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

BSW Integrated Care Board – Board Meeting in Public

Thursday 20 March 2025, 10:00hrs

Council Chamber, Wiltshire Council, County Hall, Bythesea Road, Trowbridge, Wiltshire, BA14 8JN

Agenda

Timing	No	Item title	Lead	Action	Paper ref.
Opening Business					
10:00	1	Welcome and apologies	Chair	Note	Verbal
	2	Declarations of Interests	Chair	Note	Verbal
	3	Minutes from the ICB Board Meeting held in Public on 23 January 2025	Chair	Approve	ICBB/24-25/101
	4	Action Tracker and Matters Arising	Chair	Note	ICBB/24-25/102
10:05	5	Questions from the public	Chair	Note	Verbal
10:10	6	BSW ICB Chair's Report	Chair	Note	Verbal
10:15	7	BSW ICB Chief Executive's Report	Sue Harriman	Note	ICBB/24-25/103
Business Items					
10:40	8	NHS 10 Year Plan Engagement	Olivia Lacey	Note	ICBB/24-25/104
11:10	9	BSW Operational Planning 2025-26	Rachael Backler, Gary Heneage	Note	ICBB/24-25/105
11:25	10	Refresh of BSW Implementation Plan a. Outcomes Framework	Rachael Backler	Approve	ICBB/24-25/123
11:45 – Short break – 10 mins					
11:55	11	Delegation of Specialised Commissioning from 1 April 2025	Rachael Backler, Mark Harris	Approve	ICBB/24-25/106
Committee Reports					

Timing	No	Item title	Lead	Action	Paper ref.
12:10	12	BSW ICB Quality and Outcomes Committee	Alison Moon, Gill May	Note	ICBB/24-25/107
		a. BSW Quality and Patient Safety Exception Report	Gill May	Note	ICBB/24-25/108
12:25	13	BSW ICB Finance and Infrastructure Committee	Julian Kirby, Gary Heneage	Note	ICBB/24-25/109
		a. BSW ICB and NHS ICS Revenue Position	Gary Heneage	Note	ICBB/24-25/110
12:40	14	BSW ICB Commissioning Committee	Julian Kirby, Rachael Backler	Note	ICBB/24-25/111
		a. BSW Performance Report	Rachael Backler	Note	ICBB/24-25/112
12:55	15	BSW ICB Audit Committee	Claire Feehily, Gary Heneage	Note	Verbal
		a. BSW ICB Risk Management Framework	Rachael Backler	Approve	ICBB/24-25/113
Closing Business					
13:10	16	Any other business and closing comments	Chair	Note	

Next ICB Board Meeting in Public: 22 May 2025

Glossary of Terms and Acronyms

Acronym /abbreviation	Term	Definition
ALOS	Average Length of Stay	An average of the length of time a patient stays in a hospital when admitted. May be averaged for all patients or those with specific medical or social conditions. ALOS has national and local planning implications.
	Ambulatory Care	Rapid access, immediate and urgent care where the patient can walk into a centre and be seen or be directly referred by a doctor, nurse or therapist to avoid the need to admit a patient.
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust	Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a significant provider of mental health services across a core catchment area covering Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. The Trust also provides specialist services for a wider catchment extending throughout the south west. http://www.awp.nhs.uk/
BSW	Bath and North East Somerset (BaNES), Swindon and Wiltshire	The area covered by the BSW Integrated Care System (ICS) and Integrated Care Board (ICB).
CAMHS	Child and Adolescent Mental Health Services	CAMHS are specialist NHS services. They offer assessment and treatment for children and young people who have emotional, behavioural or mental health difficulties.
CCG	Clinical Commissioning Group	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
CHC	Continuing Healthcare	NHS Continuing Healthcare is free care outside of hospital that is arranged and funded by the NHS. It is only available for people who need ongoing healthcare. NHS Continuing Healthcare is sometimes called fully funded NHS care.

Acronym /abbreviation	Term	Definition
	Commissioning	Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a cycle of work from understanding the needs of a population, and identifying gaps or weaknesses in current provision, to procuring services to meet those needs.
CIP	Cost Improvement Programme	NHS organisations use CIPs to deliver and plan the savings they intend to make. Encompassing efficiency and transformation programmes.
D2A	Discharge to Assess	Funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. They can then be assessed for their longer-term needs in the right place.
DES	Directed Enhanced Service	Additional services that GPs can choose to provide to their patients that are financially incentivised by NHS England.
DTOC	Delayed Transfer of Care	Experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.
ED	Emergency Department	An accident and emergency department (also known as emergency department or casualty) deals with life-threatening emergencies, such as loss of consciousness, acute confused state, fits that are not stopping, persistent and severe chest pain, breathing difficulties, severe bleeding that can't be stopped, severe allergic reactions, severe burns or scalds. https://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx
	Elective Care	Elective care is pre-arranged, non-emergency care which includes scheduled operations. It is provided by medical specialists in a hospital or another care setting.
EFR	Exceptional Funding Request	An Exceptional Funding Request (EFR) is the route by which A health professional can apply on a patient's behalf for treatments, drugs and devices (collectively referred to as interventions) that are not routinely funded by a CCG.
ERF	Elective Recovery Fund	The Elective Recovery Fund (ERF) is a £1 billion fund made available to help hospitals recover their levels of activity, post COVID-19 pandemic. The ERF is promising to support the cost of services working flexibly to take on the additional activity needed to reduce the growing backlog of patients requiring

Acronym /abbreviation	Term	Definition
		elective services such as outpatient appointments or surgeries. What that really means is that if services can find a way to deliver more appointments and carry out more procedures than they normally would have, they will be paid more for the delivery of services than they would otherwise. As an extra incentive, the more delivered above 'normal (19/20 baseline) ' the bigger the pot of money you get.
FDP	Federal Data Platform	The NHS Federated Data Platform (FDP) is software that enables NHS organisations to bring together operational data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment. Each NHS trust and Integrated Care Board can access their own FDP and manage all their data. The FDP will help integrated care boards (on behalf of the integrated care system) to proactively plan services that meet the needs of their local population.
FOT	Forecast Outturn	The total projected balance remaining at the end of the financial year.
HWB	Health and Wellbeing Board	The Health and Social Care Act 2012 established Health and Wellbeing Boards as forums where leaders from the NHS and local government can work together to improve the health and wellbeing of their local population and reduce health inequalities.
H2/HIP2	Health Infrastructure Plan	A rolling five-year programme announced in October 2019 of investment in health infrastructure, encompassing: capital to build new hospitals, modernise primary care estates and invest in new diagnostics and technology.
ICA	Integrated Care Alliance	Integrated Care Alliances (ICAs) involve commissioners, providers and other organisations working together to improve health and care for residents' in one locality, often co-terminous with local authority boundaries, working across organisational boundaries by choosing to focus on areas which are challenging for all partners and agreeing a picture of future population needs. In BSW, there will be three ICAs – Bath and North East Somerset, Swindon and Wiltshire.
ICB	Integrated Care Board	Each Integrated Care System (ICS) will have an Integrated Care Board (ICB), a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. When ICBs were legally established, clinical commissioning groups (CCGs) were abolished.
ICP	Integrated Care Partnership	The Integrated Care Partnership (ICP) is a statutory committee formed by the Bath and North East Somerset Integrated Care Board (BSW ICB), and local authorities in the BSW area.

Acronym /abbreviation	Term	Definition
		The BSW ICP brings together the NHS, local government, the voluntary, community and social enterprise (VCSE) sector and other partners to focus on prevention, wider social and economic factors affecting people's health and reducing health inequalities.
ICS	Integrated Care System	An Integrated Care System (ICS) is a way of working across health and care organisations that allows them to work closer together to take collective responsibility for managing resources, delivering care and improving the health and wellbeing of the population they serve. ICSs integrate primary and specialist care, physical and mental health services and health and social care
IG	Information Governance	Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations.
	Integrated Care	A concept that brings together the delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion, in order to improve services in terms of access, quality, user satisfaction and efficiency.
JSNA	Joint Strategic Needs Assessment	A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
KPIs	Key Performance Indicators	These are set out in contracts with providers and help to monitor performance. Examples of KPIs include length of stay in hospital for a particular treatment or how satisfied patients are with the care they receive.
LA	Local Authority	Local authorities are democratically elected bodies with responsibility for a range of functions as set out in government legislation. They have a duty to promote the economic, social and environmental wellbeing of their geographical area. This is done individually and in partnership with other agencies, by commissioning and providing a wide range of local services.
LES	Local Enhanced Service	Local scheme of additional services provided by GPs in response to local needs and priorities, sometimes adopting national NHS service specifications.
LMC	Local Medical Committee	LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. They interact and work with – and through – the General Practitioners

Acronym /abbreviation	Term	Definition
		Committee as well as other branches of practice committees and local specialist medical committees in various ways, including conferences.
LOS	Length of Stay	The time a patient will spend in hospital.
LPC	Local Pharmaceutical Committee	Local Pharmaceutical Committees (LPCs) represent all NHS pharmacy contractors in a defined locality. LPCs are recognised by local NHS Primary Care Organisations and are consulted on local matters affecting pharmacy contractors. In Swindon and Wiltshire, this is known as Community Pharmacy Swindon and Wiltshire. https://psnc.org.uk/swindon-and-wiltshire-lpc/
MASH	Multi Agency Safeguarding Hubs	Bringing key professionals together to facilitate early, better quality information sharing, analysis and decision-making, to safeguard vulnerable children and young people more effectively.
MDT	Multi-Disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. psychiatrists, social workers, etc.), each providing specific services to the patient.
	Never Event	Never Events are incidents that require full investigation under the NHS Serious Incident Framework, with a key aim of promoting and maintaining a learning culture within healthcare to prevent future harm. The list of Never Events is set out within this framework and are defined as patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.
	Non-elective care	Non-elective care is admitted patient care activity which takes place in a hospital setting where the admission was as an emergency.
OD	Organisational Development	Organisational development is a planned, systematic approach to improving organisational effectiveness and one that aligns strategy, people and processes. To achieve the desired goals of high performance and competitive advantage, organisations are often in the midst of significant change.

Acronym /abbreviation	Term	Definition
OPEL	Operational Pressures Escalation Levels	Framework system implemented by NHSE to provide a consistent approach in times of pressure.
	Primary Care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.
PCN	Primary Care Network	Primary care networks were introduced in January 2019 to encourage local GP practices to link up with other neighbouring practices to deliver care to groups of between 30,000 – 50,000 patients.
QIPP	Quality, Innovation, Productivity and Prevention	Quality, Innovation, Productivity and Prevention is a large scale programme introduced across the NHS to improve the quality of care the NHS delivers, whilst making efficiency savings to reinvest into frontline care.
QOF	Quality and Outcomes Frameworks	The quality and outcomes framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of quality care and helps to fund further improvements in the delivery of clinical care.
RTT	Referral to treatment	NHS England collects and publishes monthly referral to treatment (RTT) data, which are used to monitor NHS waiting times performance against the standards set out in the National Health Service Commissioning Board and Clinical Commissioning Groups
	Scheme of Financial Delegation	This Scheme of Financial Delegation contains both an overview of the Delegated Financial Limits (DFLs) and detail to support day-to-day operational decision making. It should be read in conjunction with the Standing Financial Instructions (SFIs) and the Scheme of Reservations and Delegations (SoRD) which sets out what decision-making authorities are reserved for the ICB Board or delegated to committees and individuals.
SoRD	Scheme of Reservations and Delegations	The SoRD sets out those decisions that are reserved to the ICB Board, and those decisions that the Board has delegated to committees, sub-committees, individuals, relevant bodies, incl. functions and decisions in accordance with section 65Z5 of the 2006 Act, or a local authority under section 75 of the 2006 Act committees.
	Secondary Care	Secondary care is the services provided by medical specialists, quite often at a community health centre or a main hospital. These services are provided by specialists following a referral from a GP, for example, cardiologists, urologists and dermatologists.

Acronym /abbreviation	Term	Definition
SFI	Standing Financial Instructions	The SFIs are part of the ICB's control environment for managing the organisation's financial affairs, as they are designed to ensure regularity and propriety of financial transactions. SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB.
YTD	Year to Date	A term covering the period between the beginning of the year and the present. It can apply to either calendar or financial years.

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

DRAFT Minutes of the BSW Integrated Care Board - Board Meeting in Public

Thursday 23 January 2025, 10:00hrs

Council Chamber, The Civic Trowbridge, St Stephen's Place, Trowbridge, Wiltshire, BA14 8AH

Members present:
Integrated Care Board (ICB) Chair, Stephanie Elsy (SE)
ICB Chief Executive, Sue Harriman (SH)
Primary Care Partner Member, Dr Francis Campbell (FC) *(from 10:08hrs)*
NHS Trusts & Foundation Trusts Partner Member – acute sector, Cara Charles-Barks (CCB)
Non-Executive Director for Audit and Governance, Dr Claire Feehily (CF)
Local Authority Partner Member – BaNES, Will Godfrey (WG)
ICB Chief Finance Officer, Gary Heneage (GH)
Non-Executive Director for Public and Community Engagement, Julian Kirby (JK)
ICB Chief Nurse, Gill May (GM)
Local Authority Partner Member – Swindon, Sam Mowbray (SM)
Non-Executive Director for Remuneration and People, Suzannah Power (SP)
Local Authority Partner Member – Wiltshire, Lucy Townsend (LT)
ICB Chief Medical Officer, Dr Amanda Webb (AW)

Regular Attendees:
ICB Director of Place – BaNES, Laura Ambler (LA)
ICB Chief Delivery Officer, Rachael Backler (RB)
ICB Chief of Staff, Richard Collinge (RCo)
ICB Chief People Officer, Sarah Green (SG)
ICB Interim Director of Place – Wiltshire, Caroline Holmes (CH)
ICB Director of Place – Swindon, Gordon Muvuti (GMu)
NHSE South West Managing Director (System Commissioning Development), Rachel Pearce (RP)
Deputy Chief Executive, Avon and Wiltshire Mental Health Partnership NHS Trust, Alison Smith (AS)
ICB Associate Director of Governance, Compliance & Risk
ICB Corporate Secretary

Invited Attendees:
ICB Interim Director for Mental Health – item 8

Apologies:
Chief Executive, Wiltshire Health and Care, Shirley-Ann Carvill (SAC)
Chair of the BSW Integrated Care Partnership – Cllr Richard Clewer (RC)
Non-Executive Director for Quality, Alison Moon (AM)
Voluntary, Community and Social Enterprise (VCSE) Partner Member, Pam Webb (PW)

1. Welcome and Apologies

1.1 The Chair welcomed members, officers and observing members of the public to the meeting of the BaNES, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) held in public.

1.2 The above apologies were noted. The meeting was declared quorate.

2. Declarations of Interest

2.1 The ICB holds a register of interests for all staff and Board members. None of the interests registered were deemed to be relevant for the meeting business. There were no other interests declared regarding items on the meeting agenda.

3. Minutes from the ICB Board Meeting held in Public on 21 November 2024

3.1 The minutes of the meeting held on 21 November 2024 were approved as an accurate record of the meeting.

4. Action Tracker and Matters Arising

4.1 The were no actions recorded upon the tracker. There were no matters arising not covered by the agenda.

5. Questions from the Public

5.1 A number of questions had been raised in advanced of the meeting regarding the Patford House Partnership Meical Centre estate, a surgery request for the Harnham, Salisbury area, and the rollout of the artificial intelligence powered digital front door for mental health talking therapies and the continued equity to access to services.

5.2 The questions and the full responses would be published on the BSW ICB website: https://bsw.icb.nhs.uk/documents-and-reports/

6. BSW ICB Chair's Report

6.1 The Chair provided a verbal report on the following items:

- Dominic Hardisty had resigned from the mental health Partner Member role in December, leaving a vacancy upon the ICB Board. The joint nominations process with NHS Trusts and Foundations Trusts concluded on 17 January, with the ICB Nominations and Appointment Panel meeting on 22 January 2025 to consider the nomination and the suitability of the candidate for the role against the criteria and role spec. The Chair approved the appointment of Alison Smith, the Deputy CEO of AWP to the role, subject to the necessary checks now being undertaken.
- Recruitment for the Non-Executive Director (NED) Quality and Finance roles was underway. The ICB Chair and CEO held a webinar with prospective candidates on 8 January 2025. Interviews have been scheduled for the middle of February.
- Attendance at a number of external events – the Regional 10-year Plan event in December 2024, the Health and Social Care Committee 11 December 2024, and a visit from the Minister of State, Steve Kinnock, who was interested in the nationally recognised, innovative Integrated Community Based Care programme.

7. BSW ICB Chief Executive's Report

7.1 The Board received and noted the Chief Executive's report as included in the meeting pack.

7.2 The Chief Executive provided a contemporary update:

- The ICB Oversight Assessment National Report for 2023-24 had now been published.
- The release of the reviewed NHS Oversight Framework was awaited, with the new regime to commence from April 2025. The implementation of the Framework would provide clarity of the roles of NHS England, the ICB and providers – encouraging

collaborative working and reduction of duplication. The Framework would be shared when available. ICB and provider assessments were being currently being carried out, coming together to form a system assessment. Early drafts were expected to be shared in February. This would then form the Oversight Framework for which BSW was to work to from April. Autonomy over service and decision-making would continue for BSW if good performance against measures was demonstrated. NHS England recognised that the metrics would need to evolve to move to an outcomes-based assessment, but this would be over time.

- Planning guidance was expected to be released on 28 January 2025, in the meantime NHS England have shared supplementary planning guidance, including evidence-based productivity data to inform opportunity assessments (this was to be further discussed in the private session). The full planning guidance would be a topic of discussion for the February Board development session, and then brought to the March meeting.
- Operational challenges continued across BSW, particularly for urgent and emergency care (UEC) whilst in the midst of winter. The effects of viruses such as flu, COVID and norovirus were impacting operational capacity and workforce. BSW was working well at a system and locality level to address the associated risks, though the priority remained for safe care and timely access to services. A dynamic risk approach had been applied across BSW, and schemes such as holding in ambulances with appropriate care, additional cohort areas, and corridor care were being set up. Robust care and support were in place, with colleagues striving to decompress services to return to a business as usual working environment.
- Though BSW historically performed well to support the uptake of vaccinations, this year was recording a reduction, mirroring that seen across the country. There was an evident hesitancy to consider vaccinations by the population and workforce.
- At month eight, the system was reporting a £13.3m adverse position, though considerable work was underway to deliver the financial plan.
- The ambition of the system as part of the refresh of the BSW Implementation Plan (Joint Forward Plan) was to move to balanced activity metrics with an outcomes focus.
- The ICB's Board Assurance Framework (BAF) was undergoing a significant review to ensure it became a value-adding and active tool to aid decision-making. The BAF would be a discussion topic at the February Board development session, considering also the risk appetite of the Board, reflecting on the context and environment and the ambition of the ICB.

7.3 The ICB Chief Medical Officer provided an update to the Board on the £2m investment previously approved in support of inequalities and prevention as part of the left shift agenda, guided by the case for change. The Prevention Steering Group and BSW Integrated Care Partnership (ICP) agreed to align efforts on one key target of hypertension. The hypertension business case approved in the summer, focused on the reduction of cardiovascular risk by increasing case finding and optimisation of blood pressure management. This was a comprehensive programme involving wider system partners to ensure the maximum impact. The first key areas of focus had been:

- Educate the population of cardiovascular and blood pressure risk and early diagnosis.
- Inequalities within the population - a key part was working with the VCSE to support and engage with those CORE20Plus5 population groups. Small grants had been provided to partners to provide that outreach support, targeted education, and blood pressure checks.
- A number of events had been held, with the work to continue – supported by community pharmacists, voluntary sector partners and University of Bath pharmacist students.

Community pharmacists were being optimised to offer those in community blood pressure checks.

- Local dental practices were also involved in a national pilot to offer those checks.
- Increase in outreach NHS health checks through the outreach programme, delivered with Public Health and Local Authority colleagues.
- Community development – an opportunity for the population to tell us what would help around cardiovascular. Small funding pots would be made available to develop these ideas further.
- Focus would then move to supporting these services to manage the expected increase in demand – through lifestyle interventions, health coaching in partnership with Local Authority partners and GPs, and supporting general practice through a locally commissioned service with an enabling team. Applications were being submitted to request national support through the NHS CLEAR Programme.

7.4 The Chair opened up the discussion with Board members:

- There had been a notable lack of national public health messaging ahead of winter to advise on known viruses. It was felt that this was a significant learning to take from this challenging winter period, with elements of pressures that could have been easier to manage. The Board would reflect this message back to the national Public Health team.
- It was acknowledged that the eligibility age groups set out for flu and COVID vaccinations were to be looked at regionally, noting that it was the younger age groups that had shown an increase admission to hospital.
  BSW still remained the highest with regards vaccination uptake, though overall this was lower than last year. A request was made for more granular data to be made available to the Board and via the ICB Quality and Outcomes Committee (QOC) to ensure members could scrutinise and take assurance. Though there were concerns over the future funding for COVID prevention, outreach remained an important part of the South West model.
- The Winter Plan continued to be tested, leading to a reactive response to winter pressures. Some elements and extraneous factors (such as the viruses and demand increase) were impacting on progress and the ability to move to prevention and demand management. A lessons learnt debrief would be undertaken with UEC and emergency preparedness, resilience and response (EPRR) colleagues and shared with QOC.
- Potential harm to patients during these system escalation periods was regularly measured and monitored as part of the daily calls and system oversight. There were no indications that BSW was an outlier with regards the level of harm seen.
  The Board wished to be sighted on more detailed quality metrics to assess the system at a top level of how it was managing.
  The timeliness of risks being taken to mitigate the potential harm was to be picked up through the learning, noting that required escalation from primary care to enable that better management of demand. Risks to patients in A&E were acknowledged, noting that as a result of the ambulance service critical position some patients took themselves to hospital and they were acutely ill. It was noted that when in patients were off loaded from the ambulance or sitting in ED timely recognition of patient deterioration can be compromised.
  The recent report by the Royal College for Emergency Medicines regarding UEC was acknowledged, with BSW considering the recommendations around demand and capacity, alongside that mitigation of corridor care where possible, the impact on the workforce, and taking the learning into next year. The true picture of the situation faced

by the system needed to be shared regionally and nationally, and the collaborative action and mitigations being put into place across BSW.
The system partners planning session acknowledged that the planning guidance does not routinely request quality and patient harm information, though BSW presented a high level oversight to partners to reiterate that finance and decision-making discussions needed to consider the patient centred-approach and safeguarding the most vulnerable.

- The system was subject to escalation, with daily gold calls and regional calls held. BSW was to commence discussions regarding the use of the dynamic risk assessment for all parts of the pathway, including that community level.
- Public Health responsibility – the ICB was to take on some elements of public health commissioning. The first Public Health Oversight meeting was to be held, to be clear of ICB responsibilities and the expected timeline regarding these future developments. The scope would be shared with partners in due course.

7.5 The Board wished to recognise and celebrate the extraordinary efforts of the system and workforce during this heightened period of pressure. Innovative programmes such as the Care Co-ordination Hub were having a positive impact on mitigating pressures, supporting patients at home and considering alternative services. This was to be built upon to progress further transformation.

8. BSW All Age Mental Health Strategy

8.1 The ICB Interim Director of Mental Health joined the meeting for this item, presenting the BSW All Age Mental Health Strategy, as co-produced with system partners and key stakeholders, involving also those with lived experience. A short video was shown of Lydia (a person with lived experience), to share her experience of the local offer and strategy.

8.2 The Interim Director of Mental Health talked through a number of supporting slides to share the co-production and engagement process followed, the strategic commitments, and the finalisation and transition to the five-year delivery implementation plan, with the System Implementation Delivery Group already mobilised. Bi-annual updates would be provided to the ICB Board and other forums.

8.3 The Chair opened up the meeting for discussion and comment:

- The delivery plan would need to be tighter against the financial allocation, to deliver priorities in line with the required timeline.
- The strategy presented a significant ambition over the next five years, particularly noting the current position, resources and capacity.
  The strategy's intent was to be ambitious and transformational, to push and stretch the system and partners to be brave and break from the historical norm of mental health services. The Board was to hold the ICB and system to account against delivery, seeking assurance alongside a realistic and honest review of what good was to look like against BSW's position.
- BSW was still processing its own internal narrative against the philosophical approach and ideology to mental health, being shared by America and broader global forces. The ICB would continue to address issues of equity, diversity and inclusion as its statutory duty.
- The strategy required a strengthened reference to its visions and aims in support of reducing equity and need.

- Though this was a supported strategy and approach, it was felt that this ambition needed to extend to children and young people. Publication of the delivery plan needed to be brought forward from August 2025 to move to implementation at pace.
  It was advised that the delivery element was already being formed.
  Priorities for this strategy and delivery were still in discussion and would be a focus point for the Board development session in February to further drive focus and commitments, in parallel to the overall BSW Implementation Plan eight priorities, considering also the risk appetite, left shift, early intervention and prevention.

8.4 Thanks to all those who contributed and were involved in the production of the Strategy were noted, with the underpinning philosophy and required journey recognised. Adoption of the strategy would ensure BSW mental health services remained fit for purpose.

8.5 The Board approved the BSW All Age Mental Health Strategy.

9. BSW ICB Quality and Outcomes Committee

9.1 In the absence of the NED Quality, the NED Public and Community Engagement introduced the Committee report provided by the ICB Chief Nurse against the business covered at the meeting held 7 January 2025:

- Risk being managed within UEC and the ambulance handover delays at emergency departments
- Vaccination delivery and uptake
- Positive Continuing Healthcare (CHC) workforce capacity position – meeting the 80% performance demand, though noted a 100% increase in demand was being seen against the need to undertake the CHC checklist. This demonstrated that system partners were identifying eligible patients. Capacity to now meet the demand was to be resolved to maintain the performance levels.

9.2 The draft minutes were shared for information. The next meeting of the ICB QOC is scheduled for 4 March 2025.

9a BSW Performance and Quality Report

9.3 The Board noted the BSW Performance and Quality Report. The ICB Chief Delivery Officer highlighted the following items:

- Non-Criteria to Reside (NCTR) – the Improve Together Sprint focus at SFT and for Wiltshire was into its second month. System partners were collaborating effectively, improving that operational level relationship, and agreeing required changes to processes. Correlating performance improvements were expected to be seen via the Sprint. Significant process changes were being implemented during February across all three hospitals, with oversight of the Sprint being undertaken via the Wiltshire Steering Group.
- Referral to Treatment (RTT) and Cancer – SFT and GWH were now out of regional tiering, benchmarking well on the metrics. Challenges remained at the RUH against cancer and diagnostics. Challenges continued around 65 week waits for elective care, requiring significant improvement, though forecast to be cleared by March,
- Children and young people's access to mental health services –work continued on the data upload issues with key providers, with improvements in figures now starting to be recorded and the rate improving although still with some issues to be worked through.

- The feedback from QOC was to ensure clearer remedial action plans were in place for all key supporting metrics, with expected timelines of recovery actions clarified. A further report would be taken to QOC in March.

10. BSW ICB Finance and Infrastructure Committee

10.1 It was noted that the Non-Executive Director (NED) for Public and Community Engagement continued to act as the interim Chair of the ICB Finance and Infrastructure Committee (FIC) whilst the NED Finance role remained vacant.

10.2 The approved minutes from 4 December 2024, and draft minutes from 8 January 2025 were shared for information.

10.3 The NED Public and Community Engagement spoke of the more recent meeting held on 8 January 2025, where the Committee recognised the challenging finance and infrastructure position of the system and the priority activities underway to move to an improved position by the year end. Manoeuvring space and time were reducing at pace, despite the efforts of system partners.

10.4 The next meeting of the ICB FIC was scheduled for 5 February 2025.

10a. BSW ICB and NHS ICS Revenue Position

10.5 The ICB Chief Finance Officer updated the Board on the financial position of the NHS organisations within the Integrated Care System (ICS) at month eight, highlighting the following:

- The system was reporting a £13.3m adverse position year to date. Drivers of this were largely UEC pressures and NCTR, leading to additional beds in the acutes and supporting workforce. These remained above plan.
- Non-pay pressures were also being seen, though were mainly offset by additional elective planned care performance and Elective Recovery Fund (ERF) overperformance.
- Productivity was 2% above national performance levels.
- Partners continued to look for mitigating actions to drive the position down to meet the year end target, to improve the run rate for the remainder three months of the year, as well as recovery.
- The ICB had been informed that the ERF was now to be capped on over performance levels. For BSW this would be £84.4m. The latest month nine figures indicated BSW was slightly below this, with some headroom remaining.
  The Independent Sector continued to over perform.
- BSW had not yet formally re-forecast its budgets, NHS England guidance was awaited. It was expected that BSW would achieve the under £10m movement against plan by year end.

10.6 The Chair opened it up for discussion, with it noted:

- It was acknowledged that unintended consequences of the ERF cap may be seen through perverse incentives and potentially disenfranchised behaviour. BSW was working to avoid that, noting also that the clawback still applied.
  BSW would see a significant reduction in the ERF allocation for next year, though an increase in activity, productivity and efficiency was expected. This would be further discussed at the February Board development session.

BSW would need to think differently about the elective programme in the next financial year, aligning with the Federal Data Platform (FDP), improved utilisation of the resources available, and revising its Elective Care Strategy to move forward to the ambition of a single BSW elective care service via the Acute Hospital Group.
When utilising the Independent Sector, it was to be ensured that it was treating those on the waiting list that the system needed them to treat.

- BSW was involved in the first phase rollout of the FDP, providing improved visibility of data and a single elective waiting list for BSW.
  It was suggested that analogue to digital, ERF, and FDP should be future discussion topics for Board development to aid Board member understanding and awareness.
- Productivity data was relevant to all areas of the system, being shared widely to aid understanding of all drivers. The different nature of the planning round this year would support this, bringing in that benchmarking data for acutes, community, mental health, CHC and prescribing. It was suggested that a future Board development session could also include productivity. BSW needed to aim for the upper quartile by understanding the opportunities.

10.7 The Board noted the report and the financial position of the NHS organisations within the ICS.

11. BSW ICB Commissioning Committee

11.1 The NED for Public and Community Engagement, and Chair of the Commissioning Committee advised members that the first meeting of this new Committee held on 10 December 2024 was used to normalise and interpret the terms of reference for this core, operational Committee, providing that oversight and assurance to the Board. Membership was devised to bring that diverse perspective to commissioning. Engagement and public involvement would be a key function of the Committee, recognising the ICB's duties and responsibilities to involve the public in the development of services. Close links would be formed with all aspects of the governance framework and other Board committees. This would be aligned with the ICB's role also as a strategic commissioner, the supporting national framework was awaited.

11.2 The draft minutes were shared for information. The first business meeting of the Committee would be held on 11 February 2025.

12. BSW ICB Remuneration and People Committee

12.1 The NED for People and Remuneration, and Chair of the Remuneration and People Committee advised the Board of the Committee business covered at its meeting on 14 January 2025:

- Pay awards – the ICB's payroll systems and processes surrounding approval of pay awards were discussed to provide members with assurance that there were robust with vigorous checks in place.
- NHS England's longer-term intentions for system pay parity – it was recognised this was to be determined nationally, not locally.
- An update on Project Evolve – ongoing work was being supported through the Colleague Engagement Group, and skills and gaps were now being reviewed and considered. A closure paper would be brought to the March committee meeting, including the outcome report for the Medicines Optimisation Team consultation.

- The tender for an organisational development partner was now live.
- Assurance was given to the committee that work was underway to adopt and embed the national Sexual Safety Policy, and Worker Protection Act. A further update would be brought to the March committee meeting.
- A six month update against the ICB Equalities, Diversity and Inclusion (EDI) Annual Employer Report would be brought to the March committee meeting, to include an update on the high impact actions. It was noted that EDI was to be a future Board development session topic.
- Leadership and Competency Framework and Board Appraisals would also form a discussion topic for a future Board development session.

12.2 Further to this, the ICB Chief People Officer advised that discussions had commenced in the context of the organisational change programme, and preparing the workforce for continual change during these difficult and challenging times ahead.

12.3 The next meeting of the ICB Remuneration and People Committee is scheduled for 18 March 2025.

13. BSW ICB Audit Committee

13.1 The NED for Audit, and Chair of the ICB Audit Committee advised members of the business covered by the Committee at its last meeting held 5 December 2024:

- Though the external audit process was not yet underway, the ICB or auditors did not flag any areas of concern in the preparation of the audit plan.
- The Committee started to consider how it would take assurance from the new community services provider (HCRG), recognising this brought a different kind of delivery provider and a different relationship.
  The Interim Place Director for Wiltshire and Audit Chair would discuss thoughts and concerns and ensure plans were in place to provide that level of assurance sought by the Committee.
- A positive NHS ICB and ICS Annual Cyber Security Report was received, presenting a good overall system position.
- The ICB Corporate Risk Register was reviewed, considering also the transition and mobilisation risks associated with the change in community services provider.
- The Committee received a documented record of the ICB Governance Review undertaken during 2024.
- Two review reports were received from the internal auditors:
  - Personal Health Budgets (joint review with Counter Fraud) – the Committee further requested that QOC have oversight of the progress to de-risk areas.
  - Data Quality and the ICB's collection, processing and reporting of 4-hour Emergency Department performance data – a positive report, though with a request for QOC to conduct a read-across of the data provided by system partners to consider its quality and consistency.

13.2 Further to this, the ICB Chief Finance Officer advised that an update against the HFMA Checklist had also been provided to the Committee, providing assurance of the grip and control in place against financial sustainability, and the ongoing actions.

13.3 The next meeting of the ICB Audit Committee is scheduled for 6 March 2025.

14. Any other business and closing comments

14.1 The Chair closed the meeting, noting thanks and appreciation to the staff working across BSW during this challenging winter, providing the best care possible for patients and the population.

14.2 There being no other business, the Chair closed the meeting at 12.29hrs.

Next ICB Board meeting in public: Thursday 20 March 2025

Item 4

BSW Integrated Care Board - Board Meeting in Public Action Log - 2024-25

Updated following meeting held on 23/01/2025

OPEN actions

Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
23/01/2025	*No actions recorded*					

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	7
Date of Meeting:	20 March 2025		

Title of Report:	CEO Report to BSW ICB Public Board
Report Author:	Sue Harriman, Chief Executive Officer
Board / Director Sponsor:	
Appendices:	

Report classification	Public elements of Board
ICB body corporate	Yes
ICS NHS organisations only	No
Wider system	No

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

1	Purpose of this paper
The CEO reports to the Board on sector developments that are expected to impact. the ICB, and key issues relating to ICB plans, operations, and performance.	

2	Summary of recommendations and any additional actions required
The ICB Board is invited to **note** the content of this report.	

1. National and Regional Context:

1.1 On 25th February Amanda Pritchard announced that she will stand down as the CEO of NHS England, at the end of March (NHS England » NHS Chief to stand down at end of March). Sir James (Jim) Mackey will assume the role of interim CEO with her departure. Sir James is currently the Chief Executive of Newcastle Hospitals NHS Foundation Trust and National Director of Elective Recovery, with demonstrable experience of leadership at a local, regional, and national level. Amanda has been Chief Executive since August 2021 and Chief Operating Officer since 2019, leading the NHS through the most challenging period in its 76-year history. The first woman in the health service's history to hold the post of Chief Executive, amongst a whole host of achievements it was Amanda that oversaw reforms in the Health and Care Act 2022, including the replacement of almost 200 Clinical Commissioning Groups with 42 Integrated Care Boards.

1.2 On Thursday 13th March our Chair and CEO will be joining others from across the country, in London, to be briefed by Amanda Pritchard and Sir James Mackey on the NHS England's approach, in the context of the challenging financial situation. This is

a dynamic situation with Sir Stephen Powis, the National Medical Director announcing his retirement. We are aware of breaking news at the time of writing, of other key leaders standing down from their roles in NHS England. Where necessary, the CEO will brief the Board verbally on any outcomes from that meeting (noting that papers will already have been published).

1.3 On 28th February the Government and NHS England announced that the consultation on changes to the General Medical Services (GP) Contract for FY 25/26 had concluded and that the General Practice Council (GPC) were supportive of the proposed changes (NHS England » Changes to the GP Contract in 2025/26). These proposals will see an £889 million increase in investment across the core contact, the pay recommendation being fully funded, measures to enhance GP recruitment, and the publication of a patient charter which will set out the standards a patient can expect from their practice. This will improve transparency for patients and make it easier for them to know how practices will manage their request, and what to expect from their practice.

1.4 **Inequalities Statutory Responsibilities**. ICBs are under specific legal duties to take account of health inequalities issues in the exercise of their functions. NHS England has published a Statement designed to help relevant NHS bodies understand their duties and powers relating to Health Inequalities and how they can be exercised. The Statement can be found here: https://www.england.nhs.uk/long-read/publication-of-nhs-englands-statement-on-information-on-health-inequalities/

1.5 The Statement specifies which information on health inequalities should be collected, analysed, and published. The ICB has published a report summarising what the data tells us in terms of inequalities in BSW for those areas specified, alongside action we are taking to address inequalities. Our report can be found here: BSW statement on health inequalities - Bath and North East Somerset, Swindon and Wiltshire ICB

1.6 Fairer health and well-being is one of the three objectives within our Integrated Care Strategy and both our Population Health Board and Inequalities Strategy Group support the drive of this agenda. A focus on the CORE20PLUS5 Framework (NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities) means at Place level we are targeting specific 'PLUS' groups to reduce inequalities, and our Delivery Groups each have an inequalities priority, and are working to drive improvements. These groups actively use our data – like the information we have published – to inform our work in addressing inequalities.

2. **BSW ICB updates:**

2.1 **Integrated Community Based Care Programme (ICBC) Mobilisation**. The Integrated Community Based Care contract awarded to HCRG Care Group as the lead provider, working in partnership with other providers and the voluntary sector in the system, will go live on 1st April 2025. Comprehensive mobilisation and due diligence work has been underway since October 2024 and all due diligence activity is on track for completion to ensure safe services from day one. We look forward to the transformation journey with partners, citizens and staff which will see these services bring our strategy to life over the next seven to nine years.

2.2 **Financial Position**. At Month 10 the System is reporting a £16.3m adverse position year to date (YTD). This position represents £0.4m adverse to the systems financial trajectory.

2.3 The latest full-year financial forecast indicates an outturn position of £14.9m adverse. However, the system has now received a further in-year allocation of £15.0m to

enable the system to break even at the end of the financial year. This revised forecast will be reflected in the M11 position.

2.4 In terms of the YTD position: to Month 10, the financial position continues to be impacted by:

- Urgent and Emergency Care (UEC)/ Non-elective (NEL) pressures which is driving no criteria to reside, escalation beds and workforce costs
- Slippage against efficiency plans and
- Other demand pressures.

2.5 The key movements during Month 10 were:

- A continuing drive towards enhanced BSW Productivity (4.6% regional view at Month 8) is better than the Southwest average of 4.4%, and the national average of 2.4%.
- We continue to exceed our stretch target on elective performance.

2.6 The System is awaiting the receipt of £21m of Elective Recovery Funding (ERF) associated with the elective care activity in the 24-25 period.

2.7 As part of 25-26 financial planning, the system is focused on preparing and delivering the most viable financial plan. A draft system planning deficit of £52.3m was submitted as the headline plan. There is ongoing work to find a route to break even and address some of the performance challenges ahead of the final submission.

2.8 To support and enable the reform that is required we have appointed a System Recovery and Delivery Director with the support of the NHS England regional team.

2.9 **Performance, Oversight, and Delivery.**

2.10 **Operational Planning for 25/26**: We submitted our headline plan on 27th February to NHS England and have continued work to develop our final plan submission ahead of the 27th March deadline. We have made further progress and have received feedback from NHS England which we are incorporating into our work. The main challenges are in reducing our financial deficit, improving operational performance in key areas including elective and non-elective care, and ensuring that we have delivery plans that support our operational objectives. This is covered in more detail on this agenda.

2.11 **Implementation Plan for 25/26**: Following engagement with stakeholders through our Steering Group and the Board at two development sessions, we have completed work on our local implementation plan for this year (our Joint Forward Plan). This sets out how we are working to deliver our ICP strategy and regular updates will be brought to the Board against the deliverables set out within the document. This is covered in more detail on this agenda.

2.12 **NHS Oversight Framework**. NHS England have conducted the Quarter 2 performance oversight review using the 2023/24 oversight framework. NHSE have confirmed no changes in ratings with the ICB, RUH and SFT in segment 3. GWH continue in segment 2. The main drivers of the segment 3 ratings continue to be financial performance, cancer, and diagnostics.

2.13 **Urgent and Emergency Care (UEC)**. BSW has continued in NHS England Tier 2 (regionally led support) for UEC. However, the system continues to remain challenged on UEC performance in terms of demand and system flow. This means that in some cases patients are still waiting too long in an ambulance waiting to be moved into the hospital, known as ambulance handover delays, and access to timely care for all patients attending our EDs is not where we want it to be. The Timely

Handover Process (THP) is now in place 24/7 at GWH and RUH with exceptional handover waits reducing across the system, however the average handover time has not reduced; focused work continues to improve this position. A&E 4-hour performance remains behind target, however, the system is engaged in the Regional 78% Sprint meetings with GWH, which are making a significant improvement to the 12-hour position. Clinically led discussions have taken place using the Dynamic Risk Assessment ensuring risk-based decisions are made in a timely way to minimise harm to patients. Clinically led reviews of patients who have been delayed transferring to the ED department or waiting for more than 12 hours to transfer to a bed, are taking place. Learning will be discussed at a newly established UEC System Safety Group.

2.14 The number of patients waiting to be discharged from hospital, known as Non-Criteria to Reside (NCTR) has increased, despite additional actions. This, in addition to increased Infection Prevention and Control issues, has affected the number of beds available for admission in both acute and community services, and has exacerbated the issues with patient flow. Daily NCTR meetings remain in place ensuring all partners are addressing key actions. The recent NCTR sprint in SFT with partners has provided valuable insight into the areas of change required, this learning is being shared across BSW. BSW remains the best performing across the South West for Hear and Treat rates, and there has been an improvement Cat 2 mean response time in February to 40 mins (previously 51.7mins in January).

2.15 **Elective Care**. The Elective Care Delivery Group oversees performance and recovery actions for elective targets, and the detailed remedial action plans and trajectories, for the areas requiring most improvement. The BSW entered “shadow” tiering in November for Referral to Treatment (RTT – waiting times) in relation to the 65 week wait position. In February, BSW exited “shadow” tiering although remain in regional oversight meetings.

2.16 The target to clear 65-week waits by September was not met. Validated December data shows 87 waiters in BSW acutes due to a mix of capacity, patient choice, and complexity. The February unvalidated forecast position is 56. Recovery actions to clear all 65-week waits are continuing with oversight with the regional NHS England team. RUH and SFT are planning clearance of 65-week waits for the end of March (except corneal transplants). GWH have identified risks to fully clearing 65-week waits by the end of March.

2.17 **Diagnostic Performance**. Diagnostic performance (the % of the waiting list over 6 Weeks at BSW acutes) has improved in December to 27.8% from 22.4% in November. Remedial action plans remain in place for all required modalities at the BSW acutes although there remain recurrent capacity gaps for non-obstetric ultrasound and endoscopy. As a non-recurrent solution, temporary endoscopy capacity is now in place at RUH. There are also temporary solutions in place for ultrasound including weekend working.

2.18 **Cancer Performance**. Reporting for December shows the 28 days faster diagnostic continuing to meet the national standard at 77.9%. The 62-day standard at 73.6% met the plan. Executive focus and oversight for the recovery plans continues via the Elective Care Delivery Group. RUH continue in Tiering (regionally led support) for Cancer and Diagnostics.

2.19 **Children and Young Persons (CYP) Mental Health Access**. CYP access in December was at 8,550 CYP seen in 12 months rolling against the plan of 12,742. Improvement work with partners pan-System to ensure accuracy of uploads to data systems was completed and we are awaiting feedback on the reported position. Development of Mental Health Support Teams workplan is in progress and CYP

access target apportionment to providers and improvement plans to deliver the target is also in development across all providers. To be formalised via contract variation.

2.20 **Talking Therapies**. BSW Talking Therapies (TT) completed courses of treatment is the new metric for 24/25, 4,690 people had completed a course of treatment in 12 months to December, not meeting the plan of 5,746. The ICB is working closely with AWP to resolve contractual performance issues. A further update on improvement actions has been requested by the end of this month.

2.21 **Dementia Diagnosis**. Diagnosis rates continue to slowly improve but dipped slightly in January for the first time in 2024/25 and continue below the ICB plan trajectory to meet the national target. AWP have initiated a Wiltshire and Swindon Memory Service improvement Project to review waiting lists and development of memory pathway review methodology is underway, expected delivery March 2025.We are working closely with AWP to ensure there is significant improvement planned for 25/26.

2.22 **Learning Disability and Autism (LD&A) Inpatient Rates**. In February, adult inpatients held at 25 against a target of 21, 17 of which were commissioned by the ICB and South West Provider Collaborative inpatients. There were fewer than ten children and young people – all of whom are commissioned by the Thames Valley CAMHS Provider Collaborative. Inpatient admissions remain above the planned trajectory for both children, young people, and adults. An increase in admissions is currently being reviewed to understand if this is a continued trend and evaluate the drivers. Direct management of inpatients through the weekly practice forum continues to deliver increased oversight of BSW ICB commissioned patients and discharge plans, being further strengthened with a refresh of the NHS England 12-point discharge plan to track individuals' progress. BSW ICB are now meeting monthly with the South West Provider Collaborative senior leadership team to review processes and strengthen collaborative oversight.

2.23 **Quality and Safety.** ICBs have an overarching statutory duty for quality. This is a duty to exercise their functions with a view to securing assurance and fostering continuous improvement in the quality of services for, or in connection with:

- The prevention, diagnosis, and treatment of physical and mental illness
- The protection and improvement of public health

2.24 To work effectively, there is a need for strong partnership working and intelligence-sharing across organisations, including shared ownership of risk. Clear reporting and governance arrangements must be in place within and beyond ICSs, including alignment with Regional Quality Groups.

2.25 A new BSW Quality Assurance Framework document has now been finalised in consultation with system partners and approved via BSW Quality Outcomes Committee. The document describes the framework adopted by BSW ICB to deliver on our statutory duty for quality. It sets out our vision for quality, the application of the National Quality Board (NQB) guidance, our governance arrangements and quality priorities. Additionally, it sets out the approach to driving quality improvement via the utilisation of our assurance processes.

2.26 It is expected that the Quality Assurance Framework (QAF) will be refreshed annually to support ongoing quality improvement and identification of any emerging themes across the Integrated Care System (ICS).

2.27 **Maternity and Neonatal.** Salisbury NHS Foundation Trust maternity services have now exited from the National Maternity Safety Support Programme and received a 'Good' rating from CQC in the recent report published February 2025.

2.28 Smoking in pregnancy across BSW has reduced from 10.8% in 2017/18 to 6.6% in 23/24. BSW maternity providers are now offering the national maternity incentive voucher scheme supporting pregnant people who give up smoking.

2.29 **Primary Care.** The ICB continues to work closely with primary care partners in partnership and collaboration on finalising the contract for our Locally Commissioned Services (LCS) for 2025/26. A final offer has been issued to practices, with a return deadline of 18th March. This offer is the result of joint work with GPs to develop a transparent rate card for remuneration, ensuring a fair and reasonable approach. This includes a £3 million support payment offer to GPs to help address underfunded core work. However, we continue to face risks, as 27 of our 86 practices have issued notice on phlebotomy services. We are actively engaging with the LMC and practices to resolve any concerns regarding the support payment offer. Additionally, we are presenting a paper to Primary Care Executive Group (PCEG) on 14th March outlining an options appraisal for alternative service delivery models. This will ensure continuity of care if GPs choose not to accept the support payment and proceed with their notice.

2.30 **Inequalities.** The Inequalities Strategy Group is working with Delivery Groups to define 2025/26 inequality priorities. Delivery of 36 place-based projects from the 2024/25 health inequalities programme is in its final quarter, with ten continuing into 2025/26. The 36 projects are monitored quarterly. Reports come to the Inequalities Strategy Group and the Population Health Board with onward assurance to QOC. Our evaluation has demonstrated that they have delivered improved access, wellbeing, and engagement through targeted interventions. The 10 projects that are continuing are long term in nature and will continue to undergo close evaluation and assurance of outcomes. The 2025/26 funding grant process is underway, prioritizing CORE20PLUS5 areas: cancer and severe mental illness (adults), oral health, and mental health (children and young persons). A multi-stakeholder panel will assess applications before awards in May 2025. The Equality Delivery System (EDS) was approved by the ICB Quality and Outcomes Committee in January, with three priority service areas proposed: smoking cessation in maternity, Mental Health Act detentions, and inpatient tobacco dependency treatment based on the Statement on Health Inequalities data. This data is developing into an inequalities dashboard with further work being done through the draft ICS Outcomes Framework where metrics will be segmented by age, gender, ethnicity, and deprivation.

2.31 **NHS Change – Engagement on the Government's 10 Year Plan**. During January and February, we hosted several engagement events with patient, CORE20PLUS5 and seldom-heard groups across BSW, to gather insights on health and care services for the NHS Ten Year Health Plan. We collaborated with our valued partners in the Voluntary, Community and Social Enterprise (VCSE) sector and reached out to a diverse range of people, including refugees and asylum seekers, Black and Minority Ethnic senior citizens, Muslim communities and Gypsy, Roma, Traveller, and Boater communities. The outputs from these sessions have been passed onto those developing the Ten-Year Plan, which will be published in May and will set out how the government and NHS will create a truly modern health service designed to meet

the changing needs of our changing population. Fuller details are included in the Board paper.

2.32. **Cyber Security**. The ICB has continued to promote the importance of good cyber security from Board level down, with increasing collaboration across our partner organisations to further improve our defences and response to any incidents. The ICB has met all the required cyber security standards within the NHS Data Security and Protection Toolkit.

2.33. **Annual ICB Duty – Eligible Partner Trusts.** The Guidance on integrated care board constitutions and governance sets out which trusts and which primary medical services providers may participate in the process for nominating at least one 'ordinary member' for appointment to the ICB board. The ICB must keep this list of eligible trusts and primary medical services up to date**.**

2.34. Trusts are eligible to jointly nominate the trust partner member(s) of the ICB board if:

- They provide services for the purposes of the health service within the ICB's area, and
- The relevant ICB consider them to be essential to the development and delivery of the five-year joint forward plan (forward plan condition, as described in regulations).

2.35. For the avoidance of doubt, the first point above does not require the services provided by a trust to be physically located within the area of an ICB. It is sufficient that the services they provide are accessed by patients for whom the relevant ICB is responsible, and those services are being provided for the purposes of the health service within the area of the ICB.

2.36. Where a trust providing services for the purposes of the health service, within the ICB's area, does not meet the forward plan condition (the second point above), it becomes a nominating organisation for the ICB from which the trust receives the largest proportion of its ICB income for the provision of local NHS services.

2.37. The ICB identified the following as the trusts that meet both points above, and are therefore eligible to nominate the trust partner member(s):

- Royal United Hospital NHS Foundation Trust (RUH)
- Great Wester Hospital NHS Foundation Trust (GWH)
- Salisbury NHS Foundation Trust (SFT)
- South Western Ambulance Service NHS Foundation Trust (SWAST)
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

2.38. This is set out in the ICB's Constitution.

2.39. **Modern Slavery Statement**. The ICB Modern Slavery Statement had been reviewed and revised in line with legislation, and national and local guidance and practice. Though it is not specifically implied in the Modern Slavery Act that ICBs must have a Statement, many councils, heath trusts and charities produce voluntary statements demonstrating awareness and ethical leadership by completing modern slavery transparency statements. Wider partners would expect the ICB to have oversight and scrutiny of our contracting arrangements and supply chains in respect of modern slavery. This statement provides clarity on the ICB's position and gives a greater weight to our social and ethical responsibilities via commissioning.

2.40. The ICB's Executives approved the revised statement at their meeting on 19 February 2025, and it is published on the ICB's website: https://bsw.icb.nhs.uk/document/bsw-icb-modern-slavery-statement-2025-26/

2.41. **People.** For the ICB the Medicines Optimisation Directorate consultation has completed with a new structure being implemented which is more readily aligned to the current and future target operating model of an ICB. As a result of the significant ICB workforce changes in 24/25, an Organisational Development (OD) programme is being developed with the CEO and CPO to support embedding new structures and ways of working into the organisation.

2.42. March sees the publication of the NHS Staff survey results and current work is in progress across all NHS organisations, and with region, for taking forward necessary engagement and action plans to identify cross cutting themes and specific localised actions.

2.43. The People Team have continued to work with HCRG and wider partners in the assurance, and oversight, of the ICBC mobilisation ensuring the safe transfer of the workforce.

2.44. The BSW system wide vacancy control panel continues to convene with the Group Hospitals on a weekly basis, as part of additional workforce controls with the overall aim to develop a new process once the NHS planning submission is more fully understood.

2.45. The DWP funded Work Well project on developing leadership capacity for integration of work and health is progressing with alignment and delivery being furthered through Connect to Work; this programme has mapped existing access to work pathways across each locality. Following a successfully evaluated leadership programme for domiciliary care registered managers with Skills for Care, a BSW leadership advisory group, is being established, led, and designed by the programme participants.

3. **Focus on Place (reports by exception, matters unique to a locality):**

3.1. **B&NES.** Joint working in BaNES between the ICB and Local Authority is in progress to ensure that National Better Care Fund Planning Round is supported. Health and Wellbeing Board sign-off is required by end of March, time plan agreed for the sign-off steps including ICB Chief Exec and Finance Officer, LA Directors and Health and Wellbeing Boards. The key principles to note are:

- Through the BSW BCF group, plans are currently on track to meet the deadline.
- 25/26 is a transition year with a focus on stability and consolidation. BANES ICA are supportive of this approach. This is recognised by NHS England and anticipated in the planning submissions.
- Due to collaborative working to date with colleagues including NHSE, BSW is well positioned with NHS England, which will therefore prioritise feedback to other systems first.

3.2. Health, education, and social care leaders met with Professor Sir Michael Marmott last week as part of dedicated work aiming to reduce the educational attainment gap in B&NES. Professor Sir Marmott feedback that the analysis and research undertaken by B&NES to address the drivers for the attainment gap was ‘excellent’ and commended work to date on developing key actions to address. Next steps will include focusing on priority actions.

3.3. This work links with the three priorities recently identified in an ICA workshop with partners which included, CYP Emotional Health and Wellbeing, Attainment, and Integrated neighbourhood working.

3.4. **Swindon**. Extensive work continues in Swindon to address the gaps identified by OFSTED in the inspection of children's services. We now have a clear understanding of the key challenges and are implementing a targeted approach to improve access, waiting list validation within the early help pathway. We will be reporting waiting list data and improvement trajectories through our Quality and Outcomes Committee once validation has been complete. Considerable progress has been made in Children's Acute Mental Health Services (CAMHS), with waiting times improving from 30% of patients being seen within four weeks to nearly 70% this financial year. Additionally, CAMHS has successfully mobilised the system-wide trauma pathway, which is designed to enhance outcomes for children in care.

3.5. **Wiltshire.** Work continues on the Trowbridge Integrated Care Centre, which is still on track to open in January 2026, with planning workshops now taking place on the operating model and involving a wide range of partners. Updates are due to be taken to both the Wiltshire Health Select Committee Health and Wellbeing Board in March. Discussions are also under way with *Voice It, Hear It* (engagement support funded through the Better Care Fund) to design the engagement required for the model. The ICB is also working with *Voice It, Hear It* to identify other key projects during 2025/26 that require engagement support. The locality's overall Better Care Fund submission is also in the process if being finalised jointly with Wiltshire Council before submission later in March 2025.

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

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	8
Date of Meeting:	20 March 2025		

Title of Report:	NHS 10 Year Plan Engagement
Report Author:	Olivia Lacey, Associate Director of Communications and Engagement, Dom Hall, People and Communities Engagement Specialist.
Board / Director Sponsor:	Richard Collinge, Chief of Staff
Appendices:	

Report classification	
ICB body corporate	X
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	x

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	x
2. Fairer health and wellbeing outcomes	x
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
This report was previously shared with: BSW ICB staff at a Colleague Briefing and with the BSW ICB Commissioning Committee	27/02/25 10/02/25	Update for staff and Committee members

1	Purpose of this paper

The purpose of this paper is to update the Integrated Care Board on recent engagement work carried out by the BSW ICB Communications and Engagement team which collected the views of local people on health and care for submission to NHS England as part of work to develop the NHS Ten Year Health Plan.

This engagement process took place during January and February 2025 across BSW with patient, CORE20PLUS5 and seldom heard groups and as part of a wider strategic approach with fellow South West Integrated Care Boards (ICBs). The results provide valuable insight into the views of people and communities across BSW about their experiences of health and care services and their hopes and concerns for service provision over coming years.

The findings from this engagement exercise will support further transformational work across the BSW system, including the new community-based care contract and approach.

This paper also seeks to demonstrate our renewed commitment to working with and listening to our communities. We aim to ensure that engagement is part of everyone's business at BSW ICB, is embedded in all our workstreams, and forms the basis of a strong and responsive ongoing engagement function.

2	Summary of recommendations and any additional actions required

The Board is asked to receive this report for assurance purposes.

3	Legal/regulatory implications

The Health and Care Act 2022 states all ICBs have a statutory responsibility to actively involve the public, including patients, carers, and their representatives, in the planning and decision-making processes related to healthcare services within our area, The guidance sets out how working with people and communities supports the wider objectives of integration including population health management, personalisation of care and support, addressing health inequalities and improving quality.

4	Risks

There are no specific risks relating to the engagement undertaken in support of the 10 Year Plan, however, Integrated Care Boards face significant risks if they fail to involve the public in decision-making processes, as mandated by the Health and Care Act 2022. Without public engagement, ICBs may make decisions that do not align with the needs and preferences of the communities they serve, leading to ineffective or unpopular policies.
This can result in decreased public trust and cooperation, both of which are crucial for the successful implementation of health initiatives.

Additionally, neglecting public involvement can lead to a lack of accountability and transparency, potentially causing legal and reputational issues.

5	Quality and resources impact
Engaging with communities to ensure their voices are heard while developing local health and care services will improve quality and patient experience by improving the ICBs understanding of specific needs and increasing public trust in our decision-making processes. Additionally, services designed with direct input from the community are more likely to address the root causes of health issues, leading to better health outcomes from a more empowered and involved community with a sense of ownership. The 10 Year Plan is a fundamental part of the Government's stated mission to deliver an NHS fit for the future, creating a truly modern health service designed to meet the changing needs of our changing population. The finalised Plan will be instrumental in shaping health and care services across the NHS over the coming years.	
Finance sign-off	

6	Confirmation of completion of Equalities and Quality Impact Assessment

The engagement events outlined in this paper deliberately targeted an agreed selection of CORE20PLUS5 and seldom heard groups to ensure a wide range of experiences and expectations were reflected in the findings. This was part of a nationally mandated programme which involved a variety of ways for people and communities to be part of the wider conversation about the 10 Year Plan.

Discussions with the SW communications and engagement community, following direction from national colleagues, enables individual systems to focus on reaching specific groups and cohorts in recognition that meaningful interaction with every CORE20PLUS5 group would not be achievable in the timescales. Participating groups included the following:

- Older BAME community members in Bath
- Refugees and asylum seekers in Swindon
- Gypsy, Roma, Traveller & Boater communities in Bath and Wiltshire
- Muslim community in BaNES.

7	Communications and Engagement Considerations

This programme of public engagement has been carried by the BSW ICB Communication and Engagement team as part of its commitment to ensure members of our community's voices are heard and influence key decisions to shape our services across Bath and North East Somerset, Swindon and Wiltshire. It aligns with, and supports, the nationally mandated communications and engagement approach set out to facilitate a national conversation to develop the 10 Year Health Plan.

8	Statement on confidentiality of report

This paper can be shared publicly

Community Engagement for the NHS Ten Year Health Plan

1. Introduction

1.1. The 10 Year Health Plan is part of the government's health mission to build a health service fit for the future.

1.2. The first step in the process was Lord Darzi's independent review of the NHS in England to understand the true scale of the challenge facing the health service. As a result of that investigation, the government committed to developing a plan to tackle the challenges identified.

1.3. The plan will set out how to deliver an NHS fit for the future, creating a truly modern health service designed to meet the changing needs of our changing population. The government committed to co-developing the plan with the public, staff and patients through a detailed engagement exercise.

1.4. To do this, 'Change NHS: help build a health service fit for the future', was launched in October 2024, to support a national conversation to develop the 10 Year Health Plan.

1.5. The public and health and care staff in England were encouraged to share their views, experiences and ideas at the Change NHS online portal. The portal opened on 21 October 2024 and will run until Monday 14 April.

1.6. An important part of the engagement exercise was a series of events for people across the country to share their ideas and views, including regional events with the public and health and care workers to hold more detailed discussions on how to tackle the challenges identified within the NHS.

1.7. Leaders from Integrated Care Boards, NHS trusts and senior system partners also came together for a regional South West event in December, and at other regional events across England, to share their views and contribute to the development of the plan.

1.8. During January and February 2025, the BSW ICB Communications and Engagement Team hosted a series of public engagement events to collect the views of the public for inclusion in the national development of the NHS Ten Year Health Plan.

1.9. Views were also collected via an online survey which was promoted on BSW ICB communications channels including our website, intranet and social media channels.

1.10. Our targeted engagement work gave us an opportunity to work with Voluntary, Community and Social Enterprise (VCSE) partners and seldom heard groups across BSW, establishing important links for future engagement work, giving a broad range of our communities in BSW a chance to have their voices heard, and providing new feedback and insights to inform our own transformational work.

2. Background and wider context

2.1. The public engagement exercise to support the development of the NHS Ten Year Health Plan was unveiled by the Secretary of State for Health and Social Care in October 2024 and billed as the "biggest conversation about the future of the NHS since its birth."

2.2. Every ICB was tasked with promoting an online survey which members of the public could use to share their views on health services and hosting a series of public engagement events to collect the views of local people and community groups in face-to-face and virtual settings.

2.3. NHS England supported these public engagement sessions through the provision of "Workshop in a Box" slides designed to guide discussion and generate useful feedback.

2.4. The Workshops were based around **three fundamental shifts** currently underway in healthcare:

- hospital to community;
- analogue to digital; and,
- sickness to prevention.

2.5. Workshops in BSW used a localised version of the Workshop in a Box slides to ensure suitability for local groups and to include localised information. Seven events were held in total, with 101 participants.

2.6. Other members of the public and staff across BSW also shared their views via the change.nhs.uk website.

2.7. There are natural synergies between the three shifts and several key areas of transformation for the BSW system, including the new community-based care contract which seeks to achieve a 'left shift' from acute services into a community setting.

3. Listening to diverse community groups

3.1. NHS England asked ICBs to target a wide range of different groups, including seldom heard and CORE20PLUS5 groups in order to generate a truly diverse response. At a regional level, we worked with all South West ICBs to focus on reaching specific groups and cohorts in recognition that meaningful interaction with every CORE20PLUS5 group would not be achievable in the timescales.

3.2. Our engagement outreach saw us working with community groups and VCSE organisations including:

- The Harbour Project in Swindon, a charity which supports refugees and asylum seekers
- The Bath Ethnic Minority Senior Citizens Association (BEMSCA) in Bath
- Bath Mosque
- Julian House supporting Gypsy, Roma, Traveller & Boater communities in Bath and Wiltshire

3.3. Events were held with Patient Participation Groups in Radstock, Midsomer Norton and Corsham and a special event with VCSE organisations included 40 representatives from local groups and networks.

4. Topics covered during engagement sessions

The engagement sessions held across BSW differed in terms of time and content depending on the circumstances, time available and audience understanding and knowledge of local services.

4.1. Our presentation contained top-level overviews related to the three shifts outlined above. This information was provided by NHS England as part of the Workshop in a Box slide deck, with the addition of local examples where relevant.

4.2. Slides covered:

- Background to the Ten Year Health Plan.
- The three shifts - hospital to community, analogue to digital and sickness to prevention.
- Background information about the BSW health and care landscape.
- Making better use of technology including information on Electronic Patient Records, Artificial Intelligence reading of scans and tests and up to date technology for NHS Staff.
- Moving more care from hospitals to communities including information on Hospital at Home/Virtual Wards, Community Diagnostic Centres, ambulance triage and Pharmacy First.

- Preventing sickness, not just treating it including information on early support for mental health issues in schools, National Child Measurement Programme, cervical screening and the HPV vaccination programme.

4.3. Questions and discussion points generating feedback covered:

- If the 10 Year Health Plan is a success, what 3 words describe how using the NHS will feel in the future?
- When you think about how we could use technology in the NHS, what are your hopes and fears?
- Technologies we think the NHS should prioritise are…
- What difference (good or bad) would moving more care from hospitals to communities make to you?
- Thinking about virtual wards, what sounds good and what concerns do you have?
- Thinking about community diagnostic centres, what sounds good and what concerns do you have?
- Thinking about ambulance triage, what sounds good and what concerns do you have?
- What difference (good or bad) would working to prevent sickness make to you?
- The three forms of prevention we think should be prioritised are…

5. Top level findings

5.1. NHS England South West is currently processing data collected from all ICBs in the region to provide a regional overview. They are also looking at creating a simplified version of the regional analysis that could be used alongside system-specific data, ensuring that the analysis is both high-level and detailed where necessary. These results will be circulated to the ICB when we receive them.

5.2. A top-level summary of findings is outlined below:

- **If the 10 Year Health Plan is a success, what 3 words describe how using the NHS will feel in the future?**
  - Trust, efficiency, accessibility.
  - Free to use.
  - Accessible, understanding, trustworthy.

- **When you think about how we could use technology in the NHS, what are your hopes and fears?**
  - I fear communication between the NHS and patients will be even more remote than it is now.
  - Shared care records are a great idea and will stop me having to repeat my story to different people.
  - The NHS should spend money on staff not technology.
  - The NHS App is really useful for ordering repeat prescriptions.
  - Older people and people from disadvantaged communities do not have access to technology.

- **Technologies we think the NHS should prioritise are…**
  - Shared care records and joined up systems.
  - Artificial Intelligence.
  - Improving phone systems.

- **What difference (good or bad) would moving more care from hospitals to communities make to you?**
  - It's great pharmacies can treat more people, but pharmacies are closing down everywhere.
  - Having services closer to the community would help ease traffic on our congested roads.
  - Boaters and travellers are afraid of the NHS because they feel people will judge them for their lifestyle, so being able to get treatment from a pharmacist would be really welcome.

- **Thinking about virtual wards, what sounds good and what concerns do you have?**
  - Virtual wards sound like a great idea but will only be successful if the staff are available to run them properly.
  - It would be nice to be looked after at home and be with your family.

  - Thinking about my own older family members, this is a very positive idea. People do not like to lie around in bed all day.

- **Thinking about community diagnostic centres, what sounds good and what concerns do you have?**
  - These would be welcome, if they are located in the middle of our communities and city centres.
  - If community diagnostic centres are out of city centres, homeless people will not be able to access them.
  - I live in Bath and instead of having to go for a test at the RUH, I had to go to Paulton (MIU) which is really difficult to get to.

- **What difference (good or bad) would working to prevent sickness make to you?**
  - Stopping people getting ill is difficult but would really help save the NHS money.
  - Social proscribing is a great way of helping to prevent ill health.
  - Longer terms funding is required by the VCSE sector in order to get people active and keep them away from health services.

- **The three forms of prevention we think should be prioritised are…**
  - The NHS should prioritise giving vaccines to everyone, not just older people and children.
  - The NHS should focus on physical activities and weight management.
  - Education for school children.

- **Do you have any other comments or observations?**

  - Ten years is too long for this plan. The Labour government may be replaced in four and a half years or sooner.
  - Hospitals need to employ more faith representatives to make them more aware of cultural sensitivities and help them deal more effectively with different communities. The NHS is working to address this but there is still a way to go.
  - A more joined up approach to supporting people who do not have an address would be useful.

Positive comment word cloud

Negative comment word cloud

6. Next steps

6.1. We are working with NHS England on further analysis of the results from across the South West and nationally. We are also directly linked with communications colleagues at the Department of Health and Social Care in a collaborative effort to effectively communicate the key priorities for the health and care system and deliver better outcomes for patients and the communities served.

6.2. We are clear that this engagement work will be a foundation stone on which to build the legacy described by the Secretary of State when the 10 Year Plan engagement was launched in October 2024. We plan to return to the groups we visited to offer an update on the Ten Year Health Plan when it has been published. Currently we are expecting publication in May 2025 and we anticipate that a local communications and engagement response will be required to socialise and support the embedding of the agreed Plan.

6.3. The opportunity to work with these groups and communities has opened numerous doors for BSW ICB and we are already looking at building on these relationships through further engagement work and community outreach events. For example, Bath Mosque have asked us to hold a community outreach blood pressure checking session later this year.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	9
Date of Meeting:	20 March 2025		

Title of Report:	BSW Operational Planning 2025/26
Report Author:	Danielle Harris, Head of Planning and Performance oversight
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	BSW Public Board Operational Planning update March 25

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	
ICS NHS organisations only	Yes
Wider system	

Purpose:	Description	Select
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

Previous consideration by:	Date	Please clarify the purpose

1	Purpose of this paper
The purpose of this paper is to provide members of the Board with an update on the 25/26 BSW Operational Planning Process. The paper sets out a summary of the planning priorities and guidance, the timetable and process to get to the full submission and an update on the BSW operational plan with current risks.	

2	Summary of recommendations and any additional actions required
The Board is asked to note and consider the paper, including the updates on the progress with the plan, the timelines, the risks and the development required before the full submission on 27 March 2025. The Board is meeting to review and sign off our operational plan on 26 March 2025.	

3	Legal/regulatory implications
The ICB and wider system have a statutory requirement to:	

- Publish our Operational Plan for 2025/26 (deadline yet to be confirmed by NHSE, but likely to be mid May)

Effective delivery and assurance of plans will support the ICB and wider system partners in delivering the three national priorities for the NHS which are:

- Recovering our core services and improving productivity
- Make progress in delivering the key NHS Long-Term Plan ambitions
- Continue transforming the NHS for the future

4	Risks

Risks highlighted within the supporting pack include:

- Risk of developing a well supported delivery plan with risks and dependencies fully worked through.
- Risk that the plan is not cohesive and coherent and is not fully triangulated.
- Risk to fully identify and deliver the savings plans to meet the efficiency requirement.
- Risk to delivering demand management initiatives for A&E and Non elective growth.
- Risk to delivering ambitious performance plans.
- Risk that the elective funding arrangements may change before plan submission.

5	Quality and resources impact

Any decisions made as part of our planning process could have impacts on quality and resources. These will be documented as the planning process progresses.

Finance sign-off	Gary Heneage

6	Confirmation of completion of Equalities Impact Assessment

No EQIA has been completed as part of this report. EQIAs will be required as we make decisions on the available resources and plan for next year.

7	Communications and Engagement Considerations

The system planning processes follow on from engagement at system planning launch even and development of the system planning mandate.

8	Statement on confidentiality of report

This paper is not confidential.

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BSW Operational Planning 25/26 planning round

ICB Board

20th March 2025

Purpose and contents

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

This pack provides an update on the 25/26 BSW Operational Planning process.

The pack covers the following:

- Operational Planning Priorities and planning guidance overview
- Timetable and process
- An update on the development of our BSW operational plan, including the current key risks

The Board is meeting to review and sign off our operational plan on 26th March 2025.

Our overarching system plan

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

- Across BSW we are working to implement our care model which is our vision for transforming and joining up care for our patients and residents.
- This is being done in the context of a significant challenge, and therefore we have also developed a medium term financial plan describing our plan to return to financial balance over the next two years.
- Working to make the most of the clinical and financial benefits of some big strategic changes during 2024/25 including the establishment of the new group model and the new community contract is a key part of our plan for next year – alongside delivering on the priorities set out for us by NHS England.
- For 2025/26, we have set out a number of important priorities which helps us make progress on our journey through working to deliver on the strategic changes, work together through our system delivery groups, and making sure we have the right grip and control in our organisations.

Strategic initiatives	•Delivering on strategic changes that will transform the way our system runs by implementing our BSW model of care – closer working in our Acute Hospital Alliance, implementing our MH strategy, transforming care through implementing our primary and community care delivery plan, digital transformation such as a single EPR.
Opportunities supported through system-level working	•Working together on opportunities through our delivery groups including demand management, elective productivity, mitigation of urgent care demand, procurement and corporate services consolidation.
Organisational ownership of CIPs and plan delivery	•Ensuring we have the right grip and control, delivering on our workforce plans and non-recurrent savings. Each organisation is still responsible for ownership and delivery of CIP plans, in-year forecast outturn position and respective involvement and inclusion in MTFP development and delivery.

Our approach to operational planning

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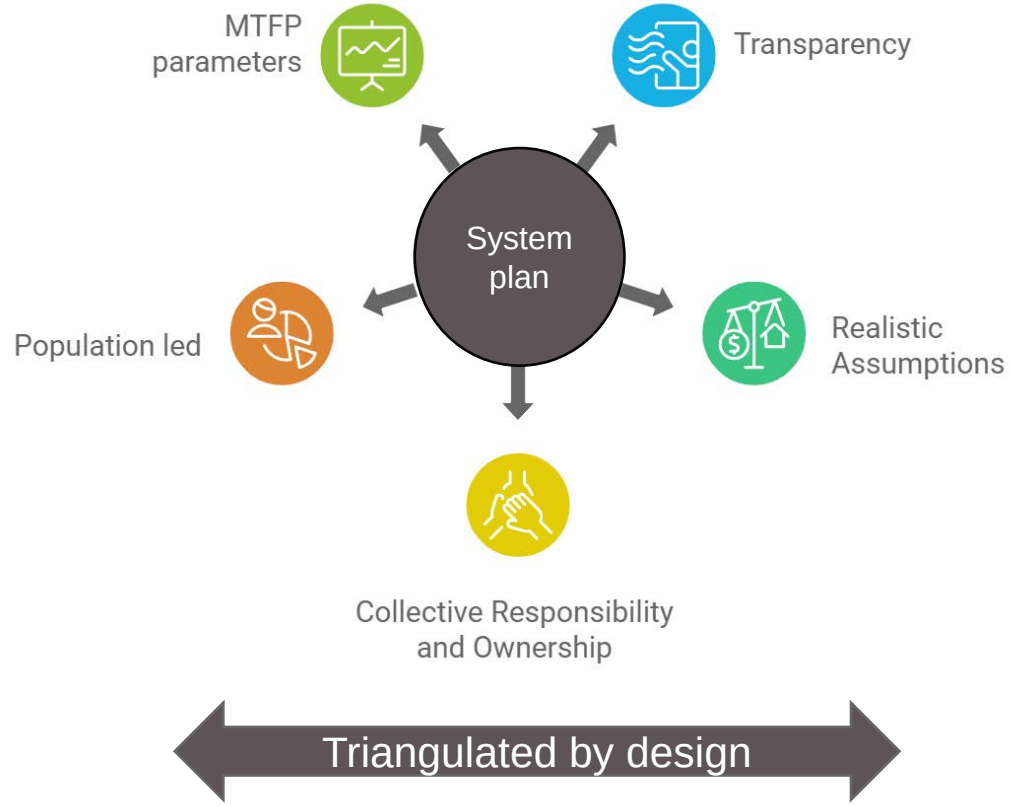
- We agreed to develop a single system plan whereby we agreed key assumptions together as NHS partners, and to work through our delivery groups to ensure that the work we are doing collectively it is embedded in our organisational plans.
- We have been working together through our System Planning and Delivery Group, and our clinical transformation delivery groups, to agree plans and ways of working.
- We started planning in December, however, due to the late release of planning guidance we still have work to do to improve our plans ahead of final submission in March.
- We acknowledge the significant financial and operational challenges that still exist in our system and are committed to working together in partnership to resolve them.



We have already made significant progress with delivery of our strategic goals which will enable better outcomes for patients and support the delivery of our plan

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- Significant strategic initiatives now in delivery phase as part of embedding the BSW Care Model:
  - Integrated Community Based Care – with the roll out of integrated neighborhood teams
  - BSW Hospitals Group
  - Single Electronic Patient Record
  - Trowbridge Integrated Care Centre
  - South Newton
- These changes re-affirm our commitment to moving care closer to patients and improving health and wellbeing working alongside our wider system partners.
- Our planning will involve right sizing our workforce alongside the reform that we need to undertake.
- The group model will help us make sure that we are reducing unwarranted variation and delivering equality of access and outcomes for our population, also addressing fragile services and corporate services.
- Through delivering these changes, we have built system relationships which have been critical to discussing and agreeing resolutions to our system challenges.

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Operational Planning Priorities and Planning Guidance Overview

25/26 Operational planning guidance overview

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- NHS England has reduced the number of national priorities for 2025/26, giving local systems greater control and flexibility over how local funding is deployed to best meet the needs of their local population. Systems are encouraged to shift their focus from inputs to outcomes, supported by changes to the financial framework.

- As the system leaders, ICBs are leading the process of planning and arranging services to deliver the expectations set out in this guidance, including ensuring the reforms are put in place to secure a sustainable health system in the future. In their role as strategic commissioners, they will drive more integrated care through the development of neighbourhood health services, as well as planning the arrangement of acute hospital services to maximise productivity and value.

- Boards of providers of health services ,are responsible for maximising value and delivering against the priorities set out in this guidance within the allocated financial envelope. Boards of providers and ICBs should use the Insightful Board to drive better outcomes, productivity and decisions. Collaboration between NHS organisations will form part of NHS England's assessment.

- Beginning in 2025/26 we will move to a more devolved system where ICBs and Hospital trusts can earn greater freedom and flexibility and patients have more choice and control. In mature, highly performing systems, it is expected that providers will be able to take on more responsibility for leading the planning and transformation of local services within a strategic framework set by ICBs.

- NHS England will have a direct relationship with both ICBs and providers to ensure they deliver on their respective roles. Best practice will be available to all to support local decisions and provide targeted direct support where it is needed.

NHSE have set out national priorities and success measures

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

- To reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026

- To improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26

- To improve patients' access to general practice, improving patient experience, and improve access to urgent dental care, providing 700,000 additional urgent dental appointments

- To improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improve access to children and young people's (CYP) mental health services, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement[2]
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement[2]
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

ICBs and providers will work together to

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- drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future. For 2025/26 ICBs and providers will focus on:
    - reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
    - making full use of digital tools to drive the shift from analogue to digital
    - addressing inequalities and shift towards secondary prevention
- living within the budget allocated, reducing waste and improving productivity. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity
- maintaining our collective focus on the overall quality and safety of our services, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of the ‘Three year delivery plan’, and continue to address variation in access, experience and outcomes

And make local prioritisation decisions

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

- To deliver the goals set out above and live within budget, providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity before taking account of any new local pressures or dealing with non-recurrent savings from 2024/25.

- Given the more focused set of national priorities, the Department of Health and Social Care (DHSC) and NHS England will reduce in size and reprioritise resources to support frontline services and improvements in productivity.

- In deciding how to prioritise resources to best meet the health needs of their local population, ICB and provider boards are expected to explicitly consider both the in-year and medium term quality, financial and population health impacts of different options (see Annex: Principles for local prioritisation). Plans should reflect the needs of all age groups and explicitly children and young people (CYP).

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Annex: Principles for local prioritisation

Systems will need to take difficult decisions about how to prioritise their resources. All organisations must review their existing governance and reporting frameworks to proactively manage quality, and mitigate, manage and escalate risks and concerns. ICBs and providers must work together to:

- put in place a robust clinically led process to support local prioritisation decisions, taking account of the 6 key principles for delivering quality care set out in 'A Shared Commitment to Quality'
- produce impact assessments and test all changes with boards as well as consider what changes require involvement, whether by consultation or otherwise, with the public, patients, staff groups and local authorities

Provider and ICB boards must:

- embed a robust quality and equality impact assessment (QEIA) process as part of financial and operational decision-making (including cost improvement plans)

In addition to considering matters required by applicable legal duties, we ask that boards consider the following principles when making local prioritisation decisions:

- safeguard the quality and safety of services, paying particular attention to challenged and fragile services
- protect access to essential services, prioritising urgent and emergency care, and those patients with the greatest clinical need
- wherever possible take actions that are consistent with narrowing existing health inequalities including inequalities in access
- take account of the medium-term quality, financial and population health impacts alongside in-year impacts

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Timetable and process

Our planning timetable

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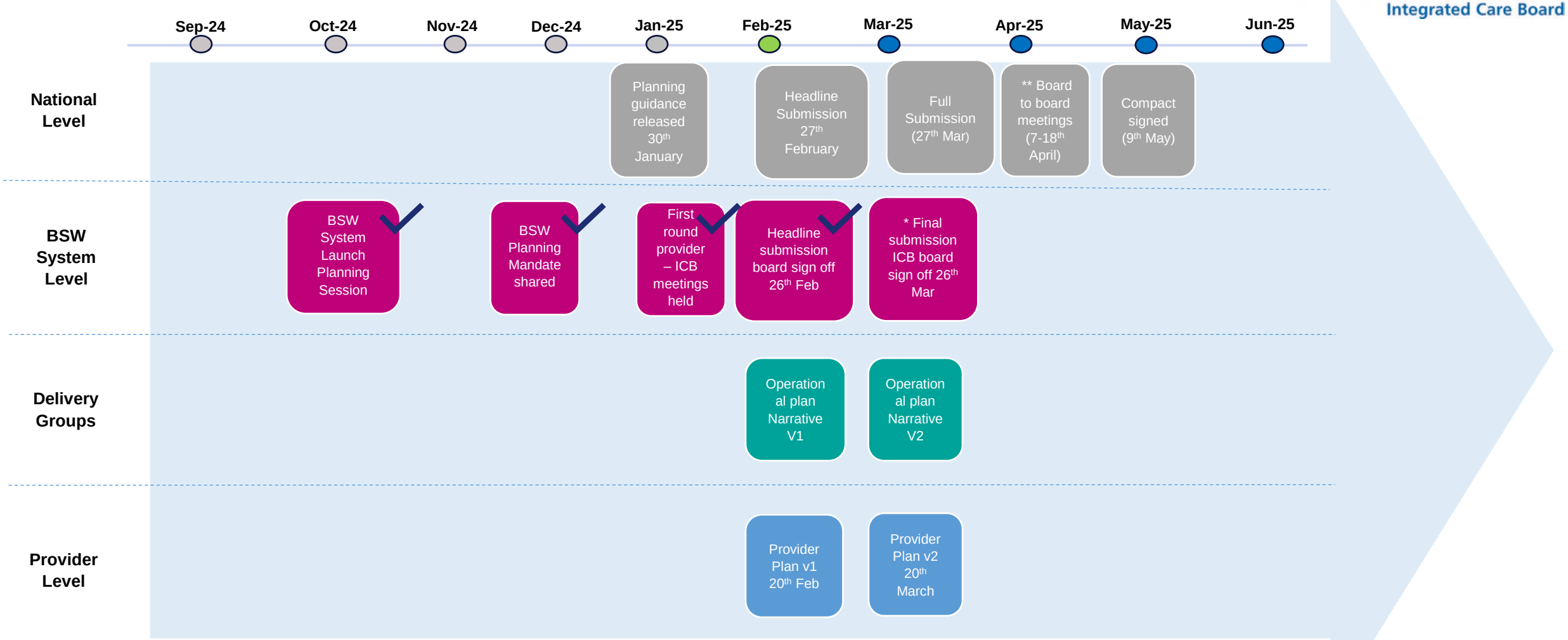

** Our board will need to sign off the plan and provide board assurance statements ahead of the submission to NHS England*

*** At the Board to Board meetings we will* agree key elements of 'Compact' setting out what our system commits to deliver, and the support NHS England will provide.

There are a number of documents we are required to submit to NHSE for the full submission

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Submission components	Description
Delivery plan 'checklist'	A set of 'checklists' have prepared based on the key actions set out in planning guidance. These are aimed to support ICBs and providers in developing their operational delivery plans. Providers / ICBs are asked to complete the 'checklist' templates , sharing how these actions are addressed in their delivery plans.
Productivity / efficiency plan	A description of activities being put in place to deliver the opportunities shared in the productivity and efficiency data packs, with quantified impact and phasing.
Plan overview	A summary of the plan as shared with the board as part of plan sign off, including key assumptions, trade-offs, and an assessment of deliverability.
Board assurance statement	A set of statements that Integrated Care Boards (ICBs) must submit as part of the full plan submission process as well as the statements provider boards must sign off and submit to lead ICBs.
Full numerical plan submission - financial, operational, and workforce plan	A series of numerical templates will be completed with finance, activity / performance, and workforce trajectories based on the format used in previous year's operational plans.

We are also developing a BSW plan overview document

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

- In this document we will set out our response to the specific requirements in planning guidance with regards to UEC, elective, primary care, community care, mental health and LDA.

- We will also ensure we focus on ensuring quality and patient safely standards are at the heart of what we do and will support addressing inequalities within our population.

- We will be clear across our delivery areas on:

  a) The transformation initiatives and schemes that will deliver the asks, and maximise our productivity opportunities

  b) The quantifiable improvement we are seeking to deliver

  c) How the delivery groups will support the implementation of these initiatives and work closely with providers

  d) Risks to delivery of the plan and mitigations.

ICB Boards are asked to sign off assurance statements

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

Governance
The Board has assured the plans for 2025/26 that form the basis of the system's (ICB and partner trusts) submissions to NHS England. This included review of the partner trusts Board Assurance returns.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.
A robust quality and equality impact assessment (QEIA) informed development of the ICB's and wider system's plans and these have been reviewed by the Board.
The system's plan was developed with appropriate input from and engagement with system partners.

Plan content and delivery
The Board is assured that the system's plans address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered across the system and are reflected in the plans of each system partner organisation.
The Board is assured that any key risks to quality linked to the system's plan have been identified and appropriate mitigations are in place.
The Board is assured of the deliverability of the system's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.

- When we make our full submission, we also have to submit a number of board assurance statements, along with any necessary caveats that we wish to make – there is a similar ask of provider boards.
- As part of preparing our submission for the board's consideration we are reviewing the above statements to ensure that the Board has the necessary information to make a decision on the above and proposing any caveats that we think necessary.

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

Full submission update

Incl. key risks and issues

Full submission development

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

We submitted our Headline plan submission on the 27th February and received feedback in early March on these submissions. We are developing the Full plan submission for 27th March with system submissions due on the 19th March.

The ICB is continuing to meet with BSW key providers and NHSE to deliver a full plan, working through the actions identified after the Headline submission:

- System to articulate next steps in closing the financial gap
- Continue to map productivity and efficiency benchmarking to fully exploit into plans
- Understand workforce assumptions (substantive, bank and agency) and triangulate with financial plans
- Review of options (organisational and system) to help support identifying further savings
- Further improvement with respect of elective and non-elective plans
- Development of key assumptions for activity and performance metrics including working up of demand management schemes with primary care, mental health, community and CYP delivery groups.

The following slides describe in more detail progress across Finance, Performance and Workforce.

Finance

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

- System is targeting a breakeven plan. It is anticipated that deficit funding of c. £23m would be allocated to the ICS, subject to a breakeven plan.
- Our headline submission was a deficit plan, and we are working on a route to break even.
- We are targeting efficiency and productivity improvements of c.6%.
- The plans are deemed ambitious, and we will need to leverage the benefits from the Provider Group model and the new community contract.
- The plan reflects the new GP settlement and the continuation of the Additional Roles Reimbursement Scheme.
- Plans include limited investments due to affordability. We continue to invest in the acute single electronic patient record system of £2.4m.
- We are still working through planned care activity. The funding mechanism for this via the Elective Recovery Fund (ERF) is capped in 25/26 which does mean a reduction in funding for the system and this will result in a reduction in provider contracts.
- We continue to plan to meet the Mental Health Investment Standard (MHIS) requirements.
- Service Development Funding (SDF) has been reduced in 25/26 and we are working through the implications.
- Specialist commissioning will be delegated to the ICB from 1st April.

Performance

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

- Work is underway in the ICB and system providers to identify how we can improve current performance and wherever possible meet the national expectation.
- Performance plans are being triangulated with finance and workforce plans as appropriate.
- Key Performance metrics include:
  - Elective waiting list metrics for referral to treatment 18 and 52 week waiters and cancer waiting times for 28 day faster diagnostic, 31 day to treatment and 62 day cancer standard. Diagnostic 6 week waits.
  - Urgent and Emergency Care metrics for ambulance handover times and A&E attendances, A&E 4 hour performance and A&E attendances over 12 hours, occupancy of hospital @ home (also known as virtual wards).
  - Bed occupancy and discharge metrics for length of stay and timely discharge
  - Mental health access metrics including children and young people, Talking Therapies, community perinatal mental health.
  - Learning Disabilities mental health inpatient care metrics and annual health checks
  - Primary Care activity metrics for general practice appointments, dental activity delivered and patients seen and pharmacy first.
  - Community activity with community care contacts and urgent community response referrals. Community waiting lists 52 weeks.

Workforce summary

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

- National guidance requires agency reductions of spend of 30 - 40 % depending on usage – not fully realised in first submissions
- National guidance required bank reductions of spend of 10 – 15% depending on usage – broadly achieved in first submission but requires validation in final
- Further NHSE guidance for final submission received & to be reflected in final submission by providers.
- Corporate functions spend opportunity in national productivity packs per provider – to be reviewed for final submission
- Final submission requires further breakdowns by professional and staff groups
- Primary Care and Mental Health workforce included in final submission
- Further work will be done on triangulation between workforce and finance and application of the NHSE triangulation tool prior to submission
- Final submission to be supported by narrative workforce KLOE/checklist per provider

Current risks and issues

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

Area	Detail
Delivery risk	There is risk to developing a full system plan that has well developed supporting delivery plans with risks and dependencies worked through. This work will need to continue post submission to ensure that we have sufficiently detailed plans for next year to allow for successful delivery. We also need to ensure that our delivery groups are sufficiently resourced and attended to ensure that we have sufficient time and energy going into delivery of these plans.
Plan alignment and triangulation	We need to ensure that as well as each organisational plan being internally coherent, that the transformation initiatives identified by our delivery groups are reflected within organisational plans. This includes ensuring that relevant savings plans are
Finance	There is a significant savings requirement of over £100m. Further work is required to fully identify these savings and ensure that we have robust delivery plans. We also need to ensure that the savings are triangulated with our workforce and operational performance plans.
Demand management	Growth is projected significantly above the funding assumption of 0.5% growth for A&E and Non Elective growth, we need to ensure we have robust initiatives in place to mitigate. Cross dependency between Delivery groups. Some delivery groups will need initiatives/prioritisation from other areas to enable an informed plan.
Operational performance	We are currently facing significant performance challenges and we have ambitious plans for next year. We will need to ensure that we are collectively supporting operational delivery to meet the targets.
Uncertainty over funding arrangements	At the time of writing, there is some uncertainty over the elective funding arrangements for next year. These will need to be fully understood before submitting our plans.

Report to:	BSW ICB Board - Meeting in Public	Agenda item:	10
Date of Meeting:	20 March 2025		

Title of Report:	BSW Implementation Plan Refresh 2025
Report Author:	Helen Peggs, Delivery Director, NHS SCW CSU
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	Appendix 1: Companion Document Appendix 2: Legislative Requirements *Both can be found on the ICB website (links below)*

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	
ICS NHS organisations only	
Wider system	X

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	X
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	X
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
Board Development Session	12 December 2025	Consider draft objectives and outcomes framework and offer feedback
Board Development Session	20 February 2025	Consider draft of implementation plan and outcomes framework and offer feedback ahead of March meeting

1	Purpose of this paper
The purpose of the paper is to present the ICB with a final draft of the annual Implementation Plan refresh for approval.	

ICBs are required to produce and publish a Joint Forward Plan. In BSW this is known as the Implementation Plan, reflecting its role in implementing the direction of travel set out in the Integrated Care Partnership Integrated Care Strategy. This year NHS England has asked ICBs to carry out a refresh, noting the fact that there is ongoing national and local engagement to inform the NHS Ten Year Plan which the government is publishing later this year. The intended audience for the Implementation Plan is for partners, stakeholders and the interested public.

In this refresh, we have also taken the opportunity to refresh our approach to our Outcomes Framework. This framework is intended to allow us to ensure that we are all clear on the major indicators that we are seeking to influence and therefore that the actions we take will be in service of a set of agreed goals. The previous version produced has not been fit for purpose due to a number of issues around access to data for particular metrics. With this new version we have sought to ensure that each metric has either nationally or locally published data.

The Implementation Plan and the Outcomes Framework are the product of considerable engagement with a wide range of partners. The set of strategic objectives and key priorities (supported by the two enabling workstreams) set out in the Implementation Plan emerged from these conversations. A steering group including representatives from Local Authority public health colleagues and provider trusts helped steer the direction of travel and provided ongoing feedback. Other engagement included:

- Board meetings in December, and February to reflect on the previous plan, take thinking forward and consider progress. Feedback we noted and have taken into account included
  - the need for the document to be as concise and focussed as possible with a small number of priorities
  - the need to keep language simple. We have edited the documents to ensure this is the case
  - to include a glossary. The Companion Document now includes this
  - the importance of explaining how the documents relate to each other and to the Integrated Partnership Strategy. We have expanded the explanation to explain these relationships
  - the importance of referencing the All Age Mental Health Strategy. This is now referenced
  - the need to strengthen our references to our work in regard of of children and young people. We have strengthened this in the Plan.
  - consideration of producing an Easy Read version. Once the Plan is finalised we will be actioning this.
- Input to drafts from a wide range of stakeholders including Local Authority public health and other partners. Wherever possible we have used this input to amend the narrative. Several mentioned the importance of prevention and we have accordingly added to the narrative.

- Health and Wellbeing Boards have had copies of the Plan and we await their formal feedback via their Chairs.
- The section on Integrated Care Alliances and their respective priorities was agreed with the relevant chairs
- The Plan also includes examples of feedback from patients and the public during engagement activities on the NHS Ten Year Plan

A log has been kept of feedback on both the Plan and the Outcomes Framework and includes responses in terms of how we incorporated suggestions. This log is available to Board members on request.

The Board is asked to approve the Implementation Plan, noting that we will carry out some further proofing checks as well as noting that we await formal confirmation of opinions from HWBs.

In addition to the main document, we have produced two further documents which can be found on the ICB website:

Appendix 1 (https://bsw.icb.nhs.uk/document/item-10-appendix-1_companion-document/) is a Companion Document to the Plan which incorporates greater detail on the work being carried out across our main system Delivery Groups. This document is intended to be used by the groups themselves to ensure that they have a shared collective understanding of the programme of work, and as such should be viewed as a working document.

We are publishing this alongside the Implementation Plan for those who wish to view more detail but we note that this document still requires further development and refinement as we meet with Delivery Group Leads to ensure that the plan of work is deliverable and sufficiently prioritised. As a more operational document once this work has been completed this document will be reviewed and approved by the ICB Executive.

Appendix 2 (https://bsw.icb.nhs.uk/document/item-10-appendix-2_legislative-requirement-delivery/) is a requirement of NHS England in that ICB's must set out as part of the plan how we are achieving our statutory duties. These have been updated from previous versions of the plan.

Copies of the documents have also been shared with NHS England South West who have made some suggestions about the approach to be considered when the next iteration is produced. This will be after the NHS Ten Year Plan has been published, which may change the focus.

2	Summary of recommendations and any additional actions required

The ICB Board is asked to:

- formally approve the Implementation Plan (Joint Forward Plan), with the caveat that we have not yet had formal confirmations of opinions from Health and Wellbeing Boards and are still carrying out final proofing checks.
- Note the Companion Document (appendix 1) and the intention for this to be used by our delivery groups, subject to further review by the ICB Executive as described above.
- Note the Legislative Requirements (appendix 2) and provide any comments.

3	Legal/regulatory implications

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts (the ICB's partner NHS trusts and foundation trusts are named in its constitution) to prepare a Joint Forward Plan (JFP) before the start of each financial year.

4	Risks

N/A

5	Quality and resources impact

Delivering on our plan should have a positive impact on quality of our services. The impact on our resources will be quantified as part of the individual business cases that will be required to deliver the different elements of the plan.

Finance sign-off	n/a

6	Confirmation of completion of Equalities and Quality Impact Assessment

Not applicable to this document although individual business cases and decisions will be subject to our normal EQIA processes.

7	Communications and Engagement Considerations

A draft of the report has been shared with the communications and engagement team and input included in terms of engagement activities on the NHS national Ten Year Plan and feedback from participants added in as quotes.

8	Statement on confidentiality of report

This is intended as a public facing document

Bath and North East Somerset,
Swindon and Wiltshire Together

Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW Together)

Implementation Plan

2025/26

FOREWORD

The Integrated Care Partnership in Bath and Northeast Somerset, Swindon and Wiltshire (BSW) was set up in July 2022. The Partnership brought together statutory and voluntary sector organisations with a joint mission to improve health and wellbeing and tackle inequalities.

Since then, significant progress has been made in the way we work together and some of our achievements are set out in this document.

2024/25 has been a year of significant change for BSW, along with many other health and care systems in the country. While we have had to deal with considerable operational and financial challenges, we have also seen areas of development including the introduction of a new BSW Integrated Community Based Care Programme and the formation of the BSW Hospitals Group.

This means that we are making great progress with the implementation of our BSW Care Model – there is more to do but we are confident that through working as partners we will continue to make the right steps to improve outcomes and reduce inequalities for our patients and residents.

The next 12 months will be an exciting time in BSW where there will be a renewed focus on community services, embracing the concept of 'neighbourhood health' focused squarely on the needs and experience of patients . The planning and preparation in place puts BSW in a good position to support local communities and the hardworking staff who care for them.

This updated Implementation Plan covering 2025-2027 sets out the actions that BSW will take as a system to jointly address the most pressing priorities, building on the solid foundations already laid.

We are expecting a new ten year plan for the NHS this year, and we will reflect on that plan and consider any potential changes to our ICP strategy and our implementation plan in due course.

INTRODUCTION

Introduction

In July 2023 BSW published its first Integrated Care Strategy, setting out the ambitions of health and care partners to improve services for local people.

This was also informed by the Health and Wellbeing Strategies set by each of our Local Authority Health and Wellbeing Boards. The Strategy set out a vision for the next five years, uniting partners behind three clear objectives.

These are:

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

Following this, Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) worked with partners to produced the first Implementation Plan demonstrating how we work together as a system and at place level to deliver our ICP Strategy.

This is our third annual refresh of that Plan carried out with the input of partners and covers our intentions from 2025 to 2027. Whilst focussing on implementation of our strategy, this plan also takes account of the annual planning guidance which NHS England issues to all ICBs and makes the link between our immediate objectives and the longer term outcomes that we are seeking to deliver collectively. The purpose of the Implementation Plan to give BSW local populations, partners and stakeholders a clear picture of the programmes of work we will be delivering and the outcomes that we are seeking to achieve to support the health and wellbeing of our population.

We are in the middle of a national and local conversation on the NHS Ten year plan, which includes engagement with our communities. During January and February 2025 we conducted a number of engagement sessions with members of the public across BSW to gather input and involving several distinct groups, including Patient Participation Groups, senior citizens from Black and Minority Ethnic (BAME) communities in Bath, refugees and asylum seekers in Swindon, the Muslim community in BaNES, and representatives from the Gypsy, Romany, Boater, and Traveller communities in Wiltshire and Bath.

Approximately 150 people attended these events and shared their views. Discussions with these groups focused on three key national shifts underway nationally in health and care: better use of technology, transitioning more care from hospitals to communities, and prioritising illness prevention over treatment. These themes are central to this Plan, and relevant feedback from our engagement sessions has been included.

Given the ongoing national conversations regarding the NHS Ten Year plan, we have sought to take a light touch approach to this refresh, although we have aimed to be more concise in our articulation of our priorities. More information on our work, our achievements and our aims for the future is contained within our more detailed Companion document. The ICB's work against its Legislative Duties is also found in the Companion document.

NHS Ten Year Plan: Feedback from patients and the public

- Broad support for 'Hospital at home' (virtual wards).
- Enthusiasm for 'Pharmacy First' (this community pharmacists to supply some prescription-only medicines, where clinically appropriate.
- Concerns over digital exclusion.
- Concerns over access to Community Diagnostic Centres.
- Belief that NHS will improve in the future.

INTRODUCTION

About BSW

The health and care needs of people living in Bath and Northeast Somerset, Swindon and Wiltshire are changing, with more people living longer, often with multiple long-term conditions.

The profile of the population varies greatly across the ICB. For example, whilst **BSW has areas of affluence, Swindon is ranked as the 98th most deprived area out of 151 Local Authority areas in England** but some smaller areas are in the 10% most deprived in the country.

BSW serves a combined local population of 940,000.

It has a complex and extremely varied demographic structure and geography which poses challenges to the delivery of health and social care.

Approximately 103,000 people from ethnic minority communities live in BSW (All Age MH Strategy, 2024). Swindon has significantly more residents from a black and ethnic minority group:

18.5% in Swindon, compared to **7.8% in BANES** and **5.6% in Wiltshire** . In all three areas the largest ethnic group after 'White British' is 'Asian/British/Asian (ONS, 2021).

The health needs of local people varies across our area. Here's a snapshot and some areas of concern:

- **180,000 people** in BSW have some form of **Mental Health condition**.
- In BSW **5.56% of the population has diabetes** yet 20% of the COVID deaths were in people with diabetes.
- **156,000 people** in BSW have 3 or more **long-term conditions**.
- **85,000 people** in BSW a**ged 65+ on 10 or more prescriptions**. This is nearly 1 in 2.85.
- The percentage of **people with a learning disability living in residential care often away from home is greater than the national average** increasing isolation.
- **60375 people live in the 20% most deprived areas.** This is 6.5% of the population.

Children and young people account for 30% of our population. While most child health indicators are better than the national average, many children have difficult living circumstances across the system:

- **1 in 4 children** do not achieve a good level of development at the end of Reception.
- **1 in 10** children are **living in poverty**.
- **1 in 200** children are **in care**.

National statistics show an increase in mental ill health in children and young adults, with 83% of this group saying that the pandemic has made their mental health worse. Across BSW, **acute hospital admissions for mental health conditions in under 18s are consistently higher than the national average**, ranging from 500 to 800 per 100,000 population each year, with rates highest in Swindon.

Future challenges

- The **BSW population is projected to grow by 6%** over the next 15 years, meaning there will be an **extra 60,000 by 2038**.
- **The number of people aged under 60 will remain stable**; all of this growth is in the over 60s, meaning a 35% growth in our 60+ population.
- **Multi-morbidity increases with age**. These population changes mean that there will be a**n additional 32,000 people with two or more long term conditions** by 2038.
- It currently costs **£340 million to provide acute, inpatient, outpatient and A&E services in BSW**. Because of demographic changes alone in 15 years this will increase to £410 million a year.

JOURNEY AND ACHIEVEMENTS

Developing our care model – our journey

Over the past four years we have been working with clinicians, staff, patients and carers to develop our health and care model.

The five main components of the model are:

1. Personalised care
Health and care professionals working together will support people with long-term physical and mental health conditions and complex needs to live well with their health conditions and take charge of their own care.

2. Healthier communities
We want people in every community across BSW to have the information, education, resources and support available so they can live their best life.

3. Integrated local teams
Local teams involving the NHS, community services, social and care workers and the third (voluntary) sector will work together in teams to provide what local people need.

4. Local specialist services
In the future, much more specialist health and care support will be available closer to where you live. Clinics that take place in hospitals today will be available in places like local health centres and on your local high street.

5. Specialist centres
Our hospitals will focus more on specialist care. Routine appointments and treatments will happen in community locations, online or over the phone. Hospitals will be for complex treatment and people who are seriously ill or injured. With less routine care happening at hospitals, specialist care will be less disrupted than it is today.

In this Plan we set out our recent progress in implementing our care model. This includes our new community contract with HCRG Group, our Integrated Care Alliances, our Hospitals' Group Model and our new diagnostic centres.

"The NHS needs to do more to join up the heath service and social care otherwise people get stuck in hospital because they don't have care at home."

Ten Year Plan workshop participant

Our care model

JOURNEY AND ACHIEVEMENTS

Some of our achievements across BSW in 2024

Transforming community services

The ICB's landmark decision to appoint HCRG Care Group as the lead partner for BSW ICB Integrated Community Based Services (ICBC) portfolio from April 2025 marks the start of a new and innovative approach to commissioning and delivery services in the community.

A new focus on community services means BSW can transform care and support for people at every stage of their lives with a focus on prevention and early intervention that will help people to manage their health proactively and stay healthier for longer.

Local people can expect to receive more health and social care in or near their homes, in a more joined up and streamlined way, embracing the concept of neighbourhood health.

Developing our All Age Mental Health Strategy

Working with partners, we have recently agreed our All Age Mental Health Strategy, recognising the growing number of both children and adults facing mental ill health.

The Strategy sets out a transformation roadmap for developing person-centred mental health services over the next five years, from pregnancy and birth, through childhood, adulthood and older adults.
The Strategy commits to ensuring timely access to high quality services for everyone and that people's voices and experiences are at the heart of how services are transformed.

Improving services through digital

BSW population's use of the NHS App continues to grow. In October BSW hit over 100,000 repeat prescriptions in a month and more than one million logins to the app.

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

Getting to know our communities

During 2024, BSW have gone further to reach directly into communities to understand their health needs through initiatives such as outreach to the Wiltshire Farming Community at the Salisbury Livestock Market.

BSW know that this outreach resulted in people getting much-needed, urgent medical care which they might not otherwise have sought – this support the essence of BSW to make a genuine difference to people's lives.

Improving our facilities

BSW have been able to invest in the facilities that house health and care services, with the green light given for Trowbridge Integrated Care Centre in November.

Capital investment in 'bricks and mortar' projects like these is not always easy to come by and along with the new community diagnostic centre in Swindon, and new builds at our acute hospitals, BSW are breathing new life into the fabric of our NHS.

JOURNEY AND ACHIEVEMENTS

Our hospitals' group model

"Working together, learning together, improving together"

In 2024, the Boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust agreed to form a Group, the purpose of which is to collectively provide high quality care for our population.

Through working as a Group, we can improve patient care and how we use our resources and help us to develop our ambitions to become anchor institutions. This follows years of increasingly close working as a provider collaborative called the Acute Hospital Alliance.

Our three Trusts have long acknowledged that we can achieve far more by collaborating than by operating independently. This includes working collaboratively with the ICB, local authorities and other partners, to deliver the priorities set out in the Integrated Care Strategy.

We are currently developing our leadership team and have appointed Cara Charles-Barks as Chief Executive of each of the three Trusts, and of our Group.

We are now setting up a Joint Committee and establishing a governance structure and operating model for our Group.

The key issues that have our immediate focus include:

- Improving access to **urgent and emergency care**, with a particular focus on reducing delays to ambulance crews safely handing their patients over to us
- Implementing a new shared **Electronic Patient Record**, so that patient records are shared between Trusts which helps ensure healthcare providers have instant access to accurate, up-to-date patient information, helping clinicians make decisions about patient care.
- Responding to the national **elective care** improvements outlined by the Government in January 2025 which will help patients get faster access to planned care

Becoming a Group also puts us in a better position to address some of our system challenges, make a shift away from a traditional acute hospital model to focus on prevention and primary and community care.

Over time, the care we deliver will reach new heights of excellence, transforming both patient outcomes and staff experiences. Our ambition is to set a standard of exceptional care across our system, eliminating variation and consistently achieving outstanding results.

JOURNEY AND ACHIEVEMENTS

Our new model for integrated community based care

At the centre of our care model is our ambition to develop integrated health and care services at neighbourhood and community level, so people have access to the support they need as close to home as possible.

From April 2025 HRCG Care Group will lead an innovative community based care partnership with the NHS, local authorities and charities that will transform care and support by providing more joined up health and social care in or near people's homes. We will be focused on delivering better outcomes for the people of BSW against the three objectives agreed in the BSW Integrated Care Strategy:

Focus on prevention and early intervention

By providing more services and support that catch illnesses and health conditions early to help people stay well and live independently for longer.

Fairer health and wellbeing outcomes

The new contract will ensure that services will be provided to meet the needs of local people, wherever they live.

Excellent health and care services

By developing thriving community-based services, we will reduce pressure on GPs and hospitals, helping reduce waiting times , joining up care pathways and making sure people get the right care, in the right place, at the right time.

We are going to transform care by:

- Building neighbourhood teams to support the health and care needs of specific communities utilising population health management approaches.
- Providing an all age single point of access for urgent clinical needs so people get the right care in the right place.
- Implementing family child health hubs to help join up care.
- Improving care pathways to help people avoid being admitted to hospital.
- Providing more specialist support in communities and primary care so people get care closer to home.
- Providing more specialist advice and support for people with a learning disability, autism or neurodiversity.

Underpinned by:

- Building a sustainable and innovative workforce so that we attract and keep enough of the right staff.
- Harnessing digital innovation to make the most of modern technology to improve health and care.
- Shifting funding and capacity into more community based care.

INTEGRATED CARE ALLIANCES

How we work in BSW – our Integrated Care Alliances

Role

BSW is made up of three 'places': Bath & North East Somerset, Swindon and Wiltshire.

In each area, health and care organisations work together as Integrated Care Alliances (ICAs) and are integral in delivering the vision on the ICB and the wider system.

As collaborative partnerships, ICAs bring together health, care, Local Authority, voluntary, and community sector organisations to improve outcomes, reduce inequalities, and promote the health and wellbeing of local populations.

ICAs focus on the integration of services to ensure residents receive joined-up, high-quality care that meets their needs.

By operating at a local level, ICAs are able to respond to the specific challenges and strengths of their communities while contributing to wider system goals.

Purpose

By working together, ICA partners ensure that services are:

- **Person-centred:** Seamless and accessible, enabling residents to receive the right care, in the right place, at the right time.
- **Focused on prevention:** Promoting early intervention to address issues before they escalate, improving long-term outcomes.
- **Aligned to tackle inequalities:** Addressing health disparities and ensuring equitable access to care for all parts of the population.
- Each ICA works in alignment with the Joint Strategic Needs Assessments (JSNAs), Health and Wellbeing Strategies, and the BSW Integrated Care Strategy. This ensures their priorities reflect both local population needs and system-wide ambitions.

Core responsibilities

- **Health and Care Strategy:** Develop local strategies to improve outcomes, informed by data and partner expertise.
- **Service Transformation:** Oversee integrated service delivery, quality, and resource use to meet local needs.
- **Tackling Inequalities:** Identify and address health disparities through targeted programmes.
- **Population Health Management:** Use data to design services that improve health and reduce inequalities.
- **Resource Alignment:** Oversee budgets, including the Better Care Fund, to support shared priorities.
- **Community Connections:** Link health and care services with voluntary and community partners for locally rooted support.

Governance and Accountability

ICAs operate as key components of the BSW ICS, providing a forum for senior decision-makers from NHS, local authority, and community partners to collaborate effectively. Each ICA is established as a formal partnership with robust governance arrangements.

Decisions are made collectively, with members working towards shared goals that benefit local populations. Regular reporting ensures accountability to the Integrated Care Board (ICB) and relevant sub-committees, local Health and Wellbeing Boards, and partner organisations.

What This Means for Our Residents

ICAs ensure that health and care services are more integrated, making them easier to navigate and more effective in meeting the needs of local populations.

Their focus on prevention, tackling inequalities, and using shared resources means better long-term outcomes and fairer access to services for everyone.

INTEGRATED CARE ALLIANCES

Priorities for our ICAs

Below we highlight three key programme areas for each ICA in 2025/26, aligned with the goals of prevention, reducing inequalities, and excellent care. These priorities represent a focus within the broader scope of ICA activities, which encompass extensive efforts to improve outcomes, tackle local challenges, and deliver the Integrated Care Strategy.

B&NES Priorities

- **Children and Young People (CYP) emotional health and wellbeing;** Developing resources on emotional health and wellbeing support, to include training tools and sustainable model of delivery, for use by colleagues working with CYP in the community.
- **Addressing the needs of 18-25 year olds;** who are not in education, training or employment, to access support and experience to develop healthy lives.
- **Integrated Neighbourhood Teams;** expanding and extending the current model in partnership with primary care and the ICBC service. Initially focussing on frail individuals.

Swindon Priorities

- **CYP emotional health and wellbeing;** offering practical support for families waiting for mental health appointments.
- **Children's Oral Health;** prevention of avoidable dental extractions in CYP. Aiming to support families with high levels of dental decay and previous extractions.
- **Working together to support all adults not in employment or training;** helping them build healthy lives. Improving health outcomes by creating pathways for employment and skills development, fostering long-term opportunities for growth and wellbeing.

Wiltshire Priorities

- **CYP emotional health and wellbeing;** development of a work plan following a comprehensive schools survey and the March joint Wiltshire Summit on improving CYP Emotional Wellbeing.
- **Children's Oral Health;** a multiagency approach to improving CYP oral health including training programmes, a dental health equity audit and other priority actions. Aiming to reduce avoidable CYP dental extractions.
- **Integrated Neighbourhood Teams;** working alongside the ICBC service to further progress and develop the Wiltshire Collaboratives, integrating the approaches.

OUTCOMES FRAMEWORK

BSW System Outcomes Framework

Why do we need an Outcomes Framework?

The way we deliver health and care across Bath and North East Somerset, Swindon and Wiltshire (BSW) is changing. We know that delivering more care is not the same as delivering better care.

What truly matters is the impact that services have on people's health, wellbeing and quality of life. That is why we have developed the system Outcomes Framework.

It is a way to ensure that every decision we make and every pound we spend delivers the best possible outcomes for our communities.

What is the BSW System Outcomes Framework?

Our Outcomes Framework is a set of clear, measurable goals that help us track how well our health and care system is meeting the needs of local people.

Instead of just measuring activity, like the number of hospital appointments, we focus on real world improvements such as are people living healthier, longer lives? Do patients feel supported in managing their conditions? Are we reducing inequalities in health across different communities?

By focusing on what truly matters to individuals, families and communities, we can work together to improve the health and wellbeing of everyone in BSW.

We have identified 20 indicators for which national data is available, as well as supplementary local outcomes that will allow us to further segment these outcomes by age (CYP and adult), gender, ethnicity, deprivation, SMI and PLD. More detail on this can be found in the Companion Document.

How we developed the framework?

We created the BSW System Outcomes Framework through a collaborative process building on feedback we received about our initial outcomes work. This included reviewing the existing data and evidence, identifying key areas where we can make the biggest impact; developing a structured approach – ensuring that selected outcome measures are clear, measurable and meaningful; testing and refining – learning from real-world use and continuously improving how we measure success.

We recognise that some important outcomes cannot yet be measured due to data limitations. When this is the case, we have either identified a proxy indicator to use while we develop an outcome measure and/or included them as placeholders in our companion document. Over time we will work to improve data collection and reporting enabling us to track these outcomes more effectively in the future.

For each outcome we have identified a national metric and a local metric. The national metric provides the opportunity to benchmark BSW to other ICBs and Local Authorities. The local metric enables more frequent and timely reporting and segmentation by place and inequalities groups. This provides the opportunity to monitor trends and explore inequalities.

What next?

The 2025/26 Implementation Plan marks the next phase of embedding the Outcomes Framework into everything we do. This is just the beginning – our framework will continue to evolve, ensuring we remain focussed on delivering the best possible health and care for all.

By continuously improving how we measure success, investing in better data and keeping outcomes at the heart of our decision making, we will drive meaningful change for our communities.

OUTCOMES FRAMEWORK

Outcomes Framework

	National indicator (Local indicator if different)
Key Outcomes	
1	Life expectancy at Birth (Years of life lost)
2	Healthy expectancy at 65 (Average age entering frailty)
3	Emergency bed days
Contributory Outcomes	
4	Infant Mortality/ Pre-term births (Years of life lost from child deaths)
5	Under 75 mortality rates for major conditions (Years of life lost for major conditions)
6	Dementia Diagnosis Rate (GP recorded dementia prevalence)
7	Premature mortality in adults with SMI (Years of life lost with SMI)
8	Admissions for self-harm
9	Population employment inactivity
10	Staff Survey engagement score

Continued on next page...

OUTCOMES FRAMEWORK

Outcomes Framework

	National indicator (Local indicator if different)
Contributory Outcomes	
11	ICS organisation leavers rate
12	Percentage of patients reporting they have a care plan/ care plan is helpful (Number of Care Plans recorded on Integrated Care Record)
13	Percentage of deaths in hospital
14	School readiness
15	Smoking prevalence
16	Obesity prevalence
17	Physical inactivity prevalence
18	Admissions for alcohol specific conditions
19	MMR vaccination rates/ Flu vaccination rates
20	Hospital admissions for dental decay

OUR STRATEGIC OBJECTIVES

Our strategic objectives – Overview

We have four strategic objectives agreed across the system. As part of developing our Implementation Plan this year, we have taken on board feedback from stakeholders that we need to be targeted in our priorities. We have therefore set out five key priorities and two enablers. These are the things that we believe will make the most difference for our local patients and citizens in the coming years and ensure that we deliver on our strategic objectives.

Strategic Objectives	Key Priorities
1. Focus on prevention and early intervention	**1.** Increase our focus on prevention, improve timeliness of access and expand diagnostic and preventative care
2. Fairer health and wellbeing outcomes	**2.** Reducing healthcare inequalities in our localities and our system
3. Excellent health and care services	**3.** Implement the vision set out in the NHS elective reform plan by redesigning our elective services, improving access and outcomes for our population **4.** Improve our urgent and emergency care services providing the right care at the right time in the right place
4. Financial recovery and sustainability	**5.** Deliver our medium term financial plan and return to financial balance
Enablers	
Workforce	**Digital**

OUR STRATEGIC OBJECTIVES

Strategic Objective: Focus on prevention and early intervention

Priority 1:
Increase our focus on prevention, improve timeliness of access and expand diagnostic and preventative care.

Why is this important?

Helping people to manage their lives to prevent ill health, ensuring they can access care closer to home and earlier in their care are key aspects of our BSW Care Model. This includes a focus on prevention for children and young people. By prevention and early intervention we can help people live longer, healthier lives and ensure our resources are used where they have the greatest impact. Through using data and local knowledge about our population we can personalise care and target our efforts on those who need it most.

What have we achieved in 24/25?

We have made progress on number of important initiatives:

- Prevention is a key system priority. This includes our approach to mental ill health prevention and our weight loss strategy helping people to maintain a healthy weight.
- Our Treating Tobacco Dependency Service is being embedded across our acute, mental health and maternity services, helping people to quit smoking.
- We developed an approach to improve early detection and optimise management of hypertension, laying the foundations for better cardiovascular health outcomes.
- We have strengthened our Community Vaccination Hub model, ensuring targeted Covid 19 and flu vaccinations for priority groups.
- We have opened up three new diagnostic centres (in Bath, Swindon and Salsbury) providing services such as such as X-rays, MRI and CT scans, blood tests, ultrasounds and endoscopies, in the community.
- We have awarded the contract for integrated community services to HRCG Care Group.

What are we doing next?

- Delivery Groups are the mechanism for implementing actions across the system. Each Delivery Group will take responsibility for delivering targeted prevention actions, including those linked to hypertension, weight management and mental health prevention.
- Through this work we are ensuring prevention remains a key system priority. This includes implementing our hypertension case management service, developing our approaches to mental health prevention and launching our weight loss strategy, supporting individuals and communities to achieve and maintain a healthy weight.
- We are increasing access to primary care including dental services as well as working to ensure that good oral health is maintained for our CYP.
- We will further reduce the number of people who smoke by expanding our stop smoking services across partner organisations.
- Developing our work in anchor institutions.
- We will form integrated neighbourhood teams with greater focus on earlier intervention.
- Boosting our uptake of vaccinations.
- We are planning to further expand our community diagnostic centres offering.

What difference will we make?

- Reduction in smoking and obesity prevalence.
- Increase in Personal Wellbeing scores and decrease in admissions for self-harm.
- Reduction in under 75 mortality and years of life lost from Cardiovascular Disease.
- Increase in percentage of patients reporting they have a care plan.
- Improved life expectancy through early diagnosis of disease.
- Maintenance of high levels of flu vaccination rates.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Fairer health and well being outcomes

Priority 2:
Reducing health inequalities in our localities and our system.

Why is this important?

Inequalities are unfair and avoidable differences that can impact health across different communities driven by factors such as education, housing, employment, ethnicity and access to health services and programmes.

Core20PLUS5 is a national NHS England approach to reduce healthcare inequalities at both national and system level. Core20 refers to the most deprived 20% of the national population. PLUS refers to ICS chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone. '5' refers to five clinical areas of focus which require accelerated improvement.

1. Maternity
2. Severe mental illness (SMI)
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension

Across BSW these include people (children and adults) from ethnic minority, gypsy, Roma and traveller and rural communities, homeless people and people living with severe mental illness.

What have we achieved in 24/25?

- Invested £1.7 million in 35 place-based projects that tackle inequalities in Core20Plus population and the wider determinants of health that lead to these.
- Through the Maternity Delivery Group targeted projects to reduce inequalities have been delivered, including: Improving accessibility to maternity services for Gypsy, Roma, Traveller, Boating, and Showman communities, ensuring services reflect population needs and co-producing 12 "Hello Baby" maternity and neonatal videos, supporting parents through pregnancy and birth, with subtitles available in 10 different languages.
- Through the Babies, Children and Young People Delivery Group, the CORE20PLUS5 framework has been used to identify the most vulnerable children and young people in our communities. The Strategic Intelligence Team is supporting to integrate reports and datasets, enabling the Delivery Group to track health outcomes and pinpoint areas for improvement.

What are we doing next?

- Investment of a further £1.7 million in place-based projects with a more targeted focus on Core20plus5 clinical areas. We will report on the impact of this investment in 25/26.
- Each Delivery Group has developed a specific priority in conjunction with the Inequalities Strategy Group in relation to reducing inequalities for 25/26. We will be measuring progress against completion and impact of these priorities (see Companion document for further detail).
- We are also working to increase our understanding of our population health data in respect to health inequalities.

What difference will we make?

- Reduced inequalities in infant mortality and pre-term births.
- Increase percentage of children who feel they have healthy ways to manage difficult feeling in Core20plus populations.
- Improved personal wellbeing scores (life satisfaction, worthwhile, happiness, anxiety) in Core20plus populations.
- Reduction in adults who feel lonely always, often or some of the time in Core20plus populations.

Example

The Salisbury Livestock Market pilot brought together health and wellbeing services in a setting familiar to the farming community. By providing health checks, mental health advice, and signposting to local services, the pilot helped to break down barriers to healthcare access in this often hard-to-reach group.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Excellent health and care services

Priority 3:
Implement the vision set out in the NHS elective reform plan by redesigning our elective services, improving access and outcomes for our population.

Why is this important?

Across BSW, almost 2000 people are waiting more than a year for an appointment, which is too long and which we are working to address. We know that there is continued variation in provision across our footprint and we need to address this too so that we secure the best possible health and care outcomes for our population.

We also need to ensure that we are providing timely access for people to elective care so that they do not get worse whilst waiting.

Alongside improving access to planned care services, we also need to ensure that we continue to provide early access to cancer services and that our diagnostic pathways are as rapid as possible to enable early diagnosis and intervention to support recovery.

What have we achieved in 24/25?

- Reduced waiting times so that no-one in BSW will wait longer than 65 weeks by March 2025.
- Increased elective activity so that more people have had access to treatment.
- Improved access to diagnostics, delivering planned reductions in diagnostic waiting times.
- Commenced work on pathway transformation in core areas.

What are we doing next?

- Implementation of new diagnostics capacity across the system to support earlier diagnosis for cancer and non-cancer related conditions.
- Prioritise service redesign of the five specialities identified in the NHS Elective Reform Plan: Cardiology, ENT, Gastroenterology, Respiratory and Urology.
- Cutting waiting times further by:
  - Reviewing 'first to follow up ratios' for all specialties so that patients only get a second outpatient consultation if they really need it and ensuring that we are following best practice guidance.
  - Meeting and sustaining an 85%-day case activity rate across all providers so as many patients as possible do not need an overnight hospital stay.
  - Maximising the use of advice and guidance whereby GPs can get expert input from a consultant before referring a patient to an outpatient appointment.
  - Further roll out of Robotic Process Automation (RPA) across outpatient services to support efficient booking processes.
  - Implementation of Patient Engagement Portal (PEP) to enable patients to manage their own outpatient appointments and booking.

What difference will we make?

Improved health gain from elective interventions through the following:

- Ensuring that greater than 65% of people on our waiting list wait 18 weeks or less for treatment across all three providers.
- Improving access to diagnostics to support earlier intervention for people with suspected cancer – reducing mortality across all populations.
- 30% of outpatient referrals from GPs benefit from advice and guidance from a specialist consultant.

Example

The Sulis Elective Orthopaedic Centre (part of the Royal United Hospitals Bath family), opened in late 2024, provides capacity for 3,750 orthopaedic NHS patients every year across BSW and beyond. Facilities at the Centre will include two new modular theatres, additional inpatient beds, and the conversion of two existing theatres to laminar flow theatres.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Excellent health and care services

Priority 4:
Improve our urgent and emergency care services providing the right care at the right time in the right place.

Why is this important?

Over the past year we have continued to see an increase in demand for urgent and emergency services and high levels of pressure on our ambulance service, emergency departments and acute hospitals.

It is important that people needing emergency or urgent care are treated swiftly and appropriately and to do this we need to make sure they are treated in the right place, with access to care as close to home as possible.

This means utilising the most appropriate primary care setting for each patient; such as a consultation within community pharmacy rather than GP practice where appropriate.

What have we achieved in 24/25?

- Increased the number of 'virtual ward' beds so that more people can be treated in their own homes.
- Through our Care Coordination approach, diverting patients to out of hospital services when appropriate.
- Worked to decrease the number of patients in hospital beds who no longer need to be there for medical care.
- Improved the way we work together across the system so that systems and processes are not causing unnecessary delays.

What are we doing next?

Reduction in emergency bed days through doing the following:

- Identify more opportunities to divert patients (when appropriate) away from urgent and emergency care services through urgent care response, expanding our care co-ordination approach and other care pathways closer to home.
- Improve and expand our 'hospital at home' service.
- Expand our Same Day Emergency Care offer in our hospitals.
- Further improvement work to reduce our acute mental stay and discharge patients when they are clinically ready.
- Ensure universal access to mental health support through patients ringing 111 and choosing option 2.
- We will be opening a new mental health unit for people with a learning disability or autism in early 2026.

What difference will we make?

- Reduction in the overall number of people attending emergency departments.
- Increase in the number of people being treated in virtual ward settings rather than in hospital to avoid a further 30 hospital admissions a month.
- Decrease ambulance journeys to hospital via the Care Co-ordination approach by a further 25 a month.
- Discharging people from hospital more quickly so freeing up 152 beds in 25/26.

Example

In 24/25 we worked to increase numbers of GP referrals to pharmacies, and the growing number of consultations (65,000K in October 2024). BSW has the second highest rate of GP referrals per 100K population in England.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Financial recovery and sustainability

Priority 5:
Deliver our medium term financial plan and return to financial balance.

Why is this important?

Ensuring that we can live with our means is an important priority because this demonstrates that we are using our funding wisely, and to deliver the best value for our population.

It is part of delivering on the triple aim of high quality, efficient services that deliver improved outcomes for our population. This is a key duty of ICBs, hospitals and the wider health system. As with all other health systems across the NHS, we are facing increasing demands for our services with a population which is growing older and in greater need and have to manage this within our allocated resources.

What have we achieved in 24/25?

In the financial year 24/25 we submitted a deficit budget. Over the past year we have developed a medium term financial plan across our NHS partners to set out how we are going to return to financial balance. This has involved identifying opportunities for partnership working to increase our scope for delivering savings through collaboration.

What are we doing next?

For 2025/26, we continue to face significant underlying deficit challenges in the order of £100m, which have been mitigated from a series of one-off measures and deferrals of spending commitments through 2024/25.

Tackling these challenges will require us to continue to postpone, mitigate and minimise new spending against planning commitments and against the underlying demographic and demand challenges across our ICS population.

Our delivery approach seeks to address this credibly and robustly. We will:

- Build on our delivery progress with substantive efficiency savings and cost controls.
- Aim once again for stretching levels of further efficiency, transformation and cost containment savings in 2025/26 and 2026/27. These will amount to £89m of in-year savings delivery in 2025/26, including £75m of new full-year efficiency programmes, built up across organisation-level transactional savings; continuing productivity drive across planned care; and benefits delivery from a range of continuing system-wide programmes.
- Work together across the system to make best use of our capital and our pooled funds, as appropriate.

These stretching levels of delivery will mitigate the underlying deficit in 2025/26 . The delivery plan then aims to reach the stability of full financial balance in 2026/27.

What difference will we make?

- Release funds to invest in secondary prevention, reducing waiting lists and improving outcomes.
- Greater levels of productivity and efficiency.
- Reduced regulatory oversight.

ENABLERS

Our enablers: Workforce

Why is this important?

The health and care workforce is its greatest asset but also presents the biggest challenge.

Workforce and skills shortages have an impact on how we deliver many of our services now and for the future. We need to ensure that we have the right workforce so that we can recruit and retain a talented workforce that are able to thrive with rewarding careers.

What have we achieved in 24/25?

- Roll out of a workforce transformation tool for identifying new skills and ways of working needed in health and care settings.
- Successful implementation of Oliver McGowan Mandatory Training on Learning Disability and Autism Training.
- Reduction in the usage of NHS temporary staffing.
- Extension of a NHSE project for increasing diversity in research with the set up of a research network with over 100 active members.
- In partnership with Skills for Care completion of leadership programme for domiciliary care registered managers.
- A range of primary care workforce development programmes.
- Implementation of a new toolkit for supporting employment of care leavers aged between 16-25 years.

What are we doing next?

- Reducing our use of and expenditure on temporary staffing.
- Recruitment to high cost and hard to recruit roles.
- Development of an integrated work and health pathway for supporting people with long term conditions access to good work.
- Implementation of workforce models for enabling new models of care closer to neighbourhoods and communities.
- Improving the equality, diversity and inclusion of our workforce.

What difference will we make?

- Look for opportunities to work more closely with our social care and other partners.
- Removal of all expensive off-framework agency usage.
- Reduction in use of temporary staffing.
- Improved workforce planning efficiency.
- Improved staff satisfaction.
- Workforce models built around the needs of communities.
- Reduction in population employment inactivity.
- Improved staff survey engagement scores and reduction in ICS organisation leavers rates.

Example

During the year we delivered a Department of Education funded project for supporting numeracy skills across Wiltshire with individual staff gaining a new maths qualification and engagement events for staff offering support and coaching for numeracy skills.

Through this 40 individuals gained new maths qualifications to support career development.

"The NHS should do more to invest in staff, they are definitely its most important asset."

Ten Year Plan workshop participant

ENABLERS

Our enablers: Digital

Why is this important?

Making better use of technology, also referred to as moving from analogue to digital, is a crucial element of plans to make the health service more efficient, safer and provide a better patient experience. Digital, Data and Technology across the ICS are also enablers for the other two shifts we are being asked to focus on (moving care from hospitals to the community, shifting from treatment to prevention).

What have we achieved in 24/25?

- The Electronic Patient Record (EPR) programme is now in the implementation phase. This will bring our three acutes onto a single digital system creating consistency and supporting our increasing collaboration.
- We have increased the number of partners using our shared care record and increased its use, meaning that health staff have access to a single set of records for patients.
- We have increased the usage of the NHS App.
- We have increased cloud based telephony within GP practices which reduces patient waiting times and increases satisfaction.
- We have continued to ensure strong cyber security is in place with increased system wide working including the creation of a system wide Cyber Tactical Advice Cell (CTAC) and ICS wide cyber exercises.

What are we doing next?

- We are refreshing our digital strategy to take account of the national priority of moving from analogue to digital, and ensure we have a joined up approach to population health management.
- We will carry out further work to explore the use of AI tools in various setting including primary care to understand the benefits and productivity these can bring.
- We will continue maturing our ICS cyber capabilities and refresh our ICS Cyber strategy including learning from our ICS wide cyber exercises.
- We will be working to expand the use of the NHS App, and look for further opportunities to use electronic means of communication.

What difference will we make?

- Use of the NHS App is currently at 59%. We aim to increase it to 75% by 26/7.
- Logins to the App are currently at 1 million a month. We aim to increase this to 1.5 million. Log-ins are even more important than uptake in that they show people are actively using the App.

Example

Example: We piloted an innovative satellite solution to address connectivity challenges in rural GP sites. The “office-in-a-box” system ensures seamless internet access during outages or in temporary medical locations.

A live test in November at a site with a planned outage tested the solution in a real-life situation. After the test, the GP partner commented: “Virtually indistinguishable from the normal setup. We wouldn’t have known it was a satellite connection”.

“I’m more than happy to use the NHS App. It makes ordering repeat prescriptions so easy”

Ten year Plan workshop participant

MEASURING PROGRESS

We are committed to working together to deliver the priorities within this Implementation Plan. Overall accountability for the plan rests with BSW Integrated Care Board.

The Board brings together partner trusts and primary care with wider system partners including our three local authority partners.

Governance and oversight for the delivery of this plan is as follows:

Delivery via ICS Delivery Groups

Our Delivery Groups have overall accountability for delivering the priorities set out here.

Each Delivery Group has a Senior Responsible Officer and we are working to align clinical leadership to these groups and make sure that these groups contain the right representation from across our partnership.

Oversight via Executive structures

We will be expanding the remit and membership of our System Planning and Delivery Executive group in 2025 to ensure it is more representative of our partnership. Population Health Board will continue to carry out oversight of our priorities in relation to outcomes and inequalities.

Accountability via BSW Integrated Care Board

We will report regularly to the Board and our Integrated Care Partnership on progress against the priorities set out here.

Oversight of ICA Priorities will also be reported via the Board for completeness, however our local Health and Wellbeing Boards have the primary role in overseeing delivery of ICA priorities.

Bath and North East Somerset, Swindon and Wiltshire Together

Published March 2025

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	11
Date of Meeting:	20 March 2025		

Title of Report:	Delegation of Specialised Commissioning from 1 April 2025
Report Author:	Mark Harris, Director of Business Support
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	Appendix 1 – Specialised Commissioning Delegation Scope

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	X
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	X
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
ICB Executive Management Committee	16/10/24	Discussion/Assurance
ICB Board Development Workshop	17/10/24	Discussion
ICB Finance & Investment Committee	6/11/24	Discussion / Assurance
ICB Commissioning Committee	11/2/24	Decision (Recommendation to Board)

1	Purpose of this paper
The purpose of this paper is to agree sign off of NHS England requirements of ICBs related to the delegation of Specialised Commissioning (Green Services) from 1/4/25.	

2	Summary of recommendations and any additional actions required

The Board is *asked to: -*

Note previous agreement at the November Board to the Principal Commissioner model supporting these arrangements and that this has now been confirmed as Somerset ICB.

- **Note** the supporting arrangements and documentation for delegation arrangements set out in 4.4
- **Note** the Executive Management Team will sign the required delegation and collaborative documents (as previously agreed).
- **Agree** to the change in SRO for the delegated role set out in 7.3
- **Agree** to the delegation of specialised commissioning responsibilities from 1st April 2025.

3	Legal/regulatory implications

The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 sets out NHS England's responsibility to arrange all reasonable requirements for the provision of specialised services. This was amended by the 2022 Health and Care Act, Section 2, which details NHSE requirement to commission specialised services.

The services were set out in the Manual for Prescribed Specialised Services 2018/19.

4	Risks

This report does not currently link to any existing risks on the Corporate Risk Register.

- The Central Commissioning Hub working to the Principal Commissioner will review all risks on a monthly basis and these will be presented to the Joint Committee.
- The financial allocation at ICB level is not finalised for Mental Health /LDAN elements and will be subject to change in 25/26 after delegation has occurred.
- There is a risk that should the ICB be designated as SOF 3 or 4, that the delegation conditions will remove the decision-making responsibilities of the ICB in relation to these services. This is assessed as low risk at this stage as there are no live changes proposed or in discussion by the ICB to current arrangements.
- There is a risk that unless the ICB works effectively with the CCH and through the Joint Committee, that we will not make improvements to the way that care is delivered to our population as a result of these changes. This will need to be worked through with the CCH over the next few months.

5	Quality and resources impact
Finance : The ICB allocation for delegated specialised commissioning services for 25/26 is £209,991,156 (Total South West allocation is £1,496,315,583) Workforce: The current NHSE team will remain as a resource to support the activities.	
Finance sign-off	Barry Young, Associate Director of Finance

6	Confirmation of completion of Equalities and Quality Impact Assessment
No EQIA has been completed as this paper relates to a change in commissioning responsibilities. Quality assurance arrangements have been part of the Safer Delegation Checklist completed by NHSE.	

7	Communications and Engagement Considerations
No communications and engagement considerations have been identified in relation to the delegation process as there are no proposed service configuration changes set out within the delegation arrangements. However, Public and Patient engagement legal obligations in relation to these services will be followed in relation to any service proposals discussed by the Joint Committee.	

8	Statement on confidentiality of report
This paper is not confidential.	

Delegation of Specialised Commissioning from 1/4/25

1. Introduction

1.1 This paper follows on from the Board agreement in November 2024 to confirm its commitment to the planned delegation of commissioning responsibility for the defined list of specialised commissioning to ICBs from 1st April 2025.

1.2 A Board development session also took place on 17th October 2024 to discuss the scope of delegation, and the development of the principal commissioning model proposed for the South West region.

1.3 The Commissioning Committee reviewed the progress on 11th February 2024 and agreed to recommend to the ICB Board the sign off of delegation of specialised commissioning responsibilities alongside the proposed principal commissioner, and joint commissioning arrangements across the South West region.

1.4 There are 175 specialised services. These are set out in the Prescribed Specialised Services Manual[1]. (Note that there are less than 175 service specifications in the manual as some cover multiple service lines). These cover a large range of services including specialised cancer and cardiac services, Neonatal services, and Adult Critical Care.

1.5 NHSE set out its intentions to delegate specialised services to Integrated Care Systems in the Roadmap for Integrating Specialised Services within Integrated Care Systems in May 2022.[2]

1.6 The initial intention was for all ICBs to take on delegation of fifty-nine services from 01/04/24 and work was undertaken to prepare for that transfer of responsibility.

1.7 Subsequently the seven ICBs in the South West collectively agreed to request that the transfer date was deferred to 1/4/25. This was agreed by the NHSE Board in December 23. Three regions did undertake the transfer on 14/24 with the remaining four regions agreed to be a second wave.

1.8 The South West Region has continued with the Joint Committee arrangement of ICBs working with the NHSE regional team in relation to specialised commissioning throughout 2024.

1.9 The full scope of services to be delegated is attached as Appendix 1.

2. Proposed commissioning model

2.1 The agreed commissioning model is a Principal Commissioner Model which has been recommended by the Joint Committee. A fundamental driver for this model being worked up was the DHSC accounting rules that only allow for financial risk sharing if the budget is hosted by a single organisation.

2.2 The key features of this model are: -

[1] https://www.england.nhs.uk/wp-content/uploads/2017/10/PRN00115-prescribed-specialised-services-manual-v6.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf

2.2.1 There is a budget risk share arrangement across the region as a whole.

2.2.2 The risk sits with the Principal Commissioner (they cannot ask for top ups to the budget in year). Conversely there is no flow back of surpluses to ICBs and any surpluses can be directed by the Joint Committee as part of its mandate and flowed to providers within systems.

2.2.3 All ICBs maintain the ability to participate in decision making at a strategic level by setting an annual mandate through the Joint Committee.

2.2.4 A Central Commissioning Hub (CCH) of current NHSE staff manage the portfolio on a day-to-day basis accountable to the Principal Commissioner, who is in turn directed by the mandate set by the Joint Committee. This allows flexibility of day-to-day commissioning matters to be managed by the CCH team.

2.2.5 The arrangement reduces the administrative burden on individual ICBs from delegation.

2.3 It should be noted that for acute services, contracts are held with individual providers, whereas for mental health and learning disability services there are lead provider arrangements.

2.4 Somerset ICB has been confirmed as the Principal Commissioner and will host the CCH team.

3. Delegation conditions

3.1 NHSE has set out four developmental conditions attached to the arrangements that will remain in force until removed by NHSE. These are enforceable requirements, which if breached would entitle NHSE to intervene directly in relation to delegated responsibilities.

3.1.1 Delegated budgets will be ringfenced to be spent on only specialised services. Any proposed variation to this arrangement would need to be approved by the NHSE South West Managing Director and Director of Finance.

3.1.2 All delegated services must be managed within the Principal Commissioner Model.

3.1.3 ICBs will be required to hold a contingency within the specialised commissioning budget of at least 0.5%.

3.1.4 If the ICB at any point is or becomes designated as SOF 3 or 4, NHSE will hold veto powers over any decisions it makes in relation to specialised commissioning.

3.2 Any proposed variations to the first three conditions would need to be approved by the NHSE South West Managing Director and Director of Finance.

3.3 The ICB Board in November 2024 agreed to these conditions noting the change outlined in 3.1.4

4. Safe Delegation Checklist and ICB requirements

4.1 A national delegation checklist has been produced and managed by NHSE regional colleagues as most actions sit with NHSE in providing documentation to evidence the delegation discussions with ICBs.

4.2 The ICB must continue to hold the Joint Committee as a Board sub-committee and receive reporting on Specialised Commissioning. This will also be covered as a topic area for assurance at the ICB Commissioning Committee going forward.

4.3 Complaints will be handled by the Somerset ICB hosted CCH complaints team.

4.4 In support of the delegation arrangements within the region the following documents have been produced and reviewed by the Joint Committee: -

- 4.4.1 Operational Arrangements document
- 4.4.2 Legal and Compliance handover report
- 4.4.3 Finance Standard Operating Procedure
- 4.4.4 Quality Framework
- 4.4.5 Risk Framework
- 4.4.6 Joint Committee Terms of Reference
- 4.4.7 Safe Delegation Checklist (Plus) – National checklist process with NHSE regions
- 4.4.8 Transition Plan

4.5 The ICB is required to send a letter of acknowledgement of the arrangements within those documents by 27th March 2025.

4.6 The ICB is also required to sign the Delegation Agreement, Collaboration Agreement and Information Governance Document. The Board has previously delegated responsibility to sign these agreements to the Executive Management Team.

4.7 The ICB is required to make updates to governance arrangements to reflect delegation as follows: -

- 4.7.1 Scheme of Reservation and Delegation - Update to record that the entirety of the delegated specialised portfolio, functions, powers and allocations has been further delegated to the Principal Commissioner.
  - 4.7.1.1 Update required: Decision-making regarding the commissioning and planning of the delegated specialised portfolio (inclusive of those portfolios received from other ICBs) has been delegated from the Principal ICBs Board to the Joint Committee.
  - 4.7.1.2 Update required: Operational management decisions relating to the delegated specialised portfolio which are not reserved to the Joint Committee in its Terms of Reference have been delegated from the Principal ICBs Board to the Central Commissioning Hub (CCH).
- 4.7.2 SFIs - The financial allocation is already fully transferred to the Principal Commissioner and the ICB retains no residual financial control.
  - 4.7.2.1 Update required: Update to reflect the authority/ approval limits of the CCH and of other staff within the CCH.

5. Risks

5.1 The Central Commissioning Hub working to the Principal Commissioner will review all risks on a monthly basis and these will be presented to the Joint Committee.

5.2 The financial allocation at ICB level is not finalised for Mental Health /LDAN elements and will be subject to change in 25/26 after delegation has occurred.

5.3 There is a risk that should the ICB be designated as SOF 3 or 4, that the delegation conditions will remove the decision-making responsibilities of the ICB in relation to these services. This is assessed as low risk at this stage as there are no live changes proposed or in discussion by the ICB to current arrangements.

5.4 There is a risk that unless the ICB works effectively with the CCH and through the Joint Committee, that we will not make improvements to the way that care is delivered to our population as a result of these changes. This will need to be worked through with the CCH over the next few months.

6. Next steps

6.1 ICB Chief Executive to send an acknowledgement letter of arrangements and supporting documents set out in 5.1 by 27th March 2025.

6.2 ICB Executive Management Team to agree and ICB Chief Executive to sign Delegation Agreement, Collaboration Agreement and Information Governance Documents by 27th March 2025.

6.3 Handover of SRO responsibility with ICB from Chief Delivery Officer to Interim Executive Director of Place – Wiltshire / Interim Executive Lead for Community, Planned Care and Cancer from 1st April 2025.

7. Recommendations

7.1 The ICB Board is asked to: -

7.1.1 **Note** previous agreement at the November Board to the Principal Commissioner model supporting these arrangements and that this has now been confirmed as Somerset ICB.

7.1.2 **Note** the supporting arrangements and documentation for delegation arrangements set out in 4.4

7.1.3 **Note** the Executive Management Team will sign the required delegation and collaborative documents (as previously agreed).

7.1.4 **Agree** to the change in SRO for the delegated role set out in 7.3

7.1.5 **Agree** to the delegation of specialised commissioning responsibilities from 1st April 2025.

APPENDIX 1

Specialised Commissioning - Service Portfolio Analysis (SPA) Detail

Service Line Code	ACUTE/MH	Delegation End State 2025/26	Service Line Description	Programme of Care (PoC) Category	Manual No.	Manual Description
NCBPS01C	ACUTE	GREEN	CHEMOTHERAPY	B02 - CHEMOTHERAPY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01J	ACUTE	GREEN	ANAL CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01K	ACUTE	GREEN	MALIGNANT MESOTHELIOMA (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01M	ACUTE	GREEN	HEAD AND NECK CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01N	ACUTE	GREEN	KIDNEY, BLADDER AND PROSTATE CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01Q	ACUTE	GREEN	RARE BRAIN AND CNS CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01R	ACUTE	GREEN	RADIOTHERAPY SERVICES (ADULTS)	B01 - RADIOTHERAPY	94	RADIOTHERAPY SERVICES (ADULTS AND CHILDREN)
NCBPS01S	ACUTE	GREEN	STEREOTACTIC RADIOSURGERY / RADIOTHERAPY	B03 - SPECIALISED CANCER SURGERY	94	RADIOTHERAPY SERVICES (ADULTS AND CHILDREN)
NCBPS01T	ACUTE	GREEN	TEENAGE AND YOUNG ADULT CANCER	B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	106	SPECIALIST CANCER SERVICES FOR CHILDREN AND YOUNG ADULTS
NCBPS01U	ACUTE	GREEN	OESOPHAGEAL AND GASTRIC CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01V	ACUTE	GREEN	BILIARY TRACT CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01W	ACUTE	GREEN	LIVER CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01X	ACUTE	GREEN	PENILE CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01Y	ACUTE	GREEN	CANCER OUTPATIENTS (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS01Z	ACUTE	GREEN	TESTICULAR CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS02Z	ACUTE	GREEN	HAEMATOPOIETIC STEM CELL TRANSPLANTATION SERVICES (ADULTS AND CHILDREN)	F01 - BLOOD AND MARROW TRANSPLANTATION	29	HAEMATOPOIETIC STEM CELL TRANSPLANTATION SERVICES (ADULTS AND CHILDREN)
NCBPS03C	ACUTE	GREEN	CASTLEMAN DISEASE	F02 - SPECIALISED BLOOD DISORDERS	103A	SPECIALIST ADULT HAEMATOLOGY SERVICES
NCBPS03X	ACUTE	GREEN	SPECIALIST SERVICES FOR HAEMOPHILIA AND OTHER RELATED BLEEDING DISORDERS (ADULTS)	F02 - SPECIALISED BLOOD DISORDERS	132	SPECIALIST SERVICES FOR HAEMOPHILIA AND OTHER RELATED BLEEDING DISORDERS (ADULTS AND CHILDREN)
NCBPS03Y	ACUTE	GREEN	SPECIALIST SERVICES FOR HAEMOPHILIA AND OTHER RELATED BLEEDING DISORDERS (CHILDREN)	F02 - SPECIALISED BLOOD DISORDERS	132	SPECIALIST SERVICES FOR HAEMOPHILIA AND OTHER RELATED BLEEDING DISORDERS (ADULTS AND CHILDREN)
NCBPS04A	ACUTE	GREEN	SEVERE ENDOMETRIOSIS	E09 - SPECIALISED WOMENS SERVICES	58	SPECIALIST ADULT GYNAECOLOGICAL SURGERY AND URINARY SURGERY SERVICES FOR FEMALES
NCBPS04C	ACUTE	GREEN	FETAL MEDICINE SERVICES (ADULTS AND ADOLESCENTS)	E09 - SPECIALISED WOMENS SERVICES	54	FETAL MEDICINE SERVICES (ADULTS AND ADOLESCENTS)
NCBPS04D	ACUTE	GREEN	COMPLEX URINARY INCONTINENCE AND GENITAL PROLAPSE	E09 - SPECIALISED WOMENS SERVICES	58	SPECIALIST ADULT GYNAECOLOGICAL SURGERY AND URINARY SURGERY SERVICES FOR FEMALES
NCBPS04F	ACUTE	GREEN	GYNAECOLOGICAL CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS04G	ACUTE	GREEN	SPECIALIST MATERNITY CARE FOR WOMEN DIAGNOSED WITH ABNORMALLY INVASIVE PLACENTA	E09 - SPECIALISED WOMENS SERVICES	115B	SPECIALIST MATERNITY CARE FOR ADULTS DIAGNOSED WITH ABNORMALLY INVASIVE PLACENTA
NCBPS04P	ACUTE	GREEN	TERMINATION SERVICES FOR PATIENTS WITH MEDICAL COMPLEXITY AND OR SIGNIFICANT CO-MORBIDITIES REQUIRING TREATMENT IN A SPECIALIST HOSPITAL	E09 - SPECIALISED WOMENS SERVICES	139AA	TERMINATION SERVICES FOR PATIENTS WITH MEDICAL COMPLEXITY AND OR SIGNIFICANT CO-MORBIDITIES REQUIRING TREATMENT IN A SPECIALIST
NCBPS05C	ACUTE	GREEN	SPECIALIST AUGMENTATIVE AND ALTERNATIVE COMMUNICATION AIDS (ADULTS AND CHILDREN)	D01 - REHABILITATION AND DISABILITY	134	SPECIALIST SERVICES TO SUPPORT PATIENTS WITH COMPLEX PHYSICAL DISABILITIES (EXCLUDING WHEELCHAIR SERVICES) (ADULTS AND CHILDREN)
NCBPS05E	ACUTE	GREEN	SPECIALIST ENVIRONMENTAL CONTROLS (ADULTS AND CHILDREN)	D01 - REHABILITATION AND DISABILITY	134	SPECIALIST SERVICES TO SUPPORT PATIENTS WITH COMPLEX PHYSICAL DISABILITIES (EXCLUDING WHEELCHAIR SERVICES) (ADULTS AND CHILDREN)
NCBPS05P	ACUTE	GREEN	PROSTHETICS (ADULTS AND CHILDREN)	D01 - REHABILITATION AND DISABILITY	134	SPECIALIST SERVICES TO SUPPORT PATIENTS WITH COMPLEX PHYSICAL DISABILITIES (EXCLUDING WHEELCHAIR SERVICES) (ADULTS AND CHILDREN)
NCBPS06Z	ACUTE	GREEN	COMPLEX SPINAL SURGERY SERVICES (ADULTS AND CHILDREN)	D03 - SPINAL SERVICES	40	COMPLEX SPINAL SURGERY SERVICES (ADULTS AND CHILDREN)
NCBPS07Y	ACUTE	GREEN	PAEDIATRIC NEUROREHABILITATION	E04 - PAEDIATRIC NEUROSCIENCES	119	SPECIALIST NEUROSCIENCE SERVICES FOR CHILDREN
NCBPS07Z	ACUTE	GREEN	SPECIALIST REHABILITATION SERVICES FOR PATIENTS WITH HIGHLY COMPLEX NEEDS (ADULTS AND CHILDREN)	D01 - REHABILITATION AND DISABILITY	126	SPECIALIST REHABILITATION SERVICES FOR PATIENTS WITH HIGHLY COMPLEX NEEDS (ADULTS AND CHILDREN)
NCBPS08J	ACUTE	GREEN	SELECTIVE DORSAL RHIZOTOMY	E04 - PAEDIATRIC NEUROSCIENCES	119	SPECIALIST NEUROSCIENCE SERVICES FOR CHILDREN
NCBPS08O	ACUTE	GREEN	NEUROLOGY (ADULTS)	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS08P	ACUTE	GREEN	NEUROPHYSIOLOGY (ADULTS)	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS08R	ACUTE	GREEN	NEURORADIOLOGY (ADULTS)	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS08S	ACUTE	GREEN	NEUROSURGERY (ADULTS)	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS08T	ACUTE	GREEN	MECHANICAL THROMBECTOMY	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS08Y	ACUTE	GREEN	NEUROPSYCHIATRY SERVICES (ADULTS AND CHILDREN)	D04 - NEUROSCIENCES	78	NEUROPSYCHIATRY SERVICES (ADULTS AND CHILDREN)
NCBPS08Z	ACUTE	GREEN	COMPLEX NEURO-SPINAL SURGERY SERVICES (ADULTS AND CHILDREN)	D03 - SPINAL SERVICES	40	COMPLEX SPINAL SURGERY SERVICES (ADULTS AND CHILDREN)
NCBPS10Z	ACUTE	GREEN	CYSTIC FIBROSIS SERVICES (ADULTS AND CHILDREN)	A01 - SPECIALISED RESPIRATORY	45	CYSTIC FIBROSIS SERVICES (ADULTS AND CHILDREN)
NCBPS11B	ACUTE	GREEN	RENAL DIALYSIS	A06 - RENAL SERVICES	15	ADULT SPECIALIST RENAL SERVICES
NCBPS11C	ACUTE	GREEN	ACCESS FOR RENAL DIALYSIS	A06 - RENAL SERVICES	15	ADULT SPECIALIST RENAL SERVICES
NCBPS11T	ACUTE	GREEN	RENAL TRANSPLANTATION	A06 - RENAL SERVICES	15	ADULT SPECIALIST RENAL SERVICES
NCBPS13A	ACUTE	GREEN	COMPLEX DEVICE THERAPY	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13B	ACUTE	GREEN	CARDIAC ELECTROPHYSIOLOGY & ABLATION	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13C	ACUTE	GREEN	INHERITED CARDIAC CONDITIONS	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13E	ACUTE	GREEN	CARDIAC SURGERY (INPATIENT)	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13F	ACUTE	GREEN	PPCI FOR ST- ELEVATION MYOCARDIAL INFARCTION	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13H	ACUTE	GREEN	CARDIAC MAGNETIC RESONANCE IMAGING	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13T	ACUTE	GREEN	COMPLEX INTERVENTIONAL CARDIOLOGY (ADULTS)	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS13X	ACUTE	GREEN	ADULT CONGENITAL HEART DISEASE SERVICES (NON-SURGICAL)	E05 - CONGENITAL HEART SERVICES	2	ADULT CONGENITAL HEART DISEASE SERVICES
NCBPS13Y	ACUTE	GREEN	ADULT CONGENITAL HEART DISEASE SERVICES (SURGICAL)	E05 - CONGENITAL HEART SERVICES	2	ADULT CONGENITAL HEART DISEASE SERVICES
NCBPS13Z	ACUTE	GREEN	CARDIAC SURGERY (OUTPATIENT)	A05 - CARDIOTHORACIC SERVICES	7	ADULT SPECIALIST CARDIAC SERVICES
NCBPS14A	ACUTE	GREEN	ADULT SPECIALISED SERVICES FOR PEOPLE LIVING WITH HIV	F03 - HIV	16	ADULT SPECIALIST SERVICES FOR PEOPLE LIVING WITH HIV
NCBPS15Z	ACUTE	GREEN	CLEFT LIP AND PALATE SERVICES (ADULTS AND CHILDREN)	E02 - SPECIALISED SURGERY IN CHILDREN	35	CLEFT LIP AND PALATE SERVICES (ADULTS AND CHILDREN)
NCBPS16X	ACUTE	GREEN	SPECIALIST IMMUNOLOGY SERVICES FOR ADULTS WITH DEFICIENT IMMUNE SYSTEMS	F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES	115	SPECIALIST IMMUNOLOGY SERVICES FOR ADULTS WITH DEFICIENT IMMUNE SYSTEMS

NCBPS16Y	ACUTE	GREEN	SPECIALIST IMMUNOLOGY SERVICES FOR CHILDREN WITH DEFICIENT IMMUNE SYSTEMS	F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES	115A	SPECIALIST IMMUNOLOGY SERVICES FOR CHILDREN WITH DEFICIENT IMMUNE SYSTEMS
NCBPS17Z	ACUTE	GREEN	SPECIALIST ALLERGY SERVICES (ADULTS AND CHILDREN)	F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	59	SPECIALIST ALLERGY SERVICES (ADULTS AND CHILDREN)
NCBPS18A	ACUTE	GREEN	SPECIALIST SERVICES FOR ADULTS WITH INFECTIOUS DISEASES	F04 - INFECTIOUS DISEASES	65	SPECIALIST SERVICES FOR ADULTS WITH INFECTIOUS DISEASES
NCBPS18C	ACUTE	GREEN	SPECIALIST SERVICES FOR CHILDREN WITH INFECTIOUS DISEASES	E03 - PAEDIATRIC MEDICINE	130	SPECIALIST SERVICES FOR CHILDREN WITH INFECTIOUS DISEASES
NCBPS18E	ACUTE	GREEN	SPECIALIST BONE AND JOINT INFECTION (ADULTS)	F04 - INFECTIOUS DISEASES	65	SPECIALIST SERVICES FOR ADULTS WITH INFECTIOUS DISEASES
NCBPS19B	ACUTE	GREEN	SPECIALIST SERVICES FOR COMPLEX BILIARY DISEASES IN ADULTS	A02 - HEPATOBILIARY AND PANCREAS	131	SPECIALIST SERVICES FOR COMPLEX LIVER, BILIARY AND PANCREATIC DISEASES IN ADULTS
NCBPS19C	ACUTE	GREEN	BILIARY TRACT CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS19L	ACUTE	GREEN	SPECIALIST SERVICES FOR COMPLEX LIVER DISEASES IN ADULTS	A02 - HEPATOBILIARY AND PANCREAS	131	SPECIALIST SERVICES FOR COMPLEX LIVER, BILIARY AND PANCREATIC DISEASES IN ADULTS
NCBPS19M	ACUTE	GREEN	LIVER CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS19P	ACUTE	GREEN	SPECIALIST SERVICES FOR COMPLEX PANCREATIC DISEASES IN ADULTS	A02 - HEPATOBILIARY AND PANCREAS	131	SPECIALIST SERVICES FOR COMPLEX LIVER, BILIARY AND PANCREATIC DISEASES IN ADULTS
NCBPS19Q	ACUTE	GREEN	PANCREATIC CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS19V	ACUTE	GREEN	PANCREATIC CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS19Z	ACUTE	GREEN	SPECIALIST SERVICES FOR COMPLEX LIVER, BILIARY AND PANCREATIC DISEASES IN ADULTS	A02 - HEPATOBILIARY AND PANCREAS	131	SPECIALIST SERVICES FOR COMPLEX LIVER, BILIARY AND PANCREATIC DISEASES IN ADULTS
NCBPS22E	MH	GREEN	ADULT SPECIALIST EATING DISORDER SERVICES	C01 - SPECIALISED MENTAL HEALTH	8	ADULT SPECIALIST EATING DISORDER SERVICES
NCBPS22P	MH	GREEN	SPECIALIST PERINATAL MENTAL HEALTH SERVICES (ADULTS AND ADOLESCENTS)	C04 - PERINATAL MENTAL HEALTH	124	SPECIALIST PERINATAL MENTAL HEALTH SERVICES (ADULTS AND ADOLESCENTS)
NCBPS22S(a)	MH	GREEN	SECURE AND SPECIALISED MENTAL HEALTH SERVICES (ADULT) (MEDIUM AND LOW) - EXCLUDING LD / ASD / WEMS / ABI / DEAF	C02 - ADULT SECURE SERVICES	6	ADULT SECURE MENTAL HEALTH SERVICES
NCBPS22S(c)	MH	GREEN	SECURE AND SPECIALISED MENTAL HEALTH SERVICES (ADULT) (MEDIUM AND LOW) - ASD	C02 - ADULT SECURE SERVICES	6	ADULT SECURE MENTAL HEALTH SERVICES
NCBPS22S(d)	MH	GREEN	SECURE AND SPECIALISED MENTAL HEALTH SERVICES (ADULT) (MEDIUM AND LOW) - LD	C02 - ADULT SECURE SERVICES	6	ADULT SECURE MENTAL HEALTH SERVICES
NCBPS23A	ACUTE	GREEN	CHILDREN'S CANCER	B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	106	SPECIALIST CANCER SERVICES FOR CHILDREN AND YOUNG ADULTS
NCBPS23B	ACUTE	GREEN	PAEDIATRIC CARDIAC SERVICES	E05 - CONGENITAL HEART SERVICES	83	PAEDIATRIC CARDIAC SERVICES
NCBPS23D	ACUTE	GREEN	SPECIALIST EAR, NOSE AND THROAT SERVICES FOR CHILDREN	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	108	SPECIALIST EAR, NOSE AND THROAT SERVICES FOR CHILDREN
NCBPS23E	ACUTE	GREEN	SPECIALIST ENDOCRINOLOGY AND DIABETES SERVICES FOR CHILDREN	E03 - PAEDIATRIC MEDICINE	109	SPECIALIST ENDOCRINOLOGY SERVICES FOR CHILDREN
NCBPS23F	ACUTE	GREEN	SPECIALIST GASTROENTEROLOGY, HEPATOLOGY AND NUTRITIONAL SUPPORT SERVICES FOR CHILDREN	E03 - PAEDIATRIC MEDICINE	110	SPECIALIST GASTROENTEROLOGY, HEPATOLOGY AND NUTRITIONAL SUPPORT SERVICES FOR CHILDREN
NCBPS23H	ACUTE	GREEN	SPECIALIST HAEMATOLOGY SERVICES FOR CHILDREN	E03 - PAEDIATRIC MEDICINE	113	SPECIALIST HAEMATOLOGY SERVICES FOR CHILDREN
NCBPS23K	MH	GREEN	TIER 4 CAMHS (GENERAL ADOLESCENT INC EATING DISORDERS)	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)	32	CHILDREN AND YOUNG PEOPLE'S INPATIENT MENTAL HEALTH SERVICE
NCBPS23L	MH	GREEN	TIER 4 CAMHS (LOW SECURE)	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)	32	CHILDREN AND YOUNG PEOPLE'S INPATIENT MENTAL HEALTH SERVICE
NCBPS23M	ACUTE	GREEN	SPECIALIST NEUROSCIENCE SERVICES FOR CHILDREN	E04 - PAEDIATRIC NEUROSCIENCES	119	SPECIALIST NEUROSCIENCE SERVICES FOR CHILDREN
NCBPS23N	ACUTE	GREEN	SPECIALIST OPHTHALMOLOGY SERVICES FOR CHILDREN	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	120	SPECIALIST OPHTHALMOLOGY SERVICES FOR CHILDREN
NCBPS23O	MH	GREEN	TIER 4 CAMHS (PICU)	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)	32	CHILDREN AND YOUNG PEOPLE'S INPATIENT MENTAL HEALTH SERVICE
NCBPS23P	ACUTE	GREEN	SPECIALIST DENTISTRY SERVICES FOR CHILDREN	E02 - SPECIALISED SURGERY IN CHILDREN	107	SPECIALIST DENTISTRY SERVICES FOR CHILDREN
NCBPS23Q	ACUTE	GREEN	SPECIALIST ORTHOPAEDIC SERVICES FOR CHILDREN	E02 - SPECIALISED SURGERY IN CHILDREN	121	SPECIALIST ORTHOPAEDIC SERVICES FOR CHILDREN
NCBPS23R	ACUTE	GREEN	SPECIALIST PLASTIC SURGERY SERVICES FOR CHILDREN	E02 - SPECIALISED SURGERY IN CHILDREN	125	SPECIALIST PLASTIC SURGERY SERVICES FOR CHILDREN
NCBPS23S	ACUTE	GREEN	SPECIALIST RENAL SERVICES FOR CHILDREN	E03 - PAEDIATRIC MEDICINE	127	SPECIALIST RENAL SERVICES FOR CHILDREN
NCBPS23T	ACUTE	GREEN	SPECIALIST RESPIRATORY SERVICES FOR CHILDREN	E03 - PAEDIATRIC MEDICINE	128	SPECIALIST RESPIRATORY SERVICES FOR CHILDREN
NCBPS23U	MH	GREEN	TIER 4 CAMHS (LD)	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)	32	CHILDREN AND YOUNG PEOPLE'S INPATIENT MENTAL HEALTH SERVICE
NCBPS23V	MH	GREEN	TIER 4 CAMHS (ASD)	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)	32	CHILDREN AND YOUNG PEOPLE'S INPATIENT MENTAL HEALTH SERVICE
NCBPS23W	ACUTE	GREEN	SPECIALIST RHEUMATOLOGY SERVICES FOR CHILDREN	E03 - PAEDIATRIC MEDICINE	129	SPECIALIST RHEUMATOLOGY SERVICES FOR CHILDREN
NCBPS23X	ACUTE	GREEN	SPECIALIST PAEDIATRIC SURGERY SERVICES - GENERAL SURGERY	E02 - SPECIALISED SURGERY IN CHILDREN	135	SPECIALIST PAEDIATRIC SURGERY SERVICES
NCBPS23Y	ACUTE	GREEN	SPECIALIST PAIN MANAGEMENT SERVICES FOR CHILDREN	E02 - SPECIALISED SURGERY IN CHILDREN	63	SPECIALIST PAIN MANAGEMENT SERVICES FOR CHILDREN
NCBPS23Z	ACUTE	GREEN	SPECIALIST PAEDIATRIC UROLOGY SERVICES	E02 - SPECIALISED SURGERY IN CHILDREN	136	SPECIALIST PAEDIATRIC UROLOGY SERVICES
NCBPS24C	MH	GREEN	FCAMHS	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)	98	SPECIALIST SECURE FORENSIC MENTAL HEALTH SERVICES FOR YOUNG PEOPLE
NCBPS24Y	ACUTE	GREEN	SKIN CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS24Z	ACUTE	GREEN	SPECIALIST DERMATOLOGY SERVICES (ADULTS AND CHILDREN)	A08 - SPECIALISED DERMATOLOGY	61	SPECIALIST DERMATOLOGY SERVICES (ADULTS AND CHILDREN)
NCBPS26Z	ACUTE	GREEN	ADULT SPECIALIST RHEUMATOLOGY SERVICES	A09 - SPECIALISED RHEUMATOLOGY	5	ADULT SPECIALIST RHEUMATOLOGY SERVICES
NCBPS27E	ACUTE	GREEN	ADRENAL CANCER (ADULTS)	A03 - SPECIALISED ENDOCRINOLOGY	9	ADULT SPECIALIST ENDOCRINOLOGY SERVICES
NCBPS27Z	ACUTE	GREEN	ADULT SPECIALIST ENDOCRINOLOGY SERVICES	A03 - SPECIALISED ENDOCRINOLOGY	9	ADULT SPECIALIST ENDOCRINOLOGY SERVICES
NCBPS29B	ACUTE	GREEN	COMPLEX THORACIC SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	18	ADULT THORACIC SURGERY SERVICES
NCBPS29E	ACUTE	GREEN	MANAGEMENT OF CENTRAL AIRWAY OBSTRUCTION (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS29L	ACUTE	GREEN	LUNG VOLUME REDUCTION (ADULTS)	A01 - SPECIALISED RESPIRATORY	4	ADULT SPECIALIST RESPIRATORY SERVICES
NCBPS29M	ACUTE	GREEN	INTERSTITIAL LUNG DISEASE (ADULTS)	A01 - SPECIALISED RESPIRATORY	4	ADULT SPECIALIST RESPIRATORY SERVICES
NCBPS29S	ACUTE	GREEN	SEVERE ASTHMA (ADULTS)	A01 - SPECIALISED RESPIRATORY	4	ADULT SPECIALIST RESPIRATORY SERVICES
NCBPS29V	ACUTE	GREEN	COMPLEX HOME VENTILATION (ADULTS)	A01 - SPECIALISED RESPIRATORY	4	ADULT SPECIALIST RESPIRATORY SERVICES
NCBPS29Z	ACUTE	GREEN	ADULT THORACIC SURGERY SERVICES: OUTPATIENTS	B03 - SPECIALISED CANCER SURGERY	18	ADULT THORACIC SURGERY SERVICES
NCBPS30Z	ACUTE	GREEN	ADULT SPECIALIST VASCULAR SERVICES	A04 - VASCULAR DISEASE	17	ADULT SPECIALIST VASCULAR SERVICES
NCBPS31Z	ACUTE	GREEN	ADULT SPECIALIST PAIN MANAGEMENT SERVICES	D07 - SPECIALISED PAIN	3	ADULT SPECIALIST PAIN MANAGEMENT SERVICES
NCBPS32A	ACUTE	GREEN	COCHLEAR IMPLANTATION SERVICES (ADULTS AND CHILDREN)	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	36	COCHLEAR IMPLANTATION SERVICES (ADULTS AND CHILDREN)
NCBPS32B	ACUTE	GREEN	BONE ANCHORED HEARING AIDS SERVICE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	30	BONE CONDUCTION HEARING IMPLANT SERVICE (ADULTS AND CHILDREN)
NCBPS32D	ACUTE	GREEN	MIDDLE EAR IMPLANTABLE HEARING AIDS SERVICE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	30	BONE CONDUCTION HEARING IMPLANT SERVICE (ADULTS AND CHILDREN)
NCBPS33A	ACUTE	GREEN	COMPLEX SURGERY FOR FAECAL INCONTINENCE (ADULTS)	A07 - SPECIALISED COLORECTAL SERVICES	106A	SPECIALIST COLORECTAL SURGERY SERVICES (ADULTS)

NCBPS33B	ACUTE	GREEN	COMPLEX INFLAMMATORY BOWEL DISEASE (ADULTS)	A07 - SPECIALISED COLORECTAL SERVICES	106A	SPECIALIST COLORECTAL SURGERY SERVICES (ADULTS)
NCBPS33C	ACUTE	GREEN	TRANSANAL ENDOSCOPIC MICROSURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS33D	ACUTE	GREEN	DISTAL SACRECTOMY FOR ADVANCED AND RECURRENT RECTAL CANCER (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS34A	ACUTE	GREEN	ORTHOPAEDIC SURGERY (ADULTS)	D10 - SPECIALISED ORTHOPAEDIC SERVICES	13	ADULT SPECIALIST ORTHOPAEDIC SERVICES
NCBPS34R	ACUTE	GREEN	ORTHOPAEDIC REVISION (ADULTS)	D10 - SPECIALISED ORTHOPAEDIC SERVICES	13	ADULT SPECIALIST ORTHOPAEDIC SERVICES
NCBPS34T	ACUTE	GREEN	MAJOR TRAUMA SERVICES (ADULTS AND CHILDREN)	D02 - MAJOR TRAUMA	72	MAJOR TRAUMA SERVICES (ADULTS AND CHILDREN)
NCBPS35Z	ACUTE	GREEN	SPECIALIST MORBID OBESITY SERVICES FOR CHILDREN	E02 - SPECIALISED SURGERY IN CHILDREN	139A	SPECIALIST MORBID OBESITY SERVICES FOR CHILDREN
NCBPS36Z	ACUTE	GREEN	SPECIALIST METABOLIC DISORDER SERVICES (ADULTS AND CHILDREN)	E06 - METABOLIC DISORDERS	62	SPECIALIST METABOLIC DISORDER SERVICES (ADULTS AND CHILDREN)
NCBPS37C	ACUTE	GREEN	ARTIFICIAL EYE SERVICE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	12	ADULT SPECIALIST OPHTHALMOLOGY SERVICES
NCBPS37Z	ACUTE	GREEN	ADULT SPECIALIST OPHTHALMOLOGY SERVICES	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	12	ADULT SPECIALIST OPHTHALMOLOGY SERVICES
NCBPS38S	ACUTE	GREEN	SICKLE CELL ANAEMIA (ADULTS AND CHILDREN)	F05 - HAEMOGLOBINOPATHIES	114	SPECIALIST HAEMOGLOBINOPATHY SERVICES (ADULTS AND CHILDREN)
NCBPS38T	ACUTE	GREEN	THALASSEMIA (ADULTS AND CHILDREN)	F05 - HAEMOGLOBINOPATHIES	114	SPECIALIST HAEMOGLOBINOPATHY SERVICES (ADULTS AND CHILDREN)
NCBPS41P	ACUTE	GREEN	PENILE IMPLANTS	B03 - SPECIALISED CANCER SURGERY	58A	SPECIALIST ADULT UROLOGICAL SURGERY SERVICES FOR MEN
NCBPS41S	ACUTE	GREEN	SURGICAL SPERM REMOVAL	B03 - SPECIALISED CANCER SURGERY	58A	SPECIALIST ADULT UROLOGICAL SURGERY SERVICES FOR MEN
NCBPS41U	ACUTE	GREEN	URETHRAL RECONSTRUCTION	B03 - SPECIALISED CANCER SURGERY	58A	SPECIALIST ADULT UROLOGICAL SURGERY SERVICES FOR MEN
NCBPS51A	ACUTE	GREEN	INTERVENTIONAL ONCOLOGY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS51B	ACUTE	GREEN	BRACHYTHERAPY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS51C	ACUTE	GREEN	MOLECULAR ONCOLOGY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS51R	ACUTE	GREEN	RADIOTHERAPY SERVICES (CHILDREN)	B01 - RADIOTHERAPY	94	RADIOTHERAPY SERVICES (ADULTS AND CHILDREN)
NCBPS58A	ACUTE	GREEN	NEUROSURGERY LVHC NATIONAL: SURGICAL REMOVAL OF CLIVAL CHORDOMA AND CHONDROSARCOMA	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58B	ACUTE	GREEN	NEUROSURGERY LVHC NATIONAL: EC-IC BYPASS(COMPLEX/HIGH FLOW)	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58C	ACUTE	GREEN	NEUROSURGERY LVHC NATIONAL: TRANSORAL EXCISION OF DENS	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58D	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: ANTERIOR SKULL BASED TUMOURS	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58E	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: LATERAL SKULL BASED TUMOURS	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58F	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: SURGICAL REMOVAL OF BRAINSTEM LESIONS	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58G	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: DEEP BRAIN STIMULATION	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58H	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: PINEAL TUMOUR SURGERIES - RESECTION	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58I	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: REMOVAL OF ARTERIOVENOUS MALFORMATIONS OF THE NERVOUS SYSTEM	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58J	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: EPILEPSY	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58K	ACUTE	GREEN	NEUROSURGERY LVHC REGIONAL: INSULA GLIOMA'S/ COMPLEX LOW GRADE GLIOMA'S	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58L	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: ANTERIOR LUMBAR FUSION	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58M	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: REMOVAL OF INTRAMEDULLARY SPINAL TUMOURS	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58N	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: INTRAVENTRICULAR TUMOURS RESECTION	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58O	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: SURGICAL REPAIR OF ANEURYSMS (SURGICAL CLIPPING)	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58P	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: THORACIC DISCECTOMY	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58Q	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: MICROVASCULAR DECOMPRESSION FOR TRIGEMINAL NEURALGIA	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58R	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: AWAKE SURGERY FOR REMOVAL OF BRAIN TUMOURS	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS58S	ACUTE	GREEN	NEUROSURGERY LVHC LOCAL: REMOVAL OF PITUITARY TUMOURS INCLUDING FOR CUSHING'S AND ACROMEGALY	D04 - NEUROSCIENCES	11	ADULT SPECIALIST NEUROSCIENCES SERVICES
NCBPS61M	ACUTE	GREEN	HEAD AND NECK CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS61Q	ACUTE	GREEN	OPHTHALMIC CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS61U	ACUTE	GREEN	OESOPHAGEAL AND GASTRIC CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS61Z	ACUTE	GREEN	TESTICULAR CANCER SURGERY (ADULTS)	B03 - SPECIALISED CANCER SURGERY	105	SPECIALIST CANCER SERVICES (ADULTS)
NCBPS73X	ACUTE	GREEN	SPECIALIST PAEDIATRIC SURGERY SERVICES - GYNAECOLOGY	E02 - SPECIALISED SURGERY IN CHILDREN	112	SPECIALIST GYNAECOLOGY SERVICES FOR CHILDREN
NCBPSACC	ACUTE	GREEN	ADULT CRITICAL CARE	D05 - ADULT CRITICAL CARE	ACC	ADULT CRITICAL CARE
NCBPSE23	ACUTE	GREEN	SPECIALIST PALLIATIVE CARE SERVICES FOR CHILDREN AND YOUNG ADULTS	E03 - PAEDIATRIC MEDICINE	64	SPECIALIST PALLIATIVE CARE SERVICES FOR CHILDREN AND YOUNG ADULTS
NCBPSECP	ACUTE	GREEN	EXTRACORPOREAL PHOTOPHERESIS SERVICE (ADULTS AND CHILDREN)	B99 - CANCER NPOC / CRG TO BE DECIDED	29	HAEMATOPOIETIC STEM CELL TRANSPLANTATION SERVICES (ADULTS AND CHILDREN)
NCBPSNIC	ACUTE	GREEN	SPECIALIST NEONATAL CARE SERVICES	E08 - NEONATAL CRITICAL CARE	118	NEONATAL CRITICAL CARE SERVICES
NCBPSPIC	ACUTE	GREEN	SPECIALIST PAEDIATRIC INTENSIVE CARE SERVICES	E07 - PAEDIATRIC INTENSIVE CARE	122	PAEDIATRIC CRITICAL CARE SERVICES

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

DRAFT Minutes of the BSW Integrated Care Board - - Quality and Outcomes Committee

Tuesday 4th March 2025, 14:00 hrs, MS Teams

Present

Members:

Alison Moon	Non-Executive Director for Quality (Chair)
Julian Kirby	Non-Executive Director for Public and Community Engagement
Suzannah Power	Non- Executive Director for Remuneration and People
Sue Harriman	Chief Executive Officer
Gill May	Chief Nursing Officer
Dr Amanda Webb	Chief Medical Officer
Cara Charles-Barks	NHS Trusts & NHS Foundation Trusts Partner Member – acute sector
Lucy Townsend	Partner Member Local Authorities, Wiltshire

Attending Officers:

Associate Director for Patient Safety and Quality – *Item 6*
Health & Care Professional Director, Swindon – *item 7*
Interim Director for Planned Care, Cancer and Community Services – *Item 8*
Ade Williams, Non-Executive Director for Quality, Designate

Apologies (members)

Gordon Muvuti	Executive Director for Place, Swindon

Welcome and Apologies

1.1 The Chair welcomed members and officers to the meeting and noted apologies. The Chair welcomed Lucy Townsend, the Parter Member Local Authorities, Wiltshire, to her first committee meeting and also Ade Williams, new Non-Executive Director for Quality who attended as an observer.

1.2 The meeting was declared quorate.

1.3 The Chair asked executive colleagues if there were any matters of concern that the committee needed to be aware of that were not on the agenda. The Chief Nurse requested the opportunity under matters arising to brief the Committee on a recent cyber incident affecting a provider.

2. Declaration of Interests

2.1 The ICB holds a register of interests for all staff and committee members. None of the interests registered there were deemed to be relevant for the meeting business. There were no other interests declared re items on today's meeting agenda.

3. Minutes of the Quality and Outcomes Committee – QOC/24-25/46

3.1 The committee reviewed the minutes of its previous meeting on the 7th January 2025 and **approved** them as a true and accurate record of the meeting.

4. Actions and Matters Arising – QOC/24-25/047

4.1 There are nine open actions on the Quality and Outcomes Committee Action Tracker, updates had been provided prior and the following updates discussed:

- Action 27 and 27a – The Chief Nurse advised that an update had been provided prior to the meeting in specific reference to a new provider.

  Action Chief Nursing Officer to update the action post meeting.

  Committee discussion noted that this action was the result of a challenge from the Local authority around access to mental health services for Children and Young People. The Chair and the BSW Chief Executive consider this issue requires a deep dive to provide assurance that the new contractual environment is improving quality and addressing the waiting list issues.

  Action Chief Nursing Officer to inform the Executive Director for Place, Swindon that a full briefing is required for the May Quality and Outcomes Committee to provide assurance around access to Mental Health Services for Children and Young People.

- Action 28 – Action tracker updated - **close**
- Action 29 - Action tracker updated - **close**
- Action 30 - Action tracker updated - **close**
- Action 31 - Action tracker updated - **close**
- Action 32 – Additional context was added to this action during the meeting, and it was agreed to **close** the action for this committee. The ICB Chief Executive and Chief Delivery Officer will discuss outside of the meeting and review at the ICB Board at a future date.
- Action 33 - Action tracker updated - **close**

4.2 **Matters Arising – Cyber incident**

4.2.1 The Chief Nursing Officer provided a confidential update on a cyber incident that affected a BSW provider. A structured major incident response was in place. The Committee was provided with assurance that there is good evidence about the

significant robustness of the provider's cybersecurity prior to the incident and about the immediate good and robust response to the incident.

5. BSW Corporate Risk Register – Emerging Risks – QOC/24-25/048

5.1 The Committee **received** and **noted** the risks pertaining to the Committee's remit (risks with scores of 15 and above).

5.2 The Chief Nursing Officer confirmed that the new risk on Vaccination Services has now been fully mitigated and is unlikely to remain at its current high score.

5.3 Insufficient capacity across urgent and emergency care particular in ambulance handover delays remains a problem even with the introduction of the dynamic risk assessment.

5.4 The Chief Nursing Officer confirmed that a full briefing was given to the System Quality Group by SWAST in relation to patient harm. A fuller deep dive is proposed for the May Quality & Outcomes Committee to provide assurance around improvement plans.

6. Quality and Patient Safety Report – QOC/24-25/049

6a. Quality and Patient Safety Exception Report

6a.1 The Committee **received** and **noted** the Quality and Patient Safety Report.

6a.2 The Committee was asked to note:

- Norovirus has impacted acute trusts with wards closing. This has been monitored closely with the ICB IPC team supporting acute colleagues with outbreak management. The figures are now plateauing with acute hospital returning to normal.
- Primary Care information has been provided by the central commissioning hub, who provide assurance and oversight on behalf of all systems in the Southwest for Pharmacy, Optometry and Dental (POD). Work is ongoing with local BI teams to provide additional performance information.
- Oversight of the complaints received across 2023-24 and quarters 1 and 2 of 2024-25. The top three services receiving complaints during 2023-24 were Acute Services, General Practice and Continuing Healthcare, with the main issues noted as Clinical Care, Access and Waiting, and Financial & Policy Issues. The top three services receiving complaints during quarters 1 and 2 of 2024-25 were Acute services, Mental Health and General Practice with the main issues noted as Communication and Clinical Care. GWH is seeing a larger number of complaints and the ICB is working with them around themes and areas of learning.
- Priorities for Patient Safety Specialists across BSW was published in January 2025. The focus for 2025/26 will be priority 5 – 'Ongoing implementation of the Framework for Involving Patients in Patient Safety' and priority 8 – 'Improving patient safety in primary care' which is being led by the ICB's Deputy Medical Director.

- 14 never events had been reported across BSW between April 2024 – February 2025. Updated national guidance will be published in the next few weeks and BSW will be working collaboratively with all providers to understand the new guidance and apply it to lessons learnt.

6a.3 Committee discussion highlighted:

- The NHS Trusts & NHS Foundation Trusts Partner Member (acute sector) reflected that never events often occur due to human factors, and suggested a deeper dive into the commonalities that might be contributing to the human factors that cause the never event in the first place. The Chief Nursing Officer confirmed that never events had been escalated to the ICB Board highlighting the learning and actions that are being taken to reduce the number of never events and improve BSW's position.

  Action Chief Nursing Officer, bring an update on never events to September Quality & Outcomes Committee to assure the committee of improvements made by the learning and actions.

- Note that as the ICB moves into its strategic commissioning role, it is likely that it will more frequently use contractual and / or commissioning levers to incentivize providers to improve e.g. in mental health talking therapies.
- The Chair highlighted that the POD data received from the central commissioning hub does not provide the Committee with assurance. The Associate Director for Patient Safety and Quality confirmed that the POD performance dashboard is evolving, and they will continue to work with the central commissioning hub to get the data the Committee needs in order to be assured.
- The Chair asked if there was anything that the Committee needed to be concerned about in relation to complaints and GWH. The NHS Trusts & NHS Foundation Trusts Partner Member replied that the three acute hospitals have different approaches to dealing with complaints and reflected that there might be an opportunity to adopt a system wide process for dealing with them.

  Action NHS Trusts & NHS Foundation Trusts Partner Member to discuss the opportunity to design a system wide approach for dealing with complaints with the Chief Nursing Officer.

- The Non- Executive Director for Remuneration and People raised concerns about the qualitive performance data for Primary Care and if it is going to become available to the Committee. The Chief Nursing Officer confirmed that they believe the relationship the ICB has with Primary Care in evolving and there will be a difference, and this will also go into the lens of patient safety.

6b. Quality Assurance Update Briefing: Mental Health Services AWP – QOC/24-25/050

6b.1 The Committee **received** and **noted** the Quality Assurance Update Briefing

6b.2 The Committee's discussions noted:

- The ICB Chief Executive confirmed that there is evidence of improvement in AWP's operational performance and financial management.
- Outcomes from the local reviews and updated actions plans need to be discussed at the AWP Board and ICB Board by the 30th June 2025.

Action Chief Nursing Officer to bring AWP updated action plans to the May Quality & Outcomes Committee prior to the ICB Board in June.

6c. Assurance of Covid Vaccination, Immunisations and Flu – QOC/24-25/051

6c.1 The Committee **received** and **noted** assurance of Covid Vaccination, Immunisations and flu. The BSW Associate Clinical Director for Immunisations and vaccinations provided an update on the vaccination programme, highlighting both successes and challenges. The BSW system has the highest uptake rates in the country for Covid and Flu in particular with health and social care workers.

6c.2 Covid vaccinations are now going into their fifth year and moving into business as usual, this means that funding is being reduced to about a third of that previously received from the 1st April 2026. The majority of vaccinations are delivered in Primary Care, however the removal of this funding affects the ability to cover the additional costs of community vaccinations, with currently no contracted service in place, the ICB's vaccination hub has been providing a wrap-around service. Over the next 6 – 12 months work is taking place to transition community vaccinations into the new HCRG community contract.

6c.3 A Key focus of the vaccination team has been to ensure a robust outreach and inequalities programme, focusing on the 'Core 20 plus 5' communities in line with the Health Inequalities strategy. The reduction in funding will impact the delivery of vaccinations, however there will be increased engagement alongside local authorities and Voluntary sector partners to signpost these communities to where vaccinations can be received.

6c.3 The Committee's discussions noted the reduction in funding and the Non- Executive Director for Remuneration and People raised concerns about the long-term assurance of the delivery of the vaccination programme. It was agreed that a further paper would be brought to the Committee in July '25 to provide assurance on future funding, which is currently being worked through.

Action Secretariat add an item to the forward plan to bring back a detailed paper on the assurance of funding for vaccinations to the July committee.

6c.4 The Committee **noted** the paper and were **assured** on the systems and processes in place to deliver the vaccination programme.

6d BSW System Quality Group Minutes – QOC/24-25/052

6d.1 The Committee **received** and **noted** the BSW System Quality Group Minutes from the 10 October 2024 meeting.

7. Population Health Board update – QOC/24-25/053

7.1 The Committee **received** and **noted** the Population Health Board (PHB) update.

7.2 The Committee **received** and **noted** the HCRG Community Based Care Partnership deep dive prepared for the Population Health Board.

7.3 The Committee discussion noted:
An update on the development of two health intelligence workspaces which will bring together the health inequalities dashboards and reports in a more user-friendly way. This will support with easier access to relevant information and highlight any issues with missing information.

7.4 The Committee **noted** the paper and were **assured** on the systems and processes in place.

8. Integrated Community Based Care Mobilisation

8a. Adult Community Waiting List Transfer – QOC/24-25/054

8a.1 The Committee **received** a paper outlining the actions underway to support the safe transfer of patients to HCRG who are currently under the care of and /or on a waiting list for treatment.

8a.2 The Committee was asked to note:

- Work is currently underway to transfer waiting lists for treatment at Wiltshire Health and Care, Great Western Hospitals, Avon and Wiltshire Mental Health Partnership and Swindon Borough Council to HCRG the new provider of community services. Validation processes are underway and engagement with the Data Protection Officer and Caldicott Guardian where there is a duty to inform patients of the transfer of their data.

8a.3 The Committee's discussions noted:

- The Partner Member Local Authorities, Wiltshire asked if there was particular attention or communication being given to the transfer of patients with learning disabilities and autism(LDA) who have particular vulnerabilities and may not be able to identify if something is not quite right. It was confirmed that the Clinical Lead for LDA is doing validation work alongside AWP around the best way of communicating with this group of individuals to ensure that they are able to understand and access what they need in the Community.

Post meeting comment: regarding support for people to make choices in respect of their ongoing care and treatment, there is a dedicated LDAN ADHD inbox which people are being pointed to if they have any additional concerns or wish to discuss the options available to them with a member of the team. This is monitored daily.

- The Chair was concerned that with potentially 5000 individuals on the ADHA waiting list would there be sufficient capacity to deal with the queries they might have to make a decision about the updated range of options available to them to help them access the right support and help, when national guidance gives them only 28 days. The Chair confirmed that she had spoken to the LDA Director.
- Non- Executive Director for Remuneration and People asked if GPs had been informed of the work being undertaken with the ADHD waiting list and a potential influx of patient calls seeking advice.

Post meeting comment: The LDA Director confirmed communications have been provided to all GPs and the Local Medical Committee notifying them of the work underway.

8a.4 The Committee **noted** the paper and were **assured** on the systems and processes in place around the transition of waiting lists. It was noted that for those on the ADHD waiting list there is a risk that if they do not respond within 28 days they could be removed from the waiting list.

8b Quality - Integrated Community Based Care Highlight Report – QOC/24-25/055

8b.1 The Chief Nursing Officer provided an update on the ICBC contract mobilisation which the Committee noted.

9. BSW Quality Assurance Framework – QOC/24-25/056

9.1 The Committee **received** the final draft of the BSW Quality Assurance Framework for approval.

9.2 The Committee was asked to note:

- ICBs have a statutory duty for Quality. This is a duty to exercise their functions with a view to securing assurance and fostering continuous improvement in the quality of services for, or in connection with:
    - the prevention, diagnosis and treatment of physical and mental illness
    - the protection and improvement of public health
- Close collaboration with Chief Nursing Officers and Deputy Chief Nursing Officers from the key providers has taken place to produce the framework; it is anticipated that the framework will be refreshed annually to support ongoing quality improvement themes.
- The Quality Assurance Framework (QAF) has been to the ICBs Executive Management Meeting and Safeguarding Partnership Boards; feedback from those meetings will be included in the final document.

9.3 The Committee discussion noted:

- The QAF quality metrics appear to be very transactional rather than quality improvement or hearing the users voice, the Chief Nursing Officer confirmed that the framework aims to shift the focus to quality improvement and these measures are just the first iteration and more would be added in the future.

9.4 The Committee **approved** the final draft of the BSW Quality Assurance Framework

10. Quality and Outcomes Committee forward plan

10.1 The Committee **received** and **noted** the Quality and Outcomes forward plan.

11. Any Other Business

11.1 The ICB Chief Executive on behalf of the ICB Executives and Chair of the ICB thanked the Chair for her time with the ICB as the Non-Executive Director for Quality, supporting the ICB in our time of need and acknowledging the enormous value she added.

11.2 There being no other business, the Chair closed the meeting at 16:15

Report to:	BSW ICB Board - Meeting in Public	Agenda item:	12a
Date of Meeting:	20 March 2025		

Title of Report:	BSW Quality and Patient Safety Exception Report
Report Author:	Clarisser Cupid, Lead for Patient Safety and Quality
Board / Director Sponsor:	Gill May, Chief Nurse
Appendices:	

Report classification	Please indicate to which body/collection of organisations this report is relevant. *Only one of the below should be selected* (x)
ICB body corporate	X
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	X
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
BSW ICB Quality and Outcomes Committee	4 March 2025	Assurance

1	Purpose of this paper
The aim of the Quality Exception report is to update the ICB Board on specific patient safety and quality workstreams	

2	Summary of recommendations and any additional actions required

The ICB Board is asked to note the information within the agenda item:

- Quality exception slides

This report outlines the following areas: achievements, alerts, risks, areas of focus, assurance, action plan, and continuous improvement for:

1.Infection Prevention and Control (IPC)

- Despite national increase in rates of Clostridioides difficile (C.diff), there has been BSW system level reduction in both reported C.diff and MSSA blood stream infection cases
- Norovirus - norovirus activity has remained high into Qtr 4 of 2025. The total number of norovirus laboratory reports during weeks 1 and 2 of 2025 was 89.8% higher than the 5-season average for the same 2-week period. This has impacted acute trusts with reported outbreaks occurring, resulting in closed beds impacting patient flow. These have been monitored closely with BSW IPC teams supporting outbreak management to maintain patient safety. As of February 25 the number of reported cases within acute trusts had reduced.
- Seasonal Influenza - Influenza activity has decreased across most indicators and is at medium activity levels for this time of year. Admissions have decreased throughout Qtr 4.

2.Maternity and Neonatal Services

- Smoking in Pregnancy: Reduced from 10.8% (2017/18) to 6.6% (2023/24); new incentive voucher scheme introduced.
- Perinatal Pelvic Health Services: 98% satisfaction rate.
- Mother-Baby Separation: Consistently meeting target of 5% or less for babies born after 37 weeks needing additional support.
- Digital System Implementation: Commenced at GWH, to be followed by SFT and RUH, enhancing cross-service working and safety.
- Clinical Negligence Scheme Compliance: All three maternity providers on target for Year 6 compliance.
- NHSE Saving Babies Lives Standards: GWH and RUH at 90%+ compliance; SFT progressing towards 90% by June 2025.
- Inequalities Workshops: Engaging with the Asian community to improve maternity and neonatal care access and experience.
- National Recommendations: Implementing actions from national reports (e.g., Ockenden, East Kent).
- CQC Maternity Survey: Positive scores across BSW providers; action plans in place for further improvements, including postnatal care and discharges.

3. Priorities for Patient Safety Specialist (PSS) (including PSIRF)

- **Priority 1 - Supporting LFPSE Implementation**: BSW providers are collaborating with Local Risk Management Systems to ensure seamless LFPSE operations, currently validating data for the national LFPSE dashboard release.
- **Priority 2 - Implementing PSIRF**: All expected BSW providers have implemented PSIRF. A PSIRF Maturity Matrix workshop is planned for April to help provide assurance to both providers and the ICB on current level of maturity and identify areas for further development. BSW has participated in national webinars on PSIRF in maternity settings and is upskilling Patient Safety teams through training sessions.
- **Priority 3 - Improving Safety Culture**: BSW ICB is enhancing safety culture through PSIRF implementation, medication safety initiatives, and a commitment to health and safety practices. These efforts aim to foster continuous learning and improvement.
- **Priority 4 - Responding to National Patient Safety Alerts**: BSW ICB supports NatPSA responses through local compliance mechanisms, coordination with stakeholders, and dedicated working groups for specific alerts such as valproate safety.
- **Priority 5 - Involving Patients in Patient Safety**: Acute providers have established Patient Safety initiatives such as Patient Safety Partners (PSP) to involve patients in safety efforts. BSW ICB will be recruiting PSP's during 25/26.
- **Priority 6 – Improving Patient Safety Education and Training**: All NHS employees, including non-patient-facing roles, are expected to complete patient safety training across five levels. BSW providers are compliant with Level 1 and 2, relevant staff have completed level 3 and PSS's across BSW have participated in level 4&5 training. Discussions are ongoing to provide independent providers access to free HSSIB training. Increased training has improved Patient Safety Incident Investigations and report writing.
- **Priority 7 – Addressing Patient Safety Improvement, Including Martha's Rule**: Organisations are at various stages of implementing Martha's Rule, which allows patients and families to request a rapid second clinical opinion.
- **Priority 8 – Improving Patient Safety in Primary Care**: The Primary Care Patient Safety Strategy, launched in September 2024, focuses on creating a supportive, learning environment and involving patients in safety improvements. General Practices are being supported in their PSIRF journey, with representation at the Patient Safety Community of Practice meeting and comprehensive support from Quality and Safeguarding teams. Renewed focus in 25/26 will focus on; Access to Freedom to Speak Up Guardians (FTSU), Quality Groups to support adoption of LFPSE and PSIRF, Greater use of LFPSE, consideration of patient safety leads in primary care and pilot approaches to share good practice.

3	Legal/regulatory implications
N/A	

4	Risks
All known risks monitored and managed through the N&Q risk register. Risks above 15 are escalated to the ICB corporate risk register.	

5	Quality and resources impact
Please outline any impact on Quality, Patient Experience and Safeguarding: This paper provides the current quality and safety information by exception. This report is to note by exception the key areas of focus for the BSW ICB Patient Safety and Quality team. The oversight of the safe and effective delivery of care across commissioned services is monitored through provider quality reporting, quality assurance meetings and visits, with participation from the ICB Patient Safety and Quality team to assess learning, agree and monitor improvements.	
Finance sign-off	

6	Confirmation of completion of Equalities and Quality Impact Assessment
N/A	

7	Communications and Engagement Considerations
N/A	

8	Statement on confidentiality of report
This report contains information that can be shared at public Board.	

NHS
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BSW ICB

Quality and Patient Safety Exception Report

March 2025

Infection Prevention and Management (IP&M)

BSW ICB continues to monitor mandated Health Care Associated Infection surveillance data across the system, with oversight and quality improvement initiatives overseen by the BSW ICS Infection Prevention and Management (IP&M) Collaborative.

- 449 cases of E-coli blood stream infections have been reported across the acute and community system to the end of quarter 3. This is 14 more than the same period last year, however BSW ICS remains second best performing ICS regionally and nationally. Analysis and improvement initiatives continue to understand impact on urgent care pathways and patient experience

- 145 klebsiella blood stream infections to the end of quarter 3, 12 cases more than the same period last year. BSW ICS currently fourth best performing ICS regionally and fourth best performing nationally.

Despite national increase in rates of Clostridioides difficile (C.diff), there has been system level reduction in both C.diff and MSSA blood stream infection cases.:

• There have been 216 C.diff to the end of quarter 3, 5 less than same period last year. BSW ICS are the second-best performing ICS regionally and are within the first quartile nationally.

•153 cases of MSSA to the end of quarter 3, 6 less than same period last year. BSW ICS are the second-best performing ICS regionally and are within the first quartile nationally

•8 cases of MRSA to the end of quarter 3, 2 less than same period last year. BSW ICS are the fourth best performing ICS regionally and within the third quartile nationally.

Action Plans and Continuous Improvement:

- Dynamic risk assessments and utilisation of system toolkits to maintain safety for patients and workforce whilst maximising bed capacity. Strict IPC precautions continue with oversight from IP&M collaborative to ensure that outbreaks are monitored and minimised.
- Task and finish groups to tackle rising rates of both Gram Negative Blood Stream Infection (GNBSI) and C.diff have both convened and are actively progressing on their assigned actions.
- Continued representation at the SW CDI collaborative for wider shared learning and to drive forward improvements in this area.
- Reviews of cases of GNBSI and C.diff with primary care colleagues to understand learning and areas of improvement have commenced with excellent engagement from GPs.

Infection Prevention and Management continued

Current system risks:

Norovirus - activity has remained high into Qtr 4. The total number of norovirus laboratory reports during weeks 1 and 2 of 2025 was 89.8% higher than the 5-season average for the same 2-week period. This impacted patients and bed capacity within acute trusts settings, with reported outbreaks resulting in closure of wards. These have been monitored closely with robust outbreak management plans in place. Numbers of reported norovirus within acute trusts is now reducing.

Seasonal Influenza - Influenza activity has decreased across most indicators and is at medium activity levels for this time of year.

National risks for awareness:

Mpox - In late January 2025, UKHSA confirmed a new imported case of Clade Ib mpox had been detected in England. This brings the total number of confirmed cases since October 2024 to 7. Nil confirmed cases of Mpox clade I in BSW to date. HCID pathways have been stress tested successfully. The risk to the UK population remains low.

Marburg virus disease (MVD) - A viral haemorrhagic fever and classified as a high consequence infectious disease (HCID) in the UK. In Jan 2025, WHO reported an outbreak of suspected MVD in United Republic of Tanzania. The risk to the UK population is low.

Avian Influenza - No cases reported in BSW**.** The risk to the wider public continues to be low.

Maternity and Neonatal

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

Achievements:

- Smoking in pregnancy at time of birth reduced from 10.8% in 2017/18 down to 6.6% in 23/24. National maternity incentive voucher scheme has been introduced in maternity services recently to support ambition to further reduce smoking in pregnancy.
- Perinatal pelvic health services survey demonstrates 98% satisfaction with services.
- Rate of separation of mothers and babies born after 37 weeks when requiring additional support is consistently meeting the target of 5% or less which supports positive experience and outcomes including breastfeeding, maternal mental health and bonding. Transitional care pathways support parents and babies to be cared for together to reduce separation.
- Implementation of single maternity digital system across BSW has commenced at GWH (to be followed by SFT and RUH). This will support cross service working and safer care with improved data flows and data intelligence supporting perinatal quality and safety surveillance.

Assure:

- All three maternity providers in BSW on target to declare compliance with the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 6 on submission date in March, following positive review of assurance evidence.
- All three maternity and neonatal providers in BSW have demonstrated compliance with requirements for NHSE Saving Babies Lives Compliance standards against agreed trajectory targets for 2024/25 - GWH and RUH at 90 or above compliance, SFT making significant progress with best endeavours with trajectory to meet 90% by June 2025.
- Inequalities workshops with Asian community pregnant/birthing people exploring experiences relating to pregnancy and birth and pregnancy loss. The feedback will support continued quality improvement activities relating to access and experience in maternity and neonatal services for this group of service users to reduce inequalities in care.
- Improvement actions in progress relating to recommendations from the national confidential enquiry for maternal deaths (MBRRACE-UK – Saving Lives, Improving Mothers' Care 2024) including prevention of venous thromboembolism and the importance of language needs of recent migrant women being considered at all stages of maternity care.

Action Plans and Continuous Improvement:

Maternity providers continuing improvement work relating to the national Three-Year Delivery Plan for Maternity and Neonatal Services which incorporates national report recommendations (including Ockenden and East Kent reports).

CQC Maternity Survey conducted in Feb 2024 with results published in November 2024 nationally. All BSW providers scored positively with scores of "about the same compared to other Trusts performance" or "Better than expected compared to other Trusts performance" across the range of survey questions with no scores of worse than expected performance scores. Providers have identified any areas of focus for continued improvement actions with an action plan in place, this includes postnatal care and discharges.

Priorities for Patient Safety Specialists (published January 2025- including PSIRF update)

NHS
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Priority 1 - Supporting organisations to transition to and embed the LFPSE service

- BSW providers have been collaborating closely with their Local Risk Management Systems to ensure the seamless operation of LFPSE functions. Currently, providers are validating their data in preparation for the release of the national LFPSE dashboard.

Priority 2 – Ongoing Implementation of the Patient Safety Incident Response Framework

- Organisations nationwide are at various stages of implementing PSIRF. However, many BSW providers are further along, with PSIRF becoming embedded into practices. Tools are being considered for the ICS, and a PSIRF Maturity Matrix workshop is planned for April to develop a maturity audit tool, which will help both the system, and its partners recognise the level of implementation.

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

- **Maternity Webinar One** covered topics such as supporting proportionate responses, systems-based responses to PSIs, and overcoming challenges. [Link to Recording: PSIRF in Maternity - webinar 1 - NHS Patient Safety - FutureNHS Collaboration Platform].
- **PSIRF Training**: Training has been accessed via HSSIB, and BSW ICS commissioned MedLed to deliver additional face-to-face sessions in Autumn 2024. Providers across BSW are upskilling their Patient Safety teams to offer in-house training. The National PSIRF team is also gathering feedback from organisations that have developed their own in-house PSIRF training modules and have held focused groups.
- BSW has been participating in the piloting of PSIRF in primary care. The findings from the national pilot is expected soon.

Priority 3 - Improving Safety Culture

- BSW ICB is actively enhancing safety culture through several key initiatives:

1. **Implementation of PSIRF**: This framework shifts the NHS's response to incidents, promoting curiosity and learning from events to improve safety using the SEIPs methodology. The ICB remains a 'critical friend' and supports the system wide learning approach.
2. **Medication Safety**: The BSW Together Medicine Safety and Quality Group focuses on improving systems and practices related to prescribing, dispensing, and monitoring medications. They also encourage reporting patient safety events to learn and enhance practices.
3. **System Learning and Improvement**: The ICB is working with system partners to implement relevant oversight groups and specific improvement activity to maximise learning and system improvement e.g. UEC safety and learning group and the recent discharge audit.

Priority 4 – Supporting the response to National Patient Safety Alerts

BSW ICB is actively supporting the response to National Patient Safety Alerts (NatPSAs) through several key actions:

Local Compliance Mechanisms: The BSW ICB Quality schedule ensures local mechanisms are in place to comply with NatPSA actions, aligning with the NHS standard contract and national patient safety strategy.

Coordination and Oversight: The ICB coordinates with stakeholders, including clinical leads and safety teams, to oversee NatPSA implementation. This includes regular updates and reviews in provider reporting to ensure all necessary actions are taken.

Valproate Safety Group: For specific alerts like valproate safety, BSW ICB has established dedicated working groups with specialists to implement new regulatory measures and improve patient safety.

Priorities for Patient Safety Specialists (PSS)

NHS
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Priority 5 – Ongoing implementation of the Framework for Involving Patients in Patient Safety

- Acute providers across the system have established Patient Safety Partners (PSPs) who actively support the Patient Safety Strategy and their Executive Boards.
- The ICB supports PSPs and has held two workshops (2024 and 2025) to gather their views on the roles and how they can be further developed across the system.
- A system-wide PSP peer support group is planned for 2025
- BSW ICB will be recruiting PSPs in 2025/ 2026

Priority 6 – Improving Patient Safety Education and Training

All NHS employees, including non-patient-facing roles, are expected to complete certain elements.

There are five levels of training:

Level 1 &2 is online training and is recognised as mandatory training for all acute, community and mental health providers.

Further levels of training have been undertaken by key member of the provider quality teams with specific roles and Patient Safety Specialist across BSW have participated in the level 4&5 .training accredited by Loughborough University.

Priorities for Patient Safety Specialists

NHS
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Priority 7- Addressing patient safety improvement, including the implementation of Martha's rule in acute trusts

What is Martha's rule? It is a patient safety initiative to support patients, families, carers and staff to feel empowered to question if they have any worries or concerns about the treatment of a patient, and to escalate those concerns if they feel that a patient is deteriorating. There are 3 components to Martha's rule:

1. Patient will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

All 3 Acute sites are part of phase 1 of Martha's rule roll out and by the end of March 2026 are expected to have implemented all 3 components of Martha's rule in all appropriate settings

The patient safety collaboratives, that sit within the Health Innovation Networks (HIN) are providing implementation and Improvement expertise through delivery of Quality Improvement methodology and facilitating Communities of Practice (COPs)

The national publication of results from all pilot sites is awaited. During 25/26 the national programme will continue to work with pilot sites. There will be on-going discussions exploring the testing in the following settings:

1. Mental Health
2. Community
3. Maternity
4. Neonates

Priorities for Patient Safety Specialists (PSS)

NHS
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Priority 8 – Improving patient safety in primary care

The Primary Care Patient Safety Strategy was launched in September 2024 and focuses on:

1. developing a supportive, learning environment and just culture in primary care, with sharing across the system so that the services can continually improve

2. ensuring that the safety and wellbeing of patients and staff is central, and that our approach to managing safety is systematic and based on safety science and systems thinking

3. involving patients in the identification and co-design of primary care patient safety ambitions, opportunities and improvements

- Across BSW, General Practices were invited to express interest in becoming pilot sites for the implementation of PSIRF, led by Deputy Chief Medical Officer.
- Primary Care is now represented at the Patient Safety Community of Practice meeting, encouraging involvement in key discussions and decisions. Comprehensive support is offered to primary care, including collaborative efforts between Quality and Safeguarding teams. Assurance visits are conducted as needed to provide additional guidance and support.
- Renewed focus during 25/26:

Bath and North East Somerset, Swindon and Wiltshire
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DRAFT Minutes of the BSW Integrated Care Board – Finance and Infrastructure Committee Meeting

5 March 2025, 09:00-11:30hrs via MS Teams

Members present:

Julian Kirby	Interim Finance Committee Chair - BSW ICB Non-Executive Director for Public and Community Engagement
Gary Heneage	BSW ICB Chief Finance Officer
Amanda Webb	BSW ICB Chief Medical Officer
Sue Harriman	BSW ICB Chief Executive
Alison Moon	BSW ICB Interim Non-Executive Director for Quality

Attending:

BSW ICB Deputy Chief Finance Officer
BSW ICB Assistant Corporate Secretary *(minutes)*

Sarah Green	BSW ICB Chief People Officer
Stephanie Elsy	BSW ICB Chair

BSW ICB Associate Director of Finance – for item 9b
BSW ICB Programme Director (Special Projects) – for item 9a and 9b
SFT Director of Finance – for item 9a
BSW ICB Head of Planning and Performance Oversight - for item 8
BSW ICB Head of Digital Transformation - for item 10

Paul Fox	Observer – recently appointed NED Finance

Apologies:

Claire Feehily	BSW ICB Non-Executive Director for Audit
Rachael Backler	BSW ICB Chief Delivery Officer
Laura Ambler	BSW ICB Executive Director of Place (BaNES) & LDAND, CYP
Sam Mowbray	Partner Member of the Board Local Authority Partner Member

1. Welcome and Apologies

1.1. The Chair welcomed members and officers to the meeting of the BSW Integrated Care Board (ICB) Finance and Infrastructure Committee. The meeting noted the newly appointed BSW ICB Non-Executive Director for Finance and Infrastructure joined the meeting for the welcome and apologies.

1.2. The above apologies were noted, the Chair noted that the meeting was quorate.

1.3. The meeting would be recorded to support the production of the minutes, the recording would be deleted in line with policy.

2. Declarations of Interest

2.1. The ICB holds a register of interests for all staff and Board members, no declarations were noted prior or during the meeting.

3. Minutes from the meeting held on 5th February 2025

3.1. The minutes of the meeting held on 5 February 2025 were **approved** as an accurate record.

4. Finance and Infrastructure Committee Action Tracker and matters arising

4.1. The item Planning Guidance Summary was noted as closed on the action tracker.

4.2 There were no matters arising.

5. Recovery Board and Financial Recovery Progress

5.1 The Committee **received** the Recovery Board and Financial Recovery progress providing an overview of the M10 position for the system for finance, workforce and activity in UEC and Elective. At Month 10 there is a year to date (ytd) variance of £16.3m which is broadly in line with the revised trajectory. The position is following the pro-rata share of £30m deficit funding and the year-end forecast is a deficit of £14.9m.

5.2 Since the March Committee paper pack was distributed, £15mil has been received from NHS England to enable the system to get to break even however there is work to be completed on how the money is worked through system and the methodology will go via the ICB Executive Management Meeting. It is noted that the £15mil is not enough to cover the RUH and SFT deficits.

5.3 The Committee discussion highlighted that despite the SFT sprints being undertaken, this has not given the results expected. Further in-depth discussions happened at Recovery Board on Friday 28th February, the sprint was completed over a 3-month period during winter in which demand increased. A Recovery Director has been appointed to support the key gaps in the redesign to address the instability.

5.4 The discussion further noted there will be a focus going into planning rounds to address the NCTR numbers across the three hospitals as this drives the escalation beds which is a driver of cost and workforce numbers. There is an improvement to productivity, additional benchmarking has been released and the BSW ICB is working with providers to demonstrate the improvement in plans. There will be a review of primary care performance and a review of the data which looks at UEC Performance.

5.5 The Committee **noted** the update provided and mitigating actions being taken.

6. BSW ICB and System Revenue Positions 2024/25

6a. BSW ICB Position at Month 10

6a.1 The Committee **received** and **noted** the paper for the ICB Position at Month 10, the ICB has changed its forecast for month 10 to recognise an expected £8.4m surplus as part of the system delivering a £14.9m deficit. Due to the funding being received the forecast may move again in month 11. The biggest risk to the delivery of the ICB forecast continues to relate to anticipated funding for ARRS and ERF. The required funding forms part of both regularly monthly reporting to NHSE.

6a.2 The discussion noted the efficiencies savings are positive but there would need to be further clarity on what may be non-achieved and what reflection would be undertaken. There would be additional reporting in building dashboards for next year.

6b. BSW ICS Position at Month 10

6b.1 The Committee **received** and **noted** the paper for the ICB Position at Month 10, which was covered during item 5.

6c. NHS BSW Capital Programme –2025/26 Draft Plan Submission

6c.1 The Committee **received** and **noted** the paper for the NHS BSW Capital Programme –2025/26 Draft Plan Submission. The following summary was highlighted to the committee:

- Capital allocation was £113mil and first submission came at £78mil, all actions discussed in depth at Recovery Board.
- £39mil of operational capital, however due to day-to-day demands not enough of this capital as an allocation to this system.
- First year of the Primary Care utilisation fund, looked at the outputs of PCN toolkit to prioritise 10 revenue neutral investments across Primary Care as per NHSE guidelines.

6c.2 There is a capital allocation of £41mil to expand the community diagnostic sites but no additional revenue for the expansion. This is not affordable across the system and the ICB is exploring alternative ways to use the community funding to fund other diagnostic areas. The Committee agreed a careful approach is needed.

7. BSW Investment Panel Update

7.1 The Committee **received** and **noted** the BSW Investment Panel Update Paper. The Recovery Board had asked the Investment Panel to review the cases that were approved previously in the financial year on the basis of ERF affordability and identified the three cases which met this criteria. Two of the cases submitted the additional information required and the cases came back to the panel for review while the third case has not submitted the additional information.

- The first case had recruited to the role and had the person in place therefore no savings could be made, and the case is also a significant clinical priority.

- Recruitment had not started on the second case and alternative options needed to be explored therefore more work to be done by RUH to look at other options for collaborative working with other providers.

7.2 The Investment Panel received a new investment request, the panel discussed the case however due to being in the planning round it would need to be looked at as part of financial and operations. Therefore, the decision was deferred until the outcome of planning round.

8. 2025/26 Planning Update

8.1 The BSW ICB Head of Planning and Performance Oversight Planning joined the Committee to provide the planning update. The formal submission is on 19th March 2025. The 2025/26 Planning Update Headline Submission Paper was **received** and **noted** by the Committee.

8.2 The financial update noted that there is a deficit of £52 mil across BSW system, and the underlying deficit has not improved. The cost base is continuing to grow, and an exercise is ongoing with each acute provider to look at plans and investments. A flash report for finances identified a route to breakeven but will mean providers supporting the plan to move all organisations from 4% CIP to 4.7% CIP. This equates to an additional efficiency of £11m for the Group and £10m for the ICB. The Group element is expected to be delivered from leveraging the benefits of a Group model.

8.3 The Committee discussion highlighted the 3 hospital organisational plans had different assumptions such as with workforce, beds reductions and inflation. Collaborative working is underway to work as a collective to understand the accountability of each area which is expected to lead to reform. The Boards of the three trusts are still working together to see how this will work in a collaborative space, the BSW ICB Chair wrote to the three chairs to ask them to move at pace to develop their infrastructure.

8.5 The data demonstrates variation between the three acutes against national benchmarking, there are improvement plans in place and collaborative working as a system to improve performance. Although NCTR was not a focus in the headline submission, provider plans are to achieve 10% target, this is really ambitious given the current NCTR position. NHSE feedback on the initial headline submission has shown some quick win areas for the ICB and targets to work on prior to full submission.

8.6 As part of workforce planning there is work with the chief people officers of the acutes to better understand and address the workforce issues and triangulation with the workforce agenda and the reform needed and looking at a stronger position to help transformation of service delivery.

8.7 The discussion noted there needed to be a focus on inequalities and transformation alignment of the plan and embedding the concept ensuring there is objectives around equalities and prevention.

8.8 As part of the next steps it will be important to submit the plan and look at delivery and work within the delivery groups and how they operate and there is an expectation they show development of plans and outcomes utilising outcome frameworks and investment in change of the model.

9. Commissioning and Business Cases Financial Assurance

[Commercial in confidence]

10. Update from Digital Delivery Group

10.1 The Committee **received** and **noted** the paper for the Update from Digital Delivery Group noting recent activity. The paper outlines the priorities for next 12 months and changes in reporting processes for this committee noting the 2025/26 planning guidance in which the digital strategy needed a refresh.

10.2 The BSW ICB Head of Digital Transformation joined the Committee, key recommendations include refreshing digital strategy and strengthen the reporting route including Business as Usual activities and a focus on the following:

- The Electronic Patient Record programmes across the acutes.
- The Integrated Care Record Programme is growing in use and a recent evaluation identified £9 of productivity savings for every £1 invested.
- Refreshing the Digital Strategy
- Utilisation of the digital market expansion and use of AI and improving the toolkits in line with policy.

10.3 The discussion noted delays in EPR rollout and queried what the board assurance was due to the risks to achievement and discussion of digital leadership. It is understood that there is an established shared care record committee in place already, some partners not engaged in this but are on to completing projects within this space to assist with rollout.

10.4 The Committee **noted** the item, and the update provided, regular updates will be brought back to the Committee during 25/26.

11. BSW ICB Finance and Infrastructure Committee Forward Planner (taken as item 10)

11.1 The forward planner included within the pack detailed the upcoming agenda items until March 2026. The Committee **noted** the item.

12. Any Other Business (taken as item 11)

12.1 No other business was raised prior or during the meeting.

12.2 The Chair closed the meeting at 11:06hrs

Next meeting of the BSW ICB Finance and Infrastructure Committee:
Wednesday 2 April 2025, 09:00-11:30hrs via MS Teams

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	13a
Date of Meeting:	20 March 2025		

Title of Report:	Finance Report - BSW ICB and NHS ICS Revenue Position
Report Author:	Michael Walker, Head of Financial Accounting - Reporting
Board / Director Sponsor:	Gary Heneage, Chief Finance Officer
Appendices:	Month 10 Reporting Pack

Report classification	Please indicate to which body/collection of organisations this report is relevant. *Only one of the below should be selected* (x)
ICB body corporate	
ICS NHS organisations only	X
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	
3. Excellent health and care services	

Previous consideration by:	Date	Please clarify the purpose

1 Purpose of this paper

The purpose of the paper is to provide an update on the financial position of BSW Integrated Care System (ICS) at Month 10.

At M10 the system is reporting a £16.3m adverse position year to date (YTD) against a breakeven plan. This is £0.4m off the internal system recovery trajectory agreed by the internal recovery board.

The system YTD adverse variance of £16.3m is being driven primarily by:

- £9.6m related to higher bed use including NCTR above plan
- £10.4m related to challenges to delivery of efficiency plans due to operational demand pressures.
- £4.7m non-pay and additional clinical supplies/drugs pressures
- (£8.7m) additional income from elective delivery and other income

Recovery actions are being pursued by all organisations and monitored via an internal recovery board.

A further allocation of £15.0m has been received in Month 11 which will enable the system to achieve break even by the end of the financial year.

2	Summary of recommendations and any additional actions required
The Board is asked to **note** the report and the financial position of the system.	

3	Legal/regulatory implications
The system has an obligation to work together to deliver the submitted and approved system plan for the year and to work to delivery of a break-even position. Each organisation also has individual statutory requirements to meet.	

4	Risks
If the system doesn't deliver a breakeven position, then there is a risk that deficits will need to be repaid in 25/26 which will increase the future efficiency requirements. Non delivery will also lead to regulatory qualifications. Deficits may mean that NHS providers will need to request additional cash support from NHSE which will lead to additional PDC charges.	

5	Quality and resources impact
The financial plan is contingent on the delivery of £141.9m of efficiency schemes. The information presented is an aggregation of GWH, RUH, SFT and ICB reporting metrics.	
Finance sign-off	Gary Heneage

6	Confirmation of completion of Equalities and Quality Impact Assessment
N/A	

7	Communications and Engagement Considerations
N/A	

8	Statement on confidentiality of report
The financial position noted within the reporting pack has been approved by all parties and reflects the position reported to their Boards. It is therefore sensitive but not confidential.	

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

NHS BSW ICS Finance Report

January 2025 (Month 10)

Executive Summary

NHS
Bath and North East Somerset, Swindon and Wiltshire
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- National reporting from Month 10 reflects the receipt of £30m deficit funding. Plans have been adjusted by organisation to report against the break-even position.
- Productivity continues to be above national levels.
- The M8 system position for BSW shows a £16.3m adverse variance against plan.
- Formal reforecasting guidance has been received, and the system is forecasting a £14.9m deficit at Month 10.
- **We have subsequently been informed that we will receive a further allocation of £15.0m in Month 11, this will enable the system to achieve break even at the year end.**

Key issues for escalation

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Alert, Assure, Advise	
Alert	• M10 YTD adverse variance of £16.3m • The key drivers are: continued UEC pressures, non pay and slippage against efficiency schemes • NCTR/Escalation continues to impact financial position. • The adverse variance at M10 represents a £0.4m divergence from the systems planned position after interventions.
Assure	• System FY forecast outturn agreed at £14.9m deficit. The forecast has been formally changed to this. This will be adjusted in M11 to reflect the additional allocation of £15.0m to bring the system back to break even. • This position is after the previously agreed £30m support funding. • The forecast for ERF has also been adjusted to reflect the ceiling of £84.4m.
Advise	• National reporting regarding ERF for 24/25 validated achievement has not been confirmed. There is c. £20m (M9 £32m) of anticipated ERF income in the reported position.

ICS revised in year financial trajectories

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	GWH				RUH				SFT				ICB				System			
	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG
Financial Position (£m)*	(1.7)	(1.8)	(0.1)		(8.9)	(9.0)	(0.1)		(12.4)	(12.6)	(0.2)		7.1	7.1	0.0		(15.9)	(16.3)	(0.4)	

Month 10 Financial position vs Plan:

- The system is reporting a £0.4m variance against the revised financial trajectory.
- This represents an adverse movement from Month 9 of £3.4m (M9 YTD £12.9m).
- The system has had detailed discussions with NHS England, and the full-year outturn position has been aligned to a £14.9m deficit.

RAG Ratings	
RED	Over 15% deviation against YTD plan
AMBER	Between 5-15% deviation against YTD plan
GREEN	Between 0-5% deviation against YTD plan

Note: additional allocation of £15.0m in Month 11 to bring the system back to break even

ERF is making a significant contribution to our position as we are over-delivering against our target

NHS
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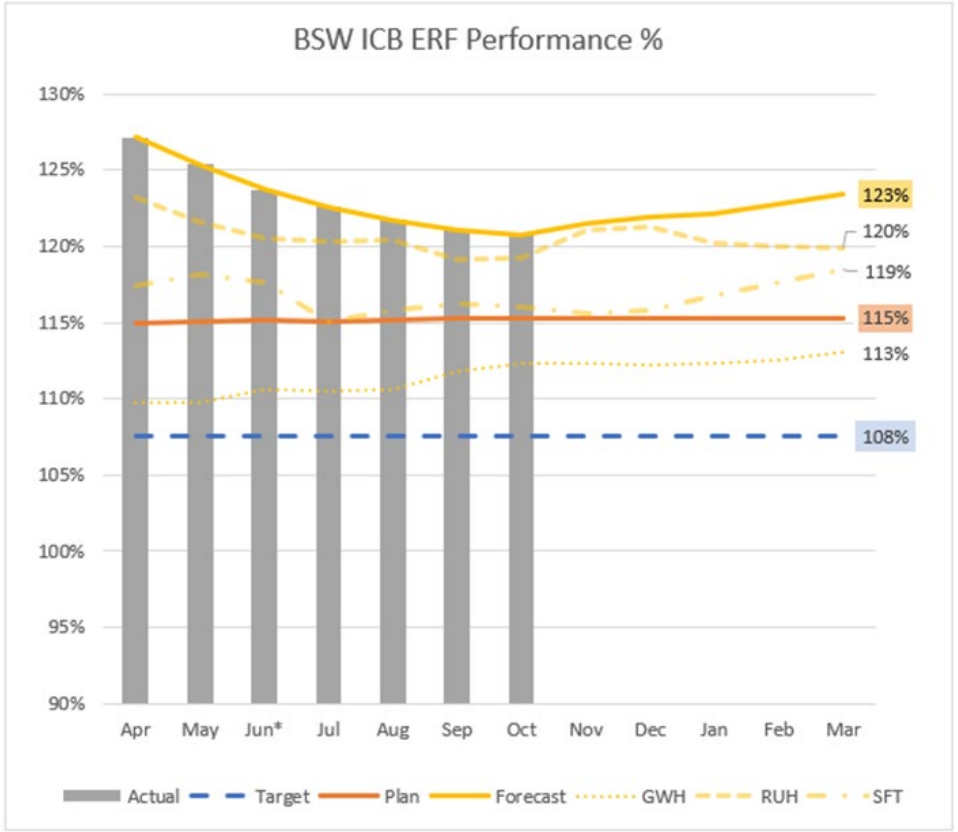
Elective Recovery Fund (BSWICB) - Month 10	Year to date £m				Annual £m			
	Baseline (100%)	Actual	ERF income year to date	%	Baseline (100%)	Forecast	Income above baseline	%
GWH	63.3	71.0	7.8	112.3%	75.5	85.4	9.9	113.1%
RUH	56.3	67.8	11.4	120.2%	68.5	82.1	13.6	119.9%
SFT	36.7	42.9	6.2	116.8%	44.2	52.4	8.2	118.5%
Inter	20.3	22.7	2.4	112.0%	24.6	27.6	3.0	112.2%
Independent	41.6	56.4	14.8	135.5%	50.4	69.3	18.9	137.4%
A&G BSW system	-	5.9	5.9	-	-	8.1	8.1	-
CDC Income	-	1.2	1.2	-	-	1.4	1.4	-
Total	**218.2**	**267.9**	**49.6**	**122.7%**	**263.2**	**326.3**	**63.1**	**124.0%**
Target	**234.8**	**107.6%**			**283.2**	**107.6%**		
Income above target	**33.1**	**14.1%**			**43.2**	**15.3%**		



- Overall ICB year to date performance is 122.7% compared to stretch plan of 117%
- Forecast performance is 124% generating additional ERF income of £43.2m above target
- Performance data is awaiting national validation. There are small differences between ICB and Provider reported data.

ICS Efficiencies & Recurrent Position

NHS
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	YTD Plan £m	Actual £m	Variance £m	Delivery %	Full-Year Plan £m	Forecast £m	Forecast Variance £m	Delivery %
Recurrent								
Provider Pay	25.4	14.6	(10.8)	58%	31.9	19.4	(12.5)	61%
Provider Non-Pay	9.7	6.5	(3.1)	67%	12.1	10.0	(2.2)	82%
Provider Income	10.9	16.1	5.2	147%	13.3	21.9	8.6	165%
Provider recurrent efficiencies	46.0	37.3	(8.7)	81%	57.4	51.3	(6.0)	89%
ICB recurrent efficiencies	11.2	11.2	0.0	100%	13.4	13.4	0.0	100%
All SYSTEM recurrent efficiencies	**57.1**	**48.4**	**(8.7)**	**85%**	**70.8**	**64.7**	**(6.0)**	**91%**
Non recurrent								
Provider Pay	10.3	11.0	0.6	106%	13.1	13.5	0.3	103%
Provider Non-Pay	4.5	2.2	(2.3)	48%	6.4	3.1	(3.3)	49%
Provider Income	2.2	4.0	1.8	184%	2.8	4.7	2.0	171%
Provider non-recurrent efficiencies	17.1	17.2	0.1	101%	22.2	21.3	(1.0)	96%
ICB non-recurrent efficiencies	40.8	38.9	(1.9)	95%	48.9	47.7	(1.3)	97%
All SYSTEM non-recurrent efficiencies	**57.8**	**56.1**	**(1.7)**	**97%**	**71.2**	**68.9**	**(2.2)**	**97%**
SYSTEM total efficiencies	**115.0**	**104.5**	**(10.5)**	**91%**	**141.9**	**133.6**	**(8.3)**	**94%**

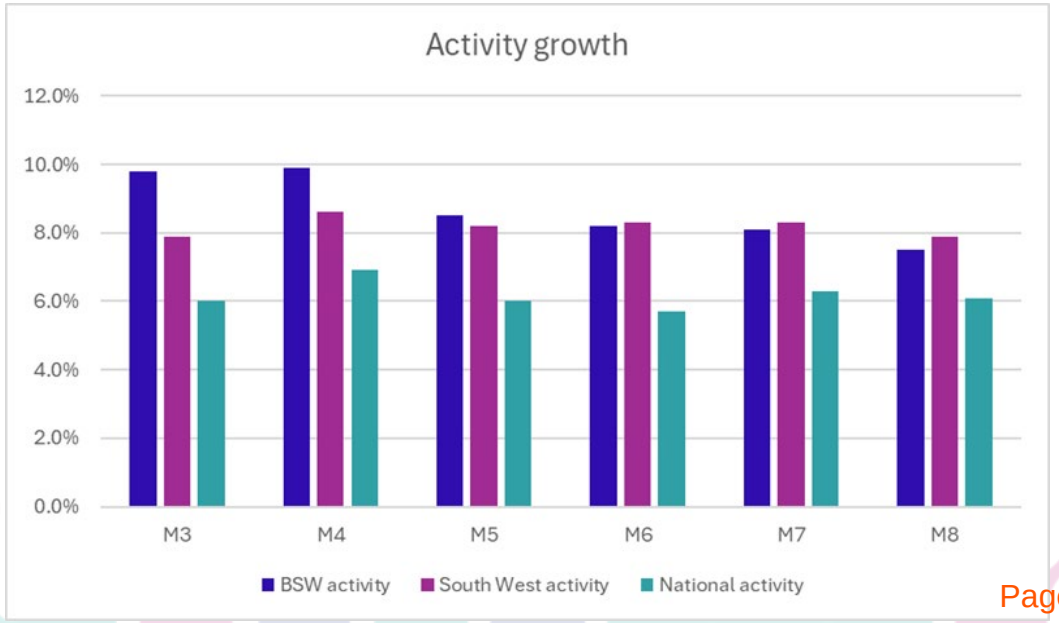
Efficiencies by Organisation	YTD Plan £m	YTD Actual £m	YTD Variance £m
GWH	17.7	14.3	(3.4)
RUH	28.8	26.4	(2.3)
SFT	16.6	13.7	(2.9)
ICB	51.9	50.0	(1.9)
	115.0	**104.5**	**(10.5)**

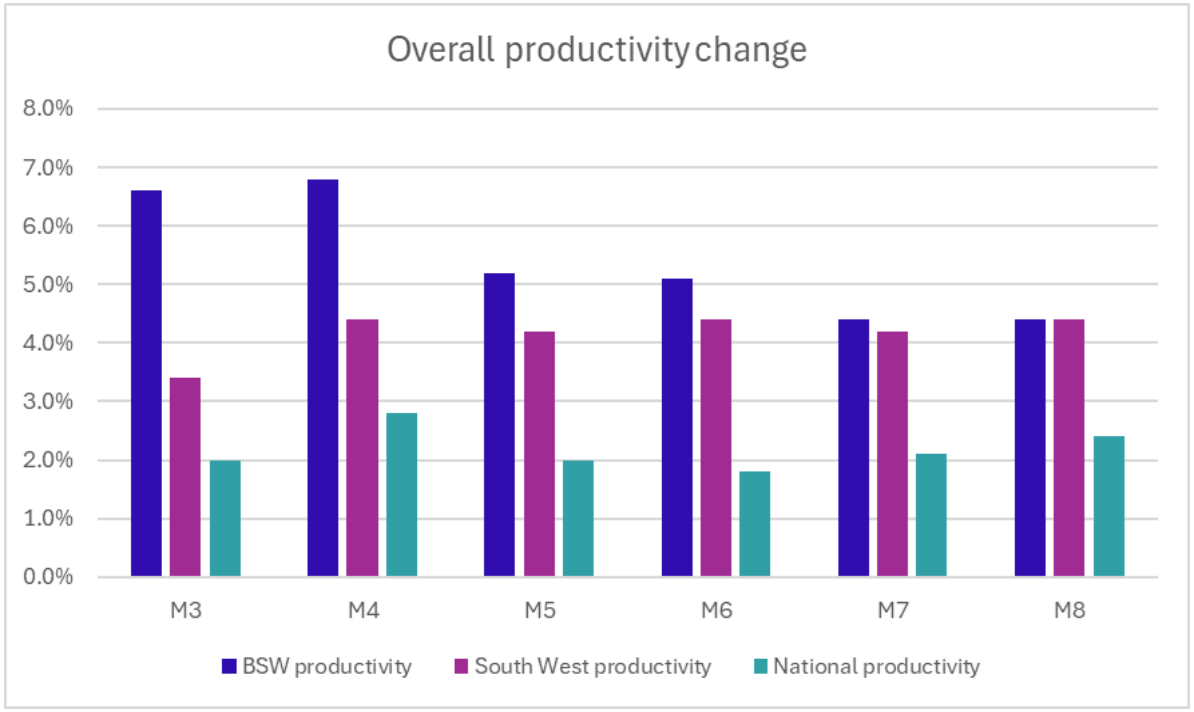
The 24/25 system plan includes £141.9m of efficiencies to deliver a breakeven position. This represents 7.0% of the overall system allocation. At M10 the system has reported forecast delivery slightly below the submitted plan, and £10.5m of slippage YTD.

Forecast planned recurrent efficiency schemes accounted for 48% of total schemes at Month 10 (Month 8: 48%).

We continue to outperform Regional and National productivity metrics

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





A continuation to drive BSW Productivity (4.6% regional view at Month 8) is better than the Southwest average of 4.4%, and the national average of 2.4%.

And are clear on the drivers of our variance to plan

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

At Month 10, the ICS has identified the following drivers of the £16.3m YTD variance*:

1. **Activity – Demand growth, NCTR and Bed base**
2. **Efficiency Schemes – challenging efficiency schemes given increased demand and operational challenges**
3. **Non-Pay – Clinical Supplies and Drugs**

Variance Drivers:	GWH	RUH	SFT	ICB	Total **
NCTR/Beds/Pay	(2.1)	(1.9)	(5.7)	0.0	(9.6)
Efficiency schemes	(3.4)	(2.3)	(2.9)	(1.9)	(10.4)
Non Pay	(2.2)	(4.8)	(3.4)	5.7	(4.7)
ERF/Income/Other	5.9	0.0	(0.6)	3.3	8.7
Month 10 Variance	**(1.8)**	**(9.0)**	**(12.6)**	**7.1**	**(16.3)**

We have identified actions to address these variances.

*Variance to break-even plan.
** Figures stated on a rounded basis, +/- £0.1m

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

DRAFT Minutes of the BSW ICB Commissioning Committee

Tuesday 11 February 2025, 09:30 – 11:00, via MS Teams

Members present:

Julian Kirby	Non-Executive Director for Public and Community Engagement
Pam Webb	ICB Partner member VCSE
Gill May	Chief Nurse Officer
Gary Heneage	Chief Finance Officer, *attended 10 -11 am*
Sue Harriman	Chief Executive Officer

Attending:

Rachael Backler	Chief Delivery Officer
Laura Ambler	ICB Executive Director of Place (BaNES)
Caroline Holmes	ICB Executive Director of Place (Wiltshire)
Gordon Muvuti	ICB Executive Director of Place (Swindon)
Olivia Lacey	ICB Communications and Engagement Lead
Stephanie Elsy	ICB Chair
Mark Harris	ICB Director of Business Support
Anett Loescher	ICB Associate Director of Governance, Compliance & Risk , *item 4*
Danni Harris	ICB Head of Planning and Performance Oversight, *Item 5*
Barry Young	ICB Associate Director of Finance, *item 9a*
Steve Maplestone	ICB Head of IM&T, *item 9b & 9c*
Richard Collinge	ICB Chief of Staff, *item 12*

Apologies (members):

Will Godfrey	ICB Partner Member Local Authorities (BaNES)
Alison Moon	Non-Executive Director Quality

1. Welcome and Apologies

1.1 The Chair welcomed members and officers to the meeting and noted apologies.

1.2 The meeting was declared quorate.

2. Declaration of Interests

2.1 The ICB holds a register of interests for all staff and committee members. None of the interests registered there were deemed to be relevant for meeting business.

3. Minutes of the Commissioning Committee – CC/24-25/003

3.1 The Committee reviewed the minutes of its previous meeting on the 10th December 2024 and approved them as a true and accurate record of the meeting.

4. Matters arising

4.1 The Chief Delivery Officer confirmed that they had spoken with the Place Directors about the impact of National Insurance increases on both the voluntary sector and domiciliary care across the system. Further discussion was needed on this complex issue prior to a decision on whether the Local Authorities and ICB's would be able to consider covering the additional cost in April '25 as part of contract uplifts.

Action: The ICB Executive Director of Place (BaNES) to formally write to the VCSE Partner member on the outcome of the discussions in relation to the Impact of National Insurance increases on voluntary sector and domiciliary care contracts across the system.

5a. Overview of Commissioning Responsibilities – CC/24-5/004

5a.1 The ICB's Associate Director of Governance, Compliance & Risk joined the meeting and presented a paper on the ICB's responsibilities for commissioning health and care services and explained the legislative background and the main arrangements in place.

5a.2 The Committee noted:

- The Health & Care Act 2022 summarises the ICB's fundamental function to commission health services that meet the needs and requirements of the people for whom the ICB has responsibility.
- NHS England has retained some commissioning functions for itself, however since 2022 NHS England has delegated significant aspects of its commissioning functions to ICBs, including primary care, pharmacy, ophthalmology and dental. A South West collaborative commissioning hub has been established that aims to support the South West ICBs to fulfil their delegated commissioning functions.
- NHS England holds the commissioning function for specialist services. Since April 2023, commissioning responsibilities for specialised services have been delegated to 9 statutory joint committees between NHSE and ICBs, that cover the whole of England.
- Section 75 of the NHS Act 2006 allows partners (NHS bodies and Local Authorities) to contribute to a common fund – the Better Care Fund- which can be used to commission health or social care related services. The ICB has in place Locality Commissioning Groups that oversee commissioning under the s75 agreements that the ICB holds with the three local authorities.
- Procurement and public involvement is part of the commissioning cycle and as such will also be in the scope of this committee.

5a.3 Committee discussion noted:

- That clarity is required to fully understand the ICB's statutory commissioning responsibilities noting the considerable number of acts and regulations that determine NHSE's, ICBs' and local authorities' commissioning responsibilities and powers.
- The importance of ensuring that NHS money is used effectively, and that there is clear oversight of and accountability for pooled budgets to ensure value for money and positive outcomes.
- The ICB Chair found the paper useful and suggested that a Board development session on the subject would be beneficial.
- The ICB Executive Director of Place (BaNES) explained the governance of the Better Care Fund (BCF) and the three Locality Commissioning Groups (LCGs).

Action: Executive Director of Place (BaNES) to look at the consistency of reporting for the BCF and LCGs.

5a4. The Committee **noted** the paper

5b. Commissioning Assurance Updates – CC/24-25/004a

5b1. The ICB Director of Business Support presented a paper detailing a collective summary of commissioning activities and issues being worked on across the ICBs portfolios.

5b2. The Committee noted:

- To better support portfolio teams' monthly meetings between the Delivery Directorate and portfolio leads will enable live discussion in response to performance, procurement or contracting issues.

5b3. Committee discussion noted:

- As a strategic commissioner of services, the ICB should have high expectations of our providers in delivering patient care, and contract performance notices should be used in a non-punitive way to work collaboratively to get performance back to where it needs to be.
- The ICB Partner member VCSE observed that the paper did not report how the ICB discharged its public involvement duties. Noted that this was an evolving report, and future iterations will report / provide assurance on the matter.

5b4. The committee **noted** the paper

6. BSW Operational Performance Report – CC/24-25/005

6.1 The ICB Head of Planning and Performance Oversight joined the meeting and presented the Operational Performance Report.

6.2 The Committee noted:

- There has been a decrease in the number of ambulance incidents and an increase in see-and-treat rates, however although there is some improvement in category two performance it still remains below plan.
- Ambulance handover delays remain challenged with a large increase during December which is not coming down. Consequently, the four-hour Emergency Department (ED) performance remains below trajectory. Provisional data for January is seeing some improvement due to a number of actions including ED validation work via 111 which has seen reduced conveyances to ED.
- There has been some improvement in the non-criteria to reside, however the situation remains volatile. Daily operational meetings are occurring to try and improve the position, with a revised plan aiming for 11.6% by the end of March ’25.
- The 28-day cancer diagnostic standard is being achieved at GWH and SFT, with RUH remaining challenged in some areas. In terms of the cancer 62-day referral to treatment standard remains off plan for all three acute trusts.
- All 65+ week waiters will be completed by the end of March ’25, with the exception of corneal transplants, due to national shortage of tissue.
- There is a significant challenge around dental access and whist improvements are being made to oral health, i.e. making sure children are brushing their teeth to avoid extractions, the ICB is measured on how regularly people can access dental services. Operational planning guidance is firmly in the space of how the ICB can commission extra dental activity.
- Data quality improvements have been made to CYP access; however, performance issues remain challenged with further deterioration. The issues have been isolated to one provider; a plan is in place which will move to a contract performance notice if there is no improvement over the next few weeks.

7. Risk Register – CC/24-25/006

7.1 The Committee **received** and **noted** risks pertaining to the Commissioning Committee’s remit.

8. ICBC Mobilisation Update – CC/24-25/007

8.1 The Committee **received** and **noted** the ICBC Mobilisation progress report.

[Commercial in confidence]

9. Investment Panel Update & Pipeline – CC/24-25/008

9.1 The Chief Financial Officer gave an overview of the investments panel’s processes and activities, including the review of ten business cases, nine of which have been approved.

9.2 Following notification of changes to elective recovery funding in November ’25, new short-term principles were introduced to tighten the process around business cases that were predicated on ERF income. Three business cases will go to the next investment panel for review to see if they should be continued.

9.3 The Committee **noted** the paper.

10. Business Cases

[Commercial in confidence]

11. Specialist Commissioning Delegation for 2025/26 onwards – CC/24-25/010

11.1 The Committee **received** and **noted** the specialist commissioning delegation paper to commence the governance sign off. Final delegation approval will take place at the ICB Board in March 2025.

11.2 The ICB Director of Business Support highlighted the following to the committee:

- It is now formally agreed that Somerset ICB will be the principal Commissioner.
- Any complaints will be dealt with by a central team at Somerset ICB.
- It has been agreed that the ICB can continue to discuss issues directly with the provider collaborative, which is important for the mental health and well-being portfolios.
- The ICB’s named SRO for the delegated functions will be the ICB Executive Director of Place (Wiltshire).
- The Chief Delivery Officer reflected how specialist commissioning delegation will fit in with local strategy and benefit the local population. NHS England are reaching out to ICBs about the future specialist commissioning strategy and what that means to localities once delegation has been completed.

12. Strategic Commissioning Framework 2025/26 – CC/25-26/011

12.1 The Committee **received** and **noted** the Strategic Commissioning Framework.

12.2 The Chief Delivery Officer highlighted the following to the committee:

- In the first years of ICBs there has been less emphasis placed on the importance of commissioning. However, there is now significant national conversation happening about the role of ICBs in commissioning and how it can be developed and strengthened over the next few years.
- As part of the work NHS England is developing a revised commissioning cycle and is emphasising the need for partnership working.
- The National Strategic Framework Working Group are aiming to publish a new framework by the end of March 2025. Early thinking describes the need for each system to develop a five-year strategic commissioning plan aligned with the Joint Forward Plan.
- Local planning is considering how to assess the needs of the population and developing a set of outcomes.

12.3 Committee discussion noted:

- Not to underestimate what resource would be needed to go from an outputs type contract to an outcome measures contract, and the affordability of an outcomes contract which tends to be longer.
- The Chair of the ICB queried what the Government's thinking is around delegating commissioning responsibilities to providers and though an ICB Board development session on the subject would be beneficial.

Action: Chief Delivery Officer to include the strategic commissioning framework and commissioning framework and responsibilities paper into a future ICB Board development session

13. Public Involvement – CC/24-25/012

13.1 The Chief of Staff highlighted that in July '24 the ICB Board had been briefed on the intent to place people at the heart of all engagement. He acknowledged that this has not progressed at the pace they would have liked partly due to workforce constraints and a significant amount of reactive work that has been required.

13.2 The ICB Communication and Engagement Lead highlighted the following to the committee:

- In Autum 2024, the government launched a conversation about the future of the NHS in order to shape a new 10-year health plan for England. This has given the ICB a mandate to engage with the population in a way that has not been seen before.
- Relationships with the ICB Delivery Groups will see communication and engagement embedded in programmes and delivery plans.

13.3 Committee discussion noted:

- With clearer commissioning intentions falling out of the operating plan for 2025/26 it will become easier to join up the engagement activity.
- The opportunities to build a community of practice across the BSW system.
- The importance of linking in with regional and national communications when engaging with public around service change and staying within the financial budget.

Action: ICB Communication and Engagement Lead to share the consolidated summaries of the 10-year-plan engagement with the Chair of the ICB

- Engagement should be embedded in everything the system does, and the public should be involved in creating strategy.

14. Forward Plan

14.1 The draft forward plan was not included in the paper pack; it will be shared with the Committee following further development.

15. AOB

15.1 The Committee reflected on the meeting and noted that there were several requests for items to be forwarded to the ICB Board. The Chief Delivery Officer and the Chief Executive reminded Committee members that in the new ways of working the Sub-committees of the ICB Board were able to consider and discharge organisational and NHS business items and pass relevant messages to the board. It was recognised that sometimes it would be useful for Board members to be sighted on information, that could be circulated outside of the ICB Board.

Action: Committee members to feedback about the first Commissioning Committee to the Chair or Chief Delivery Officer.

15.2 There being no other business, the chair closed the meeting at 12:30pm.

Next meeting: Tuesday 22nd April 2025, 09:30- 12:30 , MS Teams

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	14a
Date of Meeting:	20 March 2025		

Title of Report:	BSW Performance Report
Report Author:	Jo Gallaway, Planning and Performance Oversight Lead
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	Performance Report

Report classification	
ICB body corporate	
ICS NHS organisations only	Yes
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	X
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
ICB Commissioning Committee	10/02/25	Assurance
ICB Executive Management Meeting	19/02/25	Review of performance across the oversight framework domains

1	Purpose of this paper
The aim of this paper is to provide oversight and assurance on the safe and effective delivery of NHS operational performance to key ICB Governance meetings, particularly the Commissioning Committee and the ICB Board.	

Performance is considered in detail at a number of executive-led meetings within the system and therefore this report presents items for assurance and where necessary, escalation, for the meetings attention.

2	Summary of recommendations and any additional actions required
The Board is asked to receive this report for assurance purposes.	

3	Legal/regulatory implications
This report is part of the BSW assurance framework including the delivery of: NHS Oversight Framework, the NHS Constitution and the NHS operational plan.	

4	Risks
Performance delivery risks sit across the divisional risk registers. Risks scoring above 15 are escalated to the ICB corporate risk register. There are several risks on the BSW ICB Corporate Risk Register that reflect the challenges to delivering Operational Performance – these are considered at the Commissioning Committee as part of their review of the performance report and associated risks.	

5	Quality and resources impact
Quality impacts linked to the performance of the system are highlighted in the separate Quality reporting considered by the Quality and Outcomes Committee. The oversight of the safe and effective delivery of care across commissioned services is monitored through provider quality reporting, quality assurance meetings and visits, with participation from the ICB Patient Safety and Quality team to assess learning, agree and monitor improvements.	
Finance sign-off	Not required.

6	Confirmation of completion of Equalities Impact Assessment
N/A	

7	Statement on confidentiality of report
This report is not considered to be confidential.	

Overview of Operational Performance

1. Introduction and purpose of report

1.1. This report is provided to give an overview of current operational performance and to summarise the key information contained within the reporting attached to this document.

2. NHSE oversight

2.1. Implementation of the revised NHSE oversight framework has been delayed. We are now expecting the 2025/26 framework to be published at the end of March 25.

2.2. A Q2 review was undertaken in October 2024 (based on the 2023/24 framework). NHSE have confirmed no changes in ratings with the ICB, RUH and SFT in segment 3. GWH continue in segment 2. The next review is expected to be in Q1 based on the 2025/26 framework.

2.3. GWH and SFT have improved Cancer and Diagnostics performance and met the criteria to exit Tiering in October. RUH meetings stepped up to weekly but have now moved to fortnightly. BSW have now exited shadow tiering for RTT but remain in regional oversight meetings. BSW has continued in NHSE Tier 2 (regionally led support) for UEC.

3. Operational performance exceptions

3.1. The 2024/25 NHS Operational plan metric performance is being reviewed regularly in terms of risk to meeting the targets set for the year end plan position, given the performance year to date and known concerns / challenges with improving performance to meet the plan target. A summary of the position is shown in the report using the ‘alert, assure, advise’ framework. The Alert Section of the matrix identifies the metrics that have the highest risk of not meeting the targets we have set for 2024/25. Detailed exception reports on these items is reviewed and considered at the ICB Commissioning Committee.

3.2. **Urgent care** continues to be challenged over the Winter in particular, with significant demand due to infections and we are not meeting many of our operational planning targets. There has been some improvement in performance with Hospital @ home occupancy meeting the plan since November. The project to implement the timely handover process is a significant project for the system and due to deliver by March 25.

3.3. **Urgent Care – E.M.13 4 Hour % Total Attendances –** BSW 4hr performance increased in January (69,3%). GWH decreased slightly to 73.6% whereas SFT increased to 73.5% and RUH increased to 60.5%, however all providers continue to not meet plans. System recovery actions have included a pilot of senior clinical review of NHS111 dispositions to ED in January, an evaluation of the benefits vs cost will follow; and acute providers have been ED process mapping.

3.4. **Urgent Care – Amb.1 Ambulance – Average Response Time (Mins) Category 2 Incidents –** In BSW there was a decrease from 69 minutes in December to 57 minutes response time to category 2 incidents in January, above the 28 minutes planned. SWAST activity was very high in December (10.3% higher than Dec 23) and SWAST declared a critical incident at the end of December. Ongoing promotion of care co-ordination and more focussed daily calls to review call stacks are being put in place.

3.5. **Urgent Care – Amb.3 Ambulance – Average Handover Delays > 15 Minutes –** For Ambulance handover delays over 15 mins combined performance increased from 85 to 90 minutes. GWH continues to be the most challenged of the 3 acute trusts, with an average of 140-minute delays (up 25 minutes from December), RUH decreased in January to 76-minute delays (from 84 minutes in December) SFT continued with lowest delays, averaging 16 minutes in January (a decrease from December). The BSW Ambulance improvement Group is being relaunched for the end of February.

3.6. **Urgent Care – E.M.29 NCTR % Occupancy –** Overall BSW's NCTR occupancy is 19.4% in January. The highest NCTR occupancy % in January is at RUH at 21.8%. SFT met their H2 plan all other ICB and Trust plans were not met. Increased operational management of discharges has been put in place with daily NCTR meetings with all providers and a Care Transfer hub meeting twice daily taking a multi-agency approach.

3.7. **Elective Care – E.B.27 Cancer – 28 Days Faster Diagnosis Standard –** Cancer waiting time reporting for December shows BSW met the 28 day faster diagnostic standard improving to 77.9% (Acutes) and above plan. GWH and SFT met their plans however RUH performance remained below plan in January (variance of 1.6%). RUH continue in tiering for cancer where key recovery actions to increase activity and reduce waiting times are being monitored.

3.8. **Elective Care – E.B.35 Cancer – 62 Day Referral to Treatment Standard –** The 62 day standard performance has increased from November and was 73.6% in December above the plan of 73.4%. December performance at GWH of 73.4% falling marginally below plan of 73.7%, RUH at 71.8% against plan of 74.5% and SFT at 76.4% above plan of 70.1%. Executive focus and oversight for the recovery plans continues via the Elective Care Board.

3.9. **Elective Care – E.B.28 Diagnostics - % of WL > 6 Weeks – 9 Key Modalities –** Diagnostic (DM01) performance (the % of the waiting list over 6 Weeks - (BSW Acutes – all patients)) has increased in December to 27.8%. RUH continue in tiering for diagnostics, performance (provisional) deteriorated in December, mainly due to sickness (USS), MRI and Audiology activity (below plan) and delays in additional Echo activity. Remedial action plans are in place including maximising CDC capacity.

3.10. **Elective Care – E.M.8 Consultant-led First Outpatient Attendances –** Year to date first outpatient activity is 97.4% of plan however in January, first

outpatient activity was above plan for all three acutes. There are system actions in place to support a significant impact on outpatients by March 2026.

3.11. **Elective Care – E.M.9 Consultant-led Follow-Up Outpatient Attendances –** Consultant-led follow-up attendances have not met plan for January (variance 5289). RUH and SFT were over plan however GWH was below plan by 764. Looking at this as a % of 2019/20, the acute total for January is 108.7% (10.4% above plan 98.4%), not delivering the reduction planned. Work is underway to identify the greatest areas of variance in PIFU and first to follow up ratio, looking to share best practice across providers at specialty level.

3.12. **Elective Care – E.B.20 RTT – Waiting List 65+ Weeks –** RTT long waiters – There were 49 people (BSW Acutes) expected to be waiting at the end of February 2025 due to a mix of patient choice and capacity / complexity reasons. Actions to clear all 65 ww are continuing with weekly returns to NHSE regional team. RUH and SFT are planning clearance of 65ww for the end of March (except corneal transplants). GWH have identified risks to fully clearing 65ww by the end of March.

3.13. **Primary Care – E.D.22 Dental – % of Resident Population Seen by NHS Dentist – Adults – 24 Month Rolling and Primary Care – E.D.23 Dental – % of Resident Population Seen by NHS Dentist – Child – 12 Month Rolling –** Dental plans are new for 24/25: % of resident population seen by NHS dentist – both Adult and Children metrics are below plan at November 2024. The ICB is working to deliver the Government plan to recover and reform NHS dentistry. Actions underway include a rapid recommissioning process to replace contract hand backs and a project to understand where dental activity needs by patient demographics enabling focus on core 20 plus and deprived populations.

3.14. **Mental Health – E.H.9 CYP Mental Health Access –** CYP access (12 month rolling) in December is at 8,550 people which is 67.1% of the planned 12,742. Other (than Oxford Health) providers are working with NHSE to improve their MHSDS submissions to reflect the services they are delivering and provide historical data.
Development of Mental Health Support Teams workplan in progress and CYP access target apportionment to providers and improvement plans to deliver the target is also in development across all providers. To be formalised via contract variation.

3.15. **Mental Health – E.A.S.1 Dementia Diagnosis Rate –** Dementia diagnosis rates dipped in January for the first time in 2024/25 and continue below the plan trajectory. Swindon locality diagnosis rates are the lowest across BSW though improved on 23/24. Additional staff are having an impact on access, but this is slower than had been anticipated. AWP have initiated a Wiltshire and Swindon Memory Service improvement Project, expected delivery March 2025.

3.16. **Mental Health – E.A.4 Talking Therapies (TT) – Number of Adults Receiving a Course of Treatment –**, 4,690 people had completed a course of treatment in 12 months to December, not meeting the plan of 5,746. The work required by the TT service to bring key metrics in line with trajectory, as well as undertake recruitment is significant and at this point, we have not seen tangible improvement despite the additional investment and Full-Service Review (FSR) focus. AWP have submitted a Remedial Action Plan and are working through additional requirements requested by 31/3/25.

3.17. **Mental Health – E.A.4a Talking Therapies – Reliable Recovery Rate –** Talking Therapies Reliable Recovery rate is at 42.0% in December, below plan of 49.3%. The reliable recovery rate is consistently not meeting plan, the reliable improvement rate has exceeded plan for 5 out of 9 months however at 63.0% was 4.5% under plan (67.5%) in December

3.18. **Mental Health – E.H.31 Access to Transformed Community Mental Health Services** –Access in November continued to be above the plan, consistently performing above plan all financial year. 3rd Sector Alliance providers are now set up to submit to MHSDS, processes are being worked through to support technical capability to submit. All providers have offered assurance that their back-dated submissions will be complete by end of Jan 25. Community MH programme board mobilised to support the ongoing progress and development of the transformation.

3.19. **Learning Disability and Autism – E.K.1b_rate Inpatients (Rate per Million) All Age –** In February, adult inpatients slightly increased to 27 compared with 25 in Dec 2024 of these 19 are commissioned by the ICB and 8 are South West Provider Collaborative inpatients. We continue to discharge individuals with the longest lengths of stay. There remains fewer than ten children and young people – all of whom are commissioned by the Thames Valley CAMHS Provider Collaborative. A thematic review of CYP admissions is being concluded and the findings and recommendations will be presented to the April BSW LDAN Delivery Group. Direct management of inpatients through the weekly practice forum continues to deliver increased oversight of BSW ICB commissioned patients and discharge plans. All quality assurance visits and inpatient Care and Treatment Reviews (CTRs) are up to date for ICB commissioned patients.

4. Key workforce performance information

4.1. Agency usage expressed as a WTE continues to be below the planned levels submitted in the workforce plan, however performance does vary.

4.2. National targets relate to agency as a % of pay bill and is set at a target of less than 3.2%. All providers are significantly lower. This is alongside the reduction of off framework usage and improving price cap compliance, and a move towards NHSE price cap rates. BSW providers are adhering to this metric but there was a slight decrease in compliance in month.

4.3. Bank usage is above plan and continues to fluctuate with a slight reduction in the monthly amount of bank shifts used in month. This continues to be significantly above planned usage in all trusts and is a key driver of workforce spend above plan.

4.4. Reported vacancy rate is reported at 2.6% in January ’25. Whilst slightly better than previous months, work continues to be undertaken within the ICB with trusts to review reporting of WTE to ensure accuracy.

4.5. Sickness in month and for the 12 month period is consistent but slightly below target

4.6. 12 month rolling Turnover remains below the 12% target in the last year as well as in month turnover which is also below target

4.7. Further interrogation of workforce data including temporary staff usage, is reported as part of the monthly Workforce Assurance Report which reports to the System Planning Exec and Recovery Board.

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BSW Operational Performance Report March 2025

ICB Board, 20/03/2025

BSW Operational Performance Dashboard

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The following slides provide the latest published position on system-level key performance metrics. The data shows performance as appropriate for the metric for the BSW population, or the population being treated by BSW Acute providers.

The data is taken from the NHS oversight framework* and wider system metrics against the targets set out in the BSW 24/25 Operating Plan plus additional in year ambitions set by NHSE and BSW system partners.

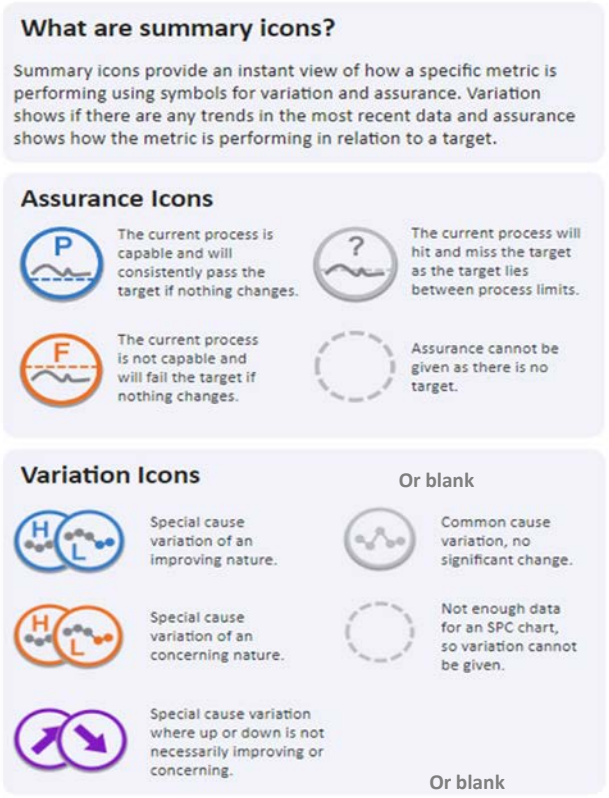
Each metric is supported by a statistical process control chart (SPC charts). SPC charts are constructed by plotting data in time order, calculating and displaying the average (the mean) and some data comparisons known as the upper and lower control limits as lines. These limits, which are a function of the data, give an indication by means of chart interpretation rules as to whether the process exhibits common cause (predictable) variation or whether there are special causes.

The summary icons shown in the dashboard indicate how a specific metric is performing using symbols for variation and assurance – more detail is shown on the right. The assurance icons are looking at delivering the target shown and are based on the actual numbers only and will not always reflect local knowledge.

Metrics with limited data points e.g. annual and those with planned / expected significant change across the year will usually need further interpretation outside of the SPC process.

The dashboard shows where the indicator is also a 2023/24 NHS oversight metric (SOF)*

* – see next slide for more information on the NHS oversight framework



Benchmarking - Metrics reported as part of the NHS Oversight Framework* include benchmarking out of 42 ICBs and this has been added for available metrics. The ranking is the latest reported on the SOF and may not be for the same period as reported in the IPD.

Finance metrics and their ranking is not included in the main oversight framework reporting. Ambulance metrics are only reported at total Trust level.

The box colour and the letter after the ranking represent the quartile: Highest performing - green, Intermediate - amber, Lowest performing- red.

Some metrics have a very few values and so the ranking for many ICBs will be at the same level these are marked as joint ranking with a "(J)" after the ranking number.

Latest update: January 2025

Benchmarking through the SOF is becoming less up to date as the focus is moved to developing the new system due 25/26.

Additional benchmarking is being used to supplement the SOF data where the data is available.

NHS Oversight Framework: BSW 24/25 Q2 Rating

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- Under the NHS Oversight Framework, NHSE are required to undertake quarterly segmentation reviews to identify where organisations may benefit from, or require, support to improve performance and quality of care outcomes for patients.
- The 2024/25 oversight framework went to consultation earlier this year and was expected to be shared during Quarter 2 but this has been further delayed. In the meantime, NHSE undertook a minimal Q1 desktop review and confirmed there were no changes in ratings. The 3 BSW acutes were all placed in Tier 2 for Cancer and Diagnostics in April as a system. In October it was agreed that GWH and SFT have met the exit criteria and can leave tiering.

2024/25 Q2	BSW ICB	GWH	RUH	SFT	AWP (Q3)
Overall Rating by segment 1-4	3 ⟺	2 ⟺	3 ⟺	3 ⟺	3 ⟺
Areas in which improvement and further assurance is required	Key areas of concern noted were • Elective – diagnostics • Mental Health CYP Access, CYP Eating Disorders, Talking Therapies and Dementia • Finance - efficiency, stability and agency spend • Virtual Wards • Urgent community response	Key areas of concern noted were • Finance - efficiency, stability and agency spend • Elective – diagnostics • Quality – CQC Maternity– Requires improvement • Cancer – 62 day backlog • SHMI	Key areas of concern noted were • Cancer – 62 day • Finance - efficiency, stability and agency spend • Elective – diagnostics	Key areas of concern noted were • Finance - efficiency, stability and agency spend • Maternity – safety support programme • Cancer – 28 day Faster Diagnostic Standard	Key areas of concern noted were • Workforce – Leaver Rate and Senior Leadership roles • Quality – CQC overall – Requires improvement • Agency spend
Tiering (Tier 2: regionally led support)	UEC – Tier 2		Cancer and Diagnostics – Tier 2		

- GWH have continued in segment 2 working through specific actions given to avoid segment 3.
- AWP were not issued a Q4 letter, in Q4 BNSSG ICB co-ordinated a separate well-led oversight review.
- NHSE ran a **Q2 review in October 2024**, and requested updates from the ICB against the previously identified areas of concern, noted above. We have been informed that there will be no changes to the ratings following the Q2 review.
- We are waiting for the new framework for 202/26 to be published, this will enable new ratings against this framework to be developed during Q1.

Segment	Support offered
1. High performing	No specific support
2. On development journey	Flexible peer support in system and NHSE BAU
3. Significant support needs	Bespoke mandated support led by NHSE region
4. Serious, complex issues	Mandated intensive support delivered through Recovery Support Programme

Alert Advise Assure

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Oversight of operational plan metric performance in terms of risk to meeting the year end plan position is shown below. Where there are multiple related metrics, core metrics have been identified for each area. More information on the metrics in the Alert and Advise sections is provided in the following slides

	Urgent Care	Elective Care	Primary care / Community	Mental Health	LDAN
Alert **- performance off plan now and most of year to date** **- high risk of not meeting year end target**	4 Hour % Total Attendances	Diagnostics - % of WL over 6 Weeks (9 Key Modalities)	% of Resident Population Seen by NHS Dentist - Adult - 24 month rolling	CYP Mental Health Access	LD - Inpatients (Rate per Million) All Age
	Ambulance - Average Response Time (Mins) Category 2 Incidents	Outpatient Transformation Consultant-led First Outpatient Attendances	% of resident population seen by an NHS dentist - Child - 12 month rolling	Dementia Diagnosis Rate	
	NCTR % Occupancy	Outpatient Transformation Consultant-led Follow-Up Outpatient Attendances	GP appointments where time from booking to appointment was two weeks or less %	Talking Therapies - Number of Adults Receiving a Course of Treatment	
	Ambulance – Average Handover Delays > 15 Minutes	RTT Long Waiters – 65+ Weeks		Talking Therapies - Reliable Recovery Rate	
		RTT Long Waiters – 52+ Weeks		Inappropriate Acute Mental Health Out of Area Placements	
Advise **- performance off plan or inconsistent or data issues** **- risk to meeting year end target**	G&A Bed Occupancy - Adult %	Cancer - 28 Days Faster Diagnosis Standard	Units of dental activity delivered		LD - % Annual Health Checks Carried Out
		Cancer - 62 Day Referral to Treatment Standard	GP Appointments		
		Cancer - Suspected cancer seen on a non-specific symptom's pathway	% lower GI suspected cancer referrals with FIT result		
			UCR Referrals – under review		
			Community Waiting List >52 Weeks		
Assure **- performance meeting plan** **- lower risk of not meeting year end target**		ERF (Elective Recovery Fund) - % Against 19/20 Baseline	Hospital @ Home: Average Occupancy %	Specialist Community Perinatal Mental Health Access	
				SMI Health Checks %	
				Access to Transformed Community Mental Health Services	

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URGENT CARE

*

Metric	Group	Benchmarking from NHSOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
4 hour % total Attendances SOF	ALL_ICB - ACUTE TOTAL	26 of 42 I	Jan-25	66.5%	69.3%	▲	76.0%	No	78.0%	▲		
4 Hour % Total Attendances (Uplift)	ALL_ICB - ACUTE TOTAL		Jan-25	69.8%	72.7%	▲	79.1%	No	78.0%	▲		
Ambulance - Average Handover Delays > 15 mins	ALL_ICB - ACUTE TOTAL		Jan-25	85	90	▲			25	▼		
Ambulance - Average Response Time (Mins) Category 2 Incidents SOF	BSW COMMISSIONER TOTAL	SWASFT level only	Jan-25	69	57	▼	28	No	30	▼		
Ambulance - Total Conveyances	ALL_ICB - ACUTE TOTAL		Jan-25	5,653	5,462	▼				▼		
Average number of adult patients in an acute hospital bed for 21 days and over	ALL_ICB - ACUTE TOTAL		Jan-25	211	238	▲	174	No		▼		
Discharges - Total	ALL_ICB - ACUTE TOTAL		Jan-25	6,467	6,337	▼				▲		
NCTR % Occupancy SOF	ALL_ICB - ACUTE TOTAL	35 of 42 L	Jan-25	18.4%	19.4%	▲	9.5%	No	10.0%	▼		
NCTR Beds Occupied	ALL_ICB - ACUTE TOTAL		Jan-25	264	286	▲	141	No		▼		

OCCUPANCY

Metric	Group	Benchmarking from NHSOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
G&A Bed Occupancy - Adult % SOF	ALL_ICB - ACUTE TOTAL	32 of 42 L	Jan-25	96.2%	97.8%	▲	97.4%	No	92.0%	▼		
G&A Bed Occupancy - Paeds %	ALL_ICB - ACUTE TOTAL		Jan-25	79.2%	66.7%	▼	82.9%	Yes		▼		
G&A Bed Occupancy - Total %	ALL_ICB - ACUTE TOTAL		Jan-25	95.4%	96.4%	▲	96.6%	Yes		▼		

* Latest Value (plan)- Based on submitted 2425 operational plans, and not updated to reflect H2 review

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

KEY for reading direction markers – on all dashboards:
▲▼ **Improvement Direction** - a fixed icon showing the direction for improvement for the metric – higher or lower.
▲▼ **Change** – the direction of the arrow denotes whether the latest value is higher or lower than the previous value
▲ the colour orange denotes the change is not in the direction for improvement
▲ the colour blue denotes the change is in the direction for improvement

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ELECTIVE CARE

	Metric	Group	Benchmarking from NHSOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
	Cancer - 28 Days Faster Diagnosis Standard SOF	BSW COMMISSIONER TOTAL	21 of 42 I	Dec-24	77.1%	77.9%	▲	75.9%	Yes	77.0%	▲	H	F
	Cancer - 31 Day Decision to Treat to Treatment Standard	BSW COMMISSIONER TOTAL		Dec-24	90.5%	92.4%	▲			96.0%	▲		
	Cancer - 62 Day Pathways SOF	ALL_ICB - ACUTE TOTAL	28 of 42 I	Feb-25	404	299	▼				▼	L	
	Cancer - 62 Day Referral to Treatment Standard	BSW COMMISSIONER TOTAL		Dec-24	66.7%	72.1%	▲	73.1%	No	70.0%	▲		
*	Cancer - Suspected cancer seen on a non-specific symptoms pathway	BSW COMMISSIONER TOTAL		Feb-25	27	16	▼	94	No		▲		
	Cancer - Waits >104 Days	ALL_ICB - ACUTE TOTAL		Feb-25	107	86	▼				▼		
	Diagnostics - % of WL over 13 weeks - All Modalities	BSW COMMISSIONER TOTAL		Dec-24	5.3%	5.8%	▲			0.0%	▼	L	F
	Diagnostics - % of WL over 6 Weeks - 9 Key Modalities	BSW COMMISSIONER TOTAL		Dec-24	21.6%	27.3%	▲	21.0%	No	5.0%	▼	L	F
	Diagnostics - % of WL over 6 Weeks - All Modalities SOF	BSW COMMISSIONER TOTAL	31 of 42 I	Dec-24	22.1%	27.3%	▲			5.0%	▼	L	F
	ERF (Elective Recovery Fund) - % Against 19/20 Baseline SOF	BSW COMMISSIONER TOTAL	1(J) of 42 H	Dec-24	122.1%	122.5%	▲	110.4%	Yes	107.1%	▲	H	P
	Outpatient Clock Stop Activity %	BSW COMMISSIONER TOTAL		Jan-25	47.8%	46.4%	▼	47.1%	No	46.0%	▲	H	
	Outpatient Reduction in Follow Up Attendances	BSW COMMISSIONER TOTAL		Jan-25	107.0%	106.1%	▼	99.4%	No	75.0%	▼		F
	RTT - Waiting List 52 Weeks+	BSW COMMISSIONER TOTAL		Dec-24	2,871	2,515	▼	1,224	No		▼	L	
	RTT - Waiting List 65 Weeks+ SOF	BSW COMMISSIONER TOTAL	14 of 42 I	Dec-24	148	120	▼	0	No	0	▼	L	F
	RTT - Waiting List 78 Weeks+	BSW COMMISSIONER TOTAL		Dec-24	8	9	▲			0	▼	L	F

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

* Please note
Suspected Cancer seen on a non-specific symptoms (NSS) pathway - the data is confirmed as correct by the receiving Trusts, the NSS pathway development has been changed / delayed since planning and hence the low data.

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QUALITY – Patient Safety

Metric	Group	Benchmarking from NHSOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
Beds closed due to D&V/norovirus like symptoms (Avg p/d)	ALL_ICB - ACUTE TOTAL		Jan-25	26	69	▲				▼		
IPC c.Diff Infection Rate SOF	BSW COMMISSIONER TOTAL	30 of 42 I	Mar-24	172.5%	168.8%	▼			100.0%	▼		
IPC E.coli Infection Rate SOF	BSW COMMISSIONER TOTAL	9 of 42 H	Mar-24	136.8%	137.4%	▲			100.0%	▼		
IPC MRSA Infection Rate SOF	BSW COMMISSIONER TOTAL	20 of 42 I	Mar-24	5	5	◄►			0	▼		
Number of Never Events	ALL_ICB - ACUTE TOTAL		Oct-24	1	3	▲			0	▼		
SHMI Rating (Summary Hospital Level Mortality Indicator) SOF	ALL_ICB - BY ACUTE	GWH 14(J) of 119 H	Nov-24		2					▼		
SHMI Rating (Summary Hospital Level Mortality Indicator) SOF	ALL_ICB - BY ACUTE	RUH 14(J) of 119 H	Nov-24		2					▼		
SHMI Rating (Summary Hospital Level Mortality Indicator) SOF	ALL_ICB - BY ACUTE	SFT 14(J) of 119 H	Nov-24		2					▼		
Mixed-Sex Accomodation Breaches	BSW COMMISSIONER TOTAL		Dec-24	334	572	▲				▼		

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

Data notes:
SHMI from oversight framework by Trust, key:1 higher than expected, 2 as expected, 3 lower than expected
Serious incidents -the PSIRF metrics will be reported when the system adoption and data quality demonstrate reliable reporting.
BSW Mortality Group is in place to analyse data, identify trends, share best practice and system quality improvement learning

BSW Integrated Performance Dashboard

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QUALITY – Patient Experience

Metric	Group	Benchmarking from NHSOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
Friends and Family Test (A&E) Percentage Positive	BSW COMMISSIONER TOTAL		Feb-24	81.0%	79.0%	▼				▲		
Friends and Family Test (Inpatient) Percentage Positive	BSW COMMISSIONER TOTAL		Feb-24	94.0%	92.0%	▼				▲		
Friends and Family Test (Maternity - Birth) Percentage Positive	BSW COMMISSIONER TOTAL		Feb-24	96.0%	93.0%	▼				▲		
Friends and Family Test (Maternity - Post Community) Percentage Positive	BSW COMMISSIONER TOTAL		Feb-24	90.0%	96.0%	▲				▲		
Friends and Family Test (Mental Health) Percentage Positive	BSW COMMISSIONER TOTAL		Feb-24	90.0%	89.0%	▼				▲		
GP Appointments Percentage With Good Experience - Annual SOF	BSW COMMISSIONER TOTAL	7 of 42 H	Dec-23		59.7%					▲		

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

Data notes:
SHMI from oversight framework by Trust, key:1 higher than expected, 2 as expected, 3 lower than expected
Serious incidents metrics are moving towards the PSIRF metrics.
A patient experience quality report will be shared

BSW Integrated Performance Dashboard

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COMMUNITY

	Metric		Group	Benchmarking from SOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
	Community Bed Occupancy		BSW COMMISSIONER TOTAL		Feb-25	93.6%	95.9%	▲	95.6%	No		◄►		
*	Community Waiting List - Local		BSW COMMISSIONER TOTAL		Jan-25	18,442	11,664	▼				▼		
	Community Waiting List >52 Weeks		BSW COMMISSIONER TOTAL		Jan-25	5	6	▲	0	No		▼		
	Community Waiting List >52 Weeks (Adult)		BSW COMMISSIONER TOTAL		Jan-25	5	6	▲	0	No		▼		
	Community Waiting List >52 Weeks (CYP)		BSW COMMISSIONER TOTAL		Jan-25	0	0	◄►	0	Yes		▼		
	Hospital at Home: Average Occupancy %	SOF	BSW COMMISSIONER TOTAL	5 of 42 H	Jan-25	98.8%	94.7%	▼	90.9%	Yes	80.0%	▲		
	Hospital at Home: Capacity		BSW COMMISSIONER TOTAL		Jan-25	171	171	◄►	175	No	175	▲		
	UCR % 2hour Response	SOF	BSW COMMISSIONER TOTAL	35 of 42 L	Nov-24	79.0%	79.0%	◄►			70.0%	▲		
	UCR Referrals		BSW COMMISSIONER TOTAL		Nov-24	1,870	1,915	▲	2,027	No		▲		

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

*January data is not complete as HCRG data not available while they were undertaking a review of community paediatric waiters to move methodology from RTT to Community waiting list in line with national requirement.

BSW Integrated Performance Dashboard

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

PRIMARY CARE

Metric	Group	Benchmarking from SOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
GP Appointments	BSW COMMISSIONER TOTAL		Jan-25	503,061	590,576	▲	598,195	No		▲		
GP appointments where time from booking to appointment was two weeks or less % SOF	BSW COMMISSIONER TOTAL	31 of 42 I	Jan-25	86.2%	86.3%	▲	90.9%	No	85.0%	▲		
IIF: Primary Care - % Lower GI Suspected Cancer referrals with an accompanying FIT result (CAN-02)	BSW COMMISSIONER TOTAL		Jan-25	79.3%	79.9%	▲	78.0%	Yes		▲		
Percentage of resident population seen by an NHS dentist - Adult - 24 month rolling	BSW COMMISSIONER TOTAL		Nov-24	28.4%	28.4%	▲	34.2%	No		▲		
Percentage of resident population seen by an NHS dentist - Child - 12 month rolling	BSW COMMISSIONER TOTAL		Nov-24	52.4%	52.7%	▲	57.9%	No		▲		
Units of dental activity delivered	BSW COMMISSIONER TOTAL		Nov-24	81,746	73,952	▼	75,512	No		▲		

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

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MENTAL HEALTH

Metric	Group	Benchmarking from SOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
Access to Transformed Community Mental Health Services SOF	BSW COMMISSIONER TOTAL		Nov-24	5,660	5,795	▲	4,950	Yes	6,114	▲		
CYP Mental Health Access SOF	BSW COMMISSIONER TOTAL		Dec-24	8,575	8,550	▼	12,742	No	13,830	▲		
Dementia Diagnosis Rate	BSW COMMISSIONER TOTAL	33 of 42 L	Jan-25	61.9%	61.3%	▼	65.6%	No	66.7%	▲		
Inappropriate Acute Mental Health Out of Area Placements	BSW COMMISSIONER TOTAL		Dec-24	5	5	◀▶	2	No	0	▼		
* SMI Health Checks %	BSW COMMISSIONER TOTAL		Dec-24	Q2 – 55.0%	56.0%		50.0%	Yes	60.0%	▲		
Specialist Community Perinatal Mental Health Access SOF	BSW COMMISSIONER TOTAL		Dec-24	1,150	1,145	▼	1,130	Yes	985	▲		
Talking Therapies - Number of Adults Receiving a Course of Treatment	BSW COMMISSIONER TOTAL		Dec-24	4,600	4,690	▲	5,746	No	9,651	▲		
Talking Therapies - Reliable Improvement Rate	BSW COMMISSIONER TOTAL		Dec-24	67.0%	63.0%	▼	67.5%	No	67.0%	▲		
Talking Therapies - Reliable Recovery Rate	BSW COMMISSIONER TOTAL		Dec-24	43.0%	42.0%	▼	49.3%	No	48.0%	▲		

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

* Please note:
SMI Health Checks – This metric is reported quarterly There has been a national change in the data source from Q2 which has seen a reduction in the results published both regionally and nationally. The BSW change is not expected to reflect a reduction in local performance. The changes continue to be reviewed.

BSW Integrated Performance Dashboard

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

LEARNING DISABILITY AND AUTISM

Metric	Group	Benchmarking from SOF	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
LD - % Annual Health Checks Carried Out SOF	BSW COMMISSIONER TOTAL	30 of 42 l	Dec-24	41.7%	48.6%	▲	50.0%	No	75.0%	▲		
LD - Adult Inpatients - Total (Rate per million) SOF	BSW COMMISSIONER TOTAL	14 of 42 l	Jan-25	36	35	▼	31	No	30	▼		
LD - Children Inpatients - Total (Rate per million)	BSW COMMISSIONER TOTAL		Jan-25	31	31	◀▶	16	No	10	▼		
LD - Inpatients	BSW COMMISSIONER TOTAL		Jan-25	32	31	▼	25	No	23	▼		
LD - Inpatients (Rate per million)	BSW COMMISSIONER TOTAL		Jan-25	35	34	▼	27	No	25	▼		

LD health checks are carried out once annually, performance starts at zero each year and most activity is in Q3 and Q4, the SPC assurance icons are not able to provide assurance on this performance format.

SOF Denotes a 2023/24 NHS oversight framework metric – see slide 2 for notes on benchmarking.

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

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	15a
Date of Meeting:	20 March 2025		

Title of Report:	Risk Management Framework – review
Report Author:	Anett Loescher, Associate Director of Governance, Risk and Compliance
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	1 – Updated Risk Management Framework

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	x
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	x
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	x
2. Fairer health and wellbeing outcomes	x
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
ICB Audit Committee	06/03/2025	Review of updated Risk Management Framework
ICB Policy Steering Group	11/03/2025	Review of updated Risk Management Framework

1	Purpose of this paper

We have been working to further develop the ICB's approach to risk management, including developing our risk management framework and our board assurance framework. At the ICB Board Development Session recently we have discussed risk and risk appetite in more detail.
We have now updated the ICB's Risk Management Framework (App 1) to reflect:

- The recent organisational change which has resulted in some changes of terminology, minor modifications of responsibilities re risk, and the establishment of a Senior Management Group which has within its remit the responsibilities of the now disbanded Risk Management Group;
- The refresh of the risk appetite statement using the Board's feedback from the February development session (we draw the Board's attention to the risk appetite section of this document and appendix C);
- The go-live and roll-out of the DecisionTime risk management tool which the ICB will be using as its risk record going forward.

As approval of the risk management framework is reserved to the Board, we therefore present the updated version for approval.

Risk training and support materials have been updated and risk training sessions for the ICB's risk leads and ICB colleagues have commenced in January.

We are further reviewing the Board Assurance Framework and this will come to the May Board for approval.

To note that the work to review the ICB's approach to risk closely links with current work to further develop the ICB's approach to planning, delivery and delivery groups, incl. tools to set outcomes and transformation targets and monitor their achievement.

2	Summary of recommendations and any additional actions required

The Board is asked to

- Approve the updated ICB Risk Management Framework incl. the updated risk appetite statement.
- Note the Board's input at recent development session is being used to inform our ongoing review of the Board Assurance Framework.

3	Legal/regulatory implications

The ICB is required to have in place adequate risk management processes and mechanisms.

4	Risks

No risks associated with the review of the Risk Management Framework. The Risk Management Framework is a risk mitigation in its own right because it sets the standard and guidance for how the ICB manages the risks that it faces.

5	Quality and resources impact
We expect a positive will benefit from the ICB's ability to recognise and identify risks early and to manage such risks appropriately.	
Finance sign-off	n/a

6	Confirmation of completion of Equalities and Quality Impact Assessment
n/a	

7	Communications and Engagement Considerations
We have engaged with the Board on the development of the risk appetite statements and the review of the Board Assurance Framework. The Board has also provided a steer for us to engage with other system partners on our approach to risk which we are considering how we carry out.	

8	Statement on confidentiality of report
This paper contains no confidential information and can be shared publicly.	

APPENDIX 1

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

BSW ICB Risk Management Framework

BSW ICB policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

BSW ICB Risk Management Framework

Purpose	Sets out BSW ICB risk management approach, risk management process, and responsibilities.
Document type	Policy
Reference Number	CP06
Version	1.3
Name of Approving Committee / Group	BSW ICB Board
Operational Date	12 January 2023
Document Review Date	January 2026
Document Sponsor (Job Title)	Rachael Backler, Chief Delivery Officer
Document Manager (Job Title)	Anett Loescher, Associate Director of Governance, Compliance and Risk
Document developed in consultation with	Executive Management Group BSW ICB Audit and Risk Committee
Intranet Location	Corporate Policies
Website Location	N/A
Keywords (for website/intranet uploading)	Risk, risk management, board assurance, board assurance framework, risk procedure

BSW ICB Risk Management Framework

Review Log

Version Number	Review Date	Reviewer	Approval	Reason for amendments
1.0	21/12/2022	Head of Risk and Information Governance	Audit Committee	Inaugural BSW ICB risk management framework, supersedes risk management framework adopted from BSW CCG
1.1	17/11/2023	Head of Risk and Information Governance	Audit and Risk Committee	Review of Risk Management Framework after a year of operation to include new process and roles and responsibilities.
1.2	22/12/2023	Head of Risk and Information Governance	Board (risk appetite statement); CDO (updates of process descriptions)	Addition of risk category descriptions, risk appetite statement; update of risk management processes due to establishment of risk management group
1.3	xx/02/2025	Associate Director of Governance, Compliance and Risk	Board	Comprehensive review to reflect updated approach incl. update of risk appetite statement, introduction of risk recording tool, and BAF review

BSW ICB Risk Management Framework

Summary

This Risk Management Framework for Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) establishes a structure for the effective and systematic management of ICB strategic and operational risks. It enables the ICB to have a clear view of the risks affecting each area of its activity, how those risks are managed, the likelihood of occurrence and their potential impact on the successful achievement of strategic and corporate objectives.

This Risk Management Framework sets out the ICB's approach to risk management, the risk management process, roles and responsibilities, and the governance and oversight arrangements that are in place to provide assurance that the ICB has processes in place to identify, record, manage, and report risks. This framework aims to:

a. ensure that risks to the achievement of the ICB's strategic and operational objectives are understood and effectively managed;
b. ensure that risks to the quality of services that the ICB commissions from health and care providers are understood and effectively managed;
c. assure the public, patients, colleagues, and partner organisations that the ICB is committed to managing risk appropriately, and has the processes in place to do so;
d. protect the services, colleagues, reputation, and finances of the ICB through the process of early identification of risk, risk assessment, and risk control and management;
e. effectively manage new and emerging risks associated with the development of new technologies and transformational programmes while making the most of innovation and opportunities;
f. ensure that the ICB adheres to regulatory compliance, acts lawfully and operates in an open and transparent way.

This document includes appendices that contain process descriptions, detailed descriptions of roles and responsibilities, and templates for risk register and board assurance framework.

BSW ICB Risk Management Framework

Contents

Introduction

This document

1. The ICB has a duty to assure itself that it 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.

2. This Risk Management Framework recognises that the ICB's risk management requirements, as a body corporate, are complex because the ICB has system functions, and its performance and achievement of strategic and operational objectives is closely connected with NHS partner organisations' performance. System risks may also be risks that are relevant to, or affect, the ICB.

3. This Framework is structured in two parts:
   - Part 1 sets out the ICB's approach to risk including risk appetite, and the Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Local Risk Registers (LRR) as key components of the ICB's risk management framework.

   - Part 2 describes the ICB's risk management process, and colleagues' roles and responsibilities relating to risk management. Appendices contain explanation of commonly used terms, guidance, and templates to facilitate proactive risk management throughout the ICB. Further information and contact points in relation to risk management are signposted throughout.

Scope

4. This Risk Management Framework applies to, and must be followed by, all colleagues of the ICB, and Board and Committee members. It applies to anyone who is contracted to work with and on behalf of the ICB, including external contractors, agency workers, and other workers who are assigned to BSW ICB.

5. This Risk Management Framework takes account of relevant national policy such as the National Quality Board's guidance on risk management, and NHSE guidance on risk management in ICSs. The Risk Management Framework takes account of regional arrangements such as the Southwest Collaborative Commissioning Hub and ensures the ICB's active engagement with the risk management activities of such regional arrangements.

Part 1 – BSW ICB Approach to Risk

Principles

6. The ICB is committed to having a risk management culture that underpins and supports the business of the ICB, including its system function and responsibilities.

7. The Board is ultimately responsible for ensuring that an effective risk-aware culture is in place and that risk is effectively managed, recorded and reported. This includes the process of risk escalation through the Board's assurance committees – this is an essential mechanism to ensure that senior managers, Executives and Board members are aware of emerging risks and that prompt action is taken to mitigate them.

8. Not all risks can be eliminated. Nor can strategic and business risks necessarily be avoided. Risk may be embraced and explored so that new and innovative schemes and projects can develop, e.g. transformation programmes. Considered risk is to be encouraged, together with experimentation and innovation but within authorised limits aligned to the ICB's risk appetite. The priority is to reduce and where possible eliminate those risks that impact on patient safety, and to reduce the ICB's financial, operational and reputational risks to tolerable levels.

9. The ICB's approach seeks to embed robust, transparent, proportionate and responsive risk management in the ICB's activities and processes relating to the discharging of the ICB's functions, duties and responsibilities. The purpose of such integrated risk management is to
    a. ensure that risks to the achievement of the ICB's strategic and operational objectives are understood and effectively managed;
    b. ensure that risks to the quality of services that the ICB commissions from health and care providers are understood and effectively managed;
    c. assure the public, patients, colleagues, and partner organisations that the ICB is committed to managing risk appropriately, and has the processes in place to do so;
    d. protect the services, colleagues, reputation, and finances of the ICB through the process of early identification of risk, risk assessment, and risk control and management;
    e. effectively manage new and emerging risks associated with the development of new technologies and transformational programmes while making the most of innovation and opportunities;
    f. ensure that the ICB adheres to regulatory compliance, acts lawfully and operates in an open and transparent way;
    g. To minimise the exposure of risk to the ICB, its colleagues and stakeholders and to protect the health and safety of all those to whom the ICB has a duty of care.

Risk Category

10. A risk may impact on several areas of business, for example finance, quality and performance. The risk category reflects where a risk's main impact may be, and the area(s) where planned risk-mitigating actions will predominantly occur. The ICB has agreed the following risk categories:

Category of Risk	Descriptor	Assurance Forum
Quality	Risks to maintaining and improving quality, and risks to compliance with quality standards including regulatory and performance standards. Risks to the quality of the patient experience.	Quality and Outcomes Committee
Safety	Risks to patient safety, and effectiveness of treatment and care. Risks to colleagues safety.	Quality and Outcomes Committee
Finance	Risks to all areas pertaining to finance and financial control including financial sustainability. Includes risks related to contractual enforcement issues.	Finance and Infrastructure Committee

Category of Risk	Descriptor	Assurance Forum
Workforce	Risks to capacity and capability, and to sustaining a skilled and effective workforce. Risks related to colleagues recruitment and retention, training and development (including succession planning) and organisational morale and culture.	Remuneration and People Committee
Regulation and Governance	Risks to compliance, and to the ability to demonstrate compliance, with regulatory standards; legal standards; standards of business conduct and governance (including Information Governance); statutory duties including those related to delegated functions.	Audit Committee; IGSG
Performance and Delivery	Risks to the ICB's and the system's ability to develop and deliver ICB / operational / system plans and priorities, including the required transformation programmes that ensure the delivery of equitable and improved outcomes for the citizens of BaNES, Swindon and Wiltshire. Risks to the commissioning of appropriate services that meet the population's needs.	Planning and Delivery Oversight Group; Commissioning Committee
Engagement and Partnership Working	Risks to effective engagement, involvement and communication with patients, carers, the public, clinicians and all other stakeholders. Risks to partnership working with wider ICS partners.	Commissioning Committee

Risk appetite

11. Risk appetite informs the target risk rating and identifies the amount of risk that we are prepared to accept, tolerate or be exposed to at any point in time. The ICB's risk appetite helps the ICB establish a threshold of impacts it is willing and able to absorb in pursuit of its objectives. Risk appetite – by defining how much exposure the organisation is willing to accept for the different categories of risk – provides a framework which enables the ICB to make informed management decisions.

12. Ultimately it is for the ICB to decide which risks it is prepared to accept. The Board of the ICB will agree the ICB's risk appetite; the Board will also agree the ICB's strategic objectives (as articulated in ICB and relevant BSW strategies such as the Integrated Care Strategy), identify the risks to achieving / fulfilling them, and agree its appetite for each risk identified to the achievement of the ICB's strategic objectives.

13. The Board will annually review the ICB's risk appetite. This review will result in a risk appetite statement. Risks throughout the ICB – whether these are risks to achieving strategic or corporate objectives, or risks relating to the ICB's daily operations – should then be managed within the ICB's risk appetite as stated in the risk appetite statement, or where this is exceeded, action should be taken to reduce the risk to within the ICB's risk appetite.

BSW ICB Risk Appetite Statement

14. The ICB aims to adopt a mature approach to risk-taking where the long-term benefits could outweigh any short-term losses. A mature approach means that the ICB is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust. In a mature approach, the ICB will work with strategic partners across the BaNES, Swindon and Wiltshire system to develop and review its risk appetite.

15. Risks will be considered in the context of the ICB's and the system's operating environment in line with the ICB's risk tolerance, and where assurance is provided that appropriate controls are in place, and these are robust and defensible.

16. The ICB will seek to minimise risks – i.e. choose ultra-safe delivery options that have a low degree of inherent risk – that could impact negatively on the quality of commissioned services, health outcomes and safety of patients, or on the ICB's ability to meet legal requirements and its statutory obligations. We will also seek to minimise any risk of adverse publicity, risk of damage to the ICB's reputation and any risks that may impact on our ability to demonstrate high standards of probity and accountability. It is expected that the levels of risk the ICB is willing to accept are subject to regular review.

Risk category	Strategic / Executive Lead	Risk appetite	Threshold score
Quality	Chief Nurse Officer	CAUTIOUS	8 (L2xI4, or L4xI2)
Safety	Chief Nurse Officer	CAUTIOUS	8 (L2xI4, or L4xI2)
Regulation and Governance	Chief Delivery Officer	CAUTIOUS	8 (L2xI4, or L4xI2)
Finance	Chief Finance Officer	OPEN	12 (L3xI4, or L3xI4)
Workforce	Chief People Officer	BALANCED	10 (L2xI5, or L5xI2)
Performance and Delivery	Chief Delivery Officer	OPEN	12 (L3xI4, or L3xI4)
Engagement and Partnership working	Chief Executive Officer	OPEN	12 (L3xI4, or L3xI4)

Risk Appetite	Description
MINIMAL	Avoidance of any risk or uncertainty. Every decision will be with the aim of terminating the risk.
CAUTIOUS	Preference for safe delivery options but is able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk.
BALANCED	Will consider all options and tolerate a modest amount of risk if the reward is demonstrated. Acceptance that some loss may occur in pursuit of the reward.
OPEN	Open to consider all options and take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward. Likely to choose an option that had a greater reward and accepts some loss.
HUNGRY	Eager to be innovative and take on risk to achieve strategic objectives. Will chose the option with greater reward and will accept any loss as the price for the reward.

Components of the ICB's risk management framework

17. The Board Assurance Framework (BAF) sets out the risks to achieving the ICB's strategic objectives and the controls that management are to put in place to minimise the likelihood or effect of those risks materialising. The BAF is built on and around the ICB's agreed risk appetite, on agreement regarding what is sufficient in terms of controls, and on agreement regarding what is sufficient in terms of the assurances that the controls are operating effectively. The Board regularly considers the BAF and makes decisions as to the addition and / or removal of risks to / from the BAF.

18. The ICB maintains one risk register which is organised in such a way as to

    a) facilitate the recording and reporting of risks by portfolio, including programmes and Delivery Groups associated with portfolios;

    b) facilitate the reporting of such operational risks (arising from the ICB's day-to-day operations) that are deemed particularly critical to the ICB's ability to fulfil its functions. These are risks that score highly in terms of their likelihood of occurring and their potential impact (scores of 15 and above); and risks that are assessed as less likely to occur with a major impact on the ICB (L score 1 x I score 5).

19. Each ICB Portfolio and each Delivery Group record operational risks arising from the Portfolio's and Delivery Group's day-to-day operations. Portfolios and Delivery Groups actively manage all recorded risks, and report risks that meet the thresholds under 18b to Senior Management Group (SMG) in the first instance.

20. The ICB has established the Senior Management Group (SMG) as an advisory group of the Executive Management Meeting (EMM). The SMG is a regular meeting of the ICB's senior managers that consider performance, delivery and risk in the round. The SMG robustly reviews the ICB's risk registers and the BAF and articulates recommendations for the Executive Management Meeting (EMM) regarding the management of risks.

21. The Executive Management Meeting regularly considers risks and the recommendations from the SMG. The Executive Management Meeting makes the ultimate decision as to the management of risks that meet the thresholds described under 18b, and highlights to the Board and its assurance committees any risks that may have an impact on the ICB's strategic objectives.

Part 2 – BSW ICB Risk Management process

Purpose of Risk Management

22. Risk refers to uncertainty, the possibility of incurring misfortune or loss, or missing opportunities. This is measured in terms of the likelihood of something happening and the impact of the possible consequences on the ICB's ability to fulfil its aims and objectives, and its statutory functions and duties.

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

25. Risk management ensures that:
    a. Risks that relate to the quality and safety of services that the ICB commissions from providers are identified, assessed, mitigated and monitored;
    b. Risks that relate to the ICB's operational performance, financial stability and effectiveness and reputation are identified, assessed, reported, mitigated and monitored;
    c. Risks that relate to the achievement of the ICB's operational and strategic objectives are anticipated and proactively managed;
    d. Effective controls are put in place, they are well designed and appropriate to mitigate the risk;
    e. Gaps in controls and assurances are identified and effectively managed;
    f. Assurances of the controls are reviewed and acted upon.

25. The description of the ICB's risk management processes ensures that;
    a. Colleagues understand and apply the ICB's risk management processes;
    b. There is clarity of the roles and responsibilities of colleagues in relation to risk management;
    c. Risk management systems and processes are embedded across the ICB and its activities;
    d. Risks are appropriately escalated to management, committees and Board.

Risk identification, description, and assessment

26. Risk identification is a forward-looking process. It aims to identify things that might happen, that might have an impact on the ICB's ability to achieve its aims and objectives, and / or that may potentially impact the ICB's and the system's ability to deliver one or more of the agreed strategic objectives.

27. Risks should be identified whether or not their sources are under the ICB's direct control. Even seemingly insignificant risks on their own have the potential, as they interact with other events and conditions, to cause great damage or create significant opportunity.

28. When the risk is identified, it needs to be described in a clear, concise and consistent manner that supports common understanding of the risk, identification of effective risk

treatments, and monitoring the effectiveness of controls and mitigating actions in reducing likelihood and / or impact of the risk materialising.

29. When the risk is identified, it needs to be analysed to understand the likelihood of it occurring, and the impact / consequence it would have should it occur. From this consideration, the risk score is derived: risk score = likelihood x impact. Appendix B provides guidance and examples to support consistent and appropriate application of scores.

30. The ICB gives each risk three scores:
    - Inherent risk – risk score before any controls or actions are applied
    - Residual risk – risk score when the risk is actively managed, i.e. controls and mitigating actions are in place and are being applied
    - Target risk – risk score that we want to ultimately achieve, i.e. where we want to get to as a result of managing the risk.

The ICB uses the following risk score matrix:

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	**5** Medium	**10** High	**15** Very high	**20** **Extreme**	**25** **Extreme**
4 Major	**4** Low	**8** Medium	**12** High	**16** Very high	**20** **Extreme**
3 Moderate	**3** Low	**6** Medium	**9** Medium	**12** High	**15** Very high
2 Minor	**2** Very low	**4** Low	**6** Medium	**8** Medium	**10** High
1 Insignificant	**1** Very low	**2** Very low	**3** Low	**4** Low	**5** Medium

31. The results of the risk analysis should be compared with the nature and extent of risks that the organisation is willing to take (its risk appetite) to determine where and what additional action is required. This leads to identification and agreement of risk treatment, i.e. what will be done to manage the risk. If risk scores exceed the ICB's stated risk appetite, action must be taken to manage the risk and reduce scores to within the risk appetite.

32. The outcome of risk identification, description and analysis is recorded on the risk register, see sections 41ff below.

Risk treatment

33. Once a risk has been identified, described and assessed, there needs to be a plan developed, agreed and implemented to manage it. In the first place this requires agreement as to the risk treatment:
    - **TREAT:** work is carried out to reduce the likelihood and / or the impact of a risk occurring. This is the most common action and involves implementing controls and action plans to contain, minimise or mitigate the risk to an acceptable level.
    - **TERMINATE:** an informed decision not to become involved in a risk situation, e.g. stop an activity, or not commence an activity.
    - **TRANSFER:** shift the responsibility or burden for loss to another party, e.g. the risk is insured against, subcontracted to another party or in other ways transferred to a third party.
    - **TOLERATE:** a decision to accept the likelihood and consequence of a particular risk happening. The risk should be tracked so managers are ready to reconsider should it start to escalate.

34. Selecting the most appropriate risk treatment option(s) involves balancing the potential benefits in terms of enabling the achievement of objectives against the costs, efforts or disadvantages (including risks) of proposed actions. In most cases the chosen option will be to treat the risk.

35. When selecting treatment option(s) and developing the treatment plan, i.e. mitigating actions, the ICB uses a SMART approach. This means that the ICB will:
    a. consider if cost, effort, and any disadvantages associated with the risk treatment are proportionate to the risk they intend to manage;
    b. set out the proposed mitigating actions;
    c. identify those who are accountable and responsible for implementing the mitigating actions;
    d. indicate the resources required to implement the treatment plan / mitigating actions;
    e. set out key performance measures to gauge effectiveness of mitigating actions and controls;
    f. describe constraints;
    g. determine the timescale for when action(s) are expected to be undertaken and completed.

36. The agreed risk treatment plan is recorded on the risk register. Assigned risk owners and risk managers are responsible for regular and robust monitoring of the risk treatment plan incl. regular updates on achievement of treatment plan milestones. Where the risk treatment plan does not have the desired effect i.e. does not reduce likelihood / and or impact of a risk, assigned risk owners and risk managers must take and record remedial actions to ensure that the risk treatment plan does deliver a reduction of likelihood / and or impact of a risk.

Risk monitoring

37. Risk monitoring plays a role before, during and after implementation of risk treatment. Through ongoing and continuous monitoring, the ICB understands whether and how a risk profile changes, and the extent to which controls and treatment plans operate as intended, i.e. reduce the likelihood and impact of a risk occurring.

38. Risk monitoring is a regular activity. It helps ensure that agreed risk treatment plans are positively impacting on risks and are supporting a reduction in current risk score. Monitoring also helps spot if risk treatment plans generate associated and unforeseen risks.

39. The regular review of risks and mitigating actions is the formal part of risk monitoring. Outcomes of the review may include:
    a. identification of a new risk;
    b. changes to a risk score;
    c. assessment of the effectiveness of agreed treatment plans / mitigating actions – are mitigating actions implemented to agreed scope and timeline; are mitigating actions on track to deliver the target risk score in agreed timelines; do mitigating actions in themselves generate risks;
    d. agreement to stop, start, adjust agreed mitigating actions;
    e. amendments to the treatment plan for an identified risk;
    f. agreement to take risks off the register, retain them, escalate them, or to add new risk(s).

40. These outcomes are recorded on the relevant risk register, see the next section for further information.

Risk recording – the ICB risk register

41. The ICB has a single risk register which is organised in such a way that Portfolios and ICB-led or ICB-funded Programme can maintain a register of all their identified risks (and no matter the risk score or whether they will be tolerated or treated). Key principles:
    a. ICB-led or ICB-funded Programmes will always be associated with an ICB Portfolio.
    b. ICB Executive Directors own the section of the overall risk register that records the risks for their respective Portfolio.
    c. Together with their identified Risk Lead, ICB Executive Directors are responsible for the maintenance and currency of their Portfolio's section on the risk register.
    d. The Programme SRO owns the section on the risk register that records the risks for their respective Programme.
    e. Programme SROs act as the conduit between the Programme and the relevant ICB Portfolio, and work with the relevant Portfolio Risk Lead/s.

42. Portfolio and Programme risk registers record all operational risks regardless of their scores. Key principles:
    a. All risks that score L1xI5=5 should be tracked and regularly be brought to the Senior Management Group's attention.

b. All high risks (scores of 10 and 12) should be closely monitored and be brought to the Senior Management Group's attention if they do not respond to mitigating actions over a period of three months.
c. All very high and extreme risks (score 15 to 25) must be escalated immediately to the Senior Management Group who will make recommendations to the Executive Management Group with regards to managing the risk.

43. Executive Directors ensure that they have oversight of all the operational risks related to their Portfolio (including the Programmes that are associated with their Portfolio), and that mechanisms are in place locally to keep risk records up-to-date and reviewed regularly. This may include having risk as a standing agenda item at Team / Department / Portfolio meetings to consider operational risks. These local mechanisms will follow and comply with this Risk Management Framework.

44. The nominated Risk Leads will regularly engage with the ICB's Senior Management Group for purposes of risk reporting. The Senior Management Group will periodically review the entire ICB risk register. The Senior Management Group will normally focus its review on risks with scores of L1 x I5, and scores of 15 to 25, and will articulate recommendations regarding the management of such risks to the Executive Management Group. For risks that score 15 to 25, the Senior Management Group may also recommend to the Executive Management Meeting a moderation of risk scores.

45. The Executive Management Meeting is responsible for agreeing the final scores of risks that have been escalated by Portfolios via the Senior Management Group; and for agreeing recommendations from the SMG. If the Executive Management Meeting arrives at a different risk scoring than proposed by a Portfolio or the Senior Management Meeting, this must be recorded together with the reasoning.
The Executive Management Meeting is responsible for deciding if risks must be escalated to the Board because of their potential to impact the ICB's and the BSW system's ability to achieve agreed strategic objectives.

Risk reporting

46. Every quarter, the Board's assurance committees (Finance and Infrastructure; Quality and Outcomes; Commissioning) will review risks with a score of L1 x I5, and with scores of 15 to 25 that fall within their particular remit / area of assurance. The purpose of this review is to gain assurance that particularly impactful risks are identified and appropriately managed. Committees may scrutinise the effectiveness of the risk management activities in place. Committees will not actively manage risks.

47. The Board's assurance committees will at least once a year consider *all* risks that fall within their particular remit / area of assurance and consider if and how these risks affect the ICB's and the BSW system's ability to achieve agreed strategic objectives and plans. The purpose of this exercise is to inform the Board's considerations of the Board Assurance Framework and any amends of it.

48. The Executive Management Meeting regularly presents the ICB's risk register to the ICB's Audit Committee, and updates the Committee on risk profiles, risk trends, and effectiveness of controls and mitigating actions. The Audit Committee will seek assurances

that the risks that relate to the achievement of the ICB's and the BSW system's strategic objectives, operational objectives, plans and targets are managed well, and may request / undertake deep dives into principal risks.

Board Assurance Framework (BAF)

49. The basis for an effective BAF is agreement of the ICB's risk appetite and risk tolerance for each strategic objective, and agreement as to what is sufficient in terms of controls and the assurances that the controls are operating effectively. The greater the risk appetite, the more controls should be put in place to effectively manage risk.

50. The BAF brings together all the relevant information about risks to the Board's strategic objectives:

    a. it is an agreement between the Board and the ICB's management which summarises:
        i. the ICB's strategic objectives;
        ii. the risks to achieving these;
        iii. the controls which management are to put in place to minimise the likelihood or effect of those risks materialising;
        iv. the assurances that the Board needs to be confident that the controls are operating effectively.

    b. it comprises:
        i. the risks which impact on the BSW system's and / or the ICB's ability to, or prevent the BSW system and the ICB from, achieving agreed strategic objectives;
        ii. risks that are system-wide in their scope and impact;
        iii. references to identified operational risks (ICB, BSW system) that have been assessed as impacting on the BSW system's and / or the ICB's ability to, achieve agreed strategic objectives;
        iv. controls and assurances for each risk;
        v. agreed mitigating actions for each risk.

51. The Board defines and owns the ICB's strategic objectives; with BSW system partners, the Board defines and owns the BSW system strategic objectives. The Board identifies, defines and assesses the risks to the ICB and the BSW system achieving these strategic objectives – these risks are placed on the BAF. The Board makes any decisions as to the inclusion or removal of risks on the BAF.

52. The Board's assurance committees regularly review the risks on the BAF that relate to their respective remit. This links with / is supported by the committees' review of risks on the ICB's risk register that relate to their respective remits. The Board's assurance committees will make recommendations to the Board regarding the BAF, including recommendations re the review of risk articulations, risk scores, and mitigations.

53. While the Board owns the BAF, the Chief Delivery Officer maintains the BAF on behalf of the Board. The Board considers the BAF regularly, and at least every six months.

Roles and Responsibilities

ICB Board	• Determines the ICB's and – in collaboration with BSW system partners – the BSW system's strategic objectives, strategic approach to risk, risk appetite. • Identifies risks to the ICB's and the BSW system's ability to achieve agreed strategic objectives. • Approves the ICB's framework for risk management. • Regularly considers the Board Assurance Framework (BAF) and the ICB's Corporate Risk Register. • Receives, and responds to, risk assurance reports and issues raised by the Audit Committee in regard to the ICB's approach to risk • Receives, and responds to, Board committees' risk assurance reports.
Audit Committee	• Scrutinises / tests the ICB's risk management arrangements and processes, their effectiveness – including via regular review of the Corporate Risk Register and Board Assurance Framework. • Provides assurance to the Board on the effectiveness and adequacy of the ICB's processes for managing risks.
Board Committees	• Consider the effectiveness of the risk management in place for operational risks related to the committee's remit. • Inform the Board's view on risk, incl. through risk assurance reports and through recommendations with regards to the BAF.
Chief Executive	• Ultimately accountable for all risks relating to the operations of the organisation. • Leads on the ICB's approach to risk, and establishment and maintenance of risk management structures and processes in the ICB. • Ensures that the BAF is developed, reviewed and reported to committees and the Board. • Ensures that business continuity and disaster recovery plans are established and regularly tested, and that risk transfer mechanisms (as and where appropriate) are in place.
Executive Management Meeting	• Owns the ICB's risk register and ensures it is maintained and up-to-date. • Makes decisions re scoring and management of very high and extreme risks. • • Collectively accountable for adequacy and effectiveness of activities to manage corporate risks.

Senior Management Group	• Acts as an advisory group of the ICB Executive Management Meeting • Regularly scrutinizes the ICB's risk register and the identified risks (including potential new risks), incl. how risks are described and scored, appropriateness and effectiveness of the specified mitigating actions; and timeframes for delivery of mitigating actions and achievement of target risk score. • Makes recommendations to EMM re the scoring and management of high and extreme risks (score 15 and above).
Executive Directors	• Own those sections of the ICB's risk register that record their Portfolio's risks, and ensure that o their respective Portfolio has appropriate processes in place to enable identification, recording and management of risks, and o the Portfolio risk register (incl. risk registers of Programmes that are associated with the Portfolio) is maintained and kept up-to-date • Nominate the Risk Lead and Deputy Risk Lead for their Portfolio • Together with their Risk Leads regularly and robustly review the risks recorded for their Portfolio (incl. risks recorded for Programmes that are associated with the Portfolio) and sign off such reviews. • With their Portfolio Risk Leads, consider and agree local risks for escalation • Promote a consistent approach to the identification and management of risk.
Risk Leads and Deputy Risk Leads	• Act as a risk champion within their respective Portfolio • Lead the establishment of appropriate processes to enable the Portfolio's identification, recording and management of risks • Co-ordinate with the Portfolio's departments and teams to regularly get a full view of all Portfolio risks. • Regularly engage with the ICB's Senior Management Group and present Portfolio risk updates for consideration.
ICB colleagues	• Apply and implement the risk management process • Actively identify risk, discuss and report it to line managers, team leads, Heads of, Risk Leads and Directors.

Training

54. The ICB Governance, Compliance and Risk team works with Portfolios and Risk Leads to enable implementation and application of the ICB's risk management framework. Training needs analyses will support targeted provision of relevant training. Management of training, and monitoring of access / completion / application / effectiveness of training, is the responsibility of line managers.

55. All individuals in scope of this policy can access advice, guidance, information and training in order to carry out their respective responsibilities re risk management:
    a. Risk Management Framework, information and guidance and training slides will be published on the ICB intranet Risk Management pages;
    b. contact bswicb.governance@nhs.net with any queries regarding the risk management framework and the processes described in it.

Equality impact assessment

56. The Risk Management Framework is an ICB internal policy to ensure compliance with ICB risk management approaches and processes. As such, it has no equality effect on the populations served by the ICB. However, effective risk management will allow us to make sure that we are progressing to achieving our strategic goal of reducing inequalities.

Monitoring effectiveness of risk management

57. Independent assurance will be gained when required, by means of the Internal Auditors, to assess the operation of the risk management framework of the organisation. Internal Audit support may also be requested to assess specific controls, areas, or risks identified through the risk management process.

Review

58. This document is reviewed every three years unless organisational changes, legislation or guidance prompt an earlier review.

APPENDICES

A – Glossary of commonly used terms in risk management

Assurance	Evidence that risks are being effectively managed (e.g. planned or received audit reviews and assurance map). Assurance happens when someone tells you what is happening and offers you triangulated evidence of how it was done. You can then judge for yourself if all is well. (In contrast, *reassurance* happens when someone tells you all is well and you believe there's no need for further checks.)
Board Assurance Framework	Comprises strategic risks as defined by the ICB's Board (in collaboration with BSW system partners, where appropriate): the major risks that could impact on the ICB's and / or the BSW system's ability to achieve agreed strategic objectives
Control(s)	Existing strategies, plans, policies, systems, standards, processes etc that are already in place and that already help manage the likelihood or impact of a risk should it materialise.
Corporate Risk Register	A distillation of all operational risks that have been identified by teams / departments / Portfolios / Executive Management Team (for the body corporate) and that are deemed to be very high or extreme.
Gaps in controls or assurances	The controls that are already in place are not sufficient (this can include controls that are in place but that are outdated). Or it has been identified that a control is not in place, e.g. a system or a policy does not exist. The assurances that can be given are patchy, i.e. fulsome evidence cannot be provided to enable e.g. a committee to objectively assess and test the assurance that is offered to the committee.
Impact	Is the consequence or effect of a risk if it actually materialises / comes true.
Issue	An event that has already occurred and that requires action to manage its impact / outcome. An issue may result in risks.
Likelihood	Is the measure of the frequency and / or chance that the identified threat or opportunity will happen, including a consideration of the frequency with which this may arise.
Operational risks	A risk or risks that have the potential to impact on the delivery of business, project or programme objectives. Operational risks are managed locally within teams / departments / Portfolios / Programmes. Significant operational risks are escalated, where appropriate, to Executive Management Meeting via the internal reporting process
Opportunity	An uncertain event that would have a favourable impact on objectives or other benefits if it occurred.
Risk	A risk is an uncertain event or set of events in the future that, should it occur, will have an effect on the achievement of business, project or programme objectives. A risk can be a threat or an opportunity.

Risk appetite	The level of risk that an organisation is prepared to accept in relation to an event / situation, after balancing the potential opportunities and threats that the situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.
Risk assessment	The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk within the organisation's risk appetite
Risk score	Risk score is the numerical value when likelihood of risk occurring is multiplied with impact of risk if it occurs. We score a risk three times, this helps us assess whether we apply the right risk management actions, and if they are effective: • **Inherent risk** – risk score before any controls or actions are applied • **Residual risk** – risk score when the risk is actively managed, i.e. controls and mitigating actions are in place and are being applied • **Target risk** – risk score that we want to ultimately achieve, i.e. where we want to get to as a result of managing the risk
Risk tolerance	The predetermined upper level of risk that can be assigned to an objective. This might be set as an overall risk rating or might specifically relate to an upper 'impact' or upper 'likelihood' rating which, if reached, must be mitigated at all costs.

B – Risk register guidance

The ICB uses the DecisionTime online risk register.

B1 – Guidance to complete the risk register

Always:

- Only use the DecisionTime online risk register, do not maintain locally saved additional or duplicate risk registers
- Describe a risk clearly in terms of its cause, what is likely to happen, and what impact it would have if it occurred.
- Score a risk in terms of its impact and likelihood using the criteria set out in the ICB's risk matrix
- For every risk, list controls i.e. the measures that the ICB is already taking to reduce the level of risk.
- Calculate three risk scores per risk: inherent, current, and target risk scores
- Articulate a clear action plan to manage a risk, clearly identify deadlines and individuals responsible for delivery of the action.

Check you input the correct information:

Risk register heading	Guide
Risk No.	A unique identifier in a numbering system assigned to a risk. The identifier should be used for reference or for cross-reference
Risk Category	This allows us to identify sources of risk
Risk Entered Date	When the risk was first included on the register
Risk Name	Short phrase that captures the nature / essence of the risk - no more than 10 words
Bodies Affected	Any organisation affected by the risk, including. the ICB
Executive Risk Owner	Name of the Executive who owns the risk, i.e. has ultimate responsibility that the risk is appropriately managed, and that the risk is escalated if it is resistant to any risk management activity
Risk Manager	Name of the individual who actively manages the risk per agreed treatment plan
Reviewing Committee	Name the committee in whose remit the risk falls. The committee regularly seeks assurance that the risk is managed appropriately
Latest Review Date	State when the risk was last reviewed

Risk register heading	Guide
Likelihood	On the date the risk was last reviewed, what was the score for the likelihood of the risk occurring?
Impact	On the date the risk was last reviewed, what was the score for the impact on the ICB if the risk were to occur?
Risk Scores	Likelihood x Impact = Risk Score, on the day the risk was last reviewed
Change in risk rating since last reviewed	Insert arrows to indicate how the risk score has changed between the latest risk review date and previous review dates. This gives an indication if the controls and mitigating actions are effective. ↑ The score has increased → The score has not changed ↓ The score has decreased
Target Risk Score	Insert the risk score that is intended. Knowing the risk appetite and risk tolerance will help – the target score should be at least equal to the risk tolerance, if not lower
Tolerance	Insert the predetermined upper level of risk that can be assigned to the risk. This might be set as an overall risk rating or might specifically relate to an upper 'impact' or upper 'likelihood' rating which, if reached, must be mitigated at all costs
Description of Risk	Describe the risk, its cause and likely effect. The risk should be articulated clearly and concisely. When wording the risk it is helpful to think about it in three parts and write it using the following phrasing: *IF xyz happens, THEN abc will happen. As a CONSEQUENCE, …*
Existing Controls	Controls currently in place such as policies, procedures, standard business processes, practices, technology that help manage the risk. A risk may have more than one control.
Assurances and Gaps in Assurance	What assurances (i.e. evidence) can be given that the controls are effective?
Mitigations	Additional activity that needs to be developed and implemented should the risk level be unacceptable after controls are applied. There may be more than one action for a risk. Information must be SMART and include Mitigation Owner and Mitigation Target Dates per mitigating action.

B2 – Guidance for Risk Scoring – Examples for some risk categories

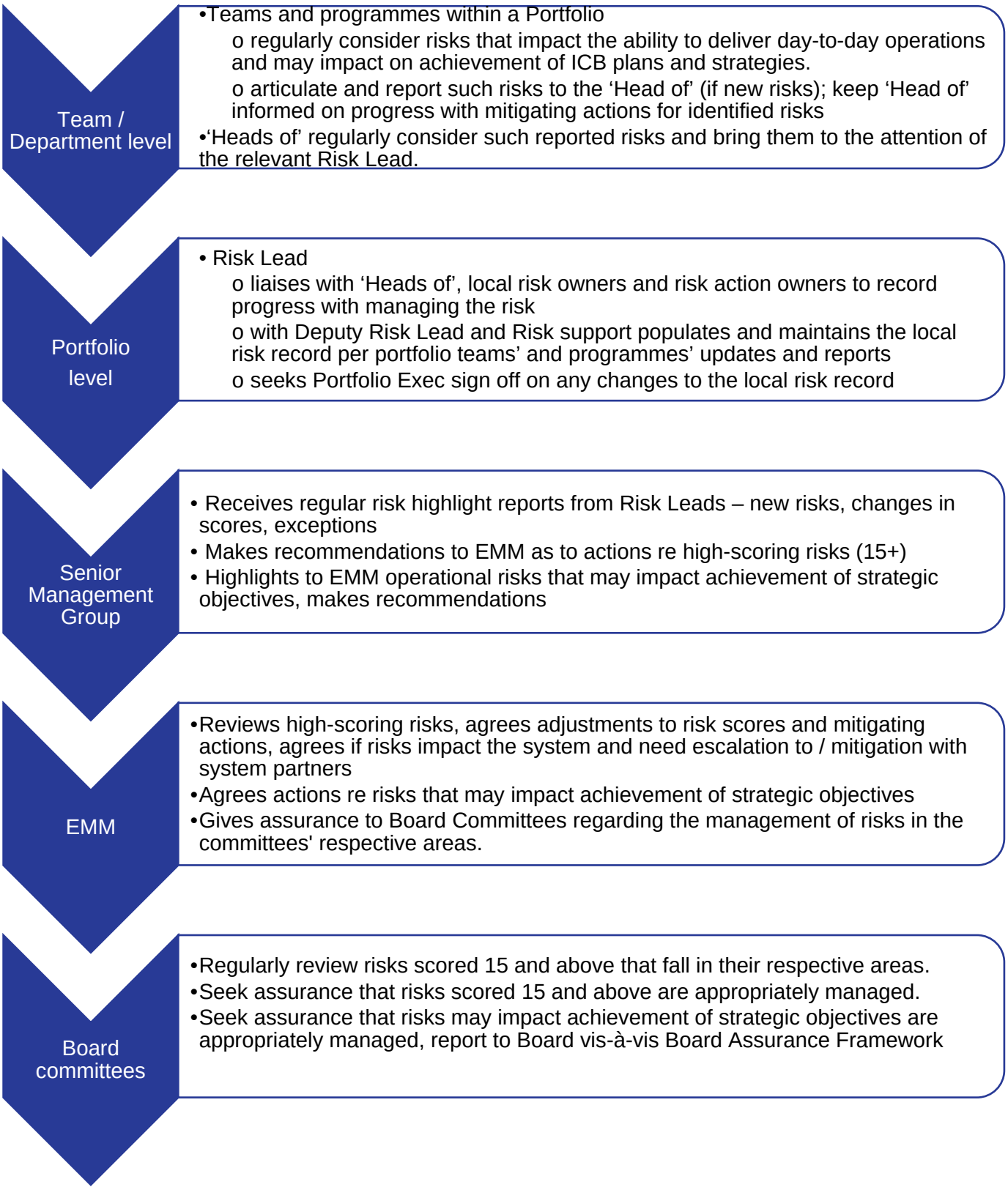
Risk assessment is about scoring a risk re the likelihood of the event occurring, and the impact it may have should it occur. This table gives illustrative examples to enable consistent scoring of impact and likelihood.

	Impact Score				
Risk category	**1 Insignificant Impact**	**2 Minor Impact**	**3 Moderate Impact**	**4 Major Impact**	**5 Catastrophic Impact**
Quality	• No other significant impacts.	• No regulatory consequences. • Adverse publicity locally. • Minor injury.	• Addressable regulatory consequences, incl. ICB undertakings. • Adverse publicity in national papers. • Major injury	• Substantial regulatory consequences, incl. ICB is under NHSE directions • Major national adverse publicity. • Death of an individual or several major injuries.	• Multiple major injuries or deaths
Safety	Patient safety in commissioned services: • Colleagues safety: • Near miss event (H&S – no-one suffered injury or harm; security – no damage to ICB property); dealt with via BAU incident management processes; nothing reportable to regulator / external agencies	Patient safety in commissioned services: • Colleagues safety: • Minor incident (H&S – one individual has a minor injury with no need for treatment; security; security – minor damage to ICB property with no impact on ICB operations, managed internally); dealt with via BAU incident management processes; nothing reportable to regulator /	Patient safety in commissioned services: • Colleagues safety: • Incident (H&S – one individual has a minor injury that requires treatment by doctor, MIU, walk-in centre; security – reversable damage to ICB property requiring external assist but with no impact on ICB operations; verbal aggression against member/s of colleagues); dealt with via BAU incident management processes; nothing reportable	Patient safety in commissioned services: • Colleagues safety: • Significant incident (H&S – one individual has significant injury that leads to hospitalisation; security – significant damage to ICB property that stops ICB from discharging 25% of its BAU for up to 24 hours and requires external assist; physical aggression against member/s of colleagues); dealt with internally via incident management and /	Patient safety in commissioned services: • Colleagues safety: Major incident (H&S – one or more fatality, several individuals with significant injuries that lead to hospitalization; security – substantial damage to ICB property that stops ICB from discharging a third of its BAU for more than 72 hours and requires external assist; dealt with through EPRR protocols incl. stand-up of multi-agency response

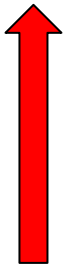
	Impact Score				
Risk category	**1 Insignificant Impact**	**2 Minor Impact**	**3 Moderate Impact**	**4 Major Impact**	**5 Catastrophic Impact**
		external agencies	to regulator / external agencies but may require assist from external agencies such as police	or business continuity processes and with assist from external agencies such as police e.g. a fall down stairs; localized flooding of a premise causing power outage and damage to ICB kit	e.g. attack on ICB colleagues with multiple casualties; cyber or ransomware attack; a large fire on an ICB premise
Finance	• Negative variance from plan and / or loss of less than 0.1% of annual allocation (£1.5m)	• Negative variance from plan and / or loss of up to 0.5% of annual allocation (£7m)	• Negative variance from plan and / or loss of up to 2% of annual allocation (£28m)	• Negative variance from plan and / or loss of up to 3.5% of annual allocation (£49m)	• Negative variance from plan and / or loss of up to and more than 5% of annual allocation (£70m)

Likelihood Score				
1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
• Extremely unlikely, almost impossible to happen – once in 10+ years	• Low likelihood but not impossible – once in 7-10 years	• Fairly likely to occur – once in 4-7 years	• More likely to occur than not – once in 2-4 years	• Almost certainly will occur – once a year

B3 – Guidance for risk management process (who does what)



B4 – Guidance for risk escalation

Risk Score		Risk Response	Action	By Whom	Escalation
		Treat / transfer			
Very high and Extreme Risk	**20-25**	Risks with these scores: • require a root-cause analysis to understand what drives the risk and its high scores. • require a comprehensive treatment plan – delivery and effectiveness of the treatment plan will be monitored and adjusted to ensure effectiveness in managing the risk (i.e. bring down scores). • may oscillate between ICB corporate risks, and BSW systems risk – an appropriate risk response may	• SMG makes recommendations to EMM re approach to managing such risks • SMG considers if / how such risks affect ICB's ability to achieve strategic objectives and BAF risks, makes recommendations to EMM re any escalation to BAF (either to amend or add BAF risks, or to highlight impact on existing BAF risks) • EMM consider SMG review and	• EG • RMG • ARC • Board	

Risk Score		Risk Response	Action	By Whom	Escalation
	15-16	therefore require action by / coordination with system partners. Approach is one of 'Manage closely' i.e. regular (recommended monthly) review, regular assessment of effectiveness and if necessary: adjustment of treatment plan, regular consideration of score	recommendations and agree course of action incl. re amendment / addition / removal of BAF risks • EMM presents the ICB's risk register to the ICB's Audit Committee, and updates the Committee on risk profiles, risk trends, and effectiveness of controls and mitigating actions. • Audit Committee will seek assurances that the risks that relate to the achievement of the ICB's and the BSW system's strategic objectives, operational objectives, plans and targets are managed well		
		Treat / transfer			
High risk	**10-12**	May require a treatment plan. If risks don't respond to treatment plan, i.e. score does not reduce despite the plan within three months – report to SMG. Approach is one of 'Monitor' i.e. less frequent review, (recommended at least every quarter) incl. assessment of effectiveness and if necessary: adjustment of treatment plan, and consideration of score	• Executive Directors / Risk Leads regularly review and update their Portfolio risks and report high risks that do not respond to treatment plan to SMG. • SMG makes recommendations re approach to risks that do not respond to treatment plan within three months	• Executive Directors and Risk Leads • SMG	

Risk Score		Risk Response	Action	By Whom	Escalation
		Tolerate / treat			
Medium, low and very low risk	**5-9**	• Risk is identified, recorded on Portfolio risk register, and action is taken to reduce the risk; effectiveness of mitigating actions is monitored. Approach is one of 'Park' – i.e. less frequent review (recommended every six months) to maintain oversight of whether risk score increases and how risk responds to mitigating actions.	• Bring to SMG if risk score increases to 10	• Risk Leads	
	L1xI5	Approach is one of 'Track' i.e. less frequent review, (recommended every quarter) incl. assessment if likelihood increases – in which case process for risks scoring 10-12 applies	• Bring to SMG if risk score increases to 10	• Risk Leads	
	1-4	• Risk is identified, recorded on Portfolio risk register, and if deemed necessary action is taken to further reduce the risk; effectiveness of mitigating actions is monitored. Approach is one of 'Park' – i.e. less frequent review (recommended every six months) to maintain oversight of whether risk score increases and how risk responds to mitigating actions.			

C – Risk Appetite by Risk Category

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
Quality	Risks to maintaining and improving quality, and risks to compliance with quality standards including regulatory and performance standards. Risks to the quality of the patient experience.	We have a **CAUTIOUS** appetite for quality risk. We will always seek to reduce the quality risks of any action and will usually choose actions that have low levels of quality risk. In some circumstances we are prepared to accept the possibility of a short-term / low level impact on some quality outcomes if there is the potential for longer-term / higher level benefit. For example, we may make a decision that could have an impact on service user experience if we believe it will result in improved health outcomes. We will actively manage risk and contribute to the evidence base for quality improvement. We will prioritise meeting patient safety and regulatory standards.	CAUTIOUS, 8 (L2xI4, or L4xI2)
Safety	Risks to patient safety, and effectiveness of treatment and care. Risks to colleagues safety.	We have a **CAUTIOUS** appetite for risks to patient safety, and colleagues safety. We will always seek to reduce the risk by focusing on the issues that lead to decreased safety. We accept that on occasion this may mean adopting approaches that may have an impact on performance. We are prepared to seek innovative approaches to improving the effectiveness of treatment and care determinants of health where this has the potential to meet our objectives.	CAUTIOUS, 8 (L2xI4, or L4xI2)
Regulation and Governance	Risks to compliance, and the ability to demonstrate compliance, with regulatory standards; legal standards; standards of business conduct and governance (including Information Governance);	We have a **CAUTIOUS** appetite for risks to governance and regulation. We will always seek to reduce the risk by acting in an open and transparent way and with integrity. We will prioritise transparency in decision making and identify and manage conflicts of interest to ensure probity in all aspects of our operation. We recognise that delivering our objectives may require us to challenge orthodoxies around regulatory requirements in the interests of “doing	CAUTIOUS, 8 (L2xI4, or L4xI2)

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
	statutory duties including those related to delegated functions.	the right thing." We expect to have very clear and proactive communication with regulators to secure their support. We will ensure we put in place the culture, systems and processes that enable us to take an innovative approach whilst meeting regulatory and governance standards and delivering our statutory duties.	
Finance	Risks to all areas pertaining to finance and financial control including financial sustainability.	We have a **OPEN** appetite for financial risk. We will seek to minimise these risks by operating robust financial controls, harnessing the benefits of joint working and looking at improving utilisation of assets and resources across the system. We are prepared to accept some financial risk when this is associated with actions that could improve productivity and value for money and/or capitalise on opportunities to accelerate or increase benefits. We are willing to invest differentially to target initiatives and reduce inequalities and we understand that implementation of innovations needs to be adequately resourced. We also understand that adequate time needs to be allowed before assessing the implementation as there may be a lag between the implementation and the desired results. We are willing to address difficult conversations about finances openly and directly, engaging with implications and risks connected to finances in an integrated way. We are looking for joined up system financial management, which takes account of the differing financial requirements and constraints of system partners.	OPEN 12 (L3xI4, or L3xI4)
Workforce	Risks to capacity and capability, and to sustaining a skilled and effective workforce. Risks related to colleagues recruitment and retention, training and development (including succession	We have a **BALANCED** appetite for workforce risks. We would always seek to minimise workforce risks by focusing on actions that could improve the effectiveness, resilience and morale of our workforce and people's satisfaction with their experience of using health and care services.	BALANCED 10 (L2xI5, or L5xI2)

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
	planning) and organisational morale and culture.	We are prepared to adopt innovative ways of working even where these require us to adopt new employment practices or challenge cultural norms which may carry high workforce risks. We are particularly interested in approaches that: • Encourage multi-disciplinary and cross organisations working e.g., creating joint posts • Create sustainable ways of recruiting, training and retaining colleagues across organisations/sectors • Enable us to align services with population needs and address inequalities e.g., by moving services into the community, • Increase efficiency, productivity and value for money	
Performance and Delivery	Risks to developing robust plans and / or delivering agreed system plans / priorities, including the required transformation programmes that ensure the delivery of equitable and improved outcomes for the citizens of BaNES, Swindon and Wiltshire. Risks to the commissioning of appropriate services that meet the population's needs.	We have a **OPEN** appetite for performance and delivery risk. We will seek to minimise these risks by using data and modelling, and by operating robust system planning processes, and equally robust system performance and delivery controls. We will encourage partners to use / adopt outcomes of research as well as innovations where this supports and drives delivery and performance. We are prepared to accept some delivery risk when this is associated with actions that could improve performance and productivity in the longer term.	OPEN 12 (L3xI4, or L3xI4)
Engagement and Partnership working	Risks to effective engagement, involvement and communication with patients, carers, the	We have a **OPEN** appetite for risks to our relationships and engagement with partners and stakeholders, and our involvement of the public.	OPEN 12 (L3xI4, or L3xI4)

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
	public, clinicians and all other stakeholders. Risks to partnership working with wider ICS partners.	We will seek to minimise these risks by working proactively with our citizens and our partners to develop our priorities and co-design and deliver transformation. We are prepared to lead difficult discussions and / or making decisions which may be unpopular, and which may carry a high risk of affecting our reputation, where this is in the interest of “doing the right thing” and delivering benefits to our population.	