubs have provided over 14,000 appointments to patients at risk of a hospital stay with respiratory illness (e.g. chest infections or 'flare-ups' of lung conditions). Adults and children across Cheltenham and Gloucester can be offered same-day face-to-face assessment and treatment within 'hubs' at Rosebank GP Practice and St Paul's Medical Centre, seven days a week.

Evaluation has shown that the areas with ARI hubs have continued to maintain a lower rate of Emergency Department ARI attendances compared to other localities. The service has received excellent feedback, with over a quarter of patients saying they would otherwise have attended A&E with their symptoms.



Supporting those with respiratory conditions closer to home

People living with long term respiratory conditions are benefiting from care closer to home.

More diagnostic tests are taking place in local community settings, making it easier for people to check their lung health without travelling far. Group support sessions are also helping people learn how to manage their condition and share experiences with others.

These improvements mean people can get the right help earlier, stay well for longer and feel more confident managing their symptoms.

Gloucestershire's award winning joined-up approach to eye health

Community optometrists can access hospital eye care records and make thoroughly informed clinical decisions thanks to the Community Ophthalmic Link, developed by BlueWorks OIMS.

The system has been used more than 9,000 times this year. By giving optometrists access to key information before and after appointments, it has helped over 1,000 people avoid an unnecessary referral to their GP or hospital.



Stronger support for people facing emotional distress

Gloucestershire Health and Care NHS Foundation Trust's Complex Emotional Needs service continues to support more people experiencing high levels of emotional distress. Working with partners across health, social care, housing, emergency services, education, and the voluntary and faith sectors, the team delivers training alongside open access therapeutic support, meaning people can get emotional help quickly and directly without needing a referral or long wait.

Over 150 people have been supported through the family service, helping families feel less isolated and better equipped to manage difficulties. The Frequent Engagement Response Network has reduced arrests and detentions by up to 75%, and more than 1,000 staff across the health and care system have now been trained in trauma-informed care.



Improve quality & outcomes across the whole person journey

What matters to you? The personalised care approach

Personalised care helps people experience and access healthcare and community support in a way that matters to them. The aim is to give people choice and control over the care they receive.

Patients can hold their own personalised care and support plans within orange folders which have been given out to around almost 5,500 individuals across the county.

Two main documents are included in the plan - a Me at My Best Plan (giving professionals key information about a patient) and ReSPECT plans, which create recommendations for a person's care/treatment in a future emergency in which they are unable to make choices.

There are now 82 in every 1,000 people over the age of 65 in Gloucestershire currently holding a ReSPECT plan. This compares to 71 in every 1,000 at the same point last year.



Digital technology is helping people with diabetes live healthier, more confident lives

Cutting-edge digital technology is transforming care for people in Gloucestershire living with diabetes. Continuous glucose monitor sensors track blood sugar levels 24 hours a day, sending readings straight to a mobile phone or reader and removing the need for regular finger prick tests. For some people with Type 1 diabetes, this technology links directly to insulin pumps, helping calculate doses automatically.

Local diabetes teams are seeing clear improvements in health, confidence and day to day independence, with families also reporting better sleep and peace of mind.

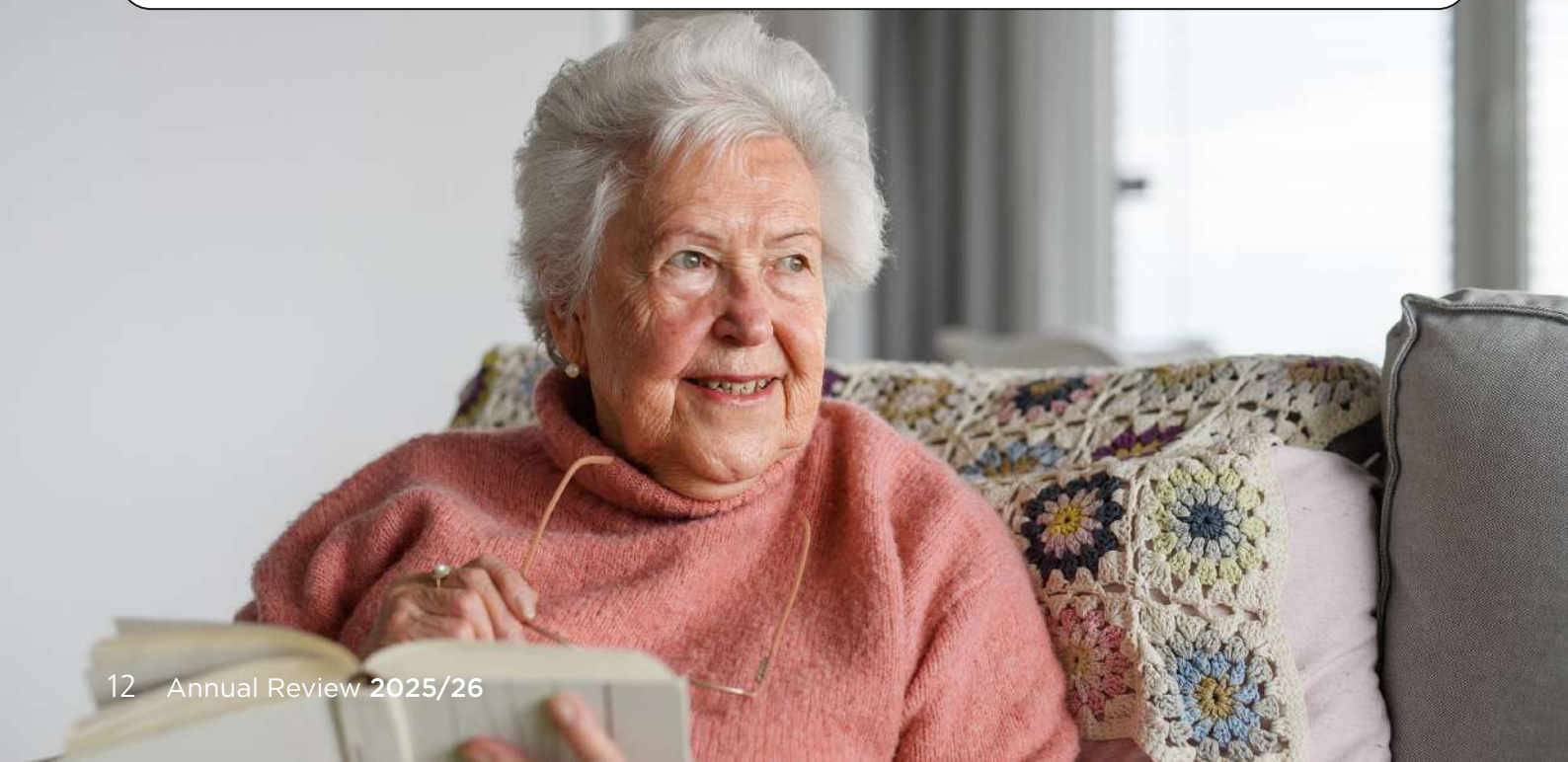


Working together to support older people to live independently for longer

A new partnership project in Gloucestershire is helping reduce falls in older people's housing by bringing together housing, care and health professionals.

Teams work directly with supported living services to spot risks early, simplify daily routines and make practical safety improvements. They also make sure residents understand the support available to them.

95% of staff taking part reported increased knowledge about falls and greater confidence in how to respond, highlighting the positive impact of this collaborative approach, which is helping to reduce avoidable harm and give residents greater reassurance.





Improving early support for frailty and dementia in Gloucestershire

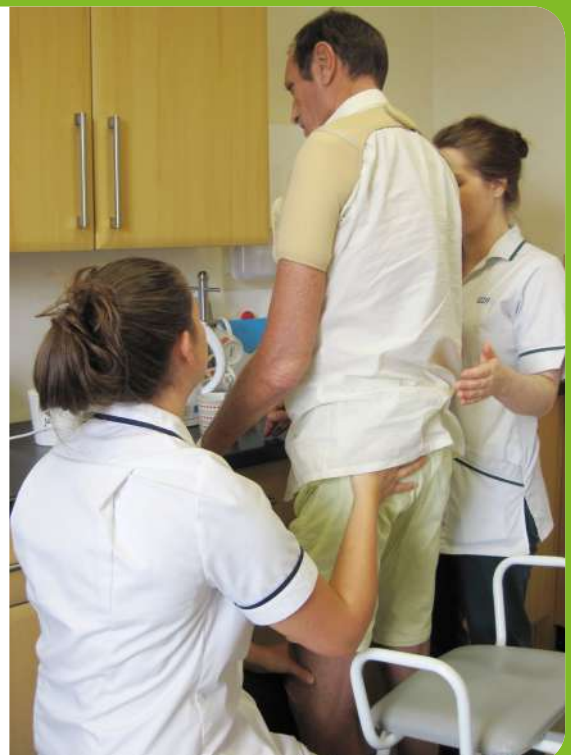
NHS Gloucestershire is bringing earlier, community-based support to people living with frailty and dementia across 16 Primary Care Networks. The new dementia co-diagnosis model means people can get a faster, more joined up diagnosis through GP teams working closely with specialist services. So far, 7 networks have adopted the model, with more preparing to follow.

Gloucestershire has also been chosen as one of seven areas nationally to lead work improving frailty care, helping more people stay independent and avoid unnecessary hospital visits.

Community Neurological Service brings life changing care into homes

More than 1,500 people have received care closer to home from the Community Neurological Service in the last 12 months. The service supports people to recover, stay independent, and avoid long hospital stays in out of county treatment centres.

A multidisciplinary team of specialist physiotherapists, occupational therapists, psychologists, speech and language therapy and therapy support workers, who work together to assess and support those with a number of conditions including stroke survivors, those with spinal cord injuries and people living with progressive conditions like Motor Neurone Disease and Parkinsons. This means people are regaining skills, confidence and control over their day-to-day lives.



Create One
Workforce
for One
Gloucestershire

**WE
WANT
YOU**



40,000 young people explore health and social care careers with 'We Want You'

The We Want You team has engaged over 40,000 young people across Gloucestershire, inspiring interest in health and social care careers. Developed with input from young people, the project offers interactive workshops, careers coaching and digital resources.

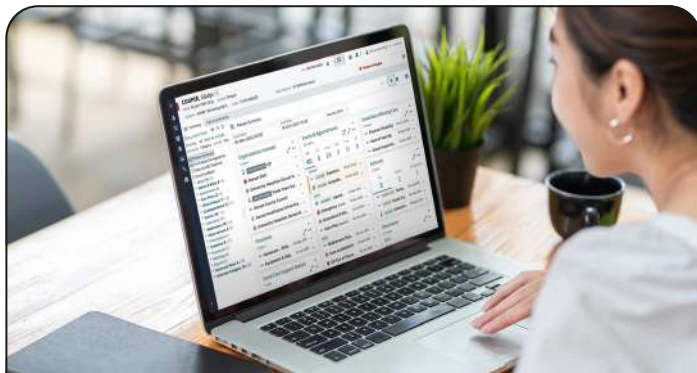
In addition to offering workshops aligned with Gatsby Benchmarks for all secondary schools, tailored workshops are also available for SEN schools, home-educated students, care leavers, refugees, and asylum seekers, and DWP/JCP initiatives, ensuring inclusive, impactful, and personalised guidance.

Opening Doors to NHS and Care Careers for Local Young People

A Widening Access Demonstrator is helping young people aged 16-30 from some of Gloucestershire's most disadvantaged communities take their next step towards a better future. The programme supports those facing extra challenges, including care experience, caring responsibilities, disability or arriving as refugees.

In its first nine months, it delivered 22 job offers and supported 68 young people into positive next steps such as starting paid work, joining apprenticeships, enrolling in college, taking short skills courses, volunteering or starting supported work placements.

These opportunities are helping young people gain confidence, skills and long-term direction.



Joined-up patient information supporting safer care across Gloucestershire

More than 12,000 health and care professionals are now using JUYI to access patient information quickly and securely. Since launching in January 2025, usage has risen sharply, with monthly logins increasing from 20,000 to nearly 80,000 by March 2026. The system has been accessed over 922,000 times, showing how firmly it is embedded in day-to-day care.

Over the past year, JUYI has expanded to include social care users, IUCS Cleo users and new Community data. In 2026, the introduction of digital read/write ReSPECT Plans will mark a major step towards a fully integrated care planning platform for Gloucestershire.

Arts, Health and Wellbeing Centre opens in Gloucester

University of Gloucestershire's new City Campus in Gloucester includes an NHS funded Arts, Health and Wellbeing Centre.

The Centre will bring together artists, researchers, health professionals and local communities to explore how creativity can support better health and wellbeing.

With early investment already enabling six PhD and 3 professional doctoral studentships and 70 people to take part in research and training programmes, the Centre is set to play a key role in improving lives through creative approaches.



Investing in modern GP practices across Gloucestershire

Building work on a new £5m GP surgery on land west of Worwell Farm in Tetbury got underway in November 2025. It will replace the existing Phoenix Tetbury surgery and is expected to open in winter 2026/27.

Plans for a new and improved building for Hucclecote Surgery were approved in February 2026. The new surgery will be built on land occupied by the former Jordans Brook House.

Two GP surgeries (Lydney Health Centre and Severnbank Surgery) plan to relocate to a preferred location in Lydney. Subject to successful planning permission, construction tender and site purchase, the surgeries plan to transform the former Co-op building on Newerne Street into a modern primary care centre.

Meanwhile, Brockworth Surgery has secured planning permission to build a new surgery on the Perrybrook estate. Subject to appointing a construction company, it is anticipated that building work will start late 2026.

Thanks to national funding, another ten surgeries are increasing their clinical consultation rooms by reconfiguring administrative and storage areas.



Improving
health and care
services today

Improve the
timeliness of care
and treatment

GP practices improve access and continuity of care for local patients

Hardworking general practice teams across Gloucestershire delivered more than 4,750,000 appointments in the last 12 months compared to 4,675,000 in the previous year.

Gloucestershire practices rank highly nationally for the rate of appointments booked within 14 days per 1,000 population. They also allow patients to book ahead for appointments; this facilitates good continuity of care but may extend the appointment beyond two weeks.

Last year's national GP Patient Survey shows high overall levels of patient satisfaction (81%) with Gloucestershire GP practices (England average 75%).

Integrated Urgent Care Service playing a key role in joining up care

A new Integrated Urgent Care Service launched in November 2024, providing the NHS 111 service (both telephone and online), a local doctor led clinical assessment service and out of hours primary care service for when GP surgeries are closed.

Via 111, the public can access a range of services including pharmacy first, GP services, including the Gloucester Health Access Centre, Community Minor Injury and Illness Units across Gloucestershire, other community services and mental health support.

On average, the service receives more than 550 calls per 24-hour period - Monday to Friday and more than 700 per 24-hour period at weekends. The service is providing between 30 to 40 out of hours appointments on weekdays and just under 150 per 24 hours at weekends.

Plans to expand dental services move forward

A contract has been awarded to Smile Together CIC for the provision of much needed NHS dental services at Quayside House Dental Access Centre (DAC) in Gloucester City.

Meanwhile, working with the University of Gloucestershire, we are progressing plans for a Centre of Dental Excellence in the heart of Gloucester City on King's Square. Alongside training the next generation of dental care practitioners, the dental training and treatment facility will also deliver NHS dental services.

Both facilities will provide urgent care appointments as well as treatment plans and regular, routine appointments for eligible people, where needed.



Joined up care helping people to leave hospital more quickly

Around 300 people each month have been supported to leave hospital more quickly when appropriate to do so thanks to the Integrated Flow Hub located at Gloucestershire Royal Hospital.

Staff from across health, social care, and the voluntary and community sector, work together to support timely care, improve decision making and significantly reduce the time it takes to get people out of hospital, when appropriate.

Ensure the services we deliver today are sustainable and safe



High winter vaccine uptake keeps Gloucestershire among England's best

Gloucestershire has delivered one of its strongest winter vaccination programmes, with uptake for both COVID and flu rising compared with last year. By the end of January, more than 74,000 COVID booster vaccines had been given, with uptake reaching 69 percent among eligible groups.

The flu programme has also made strong progress, with over 269,000 people vaccinated so far. Gloucestershire remains among the best performing areas in England, helping ease winter pressures across local services.



Pharmacy First Service expands to include contraception

All 105 pharmacies across Gloucestershire have continued to expand the range of healthcare services they provide. They can offer assessment, treatment, and, when appropriate, some prescription medicine for seven common conditions, as well as a confidential contraception service, without needing to see a GP.

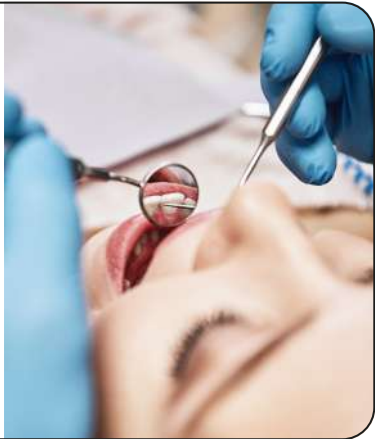
Our highly trained pharmacists can assess and treat patients for sinusitis (age 12+), sore throat (age 5+), earache (age 1-17), infected insect bites (age 1+), impetigo (age 1+), shingles and uncomplicated urinary tract infections in women (age 16-64). Now, anyone who needs emergency contraception (the morning after pill), a supply of the pill or an annual pill check can also arrange a confidential consultation at their local pharmacy.

Over the past 12 months, their expertise has helped over 51,700 local people with the seven conditions, contraception and other minor illnesses.

Expanding access to NHS dental care

We continue to make it easier for people to get NHS dental care across the county. Urgent dental appointments are available each week, including in the evenings and at weekends. Extra appointments also support people who have had urgent treatment but do not have a regular dentist.

From April, national Quality and Payment Reforms will mean most high street dentists with an NHS contract must offer a minimum number of urgent or unscheduled appointments. We are working closely with local dentists to increase the number of NHS dental places for children and adults.



Strengthening Outpatient Care for Local Patients

The NHS in Gloucestershire is making strong progress in improving outpatient care, helping people be seen more quickly and reliably. Outpatient clinics are now running 7.3% more efficiently, meaning more patients can be offered appointments sooner.

Teams have improved how clinics are planned and delivered, including start times, appointment mix and the balance between face-to-face and virtual care. The county also has the highest use of Patient Initiated Follow Up in England at 11%, giving people more control over when they return for care and helping free-up appointments for those who need them most.

Performance report



Performance Report – an overview

This overview provides a summary of:

- ▶ the role of NHS Gloucestershire Integrated Care Board (ICB) within the Gloucestershire system
- ▶ our strategic priorities
- ▶ the key risks to achieving these priorities
- ▶ how the system has performed during 2025/26.

NHS Gloucestershire Integrated Care Board (ICB)

NHS Gloucestershire Integrated Care Board (ICB) was established on 1 July 2022.

We are responsible for planning and commissioning services to meet the health needs of the Gloucestershire population (approximately 670,000 people).

The ICB plays a central role in bringing together partners across the county to improve population health, access to care and outcomes, and to deliver a shared vision for the future of health and care in Gloucestershire.

The Gloucestershire system

Within Gloucestershire, there is:

- ▶ one main acute provider (Gloucestershire Hospitals NHS Foundation Trust)
- ▶ one community and mental health services provider (Gloucestershire Health and Care NHS Foundation Trust)
- ▶ 64 GP practices
- ▶ Gloucestershire County Council and six District Councils.

A key mechanism for partnership working is through Integrated Locality Partnerships (ILPs). These are non statutory partnerships involving NHS organisations, local government, the voluntary, community and social enterprise (VCSE) sector, housing, and other partners such as police and education.

ILPs, working alongside the county's 15 Primary Care Networks, are well placed to understand local population needs and support the delivery of care closer to home.

The system also draws on expertise from organisations such as the West of England Academic Health Science Network and academic partners to support research, innovation and service improvement, ensuring practice is informed by evidence and learning.

How we work

The ICB Board includes Non Executive Directors with a range of expertise, alongside representatives from Gloucestershire County Council, NHS providers, primary care and Executive Directors. County Council representation includes the Director of Public Health and the Director of Adult Social Care, Wellbeing and Communities.

Although Gloucestershire had operated as an Integrated Care System since 2018, the Health and Care Act 2022 formalised the system and established the One Gloucestershire Health and Wellbeing Partnership. The ICB is a core member alongside NHS providers, local authorities, primary care and VCSE partners.

The system strategy, developed through public and stakeholder engagement, sets out three long term priorities:

- ▶ **Making Gloucestershire a better place for the future** - improving health and wellbeing through prevention and tackling wider determinants of health.
- ▶ **Transforming what we do** - strengthening locality working, improving equity, developing the workforce and maximising the benefits of digital technology.

- ▶ **Improving health and care services today** - improving access, reducing waiting times, strengthening urgent and emergency care and enhancing mental health support.

The strategy can be read in full here: <https://www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/#link-integrated-care-strategy>

Our constitution and statutory duties

The ICB's constitution sets out how we discharge our statutory responsibilities, including to:

- ▶ improve health outcomes and healthcare
- ▶ tackle inequalities in access, experience and outcomes
- ▶ enhance productivity and value for money
- ▶ support wider social and economic development.

The constitution also defines governance arrangements to ensure transparency, accountability and effective decision making.

Our constitution can be found on our website: www.nhsglos.nhs.uk/wp-content/uploads/2022/11/NHS-Gloucestershire-ICB-Constitution-01.07.22-v1.2-updated-11.11.22.pdf

We facilitate and champion choice for patients to enable people to choose care that best suits their circumstances in line with the NHS Choice Framework. If a GP needs to refer a patient for a physical or mental health condition, in most cases people have the legal right to choose the hospital or service they would like to go to. The ICB has patient information relating to patient choice on our website:

www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/patient-choice/

We also ensure that GPs and referrers are aware of and can support patients in accessing the choices available to them, and we build choice into our commissioning arrangements, for example when contracting new services.

When designing and transforming services, we consider the impact on patients, partners and communities. All significant service changes are supported by appropriate impact assessments and engagement, enabling evidence based decisions by the Board and its committees.

Performance

Performance in 2025/26 has been monitored against a combination of national NHS priorities, constitutional standards and the commitments set out in the One Gloucestershire Joint Forward Plan (2024–2029): www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/joint-forward-plan/

Performance Overview

The table below shows our performance assessment against system plans in 2025/26 by programme area.

Programme area	2024/25 Outturn	2025/26 Forecast
Urgent and Emergency Care	Amber	Amber/Green
Elective Care	Amber/Green	Green
Cancer	Amber	Amber/Green
Mental Health	Green	Green
Community Care	Green	Green
Primary Care	Green	Green
Diagnostics	Amber	Amber/Green

Nationally, the focus during 2025/26 has continued to be on recovery and resilience across core services, alongside improving productivity, reducing unwarranted variation and strengthening prevention. Key priority areas include urgent and emergency care, planned care, cancer services, diagnostics, primary care access and mental health.

Across the year, the Gloucestershire system has continued to work collaboratively to stabilise and improve performance. This includes system wide work to improve patient flow, reduce delays in people leaving hospital, address long waits for planned care and increase diagnostic capacity supporting both cancer and elective pathways.

Primary, community and mental health services have continued to play a critical role in sustaining access and supporting delivery in line with planned expectations, contributing to system resilience during periods of high demand. Further detail on performance against individual programme areas is set out in the Performance Analysis section.

Further detailed performance analysis is provided in the Performance Analysis section.

Key risks

The ICB's approach to risk management is described in the Annual Governance Statement. Strategic risks impacting delivery of statutory duties and system objectives are captured within the Board Assurance Framework (BAF) and reviewed regularly by the Board and Audit Committee, supported by the Corporate Risk Register.

Key areas of risk during 2025/26 include:

- ▶ delivering sustained improvements in urgent and emergency care and planned care
- ▶ ensuring primary care stability amid ongoing financial, workforce and estates pressures
- ▶ meeting productivity and financial sustainability requirements while demand continues to rise
- ▶ maintaining momentum in mental health transformation alongside workforce constraints
- ▶ safeguarding digital and estate infrastructure, including cyber security and business continuity.

In addition to strategic risks, the ICB has continued to monitor operational risks related to delivery across planned care, urgent and emergency care, cancer services and quality in provider organisations. The most significant risks and issues are explored further in the Governance Report.

Full details of the most significant risks are detailed in the Governance Report within the Risk Management Section.

An explanation of the going concern

The ICB is required to explain its consideration of its status as a going concern. This is effectively in relation to its intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

This is in addition to the Secretary of State direction that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

As a result, the governing body of NHS Gloucestershire ICB has prepared its financial statements on a going concern basis.

NHS System Oversight Framework

ICBs are assessed on their performance against their four purposes alongside their system leadership role as detailed in the NHS oversight framework. This outlines NHS England's approach to oversight and is aligned with the ambitions set out in the NHS Long Term Plan and the NHS operational planning and contracting guidance.

Element of ICB Annual Assessment	Related Statutory Duties
System Leadership	Duty to take appropriate advice Duty to consult patients and the public about decisions that affect them
Improving Population Health and Healthcare	Duty to improve the quality of services
Tackling Unequal Outcomes, Access, and Experience	Duty to reduce inequality of access and outcome
Enhancing Productivity and Value for Money	Financial duties Duty to facilitate, promote and use research
Helping the NHS to Support Broader Social and Economic Development	Duty to have regard to the effect of decisions (The Triple Aim) Duty to contribute to wider local strategies

ICBs are assessed under the NHS Oversight Framework against their four core purposes and their system leadership role. This includes assessment of progress against Joint Forward Plans, financial position, delivery of national priorities and system leadership, with input from partner organisations including Health and Wellbeing Boards and Integrated Care Partnerships.

During 2025/26, this framework has continued to provide the basis for NHS England's proportionate oversight of the Gloucestershire system.

Further information can be found here: <https://www.england.nhs.uk/nhs-oversight-framework/>



Shane Devlin
Cluster Chief Executive
15th June 2026

Performance Report – performance analysis

Introduction and context

NHS Gloucestershire Integrated Care Board (ICB) monitors the performance of health and care services across the county, with a focus on quality, safety, timeliness and outcomes for local people. Performance is assessed against national NHS priorities and constitutional standards, alongside local operational and strategic commitments set out in the Joint Forward Plan.

System performance is reviewed regularly by the ICB Board and its Committees, supported by the Integrated Performance Report. This brings together intelligence on service quality, activity, finance and workforce to provide a consistent and transparent view of delivery, risk and improvement actions across the system. Performance information is published through public Board papers and is available on the NHS Gloucestershire ICB website www.nhsglos.nhs.uk/category/board-meetings/

During 2025/26, national priorities continued to focus on recovery and resilience across core NHS services, with increased emphasis on productivity, prevention and reducing unwarranted variation. Urgent and Emergency Care, elective recovery, cancer services and diagnostics remained areas of sustained national and local scrutiny. While progress was made in improving access and outcomes, continued pressure on urgent care services - particularly during the winter months - presented ongoing challenges, driven by rising demand, seasonal illness and workforce constraints.

Improving access to primary care, including dental services, remained a key priority throughout the year. In Gloucestershire, general practice continued to deliver high levels of appointment activity, strengthening early support and management of patient needs, alongside continued access to urgent care when required.

Patient satisfaction with general practice remains favourable compared to national benchmarks. Targeted action was taken with NHS dental providers to increase activity and improve access to urgent and stabilisation care, particularly for people without a regular dentist.

The system also maintained a strong focus on vaccination uptake across eligible populations, building on the success of previous delivery programmes.

Access to mental health services remained a major national and local priority. Gloucestershire sustained high levels of access to perinatal mental health services, Children and Young People's Mental Health Services (CYPMHS) and community based support for people with Serious Mental Illness (SMI). Integrated, holistic models of care for people with SMI continued to strengthen, including improved uptake of annual physical health checks and expanded access to wider support such as employment, wellbeing and benefits advice. Delivery of Individual Placement Support (IPS) continued throughout the year, helping more people to move closer to, or return to, employment through personalised support.

Restoring and improving NHS productivity remained a core requirement following the COVID-19 pandemic. In Gloucestershire, this challenge is further intensified by sustained growth in demand and rising clinical complexity associated with an ageing population.

Gloucestershire providers have nonetheless made significant progress in addressing the productivity challenge, recognising productivity improvement not simply as an efficiency measure but as a means of creating additional capacity for patient care. This has enabled clinicians to spend more time with patients to improve outcomes, while also supporting the system to see and treat a growing number of patients as healthcare demand continues to increase.

Throughout 2025/26, the ICB and system partners maintained a strong focus on delivering positive outcomes while ensuring value for money and financial sustainability.

Productivity improvements were embedded across services, including initiatives to improve outpatient efficiency, reduce unwarranted variation and optimise clinical capacity. This included the continued use of digital patient portals to support communication and reduce missed appointments, alongside work to maximise theatre utilisation and reduce downtime within acute services.

Following the publication of the Darzi Review and the Government's commitment to a 10-Year Health Plan, engagement during 2025/26 focused on three long-term shifts: moving more care from hospitals

into communities; making better use of digital technology and data; and placing greater emphasis on prevention and reducing health inequalities. These shifts align closely with the three pillars of the One Gloucestershire Integrated Care System Strategy (www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/#link-integrated-care-strategy) and continue to shape the system's approach to performance oversight and service transformation.

Overall system performance during 2025/26 reflected delivery against statutory duties and strategic objectives within a challenging operational environment. Rising demand, workforce pressures and sustained system constraints required continued focus on access, quality, safety and financial sustainability.

Progress was made in strengthening prevention and early intervention. Primary care delivered activity consistently above plan, supporting earlier identification and management of conditions. Community pharmacy played an increasingly important role in improving access, with over 35,000 people supported through the Pharmacy First service. Strong vaccination delivery also contributed to wider system resilience.

Access to mental health services continued to improve, with CYPMHS exceeding planned levels of access and perinatal mental health services supporting over 900 women, significantly above target.

Care continued to shift into community and neighbourhood settings, in line with national priorities. Community urgent response services exceeded national response standards and contributed to a reduction in long hospital stays. Mental health services maintained a strong community-based model, with low use of out-of-area placements and sustained delivery of effective Talking Therapies, supporting care closer to home while maintaining quality and safety.

Ensuring people receive the right care in the right place was a core priority. NHS 111 performance remained strong, supporting local people to navigate to, and access, appropriate services.

Expanded use of Patient Initiated Follow-Up enabled more clinically appropriate outpatient care, releasing capacity while maintaining patient safety. Significant improvements in ambulance handover times enhanced system flow and ambulance availability, although ambulance response times continue to be challenged by activity levels above contracted demand.

Equity of access and outcomes remained central to the system's approach. Our Community Diagnostic Centre improved access for more deprived populations, and mental health access continued to compare favourably with national benchmarks. However, inequalities persist - particularly in waiting times for diagnostic tests and dementia diagnosis - and addressing unwarranted variation remains a priority.

Elective (planned care) recovery progressed throughout the year, supported by better use of theatre capacity and 18-week Referral to Treatment performance above the national average. The number of people waiting a long time for a planned procedure was reduced to a small proportion of the waiting list.

Workforce availability - particularly within diagnostics - remains the most significant risk to sustainability and will continue to be a key focus. While timeliness improved in several areas, including cancer pathways, diagnostic waiting times, especially for echocardiography, remain a key operational challenge.

Looking ahead to 2026/27, the ICB will focus on stabilising core services while accelerating system transformation, balancing immediate recovery with delivery of longer-term ambitions set out in the One Gloucestershire Joint Forward Plan (2024 - 2029) www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/joint-forward-plan/

Pillar One: Making Gloucestershire a better place for the future

Objective - Increase prevention and early intervention

Primary Care and Pharmacy First

Primary care and community pharmacy made a significant contribution to prevention and early intervention during 2025. General practice delivered on average 390,000 appointments per month, consistently 12-20% above plan, supporting earlier management of conditions and reducing escalation. Pharmacy First supported over 75,000 patients with assessment and treatment for common conditions, while community pharmacies delivered around 39,000 flu vaccinations, strengthening population health and winter resilience. Together, these interventions reduced avoidable demand for urgent and acute services.

Perinatal mental health

Access to perinatal mental health services consistently exceeded expectations, supporting over 900 women on a rolling 12-month basis against a target of 672 (over 120% of plan).

All referral-to-assessment standards were met throughout the year, demonstrating timely access and effective early intervention. Delivery was supported by stable staffing and close integration with maternity services, with ongoing monitoring to ensure sustainability as demand increases.



Children and Young People's Mental Health

Early intervention for children and young people (CYP) continued to strengthen. CYP access to mental health support exceeded the plan by 5-10%, reaching approximately 9,500 children, while performance against the 4 week referral to assessment standard recovered to around 75-85% following seasonal variation. Expansion of Mental Health Support Teams in educational settings supported earlier access and reduced reliance on specialist services.

Maternity and Early Years

Maternity services focused on early identification of risk and timely intervention through integrated working with primary care, safeguarding and perinatal mental health services. Close alignment with perinatal mental health pathways supported early access to mental health support (see mental health section above). Preventative activity prioritised early booking, personalised care planning and targeted support for women with additional clinical or social risk factors.

Individual Placement and Support (IPS)



Having seen the IPS offer grow throughout 2024/25, in 2025/26 we have maintained access to this service, helping people with severe mental health problems find paid employment which has been shown to reduce people's symptoms, improve quality of life and enable financial independence.

Pillar Two: Transforming what we do

Objective - Take a community & locality focused approach to the delivery of care

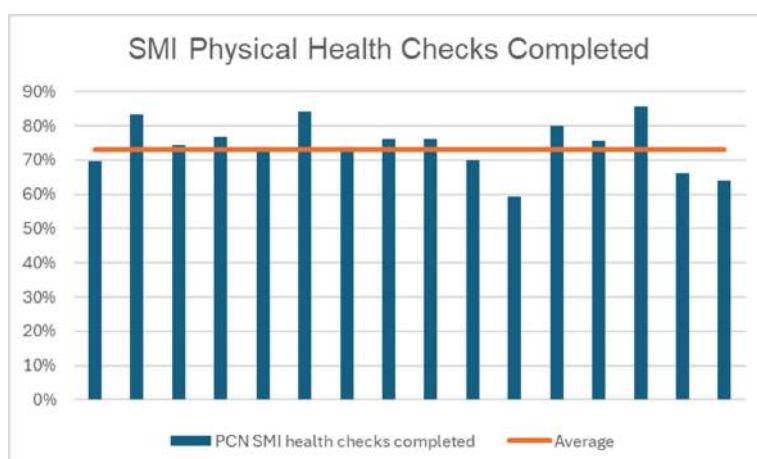
Community Services and Frailty

Delivery of care has increasingly shifted into community and neighbourhood settings. Community urgent response services achieved 75-90% of referrals within the 2 hour response standard, exceeding the national expectation of 70%. Frailty focused quality improvement across primary care and community teams contributed to a 25-50% reduction in patients needing a hospital stays over 21 days compared with the previous year. Workforce availability remains a risk in some therapy services and is being managed through targeted recruitment and pathway prioritisation.

Mental Health Support in the Community

Mental health services maintained a strong community focus. Use of out of area placements remained low compared with previous years, and Talking Therapies delivered reliable improvement rates of around 69-72%, with activity delivered above plan. These services supported people closer to home while maintaining quality and safety.

Across our Primary Care Networks (PCNs) we have seen continued uptake of physical health checks by people with Serious Mental Illness (on the register in primary care) - all but one PCN achieved above 60% (national target) with the average across the system at 73%. This gives clinicians the opportunity to support health interventions for people which will prevent worsening physical health and help to contribute to decreasing the gap in life expectancy between those with serious mental illness and the rest of the population. In our county, lower areas of uptake of health checks tend to be in higher areas of deprivation and we are actively working across primary and secondary care to improve reduce this inequality.

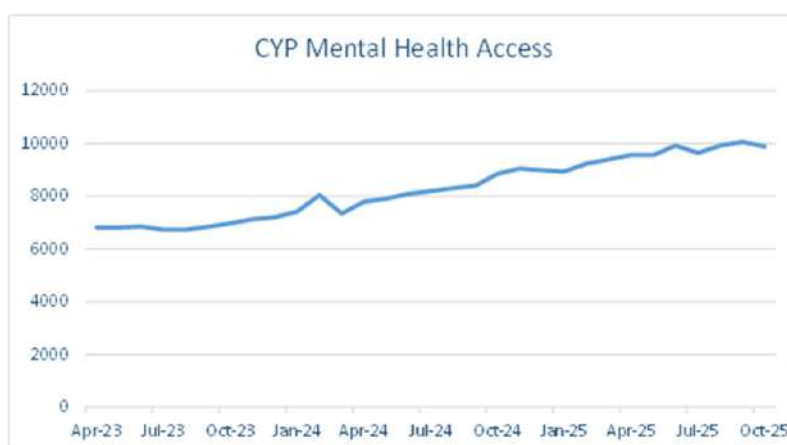


Children and Young People's mental health access/Young Minds Matter

We have continued to roll out Mental Health Support Teams (known locally as "Young Minds Matter") in our schools in a phased approach - prioritising areas of highest deprivation and greatest need. These teams offer online or in-person support to children and young people suffering from anxiety, low mood and poor sleep or similar concerns. This not only offers young people the most appropriate support for their circumstances but helps to reduce demand for more intensive mental health support.

Access to children and young people's mental health services in Gloucestershire continued to improve in 2025/26. More children and young people were able to enter care than in the previous year, reflecting sustained efforts to increase access and respond to rising levels of need.

As demand has grown, the number of children and young people on the waiting list has increased from 4,763 to 5,570 and average waiting times have risen from 54 weeks in 2024/25 to 64 weeks in 2025/26. Work continues with providers and partners to further improve timeliness while maintaining a focus on access, quality and clinical prioritisation.



Maternity and Community-Based Care

Maternity care was delivered through a community based model, with services provided across hospital, community and home settings in line with national guidance. Locality working supported continuity of carer and strengthened links with health visiting, primary care and perinatal mental health teams. This approach improved coordination across services and supported safer transitions, particularly for women requiring multi agency support.

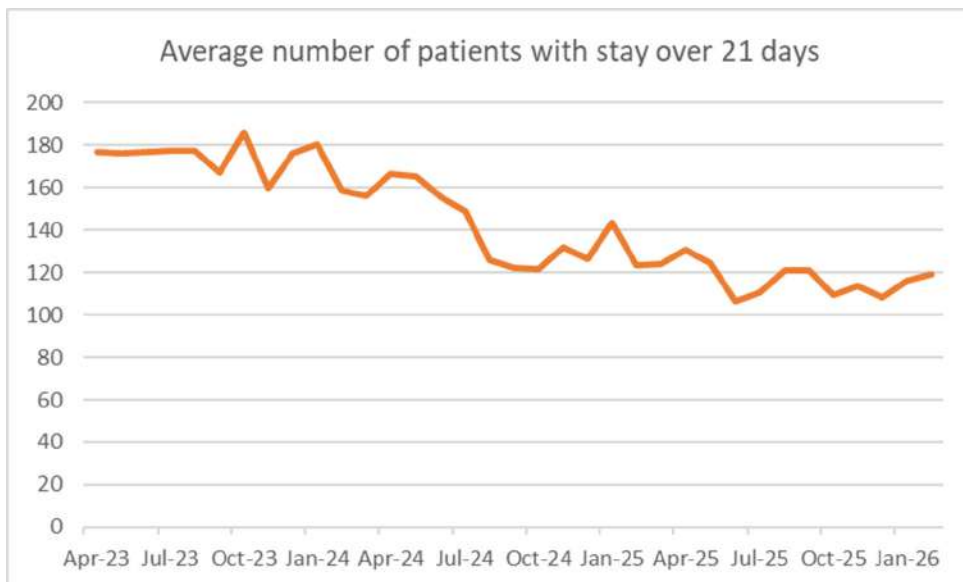
Objective: Providing the right care in the right place, when it is needed most

Maternity care and access

Maternity care was organised to ensure women received care in the most appropriate setting based on clinical need. Clear arrangements were in place so women could quickly move into obstetric-led care when needed, while community provision supported safe care closer to home for low risk pregnancies. Integration with urgent and emergency care pathways ensured rapid access to acute services where clinically indicated.

Urgent and Emergency Care

Throughout 2025/26, we have continued to implement our "Working as One" programme for Urgent and Emergency Care (UEC), which has aimed to help avoid admission to hospital, when possible, improve the care pathways across the whole UEC system and expand our offer of technological support to care, such as through our virtual wards. By optimising hospital flow, the length of stay in acute hospitals has been reduced by 14%, making it easier to ensure space for patients needing admission. Additionally, there has been a consistent reduction in patients staying in hospital for more than 21 days throughout the year, although this trend faced challenges during the winter months due to increased flu and norovirus incidence.

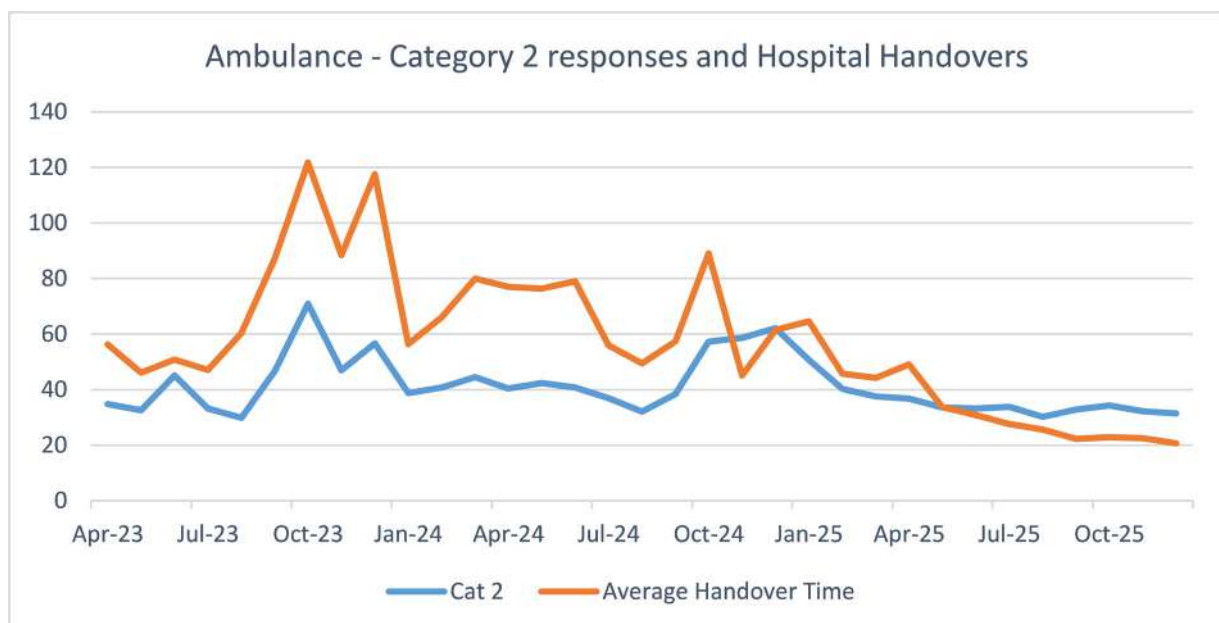


Ambulance response times

During 2025/26, ambulance response times improved compared with the longest delays seen in previous years but still did not meet the 30-minute average target for Category 2 incidents. Performance continued to be affected by seasonal pressures, particularly higher winter demand and increased patient acuity.

Hospital handover delays reduced over the course of the year, and their impact on Category 2 response times lessened in the later months. Average handover times fell from over 60 minutes in early 2024 to around 20-30 minutes during 2025, improving ambulance availability and overall flow.

System actions also supported more appropriate use of urgent care. NHS 111 performance remained strong, with call abandonment consistently below 2%. As a result, Category 2 response times improved to 30-34 minutes, but still remained above the interim target, reflecting ambulance demand running 5-7% above contract.

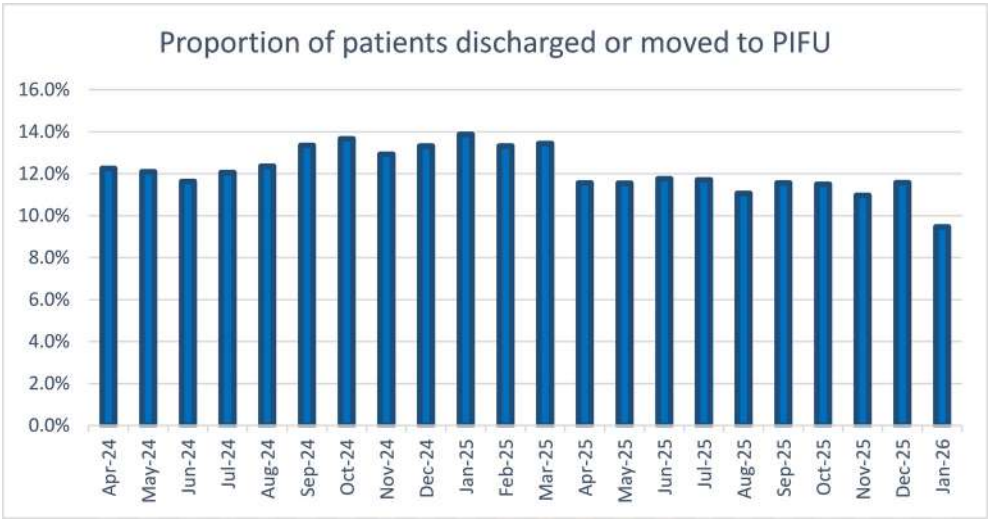


Elective (planned) Care

Patient Initiated Follow Up (PIFU)

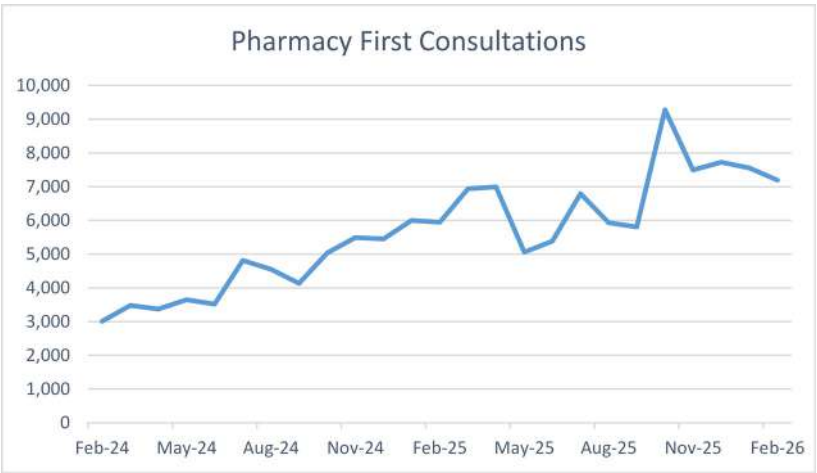
Patient Initiated Follow Up (PIFU) allows patients to request follow-up care when it is appropriate for them, supporting shared decision-making and self-management. Good levels of PIFU have been maintained, helping to manage waiting list volumes and ensure that care is prioritised for those who need it most.

During the year, elective services expanded the use of PIFU, so that follow-up care was delivered when clinically required rather than through routine appointments. This helped stabilise delayed follow-up lists, released outpatient capacity and maintained patient safety. Referral to Treatment (RTT) performance ranged between 67% and 70%, outperforming the national average of around 61%, and remained on track to achieve the 72-73% interim target by March 2026.



Pharmacy First

To assist with access to general practice, the national Pharmacy First offer has been developed to allow patients to get certain prescription medications directly from a pharmacy, without a GP appointment. In Gloucestershire, the Pharmacy First offer has helped over 35,000 local people to access assessments, advice and medications (where appropriate) for the seven conditions and other minor illnesses covered by the scheme in the first 12 months since its launch. We have seen good progress in increasing consultations throughout the year:



Objective: Equity of service provision

Diagnostics and Community Access

Equity considerations were embedded across service delivery. The Community Diagnostic Centre demonstrated higher utilisation from more deprived populations, supporting earlier access for higher risk groups. Overall diagnostic waiting times increased during the year, with around 20 to 25% of patients waiting over six weeks. This was largely due to pressures in echocardiography, where workforce shortages meant that, at peak, more than 70% of patients waited beyond six weeks. Mitigations included insourcing, use of locum capacity and pathway redesign. Workforce capacity remains a key risk to maintaining equitable access.

Serious Mental Illness and Dementia

Support for people with Serious Mental Illness remained stable, with around 80% of people with SMI taking up a physical health check, broadly in line with national expectations. Dementia diagnosis rates fluctuated between 63% and 66%, slightly below the national ambition of 66.7%, with some variation linked to data quality issues. Targeted improvement work in primary care and frailty services was put in place to reduce variation between practices and improve access to care.

Equity in Maternity Services

Equity was a core consideration in the delivery of maternity services throughout the year. Community based models of care and integrated working supported access for women living in more deprived communities and those with additional vulnerabilities.

Targeted approaches focused on reducing unwarranted variation in access and outcomes, aligned with system priorities on health inequalities and early intervention although Detailed breakdowns of maternity equity data by demographic group were not routinely reported through the Integrated Performance Reports.

Challenges remain in ensuring equitable access to maternity services and addressing wider health inequalities that influence outcomes. A health needs assessment has been undertaken which looks at outcomes alongside demographic breakdowns through the Health Inequalities in Gloucestershire work, in line with NHS England guidance on the use of information to meet statutory duties on health inequalities: <https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities-duty/>

Pillar Three: Improving our services today

Objective: Ensure the services we deliver today are sustainable and safe

Elective (Planned) Care Sustainability

Planned care services focused on maintaining recovery while supporting longer-term sustainability. Theatre utilisation averaged 81 to 82%, placing providers in the upper quartile nationally. Long waits reduced to around 120 to 140 patients waiting over 52 weeks, representing approximately 0.2% of the waiting list. Risks associated with increased reliance on independent sector capacity following the withdrawal of elective recovery funding were managed through demand modelling, targeted waiting list validation and initiatives to improve productivity and use of capacity.

Workforce and Service Safety

Across diagnostics, cancer and community services, workforce availability remained the most significant sustainability risk. Mitigations included targeted use of locum capacity, expansion of nurse-led models of care and prioritisation of high-impact pathways based on clinical risk. In mental health, low use of out of area placements and stable Talking Therapies outcomes supported safe, local care delivery.

Primary Care - General practice access and Dental access

Demand for primary care services, particularly general practice and dental provision, continued to grow during the year. We have continued to prioritise the sustainability of these services to support resilience in the face of ongoing demand. This includes the award of a new primary care contract at Quayside, which will help strengthen local capacity and improve access for patients. Together, these actions support a more stable and responsive primary care system for Gloucestershire.

During 2025/26, GP practices delivered the highest number of appointments on record and continued to expand the range of services available to patients through additional roles such as social prescribers, care coordinators, paramedics, and physiotherapists.

While performance against the “appointments booked within two weeks” measure in Gloucestershire was below the national average, the high overall volume of activity meant that the system ranked 3rd out of 41 integrated care systems for appointments delivered per head of population, and 10th out of 41 for the volume of appointments booked within two weeks.



Efforts are being made to improve access to NHS dental services by expanding and supporting the local dental workforce and promoting oral health in collaboration with our system partners. Current performance shows delivery of around 70% of contracted dental activity across the county. Plans are in place to increase activity in the coming year, including commitment to the national target to expand access to urgent dental appointments in 2026/27.

Maternity Services

Maternity services remained a key priority for the system, reflecting the continued national focus on maternity care during 2025/26. Oversight of safety and quality was provided through the Local Maternity and Neonatal System (LMNS), aligned to the national Maternity and Neonatal Delivery Plan. Improvement activity focused on outcomes for mothers and babies, including progress towards national ambitions on stillbirth and neonatal mortality rates.

Services operated within established safety, quality and governance frameworks, with a continued emphasis on multidisciplinary working and learning from incidents. Workforce capacity remained a key sustainability risk and was managed through rota planning, service integration and alignment with wider system workforce strategies. Ongoing integration with perinatal mental health and community services supported the delivery of safe and resilient maternity care.



Objective: Improve the timeliness of care and treatment

Urgent and Emergency Care

Rising demand for acute care, an ageing population with increasingly complex needs, and ongoing challenges in ensuring timely access to appropriate care following hospital discharge continue to place pressure on urgent and emergency services. Alongside this, the Working as One transformation programme has coordinated system-wide action to improve existing Urgent and Emergency Care pathways and maximise opportunities to deliver care outside of acute hospital settings. The timeliness of urgent care delivery remains a key indicator of the impact of this work:

Emergency Department (ED) waiting times

Following a period of increased cases of seasonal influenza, COVID 19 and RSV in December, infection rates stabilised at the start of 2026, consistent with expected winter pressures.

As reported to the Health Overview and Scrutiny Committee in March 2026, fewer acute beds were closed due to infection control this winter compared to previous years, despite infection rates being higher or comparable. Acute bed capacity was also more consistent, with fewer significant peaks and troughs, supporting improved system resilience.

Monthly A&E and MIIU four hour performance has remained relatively stable throughout 2025/26 to date. In February 2026, the system achieved 76.0% performance across Type 1 and Type 3 services, slightly below the operational plan trajectory of 77.2%.

Gloucestershire Hospitals NHS Foundation Trust (GHFT) achieved 62.6% four hour performance in February, an improvement from 60.1% in January, but below the planned position of 66.2%. Performance within the Minor Injury and Illness Units (MIIU) remained strong at 98.6%. Activity levels were above plan across all settings.



The proportion of patients experiencing waits of over 12 hours in Type 1 emergency departments increased in January 2026 but reduced again in February to 10.6%. While this remains above the plan trajectory of 7.9%, reducing long waits in emergency departments is a core priority within the Medium Term Plan, with focused actions underway to support sustained improvement.



Community Urgent Care

To support hospital attendance and admission avoidance, our Urgent Community Response team have been attending more referrals, with the 2-hour target for responses met in every month over the last two years:



Elective (Planned) Care

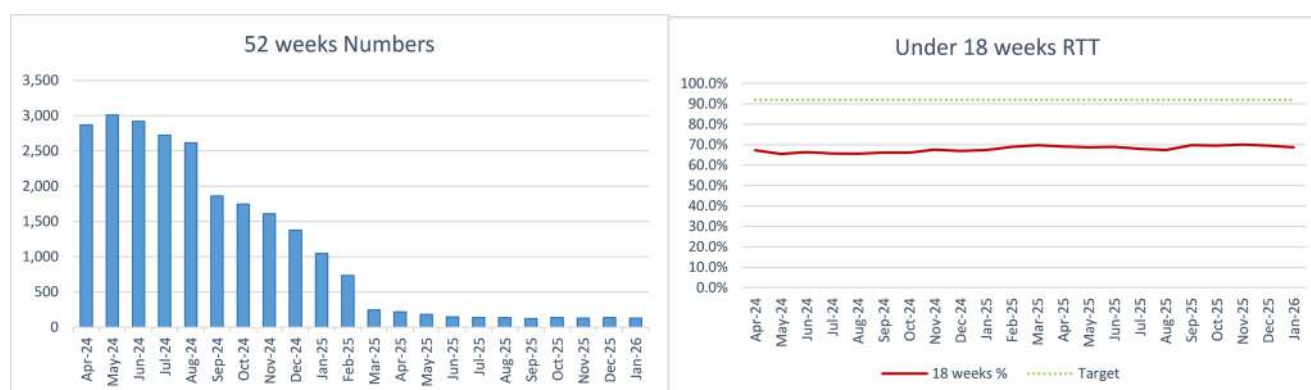
Following the significant growth in waiting lists for elective treatment, diagnostics and cancer care during the COVID 19 pandemic, the recovery of elective services has been a major priority for the NHS. Recovery is well underway, with Gloucestershire making strong and sustained progress. The system remains focused on the recovery phase, improving productivity, reducing waiting times and stabilising the size of the waiting list to ensure services are delivered in a sustainable way.

We are making services more efficient by expanding Advice and Guidance and improving secondary care pathways to ensure clinicians access specialist care effectively. We are following the 'Getting It Right First Time's Further Faster' programme - which identifies opportunities for improvements to support our recovery by ensuring only the right patients are referred, effective management of referrals, reduction in non-attended or cancelled appointments, best use of clinic capacity, and appropriate follow up (including use of Patient initiated follow up).

Referral to Treatment

The government has pledged to restore performance to the NHS constitutional target (92% of patients waiting less than 18 weeks for elective treatment) by 2029.

Gloucestershire has made significant progress in reducing the longest waiting times for planned operations and procedures as we continue to focus on improving efficiency and increasing the capacity of our services in 2025/26.



The number of patients waiting more than a year for treatment has reached the lowest levels since before the pandemic, while overall performance against the 18-week target has remained stable. Specific additional capacity has been procured during the year to support specialties with the longest waits or largest numbers of patients waiting - for example additional Ear, Nose and Throat clinics and Oral Surgery theatre lists. We have also continued to expand the offer of treatment through the independent sector where appropriate to support waiting times and increase patient choice.

Diagnostics

The system has continued to build on the success of the Community Diagnostic Centre throughout 2025/26, with overall volume of diagnostic tests delivered across the year the highest on record. We have been aiming to reduce the number of patients waiting more than six weeks for diagnostic tests, in line with the national ambition that no more than 1% of people on the waiting list should have been waiting over 6 weeks.

The COVID-19 pandemic significantly impacted performance in diagnostics with some areas particularly affected by infection control measures, such as Endoscopy. With system focus on performance recovery from the pandemic, additional capacity and pathway improvements have significantly reduced both the overall waiting list for endoscopic investigations and the number of people waiting more than 6 weeks for an endoscopy.

Some areas have remained challenging, such as provision of Echocardiograms within the six-week target - this is primarily due to workforce challenges with substantive staff difficult to recruit.

Diagnostic timeliness remained the most significant challenge, with 20-25% of patients waiting over 6 weeks despite increased activity. To mitigate this, 2,500 additional endoscopy procedures were approved and delivered through expanded capacity. Elective long waits continued to reduce, supporting improved patient experience and system flow, though sustained recovery remains dependent on workforce availability.



Cancer

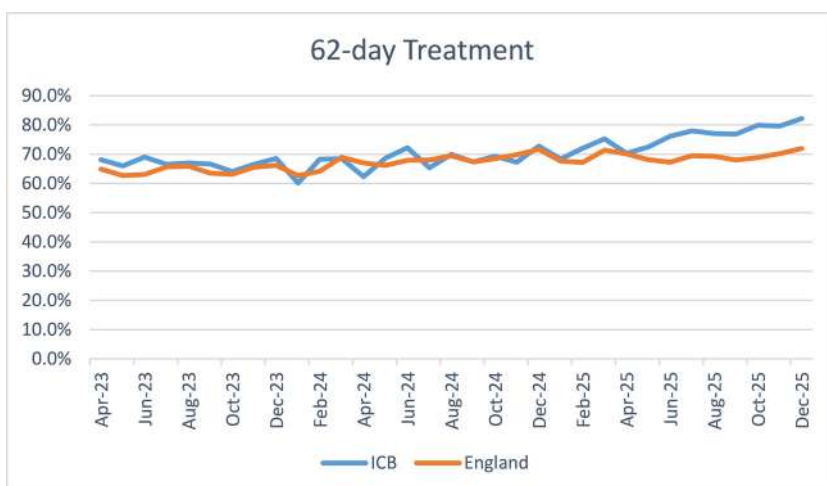
Performance against headline cancer targets has been challenging in 2025/26 due to capacity constraints within pathology services which has particularly impacted some specialties such as skin.

The Faster Diagnosis Standard (FDS), which aims for 75% of people to have cancer ruled out or receive a diagnosis within 28 days, remained under sustained pressure during 2025/26. By December 2025, performance stood at 70.6%. This position reflected a period of targeted recovery work addressing suspected skin cancer waits following seasonal increases in demand, alongside ongoing workforce and equipment capacity challenges within breast services. While performance was below the operational plan trajectory, focused recovery actions were implemented, with additional capacity in place to support improvement in breast services between February and April 2026.

Diagnostic turnaround times remain a critical enabler of cancer performance recovery. Pathology improvement plans are progressing, including increased capacity, digital reporting solutions and the outsourcing of non urgent samples. Radiology reporting turnaround times showed significant improvement earlier in the year, with all modalities achieving the seven day reporting standard in September 2025. More recent deterioration reflects ongoing staffing and operational pressures; however, recovery actions are in place to stabilise and improve performance.

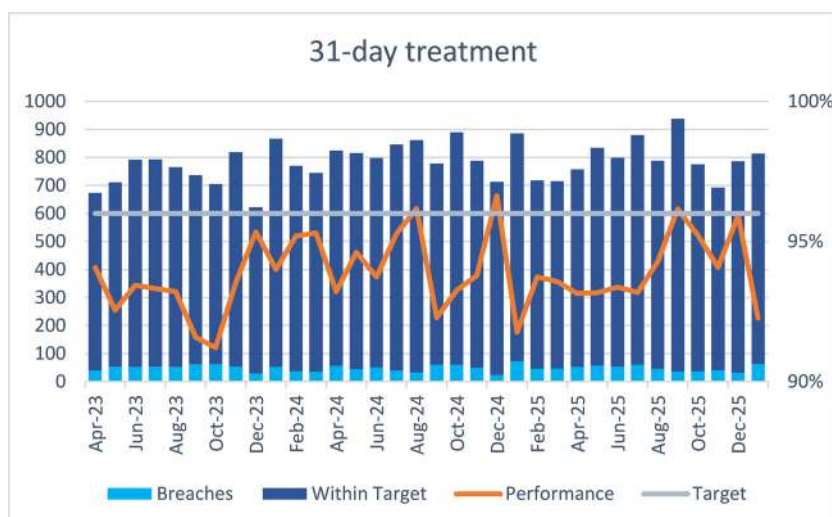


Treatment times in Gloucestershire have generally been consistent with the national average, with year-to-date 62-day treatment performance (% of people beginning their cancer treatment within 62 days of referral) averaging just under the national interim recovery target of 70%.



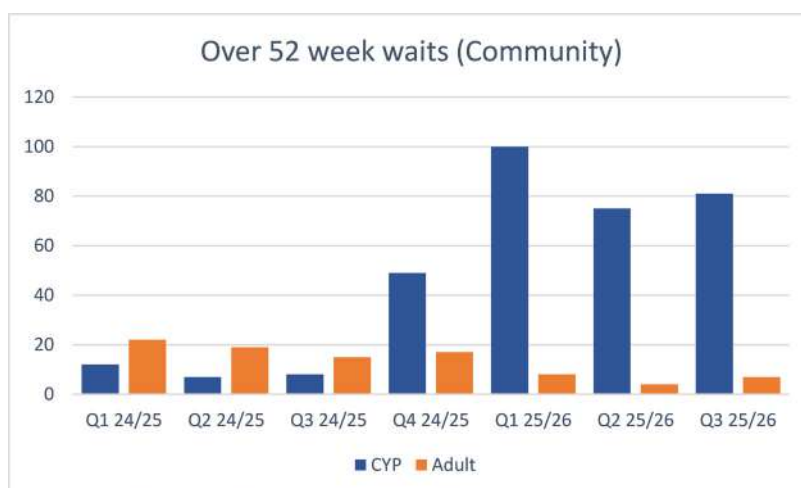
Most breaches of the treatment target have been for Skin, Lower Gastroenterological and Urological cancers, and we have committed additional capacity in these specialties to improve performance. The time spent on diagnosing these cancers in particular is impacting the ability to meet the 62-day treatment targets, so work has been carried out to optimise the pathway from referral to treatment, reducing delays.

This is demonstrated by our strong performance against the 31-day treatment target (for patients to receive treatment or surgery within 31 days of a decision to treat), which has remained above 90% all year:



Community services waiting times

The focus is not only on acute hospital services, but on ensuring timely delivery of care across all settings. Very small numbers of people continue to wait over 52 weeks for community services, and these have decreased over the year. Plans are in place to eliminate remaining long waits during the coming year.



Talking therapies in stage waits

Our talking therapies service has been focused on improving waiting times once people have commenced treatment - seeing significant reductions in the number of people waiting more than 90 days between first and second appointment in 2025/26:



Timeliness in Maternity Care

Timely access to maternity care remained a priority, with services designed to support early booking, appropriate surveillance and prompt escalation when clinically indicated. While quantitative maternity timeliness measures were not included in the Integrated Performance Reports, maternity services aligned with system wide work to improve responsiveness, continuity and coordination of care, particularly for women with complex needs.

Working in partnership to safeguard our population from abuse and neglect

As set out in Working Together to Safeguard Children 2023, the three safeguarding partners (Local Authority, ICBs and Police) must set out how they will work together with other agencies to safeguard and promote the welfare of children in their local area.

To demonstrate how the ICB has performed against this duty, please see the GSCP annual report (includes child death review arrangements) here <https://trixcms.trixonline.co.uk/api/assets/gloucestershirescp/c7af8150-8320-4680-b9ec-732ab18b0cb7/gscp-annual-report-2024.2025-final-approved-.pdf> and the ICB Safeguarding and Children in Care annual reports here <https://www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/#link-other> (2024/2025). The 2025/2026 report will be published soon and available via this link.

ICBs are responsible for the provision of effective clinical, professional and strategic leadership in safeguarding, including the quality assurance of safeguarding through our contractual arrangements with all provider organisations and agencies, including from independent providers.

We confirm NHS Gloucestershire ICB has followed the statutory assurance processes set out in the 'Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework' (SAAF). Further details can be found in the annual reports referred to above, but this includes:

- ▶ ensuring that ICB internal safeguarding arrangements are sufficient, and that safeguarding is embedded in practice
- ▶ assurance that the safeguarding arrangements of all commissioned services are appropriate
- ▶ co-operating and providing strategic health leadership within statutory local multi-agency safeguarding arrangements
- ▶ securing the expertise of Designated and Named Professionals for Safeguarding adults, children, and children in care

Our comprehensive work plan, that also serves as our quarterly assurance report to the ICB System Quality Committee, reflects our commitment to local, regional, and national safeguarding priorities. We describe within it how we sustain and enhance partnership working and strengthen safeguarding collaboration across the health system.

We updated our Safeguarding Strategy in 2025, with the following strategic objectives:

- ▶ Embed safeguarding and children in care priorities across all ICB functions through leadership, governance, and commissioning
- ▶ Strengthen multi-agency collaboration with statutory and voluntary partners
- ▶ Promote a culture of continuous learning and improvement in safeguarding practice
- ▶ Ensure the voice of children, adults at risk, children in care and care leavers are central to service design and delivery.

We have contributed to the ICB Strategic Commissioning Plan 2026/2027: Legislative Requirements and outlined our areas of focus in 2025/2026:

- ▶ Provided health system wide **safeguarding and children in care health leadership and assurance**
- ▶ Embedded **integrated safeguarding supervision** across the ICS, including monitoring compliance of mandatory safeguarding and children in care training at all levels across the ICB
- ▶ Continued to embed learning from **adult and children's statutory safeguarding reviews and Domestic Abuse Related Death Reviews (DARDR), including leading a SAR rapid review**, to prevent further harm to those most at risk of abuse and neglect
- ▶ **Reviewed the NHS provider safeguarding children dataset** to ensure it is focused, not onerous on provider services and meets our collective needs

- ▶ Managed the **ongoing capacity risk** to ensure the ICB meets statutory requirements for safeguarding and children in care through its Designated and Named Nurse and Doctor roles
- ▶ Continued to provide a **comprehensive ICB Safeguarding Primary Care Offer to General Practice** and their Safeguarding Leads, including safeguarding information sharing requirements, quality assurance visits, completion of an annual safeguarding assurance audit, facilitating safeguarding adult and children forums and other statutory safeguarding duties. Named GP working with PCNs and wider practice roles to understand health safeguarding support requirements
- ▶ Continued to deliver our **safeguarding statutory requirements**, including our health lead responsibilities at the Gloucestershire Safeguarding Children Partnership (GSCP) and Board level membership at the Gloucestershire Adult Safeguarding Board (GSAB)
- ▶ Continued as partner at the **Safer Gloucestershire Board**, including the Domestic Abuse Partnership Board (DAPB) and the new Domestic Abuse Delivery Plan and Strategy. Statutory Partner at the Serious Violence Duty Board
- ▶ Supported the delivery of the **Sexual Violence Delivery Plan and Strategy** through the Sexual Violence Strategic Board, building on the work of the Sexual Violence Partnership (SVP)

In addition during 2026/27, we will:

- ▶ Continue the ICB safeguarding leadership function to recognise, respond and manage safeguarding and children in care risk and lead the health response (individual **complex case management support** or wider themes)
- ▶ Take a wider formal **leadership role at the refreshed GSAB**, taking forward the new strategy as statutory partner and leading the Improving Practice workstream from April 2026
- ▶ Develop a provider **Safeguarding adult data set** alongside the revised children's data set, including FGM data and analysis
- ▶ Continue to represent the ICB and undertake a safeguarding health leadership role as part of the multiagency **Families First Partnership** reforms, including the **Multiagency Child Protection Team pilot**
- ▶ **CP-IS** (Child Protection information Sharing) digital system - progress a pilot alongside the ICB digital team for phase 2 roll out in scheduled care settings as set out by NHSE.

**Taskforce on Climate-related Financial Disclosures (TCFD) -
A sustainable and green NHS**

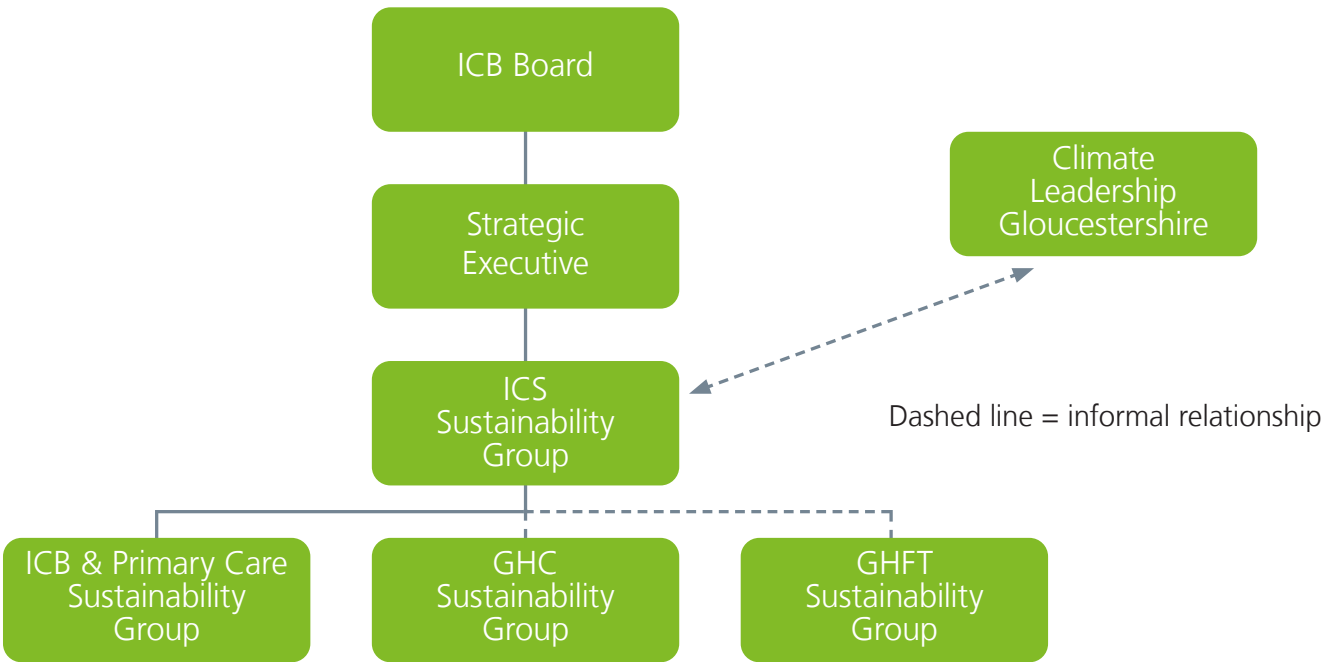
We have a legal and social responsibility to address climate change and to reduce our carbon emissions, as set out in the UK’s Climate Change Act. Climate change and people’s health are inextricably linked, with rising global temperatures and air pollution contributing to the direct increases in rates of major diseases including asthma and heart disease.

In addition, climate change brings the potential for floods, storms, and heatwaves that will significantly disrupt the delivery of healthcare services across the country. The ICS recognises the concurrent crises of climate change and health inequality as interconnected challenges that demand urgent, coordinated action. Positive action on climate change and ecological emergency frequently reduces health inequalities.

In Gloucestershire, the effects of climate change are happening now, notably seen in increased frequency and severity of flooding, and higher summer temperatures. These events threaten the physical and mental health of local people and increase the existing pressures on healthcare services.

Every NHS organisation has an essential role to play in meeting this ambition. In Gloucestershire, NHS Gloucestershire Integrated Care Board (ICB) and our partner organisations have been working together to plan how we can meet this NHS ambition together. The refreshed Green Plan, approved by the Board in March 2026, details our next steps in reducing carbon emissions within the system: <https://www.nhsglos.nhs.uk/wp-content/uploads/2026/04/NHSGlos-Green-Plan-2026.pdf>

The governance structure for sustainability is shown below. Membership of the ICS sustainability group is drawn from the ICB, Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospital NHS Foundation Trust (GHFT) and Gloucestershire County Council, with reporting into the Strategic Executive. In addition, the ICB is a member of the Climate Leadership Gloucestershire Board, ensuring the join up between health and Local Authorities within the county.



The ICB’s Chief Finance Officer (CFO) takes responsibility for Sustainability at Board level.

Sustainability is seen as key across all programmes within the ICS, with sustainability featuring within a growing range of dedicated meetings, including the Local Health Resilience Partnership (particularly looking at the long-term impacts of climate change - Adaptation) and Estates including Primary Care.

In addition, all Board and Committee papers are required to outline the impact on Sustainability and reporting against sustainability within Gloucestershire ICS is developing.

Risk management

Climate related risks, along with all other risks, are identified by teams throughout the organisation as part of the ICB's risk management policy. All identified risks feed into the ICB risk register and are managed in line with the ICB risk management approach. Risk management is described in more detail in the governance report.

Strategy

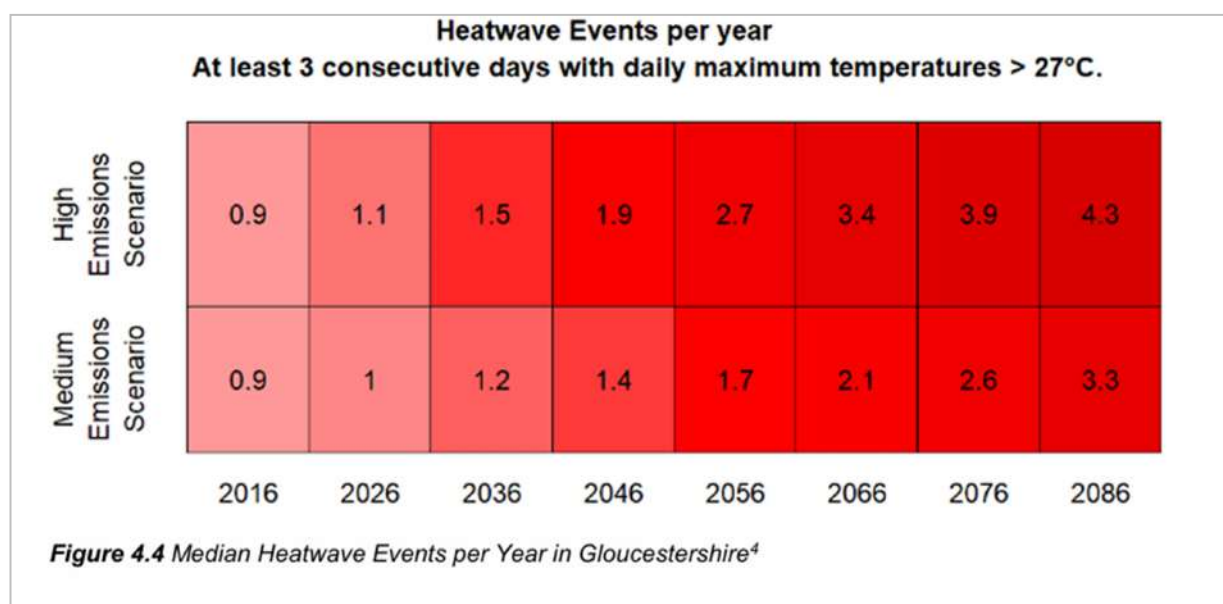
In addition, the Climate Leadership Gloucestershire partners, which include NHS organisations, commissioned a climate risk and vulnerability assessment during 2025/26:

https://www.gloucestershire.gov.uk/media/zprggygt/glos-crva-report_final.pdf

The Climate Risk and Vulnerability Assessment (CRVA) looked at medium and high emissions scenario with two timescales: 2050 and 2080. It provides evidence to understand the key climate risks across the county, demonstrating the impact, likelihood and overall risk posed by climate change across a variety of climate hazards and recommending future climate adaptation actions which will continue to bolster Gloucestershire's ability to respond to and withstand the impacts of climate change.

Within Gloucestershire the key risks identified for the health and care system are:

- ▶ Risk to public health and wellbeing from increased temperatures
- ▶ Risk to health and care service delivery from increased temperatures



- ▶ Risks to health and social care delivery through flooding, in particular surface water flooding.

Winter rainfall is expected to increase under both medium (+8%) and high (+12%) emissions scenarios.

Surface Water Flooding

Risk Category	Present Day Risk Area (Km ²)	High emissions scenario 2050 Risk Area (Km ²)
High	47	62
Medium	24	33

Risks were scored through an impact and likelihood assessment; details of the assessment process are detailed in the CRVA.

Risk	Risk Driver	Impact	Mitigations
Risk to public health and wellbeing from increased temperatures	Heatwaves are becoming more frequent; Gloucestershire experienced 4 heatwave events in 2025	Increase in health-related issues and therefore demand for services due to overheating, including mortality impacting on most vulnerable groups	Public health campaigns have been implemented to promote adaptive behaviours amongst residents Emergency response plans include adverse weather plans
Risk to health and care service delivery from increased temperatures	The 20% most deprived areas indicate that areas of higher deprivation in Gloucestershire are vulnerable to risks from overheating	Staff may also be impacted by working in increased heat	Training on climate risk identified within the green plan as a priority
Risks to health and social care delivery through flooding, in particular surface water flooding	Gloucestershire is already at risk from surface water flooding, and this risk will become more pronounced due to dense urban development and limited natural drainage	Individuals may not be able to access help and health and care staff may not be able to visit vulnerable individuals or be able to travel to work Health care infrastructure may be impacted by flooding	Organisations are reviewing risk assessments for specific sites & buildings; mitigations currently include natural flood defenses such as tree planting Emergency response plans include adverse weather plans New buildings are being designed with climate risk included

The ICB Board reviewed this report at its March 2026 meeting, and the sustainability steering group will consider key actions relevant to the ICS as a whole, actions related to specific sites will be taken forward by the appropriate organisation.

Metrics and target pillar

Key metrics are set out in the ICS Green Plan across the following areas: travel & transport, estates and facilities, climate adaptation, sustainable models of care, medicines and procurement and Workforce and System Leadership. Delivery of a number of these is through our partner organisations, Gloucestershire Health and Care NHSFT and Gloucestershire Hospitals NHSFT and specific information is included in their annual reports.

Progress against the green plan is shown below:

Priority Areas	Short/Medium term objective	Objective	Progress	
Transport & Travel	Short term	Each organisation to reduce business mileage by 20%	Business mileage: reduction achieved against 19/20 baseline. ICB 24/25 mileage 54% of 2019/20 level	
	Medium term	Green travel plan including cycle to work	Green travel plans in progress aligned to NHS green travel plan • Green Travel Plans in development • Cycle schemes in place in each organisation • Lease car scheme in place for either hybrid or fully electric vehicles • Joint plan in development with GCC and NHS partners on EV charging	
	Medium term	At least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emissions)	Joint programme of work started across the system including GCC, development of joint plan for EV charging in progression GHC installed 30 EV charging points	
Estates & Facilities	Short term	Each organisation purchases 100% of its electricity from renewable sources	Organisations purchase from renewable sources	
	Medium term	Implementation of detailed plans	ICB head quarters move Sept 23, halving office space used Gloucestershire Health & Care NHSFT: New Forest of Dean Hospital opened April 2024, built to be net zero	
			GHFT & GHC: Salix funded projects at completion 2024/25 Carbon calculations reported through Greener NHS dashboard for Trust estate Sustainability requirements included in the ICS Infrastructure draft strategy	

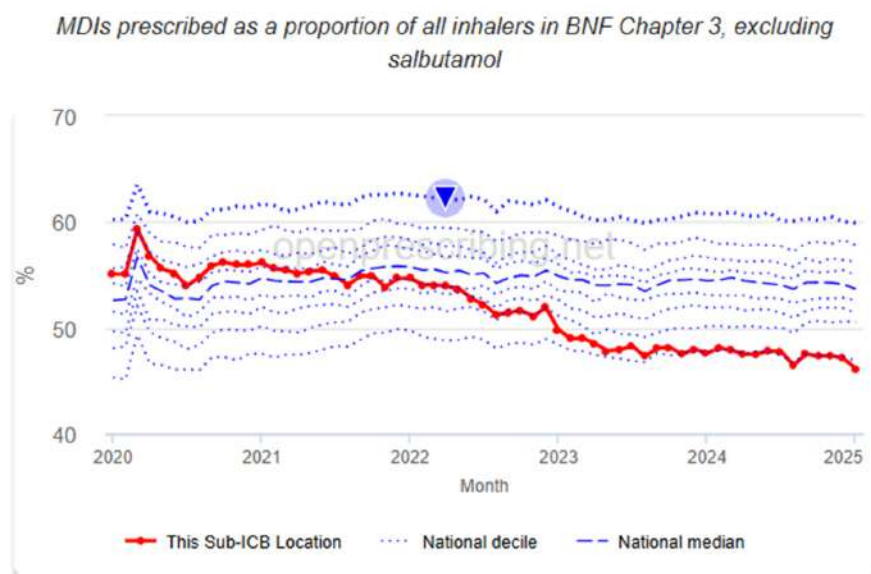
Climate Adaptation	Medium term	Undertake a risk assessment to highlight risks to continuity and resilience of supply	Climate adaptation work across Gloucestershire jointly with Local Authority & the NHS completed in 2025/26	
		Develop a Climate Change Adaption Plan outlining interventions and action to mitigate the risks	Work to review risks within the climate risk assessment started	
Sustainable models of healthcare	Short term	Ability to refer patients from primary care to the nature-based prescribing opportunities in conjunction with the VCSE sector	Nature based social prescribing scheme in place, eg Glos Wildlife Trust (programme of activities for children & young teens who are struggling with mental health issues), Wilde Earth Journeys and Tewkesbury Nature Reserve which run community activities and walks	
	Medium term	Increase access to green space and biodiversity on site	In progress	
	Short term	Increase remote consultations	Remote access consultations available for clinicians across the county including primary care 2024/25 non face to face outpatient appointments 17.58% of total outpatient appointments (April -Feb)	
	Medium term	Further rollout of virtual wards	In progress	
	Short term	Digital literacy programme jointly with GCC to enable better access to digital services by a wider range of the population	Digital literacy programme in place jointly with Gloucestershire County Council since 2023, next steps development where this becomes self-sustaining Total participants 5,037 of which 2,258 new and 2,579 returning. Support areas: internet (20.58%), employability (16.83%), on line services (13.39%), devices (10.3%), e-mail (10.18)	
	Short term	Patient portal in implementation within Gloucestershire Hospitals NHSFT	In progress	

Medicines and procurement	Short term	Reducing the proportion of desflurane to volatile gases used in surgery to 10%	Gloucestershire Hospitals NHS FT Reduction in nitrous oxide use	
	Medium term	Plans for clinically appropriate prescribing of lower carbon inhalers & how to encourage service users to return their inhalers to pharmacies for appropriate disposal Reduce meter dose inhalers prescribed by 25%	Low carbon inhaler prescribing progressed (see graph below)	
	Short term	A minimum weighting of 10% of the total score for social value should be applied in all procurement (PPN 06/20)	In place	
	Medium term	Stop use of single-use plastic cutlery, plates or cups made of expanded polystyrene or oxo degradable plastic	In progress	
	Medium term	100% of food waste recycled	Glos Royal Hospital: Food waste recycling introduced in main kitchens GHC: Food waste recycling introduced in main kitchens	
	Medium term	Reduce in appropriate use of plastic gloves	Programme on reducing inappropriate use of plastic gloves in progress	
Workforce and System Leadership	Short term	Every Trust and the ICS to ensure a board member is responsible for their net zero targets and their Green Plan (SC)	In place for all Gloucestershire NHS organisations. For the ICB this is the Chief Finance Officer	
	Medium term	Communication approach in place to ensure all staff understand the importance of sustainability for the future of health All staff understand that acting sustainably brings co-benefits to health	Varying progress across organisations	
	Short term	All GP Practices to sign up to the Green Impact Award Scheme	93% of practices signed up to Gloucestershire improvement scheme in 2024/25	

Within the ICS, medicines management teams are working to reduce the environmental impacts of medicines (that account for 25% of emissions within the NHS). Work locally is focused on reducing medicines waste and anaesthetic gases and inhalers where emissions occur at the point of use.

Reduction in nitrous oxide use at Cheltenham General and Gloucestershire Royal Hospitals has saved c. 430 t/CO₂ per annum. Progress with the work on inhalers is shown below with the ICS having made significant progress in reducing the use of metered dose inhalers which are the single biggest source of carbon emissions from NHS medicines prescribing.

Environmental impact of inhalers – Prescribing of Metered Dose Inhaler (MDI) (excluding sabutamol)



The ICB continues to consider the social and environmental impact of all its procurement and commissioning activities, with sustainability included as a factor within procurements.

Gloucestershire Hospitals NHS Foundation Trust

In November 2022, Gloucestershire Hospitals NHS Foundation Trust (GHFT) launched its Green Plan. This committed the Trust to a range of actions, initially between 2021/2025, but also longer term, which will help the system move forward on our pathway to net zero by 2040.

The Trust is now implementing a patient portal, this will enable the Trust to provide letters electronically to patients to manage their appointments, there will therefore be carbon savings from a reduction in letters and better use of clinics.

GHFT has also installed bike repair stations, extended the hours of the shuttle bus and included the 10% weighting on net zero and social value in their tenders.

Gloucestershire Health and Care NHS Foundation Trust

Gloucestershire Health and Care NHS Foundation Trust's carbon footprint Plus covers emissions outside of the organisation's direct control including supply chain, staff and service user travel and commissioned health and social care, the supply chain is the largest component of these emissions.

Improving the quality of services

Quality Governance and Assurance

The Health and Social Care Act 2012 (Section 26(14R)) requires Integrated Care Boards (ICBs) to continually improve the quality of services they commission.

The ICB Board collectively possesses the skills, knowledge and experience required to discharge its statutory duty to secure continuous improvement in the quality of services under section 14Z49 of the Health and Care Act 2022. The Board includes senior clinical leaders with extensive experience in patient safety, quality improvement and clinical governance; executives with backgrounds in commissioning, population health management and system transformation; and non executive members with expertise in risk, finance, organisational development and public accountability.

Individually, members bring substantial experience from roles across acute, community, mental health, primary care and local government settings. This breadth of expertise has enabled the Board and through the System Quality Committee to provide effective oversight of quality performance, scrutinise assurance reports, challenge variation, and support system partners to improve outcomes.

During 2025/26, the Board and through the System Quality Committee has applied this capability through regular review of quality metrics, escalation of risks, oversight of improvement programmes. This ensured that decisions were informed by clinical insight, robust governance and a focus on improving patient experience, safety and effectiveness.

These governance processes help identify good practice, highlight areas requiring improvement and drive action across the system. During 2024/25, and continuing into 2025/26, these arrangements have been reviewed and further strengthened as the ICB continues to mature.

Patient Safety and Mortality

Over the past year, Integrated Care Boards (ICBs) have undergone significant change. Despite this, we have continued to support system partners in embedding the Patient Safety Incident Response Framework (PSIRF). This represents a fundamental shift in patient safety, moving our role from one of formal oversight to that of a system convener, focused on enabling learning and driving continuous improvement.

We have maintained our weekly Patient Safety Huddles, attended by colleagues from both health and social care. These sessions strengthen our collective understanding of emerging issues and help shape a coordinated, system-wide response.

As the ICB clusters with BNSSG ICB, we are maximising opportunities to learn from both systems and further enhance our approach.

Our Quality Alert system has continued to mature, providing valuable intelligence from issues identified in primary care. Each alert now receives an individualised response, further strengthening the patient safety landscape across the county.

In our previous annual report, we set an expectation that the Summary Hospital-level Mortality Indicator (SHMI) would return to within control limits. Following significant, system-wide effort, this has now been achieved.

SHMI currently stands at 0.92, a marked improvement from a peak of 1.17. This progress reflects the strength of our collaborative approach and our shared commitment to improving the quality and safety of services.

Migrant health

The ICB Migrant Health team continue to support Primary Care and Public health teams in the registration and screening of asylum seekers arriving in initial contingency accommodation in Gloucestershire.

This year has seen a significant decrease in Home Office initial accommodation (hotels) with only one hotel remaining operational in the county.

The model the Home Office is adopting is a move towards the opening of larger HMO's (Houses of Multiple Occupancy). NHSE has introduced a service specification in which all health triage and screening takes place in ring fenced large hotels in the South East.

Primary Care - Education and Professional Development (Nursing)

Addressing Rural Health Inequalities - in recognition of Gloucestershire's demographic profile where over 70% of land is dedicated to agriculture - the Integrated Care Board (ICB) has prioritised mitigating health inequalities within farming and rural communities.

To date, the following milestones have been achieved:

- ▶ Targeted outreach: Over 250 farmers accessed free, confidential health screenings conducted at livestock markets and community hubs.
- ▶ Early Intervention: These sessions provided a critical clinical interface for addressing physical and mental health concerns; a significant portion of participants reported they would not have sought consultation through traditional General Practice routes without this outreach.
- ▶ Workforce Sustainability and Recruitment:
 - The ICB remains committed to establishing Primary Care as a premier first-destination career for the nursing workforce, through our 'Nurse on Tour' initiative, 55 student nurses gained immersive experience in community nursing, under professional supervision, these students conducted over

1,000 health checks across diverse community settings, directly contributing to regional health inequality reduction targets.

- **Workforce Support and Clinical Excellence:** To ensure the delivery of high-quality, evidence-based care, we have strengthened our communication and educational infrastructure through knowledge dissemination via the monthly newsletters to communicate essential policy updates and clinical guideline changes. The recent General Practice Nurse Conference saw attendance from over 100 primary care nurses, with particular focus areas including lower limb education, wound care, women's health, and sexual health.

Infection, Prevention and Control

The ICB continues to work in close partnership with Infection Prevention and Management (IPM) colleagues, benefiting from strong relationships across organisational boundaries.

In addition to responding to influenza outbreaks, the system has experienced a resurgence of infections not widely seen in recent years, including measles. Throughout 2025/26, system partners have responded swiftly and effectively to protect patients and local communities.

Following publication of the NHS England regional IPC strategy, work has been undertaken to map the system's workforce, training needs, governance structures and improvement programmes. These have informed the development of the **local IPC strategy**, approved by the ICB Quality Committee in 2025/26. This work is led by the **Infection Prevention Management Group**, which oversees delivery of local IPC priorities.

Local Maternity and Neonatal System (LMNS)

The ICB continues to provide oversight of maternity quality through the SQG and SQC.

The **Chief Nursing Officer** chairs the Local Maternity and Neonatal System (LMNS), which has focused on supporting the local maternity provider through another challenging year.

Through LMNS partnership working, the maternity provider has continued to make progress in reducing midwifery vacancies and strengthening both leadership and governance structures. As a system, we continue to work closely with NHS England regional colleagues to support improvement and sustainability.

The provider also continues to receive focused support through the **national Maternity and Neonatal Improvement Support Programme Team (MNIST)** and from the ICB via the **Enhanced Oversight Group (EOG)**, which is overseeing delivery of improvements linked to the CQC inspection findings.

Medicines Optimisation

The ICBs Medicines Optimisation (MO) team continues to prioritise initiatives which reduce the risk of harm associated with medicines. This includes leading on the local response to national medicines safety alerts, reviewing medication incidents reported to the ICB, proactively informing clinicians working in GP practices and community pharmacies about safety issues and managing local medication shortages to reduce the likelihood of patient harm.

The team continues to regularly update the MO digital tools which support prescribers to prescribe safely and identify patients who would benefit from a medication review or change in medication. This work includes developing and promoting the use of the medication safety risk stratification system Eclipse and the quality messages in the real time prescribing recommendations system Optimise Rx. The team has also been working with ICB commissioners to advise on medication-related issues.

The team continues to work to promote good antimicrobial stewardship to reduce the likelihood of antimicrobial resistance in the future.

Initiatives this year have included projects to reduce the course length of antibiotics prescribed in Primary Care and safe prescribing of Fluoroquinolone antibiotics where the Medication Safety Officers from the ICB, Acute Trust and Community Trust have worked together to publish safe prescribing guidance for clinicians across Gloucestershire to re-enforce national messaging. Pharmacy teams in the acute trust continue to work to reduce the number of intravenous antibiotics prescribed.

Working with people and communities



Engaging rural communities: The NHS Information Bus, with David Marshall, Information Bus Facilitator [last on the right], with colleagues from across Gloucestershire at the Livestock Market in Cirencester.

Insight

What is “Insight”?

We believe that insight is: Listening to people’s experiences and to the views of staff and volunteers involved in providing a service. Using insight is a crucial part of codeveloping and delivering support and services that are effective, safe, and continually improving.

‘Insight’ is qualitative data: people’s experiences, stories, and feedback.

Insight can tell us things that other data cannot, particularly about how people feel about their experiences.

Joining Up Insight

There is a lot of this qualitative data being shared by people in Gloucestershire with a wide range of health, care, statutory and voluntary organisations and groups.

NHS Gloucestershire Integrated Care Board (ICB) has worked in partnership with other NHS bodies, the county council, and voluntary and community organisations to set up Joining up Insight in Gloucestershire.

Joining up Insight in Gloucestershire provides a central hub for collating and storing this insight, so that people making decisions about service development can access it. It is hosted on the FutureNHS collaborative web platform.

Joining up Insight in Gloucestershire is easily accessible to a wide range of people working (or volunteering) in health and care. This open access aims to increase understanding and reducing duplication. It aims to ensure that local voices are heard, valued and influential in decision-making. To visit Joining-up Insight in Gloucestershire, gain access to the reports stored there, or to add to the collection, please email glicb.gig@nhs.net

Insight Network

Local people’s voices are heard across the One Gloucestershire ICS from the Boardroom to Integrated Locality Partnerships; through facilitated working with groups and 1:1 conversations with individuals.

People’s and communities’ views are considered alongside those of clinicians and managers, when we are planning, developing, procuring, evaluating and monitoring services.

Of particular note this year is the revitalisation of the Gloucestershire Maternity and Neonatal Voices Partnership (MNVP) which has been getting more actively involved in the current local Maternity Services Review.

The impact of Insight

We routinely report themes from insight to specialist programme and project groups, such as the Maternity Service Review Project Board and the Dental Strategy Group, as well as to the ICB System Quality Committee and the Primary Care and Direct Commissioning Committee and ICB Board.

Here are some examples of ways in which we gather and use insight:

- ▶ we collate and review national and locally collected patient experience data e.g. Friends and Family Test data
- ▶ we review the information collected by the ICB's Patient Advice and Liaison Service (PALS), which also includes details of complaints
- ▶ we create bespoke surveys to support collaborative projects with colleagues from across the ICS, including VCSE partners
- ▶ we start every ICB Board meeting with a patient story; several times a year the stories are collected and presented by Healthwatch Gloucestershire
- ▶ we look at, and provide stakeholder responses to studies carried out by key community partners such as Healthwatch Gloucestershire (HWG);
- ▶ we reflect on what matters to individuals who are part of underserved communities, considering the best methods for working with them, gaining trust and encouraging their involvement in research; and
- ▶ we record the views of the One Gloucestershire People's Panelists.

Working with people and communities Strategy

The ICB has a comprehensive Working with People and Communities Strategy <https://www.nhsglos.nhs.uk/have-your-say/working-with-you/strategy-and-insight/>

The approach set out in our Strategy ensures we meet our duty to involve people and communities in our work and supports our legal duties with regards to public involvement as set out in the ICB Constitution.

The ICB Strategy adopts the ten principles set out by NHS England for working in partnership with people and communities <https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/> but has adapted these into five key areas of focus for us locally:

1. Involving people and communities (see **Accountability**)
2. Involving you
3. Working with people and communities to tackle inequalities
4. Working with Healthwatch Gloucestershire and with voluntary and community organisations and groups
5. Communicating with you.

This year, the ICB has been involved in a national NHSE-led working group focusing on refreshing the statutory guidance on working in partnership with people and communities.

Involving you <https://getinvolved.glos.nhs.uk/involving-you>

One Gloucestershire People's Panel

Two years ago, we launched the One Gloucestershire People's Panel; with the purpose of seeking out the opinions of a representative sample of people living and/or accessing services across Gloucestershire. The Panelists' anonymous feedback is used at a county and a more local level to shape health and care services and support.

Panelists are sent links to online surveys (postal on request) about a wide range of topics relating to health and wellbeing. Examples of survey subjects promoted this year include non-medical support for health and wellbeing to inform the ICB's approach to working with VCSE organisations and communities and, to complement the national conversation, we created a survey focusing on the development of the national 10 Year Plan for Health to inform our local response to the Plan when it is published later in 2025.

5 Year Strategic Plan NOW! Engagement

In November 2025, we invited the People's Panel and the residents to think about **N**eighbourhood health and care, **O**nline, digital and technology, and **W**ellbeing, prevention and maintaining health independence as part of our local 5 Year Strategic Plan NOW! Engagement.

To read more about what people told us visit: <https://getinvolved.glos.nhs.uk/getting-ready-for-the-future-now>

Surveys

We also use surveys to obtain feedback from the people who work across the ICS.

During the last year we have co-created numerous surveys; which have resulted in plenty of quantitative and qualitative data for analysis.

We produce bespoke survey reports; using survey software which meets all our information governance requirements; recording the feedback received; which is shared with ICS and ICB programmes and projects. Some of this work is targeted towards particular communities of interest or patient groups, but other surveys are shared more widely on the public-facing Get Involved in Gloucestershire pages.

60 public and staff surveys have been developed in the last 12 months to support a range of programme and projects across One Gloucestershire ICS; here are just 10 of the subjects covered:

- ▶ Alzheimer's Society Dementia Advisor Service - User Feedback Survey
- ▶ Children and Young People's Continuing Care - have your say
- ▶ Community Midwives in Primary Care - your views
- ▶ Dementia Action Week Survey 2025
- ▶ Developing maternity services - surveys for professionals and women
- ▶ Diabetes Awareness Event July 2025
- ▶ ICB Staff Survey 2025
- ▶ Menopause Awareness Event October 2025
- ▶ On Your Mind Glos - the views of professionals and young people
- ▶ Remote Blood Pressure monitoring.

After the success of our coordination of the regional COVID-19 experience survey in 2020/21, NHS Gloucestershire ICB hosted a South-West Region Hypertension Survey in 24/25, creating individual surveys, and feedback reports for each ICB in the Region.

Information Bus activity 2025

Our NHS Information Bus has been out in the community **162 times** in the last 12 months and spoken to more than **8500 people!**

We have continued to make every effort to reach out to people who might not have the means to visit more traditional settings. Working in partnership with NHS services, voluntary sector partners and other ICS organisations is key to the success of the bus.

Targeted engagement

The Information Bus is a helpful way to take health and care messages to communities who, for a variety of reasons, may not engage with local services.

An example of this is our continuing work with the farming community. We have been visiting Cirencester Livestock Market on a monthly schedule, taking health and wellbeing support to farmers who often experience barriers to accessing the care they probably should. BBC Radio Gloucestershire spent two mornings with us reporting on our engagement with the community and the role of our Information Bus.

A lot of mutual trust has been established over the time we have been visiting Cirencester Livestock Market.

Having the Information Bus has also helped us to engage with the travelling community by parking the vehicle on the biggest council run traveller site in Gloucestershire.

It is another place we try to visit each month with similar services to those offered to the farming community.

Over this time, we have embraced the opportunity to learn more about the travelling community, in turn helping us to guide the visiting services on how best to engage and offer health and wellbeing services. Trust continues to flourish.

Involvement in Primary Care

The ICB Engagement Manager, Sophie Ayre, leads on supporting engagement across primary care. She works closely with GP practices and their Patient Participation Groups in several ways:

- ▶ Supporting the recruitment of new PPG members
- ▶ Supporting individual PPGs with information and advice
- ▶ Running a Gloucestershire PPG Network of PPG representatives
- ▶ Involving PPG representatives in shaping and developing strategies and services.

We have continued to facilitate patient involvement in the ongoing work to develop and implement Gloucestershire's dental strategy.

Patient representatives have been influential, for instance in helping shape the questions used for procurement of the new Dental Access Centre and being involved in assessing some aspects of the provider bids too.

Tackling inequalities <https://getinvolved.glos.nhs.uk/tackling-inequalities>

Insights

The ICB is committed to improving the health and wellbeing of people and communities living in Gloucestershire.

Central to this ambition is ensuring that everyone's voice is heard, especially those who have historically been overlooked or underserved by our system. To design services that truly meet people's needs, we must understand the lived experiences of all communities and work in ways that are accessible, culturally sensitive and inclusive.

To strengthen this understanding, Insights Manager Natalia Bartolome Diez, has led extensive engagement with the people and communities we do not tend to hear from.

This year Natalia has worked in particular with the following groups: The Cavern; Ebony Carers/Black Elders; Friendship Café; Women's Wellbeing Group and Crafty Sisters Group; GL11 Explorers, people from the Polish community; Sahara Sahily; and people from the Traveller community.

By spending extended time embedded with a range of diverse community groups, Natalia has gathered rich insights into how people live, what matters most to them, the barriers they face in accessing services and what changes could reduce health inequalities and improve access to services.

Working collaboratively across the Integrated Care System (ICS) and with the Voluntary, Community and Social Enterprises Sector (VCSE), Natalia has built trusted relationships with diverse communities that provide the foundation for ongoing dialogue.

Natalia has prepared an annual report which brings together these insights. It sets out the approaches used, outlines the local moral values of specific community groups and offers practical considerations for future engagement <https://getinvolved.glos.nhs.uk/tackling-inequalities>.

Working with local partners <https://getinvolved.glos.nhs.uk/involving-local-healthwatch-and-vcs-partners>

Healthwatch Gloucestershire (HWG) and Patient Stories

Throughout the year, we have continued to receive, respond and act upon reports and patient stories produced by HWG.

For instance, HWG's Report focussing on access to primary care prompted the co-development of a new information resource for local patients. Healthwatch Gloucestershire (HWG), the ICB and the LMC came together to develop the resource for local people to help them to make the most of their GP practice. This information is now freely available on GP practice websites.

Get Involved in Research in Gloucestershire

For the past three years, the ICB has been successful in securing funding from NHS England's Research Engagement Network Team to increase diversity in research locally.

Sharing the Power - One Gloucestershire Research Engagement Network (REN) brings together ICB, local authority, academic research organisations and VCSE colleagues.

Through promoting joint learning, skill-sharing and capacity building amongst research partners, people and communities across the One Gloucestershire, the REN's aim is to build upon what we have heard is important to people most impacted by health inequalities about their health and wellbeing and seeks to increase their involvement in relevant health and care research.

This year, the One Gloucestershire REN hosted REN teams from the across the South West for a Sharing and Learning event in March 2026 at the Arts, Health and Wellbeing Centre in Gloucester City; this was a great opportunity to come together to share good practice. We learned together about avenues to access demographic research data and had round table discussions about challenges, opportunities and sustainability of RENs.

Accountability

Involving people and communities (governance)

The ICB believes that working with people and communities is everyone's business not just a handful of people with "involvement, engagement, experience or communications" in their job title.

This ethos supports people across the ICS whose role it is to ensure local people can get involved and that we learn from Insight.

The ICB has a dedicated Engagement and Experience Team. The Team is led by an Associate Director for Engagement and Experience <https://www.nhsglos.nhs.uk/have-your-say/working-with-you/our-team/>

The Engagement and Experience Team is fortunate to have access to a number of tools to support its work, these include survey software (SMART Surveys) <https://www.smartsurvey.co.uk/>, an online participation space: *Get Involved in Gloucestershire* <https://getinvolved.glos.nhs.uk/> and, for reaching all parts of the county for face-to-face activities, we have the NHS Information Bus <https://www.nhsglos.nhs.uk/have-your-say/working-with-you/information-bus/>

Working with Elected representatives

We are committed to making sure that we inform, involve, engage and consult the County Council's Health and Wellbeing Board/Partnership, Health Overview and Scrutiny Committee, Adult Social Care Overview and Scrutiny Committee, and Children's Overview and Scrutiny Committee. We hold regular briefings with Members of Parliament.

We have good working relationships with the local HOSC, providing regular updates both in written format and by attending meetings. We take their role of critical friend very seriously. They are an important part of the way we work. When proposed service changes might affect constituents outside of Gloucestershire, contact is made with representatives from other areas, information provided and appropriate opportunities to get involved discussed.

Insight developments planned in 2026/27

Our focus over the next 12 months will be to consider how we will work with people and communities across the wider Cluster ICB geography including our approach to coproduction. We will need to establish new ways of working with providers as we respond to the priorities of a strategic commissioning organisation.

Equality, Diversity and Inclusion

The ICB is committed to promoting equality through commissioning accessible services that respond to the diverse needs of communities in Gloucestershire; celebrating the diversity of our workforce and ensuring staff feel they work in an environment that is fair, open and free from discrimination.

Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This includes publishing our equality objectives, information about the protected characteristics of people accessing health and care services in Gloucestershire and equality data about our employees, including gender pay gap information.

We want to understand the needs of our diverse community and strive to treat everyone as an individual, with dignity and respect, in accordance with their human rights.

In early 2025, the ICB refreshed its Equality Objectives and developed an action plan to ensure these were achieved.

Translation and Interpretation Framework

NHS England published a new Improvement framework: community language translation and interpreting services (<https://www.england.nhs.uk/long-read/improvement-framework-community-language-translation-and-interpreting-services/>) in May 2025. The framework is designed to support the provision of consistent, high-quality community language translation and interpreting services by the NHS to people with limited English proficiency.

The Framework sets out some specific actions for ICBs, NHS Trusts and Primary Care.

Many of the actions identified for ICBs have already been addressed during our NHS system-wide re-procurement of a translation and interpretation service in 2024, but some of this work is ongoing with opportunities for further improvement:

- ▶ Raising awareness of translation and interpretation services for GP practices/PCNs - we have delivered a number of awareness sessions to practices and PCNs over the last year and are presenting again at the Gloucestershire Multi Professional Educators Conference in April 2026. We are exploring further opportunities with the Primary Care Training Hub.
- ▶ Engagement with local communities to raise awareness of the translation and interpretation service and seek regular feedback from people who have accessed support (in conjunction with One Gloucestershire statutory partners).
- ▶ Explore quality improvements re. translation and interpretation service for GP practices, in particular with those practices who use the service most frequently. Our current provider offers supplementary services that may be beneficial, but come at an additional cost:
 - Wordskii on Wheels (WoW) - dedicated portable devices designed to deliver video calls in high demand areas where collaborative working and quick access to a professional interpreter is essential. Some areas of the country are also making this type of device available in reception areas.
 - Wordskii Connect - enables people to connect with the translation and interpretation service directly, e.g. for support to contact their GP practice, before they have any interaction with their health care provider.
- ▶ Re-procurement of translation and interpretation services for Pharmacy, Optometry and Dentistry. This contract has been inherited from NHS England and has been extended to ensure continuity of provision. The Primary Care Team are currently exploring a more permanent solution.

Accessible Information Standard

The Accessible Information Standard (AIS) sets out how providers and commissioners of NHS and publicly funded adult social care services should ensure disabled people and people with impairments or sensory loss can access and understand information about NHS and adult social care services and receive the communication support they need to use those services.

NHS England refreshed the AIS in 2025, and some important changes were made to add a sixth 'review stage' to help improve compliance with the Standard, and introduce a self-assessment framework to support with assurance and compliance.

Working in partnership with One Gloucestershire NHS organisations and Voluntary Community and Social

Enterprises Sector partners, we have previously developed training materials to support compliance with the Standard. These resources have been updated in line with the refreshed Standard, and we have been promoting the new requirements to GP practices.

Experience of people who identify as LGBTQ+

Our Equality Action Plan committed to achieving a better understanding of the experiences of people who identify as LGBTQ+ when accessing health and care services and support.

National and local research, in particular: 'Community Mental Health Transformation Lived experience Survey Report: LGBTQIA+ Communities' (<https://www.inclusiongloucestershire.co.uk/wp-content/uploads/Community-Mental-Health-Transformation-Lived-experience-survey-LGBTQIA-communities.pdf>), Inclusion Gloucestershire, (2024) and 'Trans and non-binary peoples' experience of accessing GPs in Gloucestershire' (<https://nds.healthwatch.co.uk/reports-library/trans-and-non-binary-peoples-experience-accessing-gps-gloucestershire>), Healthwatch Gloucestershire, (2025) concluded that people who identify as LGBTQ+ often face discrimination and have a poorer experience of health care services than cisgender people.

During 2025, we have continued to be a proactive ally of the local LGBT+ Partnership, regularly attending their meetings and providing the NHS Information Bus for Pride events across the county. This enables us to hear the voices of our local community and support awareness raising and celebratory events.

Our allyship with the community has provided insight into the challenges some Transgender people have experienced in accessing support with hormone therapy through their GP practice. Consequently, the ICB has been working collaboratively with various system partners including people who identify as transgender, the Local Medical Committee (LMC), Gloucestershire GP Collaborative, NHSE at both national and regional levels, and the Southwest NHSE Gender Dysphoria Clinic (GDC) to identify and address gaps in commissioning care for monitoring and prescribing for transgender adults needing access to hormone therapy in primary care settings. The input from the ICB Patient Advice and Liaison Service (PALS) with respect to supporting individuals has been greatly appreciated.

This work has resulted in a new interim Local Enhanced Service (LES) being launched and a Gender Affirming Awareness Session has been developed in partnership with the Primary Care Training Hub. The interim LES aims to help address the commissioning gap for NHS patients who have been assessed by the NHS Gender Dysphoria Clinics, while we gather more information about the needs of this patient group, the workload for clinicians and the outcome of the national review.

There is an opportunity to work across the ICB cluster to deliver this work and engage with the national programme for improvement.

Equality and Engagement Impact Assessment

The ICB Equality and Engagement Impact Assessment (EEIA) process is an important planning tool which encourages the consideration and documentation of equality and health inequalities issues during the commissioning of services and development and/or implementation of policy.

The development of our Equality Action Plan identified the need to raise awareness of the EEIA process and provide additional training to support ICB staff to undertake robust assessments.

The Equality and Human Rights Commission (EHRC) review of ICBs in 2024/25 suggested sharing completed EEIAs on our website as a way of demonstrating both compliance with the Public Sector Equality Duty and sharing examples of good practice. Subsequently, we reviewed our EEIA template and developed training which was delivered through a module in the Project Management training during 2025. The training was delivered across three cohorts, reaching approximately sixty staff. It was well received and as a result, we saw an improvement in the quality and numbers of EEIAs completed as part of the business planning process.

Supporting our workforce

The data and statistics we have on our workforce profile, including a breakdown of staff according to gender, ethnicity, age and disability is regularly reviewed and shared with the ICB Staff Partnership Forum.

As noted in last year's equality reporting the focus during 2025 has been very much about supporting staff through organisational change. However, we have continued to promote equality, diversity and

inclusion through additional training and events including the Inclusion Allies Programme; Equality, Diversity and Representative (EDR) training; One Gloucestershire Leadership Conference on ED&I; and an Anti-racism Conference in July 2025.

Annual Staff Survey

Although the ICB ran its own staff survey during 2025, many of the national staff survey questions were included to allow the identification of trends and enable us to benchmark against other ICBs. The data collected is still being analysed and will be reviewed against last year's data in due course.

Early analysis of the data shows that response rate from staff who have an ethnic minority background (48%) is lower compared to staff who are White British (57%). The results suggest very similar experiences between the two staff groups, with the exception of staff who 'in the last 12 months, have personally experienced discrimination at work from other colleagues'. This is reported as 21.05% for staff from an ethnic minority background compared to 2.83% for staff from a White British background. When comparing the data for staff who disclosed they have 'a physical or mental impairment that has a substantial and long-term negative effect on their ability to do normal daily activities' and those who said they did not, there is more variation in the responses.

When asked if they 'had personally experienced discrimination at work from their line manager', 16.67% of staff who disclosed a physical or mental impairment said 'yes', compared to 2.44% of staff who said they did not have a physical or mental impairment. Staff who disclosed a physical or mental impairment also reported a higher incidence of work-related stress and pressure to come to work when feeling unwell.

Further analysis of the staff survey results is required to help understand the differences highlighted above. Staff in Gloucestershire have recently been invited to join the BNSSG Staff Disability Forum and this could provide a mechanism for further staff engagement to support the data collected.

Opportunities for further work

Despite the challenges of organisational change in 2025, we have continued to promote equality, diversity and inclusion and pursue our equality objectives. The NHS Integrated Care Board (ICB) cluster arrangements across Gloucestershire and Bristol, North Somerset and South Gloucestershire, provide the opportunity to refresh much of this work, share learning across the cluster and develop a robust approach for the future.

There are a number of opportunities for the coming year, which could be considered at either a 'cluster' or 'place' level:

- ▶ Revisit the NHS Gloucestershire ICB action plan as ICB clustering progresses, developing a new set of equality objectives and governance processes appropriate for the new organisation.
- ▶ Continuation of our work to raise awareness and improve access to our translation and interpretation service, with both staff and our local communities who require support with communication. This includes the opportunity for Quality Improvement projects to support practices who are high users of the service.
- ▶ Re-procurement of translation and interpretation services for Pharmacy, Optometry and Dentistry.
- ▶ Raise awareness of the Accessible Information Standard and support the use of the new self-assessment framework in primary care.
- ▶ Work across the ICB cluster to reduce inequalities for patients who identify as transgender, engaging with the national programme for improvement.
- ▶ Establish a strategy for working with our underserved communities as we progress with our ICB cluster arrangements.
- ▶ Undertake further analysis of the NHS Gloucestershire ICB staff survey results to support post-organisational change.

For more information about our work in this area over the past 12 months visit: <https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/equality-and-diversity/>

Reducing health inequalities

Healthcare inequalities sit within the context of wider social inequalities and are evident in variations in access to services, experiences of care and health outcomes.

The vision of NHS England's Healthcare Inequalities Improvement Programme is for the NHS to deliver 'exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes.'

Tackling inequalities in outcomes, experience and access is the responsibility of all NHS organisations and one of the four key purposes of Integrated Care Boards (ICBs). However, the ICB (NHS Gloucestershire Integrated Care Board) doesn't do this in isolation and success is achieved through joint working with partners, including Gloucestershire County Council, provider health organisations and the VCSE sector.

The ICB has set out a comprehensive, long-term and systemwide approach to tackling health inequalities across the county in its 5-year Population Health and Strategic Commissioning Plan (<https://www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/population-health-and-strategic-commissioning-plan/>).

Its strategy is rooted in a clear recognition that health outcomes are unfairly distributed, often determined by where people live, socioeconomic conditions such as employment and housing, protected characteristics and the challenges faced by inclusion health groups e.g. traveller communities, offenders and people experiencing homelessness, as well as inequalities in access and experience of healthcare.

The Plan outlines how the ICB has discharged its statutory duties to reduce inequalities and how it intends to make sustained progress by working closely with local partners, communities and the voluntary sector.

A central component of the ICB's duty is its explicit strategic ambition for Health Equity, one of three overarching ambitions in the plan.

The ICB is committed to ensuring that health outcomes, experience and access are fairer across all communities acknowledging persistent gaps in life expectancy and healthy life expectancy between the most and least deprived areas - gaps of over six years for women and eight for men.

Moreover, evidence shows that people in deprived communities spend fewer years of life in good health and experience earlier onset of long-term conditions. Recognising this, the ICB has a clear aim to narrow these inequalities by preventing avoidable illness, intervening earlier to prevent symptoms from escalating, improving access and shaping services around the needs of underserved groups.

The Strategic Commissioning Plan also demonstrates the ICB's discharge of duties through the application of Gloucestershire's Integrated Needs Assessment (https://www.nhsglos.nhs.uk/wp-content/uploads/2026/03/INA_Final.pdf) and Joint Strategic Needs Assessment (<https://www.gloucestershire.gov.uk/inform/health-and-wellbeing/>), which were developed through joint work with partners - and views from patient and public engagement. These assessments identify key drivers of inequality, such as unhealthy lifestyles, high rates of chronic disease, clustering of deprivation in Gloucester, Cheltenham and the Forest of Dean, and significantly worse outcomes among people living with severe mental illness or from Asian and Asian British ethnicities.

By basing planning and commissioning decisions on robust, linked, person-level data, the ICB ensures that duties to better understand and take action to reduce inequalities inform every part of its strategy.

The ICB, along with partner organisations, is also committed to delivering the national Core20PLUS5 health inequalities frameworks for adults and children, which require accelerated improvement in five clinical areas crucial for narrowing health gaps. The clinical focus for adults is on maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case finding; for children, the focus is on asthma, diabetes, epilepsy, mental health, and oral health.

There is an expectation that ICBs will prioritise support for the most deprived 20% of their populations (Core20) and additional underserved groups.

Inequalities in Gloucestershire vary by population group and place depending on the issue considered. For example, gender-based inequalities exist in access to weight management services, while obesity prevalence disproportionately affects Core20 populations living in the most deprived areas.

The ICB's Flagship Programmes also demonstrate a strong focus on inequalities. The Neighbourhood Proactive Frailty Care programme prioritises neighbourhoods where people experience poorer health, enabling earlier diagnosis of dementia, proactive monitoring, and a 'home by default' approach to care - critical for older people who make up a large proportion of those with complex needs.

Similarly, the All-Age Community Mental Health programme responds to the clear inequities in mental health outcomes, including premature mortality rates that are over five times higher for people with severe mental illness. The expansion of Young Minds Matter in schools, improved early help via Families First, and a strengthened neighbourhood mental health offer are all central to addressing these disparities.

In addition to condition-specific responses, the ICB emphasises prevention and early detection, acknowledging that healthy life expectancy is more influenced by the social conditions in which people live than by healthcare alone. To support this, the ICB has adapted healthcare provision to improve access for those facing barriers e.g. by expanding the role of community pharmacy, modernising general practice, enhancing dental access, digital inclusion, working in partnership e.g. with local authorities, building VCSE capacity.

The ICB recognises that while digital tools can enhance access and efficiency, they also present risks of widening inequalities, especially among marginalised communities. Public engagement has highlighted concerns about loss of face-to-face contact, information security, confidence that online submissions will be monitored and the potential exclusion of people lacking digital skills or access. In response, the ICB commits to expanding digital services alongside, rather than instead of, traditional routes to care. The plan makes clear that face-to-face access will remain available and that digital options will only be used 'where people want it.'

Crucially, the ICB emphasises the importance of working with people and communities. Engagement activities - including community visits, targeted outreach, participation panels, and collaboration with seldom-heard groups have directly shaped the Population Health and Strategic Commissioning Plan. The ICB is committed to continued codesign with communities, transparency around difficult decisions and ensuring that services reflect "what matters to people."

This approach has helped to ensure that statutory duties are fulfilled not only in policy, but in lived experience and is supported by Gloucestershire's 'Joining up Your Insights' Repository, which brings together insights, evidence and learning from across the system into a shared, accessible place so that organisations are not working in silos or repeatedly commissioning the same engagement analysis or evaluation.

Looking ahead, the ICB has set out a substantial programme of work to respond to observed inequalities and make progress over the next five years. Central to this is the development of Integrated Neighbourhood Teams (INTs) which will bring together health, social care, VCSE partners and specialist clinicians within local areas, enabling proactive, personalised care aligned to local needs - particularly for older people living with frailty and for people with multiple long-term conditions. These teams are intended to intervene earlier, reduce crisis episodes and support people closer to home, especially in areas where health need is greatest.

The ICB has a clear and credible approach to reducing health inequalities. By combining robust needs analysis, targeted action, prevention, neighbourhood-based models and sustained community partnership, the ICB sets out a long-term strategy designed to improve life expectancy, narrow unfair gaps, and create a more equitable and sustainable health and care system for Gloucestershire.

A detailed ICB response to the NHSE Health Inequalities Statement is under development and will be included with the final report ICB Annual Report.

Health & wellbeing Strategy

NHS Gloucestershire Integrated Care Board (ICB) remains a committed and active partner of the Gloucestershire Health and Wellbeing Board (HWB) and has had full regard to the county's Joint Local Health and Wellbeing Strategy (2020 - 2030) in the discharge of its statutory functions during 2025/26.

The ICB's Population Health and Strategic Commissioning Plan is closely aligned to the seven strategic priorities of the Joint Local Health and Wellbeing Strategy:

- ▶ Physical activity
- ▶ Adverse Childhood Experiences (ACEs)
- ▶ Mental wellbeing
- ▶ Social isolation and loneliness
- ▶ Healthy lifestyles, with a focus on healthy weight
- ▶ Early years and best start in life
- ▶ Health and housing.

Reducing inequalities and addressing the wider determinants of health are embedded as cross-cutting principles within both the Health and Wellbeing Strategy and the ICB's commissioning framework.

The ICB remains fully committed to the shared vision that Gloucestershire is a place where everyone can live well, be healthy and thrive. By strengthening prevention, investing in community leadership and embedding partnership at the heart of strategic commissioning, we are contributing meaningfully to the delivery of the Joint Health and Wellbeing Strategy and to the long-term sustainability of our health and care system.

Strengthening prevention and improving the quality of services

In line with our statutory duty to improve the quality of services, the ICB has continued to shift its strategic focus upstream - strengthening prevention, early intervention and neighbourhood health approaches. We recognise that sustainable improvement in outcomes cannot be achieved through service redesign alone but requires a broader health and wellbeing creation model rooted in communities.

During 2025/26, the ICB has increasingly aligned commissioning decisions to prevention and population health objectives. We have strengthened the combined use of population health intelligence and community insight to inform commissioning, recognising that lived experience and deep understanding of our local communities is essential to creating effective adaptable support and services. This represents a deliberate move towards more responsive, place-based and personalised models of care.

Tackling unequal outcomes, access and experience through community partnership

The ICB recognises its statutory duty to reduce inequalities in both access, experience and outcomes.

Tackling entrenched inequalities across Gloucestershire requires targeted, sustained and partnership-based whole-system responses.

This year has marked a significant milestone in this regard with formal approval of the Gloucestershire VCSE Partnership Model. This long-term model fundamentally reshapes how the NHS works with voluntary, community and social enterprise (VCSE) organisations, positioning them as equal partners in health creation, prevention and neighbourhood health.

The model moves beyond transactional funding and engagement towards a relational, community-led approach. It establishes:

- ▶ A strengthened and coordinated VCSE infrastructure to provide the core foundations of a thriving VCSE sector and resilient, empowered communities
- ▶ A community capacity-building approach to support sustainable, locally shaped health and wellbeing activity
- ▶ A collaborative governance model that embeds co-production and shared stewardship.

This development reflects learning from Gloucestershire's Healthier Communities Together programme, which demonstrated that tackling inequalities and shifting to prevention requires community-powered approaches, strong relationships and long-term investment in local capacity and capability.

By embedding this model within our strategic commissioning framework, the ICB is creating the conditions for more equitable access, improved trust and stronger community leadership in shaping health and wellbeing in the county. This represents a structural shift towards partnership and prevention as core components of the health and care system.

Supporting broader social and economic development (the “triple aim”)

Through partnership with local authorities, district councils, housing providers and the VCSE sector, we have contributed to activity aligned with the Joint Health and Wellbeing Strategy's priorities, including housing and health, early years development, mental wellbeing and reducing social isolation.

Our increasing emphasis on prevention and community capacity contributes to long-term system sustainability. By strengthening community resilience, enabling earlier support and reducing reliance on reactive services, we are supporting both improved population health and the effective use of NHS resources.

This approach also supports local social and economic development by investing in community organisations, strengthening local leadership and building the capability of the VCSE sector as a key strategic partner. This ensures the Gloucestershire pound stays in Gloucestershire, delivers locally and goes further.

Partnership, governance and shared accountability

The ICB continues to play an active role within the Health and Wellbeing Board, contributing to the mid-point review of the Joint Health and Wellbeing Strategy (<https://www.gloucestershire.gov.uk/media/zepl3zmc/joint-health-and-wellbeing-strategy-mid-point-review.pdf>) and supporting strengthened governance and outcome measurement for the next phase.

We have worked collaboratively across the system to align the Strategic Commissioning Plan with the Health and Wellbeing Strategy. This includes strengthening neighbourhood and place working and promoting shared outcomes across partners.

Board-level sponsorship of strategic priorities and a growing emphasis on live learning, qualitative insight and lived experience are helping to ensure that impact is measured not only in activity terms but in meaningful improvements for communities and to inform future developments in real-time.

ICB facilitated Integrated Locality Partnerships (ILPs) continue to create the space for partnership connection at locality level and for partners to contribute to Health and Wellbeing Board and ICS priorities. This includes local focuses on people living with mild frailty and place-based approaches to health inequalities. Cross system representation and collaborative delivery across the six ILPs is growing year on year and connection between ILP reps and the H&WBB continues to be strong.

Looking ahead

As we move into the next phase of the Joint Health and Wellbeing Strategy (2025 - 2030), the ICB will continue to deepen its commitment to prevention, neighbourhood health and community partnerships.

Key priorities include:

- ▶ Full implementation of the VCSE Partnership Model
- ▶ Further embedding prevention within strategic commissioning and health and wellbeing support and services
- ▶ Strengthening population health management to target interventions where need is greatest
- ▶ Enhancing co-production and community voice in decision-making
- ▶ Continuing to work together to develop the health inequalities framework approach which supports each organisation in systematically identifying and responding to health inequalities within the county.

Financial Review

NHS Gloucestershire Integrated Care Board (ICB) set a balanced budget for the 2025/26 financial year, in the context of an overall system financial plan of breakeven. The budget was set within the 2025/26 NHS England financial framework.

Key elements of this included:

- ▶ A system allocation based on the financial envelope for the Gloucestershire System, plus growth and an efficiency adjustment as part of ensuring value for money
- ▶ Aligned payment incentive contractual arrangements with NHS providers for elective care (e.g. planned care) and with fixed contractual amounts for non-elective care (e.g. emergency care)
- ▶ The provision of additional funding for a smaller number of programmes outside main funding
- ▶ Additional funding to take forward the recovery of elective, or planned care, services.

The ICB financial position for the year was a small surplus of £93k.

The ICB's cumulative surplus at 31 March 2026 is £11.1m. The cumulative surplus is available to the ICB in future years to use non-recurrently as part of the development of the five-year long-term plan. Use of this funding is subject to business cases and overall affordability for the NHS.

In addition, the ICB:

- ▶ Remained within its maximum cash drawdown (the limit allocated to the ICB) as agreed with NHS England
- ▶ Complied with the Better Payments Practice Code (details provided within note 6 of the annual accounts).

Table 1 - ICB's financial performance covering 1 April 2025 - 31 March 2026

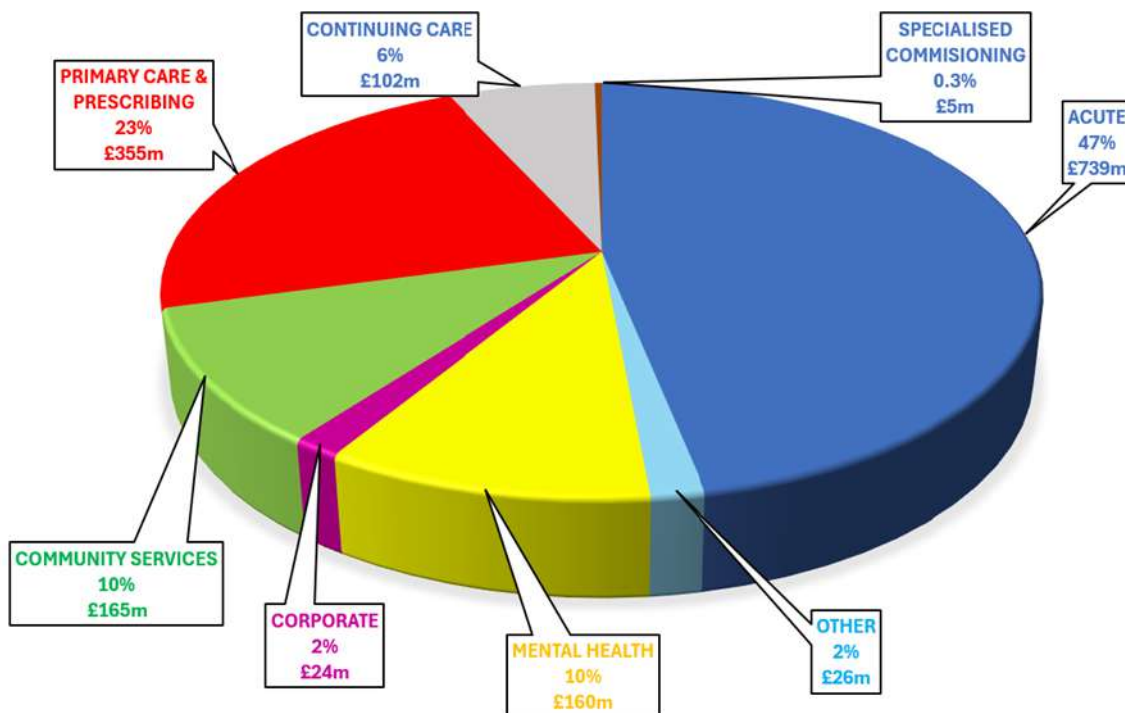
ICB Financial Summary	Programme Costs including primary care £m	Running Costs £m	Total £m
Revenue resource limit	1,552.36	24.62	1,576.98
Total net operating cost for the financial year	1,553.00	23.89	1,576.89
Surplus/(deficit) in year	(0.64)	0.74	0.093
Brought forward surplus			21.17
Drawdown in year			(10)
Cumulative surplus			11.17

System Financial Position

The NHS system in Gloucestershire is comprised of Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHT) and NHS Gloucestershire Integrated Care Board (ICB). The system 2025/26 financial plan was breakeven, and the year-end performance is set out below:

	ICB £m	GHC £m	GHFT £m	Total £m
System position Surplus/(deficit)	0.093	0.376	0.078	0.547
System target	0	0	0	0.000
Variance to target Surplus/(deficit)	0.093	0.376	0.078	0.547

The main areas of ICB expenditure (this includes expenditure by NHS organisations funded by the ICB) fell into the following areas:



The accounts as presented have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Services Act 2006 (as amended).

Mental Health Investment Expenditure

The 2025/26 plan included additional investment in mental health to ensure that the mental health investment standard was met; this standard requires an increase in spending on mental health services equal to or above the increase in the programme allocation increase for the year.

The target investment in year was £129.849m.

	2023/24 £m	2024/25 £m	2025/26 £m
Mental Health expenditure in year	106.578	114.430	130.008
ICB Total Expenditure	1,402.396	1,531.226	1,631,649
Mental Health Spend as a proportion of Total Expenditure	7.60%	7.47%	7.97%

Programme Allocation excludes any additional allocations for specific purposes such as Service Delivery Funding, Elective Recovery Funding and Discharge Grants.

For 2026/27 the increase in spending was £15.58m. Investments were made in children's services, perinatal mental health, IAPT (Improving Access to Psychological Therapies), and eating disorders, in addition to increases in existing services.

Future Financial Outlook

The National Financial and Operational Planning Framework has a changed focus for 2026/27 and future years with a greater emphasis on individual organisational accountability. Within Gloucestershire plans have been developed by individual organisations but with continued partnership working to ensure a joined up approach to deliver the system operational and strategic plans. Within this, Gloucestershire ICB has finalised the operational and financial plans for 2026/27 with a focus on:

- ▶ progressing the recovery of all services, including elective (planned care), and reducing waiting times.
- ▶ transforming the urgent care system to increase the services available within primary and community sectors to help reduce hospital admissions where individuals can be treated at home with the right support. This will contribute to improving the flow across the system services and provide a better quality and experience for individuals.
- ▶ developing communities jointly with our partners through Integrated Locality Partnership working, plus looking at how we can enable further work on prevention for our communities.
- ▶ reducing inequalities within services.
- ▶ Improving the overall value and productivity of the system.

The 2026/27 system plans build on each organisation's work on underlying recurrent costs and system-wide work on developing a longer-term financial position for Gloucestershire.

The financial situation remains very constrained and the focus on initiatives that deliver value continues. This programme of work includes:

- ▶ Service Design/Redesign with a focus on neighbourhoods, informed by intelligence on spend and patient outcomes to focus at how we deliver value to make improvements, including:
 - Urgent care pathway redesign (the service users' journey through care) with a particular focus on those who are frail
 - Reviewing the way that outpatient appointments for those with multiple long term conditions are delivered to identify changes to lead to improvements in timeliness of diagnosis and treatments
 - Mental health services.
- ▶ Transactional Savings:
 - The agreement of evidence-based activity and activity management actions with providers including appropriate controls (e.g. policies on referrals, our formulary) on the access to and type of treatment

- Engagement and influence on medicines management
- Procurement savings on contracts.

Capital

Parliament and Treasury set the Department of Health and Social Care (DHSC) a limit for how much capital it can spend. Capital spending covers long-term spend such as new buildings, equipment, and technology.

This budget limit, called the capital departmental expenditure limit (CDEL), covers all capital spending by the DHSC and the NHS, and they are legally obliged not to spend above this limit. A major part of NHS capital is allocated to Integrated Care Systems who prioritise this capital to develop a system plan with the majority going towards NHS Foundation Trusts and an amount for General Practice requirements (covering information technology and minor improvement grants).

Planning considers the need to upgrade estates, replace medical equipment and information technology equipment, plus the strategic objectives for the system.

The Gloucestershire system has received capital funding relating to its core functions plus some additional targeted funding for areas such as digitisation and new theatres.

The core capital funding for Gloucestershire was determined through a process of organisational prioritisation and a system review of the proposed programme to assess against priorities and known risks. The Joint Capital Resource plan is available here: https://www.nhsglos.nhs.uk/wp-content/uploads/2025/07/2025-26_Joint-Capital-Resource-Use-Plan_Final.docx

		Actual Expenditure			
	2025/26 Plan £'000	Primary Care & the ICB £'000	GHC £'000	GHT £'000	Total £'000
Total Operational Capital	61,812	6,496	14,802	40,005	61,303
Total system CDEL	61,812	6,496	14,802	40,005	61,303

(Primary Care: GP practices within Gloucestershire, GHC: Gloucestershire Health & Care NHS Foundation Trust, GHT: Gloucestershire Hospitals NHS Foundation Trust)

Gloucestershire Health and Care NHS Foundation Trust: The remainder of the programme was focused on the ongoing maintenance, including backlog, and replacement programme for estates, IT and equipment, plus the continuation of the net zero programme of work.

Gloucestershire Hospitals NHS Foundation Trust: a significant part of the capital programme within GHT has been focussed on backlog maintenance across both the Gloucester and Cheltenham sites plus a focus on areas of fire, electrical and water safety, and resilience. In addition, the work on replacement programme for equipment, including major items and IT has continued throughout the year.



Shane Devlin
Cluster Chief Executive
15th June 2026

Corporate Governance report



Accountability Report - Corporate Governance Report

1 April 2025 - 31 March 2026

The Corporate Governance report outlines the composition and organisation of the Integrated Care Board (ICB) governance structures and how they support the achievement of the ICB objectives.

It comprises the:

- ▶ Members' Report
- ▶ Statement of the Accountable Officer's responsibilities
- ▶ Governance Statement.

Members' report

NHS Gloucestershire ICB (The ICB) is responsible for planning and commissioning health services for a registered population of 698,761 and expected to rise to 728,030 by 2030.

The ICB was authorised on 1st July 2022 in accordance with the Health Act 2006 (as amended see s.11), and operates in line with its Constitution <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/icb-constitution/>

The ICB has a Board that comprises 18 members including Executive Directors, Non-Executive Directors and Partner members. In line with clustering with NHS Bristol, North Somerset & South Gloucestershire ICB (BNSSG) and following a period of Executive Consultation and a voluntary redundancy process a new Executive Team was appointed for the Cluster. The Board was chaired by Dame Gill Morgan who left the ICB formally in September 2025. Dr Jeff Farrar was appointed Cluster Chair of the joint NHS Gloucestershire ICB and BNSSG ICB on 1 September 2025 and is the current Chair.

Professor Dame Jane Cummings chaired the Board meetings from September 2025 to 31st March 2026 as Vice Chair..

Member profiles

For a list of ICB members and their records of attendance at ICB meetings see page 7 of this Governance Statement. Member's Profiles can be viewed on the ICB's website <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/member-profiles/>

Composition of Board

Member's Profiles can be viewed on the ICB's website www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/member-profiles

For a list of ICB members and their records of attendance at ICB meetings see <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/>

Committee(s), including Audit Committee

For a list of Audit Committee members and a record of their attendance at meetings see website: <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/> which also includes details of sub-committees of the ICB and members record of attendance at meetings.

Register of Interests

The ICB maintains a Register of Interests in line with its Standards of Business Conduct Policy and details set out within its Constitution.

The Register of Interests (<https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/using-your-information/register-of-interests/>) is updated quarterly and posted on the ICB's website on a quarterly basis. The Registers of Interests related to ICB members is included in the papers of the ICB Board meeting which is held on a bi-monthly basis. At each sub-committee of the Board a register of interests pertaining to committee members and agenda items are included in the papers. There

are registers of interest for Board members, ICB staff (those in AFC Band 8A and above), along with registers detailing any gifts and hospitality received, and are available on the ICB's website (<https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/using-your-information/register-of-interests/>).

In addition, at the start of each meeting of the ICB Board and sub-committee meetings, members are required to declare any conflicts of interests in relation to the items on the agenda and discussion is held around about how any conflicts should be handled and this is formally recorded in the minutes. The procedures for declaring conflicts of interests are detailed in the ICB's Standards of Business Conduct Policy (<https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook-2/>).

Personal data related incidents

There were no personal data related incidents that took place during the financial year 2025-26 that were reported to the Information Commissioner's Office (ICO).

Modern Slavery Act

NHS Gloucestershire ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking and meets the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Section 54 of the UK Modern Slavery Act (2015) requires commercial organisations that operate in the UK and have an annual turnover above £36m to produce a Slavery and Human Trafficking statement each year.

The statement sets out how a business is taking steps to address and prevent the risk of modern slavery in operations and supply chains. The ICB's Modern Slavery Act (2015) statement can be read on our website <https://www.nhsglos.nhs.uk/about-us/how-we-work/safeguarding/modern-slavery/>

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 requires each Integrated Care Board to have an Accountable Officer, and for that appointment to be approved by NHS England. At the start of the 2025–26 financial year, Mary Hutton continued in her role as Chief Executive of NHS Gloucestershire ICB and served as the ICB's Accountable Officer until her retirement on 18 July 2025. Following Mary's retirement, Sarah Truelove was appointed by as Chief Executive with effect from 22 July 2025 and was approved by NHS England to act as the Accountable Officer for NHS Gloucestershire ICB.

NHS England subsequently approved the appointment of Shane Devlin as Cluster Chief Executive from 1 October 2025, and in doing so confirmed his designation as the Accountable Officer for NHS Gloucestershire ICB, Sarah Truelove has acted as the Transition Chief Executive during the period 1st October 2025 - 6th April 2026.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money. They include responsibilities for:

- ▶ **Ensuring the proper stewardship of public funds** - The Act requires NHS bodies to use resources efficiently, effectively and economically. The Accountable Officer is the individual personally answerable for this.
- ▶ **Ensuring the proper discharge of the organisation's functions** - Sections 14Q and 14R require ICBs to exercise their functions effectively, efficiently and economically, and to secure continuous improvement in service quality.
- ▶ **Ensuring compliance with financial duties** - Sections 223H to 223J set out the ICB's financial duties, including breakeven and expenditure limits. The Accountable Officer is responsible for ensuring the organisation meets these statutory duties.
- ▶ **Maintaining proper accounting records and preparing annual accounts** - The Act requires NHS bodies to keep proper records and prepare accounts in accordance with directions. The Accountable Officer is the individual responsible for ensuring this happens.

- ▶ **Safeguarding public assets** - The Act underpins the requirement to protect the organisation's resources, including taking reasonable steps to prevent fraud and irregularity.
- ▶ **Personal accountability to Parliament** - Through Managing Public Money, the Accountable Officer is personally answerable to Parliament for the use of public funds.

Under the National Health Service Act 2006 (as amended), NHS England directs 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 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.
- ▶ Prepare the accounts on a going concern basis.
- ▶ Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable, and take personal responsibility for the Annual Report and Accounts and the judgements required to determine that it is fair, balanced and understandable.

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



Shane Devlin
Cluster Chief Executive
15th June 2026

Governance Statement

Introduction and context

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

NHS Gloucestershire ICB's (GICB) 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 1st April 2025 and 31st 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).

The ICB was established on 1st July 2022 and held its inaugural meeting on that day approving:

- ▶ The appointment of the Chief Executive, Executive Directors, Non-executive directors and partner members of the ICB Board.
- ▶ The ICB governance and committee structure.
- ▶ The core governance documentation to enable the ICB to operate efficiently and effectively within the scope of its legal responsibilities including the Scheme of Reservation and Delegation (SoRD). This is described in the Governance Handbook (<https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook>).

Scope of responsibility

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

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

Governance arrangements and effectiveness

The main function of the Integrated Care Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB's Constitution which incorporates the Standing Orders establishes the core purposes (strategic aims) and values of the ICB. The ICB and ICS core purposes are:

- ▶ 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 functions of the ICB and purpose of the One Gloucestershire ICS are defined in the ICS Design Framework as detailed in s.1.1.6ii of the Constitution. In addition to the four key strategic aims, the 168 statutory functions, duties and powers of CCG's were conferred to ICBs as per the Health Act 2006 (as amended).

The Constitution outlines the governance structure of the organisation and details the role and responsibilities of the Board of the ICB, its members and sub-committees, exercise of functions, decision making procedures and standards of business conduct.

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

The ICB's overarching governance arrangements are set out in its Constitution and the ICB's Governance Handbook (<https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook-2/>) which explains the powers reserved to the Board of the ICB and those powers that have been delegated to the board sub-committees, executive directors, chief executive and chief financial officer.

ICB Board - Meetings

The Board was chaired by Dame Gill Morgan since its inception in 2022 to August 2025.

Dr Jeff Farrar was appointed Cluster Chair of the joint Gloucestershire ICB and Bristol, North Somerset & South Gloucestershire (BNSSG) ICB on 1 September 2025 and is the current Chair.

The Board met on 8 occasions between 1st April 2025 to 31st March 2026. In addition to the 6 scheduled meetings the Board held an extraordinary meeting on 18 June 2025 to sign off the ICB Annual Report and Annual Accounts and another extraordinary Board meeting on 27 August 2025 to approve terms of reference for the Transition Committee. All of the Board meetings were quorate.

During the year, the Board received the following reports:

- ▶ 10 Year Health Plan
- ▶ 5 Year Population Health & Strategic Commissioning Plan
- ▶ Annual Assurance report for Emergency Preparedness Resilience and Response (EPRR) 2024-25
- ▶ Board Assurance Framework at each meeting
- ▶ Chief Executive report with a roundup of contemporary initiatives and schemes.
- ▶ Developing the Voluntary Community Sector (VCS) Model: Shift from Sickness to Prevention
- ▶ Green Plan Report
- ▶ Health Inequalities Framework and Self-Assessment Tool
- ▶ Integrated Performance Report covering performance standards, quality, workforce and finance at each meeting
- ▶ Intensive and Assertive Community Mental Health Care Review
- ▶ Minutes of the board sub-committees
- ▶ One Gloucestershire's Urgent and Emergency Care (UEC) 25/26 Operational Delivery & Winter Surge Plan
- ▶ Patient Story at each meeting
- ▶ The Joint Forward Plan updates given throughout the year; and Operational Planning updates
- ▶ Winter Planning Board Framework Statement.

From 1st April 2025 to 31st March 2026 the Board approved the following:

- ▶ ICB Annual Accounts 2024-25 and Annual Report 2024-25
- ▶ Constitution and Scheme of Reservation and Delegation Updated
- ▶ ICS Infrastructure Public Summary
- ▶ Domestic Abuse Strategy
- ▶ System Resources Terms of References
- ▶ Winter Planning Board Framework Statement

- ▶ Gloucestershire ICS System Wide OPEL Escalation Policy
- ▶ NHS Gloucestershire revised ICB Constitution
- ▶ 5 Year Population Health & Strategic Commissioning Plan
- ▶ Green Plan
- ▶ Terms of reference for the Joint Transition Committee
- ▶ Terms of reference for the Joint Remuneration Committee.

ICB Board papers are published on the ICB's website and can be found here: <https://www.nhsglos.nhs.uk/category/board-meetings/>

Audit Committee

The Audit Committee is responsible for overseeing financial assurance, including the system of internal control, counter fraud arrangements, and the review of all internal and external audit reports. The Committee has no executive members and is comprised entirely of Non Executive Members drawn from both the Integrated Care Board and the wider Integrated Care System.

The Committee also provides assurance on the organisation's risk management arrangements, ensuring that risk structures, processes and practices are robust and embedded across the organisation. It receives regular reports on risk management, including the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

The Committee met 4 times from 1 April 2025 - 31 March 2026 and also had 1 informal briefing. The committee was quorate on each occasion. The committee is chaired by Julie Soutter, Non-Executive Director. The membership of the committee and attendance at each meeting can be found here: <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/>

During this period the committee reviewed a number of internal audit reports undertaken by BDO including action plans, relating to the following service areas:

- ▶ Data Security & Protection Toolkit
- ▶ Digital Transformation/Maturity
- ▶ Contract and Procurement Pipeline
- ▶ ICS Cluster Transition
- ▶ Business Continuity & Emergency Planning
- ▶ Contracting and indicative activity plans
- ▶ Key Financial Systems
- ▶ ISFE 2 Ledger project.

In addition, the committee has oversight and receives regular reports on the following areas:

- ▶ Counter Fraud reports
- ▶ Declarations of Interests including the gifts and hospitality registers
- ▶ Risk Management reports including (Corporate Risk Register and Board Assurance Framework)
- ▶ Procurement Decisions
- ▶ Waivers of Standing Orders report
- ▶ Service Auditors reports
- ▶ Aged Debtor report
- ▶ Cyber report.

The System Quality Committee

The System Quality Committee is chaired by Professor Dame Jane Cummings, Non-executive Director and Vice-Chair of the ICB. The Committee is responsible for providing the ICB with assurance that it is delivering its functions that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act (2022). This includes reducing inequalities in the quality of care.

The Committee is also responsible for reviewing and scrutinising clinical risks, as well as governance matters covering clinical quality policies. The membership of the committee and attendance at each meeting can be found here: <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/>

During the period 1st April 2025 to 31st March 2026 the committee met 6 times and was quorate on each occasion. The committee received the following reports amongst others:

- ▶ Child Protection Medical Assessment Action Plan
- ▶ Children's Continuing Care Improvement Plan
- ▶ Delayed Related Harm Report
- ▶ Emergency Planning Resilience and Response Report (quarterly)
- ▶ Gloucestershire Hospitals NHS Foundation Trust GHFT Dementia Audit Report
- ▶ Homebirth Suspension & Action Plan
- ▶ ICB Quality Report
- ▶ Infection Prevention Management
- ▶ Maternity Needs Assessment
- ▶ Pharmacy Manufacturing Unit report
- ▶ Quality Governance Updates
- ▶ Quality Reports from both GHFT) & Gloucestershire Health & Care NHS Foundation Trust (GHC)
- ▶ Risk Report and BAF Update
- ▶ Safeguarding Reports (Quarterly)
- ▶ System Quality Group Report.

The System Quality Committee approved a range of strategies and policies including:

- ▶ Adult Continuing Healthcare (CHC) Dispute Resolution Policy
- ▶ All Age Disputes Policy
- ▶ Children in Care Annual Report
- ▶ Cobalt the Patient Safety Incident Response Framework (PSIRF)
- ▶ CYPCC Operations Policy
- ▶ EPRR Quarterly Report & Business Continuity Policy
- ▶ Equity/Choice Policy
- ▶ GICB Decommissioning Policy
- ▶ Glos HSC Framework Contract Policy
- ▶ Hybrid Closed Loop Technology Policy
- ▶ ICB System Quality Committee ToR v2.0
- ▶ Prevent Policy
- ▶ Research, Evaluation and Audit Annual Report 2024/2025
- ▶ Safeguarding 2024/25 Annual Report
- ▶ Section 117 of the Mental Health Act (S117 MHA): Aftercare Gloucestershire Joint Policy.

Primary Care & Direct Commissioning Committee (PCDC)

As the ICB has delegated authority for the commissioning of primary care, it has an established sub-committee which manages the delivery of primary care services, within the context of the overall ICB Plan. The committee's jurisdiction was expanded beyond primary care services to cover the contracting, commissioning and performance of community pharmacy, optometry and dental services from 1st April 2023. The committee is chaired by Ayesha Janjua, Non-executive Director. The membership of the committee and attendance at each meeting can be found here <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/>

During the period 1st April 2025 to 31st March 2026 the committee met on 5 occasions. Meetings were quorate on each occasion. The Committee received the following reports:

- ▶ 10 Year Plan and Neighbourhood Working
- ▶ Corporate Risk Register and Board Assurance Framework
- ▶ Corporate Risk Register and Board Assurance Framework
- ▶ Finance Report
- ▶ Gloucestershire ICB proposal to deliver Dental Urgent care.
- ▶ GP Patient Survey Results
- ▶ GP Premises Development & Delivery Plan 2024 to 2031
- ▶ Language & Translate Contract for POD Services
- ▶ Neighbourhood Health Portfolio Highlight Report
- ▶ Primary Care and Quality Performance Report
- ▶ Primary Care Highlight Reports.

The Committee approved amongst other plans:

- ▶ Application from Phoenix Health Group to close its branch surgery located in the Royal Agricultural University campus, Cirencester
- ▶ Community Pharmacy - Contractual Withholding Model
- ▶ Community Pharmacy PCN Leads (CPP CNL) 2025/26 Funding
- ▶ Community Pharmacy: Delivery and Operational Planning - Fair Shares allocations
- ▶ Community Pharmacy: Steering Group - new focus and Terms of Reference
- ▶ Dental and Optometry: Special Educational Settings Proposal (SES)
- ▶ Dental: Contract Rebasing Proposal
- ▶ Dental: Dispensing Services Quality Scheme (DSQS)
- ▶ Dental: Individual Funding Requests (IFR)
- ▶ General Practice Boundary Review
- ▶ Gloucestershire Community Pharmacy Independent Prescribing PATHFINDER Programme
- ▶ May 2025, Dental Commissioning Strategy Plan update
- ▶ Oral Health Improvement (OHI) commissioning and dental budget delegation proposal
- ▶ Practice Variation SOP
- ▶ Specialist Dental Trainee Funding Proposal.

People Committee

The People Committee is responsible for reviewing the One Gloucestershire People Strategy, to receive assurance that a robust approach to workforce planning, supply and resourcing is in place across the ICS, as well as system wide HR and Organisational Development initiatives and projects that meet the agreed ICS HR/OD/Workforce priorities. The committee is chaired by Karen Clements, Non-executive Director.

During the period April 2025 to 31 March 2026 the People Committee met on 4 occasions. The meeting was quorate on each occasion. Committee attendance can be found here: <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/>

The committee received the following reports:

- ▶ Deep-Dive on EDI - Reviewing WRES/WDES Position in the System & Organisational Action Plans
- ▶ Future governance & update on functions/ responsibilities
- ▶ ICS People Function Summary Reports
- ▶ Model ICB - Workforce Function & 10 Year Plan
- ▶ Operational Planning 2025/26 and Joint forward Plan
- ▶ Overview of Organisational Staff Survey Results
- ▶ Revised Governance Arrangements for People Programme for 2025/26
- ▶ Workforce Intelligence & Programme Highlight Report
- ▶ Workforce Intelligence & Programme Highlight Reports.

The Committee approved the following people strategies and policies:

- ▶ Complaints and Feedback Policy
- ▶ Feedback on Committee Survey and agreement of TOR
- ▶ Flexible Retirement Policy
- ▶ Get Britain Working Plan
- ▶ ICB Alcohol, Drugs and Substance Misuse Policy
- ▶ ICB Organisational Change Policy & alignment with BNSSG
- ▶ NHS Gloucestershire ICB Complaints and Feedback
- ▶ People Committee Risk Register and BAF Update
- ▶ Policy: Extension Request
- ▶ Sexual Safety - Assurance Framework
- ▶ Sexual Safety - Sexual Misconduct Policy.

System Resources Committee

The System Resources Committee is chaired by Professor Joanna Coast, Non-executive Director of System Resources; and is responsible for contributing to the overall delivery of the ICB objectives by providing oversight and assurance to the Board for matters relating to system resources allocation, performance against strategic plans and financial performance.

The Committee is responsible for helping improve population health and healthcare, oversee the collective management of resources and performance at system, place-based and organisational levels; contributing to the System Oversight Framework. The membership of the committee and attendance at each meeting can be found here.

During the period 1 April 2025 to 31 March 2026 the committee met 6 times and was quorate on each occasion. The Committee received the following reports:

- ▶ 5-Year Planning: NHS Medium Term Planning Framework
- ▶ 5-Year Planning: NHS Medium Term Planning

- ▶ 5-Year Planning: Population Model - Next Steps
- ▶ Cash Approach
- ▶ Delivering the Plan: 25/26 and beyond
- ▶ Estates BAF Risk Deep-Dive
- ▶ Findings from the Core20PLUS Staff Survey
- ▶ ICS & ICB Finance Reports
- ▶ ICS & ICB Performance Reports
- ▶ ICS Digital Strategy & Risk Mitigation
- ▶ Integrated Needs Assessment
- ▶ Medium Term Plan (inc. Financial Plan)
- ▶ Monitoring Delivery of 2025-26 Plan (inc. Transformation Portfolios: Prevention & LTC Physical Health / Working as One)
- ▶ One Gloucestershire Health Inequality Information Review
- ▶ Performance Against Key National Standards
- ▶ Planned Care, Cancer & Diagnostics Update Report
- ▶ Population Health Modelling (Part of Medium-Term Plan Development)
- ▶ Review of Recurrent Investments
- ▶ Specialised Commissioning
- ▶ System Resource Committee Risk Report
- ▶ System Resource Committee Risk Report
- ▶ Triangulation between Performance, Finance and Workforce
- ▶ Triangulation between Provider Integrated Delivery Plans and ICB Population Health & Strategic Commissioning Plan
- ▶ Urgent & Emergency Care Update Report.

Remuneration Committee

The Remuneration Committee determines and approves the remuneration, fees and other allowances for ICB employees (specifically, very senior managers, Non-executive directors). The membership of the committee and attendance at each meeting can be found here: <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/>

The Remuneration Committee is chaired by Karen Clements. The committee met on 5 occasions from 1st April 2025 to 31st March 2026. The full Remuneration Report can be found within the ICB Annual Report and Accounts.

UK Corporate Governance Code

Compliance with Governance Codes and Statutory Functions.

NHS bodies are not required to comply with the UK Corporate Governance Code. However, the ICB has drawn on the principles of good governance set out in the UK Corporate Governance Code and the former NHS CCG Code of Governance, adapting them to reflect the statutory framework for Integrated Care Boards established under the Health and Care Act 2022.

The Board is satisfied that the organisation upholds the principles and standards of best practice in leadership, accountability, transparency, and stewardship of public resources.

The arrangements in place for the discharge of statutory functions have been reviewed through internal and external audit work, with no irregularities identified. These reviews confirm that the ICB's governance,

decision making and financial management arrangements are legally compliant and operating effectively. Further assurance is provided through the work of the Accountable Officer, Chief Finance Officer, the ICB Board and its committees, particularly the Audit Committee, which maintains oversight of internal control, risk management and compliance.

The ICB has followed guidance issued by NHS England on the role, duties and powers of Integrated Care Boards and ensures that its governance arrangements remain aligned with national expectations. The organisation employs experienced and suitably qualified staff to support the effective discharge of its functions.

Discharge of Statutory Functions

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

During the financial year 2025-26 work was undertaken to improve the reporting of risk to the ICB's committees and Board. The BAF continued in its 2024-25 format which included the three core pillars in the ICS Strategy, the key strategic objectives and priorities for 2025-26. Additionally, the Corporate Risk Register's format and reporting were further improved with more visual highlight reports available to the Audit Committee and sub-committees of the Board.

The ICB has a Risk Management Framework and Strategy inclusive of the ICB's Risk Appetite which provides a systematic approach to:

- ▶ Risk identification, their cause and effect
- ▶ How risks are managed
- ▶ Creating and developing risk mitigation plans
- ▶ The likelihood of occurrence and impact
- ▶ Risk rating - escalation and de-escalation process.

The ICB's Risk Management Strategy outlines the vision and objectives of the organisation's risk management system; the strategy embodies 8 key principles to achieve effective risk management: (Integrated, Structured and Comprehensive, Customised, Inclusive, Dynamic, Informed, Audience-appropriate and Always improving). The Framework incorporates the organisation's approach to working collaboratively with system partners to develop system wide strategic risks incorporated into the Board Assurance Framework, and an agreed statement on the ICB's Risk Appetite.

Work has taken place on embedding this risk management approach in all business activities and processes of the ICB, ensuring that a risk aware culture is embraced throughout the organisation.

There is an inclusive approach to risk management involving ICS partners contributing to the development of the ICB BAF through the identification of strategic risks and the involvement of the Strategic Executive, Operational Executive and directorate teams and risk leads. The Risk Management training and support, is provided by the Governance Team on a monthly basis to risk leads and directorates and reinforces this systematic approach to identifying, managing and reporting risks as well as assessing the impact and occurrence of risk. Training has more recently focused on understanding the Audit Committee feedback on strategic risks.

The ICB ensures that staff are equipped to identify, assess and manage risk in a manner appropriate to their roles, authority and professional responsibilities. All staff have access to clear guidance through the organisation's Risk Management Strategy, Risk Policy, and supporting procedures, which set out expectations for risk identification, scoring, escalation and mitigation. Guidance is reinforced through

regular communication, accessible intranet resources, and support from the Governance Team, who provide advice, coaching and quality assurance on risk entries and mitigation plans.

Reporting & Assurance

The reporting schedule for the BAF and corporate risk register is as follows:

- ▶ **The Board** receives the Assurance Framework comprising system wide risks at every other formal meeting of the Board. The BAF includes high rated risks which should be rated 15 and above.
- ▶ **The Audit Committee** receives a report on the medium, high and significant risks at every meeting i.e. the Corporate Risk Register (12+ rating) and the BAF (15+rating).
- ▶ **The Quality Committee** receives a report showing all risks relating to Quality including safeguarding and patient safety as well as Emergency Planning Resilience and Response (EPRR) and Continuing HealthCare (CHC) at each meeting. The BAF strategic risks on quality and EPRR are also included.
- ▶ **The System Resources Committee** receives a risk report showing risks relating to performance and finance at each meeting. The BAF strategic risks on health inequalities, urgent & emergency care provision, and estates are also reported.
- ▶ **The Primary Care and Direct Commissioning committee** receives a risk report showing all risks relating to primary care at each meeting. The BAF strategic risk on primary care sustainability and resilience is also reported.
- ▶ **The People Committee** receives a risk report showing all risks relating to HR/OD and workforce at each meeting. This also includes the strategic BAF risks on workforce and Equality, Diversity and Inclusion.
- ▶ **The Operational Executive** receives bi-monthly CRR and BAF reports. The scheduling of the reports is aligned with the Board and other committee meetings.
- ▶ **Strategic Executive** receives the Board Assurance Framework on a bi-monthly basis. The Strategic Executive comprises ICS partners and is the monthly forum for partners to discuss and agree key operational and strategic issues including agreeing strategic risks affecting the system.
- ▶ **Operational Groups** (for example Primary Care Operational Group) receive reports for risks relating to their respective areas.

The Board has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

The Board receives assurance reports from its sub-committees on the controls and mitigation plans in place to manage significant and high rated risks, reported through the minutes of meetings with a specific Assurance Report provided by the Chair of the Audit Committee following each meeting. Committees routinely review risk themes and share learning across the organisation, ensuring that good practice is identified, disseminated and embedded. Overall assurance reports from committees are included in the Integrated Performance Report which is submitted to the Board on a bi-monthly basis.

Capacity to Handle Risk

The Governance Team meets with risk leads on a bi-monthly basis to discuss their directorate risk register and provide timely support and advice. Risks are transferred to a Corporate Risk Register and high rated risks 12 or more are reported to the Audit Committee and Operational Executive.

The Governance Team ensures that risk reports are made available to directors, the board sub-committees and the ICB Board in a cyclical manner. All of these forums include ICS partners who are involved in risk discussions.

Key risks identified in 2025/26

There were a number of high-level strategic risks reported in 2025-26 to the ICB Board via the Board Assurance Framework. The strategic risks identified were aligned to the ICS three pillars, strategic objectives and key priorities for 2025-26 which had been agreed with system partners and focused on key priority areas such as urgent care, workforce, the recovery of services, cyber security and financial balance, amongst others. It should be noted that the ICB/ICS BAF is correlated with our ICS partners BAFs and relevant risks included.

As of the 31 March 2026 there were 80 risks in total on the ICB Corporate Risk Register, with 27 red rated risks at 15 and above.

As of the 31 March 2026, there were 14 risks on the BAF, i.e. Approximately 11 were red rated risks at 15 and above and 3 were amber rated risks at 12. The following risks were rated as red high risks:

BAF 2. Delivery of Care: Delivery structures are unable to drive the acceleration required on delivery of the frailty & dementia co-diagnosis INT model; this is also impacted by limited capacity to drive and evaluate the change (Red).

BAF 3a. People & Culture: Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans. Current risk rating 16 (Red).

BAF 3b. Equality, Diversity and Inclusion: There is a risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse, and engaging culture for staff we employ. Current risk rating 15 (Red).

BAF 4 Quality: The risk is that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients. Current risk rating 16 (Red).

BAF 6. Primary Care: Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures. Current risk rating 20 (Red).

BAF 7. Recovery and Productivity: Failing to deliver increased productivity requirements to meet both backlogs and growing demand. Current risk rating 16 (Red).

BAF 9. Financial Sustainability: Insufficient resources to meet the delivery of our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity. Current risk rated as 16 (Red).

BAF 10. Estates: The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling delivery of high-quality care. Current risk rating 16 (Red).

BAF 11. EPRR: Failure to meet the minimum occupational standards for EPRR and Business Continuity. Current risk rating 16 (Red).

BAF 12. Cyber Security: Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS. Current risk rating 15 (Red).

BAF 13. ICB Reset: failure to meet statutory duties, regulatory and legal requirements during ICB transition and beyond.

The outstanding risks in place on 31 March 2026 will be discussed as the Gloucestershire ICB clustering arrangements with BNSSG ICB and both corporate and strategic risks will be reviewed and discussed.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the Gloucestershire 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 see the Risk Management Strategy and Framework here: <https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook-2/>

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and to publish their own Conflicts of Interest (Col) policy, which forms part of the ICB's governance handbook. While ICBs are responsible for ensuring compliance locally, NHS England's engagement with stakeholders has highlighted the value of nationally commissioned training to avoid unnecessary duplication across systems. NHS England will therefore provide updated national e learning modules on managing conflicts of interest within the new ICB arrangements and will explore additional guidance in consultation with ICB Chairs. The ICB will continue to ensure that all staff and Board members complete the required training and adhere to the Col policy, with registers maintained and reviewed regularly.

Conflicts of interest management

The ICB complies with the guidance on 'Managing Conflicts of Interest in the NHS' that was published by NHS England on 17th September 2024.

The guiding principle for conflicts of interests that decisions are made in the public interest by avoiding any undue influence is incorporated into the ICB's policy on Standards of Business Conduct that also covers the principles of collaboration, transparency and subsidiarity which are at the centre of any decision-making.

The ICB has assurances mechanisms in place reporting to the Audit Committee on the Col policy. This includes how guidance on Col is being compiled with, regular reports on compliance with the policy through Declarations of Interest registers published on the ICB website (<https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/using-your-information/register-of-interests/>), training and the management of potential conflicts in procurement and other ICB business.

The ICB has a Col training programme, which starts with induction, team meetings and all staff meetings. There are dedicated intranet pages explaining Col and providing guidance to all staff, including bank, agency workers and contractors.

Conflicts of interest process

The ICB follows a robust process for managing conflicts of interests ensuring that staff are made aware from initial appointment, and throughout their employment they are required to register their interests on an annual basis.

All staff and members of the Board are required to undertake this annual process irrespective of whether there have been any changes to their interests.

The electronic Col system Civica Declare emails staff as soon as they are appointed and repeatedly emails them requiring their interests to be declared until this has been completed; line managers are also emailed to notify them that they have interests to review and either accept/decline. The electronic email notification system provides constant reminders to staff and managers that interests must be declared annually.

Data Quality

Board members of the ICB consider data quality to be an integral part of its system of internal controls in order that it can assess both the effectiveness and performance of the organisation and its contracted services. There have been no significant concerns about data quality reported in 2025/26.

Information Governance

The NHS Data Security Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information; this is supported by the Data Security and Protection Toolkit, and the annual submission process by the ICB provides assurances to the Integrated Care Board, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

As part of the annual CAF aligned Data Security and Protection Toolkit (DSPT) submission a comprehensive assessment of information security was undertaken; further assurance has been provided by the ICB's internal auditors who reviewed the submission. The effectiveness of these measures is reported to, and monitored by, the Data Security and Awareness Working Group and the Audit Committee. This includes details of any personal data related serious incidents, the ICB's annual data security toolkit assessment and reports of other data security incidents and audit reviews.

The 2024/2025 DSPT toolkit was submitted in line with mandated timeframe on 27th June 2025 with Standards Met. 2025/2026 DSPT will be due for publication by 30th June 2026, work is currently underway in the collection of evidence with a further 2025-2026 internal audit planned.

In compliance with NHS Digital Information Governance Toolkit, the ICB ensured that all key information security risks are monitored and controlled, this is via its informatics providers: South, Central and West Commissioning Support Unit (CSU) and Countywide IT Services who ensure that the ICB operates secure information networks and systems. New systems and processes are assessed by governance and information security staff at the point of design or procurement, and appropriate safeguards to minimise risk are put in place. The ICB has a robust process for recording and managing incidents which are monitored by the CSU's governance team with input from Data and Information Security experts as required.

We place 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 developed data security and protection processes and procedures in line with the Data Security and Protection toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. For those members of staff in specialist information governance roles within the ICB, there is bespoke training provided on an annual basis i.e. for the Caldicott Guardian, Senior Information Risk Owner (SIRO) and the Data Protection Officer (DPO).

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit, and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

There are processes in place for incident reporting and investigation of serious incidents which are reported via to the Data Security and Protection Group that meets on a monthly basis. Information risk assessment and management procedures are in place and a programme to ensure that a fully embedded information risk culture throughout the organisation against identified risks.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I confirm that an appropriate framework and environment is in place to provide quality assurance of business-critical models.

Third party assurances

The ICB works in close partnership with Gloucestershire County Council to manage both the Better Care Fund and other partnership budgets.

The arrangement is governed by a Section 75 agreement. On 27th November 2024 the Board of the ICB gave approval for the renewal of the term of the Section 75 Agreement (by way of a Deed of Variation between the ICB and GCC) for a further 3-year period (1/4/2025 to 31/3/2028).

Control Issues

The ICB can state that there were no significant control issues to report.

Review of economy, efficiency & effectiveness of the use of resources

The Board has overarching responsibility for ensuring that the ICB carries out its functions economically, efficiently and effectively. To support this, the following arrangements are in place:

- ▶ Robust financial governance and controls - The ICB operates within an agreed Scheme of Delegation and established procurement processes to ensure appropriate financial oversight and value for money. The roles and responsibilities of the Accountable Officer, committees and sub-groups are set out within this report.
- ▶ Regular financial reporting to the Board - The Chief Finance Officer provides updates at each Public Board meeting through the Integrated Finance and Performance Report. Additional financial briefings are provided at Board Development sessions where required.
- ▶ Audit Committee oversight - The Audit Committee receives routine reports on financial governance, monitors delivery of the Internal Audit programme, and reviews both the draft and final annual accounts.
- ▶ Internal Audit assurance - The ICB commissions an annual programme of Internal Audit work, providing independent assurance to the Board and Executive Team on the effectiveness of internal controls and processes.
- ▶ External audit review - The ICB's annual accounts are reviewed by the Audit Committee and audited by external auditors. Following completion of their planned audit work, the external auditors will issue an independent and objective opinion on the ICB's arrangements for securing economy, efficiency and effectiveness in the use of resources.

Following completion of the planned audit work our external auditors will issue an Independent and objective opinion on the ICB's arrangements for securing economy, efficiency and effectiveness in the use of resources.

Commissioning of delegated specialised services

NHS Gloucestershire ICB signed a delegation agreement (DA) with NHS England - South West which put in place the joint NHSE and ICB systems statutory joint committee for commissioning arrangements for delegated services during the 2025/26 reporting period.

Following the ICB Board meeting held on 26th March 2025, approval was given for the full delegation of responsibility for Specialised Commissioning services to Gloucestershire ICB from NHS England under the Principal Commissioner operating model from 2025/26 (with NHS Somerset ICB assuming the role of principal commissioner).

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements - as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England - including the requirement that all conditions set out in the delegation agreement are being met.

Where there are known compliance issues, the ICB leadership will work collectively with other ICBs (e.g. through multi-ICB working arrangements with Somerset ICB as the principal commissioner) and engage with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership can provide the necessary evidence of core commissioning requirements compliance, should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of functions

The ICB has a defined Scheme of Reservation and Delegation (SoRD) as well as a Detailed Financial Delegation document which is a supplement to the Standing Financial Instructions. These documents were approved by the ICB Board on 1 July 2022. Further updates to the detailed scheme of delegation has been made and reported to the Audit Committee in November 2022.

The SoRD identifies which functions are reserved for the Board and which are delegated for discharge across the ICB in line with effective use of resources and risk management processes. In support of this the ICB has a Detailed Scheme of Delegation which identifies what financial responsibilities the following levels of authority have:

- ▶ Level 1 - Board of the ICB
- ▶ Level 2 - Chief Executive Officer (Accountable Officer)
- ▶ Level 3 - Chief Finance Officer
- ▶ Level 4 - Other Directors
- ▶ Level 5 - Budget holders, in accordance with specific levels of authority granted to individuals
- ▶ Level 6 - all other office holders.

The Board receives regular reports from all its committees to provide assurance regarding the arrangements for the discharge of delegated functions, including those relating to quality, finance, risk and performance, particularly relating to constitution targets.

The Board receives minutes from the Primary Care & Direct Commissioning Committee ensuring they are meeting their delegated duties for Primary Care and POD services and that conflicts of interests are being effectively managed.

Internal Audit provides independent assurance on the processes in place as part of the annual internal audit plan which is supplemented by the oversight of the assurance of the ICB's value for money, economy, efficiency and effectiveness by the External Auditors.

Counter Fraud arrangements

The ICB maintains comprehensive counter fraud arrangements in line with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption. These arrangements cover proactive fraud prevention, fraud risk assessment, mandatory reporting processes, and access to accredited Local Counter Fraud Specialists (LCFS) who provide investigation, training and advisory support. They are designed to meet the requirements of Government Functional Standard GovS 013: Counter Fraud, ensuring that appropriate systems, controls and assurance mechanisms are in place to prevent, detect and respond to fraud, bribery and corruption.

The Chief Finance Officer is the lead for counter fraud within the ICB and works with the nominated Local Counter Fraud Specialist to develop the annual work-plan which is approved by the Audit Committee.

The ICB's Counter Fraud Service is provided by the Gloucestershire Shared Service for NHS (GSS). GSS employs a team of three accredited Local Counter Fraud Specialists who provide the full range of Counter Fraud functions.

The Head of Counter Fraud meets regularly with the Chief Finance Officer to discuss progress against the Action Plan and areas of potential risk. The Head of Counter Fraud also meets regularly with the Audit Committee Chair to discuss the action plan and potential risks. During the period 1 April 2025 to 31 March 2026 regular reports and updates were given to the Audit Committee on:

- ▶ Counter Fraud, Bribery and Corruption Annual Report
- ▶ Counter Fraud, Bribery and Corruption work-plan
- ▶ Counter Fraud Progress reports
- ▶ Counter Fraud Staff Survey
- ▶ Counter Fraud Functional Standard Return 2024/25
- ▶ Counter Fraud, Bribery and Corruption Policy updated
- ▶ Recovery of Overpayment Policy
- ▶ National counter fraud initiative
- ▶ Counter Fraud training (face to face and e-learning)
- ▶ Current Cases and Proactive Counter Fraud Work.

Counter Fraud deliver face to face training to all staff as a part of the ICB 's Statutory and Mandatory Training Policy. This training is delivered via the directorate meetings.

The Counter Fraud Service provide a monthly face to face drop-in service for ICB staff which is advertised in the electronic Staff Bulletin. All staff are required to complete their annual e-learning module on counter fraud in addition to face-to-face counter fraud training, which is now available via their Electronic Staff Record (ESR). Managers have access to ESR manager self-service to review individual and team compliance.

The Deputy Head of Counter Fraud attends all Audit Committee meetings to provide both a written and verbal update on progress against the Counter Fraud Annual Plan and counter fraud initiatives.

Head of Internal Audit Opinion

Internal auditing strengthens the organisation's ability to create, protect, and sustain value by providing NHS Gloucestershire ICB ('GICB' or 'the ICB') board* and management with independent, risk-based, and objective assurance, advice, insight, and foresight. The primary responsibility of the internal audit service is to provide the Audit Committee with assurance on the adequacy and effectiveness of risk management, control and governance arrangements.

Internal Audit is required to provide an opinion to the ICB, through the AC, 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.

Overall, we provide **Satisfactory** Assurance (draft). 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.

No high significance findings were raised in relation to assurance audits completed during the year.

The approved internal audit annual plan for 2025/26 comprised the following assignments

- ▶ Data Security & Protection Toolkit
- ▶ Digital Transformation / Maturity (draft)
- ▶ Contract and Procurement Pipeline (draft)
- ▶ ICS Cluster Transition
- ▶ Business Continuity & Emergency Planning
- ▶ Contracting and indicative activity plans
- ▶ Key Financial Systems - ISFE1
- ▶ Key Financial Systems - ISFE 2



Shane Devlin

Cluster Chief Executive

15th June 2026

Remuneration and staff report



Remuneration and staff report

Remuneration report

The Remuneration Committee makes decisions about the remuneration, fees and allowances for board members of the ICB, and other senior staff employed outside agenda for change terms and conditions, who are appointed by or who provide services to the ICB. Details on the Remuneration Committee are shown within the Governance report including membership and number of meetings. Full details of the remuneration paid to the ICB board members and senior employees are provided within the Remuneration Report included herein, together with their pension entitlements.

Senior Managers Remuneration Report

For the purpose of this report, senior managers are defined as being 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Integrated Care Board (ICB). This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments. Such persons will include non-executive directors and partner members of the ICB board. It is the Remuneration Committee that decides the reward packages of Executive Directors of the ICB. Information on the Remuneration Committee can be found in the Governance Statement.

Remuneration Policy

The Integrated Care Board's policy on the remuneration of senior managers (defined as members of the ICB's Board and its executive directors) is designed to ensure that pay is fair, transparent, compliant with national frameworks, and supports the recruitment and retention of individuals with the skills and experience required to discharge the ICB's statutory responsibilities. Remuneration for senior managers is determined in accordance with national guidance issued by the Department of Health and Social Care, NHS England and HM Treasury. In particular, the ICB applies the NHS Very Senior Manager (VSM) Pay Framework for executive directors and other senior posts designated as VSM roles. This framework has been complied with within the ICB.

The ICB intends to continue applying the national VSM Framework and Agenda for Change arrangements in future years. Any changes to remuneration policy will be made only in response to updated national guidance or statutory requirements and will remain subject to approval by the Remuneration Committee. The ICB will continue to ensure that remuneration decisions are transparent, evidence based and represent value for money for the public.

Senior Manager Contracts

Senior officer appointments to the ICB are consistent with the employment policies of the ICB. Where appropriate, duration of contracts is determined by the needs of the business. Notice periods take account of statutory requirements and terms previously established by the NHS very senior managers' pay framework. Liability in the event of early termination is in accordance with the NHS Agenda for Change terms and conditions handbook. Further guidance is also provided by NHS England on the termination and reengagement of senior managers. They also include any additional pension benefit accrued to the members as a result of their purchasing additional years of pension service in the scheme at their own cost. Cash Equivalent Transfer Values (CETVs) are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Fair pay disclosure (Subject to audit)

The annualised range of remuneration is £24.9k to £203.9k (2024-25 £20.7k to £198.7k).

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

The banded remuneration of the highest paid member of the Governing Body in the ICB in the financial year was £200k - £205k (£195k - £200k in 2024/25) on an annualised basis. This figure is different to the remuneration table due to it being calculated on an annualised basis for part-time work. The relationship of the highest paid director to the remuneration of the organisation's workforce is disclosed in the below table. The median pay ratio has reduced slightly as a result of departmental changes in staffing.

Pay Ratio information

2025-26	25th Percentile	Median	75th Percentile
Total remuneration (£)	£37,796	£50,273	£68,631
Salary component of total remuneration (£)	£37,796	£50,273	£68,631
Pay ratio information	5.4:1	4.06:1	2.97:1
2024-25	25th Percentile	Median	75th Percentile
Total remuneration (£)	£37,338	£48,526	£66,246
Salary component of total remuneration (£)	£37,338	£48,526	£66,246
Pay ratio information	5.32:1	4.1:1	3:1

* All Remuneration relates to Salary only. There have been no performance related pay or bonuses

The average percentage change for the ICB as a whole is an increase of 3.77%/£2,191 in 2025/26.

This rise is primarily attributable to the national pay award, with the prior year comparator reflecting costs relating to Non-Executive Directors. The remuneration of the highest-paid director increased by 2.6%/£5,193 in 2025/26.

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 of pensions.

Off Payroll Engagements

For all off-payroll engagements to 31st March 2026, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2026	5
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	5

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

	Number
Number of temporary off payroll workers engaged between 1 July 2025 and 31 March 2026	5
Of which:	
Number Not Subject to off-payroll legislation	0
Number Subject to off payroll legislation and determined as in-scope of IR35	5
Number Subject to off payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance/assurance purposes during the year	0
Of which:	
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of Board/Governing Body members and/or senior officials with significant financial responsibility between 1 April 2025 and 31 March 2026:

	Number
Number of off payroll engagements of Board/Governing Body members and/or senior officials with significant responsibility during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This includes both on-payroll and off-payroll engagements	20

Remuneration Report for NHS Gloucestershire ICB 2025-26 (Subject to audit)

Name & Title	2025/26						
	Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Sub-total (band of bands)	All Pension Related Benefits (bands of £2,500) *	Total (bands of £5,000)
Dame Gill Morgan, Chair (to September 2025) ¹	30-35	0	0	0	30-35	0	30-35
Jeffrey Farrar, NHS Gloucestershire ICB and Bristol, North Somerset and South Gloucestershire ICB Cluster Chair (From 1st September 2025) ²	20-25	0	0	0	20-25	0	20-25
Mary Hutton, Chief Executive (to July 2025) ³	60-65	0	0	0	60-65	0	60-65
Sarah Truelove, Chief Executive - July 2025 to September 2025, Chief Executive (transitioning Officer) from October 2025	145-150	0	0	0	145-150	1,157.5-1,160	1,300-1,305
Shane Devlin, NHS Gloucestershire ICB and Bristol, North Somerset and South Gloucestershire ICB Cluster Chief Executive (from October 2025) ⁴	75-80	0	0	0	75-80	0	75-80
Ellen Rule, Deputy CEO/Director of Strategy and Transformation (to April 2025) ⁵	15-20	0	0	0	15-20	50-52.5	65-70
Gemma Artz, Chief Delivery and Transformation Officer (From April 2025 to March 2026) ⁶	120-125	0	0	0	120-125	165-167.5	285-290
Cath Leech, Chief Finance Officer	160-165	0	0	0	160-165	95-97.5	255-260
Mark Walkingshaw, Director of Operational Planning & Performance	150-155	0	0	0	150-155	110-112.5	260-265
Helen Goodey, Director of Primary Care & Place	150-155	0	0	0	150-155	50-52.5	200-205
Marie Crofts (Yvonne), Chief Nursing Officer	160-165	0	0	0	160-165	70-72.5	230-235
Tracey Cox, Director of People, Culture and Engagement	160-165	0	0	0	160-165	62.5-65	225-230
Dr Paul Atkinson, Chief Clinical Information Officer	145-150	0	0	0	145-150	42.5-45	190-195
Dr Ananthakrishnan Raghuram, Chief Medical Officer	130-135	0	0	0	130-135	40-42.5	170-175
Benedict Leigh, Director of Integrated Commissioning (to May 2025) ⁷	5-10	0	0	0	5-10	0	5-10
Professor Joanna Coast, Non Executive Director System Resources	10-15	0	0	0	10-15	0	10-15
Professor Jane Cummings CBE RN, Non Executive Director System Quality	20-25	0	0	0	20-25	0	20-25
Julie Soutter, Non Executive Director Audit	15-20	0	0	0	15-20	0	15-20
Karen Clements, Non Executive Director, People and Remuneration	10-15	0	0	0	10-15	0	10-15
Ayesha Janjua, Non Executive Director, Primary Care and Direct Commissioning	10-15	0	0	0	10-15	0	15-15
Dr Jo Bayley, Primary Medical Services (Primary Care Network perspective) G Doc Ltd ⁸	10-15	0	0	0	10-15	0	10-15
Dr Emma Crutchlow Primary Care Network perspective (Board participant) G Doc Ltd ⁸	10-15	0	0	0	10-15	0	10-15

*These figures are purely the benefits accruing to senior managers from membership of the NHS Pensions Scheme.

These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004(1). Para 10(1)(e)(ii)(cc) of sch8 of 2013/1981 (update to the Finance Act 2004):

*Due to changes in the NHS pension scheme and, in particular, where individuals are new in post or may have changed schemes in previous years this distorts the calculations.

1. Dame Gill Morgan left the ICB on 30th September 2025. Her full year equivalent salary is within £60k-£65k.

2. Jeffrey Farrar is the Joint Chair for the Cluster. He is formally employed and paid by NHS BNSSG ICB. The figures above represent the cost recharged to NHS Gloucestershire ICB for his services during the reporting period. His total remuneration received is within £65k-£70k.

3. Mary Hutton left the ICB on 18th July 2025. Her full year equivalent salary is within £205k-£210k.

4. Shane Devlin is the Joint Chief Executive for the Cluster. He is formally employed and paid by NHS BNSSG ICB. The figures above represent the cost recharged to NHS Gloucestershire ICB for his services during the reporting period. His total remuneration received is within £225k-£230k.

5. Ellen Rule left the ICB on 30th April 2025. Her full year equivalent salary is within £165k-£170k.

6. Gemma Artz left the ICB on 8th March 2026. Her full year equivalent salary is within £130k-£135k.

7. Remuneration relates to Work for Gloucestershire ICB. Employed by Gloucestershire County Council and recharged to Gloucestershire ICB.

8. Employed By G Doc Ltd and recharged to Gloucestershire ICB.

The Board includes representatives of system partners within Gloucestershire Integrated Care System where there is no remuneration received. This includes representatives from Gloucestershire County Council as well as the Chief Executive of Gloucestershire Hospital NHS Foundation Trust and the Chief Executive of Gloucestershire Health and Care NHS Foundation Trust who are funded by their respective organisations.

Remuneration Report for NHS Gloucestershire ICB 2024-25 (audited)

Name & Title	2024/25						
	Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Sub-total (band of bands)	All Pension Related Benefits (bands of £2,500) *	Total (bands of £5,000)
Dame Gill Morgan, Chair	65-70	0	0	0	65-70	0	65-70
Mary Hutton, Chief Executive	195-200	0	0	0	195-200	0	195-200
Ellen Rule, Deputy CEO/Director of Strategy and Transformation	165-170	0	0	0	165-170	62.5-65	230-235
Cath Leech, Chief Finance Officer	155-160	0	0	0	155-160	0	155-160
Mark Walkingshaw, Director of Operational Planning & Performance	145-150	0	0	0	145-150	17.5-20	165-170
Helen Goodey, Director of Primary Care & Place ¹	135-140	0	0	0	135-140	22.5-25	160-165
Marie Crofts (Yvonne), Chief Nursing Officer	155-160	0	0	0	155-160	260-262.5	415-420
Tracey Cox, Director of People, Culture and Engagement	155-160	0	0	0	155-160	20-22.5	175-180
Dr Paul Atkinson, Chief Clinical Information Officer	140-145	0	0	0	140-145	30-32.5	170-175
Dr Ananthakrishnan Raghuram, Chief Medical Officer	125-130	0	0	0	125-130	55-57.5	180-185
Benedict Leigh, Director of Integrated Commissioning ²	90-95	0	0	0	90-95	0	90-95
Professor Joanna Coast, Non Executive Director System Resources	10-15	0	0	0	10-15	0	10-15
Professor Jane Cummings CBE RN, Non Executive Director System Quality	20-25	0	0	0	20-25	0	20-25
Julie Soutter, Non Executive Director Audit	15-20	0	0	0	15-20	0	15-20
Karen Clements, Non Executive Director, People and Remuneration	15-15	0	0	0	15-15	0	15-15
Ayesha Janjua, Non Executive Director, Primary Care and Direct Commissioning	15-15	0	0	0	15-15	0	15-15
Dr Jo Bayley, Primary Medical Services (Primary Care Network perspective) ³	15-20	0	0	0	15-20	0	15-20
Dr Emma Crutchlow Primary Care Network perspective (Board participant) G Doc Ltd ³	5-10	0	0	0	5-10	0	5-10
Dr Olesya Atkinson, Primary Medical Services (Primary Care Network perspective)	0-5	0	0	0	0-5	0	0-5

*These figures are purely the benefits accruing to senior managers from membership of the NHS Pensions Scheme. A zero balance either means that the member has chose not to be covered by the NHS pension arrangements during the reporting year or where the figures supplied by NHS Pensions have produced a negative value.

These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004(1). Para 10(1)(e)(ii)(cc) of sch8 of 2013/1981 (update to the Finance Act 2004):

*Due to changes in the NHS pension scheme and, in particular, where individuals are new in post or may have changed schemes in previous years this distorts the calculations.

1. Remuneration relates to Work for Gloucestershire ICB. Non disclosed remuneration for role at Gloucestershire Care and Health NHSFT until August 24. Total remuneration received is within band (145-150)

2. Remuneration relates to Work for Gloucestershire ICB. Employed by Gloucestershire County Council and recharged to Gloucestershire ICB

3. Employed By G Doc Ltd and recharged to Gloucestershire ICB.

The Board includes representatives of system partners within Gloucestershire Integrated Care System where there is no remuneration received. This includes representatives from Gloucestershire County Council as well as the Chief Executive of Gloucestershire Hospital NHS Foundation Trust and the Chief Executive of Gloucestershire Health and Care NHS Foundation Trust who are funded by their respective organisations.

Pensions Report 2025-26 (Subject to audit)

Name & Title	2025/26							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employers contribution to stakeholder pension
Sarah Truelove, Chief Executive - July 2025 to September 2025, Chief Executive (transitioning Officer) from October 2025	50-52.5	145-147.5	50-55	145-150	0	1,237	1,251	16
Gemma Artz, Chief Delivery and Transformation Officer (From April 2025 to March 2026)	5-7.5	12.5-15	35-40	90-95	615	128	792	17
Tracey Cox, Director of People, Culture and Engagement	2.5-5	2.5-5	75-80	190-195	1,658	79	1,785	23
Dr Paul Atkinson, Chief Clinical Information Officer	2.5-5	0-2.5	25-30	50-55	462	33	521	21
Marie Crofts (Yvonne), Chief Nursing Officer ¹	2.5-5	2.5-5	90-95	255-260	2,232	0	113	23
Cath Leech, Chief Finance Officer	5-7.5	7.5-10	65-70	175-180	1,505	117	1,666	21
Dr Ananthakrishnan Raghuram, Chief Medical Officer ¹	2.5-5	0-2.5	80-85	210-215	1,965	0	216	19
Ellen Rule, Deputy CEO/Director of Strategy and Transformation (to April 2025)	0-2.5	0	35-40	85-90	697	2	757	2
Mark Walkingshaw, Director of Operational Planning & Performance	5-7.5	7.5-10	65-70	160-165	1,362	127	1,531	22
Helen Goodey, Director of Primary Care & Place	2.5-5	0-2.5	45-50	105-110	999	58	1,093	22

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.

¹The CETV figures disclosed relates only to their benefits in the 2015 Section of the NHS Pension Scheme. No CETV is disclosed for benefits held in the 1995 Section as the member has reached the normal pension age for that section and those benefits are no longer eligible for transfer.

Real Increase in CETV

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

Compensation on early retirement or for loss of office

There were two early retirements for 25/26 totalling £301,443.60 (there were none for 24/25).

Pensions Report 2024-25 (audited)

Name & Title	2024/25							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employers contribution to stakeholder pension
Tracey Cox, Director of People, Culture and Engagement	0-2.5	0-0	70-75	185-190	1,505	32	1,658	0
Dr Paul Atkinson, Chief Clinical Information Officer	0-2.5	0-0	25-30	45-50	400	18	462	0
Marie Crofts (Yvonne), Chief Nursing Officer	12.5-15	27.5-30	85-90	250-255	1,783	310	2,232	0
Cath Leech, Chief Finance Officer	0-0	0-0	60-65	165-170	1,404	1	1,505	0
Dr Ananthakrishnan Raghuram, Chief Medical Officer	2.5-5	2.5-5	75-80	205-210	1,745	75	1,965	0
Ellen Rule, Deputy CEO/Director of Strategy and Transformation	2.5-5	5-7.5	30-35	85-90	584	63	697	0
Mark Walkingshaw, Director of Operational Planning & Performance	0-2.5	0-0	55-60	150-155	1,235	26	1,362	0
Helen Goodey, Director of Primary Care & Place	0-2.5	0-0	40-45	100-105	892	28	999	0
Mary Hutton, Chief Executive	Mary Hutton has received her NHS pension benefits							

Staff Numbers

Average Contracted WTE of Staff Groupings aengagements only)	25/26			24/25		
	Male	Female	Total	Male	Female	Total
Governing Body members	0	1	1	0	1	1
Executive Directors	3	5	8	3	6	9
Senior Manager G0 (Band 8D and Above)	8	14	22	8	11	19
Manager G1 (Band 8A, 8B, 8C)	26	41	67	25	46	71
Clerical and Admininstrative G2 (Band 7 and Below)	57	133	190	51	126	177
Nursing, midwifery and health visiting staff	1	57	59	1	2	3
Medical and dental staff	2	3	4	1	55	56
Scientific, therapeutic and technical staff	8	23	31	8	23	31
Sub Totals	105	277	382	97	270	367
Grand Total	382			367		

Staff profile (audited)

The profile of staff within the ICB, based on the average number of Whole Time Equivalent contracted in 2025-26, is as presented in the table below. This is referred to in note 4 of the Annual Accounts.

Avg No WTE contracted (including Directors & Off Payroll engagements)	25/26			24/25		
	Director	Other Ee	Total	Director	Other Ee	Total
total Staff	9	373	382	9	365	374
of which:						
Perm	8	354	362	9	342	351
Other	1	19	20	0	23	23
of which:						
Male	3	102	105	3	100	103
Female	6	271	277	6	265	271

Total staff costs including employers national insurance and pension (Subject to audit)

	25/26			24/25		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits						
Salaries and Wages	21,559	20,916	643	21,578	20,924	654
Social Security Costs	2,872	2,871	1	2,322	2,322	0
Employer Contributions to NHS Pension scheme	4,822	4,822	0	4,638	4,638	0
Other Pension Costs	3	3	0	5	5	0
Apprenticeship Levy	93	93	0	84	84	0
Termination Benefits	9,169	9,169	0	0	0	0
Gross employee benefits expenditure	38,518	37,874	644	28,627	27,973	654

There were no significant increases in staff groups in 2025/26. There has been no significant awards made to past senior managers in 2025/26. There has been no payment to past directors in 2025/26. Nine staff on Very Senior Manager contracts earn in excess of £150,000 pa on a pro rata basis.

Exit Packages 2025/26 (Subject to audit)

There were 31 exit packages in 25/26

Exit Package cost band (inc.any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	1	£3,159	3	£19,007	4	£22,166	-	-
£10,000 - £25,000	0	-	6	£93,915	6	£93,915	-	-
£25,001 - £50,000	0	-	6	£207,824	6	£207,824	-	-
£50,001 - £100,000	0	-	9	£690,877	9	£690,877	-	-
£100,001 - £150,000	1	£138,000	-	-	1	£138,000	-	-
£150,001 - £200,000	2	£320,000	3	£480,000	5	£800,000	-	-
> £200,001		-	-	-	-	-	-	-
TOTALS	4	£461,159	27	£1,491,622	31	£1,952,781	0	£0.00

Redundancy and other departure cost have been paid in accordance with the provisions of the terms of the individual contracts of employment. Exit costs in this note are the full costs of departures agreed in the year. Where Gloucestershire ICB has agreed early retirements, the additional costs are met by Gloucestershire ICB and not by the NHS Pensions Scheme. Ill health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

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.

Analysis of other departures (Subject to audit)

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	27	£1,492
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	27	£1,492

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4.4 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under "non-contracted payments requiring HMT approval" below.

**includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.

0 non contractual payments (£0) were made to individuals where the payment value was more than 12 months' of their annual salary. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Staff Report

NHS Gloucestershire ICB employed a headcount staff of 420 equating to 360.02 WTEs as at the 31 March 2026. These figures include all permanent staff, those on short-term contracts but exclusive of staff employed on bank contracts. The annual staff turnover rate is 14.5% (staff headcount). The ICB has a well-structured HR service with the Commissioning Support Unit's People Resource function providing transactional and employee relations HR services. The ICB has an internal HR team with a Director of People, Culture and Engagement leading the service with responsibility for HR strategy and organisational development, and the Associate Director of Corporate Affairs providing operational support working closely with the CSU People Resource Team and ICS HR/OD partners.

Governance arrangements for HR

The reporting structure for HR and workforce reports continued to be supported by the ICB's People Committee which was established on 1 July 2022. The Chair of the committee was Karen Clements, (up until February 2026) Non-executive Director and the executive lead is Tracey Cox, Director of People, Culture and Engagement.

The People Committee has responsibility for the oversight and scrutiny of the effectiveness of the ICS People Function including the governance structure and the development of an ICS People strategy and plan.

The Committee routinely receives reports on the ICS workforce profile covering Gloucestershire demographics, numbers of staff employed in health and care roles, key workforce demographics (age, ethnicity, gender, disability etc) as well as workforce vacancies and sickness rates.

The People Committee has received reports on the One Gloucestershire Workforce Delivery Plan; System wide reports on key performance indicators within the Integrated People Report, Training and Development reports, Staff Retention report, the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), Gender Pay Gap (GPG) reporting and staff survey reports, as well as many other HR/OD topics. The People Committee also approves all ICB HR policies (see Governance Statement for more detail).

The Staff Side Partnership (SPF) has an important role providing staff feedback and input to the development of ICB HR plans, policies, staff events and the staff survey. Health and wellbeing is included on every agenda as well as Equality, Diversity and Inclusion. The committee meets on approximately 10 occasions during the year and the chairing of the SPF is set out in the Trade Union Recognition Agreement (TURA); and can be co-chaired between the Staff Side Representative and the Director of People, Culture and Engagement. Each directorate has one or more SPF representatives who attend the meeting along with HR / OD colleagues for the ICB. These arrangements are set out in the TURA which the ICB has agreed with SPF.

During the past year there has been strong and increased representation from staff and Trade Union representatives at SPF meetings noting that staff reps have found the forum important to staff engagement and in understanding the forthcoming changes resulting from the reduction in ICB running costs and resulting organisational change. The main focus of the SPF meetings during the financial year (April 2025 to March 2026) has been preparing staff for organisational change. The SPF has also supported the development of new policies such as Flexible Retirement, Carers Policy and the Freedom to Speak Up (FTSU) policy, as well as wellbeing initiatives and Equality, Diversity and Inclusion work particularly around creating an inclusive culture. Other key topics that the SPF has been engaged with raising awareness of the FTSU Guardian roles across the ICB, equality and diversity reports particularly the Public Sector Equality Duty.

Staff Survey & Staff Engagement

Staff survey

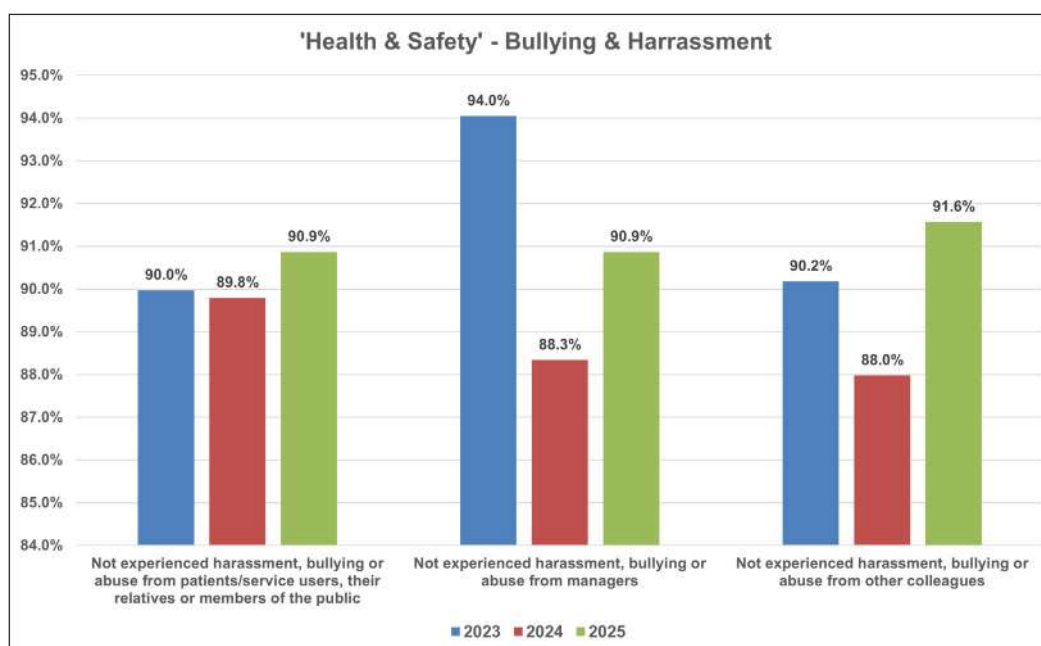
During 2025, due to the level of organisational change taking place and being planned across the ICB, the ICB decided not to participate in the national staff survey but chose to run its own local survey which included some key questions that form part of the national staff survey as well a set of local questions to understand how we could continue to support staff as they experience organisational change. We then carried out our own local analysis of the feedback and position compared to 2024.

A total of 261 questionnaires were completed, representing 60% of the workforce and much lower than the previous year (346 questionnaires and 74% median response rate).

A summary of some of the key highlights are given below.

- ▶ My immediate manager takes a positive interest in my health and well-being – 88.5% strongly agree/ agree.
- ▶ My manager gives me clear feedback on my work - 81.35% strongly agree/agree.
- ▶ My organisation respects individual differences (e.g. cultures, working style, background and ideas) - 92.4 % strongly agree/ agree compared to 79.36% in 2024.
- ▶ I feel valued by my team – 85.6% strongly agree/ agree compared to 79.31% in 2024.
- ▶ I am trusted to do my job – 91.5 % compared to 86.9% in 2024.
- ▶ I feel safe to speak up about anything that concerns me in this organisation – 80.55% of staff strongly agree/ agree compared to 66.50% in 2024.
- ▶ In the last 12-months, have not experienced MSK problems as a result of work activities: 69.84% compared to 79.2% in 2024.
- ▶ In the last 12-months, have not felt unwell due to work related stress: 50.99% compared to 66.5% in 2024.
- ▶ Not felt pressure from manager to come to work when not feeling well enough: 92% compared to 86.9% in 2024.

The following infographic shows a comparison on bullying and harassment scores compared to previous years. This shows a slight decrease between 2024 and 2025 in the number of staff who experienced bullying and harassment from patients, manager or colleagues.



Overall compared to previous years, the staff survey results reveal a mixed picture: several areas have improved significantly, especially around organisational fairness, inclusion, and psychological safety, while others—most notably job enthusiasm, burnout, and stress-related ill-health have declined. This deterioration is expected due to the high level of uncertainty that staff have been experienced due to the delays around organisational change process.

As part of the organisational change process, we are carrying out detailed equality impact assessments so that we can track and risk assess how the make-up of the ICB might be changing in response to organisational change. The impact assessments are being monitored and reviewed by the ICB's Transition Committee.

Staff Engagement

We continue to deploy a range of methods to support good staff engagement.

- ▶ Monthly hybrid Staff Meetings hosted by the Chair and Chief Executive, which is supported by a written Team Brief e-bulletin which is then distributed after the meeting.
- ▶ Weekly staff communications sent out each Friday providing the latest updates to staff.
- ▶ Monthly Team Directorate meetings.
- ▶ The Staff Award scheme to recognise staff who go the extra mile.
- ▶ Senior Managers Forum to keep staff informed about key developments and more latterly a focus on organisational change and the development of a target operating model for the clustered ICB.
- ▶ Lunch and learn sessions run by staff and the HR team to share their work and learning with other staff members including ESR self-service – managing sickness absence, booking annual leave on ESR, safeguarding training, carers support amongst other topics.
- ▶ The ICB intranet holds information on all team briefs, policies, procedures and other information.
- ▶ The ICB Executive Team meets with senior managers on a monthly basis.
- ▶ Managers hold regular one-to-one meetings with staff, and a robust appraisal system ensures that staff work towards clearly defined personal objectives which are supported with learning, training and development opportunities.

Staff Wellbeing

The ICB has a range of practical resources and events to support staff wellbeing. During 2025 we made strong use of the Wellbeing Line with regular sessions held to support staff around managing their own stress and well-being as well as a series of weekly Mindfulness Sessions.

The ICB provides an Occupational Health Service and Employee Assistance Programme. The Gloucestershire Wellbeing Line and the ICB's EAP service provides staff with counselling and support.

In response to staff requests, our organisation has delivered targeted workshops on CV writing and interview skills. The primary aim of these sessions has been to build confidence among employees and to alleviate some of the anxiety associated with the organisational restructure. By focusing on practical skills and providing guidance in areas directly relevant to career progression, these workshops have helped staff feel more prepared for potential changes, supporting their overall wellbeing during this period of uncertainty.

Staffing policies

The ICB like other NHS employers has a host of HR policies, user guides, forms and resources. Policies are formally reviewed both by the Executive Management Team and the Staff Partnership Forum (SPF) before being approved by the People Committee. Over the past 12 months a number of HR policies have been reviewed and updated please see the Governance Statement for full details of policies that have been approved.

Sickness absence data

Details of the level of sickness absence are given below. The organisation has an approved policy and associated procedure to help with the management of sickness absence.

Sickness absence is managed in a supportive and effective manner by ICB managers, with professional advice and support from ConsultHR, Occupational Health and Care First (Employee Assistance Programme) and the Gloucestershire Wellbeing Line. The ICB's approach to managing sickness absence is governed by a clear HR policy and this is further reinforced by the provision of HR support and training sessions for all line managers on the effective management of sickness absence. The manager is advised to have a supportive conversation with the staff member.

Sickness data 2025-26 NHS England data	
Monthly Sickness Absence rates for English NHS Bodies – December 2025	5.91%
Monthly Sickness Absence rates for NHS Gloucestershire Integrated Care Board – December 2025	3.72%
Monthly Sickness Absence rates for NHS Gloucestershire Integrated Care Board – Average for 2025-26 (to Dec 25)	3.63%

The figures above are provided by NHS Digital and can be found on the following website:

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/january-2026>

The Trade Union (Facility Time Publication Requirements) – Regulations 2017

The ICB confirms that for the financial year 2025-26 there were a number of union officials who attended the ICB's Staff partnership Forum. These are set out below:

RCN Stewardship (representative)	Maximum of 1.5 days per month	Additional time during the year to attend relevant TU training / meetings / case work and SPF meetings
Unison representative	Maximum of 6 hours a month	Additional time during the year to attend relevant TU training / meetings

Whilst the SPF Forum has the option to be jointly Chaired by a recognised trade union official, this option was not taken up in 2025. The SPF Forum has therefore been Chaired by the Director of People, Culture & Engagement or their nominated deputy. As we move to a clustered ICB, we plan to join up Staff Partnership Forums, and we will seek support for Co-Chair arrangements with staff side representatives.

Equality, Diversity, and Inclusion

The ICB is committed to creating an open and welcoming organisational culture for all staff, ensuring that we recruit from as wide a pool of talent as possible, create opportunities for all staff to advance their careers, in a supportive and compassionate organisation that proactively tackles discrimination, bullying and intimidation of any kind.

The ICB has an Equality, Diversity, and Inclusion statement:

NHS Gloucestershire is committed to upholding the NHS Constitution and, specifically in relation to equality, diversity and human rights, the principle which requires us to provide "a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status"

Promoting equality, valuing diversity sets out our expectation that all staff will take responsibility for promoting equality; commissioning accessible services that respond to the diverse needs of communities in Gloucestershire.

We are keen to build upon the work that is already underway across our Integrated Care System and in recognition of this, our Equality Statement links to other strategies and plans which, when combined, fully document how we will work in partnership to achieve our vision for Gloucestershire.

Our **Equality Action Plan** sets out how the ICB will work towards achieving our organisational equality objectives.

Equality Objectives

In line with the Public Sector Equality Duty requirements, we are required to have one or more published equality objectives, which are specific and measurable and cover a period of up to four years (2022-2026) which are as follows:

- ▶ To develop an Equality Statement and robust action plan for promoting equality, diversity and inclusion, which sets out clear objectives which ensure good practice across our organisation and link to wider health inequalities work that is being undertaken in our Integrated Care System.
- ▶ Build a detailed understanding of our population and their health needs, through published data sets, improvements in the quality of our data recording and robust use of Equality and Engagement Impact Assessments.
- ▶ To reduce the percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months by at least 2% per annum over the next 3 years.

Following on from the annual WRES, WDES and Gender Pay reports, an integrated action plan covering the full range of actions was produced to monitor the implementation of the many ED&I initiatives and schemes. During the last 4 years the ICB has worked with system partners on a range of ED&I programmes which ICB staff has participated including:

- ▶ Flourish scheme based on the national 'stepping up' programme available to ethnic minority staff, disabled staff and LGBTQ+.
- ▶ Reciprocal Mentoring programme.
- ▶ Allyship Programme.

In addition, the ICB has undertaken some bespoke schemes for ICB staff including:

- ▶ ED&I training commissioned for all managers and staff.
- ▶ Commissioned a programme of Train the Trainer in Building a Culture of Conscious Inclusion that system partners have participated in.
- ▶ Supported the ethnic minority community staff network within the ICB and support has been offered to staff to develop other staff networks.
- ▶ Participated in the 10,000 Black Interns scheme in 2024-25 placing 3 black interns within the ICB for 3-month placements.

It should be noted that many of the system wide offers open to ICB staff were not taken up during 2025-26, as staff were preoccupied with organisational change and the restructure. There has also been a temporary pause in the ICB's bespoke ED&I schemes during this period of change, which will recommence when the new ICB cluster is fully operational.

During the year 2025-26 some of key ED&I headlines are as follows:

- ▶ The mean (average) gender pay gap was **15.1% of hourly pay** - women compared to men; this is a disappointing increase in the GPG from 2024-25 where it was **12%**. *In 2023 it was 18% which was the same gap reported in 2022.*
- ▶ The percentage of ethnic minority community staff employed by the ICB was **9.76% a slight increase** from 2025- 2024 when it was **9%**. This compares to the 2021 Census where overall, **6.9% of the population in Gloucestershire were from an ethnic minority background** (excluding white minorities).

<https://www.gloucestershire.gov.uk/media/oeopsd4t/equality-profile-2024.pdf>

- ▶ While ethnic minority community staff continued to be ***less likely to be found in higher grade non-clinical jobs*** in the ICB they were ***more likely to be found in clinical medical and dental roles***.
- ▶ ICB employs **5.48%** of disabled staff which is an increase from the previous year when it was reported that 3% of the ICB workforce was disabled. **8.81% of staff did not disclose** which is a reduction from the previous year at 11%.
- ▶ The ICB Board comprises 11 voting members during 2025-26 of which 2 were from an ethnic minority background and none were disabled.
- ▶ Ethnic minority community and disabled people are **1.9 and 1.9 times (respectively)** less likely to be appointed to a role from shortlisting compared to their white or non-disabled counterparts.

The 2025-26 and previous years' Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap reporting can be found on our website see here: <https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/equality-and-diversity/workforce-equality/>

Other employee matters

Health and Safety at work

We are committed to ensuring the health and safety of all our employees.

It is important to us as an organisation that we provide a safe working environment for people, where their health and safety is valued, and in doing this we continue to work closely with our landlord and security management teams at Shire Hall.

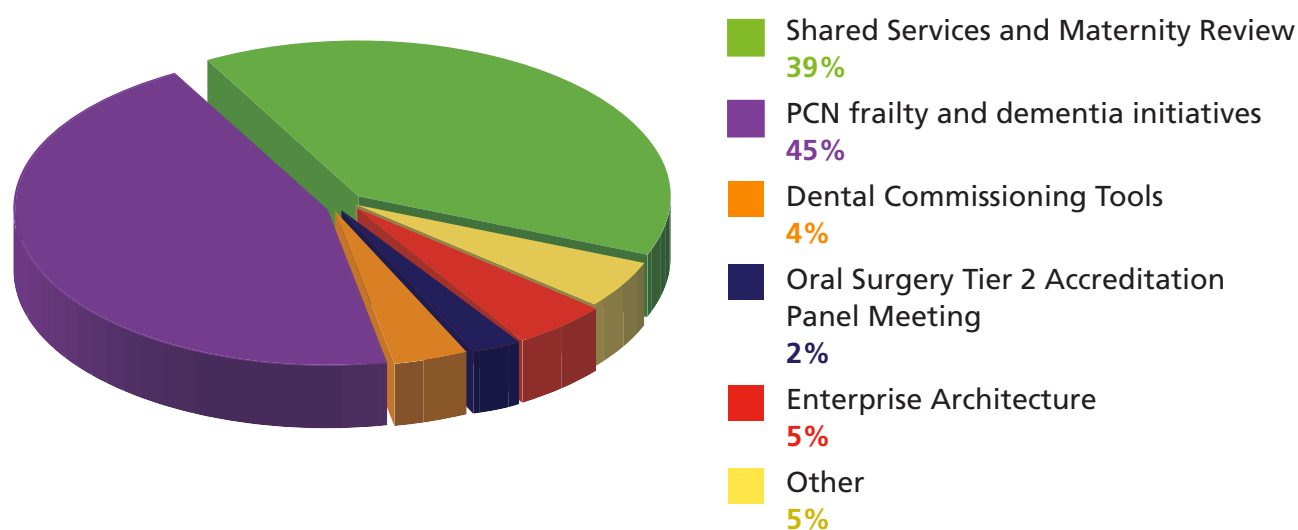
Our security management and facilities management services are provided by Gloucestershire County Council (GCC) as part of our lease agreement and FM Service Level Agreement.

The Director of People, Culture and Engagement is the Health and Safety Lead for the organisation. The Associate Director of Corporate Affairs along with the ICB Reception Team meet with the GCC FM team on a quarterly basis to discuss health and safety related to the occupancy of offices in Shire Hall.

The ICB follows GCC's policies and procedures on fire safety and evacuations, first aid, waste disposal, water and PAT testing along with all other health and safety matters. These procedures are set out in the Shire Hall Handbook which accompanies the ICB Staff Handbook. Both documents are made available to all our staff via the intranet.

Consultancy

Consultancy costs of £113k in 2025-26 were spent in the following areas:



External Audit

The ICB's external auditors are Grant Thornton UK LLP. The cost of the annual statutory audit of the 2025/26 Financial Statements was £242k. The ICB has also provided for an additional audit service from Grant Thornton of a Mental Health Investment Standard (MHIS) audit totalling £44k.

Parliamentary Accountability and Audit Report

NHS Gloucestershire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

Shane Devlin
Cluster Chief Executive
15th June 2026

The financial statements



Independent auditor's report to the members of the Board of NHS Gloucestershire Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Gloucestershire 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 cashflows 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 1.2 Clustering Arrangements to the financial statements, which describes the clustering arrangements between NHS Gloucestershire Integrated Care Board and NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board from 1 April 2026, and their expected merger on 1 April 2027. Our opinion is not modified in this respect of this matter.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the cut-off risk in the ICBs non-block and non-NHS operating expenditure and its associated payables. We determined that the principal risks were in relation to:
 - Unusual journals (including journals posted by senior management and material post year end journals).
 - Manipulation of expenditure recognition using journals close to and after year end; and
 - Deliberate over recognition of expenditure in order to meet agreed year end targets.
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus on unusual journals as defined above,
 - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the recognition of year-end manual expenditure accruals and related payable balances; and
 - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from

error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including management override of controls and the cut-off risk in the ICBs non-block and non-NHS operating expenditure and its associated payables. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the ICB operates
 - understanding of the legal and regulatory requirements specific to the ICB including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 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 Gloucestershire Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Grace Hawkins

Grace Hawkins, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
17 June 2026

ANNUAL ACCOUNTS

Completed in accordance with the DH Group Accounting Manual 2025/26 and NHS
England SharePoint Finance Guidance Library



Shane Devlin

Accountable Officer

15th June 2026

Data entered below will be used throughout the workbook:

Entity name: NHS Gloucestershire ICB

2025/26

Last year 2024/25

This year ended 31-March-2026

Last year ended 31-March-2025

This year commencing: 01-April-2025

Last year commencing: 01-April-2024

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

	Note	2025/26 £'000	2024/25 £'000
Income from sale of goods and services	3	(54,558)	(55,329)
Other operating income	3	(200)	(241)
Total operating income		(54,758)	(55,570)
Staff costs	4	38,518	28,627
Purchase of goods and services	5	1,582,135	1,495,954
Depreciation and impairment charges	5	256	256
Provision expense	5	7,793	2,873
Other Operating Expenditure	5	2,875	3,437
Total operating expenditure		1,631,577	1,531,147
Finance Expense		72	78
Net Operating Expenditure		1,576,891	1,475,655
Other Comprehensive Expenditure		-	-
Comprehensive Expenditure for the period		1,576,891	1,475,655

Statement of Financial Position for the year ended 31 March 2026

		Closing Balances 31/03/2026	Closing Balances 31/03/2025
	Note	£'000	£'000
Non-current assets:			
Right-of-use assets	7	1,900	2,156
Current assets:			
Trade and other receivables	8	13,564	12,105
Cash and cash equivalents	9	9	4
Total current assets		13,573	12,109
Total assets		15,473	14,265
Current liabilities			
Trade and other payables	10	(92,402)	(77,543)
Lease Liabilities	7	(228)	(220)
Provisions	11	(12,662)	(5,381)
Total current liabilities		(105,292)	(83,144)
Non-Current Assets plus/less Net Current Assets/Liabilities		(89,819)	(68,879)
Non-current liabilities			
Lease Liabilities	7	(1,670)	(1,898)
Provisions	11	(110)	(110)
Total Non-Current Liabilities		(1,780)	(2,008)
Assets less Liabilities		(91,599)	(70,887)
Financed by Taxpayers' Equity			
General fund		(91,599)	(70,887)
Total taxpayers' equity:		(91,599)	(70,887)

The notes on pages 7 to 21 form part of this statement

The financial statements on pages 3 to 21 were approved by the Audit Committee on 15 June 2026 with delegated authority from the Board and signed on its behalf by:



Shane Devlin
Chief Executive Officer
15th June 2026

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

	2025/26 General fund £'000	2024/25 General fund £'000
Changes in taxpayers' equity for 2025/26		
Balance at 01 April	(70,887)	(55,584)
Changes in NHS Integrated Commissioning Board taxpayers' equity for 2025/26		
Net expenditure for the financial year	(1,576,891)	(1,475,655)
Net funding	1,556,179	1,460,352
Balance at 31 March	(91,599)	(70,887)

The notes on pages 7 to 21 form part of this statement

The General Fund is the only reserve for NHS Gloucestershire ICB.

**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		(1,576,891)	(1,475,655)
Depreciation and amortisation	5	256	256
Interest Received/(Paid)		71	78
(Increase)/decrease in trade & other receivables	8	(1,459)	1,601
Increase/(decrease) in trade & other payables	10	14,858	12,921
Provisions utilised	11	(512)	(2,190)
Increase/(decrease) in provisions	11	7,793	2,873
Net Cash Inflow (Outflow) from Operating Activities		(1,555,883)	(1,460,116)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	0
Net Cash Inflow (Outflow) from Investing Activities		0	0
Net Cash Inflow (Outflow) before Financing		(1,555,883)	(1,460,116)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,556,179	1,460,352
Repayment of lease liabilities		(291)	(291)
Net Cash Inflow (Outflow) from Financing Activities		1,555,888	1,460,061
Net Increase (Decrease) in Cash & Cash Equivalents	9	5	(55)
Cash & Cash Equivalents at the Beginning of the Financial Year		4	59
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		9	4

The notes on pages 7 to 21 form part of this statement

Notes to the financial statements

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.

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 Clustering arrangements

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. NHS Gloucestershire ICB formally clustered with NHS Bristol, North Somerset and South Gloucestershire ICB on 1 April 2026. There is an expectation that they will merge on 1 April 2027.

1.3 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.4 Joint Arrangements

Where the ICB balances system collaboration with its partner organizations, it evaluates the substance of each collaborative or pooled budget arrangement to determine whether it acts as a Principal or an Agent.

The ICB does not have any Joint Operations as defined under IFRS 11. Instead, collaborative schemes, shared management structures, and Section 75 agreements are assessed under the criteria of IFRS 15 and the DHSC Group Accounting Manual to identify principal, agency, or hosted relationships.

The application of Principal versus Agency rules dictates how collaborative income and expenditure are recognized under these joint arrangements:

Acting as a Principal:

The most significant element of income is where the ICB commissions service level agreements (for Mental Health and Community Services) through liaison with the local authority. Where the ICB is the Lead Commissioner for service level agreements that include a contribution from the local authority, the ICB is acting as the principal in the relationship. The ICB provides all the administration to the contract, monitors performance, arranges the price, and holds the provider to account. In such cases, all income is recorded in the ICB accounts as gross and shown within Other Operating Revenue within Note 3, with corresponding gross expenditure recognized in Note 5.

Acting as an Agent:

Where the ICB acts as an agent (where it does not retain control over the performance obligation or service consumption), it does not recognize the gross partner income and associated expenditure within its Statement of Comprehensive Net Expenditure. Only the ICB's specific financial contribution to the arrangement is recognized.

1.5 Pooled Budgets

The ICB has entered into a pooled budget arrangement with Gloucestershire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for integrated community equipment services and note 14 provides details of the income and expenditure.

The pool is hosted by Gloucestershire County 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 agreement.

1.6 Operating Segments

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

1.7 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

- 1.7 Cont'd
- 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.
- Total net revenue expenditure for 2025/26 of £1,576,891k (2024/25 of £1,475,655k) is funded by in year revenue resource allocations from NHS England. The revenue resource allocation is accounted for by crediting the general fund, but this funding is only drawn down from NHS England and accounted for, to meet payments as they fall due. The total funding credited to the general fund during the year was equal to the revenue resource allocation (see Statement of Changes to Taxpayers Equity on page 5).
- The ICB's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such, the ICB's income from other activities is limited. The most significant element of income is where the ICB commissions service level agreements (for Mental Health and Community Services) through liaison with the local authority. Where the ICB is the Lead Commissioner for service level agreements that include a contribution from the local authority, the ICB is acting as the principal in the relationship. The ICB provides all the administration to the contract, monitors performance, arranges the price and holds the provider to account. In such cases, all income is recorded in the ICB accounts as gross and shown within Other Operating Revenue within note 3.
- 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.
- 1.8 **Employee Benefits**
- 1.8.1 **Short-term Employee Benefits**
- Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
- The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.
- 1.8.2 **Retirement Benefit Costs**
- Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
- For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.
- The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.
- 1.8.3 **National Employment Savings Trust ("NEST") Pension Scheme**
- The ICB has a small number of employees who are not enrolled into the NHS Pensions Scheme, with cover from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to the ICB is taken as equal to the contributions payable to the scheme for the accounting period.
- 1.9 **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.
- 1.1 **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.
- 1.11 **Leases**
- A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
- The ICB assesses whether a contract is or contains a lease, at inception of the contract.
- 1.11.1 **The ICB as Lessee**
- A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
- The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
- The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
- The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

Notes to the financial statements

- 1.11.1 Cont'd The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
- Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
- Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
- Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value).
- Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
- For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
- Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.
- 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.
- When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
- A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.
- 1.14 **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 with ICB.
- 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. There are no contingent liabilities and contingent assets to disclose at their present value.

Notes to the financial statements

1.17 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 when the asset has been transferred and has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are classified as Financial assets at amortised costs.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.17.1 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 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.

1.19 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.

1.20 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).

1.21 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.

1.21.1 Critical accounting judgements in applying accounting policies

A key critical judgement applied in the preparation of these accounts is the classification of the ICB's collaborative undertakings. This includes Section 75 pooled budget agreements with Gloucestershire County Council and joint service level agreements where the ICB acts as the Lead Commissioner.

This assessment determines whether the ICB acts as a Principal (recognizing gross revenue and expenditure, such as in lead-commissioned Mental Health and Community Services) or on an Agency basis (accounting for transactions on a net contribution basis). Consequently, these transactions have been accounted for in strict accordance with the accounting policy detailed in Note 1.4 Joint Arrangements.

1.21.2 Sources of estimation uncertainty

There are no sources of estimation uncertainty in the application of accounting policies.

1.22 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.

1.23 IFRS 17 Insurance Contracts

IFRS 17 Insurance Contracts replaces IFRS 4 and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts. The standard is applicable to NHS bodies from 1 April 2025 and has been adopted by the organisation for the first time in the current financial year.

The organisation has assessed the requirements of IFRS 17 and determined that it does not have any contracts within the scope of the standard. Accordingly, the adoption of IFRS 17 has had no impact on the financial statements and no additional disclosures are required.

1.24 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 FRoM. 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 FRoM. Early adoption is not permitted.

2 Financial performance targets

NHS Integrated Care Board performance against those duties was as follows:

	2025/26		Met (Y/N)	2024/25		Met (Y/N)
	Target £'000	Performance £'000		Target £'000	Performance £'000	
Expenditure not to exceed income	1,631,742	1,631,649	Yes	1,531,413	1,531,226	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	1,576,984	1,576,891	Yes	1,475,842	1,475,655	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	24,625	23,888	Yes	12,328	12,158	Yes

2.1 Performance against Resource limit

	2025/26		2024/25	
	Revenue £000	Capital £000	Revenue £000	Capital £000
Notified Resource Limit	1,576,984	0	1,475,842	0
Total Other operating revenue	54,758		55,571	
Total Income	1,631,742	0	1,531,413	0
Employee benefits	38,518		28,627	
Operating costs	1,593,131	0	1,502,598	0
Total Expenditure	1,631,649	0	1,531,226	0
In Period Surplus	93	Nil	187	Nil
ICB Cumulative surplus brought forward	21,170		20,983	
Cumulative surplus drawdown in year	(10,000)		Nil	
Notified cumulative surplus brought forward	11,170		20,983	
In period surplus	93		187	
Cumulative surplus carried forward at 31 March	11,263		21,170	

The overall notified resource limit above includes specific funding for Primary Care Delegated Co-Commissioning of £146.579m (£131.489m for 24/25)

There is specific funding for delegated commissioning of pharmaceutical, general ophthalmic services and dentistry (POD) of £61.573m (£59.794m for 24/25)

2.2 Mental Health expenditure

	2025/26 £'000	2024/25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	129,849	114,327
Eligible mental health expenditure	130,008	114,430
Mental health expenditure above/(below) minimum investment required	159	103
Mental health expenditure as a proportion of total expenditure	7.97%	7.47%

Mental health expenditure represents 7.97% of total ICB expenditure in 2025/26 (2024/25: 7.47%). This proportion is consistent with the ICB's strategic priority to maintain and enhance investment in mental health services, supported by increased funding and ongoing service demand.

3. Other Operating Income

	2025/26	2024/25
	Total	Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	422	1,272
Non-patient care services to other bodies ⁽¹⁾	38,680	38,496
Prescription fees and charges	7,877	8,011
Dental fees and charges	7,175	6,619
Other Contract income	312	931
Recoveries in respect of employee benefits	92	-
Total Income from sale of goods and services	54,558	55,329
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	-	-
Non cash apprenticeship training grants revenue	134	106
Other non contract revenue	66	135
Total Other operating income	200	241
Total Operating Income	54,758	55,570

⁽¹⁾ Non-patient care services to other bodies relates primarily to charges to Gloucestershire County Council.

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

The majority of income from sales of goods and services (Contracts) relate to contracts with Gloucestershire County Council; the timing of the income for these contracts being over a period of time.

4. Employee benefits and staff numbers

	2025/26			2024/25		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	20,916	643	21,559	20,924	653	21,577
Social security costs	2,871	1	2,872	2,322	-	2,322
Employer Contributions to NHS Pension scheme	4,822	-	4,822	4,638	-	4,638
Other pension costs	3	-	3	5	-	5
Apprenticeship Levy	93	-	93	85	-	85
Termination benefits	9,169	-	9,169	-	-	-
Gross employee benefits expenditure	37,874	644	38,518	27,974	653	28,627
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	-	-	-
Total - Net admin employee benefits including capitalised costs	37,874	644	38,518	27,974	653	28,627
Less: Employee costs capitalised	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	37,874	644	38,518	27,974	653	28,627

The ICB provided for untaken annual leave at 31st March 2026. This equated to £187k (£635k in 24/25) and is included in staff costs

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	362	20	382	351	23	374

4.3 Exit packages agreed in the financial year

	2025/26		2025/26		2025/26	
	Compulsory redundancies Number	£	Other agreed departures Number	£	Total Number	£
Less than £10,000	1	3,159	3	19,007	4	22,166
£10,001 to £25,000	-	-	6	93,915	6	93,915
£25,001 to £50,000	-	-	6	207,824	6	207,824
£50,001 to £100,000	-	-	9	690,877	9	690,877
£100,001 to £150,000	1	138,000	-	-	1	138,000
£150,001 to £200,000	2	320,000	3	480,000	5	800,000
Over £200,001	-	-	-	-	-	-
Total	4	461,159	27	1,491,622	31	1,952,781

	2024/25		2024/25		2024/25	
	Compulsory redundancies Number	£	Other agreed departures Number	£	Total Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	-	-	-	-	-	-

Analysis of Other Agreed Departures

	2025/26		2024/25	
	Other agreed departures Number	£	Other agreed departures Number	£
Voluntary redundancies including early retirement contractual costs	27	1,491,622	-	-
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	27	1,491,622	-	-

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS terms and conditions of service (Agenda for Change). Please see the Annual Report for further details (section Compensation on early retirement or for loss of office).

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

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.(2024/25 Nil).

The Annual Report includes the Remuneration Report, which includes the disclosure of exit payments payable to individuals named in that report.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	2025/26	2024/25
	Total	Total
	£'000	£'000
Purchase of goods and services		
Services from other ICBs and NHS England	1,697	2,404
Services from foundation trusts	991,187	928,076
Services from other NHS trusts	19,334	17,999
Services from Other WGA bodies	-	6
Purchase of healthcare from non-NHS bodies	207,707	200,873
Purchase of social care	8,425	9,768
General Dental services and personal dental services	28,047	26,004
Prescribing costs	111,243	113,169
Pharmaceutical services	27,276	23,842
General Ophthalmic services	6,401	6,215
GPMS/APMS and PCTMS	163,399	148,101
Supplies and services – clinical	1,142	1,281
Supplies and services – general	6,164	5,639
Consultancy services	113	125
Establishment	5,324	7,173
Transport	25	136
Premises	1,554	1,326
Audit fees ⁽¹⁾	242	234
Audit Other professional services ⁽²⁾	44	44
Other professional fees ⁽³⁾	801	442
Legal fees	392	440
Education, training and conferences	1,484	2,551
Non cash apprenticeship training grants	134	106
Total Purchase of goods and services	1,582,135	1,495,954
Depreciation and impairment charges		
Depreciation - Right of Use Asset	256	256
Total Depreciation and impairment charges	256	256
Provision expense		
Provisions	7,793	2,873
Total Provision expense	7,793	2,873
Other Operating Expenditure		
Chair and Non Executive Members	158	190
Grants to Other bodies	2,556	2,734
Research and development (excluding staff costs)	106	133
Expected credit loss on receivables	-	169
Other expenditure	55	211
Total Other Operating Expenditure	2,875	3,437
Total operating expenditure	1,593,059	1,502,520

⁽¹⁾ In Accordance with SI 2008 no 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, there is no limitation of auditor liability in respect of death or personal injury, fraud or fraudulent misrepresentation by it or its employees. In all other instances a total aggregate limit of £1m applies. The external audit fee is £241,693; representing a net spend of £201,411 together with irrecoverable VAT of £40,282.

⁽²⁾ Mental Health Investment Standard (MHIS) work was completed in 2025/26 in relation to the 2024/25 MHIS. The value of this work is £37,000 (£44,400 inclusive of VAT).

⁽³⁾ Internal Audit services are provided by an external provider BDO LLP and fees totalled £74,800 net of VAT (2024-25 £68,400 net of VAT). This is included in Other professional fees.

6 Better Payment Practice Code

	2025/26		2024/25	
	Number	£'000	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	14,993	183,503	11,622	125,710
Total Non-NHS Trade Invoices paid within target	14,266	181,522	11,277	123,854
Percentage of Non-NHS Trade invoices paid within target	95.15%	98.92%	97.03%	98.52%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,122	1,009,830	905	941,068
Total NHS Trade Invoices Paid within target	1,102	1,009,467	880	940,445
Percentage of NHS Trade Invoices paid within target	98.22%	99.96%	97.24%	99.93%

7. Leases**7.1 Right of Use Assets**

The Right of use assets relate to the ICB's office accommodation. The ICB's lease commenced in September 2023.

	2025/26			2024/25		
	Land	Buildings excluding dwellings	Total	Land	Buildings excluding dwellings	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 01 April	455	2,106	2,561	455	2,106	2,561
Additions	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-
Cost/Valuation at 31 March	455	2,106	2,561	455	2,106	2,561
Depreciation 01 April	72	333	406	27	122	149
Charged during the year	45	211	256	45	211	256
Disposals on expiry of lease term	-	-	-	-	-	-
Depreciation at 31 March	118	544	662	72	333	405
Net Book Value at 31 March	337	1,562	1,900	383	1,773	2,156

7.2 Lease Liabilities

	2025/26	2024/25
	£'000	£'000
Lease liabilities at 01 April 2025	(2,118)	(2,331)
Additions	-	-
Interest expense	(71)	(78)
Repayment of lease liabilities (capital and interest)	291	291
other	-	-
Lease liabilities at 31 March 2026	(1,898)	(2,118)

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025/26	2024/25
	£'000	£'000
Within one year	(291)	(291)
Between one and five years	(1,164)	(1,164)
After five years	(703)	(994)
Balance at 31 March	(2,158)	(2,449)
Effect of discounting	260	331
Included in:		
Current lease liabilities	(228)	(220)
Non-current lease liabilities	(1,670)	(1,898)
Balance at 31 March	(1,898)	(2,118)

This relates to the right-of-use asset which is leased from Gloucestershire County Council

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025/26 £'000	2024/25 £'000
Depreciation expense on right-of-use assets	256	256
Interest expense on lease liabilities	71	78

7.5 Amounts recognised in Statement of Cash Flows

	2025/26 £'000	2024/25 £'000
Total cash outflow on leases under IFRS 16	291	291

8 Trade and other receivables

	Closing Balance 31/03/2026 £'000	Closing Balance 31/03/2025 £'000
NHS receivables: Revenue	257	297
NHS accrued income	879	623
Non-NHS and Other WGA receivables: Revenue	282	614
Non-NHS and Other WGA prepayments	3,052	1,528
Non-NHS and Other WGA accrued income	6,840	2,620
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	1,772	5,785
Expected credit loss allowance-receivables	(25)	(223)
VAT	408	628
Other receivables and accruals	99	233
Total Trade & other receivables	13,564	12,105
Total current and non current	13,564	12,105

8.1 Receivables past their due date but not impaired

	31/03/2026		31/03/2025	
	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	33	56	100	64
By three to six months	-	6	-	54
By more than six months	8	30	-	25
Total	41	92	100	143

8.2 Loss allowance on asset classes

	31/03/2026 Trade and other receivables - Non DHSC Group Bodies £'000	31/03/2025 Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April	(223)	(57)
Lifetime expected credit losses on trade and other receivables-Stage 2	-	(169)
Amounts written off	198	3
Total	(25)	(223)

9 Cash and cash equivalents

	2025/26 £'000	2024/25 £'000
Balance at 01 April	4	59
Balance on transfer under modified absorption		
Net change in year	5	(55)
Balance at 31 March	9	4
Made up of:		
Cash with the Government Banking Service	9	4
Cash and cash equivalents as in statement of financial position	9	4
 Balance at 31 March	 9	 4

	Closing Balance 31/03/2026 £'000	Closing Balance 31/03/2025 £'000
10 Trade and other payables		
NHS payables: Revenue	1,638	2,926
NHS accruals	13,412	7,776
Non-NHS and Other WGA payables: Revenue	9,497	9,064
Non-NHS and Other WGA accruals	65,051	51,909
Non-NHS and Other WGA deferred income	-	503
Social security costs	310	283
Tax	301	312
Other payables and accruals	2,193	4,770
Total Trade & Other Payables	92,402	77,543
 Total current and non-current	 92,402	 77,543

Other payables include £1,640k for outstanding pension contributions at 31st March 2026 (£1,702k at 31st March 2025)

11 Provisions

	Closing Balance 2025/26 £'000	Closing Balance 2024/25 £'000
Current		
Redundancy	2,591	-
Continuing care	7,687	2,996
Other	2,350	2,350
Legal Claims	35	35
Total	12,662	5,381
Non Current		
Other	110	110
Total current and non-current	12,772	5,491

	2025/26					2024/25				
	Redundancy £'000	Continuing Care £'000	Other £'000	Legal Claims £'000	Total £'000	Redundancy £'000	Continuing Care £'000	Other £'000	Legal Claims £'000	Total £'000
Balance at 01 April	-	2,996	2,460	35	5,491	-	975	3,798	35	4,808
Arising during the year	2,591	5,201	-	-	7,792	-	2,975	501	-	3,476
Utilised during the year	-	(511)	(0)	-	(512)	-	(954)	(1,236)	-	(2,190)
Reversed unused	-	-	-	-	-	-	-	(603)	-	(603)
Balance at 31 March	2,591	7,686	2,460	35	12,772	-	2,996	2,460	35	5,491
Expected timing of cash flows:										
Within one year	2,591	7,686	2,350	35	12,662	-	2,996	2,350	35	5,381
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	110	-	110	-	-	110	-	110
Balance at 31 March	2,591	7,686	2,460	35	12,772	-	2,996	2,460	35	5,491

The continuing healthcare provision of £7,687k is for costs expected to be incurred in relation to backdated claims received since 1st April 2013 for continuing healthcare and which have yet to be settled. This has increased due to an increased number of potential high cost packages of care and rising costs and numbers of packages for Children's and Adult continuing healthcare. Claims are assessed for eligibility using the national guidance and toolkit.

NHS England held a provision for all backdated claims received prior to 1 April 2013. For NHS Gloucestershire, this has now been cleared and any appeal costs are within the ICB continuing care provision.

The claims outstanding at 31 March 2026 are expected to be paid within the 2026/27 financial year.

Provisions made under the 'Other' and 'Legal claims' categories relate to potential primary care costs relating to practice legal and contractual issues. During the period there were movements in the following categories

- a change in the provision relating to practices following a review of risks in this area.
- a reversal of provisions relating to dilapidation costs relating to the former headquarters of the ICB

12 Financial instruments

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 Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Integrated Care Board standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the NHS Integrated Care Board and internal auditors.

12.1.1 Currency risk

The NHS Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Integrated Care Board has no overseas operations. The NHS Integrated Care Board and therefore has low exposure to currency rate fluctuations.

12.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

Because the majority of the NHS Integrated Care Board and revenue comes parliamentary funding, NHS 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.

12.1.4 Liquidity risk

NHS Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Integrated Care Board is not, therefore, exposed to significant liquidity risks.

12.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

12.2 Financial assets

	Financial Assets measured at amortised cost 2025/26 £'000	Financial Assets measured at amortised cost 2024/25 £'000
Trade and other receivables with NHSE bodies	1,006	546
Trade and other receivables with other DHSC group bodies	130	374
Trade and other receivables with external bodies	8,993	9,252
Other financial assets	-	-
Cash and cash equivalents	9	4
Total at 31 March 2026	10,138	10,175

12.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025/26 £'000	Financial Liabilities measured at amortised cost 2024/25 £'000
Trade and other payables with NHSE bodies	803	665
Trade and other payables with other DHSC group bodies	14,246	10,067
Trade and other payables with external bodies	76,554	65,079
Lease Liabilities	1,898	2,118
Total at 31 March 2026	93,501	77,929

13 Operating Segments

The ICB consider that they have only one segment: commissioning of healthcare services for the Gloucestershire population

14 Pooled budgets

NHS Gloucestershire ICB is party to a pooled budget with Gloucestershire County Council. Under this joint arrangement, funds are pooled under S75 of the Health Act 2006 for integrated community equipment services.

This service has been running for a number of years and buys, delivers, collects, maintains and decontaminates equipment for patients in their own homes. This service is jointly commissioned by the ICB, with Gloucestershire County Council, who are the lead commissioner for the service.

The NHS ICB share of the income and expenditure handled by the pooled budget in the financial year are:

	2025/26 £000	2024/25 £000
Income	(5,653)	(5,579)
Expenditure	5,653	5,579

15 Losses and special payments

15.1 Losses

There were two losses incurred by NHS Gloucestershire in 2025/26 totalling £29k (2 in 2024/25 totalling £3k). These relate to debts that recovery options have been exhausted.

15.2 Special Payments

There were no special payments in 2025/26 or 2024/25

16 Events after the end of the reporting period

There are no events after the end of the reporting period

17 Related party transactions

The Department of Health is regarded as a related party. During the year the NHS Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example NHS England, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust, South West Ambulance Service NHS Trust, NHS Litigation Authority, NHS Business Services Authority and West of England AHSN.

In addition, the NHS Integrated Care Board has had a number of material transactions with other government departments, universities and other central and local government bodies. Most of these transactions have been with Gloucestershire County Council in respect of joint commissioning of services.

The ICB Board includes Partner Member who are jointly nominated by the NHS Foundation Trusts and Primary Care which provide services for the purposes of the health service within the ICB's area. The relevant trusts are Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust and South Western Ambulance Service NHS Foundation Trust. As such, the Chairs and Chief Executives of Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust sit on the ICB Board and the Chair of South Western Ambulance Service NHS Foundation Trust. In addition, Gloucestershire primary care providers have nominated two representatives, Dr Emma Crutchlow (Lead GP at Gloucester Health Access Centre and Matson Lane Surgery and Clinical director for G-Doc primary care provider) as Board Participant and Dr Jo Bayley (Director for G-Doc primary care provider) as Partner Member.

In formulating this note the NHS Integrated Care Board has considered all declarations of interest for Board members.

Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:

- a(i) have control or joint control of the entity
- a(ii) having significant influence over the reporting entity or
- a(iii) are a member of the key management personnel.

An entity is related to a reporting entity if any of the following conditions applies:

- b(i) the entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others)
- b(ii) one entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member)
- b(iii) both entities are joint ventures of the same third party
- b(iv) one entity is a joint venture of a third entity and the other entity is an associate of the third entity
- b(v) the entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity
- b(vi) the entity is controlled or jointly controlled by a person identified above
- b(vii) a person identified in a (i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity)
- b(viii) the entity, or any member of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity

The Declaration of Interest register can be found on our website.

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