BSW, Dorset, and Somerset ICBs - Cluster Board - Business Meeting in Public

Wednesday 16 September 2026, 10:15 - 13:15

Virtual - via MS Teams

Observe the live stream of the meeting via the NHS Dorset YouTube channel: https://www.youtube.com/nhsdorset

Agenda

10:15 - 10:25
10 min

1. Formalities

Verbal *Chair*

1.1. Declarations of Interest

Verbal *Chair*

1.2. Minutes from the meeting held in public on 15 June 2026

Enclosure for approval *Chair*

01.2. 260615_Cluster Board Meeting in Public Minutes_Draft.pdf (7 pages)

1.3. Action Tracker and Matters Arising

Enclosure for discussion *Chair*

01.3. Cluster Board 26-27_Public Action Tracker_160926.pdf (1 pages)

1.4. Questions from the Public

Verbal *David Freeman*

10:25 - 10:35
10 min

2. Cluster Chairs Report

Verbal *Chair*

10:35 - 10:55
20 min

3. Cluster Chief Executive Report

Enclosure for noting *Jonathan Higman*

03a. CEO Report to Cluster Board in Public_Sept26.pdf (15 pages)
03b. Appendix 1 VCSFE Update.pdf (4 pages)

Strategy

10:55 - 11:15
20 min

4. Developing our Integrated Needs Assessment

Information *Amanda Webb, James Whitehead, Nic Hilton*

04. Developing our Integrated Needs Assessment.pdf (16 pages)

11:15 - 11:30
15 min

5. Neighbourhood Development - Stocktake and Roadmap

Information *David Freeman, David McClay*

- 05a. Neighbourhood Development - Stocktake and Roadmap.pdf (2 pages)
- 05b. Neighbourhood Health.pdf (4 pages)
- 05c. Appendix 1 - NHSE Feedback and Single Plan.pdf (4 pages)

11:30 - 11:40
10 min

6. AMOS and Nottingham Review of Maternity Services - 10 Point Plan and Next Steps

Information *Bernice Cooke*

- 06. Amos and Nottingham Review of Maternity Services.pdf (6 pages)

Current Performance and Regulation

11:40 - 12:00
20 min

7. Performance Oversight Dashboard

Information *David Freeman*

- 07a. Performance Oversight Dashboard.pdf (2 pages)
- 07b. Performance Report.pdf (7 pages)
- 07c. Appendix 1 M3 26_27 Cluster performance overview.pdf (2 pages)

12:00 - 12:15
15 min

8. Progress on the Medium-Term Plan Mental Health, Learning Disabilities and Autism Commitment

Enclosure for assurance *Gordon Muvuti*

- 08. MHLDAN OAPs Position Statement.pdf (23 pages)

Business Items

12:15 - 12:35
20 min

9. Somerset Health and Care Academy Briefing

Enclosure for assurance *Alison Henly, Tony Rackstraw, Scott Sealy*

- 09. Somerset Health and Care Academy Board Briefing.pdf (14 pages)

Committee Assurance and Risk

12:35 - 13:05
30 min

10. Committee Reports to Board

10.1. Audit Committee in Common

Enclosure for noting *Dan Worsley*

- 10.1. In Common Audit Committee Summary Report 290626.pdf (1 pages)

10.2. Joint Strategic Finance and Resource Committee

Enclosure for noting *Adrian White*

- 10.2a. Joint Strategic Finance and Resources Committee Summary Report 290626.pdf (1 pages)
- 10.2b. Joint Strategic Finance and Resources Committee Summary Report 270726.pdf (1 pages)
- 10.2c. Joint Strategic Finance and Resources Committee Summary Report 270826.pdf (1 pages)

10.2.1. Cluster Finance Report

Enclosure for assurance *Alison Henly*

- 10.2.1a. Cluster Finance Report_cover.pdf (2 pages)
- 10.2.1b. Cluster Finance Report M4 2627.pdf (4 pages)

10.3. Joint Population Health and Commissioning Committee

Enclosure for noting *Christopher Foster*

- 10.3a. Joint Population Health and Commissioning Committee Summary_10June26.pdf (1 pages)
- 10.3b. Joint Population Health and Commissioning Committee Summary Report 040926.pdf (1 pages)

10.4. Joint Quality and Population Engagement Committee

Enclosure for noting *Caroline Gamlin*

- 10.4a. Joint Quality and Population Engagement Committee Summary_June26.pdf (2 pages)
- 104b. Joint Quality and Population Engagement Committee Summary Report_26 August 2026.pdf (2 pages)

Standing Items

13:05 - 13:10
5 min

11. Any Other Business

Verbal *Chair*

13:10 - 13:10
0 min

12. Date and Time of Next Meeting

Verbal *Chair*

Monday 16 November 2026 - 9:00hrs

DRAFT Minutes of the BSW, Dorset and Somerset ICBs Cluster Board Meeting in Public

15 June 2026, 12:30hrs

Virtual Meeting – held via MS Teams

Members present:
Cluster Chair, Rob Whiteman
Cluster CEO, Jonathan Higman
Chief Officer Strategic Finance and Resources, Alison Henly
Chief Officer for Commissioning and Place, David Freeman
Chief Medical Officer, Bernie Marden
Chief Nursing Officer, Shelagh Meldrum
Chief Officer for Population Health Improvement, Amanda Webb
Cluster Deputy Chair, Ade Williams
Cluster NED, Adrian White
Cluster NED / Place NED Dorset, Dan Worsley
Cluster NED, Christopher Foster
Cluster NED, Caroline Gamlin
Deputy - BSW - NHS Trusts and NHS Foundation Trusts Partner Member, John Palmer
BSW - Primary Medical Services Partner Member, Francis Campbell
Dorset - NHS Trust Partner Member – Mental Health, Matthew Bryant
Dorset - NHS Trust Partner Member, Siobhan Harrington *(until 13:27hrs)*
Somerset - Primary Care Partner Member, Rebecca Duffy
BSW – Local Authority Partner Member – Swindon, Sam Mowbray
Deputy - BSW - Local Authority Partner Member – Wiltshire, Jen Salter *(from 13:13hrs)*
Dorset Council (Local Authority Partner Member), Nick Ireland
Deputy – BCP Council, Laura Ambler
Deputy – VCSE Sector, Lynn Gibson

Attending:
BSW Associate Director of Governance, Compliance & Risk, Anett Loescher
Cluster Associate NED (digital) / Place NED BCP, Karl Hoods
Healthwatch, Kim Sadler
BSW ICB Corporate Secretary (minutes), Sharon Woolley

Apologies:
Cluster NED, Suzannah Power
Somerset – Foundation Trust Partner Member, Peter Lewis
BSW - NHS Trusts and NHS Foundation Trusts Partner Member, Cara Charles-Barks
BSW - BaNES Council CEO, Sophie Broadfield
BSW - Local Authority Partner Member – Wiltshire, Lucy Townsend
BCP Council (Nominated deputy - Local Authority Partner Member), Aidan Dunn
Dorset - Primary Medical Services Partner Member, Forbes Watson
Somerset Council, Duncan Sharkey
VCSE Sector, Paula Bennetts
Somerset Director of Communications and Engagement, Charlotte Callen

1. Welcome and Apologies

1.1 The Chair welcomed all to the first meeting of the Cluster Board meeting in public under the new cluster governance arrangements. It was noted that this meeting in public was being livestreamed, accessed via the Dorset ICB YouTube channel. (https://www.youtube.com/nhsdorset)

1.2 The Cluster Board was declared quorate. The above apologies and those deputies in attendance were noted.

1.1 Declarations of Interests

1.1.1 Each ICB holds a register of interests for all staff and committee members. There were no conflicts of interest declared by any members/attendees present.

1.2 Action Tracker and Matters Arising

1.2.1 The Cluster Board noted that an action tracker would be maintained for this meeting going forwards.

1.2.2 There were no matters arising not covered by the agenda.

1.3 Questions from the Public

1.3.1 One question had been raised in advance of the meeting concerning the use of Functional Electrical Stimulation (FES) treatment to improve the lives of many people with Multiple Sclerosis (MS) and making this available as a funded service for Dorset.

1.3.2 The Chief Officer for Commissioning and Place read out the question raised and the Cluster response. The full record of the question and response would be made available upon the website following the meeting.

1.3.3 The CEO further advised that consideration of services such as this were subject to understanding and reviewing the wider set of issues across the cluster and the different clinical policies in place. This complex area would be worked through in a structured way to bring clarity and consistency for the cluster.

2. Register of Interests

2.1 The Corporate Office holds and maintains the statutorily required corporate registers for each ICB and its declarations of interests. The registers for Cluster Board members' will be shared regularly with the Audit Committee and the Cluster Board, and published on the website. Members were asked to ensure the Corporate Office was made aware of any changes to declarations.

2.2 It was noted that an update and corrections were to be made to those declarations held for Cluster Non-Executive Director, Adrian White. This would be actioned before the register was published upon the website.

2.3 The Board **noted** the update and was assured that the ICB Cluster has processes in place that enable each ICB to comply with statutory requirements regarding

transparency around, and management of, interests wherever and in whatever form they may arise.

3. Cluster Chairs Report

3.1 The Chair reported on the NHS Alliance conference attended the week before. The new Secretary of State had been in attendance, who had provided a clear message of continuity against the agenda for the NHS reform, with no expected change in policy direction. Significant interest remained in the setup of the neighbourhood health arrangements and their anticipated effectiveness, though recognising it remained early on in the establishment and the discussions surrounding funding flows. There was to be a move from tariff arrangements to create new incentives to support the prevention, leftward shift, and community agenda.
Dorset had also been highlighted in the NHS Alliance workshop on integrated health working for its work in support of MacMillan as exemplar practice. This now needed to move from pilot to business as usual through how the ICB works with providers to support that shift of resources.
The acceleration and pace of use of artificial intelligence (AI) was also a focus of the conference, with good examples being shared demonstrating that added value, support to improve the quality of care and development of a new financial model.

3.2 The Chair also wished to acknowledge the letter received from Duncan Sharkey, Chief Executive of Somerset Council, who confirmed he would be stepping down from the NHS ICB Cluster Board. Duncan would continue to play a full role on the Somerset Board. Somerset Council nominated Alison Bell to be the Council's Cluster Board member going forward.

4. Cluster Chief Executive Report

4.1 The Board **received and noted** the Cluster CEO's report as included in the meeting pack.

4.2 The CEO provided a contemporary update for the following elements:

- Neighbourhood health and use of technology were big themes throughout the NHS Alliance and ConFed Expo. There was supported AI options that could bring that radical transformation at scale.
  The emergence of new care models such as the NHS online hospital had also been showcased, with four elective pathways in the first instance. Access to services would be through the NHS app, with appointments booked and held online with clinicians, accessing diagnostics via the local diagnostic treatment centres. It would support those conditions that could be managed through outpatients, rapidly changing outpatient services. How this would be commissioned on an ongoing basis was still to be reflected on, considering also how to partner with private sector organisations to support delivery.
  Radical AI solutions could bring support for general practice at the front door through triage and call handling services, to enable management of workload and that focus on long term care.
  The Secretary of State speech had advised no change to the NHS plan, through presented the challenge of pace, and use of technology to provide solutions against those problems of today.
  This raised the importance of the cluster forming partnerships with technology providers and equipping its staff with AI skills, while balancing the costs,

incentivising the move to digital, and ensuring benefits realisation. The adoption of AI technology would support that challenge of the rurality of the cluster geography expanse, as well as bring people closer to the NHS. Though AI can offer support on access, the Board was mindful that this could not be a one solution fits all, particularly when supporting those vulnerable and disadvantaged members of the population.
The discussion highlighted the importance of board-level governance, data security, and establishing guardrails for AI use.

ACTION: Artificial Intelligence to be a future topic on the Cluster Board forward planner – considering Board responsibilities regarding AI, including data security, information governance, environments for AI operation, and guardrails such as human-in-the-loop for risk-categorised AI use cases.

ACTION: Cluster Associate NED (digital), Karl Hoods, to share Board briefing papers with the Chair and CEO on the use of AI governance for further consideration when developing the partnership.

- The initial neighbourhood health centre plans had been submitted to NHS England, which consisted of an initial prioritisation of schemes. This would now be further worked through with partners to consolidate and develop the supporting detail around these.
  Though the cluster was not in receipt of government neighbourhood health centre monies in this first tranche, the cluster would now work to refine its level of prioritisation to be ready should future funding opportunities arise. The cluster was to think differently about how schemes could be delivered through alternative partnership approaches and technology, reducing reliance on NHS capital monies.
  A high-level, strategic view of neighbourhood health investments across the cluster would be maintained to ensure effective prioritisation and intervention.
- The Kings Speech had touched on the formalisation of the future and commissioning arrangements for ICBs. There is a working assumption that our ICB cluster will host the Office of Pan-ICB Commissioning, effectively the commissioning hub for the South West and on behalf of the three ICBs focussing on those delegated areas. A proposal would be brought back through the Cluster Board in due course.
- The Health Bill was progressing, which would bring the abolition of Integrated Care Partnerships, a change to the Board membership requirements, and the abolition of HealthWatch.
  The ICBs role with regards the changes to HealthWatch was to understand the implications for all and where the future of HealthWatch would sit.
  Conversations were continuing at a national level to work through the correct direction of travel.

ACTION: Chief Nursing Officer, Shelagh Meldrum, and Kim Sadler to discuss and clarify the future direction and engagement regarding Healthwatch and patient experience obligations in light of proposed changes.

- The ICB change process was progressing, with future structures now confirmed with staff. Letters had been sent to staff matched to new roles, with others entering a competitive process, with the recruitment of over 400 people to be completed by the end of July.
- Governance would need to be in place to ensure Integrated Health Organisations (IHOs) are introduced in the way that meet commissioning priorities for the cluster. The strategic ambitions note the cluster wishes to support the development of two IHOs, this was to be further worked through

with providers, with the Population Health and Commissioning Committee holding a clear role in the oversight and assurance.
- A control document was to be developed to highlight and manage risks associated with the transition and transfer of processes, with oversight provided by the Transition Committee.
- Congratulations were recorded to Dorset Healthcare University NHS Foundation Trust who have achieved Advanced Foundation Trust status.
- Paula Bennetts, representing Dorset VCS Assembly, will attend the Cluster Board business meetings on behalf of the South-West VCSE Alliances, and will provide VCSE updates into the place-based reports going forwards.
- Dr Claire Fuller, Interim Medical Director at NHS England will be in Somerset later this week, visiting the Frome and Mendip neighbourhood health centre test pilot site. Dr Fuller will be visiting other areas of the cluster in mid-July.

5. Developing our Strategic Ambitions and Submission to NHS England

5.1 The Chief Officer for Commissioning and Place introduced the supporting paper and explained that the strategic ambitions had been developed in response to a national request for ICBs to articulate their ambitions for change, building on previous planning rounds and reflecting on the feedback and discussions at the Cluster Board development workshop held on 7 May 2026. It was intended as a guide to further co-design and engage rather than a finalised strategy. There was commitment to continue to work with the public, partners and stakeholders on the further development of a supporting strategy.

5.2 The plan sets out specific, measurable, stretched, and time-bound goals, including establishing two IHO contracts, creating 47 integrated neighbourhood teams, and shifting over 50% of contracts to outcomes-based models by 2028/29, with a focus on population health, prevention, and neighbourhood care.

5.3 The need for clear year-on-year deliverables was recognised, taking account of meaningful impact, and learning from international best practices. A first draft of the 'plan on a page' visual summary was shared in meeting, to be used to communicate the ambitions and delivery approach, and seek buy-in and ownership. This was well received by the Board as a tool for ongoing discussion and alignment and would be further refined before onward sharing.

5.4 The Population Health and Commissionning Committee had held initial discussions on how the strategy was shaping, with it to turn into actions to deliver benefits to the population, considering phasing in delivery earlier to see benefits at pace. There was a need to realign incentives and develop market reform to change the way services were provided.

6. Committee Reports to Board

6.1 Audit Committees in Common

6.1.1 As the Chair of the Audit Committees in Common, Dan Worsley reported that a meeting had been held earlier that day to review the final Annual Report and Accounts 2025-26 for each ICB, recommending these on to each ICB legacy Board for approval.

6.1.2 The next meeting of the Audit Committees in Common would be held on 25 June 2026.

6.2 **Joint Strategic Finance and Resource Committee**

6.2.1 As Chair of the Strategic Finance and Resource Committee, Adrian White advised that the first meeting under the new governance arrangements had been held on 27 May 2026, considering business items such as the committee's terms of reference and finance report updates. The were no items to escalate to the Cluster Board.

6.2.2 The next meeting of the Joint Strategic Finance and Resource Committee was scheduled for 29 June 2026.

6.2.1 Cluster Finance Report

6.2.2.1 The Chief Officer Strategic Finance and Resources advised that month one figures showed the cluster on track financially against its in-year and forecast positions, with no major exceptions. That deep dive check and challenge would continue through the committees.

6.2.2.2 The Cluster Board **noted** for assurance purposes the month one financial position of the cluster and each of the three separate ICBs – NHS BSW, NHS Dorset, and NHS Somerset.

6.2.2.3 The Board agreed that although the ICB cluster was no longer managing the system budget, an understanding of the providers position needed to be maintained to assess how they were commissioned. It was early stages of new commissioning relationships, with the need to manage transitions and subcontracting relationships carefully, maintaining the fundamental principles of working together through the supporting framework.

6.2.2.4 The ambition was to move towards outcome-based contracts, with the CEO emphasising the importance of active risk management, and the need for constructive and active dialogue to collectively resolve any arising issues and ensure system stability.

6.2.2.5 The Committee would continue to monitor relationships and financial performance, seeking assurance that real-time information and collaborative problem-solving are in place.

6.3 **Joint Population Health and Commissioning Committee**

6.3.1 As Chair of the Joint Population Health and Commissioning Committee, Chris Foster provided a verbal report on the first meeting of the committee held on 10 June 2026, which had considered the cluster's strategic ambitions, plans for performance and place reporting, and that population health forward planning. The were no items to escalate to the Cluster Board.

6.3.2 The next meeting of the Joint Population Health and Commissioning Committee was scheduled for 19 August 2026.

6.3.1 Cluster Performance Exceptions Report

6.3.1.1 The Chief Officer for Commissioning and Place explained that current traditional performance reports were based on data to the end of March, with plans to transition to new, more integrated reporting methodologies.

6.3.1.2 The report noted a significant variance in 62-day cancer performance at Salisbury Foundation Trust. John Palmer explained that while recovery efforts have improved faster diagnosis standards, focus was now shifting to the end of the pathway, with Simon Sethi leading elective recovery work across the BSW Hospital Group. The Population Health and Commissioning Committee would continue to monitor this and seek assurance on progress.

6.4 Joint Quality and Population Engagement Committee

6.4.1 As Chair of the Joint Quality and Population Engagement Committee, Caroline Gamlin advised that the first meeting of the committee was to be held on 17 June 2026, with the agenda including a review of legacy quality reports and planning for future integrated reporting. The System Quality Groups were to remain in their current guise, with issues escalated to the Committee and the national System Quality Group as required. The agenda also reflected the remit of the committee to have oversight of population engagement, with the committee to consider its requirements for future reporting and assurances.

6.4.2 Additional meetings were being scheduled for July and October to receive and review the quality associated annual reports, to which invites could be extended to the wider Cluster Board as required.

7. Any other business

7.1 There was no other business. The Chair closed the meeting at 13:51hrs.

Next meeting of the Cluster Board: Wednesday 16 September 2026, 9:00hrs

Cluster Board - Action Log for Meeting in Public

Updated following meeting on 15/06/2026

OPEN actions

Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
15/06/2026	4. Cluster Chief Executive Report	Artificial Intelligence to be a future topic on the Cluster Board forward planner – considering Board responsibilities regarding AI, including data security, information governance, environments for AI operation, and guardrails such as human-in-the-loop for risk-categorised AI use cases.	Chair, Jonathan Higman, Karl Hoods, Bernie Marden	**Update 09/09/2026:** Development of specific AI board session underway - date to be confirmed shortly.	ONGOING	
15/06/2026	4. Cluster Chief Executive Report	Cluster Associate NED (digital), Karl Hoods, to share Board briefing papers with the Chair and CEO on the use of AI governance for further consideration when developing the partnership.	Karl Hoods	Briefing papers shared with Chair and CEO 15/06/26	CLOSED	
15/06/2026	4. Cluster Chief Executive Report	Chief Nursing Officer, Shelagh Meldrum, and Kim Sadler to discuss and clarify the future direction and engagement regarding Healthwatch and patient experience obligations in light of proposed changes.	Shelagh Meldrum, Kim Sadler	**Update 20/07/2026:** Shelagh and Kim met 20/07/2026 to discuss future direction with HealthWatch.	CLOSED	

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	3
Date of Meeting:	16 September 2026		

Title of Report:	Chief Executive Board Report
Report Author:	Jonathan Higman, Cluster Chief Executive
Board / Director Sponsor:	Jonathan Higman, Cluster Chief Executive
Appendices:	Appendix 1 - Cluster VCS Alliance Report

Report classification	Not Confidential
ICB body corporate	NHS BSW, Dorset & Somerset ICB Cluster Board
ICS NHS organisations only	BSW, Dorset & Somerset NHS
Wider system	BSW, Dorset & Somerset 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, developments within the Cluster since the last meeting of the NHS BSW, Dorset and Somerset Cluster Board.

2 Summary of recommendations and any additional actions required

The report sets out major developments in national policy, while also providing a summary of the work of the ICB at the six Council 'Places'. It includes detail of the new National Quality Strategy, together with the implications for ICBs of the Government's devolution agenda. The report also:

- provides an update on the ICB organisational change process.
- highlights the work underway to develop the 2026/27 Winter Plan, which will be subject to formal approval at the Board Committee in Common meeting on 25 September.
- sets out the ICB Cluster's involvement in the development of recovery plans and oversight of three cluster Providers, following escalation of performance concerns by NHS England.
- provides an update on the go-live of the new Somerset Hyper-Acute Stroke service.

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 Cluster or elements within the Cluster 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 elements within the Cluster, 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.

Cluster Chief Executives 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 BSW, Dorset and Somerset Cluster Board area.

2. National & Regional Context

2.1 NHS Quality Strategy

2.1.1 The National Quality Board has published a new NHS Quality Strategy, setting out a ten-year framework to make quality the organising principle for planning, commissioning, transformation and delivery across NHS-funded care in England. The strategy supports delivery of the NHS 10 Year Health Plan and aims to establish a consistent, system-wide approach to improving outcomes, patient experience and safety, while reducing health inequalities, unwarranted variation and strengthening public confidence in NHS services.

2.1.2 The strategy does not introduce a new set of priorities, instead it focuses on three core components of safety, effectiveness and experience. It emphasises that these areas should be considered together alongside a stronger focus on equity, transparency and value. Rather than introducing a new set of national priorities, the strategy brings together existing commitments within a single framework designed to support continuous improvement and reduce unwarranted variation in care and outcomes. Initial national areas of focus include patient safety, maternity and neonatal services, experience of care, health inequalities and improving clinical and population health outcomes.

2.1.3 A key theme of the strategy is the adoption of a Quality Management System which brings together governance, assurance, improvement, patient engagement and organisational learning within a single, systematic approach. The strategy also highlights the importance of strong leadership, greater transparency, effective use of data and insight, partnership working with patients and communities and the use of technology to support improvement.

2.1.4 For ICBs, the strategy reinforces our role as system leaders for quality with responsibility for creating the conditions in which high-quality care can be delivered consistently across organisations, places and pathways. It strengthens expectations that ICBs will lead system-wide improvement, address inequalities, align quality priorities across partners and use data to support decision-making and measurable improvement.

2.1.5 Locally, the publication of the strategy provides an opportunity to review current quality governance arrangements, assess the maturity of quality management systems and ensure that quality remains central to transformation, commissioning and improvement programmes.

2.1.6 The strategy is intended to strengthen and align existing approaches rather than create a significant new regulatory burden, and implementation will be taken forward through existing quality and governance structures.

2.2 NHS England Guidance on Preventing Unlawful Access to Patient Records

2.2.1 NHS England has published new national guidance and a supporting communications toolkit to strengthen the prevention of unlawful access to patient records. The guidance follows a number of high-profile incidents widely reported in national media and reinforces the expectation that patient information must only be accessed where there is a clear and legitimate work-related purpose.

2.2.2 The new guidance is accompanied by information for patients and service users, together with detailed advice for information governance professionals and a national staff awareness campaign under the headline "Don't let curiosity kill your career". NHS England has asked organisations to ensure staff understand their responsibilities, receive appropriate training, and are aware of the potential impact on patients when confidentiality is breached.

2.2.3 The guidance also provides greater clarity on what constitutes lawful access to records including direct care, clinical audit, quality improvement, education and training, complaint investigations and other authorised operational activities.

2.2.4 Locally, organisations across the BSW, Somerset and Dorset Cluster will continue to promote best practice in information governance internally, maintain appropriate access controls and audit arrangements and ensure staff understand their professional and legal responsibilities when handling confidential patient information. Strengthening public confidence in the NHS's ability to safeguard sensitive information remains a key priority, particularly as digital services and shared care records continue to develop.

2.3 Legal framework: Crime and Policing Act 2026 and the Mental Capacity Act and applications to Court of Protection

Crime and Policing Act 2026: Extension of Corporate Criminal Liability

2.3.1 The Crime and Policing Act 2026 came into effect on 29 June 2026 and introduces a significant change to corporate criminal liability. The legislation extends the "senior manager" attribution test to all criminal offences, meaning that an organisation may now be held criminally liable where a senior manager commits a criminal offence while acting within the actual or apparent scope of their authority. This represents a substantial expansion of previous arrangements, which were focused primarily on specified economic crimes.

2.3.2 The definition of a senior manager is not restricted to board-level positions and includes individuals who play a significant role in directing, managing or organising all or a substantial part of an organisation's activities. As a result, a wider range of actions by senior leaders may now expose organisations to criminal liability. Potential areas

include data protection, information governance, harassment, health and safety and environmental actions.

2.3.3 While the practical implications for NHS organisations are still emerging, the legislation places increased emphasis on governance, accountability, delegation of authority, training and organisational oversight.

2.3.4 This issue will continue to be monitored and will be reflected in future organisational governance arrangements where appropriate.

2.4 Mental Capacity Act: Supreme Court consideration of the Townsend case

2.4.1 The Supreme Court is currently considering the appeals in Townsend v Epsom and St Helier University Hospitals NHS Trust, a case with potentially significant implications for NHS commissioners and providers. The central issue before the Court is whether an NHS commissioning body is under an obligation to apply to the Court of Protection to resolve disputes about medical treatment, including life-sustaining treatment, where clinicians have concluded that the treatment sought on behalf of a patient who lacks capacity is clinically inappropriate and should not be offered.

2.4.2 The case follows a Court of Appeal judgment which rejected the argument that disputed treatment decisions could be treated solely as "clinical decisions" falling outside the scope of the Mental Capacity Act. The Court of Appeal held that decisions relating to the treatment of incapacitated adults, including decisions to withhold or withdraw life-sustaining treatment, engage questions of best interests and may require scrutiny by the Court of Protection where disagreement exists.

2.4.3 Should the Supreme Court uphold this approach, there could be significant implications for ICBs and NHS organisations. These may include an increase in applications to the Court of Protection, additional legal costs, increased commissioning responsibilities and wider workforce capacity and capability requirements to manage complex treatment disputes. The eventual judgment may therefore have implications for both organisational resources and financial planning.

2.4.4 At present, the case remains under consideration by the Supreme Court. A watching brief is being maintained pending judgment.

3. Cluster ICB Developments

3.1 ICB footprint submission to NHS England

3.1.1 At its meeting on 15 June 2026, the Cluster Board received an update on NHS England's consultation regarding the future footprints of Integrated Care Boards. Following this discussion, extensive engagement was undertaken with partners and stakeholders across Bath and North East Somerset, Swindon and Wiltshire (BSW), Dorset and Somerset to inform the development of a joint response.

3.1.2 Through an out-of-meeting decision process, approval was secured from the three ICB Boards and the Cluster Board enabling submission of the cluster's proposed footprint to the NHS England South West Regional Director on 14 July 2026.

3.1.3 The consultation forms part of the wider national programme to align NHS commissioning footprints with emerging strategic authority geographies and support the transition of ICBs into larger strategic commissioning organisations. Previous NHS England guidance described alignment with strategic authority boundaries as desirable "wherever feasible".

3.1.4 More recently, the Government's recent *Rewiring the State* Cabinet Statement sets out a stronger expectation that ICBs will align with strategic authority footprints as part of a broader programme of public service reform. The statement also references future alignment of police and fire and rescue service boundaries alongside strategic authorities to support more integrated local governance arrangements.

3.1.5 The cluster's submission reflects the strong collaborative relationships already in place across BSW, Dorset and Somerset and our ambition to create an effective strategic commissioning organisation capable of supporting delivery of national and local priorities.

3.1.6 It is currently anticipated that NHS England will confirm the outcome of discussions on future footprints and the implications for ICB cluster mergers towards the end of September 2026.

3.2 Change Update

3.2.1 The Cluster Transition Programme continues to make substantive progress towards the planned consolidation of the BSW, Dorset and Somerset Integrated Care Boards (ICBs). Significant developments have been achieved across organisational design, workforce transformation, governance, finance and digital enablement, including the completion of 16 transition workshops and the commencement of a programme refresh to support the next phase of mobilisation. Progress has also been made in establishing the key foundations required for merger readiness, including the development of a comprehensive programme plan, advancement of workforce processes, and the progression of critical governance arrangements for consideration by the respective ICB Boards.

3.2.2 Notwithstanding this progress, the programme continues to operate within a highly complex environment, with several strategic risks requiring close oversight. Workforce transition remains a significant area of focus, with organisational restructuring taking longer than originally anticipated and key activities, including recruitment, job matching and redundancy processes, continuing over the coming month. Financial risks also remain material, with ongoing uncertainty regarding the full cost impact of transition and service-transfer arrangements. In addition, emerging national policy developments may affect the current merger timetable, creating a risk of delay should decisions relating to devolution and the potential alignment with emerging strategic authority boundaries not be confirmed within the anticipated timeframe.

3.2.3 As the programme enters a critical phase of delivery, sustained focus will be required to manage interdependencies across workforce, governance, financial and digital workstreams, while maintaining business continuity and organisational effectiveness. Strong programme governance, proactive risk management and clear, consistent engagement with staff and stakeholders will be essential to ensuring the transition remains safe, coherent and deliverable.

3.2.4 The Cluster ICB continues to make significant progress in delivering its organisational change programme, supporting the development of a sustainable organisation aligned to future requirements and the delivery of high-quality services across Bath and North East Somerset, Swindon and Wiltshire, Dorset and Somerset.

3.2.5 The programme has progressed through a number of key stages, including organisational design, extensive staff engagement, formal consultation, consideration of feedback, confirmation of final structures, recruitment and selection activity and implementation planning. This represents a significant milestone in the delivery of the cluster's future operating model.

3.2.6 Good progress is now being made through implementation. The majority of roles have been filled while both vacancies and the number of colleagues remaining at risk continue to reduce. At the time of writing circa 85% of posts in the new structure have been filled. Attention is now focused on completing the remaining recruitment activity, concluding outstanding job evaluation work and supporting a small number of individual cases requiring further consideration. Support is also being provided to colleagues who have been unsuccessful in securing a role in the new structure and who are, therefore, at risk of redundancy.

3.2.7 The cluster is now moving into the final phases of implementation of the new structure, with a continued focus on supporting staff transition, embedding new arrangements and maintaining organisational stability and commencing a programme of organisational development to ensure that we establish a positive culture and new ways of working across the cluster. We remain committed to managing change fairly, openly and compassionately while ensuring continuity of services and delivery of organisational priorities.

3.3 2026/27 Winter Planning

3.3.1 The Winter Plan has been developed across the Cluster, bringing together partners at place from BSW, Dorset and Somerset, setting out a coordinated approach to managing anticipated winter pressures. The plan aligns with national urgent and emergency care priorities and focuses on reducing patient harm, maintaining service resilience, and supporting care closer to home. A particular emphasis is placed on reducing delayed discharges and No Criteria to Reside (NCTR), recognising improved flow as the single greatest opportunity to enhance patient outcomes and operational performance. The plan identifies rising urgent and emergency care demand, increasing patient complexity, workforce challenges, financial constraints, and seasonal respiratory illnesses as the principal risks to system resilience. To address the demand related

issues the cluster is taking forward a targeted programme of work at Place which aims to identify alternative support for the 1% of the population who account for the highest rates of attendances to our Emergency Departments.

3.3.2 Delivery will also be supported through strengthened vaccination programmes, Hospital at Home and Urgent Community Response services, enhanced system coordination, and ongoing monitoring of key performance indicators throughout the winter period. The plan includes cluster-wide IPC, vaccination, surge and escalation arrangements. The plan remains a live document and will be further refined following regional stress testing before being presented for final approval through Boards in Common on 25 September in readiness for submission to NHSE on 30 September.

3.4 Somerset Stroke Services Reconfiguration

3.4.1 The Somerset Stroke Services Reconfiguration is scheduled to be implemented on 9 September 2026 following a programme of clinical, operational and infrastructure preparations across the system. The changes were approved by NHS Somerset ICB in January 2024 following a full public consultation, clinical review and consideration of the Decision Making Business Case. The programme was developed in response to workforce sustainability challenges, patient safety, variation in access to care across locations and the need to align provision with national clinical standards and evidence on improved patient outcomes.

3.4.2 The key changes proposed were:

- **Hyper Acute Stroke Units (HASUs)**, providing specialist care during the first 72 hours after a stroke, will be located at Musgrove Park Hospital (MPH) in Taunton and Dorset County Hospital (DCH) in Dorchester
- **Acute Stroke Units (ASUs)** for ongoing inpatient recovery will be based at MPH and Yeovil District Hospital (YDH)
- **Transient Ischaemic Attack (TIA)** services will operate 7 days a week at MPH and 5 days a week at YDH

3.4.3 Patients suspected of having a stroke will be taken by ambulance to the nearest HASU (either MPH or DCH) for specialist treatment during the critical first 72 hours. After this period, patients who still need inpatient care will be transferred to an ASU so patients living closer to Yeovil will recover at YDH and those closer to Taunton will remain at MPH.

3.4.4 The programme remains on track for implementation, with significant progress made across workforce recruitment, estates development, pathway redesign, governance arrangements, communications planning and operational readiness. A number of key pre-implementation risks have been addressed, including establishing access to the Somerset Single Patient Record for clinicians in Dorchester, introducing pre-hospital video triage at DCH and completing the majority of required estates works at both hospital sites.

3.4.5 As with any major clinical service change, several operational risks will continue to be actively managed following implementation, including safe staffing levels, digital interoperability and ambulance conveyance performance. Enhanced monitoring arrangements will be in place during and immediately after Go-Live, with close clinical and operational oversight across partner organisations.

3.4.6 The reconfiguration is in line with the national strategy for Stroke services and is intended to improve the quality, resilience and sustainability of specialist stroke services, supporting better outcomes for patients while ensuring services remain clinically sustainable for the future.

3.4.7 The reconfiguration will result in some patients travelling further to access specialist stroke care, a change that has attracted local concern and prompted requests for ministerial review. However, the proposed model continues to be supported nationally. Enhanced monitoring arrangements will be in place during and after Go-Live to provide assurance on patient safety, operational performance and delivery of expected benefits, with a formal lessons learned review planned following implementation.

3.5 Governance and Delivery of the 2026/27 Provider Operating Plans

3.5.1 Following publication of the Quarter 4 National Oversight Framework and a review of performance against planning trajectories at the end of month 2 both Dorset County Hospital NHS Foundation Trust (DCH) and Great Western Hospital NHS Foundation Trust (GWH) were highlighted as National outliers, principally relating to delivery of the national urgent and emergency care standards, elective recovery and finances. In addition, University Hospitals Dorset NHS Foundation Trust (UHD) was identified for Regional oversight relating to delivery of the 12-hour emergency department waiting standard.

3.5.2 The ICB cluster has been working with these Trusts to support the development of a recovery plan which is due to be presented to the NHS England Regional Team on 10 September (21 September for GWH as part of a wider plan across the BSW Hospitals Group). The ICB has been working with the Providers to ensuring a clear contractual baseline for planning with each Trust and that commissioning plans are in place to support elective recovery, patient flow and alternatives to admission through the Winter.

3.5.3 Submission of the relevant recovery plans will be followed by a series of Board to Board meetings between the relevant organisations Board and the South West Regional Chair and Executive Team. The ICB will also be in attendance at these meetings.

3.6 Executive Leads on Integrated Care Boards

3.6.1 NHS England » Executive lead roles on integrated care boards asks that ICBs confirm to NHSE the Executive Board members who support the Chief Executive and the Board to ensure that the ICB functions effectively in relation to specific population groups and functions. The following table sets out the key roles and the relevant Chief Officer lead:

Children and young people (0-25)	Chief Officer for Commissioning and Place
Children and young people with SEND	Chief Officer for Commissioning and Place
Down syndrome (all-age)	Chief Officer for Commissioning and Place
Learning disability and autism	Chief Officer for Commissioning and Place
Looked after children	Chief Nursing Officer
Mental Health	Chief Officer for Commissioning and Place
Safeguarding (children and young people)	Chief Nursing Officer
Safeguarding (adult)	Chief Nursing Officer
Statutory medical leader	Chief Medical Officer
Statutory nurse	Chief Nursing Officer
Accountable Emergency Officer (AEO)	Chief Nursing Officer
Caldicott Guardian	Chief Medical Officer
Commissioning - core statutory duties	Chief Officer for Commissioning and Place
EPRR	Chief Nursing Officer
Financial stewardship, assurance, and governance	Chief Officer Strategic Finance and Resources
Health inequalities duties	Chief Officer for Population Health Improvement
Public and patient involvement	Chief Nursing Officer
Senior Information Risk Owner (SIRO)	Chief Officer for Population Health Improvement
Commissioning - strategic	Chief Officer for Commissioning and Place
Complaints and PALS	Chief Nursing Officer
Infection Prevention and Control (IPC)	Chief Nursing Officer
Information and Data Governance	Chief Officer Strategic Finance and Resources
Population health and equality	Chief Officer for Population Health Improvement
Quality strategy, governance and surveillance	Chief Nursing Officer

3.7 Focus on Place

Across BSW

3.7.1 Neighbourhood health planning has reached a genuine transition point: all 20 footprints across the three localities are now Health and Wellbeing Board approved, and the programme is moving from design into delivery. Through the £1.5 million BSW Neighbourhood Health Enabling and Mobilisation Programme, neighbourhoods are now beginning implementation activity focused on their priority cohorts and populations, with the aim of improving outcomes, reducing demand on acute and statutory services, and creating greater opportunity for preventative investment. Following a review of the programme approach, a greater proportion of funding is now flowing directly to

neighbourhood delivery. Indicative delivery allocations are approximately £615,000 for Wiltshire (11 neighbourhoods), £294,000 for Swindon (6 neighbourhoods) and £225,000 for B&NES (3 neighbourhoods), with the remaining funding supporting programme facilitation and population health analytics. Procurement of the facilitation partner is under way, with onboarding of the first neighbourhoods targeted for late September and costed neighbourhood delivery proposals expected by December.

3.7.2 The BSW Neighbourhood Health Workshop Series, bringing all three localities together, has also progressed: Workshop 1 in April addressed community assets and prevention, Workshop 2 in July addressed integrated neighbourhood teams and coordinated care, and Workshop 3 on 1 October in Swindon will complete the vision, covering specialist care and shared enabling foundations. Alongside this programme delivery, the ICB's own Place Team structures across all three localities are moving through recruitment as part of the wider cluster restructure, with teams expected to be fully in post by September.

Bath & North East Somerset

3.7.3 In Bath and North East Somerset, neighbourhood health planning continues to mature, with the Health and Wellbeing Board's approval of the Bath, Keynsham and Saltford, and Three Valley footprints on 7 May 2026 now the platform for delivery. Alignment between neighbourhood health planning and the national Pride in Place programme is progressing well: the community-led Neighbourhood Board for Twerton and Whiteway, established to oversee up to £20 million of ten-year government investment in one of B&NES's most deprived neighbourhoods, has appointed its co-chairs, and conversations continue on connecting this community-directed investment to the neighbourhood health programme given the shared geography and population. The new Best Start Family hub in Twerton had its soft launch in August. A multi-partner ICA and Health and Wellbeing Board governance workshop in June co-designed the proposed future model for place-based decision-making, with new arrangements to commence during Sept 2026. Work also continues on the Neighbourhood Health Centre agenda, with community partner asset mapping almost complete. Work has commenced to explore prevention opportunities in partnership with provider partners, University research teams and the Retirement Village in Keynsham.

3.7.4 The B&NES Integrated Care Alliance continues to progress its three priority areas. The Children and Young People's Emotional Health and Wellbeing stakeholder event took place in July, co-produced with young people, with outputs feeding into the system summit planned for November and alignment maintained to the Schools Health and Wellbeing Survey, SEND reform and the Families First Partnership Programme. BCF plan for 2026/27 has been completed and received national approval. Section 75 pooled budget arrangements are being refreshed ahead of the 30 September completion deadline. B&NES partners have agreed key actions from the SEND inspection, which took place in June 2026. Public health is leading a multiagency review of the impact of recent heatwaves and work on women and girls' safety as part of WECA priorities has commenced.

Swindon

3.7.5 In Swindon, the Health and Wellbeing Board approved the locality's neighbourhood health vision and its footprint, based on six integrated neighbourhood team areas mapped to community services teams and primary care networks, on 20 July 2026, alongside the BCF position for the year. Work continues on articulating for residents how NHS neighbourhood health structures and Swindon Borough Council's community hub model will work alongside each other in practice. Following the local elections in May 2026, early engagement with the newly elected council administration is under way to maintain continuity of the partnership working underpinning both neighbourhood health and BCF delivery. The ICA has begun considering the development of a Swindon Health and Care Partnership Board, reviewing draft principles, purpose and governance arrangements at its July meeting; further feedback and refinement will be required before implementation.

3.7.6 The Swindon Integrated Care Alliance continues to progress its three priority areas. The Children and Young People's Health Improvement Summit, co-produced with young people through Change Makers and Youth Voice, took place on 11 June at New College Swindon, with agreed priorities and a post-summit action plan to be governed through the Health and Wellbeing Board. The targeted oral health pathway pilot for Core20 families continues to build on its successful Health Inequalities Funding bid, with future sustainability and options for scaling under discussion. The self-harm deep dive has identified the highest-risk cohort as white females aged 15 to 19, informing commissioning and prevention strategy. BCF planning for 2026/27 has been completed and submitted, with the strategic steer centred on a single trusted community connector as the practical mechanism for preventing people falling between services and for treating loneliness and isolation as health issues.

Wiltshire

3.7.7 In Wiltshire, the Health and Wellbeing Board approved the county's eleven neighbourhood footprints, aligned to three super-areas matched to hospital catchments, at its meeting on 21 May, and a further progress paper was received on 16 July. Two areas are now in more detailed conversation within that approved structure rather than reopening it: in the north, Chippenham, Corsham, Calne and Box are working through a proposed super-INT operating model with sub-groups beneath it, and in the south, overlapping boundaries around Salisbury are being resolved through the facilitation programme. The Wiltshire Locality Planning Group is being established to take forward Stage 2 plan development, with an initial plan now targeted to the Board by the end of 2026. Two Integrated Care Centres, including the recently opened facility in Trowbridge, are now fully operational, with further estates opportunities under consideration.

3.7.8 The Wiltshire Integrated Care Alliance continues to make progress across its three priority areas. The Children and Young People's Emotional Health and Wellbeing Strategic Partnership Group is developing bid-ready prevention pilots across the Community Connections, Social Communication Needs and Someone to Talk To workstreams, while the Ageing Brilliantly Community of Practice continues to deepen collaboration between health, social care, the voluntary sector and university partners

around frailty and falls prevention. An Armed Forces and Veterans Summit, building on the Armed Forces Network Spring Conference, took place in June.

3.7.9 The June 2026 discharge and flow diagnostic identified a number of opportunities for improvement. To address these, partners are establishing a Shared Improvement Team which will run as an intensive six-month programme addressing Home First and intermediate care transformation, including strengthened clinical leadership, greater consistency in practice across organisations, and the development of improved pathways and alternatives to institutional care that support people to remain independent for longer. This will work alongside the BSW-wide urgent and emergency care reset work.

3.7.10 BCF planning for 2026/27 has been completed and submitted in line with the national deadline. For 27/28 Wiltshire has agreed a strategic steer on technology and equipment to support independence at home, and on strengthening community-based connectors who can identify need before it escalates, this is a formal focus area under neighbourhood developments supported by the BCF. Section 75 pooled budget arrangements are being refreshed ahead of the 30 September completion deadline, and Wiltshire Place Board development continues through the ICA, with a development session on 16 August and a paper due to the Health and Wellbeing Board in September.

Dorset

3.7.11 Dorset partners have continued to deliver tangible progress across the health and care system during July and August 2026. Key highlights include securing the future of the Primary Care Training Hub, NHS Dorset obtaining national funding to lead an innovative obesity care programme, achievement of a CQC "Good" rating for Dorset County Hospital emergency and medical services as well as significant progress on the new Emergency Department and Critical Care Unit development. Dorset HealthCare also received national recognition through the Defence Employer Recognition Scheme Gold Award, while system partners worked together to support residents during periods of extreme heat. In addition, SWASFT have recently been shortlisted for three Health Service Journal awards – Trust of the year, staff wellbeing and culture and provider collaboration of the year

3.7.12 The Health and Wellbeing Strategy is currently being refreshed through a coproduction approach and various design workshops. It is due to be presented to the Health and Wellbeing Board in November 2026. As part of this work, an outcomes framework is being developed to help define the strategy for the Board and show a clear link between the work held by the Delivery Groups and the outcomes the Health and Wellbeing Board want to shift. Four delivery groups are proposed to take forward the delivery of the strategy. Their focus will be on starting well, living well, ageing well and health places. The neighbourhood footprints are currently being finalised with a plan to present a set of recommendations to the Health and Wellbeing Board in September 2026 for approval. We have recently been successful in our Better Care Fund expressions of interest to participate in the communities of practices programmes for home-based intermediate care and Health and Wellbeing Boards.

3.7.13 The Neighbourhood Programme for Dorset has reflected on the feedback from the national team and is currently focused on developing the operating model, increasing the targeted cohort from 0.25% to 1% and allocating McMillan funding to test innovative ways of working, aligned to the left shift.

3.7.14 Winter preparations have commenced to ensure health services stay as resilient as possible.

Bournemouth, Christchurch, and Poole (BCP)

3.7.15 The first meeting of the BCP Place-Based Partnership was held in August, with strong attendance from partner organisations and a shared commitment to creating the conditions for BCP Place to thrive. Jointly chaired by the ICB and BCP Council, the Partnership operates as a subgroup of the BCP Health and Wellbeing Board. An early priority is the confirmation of neighbourhood footprints, building on the strong foundations established through Primary Care Networks while providing greater alignment to natural communities across BCP. Engagement is underway, with recommendations due to be considered by the Health and Wellbeing Board in October.

3.7.16 Building on the recent visit from Professor Claire Fuller, work is progressing to mobilise Integrated Neighbourhood Teams, with a draft operating model being socialised with partners and targeted initiatives focusing on proactive care for those most at risk of poor health outcomes and hospital admission. These developments will form the foundation of future neighbourhood working. Winton Neighbourhood Centre opened in August, marking a significant milestone for local primary and community care infrastructure.

3.7.17 Across the wider system, partners remain focused on winter preparedness and readiness for the planned hospital reconfiguration in April 2027. This includes implementation of the first phase of the Command Centre at University Hospitals Dorset NHS Foundation Trust to strengthen system coordination and mobilisation of an enhanced Discharge to Assess pathway for people with higher-intensity needs, supported by strong commitment from health and care partners.

Somerset

3.7.18 ***Neighbourhood health***: with footprints agreed, options on the leadership of Integrated Neighbourhood Team have been developed and are being explored by partners. The intent is to have clear lines of accountability and responsibility for facilitation and progress within Integrated Neighbourhood Teams, whilst trying to maximise the use of existing roles. Council leads are involved in assessing the options to ensure any health roles align with council plans.

3.7.19 ***Place-based decision-making***: a Somerset Health Provider Partnership has been formed and will act as a vehicle for strengthening the planning and delivery of healthcare between Somerset Foundation Trust and the GP Support Unit. The strategic intent is to formalise the partnership first through a Memorandum of Understanding, and then to consider further partnership options under the contracting models. Alongside

that, the Place team is working with council colleagues to develop the options on how health commissioning and joint Commissioning is best coordinated and overseen at Place, and how they link to existing governance at Place and within the Cluster ICB. The intent is to have a single commissioning group at Place alongside the single Provider Partnership.

3.7.20 ***General Commissioning***:

a) The reconfigured ***Somerset Stroke service*** is due to go live on the 9 September and a separate briefing is set out within this update.
b) ***Urgent and Emergency Care:*** the County continues to see an overall reduction in emergency admissions to hospital, however, Emergency Department attendances and NCTR levels continue to rise. There is a renewed focus on NCTR and diagnostic exercise underway to understand the impact of UTC temporary closures on ED attendances.
c) ***SEND Inspection***: there is anticipation of a SEND inspection in early Autumn. The Place team is working with council colleagues and the CYP team in BaNES to apply the learning from the recent BaNES inspection to our preparations.
d) ***Diagnostics:*** The new £17.8m Bridgwater Diagnostic Centre officially opened on the 18th August. The Centre, located next to the Community Hospital in the town, has capacity for 25,000 additional MRI and CT scans and marks the final stage in the development of 'three hub model' of diagnostics provision across the county.

3.4 Voluntary, Community, and Social Enterprise (VCSE) Update

3.4.1 The VCSE Alliances in Dorset & BCP, BSW and Somerset continue to strengthen neighbourhood health, prevention and work on health inequalities, combining strategic engagement with practical delivery. Since June, Alliances have deepened relationships with neighbourhood teams, expanded leadership networks, and generated significant community insight — including over 150 survey responses in Wiltshire and extensive rural access evidence in Dorset. Major programmes such as the Dorset Macmillan Anchor Programme and Somerset's Systems Leadership Development Programme are building sector capacity, while targeted initiatives (e.g., hypertension case finding, dementia toolkits, financial resilience work) demonstrate tangible impact.

3.4.2 Key challenges remain: restructuring across ICB, NHS and local authorities is slowing progress; neighbourhood funding routes are unclear; and VCSE organisations continue to request earlier involvement and consistent co production. The emerging Cluster-wide Alliance offers a coordinated mechanism for intelligence-sharing and representation, with common priorities now established. The Board is asked to recognise VCSE Alliances as core system infrastructure, support early and equal involvement in neighbourhood and commissioning work and initiate a clear discussion on sustainable funding flows into neighbourhoods.

3.4.3 A full VCSFE update is enclosed at Appendix 1

Cluster VCS Alliance Report

September 2026

Overview

The VCSE Alliances across Dorset and BCP, Bath and North East Somerset, Swindon and Wiltshire (BSW), and Somerset continue to strengthen the sector's contribution to neighbourhood health, prevention and health inequalities. Since June, activity has combined strategic engagement with practical delivery: developing neighbourhood relationships, gathering insight, strengthening leadership and improving referral pathways.

Across all three Alliances, the VCSE sector adds greatest value when engaged early, treated as an equal partner and supported to contribute sustainably. Regular South West Alliance meetings are enabling shared learning and a more coordinated Cluster voice while protecting the distinct priorities of each Place.

1. Meetings and engagement since the June Board meeting

Dorset and BCP

The Dorset VCS Assembly and VCSE infrastructure organisations have continued to work with neighbourhood teams across Dorset and BCP, bringing together intelligence from urban, coastal and rural communities. Engagement has focused on connecting neighbourhood priorities with community assets and ensuring that lived experience informs emerging plans. A major cross-sector partnership conference brought together 206 VCS, health and local authority colleagues. It generated hundreds of comments and insights, strengthened existing relationships, created new connections and identified immediate collaboration opportunities.

BSW

The Wiltshire VCSE Leadership Alliance meets bi-monthly and has grown to 66 organisations, with ICB Place updates and discussion on neighbourhood health and violence against women and girls. Swindon's Alliance met on 2 September with the Associate Director for Place; VCSE representatives are contributing to the FAST Neighbourhood Health Mobilisation Programme and development of the Place Board. In B&NES, the September Alliance will workshop neighbourhood arrangements, health inequalities and areas at risk of worsening deprivation with the Place Director. The 3SG Chief Executive is joining the new Place-based Board and supporting recruitment to its oversight groups.

Somerset

The Somerset VCFSE Collaborative continues to meet bi-monthly, maintaining strategic engagement between sector leaders and health and care partners. Leaders have considered proposed ICB boundary arrangements and met following publication of the NHS 10 Year Health Plan to identify implications and opportunities for Somerset. Discussion focused on prevention, neighbourhood health, community engagement and reducing inequalities, with key themes shared with system partners. Further engagement is taking place through research, workforce, volunteering, dementia, financial resilience, cancer and oral health programmes.

2. Key discussions and emerging priorities

Neighbourhood access, prevention and inequalities

Across the cluster, transport, geography, digital exclusion, accessibility, appointment availability and local service capacity continue to shape whether people can obtain support. Dorset rural insight includes journeys of 20-30 minutes to a GP and around 45 minutes to A&E, while BCP evidence shows how trusted community organisations can resolve housing and practical barriers that determine whether an older person can return home safely after hospital discharge. Wiltshire's Voice It Hear It programme is gathering experience from rural residents with long-term conditions to inform neighbourhood plans. B&NES is examining health inequalities and communities that may move into the Index of Multiple Deprivation while attention is focused elsewhere. Somerset is linking neighbourhood work with dementia, frailty, research, community anchors and financial resilience.

Earlier involvement, shared intelligence and co-production

VCSE organisations want involvement before decisions are made, not consultation after options have narrowed. Dorset and BCP feedback calls for co-production, shared decision-making, clearer opportunities to engage, better information sharing and visible feedback on what changed. Wiltshire's State of the Sector Survey received more than 150 responses and will inform an early September event. Somerset has published a co-produced Community Conversation Kit, developed through its Research Engagement Network, to help turn everyday community conversations into useful insight. Together, these approaches offer the Cluster a stronger route for gathering qualitative intelligence and linking it to planning and commissioning.

System change, commissioning and sustainable funding

ICBs, NHS organisations and local authorities are restructuring, delaying progress and creating uncertainty about responsibilities and decision-making routes. Central documents have not provided a clear pathway for funding VCSE organisations, and there has been no substantive Cluster conversation about how resources will flow into neighbourhoods. This risks losing the attention and goodwill of organisations repeatedly asked to co-produce ideas without knowing how delivery will be funded. There are positive commissioning examples: Wiltshire VCSE feedback changed the Home from Hospital procurement timetable so key stages avoid Christmas, and Somerset is planning a commissioning roundtable on children and young people's mental health. These examples need to develop into a consistent approach that involves the sector early and recognises the real cost of participation and delivery.

3. Progress towards a cluster-wide VCSE Alliance

- Regular meetings between the Dorset and BCP, BSW and Somerset Alliances aim to provide a consistent mechanism for sharing intelligence, challenges and opportunities.
- Common priorities are becoming clearer: neighbourhood health, prevention, health inequalities, community insight, volunteering, workforce development, sustainable capacity and more collaborative commissioning.
- Cluster representation creates a route for local VCSE perspectives to inform Board and development discussions, while each Alliance retains its Place and neighbourhood relationships.
- The next stage is to agree a shared purpose, representation arrangements and a common process for turning local evidence into Cluster intelligence and feeding decisions back to communities.

4. Achievements, challenges and next steps

Dorset and BCP achievements

- Neighbourhood relationships are developing across Dorset and BCP, supported by intelligence gathered through VCSE infrastructure organisations.
- The Volunteer Centre Dorset's conference demonstrated a strong appetite for collaboration, increased awareness of services and generated practical new connections, referral routes and opportunities.
- Evidence has made rural access barriers visible and shown how community organisations can address the non-clinical issues that affect discharge, prevention and successful care pathways.
- The three-year £750,000 Dorset Macmillan Anchor Programme is strengthening VCSE capacity, influence, peer learning and work on health inequalities. It forms part of wider £10 million Macmillan investment. The Assembly helped embed co-production requirements within funding criteria and is supporting oversight, learning and case-study development.
- The monthly Virtual Exchange webinar programme has connected smaller VCSE organisations with ICS partners: Series 1 is complete, Series 2 has begun, four webinars have been delivered and 100 attendances recorded. Neighbourhood Health and Wellbeing sessions involving NHS colleagues received particularly positive feedback and strengthened cross-sector relationships.

BSW achievements

- The hypertension case-finding project delivered 2,505 blood pressure checks; 507 results (21%) were amber or red. Early national modelling projects potential NHS savings of £2.2 million.
- Wiltshire completed State of the Sector fieldwork with more than 150 responses. Its Council-VCSE Partnership Framework has led to 18 Council VCSE Champions, a joint communications plan, an active working group, a Community Lottery projected to raise £80,000, and one paid volunteering day annually for every Council employee.
- Wiltshire influenced the Home from Hospital procurement timetable; its Leadership Alliance grew to 66 members. Swindon strengthened Place relationships, joined the FAST mobilisation programme and is planning a November conference with neighbourhood health as a sector-selected theme.
- B&NES secured VCSE involvement in the new Place-based Board, is recruiting representatives to Population Health, Neighbourhood Health and Delivery oversight groups, and will support the ICB's 1% work.

Somerset achievements

- Forty VCSE leaders completed a Systems Leadership Development Programme, strengthening confidence, partnership working and the ability to influence system change.
- VCFSE organisations remain involved in research on dementia, gambling harms, veterans' health and older women's domestic abuse; the new Community Conversation Kit provides practical, co-produced guidance for engagement and research.
- As one of 15 nationally funded Volunteering for Health areas, Somerset published a plan setting out how volunteering will be strengthened within health and social care.
- The Dementia Inclusive Communities Toolkit and Dementia Roadshow are progressing, with links to frailty, neighbourhood health and research. The Message in a Bottle initiative is also being supported.

Somerset achievements (continued)

- The Crisis and Resilience Fund is improving coordination for people facing financial hardship, strengthening referrals and building the capacity of community anchors, with clear potential to align with neighbourhood working.
- Workforce discussions cover accredited provision, shared learning, local training providers and compliance, with a focus on mental health organisations. Next activity includes a children and young people's mental health commissioning roundtable, a joint cancer-pathway workshop and oral health inequalities engagement with Public Health.

Shared challenges and next steps

- Manage the impact of ICB, NHS & LA restructuring without losing local relationships, momentum or accountability.
- Open a specific Cluster discussion about the neighbourhood funding model, including how resources will reach VCSE delivery partners and sustainably support smaller organisations.
- Agree a common reporting structure to make reporting to the Board easier and more consistent for each area. Would welcome guidance from the ICB on topics they would like us to include.

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	4
Date of Meeting:	16 September 2026		

Title of Report:	Developing our Integrated Needs Assessment
Report Author:	Nicola Hilton, Associate Director of Population Health Intelligence James Whitehead, Associate Director of Strategy & Directorate Operations
Board / Director Sponsor:	Amanda Webb, Chief Officer for Population Health Improvement
Appendices:	Embedded

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	X
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	

Previous consideration by:	Date	Please clarify the purpose
EMM	11/08/26	Discussion and endorsement
PHaCC	04/09/26	Discussion and endorsement

1 Purpose of this paper

To seek Board discussion and endorsement of a concise, decision-enabling Integrated Needs Assessment (INA) design. The proposed INA is intended to inform the Population Health Strategy, Population Health Improvement Plan, commissioning intentions, Medium Term Plan, and service reviews.

2 Summary of recommendations and any additional actions required

Cluster Board is asked to:

1. Discuss in depth the proposed design of the INA and endorse the approach

2. Agree that the INA will produce five usable outputs: a case for change on a page; a target cohort shortlist; a service review matrix; an opportunity portfolio; and strategic priority scoring.
3. Confirm that the INA will operate at cluster, place and neighbourhood levels, while retaining a single system-wide view of priority needs, inequalities, service gaps and opportunities.
4. Note the dependencies on linked and costed person-level data, information governance, public health input, provider engagement, VCSFE and community insight, and a repeatable annual intelligence cycle.

3 Legal/regulatory implications

NHS England's Strategic Commissioning Framework expects each ICB to have an Integrated Needs Assessment in place by March 2026 and to update it annually, using linked, costed person-level data, segmentation, inequalities analysis, predictive modelling, opportunity analysis and baseline mapping to inform strategic commissioning decisions. As a newly formed cluster this will be the first INA which supports the new organisation and new geography.

The principal regulatory implications are therefore board assurance, lawful data use, clear information governance, and demonstrable traceability from assessed need to strategy, improvement priorities, service reviews and commissioning intentions. ICBs also have specific statutory duties to promote equality generally and reduce health inequalities specifically.

4 Procurement

There are no immediate procurement implications arising from the development of the INA.

The INA will provide an evidence base for future commissioning, contracting and service-review decisions, including where changes may need to be considered under the NHS Provider Selection Regime or other applicable procurement routes.

NHS England's Strategic Commissioning Framework is clear that ICBs should use market management, contract management and procurement mechanisms to support quality, value for money and improved outcomes, but any specific procurement implications would be assessed separately when individual service changes or commissioning intentions are brought forward.

Procurement to detail the advice provided in this instance and the guidance to ensure compliance, governance and value for money

P&C Name	NA
P&C Signature	NA

5 Risks

High level corporate risks the INA is aimed to mitigate include:

1. *Risk that strategic priorities and commissioning decisions are not sufficiently aligned to population need*
   The INA creates a single, evidence-based case for change across the ICB, cluster, place and neighbourhood levels. It helps ensure assessed need, future demand, service gaps and inequalities are traceable through to the Population Health Strategy, PHIP, Plans and commissioning intentions.

2. *Risk that health inequalities and unwarranted variation are not systematically identified or addressed*
   The INA makes inequalities visible across need, access, experience, outcomes and resource use. It supports a clearer Core20PLUS5 and locally defined PLUS-group response, and helps ensure that improvement priorities explicitly state which gaps will be narrowed, for whom and where.

3. *Risk that resources are not targeted to areas of greatest impact, value or future demand*
   By combining population need, demand projections, cost, activity, quality, outcomes and productivity intelligence, the INA supports better prioritisation and allocative efficiency. It provides a transparent basis for deciding where to invest, redesign, review or potentially shift resources upstream.

4. *Risk that service fragility, provider capacity or future demand pressures are not identified early enough to inform planning*
   The INA links population projections, baseline service mapping, demand/capacity analysis and provider-market intelligence. This allows the ICB to identify services or pathways where current provision may not be sustainable, where demand is likely to grow, and where service reviews or strategic redesign may be required.

6 Quality and resources impact

Quality, Patient Experience and Safeguarding: The INA is expected to have a positive impact by improving the evidence base for decisions that affect access, outcomes, experience, inequalities and service safety. It will support earlier identification of underserved groups, unwarranted variation, quality concerns, service fragility and safeguarding-relevant population risks, including vulnerable children, adults, inclusion health groups and people at risk of deterioration.

Finance: There are no direct financial commitments arising from approval of the INA design. The INA is intended to strengthen future financial decision-making by linking resource allocation, commissioning intentions and service reviews to population need, value, demand, cost and outcomes.

Workforce: There are no immediate workforce changes proposed. Development of the INA will require input from existing ICB intelligence, population health, finance, quality, clinical, safeguarding, engagement, commissioning and partner teams. The INA will also help identify workforce-related risks where current service capacity or skill mix may not be aligned to future population need.

Sustainability / Green agenda: There are no direct sustainability impacts from the INA design. The INA will support a more sustainable health and care agenda by informing more preventative, proactive and locally delivered models of care, reducing avoidable activity, duplication and unnecessary travel where clinically appropriate. Future service-change proposals arising from the INA would need to assess sustainability impacts.

Finance sign off:	NA

7 Confirmation of completion of Equalities and Quality Impact Assessment

A formal EQIA has not been completed at this design stage, as the paper does not propose a specific service change or resource decision.

The INA is designed to provide the core evidence base for equality and health inequalities assessment. It will explicitly examine variation in need, access, experience, outcomes and resource use across Core20PLUS5 groups, locally identified PLUS groups, protected characteristics, inclusion health groups, cluster, place and neighbourhood.

Any subsequent strategy, PHIP programme, service review or commissioning decision arising from the INA will complete a specific EQIA, using the INA findings as its evidence base.

8 Communications and Engagement Considerations

The INA will require a clear communications and engagement approach to ensure partners, providers, places, VCSFE organisations, staff and people with lived experience understand its purpose and contribute meaningfully.

Engagement will be proportionate at this design stage, focused on testing the proposed approach, identifying priority communities and ensuring that qualitative insight is triangulated with quantitative analysis.

Particular attention will be given to Core20PLUS5 groups, locally identified PLUS groups, inclusion health communities and those who may experience barriers to access or poorer outcomes.

Once developed, the INA will be communicated as a shared system evidence

base to support strategy, the PHIP, service reviews and commissioning intentions, with clear messages about how insight has influenced priorities and decisions.

9	Statement on confidentiality of report
No restrictions	

Developing our Integrated Needs Assessment

Paper purpose

To seek Cluster Board discussion and endorsement of a concise, decision-supporting Integrated Needs Assessment (INA) design. The INA will provide an annual case for change to inform the Population Health Strategy, Population Health Improvement Plan, commissioning intentions, MTP and service reviews.

The meeting is asked to:

1. Discuss in depth the proposed design of the INA and endorse the approach
2. Agree that the INA will produce five usable outputs: a case for change on a page; a target cohort shortlist; a service review matrix; an opportunity portfolio; and strategic priority scoring.
3. Confirm that the INA will operate at cluster, place and neighbourhood levels, while retaining a single system-wide view of priority needs, inequalities, service gaps and opportunities.
4. Note the dependencies on linked and costed person-level data, information governance, public health input, provider engagement, VCSFE and community insight, and a repeatable annual intelligence cycle.

Executive summary

The Cluster ICBs need a single, credible and annually refreshed view of population need, future demand, inequalities, service performance and improvement opportunities. As part of the wider strategy roadmap, the INA will support strategic commissioning and population health improvement by translating evidence into clear choices about priority cohorts, services, resource use and improvement programmes.

A key design principle is for the INA to be a decision product, not a data bank. It will draw on JSNAs, public health intelligence, linked data, service performance, finance, quality, workforce, provider intelligence and lived experience. The core INA report will present the insight drawn from this evidence, with detailed charts, methods and place profiles held in companion products, initially as documents but then live dashboards with auditable snapshots.

The INA will create a disciplined line of sight from population need to action. It will identify what is changing, who is most affected, where current provision does not match need, and what should change next. It will inform the Population Health Strategy and PHIP, and provide a transparent rationale for service reviews, commissioning intentions and resource allocation.

This approach directly reflects the national shift towards a more explicit strategic commissioning role for ICBs. The NHS England Strategic Commissioning Framework expects ICBs to develop an INA that uses linked and costed person-level data; understands current and future need; segments and risk stratifies populations;

identifies underserved communities; assesses quality, performance and productivity; and uses opportunity analysis to support commissioning and resource allocation.

Each substantive section of the INA will therefore end with a clear decision-use statement: what the evidence means for strategy, PHIP, service review, commissioning or resource allocation. Evidence that does not support a decision will sit in the data pack rather than the core report.

1. Why this paper is being brought now

The cluster is beginning to set in place key enablers to develop a population health strategy and Population Health Improvement Plan. Those enablers form a Strategic Roadmap as outlined in Figure 1. The Strategic Roadmap sets the broader context of how specific products come together to enable the Population Health Strategy.

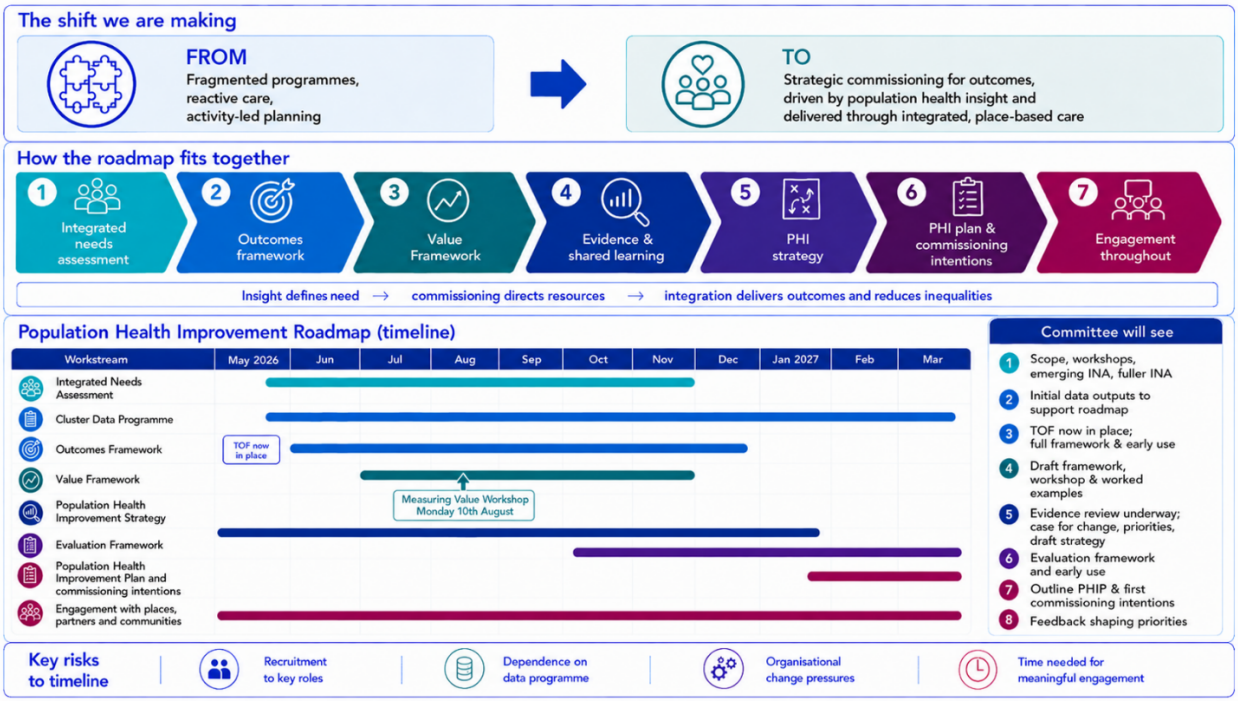


Figure 1: Outline Strategic Roadmap

The Integrated Needs Assessment, INA, is a key enabler within the roadmap that takes us towards a Population Health Improvement Strategy and Plan, and a more deliberate approach to strategic commissioning.

The move to a clustered ICB requires a shared evidence base that can support decisions at cluster, place and neighbourhood levels. The organisation needs to understand the relationship between population need, access, quality, outcomes, demand, cost, productivity, value, workforce, provider resilience and future service configuration, which builds on but is broader than a synthesis of JSNAs.

The organisation also needs a product that supports real strategic choice. An INA will identify where the system should focus effort, which cohorts should be prioritised, where variation is material, and which services or pathways require review or redesign.

The proposed INA is therefore the analytical case for change for the Population Health Strategy and PHIP. It will use JSNAs as essential inputs alongside NHS and partner intelligence to support strategic commissioning.

2. Policy and strategic context

The NHS England Strategic Commissioning Framework establishes the INA as a core component of the ICB strategic commissioning cycle. It expects an INA to set out a detailed understanding of the current and future population served by an ICB, to be shared with providers and partners and updated annually across the ICB geography. It also stipulates the INA to use linked and costed person-level data, predictive modelling, segmentation, risk stratification, identification of underserved communities, comparative performance analysis and opportunity analysis (See Appendix A).

The framework places the INA alongside baseline mapping and service reviews, all three elements being important for Board assurance. The INA is part of a commissioning architecture that will help the clustered ICB understand the gap between current provision and desired future provision, going beyond an assessment of need. This means the INA must connect population need to service performance, quality, productivity, provider sustainability and resource allocation.

The INA also supports the statutory and strategic planning context for ICBs. Joint Forward Plan / MTP guidance requires ICBs and partner trusts to explain how they will meet population health needs, and to have regard to reducing inequalities in access and outcomes. JSNAs and Joint Local Health and Wellbeing Strategies remain vital statutory place-based products; the INA will translate this evidence into a system and cluster-level strategic commissioning view to enable the Board's responsibility to our Cluster population.

The design is also aligned with Core20PLUS5, population health management, *Providing healthcare public health advice to ICBs* (DHSC, 2026), and the CQC framework for engaging with people and communities to address health inequalities. These anchors support an INA that combines quantitative analysis with lived experience, and supports the organisation to be explicit about how inequality gaps will be narrowed through strategy and delivery.

3. The proposed design summary

Proposed definition - *A concise, annually refreshed, decision-enabling case for change that identifies priority needs, cohorts, inequalities, service gaps and opportunities for action across ICB, cluster, place and neighbourhood levels to improve outcomes for our whole population.*

This definition means the INA will not try to hold every chart, dataset, method or local profile. Instead, it will synthesise evidence into a coherent judgement about what must change, where action should be focused, and which decisions should follow.

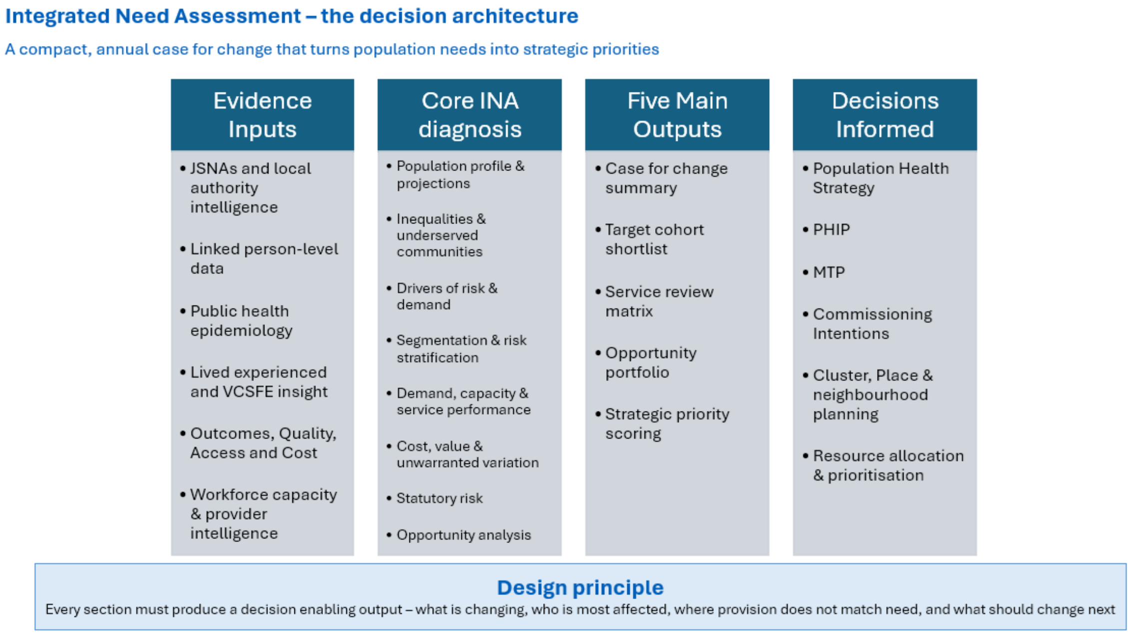


Figure 1. Decision architecture - The INA draws evidence into a core diagnosis, then produces five usable outputs that inform strategy, PHIP, commissioning and resource allocation.

The Clustering ICB's INA will ask: given what we know about need, inequalities, demand, cost, quality, access, productivity and future risk, what should the ICB and partners do differently?

The INA will build from the JSNA evidence base and add four distinctive layers. First, it will use linked person-level and pathway data where available to understand risk, demand and cost across multiple settings. Second, it will compare need with current provision, access, quality, outcomes, capacity and productivity. Third, it will identify priority cohorts and service review candidates. Fourth, it will generate a prioritised opportunity portfolio for the Population Health Strategy and PHIP.

The JSNA tells us what local populations need. The INA tells the ICB what that means for strategy, service review, commissioning, resource allocation and population health improvement. The INA is intended to make that intelligence more usable for ICB-wide and cluster-level choices, while preserving the ability to drill down to cluster, place and neighbourhood.

The INA design will be delivered through a phased approach. The same core outputs will be produced throughout, however the sophistication, depth and confidence of the analysis supporting those outputs will increase over time. The first iteration will establish a shared understanding of population need, inequalities and priorities across the Cluster. Subsequent phases will deepen the analysis and strengthen the intelligence available. This approach ensures the first INA is practical and achievable whilst providing a clear route to a more sophisticated and mature INA.

The Core Design Principles the design will use are:

1. Decision-informing: designed to inform action, not simply describe issues
2. Population-based: focused on people, places and communities
3. Equity-focused: Making inequalities and unmet need visible
4. Future-facing: Looking ahead, as well as the present
5. Evidence-led: Grounded in data, intelligence and insight
6. Refreshable: Built to evolve as needs and priorities change

4. What Questions will the INA answer?

The INA will be structured around a number of strategic questions. Whilst the INA will still review across an extensive compendium of data, this will sit in the companion document (progressing to live dashboard) structured by themes. Each theme will be evidence-based, focused on decision-making, and explicit about the implication for action. It is these themes that start structuring the evidence towards the 5 core outputs using the following structure:

Theme	Key Questions
Population Need	- What are the most significant current and future health and care needs across the Cluster? - How are demographic and population changes likely to affect future demand and outcomes?
Inequalities and Underserved Communities	- Which groups experience the poorest outcomes or greatest barriers to care? - Which inequalities should be prioritised for action?
Drivers of Risk and Demand	- What is driving need, demand and poorer outcomes? - Which drivers are most amenable to prevention or intervention?
Segmentation and Priority Cohorts	- Which population groups should be prioritised for action? - Where could targeted intervention have the greatest impact on outcomes, equity or demand?
Current and Projected Demand	- Where are demand pressures greatest today? - How are those pressures likely to change in the future?
Service Response and Sustainability	- How well does current provision align with population need? - Which services or pathways may require review, redesign or additional support?
Cost, Value and Allocative Efficiency	- Is resource allocation aligned with need, outcomes and equity? - Where are there opportunities to improve value and impact?
Statutory and Mandated Responsibilities	- Are there significant risks or gaps relating to statutory duties and protected populations? - What are the implications for planning and assurance?
Opportunity Analysis	- Where are the greatest opportunities to improve outcomes, reduce inequalities or mitigate demand? - Which opportunities should be prioritised?

Data Maturity and Future Development	- What can we say with confidence today? - What capabilities and insights need to be developed in future iterations of the INA?

Data Maturity and Phased Development:

The questions above represent the intended scope of the INA. Whilst the first iteration will provide an initial answer to many of these strategic questions, some will only be answered in greater depth as the underlying data, analytical capability and intelligence infrastructure mature.

Using a phased approach, the same core outputs will be produced throughout, however the sophistication, depth and confidence of the analysis supporting those outputs will increase over time.

As the data, intelligence and analytical capability matures, the INA will benefit from enhanced data linkage, greater automation, improved dashboard capability and more sophisticated forecasting and modelling. The first iteration is intentionally ambitious, designed to provide immediate value through a meaningful and decision-supporting assessment, with subsequent phases focused on strengthening the evidence base and increasing the depth and sophistication of the intelligence available.

The table below illustrates how capabilities will develop over each phase.

Phase	Focus	Purpose	Capability Maturity
Phase 1- November 2026	*What are the biggest issues?*	An initial INA that establishes a shared understanding of population need, inequalities, and demand pressures across the Cluster. The assessment will identify strategic priorities and provide the evidence base to inform strategic commissioning decisions, population health improvement planning and prioritisation.	• Basic data linkage & local intelligence • National datasets, published research & evidence where local gaps exist • High-level forecasting, segmentation & trend analysis • Limited automated dashboard capability, supported by manual reporting
Phase 2 –6-9 months	*What is driving these issues and who is most affected?*	A deeper INA that expands available data sources, develops linked intelligence, and provides a richer understanding of the populations, communities and pathways driving need, inequality and demand across the cluster.	• Expanded linked datasets & local intelligence • Improved segmentation & cohort analysis • Richer understanding of unmet need, variation & demand drivers • Increased dashboard capability & automated reporting

Phase 3 – 12 months and beyond	*How can we make better, more targeted decisions?*	A mature INA capability that uses advanced linked intelligence, forecasting and modelling to provide greater confidence and precision in planning, prioritisation, resource allocation and service redesign decisions.	• Mature, linked intelligence & integrated datasets • Automated, refreshable intelligence dashboards • Enhanced forecasting & predictive statistical analysis • Advanced modelling and opportunity analysis

Together these phases progressively strengthen the evidence, intelligence and analytical capability underpinning the INA, whilst continuing to support the same core priorities, opportunities and decision-making processes.

5. Usability & the five important outputs

The INA will produce five outputs designed to answer the key strategic questions facing the Cluster:

Output	Question Answered	What it will Provide
Case for Change	*What are the most important challenges facing the Cluster, and why do they matter?*	A concise strategic diagnosis summarising key needs, inequalities, future pressures, service gaps and implications for action.
Target Cohort Shortlist	*Which population groups should we prioritise to improve outcomes, reduce inequalities and manage future demand?*	Identification of the cohorts where focused action is most likely to improve outcomes, reduce inequalities or manage future demand.
Service Review Matrix	*Which services or pathways appear most misaligned with population need and require further review?*	Will highlight areas where population need appears materially misaligned with access, quality, capacity, productivity, cost or provider resilience.
Opportunity Portfolio	*What are the greatest opportunities to improve outcomes, reduce inequalities, mitigate demand or create value?*	Presents a prioritised set of opportunities for improvement, prevention, redesign or investment alongside the value each opportunity is expected to deliver.
Strategic Priority Scoring	*Why have these priorities been selected and how can we demonstrate that prioritisation is transparent and evidence-based?*	Provides a transparent and evidence-based approach to prioritisation, giving assurance that decisions are explicit and consistent.

The INA will be built around a concise case for change, supported by more detailed analyses and, in time, interactive dashboards

The design is intended to ensure the INA remains a practical decision-support tool rather than a lengthy technical report. The focus will be on the conclusions drawn from the evidence, not the evidence itself.

Not all questions will be answerable with the same level of depth and sophistication in the first iteration. However, this phased approach will progressively strengthen the evidence base underpinning the INA, enhancing the insight and precision in the priorities, opportunities and decisions it informs.

6. Governance, involvement and assurance

We will be working collaboratively to produce the INA through a system-wide process. Public health input is essential for epidemiology, inequalities, wider determinants and interpretation.

Providers and primary care are essential for validating current provision, workforce, access, quality and deliverability. Finance, contracting and planning teams are essential for cost, productivity and resource-allocation analysis.

VCSFE, Healthwatch and community partners will be involved to test whether the quantitative evidence reflects lived experience, particularly for underserved communities and groups affected by inequalities. It is vital that this involvement is sincere and meaningful. The final INA will then be able to show where lived experience changed the interpretation, prioritisation or recommended action.

Information governance and Caldicott oversight will also be central. The proposed design assumes development of linked and costed person-level data where lawful and appropriate, alongside transparent controls for pseudonymised analysis, data sharing, suppression, direct-care re-identification where applicable, and annual refresh.

We propose, in addition to the design presented here, that the companion document including prioritisation logic, the five outputs, the data limitations and constraints will be presented to Board for assurance.

7. Risks and mitigations

1. The INA becomes too long or descriptive.
   Mitigation: retain detailed data visualisation in dashboards and require every section to produce a decision-use statement.

2. Data linkage and costing are not mature enough for the full ambition in year one.
   Mitigation: publish a confidence statement and data maturity roadmap and

distinguish phase-one outputs from desired future capability.

3. Lower opportunities presented may be perceived as lower priority and this could create tension with patients, providers, geographies and clinicians.
   Mitigation: early and sincere engagement with stakeholders and clarity around what strategic prioritisation really means.

4. Prioritisation is perceived as too mechanical or too subjective.
   Mitigation: use transparent criteria, combine data with professional judgement and lived experience, and invite Board challenge before final recommendations.

5. Provider engagement is insufficient, leading to unrealistic recommendations.
   Mitigation: involve all NHS providers including primary care and operational leads in validating service baseline mapping, fragility and deliverability.

6. Co-production is under-resourced.
   Mitigation: agree a proportionate methodology with VCSFE and community partners, with clear feedback loops and evidence of influence.

8. Next steps

- Develop the INA in accordance with the design set out within this paper.
- Develop the first case-for-change narrative and five outputs for review and Board sign-off, targeting November.
- Use the agreed outputs to shape the strategy, PHIP, commissioning intentions and the service review pipeline.
- Develop the level of sophistication through phases two and three to bring the INA to full maturity.

Conclusion

The proposed INA design gives the Board a practical way to move from evidence to action. It builds from JSNAs and place intelligence, and integrates linked data, service performance, cost, quality, productivity, provider fragility, opportunity analysis and transparent prioritisation.

The central design proposal is that the INA will be short enough to use, rigorous enough to assure, and explicit enough to usefully inform decisions. Next steps will focus on producing the first case-for-change narrative and five outputs, with clear governance and a data maturity roadmap targeting November completion for a phase one INA.

Policy anchors and references

1. NHS England, Strategic Commissioning Framework
2. NHS England, Guidance on developing the Joint Forward Plan
3. GOV.UK, Health and wellbeing boards guidance
4. NHS England, Core20PLUS5 adults
5. NHS England, Core20PLUS5 children and young people
6. NHS England, Population Health Management
7. Care Quality Commission, Framework for engaging with people and communities to address health inequalities
8. GOV.UK, Providing healthcare public health advice to integrated care boards

Appendix 1: Excerpt from the Strategic Commissioning Framework specific to INAs

3.1 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.

An integrated needs assessment sets out a detailed understanding of the population served (current and future) and should be produced by March 2026, shared with providers and other partners and updated annually across the ICB geography (Note 3). This should be informed by:

- a fully linked and costed person-level data set across ICB partners that pools insight into local need and risk factors and allows for modelling of demand and cost at a person and population group level for now and predicted. This should be underpinned by the necessary data sharing agreements across partners and information governance to allow for re-identification of at-risk cohorts within clinical settings. This also includes establishing the data sharing agreements to support integration into the local NHS Federated Data Platform (NHS FDP)

- in-depth understanding of the population's drivers of risk and demand across biological, psychological and social factors and including health deterioration

and inequalities in access to health and care

- leveraging real-time data and predictive modelling to understand projected use and the real cost of health and care services, identify unwarranted variation (including across different communities) and risk in different parts of the system and potential mitigations, and support resource allocation to where it will have the greatest impact (allocative efficiency)

- a segmentation of the population and stratification of health risks, including by disaggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity, as well as focusing resources on the most efficient interventions
- an understanding of the comparative demand for, cost and performance of the services commissioned for the population served against the national position and peers using a range of the tools on offer (see section 3.3 for details)

- an opportunity analysis to identify the care models, interventions and innovations likely to have the biggest impact on health outcomes, experience and mitigatable demand

We would expect an integrated needs assessment to be in place in each ICB by March 2026 and updated annually thereafter.

It should be possible to break down the integrated needs assessment by the agreed local places (typically at a health and wellbeing board level) and neighbourhoods that make up the ICB geography. In addition, ICBs should seek to gain an understanding of population projections, future local housing and local government-led growth plans and their potential impact on demand for healthcare services.

In line with the Core20PLUS5 approach and considering health inequalities more broadly, strategic commissioners should also ensure they understand how different population groups (such as ethnic minority communities and inclusion health groups) access services and experience care and how their outcomes vary, and consequently how any gaps will be narrowed through the ICB strategy and population health improvement plan.

Note 3: The integrated needs assessment must build on and complement the joint strategic needs assessments led by local government public health teams and overseen by health and wellbeing boards within each ICS.

Official sensitive

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	5
Date of Meeting:	16 September 2026		

Title of Report:	Neighbourhood Health: Stock-take and Roadmap
Report Author:	David McClay, Place Director (Somerset)
Board / Director Sponsor:	David Freeman, Chief Officer of Commissioning & Place
Appendices:	1 - NHSE Feedback and Single Plan

Report classification	
ICB body corporate	
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	X
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	

Previous consideration by:	Date	Please clarify the purpose
Cluster ICB Executive Management Meeting	8th September 2026	Discussion

1 Purpose of this paper

The paper provides a stock-take of the Cluster's progress towards delivering the Neighbourhood Health model and sets out an 18-month Scaling Plan.
The national ambition is to develop an Integrated Neighbourhood Teams (INTs) that enables proactive, coordinated care, initially focusing on the people most at risk of emergency department attendance, or hospital admission. The Cluster's baseline assessment score of 36 indicates that approximately one-third of the required building blocks are currently in place, with opportunities in areas such as elective pathways, primary/secondary care interfaces, and data sharing.

2	Summary of recommendations and any additional actions required

The Board is asked to consider:

1. Whether the baseline scoring and feedback from NHSE resonates with Partner's perspectives?
2. Whether the content and phasing of the Scaling Plan (inc. trajectories) will accelerate delivery in the right areas?
3. Strategically how do we ensure that the early focus in Health on INTs acts as an enabler to realising the wider benefits of neighbourhood working and true primary / secondary prevention?

3	Legal/regulatory implications

The paper outlines progress against the building blocks to achieving the measures ICS's must deliver within the NHS Neighbourhood health framework.

4	Procurement	
N/A		
P&C Name		
P&C Signature		

5	Risks

As outlined in the paper, the development of INT's is a critical step in building our capability to enact the left shift and deliver on the three strategic aims within the NHS Ten-Year Plan. Robust economic modelling is required, however, the underlying premise is that needs can be met in a more proactive and cost-effective way through these new models and ways of contracting.

6	Quality and resources impact	
No resource allocation is set out within the paper, however there is a requirement to develop a business case that enables the transformation of current ways of working to future models.		
Finance sign off:		

7	Confirmation of completion of Equalities and Quality Impact Assessment

Not at this point.

8	Communications and Engagement Considerations

The team is currently scoping a communication plan to underpin INT development.

9	Statement on confidentiality of report

Public

Neighbourhood Health: Stock-take and Roadmap

1 Context:

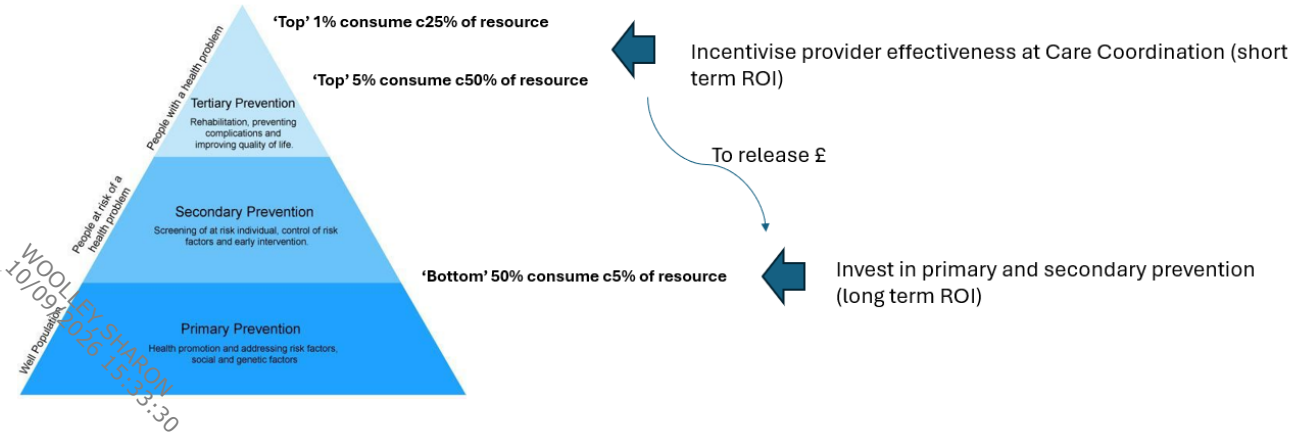
1.1 Neighbourhood health is a central plank of the NHS Ten Year Plan and provides the opportunity to deliver on the three fundamental shifts: from treatment to prevention, hospital to community and analogue to digital. Central to its delivery is the ICB's ability to incentivise an environment where teams within VCFSE, public health, acute, primary, community, social and mental health care work cohesively around the needs of people, their families and local community. This will see a shift away from the traditional commissioning portfolios of urgent and planned care, into an outcomes and life course approach.

1.2 Arguably, the greatest opportunity lies beyond the NHS and in our ability to align health and wider public sector policies on neighbourhoods, such as the Pride in Place programmes and the Cross-Government Taskforce on Community Renewal. By aligning and driving delivery of this broader range of interventions (in areas such as housing, employment, education, public health, transport, social care etc) communities themselves will be better placed to make improvements across the full aspects of their lives.

2 Initial focus:

2.1 Whilst there are wider opportunities in neighbourhood working, the strong national steer within the NHS is to ensure early focus is placed on integrating neighbourhood teams and maximising the effectiveness of proactive care planning and support.

2.2 There is a near-term requirement to improve the quality of care for residents and reduce demand on Emergency Departments, ensuring those at risk of admission are cared for more proactively in their place of residence as opposed to an acute hospital care. The aim is that by focusing on those most in need of support (and consuming the greatest proportion of healthcare spend currently), optimising care delivery for this cohort will



release current spend, that can be re-invested in secondary and primary prevention activities.

2.3 To underpin the national requirements of neighbourhood teams, NHSE has detailed specific measures within the Neighbourhood Health Framework that systems must achieve during the period of the Medium Term Planning framework (April 2026-Mar 2029):

*Frailty and Housebound Care: A **10% reduction** in non-elective (emergency) admissions and bed days for people with mid-to-severe frailty, housebound patients, and care home residents.*

*End-of-Life Care: A **10% increase** in identifying patients approaching the end of life, paired with a **10% reduction** in emergency hospital admissions for this group.*

*Long-Term Conditions: A **10% improvement** in clinical outcomes (via Quality and Outcomes Framework standards) for cardiovascular disease (CVD), diabetes, COPD, mental health, and dementia.*

*Diabetes Compliance: A **10% increase** in the number of patients receiving all eight elements of the diabetes care process bundle.*

*Paediatrics: A **10% reduction** in acute hospital outpatient appointments for children under 16, shifting their care into the community.*

***A&E Wait Times:** Neighbourhood interventions must help stabilize and improve overall A&E 4-hour performance to **85%** by March 2029 (following an interim 82% target in 2027)*

3. Building blocks - baseline assessment:

To assess readiness for the development of INTs, each ICB has undertaken a self-assessment against 100 building blocks drawn from best practice across the country. The ambition is for each Place to have the building blocks in place by March 2029.

3.1 A summary of the initial baseline scoring for our Cluster is set below:

Code	Short label	BANES	Swindon	Wiltshire	Dorset	BCP	Somerset	Cluster Av
S1	Urgent, rehabilitation and reablement capacity	4	6	5	5	5	4	4.8
S2	General practice access and variation	10	10	10	4	4	7	7.5
S3	Neighbourhood footprints	5	5	4	1	1	4	3.3
S4	INTs for priority cohorts and devolved budgets	1	3	2	3	3	6	3.0
S5	Neighbourhood approach to elective pathways	1	2	1	3	3	3	2.2
S6	Community waits	3	3	1	3	3	5	3.0
S7	Better Care Fund pooled funding	5	4	5	3	3	4	4.0
S8	Primary and secondary care interface	1	2	2	3	3	1	2.0
S9	Organisational ownership	2	2	2	4	4	2	2.7
S10	Data sharing for identification and evaluation	1	1	1	5	5	6	3.2
	Total	33	38	33	34	34	42	36

3.2 The scoring indicates that collectively the cluster places have progressed approx. 1/3 along the journey of developing INTs, with opportunities to spread learning in many of the categories. In addition, there is a collective need to develop our capability in areas such as primary/secondary care interface and elective pathways.

3.3 The national team has fed back on our initial scoring, highlighting the areas of good practice already in place within the Cluster, and making the following observations:

a) Their assessment is that the overall scoring for the Cluster (36) was below the NHSE internal assessment of Cluster maturity.
b) NHSE were expecting greater differential in the scoring between Places based on their recent visit in July, and insight into Somerset and Dorset plans through national programmes.

The NHSE single page summary of feedback is enclosed as Annex A.

3.4 In responding to the output of the self-assessment, the ICB has developed a high-level Scaling Plan that outlines the key areas to progress over the next 18 months. The purpose of the plan is to leverage the benefits of working at scale across the cluster whilst retaining place-based ownership of the agenda. Within the plan is a strong focus in the short term on the development of pro-active care and working with those most at risk of ED attendance and admission over the winter period.

Focus for the next 6 months (26/27)	12 months (Apr to Sept 27)	18 months (to Mar 28)
• Finalisation of footprints, INT leadership and accountability flows. • Confirm baseline for each of the Neighbourhood Health Framework measures. • Clarification of integrator function in each Place, with associated development programme. • Completion of initial (v1) Place Based Neighbourhood Health Plans. • Establishment of cluster-wide insight platform to identify priority cohorts (enabled by data flows). • The identification, intervention and resourcing (of intervention) for the 1% cohort. • Clarity on digital tooling required to support INTs. • Develop plan for Children's INTs. • Exploration of funding opportunities, building on the Dorset MacMillan social investment model. Evaluate existing BCF schemes. • Create new ways of working that enable spread within and between Places, and a systematic way of evaluating interventions (linked with external agencies).	• Review of effectiveness of interventions on the 1% cohort and decision on next cohort of focus (e.g 1-3%). • Assess the readiness of Providers / Provider Partnerships to hold new contract forms (SNP/MNP/IHO). • Identify NBH innovation opportunities in each Place and agree first wave of early adopters. • Review and refresh (v2) Neighbourhood health plans in light of Integrated Needs Assessment and Cluster Outcome framework. Local community engagement starting to drive plans. • Develop mechanism to support INT maturity and associated development plans. • Embed shared learning approaches within and across Place.	• Commission first round of SNP/MNP contracts (pending national consultation outcome). • Mature approach to spread and learn. • Mature INT approach to engagement, planning and coordinating care delivery. • Accelerate IHO development programme.

4 Measurement:

The ambition is to achieve the following cluster scores aligned to the delivery of the Plan:

- End of 26/27 50
- End of Sept 27 60
- End of Mar 28 70

5 Next Steps:

The Board is asked to note the outcome of the self-assessment and discuss:

- Whether the baseline scoring and feedback from NHSE resonates with Member's perspectives?
- Whether the content and phasing of the Scaling Plan (inc. trajectories) will accelerate delivery in the right areas?
- Strategically how do we ensure that the early focus in Health on INTs acts as an enabler to realising the wider benefits of neighbourhood working and true primary / secondary prevention?

ICB Chief Executive
ICB Chair

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

7 September 2026

Dear Rob and Jonathan

Neighbourhood Health – BSW Somerset and Dorset

Thank you to you and your team for meeting with us to discuss progress following the recent Neighbourhood Health Readiness Visit.

We appreciated the continued openness and constructive engagement from you and your colleagues. The follow – up discussion provided an opportunity to further review progress and consider the system's trajectory as neighbourhood health continues to develop.

There are a number of strong examples of good practice across BSW, Somerset and Dorset.

These include:

- Weymouth and Portland 'one frailty team' (65% manageable via joint triage): A 'Joint Frailty Approach' has been introduced, enabling services to compare caseloads and identify risks of duplication. In a 6 month trial period 45% of patients in caseloads were identified as having multiple referrals. Through MDT discussion it was possible to reduce one or more assessments in 87% of cases leading to resource and time savings for services and improved patient experience.
- South Coast Medical PCN integration (15 fewer GP sessions/wk): Drug chart completion in primary care has been requested for diabetic patients on insulin regardless of patient complexity. It was identified that this often did not add value for many cases. A new Standard Operating Procedure was developed through co-production with Primary and Community Care which avoided the need for the automatic input for stable / non - complex patients on fixed doses. This approach was trialled in South Coast Medical INT and improvements identified including time saving and improved staff satisfaction.
- Complex Care Teams (70% reduction in admissions for target cohorts):
  The Somerset Complex Care Teams are integrated, multidisciplinary groups operating within primary care networks to support patients (mostly identified through Brave AI) with highly complex health and social care needs. Ultimately, this compassionate care model aims to help patients live independently while successfully achieving a significant, documented reduction in emergency hospital admissions. Despite demography, Somerset has experienced year-on-year reduction in NEL admissions.

- Armed Forces Link workers (3:1 benefit ratio in avoided costs of care for AF residents): NHS Somerset Armed Forces Link Workers provide dedicated, tailored support to the entire local military community, including serving personnel, reservists, veterans, and their families. Funded by the NHS Somerset Integrated Care Board (ICB) and delivered in partnership with community organisations like ARK at Egwood, these link workers often have personal military backgrounds, offering deep firsthand understanding of service life. Operating across the county through regional hubs and outreach services, they help individuals navigate daily life challenges. They offer vital assistance with mental health, healthcare navigation, housing, military charity funding, and chronic pain management, ensuring seamless connections to essential statutory and voluntary services.

Taking together the visit and follow-up process, alongside the subsequent system and Place level self – assessments, the accompanying single page summary provides an agreed reflection of the system's current position.

We would encourage you to share the agreed single page summary with your Board and system partners to support local oversight of neighbourhood health priorities, agreed next steps and future delivery.

As discussed, the key areas of focus over the coming months include:

- Clarification of integrator function in each Place, with associated development programme.
- Completion of initial (v1) Place Based Neighbourhood Health Plans.
- Establishment of cluster-wide insight platform to identify priority cohorts (enabled by data flows).
- The identification, intervention and resourcing (of intervention) for the 1% cohort.
- Clarity on digital tooling required to support INTs.
- Exploration of funding opportunities, building on the Dorset MacMillan social investment model. Evaluate existing BCF schemes.
- Review of effectiveness of interventions on the 1% cohort and decision on next cohort of focus (e.g. 1-3%).
- Assess the readiness of Providers / Provider Partnerships to hold new contract forms (SNP/MNP/IHO).
- Identify NBH innovation opportunities in each Place and agree first wave of early adopters.

- Commission first round of SNP/MNP contracts (pending national consultation outcome).
- Mature approach to spread and learn.

- Mature INT approach to engagement, planning and coordinating care delivery.

- Accelerate IHO development programme.

Thank you again for the time and commitment shown by you and your teams throughout both the visit and follow-up process. We look forward to continuing to work with you as neighbourhood health develops across BSW, Somerset and Dorset.

Yours sincerely

Professor Claire Fuller MRCGP DRCOG MBBS
National Priority Programme Director – Neighbourhood Health

Annex:

Single slide summary

NHS Bath and North East Somerset, Swindon and Wiltshire + Dorset + Somerset Cluster ICB

4 September 2026

ICB at a glance

ICB CEO	CEO Jonathan Higman	**Local authorities**	6 upper-tier local authorities, coterminous with 6 HWBs.
ICB Chair	Rob Whiteman CBE	**Providers**	Acute: RUH Bath, GWH Swindon, Salisbury (BSW Hospitals Group, joint CEO Cara Charles-Barks); UHD and Dorset County (federated with Dorset HealthCare, joint CEO Matthew Bryant); Somerset NHS FT (integrated). BSW ICB (QOX) on the NHSE regulatory action page.
Registered population	approx. 1.96m	**Pilots and designations**	NNHIP: BCP selected (Wave 13); Devizes and Trowbridge (Wiltshire) integrated care centres in situ; NHS Neighbourhood Health site live at Dorset Place (Weymouth), July 2026 refresh.
Places	Single-executive Cluster operation live 18 March 2026 (single legal entity scheduled April 2027); Cluster Chief Officers drawn largely from the three predecessor ICBs.		

Place level maturity score

Place (fill = maturity)	Swindon and Shrivenham SCORE 38	Wiltshire SCORE 33	BaNES SCORE 33	Dorset Council Place SCORE 34	BCP Place SCORE 34	Somerset SCORE 42
Population	264,340	525,600	c. 200,000	c. 380,000	c. 400,000	588,328
HWB sign-off	Not evidenced	Not evidenced	Not evidenced	In progress	In consultation (Mar 2026)	Agreed (Joint ICP/HWB)
NbH footprints / PCNs	9 PCNs. Brunel Health Group foundation; ICA monthly; 'Team Around Me' complex-needs model; paediatric ARI hubs; Health Innovation West of England partnership (Pete Carpenter). Footprints going through HWB NbH plans for HWB sign-off Jan 2027. GBP 1.5m allocated for INT reorganisation, released on approved plans. No figures yet for how the highest-risk 1% is supported. Same for Wiltshire and BaNES	13 PCNs. Devizes (32k) + Trowbridge (51k) integrated care centres in situ; 100% GP MoU (not yet federated); Urgent Care Service (94.31% Good, June 2025); Older Persons and Housebound MDT; Diabetes Optimisation. Place Partnership expected to be operational in shadow form Sept 26. NbH plans for HWB sign off Jan 27.	6 PCNs. Not in NNHIP. NbH Plan in development (due to HWB Jan 2027). Community Wellbeing Hub (40 VCFSE partners, 10,852 referrals) an operational foundation. LGR: three combined authorities intersect the cluster (West of England, Wessex, Swindon to Thames Valley); BaNES may move to BNSSG, ICB Place infrastructure not disrupted. Place Partnership expected operational in shadow form Sept 2026. Wellbeing Hub: GBP 574k BCF + GBP 100k PH. (Bath footprint c.90k may need hub-and-spoke; aligned to SEN catchments);	9 PCNs. 9 INTs coterminous with PCNs, each with PC + DHC + social care leadership. Carousel Clinic; Weymouth and Portland 'one frailty team' (65% manageable via joint triage); Access Wellbeing. BCF devolved budget via HWB (30% activity-shift). Petal model: core INT (GPs, district nursing, VCSE) covering top 3% proactive and next 7% early intervention; c.2,350 residents proactive, below the 1% ambition. AFT population responsibility targeted before April 2027 as first step to IHO.	9 PCNs. NNHIP Wave 13. 9 INTs coterminous with PCNs, same INT Programme Board as Dorset Council. South Coast Medical PCN integrated with community provider (15 fewer GP sessions/wk); Shore Medical fortnightly MDT; Access Wellbeing MH. NHS NbH site live at Weymouth.	13 PCNs. Only fully integrated FT in England (Symphony c. 130k list + acute + community + MH). All 13 PCNs have Proactive Care teams (report 71% admission and 47.6% GP-contact reduction for complex needs). Connect Somerset (350 staff to neighbourhoods, GBP 8m VCFSE). Tri-party NHS Partnership Board from June 2026. Visit 22 Jul: real progress since pilot - Trust now working with GP collaborative, primary-care model clarified. SNEG established (LA + VCSE); considering a PCN DES variant from Oct 2026 (under consideration, not decided); 1% cohort identified but data linkage limits seeing overlap with those already in proactive care.
HLE (M/ F)	M 61.5 / F 61.4	M 63.8 / F 63.7	Pending	M 65.3 / F 65.6	M 65.3 / F 65.6	M 62.8 / F 63.0
GP federation /integrator	Pending	Pending	Pending	Dorset GP Alliance; Dorset HealthCare integrator	Dorset GP Alliance; Dorset HealthCare integrator	GPSU; Symphony (GP subsidiary of Somerset NHS FT);

Examples of practice surfaced across Places

Somerset: Armed Forces Link Workers (c. GBP 275k for 4 community + 2 hospital posts, cited 3:1 return, c. GBP 800k avoided cost); Proactive Care Teams >70% admission reduction for complex needs. Dorset: Weymouth and Portland 'one frailty team' (65% manageable via joint triage); common frailty and falls cohort, c. 2,350 residents in proactive care. BCP: South Coast Medical PCN integration (15 fewer GP sessions/wk). BSW: B&NES Community Wellbeing Hub (40 VCFSE partners, 10,852 referrals); Wiltshire Urgent Care Service (94.31% Good). All figures cluster self-reported; test at visit.

Five Goals (RAG vs England; see Annex B for scores)

G1 Health outcomes 2.27	G2 GP access and experience 3.74	G3 Planned care 3.15	G4 Urgent and emergency care 2.19	G5 Patient and staff satisfaction 2.87

G2 GP access is the strongest Goal (3.74/4, Green): BSW rank 1/42 on confidence and trust in HCP (94.8%), Dorset rank 2/42 on overall GP experience. Weakest are G1 health outcomes (2.27/4) and G4 UEC (2.19/4): all three ICBs bottom-quartile on A&E 4-hour (BSW 71.2%, Dorset 71.3%, Somerset 72.8% vs England 76.0%), BSW UCR 2-hour rank 42/42 (68.3%). Strong primary care coexists with weak UEC, the central structural test. Ratings move on documented evidence. The cluster intends Healthy Life Expectancy as its headline outcome measure, with core commissioning (whole population) and targeted Type 2 commissioning (priority cohorts) as the two delivery routes.

Enablers (Section 4)

Enabler (fill = rating)	Key point
Data	Shared care records live (Dorset Care Record; BSW EPR). Optum PHM pilot in Somerset. FDP cluster alignment not confirmed.
Workforce	Cluster CPO without a matching Chief People Officer (structural gap). Somerset Academy mobilising 26/27. c. 200 VR exits.
Finance	BSW on NHSE regulatory action (financial position). Cluster under pressure. ICBC c. GBP 160m/yr (BSW, HCRG). Left-shift target 53% to 45% acute share.
Digital	Dorset Care Record extended; BSW Hospitals Group shared EPR; GBP 8.5m BSW digital investment. Single shared record across all footprints not evidenced.
Estates	10-year BSW estate plan; Dorset GBP 10m social investment + GBP 2.5m PoC; Winton and Weymouth NHC developments.

Framework readiness: Stage 1 (foundations) and Stage 2 (NbH Plan)

Ref	Stage 1 minimum requirement (2026/27): Ref fill shows rating	Self-assessed score
S1	Reduce non-elective admissions via UCR and reablement	4.8
S2	Reduce variation; improve access to general practice	7.5
S3	Neighbourhood footprints agreed	3.3
S4	INTs for high-priority cohorts; devolved budgets	3
S5	Neighbourhood approach to elective pathways	2.2
S6	18-week community waits; eliminate 52-week waits	3
S7	BCF pooled funding plans confirmed with LAs	4
S8	Primary / secondary care interface (RTC)	2
S9	Organisational ownership of planned deliverables	2.7
S10	Data-sharing arrangements for patient identification	3.2
Stage 1 overall:		**36**

| **Stage 2 NbH Plan: seven-step readiness (overall EARLY STAGE)**

##

1 National objectives via three reform agendas **(IN PROGRESS)**
2 Support wider local goals and public service reform **(EARLY STAGE)**
3 Local objectives informed by JSNA **(IN PROGRESS)**
4 Confirm final geographies **(IN PROGRESS)**
5 Confirm organisational delivery **(EARLY STAGE)**
6 Confirm governance and operations **(IN PROGRESS)**
7 Align other initiatives **(EARLY STAGE)**

4: 6 Places. 3 ICB clusters. 5: Integrator KLOE 3. 6: Accountability KLOE 1.

Forward look – Key actions over next 6 months:

1. Finalisation of footprints, INT leadership and accountability flows.
2. Clarification of integrator function in each Place, with associated development programme.
3. Completion of initial (v1) Place Based Neighbourhood Health Plans.
4. Establishment of cluster-wide insight platform to identify priority cohorts (enabled by data flows).
5. The identification, intervention and resourcing (of intervention) for the 1% cohort.
6. Clarity on digital tooling required to support INTs.
7. Exploration of funding opportunities, building on the Dorset MacMillan social investment model. Evaluate existing BCF schemes.
8. Create new ways of working that enable spread within and between Places, and a systematic way of evaluating interventions (linked with external agencies).
9. Develop an approach to embed a strong research and innovation-led inject into NBH teams to inform new care delivery models.

Forward look – Key actions over next 18 months

1. Review of effectiveness of interventions on the 1% cohort and decision on next cohort of focus (e.g 1-3%).
2. Assess the readiness of Providers / Provider Partnerships to hold new contract forms (SNP/MNP/IHO).
3. Identify NBH innovation opportunities in each Place and agree first wave of early adopters.
4. Review and refresh (v2) Neighbourhood health plans in light of Integrated Needs Assessment and Cluster Outcome framework. Local community engagement starting to drive plans.
5. Develop mechanism to support INT maturity and associated development plans.
6. Embed shared learning approaches within and across Place.
7. Commission first round of SNP/MNP contracts (pending national consultation outcome).
8. Mature approach to spread and learn.
9. Mature INT approach to engagement, planning and coordinating care delivery.
10. Accelerate IHO development programme.

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	6
Date of Meeting:	16 September 2026		

Title of Report:	AMOS and Nottingham Review of Maternity Services – 10 Point Action Plan and Next Steps
Report Author:	Vicky Garner, Head of Quality – Maternity, Women, Children and Young People
Board / Director Sponsor:	Shelagh Meldrum, Chief Nursing Officer
Appendices:	Nil

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

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

Previous consideration by:	Date	Please clarify the purpose
NHSE SW Extraordinary Maternity and Mortuary Oversight Regional Quality Group	06/08/2026	Noting and discussion

1 Purpose of this paper

The Cluster ICB footprint comprises six maternity and neonatal services providers:

- Dorset County Hospital NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Somerset NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust

This paper briefs the Board on the findings of the National Maternity and Neonatal Investigation led by Baroness Amos and the Nottingham Review led by Donna Ockenden, NHS England's subsequent Maternity and Neonatal 10-Point Action Plan and the associated national assurance process.

The Amos investigation was published on 30th June 2026. In addition to extensive engagement with families who have used maternity and neonatal services the findings are informed by in-depth reviews across 12 NHS trusts. The investigation sought to identify systemic issues. Somerset NHS Foundation Trust was one of the trusts included within the investigation and is the subject of a separate published report. The investigation did not make provider-specific recommendations. Instead, findings from all reviews were brought together to inform a single set of national recommendations.

The Nottingham review is a deeply distressing report This is a deeply distressing report. It describes years of serious and repeated failures in care, including poor leadership and culture, a lack of accountability, unacceptable racism and discrimination and women and families being disbelieved or dismissed. It also describes extremely serious failings in post death care – failures that caused grieving families further pain and trauma at a time when they should have been treated with the utmost care, dignity and compassion. The review was the largest NHS maternity inquiry, 2500 families contributed and 2030 cases were analysed. It took a continuous learning approach. Nottingham University Hospitals NHS Trust has responded to findings as they emerged and has already taken steps to improve care. However, the report shows the scale of what still needs to change. There are 8 key headings and themes and 18 immediate and essential actions, with a total of 72 actions.

Both reviews identified recurring themes relating to care quality and safety, family experience, workforce and culture, leadership and system issues, governance and learning, clinical practice and pathways, service pressures and estates and environment. Many of the issues identified require action at provider, system and national level.

NHS England has established a new statutory role of Maternity and Neonatal Commissioner, accountable to Parliament, this role will provide the oversight needed to hold the wider system to account in maintaining a relentless focus on improving maternity and neonatal care. The Commissioner will co-chair alongside the Secretary of State the new National Maternity and Neonatal Taskforce to develop a comprehensive national action plan, expected by the end of 2026. The taskforce will oversee the establishment of the Modern Service Framework, which will set national standards for care from pre-conception through to postnatal period.

In parallel, NHS England published an initial 10-Point Action Plan requiring providers to undertake immediate self-assessment and detail improvement activity in their Board-approved assurance returns, which are required to be shared in September and December 2026.

The 10-Point Plan Actions

- **Martha's Rule:** Roll out Martha's Rule across all maternity and neonatal services.
- **Family Voice:** Listen to women and families using real-time outcome and experience data acted on at the board level.
- **Shared Leadership:** Create joint board-level accountability between Medical Directors and Chief Nursing Officers.
- **Staff Engagement:** Launch the 'Amos in Action' listening exercise so staff can help shape changes.
- **Tackling Inequality:** Address disparities in maternity and neonatal outcomes.
- **24/7 Response:** Ensure round-the-clock safety, responsiveness, and dedicated triage access.
- **Homebirth Review:** Review local homebirth services ahead of national standards.
- **Safety Incidents:** Respond to complaints and safety concerns with humanity, candour, and a trauma-informed approach.
- **Effective Triage:** Deliver safe and effective triage in all maternity units.
- **Post-Death Care:** Improve mortuary care to ensure dignity, security, and compassion

Prior to publication of the formal 10-point plan assurance process, all Cluster providers submitted initial responses through an NHS England South West regional reporting exercise. The ICB subsequently undertook a benchmarking exercise to identify common themes, variation in organisational maturity and opportunities for shared learning. Whilst these submissions do not constitute formal NHS England assurance returns, they provide a useful overview of provider responses ahead of the September baseline assessment.

To support a coordinated approach to assurance and minimise duplication for providers, the ICB has engaged with the NHS England South West regional team to explore opportunities for ICB colleagues to have visibility of provider baseline assessment submissions. This would enable alignment between regional and local assurance processes, support collaborative review with regional colleagues and help inform system oversight, shared learning and improvement activity across the Cluster.

An immediate priority for the Cluster is the alignment of Maternity and Neonatal Voices Partnership (MNVP) arrangements, recognising the importance placed by both reviews on listening to women and families. An options paper is being developed to support a consistent and sustainable model across the Cluster.

Whilst responsibility for delivery of the 10-Point Action Plan rests with providers and their Trust Boards, the ICB has an important role in maintaining system oversight, gaining assurance on implementation of, and progress against, the 10-Point Plan, identifying emerging risks and challenges, supporting collaborative improvement and facilitating the sharing of learning and good practice across the Cluster. The ICB will continue to work with providers and NHS England South

West to develop aligned assurance arrangements that support effective oversight whilst minimising duplication.

2 Summary of recommendations and any additional actions required

The Board is asked to:

1. Note the findings and themes arising from the Baroness Amos Investigation and the Nottingham Review.
2. Note the NHS England Maternity and Neonatal 10-Point Action Plan and associated national assurance process, including the requirement for provider Trust Boards to submit baseline assessments by 25 September 2026 and progress updates by 31 December 2026.
3. Note the activity of the ICB benchmarking exercise undertaken in response to the NHS England South West regional reporting exercise.
4. Support the development of maternity and neonatal governance arrangements to enable Cluster-wide oversight of provider progress against the NHS England 10-Point Action Plan, assurance submissions, associated action plans, emerging risks and opportunities for shared learning and improvement, aligned where possible to regional assurance arrangements.
5. Note the development of an options paper regarding future MNVP arrangements across the Cluster.

3 Legal/regulatory implications

Required compliance with the NHS England Maternity and Neonatal 10-Point Action Plan and the associated national assurance process.

4 Procurement

No procurement decisions are being sought through this paper.

Implementation of the recommendations arising from the reviews and the 10-Point Action Plan may require future investment, commissioning and procurement activity across key areas such as workforce, maternity and neonatal estates, service redesign and service user engagement arrangements. Further resource implications may emerge following publication of the National Maternity and Neonatal Taskforce action plan.

P&C Name	N/A
P&C Signature	N/A

5 Risks

Key Cluster themes emerging:

- Workforce resilience and sustainability.

- Variation in organisational maturity and implementation of the NHS England Maternity and Neonatal 10-Point Action Plan.
- Maternity triage capacity and compliance with national standards.
- Maternity and neonatal estate infrastructure.
- Health inequalities and service user voice.
- Governance, oversight and assurance arrangements.
- Sustainability of personalised care pathways, including homebirth services.

The ICB is developing maternity and neonatal governance arrangements to support oversight of provider assurance submissions, action plans, emerging risks and delivery of the NHS England 10-Point Action Plan. Arrangements will seek alignment with NHS England South West assurance processes wherever possible to minimise duplication and support shared learning across the Cluster.

6 Quality and resources impact

Quality, Patient Experience and Safeguarding

The reviews highlight the continued need to strengthen culture, leadership, governance, workforce, patient safety, health inequalities and engagement with women and families. Provider responses demonstrate significant improvement activity, with opportunities for further shared learning and collaboration across the Cluster.

Finance

The full financial implications remain unclear at this stage. Further resource requirements may emerge through implementation of the NHS England 10-Point Action Plan and any subsequent recommendations arising from the National Maternity and Neonatal Taskforce.

Workforce

Workforce resilience and sustainability remain key risks across the Cluster and were consistently identified within both national reviews and provider submissions.

Sustainability / Green Agenda

No significant sustainability or environmental impacts have been identified at this stage.

Finance sign off:	N/A

7 Confirmation of completion of Equalities and Quality Impact Assessment

An EQIA has not been completed at this stage, as no specific service changes or decisions are being sought through this paper.

8	Communications and Engagement Considerations
The reviews place significant emphasis on listening to women, families and staff. Ongoing engagement will include provider organisations, MNVPs, women and families, staff and wider system partners. Development of future MNVP arrangements across the Cluster will provide an opportunity to strengthen and align service user voice arrangements.	

9	Statement on confidentiality of report
This report can be shared publicly. It contains no commercially sensitive or confidential patient information.	

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	Agenda item	7
Date of Meeting:	16 September 2026		

Title of Report:	Performance Oversight Dashboard
Report Author:	Mark Harris, Director of Strategic Commissioning Delivery
Board / Director Sponsor:	David Freeman, Chief Officer
Appendices:	Appendix 1 – ICB and Provider Performance Dashboard Summary

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	
Noting	For noting without the need for discussion	X

Previous consideration by:	Date	Please clarify the purpose
Content from this paper has been discussed by Executives and Board Committees as part of wider discussion of performance.		Discussion

1 Purpose of this paper

This report provides a summary of key performance metrics for the six acute providers within the ICB cluster as well as ICB overall performance.

This report also provides a focused update of three of the providers within the cluster that are subject to increased oversight and assurance from NHS England. These were Great Western Hospital (GWH), University Hospital Dorset (UHD), and Dorset County Hospital (DCH). Included within the paper are details of actions being undertaken jointly with providers to produce and assure recovery plans alongside NHS England.

2	Summary of recommendations and any additional actions required

The Board is asked to:

- Note the enhanced NHS England escalation of the three acute provider organisations within our Cluster.
- Note the actions that the providers and the ICB are taking to support recovery and improvement.
- Note that further updates will be provided as the recovery plans move through the further stages of NHSE's enhanced escalation processes.

3	Legal/regulatory implications

NHS Oversight Framework, Legal duty to reduce inequalities.

4	Procurement

No procurement implications related to this paper.

P&C Name	
P&C Signature	

5	Risks

Outputs of the current discussions with NHSE and recovery actions will be reviewed for required updates to the risk register once completed.

6	Quality and resources impact

Please outline any impact on
Quality, Patient Experience and Safeguarding: To be reviewed following completion of recovery action plans.
Finance: To be reviewed following completion of recovery action plans. Overall financial impact is captured within financial existing financial reporting.
Workforce: None identified
Sustainability/Green agenda: None identified

Finance sign off:	N/A

7	Confirmation of completion of Equalities and Quality Impact Assessment

No EQIA has been undertaken and this will be reviewed following completion of recovery action plans.

8	Communications and Engagement Considerations

No communications and engagement considerations identified at this stage, this will be reviewed following completion of recovery action plans.

9	Statement on confidentiality of report

This report is not confidential and contains performance information reported in the public domain.

Performance Report

1. Context and Introduction

1.1. This report provides a summary of key performance metrics for the six acute providers within the ICB cluster as well as ICB overall performance (Appendix 1). Provider performance is shown as Trust wide performance, and ICB performance is shown as the total ICB population and will for some metrics include providers beyond the six acute providers (particularly for planned care).

1.2. All performance variance to date issues are being discussed at CRMs. At this stage variances (beyond those focused on within this report) are within tolerance, but we recognise the importance of continuing to assess risk and respond to bring back into plan over the remainder of the financial year. Performance will be monitored and managed via the Executive Management Group, Procurement and Contracts Oversight Group and then as appropriate in the joint Population Health and Commissioning Committee and/or Strategic Finances and Resources Committee.

1.3. This report also provides a focused update of three of the providers within the cluster that are subject to increased oversight and assurance from NHS England. These were Great Western Hospital (GWH), University Hospital Dorset (UHD), and Dorset County Hospital (DCH)

1.4. In June and July 2026, NHS England wrote to the providers expressing concern of areas of performance where they were off plan. The requirement of providers was to undertake a self-assessment and provide an action plan response.

1.5. A summary of the areas raised by NHS England is set out below :-

GWH	UHD	DCH
Elective recovery and RTT performance	Persistent underperformance against urgent and emergency care trajectories, including high numbers of 12-hour waits.	Elective waiting list growth above plan and RTT performance materially below trajectory.
Cancer performance below planned levels (noting plan did not meet NHSE requirements when set).	Failing to realise key planning assumptions plan, including reductions in patients with no criteria to reside and planned transformation programmes.	Cancer performance below planned levels.
Urgent and Emergency Care performance below		Urgent and Emergency Care performance below

expectations, with significantly higher than planned 12-hour waits.		expectations, with significantly higher than planned 12-hour waits.
Concern that the Trust was significantly off plan early in the financial year.		Concern that the Trust was significantly off plan early in the financial year.

1.6. For all three providers, NHSE challenged the boards to provide greater assurance of the effectiveness of their oversight, challenge and grip of delivery and response to risks when performance deteriorates.

1.7. Further detail by provider is set out below.

2. Focus Area - Great Western Hospital

2.1. In response to the letter received, NHS England requested that GWH and the ICB undertake a joint review of the factors contributing to the current position and produce a recovery plan supported by a robust assessment of governance, assurance and organisational capability. NHS England was clear that recovery would need to extend beyond the Trust where contributing factors related to wider system issues, including activity growth, demand assumptions and capacity constraints.

2.2. Throughout this process, the ICB has worked collaboratively with GWH, recognising that many of the challenges are also influenced by wider system pressures and not just provider performance. These include rising demand for urgent and emergency care, increasing complexity of patient need, discharge delays, pressures on community capacity and continued population growth across Swindon.

2.3. Whilst Great Western Hospital continues to face significant operational challenges, there is a shared understanding between the Trust, the ICB and NHS England regarding both the issues that require attention and the actions needed to address them. Recovery arrangements now place greater emphasis on measurable improvement, stronger governance, clearer accountability and whole-system ownership of performance. The collective objective is to deliver sustainable improvements across urgent and emergency care, elective recovery, cancer performance and financial delivery, whilst ensuring that recovery plans are credible, achievable and supported by effective system partnerships.

2.4. As part of the recovery approach, the Trust and system partners have strengthened joint oversight arrangements and focused on a number of priority actions designed to improve operational performance and resilience. These include:

2.4.1. Strengthened performance management and recovery governance arrangements across the Trust and ICB.

2.4.2. Targeted work to reduce avoidable emergency demand, including identification of patients who are frequent users of urgent care services.
2.4.3. Improvement programmes focused on patient flow, discharge and reducing delays within urgent and emergency care pathways.
2.4.4. Development of alternatives to hospital admission and greater utilisation of same-day and community-based models of care.
2.4.5. Continued focus on elective recovery, RTT improvement and reduction of long waits.
2.4.6. Enhanced system-wide ownership of recovery actions, recognising that sustainable improvement will require coordinated action across health and care partners.

2.5. A particular area of focus has been understanding the drivers of pressure within the Emergency Department. Analysis has demonstrated that a significant proportion of attendances within Majors and Resus do not subsequently require admission to an inpatient bed. This has reinforced the importance of strengthening front-door navigation, admission avoidance schemes and community alternatives, ensuring patients receive care in the most appropriate setting whilst preserving acute capacity for those with the greatest clinical need.

2.6. <u>ICB Actions Supporting GWH Recovery</u>

2.6.1. Strengthened joint oversight arrangements with GWH through enhanced recovery, performance and escalation governance.
2.6.2. Worked alongside GWH to develop and challenge recovery trajectories for urgent and emergency care, elective performance, cancer standards and financial delivery.
2.6.3. Supported targeted demand management initiatives focused on patients with the highest levels of Emergency Department attendance and emergency admissions.
2.6.4. Facilitated system-wide action to improve patient flow and discharge performance, recognising the impact of delayed discharges on acute capacity and emergency care performance.
2.6.5. Coordinated action across primary care, community services, mental health services and local authority partners to address pressures contributing to hospital demand.
2.6.6. Supported the development of alternatives to admission, including Same Day Emergency Care and community-based pathways, to reduce avoidable admissions and improve patient experience.
2.6.7. Worked with Southwestern Ambulance Service and system partners to address ambulance handover delays and improve flow through urgent and emergency care pathways.

2.6.8. Supported elective recovery through oversight of system capacity, mutual aid opportunities and activity planning aimed at reducing long waits and improving Referral To Treatment performance.

3. Focus Area – University Hospital Dorset

3.1. In response to the letter received UHD subsequently undertook a Board-led self-assessment and developed a recovery plan focused on strengthening operational delivery, governance and performance management arrangements. Alongside this, the Trust reviewed its reporting, escalation, and accountability processes to provide greater visibility of performance risks and recovery actions.

3.2. In August 2026, NHS England requested a strengthened recovery plan to be submitted by 10 September 2026. An Executive-to-Executive review with UHD, the ICB and NHS England is scheduled for October 2, 2026, which will assess the Trust's understanding of current performance challenges, the credibility of its recovery plan, the effectiveness of governance and accountability arrangements, and evidence of sustained improvement.

3.3. The Trust's recovery plan is built around a number of key improvement programmes, including:

3.3.1. Strengthened daily and weekly operational oversight of performance, including enhanced monitoring of 12-hour waits, ambulance handovers and emergency department performance.

3.3.2. Delivery of the Better Flow, Better Care programme, bringing together four clinically led workstreams focused on Emergency Department flow, Same Day Emergency Care, Sick Specialty and Sick Frail pathways.

3.3.3. Development of a redesigned emergency care model, including improvements to Same Day Emergency Care, Call Before Convey, Hospital at Home and command centre capability.

3.3.4. A renewed focus on reducing the number of patients with no criteria to reside through discharge pathway improvements, community capacity development and closer partnership working with local authorities and commissioners.

3.3.5. Enhanced oversight of quality, patient safety, operational performance, and recovery risks.

3.4. <u>ICB Actions Supporting UHD Recovery</u>

3.4.1. The ICB has worked closely with UHD throughout the process and recognises that many of the challenges affecting performance are influenced by wider system pressures, including rising demand, discharge delays, community capacity constraints, and social care responsiveness. To support recovery, the ICB has committed to:

3.4.1.1. Joint oversight of delivery through the Dorset-wide Recovery and Delivery Board and wider recovery arrangements.

3.4.1.2. Supporting development of recovery trajectories and operational improvement plans.

3.4.1.3. Leading and coordinating system actions where recovery depends on wider partner organisations.

3.4.1.4. Strengthening system governance and accountability for delivery.

3.4.1.5. Working alongside UHD through the NHS England review process.

3.4.2. The ICB has also confirmed a number of practical commitments to support UHD's recovery plan, with a shared focus on improving patient flow, reducing delays and supporting sustainable improvement in urgent and emergency care performance:

3.4.2.1. Urgent and Emergency Care Demand Management – targeted intervention through the pan-Dorset Neighbourhood and Wellbeing Programme focused on the 1.2% of Dorset residents who account for 16.5% of emergency department attendances and 21.3% of emergency admissions. The programme aims to reduce avoidable demand through proactive multidisciplinary interventions and personalised care approaches, aligned to integrated neighbourhood team development

3.4.2.2. Discharge to Assess (D2A) – implementation of the Dorset Discharge to Assess Partnership to increase assessment outside hospital, reduce discharge delays, support Home First principles and improve patient flow across the system.

3.4.2.3. Intermediate Care Investment – the ICB committed an additional £1.8 million investment in intermediate care services to address identified commissioning gaps, increase community capacity and reduce prolonged acute hospital stays.

3.4.2.4. Pathway 1 Capacity – the ICB, UHD and BCP Council committed to jointly develop and oversee a recovery plan to address Pathway 1 assessment delays, releasing up to 1,300 hours of home-based intermediate care capacity currently occupied by patients awaiting longer-term assessments.

3.4.2.5. Transfer of Care Operating Model – support for implementation of a Dorset-wide approach to improving discharge performance, Home First delivery, pathway flow and adoption of agreed system discharge standards.

4. Focus Area – Dorset County Hospital

4.1. In response to the letter received, DCH, with support from the ICB, undertook a self assessment and developed an action plan.

4.2. On 30 July 2026, NHSE concluded that the submission did not provide sufficient assurance. As a result, NHS England escalated the matter and

announced a formal Board-to-Board review process involving both the Trust and Dorset ICB, following which NHS England requested an updated recovery plan demonstrating measurable progress and clear ownership of actions across the Trust, ICB and wider system. This work is currently being undertaken through Dorset County Hospital's weekly recovery board with the return due on 10 September 2026. The Board to Board meeting is planned for 2 October 2026.

4.3. ICB Actions Supporting UHD Recovery

4.3.1. The ICB has consistently supported the Trust through the review process and has jointly recognised that some challenges relate to wider system issues, including demand growth, discharge processes, community capacity and workforce pressures. The ICB has committed to:

4.3.1.1. Joint oversight of recovery through the new performance recovery arrangements.

4.3.1.2. Supporting development and delivery of recovery trajectories.

4.3.1.3. Co-owning actions where system intervention is required.

4.3.1.4. Strengthening system-level governance and risk identification mechanisms.

4.3.1.5. Working alongside DCH through the NHS England Board-to-Board process

4.3.2. In September 2026, the ICB formally responded to DCH, confirming its support for several key recovery enablers identified by DCH. The ICB has given the following tangible commitments regarding elective funding, discharge capacity, urgent care development and demand management, strengthening the credibility of the joint recovery plan and demonstrating increased system ownership of recovery actions:

4.3.2.1. Elective and Orthopaedic recovery - the ICB agreed to support additional orthopaedic activity worth up to £1.7 million above existing contract values. This includes support for additional activity delivered through independent sector providers to reduce waiting lists, improve 18-week performance and reduce 52-week waits.

4.3.2.2. Discharge to Assess (D2A) – the ICB confirmed approval of the Discharge to Assess pathway business case, with pathway implementation expected in early September 2026. The scheme covers both BCP and Dorset Council populations and is intended to improve patient flow, reduce discharge delays, support a Home First approach and improve system capacity.

4.3.2.3. P1 Capacity - the ICB recognised ongoing pressures relating to P1 capacity and discharge arrangements. While no new funding was identified specifically for this issue, the ICB committed to using slippage from delayed D2A implementation funding to support additional P1 capacity where governance approval is secured.

4.3.2.4. Urgent Treatment Centre (UTC) - the ICB reaffirmed its support for development of a co-located Urgent Treatment Centre at DCH and supported exploring a "test of change" approach during winter 2026/27 using existing contractual funding streams. The aim would be to improve patient streaming, support patient flow, reduce avoidable admissions and inform future commissioning decisions.

4.3.2.5. Urgent and Emergency Care Demand Management - Recognising the impact of demand growth on DCH performance, the ICB committed to targeted demand management work focusing on the top 1.2% of Dorset residents who account for 16.5% of ED attendances and 21.3% of emergency admissions. The programme aims to reduce attendances and admissions in this cohort by 25% through personalised interventions and identification of service gaps.

5. Next Steps & recommendations

5.1. The next iteration of the recovery plans were submitted to South West NHS England on 10th September 2026. These will be reviewed and followed up with Board to Board discussions involving the Executive teams from the region, the relevant Trusts and representatives from the ICB (the CEO, Chief Officers for Finance and Commissioning, and the appropriate Place Director).

5.2. Performance monitoring against the recovery plans and revised trajectories is being built into our regular reporting but remains subject to further scrutiny, assurance and directions from SW NHSE.

5.3. The Board is asked to:

5.3.1. Note the enhanced NHS England escalation of the three acute provider organisations within our Cluster.

5.3.2. Note the actions that the providers and the ICB are taking to support recovery and improvement.

5.3.3. Note that further updates will be provided as the recovery plans move through the further stages of NHSE's enhanced escalation processes.

Month 3 System Operational Performance Overview

Operating Plan National Priority Metrics	Data source	Reporting month	BSW System			Dorset System			Somerset System		
			Trajectory	Performance	Variance	Trajectory	Performance	Variance	Trajectory	Performance	Variance
Elective RTT											
RTT waits under 18 weeks	FDP	Jun-26	67.1%	**66.2%**	-0.9%	65.3%	**66.7%**	+1.4%	66%	**66.4%**	-0.53%
RTT waits over 52 weeks	FDP	Jun-26	0.7%	**1.2%**	-0.5%	0.9%	**1.1%**	+0.2%	1.09%	**2.0%**	+0.97%
Planned Care											
Diagnostics (DM01) waits over 6 weeks	FDP	Jun-26	10.4%	**11.7%**	+1.3%	11.9%	**18.5%**	+6.6%	19%	**15.5%**	-3.5%
Cancer 28-day FDS	FDP	Jun-26	80.9%	**73.7%**	-7.2%	79.9%	**79.0%**	-0.9%	80.5%	**83.1%**	+2.6
Cancer 62-day standard	FDP	Jun-26	74.3%	**65.8%**	-8.5%	72.9%	**69.9%**	-3.0%	73.4%	**69.1%**	-4.3%
Cancer 31-day standard	FDP CPID	Jun-26	92.5%	**88.6%**	-3.9%	96.6%	**92.2%**	-4.4%	93.9%	**90.4%**	-3.4%
Community											
Community waits under 18 weeks %	SW CHSD	Jun-26	78%	**84%**	+6.0%	51.8%	**62.8%**	+11.0%	84.4%	**91.9%**	+7.5%
Mental Health											
MHST coverage of total pupils/learners	GOV.UK	2025/26	77% (Mar 27)	**65%**		77% (Mar 27)	**53%**		77% (Mar 27)	**45%**	
Individual placement support	Local	Jun-26	551	**590**	+39	699	**535**	164	551	**560**	+9
NHS Talking Therapies - reliable recovery	FDP	Jun-26	51%	**53.1%**	+2.1%	51%	**46.2%**	-4.8%	51%	**46%**	-5%
NHS Talking Therapies - reliable improvement	Local	Jun-26	69%	**72.8%**	+2.8%	69%	**66.3%**	-2.7%	69%	**69%**	0%
Inappropriate out-of-area placements	Local	Jun-26	4	**<10**	<10	4	**5**	1	0	**0**	0
Learning Disabilities and Autism											
Adult inpatients with LD	Local	Jun-26	10	**12**	-2	15	**17**	+2	7	**8**	+1
Autistic adult inpatients	Local	Jun-26	10	**20**	-10	6	**13**	+7	5	**16**	+11
CYP inpatients with LD/autism	Local	May-26	6	**5**	-1	1	**4**	+3	0	**0**	0
Primary Care											
Same-day clinically urgent appointments	TBC	May-26	74.1%	**80.2%**	+9.1%	77.5%	72.3%	-5.2%	76.0%	**83.1%**	+7.1%
Patient experience of GP access	TBC										
Urgent dental appointments	SW Dental										

Month 3 Trust Operational Performance Overview

Operating Plan National Priority Metrics	Data source	Reporting month	Great Western Hospitals			Royal United Hospitals Bath			Salisbury			Dorset County Hospital			University Hospitals Dorset			Somerset Foundation Trust		
			Trajectory	Performance	Variance	Trajectory	Performance	Variance	Trajectory	Performance	Variance	Trajectory	Performance	Variance	Trajectory	Performance	Variance	Trajectory	Performance	Variance
Urgent and Emergency Care																				
A&E waits under 4hrs	FDP	Jul-26	78.8%	**64.7%**	-14.1%	70.2%	**56.2%**	-14.0%	78.3%	**66.3%**	-12.0%	82.0%	**79.3%**	-7.1%	70.0%	**72.2%**	+0.2%	77%	**71.0%**	-6.0%
A&E waits over 12hrs	FDP	Jul-26	12.4%	**14.1%**	+1.7%	7.9%	**14.0%**	-6.1%	5.8%	**2.2%**	-3.6%	9.6%	**11.4%**	+5.8%	6.8%	**6.4%**	+1.4%	9.3%	**2.1%**	-7.2%
No Criteria to Reside	Local	Jun-26	n/a	**22.1%**		n/a	**21.9%**		n/a	**18.0%**		n/a	**53**		n/a	**241**		18%	**26.2%**	**+8.2**
RTT waits under 18wks	FDP	Jun-26	60.7%	**56.9%**	-3.8%	69.2%	**70.4%**	+1.2%	70.1%	**72.5%**	+2.4%	65.6%	**60.5%**	-5.1%	66.2%	**67.6%**	+1.4%	64.2%	**65.2%**	+1%
RTT waits over 52wks	FDP	Jun-26	0.8%	**2.5%**	+1.7%	1.0%	**0.3%**	-0.6%	0.1%	**0.2%**	+0.1%	0.8%	**1.8%**	-1.0%	1.0%	**1.0%**	0.0%	1.2%	**2.4%**	+1.3%
Diagnostics (DM01) waits over 6wks	FDP	Jun-26	3.9%	**6.5%**	+2.6%	13.8%	**11.8%**	-2.0%	11.1%	**13.8%**	+2.7%	22.5%	**22.4%**	-0.1%	7.4%	**13.3%**	+5.9%	10.1%	**16.7%**	+6.6%
Cancer 28-day FDS	FDP	Jun-26	80.7%	**67.9%**	-12.8%	81.2%	**76.3%**	-4.9%	80.6%	**79.0%**	-1.6%	80.0%	**75.9%**	-4.1%	79.3%	**71.5%**	-7.8%	80.7%	**83.9%**	+3.3%
Cancer 62-day standard	FDP	Jun-26	71.7%	**59.2%**	-12.5%	74.2%	**70.8%**	-3.4%	78.9%	**68.3%**	-10.6%	80.1%	**63.1%**	-17.0%	75.4%	**61.2%**	-14.2%	75.8%	**70.4%**	-5.4%
Cancer 31-day standard	FDP CPID	Jun-26	93.0%	**87.1%**	-5.9%	92.8%	**96.1%**	+3.3%	94.3%	**96.1%**	+1.8%	94.5%	**94.5%**	0.0%	96.0%	**93.2%**	-2.8%	94.7%	**90.7%**	-4.0%

Operating Plan National Priority Metric	Data source	Reporting month	SWAST		
			Trajectory	Performance	Variance
Cat2 ambulance response	FDP	Jul-26	29:42	**39:23**	+9:19

DCH – issue with June Cancer Waiting Time Submission – May 26 performance shown above (impact on Dorset ICB Cancer performance)

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	8
Date of Meeting:	16 September 2026		

Title of Report:	Progress on the Medium-Term Plan Mental Health, Learning Disabilities and Autism (MHLDA) commitment, to 'eliminate [adult] out of area placements' across B&NES, Swindon and Wiltshire (BSW) ICB, Dorset ICB and Somerset ICB
Report Author:	Catherine Connor, Associate Director - Mental Health, Learning Disabilities, Autism and Neurodiversity Emily Shepherd, Associate Director of Place - Swindon Mark Smith, Principal Commissioning Lead, All Age Mental Health, Dorset ICB Dr Georgina Ruddle, Deputy Place Director, Swindon & Deputy SRO, Mental Health, Learning Disabilities, Autism and Neurodiversity
Board / Director Sponsor:	Gordon Muvuti, Place Director – Swindon Commissioning Director SRO for Mental Health, Learning Disabilities and Neurodiversity
Appendices:	Appendix A: Cluster MHLDAN inpatient provision Appendix B: OAP Programme Risks Appendix C: Phase 1 Plan

Report classification	
ICB body corporate	
ICS NHS organisations only	
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	

Previous consideration by:	Date	Please clarify the purpose
Cluster Executive Management Meeting	25 August 2026	For discussion and approval to progress to Public Board

1 Purpose of this paper

There has been a longstanding national ambition to reduce the number of Out of Area Placements (OAPs) for people with mental health need.

NHS England has mandated that all ICBs present a paper to their Public Board which:

1. Confirms that the ICB is aware of the locations of all their MHLDAN patients placed out of area and
2. Affirms the ICB's commitment to eliminating all OAPs for Mental Health, Learning Disabilities and Autism across the cluster footprint by end of March 2028, in line with the national ambition.

This purpose of this paper is to comply with the NHS England expectation, and provide a cluster-wide overview of the:

- requirements set out in the Medium-Term Plan and associated guidance
- current cluster position
- known risks to delivery
- quality and safeguarding considerations

2 Summary of recommendations and any additional actions required

The Board is asked to:

- note the paper
- prioritise organisational resource to meet this objective, and
- receive a further update on progress in 6 months' time (or at alternative frequency as preferred by the Board).

3 Legal/regulatory implications

Policy Requirement: The medium-term plan requires ICBs and mental health providers to eliminate out of area mental health, learning disability and autism placements and locked rehabilitation by March 2028. The three cluster ICBs have committed to 0 inappropriate OAPs by the end of 2026/27 in their medium-term plan submissions.

Numbers of inappropriate OAPs will also form part of the National Oversight Framework, which assesses the performance of both ICBs and Trusts.

4 Procurement

No procurement implications have been identified at this time

Procurement sign off	N/A

5	Risks
The programme risk is held under Somerset Risk 787. A broader set of risks are also noted in Appendix B.	

6	Quality and resources impact
Quality, Patient Experience and Safeguarding: repatriating patients back into the local area is associated with significantly better patient outcomes, reduced length of stay, reduced readmissions, and enables more effective oversight of safety and quality of placement. OAPs create additional patient safety risks through reduced continuity of clinical, quality and commissioning oversight, delayed involvement of local community teams and in-reach provider support, as well as delayed access to local physical healthcare, housing and social care services; reduced family and carer participation in care planning, and challenges in maintaining safeguarding oversight and coordination. Patients placed at distance may experience delays in discharge planning and repatriation, increasing the risk of deconditioning, institutionalisation, more restrictive practice and poorer recovery outcomes. **Finance:** There are no direct financial or resource requirements associated with this programme of work at this time. **Workforce:** internal resource to be supplemented by external reviewers as appropriate. **Sustainability/Green agenda:** Achieving the medium-term plan commitment brings care closer to home, which supports green plan objectives and reduce carbon emissions	
Finance sign off:	Ian Longden, 14/08/2026

7	Confirmation of completion of Equalities and Quality Impact Assessment
An EQIA has not yet been completed. This is because detailed plans are in development and the thematic work will support delivery of a comprehensive EQIA.	

8	Communications and Engagement Considerations
The policy direction set out nationally has been informed through engagement with people with lived experience. This has been undertaken by NHS England in developing the Commissioning framework for mental health inpatient services.	

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

Progress on the Medium-Term Plan Mental Health, Learning Disabilities and Autism commitment, to 'eliminate out of area placements'

Executive summary

The three ICBs recognise that being placed in an inpatient bed that is out of area can result in a poorer experience of care or poorer outcomes for people than being placed in a local inpatient setting.

As at the end of June 2026, in the cluster, there were 94 patients in out of area inpatient beds. The three ICBs are working to repatriate people in out of area inpatient beds as soon as possible, where this is clinically appropriate to do so.

A high-level action plan for phase one is provided at Appendix C. This action plan includes:

- the opening of the Kingfisher unit, which will increase local inpatient capacity for people with Learning Disabilities and/or Autism;
- Independent case reviews for people placed out of area to consider innovative options for repatriation and/or discharge, including a thematic review with recommendations for commissioners to prevent the need for out of area placements; and
- Development and implementation of revised processes around out of area placements across the cluster, including multi-disciplinary fortnightly reviews and senior sign off.

Background:

There has been a longstanding national ambition to reduce the number of inappropriate out of area placements (OAPs) for adults in mental health or learning disability/autism inpatient settings. OAPs are associated with increased safety and quality risks, poorer patient experience, poorer clinical outcomes, higher financial cost, and often longer lengths of stay in hospital. They can also result in people being separated from friends, family and support networks, disrupting continuity of care and potentially impeding recovery. In some cases, this can include patients being unable to access local, universally commissioned services which can further affect care.

OAPs often also reflect wider issues in the functioning of the mental health system, including:

- Insufficient community mental health services, including alternatives to admission, leading to escalating need and avoidable demand on inpatient capacity.
- Insufficient inpatient capacity to meet unavoidable demand for admission.
- Poor discharge management, and insufficient housing and social care support, which can result in patients remaining in hospital when clinically ready for discharge (CRFD).

The NHS England (NHSE) Medium Term Planning (MTP) Framework 2026/27 - 2028/29 requires Integrated Care Boards (ICBs) and mental health providers to 'localise Care, reduce out of area placements and end the commissioning of locked rehabilitation inpatient services.'

Accordingly, in 2026 NHS England refreshed the historic ambitions and has set an ambition to eliminate *all* OAPs for adults in mental health or learning disability/autism inpatient settings, with the following specific targets:

- 2026/27 – Reduce the number of inappropriate OAPs by the end of March 2027
- From 2027/28 onwards - ICBs should only commission mental health inpatient services for adults and older adults that align with the Commissioning Framework for mental health inpatient services

Alongside this, NHS providers have collectively agreed a stretch target with NHS England: to work towards a 95% reduction in OAPs by March 2027

B&NES, Swindon and Wiltshire (BSW) ICB, Dorset ICB and Somerset ICB have each set their 2026/27 inappropriate OAP target as zero. Whilst this means there is a risk of non-compliance at points throughout the year, it sets the ambition to continue to reduce OAPs, working towards elimination, and is informed by recent performance improvement.

NHSE has requested that ICBs discuss at their public Board their assurance that is oversight of all OAPs, as well as their commitment to achieving the MTP requirement.

Scope and definitions:

The Department of Health and Social Care (DHSC) provides the detailed national definition of inappropriate OAPs in acute care (here). A high level definition is also provided within the Medium-Term Planning Framework 2026/27 to 2028/29, which states:

An inappropriate OAP occurs when a patient with assessed acute mental health needs who requires non-specialised inpatient care (ICB commissioned) is admitted to a unit that does not form part of the usual local network of services[1].

[1] Due to the changes to ICBs, NHS England is reviewing the definition of inappropriate and appropriate OAPs; this review may include a change to "out of area" to within cluster, or may specify a specific distance from the person's home.

In practice, most OAPs can be considered inappropriate. However, exclusion criteria exist and may apply in certain circumstances, including:

- the person becomes acutely unwell when they are away from home (in such circumstances, the admitting provider should work with the person's home team to facilitate repatriation to local services as soon as this is safe and clinically appropriate)
- a highly specialist assessment or treatment is unavailable locally
- a local placement would create a significant risk to the individual or others due to the environment
- there are safeguarding reasons such as gang related issues, violence and domestic abuse
- the person is a member of the local service's staff or has had contact with the service in the course of their employment
- there are offending restrictions
- the decision to treat out of area is the individual's choice e.g. where a patient is not from the local area but wants to be near their family and networks.

Note that this requirement does not include patients with acquired brain injury (ABI) unless there is a specific and diagnosable arising mental health need. Children and Young People (CYP) are also excluded from this national target. We know that CYP with mental health needs who are placed a long way from home can have a poor experience of care and poorer outcomes. ICBs work closely with NHS England's Specialised Commissioning teams, who commission provider collaboratives, to support improved local offers to both prevent admission to an OAP and facilitate prompt repatriation.

Cluster inpatient configuration

Appendix A includes all bed types in scope of the MTP requirement. The South-West Provider Collaborative, led by Devon Partnership Trust, has been included to provide full oversight of patients who are placed out of area and were reported in the NHS England audit return.

The South West Provider Collaborative (SWPC) is an NHS-led partnership of mental health, learning disability and autism providers across the South West, led by Devon Partnership NHS Trust, which plans, commissions and oversees specialised services across the region so that people can receive high-quality care as close to home as possible. As such these placements are not commissioned directly by the ICBs, with commissioning responsibility held by the Provider Collaborative. Local systems work closely with the SWPC to support repatriation and/or discharge into local areas.

Current position

A system census on OAPs is undertaken on a monthly basis. The below table sets out the latest position to 30 June 2026 in total across the cluster.

	BSW	Dorset	Somerset	BSW	Dorset	Somerset
Bed type	**Number of appropriate OAPs**			**Number of inappropriate OAPs**		
Psychiatric Intensive Care Unit (PICU)	0	1	0	0	2	2
Adult Acute	6	9	1	4	3	1
Older Adult Acute	0	0	2	0	0	0
Adult Mental Health Rehabilitation	6	26	2	0	2	0
Mental Health - Other	0	5	2	0	0	0
Learning Disability and/or Autism	11	8	1	0	0	0
TOTAL	**23**	**49**	**8**	**4**	**7**	**3**
TOTAL by type	**80**			**14**		
TOTAL across cluster	**94**					

Across the cluster, there are 94 patients requiring repatriation and/or discharge. In real terms. To meet the ambition, the cluster will need to repatriate and/or discharge 1 patient per week until the end of March 2028 to meet the ambition.

The cluster ICBs can confirm is aware of where all their patients who are placed out of area are currently receiving care. In line with national guidance, all patients in OAPs are subject to regular review to assess ongoing clinical appropriateness, safety, discharge barriers and opportunities for repatriation at the earliest clinically appropriate point. This includes regular visits.

Cluster challenges

Common challenges that affect the three systems, include:

- Delayed discharges – when a patient is clinically ready to leave an inpatient bed, but is unable to be discharged. This delay could be due to lack of housing, available community support packages, a shortage of care home placements, waiting on specialised equipment for home, or delays in finalising necessary administrative paperwork and medications.
- Planned or unplanned refurbishments – sometimes mental health beds need to be closed for refurbishment, affecting the overall number of beds available for local use.
- For BSW specifically, appropriate utilisation of crisis houses to support step down from inpatient to community support and intervention.
- There are rare occasions that a member of staff from the local mental health provider will need to be admitted to a mental health bed. In these instances, it is considered best practice to place outside Trust.

- Summer months and associated high temperatures appear to have an impact on requirement for mental health inpatient admissions, with higher numbers of admissions and subsequent capacity related out area placements.
- There are instances where a patient is admitted to a locally commissioned bed but where the patient is subsequently assessed and requires a SWPC bed. When there is insufficient capacity with a SWPC bed, the patient will continue to occupy a locally commissioned bed. This can mean that a new patient requiring admission may need to be admitted elsewhere in order to safely manage potential safeguarding, quality or clinical risks caused by being in an inappropriate setting.
- The Somerset PICU is currently a mixed sex ward. Service users are keen for this to continue to offer provision to both men and women as this supports recovery and rehabilitation. Female admissions to a PICU are very low. However, if there is a female already on the ward when an individual with a history of sexual offending subsequently requires admission, due to patient safety, the patient with the history of sexual offending will have a bed sourced elsewhere. Conversely, if there is a patient with a history of sexual offences is already placed on the ward and a female patient requires admission, an external bed will be identified for the female patient for her safety.
- Where patients have been in inpatient environments for prolonged periods, patients can become effectively institutionalised and resistant to moving to a different setting.

Common actions to support improvement in OAPs

1) **Inpatient Quality Transformation Programme (IQTP):** Each system is required to undertake an IQTP. This is an NHS England initiative designed to radically improve the culture, safety, and therapeutic environment of mental health, learning disability, and autism inpatient services. The programme was created to overhaul how care is delivered and to prevent future care scandals by focusing on five core objectives:
   - *Localising care:* Ensuring patients receive treatment close to home and family, rather than being placed far away.
   - *Reforming culture:* Fostering a healthy, supportive, and open environment for both staff and patients.
   - *Reducing restrictive practices:* Minimising the use of restraint or seclusion in favour of least-coercive care.
   - *Supporting local systems:* Assisting NHS providers and Integrated Care Boards (ICBs) facing immediate challenges.
   - *Improving oversight:* Ensuring hospitals are safe and held accountable.

2) **Development of the Mental Health Emergency Department (MHED)**: plans are in place to develop a MHED at Musgrove Park Hospital in Somerset and Dorset County Hospital and Royal Bournemouth Hospital in Dorset. These facilities will provide increased assessment and treatment capacity for people

in crisis, reduce pressure on urgent care services and the health-based place of safety, and reduce escalation of need that could otherwise require Mental Health Act detention, urgent admission and/or a PICU bed.

Note that in BSW system analysis indicated insufficient demand to warrant the development of dedicated MHEDs. However, discussions are live with Great Western Hospitals NHS Foundation Trust and with Salisbury NHS Foundation Trust in Swindon about improvements to the environment for people with MHLDAN needs.

3) **Development of Neighbourhood Mental Health Centres (NMHCs)**: each of the three ICBs are developing their community models to bring mental health support closer to those who need it most and address known inequalities. This will include the provision of "hospitality beds", which is expected to reduce demand for inpatient beds.

4) **Implementation of a High Impact Users Model**: a joint system workstream to improve identification, care planning and coordinated support for people with repeated crisis presentations and highly complex needs. Note that the implementation of this work has varied across systems and has traditionally fallen within the remit of urgent care commissioners with close links to MHLDAN.

5) **Community Mental Health Programme**: continuing to strengthen community services, including discharge approaches for highly complex patients. This will improve flow and access to inpatient beds, support the most complex inpatients with the longest lengths of stay, and increase capacity in the current in-area bed base.

6) **Pathway Improvements**: it has been identified that improvements could be made to aftercare and rehabilitation pathways, including Section 117. Improvements here could reduce the need for out of area and locked rehabilitation-type provision in future.

7) **Process Improvements**: an independent review has been taken by the NHS England regional team of each of the local systems. An summary of the output of this work is provided below.

8) **Learning Improvement Network (LIN)**: NHS England hosts a monthly LIN meeting to share best practice and discuss challenges. This has included the allocation of funding for flow improvement schemes.

9) **Opening of the Kingfisher Unit**: a new facility for people with a learning disability and/or autistic people who would benefit from specialist mental health treatment in a hospital, whose needs cannot be met in a mainstream mental health hospital. The Kingfisher Unit is in Bristol and is expected to receive its first patients in autumn 2026. Note that whilst the Kingfisher Unit is based in Bristol, patients admitted to bed within the Unit will not count as OAPs. This is because, in line with the DHSC definition, the Unit will form part of the usual local network of services and can be visited regularly by a

patient's care coordinator to ensure continuity of care and effective discharge planning.

ICB-specific position:
The below section summarises the position to end June 2026 for each ICB area.

BSW

Bed type	Number of appropriate OAPs	Number of inappropriate OAPs
Psychiatric Intensive Care Unit (PICU)	0	0
Adult Acute	6	4
Older Adult Acute	0	0
Adult Mental Health Rehabilitation	Neuro rehab – 2 Locked rehab - 4	0
Mental Health - Other	0	0
Learning Disability and/or Autism	11	0
TOTAL	**23**	**4**

Governance:
All Specialist Placements within BSW are considered through a structured, recovery-focused and least restrictive governance process.

Prior to escalation towards a Specialist Hospital Placement (SHP), cases are reviewed through the Tier 1 Functional Analysis Pre-Meeting process. This process ensures that all appropriate community-based, commissioned and third-sector options have been fully explored before a specialist placement is considered.

The Tier 1 process supports:

- Patient-centred and recovery-focused decision making
- Least restrictive practice
- Multi-agency collaboration
- Safe and proportionate risk management
- Robust governance and oversight
- Exploration of alternatives to hospital admission

The process also ensures that:

- Funding and commissioning pathways are reviewed
- Placement objectives and success criteria are clearly defined
- Contingency plans and discharge considerations are identified early
- Roles, responsibilities and timelines are clearly agreed
- Decisions are fully documented as part of the governance trail

If there is a consensus view that a specialist hospital placement is required, all applications are presented to a monthly Non-Contractual Activity forum. The forum is chaired by the ICB and is attended by a Trust Psychiatrist acting in an independent capacity, to ensure medical rigour is held over the appropriateness of all cases. The forum will make a recommendation and seek confirmation and approval through the Commissioning Senior Responsible Officer for Mental Health, Learning Disabilities and Neurodiversity. The Forum has recently started to be used to seek advice and expertise from neighbouring systems for complex patients to understand how a different system may approach care and treatment, based on pen portraits.

This governance structure supports safe, evidence-based and recovery-focused decision making while ensuring specialist placements remain clinically appropriate, proportionate and aligned with least restrictive principles.

The governance process also reflects the importance of ongoing review and discharge planning from the point of admission, ensuring that specialist placements remain focused on rehabilitation, recovery and progression towards community living wherever possible.

Action to date

1. Structured governance process to review and recommend approval of specialist hospital placements.
2. Monthly review of all specialist hospital placements, including review of progress against treatment plans and patient centred goals, ongoing appropriateness of placements and progress to discharge. Through robust governance processes, BSW ICB has decreased the number of specialist hospital placements. This has ensured people receive least restrictive care closer to home, but has also make significant financial impact to the ICB (included in ICB CIP)
3. ‘Flow Forward’ system meetings (previously Multi-Agency Discharge Events (MADE)), fortnightly strategic flow meetings and complex risk meetings are held regularly to strengthen system-wide oversight of high-risk or delayed patients and enabling coordinated decision-making.
4. The AWP Inpatient Quality Improvement Programme serves to improve the clinical care and environments individuals receive in AWP wards.
5. Impartial review of OAP processes and culture undertaken by NHS England regional lead. Overall, the review found that the BSW system “demonstrates clear and measurable improvement in managing OAPs, supported by the introduction of structured decision-making, flow management, and multi-agency working.”
6. Recommendations via the recent Getting It Right First Time (GIRFT) review.

Dorset

Bed type	Number of appropriate OAPs	Number of inappropriate OAPs
Psychiatric Intensive Care Unit (PICU)	1	2
Adult Acute	9	3
Older Adult Acute	0	0
Adult Mental Health Rehabilitation	13 Locked rehab - 13	0 Locked rehab - 2
Mental Health - Other	Personality Disorder Inpatient service – 2 Neuropsychiatry - 3	0
Learning Disability and/or Autism	Locked rehab – 7 PICU - 1	0
TOTAL	**49**	**7**

Governance
In Dorset, OAPs are monitored through local MHLDAN governance structures

The operational and financial oversight of OAPs is a shared responsibility between Dorset Healthcare Trust (DHC) and Dorset ICB. The Trust has responsibility for sourcing OAPs for acute mental health beds, whereas the ICB is responsible for sourcing beds for specialist mental health rehab and/or learning disabilities and/or autism. Accordingly, the Trust is responsible for funding inappropriate out of area beds, while the ICB retains financial responsibility for appropriate OAPs for both mental health and/or learning disabilities and/or autism.

Action to date

1. Significantly improved oversight and reporting processes
2. Ongoing work within DHC aligned with the Peri hospital/MH Therapeutic admissions programme which is one of 4 key transformation programmes for the Trust in 2026/27. This has 4 key workstreams looking at data, therapeutic admissions, inpatient processes, and discharges to impact key metrics such as length of stay, timely access to appropriate beds, and improving patient and staff experience. Additionally, the development of the St Ann's site through the New Hospital Program will provide an additional 10 beds to the Dorset system in 2028.
3. MADE and complex risk meetings are held regularly to strengthen system-wide oversight of high-risk or delayed patients and enabling coordinated decision-making
4. DHC are currently undertaking a review of mental health rehabilitation services to improve patient flow, reduce reliance on beds and enhance

community provision and patient recovery. This also considers out of area specialist rehab placements, which are ICB-funded, with a view to reduce numbers and repatriate over time. This is supported by NHSE lived experience resource.

5. Impartial review of OAPs processes and culture undertaken by NHS England regional lead. The review recommended improvements in system control and governance to reduce the number of patients placed out of area.

Somerset

In Somerset, NHS Somerset Foundation Trust (SFT) holds delegated responsibility for managing OAPs for its ICB commissioned beds (PICU, adult acute and older adult acute). Traditionally, Somerset has been a low user of OAPs.

Bed type	Number of appropriate OAPs	Number of inappropriate OAPs
Psychiatric Intensive Care Unit (PICU)	0	2
Adult Acute	1	1
Older Adult Acute	2	0
Adult Mental Health Rehabilitation	1 Neurorehab - 1	0
Mental Health - Other	Personality disorder inpatient - 2	0
Learning Disabilities and/or Autism	1	0
TOTAL	**8**	**3**

Governance:
In Somerset, the OAP position is reported on a quarterly basis to the Mental Health, Autism and Learning Disabilities Delivery Group.

The operational and financial oversight of OAPs is a shared responsibility between SFT and Somerset ICB. The Trust has responsibility for sourcing OAP placements for mental health and/or learning disabilities and/or autism. However, the Trust is responsible for funding inappropriate out of area beds, while the ICB retains financial responsibility for appropriate OAPs for both mental health and/or learning disabilities and/or autism.

Action to date

1. Significantly improved oversight and reporting processes
2. MADE and complex risk meetings are held regularly to strengthen system-wide oversight of high-risk or delayed patients and enabling coordinated decision-making.

3. Significant investment into both Intensive and Assertive Outreach programmes and inpatient transformation in 2026/27
4. The Somerset Inpatient Quality Transformation Programme, includes the following actions, designed to improve outcomes:
    - Increasing occupancy of step up beds
    - Implementation of a weekly Multidisciplinary team meeting
    - Ensuring consistency of access to psychological interventions across all wards
    - New and enhanced staff training and support
    - Improvements to the inpatient environment
5. Impartial review of OAPs processes and culture undertaken by NHS England regional lead. The overall finding was that the Somerset system "demonstrates high maturity across all domains, with strong embedded processes operating as intended".

Next steps:
Appendix C sets out the Phase 1 plan, which runs until December 2026. The outputs of the Phase 1 work will determine actions for future phases.

Cluster governance:
Whilst the formal clustering of the three ICBs is underway, and until associated formal governance structures are established to support the new ways of working, oversight and assurance routes will be fourfold:

- Fortnightly via the fortnightly MHLDAN Senior Leadership team meeting
- Via NHS England assessment under National Oversight Framework, which includes OAP numbers as a core metric for assessing the performance of ICBs
- Regularly contractual oversight with providers
- Six monthly via the Cluster Board.

Impact on Health Inequalities, Outcomes, Population Health and Equality and Diversity

National policy over the last ten years has increasingly focused on ending the use of OAPs in favour of treatment that is located closer to people's homes.

The impact of being placed or detained in hospital away from home can be profoundly damaging. *"The Health Services Safety Investigations Body (HSSIB) found that inappropriate mental health placements can lead to anxiety, physiological stress, PTSD, and patients dying by suicide."*

Separation can compound and exacerbate distress rather than promote recovery, whether through separation from neighbourhoods, friends, family, employment, leisure activities or local communities at a time of significant distress and

vulnerability, often involving loss of liberty through detention under the Mental Health Act. The further the placement is from everything familiar, the greater the impact, and the harder it can be for friends, relatives and care co-ordinators to visit. For people with particular protected characteristics under the Equality Act 2010, an OAP can also mean separation from cultural and faith communities, LGBTQ+ communities, and accessible living arrangements, and can increase isolation at a time when connection and support are especially important.

For groups with protected characteristics who are over-represented among people receiving OAPs, reducing their use and providing suitable local alternatives should contribute towards a reduction of associated harms and improvements in health equality.

OAPs may disproportionately affect groups who already experience poorer access, outcomes or experiences within mental health services. This includes people with learning disabilities and autistic people, people from ethnic minority communities, people living in rural and coastal areas, women requiring specialist pathways, people with complex trauma, and people experiencing homelessness.

Distance from home may exacerbate existing inequalities by reducing access to family support, advocacy services, culturally appropriate care, faith communities, education, employment support and local authority services.

We will seek to reduce inequalities through systematic review of OAP demographics, monitoring of protected characteristics, and development of local alternatives that better meet the needs of underserved groups.

Summary:

Systems are expected to eliminate *all* OAPs (acute, rehabilitation and PICU) for adults in mental health or learning disability/autism inpatient settings by end March 2028. This paper has provided an update on action to date towards delivery of this ambition, as well as Phase 1 actions. Associated risks have been identified with mitigations proposed.

A full Equality and Quality Impact Assessment will be completed as detailed implementation plans are developed. Early assessment indicates that successful reduction of OAPs is likely to have a positive impact on health inequalities through improving access to local services, social support networks, advocacy and culturally appropriate care.

In line with the NHS England requirement to present a paper to Public Board, this paper confirms that BSW, Dorset and Somerset ICBs:

- have oversight of all adult MHLDAN patients in OAPs, and
- support and are working towards delivery of the ambition to eliminate OAPs, where this is clinically appropriate and in line with patient preferences and best interests.

Appendix A: Cluster inpatient provision

Bed type	Provider	Commissioner
Adult and/or Older Adult Acute Ward(s) - St Annes Hospital (Poole) - Forston Clinic (Dorchester)	Dorset Health Care University Advanced Foundation Trust	Dorset ICB
Psychiatric Intensive Care Unit (PICU) - St Annes Hospital Poole	Dorset Health Care University Advanced Foundation Trust	Dorset ICB
Rehabilitation - Alumhurst Rd (Poole) - Glendenning Unit (Dorchester)	Dorset Health Care University Advanced Foundation Trust	Dorset ICB
Adult Acute Ward(s) - Rowan - Rydon	Somerset NHS Foundation Trust	Somerset ICB
Older Adult Acute - Pyrland	Somerset NHS Foundation Trust	Somerset ICB
Psychiatric Intensive Care Unit (PICU) - Holford	Somerset NHS Foundation Trust	Somerset ICB
Rehabilitation Ward - Willow	Somerset NHS Foundation Trust	Somerset ICB
Older Adult Organic Ward(s) - Amblescroft South (Salisbury) - Cedar Ward (BaNES) - Liddington Ward (Swindon)	Avon and Wiltshire Mental Health Partnership NHS Trust	NHS BSW ICB
Older Adult Functional Ward(s) - Hodson Ward (Swindon) - Amblescroft North (Salisbury)	Avon and Wiltshire Mental Health Partnership NHS Trust	NHS BSW ICB
Adult Acute Ward(s) - Poppy Ward (Wiltshire) - Beechlydene Ward (Salisbury)	Avon and Wiltshire Mental Health Partnership NHS Trust	NHS BSW ICB

- Sycamore Ward (BaNES) - Applewood Ward (Swindon)		
PICU Ward(s) - Ashdown ward – male only (Salisbury) **Female PICU provision housed in BNSSG footprint*	Avon and Wiltshire Mental Health Partnership NHS Trust	NHS BSW ICB
Rehabilitation Ward(s) - Windswept (Swindon) - Whittucks Road (South Glos. BSW ICB commission 5 beds)	Avon and Wiltshire Mental Health Partnership NHS Trust	NHS BSW ICB
Secure *Low secure* - Wickham Unit (Bristol) - Ash (Somerset) *Medium secure* - Fromeside (Bristol)	Avon and Wiltshire Mental Health Partnership NHS Trust/ Somerset NHS Foundation Trust	South West Provider Collaborative
Mental Health beds for people with Learning Disabilities and/or autistic people - Kingfisher Unit (Bristol) – *planned opening autumn 2026*		NHS BSW ICB (on behalf of South West ICBs)

Appendix B: OAP Programme Risks

Risk ref	Risk area	Risk score (likelihood x impact)	Score	Mitigation
OAP1	**If:** Reporting is not standardised and consistent across all bed types for both systems. **Impact:** There is reduced oversight. **Effect:** Opportunities for required intervention may be missed, increasing the risk that the MTP requirement will not be met.	3 x 2	6 Moderate risk	Seek development of a single report to include all bed types within scope of the MTP OAP requirements.
OAP2	**If:** Mental health system capacity across both systems is insufficient. **Impact:** Sustained demand and periods of system pressure may exceed available inpatient and community capacity. This is commonly observed in the summer months. **Effect:** This may lead to delays in admission and discharge, increased reliance on OAPs, and a reduced ability to provide care in the least restrictive setting.	3 x 3	9 Moderate risk	Maintain and prioritise existing flow and demand management workstreams, with strengthened operational grip through daily system oversight. Continue to optimise discharge pathways, maximise use of community alternatives (noting that forthcoming changes to the Mental Health Act for patients with Learning Disabilities and Autism will put further pressure on community provision), and proactively manage escalation during known pressure periods (e.g. bank holidays).
OAP3	**If**: There is insufficient local provision for individuals with complex needs across the three systems. **Impact:** this could result in increased use of restrictive, out of area or higher-cost placements. **Effect:** This may negatively impact patient outcomes,	4 x 4	16 High risk	Progress development cluster governance to drive strategic oversight of gaps and commissioning priorities. Strengthen integration within system governance to support whole-system planning. Undertake review to identify required service

	experience, and length of stay, as well as increasing system and financial pressures.			developments, including community capacity and specialist provision, to reduce reliance on restrictive and OAPs. Note that there is an increase of need relating to Complex Emotional Needs, ADHD and Autism, increasing need for specialist provision and/or upskilling of local services
OAP4	**If:** Alignment with the Commissioning Framework for Mental Health Inpatient Services is applied inconsistently across systems. **Impact:** There may be variation in care and interpretation of inpatient provision, creating variation in oversight and approach. **Effect:** Reducing assurance that commissioning across all bed types is in line with the framework, across all three systems.	3 x 3	9 Moderate risk	Ensure consistency of approach across ICB systems and share learning from progress to date.
OAP5	**If:** there is insufficient capacity within the ICBs to oversee and deliver actions to reduce OAPs. **Impact:** patients may continue to be in OAPs that may not be actively meeting their needs and the ICB will fail to achieve the national target. **Effect:** this will mean patients remain in prolonged OAPs, reputational risk to the ICB for failure to meet a national target.	3 x 3	12 Moderate risk	Additional resource to be secured via framework provider.
OAP6	**If:** NHS England changes the definition to OAPs. **Impact:** local plans to eliminate may need to change at pace. **Effect:** this could require short notice changes to plans	4 x 1	4 Low risk	The overall programme will be patient-centred and designed to enable sustainable prevention of future OAPs. A change in definition could even have a

				beneficial impact on numbers across the cluster.
OAP7	**If:** provider-led work to reconfigure inpatient capacity takes place without broader system engagement and oversight. **Impact:** there is a risk that there will be more demand for OAPs. **Effect:** this could jeopardise delivery of the OAPs programme and impact the quality of care provided for this patient cohort.	3 x 3	9 Moderate risk	Discussions are ongoing between the ICB and providers on the shape and timescales for any related programmes of work.
OAP8	**If:** there is insufficient community capacity, including housing, social care, and community packages. **Impact:** delayed discharges will occur for patients who are clinically ready for discharge. **Effect:** this would generate a need for more bedded capacity for patients requiring admission, which could only be met by placing out of area.	4 x 4	16 High risk	Delayed discharges are regularly reported, including the reasons for them. Thematic work from Phase 1 will identify opportunities to stimulate the market to address any gaps
OAP9	**If:** there is insufficient specialist MHLDAN workforce both in inpatient and community settings, noting the particular challenges relating to the geography and demography. **Impact:** there will be reduced flow across the system and potentially an increased need for bedded provision. **Effect:** there would be an increased length of stay, which could only be managed by placing patients out of area.	3 x 3	9 Moderate risk	Workforce planning, transformed models of care, including further developing partnerships with VCFSE via NMHCs.
OAP10	**If:** patients remain in prolonged OAPs. **Effect:** there will be increased risks relating to safeguarding, self harm, suicide, restrictive practice or loss of family involvement. It will also likely result in poorer patient outcomes and longer overall length of stays and increased risk of readmission. **Effect:** harm to patients, reputational risk to commissioners (including legal risk) and providers.	3 x 4	12 Moderate risk	Regular multidisciplinary reviews, executive oversight and repatriation plan development

Appendix C: Phase 1 plan overview for reducing OAPs

Phase 1 has two areas of focus:

1. Individual patient focused work to support repatriation and/or discharge.
2. Thematic review of cases across the cluster to identify commissioning opportunities and process improvements.

Future phases will be informed by the work at Phase 1, and will involve people with lived experience and carers.

Phase	Task	Lead	Place/cluster
Phase 1 – August to December 2026 Immediate actions and fact finding	Deep dive into locked rehab, focused initially on those with the highest length of stay, furthest from home, most clinical complexity and/or no expected data of discharge, including thematic review An output of this will be that for every patient currently placed out of area will have a repatriation or discharge plan, with expected milestones and discharge/repatriation dates.	ICB	Dorset
	Review of rehabilitation pathway – paper scheduled for consideration by DHC Board in October and wider system consideration thereafter	Dorset HC	Dorset
	Opening of Kingfisher Unit, increasing local capacity for people with LDAN needs who require an inpatient placement	ICB/AWP	BSW (for region)
	Allied Health Professional inpatient expansion	SFT	Somerset
	Review of and potential alignment of processes around OAPs across three systems	ICB	Cluster
	Review of quality and support for people placed out of area	ICB (quality)	Cluster
	Development of interim ICB OAP approval process and Panel, including quality representation	ICB	Cluster

	Formal review of all patients placed out of area monthly via the Non-Contract Activity Forum	ICB	Cluster
	Informal review of patients with imminent repatriations/discharges and or those patients whose planned discharges/repatriations are at risk of delay on a fortnightly basis (or more regularly by exception)	ICB	Cluster
	Independent reviews of patients with long OAPs and/or complex OAPs, including thematic analysis	ICB (commissioning framework provider)	Cluster

Official sensitive

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	9
Date of Meeting:	16 September 2026		

Title of Report:	Somerset Health and Care Academy- Board Briefing
Report Author:	Sarah Green, Academy Director Scott Sealey, Deputy Chief Finance Officer Tony Rackshaw, Academy Programme Director
Board / Director Sponsor:	Jonathan Higman, Cluster Chief Executive Alison Henley, Chief Finance Officer and Director of Resources
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	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	x
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	

Previous consideration by:	Date	Please clarify the purpose
Academy Board	20 August 2026	FBC and Collaboration Agreement review
SFT Finance Committee	28 August 2026	FBC and Collaboration Agreement review
ICBs Joint Finance and Resources Committee	27 August 2026	FBC and Collaboration Agreement approved
SFT Board	8 September	FBC and Collaboration Agreement approval
Somerset Council Executive	2 September	FBC and Collaboration Agreement approval

1 Purpose of this paper

This paper provides the Board with a briefing on progress towards the development of the Somerset Health and Care Academy.

It covers the overall purpose of the Somerset Health and Care Academy and provides a summary of the approval process, together with the implications of the Full Business Case (FBC) and Collaboration Agreement which had been considered by the Finance and Resources Committee. The paper also summarises the academy business plan, risks and next steps.

2 Summary of recommendations and any additional actions required

The Full Business Case and Collaboration Agreement was formally reviewed and approved through the ICB Finance and Resources Committee with agreement to:

- Approve the establishment of the Somerset Health and Care Academy via a contractual joint venture enabled by the Collaboration Agreement
- Approve the Collaboration Agreement inclusive of the schedules
- Approve the ICBs entry into the Collaboration Agreement
- Approve the proposed revenue model
- Approve the governance arrangements and delivery model, with SFT as the lead operational host
- Approve the proposed property arrangements
- Approve the construction gateway appointment delegated to Council officer programme gateway with oversight through the Joint Academy Board
- Approve progression to implementation
- Approve the ongoing requirement for system collaboration and commitment for the Academy

The Full Business Case and Collaboration Agreement has also been considered and approved by the Somerset Council Executive and the Board of Somerset NHS Foundation Trust, who are the other partners in the development.

This paper provides an overview of the development for the ICB Cluster Board, raising awareness of the development which is of strategic importance and confirming the relevant approvals which follow full consideration of the business case and collaboration agreement by the Finance and Resources Committee.

3 Legal/regulatory implications

The Full Business Case and Collaboration Agreement have several legal implications that have been captured in the documents and shared through the Finance and Resources Committee

As a summary, these are to:

- Establish a joint venture as articulated through the Collaboration Agreement that has been developed with our legal partners Bevan Brittan and with the legal representatives from each organisation.
- Enter into a Data Sharing Agreement as found in Schedule 7 of the Collaboration Agreement.
- The Lease Heads of Terms in Schedule 6.

These Full Business Case and Collaboration agreement were reviewed in full by the ICB Finance and Resources Committee and are available to Board members on request.

4 Risks

As part of the governance of the Academy there is a risk register that is regularly reviewed through the Academy Programme Delivery Group and Academy Board.

5 Quality and resources impact

The revenue model can be found in the commercial chapter of the Full Business Case and reflects the revised accommodation schedule. It should be noted that the revenue model will continue to be agile and develop as the business model of the Academy needs to be flexible to respond to changing internal and external drivers.

The delivery plan has been informed through extensive stakeholder engagement, including engagement with a range of social care providers, Skills for Care, the Registered Care Provider Association, education providers and Health Innovation Network, South West. Work is in progress to ensure training supports quality standards to further enable consistent high-quality training across all of Somerset.

There are resource implications for ongoing commitment in enabling the delivery infra structure of the Academy.

6 Confirmation of completion of Equalities and Quality Impact Assessment

As part of the Full Business Case equality considerations have informed the design of the entire programme.

For example, this includes in the design and delivery of training, engagement methods; addressing inequalities such as through access to career and using population data to target specific communities or groups. In addition, we have identified social value KPIs for the construction programme of work; these will be monitored as part of the overall programme management.

An Equality Impact Assessment has also been completed by Somerset Council. ,

7 Communications and Engagement Considerations

Since its inception the Somerset Health and Care Academy has undertaken engagement that has informed the Full Business Case and Collaboration Agreement. This engagement has taken the form of:

- Diverse range of social care providers
- A newly formed Academy social care engagement group
- Collaboration and engagement with Skills for Care and the Registered Care Providers Association
- Survey distributed through the Academy governance
- Academy co creation group with representation from across all sectors and professions
- Meetings with local colleges and universities
- NHSE engagement
- Regular meetings with communication leads from each partner
- Academy governance – sharing through delivery groups and programme delivery groups.
- The Academy legal workstream, working with our legal partner, engaged with the legal aspects and implications of the commercial agreement.
- Historic England for planning and construction
- Design meetings for the planned build with relevant leads.
- Social value KPIs for the appointed contractor identified.

Ongoing support is required for communication and engagement to ensure branding, public and staff awareness and marketing.

8	Statement on confidentiality of report
The Collaboration Agreement is a confidential legal document – and therefore is not shared with this briefing paper.	

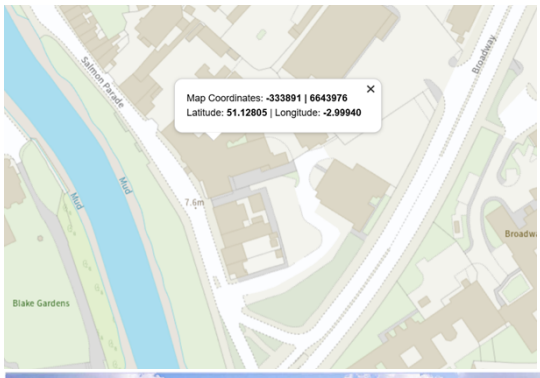
The Somerset Health and Care Academy

1. Background and purpose

1.1 The Somerset Health and Care Academy was originally agreed following a successful Levelling Up Fund (LUF) bid in 2022 awarded to Somerset Council. The bid was predicated on the regeneration of the old Bridgwater Community Hospital site into a vibrant integrated training and innovation hub for Somerset. The bid identified several anticipated improvements from the funding such as creating a new working culture across health and care, enhanced training capacity with a focus on high-quality competencies for the care sector, supporting vulnerable communities, integrated solutions for recruitment and retention and creating a centre for business and innovation.

1.2 The Academy has subsequently evolved into a strategic partnership between Somerset Council, Somerset NHS Foundation Trust and NHS Somerset ICB. It is intended to provide a collective response to workforce shortages, recruitment and retention challenges, skills development requirements, innovation opportunities and future changes in health and care delivery.

1.3 Location Plan and artists impression of the Somerset Health and Care Academy



1.4 The complex programme has entailed:

- Development and implementation of robust programme management
- Implementation, and ongoing review, of the governance structure
- Approval of Heads of Terms and Statement of Intent with each partner (April-May 2026) that informed the Collaboration Agreement
- Development of a vision and programme of work
- Extensive partner engagement
  - Agreement of revised design proposals following engagement with Historic England
  - Securing an affordable construction scheme
  - Establishment of Academy financial management arrangements
  - Development and implementation of workforce, innovation and delivery workstreams
  - Launch of initial training activities
  - Development of a procurement process to secure training from external education providers
  - Progressing the understanding and application of a collaboration between the ICB, Somerset Council and Somerset NHS Foundation Trust.
  - Development and approval of the Full Business case and Collaboration Agreement during August- September 2026

2. The Somerset Health and Care Academy Vision and Purpose

2.1 The Academy is an innovative opportunity to bring together partners to collectively respond to our workforce priorities; both for today and tomorrow. With the many policy and fiscal changes impacting our organisations the Academy is a collaborative strategic delivery mechanism that, as a collective endeavour, offers improved resilience, workforce sustainability and innovation that could not be achieved by working alone.

2.2 The vision of the Academy was designed with stakeholders from across disciplines, organisations, and sectors.

The Academy vision*: A place where health and care professionals learn, innovate, and work together for a workforce enabling healthier, resilient communities where everyone can thrive.*

'Learning Together for the health and care workforce of today and tomorrow.'

2.3 Alongside the vision there are streamlined objectives of:

- Innovation and Collaboration: Bring people, ideas, and technology together to grow and succeed.
- Skills and Workforce Development: Provide learners with the right skills and behaviours through employer-led training.
- Inclusive Career Growth: Support everyone with clear, inclusive career opportunities at every stage

2.4 The Somerset Health and Care Academy offers: a shared infrastructure and system wide asset to reduce workforce costs, improve workforce supply and capability, generate external income and enable transformation across health and social care.

3 The Full Business Case and Collaboration Agreement

3.1 The FBC was developed and presented through the following approval processes:

- Somerset NHS Foundation Trust Finance Committee - 28 August and Board 8 September 2026
- ICB Finance and Resources Committee - 27 August 2026
- Somerset Council Executive - 2 September 2026

3.2 The Full Business Case and Collaboration Agreement has been informed by the previously approved Heads of Terms and Statement of Intent together with ongoing clarification concerning aspects of roles and responsibilities, risk, revenue, construction implications, legal implications and benefits realisation.

3.3 The Full Business Case concluded that a contractual joint venture between Somerset Council, Somerset NHS Foundation Trust and NHS Somerset ICB provided the strongest strategic, operational and commercial framework for delivering the Academy and achieving the outcomes identified through the Levelling Up Fund Programme and subsequent delivery objectives.

The preferred model was found to support:

- Workforce development and training
- Recruitment and retention
- Career pathway development
- Improved collaboration
- Innovation and technology adoption

3.4 The contractual joint venture recommendation, and agreement, was developed working with our legal partners, Bevan Brittan. The venture does not establish the Academy as a separate legal entity but rather a legally binding collaboration with one organisation acting as the operational lead host. In view of organisational changes, and to fulfil the operational requirements, Somerset NHS Foundation Trust have been recommended as the lead operational host in the collaboration.

3.5 The Collaboration Agreement enables a joint venture with a legally binding arrangement to be agreed across the three Parties. Unlike an incorporated joint venture utilising a separate legal entity, a contractual joint venture enables faster mobilisation and an opportunity to test financial viability.

3.5 The Collaboration Agreement mitigates legal risks by bringing together the terms and conditions for the arrangement such as the Roles and Responsibilities, Principles of Collaboration, Business Plan, Governnace, Property and Construction arrangements, Revenue, Dispute Resolution, Termination and Data Protection.

3.6 The agreement is based on an equal risk sharing basis between the three partners and termination of the Agreement is through total project failure. Reserved matters will be

considered where there are amendments to objectives, agreements, business plans, and changes to the management of the Reserved Fund

4. The Business Plan

4.1 The Academy is not intended to be another competing provider of training. It is intended to be the partnership's strategic vehicle for the commercialising, coordinating, commissioning, developing, and enabling workforce development, innovation and transformation activity across Somerset's health and care system.

4.2 The table below, taken from the Full Business Case, outlines a future workforce ecosystem model which illustrates the potential future benefits of the Academy. The model has been informed from extensive stakeholder engagement, policy and evidence analysis and future horizon scanning.

The Future Workforce Eco system pillar	The Somerset Health and Care Academy Opportunity	Workforce Impact	System Benefit
Digital & AI Integration	Digital upskilling Innovation testing & evaluation Creating new digital roles and career pathways Connecting tech companies and forming commercial partnerships Integrating digital skills and innovation into care pathways	Workforce confident and skilled in digital tools AI-enabled care	Increased productivity Accelerated innovation Improved patient access
Community & Preventative Care	Social care is a central highly visible component of neighbourhood care with access to high-quality training and carers An integrated upskilling offer for enabling new models of care and working Skills based workforce planning A collective and sustainable health/lifestyle coaching offer Living labs for testing new technology to keep people well and at home A focus on community engagement skills Social prescribing innovation Healthy ageing and frailty skills and innovation such as frailty labs Demonstration sites for health technology through the co located ILC	Workforce focused on prevention and population health	Reduced demand for acute services Improved health outcomes Attract funding
Multi-Disciplinary Teams	Adaptive leadership skills Collective skills/OD resource and methods for supporting neighbourhood health Expanded advanced practitioner roles	Flexible, collaborative workforce across organisations	Integrated care delivery and Improved patient experience

	Transforming teams' skills; behaviour change labs and evaluation Future focused workforce labs & integrated care simulations Peer support networks Community care pathway redesign Community Diagnostic Innovation Integrated discharge innovation	Workforce equipped for working and learning together	
Hybrid Workforce	Enabling cross sector working and rural health care models Collective talent hubs and pipelines Cross sector work experience Reskilling pathways and AI supported training Joined up entry pathways	Sustainable, mobile workforce Create workforce pipelines for local population	Reduced vacancies, improved retention Strengthened local workforce
Data-Driven System	Capability for population health data A knowledge hub with knowledge mobilisation Applied research and development centered on integrated neighbourhood care, rural communities Primary care focused research	Evidence-led workforce Continuous learning culture	Improved decision-making

4.3 The Academy's business plan is designed to combine system value with commercial financial sustainability. It will use the collective capabilities and assets of the three Parties, alongside external providers, education partners, industry, and other organisations, to deliver services that are better coordinated and more efficiently delivered collectively.

4.4 The business plan will continue to evolve as the Academy mobilises; however, a 3-year plan has been developed.

Area	Year One 2026/27	Year Two 2027/28	Year Three 2028/29
Governance and Operating model	Establish JV governance, operating model and Academy team	Review effectiveness and refine	Mature operating model
Training, Education and transformation	Launch priority accredited/non-accredited offer Identify and agree integrated training, transformation priorities and business to be delivered through the Academy	Grow and further integrate the offer	Extend offer regionally/nationally
Social Care Workforce	Establish engagement model, co production and priority offer for high-quality standardised training	Scale qualifications and provider participation	Embed strategic workforce offer

Careers & Pathways	Establish early-career pathways	Implement system-wide approach	Fully integrated careers offer
Innovation	Establish service model and priorities Identify and secure aligned funding streams	Expand pilots/partnerships	Scale successful innovations
Commercial Development	Establish pricing, e-commerce, marketing and pipeline	Grow external customers and partnerships	Membership/ regional /global growth
Estates	Develop commercial model and approve building programme	Prepare for occupation	Open and optimise new facility
Partnerships	FE/HE, industry, VCFSE and providers	Affiliated partner model	Regional/national /global partnerships
Finance and sustainability	Establish financial controls and income pipeline	Grow income and monitor sustainability	Mature sustainable model
Academy Workforce	Recruit/establish lean Academy team	Review capacity against growth	Mature staffing model
Benefits Realisation	Establish baselines and measures	Evaluate benefits	Demonstrate system impact

4.5 As part of the business plan expected outcome measures have been identified such as increased social care qualifications, increased utilisation of skills funding for health and care, recruitment from local communities, parity of access to high-quality facilities, recruitment especially to entry level roles and enabling transformation programmes.

5 Construction and Design

5.1 The Levelling Up Fund grant funding has been provided to Somerset Council who own the Academy site and will retain the freehold of the Academy Building at the old Bridgwater Hospital site in accordance with the conditions of the grant funding. The Council will grant a lease to Somerset NHS Foundation Trust as part of the building to facilitate the Academy for a minimum of 5 years.

5.2 In view of affordability gaps and Historic England feedback a review of the accommodation was completed with the outcome of an affordable build and a more efficient design aligned to the business plan and revenue model.

5.3 The building will have a new independent living centre, a careers hub, flexible training rooms, clinical skills and simulation space, a studio, a primary care research hub and innovation offices. Collectively this accommodation offers a unique integration of bringing together training, innovation, health technology, careers and research that is not defined by organisational boundaries but the needs of our collective health and care priorities.

5.4 Construction delivery timelines:

Activity	Start	Finish
RIBA Stage 3	July 2026	September 2026
Bat hotel/Gate House	September 2026	October 2026
Planning Submissions	September 2026	October 2026
RIBA Stage 4	September 2026	November 2026
Planning Approvals	November 2026	December 2026
Pricing	November 2026	December 2026
Enabling Works	January 2027	March 2027
Negotiations	January 2027	February 2027
Contract Award	February 2027	March 2027
Construction	March 2027	October 2028

6 Risks

6.1 The key strategic risks identified to date by the programme are as follows:

Risk Description: The scheme is not delivered on time, leading to increased costs or reputational damage. There is a risk to the Levelling Up Funding bid and timescales for capital build if agreement cannot be reached for the Heads of Terms and Statement of Intent**.**

Key existing mitigation & live actions:

- The timeframe for spending LUF monies has been extended to end March 2028 with contractual commitment by end March 2027.
- Options around design to bring the capital cost into deliverable and affordable parameters.
- Clarity of roles and responsibilities of each partner enables the next stage of mobilisation and delivery.

Risk Description: Further validation and assurance of revenue Model in response to identified cost pressures and affordability of building costs.

Key existing mitigation & live actions:

- Completed review, stress testing and validation of property rental /service charges and proposed income streams
- Heads of Terms for capital estates agreed
- Early mobilisation of training and procurement

6.2 As part of the Academy's programme management a live robust risk register is maintained with mitigations and aligned actions. Risks are shared and escalated through the governance process of the Programme Delivery Group and Joint Academy Board.

7. Financial Implications

7.1 Within the Academy workstreams there is a specific finance delivery group that has a finance team representative from the Council, ICB and Somerset NHS Foundation Trust. All Parties are working collaboratively. As part of this group the revenue model has been reviewed through several finance committees with stress testing as part of the approval process.

7.2 There is an expectation that the Academy becomes self-financing and by the first full year of operating bringing in a modest surplus that is expected to grow year on year. As part of the model Somerset NHS Foundation Trust services currently based at the leased Exchange House building in Bridgwater will relocate to the Academy building. This move is predicted to drive a £44k cost pressure property gap for SFT and partners have agreed that this pressure will be a first call on the Academy surplus.

7.3 The revenue model was reviewed at the ICBs Finance and Resources Committee on 27 August 2026 and has been part of stress testing to predict any possible future revenue impact on partners via sensitivity analysis. The revenue model has been based on a modest, and achievable predicted income.

7. 4 The revenue model is based on the commercialisation of training and partners to commit business and related income stream for the Academy to commission training and secure innovation income streams.

7.5 The revenue model will have ongoing scrutiny through the Academy governance and form part of the annual review It is expected that as the Academy embeds as a collective strategic delivery vehicle there will be increased income and partners benefiting from efficiencies of scale and integration.

8 Legal Implications

8.1 The legal implications are addressed through the Collaboration Agreement as developed and drafted with our legal partners Bevan Brittan

9 Procurement Implications

9.1 Supported by the pubic to public collaboration principles, the Academy will access internal training expertise, business intelligence, workforce planning, expertise and core governance from each partner. Where there is a gap in relevant expertise or capacity, the Academy will seek to procure activity for training and innovation. For example, accredited programmes, high demand programmes, and specialist knowledge. Consequently, the Academy will operate a hybrid procurement strategy.

9.2 In order to fulfil the ambition of the Academy to:

- Function as a training and innovation central agency function.
- Coordinate and/or commission provision.
- Broker relationships
- Procure shared and system wide training and innovation services.
- Oversee delivery and outcomes.

a procurement process has been initiated. The process is being facilitated by Somerset NHS Foundation Trust as the lead operational host with identified Lots for social care training through to future proofed Lots such as for neighbourhood health and leadership.

10. Workforce Implications

10.1 The Academy team has been established as a lean coordinating function to lead and implement the overall business model and plan. As the Academy progresses, and with the opening of the Bridgwater site, further review will be undertaken as part of the overall affordability and target operating model work.

10.2 As the lead operational host Somerset NHS Foundation Trust will be responsible for any specific employment contracts and employment responsibility. However, it is expected that staff from each of the partners and from across the system will be part of the Academy overall delivery model in order that the Academy becomes a core integrated delivery vehicle.

11 Public and Staff Engagement

11.1 The Somerset Health and Care Academy has led extensive engagement and consultation in the development of the FBC, business plan and Collaboration Agreement

The following outlines a high-level summary of this work:

- Engagement and consultation through the Academy governance and workstreams
- Involvement and engagement of the council Adult Social Care teams and senior leadership members
- Survey disseminated through Academy governance
- Somerset councillor engagement and briefings
- Engagement with education providers with a focus on Yeovil College, UCS, Exeter University and UWE, Bristol
- Partnership working with Skills for Care and Registered Care Providers Association
- Engagement with a variety of care providers across Somerset
- Mobilisation of a social care engagement group
- Communication briefings
- NHSE engagement with possible regional and global opportunities
- Engagement with DWP, skills boards and Chamber of Commerce
- Discussion with DHSC Commercial Teams for opportunities surrounding sponsorship

12 Summary and Next Steps

12.1 The Somerset Health and Care Academy offers a highly dynamic and innovative strategic delivery vehicle for our current, and future, integrated priorities and transformation, necessary to meet the needs to our workforce and communities.

12.2 The overall programme has been a complex process uniting three partners, in times of significant change, with numerous inter dependencies. Whilst the Bridgwater site will provide a focal innovative estate, the Academy will operate as a hub and spoke model with the intention to serve all of Somerset. Indeed, there are further opportunities already in plan for cluster, regional and global partnerships.

12.3 There is a strong emphasis on workforce development of social care, a core component to the future success of neighbourhood health. It is intended that the Academy will offer parity of access to training facilities, consistent high-quality training and a collective gateway for skills and innovation able to support enhanced strategic workforce planning for social care.

12.4 The Academy also has a strong driver for enabling integration of health and care through skills, career pathways and innovation. We know that going forward we need to transform health and care services so better able to prevent illness, deliver neighbourhood models of care and better utilise opportunities from technology. This context means we have a common challenge in how together we support our current workforce and create our future workforce able to respond to the necessary transformation agenda. The Academy provides a model for partners to come together with purposeful intent for collaborating and enabling our workforce to act, think, behave, lead and engage together.

12.5 Following approval of the FBC and Collaboration Agreement the next steps will be undertaken in ensuring the ongoing momentum and mobilisation:

- Ongoing marketing to ensure consistent understanding and messaging of the purpose and intent of the Somerset Health and Care Academy
- Quantification of outcome measures
- Gaining further commitment from partners for relevant business and programmes of work to be channelled through the Academy to ensure the full potential of the Academy acting as a strategic system asset is realised.
- Construction approval and sign off in March 2027 with enabling works commencing in 2026/2027.
- Implementation of the approved governance model as part of the Collaboration Agreement

Committee Summary Report

Reporting Forum	Audit Committees in common	**Meeting date**	25 June 2026
Presented to:	NHS BSW, NHS Dorset and NHS Somerset Cluster Board		

Business considered	The Audit Committees in common considered the following business: • Audit Committee Terms of Reference • Data Security and Protection Report • Single Tender Waivers/Award without Competition • Internal Audit Plans and Reports for BSW, Dorset and Somerset • Counter Fraud/Anti-Crime Service Reports for BSW, Dorset and Somerset
Decisions made	The Audit Committees in common : • Adopted the Audit Committee Terms of Reference as approved by the Board. • Approved the BSW Internal Audit Plan • Approved the Dorset Internal Audit Plan • Approved the Somerset Internal Audit Plan
Recommendations to the recipient	To note the discussion under the Data Security and Protection Report regarding Pharmacy, Optometry and Dental (POD) and specialised commissioning governance, including the requirement for assurance mapping to confirm that responsibilities sit within the remit of the appropriate committees. To note the discussion under the Dorset Internal Audit Report regarding the Better Care Fund. The Committee received some assurance, with the position to remain under review and a management plan requested.
Escalations, for consideration and action	None at this point in time
Assurances	The Audit Committees in common assured themselves, and assure the Cluster Board, that the ICBs / the cluster • have in place appropriate Internal Audit Plans for 2026/27 which covered the key areas to support the annual Head of Internal Audit Opinion alongside pre-merger readiness and compliance with closure requirements for the existing statutory body.

Committee Summary Report

Reporting Forum	Joint Strategic Finance and Resources Committee	**Meeting date**	29 June 2026
Presented to:	NHS BSW, NHS Dorset and NHS Somerset Cluster Board		

Business considered	The Joint Strategic Finance and Resources Committee considered the following business: • Procurements and Contracting Oversight Group Terms of Reference • Financial Report for the Cluster - Month 2 including Contract Position • Contract Reporting – BSW, Dorset, Somerset • Joint Capital Resource Use Plan • Collaborative Commissioning Hub M2 Finance Reports • Committee Forward Plan
Decisions made	The Joint Strategic Finance and Resources Committee approved / agreed / endorsed / supported: • Did not approve the Procurements and Contracting Oversight Group Terms of Reference, subject to further considerations with membership, reporting routes and use of consistent terminology.
Recommendations to the recipient	None at this point in time
Escalations, for consideration and action	None at this point in time
Assurances	The Joint Strategic Finance and Resources Committee assured itself, and assures the Cluster Board, that the ICBs / the cluster • have in place appropriate mechanisms for finance monitoring and reporting, with recommendations made for areas of inclusion in future monthly finance reporting.

Committee Summary Report

Reporting Forum	Joint Strategic Finance and Resources Committee	**Meeting date**	27 July 2026
Presented to:	NHS BSW, NHS Dorset and NHS Somerset Cluster Board		

Business considered	The Joint Strategic Finance and Resources Committee considered the following business: • Procurements and Contracting Oversight Group Terms of Reference • BSWSD Cluster Medium Term Plan Further Requirements Response • Financial Report for the Cluster - Month 3 • Specialised Commissioning • Investment Panel Report • Committee Forward Plan
Decisions made	The Joint Strategic Finance and Resources Committee approved / agreed / endorsed / supported: • Approved the Procurements and Contracting Oversight Group Terms of Reference to allow the group to start meeting, subject to further changes. • Endorsed the responses submitted to NHS England for the BSWSD Cluster Medium Term Plan (MTP) Further Requirements. The Committee recognised that due to timelines, Executive management agreed to submit the MTP prior to seeking Committee assurance and endorsement. The Committee requested that it endorses and supports any future MTP amendments prior to submission.
Recommendations to the recipient	None at this point in time
Escalations, for consideration and action	None at this point in time
Assurances	The Joint Strategic Finance and Resources Committee assured itself, and assures the Cluster Board, that the ICBs / the cluster • have in place appropriate mechanisms for finance monitoring and reporting, with recommendations made for areas of inclusion in future monthly finance reporting.

Committee Summary Report

Reporting Forum	Joint Strategic Finance and Resources Committee	**Meeting date**	27 August 2026
Presented to:	NHS BSW, NHS Dorset and NHS Somerset Cluster Board		

Business considered	The Joint Strategic Finance and Resources Committee considered the following business: • Somerset Health and Care Academy Full Business Case • Financial Report for the Cluster - Month 4 • Finance Strategy Including Capital • Dental Budgets and Investments 2026-27 • Collaborative Commissioning Hub M4 Reports • Procurement and Contracting Oversight Group Report • Investment Panel Report • Committee Forward Plan
Decisions made	The Joint Strategic Finance and Resources Committee approved / agreed / endorsed / supported: • Supported the Somerset Health and Care Academy Full Business Case and collaboration agreement and agreed that the proposal should proceed to the Board with a recommendation for approval.
Recommendations to the recipient	Recommendation to approve the Somerset Health and Care Academy Full Business Case and collaboration agreement following detailed scrutiny at the Committee.
Escalations, for consideration and action	None at this point in time
Assurances	The Joint Strategic Finance and Resources Committee assured itself, and assures the Cluster Board, that the ICBs / the cluster • have in place appropriate mechanisms for finance monitoring. • That the Procurement and Contracting Oversight Group had been established with work underway for contract oversight across the cluster.

Report to:	NHS BSW, Dorset & Somerset ICB Cluster Board - Meeting in Public	**Agenda item**	10.2.1
Date of Meeting:	16 September 2026		

Title of Report:	Cluster Finance Report – Month 4 2026/27
Report Author:	Scott Sealey, Cluster Deputy Chief Officer Strategic Finance and Resources
Board / Director Sponsor:	Alison Henly, Cluster Chief Officer Strategic Finance and Resources
Appendices:	N/A

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	

Previous consideration by:	Date	Please clarify the purpose
Joint Strategic Finance and Resources Committee	27 August 2026	Assurance

1 Purpose of this paper

To present to the Cluster Board the Cluster Finance Report for Month 4, which includes the position for each of the three separate ICBs - NHS BSW, NHS Dorset and NHS Somerset.

2 Summary of recommendations and any additional actions required

The Cluster Board is asked to note for assurance purposes the month 4 financial position of the cluster and each of the three separate ICBs – NHS BSW, NHS Dorset and NHS Somerset.

3	Legal/regulatory implications
All ICBs have a regulatory requirement to break even	

4	Procurement
No issues identified	
Procurement sign off	

5	Risks
In-Common BSW, Dorset and Somerset ICB Boards must ensure they deliver the planned financial position	

6	Quality and resources impact
Financial decisions are made to deliver with regard to the best possible value for service users.	
Finance sign off:	Scott Sealy

7	Confirmation of completion of Equalities and Quality Impact Assessment
Financial decisions are made with due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share in it.	

8	Communications and Engagement Considerations
No issues identified	

9	Statement on confidentiality of report
No issues identified	

Cluster Financial Position

Month 4 – July 2026

Together across NHS Bath and North East Somerset, Swindon and Wiltshire, NHS Dorset and NHS Somerset.

Cluster Financial Position – Month 4

Finance and Use of Resources

Revenue Financial Position - Surplus/(Deficit)	Year to Date (M4)			2026/27			Monthly YTD Change £'m	Net Risk Position £'m	Monthly Risk Change £'m
	Plan £'m	Actual £'m	Variance £'m	Plan £'m	Forecast £'m	Variance £'m			
NHS BSW ICB	778.2	778.2	0.0	2,324.0	2,324.0	0.0	0.0	(18.5)	(8.5)
NHS Dorset ICB	719.1	719.1	0.0	2,136.9	2,136.9	0.0	0.0	(11.6)	(7.8)
NHS Somerset ICB	1,080.2	1,080.2	0.0	3,286.8	3,286.8	0.0	0.0	(15.0)	(5.6)
Cluster	**2,577.5**	**2,577.5**	**0.0**	**7,747.7**	**7,747.7**	**0.0**	**0.0**	**(45.1)**	**(21.9)**
Cluster NHS Providers - Variance	**(29.7)**	**(46.6)**	**(16.9)**	**0.5**	**0.5**	**0.0**	**(7.2)**		

Savings Programme	Year to Date (M4)			2026/27			Monthly YTD Change £'m
	Plan £'m	Actual £'m	Variance £'m	Plan £'m	Forecast £'m	Variance £'m	
Cluster	67.8	64.9	(2.9)	207.4	207.4	0.0	(0.7)
Of which: Recurrent	*56.6*	*55.7*	*(0.9)*	*173.7*	*173.7*	*(0.0)*	*(0.2)*

Summary

- At Month 4, all cluster ICB's have a breakeven year-to-date position and are forecasting to deliver a balanced outturn position this financial year.
- Across the cluster there are year to date pressures highlighted against Continuing Care (£7.1m - net of LD), GP Prescribing driven by No Cheaper Stock Obtainable (NCSO) Price Concessions (£5.3m) and ADHD/ASD right to choose assessments (£1.0m).
- The latest reported net risk position is £45.1m – a deterioration £21.9m this month driven by unmitigated NCSO Prescribing pressures not included in our forecast outturn position. There is no mitigation of national funding included against the Prescribing NCSO risk pressure at Month 4.
- There is a year-to-date shortfall of £2.9m included against the cluster Savings Programme at Month 4, however the total savings are forecasted in line with plan.
- NHS Providers within the cluster currently have an adverse year-to-date position of £16.9m driven by shortfalls in planned savings and operational pressures – this position is a further deterioration of £7.2m this month due to adverse in-month deterioration against GWH (£4.3m) and RUH (£2.9m).

Cluster ICB Workforce – Month 4

Month	4

	M01	M02	M03	M04	25/26 M12	YTD M04	Variance
Nurse	179.72	169.96	166.96	164.16	217.20	164.16	(53.04)
Admin	777.23	666.92	669.33	647.49	833.61	647.49	(186.12)
Contracted WTE	**956.95**	**836.88**	**836.29**	**811.65**	**1,050.81**	**811.65**	**(239.16)**
Nurse	172.42	164.61	163.02	156.81	200.41	156.81	(43.60)
Admin	738.50	653.52	656.32	626.78	823.11	626.78	(196.33)
Worked WTE	**910.92**	**818.13**	**819.35**	**783.59**	**1,023.52**	**783.59**	**(239.93)**
Agency	22.09	23.09	23.09	23.09	6.49	23.09	16.60
Secondments Out	(6.83)	(6.83)	(6.83)	(6.83)	(8.33)	(6.83)	1.50
Secondments In	11.56	11.56	10.56	10.56	4.85	10.56	5.71
Total	26.82	27.82	26.82	26.82	3.01	26.82	23.81
Total	**937.74**	**845.95**	**846.17**	**810.41**	**1,026.53**	**810.41**	**(216.12)**

The consolidated ICB workforce across the cluster stands at 810 WTE at Month 4. This is a reduction of 216 WTE this financial year.

A projection has been included this month, to show the tapering of the WTE across the remainder of this financial year aligning to the target WTE of the final cluster structure (634 WTE) from Q4.

WTE projection

	YTD actual WTE				WTE projection						
	M01	M02	M03	M04	M05	M06	M07	M09	M10	M11	M12
Total cluster WTE	**937.74**	**845.95**	**846.17**	**810.41**	**733.52**	**684.53**	**674.27**	**668.07**	**634.00**	**634.00**	**634.00**

*Main cohort of VR2 leavers in M05 (August) and M06 (September)

* Projection assumes exit by all leavers (VR and CR) by 31st December 2026

Cluster Risks and Mitigations – Month 4

The cluster has a deficit net risk position of £45.1m at Month 4. This position has deteriorated by £21.9m this month.

This adverse in-month movement is driven by the inclusion of full-year Prescribing NCSO risks for BSW (£8.5m) and Dorset (£7.6m), and the removal of mitigating income for Somerset (£5.6m).

The cluster has a CHC risk of £10.0m, in additional to the year-to-date deficit of £7.1m (net of LD) at Month 4.

The cluster continues to hold significant risks against its Savings Programme (£12.5m) and Cost of Change restructure (£9.8m).

Risks and Mitigations 2026/27	Cluster £'m	RAG	Monthly Change £'000
Risks			
Continuing Healthcare / PHC	(10.0)	R	0.0
Prescribing	(21.7)	R	(16.1)
NHS 111 & Out of Hours	(1.2)	R	0.0
Other Risk (Cost Risk, CSU, Weight Management)	(2.1)	R	(0.3)
Savings Programme	(12.5)	A	0.0
ICB Cost of Change	(9.8)	A	0.0
Elective Care Programme	(7.7)	A	(3.2)
NHS Contract - UEC	(3.0)	A	0.0
Community Contract - HCRG	(2.5)	A	0.0
Winter	(0.6)	A	0.4
Home Office	(1.0)	A	0.0
Total Risks	**(72.1)**		**(19.3)**
Mitigations			
N/R Investment Reserve / Transformation Fund	8.0	G	0.0
Contingency	5.1	G	(0.4)
Partial mitigation of N/R transition stranded costs	3.0	G	0.0
Other Mitigations (Out of Area IAPs, Weight Management)	3.8	G	3.4
PHC continuation of eligibility and package reviews	6.0	R	0.0
ISP demand management programme	1.2	R	0.0
National Funding for NCSO costs	0.0	R	(5.6)
Total Mitigations	**27.1**		**(2.6)**
Net Risk Position	**(45.1)**		**(21.9)**

Committee Summary Report

Reporting Forum	Joint Population Health and Commissioning Committee	**Meeting date**	Wednesday 10th June 2026
Presented to:	Cluster Board (Monday 15th June)		

Business considered	The Joint Population Health and Commissioning Committee considered the following business: • Terms of Reference for the Joint Population Health and Commissioning Committee • Performance Reporting • Population Health Forward Planning • Place Highlight Report • Cluster ICB Strategic Ambitions Submission
Decisions made	The Joint Population Health and Commissioning Committee: • Adopted the Committee Terms of Reference • Noted the Performance Reporting plans • Noted the Population Health Forward Planning • Noted the Place Highlight Report • Supported the Cluster ICB Strategic Ambitions Submission
Recommendations to the recipient	
Escalations, for consideration and action	No items identified for escalation.
Assurances	The Joint Population Health and Commissioning Committee assured itself that reporting would be streamlined into the Committee with the utilisation of the sub groups.

Committee Summary Report

Reporting Forum	Joint Population Health and Commissioning Committee	**Meeting date**	Friday 4th September 2026
Presented to:	Cluster Board		

Business considered	The **Joint Population Health and Commissioning Committee** considered the following business: • Update on Performance Reporting • Contract Oversight Group Exception Report • Update on Population Health Forward Plan • Place Highlight Report • Commissioning Intentions 2027/28 • Performance and Delivery Governance • Cluster Interim Decommissioning Policy
Decisions made	The **Joint Population Health and Commissioning Committee**: • Supported the proposed Cluster Performance Framework. • Population Health Forward Plan – Endorsed the proposed approach to the Integrated Needs Assessment. • Commissioning Intentions 2027/28 – Endorsed the proposed approach and next steps. • Cluster Interim Decommissioning Policy – Endorsed.
Recommendations to the recipient	None at this point in time
Escalations, for consideration and action	None at this point in time
Assurances	The **Joint Population Health and Commissioning Committee** assured itself that • Escalation processes are in place for performance and delivery issues. • Development of the Cluster Performance Framework is being supported through existing oversight arrangements. • Contract, procurement and contract performance oversight continues through established governance structures. The Committee seeks confirmation as to the reporting arrangements between the committees.

Committee Summary Report

Reporting Forum	Joint Quality and Population Engagement Committee	**Meeting date**	Wednesday 17th June 2026
Presented to:	Cluster Board Business Meeting – 16th July		

Business considered	The Joint Quality and Population Engagement Committee considered the following business: • Committee Terms of Reference • Committee Work Plan • Cluster Quality Reports • Cluster SQG Reports • Annual Reports and Additional meetings • Parliamentary Health Service Ombudsman • Mortality and Learning from Deaths • Regional Quality Update
Decisions made	The Joint Quality and Population Engagement Committee: • **Terms of Reference:** adopted and implemented, with Place Non-Executive Directors joining from July. • **Work Plan:** Agreed as a strong framework, with further refinement to improve structure, alignment and focus on key priorities. • **Quality Reports:** Received and supported, with move towards greater consistency and key risks identified across BSW, Dorset and Somerset. • **HCRG Contract & Risks:** Concerns noted on delivery and oversight; action agreed to strengthen scrutiny and address system pressures. • **SQG Reporting:** Standardisation agreed and key escalations noted, with locality groups retained for oversight. • **Annual Reports:** New approach agreed to strengthen Board engagement and oversight through dedicated sessions. • **Population Engagement:** Broader, more proactive approach agreed with improved insight and alignment of engagement functions. • **Parliamentary Health Service Ombudsman:** No fault findings noted and no open cases. • **Mortality:** Ongoing analysis supported, with plans to strengthen system-wide oversight. • **Escalations:** Key system quality risks raised to the Cluster Board, including GP services, digital governance and pathway challenges. • **Regional Update:** Strengthened regional oversight noted, with focus on improving stroke and Parkinson's care.
Recommendations to the recipient	The Joint Quality and Population Engagement recommend • Strengthen oversight and scrutiny of high-risk contracts, particularly HCRG.

	• To refine the committee work plan to improve alignment, structure and focus on priorities. • Standardise quality reporting (using the Somerset model) to support consistency and escalation. • Improve assurance through clearer evidence of quality and patient experience outcomes. • Enhance digital clinical governance and safety oversight across the system. • Broaden population engagement beyond PALS/complaints to include wider insight and proactive planning. • Strengthen partnership working and regional collaboration to support quality improvement.
Escalations, for consideration and action	• Concerns escalated on GP services in Dorset, including criteria to reside and HCRG-related issues. • Ongoing pressures in Somerset highlighted, particularly in patient transport, maternity and paediatric services. • Wider system risks raised, including digital clinical governance and primary secondary care interface challenges impacting quality and flow.
Assurances	The Joint Quality and Population Engagement Committee assured itself that • The committee is assured that quality risks are being identified, escalated and monitored through clear governance and reporting processes. • Assurance was provided that if oversight is strengthening, particularly in high-risk areas such as contracts, digital safety and system pressures. • The committee is assured that learning, improvement actions and good practice are being captured and shared across the cluster.

Committee Summary Report

Reporting Forum	Joint Quality and Population Engagement Committee	**Meeting date**	24 August 2026
Presented to:	NHS BSW, NHS Dorset and NHS Somerset Cluster Board - 16 September 2026		

Business considered	The Joint Quality and Population Engagement Committee considered the following business: • Winter Planning 2026-27 expectations and assurance update • Cluster Quality and Patient Safety report • Summary report from the local System Quality Groups and escalations to the Regional Quality Group • Local Maternity and Neonatal System Quality update • Learning from Lives and Deaths (Learning Disabilities and Autism) update. The Committee noted disparity in the LeDer reviews and requested that an update on proposed actions be presented to the next committee meeting. • Medicines Management and Optimisation update • Population Engagement discussion and future reporting requirements • Committee Forward Plan
Decisions made	There were no items for decision at this meeting.
Recommendations to the recipient	No recommendations to be made to the Cluster Board at this time.
Escalations, for consideration and action	The population engagement discussion had highlighted the need for a strengthened communications and engagement link with the Population Health and Commissioning Committee. (Member of the Communication and Engagement Team to attend PH&C Committee going forwards). The Committee felt there was a need for greater clarity on committee responsibilities given the breadth of population engagement - this is escalated to the Board to consider.

Assurances	The Joint Quality and Population Engagement Committee assured itself, and assures the Cluster Board that: • The Cluster is actively developing its Cluster Winter Plan for 2026-27, in line with the required submission timeline and NHS England expectations, with partners actively involved in the planning process. The Winter Plan and Board Assurance Statement would be presented to the ICBs Boards in Common meeting scheduled for 25 September 2026 for sign off. • Robust quality and patient safety reporting is in place for the Cluster, with a single comprehensive report developed for the Committee for assurance purposes. This will ensure the Committee is sighted on emerging issues in a timely manner.