

BSW Integrated Care Board – Board Meeting in Public

Thursday 22 January 2026, 10:00hrs

Virtual Meeting – via MS Teams Town Hall

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 20 November 2025	Chair	Approve	ICBB/25-26/114
	4	Action Tracker and Matters Arising	Chair	Note	ICBB/25-26/115
10:10	5	Questions from the public	Chair	Note	Verbal
10:15	6	Cluster Chair's Report	Chair	Note	Verbal
10:20	7	Cluster Chief Executive's Report	Jonathan Higman	Note	ICBB/25-26/116
10:35	8	BSW Outcomes Framework	Amanda Webb, Lucy Heath, Sam Wheeler	Note	ICBB/25-26/117
Committee Reports					
11:05	9	BSW ICB Quality and Outcomes Committee	Ade Williams, Gill May	Note	ICBB/25-26/118
		a. BSW Quality Exception Report	Gill May	Note	ICBB/25-26/119
11:20 – Short Break – 10 mins					

Timing	No	Item title	Lead	Action	Paper ref.
11:30	10	BSW ICB Finance and Infrastructure Committee	Paul Fox, Gary Heneage	Note	ICBB/25-26/120 ICBB/25-26/121
		a. BSW ICB and NHS ICS Revenue Position	Gary Heneage	Note	ICBB/25-26/122
11:45	11	BSW ICB Commissioning Committee	Julian Kirby, Rachael Backler	Note	ICBB/25-26/123 ICBB/25-26/124
		a. BSW Performance Report	Rachael Backler	Note	ICBB/25-26/125
		b. Medium Term Plan Update	Rachael Backler	Note	ICBB/25-26/126
12:15	12	BSW ICB Audit Committee	Claire Feehily	Note	Verbal
		a. Annual Emergency Preparedness Resilience and Response Assurance Report	Rachael Backler	Note	ICBB/25-26/127
		b. Cyber Assurance Report	Gary Heneage, Rachael Backler, Steve Mapleston	Note	ICBB/25-26/128
		c. BSW ICB Board Assurance Framework Quarter Three Report	Rachael Backler	Note	ICBB/25-26/129
		d. BSW ICB Declarations of Interest Registers	Chair	Note	ICBB/25-26/130
Closing Business					
12:50	13	Any other business and closing comments	Chair	Note	Verbal

Next ICB Board Meeting in Public: 19 March 2026

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

Thursday 20 November 2025, 10:00hrs

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

Members present:

Cluster Chair, Rob Whiteman (RW)
Cluster Chief Executive, Jonathan Higman (JH)
Primary Care Partner Member, Dr Francis Campbell (FC)
NHS Trusts & Foundation Trusts Partner Member – acute sector, Cara Charles-Barks (CCB)
Non-Executive Director for Finance, Paul Fox (PF)
ICB Chief Finance Officer, Gary Heneage (GH)
Non-Executive Director for Public and Community Engagement, Julian Kirby (JK)
ICB Chief Nurse, Gill May (GM)
Non-Executive Director for Remuneration and People, Suzannah Power (SP)
Local Authority Partner Member – Wiltshire, Lucy Townsend (LT) *(until 11:28hrs)*
ICB Chief Medical Officer, Dr Amanda Webb (AW)
Voluntary, Community and Social Enterprise (VCSE) Partner Member, Pam Webb (PW)
Non-Executive Director for Quality, Ade Williams (AW)

Regular Attendees:

ICB Chief Delivery Officer, Rachael Backler (RB)
ICB Chief of Staff, Richard Collinge (RCO)
ICB Chief People Officer, Sarah Green (SG)
Deputy CEO, AWP, Matthew Page (MP)
South West NHSE Director of Commissioning Oversight and System Coordination, Liz Cosford
ICB Corporate Secretary

Attendee:

ICB Associate Director of Estates – for item 9b
ICB Director of Business Support – for item 10b

Apologies:

Non-Executive Director (NED) for Audit and Governance, Dr Claire Feehily (CF)
Local Authority Partner Member – Swindon, Sam Mowbray (SM)
Local Authority Partner Member – BaNES, Will Godfrey (WG)
NHSE South West Managing Director (System Commissioning Development), Rachel Pearce (RP)
ICB Director of Place – BaNES, Laura Ambler (LA)
ICB Director of Place – Swindon, Gordon Muvuti (GMu)
ICB Interim Director of Place – Wiltshire, Caroline Holmes (CH)
ICB Associate Director of Governance, Compliance and Risk

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. A special welcome was given to Liz Cosford of NHS England South West, in attendance in the

absence of Rachel Pearce. It was also acknowledged that this would be the last Board meeting for Chief People Officer, Sarah Green, who leaves the ICB in January for a new role within the Somerset Academy. On behalf of the Board and ICB, the Chair wished to record thanks to Sarah and wish her well in her next challenge.

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 18 September 2025

3.1 The minutes of the meeting held on 18 September 2025 were approved as an accurate record of the meeting.

4. Action Tracker and Matters Arising

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

5. Questions from the Public

5.1 No questions had been raised in advance of the meeting.

6. BSW ICB Chair's Report

6.1 The Chair informed the Board of the following:

- Since the September BSW ICB Board meeting – the announcement of the appointment of the Cluster Chief Executive had been made, confirming appointment of Jonathan Higman to the role – which commenced in early October.
- The national budget was due to be announced on 26 November 2025, which would include reference to NHS and public service spending. The key messaging was to manage money and resources well and stay within budget. It was recognised that next year would be a challenging transition year, with deficit support funding not likely to be made available. The main role of ICBs was to implement the NHS 10 Year Plan. Demand on public services had risen considerably, with ICBs to support the transformation of the way the NHS was used, moving care and services to community and neighbourhood health settings through strategic commissioning.
- Advanced Foundation Trusts were to become the new marker of excellence for providers. On 12 November 2025, the Secretary of State for Health and Social Care announced that eight trusts will be among those assessed as part of the first wave of the Advanced Foundation Trust Programme next year, one of which was within the Cluster (Dorset Healthcare University NHS Foundation Trust). Some Trusts will be able to apply to become an integrated healthcare organisation, giving them control of the local health budget and responsibility for improving population health. This will support a shift in resources from hospitals to neighbourhood and community-based care.

7. Cluster Chief Executive's Report

- 7.1 The Board **received and noted** the Cluster CEO's report as included in the meeting pack.
- 7.2 The Cluster CEO provided a contemporary update:
- Transition programme for ICBs – Confirmation had now been received of national funding in support of the ICB cost of change programme.
The Cluster had launched its very senior manager (VSM) consultation programme on 12 November 2025. Thanks were noted to those Executives for their continued professionalism during the process, and to Sarah Green and Laura Ambler who were due to leave the ICB in January to move to new external roles.
The change process also included development of the local voluntary redundancy scheme in line with the nationally launched scheme. Work continues on the Target Operating Model, linking to the future wider organisation consultation process.
The Strategic Commissioning Framework had now been formally published, providing further clarity for ICBs on their future model of delivery, and those functions that will remain or transfer. Opportunities for functions at scale will also be considered.
 - H2 position – a series of regional and national meetings had been held to consider the second half of the year position for BSW and to refocus priorities. The RUH was facing particular challenges within the system.
Confirmation had now been received that deficit support funding was now to be released for BSW for quarters one to three.
Green shoots of improvement were being seen in elective care across the system. The remainder of the year will see the ICB continuing to manage the winter period and the urgent emergency care (UEC) pathway. The agreed route to breakeven carried significant risk with winter approaching, noting demand to hospital and no-criteria to reside (NCTR) figures. The Chair and CEO recovery session had noted good progress on UEC and improvements in ambulance handover times. Managing the risks associated with the UEC pathway remains a key enabler to achieving the improvements necessary in other areas of the system.
 - Medium term financial plan – this will cover the next three to five years, with a focus on detailed plans for 2026-27 and 2027-28. In the context of an underlying deficit of £40m, the ambitions of the system to shift care, redesign and change delivery would be challenging.
Planning guidance and allocations have already been released. The ICB, system and Cluster are working through the implications of this to reflect local commissioning intentions and the national ambition to redesign outpatient services, moving more outpatient activity from hospital into the community and with a greater utilisation of technology. There is also a focus on urgent care being more consistent and community based in order to avoid people needing to access hospital services where appropriate.
The first iteration of the Medium Term Plan (MTP) was to be submitted by 17 December 2025, setting out the five year planning narrative, and detail for the next two years of activity, finances and workforce. The Board will consider the assurance statements ahead of submission.
- 7.3 The Board discussion noted:
- It was fathomable that staff morale would be impacted by this change process, in particular now the messaging surrounding the wider organisational change process had recently changed in light of the cost of change now being funded by the Treasury. Staff had now been advised this was likely to be brought forward to commence in this financial year. The approach continued to be that of dealing in fact when communicating with staff, ensuring regular briefings and an open and transparent dialogue.

Meetings of the Colleague Engagement Group continued, with active discussions concerning morale and support to staff to manage the process.

The launch of a voluntary redundancy scheme (anticipated early December) would enable staff to make a personal choice regarding their employment with the ICB, and to leave well if desired.

The monitoring of workforce key performance indicators (KPIs) were not showing a significant change, though it was acknowledged that it was also a challenging job market.

The continued performance, commitment and professionalism shown by staff during this unprecedented time was noted and indicated the compassion within the team to support one another.

- The timeline associated with the planning process was tight, perhaps limiting the level of direct engagement with wider system partners that could be built in ahead of submission. Voluntary sector partners in particular wished to be involved and help inform the planning submission. It was acknowledged that engagement would also be factored in during the development of the commissioning plan, engagement and involvement of system partners remained essential.

Recognising the limited production time, a gap analysis against the previous Plan and Implementation Plan had been undertaken to inform the MTP.

- 7.4 It was recognised that the time and personal investment to date in building system relationships across BSW should not be lost as the ICB moved into cluster arrangements, but be captured to help develop the new ways of working and supporting plans. The Chair concluded the discussion by commending the leadership of the ICB for their continued professionalism.

8. BSW ICB Quality and Outcomes Committee

- 8.1 The draft minutes from the BSW ICB QOC meeting held on 4 November 2025 were shared for information. The Non-Executive Director (NED) Quality and Chair of the Quality and Outcomes Committee (QOC) advised that the work of the Committee remained dynamic and challenging, considering reports, data and trends. The Outcomes Framework Dashboard had been an item at the November meeting, developed by the ICB to collate information and data to indicate the performance of the system. This had been endorsed by the Committee, with the request to ensure the Board was also briefed on this tool and support adoption. The Committee had also been sighted on the Clinical Effectiveness report, noting its responsibility to monitor improvements in equity and system structural factors. The report noted that exceptional funding request applications were lower from those within high areas of deprivation, and work to improve this and raise awareness would be monitored. The work of the Infection, Prevention and Control (IPC) Team was commended and was exemplar across BSW, embedding excellence and a supporting culture.

- 8.2 The next meeting of the ICB QOC is scheduled for 6 January 2026.

8a BSW Quality Exception Report

- 8.3 The Board **noted** the BSW Quality Exception Report, which provided a comprehensive overview of key quality, safety, and performance issues across BSW. The Chief Nurse acknowledged that this was a time of transition for the ICB, though the focus remained on improving outcomes for the population, not only monitoring indicators. It was now confirmed that IPC would remain with ICB's.

- 8.4 The South West NHS England Director advised that BSW's flu vaccination uptake was at 71% for over 65's – with BSW being top for the South West region. This was due to the proactive work of the ICB team, who were actively contacting families, care homes, and primary care colleagues to ensure eligible people were targeted.
- 8.5 The Chief Medical Officer spoke more of the Outcomes Framework developed by the ICB, which was to provide that join up of data for indicators and outcomes, to ensure teams and partners were cognisant of both. The Framework contained agreed high level indicators to focus on, with each then including contributory outcomes being embedded as a focus across the system and delivery groups, to provide that logic model of activity, measures, outcomes and trajectory. Local indicators had also been developed against the high level national matrix, to monitor against demographics, per primary care network (PCN) etc – to bring together and assess, alongside the scale of the systems ambition, region and nationally - to consider change and delivery. The Cluster CEO was keen to replicate an Outcomes Framework across the cluster, to draw on the strengths of each ICBs systems, and to share the learning, to aid that improving outcomes and strategic commissioning ambitions. The dashboard would provide a clear view of the patch, drilling down to any macro issues at a place and neighbourhood level, sitting at the heart of future decision-making.
- 8.6 Both the Chief Medical Officer and the Primary Care Partner Member were keen to understand the data, factors and barriers seen from those in less affluent areas to impact any application for exceptional funding. Information was being cascaded down to PCNs to ensure awareness of disparity. With the facilitation and support of the ICB, it was anticipated that neighbourhoods would help to resolve this.

9. BSW ICB Finance and Infrastructure Committee

- 9.1 The NED for Finance, and Chair of the Finance and Infrastructure Committee (FIC) advised of business covered during committee meetings held in October and November, with the focus being on the revenue position and recovery plans for the current year. The Committee welcomed the confirmation that deficit support funding was being released by NHS England for BSW. The Committee had raised concerns over the adverse consequences for patients in relation to the freezing of capital monies, though it was understood there may now be some movement on this. The Electronic Patient Record programme was also reporting challenges with a request for additional funding, the Committee had requested a further update report for consideration. The MTP included proposals to replace block funding with activity based funding, bringing implications and opportunities to be understood by the Committee.
- 9.2 The minutes from the meetings held on 1 October 2025 and 5 November 2025 were shared for information.
- 9.3 The next meeting of the ICB Finance and Infrastructure Committee was scheduled for 3 December 2025.

9a. BSW ICB and NHS ICS Revenue Position

- 9.4 The ICB Chief Finance Officer provided an update on the financial position of the ICB and Integrated Care System (ICS) at month six, highlighting the following:

- The system was reporting £25.5m adverse to plan year to date, with ongoing drivers of under delivery of cost improvement programmes (CIP) / efficiency programmes, and non-receipt of deficit support funding.
- It had now been confirmed that quarters one to three of deficit support funding would be released for BSW, with £17.5m to be available – supporting the year-to-date position and improving the BSW Hospital Group cash position.
- BSW continued to see the impact of recent industrial action, though as per guidance, this had not been financially planned for.
- Month six and month seven were showing run rate improvements.
- As part of the H2 process, the route to breakeven had been set out to ensure breakeven, which included additional mitigations for the ICB (£2.6m) and the Group (£7.4m). The Turnaround Team were now in place at the RUH to support that work to improve the Group position, generate the savings, and close the gap.
- At month 11, the system recovery trajectory was indicating a £31.7m deficit to breakeven, month 12 assumed the full allocation of deficit support funding. £4.6m had been landed by the ICB for month 12.
- Allocations had now been released.
- Risks remain in the position – industrial action, winter, sickness, and tiering for a number of domains causing pressures.
- Operational capital used for maintenance etc remained on hold due to the Group cash position. The implications of this were being worked through. The estates element of capital was progressing. The national capital schemes were on hold due to the recovery position; it was hoped these schemes may be released once region were confident BSW would meet in year plans.

9.5 The Board discussion noted:

- The savings plans needed to up and running as per month 2026-27, this included workforce plans to enable these to be implemented and acted on from month one, with a robust triangulation of assumptions against finances. The systems collective ambition needed to realistic to ensure delivery of savings early on. Though a financially led plan, the correlation of workforce and financial was important to ensure the full year effect of savings. Progress would continue to be monitored through the BSW Strategic Delivery and Recovery Board.
- Triangulation discussions had commenced with system partners. The Board Assurance Statements in support of the MTP submission would provide that level of detail and assurance to the Board (or delegated committee). The first submission of the MTP would be scrutinised at a joint meeting of the FIC and Commissioning Committee if delegation is approved by the Board later on the agenda today. Good governance was in place to have that oversight and influence over planning.
- Efficiency programmes were to commence early on. The ICB had issued the financial targets for the efficiency programmes to Executive colleagues in support of the required first iteration before Christmas.

9.6 The Board **noted** the report and the month six financial position of the system.

9b. **BSW Green Plan**

9.7 The ICB Associate Director of Estates was in attendance to support this item, presenting the refreshed BSW Green Plan, written in line with NHS England guidance. FIC had been

sighted on the Plan on its journey to Board, commending the record of good engagement undertaken with system partners (as per appendix 2). The shared slides advised the Board of the background to the Plan and its required refresh, the Plan structure, the nine delivery areas of focus, and the next steps. On approval of the Plan, it would be published upon the ICBs website. Progress would be monitored via FIC, with an annual update for the Board to be included in the Annual Report.

9.8 The Board discussion noted:

- The Deputy CEO of AWP offered support to strengthen the plan further with case studies of delivery and the relationship between nature and health. This additional stakeholder engagement was welcomed to bring that collective ownership, shared learning, and a move to embed this way of working in support of the Plan and its actions. This was to become a golden thread throughout the ICB's and systems working.
- All ICBs were required to refresh their Plans by December 2025. The Plans also in place across the cluster and the strong cross-cutting themes would be considered when moving towards the merger.
- Capital investment was needed to ensure a number of the actions could be delivered. The estates across BSW needed significant capital investment, with some projects already in train.
BSW continued to be linked in with national discussions and forums.
- The Hospital Strategy was to be aligned to the systems Commissioning Intentions, considering all capital investments and priorities for the next five to ten years and how services are delivered, reviewing that historical list of capital priorities, and considering the 'green' element. The NHS Trusts and Foundation Trusts Partner Member for the acute sector / Group CEO emphasised that in reviewing those schemes it may be that schemes that were historically considering priorities may be de-prioritised.
- The recognition of the support and action available also from the voluntary sector would be referenced in the Plan, acknowledging they were a reputable system partner.

9.9 The Board wished to record its thanks to the team and all those involved in the significant work undertaken to refresh the Plan - despite the current environment, a good level of engagement was evident.

9.10 On conclusion of the discussion, the Board **approved** the BSW Green Plan, **noted** the proposed reporting schedule to provide oversight and assurance (six monthly basis to FIC and an annual basis to ICB Board), and **noted** that directorates were to support completion and ensure compliance with Taskforce on Climate-related Financial Disclosures requirements.

10. BSW ICB Commissioning Committee

10.1 The NED for Public and Community Engagement, and Chair of the Commissioning Committee gave credit to the Executive team and the continued servicing of the Board and its Committees, despite the personal and professional challenges and changes ahead. The Committee supported the alignment of the financial and operational plans, seeking understanding and commitment from system partners to recognise this was fundamental to delivery. The Committee would be considering how it utilises the Strategic Commissioning Framework in its decision-making going forwards. Members also acknowledged operational

challenges following the rollout of the ambulance “Wait 45” handover protocol, with the consequences for patients and colleagues to be determined.

10.2 The draft minutes were shared for information from the meeting held on 14 October 2025.

10.3 The next meeting of the Committee was scheduled for 16 December 2025.

10a BSW Performance Report

10.4 The ICB Chief Delivery Officer talked through elements of the performance report, noting that as part of the H2 process, acutes had resubmitted their trajectories to meet the year end targets, with the exception of the DM01 standard which remained part of tiering discussions. The RUH in particular was seeing an increase in demand in its urgent care services, impacting on ambulance conveyancing. NCTR recovery plans were being shared with region and will be discussed at the Recovery Board. Mitigations were in place in support of demand management. The Urgent Emergency Care (UEC) Delivery Group would maintain oversight. Elective care remained challenged, especially across Cancer areas. This was subject to recovery planning and discussions with national and regional colleagues. GWH and SFT had returned to plan against diagnostic targets. Primary Care remained below plan for GP appointments, an area of focus for the Primary Care Executive Group. Dental remained below plan, though BSW was benchmarking well nationally. Some improvement was recorded against mental health areas due AWP work.

10.5 Though the level of NCTR was not significantly improving, colleagues and partners had broken down the detail to understand the pathway and barriers, and those areas amendable to change and impact. Assurance was being sought against proposed actions to ensure a positive impact. Data quality was also being reviewed, as data and NCTR figures were known to be variable from providers. There was also more to do to seek improvement through the end to end UEC pathway. The commitment was there from system partners to meet the macro 9% target to see improvements across pathways one, two and three, maximising capacity to ensure those patients ready to go home were discharged. Colleagues were aware of the early escalation process, and the supporting guidance, policy and practice to see flow whilst meeting demand.

10.6 The Cluster CEO assured the Board that NCTR was not only an area of challenge in BSW but across the whole Cluster. The ambition and supporting internal work was there, but it remained an area of risk to double-down efforts on. The RUH had now implemented an ambulance protocol to off load within 45 minutes, moving the queue to ED as the knock-on consequences and risk. The commitment was there to move this forward, bring improvement, and to move patients to the more appropriate place, with learning and sharing across the cluster encouraged. Discussions continued with Local Authority colleagues to ensure that home support was in place also. It was evident that the actual number of NCTR patients was not increasing, it remained consistent – though not decreasing nonetheless.

10.7 Senior staff at the acutes were being empowered to ensure front line staff were aware and confident of the escalation process and able to enact these actions to see improvement and in the best interests of patients. There was also a need for the wider piece of public education, to ensure the hospitals were used as required and for what they do best. It was acknowledged that this was not only an acute issue to resolve, though a whole system effort to support.

10.8 The same principles were also being applied within the mental health care setting, with work to stop/reduce admissions, recognising that escalation was more likely to stop situations deteriorating. The mental health responder vehicle in place across BSW was now well established and supporting this work.

10.9 The Board **noted** the report for assurance purposes.

10b. BSW Medium Term Plan Update

10.10 The ICB Chief Delivery Officer acknowledged the huge ambition ahead to ensure the production of the MTP within the tight timescale set. The supporting paper updated the Board on the current stage of the planning process, key challenges, and work in train to prepare the first draft submission in December 2025.

10.11 The ICB's Director of Business Support was in attendance to support the item, providing assurance to the Board of the work underway and the surrounding governance. Weekly meetings were in place with the system Chief Operating Officer and Chief Finance Officers to ensure escalation of any arising issues. There was also joint working in place with counterparts in Dorset and Somerset ICB to ensure a consistent approach to each of the systems MTPs and to support cluster working. Key aspects being mirrored in Plans included: translating the agreed commissioning intentions into a five year Commissioning Plan; triangulation of numerical information for submission (though this may not be possible for the first submission), and the agreement and signing of the 16 board assurance statements to evidence support.

10.12 The Board **noted** the current stage of the planning process and work underway overseen by Board sub-committees, **noted** the next steps in preparing the required submissions for 17 December 2025, and **agreed delegation** to a joint meeting of the ICB Commissioning Committee and ICB Finance and Infrastructure Committee (scheduled for 16 December 2025) to approve the first draft submission in December.

10c. Strategic Commissioning Intentions

10.13 ICB Chief Delivery Officer presented the ICBs five-year Commissioning Intentions, which had been agreed with partners following internal development and external stakeholder engagement and discussion. Six of the commissioning intentions speak to the main areas of commissioning work and aligning to the Implementation Plan and NHS 10 Year Plan, with a further two linking to prevention and primary care. The intentions were to be quantifiable, with the desire of the move to left shift reflected. Providers were to understand the detail and the level of support required for the left shift, informing also the Hospital Strategy and Commissioning Intentions being developed by the Group.

10.14 The engagement undertaken to date was shown in appendix two, though it was acknowledged direct engagement was still to be factored in with the voluntary and community sector (VCSE), with meetings to be scheduled in over the next few weeks. This engagement would also inform the development of the five year Commissioning Plan, to be submitted in February. The VCSE Partner member noted that key areas of feedback from the VCSE to incorporate into the Intentions:

- Referencing Lead Provider models appropriately so as not to disadvantage/rule out placed based local VCSE organisations vital to Neighbourhood working that are

currently commissioned directly mainly through delegated pooled Sect 75/BCF funding at place.

- A need to invest in VCSE IT infrastructure to enable VCSE providers to access Shared Care Records and Integrate with the NHS app or phrase the digital offer expansion section appropriately to recognise the limitations of non NHS providers.
- Ensuring that commissioning for outcomes/incentive payments recognise the cashflow limitations of the smaller local VCSE organisations

10.15 The ambition was certainly factored in to targets to ensure achievement and shift as expected, though baselining was also to be undertaken. The Plan was to maximise the BSW pound, to understand the value of care in each setting and how the system could achieve better value. Five of the intentions are aligned to the national ambition and Elective Reform Plan. There was commitment to invest to support that ambition, pump priming transformation as required, though it was recognised that there was a level of risk against the implied investment in the Plan. The pledge was there to continue investment in prevention. There would also be a move to outcomes based contracts, considering what this would mean for new procurements. Personal value was also to be reflected on, ensuring the right care to the right people in the right place at the right time, and removal of unwarranted variation. Moving to this different way of working and model of care, with clinician support, was fundamental to achieving the Plan, maximising limited resources (workforce and financial) for the benefit of the population. The involvement of the voluntary sector would also be essential to increase system capability and support delivery of the Plan, acknowledging this may require further investment and development.

10.16 The Board acknowledged the significant work undertaken to prepare the MTP and strategic commissioning intentions. On conclusion of the discussion, the Board **agreed** the ICB Commissioning Intentions, noting the stakeholder engagement undertaken, and further **noted** that there are some further discussions ongoing with stakeholders due to timing of meetings and delivery groups. Further views and input will be taken account of in the five-year commissioning plan, which would form part of the final submission in February.

11. Any other business and closing comments

11.1 There being no other business, the Chair closed the meeting at 12.03hrs.

Next ICB Board meeting in public: Thursday 22 January 2026

Item 4

BSW Integrated Care Board - Board Meeting in Public Action Log - 2025-26

Updated following meeting held on **20/11/25**

OPEN actions

Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
20/11/2025	No actions recorded					

Report to:	NHS BSW ICB Board – Meeting in Public	Agenda item	7
Date of Meeting:	22 January 2026		

Title of Report:	Chief Executive Officer Board Report
Report Author:	Jonathan Higman, Cluster Chief Executive Officer
Board / Director Sponsor:	
Appendices:	

Report classification	Not Confidential
ICB body corporate	NHS BSW ICB
ICS NHS organisations only	BSW NHS
Wider system	BSW ICS

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	

Previous consideration by:	Date	Please clarify the purpose

1 Purpose of this paper

This report provides the Board with an update on the latest strategic developments across the NHS and more locally the developments within the Cluster and BSW.

2 Summary of recommendations and any additional actions required

The strategic focus is on the financial planning and supporting policy to set the condition for the delivery of the 10-year health plan reforms:

- NHS England 2025/26 headlines
- Autumn Budget 2025
- Resident Doctors Industrial Action
- Independent review into mental health conditions, attention deficit hyperactivity disorder (ADHD), and autism
- Government response to consultation on NHS dentistry contract: quality and payment reforms

The Board is recommended to NOTE and DISCUSS the content of this report.

3 Legal/regulatory implications

Failure to operate within the statute and regulatory framework would lead to the system being placed in special measures. Consequently, losing the capability to make local decisions for local communities.

4 Risks

Failure to understand the wider strategic and political context, could lead to the Board making decisions that fail to create a sustainable system. The Board also needs to seek assurance that credible plans are developed to ensure any significant strategic and operational risks are addressed.

5 Quality and resources impact

Failure to assess key strategic and operational developments against the quality and resource impacts for the Cluster and BSW ICB, would place the system at risk in terms of its sustainability. The Board needs to be assured that developed impacts have been assessed and significant impacts are addressed.

6 Confirmation of completion of Equalities and Quality Impact Assessment

Not applicable.

7 Communications and Engagement Considerations

This report is published for public information and includes updates and the latest news from the NHS England.

8 Statement on confidentiality of report

OFFICIAL, for public release.

Chief Executive Officer Board Report

1. Introduction

- 1.1. This report provides the Board with an overview of the latest strategic developments across the NHS and more locally across the Cluster and Bath and North East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS). It also includes reflections on the system developments during this reporting period.

2. Strategic Update – National & Regional Context

2.1. NHS England 2025/26 headlines

Sir Jim Mackey, Chief Executive NHS England, has written to [NHS staff](#) to thank them for their efforts this year recognising the significant work undertaken across the NHS in applying financial and operational discipline, reducing waiting lists, balancing the financial position, and putting the 10 Year Health Plan into action. Recognising this has been conducted against the backdrop of organisational change in the NHS, managing the winter period and industrial action.

As we head into 2026 and conduct our medium-term planning to make the first significant steps across the cluster in delivering the 10 Year Health Plan for England, the challenges of managing operational performance, financial positions and industrial relations are expected to continue. This will need to be carefully managed in the context of significant Provider transformation, including the reconfigurations being conducted under the New Hospital Programme, and changes to the organisational form of the NHS, including formal establishment NHS Bath and North East Somerset, Swindon and Wiltshire, Dorset, and Somerset ICB Cluster.

2.2. Autumn Budget 2025

The [2025 Autumn Budget](#) delivered by the Chancellor, Rachel Reeves, on 26 November 2025 delivers on the government promise of change. For health, this included: cutting the NHS waiting list in England supported by creating new Neighbourhood Health Centres; and implementing a one-year freeze on prescription charges.

Following significant health announcements in the June 2025 Spending Review and the government intent to protect and strengthen the NHS and other public services, while ensuring public money is well spent, the chancellor's budget maintained investment in the NHS. The overall health and social care budget in England is set to increase by an average of 2.4 per cent in real terms over the 2025/26 to 2028/29 Spending Review period with a strong emphasis on productivity and reform.

The Chancellor's announcements for health included: £300million of additional capital investment for NHS technology, to boost productivity, support staff and improve patient outcomes, accelerating the digital transformation, and government's commitment to drive the shift from analogue to digital technology. Freezing of NHS prescription charges in England in 2026-27, with the cost of a single prescription remaining at £9.90. Establishment of 250 new Neighbourhood Health Centres across England, with 120 operational by 2030, collocated with local health services to improve patient access to care closer to home.

2.3. Resident Doctors Industrial Action

The British Medical Association (BMA) resident doctors committee announced industrial action between 14 - 19 November and 17 – 22 December 2025. Throughout the industrial action the cluster priority remained on the safe delivery of health care services for our patients, whilst supporting staff and the right of colleagues to strike.

Hard work by NHS colleagues in managing the industrial action at a time of increased operational demand, supported patients through safe discharge processes to enable individuals to be home in time for Christmas, where possible.

2.4. Independent review into mental health conditions, attention deficit hyperactivity disorder (ADHD), and autism

In England over the last decade there has been an increase in public awareness of mental health, ADHD, and autism. We have also seen an increase in the prevalence of common mental health conditions and in parallel, demand for NHS support has risen sharply. This has created an urgent need to better understand how individuals are presenting to services and how best to meet people's needs and improve outcomes.

In support of this the Department of Health and Social Care has launched an [independent review](#) to address the rising demand for mental health, ADHD and autism services. The review will cover children, young people and adults and aims to understand the prevalence, trends and inequalities associated with these conditions. The review is expected to take up to six months. It will seek to identify approaches to provide different models of support and pathways within, and beyond, the NHS to better meet the needs of the population in a tailored, personalised, and timely way.

2.5. Government response to consultation on NHS dentistry contract: quality and payment reforms

The government has published its [response to the consultation on NHS dentistry contract](#), held from July to August 2025, in which it set its immediate

high level changes to be implemented to improve the experience of patients. It further committed to fundamentally reforming the dental contract by the end of Parliament.

In its response, the government acknowledged the concerns raised by respondents about the challenges people are facing in accessing NHS dentistry. These reforms are intended to deliver benefits for both patients and the profession; address the pressing challenges that dentists and dental teams are experiencing and that impact upon patient access to dental care. These reforms represent an important step towards improving the experience of patients by providing a focus on the highest priority patient groups, helping deliver important and evidence-based prevention activity, and introducing a quality related element into the dental contract for the first time.

This response is welcomed by the cluster; these reforms are fundamental in improving dental access for our population. The government aims to introduce legislation, where necessary, to support implementation of proposals from April 2026. NHS England will be supporting ICBs, who in turn will be working with the Local Dental Committees on the implementation of improvements to dental access, and continue to support the current good practice and evidence-based care. We are now working to ensure the proposals are embedded in our operational planning decisions for 2026/27 and beyond.

3. Local Update - NHS BSW ICB

3.1. ICB Cluster Executive team Announced.

Following a comprehensive recruitment process we have formally appointed the new Executive Directors for the NHS Bath and North East Somerset, Swindon and Wiltshire, Dorset, and Somerset ICB Cluster. The biographies for the cluster executive team are available [here](#). Expressions of Interest for the remaining Place Director roles, notably BANES and Wiltshire in the BSW area, have been taken and the selection process is on-going at the time of drafting this report. Results of this process will be published as soon as practical. This is a critical next step in the cluster transition and will help us as we work towards our shared ambition of bringing our three ICBs together, to become an outstanding strategic commissioning organisation. We will continue our focus on building a strong future together, with the opportunity to truly make a difference to our people and communities, helping them to live happy and healthy lives.

Thank you to all the Executive Directors across our organisations - they have all shown remarkable strength, resilience, and unity throughout this consultation period. Their commitment and passion for supporting our organisations and the people we serve has been unwavering.

3.2. Publication of the 2024/25 ICB Annual Assessments

Under the NHS Act 2006, NHS England conducts an annual performance assessment of ICBs considering how well it has discharged its functions during the year. NHS England conducted the assessment of how each ICB has performed against the 5 core roles aligned with the core purposes of an ICS during quarter 1 of 2025/26 and have formally published the [annual assessment of ICBs performance for 2024/25](#).

The annual assessment report recognises the significant work undertaken by colleagues across the BSW system in 2024/25 to reach this position. We, however, recognise and have continued to focus on the opportunities identified and we will continue to actively address them through 2025/26. Most critical in this work is the focus on delivery of the financial plan and planned productivity improvements through the last quarter of 2025/26.

3.3. BSW Medium Term Planning

NHS BSW ICB and system partners have submitted their draft Medium Term Plans to NHS England in line with the [Medium Term Planning Framework for 2026/27 to 2028/29](#) and we are now working on initial feedback from NHSE. The ICB completed the first planning submission in December 2025 and is awaiting formal feedback from NHSE regional team. The ICB and providers identified the areas of the submission that required further work and have been progressing those discussions following the submission and continue to work through the key strategic issues remaining, prior to the scheduled final submission in February 2026, which will be presented to the BSW Board.

Alongside the activity, performance, finance, and workforce numerical submissions, the ICB has taken the agreed Commissioning Intentions to form the “5 Year Commissioning Plan” which will also be presented for Board agreement in February 2026. This sets out in more detail, the intended impact, and timescales for those intentions. An equality impact assessment, related to the plan, is scheduled to be reviewed by the Quality and Outcomes Committee at the end of January 2026.

3.4. Financial Position - Month 8 2025/26.

At Month 8, the system was £31.7m off plan. If we factored in deficit support funding, the variance would reduce to £16.1m. The group reported a £43.2m adverse position to plan, offset by a £11.5m favourable ICB variance. The adverse position has been driven by the non-delivery of efficiency schemes (£17.7m), the loss of deficit supporting funding (£15.6m). Industrial Action costs amount to c£1.7m which were not in the plan. During December (Month 9), the system received the agreed Deficit Support Funding (DSF) for the full year totalling £23.4m. This is positive news and will help reduce the year-to-date deficit position and support the system cash position.

3.5. Financial Recovery Plan.

The system has worked closely together to agree a system recovery plan. There remains a material risk to the achievability of the financial position due to

the latest run rate across the Acute Group following a challenging M8 and (likely) M9 position and limited traction, to date, on the £7.4m Group recovery actions. Further mitigations are being developed including:

- Confirming potential additional funding from NHSE relating to industrial action and winter pressures.
- Understanding what further savings can be delivered as a result of the RUH turnaround team.
- Potential further mitigations across the system.

The position continues to be overseen by the system Strategic Delivery and Recovery Board.

3.6. Quality - National Independent Investigation into Maternity and Neonatal Services in England.

Following concerns raised by families who have experienced adverse events in some maternity services in England, Baroness Amos was appointed to lead a rapid, independent investigation into maternity and neonatal system issues across England. On 9 December 2025, after having engaged with families, staff, community organisations and MPs, Baroness Amos published her initial reflections on what she had heard to date and outlined the approach that will be taken for the investigation and next steps.

Consultations with families and staff for twelve identified NHS providers of maternity and neonatal services in England is underway. BSW maternity and neonatal service providers have not been identified for inclusion in the twelve planned site visits, however learning from this national review will be incorporated into our local service planning and quality monitoring. The initial findings from the review are planned to be published in February 2026.

3.7. Quality – Use of Escalation Spaces. During this winter period, our hospital and ambulance services are seeing a significant increase in the number of people needing to access urgent and emergency care and treatment. This pressure is also being reflected nationally, evidenced by reported delays in ambulance handover times and longer waiting times being experienced by patients within emergency departments. Although robust actions are in place aimed at continuously reducing delays to maintain patient safety and improve experience, regrettably some patients have at times needed to be cared for in escalation spaces, including within the corridors of the department.

3.8. BSW ICB's position, alongside that of NHSE, is that so-called 'corridor care' is unacceptable and must not be normalised. All efforts to eradicate 'corridor care' must continue, however, recognising that this has not always been possible, hospitals are ensuring compliance to standard operating procedures (SOPs) and safety reviews to maintain safety of care for both patients and staff where 'corridor care' is needed. Furthermore, BSW will be reviewing these SOPs and safety reviews against the recently published Principles for Providing Patient Care in Corridors (NHS England, 11th December 2025), with reported outcomes being monitored via the BSW Urgent and Emergency Care Group, BSW Quality Outcomes Committee and BSW System Quality Group.

3.9. Health Inequalities.

BSW's Outcomes Framework is strengthening how we identify and act on inequalities. New Place-based filtering allows gaps to be explored by Place alongside deprivation, ethnicity, and inclusion groups, directly informing neighbourhood health plans and shaping Medium Term Plan priorities (including transformation and prevention investment). It is also improving how we target the Health Inequalities Funding Programme, with clearer line of sight from data to investment and locally co-produced action.

The Health Inequalities Strategy refresh is progressing, structured around four pillars (Fairer Start in Life, Fairer Access, Fairer Outcomes and Fairer Experience) with enabling work on leadership and data, and measures of success in development. The draft will be shared with locality inequalities groups and the three Integrated Care Areas ahead of Population Health Board (PHB) consideration, alongside a partner-led plan for the 2026/27 programme to focus collective effort on the most persistent inequalities.

The 2025/26 Health Inequalities Funding Programme is now in mobilisation: PHB-approved grants across all three localities are moving into delivery. Inequalities are also embedded through Delivery Group priorities, locality priorities and action learning reviews, with Core20PLUS5-aligned actions including Treating Tobacco Dependency (recurrent model from 2026/27), targeted blood pressure case-finding with VCSE partners, vaccination outreach, oral health, maternity inequalities, and an outreach model for NHS Health Checks from April 2026.

3.10. Primary Care.

Primary care continues to deliver accessible, person-centred services that support prevention, early intervention, and management of long-term conditions. In 2025, we achieved key milestones, including improving access through increased online consultations in line with national guidance and strengthening resilience for winter, by expanding capacity and working closely with community, urgent, and emergency care partners. All practices achieved full compliance with the annual eDEC (the GP annual self-assessment) process, reinforcing our commitment to transparency and quality. The increased use of Advice and Guidance enabled faster access to specialist input, reducing unnecessary referrals and supporting timely, patient-centred decision-making.

In dental care, we commissioned additional units of Mandatory Dental Services to recover activity and restore pre-pandemic access levels as part of the national recovery plan.

In pharmacy, over 142 community pharmacies participated in the Community Pharmacy Consultation Service and delivered approximately 7,000 consultations per month through the Pharmacy First programme. We also progressed the HEE-funded pilot for training community pharmacists in independent prescribing as part of a national 'pathfinder' scheme, easing

pressure on GPs and urgent care, while supporting integrated clinical services. While workforce capacity remains a challenge, local campaigns for recruitment, retention, and development across all healthcare professions continue to strengthen primary care.

Looking ahead to 2026, our focus will be on accelerating digital innovation to improve patient access, expanding multidisciplinary teams as neighbourhood health develops, and tackling health inequalities through targeted outreach and integrated care models.

3.11. Urgent and Emergency Care (UEC) - Winter Pressures and Industrial Action

Throughout December, the demand across BSW and the South West in general, has been unprecedented, with South West Ambulance Service Foundation Trust seeing their highest activity on record and NHS 111 experiencing over-predicted calls. Additional bedded capacity has been created across the acute and community hospitals, however, there have been some excessive ambulance handover waits as well as an increase in the numbers of patients being cared for and treated in non-clinical escalation areas. Winter illnesses presented themselves earlier than usual with high numbers of adults experiencing flu, as well as paediatrics with flu and RSV. Paediatric acute respiratory illness (ARI) hubs have been in place in the beginning of November, along with additional provision in primary care for adults with respiratory illness.

A 4-week reset was commenced on 15 December 2025 with three key pillars of work – Call before Convey, internal improvements within the acutes and improved discharges via whole-system Multi-Agency Discharge Events (MADE), including community hospital beds. These involved each acute and community provider identifying daily areas of focus and system huddles and sharing their learning. It also involved internal focus at the RUH, GWH & SFT long length of stay reviews and improvements in pathways. System partners on site working together for complex patients that require P1-3 discharge pathways.

The 5-day Resident Doctors Industrial Action (IA) took place during December with all three acutes developing robust plans to support services to run as close to normal, as possible, with the experience and learning from previous IAs supporting the response. Small numbers of elective patients had to be rescheduled due to the IA. As with previous Resident Doctor IAs, the acute hospitals experienced improved patient flow due to increased numbers of senior clinical decision-makers.

3.12. People.

In December our Chief People Officer, Dr Sarah Green, left BSW to take up a new role at Somerset Academy. January will also see the departure of the Deputy Chief People Officer and three long term staff who have been supporting BSW for many years from the CSU. Business continuity plans have been put in place which includes backfill from the CSU. For the following few

months two Snr HRBP's and two HR advisors will support BSW to provide business as usual under the leadership of Alison Henley the newly appointed Cluster Chief Officer of Strategic Finance and Resourcing.

Staff will need further guidance and support in understanding the new executive structure and the importance of our extended leadership team in providing business continuity through this period of significant change. Our staff continue to be faced with uncertainty; however, we continue to provide support to them through workshops and wellbeing interventions.

3.13. Focus on Place (reports by exception, matters unique to a locality)

3.14. Bath and North East Somerset.

The B&NES ICA continues to make steady progress across its priorities, with strong partnership alignment and delivery assurance. Neighbourhood Health planning is underway and broadly on track, with initial development focused on building from established place-based models, including the Community Wellbeing Hub and existing population health and Joint Service Needs Assessment intelligence. Given capacity constraints across partners, the locality is taking a proportionate approach, prioritising the national requirements for the first submission and planning phased development thereafter, with a full version 1 Neighbourhood Health Plan expected by mid-January. Wider ICA delivery remains stable, with risks managed through existing governance and Health and Wellbeing Board engagement planned as plans mature.

3.15. Wiltshire.

Wiltshire ICA continues to demonstrate strong and mature place-based delivery, with effective partnership working sustained despite wider system change. Progress across priorities remains on track, supported by established neighbourhood collaborative arrangements and a clear focus on prevention, inequalities, and people with complex needs. Neighbourhood Health development is progressing well, with Wiltshire now undertaking focused visioning work to shape the locality's future neighbourhood model, informed by its rural geography and natural communities, ahead of consolidating plans into a full version 1 submission by mid-January. Wider ICA delivery has been recognised nationally, with the *Well Farmers for Wiltshire* programme winning the 2025 Health Service Journal Award for Innovation and Improvement in Reducing Health Inequalities, alongside recognition for the Military and Civilian Health Partnership.

3.16. Swindon.

The Swindon ICA continues to maintain momentum across its agreed priorities while managing a challenging operational context. Delivery against children and young people's emotional health and wellbeing and children's oral health priorities remains active, with learning from initial phases informing next steps. Neighbourhood Health planning is progressing at a measured pace, with current focus on resolving key foundations, particularly neighbourhood and Integrated Neighbourhood Team footprint alignment, before moving into

outcomes and delivery planning. The locality remains broadly on track to develop a full version 1 Neighbourhood Health Plan by mid-January. Key commissioning and operational risks, including Section 75 finalisation and provider payment issues, continue to be actively managed through established governance routes.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	8
Date of Meeting:	22 January 2026		

Title of Report:	BSW Outcomes Framework
Report Author:	Lucy Heath (Health and Care Professional Director) Sam Wheeler (Head of Strategic Intelligence)
Board / Director Sponsor:	Amanda Webb (CMO)
Appendices:	Appendix 1 – BSW Outcomes Framework Appendix 2 – Outcome Framework data with baseline and targets Appendix 3 - Outcome Framework inequalities data with targets

Report classification	Please indicate to which body/collection of organisations this report is relevant. <i>Only one of the below should be selected (x)</i>
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
BSW ICB Quality and Outcomes Committee	04/11/2025	Discussion and endorsement

1	Purpose of this paper
This paper updates the Board on the BSW Outcomes Framework and Outcomes Framework Dashboard, including how it is being used through system governance	

to support outcomes-based planning, assurance and improvement. It also includes, for noting, the proposed ambitions/targets for each outcome, including an inequalities ambition that expects disproportionate improvement for groups experiencing the poorest outcomes.

2 Summary of recommendations and any additional actions required

The Board is asked to:

- Note the purpose and use of the Outcomes Framework and Dashboard across BSW.
- Note the proposed approach to setting outcome ambitions/targets (Appendix A), including the use of peer benchmarking where national standards do not exist.
- Note the proposed inequalities ambition (disproportionate improvement for Core20, ethnic minority groups, people with Serious Mental Illness and people with a Learning Disability).
- Note the next steps to embed the framework through Delivery Group planning, deep dives, commissioning and contract discussions.

3 Legal/regulatory implications

This report supports the ICB's statutory duties under the NHS Act 2006 (as amended) to secure services in an integrated way, improve quality and reduce inequalities in access and outcomes, and supports compliance with the Public Sector Equality Duty (Equality Act 2010).

4 Procurement

Not applicable – this paper does not propose procurement activity.

Procurement sign off

5 Risks

Key risks relate to data quality/completeness, lagged national datasets and variable adoption across the system. These are mitigated through transparent indicator definitions and tooltips, training and access guidance, use of complementary local indicators for more timely monitoring, and embedding the framework through routine governance (PHB/QOC) and Delivery Group planning.

6 Quality and resources impact

Quality, patient experience and safeguarding: Enables a stronger line of sight between improvement activity and outcomes that matter to people and supports earlier identification of unwarranted variation.

Finance: No new financial resources are requested through this paper; delivery is supported within existing population health analytics and programme capacity.

Workforce: Requires time for training and adoption across Delivery Groups and partner teams.

Sustainability/Green agenda: Supports prevention and more appropriate use of care settings, aligning with system sustainability ambitions.

Finance sign-off

7 | Implementation Plan Alignment

Aligns to the BSW Integrated Care Strategy objectives and supports implementation priorities on prevention and early intervention, reducing inequalities, and delivering excellent health and care services through outcomes-based planning and assurance.

8 | Confirmation of completion of Equalities and Quality Impact Assessment

The Outcomes Framework embeds segmentation and inequalities analysis (including Core20, ethnicity, SMI and Learning Disability) to support targeted action. No service change is proposed through this paper; an Equality and Quality Impact Assessment is not required at this stage. Where future decisions are taken that materially change services or pathways, the appropriate impact assessments will be completed.

9 | Communications and Engagement Considerations

The dashboard is being rolled out through the BSW Intelligence Hub with access guidance and training sessions. The dashboard is available to all system partners. Two training sessions have already been delivered by the BSW Strategic Intelligence Team. Communications will focus on practical use cases (Delivery Group planning, deep dives, locality discussions and commissioning conversations), with feedback used to refine the tool and supporting materials.

10 | Statement on confidentiality of report

This report is not confidential.

BSW Outcomes Framework

1. Introduction

- 1.1. This report explains what the Outcome Framework is, how it is being used and the proposed approach to ambitions with targets.
- 1.2. The primary purpose is to raise awareness of the Outcomes Framework at Board level and support consistent adoption across the system. The paper also includes proposed ambitions/ targets for noting, with detail set out in appendix 2 and 3.
- 1.3. The outcomes framework and dashboard enable the Board and committees to monitor whether collective system action is improving health, wellbeing and quality of life, and whether improvements are reducing inequalities across BSW.

2. Background and wider context

- 2.1. Nationally, ICBs are expected to strengthen strategic commissioning by moving from counting activity to understanding impact – improving health outcomes, experiences and equity. The NHS' *Strategic Commissioning Framework* mandates defined outcomes and metrics. The NHS' *Fit For the Future* anchors to value-based approaches to improving Outcomes. The BSW Outcomes Framework provides a consistent local mechanism to do this.
- 2.2. The BSW Integrated Care Strategy sets out three objectives: prevention and early intervention, fairer outcomes and excellent services. The outcomes framework provides a shared view of progress against these objectives and supports prioritisation where the opportunity for improvement is greatest.
- 2.3. The framework is referenced in the BSW commissioning intentions and is being used to align Delivery Group plans, deep dives, prevention work and inequalities work, providing consistent language and measures across programmes.

3. Discussion of the issue

- 3.1. The BSW Outcomes Framework provides a single, system agreed set of outcomes and supporting indicators that helps the system answer three consistent questions: (i) what outcomes matter most, (ii) how are we performing and where is there variation, and (iii) where are the greatest inequalities and opportunities to improve.
- 3.2. Previous attempts to establish Outcomes Framework measures or an associated dashboard have been inhibited using measures which are too high-level to allow a detailed understanding of the population, are often not reported frequently and lag, making it difficult to assess changes in a timely manner. The current BSW approach uses a blend of national and local data presented in the

BSW Outcomes Framework dashboard in a way that helps address these issues, whilst keeping the dashboard simple to interpret.

- 3.3. The interactive Outcomes Framework Dashboard ([Contents - BSW Outcomes Framework - Power BI](#)) enables consistent exploration of:
 - Overall performance and trends over time.
 - Benchmarking against England, the South West, peer ICBs and peer local authorities to support understanding of relative position and ambition.
 - Variation by place and PCN.
 - Segmentation to understand inequalities (including Core20, ethnicity, age, gender and inclusion groups).
 - Evaluation of impact through tracking changes to outcomes over time
 - Clear indicator definitions and tooltips support consistent interpretation.
 - Current enhancements include statistical process control functionality and confidence intervals for more robust interpretation.
- 3.4. Board members can be provided with access to the dashboard on request. A short demonstration and/or briefing session can also be arranged to support interpretation and maximise the value of the dashboard for Board Assurance and discussion
- 3.5. The framework intentionally pairs national outcomes (important for benchmarking but often lagged and infrequent) with complementary local indicators that are more timely and segmentable for improvement. For example, where life expectancy and healthy life expectancy data is infrequent, our chosen complementary local indicators: years of life lost and healthy years of life lost provide a more responsive view of trajectory and inequality gaps to support improvement planning.
- 3.6. The Outcomes Framework is being embedded across the system:
 - **Commissioning intentions and outcomes-based commissioning.** The 2025/26 commissioning intentions include a specific focus on outcomes, using the Outcomes Framework as the shared reference point for (i) agreeing the outcomes we expect to shift, (ii) selecting meaningful indicators, and (iii) supporting a move toward outcomes-based conversations with providers and partners (alongside quality, access and finance).
 - **Delivery Group planning and assurance** - Each Delivery Group maps activities to relevant outcomes to strengthen line of sight from actions to outcomes we are seeking to improve. This supports more outcomes-based planning, clearer accountability, and better evaluation of whether activity is translating into impact.
 - **PHB deep dives and escalation** - Population Health Board uses structured deep dives (using the framework) to test whether current system cumulative activity is sufficient to achieve improvement at the required scale and pace, recommendations are escalated through QOC where needed.
 - **Health inequalities prioritisation, strategy development and investment focus.** Segmentation is used to identify the largest outcome gaps

experienced by specific population groups (including Core20, ethnic minority groups, people with Serious Mental Illness and people with a Learning Disability) and to guide the development of the system's inequalities strategy and delivery plans. This intelligence is also used to target and shape investment so that improvement is greatest where need is greatest, and gaps narrow rather than widen.

- **Prevention strategy and plan** - The draft Prevention Strategy and associated Prevention Plan use the Outcomes Framework as the starting point to identify the outcome areas where prevention can make the biggest difference to Healthy Life Expectancy and inequalities. Priority outcomes were identified using a consistent, outcomes-led prioritisation approach, and options were then generated and prioritised (including use of the Investment Panel prioritisation framework) to produce a practical, costed prevention programme with logic models and evaluation intent. This strengthens the line of sight from prevention investment (e.g., smoking, CVD risk, alcohol harm, obesity, dental prevention, vaccination and risk-factor identification) to the outcomes the system is seeking to improve and supports more transparent decision-making around prevention spend and expected impact.
- **Transformation priorities and system planning** - The Outcomes Framework is being used to support the identification and assessment of transformation priorities by providing a consistent way to describe: the problem to be solved, the outcomes and inequalities gaps to shift, and how improvement will be monitored.

3.7. Setting clear ambitions/ targets helps the system move from describing performance to being explicit about the level of improvement we are collectively aiming to deliver, and provides a consistent basis for prioritisation, assurance and accountability.

- Where national standards or targets exist, these will be used as the primary benchmark (e.g. dementia diagnosis rate, under 75 mortality from CVD)
- Where national targets do not exist, benchmarking will be used to set an appropriate level of ambition, drawing on peer ICB comparisons. We aim to be at least as good as the average of the six most similar ICBs, or where this is already achieved, progress towards the average of the best three of those peers.
- Where ICB-level data is not available or not the most recent, Local Authority data will be aggregated proportionately as a transparent proxy until ICB-level measures are available.

3.8. Inequalities ambitions are important to ensure that overall improvement translates into fairer outcomes, and that progress is greatest for those currently experiencing the poorest outcomes - so gaps narrow rather than persist (or inadvertently widen).

- Disproportionate improvement expectation - For priority outcomes, ambitions will explicitly expect faster improvement for groups experiencing

the poorest outcomes (Core20, ethnic minority groups, people with SMI and people with a Learning Disability) than for the reference population, so gaps narrow over time.

- Proposed “1.5x” rule (where a group is doing worse): Where a priority group has poorer outcomes at baseline, we will apply a consistent expectation that the rate of improvement in that group is at least 1.5 times the rate of improvement in the reference population (or BSW overall) over the target period, until the gap has materially narrowed. For outcomes where performance is deteriorating, the same principle will apply in reverse (deterioration should be slower in the priority group than in the reference population).
- Consistent measurement and pragmatic application - A consistent method will be applied across outcomes to assess whether gaps are narrowing (for example, a defined improvement in the gap over a set period, with a minimum expectation of no widening year-on-year). Where numbers are small or volatility is high, rolling averages and/or appropriate statistical approaches will be used to support interpretation.
- Data maturity ambition - Where segmentation is not currently possible due to data limitations, the ambition will be to improve data completeness and coding so gaps can be measured routinely and acted on through the Outcomes Framework.

4. Impact on resources

- 4.1. No new investment is requested through this paper. Delivery is supported within existing population health analytics and programme capacity.
- 4.2. Successful embedding requires time for training and use by Delivery Groups, place groups and partner organisations and continued support from analytical colleagues to interpret and apply insights.
- 4.3. In particular, work is required to build connections between the work of Delivery Groups and system transformation activities and the (quantified) expected impact upon BSW Outcomes.
- 4.4. Ongoing work is required to improve data quality, progress placeholder indicators and integrate additional datasets where required to strengthen segmentation and outcome monitoring.

5. Risks

- 5.1. Incomplete coding or missing data can create misleading signals. Mitigation includes clear definitions/ tool tips, data quality work with providers and local authorities and cautious interpretation using rolling averages and statistical testing where appropriate. Ultimately increased use and scrutiny of outcomes data is important to drive up the quality and completeness of BSW data.

- 5.2. Some national indicators are available annually and lagged by 12-24 months, limiting responsiveness. Mitigation includes complementary local indicators for more timely monitoring and alignment work to improve comparability.
- 5.3. Variable uptake on the outcomes framework could reduce its value, and poorly designed targets could drive unintended behaviours. This includes the confidence of stakeholders in using data and analytical reporting. Mitigation includes phased roll out through programmes, training, embedding in governance and using deep dives to test pathway logic and feasibility.

6. Stakeholder engagement including patient and public consultation

- 6.1. The outcomes framework was co-produced through engagement with Delivery Groups, Public Health, VCSE partners and clinicians, overseen by the Population Health Board.
- 6.2. Implementation engagement includes dashboard demonstrations, training sessions, access guidance and active support.
- 6.3. Patient and public insight is incorporated through existing engagement routes (e.g. ICS strategy development, Fit for the Future engagement, Locality engagement and relevant programme engagement) and will be strengthened through improvement work where pathway changes are proposed.

7. Impact on equalities

- 7.1. The framework embeds an inequalities lens through routine segmentation (Core20, ethnicity, age, gender, inclusion groups) enabling the system to identify where outcomes are poorest and where targeted action is needed.
- 7.2. The proposed inequalities ambition is that improvement should be disproportionate, those with the poorest outcomes should benefit first and fastest, so gaps narrow rather than widen.
- 7.3. Progress will be monitored through the dashboard and needs to be built into governance, with escalation where evidence suggests gaps are not narrowing or actions are not sufficient at the required scale and pace.

8. Next steps

- 8.1. Following Board noting, the Outcomes Framework Dashboard will continue phased roll-out through relevant programmes, with ongoing access to support for ICB colleagues and partner organisations.
- 8.2. Appendix 2 will be finalised with baseline and target values for each outcome, using the agreed benchmarking approach, and will be refreshed on an annual basis (or sooner where national standards change).
- 8.3. The programme of PHB deep dives will continue, with structured follow-up to ensure insight translates into delivery action, and recommendations escalated through QOC where required. Delivery Groups will continue strengthening logic models and quantifying expected impact to support assurance.

- 8.4. The dashboard will continue to be developed and enhanced by the Strategic Intelligence Team based on feedback from key stakeholders as it is further rolled out.

9. Recommendations

- 9.1. Note the content of the report and the role of the Outcomes Framework and Dashboard in supporting outcomes-based planning, assurance and improvement across BSW.
- 9.2. Note the proposed approach to setting ambitions/targets for each outcome, including the peer benchmarking approach set out in Appendix 2 and 3.
- 9.3. Note the proposed inequalities ambition of disproportionate improvement for groups experiencing the poorest outcomes, and the next steps to embed this through planning, deep dives and commissioning conversations.

Appendix 1 – BSW Outcomes Framework

National indicator (Local indicator if different)			
Key Outcomes			
1	Life expectancy at Birth (Years of life lost - YLL)		
2	Healthy expectancy at 65 (Average age entering frailty)		
3	Emergency bed days		
Contributory Outcomes		Placeholders	
4	Infant Mortality/ Pre-term births (YLL from child deaths)	A	Quality of dementia care
5	< 75 mortality (YLL) for major conditions	B	Percentage reporting an MSK condition/ GP reported MSK prevalence
6	Dementia Diagnosis Rate (GP recorded)		
7	Premature mortality (YLL) adults SMI		
8	Admissions for self-harm		
9	Population employment inactivity	C	Apprenticeship/ T-level take up in H&C
10	Staff Survey engagement score	D	Social Value quantified benefits
11	ICS organisation leavers rate	E	Carbon emissions of our providers
12	Percentage of patients reporting they have a care plan/ care plan is helpful (Number of Care Plans recorded on Integrated Care Record)	F	% LTC pts with SDM conversation
		G	No. CollboRATE (SDM)/ % scoring 9+
		H	% referred to social prescribing
13	Percentage of deaths in hospital	I	No. patients Personal Health Budget
14	School readiness	J	No. IntegRATE/ % scoring 8+
15	Smoking prevalence	K	% ICS resource invested in prevention
16	Obesity prevalence	L	Personal Wellbeing
17	Physical inactivity prevalence	M	Admissions for substance misuse
18	Admissions alcohol specific conditions	N	% children with healthy ways to manage difficult feelings
19	MMR/ Flu vaccination rates	O	Percentage of adults who feel lonely
20	Hospital admissions for dental decay	P	Avg. health gain elective interventions

Appendix 2 – Outcome Framework data with baseline and targets

Outcome Framework Indicators (where data is available)	Latest Years Data	BSW	Average 6 peers	Average best 3 peers	Target
Life Expectancy – Female (Years)	2023	84.2	84.0	84.3	84.3
Life Expectancy – Male (Years)	2023	80.8	80.3	80.8	80.8
Healthy Life Expectancy at 65 – Female (Years)	2021-23	12.7	12.3	12.6	12.7
Healthy Life Expectancy at 65 – Male (Years)	2021-23	11.4	11.1	11.4	11.4
Emergency Bed Days (per 100,000 population)	2024-25	43092	N/A	N/A	↓ 4%
Infant Mortality (per 1000 births)	2022-24	2.7	3.7	3.2	2.7
Under 75 mortality CVD (per 100,000 population)	2024	64.1	63.1	59.4	↓25%
Under 75 mortality Cancer (per 100,000 population)	2024	107.3	111.5	110.0	107.3
Under 75 mortality Liver (per 100,000 population)	2024	15.5	16.8	15.5	15.5
Under 75 mortality Respiratory (per 100,000 population)	2024	24.5	26.2	23.9	23.9
Dementia Diagnosis Rate (%)	2025	61.6	61.4	64.9	66.6
Premature mortality of people with SMI (per 100,000 population)	2021-23	73.3	83.5	78.3	73.3
Admissions for self-harm (per 100,000 population)	2023-24	226.4	142.5	97.7	142.5
People in employment (%)	2024-25	81.6	78.7	80.4	81.6
Staff Survey engagement scores (%)	2024	73.0	78.0	83.0	78.0
ICS organisation leavers rates (%)	2025	1.0	4.3	7.0	1.0
Patients reporting they have a care plan (%)	2024	46.0	42.7	44.7	46.0
Patients reporting the care plan is useful (%)	2024	48.0	47.2	47.3	48.0
Deaths that occur in hospital (%)	2023	36.2	39.3	37.6	36.2
School Readiness (%)	2023-24	69.2	68.7	69.2	69.2
Smoking prevalence in adults - 15+ (%)	2022-23	13	14.1	13.5	13
Obesity prevalence in adults (%)	2023-24	13	12.4	11.2	12.4
Physical inactivity in adults (%)	2023-24	19.1	19.6	18.7	18.7
Admission episodes for alcohol specific conditions (per 100,000 population)	2023-24	540.2	472.7	417.6	472.7
MMR vaccination rates age 5 - 2 doses (%)	2024-25	90.4	89.9	90.6	90.6
Flu vaccination rates 65+ (%)	2024-25	81.3	79.7	80.5	81.3
Hospital admissions for dental decay <19 (per 100,000 population)	2021-24	281.9	117.1	66.6	117.1
Personal Wellbeing – Low Satisfaction (%)	2022-23	5.5	5.0	4.2	5.0
Personal Wellbeing – Low Worthwhile (%)	2022-23	4.2	3.7	3.0	3.7
Personal Wellbeing – Low Happiness (%)	2022-23	9.9	7.2	6.0	7.2
Personal Wellbeing – High Anxiety (%)	2022-23	26.3	23.0	2.12	23.0
School pupils with social, emotional and mental health needs (%)	2024-25	4.6	4.3	4.1	4.3

Appendix 3 – Outcome Framework inequalities data with targets

Outcome	BSW	Core20	BAME	SMI	LD
Years of life lost (Rate per 1000)	5733	8782	2978	9811	22639
Healthy Years of Life Lost (Rate per 1000)	4136	5741	2989	N/A	N/A
Emergency Bed Days	46049	63349	33100	139293	91508
Years of life lost (under 1)	33.6	Too small numbers to segment			
Years of life lost CVD	1143	1579	520	3490	2247
Years of life lost Cancer	2095	3156	932	3443	4551
Years of life lost Liver	273	388	82	146	
Years of life lost Respiratory	491	1130	333	3275	1743
GP recorded dementia prevalence (65+)	3.4%	3.7%	4.9%	2.0%	0.6%
Years of life lost with SMI	942	2260	530	26885	19623
Admissions for self-harm	89	197	45	1321	971
No. of care plans on ICR	1535	1585	271	2456	1368
Percentage of deaths that occur in hospital	36%	40%	62%	N/A	N/A
GP reported smoking prevalence (15+)	9%	19%	7%	17%	11%
GP reported obesity prevalence (all age)	7%	9%	8%	13%	17%
Admissions for alcohol specific conditions	181	355	66	836	267
MMR vaccination rates (5 -2 doses)	TBC	TBC	TBC	TBC	TBC
Flu vaccination rates 65+	TBC	TBC	TBC	TBC	TBC
Hospital admissions for dental decay	472	861	396	635	228

DRAFT Minutes of the BSW Integrated Care Board – Quality and Outcomes Committee Tuesday 7 January 2026, 2pm, MS Teams

Members present:

Ade Williams	Non-Executive Director for Quality
Julian Kirby	Non-Executive Director for Public and Community Engagement
Suzannah Power	Non-Executive Director for Remuneration and People
Gill May	Chief Nursing Officer
Cara Charles-Barks	NHS Trusts & NHS Foundation Trusts Partner Member
Barry Coakley	Deputy Chief Medical Officer – <i>on behalf of Medical Director</i>

Attending:

Val Scrase	Community Provider – <i>from 15:15</i>
Clinical Operations Delivery Lead, LD, Autism and Neurodivergence	<i>-item 6</i>
BSW ICB Associate Director Patient Safety & Quality	<i>Item 10</i>
Clinical Manager, Vaccination Programme	<i>– item 10</i>
BSW ICB Associate Director Patient Safety & Quality	<i>Item 10</i>

Apologies (members):

Francis Campbell	Primary Medical Services Partner Member
Gordon Muvuti	Director of Place – Swindon
Lucy Townsend	Local Authority Partner Member – Wiltshire
Dr Amanda Webb	Chief Medical Officer

1. Welcome and Apologies

- 1.1 The Chair welcomed members and officers to the meeting of the BSW Integrated Care Board (ICB) Quality and Outcomes Committee. The above apologies were noted.
- 1.2 The meeting was declared quorate.
- 1.3 The Committee noted that meetings held via MS Teams were recorded, with the sole purpose to assist with the production of minutes.

2. Declarations of Interest

- 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 held on 4th November 2025

3.1 The Committee reviewed the minutes of its previous meeting and **approved** them as a true and accurate record of the meeting.

4. **Action Tracker & Matters Arising**

4.1 The Committee reviewed the action log and received the following updates:

- Action 33: VTE Assurance – The Chief Nurse confirmed that the venous thromboembolism (VTE) trajectory had been shared with the region; CQC were now assured regarding [provider name] plans. The issue remained under contractual oversight - **closed**.
- Action 35: Outcomes Framework - The Committee reflected on discussion at the ICB Board about the evolving Outcomes Framework, noting Dorset’s expanded approach as a helpful comparator. The Committee did not request a formal action but observed that BSW’s framework was maturing well and could be iteratively expanded as appropriate - **closed**

5. **Emerging Risks**

5.1 The Chief Nurse informed the Committee that there has been a recent review of all risks, at present, there are no new matters requiring escalation to the Committee. An audit of the Board Assurance Framework (BAF) is in progress, and work is ongoing to ensure alignment between identified risks and audit findings. It is anticipated that, during the transition to a cluster model, risks may arise relating to oversight of the BSW contract and associated plans. These will be monitored and reported as further detail becomes available.

6. **LeDer Annual Report**

6.1 The BSW ICB Clinical Operations Delivery Lead, LD, Autism and Neurodivergence joined the meeting and presented the Annual Report 2024/25. During the year there had been 68 LeDeR notifications across BSW, predominantly concerning working-age adults, with hospital being the most reported place of death. The increase in notifications was interpreted as a sign of improved recognition and reporting, not as a deterioration in care quality; nevertheless, the figures reflected persistent health inequalities experienced by the cohort.

6.2 The Committee was asked to note:

- LeDeR governance had transitioned from Nursing & Quality into the Learning Disability, Autism and Neurodivergence (LDAN) team, reporting via the LDAN delivery group.
- The system’s emphasis remained on implementing learning—including sustained work on dynamic support registers, Care and Treatment Reviews (CTRs), roll-out of the Oliver McGowan mandatory training, and concerted efforts to achieve over 75% annual health checks for people with a learning disability across all BSW localities.
- A significant constraint was outlined: formal LeDeR reviews had been paused due to reviewer capacity. Rapid review methodologies are being

trialled by Dorset colleagues as a potential mitigating approach to ensure timely learning

- 6.4 The Committee reviewed the annual report and acknowledged that it is accurate and reflects commendable work undertaken, particularly in areas such as vaccination programmes and Oliver McGowan training. However, members expressed concern regarding the absence of reviews, noting the potential impact on learning and assurance. The committee agreed to **approve** the report but highlighted the need for clear recommendations to strengthen future practice, including embedding a culture of continuous improvement, ensuring adequate resources, and maintaining system-wide support.

7. Quality and Patient Safety Exceptions Report

7.1 The Committee **received** and **noted** the Quality and Patient Safety Report.

7.2.1 The Committee was asked to note:

CQC inspections

- [Outcomes of reviews of BSW provider will be published on the CQC website].

Paediatric Audiology

- The national team have advised there may be more patients needing a recall, due to an error in their IT systems. Governance processes are in place to act promptly if more children in BSW need recall.

System Pressures (UEC)

- The System is still under significant pressure, interventions in December to improve flow included, call-before-conveyance initiative, a MADE event to accelerate patient discharges and the commissioning of 20 additional community hospital beds.
- With the introduction of 'wait 45' by SWAST there is a greater risk of corridor care being initiated but all providers are endeavouring to keep this to a minimum and are closely monitoring all incidents. National corridor care standards and refreshed definition are expected.

HCRG

- Current assurance level is Amber due to gaps in meeting quality schedule requirements. A Quality and safeguarding subgroup led by the BSW Deputy Chief Nursing Officer is actively engaging. HCRG has established an internal BSW Quality Board, where the ICB is a core member.

Mixed-Sex Accommodation

- Mixed-sex accommodation breaches remain a significant challenge across the system, particularly at Great Western Hospital (GWH), which is an outlier in national data. A BSW peer review is scheduled for January 2026, and findings will be shared at the February Task and Finish Group meeting.

Stroke Pathway

- The latest SNAP audit results show that SFT and GWH are currently rated at Level E, while RUH is at Level D. These ratings indicate areas for improvement across all acute sites. A national stroke network audit for GWH is planned for January 2026, and targeted actions are expected to lead to improvements in performance.

Maternity and Neonatal

- There are several serious incidents under investigation. All investigations are being conducted in line with Ockenden recommendations and the Southwest NHS standard operating procedure
- Additionally, a cluster review is underway following an increase in adverse outcomes for babies. These reviews aim to identify themes and learning to improve care.

KPMG internal audit

- The recent KPMG quality internal audit provided significant assurance overall, with only minor improvement opportunities identified. All recommended improvements are expected to be completed by the end of the financial year.

Patient Advice and Complaints – Q2

- The Quarter 2 report shows a 69% increase in complaints compared to the same period in 2024/25 and a 3% increase in PALS inquiries. The main areas of concern include difficulties accessing GP services and booking timely appointments, long waiting times for adult ADHD assessments, access issues for the Tier 3 weight management service, and communication challenges with HCRG. These areas are receiving focused attention through ICB and system-level groups, and early signs of progress are being observed.

7.3 The Committee discussion noted:

- The Non-Executive Director for Remuneration and People expressed concern that the report provided only a brief update on HCRG, given the Amber rating for quality and safety assurance. The Chief Nurse would bring a full assurance report to the next committee meeting.
- The Non-Executive Director for Remuneration and People raised concerns about Adult Learning Disability services. The committee questioned whether these issues form part of the wider assurance gap and stressed the need for urgent clarity. In response, the Chief Nurse acknowledged that this reflects the challenges of operating under a new outcomes-based contract, noting that while achieving outcomes is critical, visibility of governance and safety measures must remain non-negotiable to ensure services are delivered safely and effectively.

8. Population Health Board Update

- 8.1 The Deputy Chief Medical Officer introduced the Population Health Board (PHB) update, which provides assurance on progress in prevention, health inequalities, and population analytics. This month's focus is on prevention, including the draft BSW prevention strategy, prevention reference tool and a deep dive into alcohol-specific admissions.
- 8.2 The Committee was asked to note:
- The PHB reviewed progress on prevention and inequalities strategies and undertook a deep dive into alcohol-specific admissions. It agreed to set ambitious targets for reducing admissions and will refine its deep-dive approach to allow more detailed analysis and actionable recommendations.
 - PHB Health Analytics - Work is progressing on tools to support planning and assurance, including the Strategic Commissioning Tool and Outcomes Framework Dashboard. Enhancements will add new indicators and statistical controls, with wider system access planned through the Intelligence Hub.
 - Inequalities Strategy Group - focus on Core20PLUS priorities, including insulin pump access, military families, and mental health. Action Learning Reviews addressed tooth extractions and vaccination uptake, with initiatives such as dental incentives, supervised toothbrushing, roving clinics, and culturally sensitive engagement.
 - Prevention Strategy Group - strengthened the draft Prevention Strategy and Reference Tool, adopting a Prevent–Reduce–Delay framework. It also reviewed smoking in pregnancy, implementing incentive schemes and tobacco dependency treatment, which evidence shows can significantly improve quit rates.
 - Draft Prevention Strategy - the strategy aims to shift focus from treatment to prevention, prioritising areas like alcohol, cardiovascular disease, obesity, and dementia. Delivery will be driven by resource alignment, embedding prevention in system planning, and measuring success through the Outcomes Framework.
 - Alcohol-Specific Admissions Deep Dive- BSW's admission rate is 540 per 100,000, above peer averages. Targets are to reduce this to 473 within three years and 418 within five years, while narrowing inequality gaps. Current actions include GP screening and community services, with plans to improve early identification, strengthen pathways, and target high-risk groups.
- 8.3 The Committee discussion noted:
- the alcohol-specific admissions data and related findings would be aligned with commissioning intentions across the three local authorities, given that substance misuse services largely sit with them. Emphasised the importance of identifying need and ensuring pathways connect individuals to existing services as part of an integrated approach.

- postponed Action Learning Reviews for Learning Disability and Neurodiversity may risk further disadvantaging this vulnerable group, particularly the review aimed at improving annual health check uptake to 75%. The committee stressed the need for assurance that these reviews are rescheduled and not lost and requested future reports to include timelines and mitigation plans.

9. Mental Health Strategy and Implementation Plan

9.1 The Committee expressed strong concern that the Mental Health Strategy and Implementation Plan is repeatedly deferred, requested an explanation for the repeated delays, and expected a firm commitment on when the report will be delivered.

10. Vaccination Assurance

10.1 The Clinical Manager for Vaccination joined the meeting to provide assurance on vaccination delivery across BSW. The update focused on safety, quality, uptake, and system readiness as the region moves toward delegated commissioning in 2027.

10.2 The Committee was asked to note:

- Over the past year, the vaccination programme has successfully evolved from an emergency response to a sustainable, preventative model covering all age groups. Strong governance through the Vaccination Operational Group (VOG) and proactive reporting has supported this transition. Provider-led outreach has ensured high uptake in underserved communities, while Primary Care Networks delivered care home and housebound vaccinations effectively. Salisbury Foundation Trust achieved exceptional inpatient vaccination rates, and all acute trusts exceeded national averages for staff flu vaccinations. School-aged immunisation teams also played a vital role, delivering a significant proportion of flu vaccines. These achievements reflect a coordinated system-wide effort and position BSW well for future delegated commissioning.
- The vaccination programme faced several challenges, including variation in readiness among PCN's for seasonal programmes and slow uptake of inpatient vaccinations due to workforce constraints. Coding issues and confusion over eligibility changes for COVID and flu vaccines added complexity.
- Key risks are workforce shortages and recruitment freezes, reduced funding for outreach beyond 2026, and system changes ahead of delegated commissioning in 2027.
- To address these challenges and prepare for delegated commissioning, the programme is strengthening governance through the VOG and targeted support for providers, with escalation routes where needed. The team is working closely with NHS England on outreach procurement to ensure continuity and local

involvement, while focusing on improving inpatient pathways and maintaining high uptake.

- 10.3 The Committee discussion noted that vaccination uptake is monitored weekly with targeted interventions, and that accessibility, robust governance, and adequate funding are needed to maintain delivery standards.

11. AOB

- 11.1 There being no other business, the Chair closed the meeting at 4:10 pm

Next meeting: Tuesday 3rd March 2026, 14:00, MS Teams

DRAFT

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	9a
Date of Meeting:	22 January 2026		

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

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	
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
Quality and Outcomes Committee	06/01/26	Assurance monitoring

1	Purpose of this paper
The aim of this paper is to update the BSW ICB Trust Board on the current quality risks, and new learning by exception.	

2	Summary of recommendations and any additional actions required
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This report provides an overview of key quality, safety, and performance metrics across the Bath and North-East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) system.

The BSW ICB Board is asked to note the information provided in this report in relation to the following Quality and Safety metrics:

- 1.0 Infection Prevention and Control
- 2.0 Urgent and Emergency Care (UEC) Safety
- 3.0 Stroke/Sentinel Stroke National Audit Programme (SSNAP)
- 4.0 Mixed Sex Accommodation Breach Update
- 5.0 Quality Assurance Visits
- 6.0 Internal Quality Audit Summary
- 7.0 Paediatric Audiology update
- 8.0 Maternity and Neonates

1.0 Infection Prevention and Control (IP&C)

Clostridioides difficile (CDI):

- Significant decrease in case rates have been reported during Aug–Sep 2025; the lowest regional rate for both months.
- BSW integrated care system ranks 2nd regionally (better than) and is within 2nd quartile nationally.
- Year-to-date: 142 cases have been reported. This is 9 less than same period last year but is currently above the National Health Service England (NHSE) trajectory for 2025/26.

E. Coli Bloodstream Infection (BSI):

- There was a reported rates decrease between Jul–Sep 2025, with BSW System being the 2nd best performing ICB nationally and regionally.
- Year-to-date: 335 cases reported (23 more when compared to same time period last year) which is currently above NHS England trajectory for 2025/26.
- Community Onset, Community Acquired (COCA) cases remain the highest reported cases, with urinary tract infections being the primary source.
- During Quarter 3, a number of bed closures have been reported across acute hospitals and within some care homes due to reported COVID & influenza; United Kingdom Health Security Agency (UKHSA) rates are being monitored and IP&C practice is continuously monitored.

2.0 Urgent and Emergency Care (UEC) Safety

Pressures across the system have continued throughout quarter 3, leading to increased Emergency Department (ED) waiting times (W). W45 was implemented across the 3 Acute hospitals as of 6 October 2025, resulting in a significant improvement in ambulance handover times and a consequential increase in ambulance conveyances, impacting on flow through the ED. An audit of ambulance conveyances was completed on the 17th and 18th November at the Royal United Hospital (RUH) Bath, with the results being shared with relevant partners. Immediate next steps and further in-depth audits are being worked through across the system to review the increased demand further. Corridor care continues to increase resulting in increased quality and safety monitoring for these areas. NHSE has recently published principles for providing patient care in corridors (11th Dec 2025), with these principles to be monitored via BSW UEC Quality and Safety Sub Group, BSW Quality Outcomes Committee and BSW System Quality Group

3.0 Stroke Care – SSNAP Performance (BSW System Overview)

The Sentinel Stroke National Audit Programme (SSNAP) measures stroke care quality nationally. Following a methodology change in October 2024, ratings have dropped across the UK due to recalibrated benchmarks. Within BSW, performance remains below expected levels (bands D–E), reflecting challenges in access to stroke units, therapy delivery, and workforce capacity. Despite these pressures, audit compliance and data completeness are strong, enabling timely reporting and improvement planning. System-wide recovery actions are underway, including weekly oversight, bed capacity optimisation, and workforce planning. An external audit by the Stroke Network and NHS England is scheduled for January 2026, with the aim of improving ratings to at least band C.

The BSW Quality and Outcomes Committee has requested a further end to end stroke pathway review to scope current practice and inform system wide quality improvement plans

4.0 Mixed Sex Accommodation Breach (MSA) Update

Since April 2025, reported MSA breaches within acute hospital settings has reduced system-wide (improving), however BSW remains an outlier both regionally and nationally. Reported breaches are occurring in Emergency Departments, acute assessment areas, and Intensive Care Units (ICUs), with no non clinically justified breaches being reported on hospital inpatient wards. NHSE has set up a task-and-finish group to tackle challenges across the region and to share best practice, with BSW ICB and local providers actively involved. No patient safety incidents have been reported as a result of the MSA breaches. Monitoring continues via BSW System Quality Group and BSW Quality and Outcomes Committee.

5.0 Quality Assurance Visits

The ICB quality team have undertaken a series of joint quality assurance visits across commissioned providers to measure compliance with contractual standards set within the local quality schedule, including patient safety standards and continuous improvement objectives. A summary of the visits is detailed within this report.

6.0 BSW ICB Internal Quality Audit Summary

At the end of September and throughout October 2025, KPMG audited the design and operating effectiveness of BSW ICB controls for Quality and Patient Safety Governance, assessing alignment with the Quality Assurance and Improvement Framework (QAIF) and National Quality Board (NQB) guidance.

The overall rating received was: *Significant assurance with minor improvement opportunities (Amber-Green)*. An action plan is being progressed by leads within the Quality and BI Teams, for full completion by 31 March 2026.

7.0 National Paediatric Audiology Review Update

The publication of the national Kingdon report (Dec 2025), highlighting an honest assessment of paediatric audiology service challenges across the country, has set out a number of recommendations for consideration within each integrated care system.

All BSW providers are compliant with these reporting requirements and are contributing to system-wide learning. Service improvement plans, where identified, continue to be monitored at a system level via a dedicated Incident Management Team (IMT) process. A system harm review is scheduled for 28 January 2026, with outcomes to be reported to the BSW System Quality Group and BSW Quality and Outcomes Committee.

8.0 Maternity and Neonatal

Following a recent Prevention of Future Deaths report linked to a homebirth maternal and neonatal death in Manchester, NHS England has directed all Trusts to urgently review the safety and quality of homebirth services. This review must address three critical areas, detailed within the main body of this report.

3	Legal/regulatory implications
N/A	

4	Procurement
N/A	

5	Risks
All known risks are monitored and managed through the BSW ICB risk register. Quality and safety risks scored above 15 are escalated to the ICB corporate risk register and are reviewed within Quality and Outcomes Committee.	

6	Quality and resources impact
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	N/A

7	Operational Plan Alignment
This report aligns to the ICB priorities which is set out in the Operating Plan and the Quality Assurance and Improvement Framework.	

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

9	Communications and Engagement Considerations
N/A	

10	Statement on confidentiality of report
This report is to be presented to BSW ICB Board held in public	

BSW ICB Board Quality Update

January 2026

This report provides an overview to the Board of compliance to key quality metrics and outcomes, as required by local contract quality schedules and the BSW Quality Assurance and Improvement Framework agreed across the Bath and North-East Somerset, Swindon and Wiltshire (BSW) Integrated Care System.

1.0 Quality Indicator 1 - Infection Prevention and Control (IP&C)

The National Oversight Framework (NOF) currently reports segment rates and rankings for three of the six mandatory reportable infections: Clostridioides difficile infection, E. coli bloodstream infection, and MRSA bloodstream infection. These metrics are presented below as part of this report; however, it should be noted that no national update has been issued since the previous Quality Outcomes Committee (QOC) report. As a result, the NOF data continues to reflect the reporting period from June 2024 to June 2025.

1.1 Clostridioides difficile infection (CDI)

The ICB performance dashboard shows a decrease in CDI case rates across BSW during August and September compared with July. This is in line with UKHSA data sets, with BSW rates sitting below average regional and national rates for August to October.

Hospital Onset Healthcare Associated (HOHA) cases remain the highest apportionment category in BSW, with Community Onset Community Acquired (COCA) fluctuating month on month but still lower than HOHA cases. The ICB, in collaboration with GP practices, continue to undertake COCA reviews, to date, no significant themes have been identified.

On a 12-month rolling to quarter end distribution chart, BSW currently ranks 2nd regionally and 2nd quartile nationally for CDI case rates. Notably, BSW recorded the lowest CDI rate in the region for August and September 2025. The system saw an increase in the rates of CDI infection in October but still had the second lowest in the region.

Despite this positive trajectory, cumulative data for 2025 shows BSW has reported 164 CDI cases to date, and though this is 11 less cases than the same period last year, it still sits above NHSE trajectory figures.

NOF and Segment rates of Clostridioides difficile infections from June 24-25:

Trust	Rate	Metric Score	Rank	Segment
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SFT	1.71	3.84	123/ 134	4
GWH	1.14	2.52	49/ 134	3
RUH	1.36	3.44	101/ 134	3

1.2 MRSA Blood Stream Infections (BSI)

The ICB performance dashboard shows a decrease in MRSA BSI rates between July and September, and this is mirrored by the UKHSA data. There have been 8 cases of MRSA blood stream infection, year to date. This includes 3 in Q2. 5 have been Community Onset, Community Acquired (COCA) and 3 have been Hospital Onset, Healthcare Acquired (HOHA). MRSA case reviews that have been undertaken by the ICB for the COCA cases have identified themes of skin and soft tissue case. For the HOHA cases these have been related to line insertion activities. Nationally BSW ICB is the 5th best performing nationally and the second best performing ICB regionally for MRSA blood stream infections.

NOF and Segment rates of MRSA blood stream infections from June 24-25:

Trust	Metric (count)	Value	Metric Score	Rank	Segment
SFT	0.00		1.00	1/ 134	1
GWH	1.00		2.00	19/134	2
RUH	3.00		2.63	55/ 134	3

1.3 E. coli Blood Stream Infection (BSI)

The ICB performance dashboard shows a decrease in E. coli BSI rates between July and September, and this is mirrored by the UKHSA data with October rates continuing this downward trend. Community Onset, Community Acquired (COCA) cases remain highest apportionment category, with lower urinary tract infection remaining the leading primary source of infection. BSW ICB are the second best performing ICB for E-Coli blood stream infections regionally and third nationally

Despite this positive trajectory, cumulative data for 2025 shows BSW has reported 374 E. coli BSI cases to date. This is 20 more cases than the same period last year and currently sits above NHSE trajectory figures.

NOF and Segment rates of E-coli blood stream infections from June 24-25:

Trust	Rate	Metric Score	Rank	Segment
SFT	0.97	1.00	1/ 134	1
GWH	0.90	1.00	1/ 134	1
RUH	1.35	3.59	111/ 134	4

1.4 MSSA Blood Stream Infections

The ICB performance dashboard shows a decrease in MSSA BSI rates across BSW during August and September compared with July. This is in line with UKHSA data sets. The system saw an increase in the rates of MSSA BSI in October to just above regional and national average. On a 12-month rolling to quarter end distribution chart, BSW currently ranks 2nd regionally and 2nd quartile nationally for MSSA BSI rates. Year to date to system has reported 125 MSSA BSI, this is 17 more cases than the same period last year. 40% of cases are Hospital Onset, Healthcare Acquired (HOHA) whilst 60% are Community Onset, Community Acquired (COCA). A continued focus on these infections remains at a regional level due to the rising rate within the region and within other ICBs. A regional MSSA Improvement Collaborative is commencing in January 2026 to tackle this.

1.5 Klebsiella Blood Stream Infections

The ICB performance dashboard shows fluctuating Klebsiella BSI rates across BSW between July and September. This is in line with UKHSA data sets. The system saw a slight increase in the rates of Klebsiella BSI in October to just above regionally and national average, but over the year, the system has generally been well below regional and national rates. On a 12-month rolling to quarter end distribution chart, BSW currently ranks 2nd regionally and 3rd nationally for Klebsiella BSI rates. Year to date to system has reported 108 Klebsiella BSI; though this is 5 less cases than the same period last year, it still sits above NHSE trajectory figures.

1.6 Pseudomonas Blood Stream Infections

The ICB performance dashboard also shows fluctuating Pseudomonas rates across BSW between July and September. This is in line with UKHSA data sets. Again, the system saw a slight increase in the rates of Pseudomonas BSI in October to above regionally and national average. On a 12-month rolling to quarter end distribution chart, BSW currently ranks 4th regionally and 9th nationally for Pseudomonas BSI rates. BSW ICB pseudomonas cases are evenly split between Community Onset, Community Acquired (COCA), and healthcare attributed, with primary sources spread between lower urinary tract, upper urinary tract, hepatobiliary and lower respiratory tract. Year to date to system has reported 50

Pseudomonas BSI, though this is 1 less case than the same period last year, it still sits above NHSE trajectory figures. As outlined in the previously presented Q2 report, the new BSW Infection Prevention and Management Collaborative integrated priority workstreams, focusing on urinary tract infections, respiratory tract infections, and skin and soft tissue infections will tackle these increases in healthcare associated infection rates.

1.7 IP&C Winter pressures:

Rates of seasonal viruses are increasing across the system. Some acute providers and care homes are experiencing some bed closures due to Covid, Influenza and Norovirus - UKHSA published rates are being monitored closely.

1.9 Antivirals for Post-Exposure Prophylaxis (PEP) against influenza

New guidance from UKHSA has been released, stating that if a person is in an 'at risk' group and has been exposed due to a localised outbreak of influenza, for example in a care home, Post-Exposure Prophylaxis (PEP) can be considered regardless of vaccination status. The operationalisation of this advice is being taken forward by the ICB, in liaison with local UKHSA

2.0 Urgent and Emergency Care (UEC) Safety

Urgent and Emergency Care pressures remain high across BSW and this is reflected nationally. In September 2025, BSW ambulance handovers averaged 66 minutes with sustained Operational Pressures Escalation Levels (OPEL) 3 levels across all acute trusts. To address this, South Western Ambulance Service NHS Foundation Trust (SWAST) introduced the W45 "45-minute hard stop" on 6 October. This has significantly improved handover times, notably 31 minutes in October and 27 minutes in November, and has contributed to better Category 2 response times (36 minutes in October and 34 minutes in November, though still above the 32-minute target).

Ambulance conveyances increased in October (6,434 vs. 5,832 in September) and continued in November with (6,376), with Royal United Hospital (RUH) most affected. An audit of conveyances was undertaken to understand the reported increase during November 2025 at both the RUH and Great Western Hospitals (GWH).

Next Steps

- Clinically led real-time audits at RUH and GWH to review conveyances and explore alternatives.
- To replicate this audit at Salisbury Foundation Trust (SFT)
- End-to-end review of patient pathways to identify opportunities for earlier intervention.
- Care Coordination working group established to increase usage and expand referral criteria.

W45 improved ambulance flow without negatively impacting 4-hour ED performance (64.8% in October, 67.8% in November). However, 12-hour waits rose to 10.3% (vs. 8.4% plan, 2% national target), increasing risks of potential harm (pressure ulcers, deconditioning, dehydration, mortality). Although corridor care has increased, standard operating procedures (SOPs) and safety reviews are in place and will be reviewed against the recently published 'principles for providing patient care in corridors' (11th Dec 2025). These principles will be monitored via BSW UEC Quality and Safety Sub Group, BSW Quality Outcomes Committee and BSW System Quality Group.

3.0 Quality Indicator 32 - Stroke/SSNAP (BSW System Overview)

The Sentinel Stroke National Audit Programme (SSNAP) measures stroke care quality across the UK using evidence-based indicators grouped into seven domains, scored A–E (A = highest, E = lowest). This aligns with the BSW Quality Schedule requirement for timely stroke assessment, treatment, therapy, and referral.

Following SSNAP's October 2024 methodology change, ratings have dropped nationally due to recalibrated benchmarks, not necessarily reduced quality. Across BSW, overall SSNAP performance is below expected levels, with scores in the lower bands (D–E), reflecting system-wide challenges in access to stroke units, therapy and rehabilitation delivery and workforce capacity and recruitment. Despite these pressures, audit compliance and data completeness are consistent, enabling timely reporting and rapid improvement actions.

Current Actions and Next Steps include:

- Monitoring of system-wide recovery plans in place
- Weekly performance oversight and escalation
- Stroke Unit Standard Operating Procedure amendments to optimise bed capacity
- Workforce planning initiatives and capacity reviews

An external audit is scheduled for January 2026 by the Stroke Network and NHS England, with BSW ICB participation. The aim is to improve SSNAP ratings to at least "C" through coordinated improvement across providers.

Following a review at the BSW Quality and Outcomes Committee in January 2026, a further end to end stroke pathway review has been requested, with outcomes to be reported to both this committee and the BSW System Quality Group.

4.0 Quality Indicator 15 - Mixed Sex Accommodation Breach Update

Since April 2025, reported Mixed Sex Accommodation (MSA) breaches have reduced across the system. However, BSW continues to be an outlier at both a regional and national level. All reported breaches have occurred within Emergency Departments, assessment areas, and Intensive Care Units, with none taking place on hospital inpatient wards.

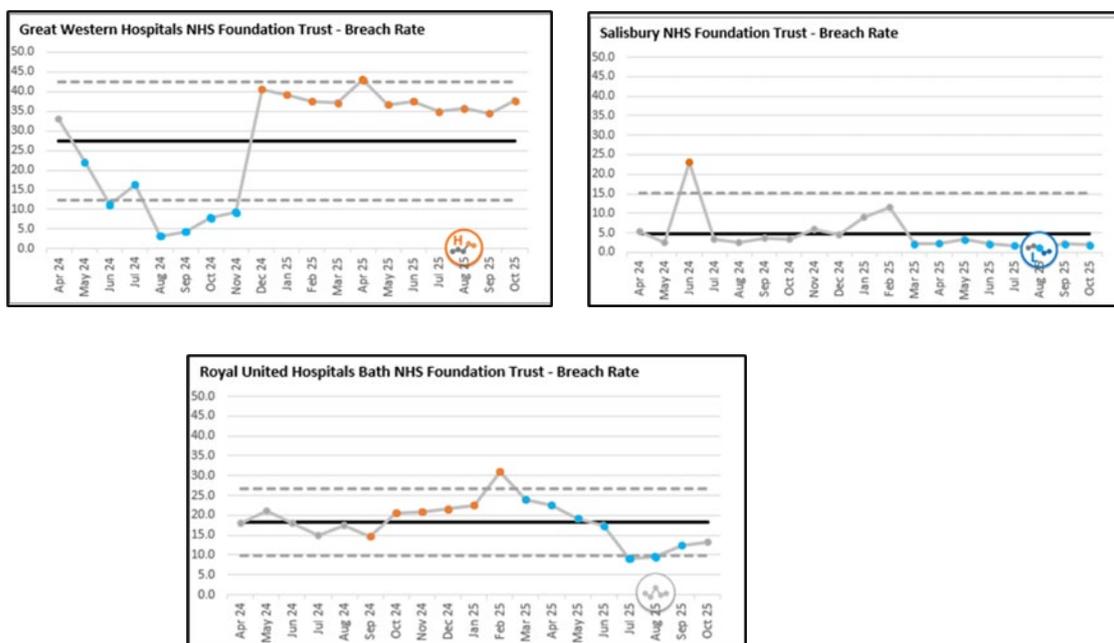
The South West Regional Quality team has established a Task & Finish (T&F) group to address key challenges across the region and to facilitate the sharing of best practice. The group Terms of Reference aim to ensure compliance with national standards on MSA breaches by analysing regional data, Identifying key themes, reviewing guidance and developing an actionable plan. The group will provide feedback to local system quality groups, Regional Team and the National Executive Quality Group.

Objectives include:

- Explore MSA breach data and identify Southwest specific trends
- Assess current guidance and ensure alignment with national standards
- Understand how providers manage MSA breaches alongside winter pressures and balancing measures
- Assist providers in adhering to MSA policy and processes
- Drive reduction of MSA breaches to an agreed acceptable level by March 2026

Peer reviews are planned across BSW during January 2026, which will be presented at the February Task & Finish Group meeting.

The current position for BSW, as discussed at the T&F meeting can be seen below.



5.0 Quality Indicator - Quality Assurance Visits

BSW ICB Quality Team has undertaken a series of quality assurance visits across commissioned providers during 2025. These visits are designed to monitor compliance with quality and safety standards, as set within the Local Contract Quality Schedule. Working

jointly with providers, these visits review governance arrangements and provide assurance on patient safety and quality outcomes. As an assurance and improvement tool, the visits also aim to identify areas of good practice and opportunities for shared learning, supporting continuous improvement and quality outcomes across the system.

To date, six visits have been completed, covering providers including community nursing services, acute hospitals, mental health services. The focus of these visits has included the deteriorating patient pathway in Emergency Departments, Mixed-Sex Accommodation breaches within Same Day Emergency Care and Medical Assessment Units, community nursing and therapy services, and mental health provision.

Overall, the visits have provided assurance that quality standards are being maintained across the system. However, targeted areas for improvement have been identified, particularly relating to Mixed-Sex Accommodation breaches at GWH's Medical Assessment Unit. These breaches are primarily due to environmental constraints, such as curtained cubicles, shared corridors, and limited toilet facilities. While these challenges remain, the unit demonstrated several strengths, including a clean and calm environment, visible leadership, professional and fully recruited staff, strong infection control measures, and no recorded complaints or harm related to breaches.

Recommendations from the visits include improving privacy in corridors and waiting areas, maintaining consistent signage, and progressing plans for additional toilet and wet room facilities as part of risk mitigation. The ICB Quality Team will continue to monitor these areas and support providers in implementing improvement actions.

6.0 BSW ICB Internal Quality Audit

A recent internal quality audit assessed the design and operating effectiveness of BSW ICB controls for Quality and Patient Safety Governance, reviewing alignment with the Quality Assurance and Improvement Framework and National Quality Board guidance. The audit, completed on 29 October 2025, provided an overall rating of significant assurance with minor improvement opportunities (Amber-Green). This reflects the clear structure for system-wide oversight of quality and patient safety, strong governance representation, and well-defined quality metrics.

Identified areas for improvement focused on strengthening oversight of provider's Patient Safety Incident Response Plans and monitoring the impact of actions taken to drive improvement. This is being taken through BSW System Quality Group, with actions scheduled for completion by 31 March 2026. Progress will be reported to the ICB Quality and Outcomes Committee in March 2026.

7.0 Paediatric Audiology Review Update

In response to the national review of Paediatric Audiology Services in England, coordination of paediatric audiology patient recalls across BSW continues to progress well and is

recognised positively by National Health Service England. The system is actively responding to the recommendations of the recently published Kingdon Report (<https://www.gov.uk/government/publications/kingdon-review-of-childrens-hearing-services-final-report/kingdon-review-of-childrens-hearing-services-final-report>), including strengthening governance, improving data collection, and supporting Improving Quality in Physiological Services accreditation.

All providers remain compliant with national reporting requirements and are engaged in system-wide learning and improvement. Updated action plans have been requested to ensure timely delivery, and regular Incident Management Team (IMT) led meetings provide robust oversight. A system learning review is scheduled for 28 January 2026, with outcomes to be shared through established governance channels, reinforcing our commitment to safe, high-quality care.

8.0 Maternity and Neonatal

8.1 National Independent Investigation into Maternity and Neonatal Services in England

Over the past 10 years there have been several independent investigations and reviews of maternity and neonatal services in some NHS Trusts across England leading to 748 recommendations for all maternity and neonatal services, but concerns are still being raised by families who have experienced adverse events in some services in England.

Baroness Amos has been appointed to lead a rapid, independent investigation into maternity and neonatal system issues across England. On Dec 9th 2025, Baroness Amos published her **initial reflections** on what she had heard to date from engagement with families, staff, community organisations and MPs, and she also outlined the approach that will be taken for the investigation and next steps.

The terms of reference for the investigation are organised around 5 workstreams:

- Local Investigation phase
- System wide review including a call for evidence from families in Jan 2026, staff surveys, Review of previous report recommendations and interviews with academic experts and national healthcare leaders such as Care Quality Commission, General Medical council, NHS England and Maternity and Neonatal Investigations and other community engagement.
- Inequalities- to develop an understanding of the experiences of Black, Asian and seldom- heard communities.
- Legal framework review regarding role of Coroners related to stillbirths and development of national recommendations.
- Development of one set of national recommendations

BSW maternity and neonatal providers have not been identified to be included in the 12 planned site visits to identified Trusts. Consultations with families and staff in the 12 identified organisations in England are underway.

Baroness Amos reflections identified some thematic issues through initial engagement with families, staff, organisations and MP's including:

- Poor communication and inadequate support for women and partners
- Women not being listened to or given the right information to make informed choices at critical moments of care as risk profile changes.
- Adversarial complaints processes and lack of family engagement in reviews of care and feedback of review reports
- Lack of empathy and disregard for women's choices
- Impact of discrimination against women of colour, working class women, women with mental health challenges and younger parents leading to poorer outcomes. Issues with culturally appropriate care and support, translation services and the need for Trust.
- Failure of regulatory bodies to protect vulnerable women and families and their perception of health professionals and organisations "marking their own homework."
- The length of time that autopsy reports take to be produced, delaying families from being able to fully grieve for their children.
- Poor standards of basic care such as cleanliness, food, provision of help
- Families also report long term impacts such as mental health challenges and family breakdown.
- Staff have described the pressures that they work under and the challenges they are facing and the areas that require improvement. They described improvements that have already taken place and also described the impact of negative publicity generating anxiety for services users and staff.

Baroness Amos also heard from some families about the high-quality compassionate care they have received.

The initial findings of the 12 investigations into identified NHS providers of maternity and neonatal services are planned to be published in Feb 2026.

BSW Maternity and Neonatal Providers and the Local Maternity and Neonatal System (LMNS) regularly triangulate data with Maternity and Neonatal Voice Partnership Leads (service user representatives) to identify themes and trends across service user feedback, complaints, incidents/litigation to identify any required areas of focus to continually improve care provision and are considering the initial published reflections from Baroness Amos against current workplans across BSW services.

The role of the Maternity and Neonatal Independent Senior Advocate (MNISA) across BSW (as part of the national pilot scheme) has provided advocacy and support for any families who have experienced an adverse event in BSW, enabling enhanced understanding of how we can further support families and continue to develop governance processes that support families to ensure that their voices are heard and integral to identification of learning that continually supports service development and provides appropriate support to parents that meets their needs. The national pilot funding is pausing at the end of March 2026 to await the national investigation recommendations.

8.2 Homebirths

Following a recent Prevention of Future Deaths report linked to a homebirth maternal and neonatal death in Manchester, NHS England has directed all Trusts to urgently review the safety and quality of homebirth services.

The review must address three critical areas:

- Operational readiness (including 24/7 midwifery cover, staff training, equipment and transfer protocols, availability of senior multi-disciplinary support and sufficient rest periods)
- Care planning and dynamic risk assessment (ensuring systematic assessment of complexity and risk, personalised care in the light of identified issues, and robust multidisciplinary communication)
- Governance and oversight (executive board accountability and robust oversight, audit programmes, and comprehensive guidance).

Trusts are expected to act promptly on any identified risks, report outcomes to their boards, and escalate urgent safety concerns to regional NHS England teams without delay. Trusts have a continuing responsibility to offer homebirth as a choice for women. This will be discussed at BSW ICB LMNS programme board with any issues identified to be escalated through Provider and ICB risk reports.

8.3 Saving Babies Lives NHSE Care Bundle

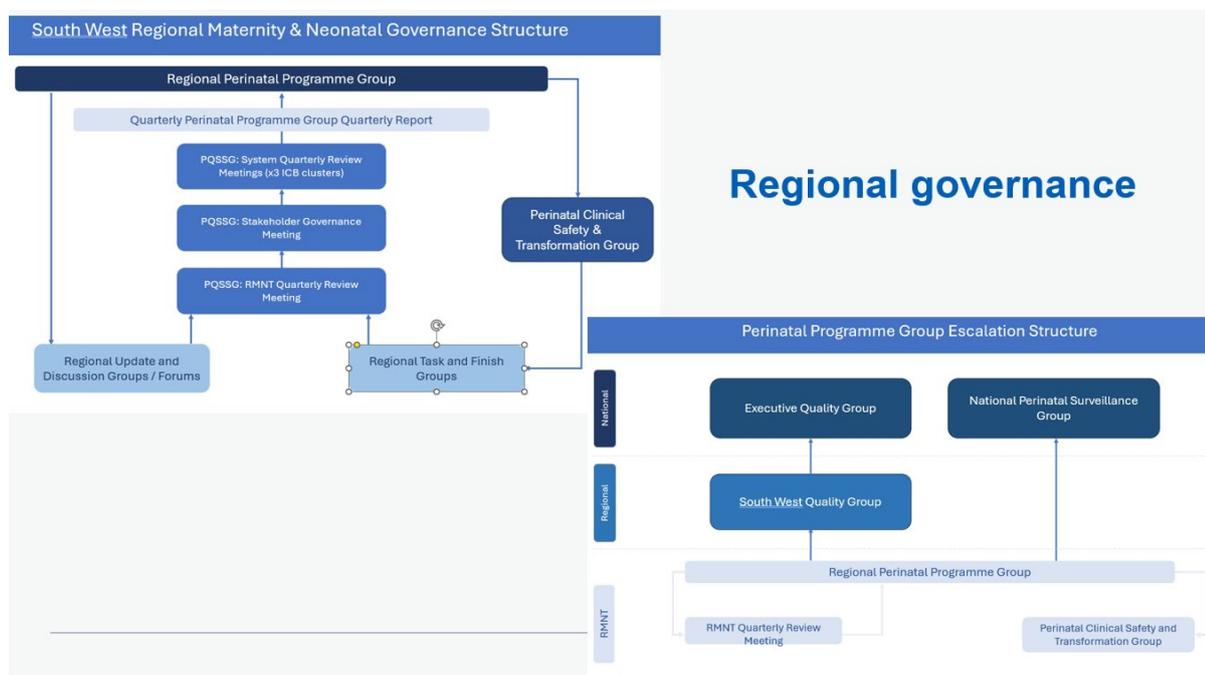
All providers have been continuing to work on implementation of NHSE Saving Babies Lives Care bundle with continued progress evidenced by BSW maternity and neonatal providers this year. Improvement work is focusing on reliable provision of next working day scans for women with recurrent reduced foetal movements, Uterine artery doppler provision in line with guidance and BadgerNet electronic reporting.

8.4 Maternity and Neonatal Perinatal Quality Oversight Model (PQOM)

This was published by NHS England in August 2025, replacing Perinatal Quality Surveillance Model (2020). BSW LMNS are transitioning to this model which emphasises increased accountability for Trust boards and the integration of regional, ICB and provider level review to enhance early identification of risks and support.

Work is underway to refresh monthly provider and LMNS board reporting templates in line with PQOM guidance.

SW regional governance structure for maternity and neonatal has been revised as below:



8.5 Regional and national tools that support Perinatal Quality Oversight

Maternity Outcomes Surveillance System (MOSS) has recently been launched nationally. It is an early safety signal system that monitors outcomes and processes at a trust site level to prompt rapid safety checks and initiate early interventions when unusual patterns occur within Trusts providing maternity care. Initial measures will be for term stillbirths and term neonatal deaths.

Additional tools are planned to be launched throughout Quarter 4 (January-March 26) including:

- A regional heat map/dashboard for risk assessment across maternity services- this will include safety indicators for each maternity provider and identify variations that signal need for additional review/assurance.
- A national inequalities dashboard.
- Daily Maternity Situation (OPEL) reporting to support provider, system, regional and national identification of need for mutual aid. BSW LMNS is exploring the potential for the data submitted to be visible through Single Health Resilience Early Warning (SHREWD) Database for BSW.
- NHS England Maternal Care Bundle – Evidence based practice focusing on 5 elements of care– Venous Thromboembolism (VTE), Neurology, Obstetric haemorrhage, mental health and pre-hospital and acute care.

Minutes of the BSW Integrated Care Board – Finance and Infrastructure Committee Meeting

Wednesday 3rd December 2025, 0900hrs, via MS Teams

Members present:

Paul Fox	Chair – BSW ICB Non-Executive Director for Finance
Sam Mowbray	Local Authority Partner Member of the Board
Gary Heneage	BSW ICB Chief Finance Officer
Amanda Webb	BSW ICB Chief Medical Officer
Sarah Green	BSW ICB Chief People Officer
Rachael Backler	BSW ICB Chief Delivery Officer
Ade Williams	BSW ICB Non-Executive Director for Quality
Julian Kirby	BSW ICB Non-Executive Director for Public Community Engagement

Attending:

BSW ICB Deputy Chief Finance Officer
 BSW ICB Assistant Corporate Secretary (minutes)
 BSW ICB Director of Business Support – item 7
 BSW ICB Head of Capital – item 5c
 BSW ICB Associate Director of Finance (Wiltshire) – item 9

Apologies (members):

Laura Ambler BSW ICB Executive Director of Place (BaNES) & LDAND
 Simon Wade GWH Director of Finance

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. Declarations of Interest

- 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.

3. Minutes of the BSW ICB Finance and Infrastructure meeting held on 5 November 2025

- 3.1 The Committee reviewed the minutes of its previous meeting and **approved** them as a true and accurate record of the meeting.

4. Action Tracker and Matters Arising

4.1 Update on Regional Response for Prime:

The BSW Chief Finance Officer confirmed that region is yet to receive a response to the Prime letter, and this is in progress with an update expected in January 2026.

4.2 **Cash Committee Position:**

The cash committee has not yet been established, and its importance across the group was stressed. The remaining focus is on securing quarter four deficit support funding to fully address the shortfall.

5a. **BSW ICB Position Month 7**

5a.1 The BSW ICB Deputy Chief Finance Officer reported a stable financial position based on last month's figures at Month 7 for the BSW ICB. The main change is the transition to the new finance system from 1 October 2025, which has resulted in some variations in reporting due to migrating balances and adopting a new chart of accounts. There were no allocations in months 7 and 8, to reduce system pressure. Underlying variances remain largely unchanged, and the forecast continues to target a £14.6m improvement, consistent with the recovery plan. It was noted there have been no formal changes to the forecast position as this is expected in M9.

5a.2 The ICB's voluntary redundancy scheme went live on 1 December 2025, applications will require funding approval from NHS England once settlement amounts are confirmed.

5a.3 The committee noted a year-to-date surplus of £10m, with confidence that the forecast £14.6m surplus by year-end is achievable and carries minimal risk. However, funding for change programmes remains constrained, as only two-thirds of the cost-of-change allocation has been received by the region, which is insufficient to fully support both Voluntary Redundancy (VR) and Compulsory Redundancy (CR) schemes. A business case will be required for NHS England approval before progressing with CR, and further engagement with the regional team is needed to confirm funding availability. Interest in VR has already been registered, and the committee acknowledged the need for robust governance through agreed gateways.

5a.4 Assurance was provided that the system financial position remains stable, though it is dependent on £1m of primary care resettlement funding yet to be secured and capped elective recovery funding which is currently not aligned to provider positions. The ICB has confirmed with providers that there is no funding above the existing envelopes.

5a.5 The Committee **noted** the update on the Month 7 position.

5b. **BSW ICS Position Month 7**

5b.1 The BSW ICB Deputy Chief Finance Officer reported no change in the year-to-date position, with improvement expected in month 9 following the release of deficit

support funding for the first three quarters. At month 7, the reported position shows a £15.3m performance deficit excluding deficit support funding, primarily due to under-delivery of the efficiency programme. Recovery actions are in place to address this gap. The committee noted the significant financial impact of recent industrial action, with a further five days planned before Christmas, making it increasingly difficult for the system to absorb associated costs.

5b.3 The Committee **noted** the update on the Month 7 position.

5c. Capital Update – taken as item 6

5c.1 The BSW ICB Head of Capital reported minimal change in the capital position to month 7, with actual spend below plan, mainly due to paused operational schemes linked to financial pressures and cash constraints. Underspend on operational capital currently stands at £11.7m, though trusts have assured delivery within the remaining five months. Risks remain around timely approvals and cash availability for national programmes, particularly community diagnostic schemes (£11m) and EPR, which will require significant capital next year. The SFT urgent treatment centre (£7m) has been approved.

5c.2 The committee discussed the two major diagnostic schemes valued at approximately £10m each, which were split over two years to aid delivery. While West Swindon has gained traction recently, Salisbury faces planning challenges and may not be delivered by March. Members noted the pause on operational capital CDEL due to self-funding requirements, while national programmes remain cash-backed but slowed by regional approval delays. Concerns were raised about the limited time left in the year and the impact on diagnostic capacity, which was intended to be addressed through these schemes.

5c.3 The committee explored options to maximise capital use within the remaining months, including leveraging newly approved private funding opportunities for future projects.

5c.4 The Committee **noted** the Capital Programme update.

6. ICB Recovery – taken as item 5c

6.1 The BSW ICB Chief Finance Officer provided an update, confirming the hospital group's commitment to deliver a £14.6m deficit and the ICB an equivalent surplus to achieve system balance. There are noted risks including winter pressures with increased acute activity and sickness, ongoing industrial action, and the challenge of reducing workforce to achieve the required exit run rate.

6.2 The committee noted progress on key RUH asks and the turnaround team at RUH, which is producing weekly flash reports and has identified improvement opportunities ahead of the next recovery board on 12 December.

- 6.3 The committee reflected on lessons for future planning, noting repeated late identification of planning requirements and emphasising that failure to meet financial targets has real-world consequences on infrastructure, not just efficiency metrics. Members explored options to utilise remaining capital, but acknowledged challenges due to high values, audit requirements, and the fact that many schemes have not yet commenced.
- 6.4 The Committee **noted** the update on Recovery Progress.

7. Medium Term Plan – Plan Update

- 7.1 The BSW ICB Director of Business Support provided an update on preparations for the first planning submission due on 17 December, covering activity plans, workforce templates, and board assurance statements. Workforce returns for primary care are on track, while voluntary sector data is delayed but mitigated with assumptions for the initial submission. Activity plans depend on provider returns, which are expected shortly; early indications show no major issues, though some assumptions and mitigations for growth will not be fully worked through before submission.
- 7.2 The committee noted the importance of consistency with provider submissions and alignment with Dorset and Somerset positions. Risks highlighted in the cover paper are material and beginning to manifest, and work continues with cluster colleagues on the narrative plan for the February full submission.
- 7.3 The committee acknowledged that the planning round is particularly challenging, not only due to tight timelines but also because of changes in transition arrangements and deficit support availability, which make agreeing planning assumptions difficult. It was noted that the first draft submission may not fully satisfy board expectations, and this will need to be reflected transparently in the board assurance statements.
- 7.4 The BSW ICB Chief Finance Officer presented the medium-term financial plan. The plan aims to ring-fence funding for change rather than covering deficits, with the ICB expected to remain balanced over the first two years, while the wider system will face a significant deficit due to the loss of £17m deficit support funding and £44m transitional funding. National growth assumptions have been applied to set initial funding envelopes, with additional spend requiring efficiencies. Community services will see targeted growth, and elective activity funding will increase substantially in 2027/28, offering potential to reduce provider gaps.
- 7.5 The BSW ICB Chief Finance Officer highlighted a major adjustment process to address historic contract imbalances, a national approach will apply a maximum shift of 2.5% per year, with £32m earmarked for these changes over time. The committee noted the complexity of the planning process and the need for further work before final submission.

- 7.6 The committee reviewed the implications of the contract x price adjustment. Members raised concerns about whether the governance mechanisms required to deliver the planned efficiencies are in place, given current gaps in assumptions around demand management and group service developments. Assurance was provided that transitional funding was intended to enable structural change, which has not progressed at the required pace, and that future investment will need to support transformation.
- 7.7 The committee noted that NHS England has already removed £18m from allocations (linked to the £19/head), reinforcing the need for significant efficiency savings. Oversight of the group's plan will be under direct NHSE scrutiny, with intervention powers limited mainly to increased monitoring. The committee agreed on the importance of maintaining investment in prevention and transformation while holding firm against pressures to divert funds from strategic priorities.
- 7.8 The Committee **noted** the update on the Medium Term Plan.
- 8a. Investment Panel Update**
- 8a.1 [commercial in confidence]
- 8b. Investment Panel Terms of Reference**
- 8b.1 Minor amendments to the committee's Terms of Reference were noted. These edits are interim, pending a full review of all committee Terms of Reference as part of the transition and cluster arrangements. It was confirmed that Somerset and Dorset ICBs do not have an equivalent committee or process in place.
- 8b.2 The Committee **approved** the reviewed BSW ICS Investment Panel Terms of Reference.
- 9. Trowbridge Integrated Care Centre Update (TICC)**
- 9.1 The BSW ICB Associate Director of Finance (Wiltshire) provided an update on the project, confirming that delays caused by lease agreements have been resolved, keeping the building opening on track for February 2026.
- 9.3 The Committee **noted** the update on the Trowbridge Integrated Care Centre.
- 10. BSW ICB Finance and Infrastructure Forward Plan**
- 10.1 The Committee noted the forward plan until March 2026.
- 11. Any Other Business**

- 11.1 The committee noted that the Board has delegated approval of the first planning submission to a joint meeting of this committee and the Commissioning Committee scheduled for 16 December.
- 11.2 With no further business to address, the Chair closed the meeting at 10:52 hrs.

Next Meeting of the BSW ICB Finance and Infrastructure Committee
Wednesday 7th January 2026 09:00hrs via MS Teams

DRAFT Minutes of the BSW Integrated Care Board – Finance and Infrastructure Committee Meeting Wednesday 7th January 2026, 0900hrs, via MS Teams

Members present:

Paul Fox	Chair – BSW ICB Non-Executive Director for Finance
Sam Mowbray	Local Authority Partner Member of the Board
Gary Heneage	BSW ICB Chief Finance Officer
Rachael Backler	BSW ICB Chief Delivery Officer
Ade Williams	BSW ICB Non-Executive Director for Quality
Julian Kirby	BSW ICB Non-Executive Director for Public Community Engagement
Simon Wade	GWH Chief Finance Officer

Attending:

BSW ICB Deputy Chief Finance Officer
BSW ICB Assistant Corporate Secretary (minutes)
BSW ICB Director of Business Support – item 7
Great Western Hospital Interim Chief Transformation and Innovation Officer – item 9

Apologies (members):

Amanda Webb BSW ICB Chief Medical Officer

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. Declarations of Interest

- 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.

3. Minutes of the BSW ICB Finance and Infrastructure meeting held on 3 December 2025

- 3.1 The Committee reviewed the minutes of its previous meeting and **approved** them as a true and accurate record of the meeting.

4. Action Tracker and Matters Arising

- 4.1 Two items were noted on the tracker and were due to be covered during the agenda.

5a. BSW ICB Position Month 8

- 5a.1 The BSW ICB Deputy CFO provided assurance regarding the financial position, noting an improvement in the year-to-date surplus by £1.5m. It was confirmed that no deficit support funding was received at Month 8. Full funding covering all four quarters was secured in Month 9, this funding has been appropriately reflected in the ICB position and is currently recorded as credits in reserves, which will be adjusted in Month 9 reporting.
- 5a.2 The BSW ICB voluntary redundancy scheme has closed.
- 5a.3 The Committee discussion noted that funding availability for the voluntary redundancy exercise remains uncertain, with national guidance still unclear. Clarity on amounts is anticipated by February/March 2026.
- 5a.4 The Committee **noted** the update on the Month 8 position.

5b. BSW ICS Position Month 8

- 5b.1 The BSW Deputy CFO presented the BSW ICS position at month 8, the ICS year-to-date deficit is £31.7m with providers forecasting a £14.6m year-end deficit, leaving a significant challenge to recover the system deficit within the remaining four months. Current forecast position is being maintained, Month 8 trajectory was met due to early recognition of £1.5m originally planned for month 12 to meet the trajectories. We are still working through industrial action impacts while awaiting clarity on national funding.
- 5b.2 The Committee noted that funding for losses from recent industrial action will only cover expenditure, not lost income from cancelled procedures, which remains around 4–5% down despite maintaining 90–95% elective activity nationally. A notional allocation has been indicated, but full coverage is unlikely.
- 5b.3 The Committee **noted** the update on the Month 8 position.

5c. Capital Update – *taken as item 6*

- 5c.1 The BSW ICB Deputy CFO reported that the capital position remains unchanged, but there are significant risks of slippage in this year's spend. Delays caused by earlier revenue constraints have impacted cash flow and procurement timelines, while some national programmes remain unapproved and unlikely to deliver within the financial year noting delays in Capital Programmes such as CDC.
- 5c.2 The Committee noted receipt of a formal letter confirming that provider oversight has moved to NHS England from 1 January 2026. This change is already evident, where regional and national teams are engaging directly with individual providers, bypassing the ICB. Concern was raised that this approach could undermine the

hospital group model and complicate ICB's role in managing future planning and coordination.

- 5c.3 Current capital plans are not yet fully aligned with the medium-term strategy, particularly regarding clinical and elective care priorities. Submissions require prioritisation against hospital group strategy. Year 1 ICB capital allocation focuses on community infrastructure. It is noted that regional engagement is positive, and these schemes are considered strategically significant for integrated care delivery.
- 5c.4 The Committee **noted** the Capital Programme update.

6. Recovery – taken as item 5c

- 6.1 The hospital group reported an initial £22m deficit (the gap expected at year end), this was reduced to £14.5m after £7.5m recovery actions. ICB surplus offset this to achieve overall break-even. Month 8 was highly challenging and the £7.5m recovery actions are now at risk. Formal reforecast deferred to Month 10 to allow mitigation planning, including risk confirmation, industrial action funding, and flexibility within ICB/regional support. Additional measures may involve RUH turnaround team and further opportunities post-Month 9 review. The Committee noted recovery actions remain extremely challenging during winter, with Month 8 impacted by increased costs and operational pressures, including 10–15% rise in ambulance conveyances limiting escalation bed closures and temporary staffing reductions.
- 6.2 It was confirmed the turnaround work at RUH is progressing well, delivering additional savings beyond the original plan. The Committee stressed the need to sustain recovery actions and mitigate year-end risks amid operational pressures. Scope exists to expand the recovery team, with cost-benefit analysis suggesting potential value. Monthly progress updates reinforce collective responsibility. Reputational risk was noted if break-even is not achieved, focus for the next 4–5 weeks is on internal solutions to close the gap.
- 6.3 The Committee queried whether achieving the financial target requires reducing staff. Response confirmed that while significant reductions (e.g., 20%) could deliver savings current operational pressures could make further staffing cuts unsafe.
- 6.4 The Committee queried whether failure to meet targets was due to higher demand or issues with delivery. Assurance given that the recovery plan was always high risk, requiring multiple factors to align. Some elements cannot be delivered due to current demand and hospital occupancy pressures. The plan was developed under significant challenge.
- 6.5 The Committee noted progress with the Joint Committee now acting as a single point of decision-making across the hospital group, improving governance since April.
- 6.6 The Committee **noted** the update on Recovery Progress.

7. Medium Term Plan – Plan Update

- 7.1 The system continues to face a significant financial gap against the break-even target. Work is ongoing to identify major changes that will improve both financial and operational performance ahead of the final plan submission in mid-February. The scale of the financial gap remains challenging, but there are now group structures in place to enable decision making at that level, with efforts focused on aligning clinical and operational assumptions.
- 7.2 The final nationally viewed position for the BSW system is a deficit of £60.3m, driven by regional treatment of deficit support funding and reserves. £16.2m of DSF support cannot be applied until near break-even. Year three allocations remain outstanding, with only a two-year revenue plan submitted.
- 7.3 The Committee received assurance regarding differential financial positions across the three acute providers. Assurance was provided that the contract switch was implemented in 2026/27 in accordance with national guidance. The Committee expressed concern that focusing on the 25/26 gap may compromise future planning, with forthcoming discussions with the region anticipated to be highly challenging.
- 7.4 The Committee discussed the relationship between reducing acute costs and workforce implications, noting that significant staff reductions would incur redundancy costs. Assurance was given that there is the potential that funding could potentially be deployed for this purpose, though this is not yet agreed at ICB level due to limited triangulation between workforce plans and CIP targets. Members emphasised the need to align financial and workforce planning and prioritise robust CIP development for 2026/27 rather than short-term measures. The Committee noted that workforce reduction targets for the current year have not been met, and while further reductions are planned for next year, they will not fully recover the shortfall, leaving the position behind original expectations.
- 7.5 The Committee **noted** the update on the Medium Term Plan.

8. BSW Investment Panel Update

- 8.1 The Committee were provided with an update on the BSW Investment Panel.
- 8.2 The Committee **noted** the update on the BSW ICS Investment Panel.

9. Electronic Patient Record Update – Taken as item 10

- 9.1 The Committee received an update on the Electronic Patient Record programme, which remains at red status and faces significant risks..

- 9.2 The Committee noted that an options appraisal was initiated following trust board concerns. Remediation and backlog work continued in parallel, with improvements underway. Assurance was given that 2026/27 pressure will reduce through cost re-profiling into 2027/28. Managing Directors and finance leads are conducting risk assessments and prioritisation. National and regional colleagues support the identified option and remain engaged. Independent programme assurance is provided by Barclay Partnership to the Joint Committee and Programme Board.
- 9.4 The Committee received assurance that governance had been strengthened. Programme structures, reporting, and workstream management have been reset with improved alignment and oversight. Testing is scheduled to commence at the end of April under the revised governance and delivery approach. Issues contributing to earlier delays are being addressed through the reset, including governance review, updated terms of reference, and full alignment to operate as a single group rather than separate trusts. Clinical engagement has improved following the shift to a mandatory group approach, strengthening prioritisation.
- 9.5 The Committee **noted** the progress update on the EPR programme.
- 10. BSW ICB Finance and Infrastructure Forward Plan**
- 10.1 The Committee noted the forward plan until March 2026.
- 11. Any Other Business**
- 11.1 With no further business to address, the Chair closed the meeting at 11:00 hrs.

Next Meeting of the BSW ICB Finance and Infrastructure Committee
Wednesday 4th February 2026 09:00hrs via MS Teams

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	10a
Date of Meeting:	22 January 2026		

Title of Report:	BSW ICB and NHS ICS Revenue Position - Finance Report
Report Author:	Michael Walker, Finance Lead – System Planning
Board / Director Sponsor:	Gary Heneage, Chief Finance Officer
Appendices:	M8 Reporting Pack

Report classification	Please indicate to which body/collection of organisations this report is relevant.
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
BSW ICB Finance and Infrastructure Committee	07/01/2026	Review and discussion

1	Purpose of this paper
<p>The purpose of the paper is to provide an update on the system financial position as at Month 8.</p> <p>At Month 8 the system is reporting £31.7m adverse to plan. The variance is driven by:</p> <ol style="list-style-type: none"> 1) Under-delivery of efficiency schemes £17.7m. Not all planned savings have been identified at Month 8 within provider organisations. Mitigating actions are in place to look to improve future delivery. 	

- 2) At Month 8, the system had not yet received c. £15.6m of Deficit support funding that was anticipated within plans. We expected to receive this in future months, and it was therefore reflected within the forecast. Receipt is reliant upon improving run rates.
- 3) Other drivers include non-recurrent Industrial Action costs, High-Cost drugs and changes in the exit run-rate.

During Month 9 the ICB was notified of and received Deficit support funding totalling £23.4m. This value is in line with the financial plans for the year.

The latest system recovery trajectory shows a full-year system breakeven position. There is ongoing work across the system to deliver the identified recovery actions.

2 Summary of recommendations and any additional actions required

The board is asked to **note** the report and the Month 8 financial position of the system.

Alert, Assure, Advise	
Alert	<ul style="list-style-type: none"> • At Month 8 the system is reporting a £31.7m adverse variance to plan which includes the loss of £15.6m of deficit support funding [DSF] (£16.1m excluding DSF). • The latest in-month position is in line with revised trajectories (M8: £31.7m Act vs £31.7m Trajectory). • This position represents an in-month adverse movement of £2.7m (£0.7m excluding DSF). £29.0m M7 vs £31.7m M8.
Assure	<ul style="list-style-type: none"> • Further work has been undertaken to close the gap to a breakeven system position. There remains ongoing work regarding the implementation of Group interventions with support of the turnaround team at RUH.
Advise	<ul style="list-style-type: none"> • At Month 8, the ICB was anticipating Quarters 1-3 of DSF to be transacted in our allocations at M9 (£15.6m). During December, the ICB received the agreed Deficit support funding totalling £23.4m.

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.

It should be noted that each organisation has individual statutory requirements to meet.

4 Procurement

N/A

Procurement sign off	n/a
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5 Risks

There is a requirement for the ICB to deliver a financial position consistent with submitted plans. Any deviation from this may have an adverse effect on the reported full-year outturn position.

6 Quality and resources impact

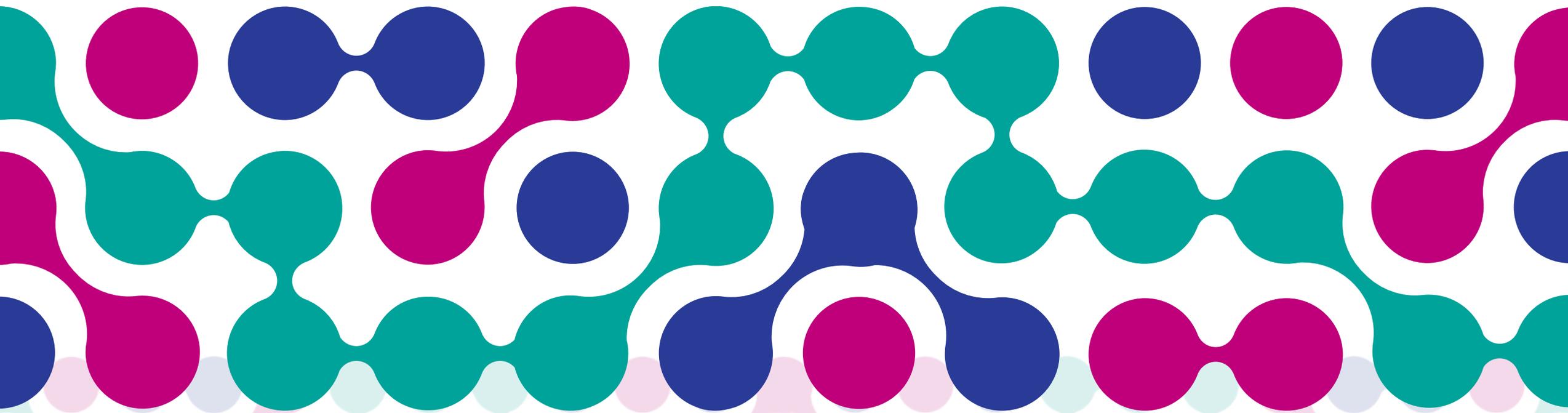
N/A

Finance sign-off	Gary Heneage
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7	Implementation Plan Alignment
N/A	
8	Confirmation of completion of Equalities and Quality Impact Assessment
N/A	
9	Communications and Engagement Considerations
N/A	
10	Statement on confidentiality of report
The information stated within the report is sensitive but not confidential.	

NHS BSW ICS Finance Report – Public Board

November 2025 (Month 8)



Key issues for escalation

Alert, Assure, Advise

Alert	<ul style="list-style-type: none">At Month 8 the system is reporting a £31.7m adverse variance to plan which includes the loss of £15.6m of deficit support funding [DSF] (£16.1m excluding DSF).The latest in-month position is in line with revised trajectories (M8: £31.7m Act vs £31.7m Trajectory).This position represents an in-month adverse movement of £2.7m (£0.7m excluding DSF). £29.0m M7 vs £31.7m M8.
Assure	<ul style="list-style-type: none">Further work has been undertaken to close the gap to a breakeven system position. There remains ongoing work regarding the implementation of Group interventions with support of the turnaround team at RUH.
Advise	<ul style="list-style-type: none">At Month 8, the ICB was anticipating Quarters 1-3 of DSF to be transacted in our allocations at M9 (£15.6m). During December, the ICB received the agreed Deficit support funding totalling £23.4m.

We are £31.7m behind plan YTD at M8



	GWH				RUH				SFT				BSW Group				ICB				System			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
Month 8 YTD (£m)*	0.0	(12.1)	(12.1)	Red	0.0	(15.9)	(15.9)	Red	0.0	(15.2)	(15.2)	Red	0.0	(43.2)	(43.2)	Red	0.0	11.5	11.5	Green	0.0	(31.7)	(31.7)	Red

- Month 8:
- The system is reporting a £31.7m adverse variance against plan. This position excludes Deficit supporting funding of £15.6m to Month 8 (Full year £23.4m).
 - If the impact of deficit support removal is adjusted, the revised variance is £16.1m adverse.

At system level, the in-month position worsened by £2.7m (month on month). However, this movement is primarily attributable to the loss of £2m Deficit Support Funding.

The YTD deficit is c.2.1% of the ICB allocations YTD.

*Note: All values are presented on a rounded basis (+/- £0.1m)

The main driver of our YTD financial position is under delivery of efficiency schemes, compounded by loss of deficit support funding

	GWH	RUH	SFT	Group	ICB	System
	£'m	£'m	£'m	£'m	£'m	£'m
M8 YTD Variance	(12.2)	(15.9)	(15.2)	(43.2)	11.5	(31.7)
Driven by:						
Deficit support funding	(6.4)		(9.2)	(15.6)		(15.6)
Efficiency schemes	(9.7)	(11.9)	(6.0)	(27.7)	10.0	(17.7)
Pay / Workforce	(2.8)	(1.9)	(0.3)	(5.0)		(5.0)
Industrial Action	(0.6)	(0.3)	(0.4)	(1.3)		(1.3)
Other items	7.3	(1.8)	0.7	6.2	1.5	7.7

The main drivers of the M8 YTD variance are:

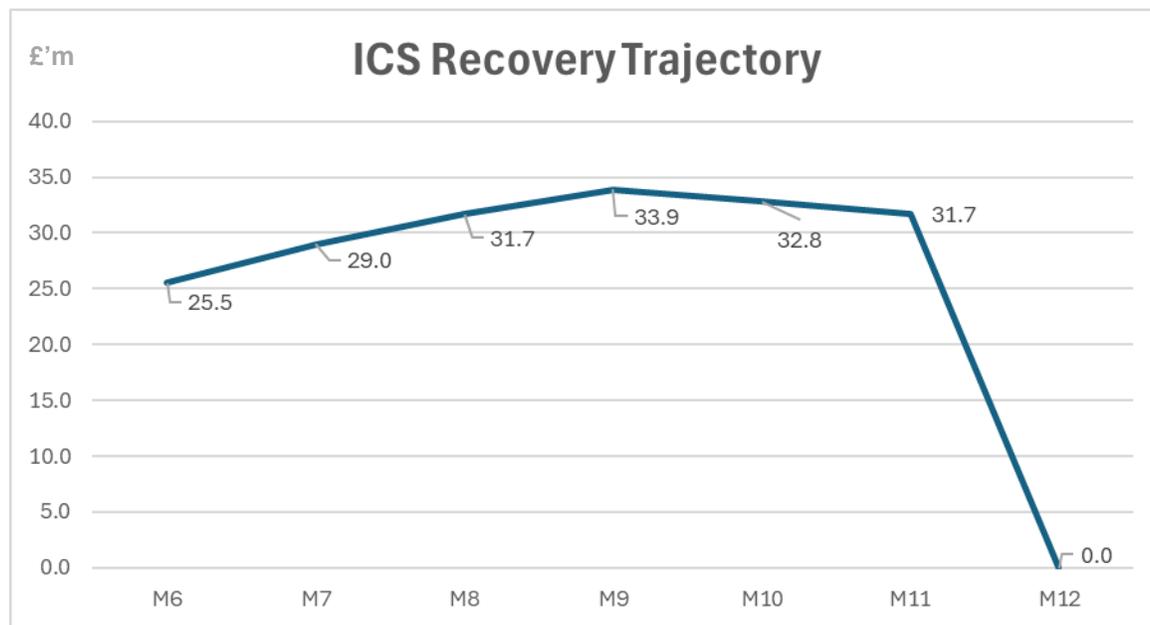
- Under delivery against planned efficiency schemes (evenly phased).
- Loss of deficit support funding.
- Additional spend on UEC.
- Impact of industrial action.

*Other includes adverse Drug expenditure, offset by other favourable non-pay movements (Estates, Consumables)

Recovery Actions

- Each organisation has prepared an individual recovery plan which feeds into the system plan.
- There is now a turnaround team in place supporting the RUH and the Group to firm up the recovery actions and help close the remaining gap of £7.4m across the Group.
- Workforce remains a challenge and we are materially off our plan.
- We continue to absorb the costs of Industrial Action which is increasing challenging (c£1.3m to date).

System recovery trajectory



- At Month 6 the system outlined a Recovery Trajectory that results in a full-year breakeven position. At Month 8, the system is in line with this Trajectory.
- £7.4m of additional Group interventions are being worked through.
- The movement in Month 12 relates to:
 - The receipt of Deficit support funding £23.4m. Quarters 1-3 now expected at M9.
 - Additional funding of £3.6m
 - ICB interventions of £1m
 - Provider interventions of £2.5m

DRAFT Minutes of the BSW Integrated Care Board – Commissioning Committee Meeting

Tuesday 16th December 2025, 09:30 – 12:30, 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
Ade Williams	Non-Executive Director for Quality
Paul Fox	Non-Executive Director for Finance

Attending:

Laura Ambler	ICB Executive Director of Place (BaNES)
Caroline Holmes	ICB Executive Director of Place (Wiltshire)
Mark Harris	ICB Director of Business Support
Richard Collinge	ICB Chief of Staff
Planning and Performance Oversight Lead (item 5)	
BSW ICB Assistant Corporate Secretary (Minutes)	

Apologies (members):

Will Godfrey	ICB Partner Member Local Authorities (BaNES) und
Gary Heneage	ICB Chief Finance Officer
Rachael Backler	ICB Chief Delivery Officer

1. Welcome and Apologies

- 1.1 The Chair welcomed members and officers to the meeting and noted apologies, and the meeting was declared quorate.

2. Declarations of Interest

- 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.

3. Minutes of the BSW ICB Commissioning Committee meeting held on 14th October 2025

- 3.1 The Committee reviewed the minutes of its previous meeting and **approved** them as a true and accurate record of the meeting.

4. Action Tracker and Matters Arising

- 4.1 There were no open items on the tracker.

4.2 Declaration of Interest: Pam Webb declared a potential conflict regarding the extension of the infrastructure contract in Swindon, as she is a trustee of the organisation involved, though she confirmed no prior knowledge of the matter.

5. Operational Performance (taken as item 6)

5.1 The Planning and Performance Oversight Lead presented the Operational Performance, highlighting:

- Planned changes to ambulance handover have reduced CAT2 response times in BSW to 36 minutes in October (4 minutes above target).
- Enhanced ED validation went live at the end of October to optimise 999 calls
- A&E 4-hour standard remains low at 64.8% in October; November data pending.
- From 6 October, SWAST instructed acutes to offload patients within 45 minutes (target 15); all acutes achieved average offload within 30 minutes, improving ambulance availability.
- System performance has improved on offloading, but this impacts ED waits; each acute has improvement plans to reduce 4-hour breaches and 12-hour waits.

5.2 The committee queried whether current performance levels could affect deficit funding. Assurance was provided that the focus remains on tracking delivery against plans and addressing provider responses through planning processes. It was noted that national deficit funding will reduce substantially next year, increasing pressure to meet expectations despite current performance gaps.

5.3 The Committee **noted** the update on the Operational Performance.

6. Commissioning Assurance (taken as item 7)

6.1 The committee received a paper setting out key commissioning activities and highlighting related engagement activities. It was noted that a key challenge identified during the planning round is mapping current commissioning activities against commissioning intentions to ensure alignment and avoid overcommitment.

6.2 The following points were highlighted to the Committee:

- **Elective Care:** National guidance will mandate a “discuss and refer” GP referral model, requiring significant implementation and patient communication.
- **Community Services:** Performance Dashboard reporting has resumed with training completed to support routine use under the outcomes-based contract.
- **Weight Management:** Work continues to improve the pathway, prescribing, and use of the national Obesity Pathway Innovation Programme to address tier 3 waits.

- **ADHD/LDAN Pathway:** Development of grant arrangements with providers to support “waiting well” and reduce reliance on costly non-local virtual providers for ADHD/autism assessments.
- **Children’s Services:** HCRG recovery actions have significantly reduced speech and language therapy waits in Swindon.
- **Mental Health:** Talking therapies remain under contract performance notice arrangements (CPN) with improvement not having been achieved across all areas raised by the ICB. Next steps for contractual escalation options under consideration.
- **Localities:** Neighbourhood health planning in all localities has started with partner workshops, and Wiltshire locality won an HSJ Award for tackling health inequalities.
- **Voluntary Sector:** Two workshops highlighted procurement challenges from the provider perspective.

6.3 The committee queried whether [talking therapy performance issues stem from backlog or low referral rates](#), noting the presence of alternative providers delivering similar services. A detailed response will be brought to committee to clarify the position and consider the impact of non-statutory provision on overall demand and waiting lists.

6.4 With regards to AWP, assurance was given that contractual levers have driven improvements and strengthened relationships. Providers are risk-rated by complexity and behaviour to guide resource allocation and balance enforcement with engagement, ensuring dynamic contract performance management.

6.5 The committee discussed the co-commissioning arrangement with BNSSG for AWP services, noting BNSSG is lead commissioner and BSW a co-commissioner. It was confirmed that standard NHS contract levers apply regardless of lead commissioner status; while formal enforcement routes go through BNSSG, BSW can act directly in practice, providing flexibility to address performance issues, including those related to talking therapies.

6.6 The Committee **noted** the Commissioning Assurance update.

7. Risk Register (taken as item 8)

7.1 The committee received an extract from the corporate risk register showing risks identified as relevant to commissioning, including those affecting planning, statutory duties, and contracting.

7.5 The Committee **noted** the Risk Register update.

8. ICBC Governance - Management of Contract (*taken as item 5*)

- 8.1 The committee received an update on ICBC contract governance with HCRG, including oversight through the Collaborative Oversight Forum, Joint Contract Oversight Group, and subgroups for quality, performance, finance, workforce, and transformation. Strengthened arrangements introduced in October aim to improve transformation assurance and internal monitoring. The outcomes-based contract, live since April, includes co-commissioners such as local authorities and Somerset ICB.
- 8.2 The committee noted that performance reporting has improved, with urgent care and waiting list metrics being validated by NHSE. Quality oversight has been strengthened through a dedicated dashboard and increased engagement from HCRG's executive quality lead. The outcomes framework and KPIs remain central to monitoring contract delivery and transformation priorities.
- 8.4.1 The Quality Outcomes Committee would receive a report on quality concerns and patient outcomes. It was noted that, as an outcome-based contract, the provider is responsible for achieving results and managing workforce arrangements, with governance and escalation processes in place. The committee agreed that oversight should remain equitable with other providers, while recognising the need to adapt to the different contractual approach.
- 8.5 The committee noted the Recovery Board's interim role in financial recovery and contract oversight. Governance will transition to a cluster model as it matures. Assurance was given that HCRG and the three acute trusts meet fortnightly at the system Recovery Board, which oversees financial recovery, quality, and patient safety impacts. The Recovery Board monitors demand management and reviews plan into 2026/27 to ensure commitments are integrated into recovery and planning, with reporting aligned to the Board.
- 8.6 The Chair noted that financial assurance and deeper insight into the HCRG contract will be presented at the February Commissioning Committee. The item was noted, with further information to be brought back to the Committee.

9. [confidential item]

10. BSW ICB Commissioning Committee Forward Plan

- 10.1 The committee requested an assurance report from the Procurement and Contracting Oversight Group re ICB's performance under the Provider Selection Regime

11. Any Other Business

11.1 There being no further business raised the chair closed the meeting at 11:01hrs.

Next Meeting:

Tuesday 10th February 09:30-12:30hrs via MS Teams

DRAFT Minutes of the BSW Integrated Care Board Joint Finance and Infrastructure Committee and Commissioning Committee Meeting Tuesday 16th December 2025, 12:00 – 12:45, via MS Teams

Members present:

Julian Kirby (chair)	BSW ICB Non-Executive Director for Public, Community Engagement
Pam Webb	Voluntary, Community and Social Enterprise Partner Member
Rachael Backler	BSW ICB Chief Delivery Officer
Amanda Webb	BSW ICB Chief Medical Officer
Sarah Green	BSW ICB Chief People Officer
Laura Ambler	BSW ICB Director of Place – BaNES
Gary Heneage	BSW ICB Chief Financial Officer
Gill May	BSW ICB Chief Nursing Officer
Paul Fox	BSW ICB Non-Executive Director for Finance

Attending:

Mark Harris	ICB Director of Business Support Planning and Performance Oversight Lead (item 5) BSW ICB Assistant Corporate Secretary (Minutes)
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Apologies (members):

Ade Williams	Non-Executive Director for Quality
Sam Mowbray	Swindon Borough Council CEO
Simon Wade	Nominated Director of Finance from a partner Trust

1. Welcome and Apologies

- 1.1 The Chair welcomed members and officers to the meeting and noted apologies, and the meeting was declared quorate.

2. Declarations of Interest

- 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.

3. Medium Term Plan First Submission Sign Off

- 3a.1 BSW ICB Chief Delivery Officer presented the overarching position and performance, noting this is the first joint review of the draft operational planning submission and associated board assurance statements. The foundational phase is complete, and work is progressing into the second phase, including engagement on key documents and activity plans. Current performance against standards remains challenging, particularly RTT, UEC, cancer, and diagnostics, with RUH most affected. Providers are committed to improvement ahead of the February final submission, though regional feedback is expected to be robust.
- 3a.2 The ICB and providers have agreed the need for stronger collective planning assumptions to address pivotal areas. Operational leads will meet this week to refine assumptions and produce a second draft in January to strengthen the final plan.
- 3a.3 Assurance was provided that the draft position was shared at the Recovery Board on Friday, and the BSW ICB Chief Finance Officer has engaged with regional finance colleagues. It was noted that the level of response will depend on comparative positions once all plans are submitted.
- 3b.1 The BSW ICB Chief Finance Officer presented the financial position, confirming that the current submission covers only a two-year revenue plan while awaiting year three allocations, further work is required to incorporate performance and workforce planning for the third year with significant effort has already gone into improving the system position. The ICB is forecast to break even in both years, while the hospital group is projecting a £45m deficit in 2026/27 before returning to balance the following year.
- 3b.2 The ICB and the hospital group are working to a 6% efficiency target. It was noted that a £45m deficit will not be acceptable to the region, and further pressure to achieve balance is anticipated. Allocations have been reduced by £19m due to Voluntary / Compulsory Redundancy changes. The committee noted that further triangulation is still required, particularly around elective recovery funding and delivery, to ensure alignment.
- 3b.3 From a system perspective, deficit funding has reduced significantly, from £23m this year to £6m next year, and transitional funding for the hospital group will fall from £70m to £38m. Additional allocations include £5m for prevention, £5m for ambulance demand, and £11m for transformation schemes aimed at shifting demand and reducing unaffordable costs across the hospital group.
- 3b.4 Assurance was provided that Dorset and Somerset face similar challenges, including differing views on growth and achievement of targets. BSW is subject to

enhanced regional scrutiny, and significant challenge is expected, particularly regarding the level of ambition on performance targets.

- 3b.6 With regards to the 50% workforce reduction and implementation timelines, the committee noted the scale of the planned reductions, and challenges including the funding of redundancies within acute hospitals. The committee noted that workforce reductions do not eliminate the hospital group deficit but contribute towards it, with further triangulation required alongside CIP plans for 2026/27.
- 3b.7 The committee queried whether efficiency savings are additional to workforce cuts, assurance provided that the £133.8m total includes all ICB and provider plans, with £4m from the ICB and £93m from the group. Emphasis was placed on starting workforce reductions immediately and maintaining an evenly phased efficiency plan to sustain focus on financial recovery throughout the year. Transformation will require workforce changes and stopping some activities to remain within the financial envelope.
- 3c.1 There is a requirement to submit to NHSE 16 assurance statements with limited commentary (500 characters each). Most areas are rated as developing. A final submission will require movement towards fully assured ratings, with dependencies noted on factors such as financial agreement. Current positioning aligns with cluster colleagues and providers, with only minor variations in supporting evidence.
- 3c.2 The committee queried why clinical leadership was scored as 3 rather than 2. The committee noted that the score reflects engagement primarily through commissioning intentions rather than across all plan components. Scoring lower was considered positive to ensure focus and improvement over the coming months. It was agreed that next steps should explicitly reference the timeliness of workforce reductions, as delays beyond Q1 would undermine delivery.
- 3c.3 A query was raised regarding completion of a quality impact assessment. Assurance confirmed that an initial high-level assessment has been completed and discussed with quality colleagues, but it has not yet been reviewed by the board. A full EQIA will be prepared for the final submission, incorporating actions linked to transformation plans and other developments.
- 3d.1 The Committee approved the draft first submission, subject to minor adjustments identified during the meeting. A revised copy incorporating these corrections will be circulated to members.

4. Any other business

- 4.1 There being no other business the chair closed the meeting at 12:43hrs

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	11a
Date of Meeting:	22 January 2026		

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 Dashboard January 2026

Report classification	
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	
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
Senior Management Group	07.01.2026	ICB Senior Management reviewed performance risks
Commissioning Committee	16.12.2025	Assurance
Executive Management Group	21.01.2026	Review of performance across the oversight framework domains

1	Purpose of this paper
<p>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 should present items for assurance and where necessary, escalation, for system meetings attention.</p>	

This paper sets out the most recent officially reported performance metrics – a more contemporary update on current system performance is provided within the CEO report, this includes the latest position on Winter and system pressures.

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 Procurement

N/A

5 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.

6 Quality and resources impact

Quality impacts linked to the performance of the system are highlighted in the Quality reporting. 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
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7 Operational Plan Alignment

This paper reports against Operational Plan metric delivery.

8 Confirmation of completion of Equalities and Quality Impact Assessment

N/A

9 Communications and Engagement Considerations

We are working with Communications to consider the impact of the public facing league tables to be reported as part of the NHS Oversight Framework.

10 Statement on confidentiality of report

This report is prepared for Senior Management Group only

Overview of Operational Performance

1. Introduction

- 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. NHS Oversight Framework

- 2.1 In December, the NHS Oversight Framework (NOF) 2025/26 including the interactive league table for all Acutes was updated to report quarter 2 data and provide a comparison to quarter 1. The BSW Acutes segments remained unchanged. The ICB / system performance was also published for Q2, this is not formally segmented or ranked in 2025/26.
- 2.2 As previously reported, in response to BSW performance not meeting plans in key metrics in Q1, the NHSE SW regional team implemented a new regime for performance oversight involving weekly meetings with NHSE covering the following: UEC, Elective (RTT), Mental Health, Cancer and Diagnostics.
- 2.3 RUH remains in Tier 1 for Elective, Cancer, Diagnostics and UEC. GWH remains in tier 1 for UEC. Neither GWH or SFT will be in tiering for Elective care or Cancer and Diagnostics. No changes have been shared yet relating to the Q2 NOF reporting.

3. Operational Performance Exceptions

- 3.1 This report monitors the 2025/26 NHS operational plan metrics. These metrics are being reviewed regularly in terms of risk to meeting the targets set for the plan position, given recent performance and known concerns / challenges with improving performance to meet the plan trajectories and targets. 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 planned. Detailed exception reports on these items are reviewed and considered at the ICB Commissioning Committee.
- 3.2 **Urgent care** continues to be challenged, and we are not meeting many of our operational planning targets. The implementation of the timely handover process is a significant delivery challenge for the system. During October NHSE asked Trusts to review and submit updated trajectories to delivery 25/26 urgent care plans.
- 3.3 **Urgent Care – Amb.1 Ambulance – Average Response Time (Mins) Category 2 Incidents** – In BSW response time to Category 2 incidents in November increased by 2 minutes to 36 minutes, with variance to plan 4 minutes. SWASFT activity up to 14,614 compared to previous month of 13,862. The % of patients conveyed to ED increased to 39.8% compared to the previous month (39.0%). Enhanced ED Validation went live at the end of

October, and will continue to monitor numbers of patients validated daily and outcomes as well as review DoS ranking

- 3.4 Urgent Care – E.B.42 – Average Handover Delay Time (Mins)** – Combined performance for average handover delays in December was 27 minutes, with no change from November, achieving plan by 7 minutes. 2 trusts met plans in December. GWH averaged 27 minute delays (achieving plan by 18mins), RUH averaged 30 minutes (achieving plan by 3 minutes) and SFT averaged 20 minutes (missing plan by 1 minutes). There has been an increase in the number of conveyances to the acutes, with the system currently being over predicted numbers previously shared by SWASFT.
- 3.5 Urgent Care – E.M.13 4 Hour % Total Attendances** – November A&E performance for BSW was 67.8%, which is an increase in performance from October by 3%, but still below the plan of 69.5% by 1.7%. GWH performance increased to 71.1% (0.1% above plan). SFT improved to 75.1% (4.1% above plan), and RUH performance increased to 57.7% from 55.8% in October (8.9% below plan). Overall demand was above predictions, particularly affected by winter illnesses commencing earlier than predicted and high numbers of paediatric attendances.
- 3.6 Urgent Care – E.M.29 NCTR % Occupancy** – BSW performance was 19.1% in December; not meeting plan by 8.6%. The highest NCTR occupancy % in December is at GWH with performance at 20.9%. IPC outbreaks have reduced the available bed base. We are working with GWH to review the recording of pathway zero patients which have increased over time. We are finalising our NCTR recovery plan which includes meeting our targets with regards to delayed discharges by pathway.
- 3.7 Urgent Care – Discharge Ready Date** – BSW performance in December was 4.2% off plan with 81% of patients discharged on their discharge ready date, compared to plan of 85.2%. BSW continues above plan for 25/26 with combined performance of 9 average days between discharge ready date and discharge; above the plan for November of 5 days. All 3 Acutes did not meet plan in December for both DRD metrics. P2 capacity in Swindon has improved. There are commissioning conversations underway regarding Wiltshire P2 Hub beds.
- 3.8 Elective Care.** RUH continue in Tier 1 for Elective, Cancer, Diagnostics and UEC for Q2 25/26 This is being monitored by NHSE and assurance for returning to plan levels is being sought. There has been an improvement in Cancer and diagnostic performance in October from previous month's position in September, and they remain below target in all metrics. RTT 18 week performance has improved and the Trust has met target for October.
- 3.9 Elective Care – E.B.27 Cancer – 28 Days Faster Diagnosis Standard** – Cancer waiting time reporting for BSW was 67.5% in October, an increase on September's performance of 61.5%, and still below national standard of 80%, with variance to local plan of 12.5%. All 3 acutes performance did not meet their plans in October. with performance improving from previous month. RUH are in Tier 1 for Cancer where key recovery actions to increase activity and reduce waiting times are being monitored. GWH are now at risk of entering Tiering for

Cancer due to a decline in performance. Risks have been identified at all providers with staffing.

- 3.10 Elective Care – E.B.35 Cancer – 62 Day Referral to Treatment Standard –**
The 62-day combined performance (BSW Acutes – all patients) improved from 60.3% in September to 65% in October, which is 10% below plan. GWH performance improved slightly from 65.8% in September to 66.7% in October (6.1% below plan from 63.3% in August to 60.3% in September, which is 13.7% below plan). RUH performance improved from 58.1% in September to 64% in October (10% below plan). SFT performance improved from 55.9% in September to 64.6% in October (14.2% below plan). High demand via screening service over the past six months at RUH increased pressure on consultant capacity in the later phases of the 62 day pathway. There are risks around funding for 25/26 for System and Acute based cancer fixed term posts, with funding managed via Cancer Alliance Networks which could impact and delay pathways for patients. Current delivery is reliant on Waiting list initiatives (WLI) both insourcing and outsourcing.
- 3.11 Elective Care – E.B.28 Diagnostics - % of WL > 6 Weeks – All Modalities –**
Diagnostics – % of waiting list over 6 weeks – All Modalities (All ICB – acute total) performance improved from 21.3% in September to 18.9% in October and remains below plan by 6.6%. When benchmarked against England, we are performing below the All-providers average, with National performance at 21.3% in October. GWH diagnostic performance improved in October. to 7.1% RUH performance improved to 29.5% in October. SFT performance dropped slightly to 12.5% in October. Validated data for October, shows an improvement in performance in the % of waiting list over 6 weeks for 9 key modalities (All ICB – acute total) from 20.3% in September to 18.3% in October. RUH are in Tier 1 for diagnostics, remedial action plans continue in place across the modalities including waiting list initiatives, insourcing and maximising CDC capacity.
- 3.12 Elective Care – E.M.38 Outpatient Follow Up % –** Outpatient follow-up attendances improved in November, at 49.2% compared to 48.7% in October and continuing to not meet plan by 2.2%. In November, all three acutes did not meet plan; GWH had a variance of 2.4%, RUH a variance of 2.4% and SFT a variance of 2.2 %. For PIFU rate GWH performance was 5.4% in November (0.5% below plan), RUH continued to meet plan with performance at 5.4% (0.7% above plan) and SFT continued with the lowest PIFU rate with performance at 1.9% (1.2% below plan). Combined performance for PIFU rate was 4.5% in November, not meeting plan by 0.2%. PIFU is inconsistent at speciality level and work is underway to identify the greatest areas of variance in PIFU and first to follow up ratio, looking to share best practice across the system providers at specialty level.
- 3.13 Elective Care – E.B.20 RTT – Waiting List 65+ Weeks –** Validated data from October, shows the 3 Acutes had 113 people waiting over 65 weeks. Local reporting (29/12/2025) shows this has reduced to show 14 patients (BSW acutes) expected to be waiting longer than 65 weeks at the end of December,

with the highest reason being cited as capacity. Of the 13 expected; 10 are at GWH, 2 are at RUH and 2 are at SFT. The increase in numbers at RUH in October were driven largely by patient choice in ENT – a number of which are children and young people, and the inclusion of 52 long waiters for the pain service. This had adversely affected performance; however, we have noted these numbers reducing through local weekly monitoring.

- 3.14 **Primary Care** – ICBs were asked to put in place an Action Plan for General Practice to improve timely access and patient experience, with the national focus on tackling unwarranted variation and Improving contract oversight, commissioning and transformation. The Plan sets out actions, expected outcomes, measurement, delivery confidence, key risks and mitigations and support requirements from NHSE. The Action Plan will be based on the General Practice Dashboard and will reference the Secretary of State General Practice Outlier Pack and local Primary Care Demand Management Dashboard and BSW ICB soft intelligence about our 83 General Practices. An Action Plan was shared with PCOG, PCEG and submitted to NHSE.
- 3.15 **Primary Care – E.D.19 Appointments in General Practice** – 548,354 GP appointments were held across BSW in November 2025, below plan by 51,637. Analysis into GP activity including the impact of e-consult activity is being scoped to support future planning. Further analysis of modes of activity shows that there has been a reduction in face-to-face appointments and telephone appointments with an increase in online appointments. However, the data reported suggests that not all online consultation activity is being reported in the GPAD data set and where it is being reported, categorisation is not consistent.
- 3.16 **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 – % of resident population seen by NHS dentist** – both Adult and Children metrics were below plan in September 2025. The ICB is working to deliver the Government plan to recover and reform NHS dentistry. The overall NHS dental market in BSW is stabilising and the focus is now on population need and resource and Actions underway include a project to understand dental activity needs by patient demographics enabling focus on core 20 plus and deprived populations and reviews to support delivery of the planned additional urgent care appointments.
- 3.17 **Primary Care – E.D.24 Units of Dental Activity Delivered** – In September 2025, 78,661 units of dental activity were delivered against the plan of 80,397 (84.8%). This is an increase of 11,871 compared to activity delivered in August 2025. Provisional national data indicates that BSW has delivered 40.4% planned activity year to date at the end of September, making BSW the 2nd highest ranked ICB in the South-West region for cumulative delivery against plan.
- 3.18 **Primary Care – Additional Urgent Dental Appointments** – All ICB's were instructed to increase the amount of urgent dental activity submitted in their 25/26 plans. BSW allocation was an extra 13,990, taking our planned activity to

54,454. October performance reports 92.2% achievement towards the cumulative target year to date. It should be noted that none of the extra activity of 13,990 was allocated for April and May and it has been allocated across the remaining 10 months of the year, so while we are currently below plan, there is a risk that our performance against the accumulative plan will decline further in future reports.

- 3.19 **Mental Health – E.H.9 CYP Mental Health Access** – CYP access (12-month rolling) in October was 10,395 people which is below planning target by 1,138 but continues to demonstrate an increase on previous months. Data quality issues remain with the introduction of version 6 MHSDS [alterations] reporting across the majority of submitting providers, with an improvement of data quality expected in Q4. CYP access target apportionment to providers and improvement plans to deliver the target are also in development across all providers. This will be formalised via contract variation. CAMHS Wiltshire & BANES mental health single point of access service navigator roles approved and expected to be fulfilled in Q3.
- 3.20 **Mental Health – E.A.S.1 Dementia Diagnosis Rate** – Performance in November is 61.9%, an improvement from October, but still below the national target of 66.7%. Swindon locality diagnosis rates continue to be the lowest across BSW. 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 Q4 25/26.
- 3.21 **Mental Health – E.A.4 Talking Therapies (TT) – Number of Adults Receiving a Course of Treatment** – In October, 7,335 people had completed a course of treatment, not meeting the plan of 8,586 by 1,251 but showing improvement over the last 10 months. The work required by the TT service to bring key metrics in line with trajectory, as well as recruitment requirement is significant. Work within AWP has been prioritised and improvement is already evident. Bi-weekly RAP oversight meetings in place, contractual reporting and oversight of performance is monitored at the Mental Health Delivery Group.
- 3.22 **Mental Health – E.A.4a Talking Therapies – Reliable Recovery Rate** – was 47.0% in October 2025, down 1% when compared to previous month, and is below national target of 48%. The CPN and associated action plan is showing positive outcomes and improved performance. Absolute numbers of people recovering have been over 300 for 3 months in a row; nearly 40% higher than the 12-month average. Reliable Improvement Rate was 68% in October 2025 a decline by 2% on previous month and not meeting target by 1%.
- 3.23 **Learning Disability and Autism – E.K.1b_rate Inpatients (Rate per Million) All Age** – Learning Disability inpatients continue above the target. The number of inpatients has improved at 41 rate per million in December. This includes patients commissioned by BSW ICB and NHSE. As at 31/10/2025 there were 33 adult inpatients (22 ICB and 11 NHSE). We continue to see a reduction in our longer length of stay adult patients (over two years) and several patients have been discharged from hospital but remain under the Mental Health Act on (extended) Section 17 leave. There continues to be a reduction in the number

of inpatients who are experiencing a delay to their discharge. Our focus on improving our Provider Collaborative commissioned adult patient performance has seen a reduction in input numbers, and we remain ahead of reduction trajectory. There are increasing numbers of Autistic inpatients which reflects the national trend particularly those with co-morbid eating disorder or disordered eating. Fewer admissions seen for people with a learning disability.

4. Key Financial Performance Information

- 4.1 We continue to see challenges across the NHSE Oversight Framework for each of the finance metrics including financial efficiency, financial stability, and Agency spending.
- 4.2 Further detail is available within the finance reports considered by the Finance and Investment Committee and the Board.

5. Key Workforce Performance Information

- 5.1 Agency usage expressed as a WTE is slightly above planned levels submitted in the workforce plan and has seen a slight increase in use in last month, but this is still well below national targets.
- 5.2 National targets relate to agency as a % of pay bill and is set at a target of less than 3.2%. All providers are lower than this rate. This is alongside the reduction of off framework usage and improving price cap compliance in shifts worked over the last year. BSW providers are adhering to this metric but there was a slight decrease in compliance in overall month.
- 5.3 Bank usage is also above plan but continues to fluctuate. This alongside high-cost agency is a key driver in workforce spend above plan.
- 5.4 Reported vacancy rate 1.8% in October 2025. This is a decrease on previous month. This continues to be reviewed with trusts to ensure accuracy and consistency.
- 5.5 Sickness in month and for the 12-month period is consistent and slightly below target, although this varies within providers, where the GWH has a higher rate of sickness and SFT the lowest.
- 5.6 The 12-month rolling turnover remains consistently within the 12% target over the last year. In October it was reported as 9.9% across the ICB acutes. In month turnover within providers is also below target alongside the rolling turnover.
- 5.7 Further interrogation and detail 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.

BSW Operational Performance Report

January 2026

ICB Board 22/1/26



BSW Operational Performance Dashboard

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 focussed on the NHS operational plan metrics and wider oversight metrics against the targets set out in the BSW 2025/26 operating plan depending on the metric reporting lag.

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.

Community Metrics – we are now receiving interim monthly reporting from HCRG that is being used to update the IPD for nationally reported metrics.

What are summary icons?

Summary icons provide an instant view of how a specific metric is performing using symbols for variation and assurance. Variation shows if there are any trends in the most recent data and assurance shows how the metric is performing in relation to a target.

Assurance Icons



The current process is capable and will consistently pass the target if nothing changes.



The current process will hit and miss the target as the target lies between process limits.



The current process is not capable and will fail the target if nothing changes.



Assurance cannot be given as there is no target.

Or blank

Variation Icons



Special cause variation of an improving nature.



Common cause variation, no significant change.



Special cause variation of an concerning nature.



Not enough data for an SPC chart, so variation cannot be given.



Special cause variation where up or down is not necessarily improving or concerning.

Or blank

BSW National Oversight Framework (NOF) Domain Scores & Rank – Quarter 2

Q1 vs Q2 National Oversight Framework Summary BSW Acute Trusts										
		GWH Q1	GWH Q2	Improved/ Declined from previous Quarter	RUH Q1	RUH Q2	Improved/Dec lined from previous Quarter	SFT Q1	SFT Q2	Improved/Dec lined from previous Quarter
Oversight Framework Segment	Score	3	3	↔	4	4	↔	3	3	↔
	Rank	76 out of 134	82 out of 134	↓	112 out of 134	105 out of 134	↑	57 out of 134	70 out of 134	↓
Average Score	Score	2.43	2.47	↓	2.70	2.68	↑	2.26	2.36	↓
Pre-Adjusted	Score	3	3	↔	4	4	↔	2	3	↓
Is segment downgraded due to financial deficit?		YES	YES	↔	YES	YES	↔	YES	YES	↔
Is the organisation in the Recovery Support Programme?		NO	NO	↔	NO	NO	↔	NO	NO	↔
Domain Scores										
Access to Services Domain	Score	2.42	2.69	↓	3.14	3.06	↑	2.22	2.19	↑
	Rank	107 out of 199	137 out of 199	↓	174 out of 199	170 out of 199	↑	79 out of 199	84 out of 199	↓
Effectiveness and Experience of Care Domain	Score	2.23	2.37	↓	2.11	2.11	↔	2.67	2.66	↑
	Rank	113 out of 203	134 out of 204	↓	85 out of 203	90 out of 204	↓	179 out of 203	177 out of 204	↑
Patient Safety Domain	Score	2.09	2.12	↓	2.94	2.8	↑	2.08	2.45	↓
	Rank	50 out of 205	52 out of 205	↓	142 out of 205	132 out of 205	↑	48 out of 205	99 out of 205	↓
People and Workforce Domain	Score	2.38	2.16	↑	2.08	2.16	↓	1.43	1.39	↑
	Rank	86 out of 205	67 out of 205	↑	61 out of 205	67 out of 205	↓	14 out of 205	13 out of 205	↑
Finance and Productivity Domain	Score	3.18	2.53	↑	2.38	2.6	↓	2.8	3.38	↓
	Rank	191 out of 205	141 out of 205	↑	129 out of 205	144 out of 205	↓	174 out of 205	191 out of 205	↓

Benchmarking by Rank

This rank is based on the average score for each domain and overall.

Green - highest quartile

Red - lowest quartile

All others are interquartile

This is independent to the segments achieved.

N.B - not all metrics rank appropriately purely based on score.

- NHSE launched a new interactive league table for all Acutes through the NHS Oversight Framework (NOF) 2025/26. **Quarter 2 summary was published in December**
- This Overview table shows the Q2 summary for each trust, setting out how it performs at the headline level and its overall league table rank compared to Q1.
- A more detailed summary dashboard is available. [NOF Summary - Q2 25 26 - Dec 2025.pptx](#)

The public dashboard can be accessed here [NOF Acute Dashboard - NHS England Data Dashboard](#)

The Model Health System (for NHS health systems and trusts only) has the full NOF breakdown per trust and can be accessed [View NHS Oversight Framework - Model Hospital](#) (note you must select a specific hospital within the organisation view to be able to see the NOF element)

BSW Integrated Performance Dashboard

URGENT CARE

Metric	Group	Direction	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
% Discharged by 5pm	ALL_ICB - ACUTE TOTAL		Dec-25	63.4%	63.6%	▲				▲	😊	😊
4 Hour % - Total Attendances	ALL_ICB - ACUTE TOTAL		Nov-25	64.8%	67.8%	▲	69.5%	No	78.0%	▲	😊	😞
4 Hour % - Total Attendances aged <18	ALL_ICB - ACUTE TOTAL		Dec-25	85.5%	85.2%	▼				▲	😊	😊
4 Hour % Total Attendances (Uplift)	ALL_ICB - ACUTE TOTAL		Nov-25	68.7%	71.4%	▲			78.0%	▲	😊	😞
Ambulance - % Handovers over 15 Minutes	ALL_ICB - ACUTE TOTAL		Dec-25	70.9%	72.2%	▲				▼	😊	😊
Ambulance - % Handovers over 45 Minutes	ALL_ICB - ACUTE TOTAL		Dec-25	13.7%	14.3%	▲				▼	😞	😊
Ambulance - Average Handover Delay Time (mins)	ALL_ICB - ACUTE TOTAL		Dec-25	27	27	◀▶	34	Yes	45	▼	😞	😊
Ambulance - Average Response Time (Mins) Cat 2 Incidents	BSW COMMISSIONER TOTAL		Dec-25	34	36	▲	32	No	30	▼	😞	😊
Ambulance - Total Conveyances	ALL_ICB - ACUTE TOTAL		Dec-25	6,376	6,835	▲				▼	😞	😊
Attendances in A&E over 12 hours	ALL_ICB - ACUTE TOTAL		Dec-25	2,098	2,107	▲				▼	😊	😊
Average days between DRD and discharge	ALL_ICB - ACUTE TOTAL		Dec-25	9	8	▼	5	No		▼	😊	😊
Average days between DRD and discharge - P0	ALL_ICB - ACUTE TOTAL		Dec-25	5	4	▼				▼	😊	😊
Average days between DRD and discharge - P1	ALL_ICB - ACUTE TOTAL		Dec-25	8	10	▲				▼	😊	😊
Average days between DRD and discharge - P2	ALL_ICB - ACUTE TOTAL		Dec-25	16	10	▼				▼	😊	😊
Average days between DRD and discharge - P3	ALL_ICB - ACUTE TOTAL		Dec-25	22	20	▼				▼	😊	😊
Average LoS - Non-elective spells (acute)	ALL_ICB - ACUTE TOTAL		Dec-25	7	7	▲	7	No		▼	😞	😊
Average number of adult patients in an acute hospital bed for 21+ days	ALL_ICB - ACUTE TOTAL		Dec-25	213	189	▼				▼	😞	😊
NCTR % Occupancy	ALL_ICB - ACUTE TOTAL		Dec-25	19.9%	19.1%	▼	10.5%	No	10.0%	▼	😊	😞
NCTR Beds Occupied	ALL_ICB - ACUTE TOTAL		Dec-25	282	284	▼	147	No		▼	😊	😊
Patients % Discharged by Midday	ALL_ICB - ACUTE TOTAL		Dec-25	15.6%	16.1%	▲			33.0%	▲	😊	😞
Patients discharged on discharge ready date	ALL_ICB - ACUTE TOTAL		Dec-25	80.9%	81.0%	▲	85.2%	No		▲	😞	😊
Total attendances at all type A&E departments.	ALL_ICB - ACUTE TOTAL		Nov-25	28,444	54,682	▲	27,026	No		▼	😞	😊

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

BSW Integrated Performance Dashboard

OCCUPANCY

Metric	Group	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 %	ALL_ICB - ACUTE TOTAL	Dec-25	98.9%	95.8%	▼			92.0%	▼		
G&A Bed Occupancy - Paeds %	ALL_ICB - ACUTE TOTAL	Dec-25	80.0%	75.0%	▼				▼		
G&A Bed Occupancy - Total %	ALL_ICB - ACUTE TOTAL	Dec-25	98.3%	94.8%	▼	95.6%	Yes		▼		

BSW Integrated Performance Dashboard

ELECTIVE CARE

Metric	Group		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	ALL_ICB - ACUTE TOTAL		Oct-25	61.5%	67.5%	▲	80.0%	No	80.0%	▲		
Cancer - 31 Day Decision to Treat to Treatment Standard	ALL_ICB - ACUTE TOTAL		Oct-25	89.1%	92.3%	▲	93.8%	No		▲		
Cancer - 62 Day Referral to Treatment Standard	ALL_ICB - ACUTE TOTAL		Oct-25	60.3%	65.0%	▲	75.0%	No	75.0%	▲		
Diagnostics - % of WL over 6 Weeks - 9 Key Modalities	ALL_ICB - ACUTE TOTAL		Oct-25	20.3%	18.3%	▼	12.4%	No	5.0%	▼		
* Diagnostics - % of WL over 6 Weeks - 9 Key Modalities (Provisional)	ALL_ICB - ACUTE TOTAL		Nov-25	18.3%	18.2%	▼	11.4%	No	5.0%	▼		
Diagnostics - % of WL over 6 Weeks - All Modalities	ALL_ICB - ACUTE TOTAL		Oct-25	21.3%	18.9%	▼			5.0%	▼		
Outpatient Follow Up %	ALL_ICB - ACUTE TOTAL		Nov-25	48.7%	48.9%	▲	46.9%	No	46.0%	▼		
RTT - % Waiting List < 18 Weeks	ALL_ICB - ACUTE TOTAL		Oct-25	62.3%	62.6%	▲	60.7%	Yes		▲		
* RTT - % Waiting List < 18 Weeks (Provisional)	ALL_ICB - ACUTE TOTAL		Nov-25	62.5%	63.1%	▲	61.8%	Yes		▲		
RTT - % Waiting List < 18 Weeks for 1st Appointment	ALL_ICB - ACUTE TOTAL		Nov-25	64.7%	66.3%	▲	66.5%	No		▲		
RTT - % Waiting List 52 Weeks+	ALL_ICB - ACUTE TOTAL		Oct-25	1.2%	1.2%	▲	1.5%	Yes	1.0%	▼		
* RTT - % Waiting List 52 Weeks+ (Provisional)	ALL_ICB - ACUTE TOTAL		Nov-25	1.2%	1.2%	▼	1.3%	Yes	1.0%	▼		
RTT - Incomplete Pathways	ALL_ICB - ACUTE TOTAL		Oct-25	109,353	109,631	▲	101,949	No		▼		
* RTT - Incomplete Pathways (Provisional)	ALL_ICB - ACUTE TOTAL		Nov-25	109,631	109,637	▲	100,700	No		▼		

* To provide us with a more up to date picture, local providers are sharing their provisional submissions with us ahead of NHSE publishing the data

BSW Integrated Performance Dashboard

QUALITY – Patient Safety

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
IPC c.Diff Infection Rate	BSW COMMISSIONER TOTAL		Oct-25	1	2	▲			1	▼		
IPC E.coli Infection Rate	BSW COMMISSIONER TOTAL		Oct-25	5	5	▼			1	▼		
IPC Klebsiella Bacteraemia Infection Rate	BSW COMMISSIONER TOTAL		Oct-25	2	2	▲				▼		
IPC MRSA Infection Rate	BSW COMMISSIONER TOTAL		Oct-25	0	0	◀▶			0	▼		
IPC MSSA Infection Rate	BSW COMMISSIONER TOTAL		Oct-25	1	2	▲				▼		
IPC Pseudomonas Bacteriemia Infection Rate	BSW COMMISSIONER TOTAL		Oct-25	1	1	▲				▼		
Mixed-Sex Accomodation Breaches	BSW COMMISSIONER TOTAL		Oct-25	475	527	▲				▼		
SHMI Banding (Summary Hospital Level Mortality Indicator)	ALL_ICB - BY ACUTE	GWH	Jul-25	2	2	◀▶				▼		
SHMI Banding (Summary Hospital Level Mortality Indicator)	ALL_ICB - BY ACUTE	RUH	Jul-25	2	2	◀▶				▼		
SHMI Banding (Summary Hospital Level Mortality Indicator)	ALL_ICB - BY ACUTE	SFT	Jul-25	2	2	◀▶				▼		
SHMI Value (Summary Hospital Level Mortality Indicator)	ALL_ICB - BY ACUTE	GWH	Jul-25	98.6%	98.9%	▲				▼		
SHMI Value (Summary Hospital Level Mortality Indicator)	ALL_ICB - BY ACUTE	RUH	Jul-25	109.5%	108.0%	▼				▼		
SHMI Value (Summary Hospital Level Mortality Indicator)	ALL_ICB - BY ACUTE	SFT	Jul-25	91.9%	91.3%	▼				▼		
UEC - % Admissions via ED for Most Deprived Quintile	BSW COMMISSIONER TOTAL		Nov-25	8.7%	8.2%	▼				◀▶		
UEC - % ED Attendances for Most Deprived Quintile	BSW COMMISSIONER TOTAL		Nov-25	9.0%	8.9%	▼				◀▶		
UEC - % Major Attendances with DTA Within 3 Hours	BSW COMMISSIONER TOTAL		Nov-25	40.9%	43.6%	▲				▲		
UEC - Hospital at Home: Average Occupancy %	BSW COMMISSIONER TOTAL		Nov-25	93.3%	96.4%	▲				▲		

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

QUALITY – Patient Experience

Metric	Group	Provider	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		Oct-25	78.6%	77.8%	▼				▲		
Friends and Family Test (Dental) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	97.2%	95.2%	▼				▲		
Friends and Family Test (Inpatient) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	95.7%	95.4%	▼				▲		
Friends and Family Test (Maternity - Antenatal) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	89.1%	78.6%	▼				▲		
Friends and Family Test (Maternity - Birth) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	94.2%	95.8%	▲				▲		
Friends and Family Test (Maternity - Post Community) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	97.8%	89.3%	▼				▲		
Friends and Family Test (Maternity - Post Ward) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	91.9%	97.1%	▲				▲		
Friends and Family Test (Mental Health) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	84.4%	88.7%	▲				▲		
Friends and Family Test (Outpatient) Percentage Positive	BSW COMMISSIONER TOTAL		Oct-25	94.5%	94.9%	▲				▲		

BSW Integrated Performance Dashboard

PRIMARY CARE

Metric	Group	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
COVID Vaccination Uptake	BSW COMMISSIONER TOTAL	Nov-25	90,723	12,601	▼				◀▶		
Dental - Additional urgent appointments	BSW COMMISSIONER TOTAL	Oct-25	3,678	3,509	▼	4,538	No		▲		
Dental - Additional urgent appointments (cumulative)	BSW COMMISSIONER TOTAL	Oct-25	21,266	24,775	▲	26,870	No		▲		
Dental - Hospital Tooth Extractions of Children under 10	ALL_ICB - ACUTE TOTAL	Nov-25	67	18	▼				◀▶		
Dental - Hospital Tooth Extractions of Children under 10	BSW COMMISSIONER TOTAL	Nov-25	69	22	▼				◀▶		
Dental - Percentage of resident population seen by an NHS dentist - Adult - 24 month rolling	BSW COMMISSIONER TOTAL	Sep-25	28.5%	28.6%	▲	28.7%	No		▲		
Dental - Percentage of resident population seen by an NHS dentist - Child - 12 month rolling	BSW COMMISSIONER TOTAL	Sep-25	54.1%	54.5%	▲	55.3%	No		▲		
Dental - UDA - Percentage of activity delivered	BSW COMMISSIONER TOTAL	Sep-25	72.0%	84.8%	▲	86.7%	No		▲		
Dental - UDA - Units of activity delivered	BSW COMMISSIONER TOTAL	Sep-25	66,790	78,661	▲	80,397	No		▲		
GP Appointments	BSW COMMISSIONER TOTAL	Nov-25		548,354		599,991	No		▲		
GP Appointments % Same Day	BSW COMMISSIONER TOTAL	Nov-25		38.1%	▲				◀▶		
GP appointments where time from booking to appointment was two weeks or less %	BSW COMMISSIONER TOTAL	Nov-25		84.8%				85.0%	▲		
IIF: % of patients on QOF LD register aged 14+ who received an annual LD Health Check (HI-03)	BSW COMMISSIONER TOTAL	Oct-25	26.0%	32.7%	▲				▲		
IIF: Primary Care - % Lower GI Suspected Cancer referrals with an accompanying FIT result (CAN-02)	BSW COMMISSIONER TOTAL	Oct-25	77.5%	77.3%	▼	80.0%	No		▲		

BSW Integrated Performance Dashboard

MENTAL HEALTH

Metric	Group	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 Community Mental Health Services	BSW COMMISSIONER TOTAL	Oct-25	7,265	7,335	▲				▲		
Access to Talking Therapy Services	BSW COMMISSIONER TOTAL	Oct-25	3,865	3,770	▼				▲		
Access to Transformed Community Mental Health Services	BSW COMMISSIONER TOTAL	Apr-25	6,290	6,375	▲				▲		
Average length of stay for Adult Acute Beds	BSW COMMISSIONER TOTAL	Oct-25	63	65	▲	76	Yes	75	▼		
* CYP Mental Health Access	BSW COMMISSIONER TOTAL	Oct-25	10,220	10,395	▲	11,533	No	13,830	▲		
Dementia Diagnosis Rate	BSW COMMISSIONER TOTAL	Nov-25	61.8%	61.9%	▲			66.7%	▲		
Inappropriate Acute Mental Health Out of Area Placements	BSW COMMISSIONER TOTAL	Oct-25	4	4	◀▶	0	No	0	▼		
Number of people accessing Individual Placement and Support	BSW COMMISSIONER TOTAL	Oct-25	520	530	▲	495	Yes	495	▲		
Number of people accessing Individual Placement and Support - Jul 24 onwards	BSW COMMISSIONER TOTAL	Oct-25	520	530	▲	495	Yes	495	▲		
SMI Health Checks %	BSW COMMISSIONER TOTAL	Sep-25	58.0%	56.0%	▼			60.0%	▲		
Specialist Community Perinatal Mental Health Access	BSW COMMISSIONER TOTAL	Oct-25	1,110	1,125	▲	1,100	Yes	1,130	▲		
Talking Therapies - Number of Adults Receiving a Course of Treatment	BSW COMMISSIONER TOTAL	Oct-25	6,975	7,335	▲	8,586	No	10,340	▲		
Talking Therapies - Reliable Improvement Rate	BSW COMMISSIONER TOTAL	Oct-25	70.0%	68.0%	▼	67.0%	Yes	67.0%	▲		
Talking Therapies - Reliable Recovery Rate	BSW COMMISSIONER TOTAL	Oct-25	48.0%	47.0%	▼	48.0%	No	48.0%	▲		

* Inappropriate Acute Mental Health Out of Area Placements data is suppressed to quantities of 5. A record of 4 therefore means 1 to 4.

BSW Integrated Performance Dashboard

LEARNING DISABILITY AND AUTISM

Metric	Group	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	BSW COMMISSIONER TOTAL	Nov-25	32.3%	39.5%	▲	38.3%	Yes	75.0%	▲		
LD - Adult Inpatients - Total (Rate per million)	BSW COMMISSIONER TOTAL	Dec-25	51	45	▼	31	No	30	▼		
LD - Children Inpatients - Total (Rate per million)	BSW COMMISSIONER TOTAL	Dec-25	26	26	◀▶	21	No	10	▼		
LD - Inpatient care for adults with a learning disability	BSW COMMISSIONER TOTAL	Dec-25	13	13	◀▶	10	No		▼		
LD - Inpatient care for autistic adults	BSW COMMISSIONER TOTAL	Dec-25	24	19	▼	12	No		▼		
LD - Inpatients (Rate per million)	BSW COMMISSIONER TOTAL	Dec-25	46	41	▼	29	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.

BSW Integrated Performance Dashboard

WORKFORCE

Metric	Group		Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
Agency Usage % - all staff	ALL_ICB - ACUTE TOTAL		Oct-25	0.9%	0.8%	▼			2.0%	▼		
Bank Usage % - all staff	ALL_ICB - ACUTE TOTAL		Oct-25	5.3%	5.4%	▲			4.0%	▼		
Sickness Rate - 12m	ALL_ICB - ACUTE TOTAL		Oct-25	4.5%	4.5%	◀▶			5.0%	▼		
Sickness Rate - in month	ALL_ICB - ACUTE TOTAL		Oct-25	4.7%	5.0%	▲			5.0%	▼		
Turnover Rate - 12m	ALL_ICB - ACUTE TOTAL		Oct-25	10.0%	9.9%	▼			10.8%	▼		
Turnover Rate - in month	ALL_ICB - ACUTE TOTAL		Oct-25	0.9%	0.8%	▼			1.0%	▼		
Vacancy Rate - all staff	ALL_ICB - ACUTE TOTAL		Oct-25	2.3%	1.8%	▼			6.0%	▼		

BSW Integrated Performance Dashboard

FINANCE

Metric	Group	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Planning Target	Improvement Direction	Variation	Assurance
Agency Spend vs agency ceiling (% over plan YTD)	ALL_ICB - ACUTE TOTAL	Nov-25	74.0%	70.0%	▼			0.0%	▼		
Agency Spend vs agency ceiling (% over plan YTD)	BSW NHS ICS - TOTAL	Nov-25	74.0%	70.0%	▼			0.0%	▼		
Efficiencies % recurrent Actual	ALL_ICB - ACUTE TOTAL	Nov-25	49.0%	50.0%	▲			79.0%	▼		
Efficiencies % recurrent Actual	BSW COMMISSIONER TOTAL	Nov-25	100.0%	100.0%	◀▶			79.0%	▼		
Efficiencies % recurrent Actual	BSW NHS ICS - TOTAL	Nov-25	60.0%	62.0%	▲			79.0%	▼		
Financial efficiency - variance from efficiency (?m YTD)	ALL_ICB - ACUTE TOTAL	Nov-25	£-23.1	£-25.2	▼			0	▼		
Financial efficiency - variance from efficiency (?m YTD)	BSW COMMISSIONER TOTAL	Nov-25	£10.3	£10.2	▼			0	▼		
Financial efficiency - variance from efficiency (?m YTD)	BSW NHS ICS - TOTAL	Nov-25	£-12.8	£-14.9	▼			0	▼		
Financial stability - variance from plan (?m YTD)	ALL_ICB - ACUTE TOTAL	Nov-25	£-39.0	£-43.2	▼			0	▼		
Financial stability - variance from plan (?m YTD)	BSW COMMISSIONER TOTAL	Nov-25	£10.0	£11.5	▲			0	▼		
Financial stability - variance from plan (?m YTD)	BSW NHS ICS - TOTAL	Nov-25	£-29.0	£-31.7	▼			0	▼		
Mental Health Investment - variance from plan (? m YTD)	BSW COMMISSIONER TOTAL	Nov-25	0	0	◀▶			£1.0	▲		

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	11b
Date of Meeting:	22 January 2026		

Title of Report:	Medium Term Plan Update
Report Author:	Claire Bullock, Head of Delivery
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	Appendix 1 – Working draft of 5 year Strategic Commissioning Plan (strategy) Appendix 2: NHS Planning Framework for Five Year Plan Content Appendix 3 – Planning timeline (final submission)

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

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 Executive Management Meeting	21/01/2026	Review of draft
BSW ICB Board Development session	17/12/2025	Discussion on commissioning intentions
BSW Board Public session	20/11/2025	Discussion/Assurance of commissioning intentions
BSW Commissioning Committee	14/10/2025	Discussion of commissioning intentions

1	Purpose of this paper
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The purpose of this paper is to:

- Present and socialise the working draft of the Five Year Strategic Commissioning plan (strategy) for BSW, which is part of the requirement for the planning submission on 12 February 2026 for the NHS Medium Term Planning Framework (published on 24 October). Due to the timing of board meetings and the planning submission, the Board will be meeting in an Extraordinary private session on 10th February to sign off the various components of the plan. This working draft is therefore being brought to this board meeting for socialisation and consideration ahead of sign-off;
- Describe the remaining work to be undertaken 10th February;
- Describe the timeline for the planning process to achieve the final submission on 12 February.

2	Summary of recommendations and any additional actions required
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The ICB Board is asked to:

- Note the draft of the five year strategic commissioning plan for BSW and provide and feedback prior to the final draft.
- Note the next steps in preparing the requirement submissions for December 2025.

3	Legal/regulatory implications
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In undertaking its planning the ICB is following the national planning guidance and policy set out in:

- Planning Framework for the NHS in England (September 2025)
- Medium Term Planning Framework – delivery change together (October 2025)
- Strategic Commissioning Framework (November 2025)
- Further technical guidance supporting the above (due for publication in November 2025)

4	Procurement
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No procurement considerations at this stage of the process.

Procurement sign off

N/A

5	Risks
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There are a number of risks which impact the delivery of this five year plan:

- Financial stability and sustainability, including delivery of financial improvement plans
- Continued impact of urgent care pressures on the system
- Capacity and capability of the workforce to be able to deliver and sustain services
- Capacity within the system to deliver all workstreams/delivery plans

6	Quality and resources impact
No specific resource details /implications at this stage of the process, noting that this will be set out in the content for the relevant submissions during this next stage. No detailed financial commitments are made yet in the content of the commissioning intentions which are setting strategic direction.	
Finance sign-off	N/A

7	Implementation Plan Alignment
The planning process will allow us to review and where appropriate confirm the commitments set out in our previous plans.	

8	Confirmation of completion of Equalities and Quality Impact Assessment
An EQIA is currently being carried out as part of this planning round for February 2026.	

9	Communications and Engagement Considerations
We will be continuing our work with stakeholders as part of the planning cycle and the final plan.	

10	Statement on confidentiality of report
This report is not confidential.	

Medium Term Plan Update

1. Introduction

1.1. The purpose of this paper is to:

- Present a working draft of the BSW Five Year Strategic Commissioning plan (strategy), prior to the sign off of the final plan (extraordinary board 10th February), as part of the requirement for the planning submission on 12 February 2026 for the NHS Medium Term Planning Framework (published on 24 October);
- Due to the timing of board meetings and the planning submission, the Board will be meeting in an Extraordinary private session on 10th February to sign off the various components of the plan. This working draft is therefore being brought to this board meeting for socialisation and consideration ahead of sign-off;
- Outline the remaining work in finalising the plan prior to the February planning submission
- Describe the timeline for the planning process to achieve the final submission on 12 February

2. Purpose of the Five Year Strategic Commissioning plan

- 2.1. In 2025 NHS England published its guidance for the Five Year plan as part of the [Planning Framework](#) and the 10 year health plan, which set out the requirement that five year organisation plans will be one of the core outputs of the integrated planning process.
- 2.2. Each ICB and NHS Trust is expected to develop a five year plan and submit this to NHS England as part of the annual planning process. These plans should be refreshed each year. At the time of writing the ICB commissioning plan, we have not yet had sight of the trust plans.
- 2.3. Although the five year Plan is required at an ICB level, ICB Clusters are recommended to work together to discuss and align where possible. The template for BSW has been developed as a cluster and all three ICB's are using a consistent approach based on the national guidance.
- 2.4. In line with NHSE guidance the five year ICB plan should set out how the Integrated Care Board (ICB) intends to deliver its strategy for the five year period, from 2026-27 to 2030- 31. It should be noted that this plan will be aligned to activity, performance and workforce plans and aligned over the lifetime of the plan, so may require further iterations.
- 2.5. The plan will consider the ICB's integrated needs assessment (this will be as an appendix to the final plan) and baseline mapping of current performance and quality of care to describe the ICB's commissioning intentions to improve population health outcomes and ensure equitable access to healthcare in line with the outcomes and priorities described in the ICB's five year Commissioning plan.

- 2.6. The five year Strategic Commissioning Plan will provide clarity for healthcare providers and other partners on how the ICB intends to allocate resources, and what outcomes will be achieved as a result.
- 2.7. The commissioning plan should translate national and local strategic priorities into local action, demonstrate how partners will practically work together to improve health outcomes, and describe the financial framework that will be used to support financial sustainability and value for money.
- 2.8. The commissioning plan should also set out, where appropriate, where the ICB intends to commission jointly with local government and/or delegate commissioning to another provider(s), as well as identify where system and/or service reconfiguration may be required to deliver the agreed priorities (including potential decommissioning options).
- 2.9. It should be noted that commissioning intentions contained in the plan have not been a standard feature of planning rounds over previous years and should be viewed in the context of setting strategic direction for how commissioning will be approached by the ICB over the next five years to make significant changes in enacting the 10-year plan.
- 2.10. There is no requirement to undertake consultation or engagement of the commissioning intentions beyond provider stakeholders, and NHSE steer is to ensure that they do not pre-judge the outcome of any future engagements required in fulfilling the strategic intent as those areas progress over the 5-year period.
- 2.11. ICBs will be required to submit their five year Strategic Commissioning Plan on **12th February at 12 noon**. This will include the following appendices:
- 2.11.1. BSW ICB Delivery Plans for Commissioning Intentions
 - 2.11.2. BSW Full Integrated Needs Assessment
 - 2.11.3. BSW ICB Statutory Functions
- 2.12. The BSW ICB board will have the sign off of the final plan and other requirements for the final submission on 12th February. An extraordinary board has been scheduled for 10th February to do this. Prior to this, the Commissioning Committee has been overseeing the progress of planning activities, with regular updates to the Finance and Infrastructure Committee.
- 2.13. We are also holding an extraordinary Finance and Infrastructure Committee on 4th February for the financial assurance of the detailed finance, activity and workforce plans and a Quality Outcomes Committees scheduled for the sign off of the EQIA on the planning process.
- 2.14. Set out below is a reminder as to what is required for the final planning submission in February:

Submission	Requirement
Full submission	<ul style="list-style-type: none"> • updated 3-year revenue and 4-year capital plan return • updated 3-year workforce return

	<ul style="list-style-type: none"> • updated 3-year operational performance and activity return • integrated planning template showing triangulation and alignment of plans • 5-year narrative plan (shared in this paper) • board assurance statements confirming oversight and endorsement of the totality of the plans
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3. The BSW 5 year Commissioning Plan

- 3.1. The commissioning plan set out in this paper sets out the ambition of BSW ICB to further transform health services over the next five years, working as part of the wider ICB cluster.
- 3.2. This takes forward the work previously set out in the BSW ICP strategy, and articulated in our BSW Care Model, and now incorporates the ambitions articulated in the NHS Ten Year Plan.
- 3.3. We began this process by setting out our Commissioning Intentions which were approved by the Board last year, and have now through this processes added further detail to these intentions and set out a bold plan for transforming a range of key services that will deliver the three shifts. Whilst further work needs to be completed on this plan, including quantifying the activity shifts, we have now made sufficient progress to share with the Board.
- 3.4. The quantification of these shifts, which will be estimates only, is being completed in line with our already established Outcomes Framework – this for example sets out our ambition to limit and contain ED attendances at 24/25 levels, by expanding and transforming our primary and community care offer. Delivering on these outcomes will drive the delivery of our intentions and be the key metrics by which we will evaluation success.
- 3.5. For Board assurance, we also below set out a number of important pieces of work that have been carried out as part of developing this plan:
 - Developed strategic commissioning intentions and engaged upon them with key stakeholders including local authorities, VSCE sector, ICA's, delivery groups, and neighbouring ICB cluster systems. There were six initial intentions but following engagement, two were added for Primary Care and Prevention.
 - The narrative for the five year strategic commissioning plan has been developed in collaboration with ICB portfolio and commissioning leads to further develop the commissioning intentions and delivery milestones and timescales. This has included a review of existing work and consideration of key workstreams required to enable delivery of the commissioning intentions.
 - Alignment to the 10-year plan has been central to the development of the plan and a comparative piece of work was completed against the BSW Implementation plan and the 10-year plan to identify ambitions and opportunities for BSW.

- Updated our population demographic and demand forecast work (formerly called our case for change) to create our population health needs assessment
 - Reviewed progress against the BSW Care Model and our associated clinical strategies. The BSW Hospitals Group is creating a new clinical strategy and this will be available shortly, and hopefully in time to inform the final submission.
- 3.6. The plan has been developed with a cluster approach based on the national guidance; regular meetings and sharing of drafts have taken place to ensure alignment and consistency all three ICBs in the cluster. Specific sections have been added in addition to the national guidance (eg. Engagement, Monitoring Delivery).

4. Next steps

- 4.1. There is further work to do ahead of finalising this plan ahead of Board review and submission in February. The next steps will focus on the following areas:
- Reviewing and refining a more concise version of the 5-year plan, incorporating Board feedback, and NHSE feedback on our first planning submission and commissioning intentions
 - Translating and quantification of the commissioning intentions into activity plans, including aligning this with the ambitions set out in our BSW Outcomes Framework and our ICBC Outcomes Framework
 - Ongoing work for activity, finance and workforce plans ahead of the February submission
 - Finalise the detailed delivery plans that will form an appendix to this plan
 - Socialisation of the plan with Integrated Care Alliances
 - Endorsement of the 5 year plan by all three Health and Wellbeing Boards in BSW.
 - An EQIA to be completed on the Integrated planning process and agreed by QOC on 2nd February 2026
 - Detailed proposals to be agreed for key transformation projects to be agreed as part of the protected transformation fund and summarised in the plan

5. Risks

- 5.1. There is a risk regarding the organisational change and the subsequent reduction of capacity and capability to support future delivery across the ICBs in delivery of this plan.
- 5.2. The planning framework sets out some significant ambitions in relation to major transformation in some key areas – we will need to further consider and plan for the potential consequences of these, including performance consequences. For example, with the planned changes to Advice and Guidance, we will need to work with providers to ensure that the implementation is fully planned and can

be delivered, and model through the potential performance impact. This work will be completed for each area in the coming weeks.

- 5.3. There is insufficient capacity across the entire system pathway to meet demand and support flow for Urgent and Emergency Care, resulting in missed targets, high NCTR, insufficient flow, patient harm, and inability to shift resources from managing pressures into the transformation of care.
- 5.4. The current planned care and cancer wait times and capacity to deliver these could impact on the system's ability to meet targets
- 5.5. The delays to national guidance for neighbourhood health and uncertainty of the role different stakeholders will play e.g. is it a primary or community led mode could impact delivery
- 5.6. There is a risk that if the Single Electronic Patient Record Programme is not delivered safely and on time, this could result in material operational disruption within the acutes and across the wider system.
- 5.7. Regarding the sufficiency of capital funding for the ICB and system, finite resource could be spent on schemes that don't support the delivery of system objectives or create revenue pressures which add to the system underlying deficit and ongoing savings requirements.
- 5.8. There are various risks regarding specific ICB activities and operations across primary care (GP, dental, SW hub), urgent and emergency care and flow, planned care, mental health, s117 aftercare that all point to capacity and financial constraints as a risk to the ICB's ability to achieve delivery of in-year aims and objectives.
- 5.9. Limited engagement resource so capacity to support the planned transformation agenda could be constrained

6. Recommendations

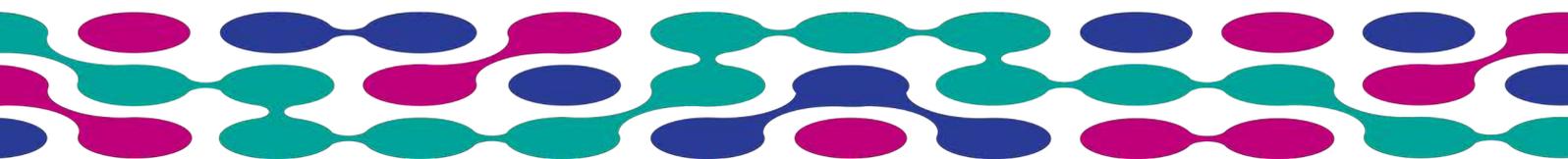
- 6.1. The Board is asked to:
 - Note and provide feedback to the current working draft of the 5-year strategic commissioning plan as part of the planning process and work undertaken to date.
 - Note the next steps and timeline in preparing the requirement for the final submission of the 5-year plan for February 2025.

BSW Five Year Commissioning Plan (Strategy)

2026/27 to 2030/31

Working Draft 15 January 2026 V1.1

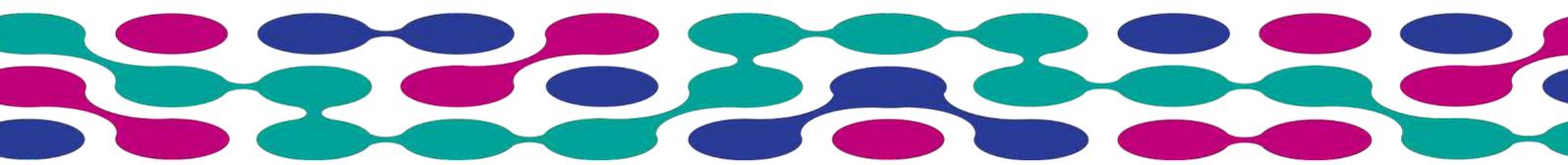
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Foreword by Cluster Chair

Rob Whiteman CBE, Chair NHS Bath & North East Somerset, Swindon and Wiltshire ICB, NHS Dorset ICB and NHS Somerset ICB

It's a real privilege to introduce our new cluster, which brings together the collective strengths of NHS Bath & North East Somerset, Swindon and Wiltshire ICB, alongside NHS Dorset ICB and NHS Somerset ICB. By joining forces, we're combining the expertise, experience, and passion of three systems. Working together means we can share what we do best, learn from each other, and deliver care that is more consistent, more efficient, and more responsive to the people we serve. This is about planning for the future as one team; building a high-performing strategic commissioning organisation that can make bold, long-term decisions and achieve more for our communities as we move towards full merger in April 2027.

Many people in our communities live a significant part of their lives in poor health, and those in our most disadvantaged areas experience this earlier and more severely. This is not just a health issue; it affects families, communities, and the economic wellbeing of our region. We must act together to change this.

Our new cluster brings together our three Integrated Care Boards to work as one strategic commissioning organisation, ahead of our planned merger in April 2027. We need to plan for the long term, focusing on outcomes, and making sure every pound we spend delivers the greatest value for our population. It also means working differently, moving away from short-term fixes and towards evidence based and outcome-driven commissioning that tackles the root causes of ill health.

We know there remain significant challenges to overcome. We need to reimagine how we better support people in their communities; we will do this by building neighbourhood teams, working together with our partners across the NHS, local authorities, the voluntary and community sector and with the public. We want to improve access to GP services and NHS dentistry whilst at the same time continuing to improve access to mental health support, reducing waiting times for planned treatments and continuing the improvement we have seen over the past year in our ambulance response times.

We will make these changes supported by the latest technology and while creating a health and care system that is financially sustainable, with the workforce required to meet the care needs of our population. We also know that not everyone has the same experience, and those living in our most disadvantaged communities are least likely to receive the support they need to thrive. It is important to be clear that in the years covered by this plan, local partners will face difficult choices as a result of challenging financial positions, but we are committed to doing everything we can to deliver on the three key shifts set out in the Government's 10-Year Health Plan, moving more care from hospitals to communities, making better use of technology and preventing sickness - not just treating it.

None of our achievements, nor our aspirations for the future, would be possible without the dedication, talent and compassion of the inspirational people who work in our local health and care services – from across the statutory and the voluntary, community, and social enterprise (VCSE) sectors, and I would like to thank them for everything they do.

Our three ICB Strategic Commissioning Plans contain many shared ambitions and some locally set commissioning intentions. They set out the actions we will take to build on the solid foundations already laid and rise to the challenges we face.

At the time of finalising and publishing this, in February 2026, we are in a time of unprecedented change for the NHS. We are in a period of consultation with staff across our three ICBs as part of the government-led requirement to reduce our running costs by 50% ahead of our intended merger in April 2027. We have made some good first steps to work together, with Jonathan Higman appointed as our cluster chief executive in September 2025. We also have a newly appointed cluster executive team, who are working hard to set us on the path to becoming a high-performing strategic commissioning organisation.

Alongside the changes to ICBs are the changes in NHS England and their merger with the Department of Health and Social Care. The NHS landscape is evolving, and we will continue to work with our partners, maintaining our focus on supporting our people and communities to live healthier lives.

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1. Cluster Introduction

Chief Executive Jonathan Higman, BSW ICB, Dorset ICB, Somerset ICB

I'm delighted to introduce our new cluster across Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, Dorset ICB and Somerset ICB. Whilst we are currently three systems, we have a shared mission: to help people live healthier lives, tackling unfair differences in access and outcomes, and making the best use of every pound we spend. By bringing our strengths together, we can go faster on the things that matter most for our communities.

The NHS 10 Year Health Plan focuses on three shifts, and this set the direction for how we commission services in the future:

- From hospital to community we will focus on delivering more joined up support close to home, with neighbourhood teams as the default place people get help.
- From analogue to digital we will focus on simple, secure digital tools like the NHS App and shared care records that make care easier to find, book and manage. We will look for digital innovation which will support people to live healthier lives.
- From sickness to prevention we will focus on earlier help to reduce the risks around smoking, high blood pressure, excess weight and harmful alcohol use, so fewer people reach crisis.

Most importantly, we will design our future services with people and communities, not for them. We will keep listening and work with people through neighbourhood plans, VCSE partnerships, health and wellbeing boards, and ongoing public engagement so local insight shapes decisions.

What we're already doing in common – our one shared approach

Across BSW, Dorset and Somerset, our plans point in the same direction. Together we will:

- **Commission for outcomes, not just activity.** We will put outcomes frameworks into contracts and hold ourselves to reducing unwarranted variation and closing inequality gaps. This gives providers clear goals.
- **Build a Neighbourhood Health Service.** Integrated neighbourhood teams (INTs) will wrap care around people with primary care, community services, local authority and VCSE partners working as one team.
- **Improve urgent and emergency care by strengthening the community front door.** We will redesign same day and out of hours access, develop single points of access, and recommission Integrated Urgent Care (IUCS) so more needs are met safely at home.
- **Transform planned care pathways.** We will expand advice and guidance and community based diagnostics; use data and clinical standards to reduce waits; and make follow-up more personalised and efficient.
- **Focus prevention where it matters most.** Systemwide tobacco dependence support, better hypertension case finding and treatment, integrated healthy weight support, targeted alcohol harm work and improved vaccination access are shared priorities.

- **Use data well.** We will link up and responsibly use data across partners (e.g. Dorset's Intelligence & Insight capability, Somerset's Linked Data Platform, BSW's Outcomes and Intelligence Hub) and adopt national tools like the Federated Data Platform to target support and track impact.
- **Make digital the easy option and keep nondigital routes open.** Shared care records, modern EPRs, NHS App integration, remote monitoring and inclusive digital support will be built into contracts and everyday practice.
- **Strengthen mental health and neurodiversity support.** Earlier help in the community, crisis alternatives to inpatient care, dementia pathway improvements, and fair physical health checks for people with serious mental illness, are shared commitments across the cluster.
- **Improve support for children and young people.** Speech and language, SEND reforms, family hubs, and fairer access to specialist care are shared areas of work so children get help earlier and closer to home.
- **Tackle dental access and oral health.** We will stabilise the market, widen access - especially for vulnerable groups and strengthen prevention in schools and communities.
- **Align money to value.** We will grow transformation funds, use pooled budgets (e.g., Better Care Fund) and outcome based payments to shift resources into prevention and neighbourhood care.
- **Invest wisely in estates and infrastructure.** Modern, flexible spaces including community hubs, diagnostics closer to home, greener buildings will support the left shift and make access easier, especially in rural areas.

What's next

We are clustering now and intend to merge into a single strategic commissioning organisation by April 2027. This will help us plan at scale, reduce duplication and get the best value for our communities, while keeping decisions grounded in local needs. We will do this within the new NHS national framework, building the skills, data and market shaping capability that strategic commissioning requires. Our promise is simple: we will keep people and communities at the heart of our commissioning intentions; we will measure the outcomes that matter; and we will work as one team across the 6 places in our cluster to deliver for our people and communities.

2. Purpose & Scope

This plan will set out how we intend to deliver our strategy for the five-year period, from 2026/7-2030-31 and clearly articulate how the commissioning intentions will deliver on the agreed outcomes and the path to delivery with clearly set out targets and trajectories.

In developing these paths to delivery, the commissioning plan will:

- Consider the ICB's integrated needs assessment and baseline mapping of current performance and quality of care to describe our commissioning intentions to improve population health outcomes and ensure equitable access to healthcare in line with the outcomes and priorities described in the ICB's five-year Commissioning Strategy.

- Provide clarity for healthcare providers and other partners on how the ICB intends to allocate resources, and what outcomes will be achieved as a result,
- Translate national and local strategic priorities into local action
- Demonstrate how partners will practically work together to improve health outcomes
- Describe the financial framework that will be used to support financial sustainability and value for money.

The plan will demonstrate also how the ICB Embed feedback and experience from patients, service users, people and communities to inform commissioning intentions and evidence partnership working across Public Health, local Government and the VCSFE sector to deliver on our agreed outcomes.

3. Strategic Commissioning Overview

The Model ICB Blueprint marked the first step in a programme of work to reshape the purpose, role and functions of integrated care boards (ICBs), laying the foundations for delivery of the 10 Year Health Plan and following the announcement of a significant reduction in the operating costs for ICBs from 2026/27. This strategic commissioning framework supports ICBs in commissioning NHS services as well as others with this function – regional NHS teams currently and in future some providers, to understand what strategic commissioning means in practice. It updates the commissioning cycle and sets out the important enablers to support effective commissioning. We use the term ‘strategic commissioning’ to describe the updated approach to commissioning as presented in the framework.

Strategic commissioning is a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare. As strategic commissioners, the ICB are accountable for creating the best value for the public from their NHS budget. ICB’s should consider how the budget should be spent within their population to secure high quality accessible healthcare now and in the future and ensure that the health services they plan, and commission uphold the rights and values outlined in the NHS Constitution for patients, the public and staff. ICBs will also work alongside government, including local government, to address the wider determinants of health, such as employment, in line with the government’s health mission and the 4th purpose of ICBs to support wider socioeconomic development.

Strategic commissioning comprises four stages:

1. **Understanding the context** – ICBs will use joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.
2. **Developing long-term population health strategy** – ICBs will focus on long-term population health strategy and planning and care pathway redesign. They

will use national modern service frameworks and guidance to create the evidence base for new integrated models of neighbourhood care that maximise value, guiding the development of population health improvement plans.

3. **Delivering through payor function and resource allocation** – ICBs will understand and allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services to deliver the outcomes set out in the ICB strategy and population health improvement plan.
4. **Evaluating impact** – ICBs will rigorously evaluate the outcomes from commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence.

4. BSW Context

4.1 Summary of BSW Integrated Needs Assessment

This section provides a high-level summary of the Integrated Needs Assessment (INA) for BSW. It draws together key messages from the three place-based JSNAs (B&NES, Swindon and Wiltshire), system-wide analysis of the health and care economy, and baseline performance using the BSW Outcomes Framework. The full INA (including detailed place-level needs, segmentation, and supporting analysis) can be accessed separately and should be read alongside this Medium Term Plan.

4.1.1 Local context and population health needs (JSNA summary) *[section being reviewed and updated incorporating further detail and feedback from public health leads]*

Across BSW, JSNA evidence highlights generally good health outcomes overall, but substantial variation by place and neighbourhood. Swindon has a younger and more diverse population profile and the greatest concentration of deprivation. B&NES and Wiltshire have older population profiles, with rurality creating additional access barriers (transport, distance, connectivity and digital exclusion). Wider determinants (housing affordability, employment, education, transport and community infrastructure) shape both need and inequality, and this is compounded for inclusion health groups and people living with long-term conditions.

While we recognise a wider set of Core20PLUS inclusion groups, deprivation and ethnicity are two of our key inequality dimensions where we have the strongest and most consistent data across BSW. They also frequently intersect, for example, a higher proportion of our CORE20 population are in the Asian ethnic group, relative to the other deprivation deciles. This suggests we could benefit from targeting some of our inequalities work where ethnicity and deprivation intersect.

The JSNAs also highlight the growing burden of long-term conditions and multi-morbidity, rising demand linked to frailty, and sustained pressures in children and young people’s services (including SEND and mental health). Preventable risks remain key drivers of future ill health and demand, particularly smoking, excess weight/obesity and alcohol-related harm, with risk and outcomes strongly patterned by deprivation and place.

4.2 Health and Care Economy: Key Messages from the BSW Case for Change

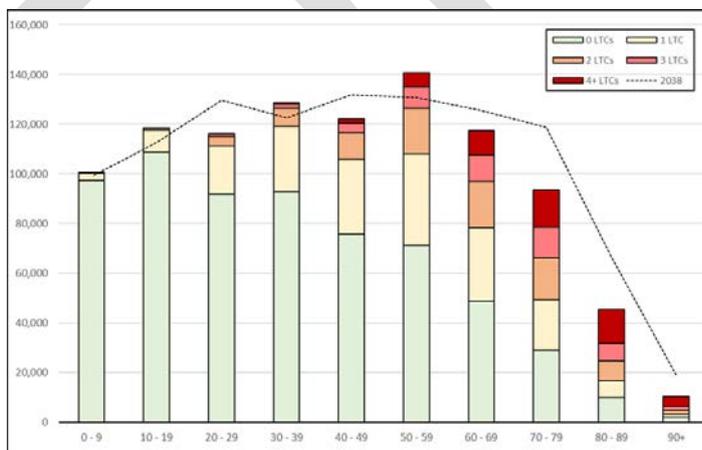
The system context is shaped by demographic change, increasing complexity, and constrained capacity. The case for change shows that:

1) Our population is ageing, and this will materially increase need:



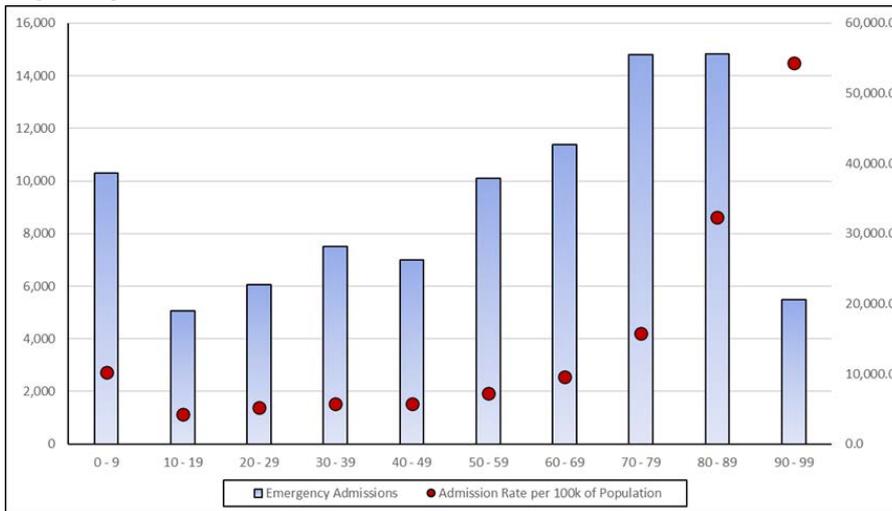
This figure provides the demographic context and supports the case for shifting investment and delivery models towards prevention, earlier intervention, and community-based support.

2) More older people means more multi-morbidity:



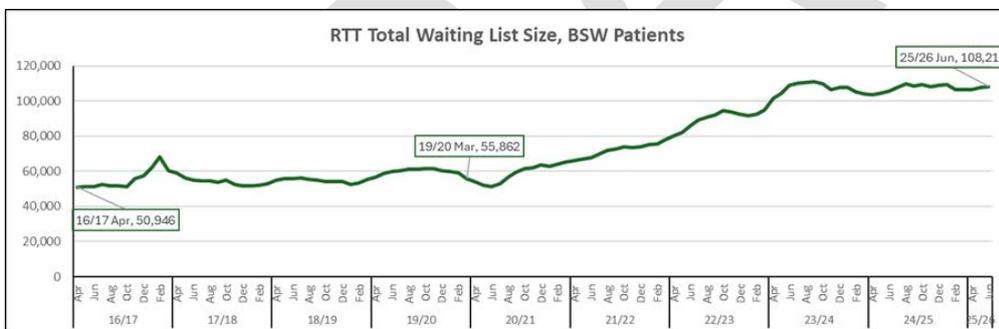
This illustrates the growth in long-term condition burden and the implications for proactive, coordinated care (particularly for people living with frailty and multiple conditions).

3) Demand pressures will increasingly show up in urgent care and acute bed capacity:



Without change, pressures on already stretched acute beds, ambulance dispatch and ED attendances will rise. Together, these reinforce why the Medium Term Plan must deliver the “hospital to community” shift, with integrated neighbourhood delivery and improved flow. These figures help connect the INA evidence base to urgent and emergency care priorities and the need for prevention and proactive community support to reduce avoidable crisis activity.

5) Access and waiting times remain a significant challenge across services:



This supports the MTPF expectation that systems address access and productivity alongside transformation.

4.3 Baseline Mapping of Current Performance

The Integrated Needs Assessment is anchored in the BSW Outcomes Framework, which provides the shared baseline for performance, variation and inequalities. For this summary we use three headline outcomes that together capture length of life, quality of life, and avoidable crisis/system pressure:

- Life expectancy and Years of Life Lost (YLL): establishes the baseline for premature mortality and highlights where preventable death and inequality gaps are greatest.

- Healthy life expectancy and Healthy Years of Life Lost (HYLL): provides the baseline for quality-of-life impact and identifies where people are spending more years in poor health.
- Emergency bed days: provides a system pressure proxy and highlights where urgent, reactive care use is concentrated and where proactive, integrated community support should have the greatest impact.

Outcome	Latest data date	BSW (latest data)	Benchmark (Average 6 peers ICBs)	Trend
Life Expectancy (Female)	2023	84.2	84.0	=
Life Expectancy (Male)	2023	80.8	80.3	=
Healthy Life Expectancy at 65 (Female)	2021-23	12.7	12.3	=
Healthy Life Expectancy at 65 (Male)	2021-23	11.4	11.1	=
Emergency Bed Days	9/24-9/25	43092		↑

Implications of the 10 Year Plan (10YP) and Medium Term Planning Framework (“MTPF- delivering change together”)

Taken together, the Integrated Needs Assessment evidence base supports the MTPF direction of travel and the three shifts:

- **Sickness to prevention:** tackling preventable risks and improving early intervention, particularly in communities experiencing the poorest outcomes.
- **Hospital to community:** strengthening neighbourhood and community delivery so people receive proactive, coordinated support and reliance on urgent reactive care reduces.
- **Analogue to digital:** improving data, segmentation and outcomes measurement so commissioning can target highest-need cohorts and track impact consistently.

4.4 Activity and Performance

Integrated Health Boards and the wider NHS face significant challenges which include longer waiting times to access services and increased demand. To fully understand the challenges faced by the BSW System, we have in place an Integrated Performance Dashboard to provide oversight of the key operational standards, including those outlined within the NHS Oversight Framework (NOF) which is reported on both an ICB and Provider basis.

BSW ICS faces many of the same challenges as a system as other parts of the NHS, and although progress has been made across many performance standards, we face particular challenges, and benchmark as an outlier for Urgent and Emergency care and some elements of Elective care. We have identified improvement opportunities in the following areas:

Urgent & Emergency Care

- Ambulance Cat 2 response time and ambulance handovers: We have implemented a change in handover process at our acutes to ensure faster transfer of patients (within 45 minutes), which has significantly improved our handover times, although it has increased demand in A&E which needs to be addressed.
- A&E 4 hour standard – BSW are performing nationally in the lowest quartile (Q2) for 4-hour performance at Type 1 A&E departments, and challenges remain in meeting operational planning ambitions set out for 26/27- 28/29.
- NCTR - We continue to have a high number of patients in BSW Acute hospitals and in Intermediate Care Beds who are occupying a bed in hospital after their discharge ready date. To achieve improved hospital flow, we need to reduce the time between discharge ready date and the actual discharge date across all pathways.

Elective care

- RTT – The system is improving RTT 18 week and 52 week performance in line with 25/26 plans though RUH are not meeting plans. BSW will be challenged to meet constitution standard of 92% by 2029. The increase in the waiting list in year by 3.3% is a national outlier and the waiting list needs to reduce by almost 50% to 57,520 to support the 92% standard delivery by 28/29.
- Cancer services- 28 day faster diagnosis & 62 day referral to treatment performance below target and national average for the System and Acutes, although challenging robust plans are in place to meet the MTP plan targets.
- Diagnostics- Although 6 week performance is in line with region and currently performing better than national, a significant improvement is required to meet the MTP plan targets and the national standard of 1% by March 29.

Mental Health & Learning Disabilities

- Talking Therapies – Completed Courses of Treatment: Numbers of courses completed is below plan and fair shares (not benchmarked). Service development will be needed in the MTP to improve the number of adults receiving a course of treatment in Talking Therapies.
- Dementia Diagnosis rate is in line with region though substantially below national performance and target, a significant improvement is required to meet the national standard.
- CYP Access (age 0 to17, 1+ contacts) BSW are bottom quartile for CYPMH Access rate per 100,000 and improvement is required.

Primary Care & Community care:

- Dental: Delivery of planned units of dental activity (regular and urgent) needs to increase to meet BSW ambitions and ensure we meet our nationally agreed targets, including the implementation of the dentistry contract reforms focusing on enhancing access to urgent and unscheduled care.
- Ensuring there are sufficient GP appointments made available for patients including same day appointments is a priority to help reduce pressures on the urgent and emergency care system. The roll out of online triage systems across BSW also aim to support this.

Effectiveness and experience of care:

- Improving infection rates across all services is a priority to reduce closure of beds and support flow through patient pathways, improving patients experience of care.

BSW ICB is committed to actively managing the local health and care market to ensure services are sustainable, high-quality, and responsive to population needs. We will work closely with our Providers to support service resilience, innovation, and collaborative approaches, while identifying opportunities to address gaps or improve patient outcomes. During 2026/27, we will strengthen our understanding of provider capacity, workforce pressures, and investment requirements, engaging providers in shaping future service models. Where appropriate, commissioning levers will be used to secure high-quality, cost-effective services that deliver equitable access and improved patient outcomes.

4.5 Quality

Quality is defined in statute as having three dimensions: safety, clinical effectiveness and patient experience and is a shared goal that requires system commitment and action to ensure that we provide the highest quality health and care services.

BSW System Quality is based on these principles:

- Collaboration, trust and transparency
- Transformation
- Equity and equality

The use of the Juran Trilogy Model of quality planning, quality control and quality improvement will be central to the planning and delivery of care. This is described within the BSW Quality Assurance and Improvement Framework (QAIF) and sets out the vision for quality through the application of the National Quality Board (NQB) guidance (further strategy publication due in 2026). The QAIF also sets out our governance arrangements for monitoring our quality priorities, including the use of agreed performance and quality assurance metrics and patient and service user reported outcomes and experience.

In practice this means that the system will deliver care that is safe, effective, well led, sustainably resourced and equitable. Our commitment includes the need to shape and

design the delivery of services by working with local communities, ensuring engagement with children, young people and adults that use local services (experts by experience), alongside health and care professionals and the voluntary sector. We will continue to monitor quality and safeguarding standards via metrics and agreed outcomes framework.

The care experience of the population will be positive through responsive, caring and personalised delivery and measured through a variety of feedback tools including patient and colleague surveys, Friends and Family Test (FFT) and review of patient and service user concerns, complaints and compliments to identify real time trends and themes for shared learning.

A collective reporting and shared learning approach will be achieved through existing governance structures and improvement networks and Communities of Practice, for example, Patient Safety Specialists; System Mortality Group oversight (including LeDeR oversight); Infection Prevention and Management Collaborative (with a focus on the continuous reduction in avoidable healthcare associated infections i.e., Clostridium Difficile infections and E Coli blood stream infections), vaccination delivery and communicable disease management); Medicines Optimisation and Safety (including oversight of antimicrobial stewardship and antimicrobial resistance), Digital transformation / clinical safety oversight and BSW Local Maternity and Neonatal System.

Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plans (PSIRP)

PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There are four key principles fundamental to the effective delivery of PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learn from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system function and improvement.

The BSW Patient Safety Specialists Community of Practice has worked collaboratively to support the implementation of the PSIRF and PSIRPs across all commissioned provider services. Following a recent internal audit of ICB quality assurance processes, monitoring of provider Patient Safety and Incident Response Plans (PSIRP) will be further strengthened as part of quality planning and quality control, via formal contractual governance oversight and BSW system shared learning and improvement group.

Quality Governance

The integral relationship with BSW System Quality Group (SQG) will be essential in ensuring:

- Positive system assurance, via quality control and improvement processes, that statutory duties are being met, concerns and risks are being effectively mitigated, and improvement plans are having the desired effect
- Confidence in the ongoing quality improvement of best practice pathways, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation are being addressed, utilising a person-centred approach to care delivery and outcome reporting
- A vehicle for wider thematic learning and improvement
- A clear governance structure, as described in BSW Quality and Improvement Framework, to recognise early warning signs and instigate a rapid quality review process and monitoring of quality improvement plans where statutory duties and contractual quality requirements are not being met
- Use of Equality Quality Impact Assessments (EQIA) to evidence the impact of transformation plans
- Horizon scanning for evidence-based research guidance and innovation, together with robust processes for timely response to new and emerging national guidance.

Quality Focus:

Maternity and Neonatal Services

Following concerns raised by families who have experienced adverse events in some maternity services in England, Baroness Amos was appointed to lead a rapid, independent investigation into maternity and neonatal system issues across England. In Dec 2025, after having engaged with families, staff, community organisations and MPs, Baroness Amos published her initial reflections on what she had heard to date and outlined the approach that will be taken for the investigation and next steps.

BSW maternity and neonatal service providers have not been identified for inclusion in the planned site visits, however learning from this national review will be incorporated into BSW current and future service planning and quality monitoring.

The Maternity Outcomes Surveillance System (MOSS) has recently been launched nationally and locally. This early safety signal system monitors outcomes and processes at a Trust site level to prompt rapid safety checks and initiate early interventions when unusual patterns occur within Trusts providing maternity care. Initial measures will be for term stillbirths and term neonatal deaths.

Additional tools are planned to be launched throughout Quarter 4 (January-March 26) and beyond, and will be further developed as part of ongoing quality planning, assurance and improvement monitoring including:

- A regional heat map/dashboard for risk assessment across maternity services. this will include safety indicators for each maternity provider and identify variations that signal need for additional review and assurance.
- A national inequalities dashboard.

- Daily Maternity Situation (OPEL) reporting to support provider, system, regional and national identification of need for mutual aid. BSW LMNS is exploring the potential for the data submitted to be visible through Single Health Resilience Early Warning (SHREWD) Database for BSW.
- NHS England Maternal Care Bundle. An evidence based practice focusing on 5 elements of care, namely, venous thromboembolism (VTE), neurology, obstetric haemorrhage, mental health and pre-hospital and acute care.

Infection Prevention Management

The BSW Infection Prevention and Management Collaborative will continue to support and inform infection prevention standards and practices across the current BSW system, whilst cluster arrangements are finalised. This will ensure continued surveillance of healthcare associated infections, provision of clear guidance aligned to evidence based practice (including AMR and AMS) and provision of monitoring and improvement tools aimed at continuously reducing the incidence of avoidable infections, which can have a significant impact on priorities such as Urgent and Emergency Care and Planned Care.

Urgent and Emergency Care (UEC)

Improving safety and experience of care within UEC pathways is central to meeting planning priorities, therefore quality planning, quality control and quality improvement oversight for UEC will include use of defined UEC metrics and a requirement to report against a UEC outcomes framework. Following the publication of Principles for Providing Patient Care in Corridors (NHSE 11th Dec 2025), providers will continue to review and report against their organisation's SOPs to ensure compliance to these principles, recognising the priority aim of eradicating corridor care completely as soon as possible.

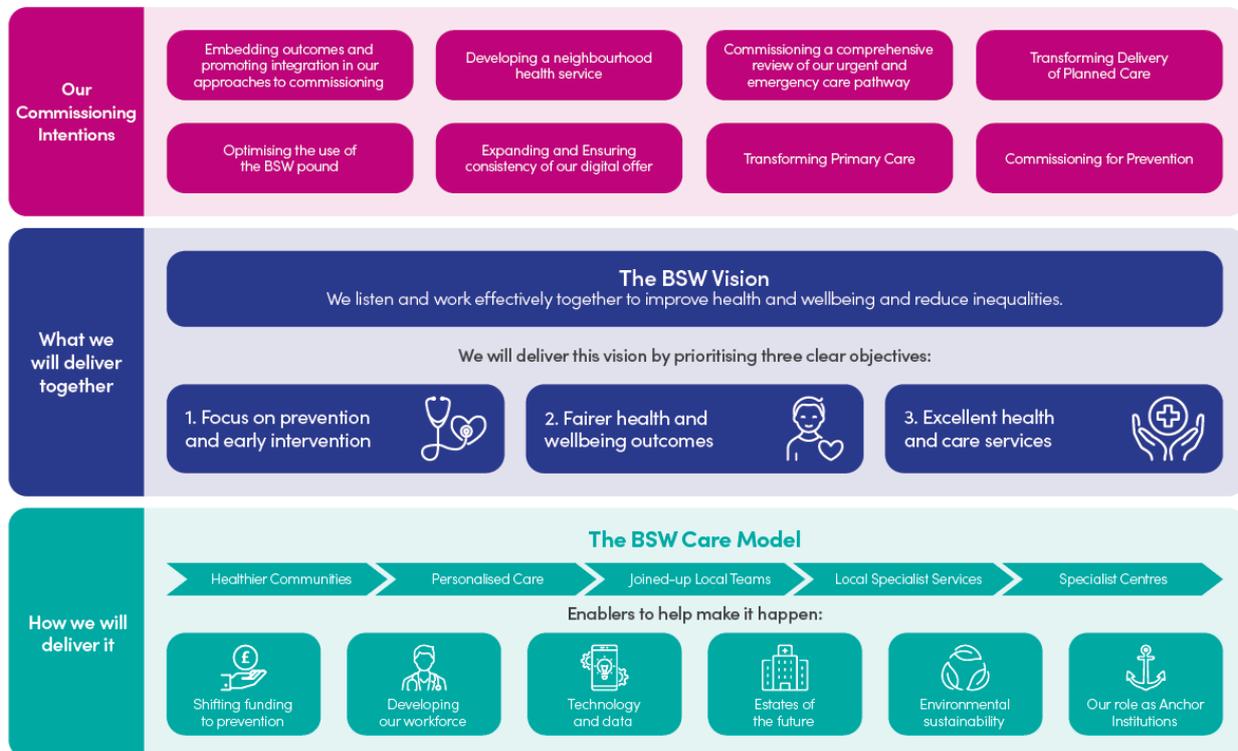
All Age Continuing Care

BSW ICB will continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation while meeting statutory NHS Continuing Healthcare duties. The ICB will prepare for full transition to AACC Data Set v2.0 and its digital infrastructure by March 2027, replacing the current quarterly collection to improve monitoring

5. Vision, Aims and Strategic Objectives



Our Integrated Care Strategy on a page



Our vision: We listen and work effectively together to improve health and wellbeing and reduce inequalities.

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:

- 1) Focus on prevention and early intervention
- 2) Fairer health and wellbeing outcomes
- 3) Excellent health and care services

Following this, we worked with partners to produce the first Implementation Plan demonstrating how we work together as a system and at place level to deliver our ICP Strategy through our Integrate Care Partnership ‘BSW Together’.

Aligning to the NHS 10-Year Health Plan, we are moving to a more ambitious tone and pace, focusing on the three key shifts:

1) Hospital to Community:

- Shifting care delivery from acute settings to neighbourhood-based services
- Establishing Neighbourhood Health Centres as integrated hubs

2) Sickness to Prevention:

- Tackling wider root causes of ill health (e.g., housing, employment, air quality)
- Embedding genomics and predictive analytics in screening and prevention

3) Analogue to Digital:

- The NHS App becoming the central platform for care navigation and self-management
- AI, robotics, and shared care records driving efficiency and personalisation

Our [ICS Strategy from 2023-2028](#) describes our vision and ambitions for BSW in more detail.

Our existing plans align to the 10 year plan though a shared emphasis on prevention, equity, and integrated care and both plans support transformation of outpatient and diagnostic services, with a common vision for personalised, community-based care. To meet our aim of becoming more ambitious in tone and pace, we have identified that we need to reflect the NHS Plan's urgency and radical tone in our five year plan and embedded digital transformation, genomics, AI, and employment support to truly respond to these strategic shifts. The next section sets out our more detailed strategic commissioning intentions over the next five years.

6. Strategic Commissioning Intentions 2026/27-2030/31

Our strategic commissioning intentions set out how BSW ICB will commission to deliver the NHS Ten Year Plan, as we move into a strategic commissioning role working across our BSW, Dorset, Somerset Cluster.

These intentions build on the work that we have already put in place across BSW to implement our BSW Care Model. They aim to set out a roadmap for how we will continue this work, whilst aligning with the Ten Year Plan. However, they are deliberately strategic in nature, and we will be setting out in more detail over the rest of the planning round how we will put these into action.

These intentions have been developed in dialogue and discussion with stakeholders over the recent weeks, and we know that they are widely supported. There is a real commitment across our system to develop on the national vision of shifting care from hospitals into our communities and supporting our populations to stay well for as long as possible. This will help us improve outcomes for our population, which is a commitment we have already made as part of developing our BSW Outcomes Framework.

In BSW, we are facing a significant financial challenge and we know that resolving that challenge can only be done through collective action, and by delivering on the three shifts set out in the Ten Year Plan. This means resetting the way that we are working together across the system, including focusing our collective efforts on reducing unwarranted

variation and narrowing inequalities in outcomes, so that all communities benefit equally from the changes we make.

As part of this reset, we will be clear about our expectations of providers and in turn, what they can expect from the ICB in its role, to support this, we will develop and agree a new accountability framework for the system so that all parties are clear on the roles and responsibilities that we are respectively undertaking.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve outcomes for our population over the next five years. We note that these are strategic commissioning intentions. They are structured thematically, not by provider as we are seeking to enable whole pathway change. They also do not cover the entire range of work that is undertaken by the ICB or partners, this is set out in our [BSW Implementation Plan](#) and the [Companion Document](#).

6.1 Embedding outcomes and promoting integration in our approaches to commissioning

As part of delivering on our care model we developed a system outcomes framework that sets out the improvements in health, equity and quality of life that matter most to our population. This was approved by the BSW ICB Board earlier this year. We want to ensure that all providers are working in support of delivering improved outcomes.

For 26/27, we will embed our system outcomes framework in our contracts with an explicit ask of providers to demonstrate how they are contributing to relevant outcomes, delivering national best practice, acting on patient reported outcomes and reducing inequalities.

Coalescing around our outcomes framework is key to helping us shift from organisational-led planning and delivery of care, into working in a way that supports delivery of better outcomes through integrated pathways.

Population health management will underpin this shift. By linking data, evidence and clinical insight, we will identify the groups and neighborhood's where outcomes are poorest, target resources to those with greatest need, and design services that prevent ill health, reduce inequalities and support people to stay well at home.

This also means having real discussions about value. We will identify where care can be delivered in a setting that adds greatest value for patients and populations, and where duplication or low-value services can be reduced. In doing so, we will explicitly prioritise action in communities experiencing the poorest health and greatest inequity and engage local communities in shaping these changes.

This will therefore also require a comprehensive review of our services with a clear ambition to decommission services that are duplicative or not delivering value.

We will engage with local communities as we do this work making sure that we embed service user voices to co-produce service developments.

Progress to date:

We have made significant progress in this area to date through our portfolios of work supporting delivery of our overarching implementation plan. This has included:

- **BSW Outcomes Framework established and being embedded:** The Outcomes Framework and interactive dashboard are in place and being rolled out through the Intelligence Hub, supporting consistent use of trends, benchmarking, place/PCN variation and inequalities segmentation, alongside guidance and training to support adoption.
- **Outcomes-led governance and deep dives:** The Outcomes Framework is being used to structure Population Health Board deep dives and system performance conversations, bringing partners together around variation and inequalities and informing integrated pathway and commissioning work (e.g., dementia, with a focus on improving diagnosis rates and quality of care).
- **ICBC contract – outcomes-led integration:** Our Integrated Community Based Care (ICBC) contract was commissioned using an ICBC outcomes framework (developed ahead of the BSW Outcomes Framework); it aligns closely and is being reviewed to strengthen alignment further. ICBC provides the delivery platform for integrated models across primary, community and acute care, with a consistent focus on outcomes and inequalities; this includes commissioning work underway for transformed LDAN pathways (reducing out-of-area placements) and embedding CYP early help requirements through ICBC aligned to neighbourhood health and Family Health Hubs.
- **Pooled funding (BCF/Section 75) strengthening integration and accountability:** Through pooled funding arrangements we have strengthened integration and outcome accountability via joint ICB–Local Authority oversight, reporting against BCF metrics, shared performance dashboards and routine provider assurance/contract review, strengthening our ability to track impact, value for money and equity of access.
- **Neighbourhood and place governance aligned to outcomes:** Neighbourhood governance and assurance is in place through Health and Wellbeing Boards, Integrated Care Alliances and the BSW Neighbourhood Health Working Group, bringing system partners together to support integrated delivery. The Outcomes Framework is embedded in Neighbourhood Health Plans to provide baseline outcomes and place-based inequalities insight to drive action on prevention, inclusion and equitable access.
- **Ageing Well / frailty integration:** The BSW Ageing Well Strategy is in place and implementation is underway to deliver more integrated frailty pathways across acute and community settings, informed by a completed Frailty-ED (GIRFT) review (including recommendations for RUH and GWH) and work to scope direct access to acute frailty teams and reduce variation and duplication across providers.
- **Consistent discharge standards across partners:** Work is underway to develop a system wide “Leaving Hospital” framework so providers operate to the same standards and processes, including a clear approach to patient choice and consideration of legal requirements for people with restricted options.

- **System-wide alignment to outcomes (primary care):** Primary care priorities and metrics for 2025/26 have been explicitly mapped to Outcomes Framework indicators, strengthening shared focus on outcomes, prevention and inequalities.

Key Workstreams

Over the next five years we will deliver these intentions through the following workstreams:

- **Outcomes-based commissioning and contracting:** embed the BSW Outcomes Framework into an increasing number of contracts, including commissioning routes in primary care (GP, community pharmacy, optometry and dental), supported by a cluster-wide review of local enhanced/commissioned services (building on the recent BSW LCS review). The ICB recognises the need to identify and agree the proportionate approach to measuring and reporting outcomes for the VSCE sector in undertaking this ambition.
- **Align contract frameworks to transformation priorities:** continue to develop and refine the ICBC outcomes framework, strengthening its alignment to the BSW Outcomes Framework and ensuring it is mapped to, and used to track, transformation priorities.
- **Neighbourhood intelligence to inform joint commissioning:** use Neighbourhood Health data and impact assessment processes (IIA) to inform joint commissioning, capacity planning and prioritisation at place and neighbourhood level.
- **Partner and community insight built into decisions:** strengthen decision cycles by routinely incorporating provider and VCSE feedback, alongside performance and outcomes data.
- **Build the outcomes evidence base (PROMs and placeholder metrics):** strengthen contractual requirements for providers to collect, submit and use outcomes data, particularly patient-reported outcomes and other agreed measures, to address current gaps in the Outcomes Framework. This includes developing and implementing data collection for placeholder measures where data is not yet available (e.g., quality of care in dementia), alongside national best practice and inequalities reporting.
- **Use outcomes to drive collaboration:** use the Outcomes Framework as a practical mechanism to align providers around shared priorities and support collaboration in delivering the BSW care model.
- **Place-based PHM to guide investment and disinvestment:** strengthen population health intelligence and segmentation at place level to target high-need cohorts and geographies and to inform investment and disinvestment decisions within pooled budgets.
- **Value reviews and reducing duplication:** systematically review services for value and impact and decommission or redesign where services are duplicative or not delivering best value, reinvesting where this will improve outcomes and equity.

What it means for the Three shifts

Sickness to Prevention:

- **Commissioning decisions anchored in outcomes and prevention impact:** use the BSW Outcomes Framework and place-based PHM segmentation to prioritise preventive investment, target high-need cohorts and geographies, and track disproportionate improvement for groups experiencing the poorest outcomes.
- **Evidence-led reinvestment:** strengthen value reviews and disinvestment/reinvestment decisions so funding shifts towards interventions with the greatest prevention and inequalities impact.

Hospital to Community

- **Contracting and pooled budget levers to support “care closer to home”:** embed outcomes and integration expectations across an increasing number of contracts and pooled arrangements (including ICBC and BCF/Section 75), aligning providers around shared outcomes and integrated pathways.
- **Single set of place expectations:** use outcomes-based alignment across place governance (ICAs / neighbourhood plans) so partners work to a consistent set of priorities and measures, reducing duplication and unwarranted variation.

Analogue to Digital

- **Outcomes data as a core requirement:** strengthen contractual expectations for outcomes measurement (including PROMs) and require development/collection of data for Outcomes Framework “placeholders” where gaps exist (e.g., quality of dementia care), improving the evidence base for commissioning.

Place analytics for decision-making: build consistent place-level analytics capability to support targeting, monitoring and evaluation, alongside inclusive access approaches to avoid digital exclusion (with delivery actions set out in the Digital commissioning intention).

6.2 Developing a Neighbourhood Health Service

Neighbourhood Health is the organising approach through which BSW will plan, align and commission services at the scale that best reflects how people live their lives and experience care. It is not a single programme or prescribed model. Instead, it provides a shared commissioning and partnership framework that brings together the NHS, Local Authorities, the VCSE sector and communities around agreed priorities, outcomes and population groups at neighbourhood level. This approach supports a shift from reactive and fragmented care towards earlier intervention, prevention and more coordinated support, particularly for people with complex or long-term needs. Engagement with local people and communities is integral to shaping priorities and services.

Neighbourhood Health Plans are the primary mechanism for delivery. They align partners, commissioning intent and outcomes within defined neighbourhoods, providing a shared understanding of population need, inequalities and priorities. These plans are outcomes-focused, informed by population health insight, and enable more targeted and locally responsive commissioning while remaining aligned to system-wide priorities and the BSW Outcomes Framework.

Delivery of Neighbourhood Health in BSW is underpinned by the Integrated Community-Based Care (ICBC) contract. From April 2025, the ICBC contract establishes a community-based partnership to support more joined-up, preventative and personalised care across the life course. Over time, this will enable more care to be delivered in or near people's homes and neighbourhoods, supported by integrated working across community services, local authorities, primary care and the VCSE sector.

As part of this transformation, a stepped care model is being developed with partners. This includes a digital front door and single point of access for patients and professionals, with access to same-day urgent support seven days a week. Integrated Neighbourhood Teams form a core component of the model, bringing together community health professionals, GP and practice colleagues, local authority practitioners and VCSE partners. These teams will initially focus on priority cohorts at highest risk of hospital admission, while developing preventative approaches as the model matures. The digital front door, single point of access and Integrated Neighbourhood Teams are expected to go live from April 2026 and develop progressively over the following one to three years. Over time, access to outpatient services and diagnostics closer to home will also expand, supported by digital tools such as the NHS App.

Alongside the ICBC contract, BSW will develop new single-neighbourhood and multi-neighbourhood contracting arrangements with general practice over time. These arrangements are intended to support neighbourhood delivery and a more unified approach across partners, while existing GP contracts remain in place during transition. Further detail on these arrangements is set out elsewhere in this plan.

From a commissioning perspective, Neighbourhood Health strengthens Place as the level at which joint commissioning, governance and alignment are most effectively brought together. This includes the use of pooled budgets and joint arrangements, such as the Better Care Fund and Section 75 agreements, to support integrated delivery across organisational boundaries. Over time, further ICB budgets may be delegated at place level to support more targeted local investment.

Neighbourhood Health also provides the framework through which wider system reform is integrated locally, including national prevention and early intervention priorities and reforms across primary care, community services, urgent and planned care. The approach is intentionally flexible, recognising variation in population, geography and maturity across BSW, while operating within a shared strategic framework. Neighbourhood arrangements will continue to evolve over the five-year period, supported by outcomes-based assurance and system governance.

For local people and communities, Neighbourhood Health is intended to improve access, experience and outcomes through more joined-up, proactive and preventative support shaped around neighbourhood need. For the workforce, it provides clearer shared purpose, stronger collaboration and more sustainable ways of working across organisational boundaries.

In line with the NHS Ten Year Plan, BSW's ambition is to deliver care as locally as possible: digital by default where appropriate, delivered at home or in neighbourhood settings wherever feasible, and in hospital settings only where necessary.

Progress to date:

- In year 1 of the ICBC contract, the foundations for integrated neighbourhood teams,

the digital front door and single point of access have been put in place. Partnership development with the VCSE sector is underway and key care pathways are being reviewed, and services harmonised to ensure equal access across BSW. New workforce models and roles are being developed to support neighbourhood health including navigator roles that will support people to access the right services for their needs. INTs will be live across BSW by April 2026.

- The development of a 10-year Integrated Estate Plan for Community Based Services is underway, supporting the longer-term shift towards neighbourhood delivery models and care closer to home, with further investment in neighbourhood hubs planned from 26/27.
- Ongoing monitoring of investment in VCSE-delivered services, with an ambition to increase the proportion of spend to 5% by start of 2027/28 where this supports neighbourhood priorities, prevention and inequalities reduction.
- VCSE partners deliver approximately £5.6m of services through the Better Care Fund across the three localities, contributing to prevention, reablement, wellbeing and inequalities reduction.
- Collaborative working with Local Authorities and provider partners across BSW to ensure new social care and education reforms align with health reform to reduce duplication and maximise efficiencies, supporting system coherence.
- Development of a Population Health Improvement Plan aligned to national Neighbourhood Health requirements, triangulating finance, workforce and quality considerations to support deliverability and phasing.
- Early development of Integrated Neighbourhood Teams, supported by a developing neighbourhood outcomes approach that includes population-level indicators such as urgent care utilisation and emergency bed days for the most complex population cohorts.
- Progress on priority population cohorts and prevention-focused pathways, including Hypertension - General Practice pathway transformation to receive more hypertension case finding, Community Blood Pressure Checks and Outreach Health Checks, Health Coaching and Community Empowerment
- Development of an integrated weight management model that supports adoption and implementation of new drug-based treatments as well as non-medical support (healthy eating programmes, exercise management, psychological support)
- Monitoring and implementation of a programme for systematic development of integrated, risk stratified, MECC enabled pathways across Community, Primary and Acute services, aligning with GIRFT
- Delivery of the system wide clinical frailty strategy
- Strengthening of community vaccination infrastructure to support access, prevention and population coverage.

Key Workstreams

Over the next five years we will deliver these intentions through the following workstreams:

- Neighbourhood Health services will continue to be developed through the following strategic workstreams, recognising local variation in pace and maturity:
- Develop locality-based Neighbourhood Health Plans that define shared priorities and outcomes and commissioning intent for each population working jointly with general practice, planned and proactive care. Population segmentation and population health management insight will inform these plans. ICAs will work with

Health and Wellbeing Boards to develop plans and initiatives that tackle the wider determinants of health and create connections between community assets and health outcomes.

- Embed Integrated Neighbourhood Teams as the visible organising structure for neighbourhood delivery, with local flexibility in form and phasing. This includes early consideration of children and young people, prevention and wider determinants of health from the outset and aligning with wider system reform programmes including the Families First Partnership Programme. This includes consideration of children and adults with learning disabilities and autistic people as priority cohorts within neighbourhood planning and delivery. This will be supported by continued engagement with service users, the VCSE sector and targeted population cohorts.
- Building on the ICBC contract as the delivery vehicle for Integrated Neighbourhood Teams (INTs), supported by the wider community stepped care model, and working in collaboration with wider partners including PCNs, local authorities and the VCSE, to embed the six initial core components of the Neighbourhood Health Service.
- Strengthen joint commissioning and shared accountability across ICB and Local Authorities through the Better Care Fund and other pooled budget arrangements, ensuring alignment with neighbourhood priorities.
- Collaborative development of Neighbourhood-level outcome measures and evaluation methods with providers, including acute, VCSE and local authority partners aligned to the BSW Outcomes Framework, the ICBC outcomes framework and focused on learning and improvement.
- Using the opportunity and capacity that wider primary care offers (including community pharmacy, optometry, dentistry) to improve access, support urgent care, deliver prevention and reduce health inequalities in local neighbourhoods.
- Supporting stronger relationships between providers and local populations to build trust and encourage active participation in health decisions.
- Work with primary, secondary care and wider partners to deliver a transformation in outpatient referral, diagnostic and treatment pathways which will lead to a year-on-year increase in outpatient activity in community and neighbourhood settings beginning with priority pathways and helping people to access care closer to home.

What it means for 3 shifts

Sickness to Prevention

Neighbourhood Health supports a stronger focus on prevention and early intervention, aligned to national public health priorities and delivered through our neighbourhood teams and community stepped care model. This includes continued expansion of vaccination, screening and proactive case finding, informed by population need and neighbourhood insight. Over time, neighbourhood teams will increasingly use genomic approaches to help identify patients at risk of developing long term conditions.

Hospital to Community

Neighbourhood Health provides a clear direction of travel towards more care being delivered in community and neighbourhood settings, where this improves outcomes and experience. The stepped care model will support people with easy access to advice and support through the digital front door and single point of access, which will also co-ordinate strengthened urgent and planned care services, enabling more people to be treated in their own homes and where they live. People who need more specialist support will receive this in the community unless it is required in an acute setting. Integrated

neighbourhood teams (our teams of teams) will bring together partners to share information, expertise, advice and provide coordinated and joined up care, supporting more people to remain at home. This will be supported by joint commissioning approaches and appropriate use of community and neighbourhood infrastructure, recognising that models and pace of change will vary locally. On a phased basis, the number of integrated care centres / neighbourhood hubs will be expanded across BSW, allowing patients to access several services as part of a “one stop shop” offer and professionals to share accommodation, increasing communication and multi-disciplinary working.

Analogue to Digital

Neighbourhood Health will be supported by progressive improvement in digital access and information sharing across settings, enabling more joined-up care, improved population insight and better engagement with local communities, in line with wider system digital strategy. Through the ICBC contract, a digital front door for patients will be live from April 2026 enabling them to have easy access to information, make referrals and request support. The digital front door will support a single point of access for both patients and professionals and will be fully integrated with the NHS app which will be the future route for patients to manage their care digitally. As part of our community and neighbourhood transformation, use of the integrated care record will increase 10% year on year, and remote monitoring will expand by 25% each year to support people with long term conditions and those cared for at home will be expanded. Professionals will also have access to all diagnostic tests for their patients.

6.3 Commissioning a Comprehensive Review of our Urgent and Emergency Care Pathway

We know from a wealth of evidence, including our case for change, an ICB led review into demand, and our recent engagement activities that we need to ensure we have a sustainable urgent and emergency care (UEC) pathways that meets the needs of our current and future population. We have already made significant investments in some areas of our UEC pathway, including the development of Urgent Treatment Centres (UTC's) and Same Day Emergency Care (SDEC) services in our acute hospitals. We have also commissioned BSW Community Health as part of our Integrated Community Based Contract (ICBC) contract to review the provision of some of our UEC services e.g. Minor Injury Units (MIUs) and virtual wards (Hospital at Home).

It is our intention to work with all partners to undertake a collective review of urgent and emergency care demand and capacity the whole pathway, with the aim of ensuring that we have a plan to deliver a pathway of care that is fit for purpose for our future population and the envisaged demand. This will need to include services that we jointly commission with other ICBs as well.

We will undertake this over the rest of this year, with the aim of identifying any gaps in our existing commissioning and including them in our detailed commissioning intentions for next year.

Progress to date:

- Same Day Emergency Care (SDECs) -- Undertake a comprehensive review of existing SDEC pathways, along with peer-to-peer learning and implementation of profiles on the Directory of Services Commissioning a comprehensive review of our UEC Pathway
- Frailty Strategy / Pathways / Frailty-ED (GIRFT) - Embedding outcomes and promoting integration in our approaches to commissioning, developing a systemwide Frailty Strategy that all partners are signed up to
- Co-located Urgent Treatment Centre (UTC) at SFT -- In line with national recommendations, the capital works are underway
- Hospital at Home maximisation - Embedding outcomes and promoting system integration in our approaches to commissioning to provide equity of services
- Hear and Treat and See and Treat - Commissioning a comprehensive review of our UEC Pathway. BSW have good Hear & Treat rates compared to other systems, work in place to maintain this and further work to increase See & Treat rates
- Mental Health vehicles & service desk now in place with MH vehicles live from October 25
- Pharmacy First expansion with Pharmacy First referrals live from RUH and planned go live for GWH in Q3
- Enhanced ED Validation via Healthhero Pilot undertaken Jan – Mar 25 which showed positive outcome. Healthhero commissioned from 24th October until end March 26 to run this service
- Maximisation of Care Coordination Centre which is led through Community Delivery Group and sub-contracted by HCRG to Healthhero

Over the next five years we will deliver these intentions through the following workstreams:

Key Workstreams

- Identify any gaps in our current commissioning by undertaking an end to end pathway review, and including them in our detailed commissioning intentions for next year.
- Systemwide engagement to develop pathways providing equity of service for patients across BSW. Strengthen community offers and dedicated specialist support to reduce preventable crisis attendances and admissions, learning from commissioning of inpatient, outreach and enhanced community offer in 25/26.
- Commission Hospital @ Home for other pathways, for example paediatrics.
- Review of Urgent Treatment Centres, to support the shift from MIUs to UTCs, as well as implement co-located UTC at SFT and review of UTC at RUH with opportunity to relocate.
- Develop a fully joined up strategy and pathway for frailty patients.
- Strengthen the Place commissioning role in flow and discharge through the Better Care Fund and Section 75 agreements and use pooled funding to integrate intermediate-care capacity across NHS and social-care partners.
- Increase use of services in Community Pharmacy, Optometry and Dentistry, to support patient access and reduce pressures on general practice and UEC settings.
- Use our commissioning levers to end the use of inappropriate out of area placements for mental health so people remain connected to their support networks and local teams.

- Further the implementation of our mental health strategy, including commissioning mental health community rehabilitation, and crisis alternatives reserving inpatient beds for the most complex needs.

What it means for 3 shifts

Sickness to Prevention

- Signposting for patients and public to encourage self-care and prevention

Hospital to Community

- Increase the use of services in the Community Pharmacy, Optometry and Dentistry to reduce pressure on hospitals
- Commissioning Hospital @ Home for pathways like paediatrics

Analogue to Digital

- Use digital technologies to enable a more streamlined pathway for patients and utilise tools such as remote monitoring.

6.4 Transforming Delivery of Planned care

The NHS Elective Reform Plan set out a clear requirement for transformation for planned care services. This is key to ensuring we are delivering the Referral to Treatment 18 week target by March 2029, but also as part of our wider commitment to invest more in prevention and keep people well outside of hospital.

A key focus will be to ensure a partnership between primary, community and secondary care so that most people are managed in neighbourhoods, avoiding unnecessary attendances and keeping hospital capacity focused on complex care. We will explore options for radical change in service delivery or recommissioning with a specific focus on ENT, gastroenterology, respiratory, urology and cardiology as priority services set out in the elective reform guidance. We will also consider fragile services in BSW such as dermatology. We will do this in collaboration with BSW Hospitals Group to confirm these are the right services to look at first, as we also explore options for contracting models.

Across all of our planned care services, we will need to make the most of the available digital technologies to enable a more streamlined pathway for patients, and to move away from a traditional referral approach to a joint approach between primary and secondary care. We will seek to put these arrangements in place in line with the national direction of travel, working with primary and secondary care colleagues to agree this. The ICB has a plural market of acute, independent sector, and community/primary care based alternatives to hospital care.

The ICB will work with all providers to ensure common application of clinical standards and practices, enabling choice whilst also reducing referral rates where clinically appropriate. We will embed these requirements as part of our contracts and be clear on our expectations with regards to a reduction in long waits, removal of variation in performance and better management of system demand.

We have also heard from our engagement work that we need to review our diagnostic provision and make sure that our strategy works towards making our facilities as accessible as possible to the public.

Progress to date

- We have opened up three new diagnostic centres (in Bath, Swindon and Salisbury) providing services such as X-rays, MRI and CT scans, blood tests, ultrasounds and endoscopies, in the community.
- Reduced waiting times so that no-one in BSW will wait longer than 65 weeks by March 2025
- Increased activity across the footprint using the independent sector
- Improved access to diagnostics, delivering planned reductions in diagnostic waiting times
- Commissioned and developed new capacity at Sulis Hospital
- Commenced work on pathway transformation in core areas
- Implemented a Community Pharmacy Blood Pressure Check Service, including supporting VCSE with outreach clinics
- Developed a New Medicines Service
- Integrated dashboard for elective for BSW
- Discharge Medicines Service

Over the next five years we will deliver these intentions through the following workstreams:

Key Workstreams

- Commission services that enable a radical change in service delivery or recommissioning for ENT, Respiratory, Cardiology, Urology, Dermatology and Gastroenterology. This will require a whole system focus, creating end-to-end pathways that make best use of primary care, community and secondary care expertise at the right point in the care pathway.
- Ensure that delivery models support earlier access to elective intervention and address the disproportionate impact of long waiting times on Children and Young People.
- A shift away from a traditional referral approach to a joint approach between primary and secondary care and we will be implementing nationally mandated changes to Advice and Guidance to create a 'discuss with' rather than 'refer to' model.
- Embed clinical standards and practice in our contracts e.g. GIRFT so that we ensure patients are able to access the right service for their needs, and we reduce the number of procedures of limited clinical value at all providers. .
- Straight to test pathways for clinically appropriate patients, with the 10 largest specialties by volume (all specialties by 2029).
- Right sizing our diagnostic provision to ensure we make best use of all available capacity (including CDCs) and to enable delivery of redesigned care pathways and using future capital to invest in more diagnostic capacity to support our neighbourhood health ambitions.
- Commission new or improved pathways that support faster diagnosis of cancer – including addressing current inequalities in uptake of screening across our population and making best use of new AI and digital tools.
- Begin scoping for genomic screening integration and workforce training
- Transformation to an all-age needs-based Neurodiversity pathway through our ICBC Programme, VCSFE waiting well support and National ADHD Service Development Programme.

- Transformation of CYP community pathways including sleep and neuro-disabilities through our ICBC programme.
- Commission new or improved pathways that support faster diagnosis of cancer – including addressing current inequalities in uptake of screening across our population.

What it means for 3 shifts

Sickness to Prevention

We will deliver the Referral to Treatment 18-week Referral to Treatment (RTT) target by March 2029 through maximising capacity within all our commissioned services and investing in preventative services to keep more people well outside of hospital. This will include developing new care pathways that provide earlier access to specialist provision in our communities, linked with our neighbourhood health ambitions.

Through straight to test pathways and increased use of community diagnostics, enabling earlier diagnosis to prevent deterioration, and enabling more people to be managed in community settings.

The delegation of screening commissioning to ICBs affords the opportunity to consider how and where our screening offers are provided. We will work with partners across our system to ensure that service provision continues to reflect population health needs and we maintain strong levels of uptake in core screening programmes. We will ensure that commissioned activity provides sufficient capacity for us to act rapidly where people require further intervention, with the intention to increase the number of people treated with lower grade cancers.

Hospital to Community

Through integrated care pathways, we will maximise the expertise that exists in primary, community and secondary care so that a greater proportion of the care pathway is delivered in a community setting. This will avoid the need for people to travel to hospital settings and ensuring that specialist capacity is focused on the most complex care. We will align delivery with our neighbourhood health and needs, with tailored offers that reflect population health needs.

We will continue to commission capacity from a range of providers, maintaining our commitment to supported patient choice in BSW. We will require all partners to work within our integrated care pathways so that people can be confident that they will receive the same level of service wherever they choose to receive treatment

Analogue to Digital

In line with national guidance, we will use digital technologies to enable a more streamlined pathway for patients and move away from a traditional referral approach to a 'discuss with rather than refer to' model. We expect that this will provide operational efficiencies, ensuring that face-to-face capacity is used for those people with more clinically complex needs. This new model will be deployed across all providers.

We will ensure that signposting to enable active waiting for patients is delivered through the NHS App, so that more people have easy access to information about how they can self-manage whilst they wait for interventions – improving outcomes and engagement.

We will work with the BSW Hospitals Group to ensure that opportunities to improve productivity through application of AI are maximised.

6.5 Optimising use of the BSW pound

In order to support delivery of the above commissioning intentions, we need to move to a new financial framework across the system that prioritises investment in the left shift of care and prevention of ill health. As set out earlier in this document, returning the system to financial balance is a key part of our plan to ensure that we can continue to provide efficient and effective services.

The majority of our Provider contracts are mostly either fixed or item of service based. We will need to move to contracts that better support the type of change we are seeking to achieve in the areas described above, this could include alternative payment models that can be aligned to different outcomes, support transformation and incentivising whole pathway improvements or lead provider models (where appropriate) to incentivise collaboration with clear requirements to sub-contract with other providers, including VCSE.

We intend to align deficit support/transitional support funding paid to intra-NHS providers to service transformation and whole pathway improvement. Achieving this change is critical to returning to financial balance and allowing us to spend deficit support in ways that deliver more value for our population.

Progress to date:

- As part of the 26/27 plan, we have ringfenced 0.6% (c.£12m) for investment in transformation and key enabler schemes. The schemes will be agreed through the Investment Committee framework process.
- In addition, a further £5m has been set aside to support mitigations of ambulance demand. The schemes are being developed using the same protocols.
- As per the medium term plan the system will be breakeven in year two.
- Schemes are in place for prevention and health inequalities funding.

Over the next five years we will deliver these intentions through the following workstreams:

Key Workstreams

- We will drive equity and optimise the use of the BSW pound.
- The system must be financially sustainable by the end of year 2 with the ambition to eliminate the underlying deficit as deficit support funding and transitional support funding is removed.
- Our ambition is to generate an annual transformation fund of 3% for reinvestment in initiatives that support local commissioning priorities each year over the life of the plan. This will start at 0.6% and grow by 0.6% each year. (generating the required 3% non-recurrent surplus by year 5).
- We will make greater investment upstream in demand management schemes and agree a roadmap to move acute based services to more appropriate settings.
- We will commission for outcomes and value and will support a change in how

resources are deployed with the rate of expenditure growth increasing into services outside hospitals, drugs and digital to manage the levels and impact of demand on acute. (£10m from year 1). By year 5, we will aim to increase our contracts linked directly to outcomes from 5% to 25%.

- Collaboration will be incentivised with clear requirements to sub-contract with other providers, including the VCSE sector.
- Improved targeting of allocations based on the data from population health management to remove variation in provision and outcomes and align funding with need.
- Devise and set clear ROI criteria and critical success factors for all service expenditure including robust business cases to inform service changes.
- Identify two pathways or conditions areas where we can test new payment approaches.
- Support increase in High-Value prescribing equitably across the system

What it means for 3 shifts

Sickness to Prevention

- Drive transformation, integration and the shift from sickness to prevention.
- Improved targeting of allocations based on the data from population health management to remove variation in provision and outcomes and align funding with need.

Hospital to Community

- Shift more care to the community using the new ICBC contract
- Development of the annual transformation fund to reinvestment in initiatives that support local commissioning priorities

Analogue to Digital

- Support change in how resources are deployed with the rate of expenditure growth increasing into services outside of hospitals, including digital to manage impact on hospitals

6.6 Expanding and Ensuring Consistency of our Digital Offer

The ICB published a 5 year Digital Strategy in March 2023 that is now being refreshed in light of the ten year plan publication and the shift from analogue to digital.

We will commission in a way that ensures digital is the default for access, information and follow-up, supported by inclusive alternatives to avoid digital exclusion. This includes expanding the use of the NHS App as a single digital front door, ensuring shared care records are accessible across providers, and embedding approaches such as patient-initiated follow-up and remote monitoring where clinically safe.

This means that we need to commission services that are aligned an integrated digital footprint, with a clear expectation that all providers will use the suite of national tools that are available such as the Federated Data Platform:

- Commissioning for responsible innovation, enabling providers to exploit new technologies, such as those that use AI, to deliver more efficient and safer pathways of care. Tools will be deployed in line with national guidance such as the Digital Technology Assessment Criteria, (DTAC) and be evaluated to evidence benefits
- Commission clear requirements for providers regarding digital exclusion and NHS app integration, e.g. outreach work into disadvantage communities, improved engagement with “Get Connected” groups, development of ICS digital inclusion roadmap.
- Commission the integration of the NHS App and a single digital front door, to ensure providers have contractual obligations to integrate with the NHS App once onboarding for the sector is available nationally.

Progress to date

- 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.

Key Workstreams

- Extension of the deployment of the Integrated Care Record; new partners, use cases, data, infrastructure, and user interface.
- Implementation of Acute EPR programme in preparation for go live in 2027/28.
- Expansion of AI policies, guidance, training and governance within organisations to support AI adoption as part of overall digital roadmaps. Implementation of specific AI-enabled pilots in areas such as Ambient Voice Technology, administrative workflows, Referral triage and decision support, and others.
- Convergence onto single key cyber tooling across BSW Hospitals Group, SIEM to sentinel clustering once available nationally, improvement in organisations' ICS cyber score.
- Working with partners and the public to increase uptake and usage of NHS App.
- Expansion of national and local product incubation of the Federated Data Platform. Products include Cancer360, PLICS, Shared PTL and ICS PHM.
- Consolidation of infrastructure across Hospitals Group and across ICB cluster.
- Transition away from bleeps for Hospitals Group (subject to business case approval), streamlining of community based acute services connectivity provision, single service management tool across Hospitals Group
- Development of a plan to improve digital literacy offer across the Hospitals Group

- Baseline exercise to understand capability and identify gaps in DDAT Digital Skills
- Support providers to design pathways that allow patients to take greater control of their own health management through using wearables, remote monitoring and virtual support.

What it means for the 3 shifts:

Sickness to Prevention:

- Promoting early intervention to address issues before they escalate, improving long-term outcomes.

Hospital to Community

- Making health services more efficient, safer and provide a better patient experience so that patients can access support through the use of technology in their communities

Analogue to Digital

- Digital Transformation and GPIT
- Prioritised digital inclusion through targeted outreach and training

6.7 Transforming Primary Care

Primary Care including general practice, community pharmacy, primary care dentistry, and optometry is central to the delivery of the NHS Ten Year Plan and the transformation ambitions of the new NHS operating model.

In BSW, Primary Care providers deliver the vast majority of patient contacts and are critical to enabling the shift from hospital to community, supporting prevention, and improving population health outcomes. Primary Care are key to delivering the neighbourhood health service vision, reducing unwarranted variation, and improving access and equity across all contractor groups. Our goal is therefore to enhance efficiency and integration across out of hospital care.

We recognise that each Primary Care sector operates under nationally negotiated contracts and frameworks, which provide consistency and clarity across England. However, in BSW we are committed to ensuring that these national arrangements do not constrain local innovation, improvement, or integration. This includes building on the ICBC contract and expanding Integrated Neighbourhood Teams (INTs) to deliver joined-up care across general practice, pharmacy, dental, and optometry, alongside community and mental health services.

Progress to date:

- Delivering modern general practice and targeted support to identified practices, focusing on high-impact patient contacts and efficient care models.
- Reviewing the commissioning for frailty (including Transforming Care in Older

People in Wiltshire) to align with BSW Frailty Programme including Care Home support through INTs and Primary Care Networks and domiciliary dental care.

- Strengthening partnerships between primary care, community services, and urgent care providers to improve patient flow and reduce demand on GP appointments.
- Developing and implementing a primary care workforce strategy for all primary care contractor groups.
- Contributing to implementing a system-wide, collaborative approach to the secondary prevention of cardiovascular disease by increasing case finding and optimising hypertension management.
- Creating additional capacity for urgent dental care across the system
- Community services dental review
- Ensuring all GP practices are transitioned onto a compliant online consultation product
- Maximising community pharmacy services (inc. BP monitoring and contraception) and the use of prescribing qualifications to move services closer to home by expanding the roll out of Pharmacy First.

Key Workstreams

- Develop our approach to Integrated Neighbourhood Teams (covered earlier in this document) and ensure that primary care services are at the heart of emerging neighbourhood working.
- This will include making sure that we are working together to put in place strategies for optimising the management of long-term conditions, improving frailty care and ensuring continuity of care.
- As part of this, we will engage with Primary Care on embedding Population Health Management as set out in the Neighbourhood Health Framework.
- All primary care providers will be engaged in development and maturation of Neighbourhood health models based on the needs of the population.
- We will utilise population segmentation to support signposting to the most appropriate location, developing multidisciplinary teams in at-scale urgent care hubs.
- This will allow GP practices to focus on the more complex patients and the low complexity to be managed by other health and social care professionals.
- We will develop Primary Care specific Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) to ensure a patient focus for outcomes regarding any interventions. This will identify any barriers to access as well as improve responsiveness to demand, leading to better health outcomes.
- We will commission approaches that enable patients to access care through multiple channels including telephone, online, NHS App, and walk-in supported by structured information and clear signposting. PCNs will be expected to lead improvement in access by optimising capacity, deploying multi-professional teams, and using digital tools effectively and appropriately. For example, online access for non-urgent queries, digital long term condition management to upload measures such as blood pressure and glucose readings.
- We will also strengthen the role of community pharmacy and optometry in urgent care navigation, ensuring patients can access timely advice and treatment closer to home. National requirements such as GP Connect functionality will be embedded,

alongside initiatives like Pharmacy First, to reduce pressure on general practice and improve patient experience.

- We will commission urgent dental care services to continue to reduce the demand on other services, increasing activity in line with national targets.
- We will work jointly to support primary care to improve recruitment, training, retention and job satisfaction cross all primary care workforce.

What it means for the 3 shifts:

Sickness to Prevention:

- Promoting early intervention to address issues before they escalate, improving long-term outcomes.
- Utilising population segmentation to identify patients before they experience negative health outcomes to stay well and stay at home

Hospital to Community

- Using patient experience to improve accessibility of the most appropriate service closer to the patients home e.g. Pharmacy First and online access
- Align ICA priorities with emerging neighbourhood health plans

Analogue to Digital

- Development of digital services being used by providers e.g. AI transcription, triage and data processing, as well as use by patients, e.g. uploading health data digitally
- Prioritised digital inclusion through targeted outreach and training

6.8 Commissioning for Prevention

Prioritising the focus on prevention is essential for delivering high-value care, improving population health, reducing future demand on services, and tackling health inequalities. Early identification and intervention help people live longer, healthier lives while ensuring resources are used where they have the greatest impact.

Shifting from sickness to prevention, central to the NHS Ten-Year Plan and our BSW Care Model, requires funding for value, not activity: moving resources from treatment to earlier, higher-impact prevention interventions that improve outcomes, cut inequalities and reduce avoidable demand.

We will commission end-to-end pathways for prevention utilising Population Health Management (PHM) methods. We will align commissioning with local authorities to coordinate coherent prevention pathways, ensuring continuity from early identification through to treatment and maintenance. Building on tobacco dependence and cardiovascular risk, we will selectively invest in high impact, major modifiable risk factors (tobacco, alcohol, obesity, cardiometabolic risk). Neighbourhoods will be a focal point, uniting partners around shared outcomes.

Progress to date:

- **Treating Tobacco Dependence (TTD):** A system-wide commissioning model has

been agreed to stabilise and scale TTD as a priority prevention and inequalities intervention from April 2026 (2026/27), including recurrent funding and a preferred Host Trust approach to standardise pathways, reporting and delivery across acute, maternity and mental health settings, with mobilisation underway.

- **Hypertension early detection and optimisation:** We have developed a whole-system approach to improve early detection and optimise hypertension management, building delivery across general practice, community pharmacy and VCSE outreach with an explicit focus on reach into Core20PLUS communities and evaluation of impact.
- **Weight management pathway development:** Work has progressed to develop an integrated weight management approach that brings together behavioural support and pathway redesign (and, where appropriate, the introduction of new treatment options) to improve access, reduce waiting times and support healthier weight outcomes, with an explicit focus on equity of access.
- **Alcohol-related admissions deep dive (in progress):** The Population Health Board has initiated an outcomes-led deep dive into alcohol-specific admissions, with the first session completed and a second session planned to agree a focused set of partner-owned recommendations. Early findings highlight the importance of using peer benchmarking (not just England/SW averages), understanding local variation (including PCN-level variation), and targeting action to narrow inequalities (Core20 deprivation gap, SMI and LD), with work underway to strengthen locally usable indicators and ongoing monitoring.
- **Targeted vaccination delivery:** We have strengthened our Community Vaccination Hub model to improve targeted Covid-19 and flu vaccination uptake for priority groups.
- **BCF/VCSE prevention delivery infrastructure:** VCSE partners currently deliver around £5.6m of BCF-funded services across BSW, contributing to prevention, reablement, wellbeing and inequalities reduction, with joint ICB/LA oversight through BCF/Section 75 governance and structured locality engagement.
- **ICBC prevention levers:** The ICBC contract includes prevention outcomes within its outcomes framework and an expectation to increase investment in the VCSE sector, strengthening community-based prevention and earlier intervention closer to home.

Over the next five years we will deliver these intentions through the following workstreams:

Key workstreams:

- **Deliver the BSW Prevention Strategy and Plan (Prevent–Reduce–Delay):** Implement the agreed prevention approach across partners and places, embedding prevention consistently in neighbourhood, community and system delivery. The Prevention Strategy (2025–28) and Prevention Plan are currently in draft and will be finalised and ratified through 2025/26, enabling delivery from April 2026.
- **Baseline prevention spend and shift investment over time (2025/26):** Establish a system-wide baseline for prevention spend across NHS, Local Authorities and VCSE, and agree a multi-year ambition to increase the proportion of total resources invested in prevention, governed through a prevention outcomes and inequalities framework aligned to the system outcomes framework to ensure investment shifts are evidence-led and deliver measurable impact.
- **Commission end-to-end prevention pathways (clear provider expectations):** Commission and/or align whole pathways spanning identification, brief intervention,

treatment, maintenance and relapse prevention, aligning funding to outcomes and equity with clear expectations for pathway leadership, collaboration and shared outcomes across providers, and optimising existing investment where possible.

- **Align prevention commissioning with Local Authorities (single pathway approach):** Strengthen NHS–Local Authority partnership working so prevention services operate as a single pathway (e.g., smoking cessation and alcohol harm), with continuity across settings and clearer accountability for outcomes and inequalities impact.
- **Grow VCSE and community delivery (building on the 5% ICBC requirement):** Expand community-based prevention delivery in trusted settings, building on the ICBC commitment to increase VCSE investment, targeting high-need cohorts and geographies to improve equity of access and measurable prevention outcomes.
- **Utilise all care providers in delivery of prevention:** Providers such as Community Pharmacy have a key part to play in the delivery of prevention, widening access in harder to reach communities.
- **Focus on the highest-impact prevention priorities:** Concentrate system effort on tobacco, obesity, harmful alcohol use, polypharmacy (compliance and safety) and cardiometabolic risk, spanning identification through to relapse prevention. This includes scaling priority programmes such as hypertension expansion into broader CVD prevention, an integrated obesity/weight management pathway, optimised smoking cessation/TTD, improved vaccination uptake (including targeted flu and Covid-19 programmes), increasing the prescribing of high-value CVD medication, and the alcohol-related admissions deep dive actions as they are agreed—supporting the NHSE target to reduce CVD premature mortality by 25% over ten years.
- **Measurement and evaluation (provider contribution):** Develop a consistent prevention measurement and evaluation approach, agree a core indicator set (including inequalities breakdowns), and, where data gaps exist, require providers to develop and implement outcomes data collection and reporting so prevention impact and value can be tracked over time.
- **Delivery Groups drive implementation and assurance:** Delivery Groups are the mechanism for implementing prevention actions across the system, with each Delivery Group accountable for a defined set of prevention deliverables and for reporting progress and impact through system governance.
- **Providers as anchor institutions (coordinated system approach):** Set a clear expectation that NHS providers act as anchor institutions—using their influence, assets and employment power to improve health and reduce inequalities—and coordinate this activity across the system so it adds value, avoids duplication and aligns with neighbourhood priorities and prevention outcomes.

What it means for the 3 shifts:

Sickness to Prevention:

- **Shift commissioning and investment upstream:** establish the baseline prevention spend and a multi-year ambition to increase the proportion of resources invested in prevention, governed by a prevention outcomes and inequalities framework.

- **Commission end-to-end prevention pathways:** align funding to outcomes and equity across tobacco, cardiometabolic risk (hypertension→CVD), healthy weight, harmful alcohol and medicines safety—spanning identification through relapse prevention.
- **Use every setting as a prevention touchpoint (examples):** utilise community pharmacy to deliver key prevention interventions (e.g., BP checks, smoking cessation support, contraception/EHC where relevant) and implement the vaccination strategy so people can receive the right vaccines at the most appropriate point in their pathway.

Hospital to Community:

- **Deliver prevention closer to home through neighbourhood and community models:** grow VCSE and community delivery in trusted settings and use neighbourhood teams to provide earlier intervention for high-need cohorts and communities.
- **Integrate NHS and Local Authority prevention into a single pathway (hospital → community):** Align LA and NHS offers so needs identified in hospital are routinely followed through with timely referral into community-based support, reducing avoidable escalation and repeat use of urgent care.
- **Strengthen place and neighbourhood leadership and alignment (examples):** strengthen community pharmacy leadership within neighbourhoods; link community-led approaches (including outreach) to pharmacy prevention services (e.g., BP checks); align ICA priorities with neighbourhood health plans.

Analogue to Digital:

- **Measure and manage prevention as outcomes-led commissioning:** agree a core prevention indicator set (with inequalities breakdowns) and require providers to improve data capture where gaps exist so impact can be tracked consistently.
- **Target population health management using place analytics:** build place-level analytics capability to identify high-need cohorts/geographies and target prevention investment and outreach.
- **Digital inclusion by design:** ensure prevention offers are “digital-first where appropriate” with inclusive non-digital routes, supported by targeted outreach, training and accessible communications.

7. Strategic Commissioning Capabilities

The Strategic Commissioning Framework (2025) describes that ICBs will need the following to be successful in their role as strategic commissioners:

- capability in strategic leadership and partnership working with other commissioners, providers, local government and service users to co-design services and improve population outcomes
- effective and broad multidisciplinary clinical and professional leadership embedded in how they work to drive cross-organisation improvements
- access to high quality data analysis, sustained and meaningful engagement with people and expertise to inform decision-making and target interventions. This will include having a greater understanding of how to identify geographical and demographic inequalities and what is working well locally and elsewhere, and greater use of technology in the solutions commissioned.
- triangulating demand analysis with
- an ability to involve people and diverse communities and understand their experiences through asset-based approaches that facilitate co-production and empower community-driven solutions
- strong relationships with their local government partners (including adult social care, children's services, housing and public health) within their footprint; to build a shared understanding of their population and work together to improve outcomes, tackle inequalities and develop neighbourhood health
- an ability to use market management (including modelling impacts of shifts of activity between care settings by triangulating forecast demand analysis with needs based intelligence), contract management and procurement mechanisms to support a focus on quality, value for money and delivery of improved outcomes
- to develop a shared understanding with providers of current and future delivery costs, ensuring each investment improves access, care quality, efficiency and outcomes
- to develop the skills and capability of the workforce and effectively deploy it across the whole health and care system, to deliver effective strategic commissioning

As an ICB and in our new role as strategic commissioners, we are committed to developing the skills and capability we need to fulfil this role. From 26/27, we will start changing this by working with providers to move funding towards local, outcome-based care. This means care will be fairer, more patient-focused, and give better value for public money. Our goal is to improve people's experience and health outcomes. To do this, we will move from planning based on historic activity and organisations, to commissioning based on needs and outcomes alongside activity.

- Maintain strong engagement with patients, carers, and communities to co-design services.
- Provide regular updates to stakeholders to ensure alignment and shared learning.

Through these coordinated efforts, BSW ICB will deliver transformation programmes that improve access, outcomes, and sustainability, while enabling the shift of care and resources from acute settings to community-based services.

In developing a more sustainable approach to transformation and enabling this 'left shift' we have recognised that a new approach is required to start changing the dialogue to shift of resources and ways of working to deliver major transformation. To support this, a ring-fenced fund for Transformation has been created for BSW, for 26/26 this will be £11.6 million (0.6%) which will not be used for deficit reduction. The purpose of the fund is to enable changes that cannot be funded through baseline allocations, removing structural barriers to efficiency, productivity, and quality and to create enduring benefits that release capacity, reduce avoidable cost, or materially improve outcomes in subsequent years. It must also enable better value from annual running costs. The fund should not be used to plug recurrent deficits, support additional capacity or support business-as-usual delivery, temporarily prop up unsustainable services, fund activity growth without system redesign, or create additional net recurrent cost to the system baseline.

All proposals to the fund should align to a set of principles as follows:

1. Non-recurrent, enabling investment-one-off spend that unlocks future benefit (e.g. digital, estates reconfiguration, capability build, transition costs).
2. Clear line of sight to recurrent benefit-benefits realised in FY 2025/26 and beyond, such as:
3. Cash-releasing savings
 - Capacity release (clinical and managerial)
 - Avoided cost growth for the three BSW acute providers (ability to take costs out)
 - Productivity improvements
4. System-level impact, preference for proposals that:
 - Cross organisational boundaries
 - Reduce duplication or variation
 - Improve whole-pathway performance rather than single-service optimisation
5. Deliverability within the funding window-spend profile achievable within agreed timelines, dependencies understood and manageable, accountable leadership and delivery capability in place, scalability or reusability, solutions that can be scaled, replicated, or reused across the system or in future years are prioritised.

9. Financial Plan

BSW ICB expects to receive in the region of £2.5bn of funding in 2026/2027 to provide a broad range of primary, secondary and specialised services for our population.

The BSW system comprising the ICB and the three main acute NHS providers within the geography (GWH, RUH and SFT) are currently spending more on the ongoing commitments for the system than the ongoing funding received to provide services for the population.

The system has managed to get to an overall breakeven position with additional non-recurrent national support funding for the last couple of years. This funding is expected to be withdrawn.

All NHS organisations have a statutory duty to not spend more than the funding they receive in a year. This means that recovery interventions will need to be undertaken to address the overspending to avoid a future deficit. On an ongoing basis c.5% more is being spent than we receive in funding.

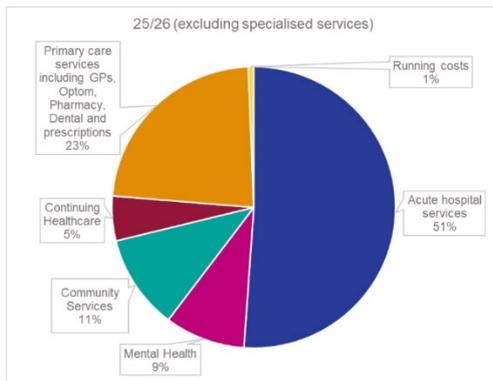
Addressing the overspend whilst continuing to meet the needs of our population will require changes to the services that we currently commission. This may mean ceasing some services, significant changes to existing services or adding new services.

The system is committed to meeting its financial statutory duties and returning to a breakeven position and to a sustainable financial balance.

The system planned to deliver efficiency in 25/26 of £125m or 5.6%. Once we include productivity improvements, this increased to c.6.5%. This was a significant stretch for the system in the context of historical under-delivery of recurrent CIP schemes. Despite this high level of efficiency, the ongoing overspend is expected to remain at c.5% as we enter into 26/27.

The efficiencies delivered in 25/26 have failed to deliver the level of recurrent reductions in spend required or the productivity improvements to materially reduce waiting lists. Continued operational challenges connected with service demand have meant that both waiting lists and demand for non-elective services have exceeded planned levels. We have also continued to see higher levels than expected of patients occupying beds despite being medically fit for discharge.

The chart below indicates how the ICB planned to spend its resources for 25/26:



In addition to the funding that the ICB receives directly there is separate funding streams allocated to the BSW population to support specialised services. This funding is directed into the following areas of spend but the services are commissioned jointly for all ICBs across the South West.

The ICB commissions services from both NHS and Non-NHS provider organisations and currently c.40% of all service spend is with GWH, RUH and SFT. Not all hospital-based services are delivered with BSW, and patients regularly use providers in Bristol, Oxford, Gloucester and Southampton. More specialist provision is also used in London.

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10. Workforce Plan

Over 35,000 people work in health and care in BSW across a wide range of professions, in a variety of settings and across multiple employers. We have a highly skilled, dedicated and committed workforce across our ICP area. However, gaps in the health and social care workforce will be one of the key barriers to improving services in BSW over the coming years. Our priority is to improve both recruitment and retention of staff across BSW by creating a culture in which our workforce enjoy satisfying careers, feel valued and are able to make their best contribution. We will do this by focusing on the following four ambitions:

- Creating inclusive and compassionate work environments that enable people and organisations to work together
- Making BSW an inspiring and great place to work
- All staff feeling valued and having access to high quality development and careers
- Using resources wisely to reduce duplication, enhance efficiency, productivity and share learning

We will ensure that the equality, diversity and inclusion of our workforce improves and ensure that all providers of services comply with the minimum requirements of the Public Sector Equality Duty (PSED). As the published model blueprint indicates, the ICB's role is shifting to that of strategic commissioners with the aim of planning for the future of healthcare services, allocating resources and focusing on removing health inequalities and improving outcomes for the population we serve.

We will continue to build on the progress in reducing our use of and expenditure on temporary staffing in our NHS provider organisations as well as supporting initiatives to recruit into high cost and hard to recruit roles.

The ICB will continue to ensure that, where relevant, that workforce plans for NHS providers are triangulated across finance, activity and workforce. We will maintain relationships with NHSE and other arms lengths bodies to utilise provided tools and models as well as using relevant data and information to better inform and influence plans.

The BSW ICB Work and Health Partnership project will continue to build on its success in delivering the Work Well programme with its intent to support individuals with health conditions in overcoming barriers to employment.

BSW Strategic Vision for our Workforce

Over the next five years, BSW will develop workforce plans that aim to support and deliver the following priorities:

Hospital to community

In BSW, we have developed a Primary Care and Community Delivery Plan that sets out how we plan to transform care for our population. As part of our plan, we have commissioned our Integrated Community Based Care Contract including community Integrated Neighbourhood Teams (INTs). This aligns to the new national ambition set out for Neighbourhood Health. Our five - year workforce plan will be informed by the required workforce needs of the ICBC contract and the commissioned HCRG stepped care model. This will also draw in the workforce needs of wider partners including PCNs, local authorities and the VCSE.

Primary care

Primary Care including general practice, community pharmacy, primary care dentistry, and optometry is central to the delivery of the NHS Ten Year Plan and the transformation ambitions of the new NHS operating model.

Primary Care are key to delivering the neighbourhood health service vision, reducing unwarranted variation, and improving access and equity across all contractor groups. Our goal is therefore to enhance efficiency and integration across out of hospital care. We recognise that each Primary Care sector operates under nationally negotiated contracts and frameworks, which provide consistency and clarity across England.

As part of our workforce plan, we will work jointly to support primary care to improve recruitment, training, retention and job satisfaction across all of the primary care workforce.

We will use data and intelligence to understand supply pipelines into roles such as community pharmacy and optometry in urgent care navigation, ensuring patients can access timely advice and treatment closer to home.

Mental Health

The BSW Mental Health Strategy 2025 – 2030 commits to improvements in commissioned services so we achieve good mental health for the people living in our area.

Workforce is identified as a key enabler of this strategy, and we are committed to make our area an excellent place to work in mental health. We know our key challenges include national shortages of mental health care professionals which is replicated in BSW, high staff turnover and in turn high vacancy rates and heavy reliance on agency staff to fill vacancy pressures in the clinical workforce. The temporary nature of their relationship with service users means they can't always provide consistency of treatment and interventions which impacts upon people accessing our services.

Our workforce plan will encompass these known challenges and BSW mental health providers will progress a number of actions to expand and develop the workforce including: Clinical associate psychology trainees, Talking Therapies workforce expansion through low and high intensity trainee , Apprenticeships ,Overseas recruitment ,Training for professionals to enhance their work with service users, Connect 5 Training, Oliver McGowan Mandatory Training, Cross provider training programmes and Recruitment of mental health professionals in primary and urgent and emergency care. Success will be measured by a bi-annual improvement forum where providers will share and commit to

measurable actions to improve recruitment and retention and optimise staff skills and wellbeing.

Learning Disabilities Autism and Neurodivergence (LDAN)

Our workforce plan will encompass the following priority areas:

- Workforce requirements for the new Kingfisher unit and outreach team provided by Avon and Wiltshire Mental Health Partnership NHS Trust. Building on the existing dedicated workforce workstream that has been part of the programme and has included use of the Aspire Nursing Programme and training of Advance Clinical Practitioners (ACP's). The intention is to continue to support and offer and consider how this can be implemented within community settings as part of the ICBC transformation priorities.
- Development of new all age Neuro Diversity pathway with HCRG and requirement for a needs-based approach including our VCSE partners
- Expansion in numbers of LDAN keyworkers
- ICBC Transformation work of LDAN Community Services (HCRG) including development of existing workforce to support autistic people without a learning disability and meeting the forensic needs of people with LDAN as part of community-based services – linked to ICBC outcomes.
- Upskilling of mainstream mental health services (inpatient and community) to meet the specific needs of autistic people with co-morbid mental illness.

Urgent and Emergency Care

The workforce plan will respond to the review of the UEC pathway including the review of workforce requirements for delivery of Urgent Treatment Centres and to support the shift from MIUs to UTCs. It will also reflect any expansion of Hospital @Home for other pathways, such as for children, and will outline the implied workforce requirements.

Analogue to digital

The ICB published a 5-year Digital Strategy in September 2024 that is now being refreshed in light of the ten-year plan publication and the shift from analogue to digital. We will commission in a way that ensures digital is the default for access, information and follow-up.

Our workforce plan will need to respond to the increasing need for a suitably skilled and competent workforce across a range of cyber professions to support the ambitions of the NHS ten-year plan. We know that filling specific digital roles is a challenge across BSW due to competition from other employers and skills gaps in our existing workforce. The ICS Cyber Strategy outlines how the expansion of relevant professional apprenticeships will take place to respond to the increasing workforce required and this will be incorporated into our five-year workforce plan.

11. Digital Strategy

To meet the current and future needs of our population we need to make significant changes in the way we deliver services. Technology is an important enabler to make these changes. Digital solutions give us the potential to work differently, facilitating better, safer care and experience and more efficient and effective use of resources, both financial and time. 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).

Healthcare is more than ever, dependent on digital solutions for the prompt, safe and effective delivery of data and information to those that need it, be they staff, patients or their carers.

The opportunity digital presents to the NHS and social care is recognised by the Government as one of the transformational shifts the NHS must make over the next ten years.

The organisations of BSW have a shared aim to exploit this opportunity to the benefit of our patients, population, staff and organisations.

We have identified five strategic themes and agreed a set of principles that will ensure a consistent approach to delivering digital across all our organisations.

By delivering against the priorities identified within this strategy we will increase the digital maturity of our organisations, reduce our carbon impact, improve services for our patients and improve the working conditions for our staff.

Delivery is however not without risks. The BSW system is under financial pressure which impacts the ability to invest in digital technologies, and where national funding is available it is often capital where revenue funding is required. The capacity and resource to support the Digital, Data and Technological change is limited both within specialist teams and the frontline. The transition of NHS England into the Department of Health and Social Care and the ICB merge will also impact at a local level.

How we seize this digital opportunity will define the future of care in BSW. Encapsulated by our vision of:

“Working together to deliver innovative digital solutions that enhance patient outcomes, staff experience, and streamline healthcare services”



Figure 1. BSW Digital Strategic Themes to 2029

12. Infrastructure Strategy

Infrastructure is a critical enabler for delivering the transformational changes set out in the BSW Integrated Care Strategy. We aim to provide a modern, fit-for-purpose estate with seamless digital connectivity, designed for efficiency, sustainability, and flexibility to support high-quality care closer to home. As the third largest cost after workforce and medication, infrastructure must be financially sustainable and optimally utilised.

Our Enabling Infrastructure Strategy (2025–2035) sets out our vision and objectives for reshaping and enhancing our estate and digital infrastructure over the next decade. It aligns with the BSW Together Integrated Care Strategy and Primary & Community Care Delivery Plan and is underpinned by six priorities:

- Empowered decision making
- Transformative digital solutions
- Workforce excellence
- Building a greener future
- Informed infrastructure spending
- Building a better future together

Delivering this vision requires significant investment for backlog maintenance and additional space, depending on the level of clinical transformation achieved. For 2026/27, the system has an operational capital envelope of £46.4m, supplemented by national programmes.

Summary of NHS Bath and North East Somerset, Swindon and Wiltshire ICB CDEL Allocation	26/27	27/28	28/29	29/30	Total
	£m	£m	£m	£m	£m
Operational Capital (CDEL)	41.56	43.50	44.39	45.26	174.72
Primary Care BAU Capital (GPIT/MIG)	1.88	1.88	1.89	1.89	7.53
National Programme - Primary Care Utilisation Fund	0.75	0.75	0.75	0.75	3.00
Strategic Primary Care Fund	3.00	3.14	3.21	3.27	12.61
Total	47.19	49.27	50.23	51.17	197.86

Funding sources will include annual ICB capital allocation, national NHS capital programmes, Section 106 and CIL contributions, local authority borrowing, private sector partnerships, charitable funds, and capital disposal receipts (estimated £10.1m, with 50% reinvested locally).

Data-led decision making is central to our approach for planning and prioritising investment. We will use key planning tools to model demand and capacity across acute, community, mental health and primary care settings, ensuring that our estate strategy is evidence-based and aligned to population needs. This includes applying advanced modelling techniques to forecast future service requirements and identify opportunities for co-location and optimisation.

Alongside this, we will maintain a robust categorisation of our estate into Core, Flex and Tail assets, enabling us to target investment where it delivers greatest value, improve utilisation of existing facilities, and plan disposals to release capital for reinvestment. These actions will ensure that decisions on infrastructure are transparent, data-driven and support the delivery of our strategic objectives for prevention, equity and care closer to home.

The development of our infrastructure plan is shaped by several critical dependencies that influence both timing and scope. Population growth and housing development across BSW will significantly impact demand for health and care services. Forecasts indicate an additional 62,000 residents and 57,000 new homes by 2038, with the most substantial growth in the over-60 population. This demographic shift requires close alignment with Local Plans and proactive engagement with local authorities to secure developer contributions through Section 106 and Community Infrastructure Levy agreements.

Clinical service transformation is another key dependency. Our infrastructure requirements are informed by ADEPT modelling, which supports the 'left shift' of care from acute hospitals into community settings. This approach demands flexible, modern facilities that can accommodate integrated neighbourhood teams and deliver care closer to home, reducing pressure on acute sites while improving patient experience.

Digital enablement underpins the success of our infrastructure strategy. The delivery of the BSW Digital Strategy, including shared electronic patient records, virtual wards, and remote monitoring will be essential to optimise estate utilisation and support new models

of care. Investment in digital connectivity and space for virtual consultations is therefore a critical dependency.

Workforce expansion also influences infrastructure planning. The NHS Long Term Workforce Plan requires modern facilities for recruitment, retention, and training, alongside spaces that promote collaborative working and staff wellbeing. Without sufficient physical capacity, workforce productivity improvements cannot be achieved.

Finally, sustainability commitments and governance frameworks shape our approach. Compliance with the NHS Net Zero Building Standard and delivery of the BSW Green Plan depend on system-wide investment and external factors such as National Grid upgrades to support electrification. Governance arrangements, including the implementation of the BSW Capital Investment Framework and Investment Panel, ensure prioritisation and affordability. In addition, the forthcoming end of the Great Western Hospital PFI contract in 2029 requires early planning to manage transition and mitigate operational risk.

The National Programme, with indicative allocations to BSW capital provides investment opportunities over four years (2026/27–2029/30) to support constitutional standards and the ‘left shift’ of care into community settings. This indicative multi-year settlement enables strategic investment across six programme areas, with our total allocation over this period set out in the following table:

Note: This table will be completed with numbers once we have confirmed BSW allocations by the National Team and Region, so this is included as a holding position.

Summary of NHS Bath and North East Somerset, Swindon and Wiltshire ICB CDEL Allocation	26/27	27/28	28/29	29/30	Total
	£k	£k	£k	£k	£k
National Programme Estates Safety Fund					
National Programme Diagnostics Schemes					
National Programme UEC Schemes					
National Programme Mental Health, Learning Disability and Autism Schemes					
National Programme Community Schemes					
National Programme Elective Scheme Completion					
Total Value of PDC for Proposed Schemes					

We are developing a capital pipeline scheme that will be integral to delivering the ICB’s strategic objectives across the following themed areas:

- **Diagnostics:** Expanding CDCs and replacing outdated equipment improves access to timely tests and supports elective recovery by reducing waiting times. Locating diagnostics in community settings aligns with the ambition to deliver care closer to

home and tackle health inequalities.

- **Urgent and Emergency Care:** Investments in Model EDs, UTCs, and SDEC units enhance patient flow and reduce A&E waiting times, directly supporting constitutional standards. Ambulance hubs and home-based UEC care strengthen system resilience and integrated neighbourhood services.
- **Mental Health, Learning Disability & Autism:** Developing NMHCs and MHEDs ensures people in crisis receive care in therapeutic settings, reducing inappropriate hospital admissions and out-of-area placements. Crisis accommodation supports personalised care and parity of esteem for mental health.
- **Community Health Services:** Estate and digital upgrades increase capacity for proactive care and multidisciplinary working, supporting prevention and early intervention.
- **Elective Care:** Completing surgical hubs and day case units addresses the elective backlog and improves productivity, supporting RTT standards.
- **Primary Care Estates:** Upgrading GP premises creates additional clinical space, supports workforce expansion, and facilitates integrated care delivery within neighbourhoods. Strategic estate investment replaces outdated buildings and co-locates services with local authority and community partners.

Collectively, our schemes will enable the left shift of care from acute hospitals to community and primary care settings, improve access and reduce waiting times, address health inequalities, support digital transformation and workforce productivity, and deliver sustainability goals by embedding NHS Net Zero principles in all new developments.

Infrastructure priorities are fully aligned with the objectives of the Integrated Care Strategy: Prevention and early intervention, fairer health outcomes, and excellent health and care services.

Delivery will be supported by the BSW Capital Prioritisation Framework, categorising investments into three bands: Band 1 for major schemes attracting national funding, Band 2 for ICS-funded small projects, and Band 3 for local minor capital expenditure. Our plans underpin these priorities and will be refreshed annually to maintain alignment with evolving clinical and population needs.

Devizes Integrated Care Centre (opened 2023) and Trowbridge ICC (completion 2026). Community Diagnostic Centres in Bath, Swindon, and Salisbury. Sulis Orthopaedic Centre supporting elective recovery are current examples of where we are delivering against our vision as well as significant investment into Primary Care during 2025/26 to increase clinical capacity.

13. Engagement

Ensuring that the voices of local people are listened to is so much more than a statutory obligation. Without these views, we cannot develop and deliver services that truly reflect the needs of the people we serve. Local people and communities possess a unique perspective on the local health and care system, along with a real-world view of how services are delivered within our communities. It is essential that we listen to these insights as we plan for the future.

We held an extensive local conversation on the NHS Ten year plan 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. Discussions with these groups focused on three key national shifts underway nationally in health and care.

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.

The themes identified in this conversation as well as other engagement we have done with our communities are central to this plan include:

Prevention and early intervention

- Broad support for preventing illness rather than just treating it, but much debate about the best way of doing this
- Improved health education in schools is widely believed to be the best route
- More emphasis should be placed on nutrition and physical activity programs, subsidised where possible for disadvantaged communities
- Calls for long-term funding for VCSE partners and better outreach to marginalised communities
- Worries about affordability of healthy food, "nanny state" interference and unintended consequences of screening creating more patients the system would not be able to cope with

Access and navigation of services

- Low awareness and unclear routes into services, particularly with weight management and frailty, were highlighted
- People want clearer signposting, the ability to self-refer and better communication about eligibility criteria
- Transport and rural access challenges were common concerns, with calls for mobile units and patients from rural areas highlighting the difficulty of attending Community Diagnostic Centres if they were situated away from town centres
- There is frustration with poor coordination between hospitals and GPs. People want “joined-up” referrals and discharge processes

Digital vs face-to-face care

- Strong support for shared care records and technology to improve efficiency, while there is criticism for what is seen as a disjointed approach between primary and secondary care
- High levels of concern about digital exclusion for older or disadvantaged groups in terms of booking GP appointments and a preference for face-to-face appointments for complex issues
- Cybersecurity and data privacy were raised as ongoing worries

Workforce and infrastructure

- There were repeated questions about staffing shortages, pay and recruitment needed to deliver plans such as Hospital at Home, services at TICC, Community Diagnostic Centres and the hospital to community shift
- Practical delivery concerns for rural areas and fears that plans may not be realistic

Communication and Cultural Sensitivity

- Desire for clearer explanations of clinical terms and less use of jargon
- Need for translation services and culturally sensitive care

Behavioural and Social Factors

- Learned behaviour drives A&E attendance, even when alternatives exist
- Emotional and psychological support needs were raised by many in relation to weight management discussions, alongside stigma concerns

Service Design Feedback (mainly connected to Trowbridge Integrated Care Centre)

- Positive sentiment toward bringing care closer to home
- Persistent requests for:
 - Extended opening hours for Minor Injury Units

- Local maternity options and short-stay beds
- Mixed views on whether new facilities represent real service improvements or just “same services, new building.”

We will continue to engage with our patients and local population on a regular basis, using a coproduction methodology that actively involves people and communities (based on Care Quality Commission’s [Framework for engaging with people and communities to address health inequalities \(2025\)](#)). By using both quantitative and qualitative insights to inform our integrated needs assessment, this will provide us with a comprehensive understanding of the lived experience of those receiving health and care support.

Areas of engagement that align with our commissioning intentions will include:

Developing a Neighbourhood Health Service

Place based engagement with communities to inform the development of Neighbourhood Health. Within this we will also be working closely with the Gypsy, Roma, Traveller and Boating communities as well as Veterans to gain a better understanding of how they view Neighbourhood Health and how to best to communicate the idea of Neighbourhood Health to them.

Commissioning a comprehensive review of our urgent and emergency care pathway

Expanding on the “Big A&E Survey” carried out in 2025, we will work on delivering further engagement activities to support the review of the currently commissioned UEC pathway.

Transforming Delivery of Planned care

Engagement work planned to support the development of the BSW Diagnostics Strategy to include Community Diagnostic Centres.

Transforming Primary Care

Working closely with our local Patient Participation Groups (PPGs) to gather feedback across Primary Care.

Commissioning for Prevention

Building on engagement work carried out at the end of 2025 on BSW Weight Management Services, we will look to codesign pathways and a system wide approach to compassionate language around weight management and obesity.

The ICB’s work in this area against its Legislative Duties is also found in Appendix 4.

14. Monitoring Delivery

We are committed to working together to deliver the intentions set out in this plan for BSW and using our agreed BSW outcomes framework indicators, performance reporting and our governance and assurance processes, we will track and monitor our progress.

The BSW outcomes framework is a tool designed to define the outcomes that are of value to our population. It will enable the measurement of the effectiveness of our activities and interventions in delivering improved health outcomes for the population. The framework shall provide a robust, evidence-based approach to monitoring progress

and addressing inequalities. It enables the Integrated Care System (ICS) to align its priorities with measurable and actionable goals, ensuring that our efforts translate into meaningful change for our communities. By embedding this Outcomes Framework into our commissioning and contracting, we will ensure a structured, equitable, and transparent approach to improving health outcomes across our communities and by the end of the five year period we aim to see a measurable improvement in these outcomes.

As per the guidance set out for ICB's in the [strategic commissioning framework](#), we will rigorously evaluate the outcomes from our commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence. We will monitor and evaluate the performance (quality, operational or financial) of the services we commission by:

- understanding gaps or challenges in the achievement of agreed priorities or within individual commissioned services (such as those in the national planning priorities: for example, urgent and emergency care and elective care)
- learning from and adapting services (including decommissioning and scaling successful innovations where appropriate)
- ensuring quantitative metrics are triangulated with qualitative data, professional insight and regulatory intelligence to fulfil this function effectively (such as complaints, 'You and Your General Practice', Freedom to Speak Up, Patient Safety Incident Response Framework and safety incident data)

To support achievement of this and in meeting the national guidance, we will set up an evaluation approach by March 2027, supported by an intelligence function and working with other partners as appropriate. The approach will encompass both quantitative and qualitative data, including feedback from staff (ICB, provider and other partners), communities and people using services.

15. Risks and Mitigations

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. The 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 ICB's Risk Management Framework sets out the ICB's approach to risk management, key decision-makers with regards to risk management, the ICB's risk appetite and risk categories, and key processes to manage operational risks (held on the ICB's operational risk register) and risks to the ICB's ability to achieve its strategic objectives (held on the ICB's Board Assurance Framework, BAF).

BSW ICB holds the following risks on its BAF and operational risk register which it deems to be relevant for this plan, and the ICB's ability to deliver it:

Risk	Risk Score (LxI)	Likelihood	Impact (on the ICB / system if the risk does materialize)	Mitigating Action
NQ2, Ambulance to Hospital handover delays (Ambulance Improvement) impact on system's ability to meet targets	20	5	4	Close monitoring of contract performance; Acute UEC Programme focusing on front door, in hospital and discharge; Expansion of SDEC offers at RUH and SFT to avoid handover at ED
Fin05, Sufficiency of capital funding for the ICB and system, finite resource could be spent on schemes that don't support the delivery of system objectives or create revenue pressures which add to the system underlying deficit and ongoing savings requirements	20	5	4	Capital plan; close oversight and monitoring through ICB / ICB committees
PCC9, PCC2, PCC1 Planned care and cancer wait times, capacity impact on system's ability to meet targets	16	4	4	GWH, RUH, SFT run recovery projects; ICB close monitoring and oversight
ICBCorp01, Organisational change impacts on ICB's capability to deliver its functions	16	4	4	ICB / cluster change programme: capabilities mapping exercise to identify essential roles and high-risk loss areas; business continuity plans
#74, Single Electronic Patient Record Programme not delivered safely and on time could result in material operational disruption within the acutes and across the wider system	16	4	4	Acute Group has in place Board-led governance providing leadership and assurance against a set of readiness checkpoints that assess the various component parts of the EPR programme
Various risks re specific ICB activities and operations across primary care (GP, dental, SW hub), urgent and emergency care and flow, planned care, mental health, s117 aftercare that all point to capacity and financial constraints as a risk to the ICB's ability to achieve delivery of in-year aims and objectives	average 15			Mitigations focus on close collaboration with providers and on close monitoring of finances
BAF01, Urgent and Emergency Care, insufficient capacity across the entire system pathway to meet demand and support flow, resulting in missed targets, high NCTR, insufficient flow, patient harm, and inability to shift resources from managing pressures into the transformation of care	15	3	5	UEC strategy, oversight of SWAST contract, focus on infection prevention and control, oversight of out-of-hospital capacity

Risk	Risk Score (LxI)	Likelihood	Impact (on the ICB / system if the risk does materialize)	Mitigating Action
BAF02, Elective Care, system fails to deliver on the specific expectations set out in the elective care reform plan, leading to wait times / lists remaining high, loss of Elective Recovery Fund (ERF), continued increased demand for urgent and emergency care and primary care, continued operational systems pressures	16	4	4	Providers activity plans and recovery plans, close monitoring via contract meetings, increased use of CDC capacity
BAF03, Prevention, no actions and incentives for residents to stay healthy, resulting in inability to prevent disease, injury or ill-health or avoidable complications associated with long-term conditions, leading to continuation of operational pressures and failure to deliver intended health outcomes	16	4	4	Prevention strategy incl. CYP / MH / frailty prevention, hypertension programme delivery and continuation beyond year 1, stronger prevention reporting and data
BAF04, Health inequalities, efforts not focused on improving health inequalities and addressing unwarranted variation, resulting in little or no impact on the health and outcomes of those who are adversely affected by current ways of working	16	4	4	BSW inequalities strategy, Deliver 2025/26 inequalities commissioning model, inequalities dashboard
BAF06, Financial delivery, financial cost pressures are not controlled, resulting in BSW overspending / breaching revenue or capital plan, not achieving statutory financial duties, and leading to intervention from NHSE including reduced local discretionary decision making, reduced capital resources, reduced opportunity to apply for additional funds, and loss of deficit support funding	20	4	5	identify the root cause of BSW's strategic deficits, support from experienced consultant, financial recovery plans medium-term plan, efficiency pipeline for 2026/27 and beyond
BAF07, Wider determinants of health, failure to address wider determinants of health, leading to people not having the opportunities and means to stay healthy, resulting in continued high / increased demand for health and care services, operational pressures, inequalities of access and health outcomes	16	4	4	Medium Term Plan, system outcomes framework / reporting mechanisms
BAF09, Future of the BSW ICB, running cost reduction leads to ICB's inability to deliver statutory functions and short- to medium-term plans	20	4	5	Options for future footprint, functions and strategic objectives, programme plan to manage the change, plan/s to facilitate retention and delivery of as many strategic and planned objectives for the benefit of the BSW population as possible

16. Governance

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

During the business year 2025/26, the BSW ICB's governance and decision-making arrangements will ensure appropriate decision-making and oversight and assurance with regards to the approval, implementation and delivery of the plan. The relevant forums in the BSW ICB's governance arrangements are:

BSW ICB Board – approval of the plan

- BSW ICB Commissioning Committee – oversight and assurance of the plan and its delivery, risk monitoring and assurance that risks are managed, and commissioning decisions where the value of the commissioned services contracts reach the relevant threshold per the BSW ICB's SoRD and Scheme of Financial Delegations (the BSW ICB Board is the decision-maker for the most high-value commissioning decisions)
- BSW ICB Executive Management Group – day-to-day monitoring, operational decision-making in line with the BSW ICB's SoRD and Scheme of Financial Delegations, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes

From 1 April 2026, BSW, Dorset and Somerset ICBs will closely collaborate as a cluster. The intention is to have in place cluster governance and decision-making arrangements. While these arrangements have not been finalized at this point in time, we anticipate the following as relevant forums for decision-making, oversight and assurance with regards to the delivery of the plan – to note that this is indicative only at this point in time and may be subject to change:

- Cluster Board – approval of any material changes to the plan, decision-making with regards to very high-value commissioning decisions, decision-making with regards to novel or contentious commissioning models
- Joint cluster committee for commissioning – oversight and assurance of the plan and its delivery, commissioning decisions, risk monitoring and assurance that risks are managed
- Joint cluster Executive Group – day-to-day monitoring, operational decision-making, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes
- TBC: Place 'boards' may play a role in the oversight and assurance of the plan and its delivery where intentions have particular local / place implications

Oversight via Executive structures

The Cluster executive structure will have overall oversight of the commissioning intentions as set out in this plan. The Population Health Board will hold the oversight of the Population Health Improvement as part of this plan and our priorities in relation to outcomes and inequalities.

Accountability

We will report regularly to the ICB board on progress against the priorities set out here.

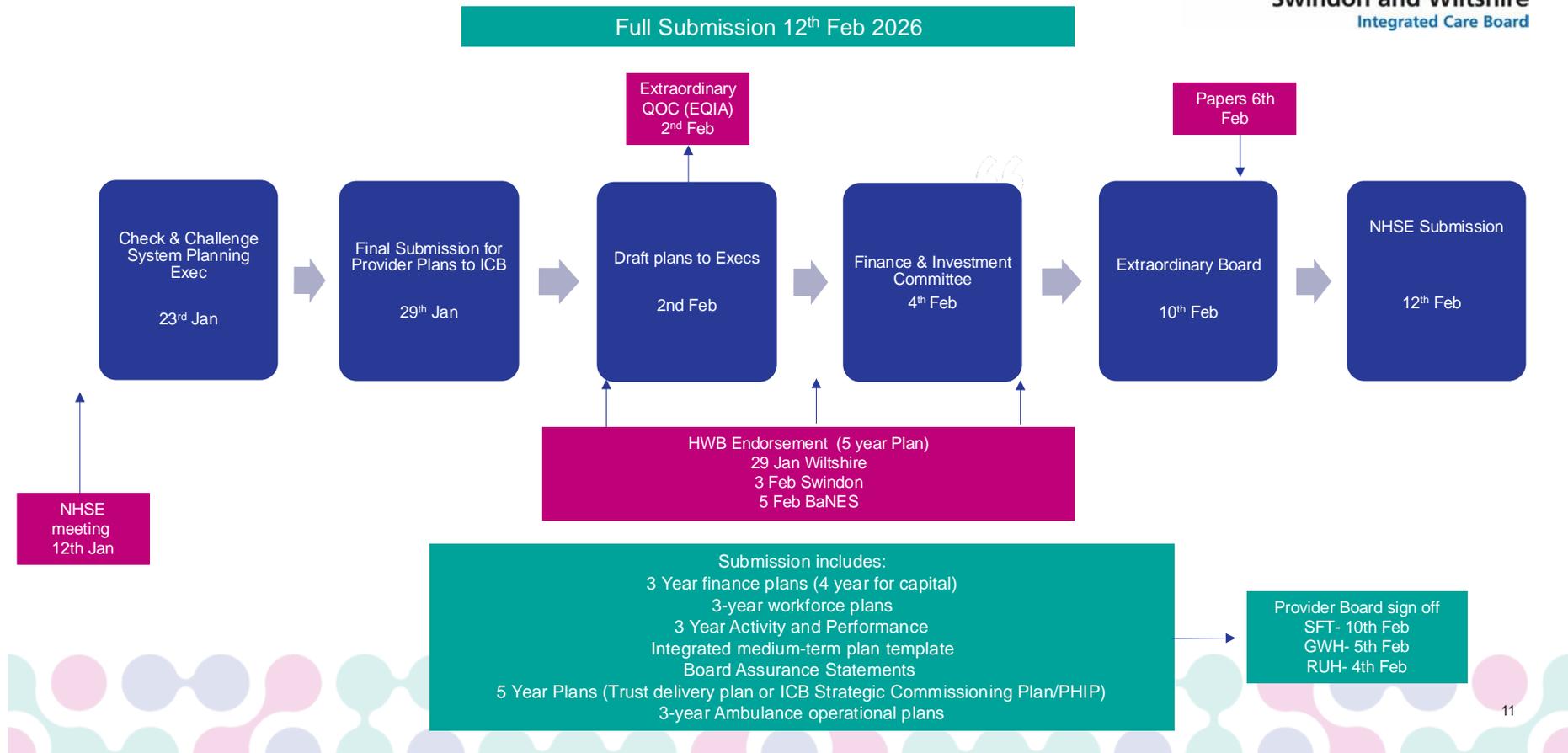
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Appendix 2: NHS Planning Framework for Five Year Plan Content

1. Executive summary	<ul style="list-style-type: none"> • Overview of the ICB's Commissioning Strategy including vision and desired outcomes • How the Strategic Commissioning plan will seek to deliver the outcomes and key points of the plan
2. Health economy / Population health context	<ul style="list-style-type: none"> • Summary of integrated needs assessment and baseline mapping of current performance and quality of commissioned services • High level analysis of population health need now and in the future, the health and care economy and the implications of 10YHP and objectives in MTPF-delivering change together for the development and commissioning of provision. • Assessment of the quality, performance and productivity of existing provision and improvement opportunities including relevant benchmarking and clear identification of underserved communities
3. Commissioning intentions for 2026/26 – 2030/31	<ul style="list-style-type: none"> • A methodology/framework to set out priority commissioning intentions over the five-year period • Each priority/commissioning intention as a minimum should include: <ul style="list-style-type: none"> • defined outcomes and metrics • clear milestones and delivery timescales • delivery scale (e.g., neighbourhood, place, ICB, pan-ICB — potentially one or more levels) • governance arrangements
4. Finance	<ul style="list-style-type: none"> • An overview of the financial ambitions over the 5 years • Evidence of the financial rigour applied in decision making and the maintaining of long-term financial sustainability
5. Workforce	<ul style="list-style-type: none"> • Identify how their strategic commissioning plan will be impacted and supported by the workforce, including consideration of the workforce impact and implications of the 10YHP, the Medium-Term Planning Framework, and the Strategic Commissioning Framework • Set out the organisations strategic vision for its workforce across 5 years, including how the workforce will support the three shifts and the required productivity improvements
6. Transformation and new care models	<ul style="list-style-type: none"> • A description of the organisations approach to transformation • Summary of how the organisation will co-ordinate and work with all partners to deliver major transformation programmes including embedding digital transformation and enabling the 'left shift' by supporting the shift of resources from acute to community services and increasing community and neighbourhood health capacity • Description of new care models to maximise value for patients and taxpayers aligned to 10YHP and how the ICB will embed these models
7. Enablers	<ul style="list-style-type: none"> • Key enablers for the plan, how they will be resourced, any dependencies that have been considered in the development of the plan and how they will be aligned to support the plan. The key enablers could be: digital, data and technology; estates and facilities; workforce
8. Risk and mitigations	<ul style="list-style-type: none"> • Risk model • High-level risk analysis including: <ul style="list-style-type: none"> • assessment of likelihood • financial and non-financial impact • mitigating actions which should be implementable internally without the need for external resource i.e. additional funding from the centre

Appendix 3: Planning Timeline

Governance for Full Submission



Report to:	BSW ICB Board - Meeting in Public	Agenda item:	12a
Date of Meeting:	22 January 2026		

Title of Report:	Annual Emergency Preparedness, Resilience and Response (EPRR) Core Assurance Update
Report Author:	Louise Cadle, Associate Director for Emergency Preparedness Resilience and Response
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	1: NHSE letter

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	
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 Executive Management Meeting	16 th October 2025	Assurance
BSW ICB Audit Committee	4 th December 2025	Assurance

1	Purpose of this paper
<p>The purpose of the paper is to provide an update on the submission of BSW ICB's Annual EPRR Core Standards Assurance for 2025. Within the EPRR Core Assurance, the ICB must share the outcomes of the assurance with its Board. The ICB has self-assured itself as fully compliant for 2025 and NHS England have confirmed they agree with our self-assessment and the 'formal' confirmation and challenge meeting took place 17th October 2025.</p>	
2	Summary of recommendations and any additional actions required
<p>BSW ICB Board Meeting in Public are asked to note the contents of the report.</p>	
3	Legal/regulatory implications
<p>Statutory duties as a Category One Responder detailed within the Civil Contingencies Act 2004 NHS England Emergency Preparedness Resilience and Response Framework 2022</p>	
4	Procurement
<p>N/A</p>	
<p>Procurement sign off</p>	
<p style="text-align: right;">N/A</p>	
5	Risks
<p>The key risk is that the ICB and Integrated Care System (ICS) NHS organisations will not be able to fulfil its role in supporting the local health economy during the response and recovery to an emergency incident whilst maintaining high levels of service for the local population.</p>	
6	Quality and resources impact
<p>Effective arrangements for the management of any emergency within the health economy will support the ongoing provision of high-quality care for patients, minimise any financial consequences following an incident.</p>	
<p>Finance sign-off</p>	
<p style="text-align: right;">N/A</p>	
7	Implementation Plan Alignment
<p>EPRR links to operational plan and delivery enabling the NHS to maintain core services.</p>	
8	Confirmation of completion of Equalities and Quality Impact Assessment
<p>The planning arrangements give the assurance that the ICS is prepared and can react in any major incident situation supporting all protected characteristics with a positive impact intended by giving staff and the public assurance that the ICS has clear plans in place to react to any type of major incident or emergency.</p>	

9	Communications and Engagement Considerations
N/A	

10	Statement on confidentiality of report
This report is not considered confidential	

BSW ICB Emergency Preparedness, Resilience and Response Assurance Report 2024/25

1 Introduction

- 1.1 The report outlines the continued progress of the EPRR agenda up to end of August 2025 and provides an overview of how the ICB has continued to progress and maintain standards whilst embedding learning from incident response.
- 1.2 The report has been shared with NHS England and formed part of our annual assurance evidence. A copy of the final assurance letter can be found in the Appendix.

2 Background Assurance Process

2.1 The table below details the assurance compliance for BSW ICB since 2022.

2022	2023	2024	2025
Substantial	Substantial	Full	Full (ratified by NHSE)

2.2 The table below details the assurance compliance for BSW ICS

Organisation	2023	2024	2025	
Great Western Hospital NHS Foundation Trust	Full	Substantial	Substantial	↔
Royal United Hospital NHS Foundation Trust	Substantial	Full	Full	↔
Salisbury NHS Foundation Trust	Substantial	Full	Substantial	↓
Healthero (formerly Medvivo)	Full	Full	Full	↔
HCRG Care Group	Substantial	Substantial	Full	↑
EMed (Non-Emergency Patient Transport)	Non-compliant	Substantial	Full	↑

2.3 GWH and Salisbury have action plans are in place with ICB oversight to monitor progress of partial compliance core standards.

3 EPRR 2024/25

3.1 The structure of the EPRR team is detailed below:

- Rachael Backler – Chief Delivery Officer and Accountable Emergency Officer
- Louise Cadle – Associate Director for EPRR and Deputy Accountable Emergency Officer
- Tracey Merrifield – EPRR Lead
- Lorraine Binsted – EPRR Officer

- On-call team 24/7 support – covering a three-tier approach for operational, incident and executive cover

4 Training and Exercising

This section provides a summary of training and exercising that have taken place since September 2024 and details the attendance from ICB colleagues thus ensuring EPRR is embedded across operational teams.

4.1 Training

Training Title	Training Provider	Date	Participants from ICB
A&S CBRN Awareness Session	A&S LRF and SMEs	25/09/2024	5
Counter Terrorism Threat and Risk Briefing (part of AEO development day)	CTSA Wiltshire Police	01/10/2024	4
ESRI Overview session	W&S LRF	22/10/2024	2
NHS SE Virtual Conference – Hospital Evacuation	NHSE SE	29/10/2024	3
Principles of Health Command (PoHC)	BSW ICB	06/11/2024	2
Recovery Workshop	W&S LRF	05/11/2024	3
Strategic Command Training via A&S LRF	Bond Solon	05/11/2024	1
Southern Cat. 2 Forum	W&S LRF	11/11/2024	3
CBRN Workshop and Climate	EPS	14/11/2024	1
Hinkley Point C Site Visit	A&S LRF	19/11/2024	2
SW Collaborative Day	NHSE SW	26/11/2025	1
Emergencies on Trial via A&S LRF	Bond Solon	27/11/2024	2
BaNES Health Protection Board	BSW ICB presented session on LHRP awareness and work progress	17/12/2024	
Disaster Victim Identification	EPS NW	19/12/2024	1
EPS UK Resilience Lessons Digest 5 – Learning to Manage	EPS	30/01/2025	1
SW Collaborative Day	NHSE SW	01/02/2025	2
Emergency Planning College (EPC) Risk Management in Civil Protection Training	EPC	27/02/2025 & 28/02/2025	2
Strategic Log Keeping	Bond Salon	04/03/2025	1
SW EPRR Collaborative (CBRN focus)	NHSE	08/04/2025	1
Protection of Premises Webinar	NHSE & CT Policing	08/04/2025	1
Winter Planning and Response debrief	BSW ICB	10/04/2025	17
Summer Preparedness webinar	UKHSA	10/04/2025	1

ICB RD Training	BSW ICB EPRR	15/04/2025	2
NHSE SW Lunch and Learn	NHSE	29/05/2025	5
RIAT On-call Briefing	BSW ICB EPRR	03/07/2025	3
Industrial Action on-call training briefing	BSW ICB EPRR	24/07/2025	4
Independent Sector – Business Continuity & Resilience awareness session	BSW ICB EPRR and SSEN	06/08/2025	4
Resilience in Primary Care Awareness session	BSW ICB EPRR, SSEN & W&S LRF	07/08/2025	4

4.2 Exercising

To note a weekly on-call alert cascade exercise takes place to ensure on-call are reminded of the process for receiving alerts.

Name of Exercise	Type of Exercise	Date	Exercise Lead	ICB Participants
Exercise Dynamo	Multi-Agency NPO	03/09/2024	W&S LRF	3
Exercise Chaus	Health and Social Care Call (part of AEO development day)	01/10/2024	BSW ICB	3 (1 facilitator)
Investing in Infrastructure	Cyber Crime tabletop (part of AEO development day)	01/10/2024	Wiltshire Police Cyber Team	4
Exercise Propaganda	Cyber Tabletop	09/10/2024	BSW ICB and NHSE Cyber Lead	10
Recovery Workshop	Recovery - tabletop	05/11/2024	W&S LRF	2
NHSE Walls have Ears	Cyber Exercise	14/11/2024	NHSE	2
Exercise Rise	ESRI (Beacon Project) Stress test of system	03/12/2024	W&S LRF	2
SWAST MIMS cascade	MI alert cascade	03/12/2024 14/01/2025 31/01/2025 01/04/2025 07/05/2025 05/06/2025 01/07/2025	SWASFT	Acute Trusts
Porton Down off-site plan exercise	Walkthrough of off-site plan	21/01/2025	Wiltshire Council and DSTL	4
Exercise Soprafatta	Mass Casualty distribution exercise	12/02/2025	SWASFT/ICB	Acute Trusts, SWASFT,

				WH&C, ICB (5) NHSE
Weekly ICB Alert Cascade communications exercise to on-call team	Communications Cascade	Weekly (Monday's)	BSW ICB On-call	BSW On-call – Operational, Incident and Executive
NHSE Communication Exercise	NHSE	12/05/2025	BSW ICB On-call	ICB on-call responded
BSW ICB Exercise Toucan	Cascade to providers	12/05/2025	BSW ICB EPRR	
SW Regional Pandemic Preparedness Workshop	Workshop	17/07/2025	UKHSA	3
SW Winter Planning event	Workshop	23/07/2025	NHSE	7

4.3 Incident Response

4.3.1 ICB has co-ordinated several incidents over the last year which has enabled colleagues to exercise our Incident Response Plan. Each incident has provided an opportunity for identifying lessons which have been built into training and plan review. The table below shows the variety of scenarios that the ICB have been involved in over the last year. Records are held of ICB colleagues involved in the responses.

4.3.2 A 'Red Flag' process is in place from NHSE which provides a process for recording incident declarations.

Red Flags from September 2024 to date

Date opened		Red Flag Reference	Red Flag Status	Key headline	Date Red Flag closed
21/02/2025		RF343 RF365	Major Incident	<ul style="list-style-type: none"> Declaration in response to incident – RF 343 Stepped back to business continuity incident 03/03/2025 – RF 365 Stood down BC incident Multi-agency response SCG remains in place 	RF 343 Closed 03/03/2025 RF 365 closed 10/04/2025
03/05/2025		RF 456	Business Continuity	<ul style="list-style-type: none"> Salisbury Walk-in Centre, loss of phone lines (bank holiday weekend) Utilised SPOC email address 	Closed 06/05/2025 @ 16.42

				<ul style="list-style-type: none"> ICB supported with communications to Pharmacies, social media platforms and websites 	
28/05/2025		RF 492	Business Continuity	<ul style="list-style-type: none"> GWH declared a business continuity incident in relation to pathology LIMs disruption, due to additional workload impacting primary care, ICB declared to monitor patient safety 	
25/07/2025		RF 566	Business Continuity	<ul style="list-style-type: none"> BMA Residential doctors' industrial action full walk out 	Closed 30/07/2025

4.3.3 The following table details the number of non-NHS incidents that the ICB and wider NHS are called into support, this is a mechanism called 'Operation Link' some incidents may not have casualties but require NHS support such as identifying vulnerable people, considering the impacts of a multi-agency incident on health and care.

Date	LRF Responding	Health attendance	Key headline
06/12/2024	A&S	ICB	<ul style="list-style-type: none"> PEAT in relation to Storm Darragh TCG @ 13.15 ICB incident on call / EPRR attended
04/01/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link notification regarding weather, potential flooding in Bath and Radstock area
08/01/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link regarding amber weather warning for SW England
14/01/2025	A&S	ICB	<ul style="list-style-type: none"> Exercise Blue Core notification
23/01/2025	A&S	ICB	<ul style="list-style-type: none"> Exercise Vulcan Op Link – MI petroleum storage depot in Portishead
26/01/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link notification re teleconference at 16.45 regrading flooding in Chard and South Petherton
27/01/2025 & 28/01/2025	W&S	ICB	<ul style="list-style-type: none"> PEAT Storm Herminia Flooding in the Salisbury city centre area
11/02/2025	W&S	ICB	<ul style="list-style-type: none"> Op Link situational awareness briefing regarding a mains gas leak, Foundry Lane, Chippenham
16/02/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link overturned vehicle M4 lane closure

17/02/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link – incident at Costco, Avonmouth following reports of customers feeling unwell, casualties treated at scene by SWAST
21/02/2025	W&S	ICB	<ul style="list-style-type: none"> Op Link notification situational awareness
21/02/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link notification situational awareness
26/02/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link notification regarding M5 closure J24 to 25 following serious RTC
28/03/2025	W&S	ICB	<ul style="list-style-type: none"> Op Link partner information only regarding potential chemical incident
31/03/2025	W&S	ICB	<ul style="list-style-type: none"> Op Link test message only
02/04/2025	W&S	ICB	<ul style="list-style-type: none"> Op Link test message only
18/04/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link Queen Hill Road Evacuation
02/05/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link Briefing for information only – Bomb threat, Blaze High school evacuation (Bristol)
14/05/2025 @ 09.44 & @09.49	W&S	ICB	<ul style="list-style-type: none"> Op Link – partner information only. Suspicious package, Swindon
16/05/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link briefing for information only. Protest in Bristol, City Centre, 17/05/2025, city centre may be busy with traffic, best avoided
19/05/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link test call
22/05/2025	SWAST MI Standby@16.50 SWAST MI Stand-down 17.30	ICB	<ul style="list-style-type: none"> Fire in hospital roof at St Michael's, UHB, further updates via MIMs system
22/05/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link meeting @ 18.00 regarding Fire at UHB. No actions for BSW.
31/05/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link briefing, RTC M5 junction 13-14, fatalities
31/05/2025 @ 12.15	A&S	ICB	<ul style="list-style-type: none"> Op Link notification M5 southbound re-opened
31/05/2025	SWAST MI standby @ 12.50 SWAST MI cancelled 13.17	ICB	<ul style="list-style-type: none"> Links to M5 RTC
31/05/2025 @ 15.10	W&S	ICB	<ul style="list-style-type: none"> Op Link situational awareness briefing to be held at 16.30 regarding a boat fire/explosion at Lechlade
31/05/2025 @ 15.36	A&S	ICB	<ul style="list-style-type: none"> Links to M5 RTC, National Highways opened two lanes on north bound carriageway
11/06/2025	AWP	ICB	<ul style="list-style-type: none"> Incident Green Lane Hospital, Devizes, male on roof

14/06/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link activation of MS Teams calls at 16.30 relating to potential house collapse in Farnborough ICB attended TCG @ 16.30 and 19.00
30/06/2025	SWAST MI standby @ 09.57 SWAST MI cancelled @ 11.00		<ul style="list-style-type: none"> Log into MIMs for further details
17/07/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link activation of MS Teams meeting at 15.30 regarding RTC involving coach at A396 just outside Minehead
17/07/2025	SWAST MI declared @ 15.36		<ul style="list-style-type: none">
17/07/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link activating an SCG at 17.00 today re RTC A396
17/07/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link update – noting SCG pushed back to 17.15
17/07/2025	SWAST MI scene evacuation complete 18.50	ICB	<ul style="list-style-type: none"> Relates to RTC A396
17/07/2025	SWAST MI stand-down @ 19.17		<ul style="list-style-type: none"> Relates to RTC A396
22/07/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link briefing only – currently a fault with EE mobile phone 999 calls
31/07/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link Information, traffic disruption A39 Chiltern, Polden Hill, fatal RTC
03/08/2025	A&S	ICB	<ul style="list-style-type: none"> Op Link activating MS Teams call at 01.00 relating to large fire at Chestnut Farm, Claverham
10/08/2025	RUH	ICB	<ul style="list-style-type: none"> Business Continuity declaration due to lack of bleep capacity

4.4 BSW ICB Collaboration with Partners

4.4.1 A summary of attendance is maintained and includes attendance at both Local Resilience Forums business management meetings and their appropriate subgroups e.g. risk working groups, training and exercising, mortality, warning and informing, Porton Down Engagement, Event Safety Advisory Groups.

- 4.4.2 Several Southwest collaboration meetings are attended and the ICB represent the ICS at: NHSE SW EPRR Collaborative, SW CBRN Group, SW Radiation Monitoring Unit Group now SW Radiation Monitoring Network.

5 BSW Local Health Resilience Partnership (LHRP)

- 5.1 BSW LHRP continued to evolve in 2024/2025 with the continued strong collaborative network and the workplan demonstrates the collaboration with providers and partners across the integrated care system. The monthly provider reports which are collated for LHRP BMG provide focus for situational awareness and sharing of incident learning and are discussed monthly at BMG, in addition the monthly risk updates provide a strong foundation for discussion and enables the risk management cycle to highlight gaps in capabilities.

BSW LHRP Risk Working Group

- 5.2 This group comprises of representatives from acute, community, mental health and ICB. The group meet monthly prior to the LHRP BMG and feed into both the LHRP and Avon & Somerset and Wiltshire & Swindon Local Resilience Forum risk groups. A dashboard has been developed (adapted from A&S Risk Management Group) which links risks and creates review dates based on an algorithm. It does not duplicate LRF Community Risk Registers and where risks are held in other services the risk remains with that group.
- 5.3 Risk is based against likelihood and impact based on National Risk Strategic Assessment scoring. The risk is rated against seven capability elements, scoring dictates level of action required based on the algorithm. Most recently due to the progression of the RWG the group have been able to provide advice and information in relation to the health narrative for which risk is assessed against on the W&S LRF risk register, continuing to forge greater collaboration and understanding of the health arena.

Embedding Learning

- 5.4 Learning from incidents over the last year has played a significant role in developing of processes and building into training and exercising. Four key themes have been identified in debriefs: initial alert and informing, incident declaration, communications, and coordination.
- 5.5 The LHRP has worked hard to resolve these with a review of the LHRP Incident Response Plan and detailed analysis of the incident response road map from start to finish.

6 Key Headlines and Examples of Good Practice

- Development of Personal Development Plans for all on-call and EPRR team (noting further work required but delayed because of NHS reforms)
- Roll out of structured EPRR training programme within ICB including a training portfolio (slowed due to NHS reform announcement while assessment of the implications to the on-call team)
- BSW LHRP Risk Group, for which the ICB chair this sub-group continues to demonstrate continual improvement including development of a new style LHRP executive report
- Greater ICB involvement in the Local Authorities Event Safety Advisory Group process, where ICB in attendance to ensure ICS represented information cascades through to the LHRP BMG with an events calendar to ensure robust situational awareness for all providers
- HCRG Care Group took over as the lead community provider for BSW ICS on 1st April 25. Significant work continues across the ICB to ensure a successful transition and merger of EPRR processes.
- Review of national Joint Organisational Learning (JOL) notifications and signposting where appropriate to LHRP agenda to ensure ICS is sighted on learning opportunities, and JOL is a standing agenda item on the LHRP agenda
- UKHSA Exercise Solaris led by the ICB for the system discussed the scenario of a novel influenza strain and the importance of early coordination and communication, this was a dress rehearsal for Exercise Pegasus in the autumn of 2025. The exercise allowed the onward reporting of learning and is understood will support the format of exercise Pegasus. An observation of the exercise was the emotion the discussion brought to the fore and this is being recognised ahead of the launch of Exercise Pegasus.
- The ICB's Associate Director of Estates, BSW ICB demonstrated the Shape Tool a free GIS system supported by the Department of Health and Social Care designed to assist various bodies in analysing properties, view emergency activities, and utilise planning tools.

7 Forward Look

- Horizon scanning and monitoring of changing NHS landscape due to reform and ensuring the ICB remains compliant with statutory duties
- Review of ICB Business Continuity Procedures in line with NHS reform changes and transition to clustering, this will include ensuring the ICB maintains a 24/7 on-call team (trained and competent)
- Lead the national Tier One Pandemic Preparedness Exercise Pegasus for the ICB's response, ICS and Wiltshire and Swindon Local Resilience Forum
- Establish a resilient LHRP communications subgroup to look at the risks associated with resilience in the communication arena, to include the Public Switch Telephone Network development in relation to vulnerable individuals
- Professional development session BSW ICS AEO Development Day 30th September 2025 the theme for the session is Chemical Biological Radiological Nuclear

- Deliver a BSW ICS Winter exercise to test the response to winter pressures and concurrent issues (October 2025)
- Support the delivery of and ICS Cyber Exercise (part 3) November 2025
- Deliver Exercise Sopraffatta (part 2) for community and Minor Injuries Units in February 2026 that will scope wider health support to a mass casualty scenario

8 Summary

- 8.1 2024/2025 has seen a significant step forward in the EPRR agenda, with a drive to continual improvement (noting the NHSE EPRR Core Standards are minimum standards), there is a clear determination to exceed these standards.
- 8.2 The work continues despite the announcements in the spring regarding NHS reforms, although it must be noted some elements of the work programme have been paused and areas reprioritised to ensure the current position is maintained against a backdrop of uncertainty.

Our Reference: BSW/Nov25

To: Rachel Backler, Executive Director of Planning and Performance (Accountable Emergency Officer) NHS BSW ICB

Keith Grimmatt
NHS England South West
Head of EPRR

Copy: Louise Cadle, Ass Director EPRR
Ian Phillips, Dep. Director Resilience

Tel: 07783 816496
Email: k.grimmatt@nhs.net

6 November 2025

Sent by email

Dear Rachel,

NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) and System Emergency Preparedness, Resilience and Response core standard assurance confirm and challenge outcome.

Thank you for preparing and submitting your self-assessment, supporting evidence. This letter summarises the outcome of the meeting held on 17 October 2025, which you were unable to attend, capturing agreed actions and points from the discussions.

ICB Outcome Summary

Organisation	2024	2025
NHS BSW ICB	Full	Full

Your organisational compliance level for 2025 is Full, with the assessment showing full compliance against 100% of applicable standards (47 of 47). See annex 1 for descriptors.

ICB Good Practice and Innovation

1. Leadership for the entire BSW Health System and Wiltshire and Swindon LRF and key contributor for Avon and Somerset LRF
2. Leading the way in professional development sessions including system AEOs with a Chemical Biological Radiological Nuclear themed Development Day
3. Planning and delivery for Exercise Pegasus Tier 1 Pandemic Exercise

NHS England Observations

It has been a turbulent year for the NHS with significant restructures underway creating uncertainty for the future delivery of EPRR across organisations. The BSW ICB team has continued to engage with NHS England (NHSE) South West throughout the year helping to evidence the maintenance of full compliance for 2025.

Deep Dive Review

In 2025 NHS England did not conduct a deep dive review.

System Outcome Summary

You provided a full and concise overview of the approach you have used to undertake the EPRR Core Standards confirm and challenge process for 2025.

Organisation	Compliance 2024	Compliance 2025
Great Western Hospital NHS Foundation Trust	Substantial	Substantial
Royal United Hospitals Bath NHS Foundation Trust	Full	Full
Salisbury NHS Foundation Trust	Full	Substantial
HealthHero (Formely) Medvivo	Full	Full
HCRG	Substantial	Full
EMed	Substantial	Substantial
SWASFT	Full (Dorset ICB)	Substantial (Dorset ICB)

NHS England System Observations

NHSE noted that the two Acute Providers self-assessing as Substantial have had changes in their EPRR resourcing, with the loss of their respective EPRR Leads. Neither has been formally replaced reducing their respective resources to deliver EPRR.

Next Steps

The outcome of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHSE South West Regional Executive Team before being submitted to the NHSE National Resilience Team.

We welcome any reflections you may have on this year's assurance process and invite your feedback via your EPRR practitioners.

If you would like to discuss any elements of the confirm and challenge process and/or the contents of this letter, please do not hesitate to contact me directly.

Finally, thank you again for the hard work put into this year's assurance process while contending with significant system pressures, issues and incidents.

Yours Sincerely,



Keith Grimmatt, Head of EPRR

NHS England South West

Annex 1

Organisational rating	Criteria
Full compliance	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	12b
Date of Meeting:	22 January 2026		

Title of Report:	Cyber Assurance Report
Report Author:	Steve Mapleston BSW ICB Head of IT
Board / Director Sponsor:	Gary Heneage - CFO Rachael Backler - Chief Delivery Officer (ICB SIRO)
Appendices:	Public Version of Cyber Strategy Attached

Report classification	Please indicate to which body/collection of organisations this report is relevant.
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	
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	X

Previous consideration by:	Date	Please clarify the purpose
ICB Board Private Session	20/11/25	ICS Cyber Strategy Approval
ICB Audit Committee	4/12/25	ICS and ICB Cyber security report (6 Monthly update)

1	Purpose of this paper To give a public update to Board on the ICS cyber strategy and Cyber Assurance/ Please note the full ICS cyber strategy and detailed cyber assurance information has been discussed in the previous ICB Board private session and ICB Audit Committee. FOI requests seeking details around network and device security are exempt under exemption 24 (national security)
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2	Summary of recommendations and any additional actions required
The ICB Board is asked to note this update.	

3	Legal/regulatory implications
<p>The ICB has a legal responsibility to cyber security both for itself and the wider ICS under Network and Information Systems Regulations (NIS Regulations). https://www.gov.uk/government/publications/network-and-information-systems-regulations-2018-health-sector-guide</p> <p>As outlined in the Cyber Security Strategy for Health and Social Care: 2023 to 2030, all Integrated Care Boards (ICBs) and ICSs remain fully accountable for their own cyber security. NHS England and the Department of Health and Social Care (DHSC) have previously asked ICSs to develop board-approved cyber security strategies in collaboration with their ICBs</p>	

4	Procurement
N/A as this paper does not recommend purchase of individual products. Note any procurement of cyber solutions will follow the appropriate route in line with the ICB SFIs	
Procurement sign off	N/A

5	Risks
ICS wide cyber risk on corporate risk register (BSW ICB 16) current risk score 15. Please note risk cannot currently be directly compared across the cluster due to different likelihood and impact definitions.	

6	Quality and resources impact
Disruption from a cyber-attack may impact any area across multiple providers, where clinical systems are impacted there will be significant impact on Quality, Patient Experience and Safeguarding	
Finance sign-off	N/A

7	Implementation Plan Alignment
<p>https://bsw.icb.nhs.uk/about-us/bsw-implementation-plan/</p> <p>Implementation plan states: - “We will continue maturing our ICS cyber capabilities and refresh our ICS Cyber strategy including learning from our ICS wide cyber exercises.”</p>	

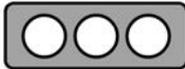
8	Confirmation of completion of Equalities and Quality Impact Assessment
N/A	

9 | Communications and Engagement Considerations

Comms team have been involved in promoting cyber advice e.g. use of multi factor authentication and ongoing support will be required to support education of users

10 | Statement on confidentiality of report

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This paper has been created as a public update and can be shared as required. Due to the public nature detailed information around the network security and systems has been omitted.

FOI requests seeking details around network and device security are exempt under exemption 24 (national security)

1. Introduction

- 1.1. The wider NHS in response to the 10-year plan is entering a significant period of reform and change with an increasing reliance on digital solutions. This creates cyber challenges both from the change programme but also from the reliance on digital increasing the impact from any cyber-attack.
- 1.2. Although we have had no major incidents of note over the past 6 months it is worth noting major incidents are on the rise nationally and internationally.
- 1.3. The first patient death linked to a cyber-attack in London had been made [NHS ransomware attack contributed to patient's death - BBC News](#):
- 1.4. Significant work is continuing across the ICS via the BSW ICS Cyber Group to further understand our cyber risk/weaknesses and to improve upon the key metrics we are now using across the ICS, we now use a single cyber metric to combine all existing national metrics into one easy to understand and track score.

2. Governance and Assurance - Network and Information Systems Regulations (NIS Regulations) and Data Protection Security Toolkit DSPT.

- 2.1. As the ICB is a category one responder it falls under the NIS regulation <https://www.gov.uk/government/publications/network-and-information-systems-regulations-2018-health-sector-guide>. The category 1 Data protection Security Toolkit (DSPT) is the main assurance mechanism used by NHSE.
- 2.2. For 24/25 the DSPT for category 1 organisations has changed significantly as it has moved to the Cyber Assessment Framework (CAF) with an NHS overlay added to it. The ICB have now reached standards met with an extremely positive audit report resulting in no additional IT actions
- 2.3. For 25/26 the DSPT requirements are not changing thus meeting DSPT will largely be a process of updating evidence to show the controls are still in place. Future years are like to be increasingly complex as ICB mergers take place.
- 2.4. Due to the ICB's role in commissioning services across the wider ICS, the ICB does have a responsibility under NIS for the wider cyber security of the ICS, however this does not remove the individual obligation of each organisation.

3. ICS Cyber Strategy

- 3.1. The updated ICS cyber strategy has now been approved by the ICS Board. Our strategy has been created in line with the national Cyber security strategy for health and adult social care to 2030 and created in conjunction with key local stakeholder such as Trusts, Local Authorities, Community and the NHS England Regional Cyber security lead. Please see attached full public summary.
- 3.2. As the 3 ICBs cluster and become a single organisation and the target operating model develops we will need to converge our cyber strategies into one. As all 3 strategies are based on the national 2030 cyber strategy, they have many elements in common.

3.3. The BSW ICS strategy is based on the following key principles

- ICS Collaboration
- Common cyber toolsets with standard ICS processes and policies
- Making full use of national tools over other solutions
- Mature the use of common tools we already have
- Consistent ICS Cyber Risk Management and board reporting.
- Growing our own cyber talent
- Building on our Cyber Technical Advice Cell for incidence response
- Further links with Local Authorities and other non-NHS local providers
- Targeted realistic and achievable
- Aline to the national DSPT CAF

4. Cyber Monitoring

- 4.1. We have multiple nationally provided cyber metrics which are consistent and clear across all NHS organisations which are automatically collected
- 4.2. Due to all these different metrics which all require different actions and focus to maintain and improve the scores it has become difficult to get a single picture of where each organisation is on its journey to have “perfect metrics”. Due to this we have agreed a method to combine and appropriately weight all our existing metrics into a single easy to understand score show and monitor how each organisation is performing.
- 4.3. The scores are updated monthly to track overall progress; detailed underlying scores are still available and can be used to identify key areas of improvement.
- 4.4. As part of the ICB Windows 11 upgrade, the ICB has opted to fully review the desktop security configuration in line with best practice .
- 4.5. The ICB is also expanding the use of additional national cyber team (CSOC) active services and monitoring.
- 4.6. The ICB has recently completed its yearly external penetration test.

5. ICB & ICS Cyber Risk

- 5.1. ICS wide cyber risk on corporate risk register (BSW ICB 16) current risk score is 15. (No Change)
- 5.2. ICB Cyber risk 10 (No change)
- 5.3. Please note the ICB cyber risk as an individual organisation will be lower than the ICS as a whole due to the likelihood of the ICB being attacked naturally lower than the likelihood of one out of multiple ICS organisation being attacked.
- 5.4. We continue to engage with NHSE around supplier cyber risk due to the need for a national approach. It is our strategy that it is not practical for each ICS to have a different set of questions to assess suppliers and multiple assessments taking place for the same supplier. We are currently using the NHS Digital Technology Assessment Criteria (DTAC) to assess at the point of procurement/contracting.

- 5.5. Across the health sector and beyond ransomware continues to be the biggest driver of serious incidents, thus our prioritisation on ensuring full use of the national solution and services.
- 5.6. We continue to ensure Multifactor Authentication (MFA) is used wherever possible in line with the NHS MFA policy [Multi-factor authentication \(MFA\) policy - NHS England Digital](#) and in line with the policy the ICB SIRO approves any legitimate exceptions.

6. Training and exercising

- 6.1. This year's ICS wide cyber exercise will take place in March 2026, the scenario will be one provided by NHSE that we will not have prior sight of.
- 6.2. The ICB recently conducted its yearly simulated phishing test; this consists of a simulated fake phishing email, however if clicked and information inputted it directed colleagues to a training on how to spot the signs of a phishing attack.
- 6.3. Results were extremely positive with very low rates of staff inputting data, this shows an increasing trend of awareness within the ICB and well below the national average. Even more positively over 100 staff actively reported the email as phishing using the NHS report phishing button.

7. National Policy

- 7.1. The ICB Head of ICB is a member of the NHS England cyber reference group which advises NHSE on upcoming cyber policy and initiatives, giving the ICB an early indication of national direction and ability to join national pilots.
- 7.2. The ICB Head of IT is also now a member of the national DSPT Advisory group as a ICB representative giving NHSE feedback of proposed future DSPT changes.
- 7.3. The ICB head of IT is also working with NHSE to review the upcoming GP IT operating model from a cyber perspective alongside the NCSC and regional cyber security leads.

8. Resources & Funding

- 8.1. £124K national cyber revenue was received which has been passed to the Trust to align cyber tooling as they move forward with their group model.
- 8.2. Properly resourcing cyber will always be a challenge, there will always be more that could be done and additional defences that could be put in place. We therefore need to take a risk-based approach to ensure we have a proportionate and focused response within a reasonable level of resources.
- 8.3. The financial impact of a major cyber-attack would be material, for example the estimated cost of the attack on the Irish healthcare system was €102 million. and Adastra have just received a £3M ICO fine.
- 8.4. It also needs to be recognised even with funding recruitment to cyber roles is particularly challenging due to a national lack of expertise which is further exacerbated by Agenda for Change banding. This is one of the driving factors toward the ICS cyber strategy to use national tools and work closer together on

cyber to make the best use of the talent we have (and can get) and create more opportunities to grow, retain and develop our own talent from within.

- 8.5. Uncertainty around national NHSE funding is creating barrier to planning also further impacting resources. NHSE and DH are fully aware of the issues created by in year capital and a pressing for multiyear funding streams that include significant revenue.
- 8.6. There are real opportunities to make better use of cyber resource as the 3 Trusts come closer together and develop their future operating model as a hospital group and as the 3 ICBs come together as a cluster..

9. Key next steps over next 6 months

- Ongoing work to improve cyber metrics following completion of Windows 11
- Continuation of secure configuration on workstations and servers.
- Progression with key initiatives agreed
- Input into Trust IT operating model.
- ICB DSPT CAF assurance for 25/26 including internal audit
- Minimise impact on cyber for upcoming VR and CR process. Ensuring we keep doing the basics well.
- ICS cyber exercise
- Review Cyber strategy over the cluster as Target Operating Model develops.
- Investigate use of cyber apprenticeships.

10. Recommendations

- 10.1. The Board is asked to note this report.



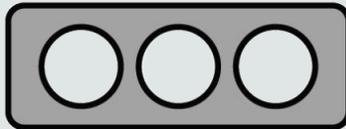
Bath and North East Somerset,
Swindon and Wiltshire Together

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

Our Cyber Strategy Summary 2025-2030

Defend as One to become the most cyber secure ICS in the country

TLP:CLEAR



Disclosure is not limited

Please note this is a public summary of the ICS cyber strategy, the content has been significantly simplified, and full details of ICS cyber security systems and improvement have been removed.

The full version is TPL: Amber Strict Limited disclosure, restricted to participants' organization.

FINAL Board Approved November 2025



Section 1

Summary

The Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS) Cyber Strategy 2025–2030 sets out a unified, collaborative, and risk-based approach to cyber security across the region’s health and care system. With the vision to “**Defend as One to become the most cyber secure ICS in the country,**” this strategy aligns with national priorities and responds to the growing complexity and severity of cyber threats.

Strategic Context

Healthcare is increasingly reliant on digital infrastructure, making cyber resilience essential to patient safety and service continuity. The strategy responds to rising national threat levels, regulatory changes, and the need for consistent measurable cyber maturity metrics across partners to ensure we focus on getting the basics right.

Key Strategic Priorities

- **System-wide collaboration** through shared tools, policies, playbooks, and governance.
- **Adoption of national services** making full use of current and future national NHS cyber services.
- **Standardised cyber risk management** and performance tracking via a unified ICS cyber score.
- **Investment in workforce development** through apprenticeships and training.
- **Annual cyber exercises** to test and improve incident response across the ICS

Strategic Objectives

- Aligned standardised deployment of **logging and privilege access management solutions** by April 2026.
- Implementation of **standardised security baselines** for all devices.
- Aligned standardised **use of antivirus and endpoint protection**.
- Engagement with the **NHS Cyber Security Apprenticeship Scheme**.
- Continued development of the **Cyber Cell** for incident coordination.

Due to NHS England’s scope only NHS organisations and GP primary care are in scope for centrally funded national cyber services. This strategy intent remains applicable to wider system partners where the strategy objectives do not include the adoption of national cyber services or solely rely on NHS funding streams. As a result BSW NHS orgs will be asked to approve this strategy where other partners will be asked to note and create alignment in applicable areas.

External Drivers

- Hostile cyber-attacks are a Tier 1 national risk.
- Ransomware and supply chain attacks remain prevalent.
- Regulatory shifts, including the DSPT alignment with the Cyber Assessment Framework (CAF), require proactive compliance.
- Move for analogue to digital growing the number of digital systems

Delivery and Governance

The strategy is governed by the BSW Digital Board, Technical Design Authority (TDA), and Cyber TDA, with delivery milestones set through to 2027. Success will be measured through improved cyber scores, reduced risk exposure, and enhanced system-wide resilience.



Section 2

Context

Healthcare is more than ever, dependent on digital solutions for the prompt, safe and effective delivery of data and information to those that need it, this will only increase in the future as we become more reliant on digital technologies.

Cyber incidents remain a real and present risk to business functions, organisational objectives, and patient safety.

Confidentiality, Availability and Integrity of the data that we process and store on behalf of our patients and that is required for operational functions is fundamental. There are legal, regulatory, and ethical obligations that ICS member organisations must fulfil

Our strategy outlines how the ICB will bring together the ICS member organisations to collaboratively deliver long term cyber security direction and objectives. Our strategy outlines objectives and how they are aligned to the five pillars in the Cyber security strategy for health and social care: 2023 to 2030

[Cyber security strategy for health and adult social care to 2030 - NHS England Digital](#)

All recommendations in this strategy are based upon key principles firmly grounded to the overarching ICS principle to “**work together**” and “**defend as one**”.

Each initiative within our strategy will link back to the 5 pillars

5 pillars of Cyber security strategy for health and adult social care to 2030

1 Focus on greatest risks and harms

- Understand risks
- Increased visibility
- Proportionate mitigations
- Network and Information Systems (NIS) regulations are understood and used

2 Defend as one ← **Key overarching BSW ICS Cyber Principle**

- Collaborative working
- Coordinated threat intelligence
- Clear accountability
- Services fully used

3 People and culture

- Cyber security as a profession
- Diverse cyber workforce
- A 'just culture' of fairness, openness and learning
- Everyone understands their role

4 Build secure for the future

- Emerging risks understood
- Critical supply chain engaged
- Secure by design
- Clear and aligned standards

5 Exemplary response and recovery

- Minimise the impact of a cyber-attack on patient and service user care



Section 3

Strategic Vision

Vision

“Defend as One to become the most cyber secure ICS in the country”

The BSW’s cyber security sets out to make our ICS a cyber resilient healthcare system by implementing cost-effective, collaborative, agile, risk-based and intelligence-led security capabilities, prioritising making best use of national and regional solutions.

We will deliver this by taking a joined-up ICS wide approach to cyber doing things once across the ICS where practical to **‘defend as one’**

Where national toolsets are not available and the need for additional IT / Cyber toolsets are required, the ICS will collectively agree the toolset approach to be adopted, to ensure the **‘defend as one’** approach is achieved. Where existing toolsets exist today, the future approach will be to move to a unified toolset approach and delivery model



BSW Cyber Strategy

Agreed Principles: All cyber initiatives created as a result of this strategy should be tested against the key agreed principles shown below, this is critical to ensure a single vision and approach. Schemes that do not align with these principles should not take place.



- **ICS Collaboration**
- **Common cyber toolsets with standard ICS processes and policies**
- **Making full use of national tools over other solutions. Mature the use of common tools we already have**
- **Consistent ICS Cyber Risk Management and board reporting.**
- **Growing our own cyber talent**
- **Building on our Cyber Cell for incidence response**
- **Further links with Local Authorities and other non-NHS local providers with robust contracts**
- **Targeted realistic and achievable**
- **Alignment to the national Data Security Protection Toolkit**

Please not this is a public summary of the ICS cyber strategy, the content has been significantly simplified, and full details of ICS cyber security schemes and improvement have been removed.

The full version is TPL: Amber Strict Limited disclosure, restricted to participants’ organization.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	12c
Date of Meeting:	22 January 2026		

Title of Report:	Quarter 3 Board Assurance Framework
Report Author:	Anett Loescher, Associate Director of Governance, Compliance and Risk
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	App 1 – Q3 BAF

Report classification	Please indicate to which body/collection of organisations this report is relevant. <i>Only one of the below should be selected (x)</i>
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
Executive Management Meeting	19/11/2025	Consideration of operational risk report for October / November
Chief Officers	w/c 24/11/2025	BAF review and updates
Audit Committee	04/12/2025	Assurance
Executive Management Meeting	17/12/2025	Review of risk report and BAF

1	Purpose of this paper
<p>The ICB maintains a register of its operational risks, and a Board Assurance Framework (BAF) specifically for the risks to the ICB's ability to achieve its strategic objectives as articulated in Our Integrated Care strategy - BSW Together. These strategic objectives are solely those of BSW system and BSW ICB. The</p>	

ICBs / the cluster are aware that BAFs, and approaches, mechanisms, processes and tools to manage cluster risks need to be developed and / or aligned in the near future.

We present the BSW ICB BAF for Q3 to the Board. This is to bring to the Board's attention the key risks to the achievement of the ICB's strategic objectives; and for assurance that the ICB has in place mechanisms and processes to identify and manage operational and strategic risks.

In summary, the risk position has not changed since the Q2 risk report. The ICB's risk environment remains volatile. The ICBs' and the cluster's organisational change to achieve the mandated reduction in running costs by the end of the business year continues to dominate considerations of risk.

Transition risks

The ICB's Transition Programme owns and manages the register of all risks related to the programme that delivers the transition from ICBs' current to future state. The Transition Programme regularly brings that risk register to the Joint BSW, Dorset and Somerset Transition Committee, for assurance.

2 Summary of recommendations and any additional actions required

The Board is asked to

- note the Q3 risk position as articulated in the BAF
- confirm that the BAF risk articulations remain appropriate and that the Q3 BAF risk scores and assessments are an accurate reflection of the position
- take assurance that the ICB has in place arrangements and processes to identify and manage risks to the ICB's ability to achieve its strategic objectives.

3 Legal/regulatory implications

The ICB is required to have in place effective system and arrangements for the management of risks.

4 Risks

Without appropriate arrangements to identify, manage and monitor risks, the ICB is vulnerable to risks materialising and impacting the ICB (and / or the BSW system) negatively.

5 Quality and resources impact

All can be negatively impacted if risks are not appropriately identified and managed.

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 paper can be published.	



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

BSW ICB Board Assurance Framework

2025-26

Version control log

Version Number	Review Date (date when approval was given)	Approved by	Summary of amendments
1.0	22 May 2025	BSW ICB Board	Substantial review and re-design of the BSW ICB BAF
1.1	18 Sept 2025	BSW ICB Board	Q2 2025/26 updates noted
1.2	22 Jan 2026	BSW ICB Board	

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1 Overview

Background

The BSW Integrated Care Partnership and the BSW ICB Board agreed the BSW Integrated Care Strategy in May 2023. The Strategy sets out our Strategic Objectives, and the BAF is structured around those. Section 2 summarises the strategic framework as articulated in the BSW Integrated Care Strategy.

The Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) is intended as a tool to focus the ICB Board on those risks which might compromise the achievement of our agreed Strategic Objectives (SO). When we identify and assess such risks, we take into consideration the controls that we have in place to mitigate the likelihood and / or impact of a risk, and the sources of assurance which the ICB Board can rely on to determine the effectiveness of those controls. Where we identify gaps in controls or assurances, we identify actions to address those gaps. The aim of comprehensive controls, together with other agreed mitigating actions, is to reduce the likelihood and / or impact score of the risk towards the stated target risk score. The target risk score is aligned with our Risk Appetite Statement (Appendix 1 of our ICB Risk Management Framework and replicated as Appendix 1 of this BAF, for ease of reference).

The BAF is a dynamic document, and we will continue to develop and improve it so that it truly fulfils its purpose as a tool for strategic risk-informed discussions.

Summary assessment for Q3 2025/26

Risk environment in Q3 2025/26

The ICB continues to operate in an environment of significant uncertainties and volatilities. These have a direct impact on the ICB's ability to achieve its strategic aims and objectives:

- National mandate that ICBs reduce their running costs by 50%, with 'costs out' by Q4 2025/26 has had an impact already on staffing levels (due to recruitment freeze), morale and capacity to deliver BAU activities and / or transformative activities. The announcement in November that cost-of-change funding is now available and that ICBs therefore must expedite organisational change via VR and CR before the end of the business year is exacerbating these negative effects on the workforce.
- The ICS's financial situation continues to be high-risk, and we are under significant regional scrutiny in light of our variance to plan.
- There remains the potential for industrial action from junior doctors.
- ICBs are required to produce a medium-term plan (MTP; guidance pending at time of writing) to describe, within a 5-year horizon, strategic commissioning intentions vis-à-vis population health and care needs and demands, and national targets. The MTP potentially poses an opportunity risk to the ICB.
- Going into winter we will likely see increased demand for services incl. UEC that could not be anticipated; this year's early rise of cases of respiratory illnesses is a case in point.
- The ICBC contract is still embedding.
- The Hospital Group model is still embedding, the Group has not yet realised its ambitions for oversight and grip over its entire performance and delivery, incl. the provision and delivery of UEC.
- The ICB is going through major change and must pay equal attention to both the change / transformation work and its BAU which causes pressure points across the organisation.

To note the publication of the [Strategic Commissioner Framework](#) and the autumn budget (see [NHS Confed briefing](#)).

Summary assessment of BAF risks in Q3

	Q1	Q2	Q3	Q4
Top strategic risks	BAF06, Financial delivery, L4xI5=20 BAF09, Future of the ICB, L4xI5=20	BAF06, Financial delivery, L4xI5=20 BAF09, Future of the ICB, L4xI5=20	BAF06, Financial delivery, L4xI5=20 BAF09, Future of the ICB, L4xI5=20	
Strategic risks with highest / lowest number of linked operational risks	BAF06, Financial delivery, 11 linked operational risks BAF04, Health inequalities, 0 linked operational risks BAF07, Health outcomes, 0 linked operational risks	BAF06, Financial delivery, 3 high-scoring op. risks linked operational risks BAF01, UEC, 3 high-scoring op. risks linked operational risks	BAF06, Financial delivery, 3 high-scoring op. risks linked operational risks BAF01, UEC, 3 high-scoring op. risks linked operational risks	
Actions	--	27 actions assigned in Q1. Of those: <ul style="list-style-type: none"> • 8 complete/BAU • 12 on track • 4 delayed (BAF05, BAF09) • 1 problematic (BAF08) • 1 void (BAF05) 	45 actions assigned in Q1 and Q2. Of those: <ul style="list-style-type: none"> • 17 complete • 15 on track • 10 delayed (BAF03, BAF04, BAF05, BAF08, BAF09) • 1 problematic (BAF08) • 1 void (BAF05) 	
Assurance ratings	8 strategic risks have a partial assurance rating 1 strategic risk has a no assurance rating	7 strategic risks have a partial assurance rating 2 strategic risks have an acceptable assurance rating	8 strategic risks have a partial assurance rating 1 strategic risk has an acceptable assurance rating	

Recommendations – Q3 2025/26

The Board is asked to

- Confirm that the risk articulations remain appropriate.
- Confirm that the Q3 risk scores and assessments are an accurate reflection of the position
- Note the BAF Q3 report

Additional information

We use these keys throughout for progress on actions rating and assurance assessment ratings:

Assurance Assessment Ratings	
 Significant Assurance	High level of confidence in appropriateness, effectiveness, delivery of BAF risk mgt.
 Acceptable Assurance	Confidence in appropriateness, effectiveness, delivery of BAF risk mgt., possible to improve
 Partial Assurance	Some areas of concern re appropriateness, effectiveness, delivery of BAF risk mgt.
 No Assurance	No confidence in appropriateness, effectiveness, delivery of BAF risk mgt.

Actions – progress assessment (PA)	
 Complete / BAU	Action completed, now business as usual
 On Track	Improvement on trajectory, on track, near completion
 Delayed	Delivery remains feasible. Actions not completed; further interventions required
 Problematic	Off track / trajectory / milestone breached. Recovery plan required

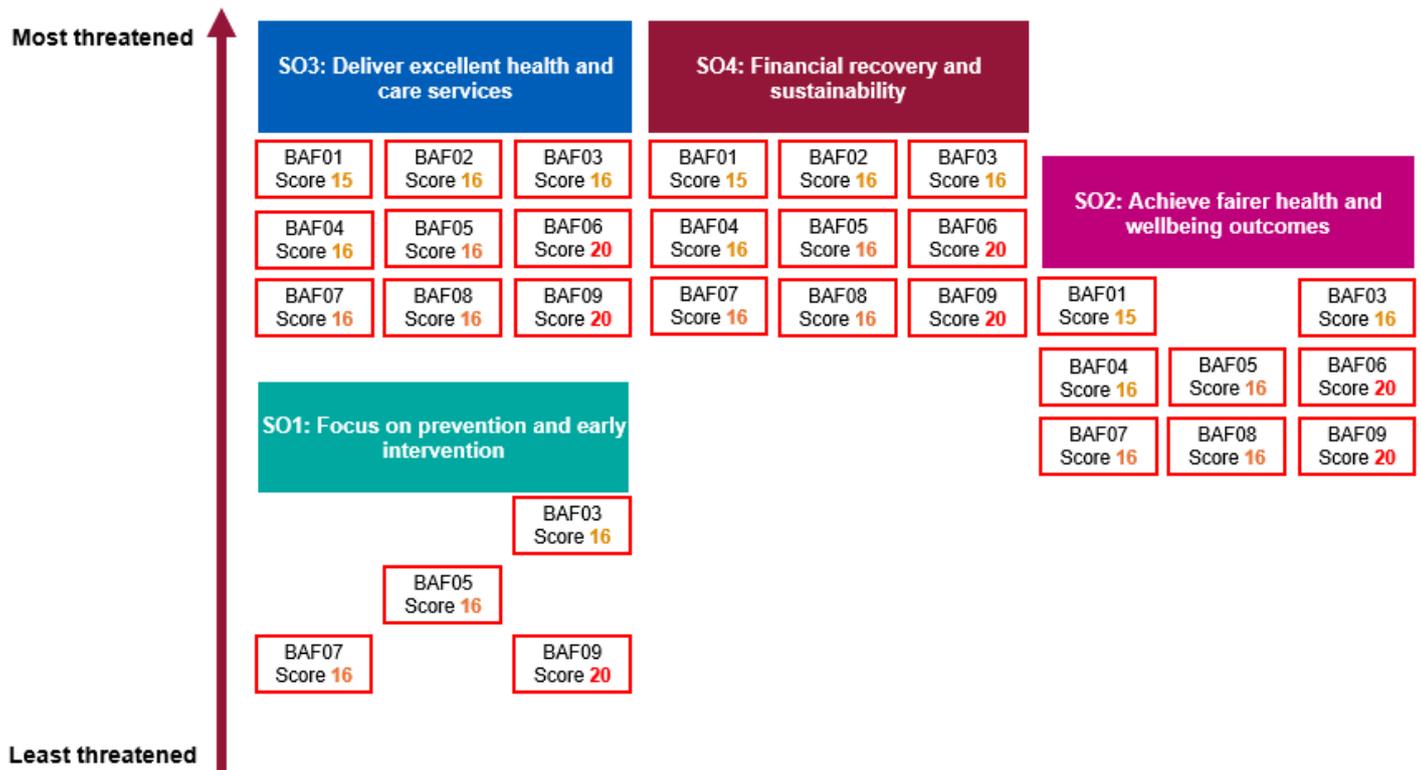
2 BSW Strategic Framework

The [BSW Integrated Care Strategy](#) describes our vision and strategic objectives; our [Implementation Plan](#) describes our strategic priorities for 2025/26. In summary:

Healthy pregnancy, birth and neonatal care	Start well 0-25 years	Live well 25-64 years	Age well +64 years	Die well	What achievement of our strategic objectives will mean
<p>Mothers have a healthy pregnancy and a good birth experience</p> <p>Babies are born in good health</p> <p>Parents approach parenting with confidence</p>	<p>Children, young people and families have a healthy environment in which they can grow up in</p> <p>Mental health support is available for children and young people who need it</p> <p>The most vulnerable children and young people are well-supported, incl. those in and leaving care, and those who need to be kept safe</p> <p>Children are ready to start education</p> <p>There are better links between health and care services and schools</p>	<p>Individuals are supported to look after their own health and wellbeing</p> <p>All residents benefit from living and working in places that promote health and wellbeing</p> <p>Those with physical disabilities, learning disabilities and mental health conditions are in good health. Their care and support includes access to opportunities such as accommodation, housing and employment</p>	<p>Older people feel that they are happy, independent and in control of their own care</p> <p>The health and wellbeing of carers is prioritised and supported</p> <p>When needed, health and care services are delivered at home, or as close to home as possible</p>	<p>Individuals are consulted on where they would like their life to end and how they would like to be cared for in the final months of their life</p> <p>Individuals feel that their wishes are respected by staff and those around them</p> <p>Comprehensive support services are provided for individuals and their loved ones through palliative care, incl. bereavement support for families.</p>	
SO1 Focus on prevention and early intervention		SP1 Increase our focus on prevention, improve timeliness of access and expand diagnostic and preventative care		Our strategic objectives, and priorities for 2025/26	
SO2 Achieve fairer health and wellbeing outcomes		SP3 Reducing healthcare inequalities in our localities and our system			
SO3 Deliver excellent health and care services		SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place			
SO4 Financial recovery and sustainability		SP6 Deliver our medium-term financial plan and return to financial balance			

3 Threats to our strategic objectives and strategic priorities – assessment for Q3 2025/26

In Q3 we see the same position as in Q2.



4 Board Assurance Framework dashboard Q3 2025/26

Ref	Risk title	Q1			Q2			Q3			Q4			Target			Date	Risk moves	Assurance assessmt	Action status	Linked op. risks	Threat to Strategic Objectives
		L	I	S	L	I	S	L	I	S	L	I	S	L	I	S						
BAF01	Urgent and Emergency Care	3	5	15	3	5	15	3	5	15				2	3	6	31/03/2026	—	partial	4(Q1): 1 on track 3 complete/BAU	Q3: 1 w score 20 2 w score 16	S02 S03 S04
BAF02	Elective care	4	4	16	4	4	16	4	4	16				2	3	6	31/03/2026	—	acceptable	3(Q1), 3(Q2): 1 on track 5 complete/BAU		S03 S04
BAF03	Prevention	4	4	16	4	4	16	4	4	16				3	3	9	31/03/2026	—	partial	3(Q1), 6(Q2): 4 on track 1 complete/BAU 4 delayed		S01 S02 S03 S04
BAF04	Health inequalities	4	4	16	4	4	16	4	4	16				3	3	9	31/03/2026	—	partial	3(Q1), 4(Q2): 3 on track 2 complete/BAU 2 delayed		S02 S03 S04
BAF05	Workforce	3	4	12	4	4	16	4	4	16				3	3	9	31/03/2026	—	partial	3(Q1): 1 delayed 1 void 1 complete/BAU	Q3: 1 w score 20 2 w score 16	S01 S02 S03 S04
BAF06	Financial delivery	4	5	20	4	5	20	4	5	20				3	4	12	31/03/2026	—	partial	2(Q1), 5(Q2): 4 on track 2 complete/BAU	Q3: 2 w score 20 1 w score 16	S02 S03 S04
BAF07	Wider determinants of health	4	4	16	4	4	16	4	4	16				3	3	9	31/03/2026	—	partial	2(Q1): 1 on track 1 complete		S01 S02 S03 S04
BAF08	Health outcomes	4	4	16	4	4	16	4	4	16				3	3	9	31/03/2026	—	partial	4(Q1): 1 complete/BAU 1 problematic 1 on track 1 delayed		S02 S03 S04
BAF09	Future of the ICB	4	5	20	4	5	20	4	5	20				3	5	15	31/03/2026	—	partial	3(Q1): 1 complete/BAU 2 delayed	Q3: 1 w score 16	S01 S02 S03 S04

5 Board Assurance Framework – Analysis

BAF01: Urgent and Emergency Care

Commissioning Committee | ICB Chief Nurse Officer | 22/04/2025

Risk description

- **IF** (likelihood / probability) Urgent and Emergency Care (UEC) does not have sufficient and appropriate capacity¹ across the entire system pathway to meet demand and support flow,
- **THEN** we will not achieve ambulance targets, will not reduce NCTR, will not get patients into the most appropriate care settings, will not free up hospital capacity for elective care, patients will come to harm, system performance incl. financial will deteriorate.
- As a **CONSEQUENCE** (impact), we will continue to focus system resources on managing pressures instead of routing resources into the transformation of care, and we will not achieve our strategic objectives SO2, Fairer health and wellbeing outcomes; SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	SO2 Achieve fairer health and wellbeing outcomes	SO3 Deliver excellent health and care services	SO4 Achieve financial recovery and a long-term sustainable health and care system
SP1 Transform community services, improving timeliness of access and expanding diagnostic and preventative care	SP3 Reducing healthcare inequalities in our localities and our system	SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population	SP6 Deliver our medium-term financial plan and return to financial balance
		SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place	

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked operational risks
Likelihood	3	3	3		2	Treat 31/03/2026	Low
Impact	5	5	5		3		Mod
Score	15	15	15		6		High
Movement	-	-	-				Extreme

Rationale for current risk score and progress made in the quarter

- In Q3, we assessed the likelihood of this risk materialising as 3, and the impact of the risk should it materialise as 5. The rationale for this assessment is that:
 - Comprehensive winter plan has been developed, with further mitigations and commissioning of additional services to manage winter and to mitigate the risk as such

¹ Capacity here does not primarily mean workforce. Rather, capacity means the arrangements and structures that are needed to effectively meet and respond to the population's demand for urgent and emergency care services.

- We're not reducing the score yet because the winter plan changes and services are just coming online – we will assess impact of mitigations at Q4
- RUH and GWH remain at tier 1 for UEC
- Despite a good uptake of the flu vaccination, BSW is currently at 71% of its target for housebound and care homes cohorts; children's respiratory disease numbers are up; currently targeting / prioritising those cohorts in particular for vaccinations.

Key controls

- BSW Implementation Plan 2025/26
- BSW Outcomes Framework
- NHS Planning Guidance 2025/26
- NHS statutory targets
- Daily System Control Centre (SCC) calls and battle rhythm of Gold calls
- UEC Delivery Group oversight of immediate action plans to increase flow
- BSW Winter Plan (for winter) incl. winter assurance framework
- BSW Quality Assurance Framework
- System Quality Group
- Regional performance meetings
- Q3 - Weekly system overview meeting (winter)
- Q3 - Recovery board now has direct oversight of SWAST demand and NCTR

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1st line (ICB)	Locality meetings are in place for NCTR led by place directors	-	●	●		
2nd Line (system)	Regular performance reports incl. recommended adjustments of plans	●	●	●		
	Monthly performance reports from UEC Delivery Group to PDEG	●	●	●		
	Monthly system performance report to EMM, QOC, FIC and Board	●	●	●		
	Winter Plan assurance by UEC Delivery Group, acutes, QOC	-	●	●		
	Patient safety reports	●	●	●		
3rd Line (external)	NHSE regional assurance meetings	●	●	●		
	NQB oversight of incidents, patient experience, learning – ICB attendance and SQG reports by exception	●	●	●		
Overall assessment		●	●	●		

Assurance Assessment Ratings	
 Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
 Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
 Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
 No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gaps identified in Q1 – remains the same in Q2 and Q3:
 - BSW has no urgent and emergency care strategy. Same status in Q2 and Q3 though strategy development commenced.
- The SWASFT contract is managed by Dorset ICB on behalf of the SW ICBs. We are somewhat removed from this and believe that we should have more visibility of / tighter control over the SWASFT contract to ensure SWASFT delivers / contractual levers are deployed as and when appropriate. Same status in Q2 but steps taken to ensure BSW has greater grip on the contract. Q3 – closer oversight in place, and detailed demand and capacity analysis based on SWAST data (conveyance; will influence contract with SWAST)

Assurances:

- Gaps identified in Q1 – remains the same for Q2, Q3:
 - We don't have good data (complete, up-to-date) for out-of-hospital capacity where patients could either be treated / cared for or be discharged to in order to improve flow –
 - Data situation improved in Q3 (incl. breakdowns of BCF, community, primary care schemes) but need to review outputs of SWAST demand analysis and need to confirm discharge to assess capacity through LA arrangements

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1(Q1)	Develop a BSW UEC strategy	Identification of problems, drivers and solutions; clear measurable objectives and targets; buy-in and commitment from health and non-health organisations to deliver to objectives	Jo Williamson	30 March 2026	<p>July 2025: in development – in light of clustering, this is a 'bridging' arrangement until we are in a position to develop a UEC strategy that is right for the cluster</p> <p>December 2025: UEC strategy per se remains in development, moving to an end-to-end review in Q4 (in context of commissioning intentions for pathways out of acutes)</p>	
2(Q1)	Facilitate greater oversight of SWASFT contract	Firmer grip on contract will enable earlier identification of issues and enable intervention to bring contract performance back on track	Claire Croxton	30 June 2025; continuous from July 2025	<p>July 2025: for BSW, we have good oversight of the contract and its performance in BSW; good relationships enable us to manage the contract robustly incl. mitigating financial loss if targets are not met</p> <p>December 2025: Is now BAU</p>	
3(Q1)	Develop / enhance dedicated focus on infection prevention and control	Reduce number and impact of outbreaks such as ward / bed closures to maximise hospital capacity	Connie Timmins	Continuous	<p>July 2025: BSW ICS Infection Prevention and Management Collaborative have in place an outbreak risks and consideration framework for the robust oversight and management of infections, including seasonal viruses such as Influenza like illness and gastrointestinal</p>	

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
					<p>illness. The framework supports the risk assessment for use of closed beds during periods of outbreak and recommendations to reduce impact of circulating community levels of infection on inpatient ward areas and residential settings, such as care homes</p> <p>December 2025: Ongoing implementation of the risk and consideration framework continues as we progress through the winter period. Winter readiness webinar has been held with social care and primary care to support management of cases, prevent admissions and reduce outbreaks in the community</p>	
4(Q1)	Establish oversight of out-of-hospital capacity	Better understanding of out-of-hospital capacity and subsequent ability to address issues incl. by defining and monitoring clear measurable objectives, targets and KPI;	Jo Williamson	Closed, monitoring continuous	<p>July 2025: Strong oversight on NCTR tolerances for out-of-area patients in place BSW-wide escalation process for NCTR being implemented Monthly highlight reports for delivery groups link to out-of-hospital capacity actions and deliverables for the relevant delivery groups HCRG contract, clear understanding of reduction in attendance (hospital admissions and walk-ins) BCF schemes</p> <p>December 2025: Clearer on learning from SWAST demand; BAU</p>	

Actions – progress assessment (PA)	
	Complete / BAU Action completed, now business as usual
	On Track Improvement on trajectory, on track, near completion
	Delayed Delivery remains feasible. Actions not completed, further interventions required
	Problematic Off track / trajectory / milestone breached. Recovery plan required

BAF02: Elective Care

Commissioning Committee | Caroline Holmes | 22/04/2025

Risk description and impact on strategic objective / s

- **IF** (likelihood / probability) the system fails to deliver on the specific expectations set out in the elective care reform plan,
- **THEN** cancer and planned care waiting times will not reduce in line with national expectations.
- As a **CONSEQUENCE** (impact), there will be patient harm, reputational damage to the ICS, a loss of Elective Recovery Fund (ERF), continued increased demand for urgent and emergency care and primary care, continued operational systems pressures, and we will not achieve our strategic objectives SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	SO2 Achieve fairer health and wellbeing outcomes	SO3 Deliver excellent health and care services	SO4 Achieve financial recovery and a long-term sustainable health and care system
SP1 Move care closer to our communities	SP3 Reducing healthcare inequalities in our localities and our system	SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population	SP6 Deliver our medium-term financial plan and return to financial balance
SP2 Prioritise prevention activities working through and with localities and communities		SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place	

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks
Likelihood	4	4	4		31/03/2026	Treat	Low
Impact	4	4	4				Mod
Score	16	16	16				High
Movement	-	-	-				Extreme

Rationale for current risk score and progress made in the quarter

- In Q3, we assessed the likelihood of this risk materialising as 4, and the impact of the risk should it materialise as 4. The rationale for this assessment is that:
 - In Q2 we considered adjusting the score to reflect that the RUH had moved into Tier 1. In Q3, we assessed that since this affects only one of our three acute providers, the system risk should remain the same.
 - The elective care plan is developed and we are in implementation. We see some improvement in performance.
 - Contracts and indicative activity plans are agreed with Independent Sector providers to support system recovery however these are currently above plan in terms of cost and activity, reflecting

continued demand for services. The ICB has exercised its contractual right to investigate overperformance and this is kept under continuous review.

- Although there has been improvement in performance against national standards in two of our three acute providers (GWH and SFT), RUH performance has deteriorated since the start of the year meaning that the Trust is in Tier 1 oversight with NHS England. Some improvement is evidenced and detailed recovery action plan implemented.
- The BSW-wide waiting list for elective care has increased in Q2 against a national requirement to limit demand to 0.2%. Waiting list size is decreasing at RUH but continues to grow at SFT and GWH.
- None of the three acutes are on plan to deliver 28-day Faster Treatment Diagnosis (FDS) standards in year. There is variable delivery against plan of 31- and 62-day standards. Remedial action plans are in place at RUH and form part of Tiering. Additional investment has been provided by SWAG to support improvement.
- Diagnostic waiting times are high, with both SFT and RUH being worse than plan in Q2 (similar as in Q1). GWH are above plan and performed well in Q1. RUH position is significantly off plan, and subject to scrutiny through Tiering. Community Diagnostic Centre (CDC) activity is below plan, with the greatest under-delivery in year at Sulis CDC.
- Longest waiting patents are being treated ahead of 21 December 2025 per national mandate. We should commence Q4 with close to zero 65-week waiters.
- The RUH identified a number of patients who have not been added correctly to the waiting list, resulting in significant (potentially >100 weeks) waiting times for patients. Following review these patients have been added to the waiting list and are being treated and monitored.
- Strategic commissioning intentions for elective care are developed and will guide ongoing improvement against national mandate and metrics.

Key controls

- BSW Implementation Plan 2025/26
- BSW Outcomes Framework
- NHS Planning Guidance 2025/26
- NHS Elective Reform Plan
- NHS statutory targets
- NHS tiering per oversight framework (Q2: RUH has gone into tier 1 for elective performance, diagnostic waiting times and cancer standards)
- Contract Review Meetings with Independent Sector Providers and initiation of Activity Query Notices as per contract
- Ongoing monitoring of performance through BSW wide Recovery Board
- SWAG Cancer Alliance investments agreed with focus on faster diagnosis – implementation from Q2.
- Quality Oversight Committee advised and overseeing impact of any harm to patients resulting from incorrect waiting list management.
- Strategic commissioning intentions (Q3)
- NHS medium term planning guidance (Q3)

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1st Line (ICB)	Contract review meetings with providers incl. acutes	●	●	●		
2nd Line (system)	Regular performance reports incl. recommended adjustments of plans	●	●	●		
	Monthly performance reports from Elective Care Delivery Group	●	●	●		

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
	Bi-monthly system performance report to EMM, Commissioning Committee and Board	●	●	●		
3 rd Line (external)	NHSE regional assurance meetings with ICB involvement	●	●	●		
	NHSE tier 1 meetings with RUH	-	●	●		
Overall assessment		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gap identified in Q1 – remains the same in Q2, Q3: None

Assurances:

- Gap identified in Q1 – remains the same in Q2, Q3:
 - Contract review meetings to be strengthened in terms of frequency, scope and seniority of attendees. Meetings largely now in place but need to establish for acute providers – hence no change from amber to green

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1(Q1)	Contract review meeting plan to be developed	More robust oversight and management of contracts	Jane Rowland	30 June 2025	July 2025: Complete. Plan developed and being implemented.	
2(Q1)	Indicative activity plans developed for all providers to meet trajectories and cost envelope	Activity aligned with performance	Jane Rowland, Mark Harris	30 June 2025	July 2025: Complete. Plan developed and being implemented for independent sector providers. August 2025: Overperformance against plan at Month 4 – contract levers being exercised through Contract Review Meetings	

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
3(Q1)	RUH elective recovery plan being developed	Agreed trajectory and recovery plan to meet national targets by end of FY 2025/26	Jane Rowland	30 August 2025	August 2025: Progressing. Deep dive being undertaken into diagnostic performance; 12-week challenge underway to deliver stepped change in performance including strengthening validation, management and oversight of waiting lists December 2025: plan developed and implementing	
4(Q2)	Long term plan to deliver cancer standards to be developed and provided to ICB and Region as part of Tiering	Delivery of cancer standards as per plan	Jane Rowland & RUH	30 September 2025	August 2025: In-sourcing arrangements in place to support improvement in specialties where there is greatest distance from plan Long-term plan in development to be provided to region by mid September December 2025: plan developed and implementing	
5(Q2)	Diagnostics Recovery Plan for RUH to be developed and reported to Region and ICB as part of Tiering	Recovery to planned trajectories	Jane Rowland & RUH	30 September 2025	August 2025: Deep dive analysis in development led by RUH COO. This will include: <ul style="list-style-type: none"> - Use of CDC capacity at Sulis and associated booking pathways - Review of pathways where diagnostics is having the greatest impact on RTT performance overall December 2025: plan developed and implementing	
6(Q2)	Increase use of CDC capacity to ensure improved use of available resources	Increased use of CDC in line with original plan	Jane Rowland	31 March 2026	August 2025: Diagnostics performance meeting established to review planned activity month on month Plan in place to improve use of Sulis CDC (where there is the greatest distance from plan) Further work underway to understand gap at Salisbury CDC and plans to address December 2025: SFT starting to recover their plan. Sulis still significantly away from plan	

Actions – progress assessment (PA)		
	Complete / BAU	Action completed, now business as usual
	On Track	Improvement on trajectory, on track, near completion
	Delayed	Delivery remains feasible. Actions not completed, further interventions required
	Problematic	Off track / trajectory / milestone breached. Recovery plan required

BAF03: Prevention

Quality and Outcomes Committee | ICB Chief Medical Officer | 22/04/2025

Risk description

- **IF** (likelihood / probability) we do not take the right actions and provide the right incentives for residents to stay healthy,
- **THEN** we will not prevent disease, injury or ill-health or avoidable complications associated with long-term conditions.
- As a **CONSEQUENCE** (impact), we will continue to see operational pressures on our health and care system, and will not deliver the intended improvements in population health. We will not achieve our strategic objectives SO1 Focus on prevention and early intervention. SO2, Fairer health and wellbeing outcomes; SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	●	SO2 Achieve fairer health and wellbeing outcomes	●	SO3 Deliver excellent health and care services	●	SO4 Achieve financial recovery and a long-term sustainable health and care system	●
SP1 Move care closer to our communities		SP3 Reducing healthcare inequalities in our localities and our system		SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population		SP6 Deliver our medium-term financial plan and return to financial balance	
SP2 Prioritise prevention activities working through and with localities and communities				SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place			

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks	
Likelihood	4	4	4		3	Treat	Low	
Impact	4	4	4		3		Mod	
Score	16	16	16		9		High	
Movement	-	-					Extreme	

31/03/2026

Rationale for current risk score and progress made in the quarter

- In Q3, we assessed the likelihood of this risk materialising as 4, and the impact of the risk should it materialise as 4. The rationale for this assessment is that:
 - National and regional developments: National policy (Fit for the Future, forthcoming Medium Term Plan) signals a longer-term emphasis on prevention, but annual performance and financial requirements continue to drive short-term priorities and limit the system's ability to shift investment upstream.
 - ICB development: Commissioning intentions include a prevention commissioning intention for 2026/27 onwards, strengthening the visibility of prevention within the planning round and improving

alignment between strategic ambition and commissioning priorities. The Prevention Strategy is in near-final draft and scheduled for PHB approval in January, providing greater clarity on priorities and future direction.

- Cluster development: The transition to the new cluster arrangements increases uncertainty regarding future governance, funding commitments and prioritisation. There is not yet confirmed investment beyond 2025/26.
- Commissioned activity and delivery: Delivery of the hypertension programme is progressing with early improvement in case finding and optimisation. Recurrent funding for Treating Tobacco Dependence (TTD) has been agreed and commissioning intentions accepted by Exec with early implementation discussion with providers started.
- An expression of interest has been submitted for the national prevention accelerator, and the outcomes is awaited. A bid for Obesity Pathway Innovation Programme is being submitted. If successful, these bids could bring additional national investment, evaluation support and capacity into BSW, strengthening delivery and accelerating progress on system-wide prevention priorities.

Key controls

- BSW ICS Strategy 2023-2028 and Implementation Plan 2025/26
- BSW Outcomes Framework
- NHS Planning Guidance 2025/26
- Hypertension programme delivery plan and monitoring and evaluation dashboard
- Prevention Strategy Group Terms of Reference, Workplan and draft prevention strategy (Q3)
- Delivery Group annual plans with prevention actions
- BSW Commissioning Intentions (Q3)

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1st Line (ICB)	Delivery Groups highlight reports include prevention KPIs Hypertension reports to PSG/ Community Delivery Group Programme.	●	●	●		
2nd Line (system)	Vaccination rates report to NHSE	●	●	●		
	Screening rates (national screening programmes) reports	●	●	●		
	QOC receives quarterly updates from Population Health Board including assurance on prevention progress.	●	●	●		
3rd Line (external)	Data collation into NHSE and mirrored back to ICBs	●	●	●		
Overall assessment	Although the above are in place, we assess that the controls and assurance framework for this risk requires improvement.	●	●	●		

Assurance Assessment Ratings	
	Significant Assurance High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
	Acceptable Assurance Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
	Partial Assurance Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
	No Assurance No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

Gaps identified in Q1, remains the same in Q2, Q3

- No approved prevention strategy with measurable targets (unclear mandate and scale) – see actions 1a / 1b.
- No sustainable multi-year funding mechanism which leaves programmes fragile and short-term – see actions 2 / 3b
- Delivery Group prevention actions not yet underpinned by logic models or linked to outcomes – see action 6b.

Assurances:

Gaps identified in Q1, remains the same in Q2, Q3

- System-wide prevention reporting remains incomplete and variable in quality. Vaccination rates are reported nationally to NHSE, and screening rates are monitored through national programmes. Data on smoking, obesity and physical inactivity prevalence and admissions for alcohol specific conditions are included in the outcomes framework. There are national reports on the impact of Treating Tobacco Dependence. Evaluation tools for hypertension and obesity have been developed. However, assurance is uneven across other prevention domains, data quality is inconsistent, and overall the system lacks a comprehensive framework to evidence prevention impact beyond hypertension. see Action 5.
- Delivery capacity fragmented and variably resourced which means that prevention programmes rely on multiple delivery arms (NHS providers, Local Authorities, VCSE). Current activity is not yet at the right scale or consistently aligned to strategic priorities, see Actions 2, 3b, 4, 6b.

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1a(Q1)	Develop BSW prevention strategy	Clear articulation of priority prevention areas and partner accountabilities, creating a framework for future commitment to programmes	Amanda Webb, CMO	31 Dec 2025	August 2025: Development underway led by Prevention Strategy Group and supported by Task and Finish Group. December 2025: Draft is going to Prevention Strategy Group in December and Population Health Board in January	
1b(Q1)	Secure approval of prevention strategy by body responsible for implementation/in a position to make commitments	Commitment to prevention strategy from the cluster.	Amanda Webb, CMO	31 Mar 2026	August 2025: Paused, pending cluster governance December 2025: Remains paused pending cluster governance.	
2(Q1)	Secure multi-year prevention funding commitment	Sustainable financial commitment to implement and scale prevention programmes	CFO/CMO	To be agreed	August 2025: Delayed, pending cluster governance and resource prioritisation. December 2025: Included within the BSW MTP	

					assumptions. Cluster commitment pending cluster governance.	
3a(Q1)	Deliver year 1 – Hypertension Programme	Reduction of CVD risk through increased case finding, optimisation of treatment, and prevention of CVD events and deaths – including measurable impact on health service use (e.g. reduced emergency admissions and complications)	Amanda Webb, CMO	Phased: 2025/26–2026/27	August 2025: Programme is live and on track within revised funding envelope. Delivery is phased, with activity running across 25/26 and into 26/27. December 2025: No Change	
3b(Q1)	Secure continuation of Hypertension Programme (Years 2–3)	Embedding a multi-year programme to sustain risk reduction, expand case finding and optimise treatment, thereby preventing further CVD events, deaths and related health service pressures	Amanda Webb, CMO	2025/26	August 2025: Delayed, pending cluster governance. BSW ICB is not in a position to commit beyond 25/26 due to transition to cluster. The business case developed for BSW may need revising to reflect the cluster considerations. December 2025: Included within the BSW MTP assumptions. Cluster commitment pending cluster governance.	
4(Q1)	Develop business cases for CYP Mental Health and Frailty Prevention	Broaden prevention programmes to widen system commitment	Amanda Webb, CMO	2025/26	August 2025: Delayed, pending cluster governance and mandate. Early scoping work undertaken. December 2025: Awaiting outcome from Prevention Accelerator EOI and OPIP bid – these could provide opportunities to broaden prevention programmes.	
5(Q1)	Develop prevention reporting approach and metrics	System commitment to track, evidence and reinforce prevention programmes through measurable outcomes and ROI	Amanda Webb, CMO	30 July 2025 Revised to 31 Mar 2026	August 2025: Reporting framework linked to Outcomes Framework under design; building on learning from hypertension programme. December 2025: Outcomes Framework dashboard published. Prevention outcomes framework described in Prevention Strategy. Development to follow.	
6a(Q1)	Delivery Groups to include prevention actions in annual plans	Demonstrates system-wide commitment to prevention across all care domains	Delivery Groups	31 March 2026	August 2025: All Delivery Groups have included a prevention element within their plans.	

					December 2025: Prevention included within commissioning intentions.	
6b(Q1)	Strengthen Delivery Group prevention actions (scale, logic model, outcome linkage)	Coherent, measurable and appropriately scaled prevention interventions embedded in Delivery Group work programmes	Prevention Strategy Group Delivery Groups	31 Mar 2026	August 2025: Further work needed to ensure actions are robust, outcome-linked and at the right scale. December 2025: No Change	

Actions – progress assessment (PA)	
	Complete / BAU Action completed, now business as usual
	On Track Improvement on trajectory, on track, near completion
	Delayed Delivery remains feasible. Actions not completed, further interventions required
	Problematic Off track / trajectory / milestone breached. Recovery plan required

BAF04: Health inequalities

Quality and Outcomes Committee | ICB Chief Medical Officer | 22/04/2025

Risk description

- **IF** (likelihood / probability) we do not focus our efforts on improving health inequalities and addressing unwarranted variation,
- **THEN** we will have little or no impact on the health and outcomes of those who are adversely affected by current ways of working.
- As a **CONSEQUENCE** (impact), there will be sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care, and worsened quality of service experienced. We will not achieve our strategic objectives SO2, Fairer health and wellbeing outcomes; SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	SO2 Achieve fairer health and wellbeing outcomes	SO3 Deliver excellent health and care services	SO4 Achieve financial recovery and a long-term sustainable health and care system
SP1 Move care closer to our communities	SP3 Reducing healthcare inequalities in our localities and our system	SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population	SP6 Deliver our medium-term financial plan and return to financial balance
SP2 Prioritise prevention activities working through and with localities and communities		SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place	

Risk movement over time and current score (Q 2)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks
Likelihood	4	4	4		3	Treat	Low
Impact	4	4	4		3		Mod
Score	16	16	16		9		High
Movement	-	-					Extreme

31/03/2026

Rationale for current risk score and progress made in the quarter

- In Q3, we assessed the likelihood of this risk materialising as 4, and the impact of the risk should it materialise as 4. The rationale for this assessment is that:
 - Commissioning intentions aim to embed health inequalities across all programmes, ensuring equity expectations are built into neighbourhood health, planned care, UEC, primary care, digital and prevention. This provides stronger system alignment than in previous quarters.
 - Development of the health inequalities strategy is progressing. This offers clearer strategic direction for 2025/27 onwards for BSW.

- Cluster development: The transition to the new cluster arrangements increases uncertainty regarding future governance, funding commitments and prioritisation.
- The outcomes framework dashboard now enables segmentation by inequality groups, representing a significant enhancement in system insight. This supports better targeting, prioritisation and monitoring or variation across Core20Plus groups and neighbourhoods.
- Targeted £1.7m inequalities investment for 2025/26 is being deployed, with delivery now underway. Sustainability beyond 2025/26 remains uncertain but funding activity for the current year is progressing.
- Health inequalities funding included in the BSW MTP assumptions.

Key controls

- BSW ICS Strategy 2023-28 and BSW Implementation Plan 2025/26 with clearer strategic commitment to tackling health inequalities
- BSW Outcomes Framework segmented by inequality groups (age, gender, ethnicity, deprivation) providing a foundation for targeting investment and measuring gaps.
- Core20PLUS5 (adults) and Core20PLUS5 (children)
- NHS Planning Guidance 2025/26
- BSW Commissioning Intentions (Q3).
- Inequalities Strategy Group (ISG) established with agreed work programme, providing system leadership and oversight. Inequalities strategy under development (Q3).
- 2025/26 inequalities commissioning model in place, supported by £1.7m investment, co-designed with partners using Decision Quality principles and a Core20PLUS5 focus.
- Delivery Group priorities – all Delivery Groups have identified Core20plus5 priorities in their annual plans.
- National requirements and reporting – inequalities reflected in NHS planning guidance, with reporting on vaccination, screening and other metrics monitored through NHSE returns.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1st Line (ICB)	Delivery Groups programme specific performance reports	●	●	●		
	Regular reports on impact of health inequalities monies	-	●	●		
2nd Line (system)	Bi-monthly system performance report to EMM, Committees and Board	●	●	●		
3rd Line (external)	Data collation into NHSE and mirrored back to ICBs	●	●	●		
Overall assessment		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gaps identified in Q1, remains the same in Q2, Q3
 - No approved system-wide inequalities strategy with measurable targets – strategic commitment is not yet translated into a framework that mandates delivery at scale. see Actions 1a / 1b.
 - No mechanism to allocate resources beyond 2025/26 – the absence of cluster-level governance means continuation into 2026/27 and implementation of the Outcomes Framework–led model is at risk. see Action 2b.
 - Delivery Group inequalities actions are not yet consistently underpinned by strong logic models or linked to measurable outcomes. see Action 3.

Assurances:

- Gaps identified in Q1, remains the same in Q2, Q3
 - Inequalities dashboard currently developed at BSW level and may not be easily scalable to the cluster footprint. This introduces uncertainty for the 2025/26 commissioning approach, as consistent data will be required to support future decision-making at a cluster level.
 - Assurance remains fragmented across programmes – vaccination and screening rates are reported nationally, and some data exists on smoking and obesity, but reporting is uneven across other domains and not collated into a single assurance framework.
 - Limited external validation – assurance currently relies on local self-reporting, with national oversight largely focused on a narrow set of statutory metrics.
 - **Q3:** We have strengthened assurance through the development of the Outcomes Framework dashboard and have begun using it to identify priority inequalities and target improvement. However, current reporting remains descriptive. The dashboard does not yet quantify the size of gaps or test statistical significance between groups (e.g., White vs ethnic minority populations, Core20 vs Other80). This limits full system-wide assurance and is the next stage of development (see Action 4).

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1a(Q1)	Develop refreshed BSW inequalities strategy	Clear articulation of priority inequality areas and partner accountabilities, creating a framework for future commitment to programmes	Amanda Webb, CMO	31 Dec 2025	August 2025: Development underway led by Inequalities Strategy Group, supported by Task and Finish Group. December 2025: Draft is going to Inequalities Strategy Group in January and Population Health Board in January	
1b(Q1)	Secure approval of inequalities strategy by body responsible for implementation/ in a position to make commitments	Commitment to inequalities strategy from the cluster.	Amanda Webb, CMO	31 Mar 2026	August 2025: Paused, pending cluster governance and resource prioritisation. December 2025: No Change	

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
2a(Q1)	Deliver 2025/26 inequalities commissioning model	Structured commissioning approach using Decision Quality principles and a Core20plus5 focus ensuring resources directed to clearly defined inequality outcomes	Amanda Webb, CMO	31 Mar 2026	August 2025: £1.7m investment aligned to Core20PLUS5 priorities, co-designed with partners and communities. December 2025: Delivery underway	Green
2b(Q1)	Deliver 2026/27 inequalities commissioning model	Outcomes Framework-led commissioning using Decision Quality principles, targeting the largest inequality gaps, focusing on a small number of priority outcomes with measurable system-wide impact	Amanda Webb, CMO	31 Mar 2027	August 2025: Paused pending cluster governance. Foundations in place: Decision Quality approach tested in 2025/26. Outcomes Framework in place and segmented by inequalities groups. December 2025: Plan progressing. Funding included in BSW MTP assumptions.	Orange
3(Q1)	Develop and embed inequalities dashboard	Use the outcomes framework data segmented by age, gender, ethnicity and deprivation to inform a dashboard that tests the size and statistical significance of gaps. Provides systematic, evidence led assurance on inequality gaps.	Amanda Webb, CMO	31 Dec 2025	August 2025: Initial segmentation is in place within the Outcomes Framework. Work to build the full dashboard is underway but not yet complete. December 2025: Dashboard published	Blue
4a(Q1)	Delivery Groups to include inequality actions in annual plans	Demonstrates system-wide commitment to inequalities across all care domains	Delivery Groups	31 March 2025	August 2025: All Delivery Groups have included an inequality element within their plans. December 2025: No Change	Blue
4b(Q1)	Strengthen Delivery Group inequalities actions (scale, logic model, outcome linkage)	Coherent, measurable and appropriately scaled inequality interventions embedded in Delivery Group work programmes	Prevention Strategy Group & Delivery Groups	31 Mar 2026	August 2025: Further work needed to ensure actions are robust, outcome-linked and at the right scale. December 2025: Action Learning reviews between ISG and DGs underway	Green

Actions – progress assessment (PA)	
	Complete / BAU Action completed, now business as usual
	On Track Improvement on trajectory, on track, near completion
	Delayed Delivery remains feasible. Actions not completed, further interventions required
	Problematic Off track / trajectory / milestone breached. Recovery plan required

BAF05: Workforce

Remuneration and People Committee | ICB Chief People Officer | 22/04/2025

Risk description

- **IF** (likelihood/probability) we do not develop and implement a longer term workforce plan to support delivery of our current plans and strategies,
- **THEN** workforce gaps will increase, employee health and wellbeing will be affected, and turnover may increase; and the future pipeline will destabilise.
- As a **CONSEQUENCE** (impact) we will be unable to meet the requirements of the NHS Long Term Workforce Plan, will see a deterioration of employee health, wellbeing and retention, and experience actual or potential impact on service delivery and quality of care, including detrimental impacts on quality of care that typically arise when workforce is less inclusive. We may continue to see use of high-cost agency staff, with adverse effects on BSW finances.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	•	SO2 Achieve fairer health and wellbeing outcomes	•	SO3 Deliver excellent health and care services	•	SO4 Achieve financial recovery and a long-term sustainable health and care system	•
SP1 Move care closer to our communities		SP3 Reducing healthcare inequalities in our localities and our system		SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population		SP6 Deliver our medium-term financial plan and return to financial balance	
SP2 Prioritise prevention activities working through and with localities and communities				SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place			

Risk movement over time and current score (Q 1)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks		
Likelihood	3	4	4		3	Treat	Low		
Impact	4	4	4		3		Mod		
Score	12	16	16		9		High		
Movement	-	↑	-				Extreme		

Rationale for current risk score and progress made in the quarter

- In Q3, we assessed the likelihood of this risk materialising as 4, and the impact of the risk should it materialise as 4. The rationale for this assessment is similar to Q2:
 - HR capacity and capability re complexity of ICB change process affects the capacity and capability to do any strategic workforce planning at all
 - There is not sufficient clarity what responsibilities and accountabilities re strategic workforce planning transfer out to region and / or remain with the ICB, and what the target operating model for strategic workforce planning is – some strategic workforce planning work is already moving to

region / providers while the ICB is expected to remain accountable and have oversight for those areas of activity. There is a view that strategic workforce planning and assurance will move entirely to region

- Key parties who are involved in workforce planning undergo significant change processes alongside the ICB

Key controls

- BSW Implementation Plan 2025/26
- NHS Planning Guidance 2025/26
- Monthly tailored pulse surveys with the ICBs' staff (replaces NHS staff survey)
- Get Britain Working white paper (health integration) (incl. implementation plan and policy design)
- SW Inclusion Strategy
- NHS EDI high impact plan
- Public Sector Equalities Duty
- Skills for Care Strategy
- Neighbourhood Health policy recommendations re workforce
- SW NHSE workforce delivery group

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1st Line (ICB)	Workforce Delivery Group highlight reports	●	●	●		
2nd Line (system)	Employee wellbeing reports incl. oversight and benchmarking of staff survey results across BSW and SW	●	●	●		
	System and SW benchmarks re sexual violence and aggression	●	●	●		
	Recovery Board oversight reports re workforce	●	●	●		
3rd Line (external)	NHSE regional assurance meetings (regional workforce delivery group, SW regional people board)	●	●	●		
Overall assurance		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gaps identified in Q1 – remains the same for Q2, Q3:
- There is no system oversight of education strategy, and/or strategic intent for education is not joint up; BSW has no strategy or plan re how to use education partnerships to address workforce risks
- BSW has no approach or mechanisms to pull local authorities, employers, education into workforce planning

- Lack of clarity where workforce functions and accountabilities will lie in the near future, at the end of the NHS reorganisation

Assurances:

- Gaps identified in Q1, remains the same in Q2, Q3:
- there is a lot of assurance activity, but it is not clear who is now accountable for driving delivery of workforce strategy / plans as enabler
- workforce data is NHS-centric, we don't have good data, or access to good data, for care and voluntary sector workforce
- **Q3** – workforce delivery group now led by providers, and ICB does not receive assurance reports anymore hence does not have close oversight

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1	Develop, implement a BSW approach to workforce planning that commits key partners / organisations to active involvement in health and care workforce planning	Gauge extent to which partners / organisations understand impact they have or can make on health and care workforce planning, identify means to engage partners / organisations in health and care workforce planning, obtain partners' / organisations' buy-in to health and care workforce planning and relevant actions pertaining to partners / organisations	Sarah Green	30/08/2025 Revised to 31/03/2026	July 2025: progressing at ICS level but there are indications that workforce planning will move to region; we now need to consider the transfer / handover of strategic workforce planning from the ICB to the region, and the effect that this transfer will have on system-level workforce planning December 2025: ICB for remainder of 2025/26 remains responsible for workforce planning process as part of MTP.	
2	As part of the BSW approach (action 1), develop, implement a strategy / plan to utilise education and education providers for purposes of workforce planning and delivery	Understand any education and / or education providers' plans, activities etc already in place that are relevant to health and care workforce planning, establish strategic relationships with education and education providers to support creation of workforce pipelines etc	Sarah Green	30/08/2025	July 2025: Void, superseded by ICB model blueprint and transfer of strategic workforce planning to region	
3	Develop, expand workforce data capture to care and voluntary sectors	Gain clearer view of capacity and capability in non-NHS health and care workforce, build nuanced data to enable workforce projections and trends, and to inform workforce planning incl. targeted interventions	Sarah Green	30/08/2025 Revised to 31/03/2026	July 2025: Data capture has commenced but it is unclear if / how we should continue this work if strategic commissioners pivot to using this data to inform commissioning intent rather than workforce planning December 2025: Currently capturing data that is available, but not	

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
					expanding the capture. Maintenance of status quo	

Actions – progress assessment (PA)

	Complete / BAU	Action completed, now business as usual
	On Track	Improvement on trajectory, on track, near completion
	Delayed	Delivery remains feasible. Actions not completed, further interventions required
	Problematic	Off track / trajectory / milestone breached. Recovery plan required

BAF06: Financial delivery

Finance and Infrastructure Committee | ICB Chief Finance Officer | 22/04/2025

Risk description

- **IF** financial cost pressures are not controlled leading to BSW overspending / breaching our revenue or capital plan,
- **THEN** we will not achieve our statutory financial duties.
- As a **CONSEQUENCE**, there may be discretionary or compulsory (financial / regulatory) intervention from NHSE including reduced local discretionary decision making, reduced capital resources, reduced opportunity to apply for additional funds, and loss of deficit support funding of £23.4m. We will not be able to achieve our strategic objectives SO2, Fairer health and wellbeing outcomes; SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	SO2 Achieve fairer health and wellbeing outcomes	SO3 Deliver excellent health and care services	SO4 Achieve financial recovery and a long-term sustainable health and care system
SP1 Move care closer to our communities	SP3 Reducing healthcare inequalities in our localities and our system	SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population	SP6 Deliver our medium-term financial plan and return to financial balance
SP2 Prioritise prevention activities working through and with localities and communities		SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place	

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks
Likelihood	4	4	4		3	Treat 31/03/2026	Low
Impact	5	5	5		4		Mod
Score	20	20	20		12		High
Movement	-	-	-				Extreme

Rationale for current risk score and progress made in the quarter

- In Q3, we continue to assess the likelihood of this risk materialising as 4, more likely to occur than not, with an impact of 5, catastrophic. Our current assessment is driven by the following:
 - The cash regime has changed. If we don't hit the 2025/26 plan, it will be difficult to support capital programmes and there will be significant cash challenges across the system (potential of less than 3 days of cash). The provider group is modelling different scenarios to manage the cash position should the plan not be achieved.
 - Although the messaging has been that there is now funding for the cost of change, this is likely not to cover all cost. This will limit the scale of change that is affordable in 2025/26.

- Providers and the Group are implementing the agreed financial recovery plan, though not all savings have been operationalised.
- There are indications that we will receive deficit support funding for Q1 to Q3 (to be confirmed).

Key controls

- BSW Implementation Plan 2025/26
- BSW Operating Plan 2025/26
- BSW Capital Plan 2025/26
- NHS Planning Guidance 2025/26
- NHS statutory targets
- Oversight and monitoring reports incl. monthly finance report / performance against budget, monitoring of operational performance
- Need for national permission to move forecast
- BSW Recovery Board and financial recovery plans

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1 st Line (ICB)	Monthly performance reports from Delivery Groups	●	●	●		
2 nd Line (system)	Regular finance reports incl. recommended adjustments of plans	●	●	●		
	Bi-monthly system finance report to EMM, Finance and Infrastructure Committee, and Board	●	●	●		
3 rd Line (external)	NHSE regional assurance meetings for finance (monthly)	●	●	●		
Overall assurance		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gap identified in Q1 – remains the same for Q2, Q3:
- Inadequate / incomplete data to support real-time and effective decision-making
- No roadmap to deliver the efficiency requirements for 2025/26, no pipeline for efficiency savings 2026/27
 - Q3: there is a recovery plan but no confirmed pipeline for 2026/27 and beyond
- There is no clear set of agreed actions that we will take in order to reduce the underlying deficit, or a timeline within which to reduce the deficit
- Root cause for structural deficit has not been identified and addressed

Assurances:

- Gap identified in Q2, Q3:

- Hospital Group reporting is adequate, but Group's delivery, traction and pace of the plan has been the issue for 2025/26

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1(Q1)	Agreement over minimum data set and data format required in order to effectively identify the root cause of BSW's strategic deficits	Clarity over the cause of current operational and financial deficits, and ability to set / agree appropriate actions incl. as part of 2026/27 planning round	Rachael Backler	31/10/2025	July 2025: Started work on deconstructing block contracts (deadline mid-Sept) Work commenced to identify drivers of underlying deficit December 2025: Work to deconstruct block contracts has progressed, identified ca £5m additional recurrent funding into the Hospital Group	
2(Q1)	Development of a clear set of operational actions to reset BSW and set milestones for recovery / sustainability	Clarity of interventions required, of scale and time horizon to deliver interventions and to see their impact materialise; ability to inform 2026/27 planning round accordingly	Rachael Backler	31/10/2025	July 2025: Close. Will form part of financial recovery plans	
3(Q2)	Strengthen escalation and oversight of Delivery Group/s	Assurance that plan is delivered at pace and has traction	Rachael Backler	31/10/2025	July 2025: n/a, new action as of July 2025 December 2025:	
4(Q2)	External finance support from experienced consultant	Support financial recovery and in-year financial position	Gary Heneage	31/12/2025	July 2025: n/a, new action as of July 2025 December 2025: In place. Turn-around team appointed in RUH to conclude initial findings by December	
5(Q2)	Develop and implement financial recovery plans (incl. development of a clear set of operational actions to reset BSW and set milestones for recovery / sustainability)	Financial recovery plan demonstrates a route back to break-even	Gary Heneage	22/08/2025	July 2025: n/a, new action as of July 2025 December 2025: Balanced recovery plan is in place subject to operationalising some of the interventions. Enabled release of deficit support funding.	
6(Q2)	Work on medium-term plan		Mark Harris	31/12/2025	July 2025: n/a, new action as of July 2025 December 2025: In progress and working to published deadlines	
7(Q2)	Develop / assess efficiency pipeline for 2026/27 and beyond (with Delivery Groups)		(Gary Heneage) Rachael Backler	31/12/2025	July 2025: n/a, new action as of July 2025 December 2025: Initial targets have been published and delivery plans are being worked up	

Actions – progress assessment (PA)		
	Complete / BAU	Action completed, now business as usual
	On Track	Improvement on trajectory, on track, near completion
	Delayed	Delivery remains feasible. Actions not completed, further interventions required
	Problematic	Off track / trajectory / milestone breached. Recovery plan required

BAF07: Wider determinants of health

Board | ICB Chief Executive Officer | 01/05/2025

Risk description

- **IF** (likelihood / probability) we and our partners do not manage to address wider determinants of health (housing, employment opportunities, education and others)
- **THEN** people will not have the opportunities and means to stay healthy.
- As a **CONSEQUENCE**, we will continue to see high and increased demand for health and care services, operational pressures, inequalities of access and health outcomes. We will not achieve our strategic objectives SO1 Prevention and early intervention; SO2, Fairer health and wellbeing outcomes; SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	●	SO2 Achieve fairer health and wellbeing outcomes	●	SO3 Deliver excellent health and care services	●	SO4 Achieve financial recovery and a long-term sustainable health and care system	●
SP1 Move care closer to our communities		SP3 Reducing health inequalities in our localities and our system		SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population		SP6 Deliver our medium-term financial plan and return to financial balance	
SP2 Prioritise prevention activities working through and with localities and communities				SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place			

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks		
Likelihood	4	4	4		3	Treat	Low		
Impact	4	4	4		3		Mod		
Score	16	16	16		9		High		
Movement	-	-	-				Extreme		
						31/03/2026			

Rationale for current risk score and progress made in the quarter

- As in Q2, we assess the likelihood of the risk materialising as 4, i.e. more likely to occur than not. This is due to the absence of a BSW-agreed strategy / approach to determine the wider determinants of health that BSW seeks to focus on vis-à-vis the stated objectives of the Integrated Care Strategy. The ability of the ICB to act and influence in this space in the short term has been diminished. In the medium to long term, the new role of the ICB as strategic commissioner should allow the ICB to more fully focus in this important area.
- We assess the impact of the risk materialising as 4, major, because not addressing wider determinants of health will see a continuation of existing health and disease trends which will in turn lead to a continuation of increased demands on the health and care system

Key controls

- BSW Implementation Plan 2025/26
- BSW Outcomes Framework
- Medium-term plan
- Commissioning intentions (Q3)

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1 st Line (ICB)	(None in Q1) Medium-term plan once developed and implemented	●	●	●		
2 nd Line (system)	(None in Q1) Medium-term plan once developed and implemented	●	●	●		
3 rd Line (external)						
Overall assurance		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gap identified in Q1, remains the same in Q2, Q3:
- We do not have a system understanding / agreement of the wider determinants of health that BSW collectively seeks to focus on.
- We do not have a system overview of partners' plans and activities to address wider determinants of health.

Assurances:

- Gap identified in Q1, remains the same in Q2, Q3:
 - Lack of join-up re system understanding and approach on wider determinants of health and ill / good health and / or health outcomes, and impact of measures that address wider determinants of health. Potential for ICP to lead work in this area

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1(Q1)	Start development of our ICB Medium Term Plan, which will include a refresh of our case for change	Clear statement of intent with regard to future of services and areas for action	Rachael Backler	December 2025	July 2025: commencement of medium-term plan development is imminent, awaiting national guidance	

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
	and an assessment of the major areas of focus.				December 2025: Plan developed, moving to implementation	
2(Q1)	Continue development of our system outcomes framework reporting mechanisms, building on the work set out in the BSW Implementation plan	Ability to report against our agreed system outcomes	Rachael Backler	End-Sep 2025	July 2025: reporting mechanisms in place and embedding December 2025: Complete, reporting continues	

Actions – progress assessment (PA)	
	Complete / BAU Action completed, now business as usual
	On Track Improvement on trajectory, on track, near completion
	Delayed Delivery remains feasible. Actions not completed, further interventions required
	Problematic Off track / trajectory / milestone breached. Recovery plan required

BAF08: Health outcomes

Board | ICB Chief Delivery Officer | 01/05/2025

Risk description

- **IF** (likelihood / probability) we cannot ensure high quality, equitable and safe patient care,
- **THEN** we will be unable to achieve high standards of quality and safety,
- As a **CONSEQUENCE**, there will be actual or potential harm to patients, loss of reputation, intervention from regulators. We will fail to deliver our statutory quality duties and we will see increased costs associated with poor standards of care. We will not achieve our strategic objectives SO2, Fairer health and wellbeing outcomes; SO3, Excellent health and care services; and SO4, A sustainable health and care system.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	SO2 Achieve fairer health and wellbeing outcomes	SO3 Deliver excellent health and care services	SO4 Achieve financial recovery and a long-term sustainable health and care system
SP1 Move care closer to our communities	SP3 Reducing health inequalities in our localities and our system	SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population	SP6 Deliver our medium-term financial plan and return to financial balance
SP2 Prioritise prevention activities working through and with localities and communities		SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place	

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks
Likelihood	4	4	4		3	Treat 31/03/2026	Low
Impact	4	4	4		3		Mod
Score	16	16	16		9		High
Movement	-	-	-				Extreme

Rationale for current risk score and progress made in the quarter

- In Q3, we assessed the likelihood of this risk materialising as 4, and the impact of the risk should it materialise as 4. The rationale for this assessment is that:
 - We have now had the NHS 10-year plan and developed commissioning intentions
 - We have an emerging strategy for how we deepen the implementation of our care model and getting traction re progress of ICBC contract, and Hospital Group is embedding
 - Planning is complete, implementation now needs focus and attention

Key controls

- BSW Implementation Plan 2025/26
- BSW Outcomes Framework
- Outcomes based ICBC contract, ICAs and joined-up work
- Integrated Care Strategy
- Core20PLUS5 framework and targets
- National targets
- BSW Quality Framework
- Commissioning intentions and commissioning plan
- Embed outcomes framework into contracts
- National planning framework

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1st Line (ICB)	ICB performance report	●	●	●		
	ICB quality exception report			●		
2nd Line (system)	Reporting against outcomes framework (outcomes dashboard)	●	●	●		
	Reporting against implementation plan	●	●	●		
	Reporting against outcomes in ICBC framework (through community delivery group)	●	●	●		
3rd Line (external)	Regional team carrying out enhanced monitoring in respect of Tier 1 organisation (RUHB)	-	●	●		
Overall assessment		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gap identified in Q1, remains the same in Q2, Q3 – none

Assurances:

- Gap identified in Q1, remains the same in Q2, Q3 – none

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1(Q1)	Delivery programmes must determine specified and measurable deliverables	Clear programme of work and ability to hold delivery programmes to account for progress	Claire Bullock	30/05/2025	August 2025: Each delivery group has formulated a plan on a page that sets out specific deliverables and KPIs December 2025: Each delivery group has specified and measurable deliverables and these are now reported through a monthly highlight report to the BSW Strategic Delivery & Recovery Board. A programme workbook has also been developed for use by all delivery groups.	
2(Q1)	Engage closely with ICAs to ensure focus on and delivery of commitments	Enhanced system working through ICA focus on agreed outcomes	Place Directors	30/06/2025	August 2025 Dialogue with ICAs is ongoing December 2025:	
3(Q1)	Enhanced oversight of Tier 1 organisations carried out by regional team	Provision of support where needed and enhanced oversight to return to required performance levels	Regional team	Ongoing	August 2025 Tiering letter received on 6 th August 2025 December 2025: Tiering meetings happen weekly	
4(Q1)	Review of delivery groups progress and regular reporting into strategic delivery and recovery board	Check and challenge on delivery of agreed deliverables and KPIs	Recovery Board	End-Dec 2025	August 2025 First two groups have started reporting (UEC and Elective). December 2025: Reporting was paused and is now restarting	

Actions – progress assessment (PA)

	Complete / BAU	Action completed, now business as usual
	On Track	Improvement on trajectory, on track, near completion
	Delayed	Delivery remains feasible. Actions not completed, further interventions required
	Problematic	Off track / trajectory / milestone breached. Recovery plan required

BAF09: Future of the BSW ICB

Board | ICB Chief Executive Officer | 01/05/2025

Risk description

- **IF** as a result of implementing the mandate to cut 50% of ICB running costs, the ICB is unable to successfully maintain and deliver its statutory functions and ensure it contributes to the four core purpose of an ICS,
- **THEN**
 - Delivery of our operational and implementation plan will not succeed, resulting in poorer outcomes for our population and poor delivery against our financial and operational targets;
 - colleagues may be displaced or made redundant, and with them knowledge, expertise, specialist skills and professional networks that are essential for the delivery of ICB functions;
 - there is an opportunity to re-imagine at-scale and place-based strategic commissioning, and with it opportunities for exploiting, building up and creating (new) specialist capabilities – there is also a risk that we do not grasp and exploit these opportunities
- **As a CONSEQUENCE**, the ICB may not be able to drive the achievement of the strategic objectives or planned objectives as set out in the Integrated Care Strategy and the Implementation Plan. Achievement / delivery of the intended improvements in health and care services and / or health outcomes for the BSW population may be in jeopardy, as may the recovery / transformation / sustainability of the health economy in BSW.

Impact on strategic objectives and strategic priorities for the year

SO1 Focus on prevention and early intervention	●	SO2 Achieve fairer health and wellbeing outcomes	●	SO3 Deliver excellent health and care services	●	SO4 Achieve financial recovery and a long-term sustainable health and care system	●
SP1 Move care closer to our communities	●	SP3 Reducing health inequalities in our localities and our system	●	SP4 Implement the NHS elective reform plan: redesign our elective services & improve access and outcomes for our population	●	SP6 Deliver our medium-term financial plan and return to financial balance	●
SP2 Prioritise prevention activities working through and with localities and communities	●			SP5 Improve our urgent and emergency care services, providing the right care at the right time in the right place	●		

Risk movement over time and current score (Q x)

	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Target score / date	Agreed treatment	Linked risks		
Likelihood	4	4	4		3	Treat	Low		
Impact	5	5	5		5		Mod		
Score	20	20	20		15		High		
Movement	-	-	-				Extreme		

Rationale for current risk score and progress made in the quarter

- In Q3, we continue to assess the likelihood of this risk materialising as 4, and the impact of the risk should it materialise as 5. The rationale for this assessment is that the ICBs' organisational change is underway and there has as yet not been an opportunity to start the development of a cluster strategy.

Key controls

- Nationally issued model ICB framework (Q3: the model ICB blueprint is largely obsolete; ICB functions that the blueprint previously identified as 'transfer out' have been confirmed as remaining with ICBs for the time being)
- Strategic options appraisal with NHSE (SW and national) and with SW ICBs re the form and functions of future ICB covering BSW
- Strategic conversations with BSW partners, in particular Hospital Group and Local Authorities, re delivery of strategic and planned objectives despite NHS structural change incl. via delegation and / or transfer of functions
- BSW ICB organisational change process
- NHSE Boundary change and mergers guidance for ICBs

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	Commentary
1 st Line (ICB)	Formal change programme and its plans	●	●	●		
	Regular change programme progress reports to EMM and Board	●	●	●		
	Regular ICB performance reports	●	●	●		
2 nd Line (system)	Regular performance reports	●	●	●		
3 rd Line (external)	NHSE (SW, national) guidance on and through change process	●	●	●		
Overall assessment		●	●	●		

Assurance Assessment Ratings	
Significant Assurance	High level of confidence in appropriateness, effectiveness of controls & assurances to manage risk
Acceptable Assurance	Confidence in appropriateness, effectiveness of controls & assurances to manage risk, possible to improve
Partial Assurance	Some areas of concern re appropriateness, effectiveness of controls & assurances to manage risk.
No Assurance	No confidence in appropriateness, effectiveness of controls & assurances to manage risk

Gaps in controls and / or assurances

Controls:

- Gap identified in Q1, Formal programme plan to manage all aspects of the change, **closed** in Q2, see action 2(Q1) below

Assurances:

- Gap identified in Q1, remains the same in Q2, Q3: None

Mitigating actions

Actions that we take to address gaps in controls and / or assurances, and to reduce likelihood and / or impact of the risk.

No.	Action Required	Intended outcome of action	Assigned to	Due Date	Quarterly Progress Report	RAG
1(Q1)	Develop options for future footprint, functions and strategic objectives of ICB, explore opportunities offered by strategic commissioner business model	Agreed option to move towards will provide certainty when planning and implementing the change process		30 May 2025 31 Jan 2026	July 2025: target operating model development progressed but has reached pause while awaiting (confirmation of) key appointments December 2025: Has transitioned to cluster leadership – TOM development in progress	
2(Q1)	Develop a programme plan to manage the change	Clarity on timelines, deliverables and accountabilities re developing and implementing the target ICB, ability to assess progress towards readiness to operate as target ICB	Rachael Backler	30 May 2025	July 2025: Complete. Transition programme plan and programme governance in place and fully operational; approach to risk agreed and embedding	
3(Q1)	Develop plan/s to facilitate retention and delivery of as many strategic and planned objectives for the benefit of the BSW population as possible	Limited impact of NHS change on BSW population, ability to secure intended health outcomes for BSW population, ability to ensure stability / sustainability of the health economy in BSW		31 July 2025 tbc	July 2025: will be wrapped into medium-term plan; implicit in change programme plan December 2025: Has transitioned to cluster leadership – cluster strategy to take account of BSW population needs	

Actions – progress assessment (PA)	
	Complete / BAU Action completed, now business as usual
	On Track Improvement on trajectory, on track, near completion
	Delayed Delivery remains feasible. Actions not completed, further interventions required
	Problematic Off track / trajectory / milestone breached. Recovery plan required

Appendix 1 – Risk Appetite

The ICB Board has agreed its risk appetite within 7 risk categories

Risk category	Strategic / Executive Lead	Risk appetite	Threshold score
Quality	Chief Nurse Officer	CAUTIOUS	8 (L2x14, or L4x12)
Safety	Chief Nurse Officer	CAUTIOUS	8 (L2x14, or L4x12)
Regulation and Governance	Chief Delivery Officer	CAUTIOUS	8 (L2x14, or L4x12)
Finance	Chief Finance Officer	OPEN	12 (L3x14, or L3x14)
Workforce	Chief People Officer	BALANCED	10 (L2x15, or L5x12)
Performance and Delivery	Chief Delivery Officer	OPEN	12 (L3x14, or L3x14)
Engagement and Partnership working	Chief Executive Officer	OPEN	12 (L3x14, or L3x14)

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.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	12d
Date of Meeting:	22 January 2026		

Title of Report:	BSW ICB Declaration of Interests Registers
Report Author:	Anett Loescher, Associate Director of Governance, Compliance and Risk
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	<ul style="list-style-type: none"> Register of Interests – Board Members Register of Interests – Regular Board Attendees (Available to view via the BSW ICB website – Corporate Registers)

Report classification	Please indicate to which body/collection of organisations this report is relevant. <i>Only one of the below should be selected (x)</i>
ICB body corporate	YES
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
Associate Director of Governance, Compliance and Risk	Monthly	Regular maintenance review of registers (interests, gifts / hospitality / sponsorship)
BSW ICB Audit Committee	04/12/25	Review and Assurance

1	Purpose of this paper
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The ICB Corporate Office holds and maintains the statutorily required corporate registers for declarations of interests.

The latest registers of Board members' and regular attendees' interests are published on the ICB website upon the [ICB Corporate Registers page](#). This satisfies the requirement of the BSW ICB Standards of Business Conduct Policy for at least annual review of the Board members' register of interest, by the Board.

In compliance with the Health and Care Act 2022 and the BSW ICB Standards of Business Conduct policy, the Corporate Office also maintains a comprehensive register of interests for all ICB committee members, employees, and individuals working for / on behalf of the ICB. This full register is kept as an internal document, but is available to the public on request, per the Health and Care Act 2022.

2 | Summary of recommendations and any additional actions required

The Board is asked to **note** this update, and to take assurance that the ICB has processes in place that enable it to comply with statutory requirements regarding transparency around, and management of, interests wherever and in whatever form they may arise.

3 | Legal/regulatory implications

The ICB is compliant with law and regulations by maintaining corporate registers for conflicts of interests; gifts, hospitality, and sponsorship; and procurement decisions. These registers must be made available to the public, and the ICB does so by publishing these registers on its website.

4 | Procurement

n/a

Procurement sign off

5 | Risks

6 | Quality and resources impact

Finance sign-off

N/A

7 | Implementation Plan Alignment

n/a

8 | Confirmation of completion of Equalities and Quality Impact Assessment

N/A

9 | Communications and Engagement Considerations

n/a

10 | Statement on confidentiality of report

The corporate registers are published on the ICB website once reviewed.