

BSW, Dorset and Somerset ICBs Boards in Common - Meeting in Public



Friday 25 September 2026, 14:00 - 15:00

Virtual via Teams

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

Agenda

- 14:00 - 14:05
5 min

1. Formalities

1.1. Welcome, apologies and quorum

VerbalChair

1.2. Declarations of Interest

VerbalChair

1.3. Minutes of Recent In-Common BSW, Dorset, and Somerset Board Meetings

Enclosures for approvalChair

(a) Minutes of the In Common BSW Dorset and Somerset Board meeting held on 11 May 2026

- for approval by BSW ICB, Dorset ICB and Somerset ICB Boards

01.3. In Common BSW Dorset and Somerset Board draft minutes 110526 v1.pdf (7 pages)

1.4. Action Tracker

Enclosures for reviewChair

01.4. Action Tracker 250926.pdf (1 pages)
- 14:05 - 14:10
5 min

2. Questions from the Public

Verbal

No questions raised in advance of the meeting
- ## Standing Items
- ## Items for Decision
- 14:10 - 14:30
20 min

3. 2026-27 Cluster Winter Plan

DecisionShelagh Meldrum

03. 2026-27 Cluster Winter Plan Board 250926.pdf (8 pages)

03. x Appendix 1 Cluster ICB Winter Plan 2026-2027 FINAL 250926.pdf (31 pages)

14:30 - 14:40 4. Cluster Standards of Business Conduct Policy

10 min

Decision Alison Henly, Anett Loescher

 04a. Standards of Business Conduct Policy_coversheet.pdf (3 pages)

 04b. Standards of Business Conduct Policy v1.pdf (36 pages)

14:40 - 14:55 5. ICB to ICB Delegation Agreement

15 min

Decision Anett Loescher

 05a. ICB-to-ICB Delegation Agreement_coversheet.pdf (3 pages)

 05b. ICB-to-ICB Delegation Agreement.pdf (20 pages)

Items for Noting/Assurance/Discussion (there are no items)

Closing Items

14:55 - 14:55 6. Any Other Business

0 min

Verbal Chair

14:55 - 14:55 7. Date and Time of next meeting

0 min

Verbal Chair

In light of the new cluster governance arrangements, future meetings will be held as required and will be notified accordingly on respective ICB websites.

Lower Steph
23/09/2026 14:16:08

Minutes of the In-Common BSW, Dorset and Somerset ICB Boards meeting

11 May 2026, 9.30am

Virtual Meeting – held via MS Teams

Members present:

ICB Cluster	Name
Cluster Chair	Rob Whiteman
Cluster Chief Executive	Jonathan Higman
Cluster Non-Executive Director/Deputy Chair	Ade Williams
Cluster Non-Executive Director	Christopher Foster
Cluster Non-Executive Director	Caroline Gamlin
Cluster Non-Executive Director	Suzannah Power
Cluster Non-Executive Director	Adrian White
Cluster Non-Executive Director	Dan Worsley
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

BSW ICB	Name
BSW ICB Primary Care Partner Member	Francis Campbell
BSW ICB NHS Foundation Trust Partner Member (nominated deputy)	Lisa Thomas (Managing Director of Great Western Hospitals NHS Foundation Trust)
BSW ICB Local Authority Partner Member	Cllr Lesley Mansell

Dorset ICB	Name
Dorset ICB Primary Care Partner Member	Forbes Watson

Somerset ICB	Name
Somerset ICB Primary Care Partner Member	Rebecca Duffy
Somerset ICB Local Authority Partner Member	Duncan Sharkey

Attending:

BSW ICB - In attendance, non-voting:	
Associate Director of Governance, Compliance & Risk	Anett Loscher

Dorset ICB - In attendance, non-voting:	
Dorset ICB Deputy Head of Corporate Governance (minutes)	Steph Lower

Apologies:

BSW ICB	Name
BSW ICB NHS Foundation Trust Partner Member	Cara Charles-Barks

Dorset ICB	Name
No apologies.	

Somerset ICB	Name
Somerset ICB NHS Foundation Trust Partner Member	Peter Lewis

ICBinC
26/001

Welcome, apologies and quorum

The Chair welcomed all to the In-Common BSW ICB, Dorset ICB and Somerset ICB Boards meeting. Each Board would remain autonomous.

The BSW ICB, Dorset ICB, and Somerset ICB Boards were each declared quorate. The above apologies were noted.

ICBinC
26/002

Conflicts of Interest

Each ICB held a register of interests for all staff and committee members.

The Chair declared the following changes in interests and would provide confirmation to the corporate governance team accordingly:-

- stood down as Chair of the Housing and Finance Institute
- appointed Lead non-Executive Director at the Ministry of Justice (effective 4 May 2026).

Action: Chair

No other declarations were received.

ICBinC
26/003

Minutes

The minutes of the public BSW Board held on 18 March 2026 were agreed as a true and accurate record by BSW Board members present.

The minutes of the Part 1 Dorset Board held on 12 March 2026 were agreed as a true and accurate record by Dorset Board members present.

The minutes of the Part A Somerset Board held on 26 March 2026 were agreed as a true and accurate record by Somerset Board members present.

Lower Steph
23/09/2026 14:04:52

Resolved: the minutes of the public BSW Board held on 18 March, the minutes of the Part 1 Dorset Board held on 12 March 2026, and the minutes of the Part A Somerset Board held on 26 March 2026 were approved.

ICBinC
26/004

Action Logs

The action log of the public BSW Board held on 18 March 2026 was considered, and approval was given by BSW Board members present for the removal of completed items.

The action log of the Part 1 Dorset Board held on 12 March 2026 was considered, and approval was given by Dorset Board members present for the removal of completed items.

The action log of the Part A Somerset Board held on 26 March 2026 was considered, and approval was given by Somerset Board members present for the removal of completed items.

In relation to the local authority and Director of Public Health (DPH) representation action, the Chief Executive advised that whilst there would not be an additional DPH member role, live discussions continued and it was anticipated that Alison Bell, DPH for Somerset would represent Somerset Council on the Cluster Board but not on behalf of all DPHs. Board papers would be shared with all six DPHs in advance to enable comments to be fed into the Board.

Resolved: the action log of the public BSW Board held on 18 March, the action log of the Part 1 Dorset Board held on 12 March 2026, and the action log of the Part A Somerset Board held on 26 March 2026 were considered and approval was given for the removal of completed items.

ICBinC
26/005

Cluster Chair's Update

The Cluster Chair noted this was the first In-Common BSW, Dorset and Somerset Boards meeting and due to the nature of the meeting to approve the governance arrangements to enable the organisations to move forward as a cluster, there would not be a public questions item. However public questions would be taken at the inaugural meeting of the Cluster Board due to be held on 15 June 2026.

The Chair welcomed the appointment of Dame Gill Morgan DBE as the NHS England South West Regional Chair.

Resolved: The BSW, Dorset and Somerset ICB Boards noted the update.

ICBinC
26/006

Cluster Chief Executive Officer's Report

The Cluster Chief Executive presented his report and invited feedback on the revised format (national, cluster and place).

Key points to note included:-

- Work was underway to respond to the Sir Jim Mackey letter regarding how the cluster intended to enhance and augment its plans to deliver its

ambitions, particularly in relation to strategic commissioning in delivery of the three shifts and wider NHS strategy.

The recent Board Development session discussed the cluster ambitions which included priorities such as neighbourhood health and frailty. The discussions would be used to help shape the system response, aligning with national frameworks and guidance.

There was optimism there was the right content to articulate an ambitious set of plans, however there would be stages to get through to enable confidence in the deliverability.

- The Board noted the upcoming visit by Dr Claire Fuller, NHS England Medical Director to Somerset as part of a national stocktake on neighbourhood health, with a wider cluster visit expected in June. The visits would help frame consistency across the cluster.
- There was no immediate resolution expected in relation to the ongoing BMA industrial action and planning continued accordingly.
- The Transition Committee had oversight of the organisational transition and following discussion, it was agreed that a structured update be brought back to the Transition Committee covering transition assurance, including continuity of statutory obligations and key non-people dependencies as staff departed under the voluntary redundancy arrangements.

Action : CEO

The staff consultation on the proposed structures had closed and the executive team was reviewing the themes and specifics from the extensive feedback received. It remained a difficult time for staff and significant well-being and support measures were in place. Looking ahead, building the new organisation from an organisational development (OD) perspective was critical and the Boards offered their support on the OD plan being drafted for the new organisation to set a positive environment on the back of the present unsettling period.

- A future Cluster Board item was agreed to set out the strategy for neighbourhood development across the cluster and as part of this to take into account the learning from the neighbourhood health pilots (Frome and Mendip and Weymouth and Portland) and associated national visits/insights. The national team had stated no further funding would be available after the pilots ended and consideration would need to be given to the associated challenges of no further funding.

Action: CEO/Place Directors

- In relation to the NHS England regional response letters to each ICB within the cluster following submission of the final medium term plans for 2026-27 – 2028-29, clarity was requested on assurance against compliance with the conditions set out in the letters. It was agreed these would be taken through the committees (Strategic Finance and Resources and/or the

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23/09/2026 14:04:52

Commissioning Committee as appropriate) to report progress and provide assurance.

- Following a query regarding how material disagreements (including those raised with the region) could be surfaced between the strategic commissioner and providers, material financial risks would be taken through the Joint Strategic Finance and Resources Committee with commissioning impacts considered through the Joint Commissioning and Population Health Committee. Cross representation between committees would support this. Alongside this there were a number of regular individual ICB and cluster Chief Finance Officer meetings to discuss the financial position and drivers for each organisation and regular contract discussions.
- Regarding place governance/delegations, a discussion paper would be brought back to a future Cluster Board consolidating the place governance arrangements and proposals for delegation to the six places. This would then test whether a working group was needed to assist with the work.

Action: CEO

Resolved: The BSW, Dorset and Somerset ICB Boards noted the CEO update.

Items for Decision

**ICBinC
26/007**

Governance Arrangements

The BSW ICB Associate Director of Governance, Compliance and Risk introduced the report on Governance Arrangements.

Key points to note included:-

- the three ICBs remained sovereign corporate entities until merger and therefore must each retain a Board and not form a single joint Board. Whilst the individual Boards could delegate functions, they would remain accountable and would be required to produce individual annual reports and accounts at the end of the financial year.
- the ICB Boards would form a joint committee – the Cluster Board – and delegate the majority of their responsibilities and powers to that Cluster Board. The ICB Boards would meet only to transact the business they could not delegate.
- whilst the three ICBs remained sovereign corporate entities, they must each retain an Audit Committee and must not form a single joint Audit Committee. Therefore, the Audit Committees would meet in-common and consider the ICBs' business in the round.
- The proposed joint Remuneration Committee Terms of Reference were approved by the individual Boards in March 2026.
- The remaining committees would become joint committees with membership aimed to facilitate cross-representation.
- The Functions and Decisions map included in the pack provided a visual of the governance arrangements and the flow of accountability.

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23/09/2026 14:04:52

- If approved, the Boards would be approving the decision-making and accountability framework for the cluster, and all previous committees of the Boards would be disbanded.

D Sharkey left the meeting.

4(a) Scheme of Reservation and Delegation (SoRD)

There was no feedback received on the proposed SoRD.

4(b) – Standing Financial Instructions (SFIs)

The wording on minimising financial loss/value for money and the importance of contract pipeline/end of contract management was highlighted. It was confirmed that these would be considered through committee oversight (including counter fraud and potential contract oversight group arrangements) and consideration would be given to how to feed the above into the relevant terms of reference.

Action: A Henly/A Loscher

The delegation limits had been set relatively high recognising the size of the cluster and there was a need to ensure the tolerances were right for Board involvement in strategic decisions. It was suggested this could be reviewed by the Audit Committee.

It was noted the £10M threshold relating to the whole-life contract value may require review as longer contracts were used.

4(c) - Terms of Reference

Assurance was given regarding the flexibility to review the Terms of Reference as the committees learned what worked. It was recommended committees have a standing item on their agenda to provide tangible reasons to amend the Terms of Reference.

Confirmation was given that the Terms of Reference allowed for Chairs to invite attendees/observers to any meeting.

4(d) Functions and Decisions Map

There was no feedback on the proposed Functions and Decisions Map.

Conclusion

The Boards of NHS BSW, Dorset and Somerset ICBs approved Items 4(a) to 4(d) subject to the minor points raised above in relation to the SFIs and Terms of Reference.

Appointment of Deputy Chair

The Boards of NHS BSW, Dorset and Somerset ICBs approved the appointment of Ade Williams as the Deputy Chair.

Resolved: the Boards of NHS BSW, Dorset and Somerset ICBs approved the following subject to the minor points raised in relation to the SFIs and Terms of Reference:

- (a) Scheme of Reservation and Delegation (SoRD)**
- (b) Standing Financial Instructions(SFIs)**
- (c) Cluster Committees – Terms of Reference**
- (d) Functions and Decisions Map**
- (e) Appointment of the Deputy Chair**

Items for Noting/Assurance/Discussion

There were no items.

Closing Items

**ICBinC
26/008**

Any Other Business

There was no other business.

**ICBinC
26/009**

Key Messages and Review of Part 1 meeting

The Chair gave thanks to all for their contributions and recognised the business of meeting would enable mobilisation of the cluster governance.

**ICBinC
26/010**

Date and Time of next meeting

Future meetings would be held as required and would be notified accordingly on respective ICB websites.

Lower Steph
23/09/2026 14:04:52

In-Common BSW Dorset and Somerset ICB Board - Action Tracker

Updated following meeting on

11-May-26

Action number	Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
001	11/05/2026	ICBinC26/002	Chair to provide confirmation of changes in interests to the corporate governance team.	Chair	Chair has updated his changes in interests to the corporate governance team.	Closed	22/05/26
002	11/05/2026	ICBinC26/006	Structured update be brought back to the Transition Committee covering transition assurance, incl continuity of statutory obligations and key non-people dependencies as staff depart under VR.	CEO	Transition Committee given assurance documentation.	Closed	01/09/26
003	11/05/2026	ICBinC26/006	Future Cluster Board item to set out the strategy for neighbourhood development across the cluster including the learning from the pilot work in Dorset and Somerset along with the associated national visits/insights.	CEO/Place Directors	Added to the cluster board forward planner for the October Development Session and the November formal business meeting.	Open	TBC
004	11/05/2026	ICBinC26/006	Future Cluster Board discussion paper consolidating the place governance arrangements and proposals for delegation to the six places.	CEO/Place Directors	Added to the cluster board forward planner for July, August and September - date TBC.	Open	TBC
005	11/05/2026	ICBinC26/007	Committee Terms of Reference to be updated accordingly.	Alison Henly/Anett Loscher	Completed - updated Committee Terms of Reference now on each ICB's website.	Closed	May 2026

Lower: Steph
23/09/2026 14:04:56

Report to:	In-Common BSW, Dorset and Somerset ICBs Boards	Agenda item	3
Date of Meeting:	25 September 2026		

Title of Report:	Cluster Winter Plan
Report Author:	Emma Hallewell, Planning Lead
Board / Director Sponsor:	Shelagh Meldrum, Chief Nursing Officer
Appendices:	Appendix 1 – Cluster Winter Plan 2026/27 Appendix 2 – Winter Board Assurance Statements

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

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

Previous consideration by:	Date	Please clarify the purpose
Chief Nursing Officer, Shelagh Meldrum	22.09.2026	Approved
Executive Management Group	22.09.2026	Approved
Post-stress Test Winter Planning Meeting	21.09.2026	Final plan discussed with recommendations and additions from the group
Executive Management Group	08.09.2026	Members were presented with 1 st iteration / draft winter plan and an outline of next steps.
Executive Management Group	25.08.2026	Members were provided with an update on the approach to 2026/27 winter planning including: • Summary of the national planning expectations • Overview of cluster wide approach • Key milestones and timelines

1 Purpose of this paper

The purpose of this paper is to present the Board with the final Cluster Winter Plan for 2026/27. The paper seeks to:

- Provide assurance and the level of maturity on the cluster programmes and interventions in place to manage winter pressures.
- Review the ICB Board Assurance Statements & checklist alongside the Winter Plan to enable sign off the documents in readiness for submission to NHS England.
- Highlight any gaps in assurance, emerging risks and mitigations.

Key Messages

- The principal risk to winter resilience remains sustained acute occupancy driven by discharge delays, No Criteria to Reside (NCTR) performance and community capacity constraints.
- Prevention and admission avoidance programmes will help moderate avoidable demand, particularly amongst high-risk cohorts and vulnerable populations.
- Winter success will ultimately depend on improvements in patient flow through delivery of NCTR reduction trajectories, discharge productivity improvements and sufficient community capacity.
- Residual risks remain in acute flow, Pathway 1 capacity, Pathway 2 and 3 capacity and workforce resilience

2 Summary of recommendations and any additional actions required

The Boards are asked to:

- Review** the Winter Plan and associated Appendices, and
- Discuss** and **Approve** the Board Assurance Statements for submission to NHS England on the 30 September 2026.

3 Legal/regulatory implications

The ICB has a statutory duty to prepare a Winter Plan in line with national guidance.

4 Procurement

No procurement considerations at this stage of the process.

P&C Name

P&C Signature

5 Risks

Winter Planning risks have been assessed and identified against national planning requirements, the Urgent and Emergency Care recovery letter and against the board assurance statements (BAS) and checklist. A summary of risks can be found in **Appendix 1**.

6 Quality and resources impact

NHS England has confirmed that there will be no additional financial resource for Winter Planning. At this stage, plans have not articulated any funding requirements.

Finance sign off:

7	Confirmation of completion of Equalities and Quality Impact Assessment
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An EQIA has been developed to support the Cluster Winter Plan 2026/27 and assesses the potential impact of planned interventions
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8	Communications and Engagement Considerations
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The Cluster Winter Plan has been developed through active engagement with system partners across each Place, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues. The plan is supported by a cluster wide escalation communication plan which includes a range of assets to support system resilience throughout the winter period.

9	Statement on confidentiality of report
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N/A

2026-27 Winter Planning Update

1. Introduction

1.1. The purpose of this paper is to present the Boards with the final 2026/27 Cluster Winter Plan and seeks to:

- Provide assurance on the actions, programmes and interventions in place to manage winter pressures and to demonstrate level of preparedness in line with the NHS England (NHS E) winter planning requirements.
- Provide assurance against Board Assurance Statements (BAS) and checklists with a view to finalising and signing off in readiness for submission to NHSE.
- Identify and assess the key risks and mitigations for winter resilience, highlighting where programmes are mature and where further development is required.
- Set out the next steps and actions necessary to maintain patient safety, system resilience and effective delivery of Urgent and Emergency Care (UEC) throughout the winter period.

2. Approach to Planning & Signing Off of Board Assurance Statements

- 2.1. The Cluster ICB Winter Plan 2026/27 can be seen in **Appendix 1**. It sets out the cluster-wide approach to managing winter pressures across BSW, Dorset and Somerset. It aligns with national UEC recovery requirements and focuses on prevention, reducing avoidable admissions, improving patient flow, maintaining operational resilience and delivering safe care throughout winter 2026/27.
- 2.2. The Cluster Winter Plan 2026/27 presents a Winter Readiness Risk-Assessment which aligns to the UEC recovery letter and NHSE winter planning expectations outlined in the BAS (**Appendix 2**) and checklist and aims to provide assurance against the BAS and identify risks in programme development and maturity.
- 2.3. It is recommended that the Board use the BAS cross-reference checklist to review the relevant evidence and supporting documents to agree on and support approval of the BAS. The ICB BAS has been cross referenced with Provider Trust Board BAS and where confidence levels are not aligned Board are asked to agree the ICB position.
- 2.4. The plans have been developed collaboratively with place leads and system partners and informed by lessons learned from Winter 2025/26. The plan is supported by an EQIA.
- 2.5. To further support the BAS and delivery of the winter plan, several cluster-wide programmes are being implemented and include:
- Vaccination Programme.
 - Infection Prevention and Control.
 - System Coordination and Resilience.
 - Communication Plan.
- 2.6. Following presentation of the plan at Executive Management Group on 8 September, the plan has been revised and consolidated to present a Winter Readiness Risk-Assessment which aligns to the UEC recovery letter and the BAS and checklist – (**Appendix 2**).

- 2.7. The approach to the risk assessment works on the assumption that prevention underpins system resilience and then focuses on three key areas of delivery which are:
- Compliance with UEC Recovery Requirements.
 - Demand Management and Admission Avoidance.
 - System Flow and NCTR.
- 2.8. Demand and capacity modelling remains an area of developing maturity, limiting our ability to quantify the impact of winter interventions against forecast demand and demonstrate whether planned capacity is sufficient. Greater clarity is required on intervention-level impact measures, expected benefits and how these will be monitored through winter to identify residual gaps and inform escalation.
- 2.9. Whilst Cluster wide demand and capacity analysis is a developing area of work planning assumptions are based on demand forecasts for all six main acute providers across the cluster, UEC demand analysis and local intelligence.
- 2.10. The plan will remain a live document and will continually be developed and adapted as we move closer to and through winter.
- 2.11. A suite of metrics will be used to monitor delivery of the plan and will reflect both UEC performance and prevention initiatives. In the short term the plan will be monitored through a combination of the DiiS system visibility dashboards and SHREWD. A task-and-finish group will continue to develop Cluster wide dashboards that reflect both seasonal demand and preventative community / neighbourhood initiatives which aim to reduce the impact of seasonal pressures.
- 2.12. UEC Delivery groups will meet monthly (increasing in frequency as pathway risks increase) to understand the drivers of urgent care demand. These meetings will generate live recommendations for pathway and service adjustments. In addition, a series of winter plan touchpoint meetings have been scheduled to monitor delivery of the plans at place.

3. Cluster ICB Winter Plan 2026/27

- 3.1. The plan demonstrates reasonable assurance in prevention, admission avoidance, vaccination, discharge improvement programmes and system oversight. However, the main residual risk is the interdependency between acute flow, discharge performance, community capacity and workforce availability.
- 3.2. If demand exceeds forecasts or community discharge capacity does not keep pace, the system is likely to experience worsening occupancy, increased ambulance delays, more corridor care and deterioration in performance against winter standards.
- 3.3. The key risks around winter readiness across each place are presented within the plan and include:
- Acute occupancy / NCTR.
 - Ambulance handovers & Corridor Care - numerous interdependencies impacting flow and occupancy, compounded by the removal of Hospital Ambulance Liaison Officers (HALOs).
 - Pathway 1 Capacity.
 - Pathway 2/3 discharge capacity.
 - Workforce Resilience.

- 3.4. The greatest residual risk remains pressure within the acute care pathway, particularly where delays in discharge and community capacity constraints lead to sustained high occupancy and reduced system flow.
- 3.5. Overall, there is reasonable assurance across the plans that appropriate winter planning arrangements are in place to support system resilience. Planning is aligned to national requirements and includes established governance, escalation processes, surge planning, and regular performance oversight.
- 3.6. Several risks and dependencies remain, and it is recognised that further work is required to strengthen assurance around developing initiatives and programmes. While the fundamental planning arrangements are established, assurance is reduced by ongoing dependencies relating to acute flow, discharge capacity and workforce resilience.

Residual Risks against Winter Initiatives and Assurance

- 3.7. High acute occupancy and NCTR remain the single most significant operational risk largely due to persistent high occupancy and insufficient community capacity. This impacts on ambulance handovers and our ability to eliminate corridor care, further increasing risk.
- 3.8. Capacity within Pathway 1 remains vulnerable due to increasing demand, limited domiciliary care capacity, and homecare market constraints.
- 3.9. Pathway 2 & 3 discharge capacity has been identified as a risk with place leads citing social care workforce and patient complexity as the main contributory factors.
- 3.10. Finally, workforce availability across health, community and social care services remains a cross-cutting risk impacting winter resilience.

Identified Gaps from Risk Assessment and Stress Test Event

- 3.11. Each place has carried out a risk assessment to understand levels of confidence and provide assurance against the UEC Recovery letter and BAS. The following risk assessment has been carried out against three broad delivery areas;
 - Compliance with UEC Recovery Requirements.
 - Demand Management and Admission Avoidance.
 - System Flow and NCTR Reduction.
- 3.12. The RAG ratings represent an assessment of the level of assurance, confidence and programme maturity against the BAS, rather than an assessment of delivery risk.
- 3.13. On 16 September 2026 NHSE held an event to stress test ICB and provider plans. This largely validated the key risks and dependencies already identified within place and cluster plans, whilst identifying several areas requiring further development ahead of winter:
 - **Children and Young People's (CYP) Winter Preparedness**-no clear evidence of a comprehensive CYP winter resilience approach.
 - **Mental Health Integration**-mental health pathways require stronger integration into winter escalation arrangements and operational planning.
 - **Workforce Mutual Aid**-mutual aid arrangements, NHS Passport processes and workforce surge plans need further testing.

- **Community and Care Home Escalation**-escalation arrangements for care homes, virtual wards and community services require greater clarity and operational detail.
- **System Coordination and Decision-Making**-further work is needed on:
 - Governance arrangements.
 - Escalation triggers.
 - Discharge authority.
 - Communication and decision-making pathway

4. Next Steps

- 4.1. The immediate priority will be for Place leads continue to work with providers to strengthen programmes according to the residual risks, these areas are as follows:
- Delivery of NCTR reduction trajectories.
 - Pathway 1 domiciliary care capacity improvements.
 - Pathway 2 and 3 discharge capacity improvements.
 - Acute flow and occupancy reduction programmes.
 - Strengthen community capacity and community holding handover implementation.
 - High-intensity user interventions.
 - Workforce resilience and community capacity expansion.
- 4.2. Following the stress testing event and the gaps identified, the following will be actioned:
- Develop CYP winter preparedness.
 - Integrate Mental health into Winter planning.
 - Test workforce mutual aid arrangements.
 - Strengthen community and care home escalation.
 - Clarify system coordination and decision making.
 - Ongoing monitoring requirements including review of demand forecasts and continuous update of risks and mitigations throughout winter.
- 4.3. The Winter Plan will remain a dynamic plan and will be updated as initiatives mature and will reflect changes where in year performance differs to our expectations.
- 4.4. Following Board approval and sign-off, the plans and Board Assurance Statements will be submitted to NHSE on 30 September 2026.

5. Conclusion

- 5.1. The Cluster Winter Plan 2026/27 sets out a comprehensive, collaborative approach to winter preparedness across BSW, Dorset and Somerset. The Winter Readiness Assessment provides reasonable assurance that the key requirements of the UEC Recovery Plan and Board Assurance Statements are being addressed through a range of preventative, operational and escalation measures.
- 5.2. Planning is well developed across all places, supported by strong system leadership and learning from previous winters and regional stress-testing exercises.
- 5.3. Key residual risks remain, particularly acute bed occupancy and patient flow, which depend on improvements in NCTR, discharge processes, community capacity and social care provision. Rising demand, workforce pressures and ambulance handover delays also threaten winter resilience. Further work is needed to strengthen CYP

preparedness, mental health integration, workforce mutual aid, community and care home escalation, and system-wide decision-making.

- 5.4. The plan provides a strong framework for managing winter pressures, with continued oversight, performance monitoring and collaboration essential to maintaining patient safety and service performance.
- 5.5. As a live programme of work, the plan requires ongoing executive oversight, risk management and partnership working. Subject to delivery of identified actions and closure of remaining gaps, the Cluster is well placed to manage winter pressures while maintaining patient safety, improving outcomes and delivering care close to home.
- 5.6. The Boards are asked to:
 - **Review** the Winter Plan and associated Appendices, and
 - **Discuss** and **Approve** the Board Assurance Statements for submission to NHS England on the 30 September 2026.

Cluster ICB Winter Plan

2026-2027

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



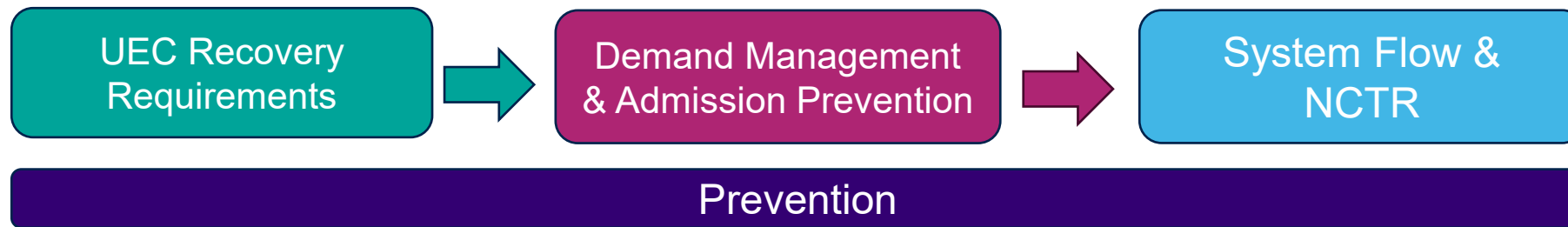
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- The Cluster Winter Plan 2026/27 presents a Winter Readiness Risk-Assessment which aligns to the UEC recovery letter and NHSE winter planning expectations outlined in the Board Assurance Statements and checklist and aims to provide assurance against the Board Assurance Statements and identify risks in programme development and maturity.
- Winter planning seeks to understand where we anticipate spikes in activity, pressure and increased demand and sets out a comprehensive range of actions to prevent and respond to surge and extreme surge pressures while maintaining safe service delivery and business-as-usual operations.
- Winter plans aim to mitigate risk and ensure people are treated closer to home wherever possible.
- In line with NHS England planning expectations, the Cluster ICB has appointed a named Executive Winter Lead: Shelagh Meldrum, Chief Nursing Officer.
- The plan has been developed collaboratively with all system partners and approved through established place-based governance arrangements as well as Cluster ICB governance.
- Planning assumptions have taken account of anticipated seasonal variations in demand and the potential impact on delivery of key operational & national objectives.
- Each acute provider and South Western Ambulance Services NHS Foundation Trust (SWASFT) has developed their own winter plans. This document summarises the maturity of cluster-wide actions and initiatives to manage winter pressures.
- The plan has been tested through a regional winter resilience exercise, with outcomes incorporated alongside lessons learnt from Winter 2025/26.
- This plan will remain dynamic and risks will be updated as initiatives and programmes mature.
- The Board will receive regular updates on delivery, performance, and emerging risks throughout the winter period.

Approach to Planning



- The Cluster Plan presents a high-level overview of all winter plans at Place with the aim of presenting the collective risks & mitigations and highlighting any gaps in the plan.
- The plan recognises that the single biggest threat to patient safety and operational resilience during the winter period is sustained acute occupancy and its impact on timely access to care
- The underlying challenge is maintaining effective system flow. Whilst prevention and admission avoidance intervention are important moderators of demand, winter resilience will ultimately depend on the system's ability to improve patient flow and release capacity across acute, community, mental health and social care services.
- The winter readiness assessment reflects the areas which have the greatest influence on system flow and resilience:



- Forecasting of demand, admissions, discharge performance and ambulance handovers provides an evidence-based view of anticipated operational pressures and will support ongoing monitoring of winter risks and performance.
- An Equality and Quality Impact Assessment has informed development of the plans to ensure consideration of quality, safety and health inequalities
- Delivery is enabled through a cluster-wide, standardised approach to:
 - Communication
 - IPC & Vaccination
 - Surge and Escalation Plans / EPRR

Our Winter Focus:

Our approach is to reduce avoidable demand, improve alternatives to ED attendance and hospital admission through creating capacity, better flow and targeted support where operational pressures are greatest.

1. Reduce avoidable demand

- Proactive support for the highest-risk 1% cohort
- Respiratory optimisation and vaccination
- Proactive management of vulnerable cohorts

2. Maximise alternatives to admission

- Neighbourhood and care co-ordination approaches
- Community alternatives to attendance and admission
- Primary care and urgent care support

3. Create capacity through better flow

- Reducing NCTR
- Improving discharge pathway performance
- Removing barriers to patient flow
- Reducing handover delays and corridor care

4. Manage peak pressure

- Capacity focused on highest risk areas
- Support in areas of greatest operational risk
- Coordinated escalation and system response

Demand Forecasting



- Demand and capacity modelling remains an area of developing maturity, limiting our ability to quantify the impact of winter interventions against forecast demand and demonstrate whether planned capacity is sufficient. Greater clarity is required on intervention-level impact measures, expected benefits and how these will be monitored through winter to identify residual gaps and inform escalation.
- Whilst Cluster wide Demand and Capacity analysis is not as mature as we would like it to be plans have been developed based on intelligence at place.
- In addition, forecasts were produced for all six main Acute Providers across the Cluster which align with local intelligence and assumptions embedded in the plans.
- Further work is required across the cluster to develop and refine our demand modelling, forecasting and monitoring. Next steps include:
 - Develop reporting to monitor forecast performance against:
 - **2026/27 Provider Operational Plans** to identify risks, variances and areas of misalignment.
 - **Actual activity levels**, with monthly review of forecast performance and model updates as required.
 - **Forecast accuracy measures** to validate model performance and reliability.
 - Evaluate the impact of winter mitigations and operational interventions, working with Place and Provider teams to incorporate local intelligence and operational insight.
 - Continue to enhance the forecasting approach by incorporating:
 - The impact of interventions and mitigation schemes.
 - Local intelligence and operational expertise.
 - Operational capacity constraints and service changes.
 - Changes to patient pathways and models of care

Demand and Capacity - BSW

System Growth

- Overall growth in front-door demand has continued into spring following a 5.5% increase over the 2025/26 winter period.
- The growth can be attributed to adult patients (both working age and older adults) with a 5.8% uplift on the same period last year.
- This is equivalent to an additional 30 attendances per day.
- The biggest impact has been seen at GWH with growth of 10.6%. RUH have seen growth of 5.2%, with higher demand for patients aged 65+.
- Based on current trends, we could see a **further 4.4% increase in activity** this coming winter and additional activity of 23 arrivals per day, 76 per day greater than winter 23/24 and almost 18 thousand more arrivals in total. A 10% uplift would see an additional 109 arrivals per day.

Acuity

- Overall, front-door demand has increased this past winter by 4.7%, across all department types, with the main driver of this growth observed in type 1 departments (5.5%).
- Type 1 ED attendances has increased by 8% over the last two winters and by 5.5% this past winter. Type 1 demand has proven to be more significant than expected, during the last financial year, with observed activity **1.8% over plan**.
- The biggest impact has been seen at GWH with annual activity growth of **9.7%** (7.3% above plan). RUH have seen growth of 5.6%, however this is within the expected levels originally planned (-1.6%)

Demand and Capacity - Dorset

System Growth

- For DCH there is an 8.6% increase in Type 1 ED attendances in Q1 26/27 25/26 levels (7% over Operational Plan)
 - Walk-ins increased by 8% (833 attendances) and is attributed to increased activity from West Dorset PCNs.
 - Ambulance conveyances 11% (482 attendances) similarly from West Dorset PCNs
 - Type 3 (UTC activity) reduced by 3.6% over same 3-month period.
 - Majority of ED demand from West/Central Dorset PCNs
- For UHD there is a 4% increase in Type 1 Ed attendance Ambulance Conveyances

System Growth (Apr-Jul 25 vs Apr-Jul 26)

- Ambulance conveyances have increased by 3.9% (585 arrivals) with the majority of this increase from the South Somerset / Yeovil geography
- Overall growth in front-door demand to ED has reduced in 25/26 by -8.3% but there are differing patterns observed when comparing Somerset FT sites (Musgrove Park Hospital (MPH) -2.1%, Yeovil District Hospital (YDH) -16.6%) – this is due to the opening of the co-located UTC at YDH from October 25. When including YDH co-located UTC, overall demand to ED has increased in 25/26 by 10.2% (or +25 attendances per day).
- Patient groups with observed growth include <5, 19-<65 and 65-<85 years
- Without mitigation there is a risk that YDH could continue to exceed planned levels of activity (+14.1%) across the site (ED (+15.8%) and co-located UTC (+9%)) which equates overall to a continued 25 attendances per day above planned levels (+21 to YDH ED, +4 to co-located UTC)
- Type 3 (UTC activity) excluding YDH co-located UTC has reduced by 14.6% over same 4-month period, and including the co-located UTC has increased overall by 0.5%
- Emergency admissions with a LOS >1 day in Somerset (ICB) has reduced by -3.0% when comparing Apr-Jun 26 to the same period in 2025, and >7-day LOS by -9.4% however overall length of stay remains higher than planned levels particularly on the YDH site (with a 2-day differential to the MPH site) and above plan
- Longer length of stay is attributed to the number of patients occupying a hospital bed with No Criteria To Reside, and is significantly higher than plan with 215 patients occupying 25.4% of beds (July) compared to a plan of 17.0%

Winter 2026/27 Planning Assumptions



In addition to delivering the activity levels committed to in Cluster Operational Plans, our Winter Plans are based on the following assumptions:

Assumption

- Respiratory illnesses are the single biggest driver of demand during December and January
- ED attendance - baseline growth in Type 1 with surges in acuity and volume during Winter
- Elimination of Corridor Care
- Timely handover - 45-minute timely handover, reducing to 30 minutes from 1 January 2027
- Timely Discharge – minimum of 30% discharges taking place before midday & 80% of discharges taking place before 5pm, 7 days per week
- Ambulance response - mean average response time of 18 minutes with at least 9 out of 10 Category 2 call answered within 40 minutes
- At least 95% of patient arriving at ED should be admitted, transferred or discharged within 4 hr
- No more than 2% of patient should experience total waits more than 12 hours
- Vaccination uptake - achieve equal to or higher vaccination uptake levels compared to October – March 2025/26 for every eligible group

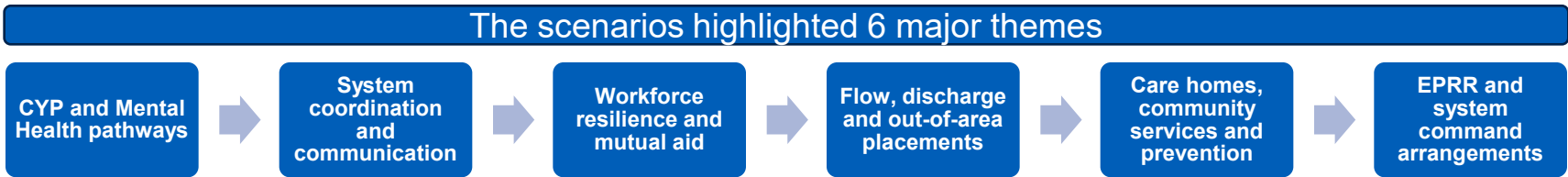
Regional Winter Stress Test: What did we learn?



System partners attended the regional Winter Stress-Test event in Taunton on 16 September 2026. Key learning and messages are as follows:

National Updates - Key Messages	
- No G&A beds should be closed. - Ambulance handovers must occur within expected standards. - Systems need to comply with national operating models. - Community Bed Model guidance is expected shortly. - Discharge remains a national priority.	- NHSE and GIRFT will work together to support delivery. - National Winter Cell will be established - Increased acute oversight and assurance processes are anticipated. - Winter battle rhythm arrangements will be established from October

The exercise largely validated the key risks and dependencies already identified within place and cluster plans, reinforcing that winter resilience depends on effective flow, community capacity and integrated system working



The exercise validated our overall approach and highlighted the following areas for further strengthening ahead of winter:

1. CYP Winter Preparedness – further strengthening of CYP winter resilience approach.
2. Mental Health Integration – strengthen integration of mental health pathways within winter escalation arrangements.
3. Workforce Mutual Aid – further testing and assurance of mutual aid and surge workforce arrangements.
4. Community and Care Home Escalation – clarify escalation arrangements across care homes, virtual wards and community pathways
5. System Coordination and Decision-Making - further refinement of governance, escalation triggers, discharge authority and communication flows.

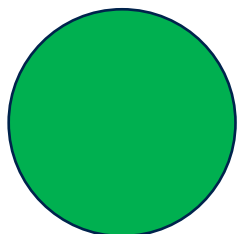
Winter Readiness Assessment by Place



The purpose of this section is to understand levels of confidence and provide assurance against the UEC Recovery letter and Board Assurance Statements. The following readiness assessment has been carried out against three broad delivery areas:

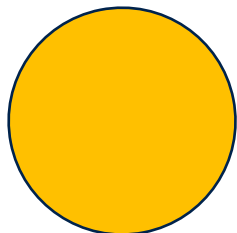
- Compliance with UEC Recovery Requirements
- Demand Management and Admission Avoidance
- System Flow and NCTR Reduction

The RAG matrix will remain a dynamic assessment tool leading up to and during winter.



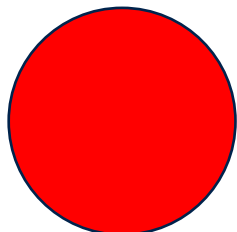
Green – (Low risk, high assurance).

- Operationally ready, or confidently on track to be operational before end October.
- No significant barriers to delivery.
- Proceeding as planned



Amber – (At risk, moderate Assurance).

- Remains deliverable for winter, but only if key risks, dependencies or milestones resolved before end October.
- Requires active management by all partners to achieve readiness



Red – (Limited assurance, off-track, delivery at risk).

- Unlikely to be operationally ready by end October based on current assessment
- Major risks or dependencies remain unresolved
- Executive intervention required

Compliance with UEC Recovery Requirements as at 22.09.2026



Assessment of place-level assurance against the specific requirements set out in the regional UEC Recovery Letter, highlighting delivery status, key risks and residual gaps ahead of winter.

Delivery Area	BaNES	Swindon	Wiltshire	Somerset	Dorset	BCP
Senior decision-maker available to SWAST, NHS111, Primary Care and Community Services for a minimum of 12 hours a day, 7 days per week						
Alternative urgent care pathways, including Urgent Community Response and Virtual Wards, operational and accessible for 12 hours a day, 7 days per week						
Patients actively assessed for, and where clinically appropriate directed towards alternatives to Emergency Department attendances or hospital admissions						
Delivery of the 45-minute timely handover protocol alongside corridor care improvement plans						
Improving discharges seven days per week, with a minimum of 30% of discharges before midday and 80% before 5pm, supporting reduction in NCTR						
Plans to implement community holding handovers						
Monthly system meetings with SWAST and providers to understand urgent care demand, missed opportunities for non-conveyance and required pathway changes						

Compliance with UEC Recovery Requirements



Assurance

- All places have demonstrated progress against the UEC Recovery requirements, with the majority of actions assessed as either delivered or on track for delivery ahead of winter.
- Alternative urgent care pathways, including Urgent Community Response, Virtual Wards and wider community services, are in place across the region, supporting admission avoidance and patient redirection.
- Arrangements are established across systems to provide senior clinical decision-maker support and enable redirection to alternatives to ED attendance and hospital admission.
- Monthly system oversight arrangements with SWAST and providers are in place to review demand, identify non-conveyance opportunities and support pathway improvement.
- Overall, there is reasonable assurance that the UEC Recovery requirements are being implemented, with no widespread areas of non-compliance identified.

Residual risk and areas for further development

- Variable levels of implementation remain across places, with a number of requirements currently assessed as partially compliant rather than fully delivered
- Delivery of the 45-minute ambulance handover standard and reduction of corridor care remain dependent on sustained improvements in whole-system flow, discharge performance and hospital occupancy.
- Community holding handover arrangements represent the most significant area of risk, with implementation not yet complete in several systems.
- Consistency of senior clinical decision-maker availability and 12-hour pathway coverage could be strengthened in some places.
- Ongoing focus is required on community capacity, workforce resilience and pathway utilisation to ensure resilience during periods of peak winter demand.
- Dorset continues to identify specific risks relating to patient flow and HALO arrangements.

Demand Management and Admission Avoidance as at 22.09.2026



Assessment of the key interventions in place to reduce avoidable demand on urgent and emergency care services, minimise emergency attendance and admission, and mitigate forecast winter pressures.

Delivery Area	BaNES	Swindon	Wiltshire	Somerset	Dorset	BCP
High Intensity Users (1% Cohort)						
Respiratory and Seasonal Demand						
Alternatives to ED Attendance						
Alternatives to Conveyance and Admission						
Capacity to Manage Demand Growth / Surge						

Assurance

- All places have established programmes focused on prevention, high-intensity users and the highest-risk cohorts, including targeted neighbourhood-based approaches for the top 1% of the population.
- Strong prevention programmes are in place, including vaccination, respiratory optimisation, care home support and management of long-term conditions.
- Plans demonstrate a broad range of alternatives to attendance, conveyance and admission, including care coordination, UCR, Hospital at Home, and community-based pathways.
- All places have identified additional capacity and surge arrangements to support periods of increased demand.
- Overall, there is reasonable assurance that plans include a comprehensive approach to demand management and admission avoidance.

Residual risk and areas for further development

- Many interventions are newly mobilised or continuing to scale, and their impact will need to be realized before peak winter demand
- Vaccine uptake and engagement of targeted cohorts.
- Workforce resilience and capacity constraints across health and care services.
- Respiratory demand exceeding planning assumptions.
- Delivery of some surge and community capacity schemes remains dependent on workforce and funding

System Flow and NCTR Reduction as at 22.09.2026

Assessment of the interventions in place to improve patient flow, support timely discharge, reduce NCTR and maintain capacity across acute, community and social care services.



Delivery Area	BaNES	Swindon	Wiltshire	Somerset	Dorset	BCP
Identification and Management of NCTR Patients						
Discharge Processes and Productivity						
Pathway 1 Capacity and Performance						
Pathway 2 and 3 Capacity and Performance						
Acute Flow and Occupancy						
System Flow Leadership and Escalation						

System Flow and NCTR Reduction

Assurance

- All places have established programmes to reduce NCTR, improve discharge performance and increase system flow.
- Pathway 1, 2 and 3 improvement plans are in place, supported by executive oversight, discharge coordination and escalation arrangements.
- Acute providers have active flow improvement programmes focused on occupancy, discharge, SDEC utilisation and patient flow.
- Overall, there is moderate assurance that the required flow and discharge improvement programmes are in place ahead of winter, although delivery remains dependent on significant improvements in flow, discharge performance and community capacity.

Residual risk and areas for further development

- Acute occupancy and patient flow remain the single biggest operational risk across the Cluster.
- Delivery of NCTR trajectories remains dependent on sustained improvements in discharge performance, Pathway 1-3 capacity and community flow..
- Pathway 1, 2 and 3 capacity continues to be constrained by demand, workforce availability and social care capacity.
- Community holding handovers require further development and testing ahead of winter

Priority Capacity Risks During Winter Surges



- Each Place has assessed which areas are most at risk of insufficient capacity during periods of demand surge.
- There is no national winter funding expected so any surge capacity would need a local funding source and agreement on criteria for triggering mobilisation
- Work is ongoing through Place discussions to further develop plans

Place	Priority Capacity Requirements
Somerset	Increased 111 and urgent care demand, with potentially avoidable ED attendance and ambulance conveyance during peak winter periods via additional winter clinical surge capacity.
	Seasonal pressure on Primary Care, particularly respiratory illness and same-day urgent demand, with potential displacement of demand into UEC via Targeted Primary Care winter surge capacity, potentially focused on peak respiratory periods and additional same-day/urgent capacity.
	Insufficient capacity to support discharge during periods of peak winter demand, contributing to NCTR and acute bed pressures
	Potential P2/intermediate care capacity constraints affecting flow from acute care
	Acute front-door pressure affecting timely assessment, decision-making, ED flow and 4-hour performance via Additional SFT senior clinical decision-making capacity, building on the winter model funded in 2025/26.
Dorset and BCP	Funding to staff new UTC development at DCH
	Additional direct booking GP capacity from 111 for peak period (building on successful schemes from last year)
	P1 surge capacity in the East and West. Scope to fund through agreed additional intermediate care investment
	Additional social work capacity to expedite assessment and increase rate of discharge from P1 and P2 capacity. Recruitment lead-in time to be considered
B&NES	Primary Care capacity to support respiratory surge - Currently looking at funding sources
	Currently Discussing P1 capacity - P1 Capacity requirement to be confirmed.
Swindon	P3 Capacity - Proposals to be developed further
Wiltshire	Gaps in BAU provision for P1 and P2 discharges. Further gap in surge provision for P1 and P2 during peak winter periods. Primary care seasonal capacity gap being addressed through primary care funding.

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

Residual Risks and Development Priorities



The Winter Readiness Assessment and Regional Stress Test largely validated the key risks and dependencies already identified within place and cluster plans. The following residual risks and development priorities will continue to be actively managed ahead of and throughout winter.

Residual Risks

- Acute occupancy / NCTR - remains the single biggest operational risk
 - Dependent on improvements in discharge performance and community capacity
- Ambulance handovers & Corridor Care
 - Numerous interdependencies impacting flow and occupancy
 - Removal of HALOs
- Pathway 1
 - Increasing demand
 - Domiciliary Care Capacity
 - Homecare market constraints
- Pathway 2/3 discharge capacity
 - Social care workforce
 - Patient complexity
- Workforce Resilience

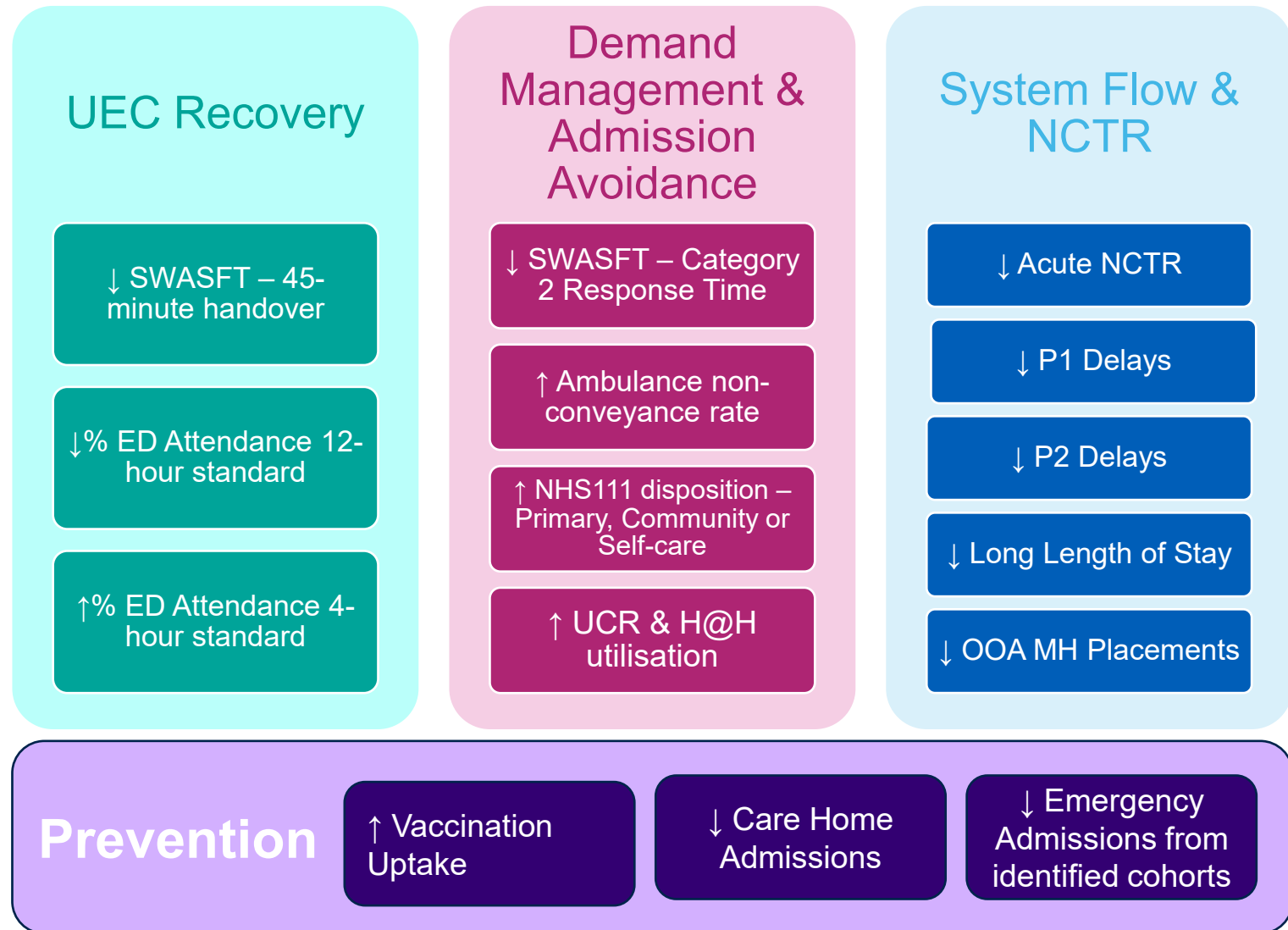
Areas for further development

- Community Holding Handovers
 - Lack of agreed operational models
 - Potential impact on ambulance responsiveness
 - Limited evidence of implementation timelines
- CYP Winter Preparedness – Further development of a comprehensive CYP winter resilience approach
- Mental Health Integration – Further integration of mental health pathways within winter escalation arrangements.
- Workforce Mutual Aid - Mutual aid, NHS Passport arrangements and workforce surge plans require further testing.
- Community and Care Home Escalation - care homes, virtual wards and community services require clearer operational escalation plans.
- System Coordination and Decision-Making - clarification needed regarding governance, escalation triggers, discharge authority and communication flows.

Monitoring - how will we measure success?



- This plan will remain a live document.
- There will be continuous development and adaptations as we move closer to and through winter.
- The plans will be updated with any additional initiatives implemented and changes to those already identified.
- UEC Delivery groups together with SWASFT and providers will meet monthly (increasing in frequency as pathway risks increase) to understand the drivers of urgent care demand. These meetings will generate live recommendations for pathway and service adjustments.
- The plans will be monitored through a combination of the Diis system visibility dashboards and SHREWD.
- A task-and-finish group will continue to develop Cluster wide dashboards that reflect both seasonal demand and preventative community / neighbourhood initiatives which aim to reduce the impact of seasonal pressures.



Winter Plan Governance



Quality and Population Engagement Committee
Population Health & Commissioning Committee

Executive Management Group

Integrated Care Alliance

UEC Delivery Group
(as sub-group of One Dorset Provider Collaborative)

Somerset Health Provider
Partnership Board

BaNES

Swindon

Wiltshire

Dorset

BCP

Somerset

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

Cluster Wide Winter Programmes & Responsibilities

Board Assurance Statements (BAS) - Supporting Information

The following section provides assurance against the BAS requirements and checklist.



Equality & Quality Impact Assessment



- An Equality and Quality Impact Assessment (EQIA) has been developed to support the Cluster Winter Plan 2026/27 and assesses the potential impact of planned interventions.
- The EQIA has been informed by the priorities and actions outlined within the Cluster Winter Plan, including prevention and vaccination programmes, alternatives to Emergency Departments, patient flow improvements, emergency care resilience and surge and escalation arrangements.
- Building on established approaches and learning from previous years, the EQIA will evolve alongside the development and finalisation of Cluster, ICB and Place-based winter plans. It will ensure that quality and equality considerations are embedded throughout the planning process and that risks are highlighted and any mitigations put in place
- Quality team representation at Cluster and Place planning meetings is required to provide ongoing oversight, challenge and assurance, ensuring that equality, quality and patient safety considerations are reflected in decision-making and implementation arrangements across the system.
- An EQIA panel took place on the 17 September where the document was approved
- The EQIA will remain a live document and will be reviewed as plans develop, risks emerge and delivery arrangements are refined throughout the winter period.

Cluster Vaccination Programme (*checklist 1.1*)



Respiratory illness is expected to remain a major driver of winter demand, with consistent seasonal surges in RSV and influenza occurring between November and January, alongside ongoing COVID-19 winter waves. Historical trends indicate the greatest pressure is likely to occur during December and January, particularly among children, older adults and people with underlying respiratory conditions.

- **Cluster-wide oversight is in place across BSW, Dorset and Somerset** to provide assurance that eligible populations have access to the priority vaccination programmes identified within BAS 1.1: **RSV, pneumococcal, seasonal influenza and COVID-19**, alongside wider childhood vaccination programmes.
- **Autumn/Winter Flu and COVID-19 delivery arrangements are being assured through a single cluster provider laydown**, providing visibility of participating providers, geographic coverage, care home and housebound provision, alternative delivery routes and any residual gaps requiring action or escalation.
- **RSV is established as a year-round programme**, with access for eligible pregnant women and older adults, including older adult care home residents, monitored alongside seasonal vaccination delivery.
- **Pneumococcal vaccination forms part of cluster performance oversight**, enabling variation in coverage to be identified and areas requiring further review or intervention to be targeted.
- **Performance and equity will be monitored throughout winter** by programme, ICB, cohort and locality, including variation at PCN/practice level and by deprivation, ethnicity and geography, to identify inequalities in access or uptake.
- **Targeted action will be taken where lower uptake, unwarranted variation or access gaps are identified**, working with providers and local systems to improve access for priority and underserved cohorts.
- **Care home and housebound provision is subject to specific oversight**, with delivery responsibility and alternative provision identified to support continuity of access where practices do not deliver directly.
- **Material operational risks, gaps and areas of exception are subject to cluster oversight and escalation**, including provider readiness, vaccine supply, inpatient vaccination arrangements and unresolved geographic or cohort access.

Cluster Infection, Prevention & Control (*checklist 1.1*)



Respiratory viruses and gastrointestinal infections such as norovirus are expected to remain significant contributors to winter pressures across health and care settings. Seasonal increases in influenza, RSV, Covid-19 and norovirus can result in outbreaks, increased healthcare demand, workforce absence and disruption to patient flow. Robust infection prevention and control arrangements are therefore essential to reducing transmission, protecting vulnerable populations and maintaining system resilience throughout the winter period.

- **Cluster-wide IPC oversight** is being developed across BSW, Dorset and Somerset to support a coordinated approach to infection prevention, outbreak preparedness, surveillance and health protection throughout the winter period.
- **Data and Surveillance will be used to identify emerging risks and trends**, including respiratory infections, norovirus activity, outbreaks and other communicable disease incidents, drawing on UKHSA surveillance, local intelligence and provider reporting.
- **Established outbreak management, escalation and antiviral pathways** are in place across the cluster, supporting the timely management, escalation and resolution of respiratory and gastrointestinal outbreaks across health and care settings.
- **Partnership working with UKHSA, local authorities, NHS providers, primary care and adult social care** will support a coordinated approach, ensuring risks are identified and managed at the earliest opportunity.
- **Provider IPC preparedness will be supported and assured throughout winter**, including outbreak management arrangements, escalation processes, implementation of national guidance, staff education and organisational readiness to respond to seasonal infection pressures.
- **Respiratory and gastrointestinal infection prevention measures will continue to be promoted** across health and care settings, supporting early identification of cases, appropriate management of outbreaks and measures to reduce transmission.
- **IPC learning, engagement and sharing of best practice will support preparedness across health and care settings**, strengthening system resilience and supporting consistent approaches across the cluster.
- **Material IPC risks, significant outbreaks and emerging health protection threats will be subject to appropriate oversight and escalation**, enabling a timely and coordinated response where patient safety or service continuity may be affected.

Leadership, Oversight & On-Call section (*checklist 7.1 & 7.2*)

- The clustered ICBs have a two tier on call system - Tactical and Strategic, operating 24/7 with support from a 24/7 Communications on Call function as needed. Clinical support is available as required.
- The System Control Centre (SCC) is in place across the cluster operating 7 days a week 0800-1800 from 01 September. The SCC will actively monitor system intelligence, provider escalation, demand and capacity, ambulance performance and patient flow, using SHREWD and other available intelligence to identify emerging risks and intervene at the earliest opportunity.

EPRR (*checklist 7.3 & 7.4*)

- Command and control arrangements are in place in line with expected roles and responsibilities as they pertain to Strategic & Tactical Command. This is reflected in suite of EPRR guidance and system surge & escalation plans.
- The cluster Severe Weather Plan is drafted with expected sign off at EMG on 6th October. The cluster has established Industrial Action protocol that have been aligned under a single SOP. Mutual Aid arrangements are documented within the suite of EPRR guidance.

System Co-ordination Centre – (*checklist 8.1, 8.2 & 8.3*)



- The Cluster System Coordination Centre (SCC) will provide proactive, system-wide oversight of operational pressures, patient flow and associated risks during hours of operation. The SCC will actively monitor system intelligence, provider escalation, demand and capacity, ambulance performance and patient flow, using SHREWD and other available intelligence to identify emerging risks and intervene at the earliest opportunity.
- The SCC will work with providers and system partners to resolve pressures at the lowest appropriate level, escalating through the agreed tactical, strategic and Gold arrangements where local resolution is insufficient. Where pressures or risks persist outside SCC operating hours, the ICB on-call function will provide appropriate oversight, challenge and coordination, including escalation where required to ensure continuity of system leadership, patient flow and safety.
- The SCC will operate on a 7-day basis, providing consistent system coordination and oversight across the cluster. The operating model is designed to provide resilience across normal operational periods and can be flexed in response to increased system pressure, significant incidents, periods of surge, adverse weather, industrial action or other emerging risks.
- Where the level of operational pressure requires it, SCC operating hours can be extended, with additional tactical coordination and escalation arrangements activated, as necessary. The SCC will work closely with the ICB on-call function to ensure there is no gap in system oversight outside core operating hours.
- The SCC will maintain proactive and structured engagement with the NHSE Regional Team, providing timely intelligence, escalation and assurance regarding system operational pressures and emerging risks.
- The SCC will maintain regular communication with NHSE through agreed reporting arrangements, including escalation of significant operational concerns, system incidents and emerging risks. Where regional support, intervention or decision-making is required, the SCC will ensure that escalation requests are clear, evidence-based and include the specific action or support required from NHSE.
- The SCC will also ensure that learning, regional intelligence and emerging national or regional risks are communicated back into the system and incorporated into operational planning and escalation arrangements

Communication Plan – (checklist 8.3)



- The current communication plan is a live document currently in development.
- The Cluster Communication Plan for winter aligns to the Southwest operational pressure's escalation communications protocol. The protocol serves as a communications framework for managing public and staff messaging during periods of high operational pressure in the Southwest NHS, ensuring communications are coordinated, targeted, and focused on directing people to the right care rather than publicising internal escalation statuses
- The Cluster Communication Plan aims to:
 - Support effective communication with the public and staff when healthcare services are under significant pressure.
 - Avoid individual organisations independently announcing incidents, critical incidents, or escalation levels, and instead promote a collective "one NHS voice" approach.
 - Encourage the public to take appropriate actions, such as using NHS 111, pharmacies, and other suitable services, rather than defaulting to Emergency Departments.
 - Reduce unnecessary demand on urgent and emergency care services while ensuring people still seek care when needed.
 - Maintain public confidence in NHS services and avoid creating confusion through frequent updates on internal escalation statuses.
- The Cluster communications plan emphasises that at times of extreme pressure, communication should:
 - Focus on what the public should do, rather than what they should not do.
 - Promote positive actions such as vaccinations, self-care, use of pharmacies, NHS 111, and support for vulnerable people.
 - Be coordinated across system boundaries because patients and media operate across multiple NHS organisations.
 - Avoid publicising internal management tools such as OPEL levels, business continuity incidents, or critical incidents, as these can confuse the public and distract from the desired messages.

Winter Planning 26/27

Board Assurance Statement (BAS)

Integrated Care Board (ICB)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Integrated Care Board's (ICB) name at the top of the tab.

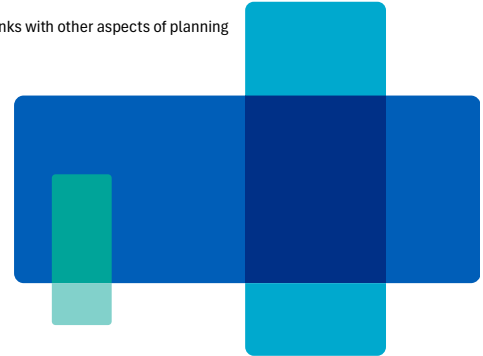
This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



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Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Integrated Care Board (ICB): Dorset, BSW & Somerset Cluster ICB

If Other, write ICB Name here:

Contact details (email, phone number): shelagh.meldrum@nhs.net

Date: 25/09/2026

Please complete these sections

Assurance statement			Is this in place? (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance					
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.			
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.		Iterative EQIA has been completed and informed the plan (included in appx)	
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.		All place partners were actively engaged and contributed to the development of the Cluster Winter Plan.	
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.		Cluster CNO is lead executive and Accountable Emergency Officer (AEO)	
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		The regionally led winter stress-test took place on 16th September 2026 and outcomes have been included in the plan	
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.		Governance arrangements, escalation processes and operational leadership arrangements are in place with winter planning effectiveness being monitored through EMG.	
	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.		Cluster-wide IPC oversight is being developed across BSW, Dorset and Somerset to support a coordinated approach to infection prevention, outbreak preparedness, surveillance and health protection throughout the winter period.	
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/		Established outbreak management, escalation and antiviral pathways are in place across the cluster, supporting the timely management, escalation and resolution of infectious diseases and incidents. Partnerships working with UKHSA, local authorities, NSA providers, primary care and adult social care will support a coordinated approach.	

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Winter Planning 26/27

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention and vulnerable cohorts					
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.		Cluster wide oversight is in place to provide assurance that eligible populations have access to priority vaccination programmes. Autumn/Winter Flu and COVID-19 delivery arrangements are being assured through a single cluster provider laydown, providing visibility of participating providers, geographic coverage, care home and housebound provision, alternative delivery routes and any residual gaps requiring action or escalation.	
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.		All places have active programmes targeting high-intensity with variations in development and maturity: •Somerset has a mature established service. •BaNES has established a dedicated multi-agency task-and-finish group with care plan deployment by October. •Wiltshire has identified the cohort and commenced multi-agency planning. •Dorset / BCP is aligning neighbourhood and winter planning programmes around frailty and respiratory cohorts.	
Flow, occupancy and discharge					
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.		All places have established operational plans and governance arrangements to improve patient flow and reduce avoidable bed occupancy. While bed demand, discharge performance and NCTR are being actively managed, delivery of NCTR reductions and discharge pathway capacity remain key risks that temper assurance.	
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.		Coordinated system-wide flow, discharge and escalation arrangements are in place to mitigate corridor care. However, acute occupancy pressures and discharge capacity constraints mean it remains a residual operational risk requiring ongoing oversight.	
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.		The Board is assured that discharge planning is supported by multi-agency coordination, executive oversight, performance monitoring and escalation processes. While partners have established arrangements to manage discharge performance, NCTR and pathway capacity, ongoing pressures in domiciliary care, community capacity and NCTR delivery continue to moderate assurance.	
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.		The plans do not provide explicit evidence that every provider has formally completed a baseline assessment against the national model discharge pathway. Assurance is therefore inferred from the comprehensive review of discharge performance, pathway-specific risks and improvement programmes rather than a documented compliance assessment.	
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.		Absence of explicit evidence of holiday-specific occupancy reduction plans and by ongoing risks relating to discharge capacity, acute occupancy and delivery of NCTR reductions.	
Demand, capacity, and surge management					
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.		Winter planning has been informed by preliminary demand forecasts, UEC demand and demand driver analysis and local intelligence and is supported by by surge planning, OPEL escalation frameworks and additional capacity schemes. Further work is needed to strengthen & integrate demand forecasting and quantifying surge	
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.		Plans provide evidence of workforce resilience planning, but identifies primary care workforce resilience as an ongoing risk across places. Workforce constraints are noted as a risk to the expansion and delivery of community-based alternatives to	
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.		All places demonstrate robust surge planning: •OPEL frameworks. •Workforce resilience plans.	
Primary Care, NHS 111 and admission avoidance					

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4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.		RAG is assessed as red until funding confirmed for additional winter seasonal capacity for BSW and Somerset (Dorset confirmed support for additional primary care respiratory services - plans underway to be in place by end of October. NHS 111 clinical assessment services and executive oversight. GP-specific demand modelling is needed to strengthen plans.	
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.		PC capacity and NHS 111 referral pathways form part of winter planning arrangements. Evidence at Place (as per ICB Primary Action Plan submitted to Board) regarding practice-level compliance with contractual requirements, including opening hours, online consultations, same-day urgent access standards and NHS 111 direct booking capacity.	
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.		Additional PC capacity and NHS 111 referral pathways are in place to support urgent care demand. All PCNs deliver Enhanced Access (evenings and weekends) under national DES requirements but no requirements under DES to make appointments available to 111. Further discussion required with PCNs and LMCs.	
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.		Across the three legacy ICBs, there is a consistent focus on delivering mandated urgent dental care through regular performance monitoring, contract management, and maximising capacity. Both BSW and Dorset are performing above their year-to-	
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.		A Pharmacy First model is in place across the Cluster, with community pharmacies providing essential, advanced and locally enhanced services to support system capacity. PNA (2025-2028) across the three legacy ICBs found existing provision to be sufficient for population need.	
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.		DOS is now managed by SW DOS team. The DOS is up to date, maintained and amended as needed by the SW DOS team.	
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.		A cluster wide winter plan is aimed at influencing behaviour change to help manage pressures on primary and secondary care services.	
Community Health Capacity					
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.		The plans show strong evidence of UCR, Virtual Ward, Hospital at Home, clinical assessment arrangements and other community alternatives to admission are established across all places, supported by escalation arrangements, executive oversight and access to senior clinical decision-making through SPOA and care coordination functions.	
Whole System Response					
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.		Place based system flow programmes in place focused on discharge and intermediate care. UTCs network provides alternatives to ED attendance. H@H step up in place. Additional investment into frailty in BSW primary care and care homes. Additional support for care homes in BCP. Somerset BCF supports prevention and treatment.	
Leadership, operational grip and resilience					
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.		The clustered ICBs have a two tier on call system - Tactical and Strategic, operating 24/7 with support from a 24/7 Communications on Call function as needed. Clinical support is available as required.	
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.		The SCC has been operating across the cluster 7 days a week (08:00 to 18:00) since 1 September, providing proactive oversight of system pressures, demand and capacity, ambulance performance and patient flow, using SHREWD and other intelligence sources to identify and respond to emerging risks at the earliest opportunity.	
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.		Command and control arrangements are in place in line with expected roles and responsibilities as they pertain to Strategic & Tactical Command. This is reflected in suit of EPRR guidance and system surge & escalation plans.	
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.		The cluster Severe Weather Plan is drafted with expected sign off at EMG on 6th October. The cluster has established Industrial Action protocol that have been aligned under a single SOP. Mutual Aid arrangements are documented within the suite of EPRR guidance.	
	7.5	The Board is assured that plans are in place to support staff welfare through periods of high demand.		Plans demonstrate workforce resilience planning for each organisation	
System Co-ordination Centres					
	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.		The Cluster SCC will provide proactive system-wide oversight of operational pressures, patient flow and associated risks, using SHREWD and other intelligence sources to monitor demand, capacity, escalation status and ambulance performance, enabling early identification and proactive management of emerging	

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8	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.		The SCC will provide 7-day system oversight and coordination, with flexible escalation arrangements and extended operating hours available during periods of increased pressure, ensuring continuous oversight in partnership with the ICB on-call function.	
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.		The SCC will maintain proactive and structured engagement with NHSE Regional Team, providing timely intelligence, escalation and assurance regarding system operational pressures and emerging risks. Regular reporting arrangements, including escalation of significant operational concerns, system incidents and emerging risks. Where regional support, intervention or decision-making is required, the SCC will ensure that escalation requests are clear, evidence-based and include the specific action or support required from NHSE.	

BAS Self-Assessment Dashboard

ICB

Overall Assessment Rating: Awaiting Assessment



Rating

Section A	Governance	Awaiting assessment
Section B	Prevention and vulnerable cohorts	Awaiting assessment
	Flow, occupancy and discharge	Awaiting assessment
	Demand, capacity, and surge management	Awaiting assessment
	Primary Care, NHS 111 and admission avoidance	Awaiting assessment
	Community Health Capacity	Awaiting assessment
	Whole System Response	Awaiting assessment
	Leadership, operational grip and resilience	Awaiting assessment

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Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

Integrated Care Board (ICB) name:

ICB CEO/AO name:

Date reviewed:

ICB Chair name:

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Please confirm date reviewed

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Report to:	NHS BSW ICB Board, NHS Dorset ICB Board, NHS Somerset ICB Board	Agenda item	4
Date of Meeting:	25 September 2026		

Title of Report:	Standards of Business Conduct Policy
Report Author:	Anett Loescher, Deputy Director Governance, Compliance, Risk
Board / Director Sponsor:	Alison Henly, Chief Officer Strategic Finance and Resources
Appendices:	Draft Standards of Business Conduct Policy

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

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

Previous consideration by:	Date	Please clarify the purpose
Executive Management Group	8 Sept 2026	Endorsement and recommendation to the Boards for approval

1 Purpose of this paper
This item presents to the ICB Boards the proposed streamlined Standards of Business Conduct Policy for the three ICBs in the Cluster. The policy sets out how the ICBs will comply with the statutory requirements of the Health and Care Act 2022 with regards to conflicts of interests of their board and committee members, employees, and anyone who works for or on behalf of the ICBs. The approval of the policy is reserved to the ICBs' Boards. This cannot be delegated, and each Board needs to approve the policy so that it can come into effect across the three ICBs.

Previously, each ICB had its own Standards of Business Conduct Policy / Conflicts of Interest Policy. Although these policies were largely similar, they differed, in particular on points of process. The proposed policy remedies this. Its approval and adoption will enable a consistent approach and standard across all three ICBs to manage interests, and conflicts of interests, transparently and in compliance with the Health and Care Act 2022. This will be further supported by the roll-out across the three ICBs of the tool to record and analyse interests that BSW and Somerset ICBs have been using successfully over the past years (Civica Declare).

2 Summary of recommendations and any additional actions required

NHS BSW ICB Board, NHS Dorset ICB Board, NHS Somerset ICB Board are each asked to **approve** the Standards of Business Conduct Policy.

3 Legal/regulatory implications

The Health and Care Act 2022 makes it a statutory requirement that

- ICBs maintain, and make available to the public, registers of the interests of their board members, committee members, and employees;
- ICB board members, committee members, and employees declare conflicts of interest;
- ICBs make arrangements to manage actual and potential conflicts of interest in such a way that they do not, and aren't perceived to, affect the integrity of the ICB's decision-making

The Standards of Business Conduct Policy translates this statutory requirement into standards and procedures for the ICBs, thus safeguarding against the ICBs' non-compliance with or breach of the law. The policy is therefore a key control of compliance risks. The policy closely follows the 2024 guidance [NHS England » Managing conflicts of interest in the NHS](#) and has taken account of the 2024 [NHS England » Guidance on integrated care board constitutions and governance](#) also.

4 Procurement

n/a

P&C Name

P&C Signature

5 Risks

The adoption of one Standards of Business Conduct Policy across all three ICBs mitigates risks of non-compliance that could arise from slightly different interpretations of legislation and guidance, approaches, standards, and processes, which would prevail if the ICBs continued to maintain three policies.

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Consequences of non-compliance can be severe for individuals, incl. disciplinary action, dismissal from post or office, or investigations of the criminal offences of fraud, bribery or corruption if a breach of the policy is evident such as the wilful withholding of information about interests. For the ICBs, non-compliance can seriously impact business e.g. abandonment or challenge of procurements, or loss of public and provider confidence.

6 Quality and resources impact

The policy acts as a control of risks associated with fraud, bribery and corruption which would negatively and potentially severely impact quality and resources.

Finance sign off:

7 Confirmation of completion of Equalities and Quality Impact Assessment

Not required for this policy.

8 Communications and Engagement Considerations

ICBs must publish their Standards of Business Conduct Policy on their websites. This will be actioned as soon as the Boards have approved the policy. Internal communications will inform everyone in scope of the policy about relevant processes to declare and manage interests, and how to report suspicions or occurrences of non-compliance or breach.

9 Statement on confidentiality of report

This paper can be shared publicly.

NHS BSW ICB, NHS Dorset ICB and NHS Somerset ICB Standards of Business Conduct Policy

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ICB Standards of Business Conduct Policy

Purpose	Details the ICBs' expectations regarding standards of business conduct. Sets out how the ICBs manage conflicts of interest, gifts and hospitality, and sponsorship.
Document type	Policy
Reference Number	CP08
Version	1.0
Name of Approving Committees/Groups	The Boards of NHS BSW ICB, NHS Dorset ICB and NHS Somerset ICB
Operational Date	1 October 2026
Document Review Date	1 October 2027
Document Sponsor (Job Title)	Chief Officer for Strategic Finance and Resources
Document Manager (Job Title)	Deputy Director of Governance, Compliance, Risk
Document developed in consultation with	n/a
Intranet Location	
Website Location	https://bsw.icb.nhs.uk/about-us/governance/our-constitution-and-governance-handbook/ https://nhssomerset.nhs.uk/about-us/governance/ https://nhsdorset.nhs.uk/about/constitution/
Keywords (for website/intranet uploading)	Business conduct, conflict of interest, hospitality, gifts, sponsorship

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ICB Standards of Business Conduct Policy

Review Log

Version Number	Review Date	Name of reviewer	Approval Process	Reason for amendments
1.0	25 Sept 2026	Deputy Director of Governance Compliance Risk	BSW, Dorset and Somerset ICB Boards	Formal adoption of the policy by the NHS BSW ICB Board, NHS Dorset ICB Board and NHS Somerset ICB Board, to fulfil statutory requirements

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Standards of Business Conduct Policy

Summary of Policy

This policy details the ICBs' expectations, principles, roles and responsibilities, and processes with regards to the management of conflicts of interest, gifts and hospitality and sponsorship; outside or secondary employment; personal conduct, confidentiality and speaking on behalf of the organisation.

This policy applies to ICB employees, members of the ICBs' Boards and of the ICBs' committees and sub-committees, and anyone contracted to work for or on behalf of the ICBs, including consultants, students, trainees, agency staff, seconded colleagues, bank staff.

A conflict of interest is a set of circumstances in which an individual's ability to exercise objective judgement or act objectively in a role is, could be, or is seen to be impaired or otherwise influenced by their involvement in another role or relationship.

Closely associated to this are gifts, offers of hospitality, and offers of sponsorship which may influence a person's judgement or decisions, or be perceived to do so.

Conflicts of interest cannot be entirely avoided, nor can offers of gifts, hospitality or sponsorship. However, they must be recognised, declared and managed appropriately.

The policy signposts internal and external sources of advice and guidance, and the training offers and requirements regarding the management of conflicts of interest.

Associated policies are the ICBs' Anti-Fraud, Anti-Bribery and Anti-Corruption Policies; and the ICBs' Information Governance Policies.

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Standards of Business Conduct Policy

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INTRODUCTION & PURPOSE

1. This policy details the expectations regarding standards of business conduct for the BSW, Dorset and Somerset ICBs (the ICBs) including the management of conflicts of interest.
2. The ICBs aspire to the highest standards of corporate behaviour and responsibility. The ICBs recognise that a perception of wrongdoing, impaired judgement or undue influence alone can be detrimental.

This policy reflects and supports the seven principles of public life (see point 6 below), and the ICBs expect all individuals within the ICB to adhere to these principles.

3. This policy supports a culture of openness and transparency in business transactions. All individuals are required to:
 - ensure that the interests of patients remain paramount at all times.
 - be impartial and honest in the conduct of their official business.
 - use public funds entrusted to them to the best advantage of the service, always ensuring value for money.
 - ensure that they do not abuse their official position for personal gain or to the benefit of their family or friends.
 - ensure that they do not seek to advantage or further private or other interests in the course of their official duties.
4. The requirements of the ICBs' Constitutions, Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions will prevail over requirements of this policy where conflicting advice is given. This policy should be read in conjunction with the ICBs' Anti-Fraud, Bribery and Corruption Policies, the Confidentiality and Safe Haven Policies, and the Freedom to Speak Up Policies.

SCOPE

5. This policy applies to:
 - ICB employees;
 - ICB Board members;
 - ICB committee and sub-committee members;
 - Third parties acting on behalf of the ICBs under any contract arrangements, incl. contracted clinical experts and pathway leads, commissioning support, shared services, and individuals acting as senior responsible officers (SROs) for programmes of work and work streams;
 - Agency staff engaged by the ICBs, seconded colleagues, bank staff;
 - Contractors of the ICBs.

These are collectively referred to as 'individuals' hereafter.

6. The ICBs expect any bidders and suppliers to have due regard to the ICBs' Anti-

Bribery, Corruption, Fraud policies, and to the cluster ICBs' Standards of Business Conduct Policy.

PRINCIPLES OF BUSINESS CONDUCT

Principles

7. All individuals in scope of this policy should observe the principles of good conduct in the way they do ICB business. Individuals should always:
 - Adhere to the [seven key principles of the NHS Constitution](#)
 - Adhere to the [Seven Principles of Public Life](#) (the Nolan Principles)
 - Comply with the requirements of the ICBs' Constitutions and the [ICBs' policies](#), and be aware of the responsibilities outlined within.
 - Act in good faith and in the interests of the ICBs
 - Adhere to and comply with the law and regulations

Prevention of bribery, corruption, and fraud

8. All individuals in scope of this policy must be aware of their duties and responsibilities arising from the [Bribery Act 2010](#).
9. In its simplest terms, bribery is the practice of offering something in exchange for benefits. Whilst money is a classic form of bribe, bribes can also be more intangible, and they might include things like the offer of property, valuable objects, or a promise to perform a particular service in the future. In order to be considered a bribe, there must be an offer and acceptance with the understanding that the individual who accepts the bribe will be doing something in return.
10. While this differentiates bribes from gifts that are offered in genuine good will, the perception may be that gifts or hospitality are used to influence decision-makers. It is therefore important to remain vigilant and transparent re offers of gifts and hospitality, to declare such offers, and manage such offers in accordance with this policy.
11. The [Fraud Act 2006](#) created a criminal offence of fraud and defines three ways of committing it: by false representation; by failing to disclose information; and by abuse of position.
12. No individual must use their position to gain advantage. Declaring interests is an important mechanism to safeguard against fraud.
13. The ICBs' Anti-Fraud, Anti-Bribery and Anti-Corruption Policies apply and must be adhered to.

Confidentiality

14. During their work with or for the ICBs, many individuals will handle or be exposed to information which is deemed personal, sensitive or confidential.

15. Any such information, and disclosure of information, must be managed and handled in accordance with the requirements of the law and regulations, including data protection legislation, freedom of information law, confidentiality rules and regulations as applicable to the NHS, and procurement legislation and regulation.
16. Individuals must not use information that they are privy to for their own gain, neither during their work for or on behalf of the ICBs nor following the termination of their contract, employment or relationship with the ICBs.
17. Individuals must not disclose information on the operations of the ICBs which might provide a commercial advantage to any organisation (private or NHS) who is in a position to have commercial relationships with the ICBs.

For particularly sensitive procurement/contracts individuals may be asked to sign a non-disclosure agreement.

18. The ICBs' Information Governance Policies apply and must be adhered to.

CONFLICTS OF INTEREST

Definition

19. A conflict of interest is a set of conditions/circumstances in which an individual's ability to objectively exercise judgement or objectively act in a role is, could be, or is seen to be impaired or otherwise influenced by their involvement in another role or relationship. Both perceived and actual conflicts of interest must be managed to maintain probity and public trust.
20. A conflict of interest can occur when there is the possibility that an individual's judgement regarding their primary duty to NHS patients may be influenced by a secondary interest they hold. Such a conflict may be:
 - Potential – there is the possibility of a material conflict between one or more interests in the future
 - Actual – there is a material conflict between one or more interests
 - Perceived – an observer could reasonably suspect there to be a conflict of interest regardless of whether there is one or not.

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21. Conflicts can occur with interests held by the individual or their close family members, close friends and associates and business partners (dependent on the circumstances and the nature of such relationships).
22. The ICBs have in place mechanisms for the effective management of actual, potential and perceived conflicts of interest. These mechanisms include:
 - Identify and minimise the risk of conflicts of Interest at the earliest possible opportunity.
 - Create an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.
 - Acknowledge that a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them occurring.
 - Assume the existence of a conflict of interest, if in doubt, and manage it appropriately rather than ignore it.
 - Accept that for a conflict of interest to exist, financial gain is not necessary.
23. Conflicts of interest are inevitable, but in most cases, it is possible to handle them with integrity and probity by ensuring they are identified, declared and managed in an open and transparent way.
24. Appendix A provides detailed definitions, and examples of interests to support identification and correct declaration of interests.

Management of conflicts of interest

25. The ICBs will facilitate an environment where all individuals feel able, encouraged and obliged to be open, honest and upfront about actual or potential conflicts. This will lead to effective identification and management of conflicts. In deciding whether any role or relationship or interest would impair or otherwise influence the individual's judgement or actions in their role within the ICBs, the ICBs will exercise discretion and consider each case separately.

Where there is doubt, the existence of a conflict of interest will be assumed and managed accordingly.

26. While conflicts of interest cannot always be avoided the ICBs will proactively manage conflicts of interest by:
 - a) Maintaining and reviewing Registers of Declarations of Interest, as required by the [Health and Care Act 2022](#).
 - b) Managing membership of formal committees and decision-making bodies supporting the ICBs.
 - c) Implementing clear meeting and decision-making procedures.
 - d) Working within the ICBs' Constitutions, Standing Financial Instructions and Schemes of Reservations and Delegations.
 - e) At meetings, being aware of the law and good practice.

Declarations of interests

27. The ICBs need to be aware of all situations where an individual has interests outside their

role, and where that interest has potential to result in a conflict of interest between the individual's interests and their ICB duties. The ICBs therefore requires all individuals in scope of this policy to make declarations of interests.

When to make a declaration

28. When applying to senior roles

- All applicants for a senior role in the cluster (Band 8b and above), its Boards, committees and sub-committees will be required to declare any relevant interests. The relevant ICB will request this declaration as part of the application process, and candidates should ensure to complete relevant 'other supporting information' sections of application forms and / or pro-actively declare any interests.

29. When appointing into senior roles

- On appointing Board members, committee and sub-committee members or senior colleagues, the ICBs will need to consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. This will need to be considered on a case-by-case basis assessing the materiality of the interest, i.e., whether the individual (or any person with whom they have a close association) could benefit (whether financially or otherwise) from any decision the ICBs might make. This will be particularly relevant for decision-making roles such as Board members, committee and sub-committee members, and Executive and senior management roles.
- The ICBs will also need to determine the extent of the interest and the nature of an individual's proposed role within the ICBs. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role.

30. When appointed

- Following appointment, and regardless of whether an individual declared interests as part of the recruitment / selection / appointment process, all individuals in scope of this policy must make a formal declaration of interests within 28 days of assuming a role with / for the ICB. The process for doing this is outlined below. Where there are no interests to declare a nil return is required (i.e., a declaration in writing that the individual has no interests).
- If interests arise at a later stage, or if an individual changes role in the ICBs, a declaration of interests is required. The declaration should be made as soon as reasonably practicable and by law within 28 days after the interest or change in role arises.

31. When becoming aware of an interest

- As soon as an individual becomes aware of an interest which could lead to a conflict of interest where the ICBs are considering an action or decision, the individual should make

an updated declaration. This declaration should be made within 28 days of the new interest arising.

32. Annually

- All individuals in scope of this policy will be asked on an annual basis to review and update or confirm their declarations of interest. This includes nil declarations where an individual has no interests to declare.

What to declare

33. Appendix A provides detailed guidance and examples for declarable interests. In summary, anything that potentially influences an individual's objectivity on a matter and ability to objectively make a decision, or can be perceived to do so, should be declared. This includes interests that family members hold.

34. Declarations must be precise, and all fields in the Civica Declare portal must be completed.

Colleagues who have businesses, directorships etc. registered with Companies House must ensure that information they provide to the ICBs matches information that can be obtained from Companies House precisely.

Colleagues who maintain publicly accessible internet profiles on business networks like LinkedIn, or whose professional information is publicly accessible on websites of organisations that they have involvement with, must carefully consider if any such activities must be declared as interests, or could give rise to interests.

How to make declarations

35. The ICBs use the Civica Declare online portal for recording declarations of interests.

36. Individuals in scope of this policy receive automated notifications to declare interests, and weekly reminders when the 28-day deadline for a declaration has passed.

When the 28-day deadline has passed, a chaser will be issued within 7 days past the deadline to the individual. If the chaser is not actioned, another chaser will be sent within 7 days following the first chaser, to the individual and their line manager. Failure to make a declaration of interest may result in disciplinary action.

37. Line managers receive automated notifications when their direct reports make a declaration of interest. Line managers must sign off their direct reports' declarations of interest within 7 days of notification. This sign-off is to ensure that line managers have discussed with their direct reports the interest and agreed the actions to manage any conflicts arising from the interest.

38. If individuals do not make declarations despite the two chasers, or line managers do not sign off on declarations, these instances will be reported to the Executive Management Group who will agree actions to address non-compliance.

39. Notifications to complete a declaration of interests are triggered by the annual anniversary of a declaration, by job changes within the ICBs and recorded on ESR, or by onboarding

of new ICB colleagues on ESR.

40. The Civica Declare portal has a 'how to' guide to support individuals when making declarations of interest. The portal allows users to raise 'tickets' with any queries re the use of the portal, and these tickets will be responded to.

Individuals can also request support and guidance from the Corporate Governance Team via the dedicated Conflicts of Interest inbox, bswicb.coisupport@nhs.net.

Register of Interests

41. The ICBs' Registers of Interests are held and maintained by the ICB Corporate Governance Team. It is the responsibility of the Deputy Director of Governance, Compliance, Risk to ensure that the ICBs' registers are up to date.
42. Interests remain on the registers for six months after the interest has expired, or the individual has ended their relationship with the ICBs. A historic record of interests is retained for a minimum of six years from the date on which it expired or the individual ended their relationship with the ICBs. The Registers of Interests will give the following information:
- Name of individual.
 - Position within, or relationship with, the ICBs.
 - Type of interest.
 - Description of interest.
 - Relevant dates relating to the interest (i.e., from when to when the interest existed).
 - Action taken to mitigate risk.
43. The Registers of Interests for ICB Board members, committee members and sub-committee members will be reviewed by the ICB Boards at least once a year, and will be published on the relevant ICB's website as well as in the relevant ICB's Annual Report.
44. In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm, and where authorised by the Conflicts of Interest Guardian, an individual's name may be redacted from the published register. The individual must believe that substantial damage or distress may be caused to themselves or somebody else by the public disclosure, and a request to withhold from publication, in writing, can be made to the Conflicts of Interest Guardian. Decisions not to publish information are made by the Conflicts of Interest Guardian, who should seek appropriate legal advice where required, and who will inform the ICBs' Boards of any such decision. The ICBs should retain a confidential un-redacted version of the register.
45. The ICBs' full registers of interests (i.e. interests of all individuals in scope of this policy) will not be published but are available to the public on request.
46. For the ICB Boards, committees and sub-committees, the Deputy Director of Governance, Compliance, Risk and legal or their nominee, discussing with the Conflicts of Interest Guardian where appropriate, will consider every interest declared on appointment, on refreshed declarations of interest, and any declared new interests.

This may identify conflicts of interest that are profound and acute. The Deputy Director of Governance, Compliance, Risk and Legal will bring this to the attention of the Conflicts of Interest Guardian, and it may be decided that the interest is not manageable. If this is the

case, the ICBs' Chair must be informed as in order to manage such a conflict of interest, an individual may be required to step down from a particular role or move to another role within the ICBs.

Managing ICB Boards, committees and sub-committees memberships

47. The Conflicts of Interest Guardian will, with the Deputy Director of Governance, Compliance, Risk, ensure that for every interest declared on appointment or declared as a new interest by ICB Boards, committee or sub-committee members, arrangements are in place to manage the conflicts of interest, to ensure the integrity of the decision-making process, and to protect individuals and the resources and reputation of the NHS.
48. Where an individual declares a significant interest that would prejudice their objective decision-making, the individual should not be a voting member of a committee, in particular of committees, sub-committees or advisory groups that make or inform commissioning and contracting decisions.
49. For previously recorded declarations of interest, steps will be taken to ensure that Committee membership supports decision making as far as is reasonably practicable.

Management of meetings and decision making

50. Ahead of each meeting and in view of agenda items, the Chair of a meeting should consider what conflicts are likely to arise and how they should be managed. The meeting minutes will record declarations of interest and how the Chair managed conflicts of interest – this could include:
 - Requiring the member not to attend the meeting.
 - Ensuring the member does not receive meeting papers for the relevant item.
 - Requiring the member to not attend all or part of the discussion and decision on the relevant item; In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public seating area.
 - Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared.
 - Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate in both the discussion and in any decision.
 - Removing the member from the group or process altogether.
51. The agenda for all decision-making meetings will contain a standing item, at the commencement of each meeting, requiring members to declare any interests relating specifically to the agenda items being considered, including those interests already formally declared and recorded in the Register of Interests.
52. The Chair of the meeting will decide whether there is a conflict of interest and ensure that the appropriate course of action is taken. The Chair of a meeting may consult with the

Deputy Director Governance, Compliance, Risk or the Conflicts of Interest Guardian.

53. Failure to disclose an interest may render the individual liable to disciplinary action which could ultimately result in termination of employment or office. Where others at the meeting are aware of facts or circumstances which may give rise to a conflict of interests which has not been declared, this must be brought to the attention of the Chair of the meeting so that they can take the appropriate course of action.
54. Where the Chair of a meeting has an interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and an unconflicted member will act as Chair for the relevant part of the meeting.
55. Should the situation arise that a significant number of individuals (more than 50%) are deemed to be prevented from taking part in a meeting because of conflicts of interests, the Chair of the Board / committee / sub-committee will determine whether the discussion can proceed. In making this decision, the Chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the relevant ICB's Standing Orders and approved committee Terms of Reference.
56. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the Chair of the meeting shall consult with the Deputy Director of Governance, Compliance, Risk on the action to be taken. This may include:
 - requiring another of the ICBs' committees which can be quorate to progress the item of business, or if this is not possible a recommendation on decision can still be taken by remaining members and referred to the ICBs' Audit Committees for ratification of a final decision.
57. Advisory committees bring together experts from a specific field of practice and often draw from a relatively small pool of individuals. It is likely that these advisors will have interests relevant to the subject matter. The chair should not normally have any specific direct or indirect financial or non-financial interests. Advisors must declare their interests on being invited to participate and, where there are material interests, should be allowed to participate but must not participate in decision making.
58. Minutes of meetings must detail all declarations made along with the course of action taken and any new declarations must be recorded in the Register of Interests. The minute will include:
 - who has the interest?
 - the nature and magnitude of the interest and why it gives rise to a conflict.
 - the item(s) on the agenda to which it relates.
 - how the conflict was agreed to be managed.
 - evidence that the conflict was managed as intended.

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Transparency in procurement and commissioning

Procurement Policy

- 59. The ICBs recognise the importance in making decisions about the services they procure in a way that does not call into question the motives behind the procurement decision. The ICBs will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers, and compliant with relevant laws and regulations.
- 60. The ICBs' Procurement Policies apply and must be adhered to.
- 61. The ICBs will also identify as soon as possible where colleagues might transfer to a provider (or their role may materially change) following the award of a contract. This will be treated as a relevant interest to be managed.

Contractors and people who provide services to the ICBs

- 62. Anyone seeking information on, or engaging with the ICBs in relation to, the potential provision of services or facilities to the ICBs, will be required to make a declaration of any relevant or potential conflict of interest.
- 63. Anyone contracted to provide services or facilities directly to the ICBs will be subject to the same provisions of this policy in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.
- 64. Bidders should declare any conflicts of interest, to allow commissioners to ensure that they comply with the principles of equal treatment and transparency. When bidders declare an interest, the commissioners must decide how to manage such interests.
- 65. The ICBs' Procurement Policies apply and must be adhered to.

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Contract monitoring

66. The individuals involved in contract monitoring should have no direct or indirect financial, professional, or personal interest in the provider that could be perceived to prevent them from carrying out their role in an impartial, fair and transparent manner.
67. As part of the procurement process and commissioning cycle, contract monitoring meetings need to consider conflicts of interest. The chair of a contract management meeting should invite declarations of interests, record any declared interests in the minutes of the meeting and manage any conflicts appropriately and in line with this policy. This also applies where a contract is held jointly with another organisation such as the Local Authority or with other ICBs under lead commissioner arrangements.

GIFTS, HOSPITALITY AND SPONSORSHIP

68. The ICBs acknowledge that individuals may receive offers of gifts, hospitality, and sponsorship while undertaking ICB business. Individuals must not accept gifts, hospitality or other benefits which might reasonably be seen to compromise their professional judgement or integrity.
69. Colleagues should not ask for or accept gifts, gratuities, or honoraria (such as grants, scholarships) from any individual or organisation that may be capable of being construed as being able to influence any decision or cast doubt on the integrity of such decisions.

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70. Where acceptance of gifts, hospitality or sponsorship requires prior approval, the following applies:

Recipient	Approval Required from
Non-Executive Members and Partner Members of the ICBs' Boards (excluding Chair)	ICB Chair
ICB Chair	NED Audit
ICB CEO	ICB Chair
ICB staff	Line manager

Gifts

71. Individuals should not accept gifts that may affect, or be seen to affect, their professional judgement.
72. Gifts – from suppliers or contractors
- always decline gifts of any nature or value from providers / suppliers (current or potential), and declare the offer within 28 days;
 - you may accept low cost branded promotional aids with a value under £6 in total, and this need not be declared;
73. Gifts from other sources (e.g., patients, families, service users):
- do not ask for any gifts;
 - always decline gifts of cash and vouchers (e.g., vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICBs), and declare the offer within 28 days;
 - modest gifts under a value of £50, from members of the public to colleagues for work well done (such as flowers or small tokens of appreciation) can be accepted where there is no risk that the gift could be suspected of influencing the ICBs' actions, or where the cost of returning the gift would not be warranted. These gifts do not need to be declared;
 - do not accept gifts valued at over £50, declare any offers within 28 days;
 - treat multiple gifts from the same source over a 12-month period and with a cumulative value of over £50 in the same way as a single gift over £50;
 - use a common-sense approach when valuing a gift, i.e., use an actual amount if known, or an estimate that a reasonable person would make as to the gift's value).
74. Declarations of gifts – offers, accepted offers, and declined offers – should be made via the Civica Declare online portal.
75. It is not appropriate to give gifts to individuals or organisations at public expense.

Hospitality

76. Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of working hours. As a result, individuals will sometimes appropriately receive hospitality. Individuals receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety, and might influence behaviour.
77. Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education, and training events, etc.
78. Modest hospitality is an accepted courtesy of a business relationship. However, the organisation or individual receiving the hospitality should never put themselves in a position where there could be any suspicion that their business decisions could have been influenced by accepting hospitality from others.
79. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, where it may be accepted but should be modest and reasonable, approved by a director in advance and declared.
80. Hospitality – principles
- do not ask for or accept hospitality that may affect, or be seen to affect, your professional judgement;
 - only accept hospitality when there is a legitimate business reason and it is proportionate to the nature and purpose of the event, e.g. a buffet lunch at a conference;
 - be cautious when an actual or potential supplier or contractor offers hospitality – you may accept this if it is modest and reasonable, but obtain senior approval and declare the hospitality;
81. Meals and refreshments
- you may accept these up to value of £25, and need not declare this;
 - you may accept these of a value between £25 and £75, and you must declare this;
 - you should refuse these if they are over the value of £75, and declare the offer; in exceptional circumstances senior approval may be given to accept meals and refreshments of a value over £75; such acceptance and senior approval must be declared, and a clear reason why this was permissible must be recorded.
82. Travel and accommodation
- you may accept modest offers to pay some or all of the travel and accommodation costs related to attendance at events, and you must declare this;
 - offers beyond 'modest' or that the ICBs would not usually offer – e.g. business class / first class travel and accommodation incl. domestic travel, or offers of foreign travel and accommodation – must be approved by senior staff before accepting, and should only be accepted in exceptional circumstances; such acceptance and senior approval must be declared, and a clear reason why this

was permissible must be recorded

83. Declarations of hospitality – offers, accepted offers, senior approval and reasons for acceptance – should be made via the Civica Declare online portal.

Sponsorship

84. Sponsorship by commercial companies, including the pharmaceutical sector, is a common practice and reduces NHS expenditure. Individuals in scope of this policy may be offered commercial sponsorship for courses, conferences, events, post/project funding, meetings, and publications in connection with the activities which they carry out for or on behalf of the ICBs.
85. Acceptance of commercial sponsorship
- should only be approved if a reasonable person would conclude that the event will result in a clear benefit to the ICBs or NHS;
 - must not in any way compromise commissioning decisions of the ICBs or be dependent on the purchase or supply of goods or services;
 - does not imply endorsement by the ICBs of any product or company, and there should be no promotion of products apart from that agreed in writing in advance;
 - is disclosed in the papers relating to the meeting and in any published proceedings where a meeting is sponsored by external sources;
86. Sponsors will not have access to patient or individual confidential information. No information must be supplied to the sponsor from which they could gain a commercial advantage, or which is not normally in the public domain.
87. Sponsors representatives may attend and take part in events that they sponsor but may not have a dominant influence over the content or main purpose of the event. Involvement of a sponsor will always be transparently identified.

Hospitality, gifts, and sponsorship register

88. The ICBs maintains registers of hospitality, gifts, and sponsorships. Declarations of offers – whether declined or accepted, see sections above – must be made within 28 days of offer via the Civica Declare online portal.
89. The Registers for Board and committee members will be presented to the In-Common Audit Committee at least once a year. The Registers will be published on the ICBs websites and will be referenced as part of the Annual Reports.

OUTSIDE EMPLOYMENT AND PRIVATE PRACTICE

90. All individuals in scope of this policy must inform the ICBs if they are employed or engaged in, or wish to engage in any employment or consultancy work in addition to their work with the ICBs. The purpose of this is to ensure that the ICBs are aware of any potential conflicts of interest.

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91. Clinical colleagues must declare their general practice, any private practice (giving the name of the private facility, when they practice and what they practice as part of their declarations of interests). Outside employment and private practice must be declared as a potential conflict of interest.
92. Individuals must obtain prior permission to engage in secondary employment, and the ICBs reserve the right to refuse permission where they believe a conflict will arise which cannot be effectively managed. All existing outside employment should be declared on appointment.

INITIATIVES

93. As a general principle, any financial gain that results from an individual's external work using the ICBs' time or title (e.g. speaking at events or conferences, writing articles) and/or which is connected with the ICBs business must be passed to the ICBs' Chief Officer for Strategic Finance and Resources to pay in to the ICBs.
94. Any patent, designs, trademarks, or copyright resulting from the work (e.g. research) of an individual as part of their contract for services / employment with the ICBs shall be the intellectual property of the ICBs. Individuals with existing relevant patents will be expected to declare these where they might give rise to a conflict of interest with regard to their primary duty to the NHS.
95. Approval from the appropriate line manager should be sought prior to entering into any obligation to undertake external work connected with the business of the ICBs.
96. Where the undertaking of external work benefits or enhances the ICB reputation or results in financial gain for the ICBs, consideration will be given to rewarding colleagues, subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health.

RAISING CONCERNS AND BREACHES

97. There will be situations when interests are not identified, declared, or managed appropriately and effectively.

Where this happens innocently or accidentally, e.g. through an oversight, this is referred to as 'poor practice incident'.

Where interests are not identified, declared, or managed because of the deliberate actions of colleagues or other organisations, including with fraudulent intent, this is referred to as a 'breach'.

Raising concerns

98. Effective management of conflicts of interest requires an environment and culture where individuals feel supported and confident in declaring relevant information, including notifying any actual or suspected breaches of the rules.
99. It is the duty of every individual in scope of this policy to speak up about genuine

concerns in relation to the declaration and management of conflicts of interest.

Individuals should not ignore their suspicions or investigate themselves, but speak to the Deputy Director of Governance, Compliance, Risk in the first place. All such notifications will be recorded and held in the strictest confidence.

Individuals who wish to notify the ICBs that they have accidentally or knowingly breached this policy should contact the Deputy Director of Governance, Compliance, Risk.

100. To make reports of a poor practice incident and / or breach of policy, individuals should complete a non-compliance form (Appendix B) and send it to bswicb.clustergovernance@nhs.net
101. Anyone from a partner organisation wishing to report should ensure that they comply with their own organisation's relevant policies to obtain appropriate protection. Providers, patients and other third parties can make a complaint under the Procurement Patient Choice and Competition Regulations.

Investigating incidents and breaches, and reporting

102. Where individuals have concerns about the administration and application of the ICBs' policy on conflicts of interest management, they should report these to the Deputy Director of Governance, Compliance, Risk. The Deputy Director of Governance, Compliance, Risk will investigate the alleged poor practice incident / breach. In order to investigate an alleged poor practice incident / breach, the Deputy Director of Governance, Compliance, Risk may request information from any individuals who may have witnessed the alleged incident / breach and may request any relevant written material such as meeting papers or meeting minutes. Following investigation, the Deputy Director of Governance, Compliance, Risk will:
 - Assess the severity of the incident, and whether it is serious enough to be treated as a breach of this policy. A breach includes the deliberate withholding of information about a conflict of interest, including with fraudulent intent.
 - Assess what action is required in response.
 - Consider who else inside and outside the organisation should be made aware.
 - Prepare a report about the incident / breach, including recommendations how to address/remedy the concerns raised.
103. The Conflicts of Interest Guardian will consider the Deputy Director of Governance, Compliance, Risk's report and recommendations, and decide which course of action to take, including implementation of recommendations made by the Deputy Director of Governance, Compliance, Risk. The Conflicts of Interest Guardian will inform the Audit Committees about the incident and actions taken.
104. Should the Deputy Director of Governance, Compliance, Risk and the Conflicts of Interest Guardian conclude that the matter is serious enough to be treated as a breach of this policy, they will refer the matter to the relevant ICB's Local Counter Fraud Service (LCFS).
105. Actions taken in response to a poor practice incident or a breach may include:
 - informal action against colleagues including as reprimand, signposting to training and/or guidance.

- formal disciplinary action such formal warning, requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal.
- report to the statutory regulated healthcare professional body.
- assessment as not a fit and proper person.
- legal action, including investigation and prosecution under fraud, bribery, and corruption legislation.
- contractual actions against other organisations.
- review of ICBs' policies and procedure to clarify expectations and requirements in regard to ICBs' colleague's conduct of business.

106. Anonymised details of breaches will be published on the relevant ICB website and reported to the relevant ICB Board. The LCFS will include relevant breaches in their reports to the In-Common Audit Committee.

Impact of non-compliance

107. If conflicts of interest are not effectively managed, the ICBs could face civil challenges to decisions made. For instance, if breaches occur during a service re-design or procurement exercise, the ICBs risk a legal challenge from providers that could potentially overturn the award of a contract, lead to damages claims against the ICB, and necessitate a repeat of the procurement process. This could delay the development of better services and care for patients, waste public money and damage the ICBs' reputation.
108. Individuals who fail to disclose relevant interests, outside employment or receipts of hospitality, gifts, or sponsorship, as required by this policy or the ICBs' standing orders and financial policies, may be subject to investigation and, where appropriate, to disciplinary action which could ultimately result in the termination of their employment or position with the ICBs. In extreme cases, deliberate failures to declare interests could also lead to criminal proceedings including for offences such as fraud, bribery, and corruption.
109. Statutorily regulated healthcare professionals who work for, or are engaged by, the ICBs are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The ICBs will report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. Consequences for inappropriate action could include fitness to practise proceedings being brought against the individual and possibly being struck off by their professional regulator as a result.

ROLES & RESPONSIBILITIES

Accountable Officer

110. The Accountable Officer has accountability for the ICBs' management of conflicts of interests. The Accountable Officer will actively demonstrate leadership in this area and champion the highest standards of business conduct within the ICBs.

Conflicts of Interest Guardian

111. This role will be undertaken by the NED Audit, supported by the Deputy Director of Governance, Compliance, Risk.
112. The Conflicts of Interest Guardian should, in collaboration with the Deputy Director of Governance, Compliance, Risk:
- Act as a conduit for GP practice staff, members of the public, and health and care professionals who have any concerns with regards to conflicts of interests.
 - Be a safe point of contact for individuals in scope of this policy to raise any concerns in relation to this policy.
 - Consider and approve for acceptance offers of hospitality where applicable.
 - Support the rigorous application of conflict-of-interest principles and associated policies.
 - Undertake investigations into reported breaches, as detailed above.
 - Provide independent advice and judgment (or seek legal advice where necessary) where there is any doubt about how to apply conflicts of interest policies and principles in a particular situation.
 - Provide advice on minimising the risks of conflicts of interest.
 - Notify NHS England and professional regulatory bodies of breaches where appropriate.

ICB Boards, committee, and sub-committee members

113. The ICB Boards will role-model good business conduct and lead the ICBs' conflict of interest management by example. The Boards will formally review the ICBs' Register of Interest (Board members) at least once a year to ensure transparent decision making.
114. The Audit Committees will receive the ICBs' Registers of Gifts, Hospitality and Sponsorship at least once, and any reports regarding poor practice incident or breach investigations.
115. All ICB Boards, committee and sub-committee members will declare all interests on joining the organisation and ensure that their declarations of interest remain complete and up to date at all times. Members will also disclose, at all committee meetings, interests relevant to any agenda items. Members will undertake the required conflicts of interest training and refresher training.
116. Executive members of the ICB Boards have an on-going responsibility for ensuring robust management of conflicts of interest and providing leadership in this regard.
117. NEDs provide scrutiny, challenge, and an independent voice in support of robust and transparent decision-making and management of conflicts of interest.

Chairs of meetings

118. Chairs of meetings have a responsibility to ensure this policy is robustly applied to all committee, sub-committee, and other meetings, in particular those that make and / or inform commissioning and procurement decisions. Chairs' responsibilities regarding managing conflicts in meetings are detailed in paragraphs above.

Deputy Director of Governance, Compliance, Risk

119. This role has responsibility for:
- day-to-day management of conflicts of interest matters, queries, and administration.
 - maintaining the ICBs' Registers of Interests and the Registers of Gifts, Hospitality and

Sponsorship.

- supporting the Conflicts of Interest Guardian to enable them to carry out their role effectively.
- providing advice, support, and guidance on how conflicts of interest, and offers of gifts, hospitality and sponsorship should be managed.
- facilitating appropriate training and monitor completion.
- liaising with LCFS and investigating incidents and breaches.

Individuals in scope of this policy

120. Individuals in scope of this policy are required to familiarise themselves and adhere to this policy. Individuals must declare interests, and offer of gifts, hospitality and sponsorship as described in this policy. In doing so, individuals must ensure that they discuss these matters with their line manager incl. mitigating actions. Line managers must ensure that they periodically check with their direct reports whether any declarations need to be made or updated and must sign-off declarations before submission. Individuals are expected to undertake and complete training on an annual basis.

TRAINING

121. Training on the management of conflicts of interest will be offered to all individuals in scope of this policy. Individuals' seniority and likely status as decision-makers where procurements and commissioning are concerned determine the respective training requirements, see Appendix C.

EQUALITY IMPACT ASSESSMENT

122. An Equality Impact Assessment (EIA) assesses the impact of services, policies, and changes to existing services on equality. An EIA aims to identify, on the basis of evidence, any impact on the nine protected characteristics, and any adjustments to reduce or eliminate any negative impact.

123. An EIA was undertaken, and no impacts were found.

MONITORING EFFECTIVENESS

124. Internal audits of the ICB's¹ conflicts of interest management will test the effectiveness of this policy. Reports of non-compliance with this policy, and completion rates for declarations of interest and for conflict-of-interest training will be indicators of the effectiveness of this policy.

REVIEW

125. This document is reviewed every three years unless organisational changes, legislation or guidance prompt an earlier review. Recurrent instances of non-compliance will be investigated to ascertain the source of non-compliance. If it is found that the policy itself is a source of non-compliance, e.g. is not sufficiently clear, this will trigger a review also.

REFERENCES AND LINKS TO OTHER DOCUMENTS

References

- Health and Care Act 2022, <https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted>
- NHSE (2024), Managing Conflicts of Interest in the NHS, <https://www.england.nhs.uk/long-read/managing-conflicts-of-interest-in-the-nhs/>
- Committee on Standards in Public Life (1995), The Seven Principles of Public Life (The Nolan Principles), <https://www.gov.uk/government/publications/the-7-principles-of-public-life>
- Professional Standards Authority (2013), Standards for members of NHS boards in England, https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-members-of-nhs-boards-and-cggs-2013.pdf?sfvrsn=d5f77f20_2
- [NHS Constitution](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#principles-that-guide-the-nhs) <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#principles-that-guide-the-nhs>
- [NHS-BSW-ICB-Constitution-V5 NHSE-approved-150426.pdf](#)
- [NHS-Somerset-ICB-Constitution-v1.6-150426.pdf](#)
- [NHS-Dorset-ICB-Constitution-master-v2.3-150426.pdf](#)
- [Equality Act 2010](#) <http://www.legislation.gov.uk/ukpga/2010/15/contents>
- [Bribery Act 2010](#) <https://www.gov.uk/government/publications/bribery-act-2010-post-legislative-scrutiny-memorandum>
- [The Fraud Act 2006](#) <https://www.cps.gov.uk/legal-guidance/fraud-act-2006>

Other documents

ICBs' policies / procedures that are relevant to this policy:

- BSW ICB Procurement Policy
- Dorset ICB Procurement Market Management Policy
- Somerset ICB Procurement Policy on their intranet
- BSW ICB Anti-bribery, Anti-fraud, and Anti-corruption Policy
- Dorset ICB Anti-bribery, Anti-fraud, and Anti-corruption Policy
- Somerset ICB Anti-bribery Policy
- BSW ICB Information Governance Policies
- Dorset ICB Information Governance Policies
- Somerset ICB Information Governance Policies

- BSW, Dorset and Somerset ICB Cluster [Standing-Financial-Instructions.pdf](#)
- BSW, Dorst and Somerset ICB Cluster [Scheme-of-Reservations-and-Delegation.pdf](#)

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APPENDICES

A – Definitions

Financial interests: where an individual may get direct financial benefits from the consequences of a decision their organisation makes.

This could include:

- A director (including a non-executive director) or senior employee in another organisation which is doing or is likely to do business with a health or social care organisation, including involvement in a new care model.
- A shareholder, partner or owner of an organisation which is doing, or is likely to do business with a health or social care organisation.
- Someone in outside employment.
- Someone in receipt of secondary income.
- Someone in receipt of a grant.
- Someone in receipt of other payments (e.g., honoraria, day allowances, travel, or subsistence).
- Someone in receipt of sponsored research funding.
- Someone who holds a patent

Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a decision their organisation makes, (for example, increasing their professional reputation or status or promoting their professional career).

This could include situations where the individual is:

- An advocate for a particular group of patients.
- A clinician with a special interest.
- An active member of a particular specialist body.
- An advisor for the Care Quality Commission (CQC) or National Institute of Health and Care Excellence (NICE).
- A research role.

Non-financial personal interests: where an individual may benefit personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.

This could include where the individual is:

- A member of a voluntary sector board or has a position of authority within a voluntary sector organisation.
- A member of a lobbying or pressure group with an interest in health and care.

Indirect interests: where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

This could include:

- Close family members and relatives.
- Close friends and associates.
- Business partners (including fellow GP partners).

Whether an interest held by another person gives rise to a conflict of interests will depend on the nature of the relationship and the role of the individual within the ICBs. If in doubt, the individual should assume that a potential conflict of interest exists and make a declaration.

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Situations to be aware of, as they may give rise to conflicts of interest

Outside employment

What are the issues?
Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles, and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation.
Principles and rules
• Declare any existing outside employment on appointment, and any new outside employment when it arises. • Where a risk of conflict of interest is identified, the actions outlined in this policy must be considered and applied to mitigate risks. • Seek prior approval from the ICBs to engage in outside employment.
What should be declared
• Staff name and role with the ICBs/ICB. • A description of the nature of the outside employment (e.g., who it is with, a description of duties, time commitment). • Relevant dates. • Action taken to mitigate against a conflict

Shareholding and other ownership interests

What are the issues?
Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with the ICBs. For instance, if they are involved in the ICBs' procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.
Principles and rules
• Declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership, or consultancy which is doing, or might be reasonably expected to do, business with their organisation. • No need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts. • Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest, the actions outlined in this policy must be considered and applied to mitigate risks
What should be declared
• Staff name and role with the ICBs. • A description of the nature of the shareholding/other ownership interest. • Relevant dates. • Action taken to mitigate against a conflict

Patents

What are the issues?
Conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment, or resources from the ICBs, then this too could create risks of conflicts of interest.
Principles and rules
• Declare patents and other intellectual property rights you hold (individually, or by virtue of association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation. • Seek prior permission from the ICBs before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the ICB's own time, or uses its equipment, resources, or intellectual property. • Where holding of patents and other intellectual property rights give rise to a conflict of interest the actions outlined in this policy must be considered and applied to mitigate risks.
What should be declared
• Name and role with the ICBs. • A description of the patent or other intellectual property right and its ownership. • Relevant dates. • Action taken to mitigate against a conflict

Loyalty interests

What are the issues?
As part of their jobs staff need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.
Principles and rules
Declare loyalty interests if you are involved in decision making and: • Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory, or other body which could be seen to influence decisions they take in their NHS role. • Sit on advisory groups or other paid or unpaid decision-making forums that can influence how their organisation spends taxpayers' money. • Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners. • Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities. • Where holding loyalty interests gives rise to a conflict of interest the actions outlined in this policy must be considered and applied to mitigate risks.

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What should be declared

- Name and role with the ICBs.
- A description of the nature of the loyalty interest.
- Relevant dates.
- Action taken to mitigate against a conflict

Donations

What are the issues?

A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services.

As a major public sector employer, the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or fundraising activities for charity.

Conflicts of interest can arise.

Principles and rules

- Treat donations by suppliers or by bodies seeking to do business with the ICBs treated with caution, do not routinely accept them. In exceptional circumstances a donation from a supplier may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Do not actively solicit charitable donations unless this is a prescribed or expected part of your duties for the ICBs, or is being pursued on behalf of another charitable body and is not for your own personal gain.
- Obtain permission from the ICBs if in their professional role you intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- You may make a donation to a charitable fund in lieu of a professional fee you receive, subject to ensuring that you take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared

- Name and role with the ICBs.
- A description of the donation.
- Relevant dates.
- Action taken to mitigate against a conflict

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Sponsored posts

What are the issues?
Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. Safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.
Principles and rules
• Seek formal prior approval from the ICBs before you establish external sponsorship of a post. • Avoid rolling sponsorship of posts unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing. • Record in writing that the sponsorship of a post will have no effect on purchasing decisions or prescribing and dispensing habits; detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise. Auditing arrangements should be established to ensure this is the case. • Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided. • Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.
What should be declared
• Name and role with the ICBs. • A written record of the sponsored post arrangements. • Any other interests arising as a result of the association with the sponsor. • Relevant dates. • Action taken to mitigate against a conflict

Sponsored research

What are the issues?
There is potential for conflicts of interest to occur when research funding by external bodies does or could lead to a real or perceived commercial advantage for these bodies. There needs to be transparency and any conflicts of interest should be well managed.
Principles and rules
• Funding sources for research purposes must be transparent. • Any proposed research must go through the relevant approvals process. • There must be a written protocol and written contract between staff, the ICBs, and/or institutes at which the research will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. • The research must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
What should be declared
• Name and role with the ICBs.

- A written record of the sponsored research arrangements.
- Description of the nature of the nature of their involvement in the sponsored research.
- Relevant dates.
- Action taken to mitigate against a conflict

Clinical private practice

What are the issues?

Existing provisions in contractual arrangements make allowances for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves. Professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. The ICBs must ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff re outside employment.

Principles and rules

- Clinical colleagues should declare all private practice on appointment, and/or any new private practice when it arises including:
 - where they practise (name of private facility)
 - what they practise (specialty, major procedures).
 - when they practise (identified sessions/time commitment)
- Where clinical private practice gives rise to a conflict of interest then the actions outlined in this policy must be considered and applied to mitigate risks.

What should be declared

- Name and role with the ICBs.
- A written record of the sponsored research arrangements.
- Description of the nature of the nature of their involvement in the sponsored research.
- Relevant dates.
- Action taken to mitigate against a conflict

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B – Training requirements

The table sets out training requirements re conflicts of interest for all individuals in scope of this policy.

	Module 1 (annually)	Module 2 (every 3 years)	Module 3 (every 3 years)	Rationale
All ICBs' staff	x			All colleagues need a basic understanding of what conflicts of interest are, why it is important to recognise and manage them
ICBs' staff at 8b and above	x	x		Colleagues at 8b and above are likely to be decision-makers and / or in a position to influence decisions, incl. budget holders / commissioning leads / finance leads / procurement leads, and must have a higher awareness and understanding of the risks associated with conflicts of interest and not managing them - e.g., procurement challenges, probity of decisions being challenged etc
Corporate Governance team				
Dept Director of Governance, Compliance, Risk	x	x	x	The team are the advisers to Boards, committees, senior decision-makers, and must therefore have in-depth understanding of how to recognise and manage conflicts of interest robustly
Board Secretary	x	x	x	
Assistant Board Secretaries	x	x	x	
	x	x	x	
ICB Board members (all, regardless of Partner / NED / Exec / other member categories)	x	x	x	Board members and cluster ICB Executives are the most senior decision-makers of and for the ICBs. Not only must they be guided by a thorough understanding of conflicts of interest and how to manage them. The Boards and Executives also must set the tone / culture for the ICBs and must be seen to take conflicts of interest seriously, incl. perceived conflicts, and conflicts of loyalty.
Chief Officers	x	x	x	

Report to:	NHS BSW ICB Board, NHS Dorset ICB Board, NHS Somerset ICB Board	Agenda item	5
Date of Meeting:	25 September 2026		

Title of Report:	ICB-to-ICB Delegation Agreement
Report Author:	Anett Loescher, Deputy Director Governance, Compliance, Risk
Board / Director Sponsor:	Alison Henly, Chief Officer Strategic Finance and Resources
Appendices:	Delegation Agreement

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

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

Previous consideration by:	Date	Please clarify the purpose
Executive Management Group	08/09/2026	Consideration and endorsement / support

1 Purpose of this paper
This paper presents to the ICBs' Boards, for approval, the proposed Delegation and Joint Working Agreement (the Agreement) through which the ICBs in the cluster enable one another to exercise jointly and / or on behalf of one another the vast majority of their functions. The Agreement has been drafted by the ICBs' legal advisers. When approved, it will provide the formal legal framework and basis for the ICBs' cluster working, from September 2026 onwards until merger. The Agreement will help ensure that while the ICBs remain legal entities in their own rights, each ICB remains able to be held accountable for all and any business conducted and decisions made on its behalf / in its name, by teams who work 'as one' across organisational boundaries and officers who are appointed in de facto joint roles.

The agreement is quite broadly phrased to cover the entirety of an ICB's "function of arranging for the provision of services for the purposes of the health service in England" and any ancillary functions to support this. The Agreement references a Joint Controller and Data Sharing Agreement, schedule 4. These agreements have been in place since June 2026 and will be appended to the Agreement.

In describing what the ICBs delegate to one another and / or exercise jointly, the draft agreement takes into account the 2024 guidance [NHS England » Arrangements for delegation and joint exercise of statutory functions](#) and the [National framework for NHS continuing healthcare and NHS-funded nursing care](#) which both point to decisions that the ICBs cannot delegate, make jointly, or on behalf of one another. These are reflected in the ICBs' Scheme of Reservations and Delegations (SoRD) also, and the Agreement references the SoRD accordingly.

The approval of this Agreement is reserved to each ICB Board. Once approved by the Boards, the Agreement will support the full implementation and go-live of the ICBs' new organisational structures.

2 Summary of recommendations and any additional actions required

The ICBs' Boards are invited to approve the Agreement.

3 Legal/regulatory implications

The proposed Agreement makes use of section 65z5 of the Health and Care Act 2022 which allows an ICB "to arrange for any functions exercisable by it to be exercised by or jointly with" another ICB. At the same time, the Agreement takes into account any limitations or restrictions on such joint exercise of functions, as set out in regulations.

The Agreement offers protection against challenges to the ICBs' joint exercise of their functions, and to the lawfulness of decisions.

4 Procurement

n/a

P&C Name

P&C Signature

5 Risks

The ICBs' clustering and new organisational structures invite the perception that the Cluster is a corporate entity and replaces the ICBs. This gives rise to the risk that the three ICBs in the Cluster, who remain sovereign legal entities in their own rights, lose the ability to be held accountable for the discharge of their statutory functions and their decisions. The Agreement mitigates this risk by clearly

articulating that the ICBs remain as legal entities and choose to jointly exercise their functions.

6 Quality and resources impact

Positive impact due to clarification of accountabilities and avoidance of costly challenges.

Finance sign off:

7 Confirmation of completion of Equalities and Quality Impact Assessment

Not required for the purposes of this paper or the Agreement

8 Communications and Engagement Considerations

Senior leaders in the ICBs should be made aware of the Agreement and asked to familiarise themselves with its contents. Where the Agreement has implications on day-to-day operations and decision-making, this should be communicated clearly and operations and decision-making processes designed accordingly, e.g. for CHC where the ICBs cannot make eligibility decisions for or on behalf of one another.

9 Statement on confidentiality of report

This report should be kept internal until the final Agreement and recommendation to approve goes to the ICBs Boards meeting in common.

Dated _____ 2026

(1) **NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE
INTEGRATED CARE BOARD**

- and -

(2) **NHS SOMERSET INTEGRATED CARE BOARD**

- and -

(2) **NHS DORSET INTEGRATED CARE BOARD**

Delegation and Joint Working Agreement in Respect of ICB Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1 PARTICULARS

- 1.1 This Agreement records the particulars of the agreement made between NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board ("**BSW ICB**"), Somerset Integrated Care Board ("**Somerset ICB**") and Dorset Integrated Care Board ("**Dorset ICB**") (together "**the ICBs**") named below:

ICB Name	ICB Area	ICB Email Address for Notices
BSW ICB	The area covered by BSW ICB is coterminous with the District of Bath and North East Somerset, Borough of Swindon, and County of Wiltshire, plus part of the District of Vale of White Horse (Lower Layer Super Output Areas: E01028745, E01028746, E01028747, E01028748)	[Insert Address]
Somerset ICB	The area covered by Somerset ICB is fully coterminous with Somerset Council.	[Insert Address]
Dorset ICB	The area covered by Dorset ICB is the District of Bournemouth, Christchurch and Poole and the District of Dorset.	[Insert Address]

- 1.2 This Agreement is effective from 1 September 2026 (the "**Effective Date**").
- 1.3 The Delegated Functions included in this Agreement are set out in Schedule 2 and will be exercised jointly by the Parties.
- 1.4 This Agreement comprises:
- 1.4.1 the Particulars (clause **Error! Reference source not found.**);
 - 1.4.2 the Terms and Conditions (clauses **Error! Reference source not found.** to 24); and
 - 1.4.3 the Schedules.

Signed by	NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board [Insert name of Authorised Signatory] [Insert title of Authorised Signatory] (for and on behalf of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board)
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Signed by	Somerset Integrated Care Board [Insert name of Authorised Signatory] [Insert title of Authorised Signatory] (for and on behalf of Somerset Integrated Care Board)
Signed by	Dorset Integrated Care Board [Insert name of Authorised Signatory] [Insert title of Authorised Signatory] (for and on behalf of Dorset Integrated Care Board)

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TERMS AND CONDITIONS

2 INTERPRETATION

- 2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 (Definitions and Interpretation).
- 2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:
- 2.2.1 the Particulars and Terms and Conditions (clauses **Error! Reference source not found.** to 24); and
 - 2.2.2 all Schedules.
- 2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and joint exercise of functions and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

3 BACKGROUND

- 3.1 The Parties currently operate as a 'cluster' and act in close collaboration in anticipation of a formal merger. This arrangement is reflected in the Parties' restructuring and resulting organisational and staffing structures. To enable this cluster arrangement, the Parties have utilised powers under Section 65Z5 and Section 65Z6 of the NHS Act to establish joint governance arrangements.
- 3.2 The 'cluster' arrangement has been implemented ahead of an intention for the ICBs to enter into a formal merger planned for April 2027, and to support the Parties to work jointly in the exercise of their functions.
- 3.3 By this Agreement the Parties will jointly exercise the Delegated Functions under section 65Z5 of the NHS Act while retaining the Reserved Functions.
- 3.4 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between the Parties.
- 3.5 This Agreement sets out the terms that apply to the joint exercise of the Delegated Functions by the Parties and the associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4 TERM

- 4.1 This Agreement has effect from the Effective Date set out in the Particulars and will remain in force until:
- 4.1.1 terminated in accordance with clause 20 (*Termination*), or
 - 4.1.2 any Party is abolished as part of the establishment of a new ICB.

5 PRINCIPLES

- 5.1 In complying with the terms of this Agreement, the Parties must:
- 5.1.1 at all times have regard to the Triple Aim;

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- 5.1.2 at all times act in good faith and with integrity towards each other;
- 5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;
- 5.1.4 consider how in performing their obligations they can address health inequalities;
- 5.1.5 at all times exercise functions effectively, efficiently and economically;
- 5.1.6 act in a timely manner;
- 5.1.7 share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and
- 5.1.8 have regard to the needs and views of the other Parties and as far as is lawful and reasonably practicable, take such needs and views into account.

6 DELEGATION

- 6.1 In accordance with their statutory powers under section 65Z5 of the NHS Act, the Parties hereby delegate the exercise of the Delegated Functions to each other to empower them to jointly exercise the Delegated Functions to commission a range of services for their Populations, as further described in this Agreement ("**Delegation**").
- 6.2 The Delegated Functions are the functions described as being delegated to the Parties as have been identified at Schedule 2 to this Agreement.
- 6.3 The Delegation in respect of each Delegated Function has effect from the relevant Effective Date of Delegation.
- 6.4 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed, each Party will comply with the terms of its Scheme of Reservation and Delegation when entering into any new Contract in respect of the Delegated Functions.
- 6.5 The decisions of a Party in the exercise of Delegated Functions (whether taken jointly or on its own) and made in accordance with the terms of this Agreement shall be binding on the other Parties.
- 6.6 Unless expressly provided for in this Agreement, a Party is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions on behalf of another Party. Any such purported decision is invalid and not binding on the other Party unless ratified in writing by that Party in accordance with its Scheme of Reservation and Delegation and Standing Financial Instructions.

7 EXERCISE OF DELEGATED FUNCTIONS

- 7.1 The Parties agree that they will exercise the Delegated Functions jointly and in accordance with:
 - 7.1.1 the terms of this Agreement;
 - 7.1.2 all applicable Law and Guidance;
 - 7.1.3 their constitutions; and
 - 7.1.4 Good Practice.

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- 7.2 The Parties must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.
- 7.3 Where a Party exercises a Delegated Function (either jointly or by itself), that Party must perform the Delegated Function in such a manner as to ensure the Parties comply with their statutory duties in respect of the Delegated Functions.
- 7.4 The Parties must at all times comply with their own governance arrangements and ensure that they act in accordance with their Schemes of Reservation and Delegation as appropriate, including but not limited to, ensuring that Contracts are entered into in accordance with each Party's respective governance arrangements.

8 PERFORMANCE OF THE RESERVED FUNCTIONS

- 8.1 No Party will exercise the Reserved Functions on behalf of another Party, including but not limited to those set out in the relevant Schedule 3 this Agreement.
- 8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated, in which event consequential changes to this Agreement shall be agreed between the Parties pursuant to clause 19 (*Variations*) of this Agreement.
- 8.3 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until the Parties agree otherwise. In the event that a Party identifies such a conflict or inconsistency it will inform the other Parties as soon as is reasonably practicable.

9 FINANCE

- 9.1 The Parties acknowledge that they must comply with their statutory financial duties, including those under Part 11 of the NHS Act.
- 9.2 Each Party will comply with the terms of its Standing Financial Instructions and Scheme of Reservation and Delegation in respect of the exercise of the Delegated Functions.
- 9.3 The Parties may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds in accordance with section 65Z6 of the NHS Act, subject to any further approval required in line with each Parties constitution.

10 BREACH

- 10.1 If a Party does not comply with the terms of this Agreement (including if a Party exceeds its delegated authority under the Delegation) the Parties have the right to:
- 10.1.1 terminate this Agreement in accordance with clause 20 (*Termination*) below; and/or
- 10.1.2 exercise their rights under common law.

11 NOT USED

12 LIABILITY

- 12.1 Each Party is liable in respect of any Losses arising in respect of that Party's own negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation.

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- 12.2 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by that Party of any Delegated Function are enforceable by or against that Party only, in accordance with section 65Z5(6) of the NHS Act.

13 CLAIMS AND LITIGATION

- 13.1 If a Party receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim relating to another Party, they must immediately notify the relevant Party and send to them all copies of such correspondence.
- 13.2 The Parties must co-operate fully in relation to such Claim and the conduct of such Claim, and provide such assistance as is reasonable in the circumstances.
- 13.3 Each Party shall be responsible for and shall retain the conduct of any Claim arising from that Party's exercise of Delegated Functions, unless it has been agreed that another Party should take over conduct of the Claim.

14 DATA PROTECTION AND FREEDOM OF INFORMATION

- 14.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.
- 14.2 Each Party must comply with the Schedule 4 (*Data Sharing Agreement and Information Sharing Agreement*).
- 14.3 Each Party shall provide to the other all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR.

15 CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

- 15.1 The Parties must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

16 CONFIDENTIAL INFORMATION OF THE PARTIES

- 16.1 Subject to clauses 16.2 to 16.3, the receiving Party agrees:
- 16.1.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;
 - 16.1.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and
 - 16.1.3 to maintain the confidentiality of the disclosing Party's Confidential Information.
- 16.2 The receiving Party may disclose the disclosing Party's Confidential Information:
- 16.2.1 in connection with any Dispute Resolution;
 - 16.2.2 in connection with any litigation between the Parties;
 - 16.2.3 to comply with the Law;
 - 16.2.4 to any appropriate Regulatory or Supervisory Body;

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- 16.2.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 16.1;
 - 16.2.6 to NHS Bodies for the purposes of carrying out their functions;
 - 16.2.7 as permitted under any other express arrangement or other provision of this Agreement.
- 16.3 The obligations in clauses 16.1 and 16.2 will not apply to any Confidential Information which:
- 16.3.1 is in or comes into the public domain other than by breach of this Agreement;
 - 16.3.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or
 - 16.3.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.
- 16.4 This clause 16 will survive the termination of this Agreement for any reason for a period of 5 years.
- 16.5 This clause 16 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

17 NOTICES

- 17.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.
- 17.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

18 DISPUTES

- 18.1 If a Dispute arises out of or in connection with this Agreement, then the Parties may escalate the Dispute to the Deputy Director of Governance, Compliance and Risk who shall decide whether to escalate the Dispute to the Chair, or if it may be resolved through an alternative route.
- 18.2 If a Dispute is referred to the Chair, it may be considered and resolved jointly with the Chief Executive.

19 VARIATIONS

- 19.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.
- 19.2 The Parties may notify each other of a Variation Proposal in respect of this Agreement.
- 19.3 The Variation Proposal will set out the variation proposed and the date on which the variation is to take effect.
- 19.4 Each Party must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on all Parties confirming either:
 - 19.4.1 that it accepts the Variation Proposal; or

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19.4.2 that it refuses to accept the Variation Proposal, and sets out reasonable grounds for that refusal.

19.5 If all Parties accept the Variation Proposal, all Parties agree to take all necessary steps (including executing a variation agreement) in order to give effect to any variation.

20 TERMINATION

20.1 This Agreement will terminate automatically upon any Party being abolished as part of the establishment of a new ICB.

20.2 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by a Party at any time, including in (but not limited to) the following circumstances:

20.2.1 a Party acts outside of the scope of its delegated authority;

20.2.2 a Party fails to perform any material obligation owed under this Agreement;

20.2.3 a Party persistently commits non-material breaches of this Agreement;

20.2.4 to give effect to legislative changes;

20.2.5 failure to agree to a variation in accordance with clause 19 (*Variations*); and/or

20.2.6 the Parties agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed.

20.3 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this clause 20 (*Termination*)) except that the provisions referred to at clause 22 (*Provisions Surviving Termination*) will continue in full force and effect.

20.4 As an alternative to termination of the Agreement in respect of all the Delegated Functions, a Party may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

21 CONSEQUENCE OF TERMINATION

21.1 Termination of this Agreement, or termination of a Party's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

21.2 For a reasonable period before and after termination of this Agreement or termination of a Party's exercise of any of the Delegated Functions, the Parties must:

21.2.1 co-operate with each other and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions;

21.2.2 provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate; and

21.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing Contracts between a Party and any third party which relate to or are associated with the Delegated Functions.

22 PROVISIONS SURVIVING TERMINATION

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- 22.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 22.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.
- 22.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:
- 22.2.1 Clause **Error! Reference source not found.** (*Finance*);
 - 22.2.2 Clause 12 (*Liability*);
 - 22.2.3 Clause 13 (*Claims and Litigation*);
 - 22.2.4 Clause 14 (*Data Protection and Freedom of Information*);
 - 22.2.5 Clause 18 (*Disputes*);
 - 22.2.6 Clause 20 (*Termination*);
 - 22.2.7 **Error! Reference source not found.** (*Further Information Governance and Sharing Provisions*).

23 SEVERABILITY

- 23.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

24 GENERAL

- 24.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between the ICB's.
- 24.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.
- 24.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

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SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.
2. Reference to any statute or statutory provision, Law, Guidance, or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.
3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.
4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.
5. References to any body, organisation or office include reference to its applicable successor from time to time.
6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.
7. Use of the singular includes the plural and vice versa.
8. Use of the masculine includes the feminine and all other genders.
9. Use of the term "including" or "includes" will be interpreted as being without limitation.
10. The following words and phrases have the following meanings:

Agreement	means this agreement between the Parties comprising the Particulars, the Terms and Conditions and the Schedules;
Ancillary Functions	means statutory duties and powers connected with the exercise of a Delegation Function;
Area	means the area described in the Particulars;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;

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Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to a FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Continuing Healthcare Functions	means functions exercised under Part 6 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations;
Contracts	Means any contract or arrangement in respect of the commissioning of any other Delegated Services;
CQC	means the Care Quality Commission;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Delegated Functions	means the statutory functions delegated by a Party to another Party under the Delegation and as set out in detail in this Agreement, including at Schedule 2;
Delegated Services	Means the services commissioned in exercise of the Delegated Functions;
Delegation	means the delegation of the Delegated Functions from the Parties to each other as described at clause 6;

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Delegation Guidance	means guidance issued by NHS England “ <i>Arrangements for Delegation and Joint Exercise of Statutory Functions</i> ” NHS England » Arrangements for delegation and joint exercise of statutory functions
Dispute	means a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;
EIR	means the Environmental Information Regulations 2004
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
NHS Funded Nursing Care Functions	means functions exercised under Part 6 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which a Party has a duty to have regard (and whether specifically mentioned in this Agreement or not);
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
Exceptional Funding Request Functions	means functions of an Integrated Care Board exercised under the NHS Act 2006 in accordance with an Individual Funding Request or Exceptional Funding Request policy of a Party;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;

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Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/long-read/managing-conflicts-of-interest-in-the-nhs/
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause Error! Reference source not found. (<i>Particulars</i>);
Party/Parties	means a party or all parties to this Agreement;
Patient Advice and Liaison ('PALS') and Complaint Functions	means functions of an Integrated Care Board exercised under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Personal Health Budget Functions	Means functions exercised under Part 6A of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations and the Care and Support (Direct Payments) Regulations 2014;
Population	means the individuals for whom a Party is responsible for commissioning health services;
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council;

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- (viii) the General Optical Council;
- (ix) the General Pharmaceutical Council;
- (x) the Healthcare Safety Investigation Branch; and
- (xi) the Information Commissioner;

Reserved Functions	means statutory functions of a Party that have not been delegated under this Agreement including but not limited to those set out in the Schedule 3 to this Agreement;
Safeguarding Functions	Means functions exercised under the Care Act 2014, the Children Act 1989, the Children Act 2004, and the Children and Social Work Act 2017 insofar as they relate to duties and powers of an Integrated Care Board regarding safeguarding of children and adults;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 117 Aftercare Functions	means functions exercised under section 117 Mental Health Act 1983;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Special Educational Needs and Disability Functions	means functions exercised under Part 3 of the Children and Families Act 2014 insofar as they relate to statutory powers and duties of an Integrated Care Board;
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Standing Rules	National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
Triple Aim	means the duty to have regard to the wider effects of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;

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Variation Proposal

means a written proposal for a variation to the Agreement, which complies with the requirements of clause 19.3.

SCHEDULE 2**Delegated Functions****1 DELEGATED FUNCTIONS**

1.1 The following Delegated Functions are included in this Agreement¹:

Delegated Functions	Effective Date of Delegation
Functions in relation to the commissioning of services under section 3 and 3A of the NHS Act	1 September 2026
Continuing Healthcare Functions	1 September 2026
NHS Funded Nursing Care Functions	1 September 2026
Personal Health Budget Functions	1 September 2026
Exceptional Funding Request Functions	1 September 2026
Safeguarding Functions	1 September 2026
Special Educational Needs and Disability Functions	1 September 2026
Section 117 Aftercare Functions	1 September 2026
Patient Advice and Liaison Service and Complaints Functions	1 September 2026

1.2 The exercise of Delegated Functions include the exercise of any necessary Ancillary Functions.

2 GENERAL OBLIGATIONS

2.1 The role of a Party when jointly exercising Delegated Functions includes:

- 2.1.1 decisions in relation to the commissioning and management of Delegated Services;
- 2.1.2 planning Delegated Services in the Area, including carrying out needs assessments and regular reviews;
- 2.1.3 undertaking reviews of Delegated Services in respect of the Area;
- 2.1.4 co-ordinating a common approach to the commissioning and delivery of Services with other health and social care bodies in respect of the Area where appropriate;
- 2.1.5 to manage the Contracts and exercise all of the delegating Party's rights and obligations under Contracts insofar as is necessary to exercise Delegated Functions; and

¹ This table must be completed to indicate which services are included in the Delegation.

- 2.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

SCHEDULE 3

Reserved Functions

1 INTRODUCTION

1.1 The following functions are Reserved Functions:

- 1.1.1 Deciding whether a person has a primary health need in accordance with paragraph (5)(b) of regulation 21(3) of the Standing Rules (duty of relevant bodies: assessment and provision of NHS Continuing Healthcare);
- 1.1.2 Determining whether a person has a need for nursing care in accordance with regulation 28(4) of the Standing Rules (persons who enter relevant premises or who develop a need for nursing care);
- 1.1.3 Onward delegation of functions to providers under section 65Z5 NHS Act;
- 1.1.4 Functions in relation to management of conflicts of interest and maintaining a register of interests;
- 1.1.5 The use of a Party's seal;
- 1.1.6 Duty to notify the Secretary of State of reconfiguration proposals;
- 1.1.7 Any other functions not defined as Delegated Functions;
- 1.1.8 Functions that are not permitted under statute to be, or are prohibited under the Delegation Guidance from being, exercised jointly by one Party on behalf of another Party; and
- 1.1.9 Functions that are determined as reserved in the Parties' constitutions and schemes of reservation and delegations.

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SCHEDULE 4

Data Sharing and Information Sharing Agreement

[ICB to insert its Data Sharing and Information Sharing Agreement]

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