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

*Monday 16 November 2026, 09:00 - 12:20*

**Virtual - via MS Teams**

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

## Agenda

**09:00 - 09:10**
10 min

### 1. Formalities

*Verbal* *Chair*

#### 1.1. Declarations of Interest

*Verbal* *Chair*

#### 1.2. Minutes from the meeting held in public on 16 September 2026

*Enclosure for approval* *Chair*

01.2. 260916_Cluster Board Meeting in Public Minutes_Draft.pdf (10 pages)

#### 1.3. Action Tracker and Matters Arising

*Enclosure for discussion* *Chair*

01.3. Cluster Board 26-27 Public Action Tracker_161126.pdf (1 pages)

#### 1.4. Questions from the Public

*Verbal* *Bernie Marden, David Freeman*

**09:10 - 09:20**
10 min

### 2. Cluster Chairs Report

*Verbal* *Chair*

**09:20 - 09:40**
20 min

### 3. Cluster Chief Executive Report

*Enclosure for noting* *Jonathan Higman*

03a. CEO Public Report_Nov 26.pdf (17 pages)
03b. App 1_Communications and Engagement Insights Report Nov26.pdf (16 pages)

## Strategy

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**09:40 - 10:05**
25 min

### 4. ICB Cluster Priorities for the next 12 months and the ICB CEO Delivery Compact

*Information* *Jonathan Higman*

04a. Cluster Priorities and Compact_Nov 2026.pdf (8 pages)
04b. App 1_Priorities Slide.pdf (1 pages)

04c. App 2_Integrated Care Boards Compact 2627.pdf (7 pages)

**10:05 - 10:30**
25 min

## 5. Strategic Commissioning Intentions 2027/28- 2031/32

*Decision* *David Freeman*

05a. Strategic Commissioning Intentions.pdf (10 pages)
05b. App 1_Commissioning Intentions FINAL DRAFT.pdf (20 pages)

**10:30 - 10:55**
25 min

## 6. Delivering Population Health Improvement through Place-Based Partnerships and Neighbourhood Health

*Information* *David Freeman*

06. Delivering PHI through Place-Based Partnership and NbH.pdf (15 pages)

# Current Performance and Regulation

**10:55 - 11:15**
20 min

## 7. Performance Dashboard (Contracted Activity and Associated Performance)

*Information* *David Freeman*

07a. Performance Dashboard_November 2026.pdf (5 pages)
07b. Appendix 1 - Cluster IPR - Oct 26 Summary.pdf (4 pages)
07c. Appendix 2 - Activity v Plan Monitoring.pdf (4 pages)

**11:15 - 11:35**
20 min

## 8. Thirlwall Enquiry: Implications and Required Actions for Cluster Maternity and Neonatal Services

*Information* *Shelagh Meldrum*

08. Thirlwall Inquiry - Implications and Actions.pdf (7 pages)

# Committee Assurance and Risk

**11:35 - 12:15**
40 min

## 9. Committee Reports to Board

### 9.1. Audit Committee in Common

*Enclosure for noting* *Alison Henly - in the absence of Dan Worsley*

09.1. In Common Audit Committee Summary Report_240926.pdf (1 pages)

### 9.2. Joint Strategic Finance and Resource Committee

*Enclosure for noting* *Adrian White*

09.2. Joint Strategic Finance and Resources Committee Summary Report_261026.pdf (1 pages)

#### 9.2.1. Cluster Finance Report

*Information* *Alison Henly*

09.2.1a. Cluster Finance Report Month 6 202627.pdf (3 pages)
09.2.1b. App 1_Cluster Finance Report M6 2627.pdf (4 pages)

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### 9.3. Joint Population Health and Commissioning Committee

*Enclosure for noting* *Christopher Foster*

09.3. Joint PHaCC_Committee Summary Report_211026.pdf (2 pages)

### 9.4. Joint Quality and Population Engagement Committee

*Enclosure for noting* *Caroline Gamlin*

09.4a. Joint Quality and Population Engagement Committee Summary Report_210926.pdf (1 pages)
09.4b. Joint Quality and Population Engagement Committee Summary Report_291026.pdf (1 pages)

## Standing Items

**12:15 - 12:20**
5 min

## 10. Any Other Business

*Verbal* *Chair*

**12:20 - 12:20**
0 min

## 11. Date and Time of Next Meeting

*Verbal* *Chair*

**Monday 18 January 2027 - 9:00hrs**

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

## 16 September 2026, 10:15hrs

## Virtual Meeting – held via MS Teams

**Members present:**
Cluster Chair, Rob Whiteman
Cluster CEO, Jonathan Higman
Chief Officer Strategic Finance and Resources, Alison Henly
Chief Officer for Commissioning and Place, David Freeman
Chief Medical Officer, Bernie Marden
Deputy - Chief Nursing Officer, Bernice Cooke
Chief Officer for Population Health Improvement, Amanda Webb
Cluster Deputy Chair, Ade Williams
Cluster NED, Adrian White
Cluster NED, Suzannah Power
Cluster NED / Place NED Dorset, Dan Worsley
Cluster NED, Chris Foster *(until 11:00hrs)*
Cluster NED, Caroline Gamlin
BSW - NHS Trusts and NHS Foundation Trusts Partner Member, Cara Charles-Barks
BSW – Local Authority Partner Member – Swindon, Sam Mowbray
Deputy - BSW - Local Authority Partner Member – Wiltshire, Amy Jones
Dorset - NHS Trust Partner Member – Mental Health, Matthew Bryant
Dorset - NHS Trust Partner Member, Siobhan Harrington
Dorset Council (Local Authority Partner Member), Cllr Nick Ireland
Deputy – BCP Council, Laura Ambler
Dorset - Primary Medical Services Partner Member, Forbes Watson *(from 11:02hrs)*
Somerset – Foundation Trust Partner Member, Peter Lewis
Somerset – Local Authority Partner Member – Alison Bell
Somerset - Primary Care Partner Member, Rebecca Duffy

**Attending:**
Healthwatch, Louise Bate
Corporate and Board Secretary (minutes), Sharon Woolley
Place Director for Somerset, David McClay
Place Director for Swindon, Gordon Muvuti
Associate Director of Strategy & Directorate Operations, James Whitehead
Somerset Health and Care Academy Programme Lead, Tony Rackshaw
Deputy Chief Officer Strategic Finance and Resources, Scott Sealy

**Apologies:**
Chief Nursing Officer, Shelagh Meldrum
Voluntary, Community and Social Enterprise (VCSE) Sector, Paula Bennetts
BSW - Primary Medical Services Partner Member, Francis Campbell
BSW - BaNES Council CEO, Sophie Broadfield
Associate Director of Governance, Compliance & Risk, Anett Loescher
BSW - Local Authority Partner Member – Wiltshire, Lucy Townsend
BCP Council (Nominated deputy - Local Authority Partner Member), Aidan Dunn

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## 1. Welcome and Apologies

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

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

### 1.1 Declarations of Interests

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

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

1.2.1 The minutes from the Cluster Board meeting in public held on 15 June 2026 were approved as an accurate record.

### 1.3 Action Tracker and Matters Arising

1.3.1 The action tracker was reviewed, noting the two closed actions and the update added against the open action concerning the scheduling of a Board artificial intelligence (AI) session.

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

### 1.4 Questions from the Public

1.4.1 One question had been raised in advance of the meeting concerning commissioning of children's palliative and end of life care, particular for the BSW area.

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

## 2. Cluster Chairs Report

2.1 The Chair advised that he continued to be involved in a number of meetings with Board members and ICB partners to identify the priorities for this year, and to support the development of the strategy into next year.

2.2 With regards the ICB footprint consultation, a formal response had been submitted to NHS England, noting the desire to ensure the existing cluster footprint remained, whilst noting also the opinions and thoughts of local authority partners.

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2.3 The Government had made a clear statement that it would like to see alignment by the end of this Parliament in 2029, with a rule of thumb that Mayors are served by one ICB, whilst ICBs can serve more than one Mayor. The movement towards Mayors and strategic authorities would continue. The suggestion was to respond positively to this direction of travel and that work on developing Place Memorandum of Understandings continued, expanding to how we would make it work on the

ground should B&NES and potentially Swindon authorities change ICB. Further announcements were anticipated around the budget release. Members were mindful on the potential impact of these changes to the arrangements for mental health services, acute services, and community services.

2.4 The commitment was there for the cluster ICBs to work with Council colleagues to develop clear and pragmatic working arrangements, remaining adaptive to what happens into the future, whilst also ensuring this period of uncertainty does not distract from the ongoing work and transformation.

**3. Cluster Chief Executive Report**

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

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

- The cluster ICBs were now emerging from the significant organisational change process. Around 90% of the posts within the new structure had now been appointed to, noting the significant reduction in posts – 650 posts against the 1100 recorded across the three organisations at the start of the process. A number of colleagues had moved on in various ways, with 90 colleagues remaining at risk of redundancy. The first round of compulsory redundancies had recently been approved by the Joint Remuneration and People Committee, to progress on to NHS England for sign off.
  The cluster now moves into a phase of bringing the new teams together and recognising the challenge between the work at place and the work at cluster. The relationships and ways of working, particularly with provider colleagues, would need to change and evolve to reflect the change in structure.
  An Extended Leadership Network had been established to support that next phase and the continued organisational transition work.
  An all-colleague event was being planned for 12 October 2026.
- The National Strategic Commissioning Development Programme was to commence from October, looking at strategic commissioning, alongside commissioning that may move to integrated care organisations or partnerships.
- National work had commenced on the development of a compact between the 26 ICBs, a statement to set out the commitment for delivery and the priorities going forward. The compact would be brought to Cluster Board for sign off in due course, ensuring this aligned with the cluster ICB priorities.
- Cluster Board development sessions were being organised - 15 October 2026; to focus on value-based healthcare and the financial strategy, and an additional session for early December to consider what AI means for the organisation and the Board (and the different roles), and how it can support delivery of care. AI was a fast-moving agenda and would play an important part in the leftward shift required, whilst acknowledging the need to ensure governance, information security, recovery, and safeguards were all appropriate, whilst enabling progression.
- The Somerset Stroke Services Reconfiguration was now live following a programme of clinical, operational and infrastructure preparations across the system. There were now two hyper acute stroke units across the cluster patch, one at Dorset County Hospital, and one at Musgrove Park Hospital, centralising that first 72 hours of care at Dorchester and Yeovil to improve the

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outcomes for the population. Thanks were recorded to all partners and their teams involved in supporting the programme.

3.3 The Board noted the work to confirm Executive Board Member lead roles, though it was queried if there should be a 'maternity' role also listed following the recent national investigations and reviews. This would be followed up with the national team to seek guidance.
ACTION: Advice and direction to be sought from the national team regarding the requirement of the inclusion of a 'maternity' Executive Board Member lead role.

3.4 The request for additional assurance around risk mitigation was noted, as also raised via the Transition Committee. Though the Committee had been appreciative of the ongoing work and the complex change process, greater assurance was needed in support of the risks associated with transition to the new operating model, acknowledging that workforce capacity had greatly reduced. Destinations for all of the discontinuing ICB activities had not yet been confirmed, noting also that partners who were meant to be taking on some of that activity are not yet ready to receive it.

## 4. Developing our Integrated Needs Assessment

4.1 The Chief Officer for Population Health Improvement presented the Integrated Needs Assessment (INA), explaining that it formed part of a population health improvement roadmap, linking population need to the population health strategy, population health improvement plan, commissioning intentions, measurable outcomes and value-based resource allocation. The INA was to be a concise, annually refreshed decision-enabling case for change, covering current and future need, inequalities, demand, capacity, outcomes, cost, quality, workforce, provider insight and lived experience.

4.2 The Associate Director of Strategy and Directorate Operations joined the meeting for this item and talked through a number of supporting slides. The five outputs were described; a Case for Change identifying major challenges and future pressures; a Target Cohort Shortlist identifying populations where focused action could have greatest impact; a Service Review Matrix identifying pathways misaligned with need, access, quality, productivity or sustainability; an Opportunity Portfolio describing interventions and care models; and Strategic Priority Scoring using criteria including scale, severity, inequality, trend, value, deliverability and strategic fit.

4.3 The phase one INA was to be completed for November 2026, using existing intelligence, basic linkage, high-level forecasting, segmentation, trend analysis and some manual reporting. Over the following six to nine months, richer linked datasets would be added, cohort analysis, unmet-need and variation analysis undertaken, and stronger dashboards created. After the initial 12 months it was intended to become a mature, automated and refreshable model with enhanced predictive analysis and opportunity modelling. Predictive modelling would be included from phase one, although its sophistication would increase over time.

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4.4 It was queried whether the INA would describe NHS, system or population challenges and how inequalities and local variation would be retained. Though this was an NHS commissioning document, it would be based on the needs of the whole population and informed by provider, partner and local insight. Public Health

consultants from all six local authorities were already involved, with wider engagement planned throughout. Noting concerns raised about complex language, the outputs would be presented simply, with detailed data available underneath. Products were intended to be publicly accessible and eventually supported by drill-down dashboards.

4.5 Assurance was given to the Cluster Board that the Case for Change would preserve visibility of population needs even when action was deferred, while Strategic Priority Scoring would incorporate value, affordability, trade-offs and deliverability. The INA may therefore identify services for review that lead either to new commissioning or clinically appropriate decommissioning. This guiding layer would inform the financial strategy and commissioning decisions.

**5. Neighbourhood Development - Stocktake and Roadmap**

5.1 The Chief Officer for Commissioning and Place and the Place Director for Somerset presented the cluster's neighbourhood-health baseline and development plan. Neighbourhood health and integrated neighbourhood teams were priorities in the national NHS 10-year health plan. It was recognised that all three ICB areas had already developed neighbourhood work to different degrees.

5.2 The initial focus remained on integrated neighbourhood teams and the highest-risk population, particularly people most at risk of admission, while building capability to extend into primary and secondary prevention.

5.3 The baseline used a set of measures developed through Claire Fuller's national stocktake. The Cluster Board were cautioned that some labels, including general-practice access, mainly assessed the transparency and public discussion of variation, rather than the quality of access itself. The national team considered Somerset and Dorset potentially underscored, but advised retaining the current scores and using the next assessment to strengthen local ownership and prioritisation.

5.4 The Board discussion noted that:

- It was questioned whether averaged scores could hide wide variation in primary care network maturity and local priorities.
  It was clarified that early co-ordination and common outcomes were needed to achieve economies of scale and reduce acute pressure, while longer-term delivery should allow local teams flexibility to innovate.
- Claire Fuller's distinction between a first tier focused on NHS services and interventions for the highest-risk groups, and a second tier focused on healthy neighbourhoods and wider determinants with local authority and VCSE partners was explained.
- The need to move from discussion to action at pace to make that noticeable difference was emphasised, using the initial high-risk cohort to build momentum.
- Local authorities have an immediate role in discharge, social care and reducing hospital pressure, not only a long-term role in wider determinants.
- Primary prevention and wider determinants were to be protected, with VCSE, pharmacy and social-care partners being core contributors. The INA would help monitor opportunity costs. Future multi-neighbourhood and single-

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neighbourhood provider contracts could provide commissioning leverage while preserving shared outcomes and local flexibility.

- Neighbourhood delivery was to connect to digital and estates strategies, particularly from the perspective of people using services. Further work was needed to create a consistent digital and physical offer across health and wider public services, including a simpler single front door that can operate online or in person.

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

6.1 The Deputy Chief Nursing Officer presented the report, describing the ICB's systems and processes for responding to the published AMOS and Nottingham maternity and neonatal reviews, rather than reviewing maternity services in full. It was noted that the subsequent Thirlwall report received the previous day also required consideration and that action would be needed at national, regional and system levels through collaborative governance.

6.2 The ICB had requested sight of providers' ten-point-plan responses and self-assessments (including of those outside of the cluster), but NHS England currently intended to collate and share them regionally. The ICB would continue seeking access and considering services used by its population elsewhere.

6.3 Health visitors and other public health nursing services would be connected to the recovery plan and involved in a system-wide response; this was not only for maternity providers to action. The Head of Quality had already received most provider returns and would continue to support and engage with providers and other stakeholders. Themes from the reviews may apply beyond maternity, providers should share their submissions to support collective learning, including on inequalities.

6.4 Recommendations from the review, such as triage models, would require fundamental changes to how services were organised and should be considered sooner rather than later to bring immediate improvement and sustainability to services.

6.5 Staff surveys and other provider measures were being used to identify hot spots and early warning signs relating to leadership, culture and accountability. Providers were working to increase participation.

6.6 A specific maternity-focused discussion would be convened, with accountabilities clarified between provider service delivery and ICB contractual oversight.
ACTION: Convene a cross-cluster maternity discussion involving providers, public health nursing, local authorities, relevant external providers and other stakeholders to interpret the review findings, clarify accountabilities, agree system actions and address longer-term service sustainability and triage arrangements.

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## 7. Performance Oversight Dashboard

7.1 The Chief Officer for Commissioning and Place explained that NHS England assumed performance-management and oversight responsibilities from 1 April 2026, while ICBs retained contract-delivery responsibilities. Contract review meetings had been re-established, contract outcomes and value reporting were

being reset, and month-three performance was generally within normal tolerances with improvement discussions underway.

7.2 Three providers were in enhanced oversight: Great Western Hospital and Dorset County Hospital through a national process, and University Hospitals Dorset through a regional process. Recovery plans were being developed with providers, updated submissions had been sent to NHS England, and provider-to-board meetings with NHS England and ICB senior leads were planned for October.

7.3 The Board noted corrections to two statements within the report. University Hospitals Dorset entered regional enhanced oversight because of 12-hour waits only; though no criteria to reside work remained an important system challenge, this was not the trigger. Financial concerns were also not part of the escalation for Dorset County Hospital. The NHS England letters did not contain those two items. The errors reflected loss of organisational memory during restructuring and confirmed that the underlying issues were not being ignored. Though the ICB was aware of the wider pressures, the new thresholds and speed of the oversight process had not been understood early enough. Future performance reporting would bring material issues to the Cluster Board with context, actions, options and recommendations, rather than presenting unresolved operational problems without analysis.

7.4 It was questioned whether significant red metrics, including widespread variance against the 62-day cancer standard, should be brought to the Cluster Board even when providers had not received escalation letters. It was agreed that contract review meetings and the Procurement and Contract Group would need to identify and escalate material issues more coherently. The Cluster Board would continue to receive assurance about the ICB's commissioning and contract-management capability. The Board would need to distinguish contractual performance discussions from population-level commissioning discussions, using the wider framework to drive the right conversations, and avoid simply repeating provider-board conversations.

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

8.1 The Place Director for Swindon was in attendance, reporting on the cluster's controls for reducing inappropriate out-of-area placements. The paper reported on the reported 80 appropriate and 14 inappropriate placements, noting the national requirement to eliminate inappropriate placements. Every patient's location and care were known. Placements were regularly reviewed against clinical appropriateness and patient-centred goals, forward-looking meetings were being introduced, and a cluster-wide assurance process was operating with the Quality Team.

8.2 The clusters' objective was not to chase a target but to provide patient-centred care, patients would only be brought back where robust local care plans were in place, including appropriate local authority partnership arrangements. The opening of the Kingfisher unit would support local provision for people with learning disabilities.

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8.3 A fortnightly cluster assurance group with the senior leadership team would monitor personalised care plans, with further reporting requirements expected through the emerging oversight framework. It was confirmed that equivalent processes applied

to children and younger adults, and that an Equality and Quality Impact Assessment (EQIA) had been completed and would be linked to detailed plans and future commissioning decisions.

## 9. Somerset Health and Care Academy Briefing

9.1 The Somerset Health and Care Academy Programme Lead and Deputy Chief Officer Strategic Finance and Resources joined the meeting for this item. The Board was briefed on the progress on the development of the Somerset Health and Care Academy, a joint venture for training and innovation involving Somerset Council, the ICB, and Somerset NHS Foundation Trust. This was a project developed jointly over several years. Somerset Council was to provide the building using levelling-up funding, with the collaboration agreement, full business case and heads of terms supporting the arrangement.

9.2 The Academy was intended to support recruitment, retention and workforce development, align training with commissioning, transformation and neighbourhood-care priorities, and provide wider benefits across the cluster. The location near the M5 could create opportunities beyond Somerset.

9.3 The Strategic Finance and Resources Committee had reviewed and supported the business case at its August meeting, including the ICB's position as a one-third risk sharer, and sensitivity analysis showing when additional funding might be required. The Committee considered the case conservative and the financial risks acceptable, while noting that any potential surplus was already intended to address joint-venture capital deficits.

9.4 The Cluster Board confirmed its **support** for the continued development of the Somerset Health and Care Academy.

## 10. Committee Reports to Board

### 10.1 Audit Committees in Common

10.1.1 The Committee report to the Cluster Board from the meeting held on 25 June 2026 was noted.

10.1.2 As the Chair of the Audit Committees in Common, Dan Worsley reported that work was underway to consolidate cluster risk across the three statutory bodies, and that the next Audit Committees in Common meeting would examine cyber risk via the information governance update report from both top-down and bottom-up perspectives. The work was intended to inform the Transition Committee's development of a cluster risk register.

10.1.3 The next meeting of the Audit Committees in Common would be held on 24 September 2026.

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### 10.2 Joint Strategic Finance and Resource Committee

10.2.1 The three Committee reports to the Cluster Board from the meetings held on 29 June 2026, 27 July 2026, and 27 August 2026 were noted.

10.2.2 As Chair of the Strategic Finance and Resources Committee, Adrian White advised that the Committee had approved the terms of reference for the Procurement and Contract Group, an internal operations group to bring additional support and scrutiny, to report into the Committee on activity. At the July meeting, the Committee had endorsed the response made against the NHS England for the Cluster Medium Term Plan Further Requirements submission. The Committee recognised that some business elements brought tight timelines, but requested that the governance sequency be considered going forwards to ensure the Committee is sighted before submissions are made. The August meeting had taken financial oversight assurance, including understanding the provider variance and challenging itself around the ICBs own financial performance. Although the cluster was reporting break even and forecasting break even for the full year, there was considerable stretch on continuing care budgets and on prescribing budgets. Deep dives on those two items would be brought to forthcoming Committee meetings.

10.2.3 The next meeting of the Joint Strategic Finance and Resource Committee was scheduled for 28 September 2026.

**10.2.1 Cluster Finance Report**

10.2.3.1 The Chief Officer Strategic Finance and Resources reported a £45.1m net risk position for the ICB, driven predominantly by GP prescribing and all-age continuing healthcare. The main identified driver of the prescribing pressure was price increases, particularly in no-cost-alternative supply areas, although only two months of delayed prescribing data were available. The available evidence indicated a price rather than volume problem. Continued repeat-prescribing reviews were still encouraged as they remained a practical way to reduce unnecessary use. The cluster was currently the only one known to be reporting the issue in this way, national benchmarking was awaited. The Strategic Finance and Resources Committee would compare performance across the cluster while national work sought wider information.

10.2.3.2 The Committee would stress-test mitigation plans, with deep dives on continuing healthcare and prescribing scheduled for September, and an additional review of right-to-choose ADHD and neurodiversity pathways planned for October. The risks were being identified early and brought to Committee for action; the October meeting would assess whether genuine mitigations were reducing the risk and supporting a balanced position.

10.2.3.3 Acknowledging the disputed continuing healthcare cases and local authority financial pressures, the Committee would reconcile the risk figure with discussions already taking place with local authorities, testing whether the amount was accurate, assessing the partner impact. Workforce capacity had affected the timing of the plan, so further information would be available after those discussions.

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

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10.3 **Joint Population Health and Commissioning Committee**

10.3.1 In the absence of Chris Foster, the Chair of the Joint Population Health and Commissioning Committee, the two Committee reports to the Cluster Board from the meetings held on 10 June 2026 and 4 September were noted.

10.3.2 The next meeting of the Joint Population Health and Commissioning Committee was scheduled for 21 October 2026.

10.4 **Joint Quality and Population Engagement Committee**

10.4.1 The two Committee reports to the Cluster Board from the meetings held on 17 June 2026, and 24 August 2026 were noted.

10.4.2 As Chair of the Joint Quality and Population Engagement Committee, Caroline Gamlin advised that the population engagement discussion at its August meeting had highlighted the need for a strengthened communications and engagement link with the Population Health and Commissioning Committee. A member of the Communication and Engagement Team was now to attend the Population Health and Commissioning Committee meetings going forwards.

10.4.3 The Committee welcomed the Boards thoughts on strengthening its population engagement remit. It was suggested that the Health and Wellbeing Boards could be utilised to join up engagement activity across cluster and place; a strategic discussion was needed to use limited engagement capacity collectively.

10.4.4 The Committee were assured that the team had a good handle of quality issues across the cluster, though mindful an alerting system might be up and coming.

10.4.5 The June report wording appeared to describe generic Dorset GP-service concerns and criteria-to-reside issues as one matter. It was clarified that the GP concern, related to one external provider operating several practices, and that the criteria-to-reside issues were separate. The report wording would be amended and tightened accordingly.

10.4.6 An additional meeting of the Committee was scheduled for 21 September 2026 to receive and review the quality associated annual reports, to which invites had been extended to the wider Cluster Board.

11. **Any other business**

11.1 There was no other business. The Chair closed the meeting at 12:57hrs.

**Next meeting of the Cluster Board**: Monday 16 November 2026, 9:00hrs

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## Cluster Board - Action Log for Meeting in Public

**Updated following meeting on 16/09/2026**

### OPEN actions

| Meeting Date | Item | Action | Responsible | Progress/update | Status | Expected Completion Date |
|---|---|---|---|---|---|---|
| 15/06/2026 | 4. Cluster Chief Executive Report | Artificial Intelligence to be a future topic on the Cluster Board forward planner – considering Board responsibilities regarding AI, including data security, information governance, environments for AI operation, and guardrails such as human-in-the-loop for risk-categorised AI use cases. | Chair, Jonathan Higman, Karl Hoods, Bernie Marden | **Update 09/09/2026:** Development of specific AI board session underway - date to be confirmed shortly.<br>**Update 02/10/2026:** Additional Cluster Board development session scheduled for 7 December 2026. | CLOSED | |
| 16/09/2026 | 4. Cluster Chief Executive Report | Advice and direction to be sought from the national team regarding the requirement of the inclusion of a 'maternity' Executive Board Member lead role. | Sharon Woolley | **Update 02/10/2026:** Regional team advised that a maternity Executive Board Member lead role was not yet mandatory, though may be considered as part of the outcomes from recent national investigations and reports. ICBs would be advised accordingly. | CLOSED | |
| 16/09/2026 | 6. AMOS and Nottingham Review of Maternity Services - 10 Point Plan and Next Steps | Convene a cross-cluster maternity discussion involving providers, public health nursing, local authorities, relevant external providers and other stakeholders to interpret the review findings, clarify accountabilities, agree system actions and address longer-term service sustainability and triage arrangements. | Shelagh Meldrum, Bernice Cooke | **Update 02/10/2026:** Cluster system meeting being convened by the Head of Quality, a date to be set once provider 10 point action plans are received by regional colleagues, and the national and regional requirements for next steps are shared.<br>Governance arrangements at provider level with ICB representative are in place, where these specific reports and any subsequent actions are being monitored. | ONGOING | |
| | | | Jonathan Higman | **Update 06/10/2026:** Additional strategic meeting also organised for 26 October 2026 - involving Trust partners from around the cluster. | CLOSED | |

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|---|---|---|---|
| **Report to:** | Cluster Board - Meeting in Public | **Agenda item** | 3 |
| **Date of Meeting:** | 16 November 2026 | | |

| | |
|---|---|
| **Title of Report:** | Chief Executive Board Report |
| **Report Author:** | Jonathan Higman, Cluster Chief Executive |
| **Board / Director Sponsor:** | Jonathan Higman, Cluster Chief Executive |
| **Appendices:** | 1 - Communications and Engagement Insights Report November 2026 |

| | |
|---|---|
| **Report classification** | Not Confidential |
| **ICB body corporate** | NHS BSW, Dorset & Somerset ICB Cluster Board |
| **ICS NHS organisations only** | BSW, Dorset & Somerset NHS |
| **Wider system** | BSW, Dorset & Somerset ICS |

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

| **Previous consideration by:** | **Date** | **Please clarify the purpose** |
|---|---|---|
| | | |

## 1 Purpose of this paper

This report provides the Board with an update on the latest strategic developments across the NHS and, more locally, developments within the Cluster since the last meeting of the NHS BSW, Dorset and Somerset Cluster Board.

## 2 Summary of recommendations and any additional actions required

The report sets out major developments in national policy, while also providing a summary of the work of the ICB at the six Council 'Places'. It includes

- An update on the changes to the National NHS Operating Model, including the implications relating to a delay to ICB merger for our Cluster.
- An overview of the recent devolution announcements and the proposed creation of Strategic Mayoral Authorities across the cluster footprint.
- Progress with the SEND reform plans across the Cluster
- An update on the BSW Community Services contract following recent political and media interest.
- A new Communications and Engagement Insight report which will be included within this report in the future.

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

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| 3 | Legal/regulatory implications |
|---|---|
| Failure to operate within the statute and regulatory framework would lead to the Cluster or elements within the Cluster being placed in special measures. Consequently, losing the capability to make local decisions for local communities. | |

| 4 | Risks |
|---|---|
| Failure to understand the wider strategic and political context, could lead to the Board making decisions that fail to create a sustainable system. The Board also needs to seek assurance that credible plans are developed to ensure any significant strategic and operational risks are addressed. | |

| 5 | Quality and resources impact |
|---|---|
| Failure to assess key strategic and operational developments against the quality and resource impacts for the Cluster and elements within the Cluster, would place the system at risk in terms of its sustainability. The Board needs to be assured that developed impacts have been assessed and significant impacts are addressed. | |

| 6 | Confirmation of completion of Equalities and Quality Impact Assessment |
|---|---|
| Not applicable. | |

| 7 | Communications and Engagement Considerations |
|---|---|
| This report is published for public information and includes updates and the latest news from the NHS England. | |

| 8 | Statement on confidentiality of report |
|---|---|
| OFFICIAL, for public release. | |

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**Cluster Chief Executives Board Report**

## 1. Introduction

1.1 This report provides the Board with an overview of the latest strategic developments across the NHS and more locally across the BSW, Dorset and Somerset Cluster Board area.

## 2. National & Regional Context

### 2.1 National policy and legislation update

2.2 A number of significant national developments have taken place in recent weeks which will shape the future operating environment for Integrated Care Boards and the wider health and care system.

2.3 The Secretary of State for Health and Social Care has provided further detail on the Government's plans to bring NHS England back into the Department of Health and Social Care (DHSC) from 1 April 2027, subject to the passage of the Health Bill. The reforms are intended to create a single national organisation with clearer accountability, bringing policy development, operational delivery, social care and public health expertise closer together while reducing duplication between the two organisations. The Government has said the changes are designed to support delivery of the NHS 10-Year Health Plan, strengthen integration between health and care services and enable a greater focus on prevention and neighbourhood health.

2.4 Under the proposed arrangements most national delivery functions currently undertaken by NHS England will transfer into a new NHS Group within DHSC, while the existing seven NHS regional teams will be retained through a temporary Special Health Authority accountable to the SOS. The Government has emphasised that regional teams will remain close to frontline organisations during the transition period and support a longer-term shift towards greater devolution of responsibility to local systems and communities.

2.5 Alongside these changes, the Government has announced that it will no longer proceed with plans to abolish local Healthwatch organisations and Healthwatch England following significant national engagement and feedback regarding the importance of maintaining an independent patient voice.

2.6 The SOS has said that patient and public experience must remain central to decision-making and has announced plans to appoint a new Patient Experience Director alongside setting up a national Clinical Council to strengthen clinical leadership and advice to Ministers. These developments provide continued assurance that independent patient voice arrangements will remain an important part of the health and care landscape.

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2.7 The Government has provided greater clarity on the future development of devolution across England. For the South West this includes plans for a new Mayoral Authority

covering Dorset, Somerset, Wiltshire and Bournemouth, Christchurch and Poole (BCP), alongside confirmation that Swindon will join a separate Mayoral Authority with Berkshire and Oxfordshire, with elections to both new Mayoral Authorities taking place in 2028. While the immediate focus of these authorities will be on economic growth, skills and productivity, the reforms are expected to have wider implications for public services and system governance over time.

2.8 The Government has also reinforced its commitment to ending rough sleeping, with the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government recently writing jointly to Integrated Care Boards, local authorities and Mayoral Authorities setting out expectations for coordinated local action. The letter highlights the significantly poorer health outcomes experienced by people who sleep rough and calls for stronger partnership working across housing, health and care services to support prevention, early intervention and access to accommodation and support. Local systems are being asked to strengthen leadership and governance arrangements, improve identification and referral pathways, develop integrated multi-disciplinary support, enhance mental health and substance misuse provision and ensure that nobody is discharged from hospital into rough sleeping. The Government has emphasised the role of neighbourhood health approaches in tackling homelessness, addressing health inequalities and supporting greater integration across local systems.

2.9 For the BSW, Dorset and Somerset ICB Cluster, all of these developments further reinforce the importance of strong partnership working across local government, the NHS and the VCSFE sector. While the detail and implications of national reforms will continue to emerge our focus remains on delivering improved health outcomes, reducing inequalities and providing high-quality services for the communities we serve, while ensuring the Cluster is well positioned to respond to future changes in the wider public sector landscape.

## 3. Delay in merger

3.1 Following confirmation that BSW, Dorset and Somerset Integrated Care Boards (ICBs) will not merge in April 2027, planning is being re-based on a potential merger on 1 April 2028, subject to formal national confirmation. Until any legal merger, each ICB remains a separate statutory organisation, retaining responsibility for its decisions, statutory duties and liabilities. This requires continued organisation-specific Board accountability, annual reports and accounts, audit arrangements, employment responsibilities, data protection obligations and statutory reporting. Joint working and delegation arrangements enable closer collaboration but do not remove each ICB's ultimate accountability.

3.2 There is much that we can continue to streamline and simplify to work as if we are a merged organisation. The response is to adapt the transition programme to support effective joint working while preserving the statutory responsibilities of the three legacy ICBs, preparing for a potential future merger. Priorities include clear decision-making and delegation arrangements, auditable records for each ICB, and continued assurance of quality, safeguarding and emergency preparedness. Policies, processes and

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reporting can be aligned where appropriate, provided each organisation remains able to demonstrate compliance. The extended timetable also retains separate corporate requirements and results in additional associated costs; the financial and workforce assessments of the delay in merger are currently being worked through.

## 4. ICB Cluster Developments

### 4.1 SEND Reform Plans

4.2 It has been confirmed by the Department for Education that all six SEND Reform Plans have received national approval. Each of the six place SEND partnerships collaboratively developed plans for submission, which were shared and approved by the Board on 15 June 2026. The approval of these plans marks a significant milestone with focus now moving to delivery. Alignment work continues across these plans and the reform requirements of the Families First Partnership Programme, Best Start in Life and neighbourhood agendas to maximise opportunities and support early intervention and prevention to improve outcomes.

4.3 Each place will have post approval meetings with the DfE and NHSE to confirm delivery oversight arrangements and receive feedback on any elements of the plan that may need further strengthening. A key element for the ICB is the commissioning of Advanced Salt Practitioners and Experts at Hand models both of which are progressing at pace following the plan approval being received.

4.4 Further work is being undertaken with Local Authority partners to understand any implications of the plan approval and future updates on progress will be provided to the Board.

4.5 Alongside the national approval of all six local SEND Reform Plans, local systems continue to engage with a range of external assurance and improvement activities. Most recently, the Somerset Local Area Partnership has been notified of a joint Ofsted and Care Quality Commission (CQC) Area SEND inspection, which (at the time of writing) has commenced. Similar inspection and assurance processes have taken place, or are expected to take place, across a number of systems nationally. There is more information about a recent Local Area SEND Inspection in Bath & North East Somerset in the Place update below (5.1). These activities provide an important opportunity to assess the effectiveness of local SEND arrangements, partnership working and outcomes for children and young people with SEND.

## 5 Focus on Place

### 5.1 Bath & North East Somerset

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Our new B&NES Place-based governance arrangements are being embedded, with our first Place-Based Partnership Board taking place at the end of September. We are starting to establish our neighbourhood steering groups, working closely with local GP and VCSFE leaders to ensure that representation reflects the populations in each of our three neighbourhoods and the breadth of community assets.

Reducing urgent care demand remains an area of significant focus and we are taking a multi-faceted approach to this, built from local population health needs. Analysis of our 1% cohort has demonstrated that demand for primary care and hospital-based services is particularly high in those people who are frail and housebound and we are focusing our first actions on this group of 83 people. Working with primary care, our local authority and VCSFE organisations through our established B&NES Community Wellbeing Hub, we will ensure robust multiagency care plans are in place and visible whilst also identifying proactive interventions we can put in place to reduce demand across all services. We will translate learning from this approach into future subsequent sub-sets of our 1% cohort. Alongside this, primary and secondary care colleagues are working together to implement the Supportive and Palliative Care Indicators Tool (SPICT) in two care homes in B&NES. The aim of this tool is to enable earlier identification and intervention to prevent risk of deterioration and hospital admission. Learning from this work will contribute to further roll out across our B&NES system.

In addition to this work, we are continuing to work with partner colleagues across our B&NES system through the RUH-led Every Minute Matters programme to reduce NCTR and avoid admission where clinically appropriate. This includes embedding revised escalation processes to support flow. Winter funding for primary care will be deployed during November and we are working closely with colleagues to ensure that this is supported by effective streaming at the front door of our acute hospital, with the aim being to redirect people to the right service for their needs where clinically appropriate, including GP appointment, MIU and our Urgent Treatment Centre.

Following our Local Area SEND Inspection in June 2026, we have worked with colleagues in the Local Authority and NHSE to define health-specific actions within the B&NES Local Area Strategic Improvement Plan (SIP). Implementation will support wider SEND transformation.

## 5.2 Swindon

Swindon Place continues to make good progress in strengthening place-based leadership and neighbourhood health delivery, with the Place Team now fully recruited and a revised governance structure due for approval by the inaugural Place Board this month.

Significant work is underway with system partners to develop neighbourhood health plans through a co-produced, community-led approach, alongside progression of the Neighbourhood Mental Health Centre and targeted health inequalities programmes. Operationally, the Community Diagnostic Vehicle pilot has delivered encouraging outcomes, preventing hospital conveyance for 92% of patients seen, while the Primary Care/UTC diversion scheme continues to reduce pressure on urgent care services.

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However, system pressures remain significant, particularly at Great Western Hospital, where demand continues to exceed estate and bed capacity, resulting in ongoing corridor care, elective and urgent care recovery challenges, and winter resilience risks. Mental health services are demonstrating improving performance, particularly in Talking

Therapies and dementia diagnosis rates, although risks remain around memory assessment waiting times and the planned closure of local autism support services, which could increase demand on urgent and mental health pathways. Overall, the focus remains on strengthening neighbourhood delivery, reducing inequalities, supporting winter resilience and mitigating system flow pressures across Swindon.

### 5.3 Wiltshire

The first meeting of the Wiltshire Place Board is planned for December 2026, with terms of reference being finalised alongside its sub group structure and confirmation of the functions the cluster ICB will delegate to it. The Section 75 agreement remains in place and is being updated to reflect the new governance arrangements.

The Wiltshire Place Team is now fully in post. Its focus in these first months has been on establishing sound working processes and good relationships, both across the ICB and with Wiltshire partners, so that joint work rests on clear ways of working. Recruitment is completing for the Community Portfolio Lead within the cluster Community Services and Primary Care Portfolio team.

Mobilisation of the Neighbourhood health development programme is moving into delivery. Fractal has been appointed as facilitation partner across BSW (hosted by Wiltshire), and partners will be onboarded at pace. Recruitment is under way for a programme manager to support integrated neighbourhood team mobilisation. This programme gives INTs the space to develop relationships, operational ways of working and identify priority populations together.

The Wiltshire Neighbourhood Health Plan is being drafted through the Locality Planning Group, for the Health and Wellbeing Board in January 2027. Partners are collaboratively drafting the plan following successful conclusion of the workshop series aligned to the BSW and Place Neighbourhood Health visions. A workshop with the Families and Children’s Transformation programme, to shape the children and young people content, is planned for November.

The Wiltshire team will present Well Farmers for Wiltshire, and the county’s approach to rural health provision, at the national Health Inequalities Improvement forum in November. This recognises the work of local partners with farming communities, which is also continuing through the development of a 'Rural Health Toolkit' currently being led by the Wiltshire Health Inequalities Group (part of the Place Board Sub Group Structure).

Wiltshire GP Practices and Primary Care Networks (PCNs) are now planning their delivery of the approved additional same day primary care capacity for this winter, supporting practices manage increased demand over winter, providing patients with greater access to care closer to home, and support redirection of unnecessary urgent care attendances; plans will be different based on the needs of the varied communities across the county. Within urgent care, Salisbury NHS Foundation Trust’s Urgent Treatment Centre is on track to open in December and the Place Team are working to support the final arrangements and to develop a local plan for Urgent and Emergency

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Care (UEC) in the community ready for winter, ensuring that we offer the right pathway for people needing urgent treatment. HCRG Care Group's single point of access has continued to improve its performance with average call answer waiting times now less than 3 minutes.

Wiltshire partners continue to make good progress on Home First and intermediate care. Salisbury hospital has maintained resilient performance through the recent capacity and flow pressures with a No Criteria to Reside (NCTR) figure of c46 against a March target of 35 - this is a reduction of over 30 cases in the last 3 months. Partners are working closely on winter surge pressures, to sustain that performance and to use what has been learnt to support the rest of the system.

Within the Primary Care and Community Portfolio, work continues on refining the primary care operating model across the cluster, with ongoing discussions to transfer the relevant functions for primary care medical services, community pharmacy, optometry and dental services, into Place, Cluster and the portfolio teams, clarifying the interdependencies and leads and developing governance to support these functions across our new model of care, mindful of our responsibilities under the delegated arrangements from NHSE. Work is also underway to scope the programme to develop the cluster approach to Single Neighbourhood Provider (SNP) and Multi-Neighbourhood Provider (MNP) contracts, working closely with Chief Medical Officer (CMO) and the GP leadership across the cluster.

**5.4 Dorset**

Dorset partners have continued to make significant progress in delivering integrated, high-quality care across the county during September and October 2026. Key achievements include the launch of a new hyperacute stroke service across Dorset and Somerset, providing faster access to specialist stroke treatment 24 hours a day, seven days a week; and further development of the Dorset Care Record through Dorset's participation in the Interweave Partnership, strengthening information sharing and supporting more joined-up care across health and care organisations. Alongside these developments, partners have focused on winter preparedness, with strong public engagement and mobilisation of seasonal flu and COVID-19 vaccination programmes to protect vulnerable residents and support system resilience.

In September 2026, the Health and Wellbeing Board approved the neighbourhood footprints for Dorset, and work has continued in finalising the refresh of the Health and Wellbeing strategy and the development of 4 delivery groups - starting well, living well, ageing well and healthy places. The Dorset Place-Based Partnership Framework is in development with its main aim to provide a shared governance and delivery model that brings together NHS organisations, local authorities, voluntary and community sector partners, and other stakeholders to improve outcomes for local populations. Its purpose is to enable collective leadership, joint decision-making and integrated working at place level, ensuring services are designed and delivered around the needs of communities. Through strengthened partnership working, the framework supports prevention, reduces health inequalities, improves the coordination of health and care services, and ensures resources are used effectively to achieve better outcomes for residents and greater

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system sustainability. The proposed approach is being presented to the Health and Wellbeing Board November 2026 alongside the refreshed strategy.

The Neighbourhood Health and Wellbeing Programme Board has developed a proposal for a new 1% Population Programme, building on the successful foundations and learning from the Neighbourhood Needs Health Improvement Programme (NNHIP). The programme aims to proactively identify and support the small proportion of Dorset residents with the most complex needs and highest risk of deterioration, helping to improve outcomes and reduce avoidable demand on health and care services, particularly over the winter period. Designed to be straightforward for neighbourhood teams to implement, the programme will strengthen integrated working across health, care and community partners, enabling rapid delivery of key interventions such as advance care planning, treatment escalation planning through the Dorset Care Plan, and medicines optimisation. Neighbourhood teams will then work with partners to co-produce local care coordination plans, ensuring a proactive, personalised and joined-up approach to supporting Dorset's most vulnerable populations.

The Winter Respiratory Commissioning Programme has been launched and aims to enhance the proactive and reactive management of respiratory conditions during the winter period by providing additional multidisciplinary respiratory support within neighbourhoods, helping people to remain well at home, reducing avoidable emergency department attendances and hospital admissions, and strengthening system resilience during periods of increased seasonal demand. Eight out of nine neighbourhoods have submitted proposals to deliver both elements of this scheme

### 5.5 Bournemouth, Christchurch and Poole (BCP)

Bournemouth, Christchurch and Poole Place continues to progress a number of key strategic and operational priorities. Work on neighbourhood footprints is advancing, with recommendations due to be considered through Place Based Partnership governance in November in advance of Health and Wellbeing Board agreement in January.

Alongside this, the neighbourhood programme has moved into mobilisation of the 1 per cent cohort approach, with a focus on extending proactive, multidisciplinary support to residents at highest risk of admission over the winter period, helping to reduce avoidable demand and improve outcomes. The Place team have also initiated work to address homeless health needs in the BCP conurbation, working in partnership with the local authority housing team to bring providers together to codesign an inclusive health offer as part of the government’s rough sleeper programme.

Winter preparedness remains a key priority across the Place, with continued focus on improving P1 flow, extending the Discharge to Assess (D2A) approach and strengthening system coordination. This includes implementation of enhanced Single Point of Access (SPOA) arrangements and development of the Command Centre model to support operational oversight and timely intervention during periods of system pressure. Preparations for hospital reconfiguration in April 2026 continue at pace, with work focused on operational and system readiness and pathway alignment. Key risk

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areas remain flow constraints across the BCP footprint and sustained performance against NCTR trajectories, both of which require continuation of stronger and more active system-wide management to deliver the improvements required over winter.

## 5.6 Somerset

General Commissioning

- Patients presenting at Emergency Departments with conditions more appropriately managed in primary care are being redirected to established hub appointments, supporting timely access to care and improved patient flow.
- The Cluster Winter Plan is now live, with delivery underway across system partners to support winter resilience, improve patient flow, and maintain access to urgent and emergency care services throughout the winter period.
- Approval was granted for a six-month winter uplift to the Somerset Ambulance Doctor Service (SADS), delivered through SWAST. The enhanced service will provide senior clinical assessment and decision-making support for patients attended by ambulance crews, supporting care closer to home, reducing avoidable Emergency Department attendances and admissions, and improving winter system flow. Previous evaluations have demonstrated positive outcomes, including increased non-ED dispositions and potential reductions in inpatient bed days.

Place-Based Decision-Making

- The joint CQC and Ofsted Special Educational Needs and Disabilities (SEND) inspection commenced on 2 November 2026 and concluded on 20 November 2026.
- Health, education, and local authority partners continue to work collectively throughout the inspection period, supporting evidence gathering, stakeholder engagement and system-wide coordination. A summary of inspection findings, recommendations and implications for Somerset Place will be reported through the appropriate governance arrangements once the final report is received.
- The Somerset Board has approved revised governance arrangements to support delivery of key system priorities, including the refresh of the Health and Wellbeing Strategy, development of a model for neighbourhood working, development of a Somerset vision and plan for joint commissioning, and coordination of population insight and outcomes. These arrangements will operate alongside the newly established Provider Partnership Board.

Neighbourhood Health

- Somerset Place has supported the development of estates investment proposals for a new GP surgery in Bruton and the reconfiguration of existing accommodation at Wellington Medical Centre to increase General Medical Services (GMS) capacity, supporting the development of sustainable community-based services and improved access to care closer to home.
- Additional general practice capacity is being delivered through targeted Acute Illness Hubs across CLICK, South Somerset West and Yeovil PCNs, focusing on areas of identified need and anticipated winter pressures. This targeted investment aims to strengthen local capacity to manage acute illness closer to home, improve timely access to care, support winter resilience, and reduce avoidable attendances at Emergency Departments.

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## 6. Voluntary, Community, and Social Enterprise (VCSE) Update

### 6.1 Overview

The VCSE Alliances across Bath and North East Somerset, Swindon, Wiltshire, Dorset, BCP and Somerset continue to investigate and plan for opportunities to increase the sector's contribution to neighbourhood health, prevention and health inequalities in support of the delivery of the NHS 10 Year Plan. Since September, activity has continued to combine strategic engagement with practical delivery: developing neighbourhood relationships, gathering insight, strengthening leadership and improving referral pathways.

Whilst each of the three Alliances look to grow their influence and contribution they appreciate that this must be done sustainably across both NHS and Local Authority boundaries. Increasingly the sector is drawn towards providing greater value and must be included in strategic commissioning and planning at the earliest stage as a trusted partner. Regular South West Alliance meetings continue to share learning and develop partnership working opportunities.

### 6.2 Update from Wiltshire VCFSE Sector

- The Wiltshire Leadership Alliance met in October and will soon be reviewing membership of the Place based ICA subgroups which are being formulised.
- The Neighbourhood Plan in Wiltshire is being drafted with VCSE membership on the working group. The Voice It Hear It voice programme led by VCSE partners has recently undertaken consultation on long term health conditions, access, rurality and transport challenges. Insights from this will be fed into the draft Neighbourhood Plan.
- The ICB becoming a signed-up partner to the VCSE-WC Partnership Framework which is an important document co-produced to improve partnership working, communication and processes

### 6.3 Update from Somerset VCFSE Sector

- Spark Somerset published their Impact Report 2025/26. This can be accessed via the Spark website
- The report outlines the work of the organisation supporting charities and community groups by delivering training and networking events and helping to secure more than £1.5 million in funding. Through Spark a Change, our volunteering website, 1,550 new volunteers signed up and 423 volunteering opportunities were advertised.
- The report also highlights investment in local groups, support for the development of Somerset's Vision for Volunteering, and the ways they have brought people together through partnerships, peer networks and community projects.

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## 6.4 Update from Dorset VCFSE Sector

- The DVCSA has worked with infrastructure organisations in the county to ascertain what progress is being made to improve outcomes and community insights. Whilst a final report has yet to be produced some early themes have been identified as:

    - Access is an inequality in its own right. Rurality, transport, mobility, digital capability and communication needs can combine to make theoretically available services practically inaccessible.
    - Waiting has consequences. Long waits affect pain, mobility, independence, mental wellbeing, family life and people's ability to participate in ordinary life. Community support during waiting periods therefore warrants consideration.
    - Trusted relationships matter. People experiencing anxiety, previous negative experiences, communication difficulties or exclusion may need trusted community routes before they can engage successfully with formal services.
    - Health problems rarely occur in isolation. The case evidence repeatedly connects health with income, housing, transport, caring responsibilities, social connection and ability to navigate services.
    - Community infrastructure can reveal and sometimes resolve the space between services. The evidence is strongest where VCSE organisations identify practical barriers that do not sit neatly within a statutory pathway and either connect people to support or bring partners together around the problem. Involve the community early. The VCS is asking not simply to be consulted, but to be involved early, recognised as part of the solution and able to see what happens next. Partnership enthusiasm is present, but the event feedback makes clear that maintaining it will depend on communication, accountability and visible progress.

## 7. Update on Community Health Services in BSW

This update has been prepared jointly by NHS Bath and North East Somerset, Swindon and Wiltshire, Dorset and Somerset ICB Cluster and HCRG Care Group. In this update, “we” means BSW, Dorset and Somerset ICBs and HCRG Care Group together. Where an action or decision belongs to one organisation, it is named.

## 7.1 Summary

- We have heard the experiences MPs have shared, including in the Westminster Hall debate. We take every concern seriously, and we have asked MPs to pass on constituents’ details so that we can investigate and put things right.

- The Single Point of Access (SPA) launch on 1 April 2026 was not as smooth as it should have been. Between April and September 2026, calls answered within 10 minutes rose from 51% to 82%, and the average wait fell from 5 minutes 38 seconds to 2 minutes 55 seconds. This is still below the 95% target, and the ICB has had the SPA under enhanced quality surveillance since May 2026.

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- Waits for some services remain long, notably wheelchair services, where demand is up 13.9% year on year. The wheelchair and musculoskeletal (MSK) pathways are on the

timetable to be reviewed in the second half of 2026/27. Overall, BSW Community Health reports into NHS England that 79.3% of appointments held within 18 weeks of referral, against a national standard of at least 78%.

- The vacancy rate is 5% (September 2026), against a national NHS figure of 6.7%. Sickness absence is 5.9%, slightly above the national figure of 5.3%. Turnover is 12% averaged across the contract to date, within the NHS range of 10–15%.

- Administration is being centralised only where it is more effective; it is not a blanket decision. In response to feedback from nursing teams, fixed-term administrators are being restored to integrated neighbourhood teams that asked for them.

- The 7-year, outcomes-based contract began on 1 April 2025, bringing more than 130 services from 9 organisations together. It is in month 19 of 84: Year 1 built the foundations, and Year 2 (2026/27) is about consolidating the foundations and beginning transformation at scale.

### 7.2 Listening, and raising individual concerns

We have heard concerns from MPs raising the experiences of their constituents, including in a recent debate in Westminster Hall debate led by Sarah Gibson, MP for Chippenham. We heard the stories that were shared, and we acknowledge that together we need to improve and to keep listening. No case is being dismissed. No service will ever be perfect, but what matters is that we listen, take concerns seriously and learn from them. We are committed to working together with our patients, service users, MPs and communities to make sure we rebuild trust and confidence in our services.

### 7.3 About the contract

Since 1 April 2025, BSW ICB has commissioned community health services for people of all ages across Bath and North East Somerset (B&NES), Swindon and Wiltshire through one contract, with the three councils as co-commissioners. HCRG Care Group (formerly Virgin Care) was selected after a competitive tender in October 2024 and delivers the services as BSW Community Health. The contract runs for 7 years and covers care from birth to end of life, with an annual value of approximately £157m. It is delivered under the standard NHS contract, so HCRG Care Group has the same core expectations on quality, performance and reporting as any NHS provider.

### 7.4 How the contract is overseen

BSW ICB's Joint Contract Oversight Group (JCOG), which the co-commissioning councils attend, oversees performance, quality and safety, and transformation every month.

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The SPA is the only service under enhanced oversight: the ICB has had it under enhanced quality surveillance since May 2026. These arrangements remain in place until there is sufficient assurance that progress is being made to improve quality and

safety of services and that appropriate governance and oversight arrangements are in place.

### 7.5 What happens if performance does not improve?

The services are delivered under the standard NHS contract, and the standard performance interventions apply if they are needed.

### 7.6 Progress so far

The contract is now in month 19 of 84. It was never meant to deliver everything in its first 12 months. Year 1 (2025/26) mapped services, set baselines and built the foundations: 17 new neighbourhood teams, adult services open 8am to 8pm, 7 days a week, a single management structure, and administration and support teams brought together. Year 2 (2026/27) is about transformation at scale and stabilising performance where needed. Priorities include expanding Hospital at Home and virtual wards, priority clinical pathways and developing the SPA.

Progress is best judged against the contract's six outcomes, rather than isolated activity figures: improving health and wellbeing; increasing life expectancy; reducing the impact of long-term conditions; improving access and experience; a sustainable workforce and support for carers; and making the most of digital, estates and information. Some outcomes, such as life expectancy, take years to move; others show early progress now.

Early signs of progress include:

- **Staying well:** frailty screening has been offered to 7,582 people aged 60 and over (74% of those eligible). Of the 210 people who completed a Steady on Your Feet falls plan, 77% had not fallen since.
- **Health inequalities**: more than 20 seldom-heard communities have been engaged. The "no wrong door" approach means people can access services whether or not they are registered with a GP.
- **Care at or near home**: the care coordination service, which gives paramedics real-time clinical advice, avoided 4,869 hospital admissions in 12 months.
- **Access and experience**: self-referral has been available since 1 April 2026. In Year 1, 81% of children were seen within 18 weeks, and over 90% of people approaching the end of life died in their preferred place. In Q1 2026/27, 93.8% of FFT responses rated the service good or very good.
- **Digital and data:** HCRG Care Group has invested £7m in setting up the service; 95% of referrals are electronic. Weekly performance data, including SPA data, is published at www.bswcommunityhealth.com (in "news").

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## 7.7 The Single Point of Access

The SPA replaced around 200 separate points of entry for community services, none of which reported on demand or response times. It gives people one front door, online, by phone and in person, 24 hours a day (8pm to 8am for urgent end-of-life and catheter queries only), and people can use it without a GP appointment.

The SPA launched on 1 April 2026. Despite significant planning, the launch was not as smooth as it should have been, and HCRG Care Group is sorry that some people waited too long to speak to the service or to hear back. The target, set by HCRG Care Group itself and based on the NHS target for similar services, is for 95% of calls to be answered within 10 minutes.

| Month (2026) | Total calls | Average wait (min:sec) | Answered within 10 minutes | Answered within 1 minute |
|---|---|---|---|---|
| April | 68,341 | 05:38 | 51% | 26% |
| May | 51,520 | 06:07 | 54% | 27% |
| June | 58,143 | 06:13 | 48% | 24% |
| July | 53,833 | 04:09 | 71% | 38% |
| August | 44,473 | 03:34 | 78% | 45% |
| September | 50,641 | 02:55 | 82% | 53% |

Performance is below the 95% target HCRG Care Group has set itself, but between April and September 2026 the share of calls answered within 10 minutes rose from 51% to 82%, and the average wait fell from 5 minutes 38 seconds to 2 minutes 55 seconds. In the week of 5 October 2026, the average wait was below 3 minutes. There is no earlier comparison, because none of the previous 200 entry points were measured.

A computer problem at launch caused a backlog of routine, planned referrals. It was cleared in September 2026 under an action plan agreed with the ICB. Urgent referrals were processed in normal timeframes throughout and were never delayed.

Since launch, HCRG Care Group has added 18.5 whole-time-equivalent community health navigators, introduced dedicated end-of-life, reasonable adjustments and professionals' lines, slowed down the recorded message and simplified referral forms.

BSW ICB has had formal enhanced quality surveillance of the SPA in place since May 2026 under the National Quality Board framework. A Quality Improvement Group which NHS England and Care Quality Commission attend, tracks an agreed action plan. The surveillance will continue until the ICB is assured that improvement has been made and is sustained. Following improved performance, discussions on de-escalation are now under way.

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09/11/2026 16:18:19

## 7.8 Waiting times

The services transferred with existing waits, some of them long-standing, for example in wheelchair services. Demand is very high: demand for wheelchair services is up 13.9% year on year. Against the national 18-week referral-to-treatment standard of at least 78% of appointments held within this timeframe, BSW Community Health reports 79.3%.

The transformation work will help, but it takes time. The wheelchair and MSK pathway reviews take place in the second half of 2026/27, and wheelchair users will be invited to take part. The rehabilitation pathway is reviewed in Year 3.

## 7.9 Workforce

The vacancy rate is 5% (September 2026), below the national NHS figure of 6.7%, and CQC found that the services it inspected were appropriately staffed. Like the rest of the health and care system, the service still faces workforce pressures. The table below sets out the main workforce figures.

| Measure | BSW Community Health | Comparison |
|---|---|---|
| **Staff turnover** | 12%, averaged across the contract to date | NHS range 10–15% |
| **Vacancy rate** | 5% (September 2026) | National figure 6.7% (June 2026) |
| **Sickness absence** | 5.9% (September 2026) | National figure 5.3% |
| **Redundancies since 1 April 2025** | 56 colleagues (1.6% of the workforce) | - |

## 7.10 Changes to administrative support

HCRG Care Group has heard concerns, from MPs and from its own teams, that administrators are being removed from services. Administration is being centralised only where it is more effective, so that multi-skilled colleagues can support several services and respond to demand; it does not mean that everyone does everything. It is not a blanket decision, and it will not be right for every service.

WOOLLEY CHAMPION
09/11/2026 8:14:19

HCRG Care Group has listened to feedback from nursing teams in its integrated neighbourhood teams (INTs). In response, it is restoring fixed-term administrators to the teams that have asked for them, while it works with them to understand the work being done and the ways of working. Many inherited services relied heavily on paper, with

administrators printing out and scanning in notes. Where this still happens, HCRG Care Group is reviewing whether the process adds value, or whether there is a different way to work which might reduce the need for administration staff while maximising the time clinicians spend with patients.

## 8. Communications and Engagement

8.1 Every day, people across BSW, Dorset and Somerset share their experiences, ideas and feedback with us. Whether it's through direct enquiries, social media, patient groups or conversations with local organisations, those voices help shape the way we communicate, engage and improve services.

8.2 The feedback we receive helps us understand what's working well and where we need to do better. Over recent months, patients, carers and community groups have shared a consistent message: access to care and communication matter most.

8.3 In appendix 1 you'll read some of the key themes we've been hearing from local communities, alongside examples of how we're turning feedback into action.

8.4 A key lesson from previous years is that local voices matter. We've learned that campaigns are most effective when they reflect real experiences, local stories and trusted community networks rather than a one-size-fits-all approach. In this month's update we have shared the latest health prevention campaigns and seasonal advice designed to help people and communities stay well, access the right care and make informed choices this winter.

**Appendix 1**

Communications and Engagement Insights Report November 2026

WOOLLEY,SHARON
09/11/2026 16:18:19

# Listening, learning and taking action together

## Communications and Engagement Insights Report

**November 2026**




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09/11/2026 15:28:19

# In the spotlight

Every day, people across BSW, Dorset and Somerset share their experiences, ideas and feedback with us. Whether it's through direct enquiries, social media, patient groups or conversations with local organisations, those voices help shape the way we communicate, engage and improve services.

In this edition, you'll find some of the key themes we've been hearing from local communities, alongside examples of how we're turning feedback into action. We're also sharing the latest health prevention campaigns and seasonal advice designed to help people and communities stay well, access the right care and make informed choices this winter.

Because the best communication starts with listening.

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09/11/2026 16:18:19

# What communities have been telling us

Over the past few months, we've been listening to patients, carers, community groups and local partners across the cluster. While everyone's experience is different, we've heard some clear and consistent messages.

Three themes have stood out this quarter:

1. **Access to services** remains a major concern, particularly for ADHD and autism assessments, NHS dentistry, GP appointments and mental health support.
2. **Communication and care coordination** continue to have a significant impact on people's experience of care.
3. **Health inequalities** remain a challenge, with some groups and communities facing greater barriers to accessing support than others.

The good news is that people continue to speak highly of the dedication, kindness and professionalism of NHS and care staff. However, many tell us that their overall experience is often shaped by how easy it is to access services, find the right support and stay informed about their care.

Across all our feedback channels, these messages came through time and again:

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09/01/2026 10:28:16

**"I'm struggling to get the help I need."** ● **"I just want to know what's happening."** ● **"I wish services worked together better."**

People told us that getting the help they need can sometimes feel difficult and frustrating. Long waits, complex referral processes and a lack of updates often left people feeling uncertain about what would happen next or who to contact.

Some shared experiences of having to repeat their story to different teams or feeling that their care wasn't joined up. By listening to these experiences, we can better understand what matters most to people and work with our partners to make services simpler, more connected and easier to navigate.



# Insights by numbers

| Source | Number | Key themes |
|---|---|---|
| **Public and patient enquiries** | 1213 | • Dental: access including urgent care, complaints about treatment and charges<br>• ADHD: waiting times and Right to Choose<br>• CHC/Funding: navigating assessments and eligibility, with challenges around funding decisions, changes to care packages. |
| **MP enquiries and Parly Hubs** | 144 | • Access, waiting times and capacity including dental services<br>• Clinical services, outcomes & inequalities including ADHD waiting times<br>• Funding, policy and commissioning including patient transport and continuing health care funding |
| **FOIs** | 436 | • All Age Continuing Care<br>• Mental Health services including ADHD and Autism<br>• Digital technology<br>• Primary Care |
| **Media enquiries** | 45 | • Service access, capacity & workforce<br>• Service change & commissioning<br>• Emerging issues, innovation & NHS change |

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09/11/2026 18:19

# Community voices

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09/11/2026 16:18:19



# What we've been hearing

Every piece of feedback helps us understand what's working well and where we need to do better. Over recent months, patients, carers and community groups have shared a consistent message: access to care and communication matter most.

Access remains the biggest concern. People continue to tell us they face challenges accessing services such as GP appointments, NHS dentistry, mental health support, ADHD and autism assessments, and some specialist services.

**"I don't mind waiting if I know what's happening. It's the uncertainty that's difficult."**

Many people say that clear information about waiting times, their place on a waiting list and available options would make a real difference to their experience.

Communication also plays a huge role in how people feel about their care. We regularly hear concerns about a lack of updates, difficulty finding the right person to contact, and uncertainty about what happens next.

**"A quick update would have made me feel much more reassured."**

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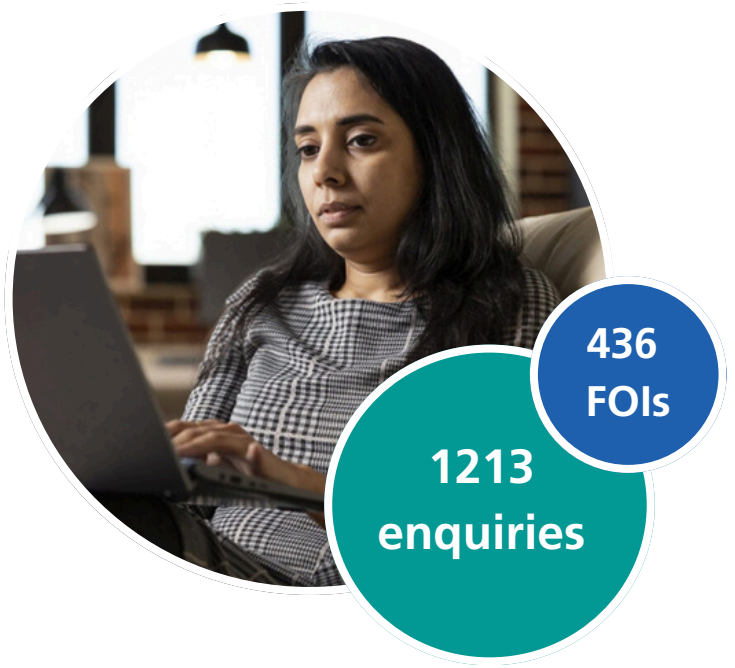
The good news is that small improvements in communication can have a big impact.

Keeping people informed, explaining what to expect, and making services easier to navigate can help build confidence and improve experiences, even when services are under pressure.

Thank you to everyone who continues to share their experiences. Your feedback helps us shape and improve local health and care services for everyone.


436
FOIs
1213
enquiries

# Young people turning to TikTok and AI for health advice

Young people in Dorset are increasingly turning to TikTok, social media and artificial intelligence (AI) for health information, according to a new report from Healthwatch Dorset, developed with local youth volunteers.

The survey of 55 people aged 16 to 30 found that nearly three-quarters (73%) access health information online, with 51% using TikTok and 33% using AI tools. However, only 24% said they routinely check whether information comes from trusted organisations such as the NHS or BBC

## A young participant said:

**"Most people my age will search online or on social media first. It's quick and easy, but it can be hard to know what's reliable."**

While awareness of NHS services was generally good, confidence in using them was often lower. Although 82% of respondents knew what NHS 111 is used for, almost half said they would not feel confident using the service. Young people also highlighted barriers to accessing mental health support, including stigma and difficulties navigating services.

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Louise Bate, Manager at Healthwatch Dorset, said:

**"Young people told us they want health information that is accessible, relevant and available through the platforms they use every day. They also want greater confidence in navigating NHS services and knowing where to turn when they need help. We hope these findings will help local services better understand and respond to those needs."**

The report recommends increasing NHS-verified content on the platforms young people use most, improving health literacy and awareness of NHS services, and continuing to involve young people in shaping health and care support.

The full report, How Young People Access Health Information in Dorset, is available on the Healthwatch Dorset website



# Minor Injury Units praised by patients

More than 20,800 people attended Minor Injury Units (MIUs) in Chippenham, Trowbridge and Paulton over a five-month period, with a new review showing patients highly value the services for providing quick, compassionate care closer to home.

The review, carried out by HCRG Care Services, combined service data, patient feedback and site visits to understand how MIUs are working for local people. Patients consistently described the units as convenient, welcoming and effective.

**One patient said:"Really happy it's here and local."**

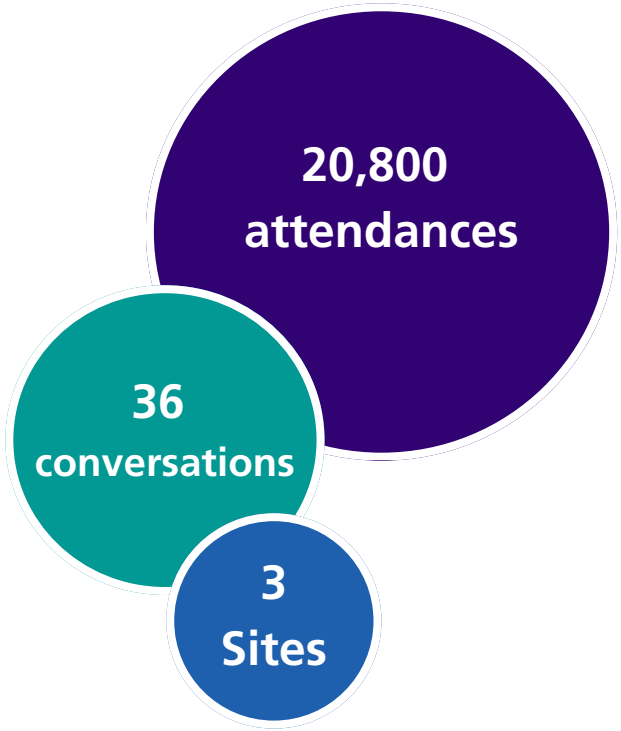
**Another described the service as: "Better than going to A&E."**

The findings show MIUs support people of all ages, with particular demand from children and young people and older adults. Access to diagnostic services such as X-rays was also highlighted as a key benefit by patients.

A spokesperson for HCRG said:
"This review confirms that Minor Injury Units are making a real difference to local people. Patients told us they value being able to access timely, compassionate care closer to home, and we're committed to continuing to listen, learn and work with communities to further improve services."

While the overall picture was overwhelmingly positive, the review identified opportunities to improve public awareness of what MIUs offer, when to use them and the services available at each site.

The findings will help inform future service improvements and support ongoing efforts to provide the right care, in the right place, at the right time.



# Campaigns in action



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# Staying well this Winter

As winter approaches, NHS teams across BSW, Dorset and Somerset are once again working together to help people stay well and get the right care when they need it. Our winter campaign has been shaped by feedback from local communities, patients and carers about the support and information they need most.

We've heard people tell us:

**"I don't always know where to go for help."**

**"It's hard to find trusted advice when family members are unwell."**

**"I want to stay healthy and independent during the winter."**

**In response, we'll be sharing practical advice throughout the season on vaccinations, staying warm and well, mental wellbeing, and the services available in local communities. We'll also be highlighting how community pharmacies can help with many common illnesses, often without the need for a GP appointment.**

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**You'll see regular updates across our social media channels, including tips from the "Little Things to Stay Well" campaign, which promotes simple actions people can take to look after themselves and support those around them.**

**This winter, our focus is simple: providing clear, practical information that helps people access the right support, stay healthy and feel confident about where to turn when they need help.**



# Listening and learning

A key lesson from previous years is that local voices matter. We've learned that campaigns are most effective when they reflect real experiences, local stories and trusted community networks rather than a one-size-fits-all approach. That's why we'll continue to work with patients, carers, voluntary organisations, community groups and healthcare staff throughout the winter to ensure our messages are relevant, practical and useful.

Together, we can help more people stay well this winter, get the right care when they need it, and support our health and care services through the busiest time of year. Over the coming months, we'll be sharing advice, information and local stories to help people stay well, including:

**Vaccination campaigns** promoting flu, COVID-19, RSV and other seasonal vaccinations for eligible groups.

**Winter wellbeing** advice covering infection prevention, self-care, staying warm, mental wellbeing and supporting vulnerable friends, family and neighbours.

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**Pharmacy First** awareness campaigns, highlighting how pharmacists can treat many common conditions without the need for a GP appointment.

**Right Service, Right Time** information to help people understand when to use NHS 111, community pharmacies, minor injury units, urgent treatment centres and emergency services.

**Support closer to home**, including services that help people receive care in their communities and recover safely after leaving hospital.

**Targeted support for communities most at risk**, using local insight and population health information to focus activity where it can make the biggest difference.



# Vaccinations across the cluster

The Communications and Engagement team has played a key role in supporting this year's seasonal vaccination programme across BSW, Dorset and Somerset. Activity has focused on raising awareness, encouraging uptake and helping people understand how and where they can access vaccinations following changes to local delivery arrangements, including the reduced availability of community clinics.

Through targeted campaigns, media engagement and partner communications, the team has worked to reach priority audiences, reduce barriers to access and support vaccination uptake across the cluster.

- Vaccination posts have been seen more than **148,000 times** across our social media channels.
- People have engaged with vaccination content over **6,700 times** through clicks, comments, reactions and shares.

Alongside our public campaign, trust colleagues have supported staff vaccination programmes, contributing to a strong start across the cluster, with Great Western Hospitals NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust among the top-performing NHS trusts nationally for staff vaccination uptake.

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Together, these efforts are helping protect our workforce and communities ahead of winter.

### Shining a light on tackling inequalities - case study

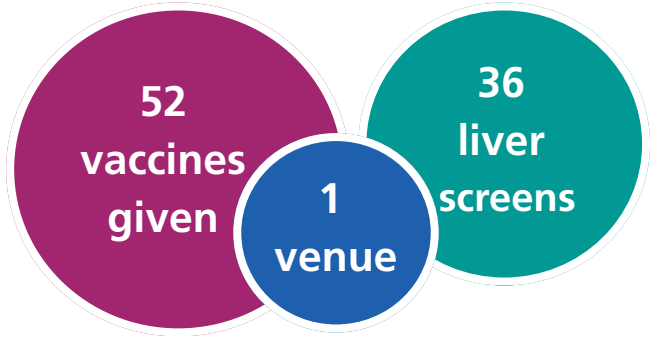
A vaccination programme for people experiencing homelessness is helping bring preventative care directly to some of the communities least likely to access traditional healthcare.

By working through trusted local partners and delivering vaccinations in familiar settings, the programme is making it easier for people to get the support they need.

This targeted approach supports the ambitions set out in the NHS 10-Year Health Plan and wider national priorities to reduce health inequalities through earlier intervention and prevention.

The work has also attracted positive media attention, including a BBC News feature on flu vaccinations delivered through the HealthBus Trust in Bournemouth, helping raise awareness of the health challenges faced by people experiencing homelessness and the importance of equitable access to care.

As well as increasing vaccine uptake, the programme is creating opportunities to connect people with wider health and support services, supporting efforts across the cluster to improve outcomes, reduce inequalities and prevent avoidable ill health.



# In the news

Over recent months, the Communications and Engagement team has successfully raised the profile of the cluster through a mix of proactive storytelling, strategic media engagement and rapid issue management. By working closely with journalists, clinicians and system leaders, we secured widespread coverage across regional and national outlets including BBC, ITV and major local news titles.

This coverage has helped to:

- Increase public understanding of key service changes and transformation programmes.
- Promote winter vaccination uptake and other health campaigns.
- Highlight innovative work to reduce health inequalities and improve access to care.
- Showcase the achievements of NHS organisations across BSW, Dorset and Somerset.
- Give clinical and executive leaders a platform to engage directly with patients, partners and communities.

Through strong media relationships and compelling local stories, we continue to strengthen trust, awareness and engagement across the populations we serve.

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Collectively, this coverage has amplified organisational priorities, strengthened confidence in local NHS services and supported delivery of our strategic objectives.

## Recent media highlights

### Stroke service transformation

- Coverage secured across **BBC South**, **BBC Somerset**, **ITV Westcountry**, the **Somerset County Gazette**, **New Blackmore Vale** and other regional titles, supporting implementation of the new stroke pathway across Somerset and Dorset.
- Enabled clinical leaders to explain the benefits of the new model and support public understanding of a significant service change.

### Health inequalities and outreach vaccination programmes

- National coverage secured on **BBC Breakfast** and **BBC News**, alongside regional coverage on **BBC South Today**, **BBC Dorset**, **BBC Points West** and **BBC Wiltshire**, highlighting vaccination outreach work for people experiencing homelessness and other vulnerable groups.

### Winter vaccination campaign

- Widespread coverage achieved across **BBC Somerset**, **BBC Dorset**, the **Bournemouth Echo**, **Dorset Echo**, **Wiltshire Times**, **Gazette & Herald**, **Swindon Advertiser** and other local media, helping promote vaccination uptake and winter preparedness.

# Our cluster



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# Working together across our cluster

Staff across the NHS organisations serving Bath and North East Somerset, Swindon and Wiltshire, Dorset, and Somerset are being brought closer together through shared branding designed to strengthen collaboration and build a single cluster culture.

The initiative follows significant progress in developing a shared identity and way of working across the three Integrated Care Boards (ICBs), with colleagues increasingly working across organisational boundaries to improve services for local communities.

The cluster will continue to use the interim identity: **Working together across NHS BSW, NHS Dorset and NHS Somerset**, helping create a strong sense of belonging while retaining the statutory identities of each organisation.

The approach is intended to reinforce shared values, support culture change and provide a clear and consistent identity for staff working across the cluster footprint.

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**Listening, supporting and making a difference**

After receiving unexpected news about her treatment through the NHS App, a patient living with severe pain contacted the team feeling distressed and worried about what would happen next.

By working closely with the Trust PALS and funding teams, we were able to provide reassurance, help get her care back on track and secure approval for her treatment. The patient thanked the team, saying: "I'm so grateful, you've done so much."



For more information please email:
communication@nhsdorset.nhs.uk




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Official sensitive

| Report to: | Cluster Board – Meeting in Public | Agenda item | 4 |
|---|---|---|---|
| Date of Meeting: | 16 November 2026 | | |

| | |
|---|---|
| Title of Report: | ICB Cluster Priorities for the next 12 months and the ICB CEO Delivery Compact |
| Report Author: | Jonathan Higman, Chief Executive |
| Board / Director Sponsor: | Jonathan Higman, Chief Executive |
| Appendices: | A. ICB Cluster Priorities<br>B. Integrated Care Boards CEO Delivery Compact |

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

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

| Previous consideration by: | Date | Please clarify the purpose |
|---|---|---|
| Executive Management Group | 13 October 2026 | Discussion, consideration and endorsement |
| Board Development Session | 15 October 2026 | Discussion, consideration and endorsement |
| Transition Committee | 22 October 2026 | Discussion, consideration and endorsement |

## 1 Purpose of this paper

This paper sets out the ICB Cluster's proposed priorities for the remainder of 2026/27 and 2027/28. These have been developed by the Chief Executive and the ICB Executive Team.

In addition, the Chief Executive has been involved in discussion with the Chief Executives of the other 25 ICB/ICB Clusters across the country to set out a delivery 'Compact' which sets out the areas of collective action over the coming period. As the ICB moves into the next phase of organisational change and with the context of the uncertainty provided by the National devolution agenda, it is important that the ICB Cluster is clear about its initial priorities.

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This report provides:

- A summary of the ICB Cluster's priorities for the remainder of 2026/27 and into 2027/28.
- A cross-reference between those priorities and the National ICB CEOs delivery Compact.

## 2 Summary of recommendations and any additional actions required

The Board is asked to:

1. Note and endorse the proposed organisational priorities.
2. Discuss the alignment between the ICB Cluster organisational priorities and the commitments contained within the Integrated Care Boards CEOs Delivery Compact.
3. Support incorporation of the identified priorities into the development of the Cluster's commissioning intentions and operational planning.

## 3 Legal/regulatory implications

No direct implications, although the priorities will provide focus for the entire organisation as it develops its strategic commissioning capabilities over the coming months.

## 4 Procurement

No immediate implications.

| | |
|---|---|
| P&C Name | |
| P&C Signature | |

## 5 Risks

The Risks are noted in section 4 of this report.

## 6 Quality and resources impact

The priorities focus on improving access, reducing demand on urgent care services and improving outcomes through earlier intervention and better service design.

The ICB is considering the resources required to deliver the priorities. They will be reflected in the forthcoming commissioning intentions and financial strategy.

| | |
|---|---|
| Finance sign off: | |

## 7 Confirmation of completion of Equalities and Quality Impact Assessment

An EQIA has not been developed at this stage.

## 8 Communications and Engagement Considerations

Communications and Engagement is underway within the ICB cluster as part of the transition work. The focus is to ensure that colleagues across the cluster are aware of the priorities and working to support delivery. The priorities were launched at the first ICB all colleague day on 12 October 2026.

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## 9 Statement on confidentiality of report

This is a public document and can be shared.

## 1 Background

1.1 The organisational priorities establish three overarching areas of focus:

**Priority 1: Make progress against our strategic ambitions**

1.2 Key delivery areas:

- Complete the Cluster Integrated (Health) Needs Assessment.
- Take actions through our commissioning intentions for 2027/28 to start to shift our investment profile towards earlier intervention, prevention and population health improvement.
- Establish place-based working arrangements and strengthen partnerships.
- Determine the future model of acute services, allowing providers time to respond to the change in the investment profile and the shift to new neighbourhood care models and the increasing use of technology.
- Develop our neighbourhood health and population health management approaches.

**Priority 2: Bring our new organisational model to life**

1.3 Key delivery areas:

- Implement the operating model arising from organisational redesign.
- Embed organisational values and behaviours.
- Build a digitally enabled organisation, including the effective use of data, digital and AI.

**Priority 3: Deliver tangible improvements for our population**

1.4 Key delivery areas:

- Reduce Emergency Department attendances, with a particular focus on the ‘1% cohort’ across the cluster.
- Reduce the number of patients whose discharge from hospital is delayed.
- Improve access to dentistry.
- Reduce outpatient waiting times, with a particular focus on a new commissioned pathway for Attention Deficit Hyperactivity Disorder (ADHD) and neurodevelopment.
- Implement consistent Continuing Health Care arrangements.
- Eliminate inappropriate out of area placements for people with mental health needs.

1.5 There is a clear strategic narrative that runs through the three priorities which can be set out as follows:

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1.6 **Our first task is to create the capability to deliver it.** Bringing the three ICBs together gives us an opportunity to create a stronger strategic

commissioner, operating at greater scale while remaining connected to Place and neighbourhoods. Our new organisational model, values and ways of working, alongside much stronger use of data, insight, digital and AI, need to equip us to make better strategic choices and deploy our collective resources differently.

1.7 **Second, we need to start making some of those strategic choices.** Our Integrated Health Needs Assessment should give us a shared evidence base for determining where we can make the greatest difference to population health. We then need to translate that into decisions about where we invest, including beginning to shift the profile of spend away from hospitals, developing Place and neighbourhood working, strengthening joint commissioning with our six councils, and determining the future configuration of acute services which responds to this.

1.8 **Neighbourhood health is particularly important because it is where much of this strategy comes together.** Consistent neighbourhood geographies and teams, coupled with effective frailty models, give us the opportunity to move from a collection of individual services towards proactive, coordinated support built around populations and communities.

1.9 **But our work also has to deliver benefits now.** We cannot ask our population to wait for a future model of care. During 2026/27 and into early 2027/28 we, therefore, also need to demonstrate tangible improvements, including reducing ED attendance and delayed discharges, improving access to dentistry, reducing outpatient waiting times with a particular focus on waits for ADHD/neurodevelopmental assessment for children and young people, improving consistency in continuing health care and eliminating inappropriate out-of-area mental health placements.

1.10 The ICB CEOs Delivery Compact establishes a collective ambition across all 26 Integrated Care Boards in England focused on neighbourhood health, prevention, population health management, quality, inequalities, modern commissioning, productivity and financial sustainability.

1.11 An oversight arrangement has been developed to support delivery of the Compact which includes a national dashboard to benchmark and track progress against 5 indicators:

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- ED attendances per 1,000 population
- Elective referrals per 1,000 population
- Non-elective average length of stay greater than 1 day
- Elective average length of stay greater than 1 day
- The percentage of children seen by a dentist in the last 12 months.

## 2 Assessment

### Cross-reference of ICB Cluster Priorities to the Compact

2.1 There is good alignment between the ICB Cluster Priorities and the Compact which will support focus and delivery. The following tables explicitly set this out.

**Priority 1: Make Progress Against Our Strategic Ambitions**

| Cluster Priority | Relevant Compact Commitment |
|---|---|
| **Complete Integrated Needs Assessment** | Population health management and commissioning around population need. |
| **Shift investment towards prevention and population health** | Neighbourhood health, prevention and population health commitment. |
| **Place-based partnerships** | Place, local government and joint commissioning commitment. |
| **Future model for acute services** | Modern commissioning and contracting; pathway redesign and service transformation. |
| **Neighbourhood health and population health management** | Neighbourhood health teams are the primary collective delivery priority of the Compact. |

2.2 This priority demonstrates strong overall alignment with the Compact. Both documents place neighbourhood health, prevention, population health management, integration and commissioning around need at the centre of system transformation. The local priorities effectively translate the Compact's strategic ambitions into our Cluster's delivery actions.

**Priority 2: Bring Our New Organisational Model to Life**

| Cluster Priority | Relevant Compact Commitment |
|---|---|
| **New operating model implementation** | Modern commissioning and strengthened strategic commissioning capability. |
| **Embed values and ways of working** | Collective leadership, partnership working and accountability. |

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| | |
|---|---|
| **Build a digitally enabled organisation** | Shift from analogue to digital and improved use of information to support commissioning decisions. |
| **Use of data and AI** | Evidence-based commissioning, population health management and innovation. |

2.3 The organisational redesign provides the capability foundation required to deliver the Compact and the Cluster priorities. The emphasis on digital maturity, intelligence-led decision making and organisational culture supports the ambition to modernise commissioning and accelerate the shift to digital approaches.

**Priority 3: Deliver Tangible Improvements for Our Population**

| Cluster Priority | Relevant Compact Commitment |
|---|---|
| **Reduce Emergency Department attendances** | Compact objective to reduce emergency department attendances through neighbourhood health and frailty models. |
| **Reducing delayed discharges** | No specific compact commitment. |
| **Improve access to dentistry** | One of the Compact's initial focused collective commissioning priorities. |
| **Reduce outpatient waiting times with a particular focus on ADHD/Neurodevelopmental assessment waiting times for Children and Young People** | One of the Compact's initial collective priorities for commissioning transformation. |
| **Implement consistent Continuing Care process** | Compact focus on all-age continuing care and demand management. |
| **Eliminate the inapproriate use of out of area placements for people with mental health needs.** | No specific compact commitment. |

2.4 There is very strong alignment between the tangible Cluster improvement priorities and the Compact's initial delivery programme. Dentistry, ADHD and Continuing Care are explicitly identified as initial collective commissioning priorities, whilst admission avoidance and reduced emergency demand directly support the neighbourhood health and frailty programme.

## 3 Overall Strategic Alignment

3.1 The Cluster priorities align closely with the four themes embedded within the Compact:

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### Neighbourhood Health and Prevention

3.2 Cluster priorities place neighbourhood health, prevention, population health management and partnership working at the centre of delivery.

### Quality, Outcomes and Inequalities

3.3 The priorities focus on improving access, reducing demand on urgent care services and improving outcomes through earlier intervention and better service design.

### Modern Commissioning

3.4 The future acute model, continuing care reform, place-based working and organisational redesign all support the move towards strategic commissioning described in the Compact.

### Productivity and Sustainability

3.5 Out of area placement reduction, digital enablement, AI adoption and pathway redesign contribute to improved value, productivity and sustainable use of resources.

## 4 Risks and Considerations

| Risk | Mitigation |
|---|---|
| **Organisational redesign impacts pace of delivery** | Clear accountability, phased implementation and leadership oversight. |
| **Delivery capacity across multiple priorities** | Prioritisation through corporate planning and performance management. |
| **Financial pressures constrain transformation investment** | Strong focus on productivity, digital enablement and prevention-based investment. |
| **Dependence on partnership working for neighbourhood health delivery** | Formal place-based governance and strengthened collaborative arrangements. |

## 5 Conclusion

5.1 The ICB Cluster priorities provide local delivery framework that is strongly aligned with the ambitions and commitments contained within the Integrated Care Boards CEO Delivery Compact.

5.2 The strongest areas of alignment are:

- Neighbourhood health and prevention.
- Population health management.

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- Strategic commissioning.
- Dentistry access improvement.
- ADHD pathway transformation.
- Continuing Care reform.
- Reducing demand on acute hospital services.
- Productivity and financial sustainability.

5.3 Collectively, the priorities position the Cluster ICB to contribute fully to the Compact's ambition of improving outcomes, reducing inequalities and creating sustainable neighbourhood-based health and care services.

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# From strategic ambition to better health and care for our population

## Our priorities for the remainder of 2026/27 and 2027/28

*Working together for a healthier tomorrow*

NHS

Healthier people
Stronger communities
A fairer, more sustainable future

## 1 Make progress against our strategic ambitions

**Complete our Integrated (Health) Needs Assessment**
Finalise our cluster Integrated (Health) Needs Assessment, establishing our population health improvement priorities.

**Shift investment towards prevention and community care**
Start to shift the profile of spend away from hospitals through a targeted investment fund for 2027/28.

**Establish Place based working**
Establish our new Place based working arrangements and review the arrangements for joint finding/ commissioning with our six Councils.

**Determine the future model for acute and maternity services**
Determine the future model for the provision of acute services across the cluster, starting with BSW, a cluster wide review of maternity service provision (taking account of the national maternity reviews) and supporting implementation of the acute services review in Dorset.

**Develop neighbourhood health**
Finalise neighbourhood health geographies and progress the consistent establishment of neighbourhood health teams and frailty models across the cluster.

## 2 Bring our new organisational model to life

**Bring the three ICBs together**
Complete our programme of organisational change and bring the three ICBs together to work as a single new organisation.

**Embed our values and ways of working**
Embed new organisational values and ways of working through our organisational development programme and ensure the cluster takes the full opportunities presented by the national strategic commissioning development programme.

**Be a digitally enabled organisation**
Create a digitally enabled organisation, including a structured approach to the use of data/insight and AI in our work.

## 3 Deliver tangible improvements for our population

**Reduce ED attendance**
Reduce rates of ED attendance across the cluster.

**Reduce delayed discharges**
Reduce the number of people whose discharge from hospital is delayed, including the implementation of consistent P1 pathways across the cluster.

**Improve access to dentistry**
Improve access to dentistry.

**Reduce outpatient waiting times**
Reduce outpatient waiting times across the cluster, with a particular focus on improving access to ADHD and neurodiversity assessment and diagnostic services for children and young people.

**Implement consistent Continuing Care**
Implement consistent All Age Continuing Care processes across the cluster.

**Eliminate out of area placements**
Eliminate inappropriate out of area placements for people with mental health needs.

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HEALTHIER PEOPLE | STRONGER COMMUNITIES | A FAIRER, MORE SUSTAINABLE FUTURE

We listen and learn | We work together | We make a difference | We use resources wisely

*A healthier tomorrow, together*

## 1. WHY - Purpose

This compact sets out the shared commitment of participating Integrated Care Boards to work collectively where doing so will achieve greater impact, consistency or value than systems acting independently. It is a focused statement of the things we will do differently together, rather than a comprehensive commissioning strategy or restatement of our individual statutory responsibilities.

Through our collective leadership, we will support delivery of the 10-Year Health Plan by strengthening strategic commissioning and accelerating the shift from hospital to community, treatment to prevention and analogue to digital. Neighbourhood health will be a defining principle of our approach, bringing together population health management, prevention, early intervention and integrated care closer to home.

Our purpose is to improve access, safety, quality and outcomes for residents, reduce inequalities, use NHS resources effectively and mitigate clinical and financial risks for people, communities and providers. We will use evidence, patient and carer experience, clinical outcomes and a better understanding of service cost and value to inform our commissioning decisions.

We recognise the need to demonstrate tangible benefits now. By focusing on a small number of shared priorities, whilst also delivering our local priorities, we will accelerate delivery, reduce unwarranted variation and achieve greater impact at scale and pace than would be possible acting alone.

## 2. WHAT - Our Collective Ambition

Our collective ambition is to improve access, safety, quality and outcomes for our populations; reduce health inequalities; create sustainable health and care systems; and ensure that NHS resources are directed towards the services and interventions that deliver the greatest value.

We will use strategic commissioning to enable a consistent approach to neighbourhood health, prevention, population health management and care closer to home. We will commission around population need and whole pathways, rather than organisational boundaries, and create the conditions for providers and partners to transform care.

We will focus initially on a small number of outcomes that matter to residents and can be improved through collective action. These will reflect quality, safety and clinical outcomes; patient and carer experience and access; inequalities and population health; demand and capacity; healthcare utilisation; productivity; and financial sustainability.

Our commitments are set out below: first, how we will work differently together; and second, the initial priorities through which we will demonstrate impact.

## 3. HOW we will Achieve this.

We will work collectively where this creates greater value, consistency or impact than acting independently. We will share and adopt best practice, develop common approaches where appropriate and reduce unwarranted variation rather than duplicating solutions across systems.

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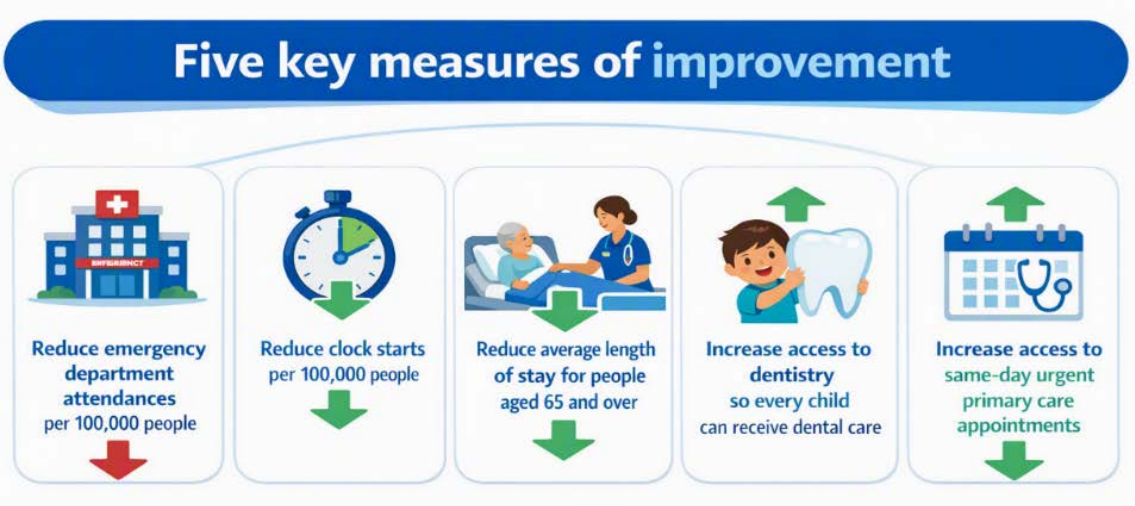
We will commission around population need and whole pathways, using neighbourhood health as a foundation for integrating prevention, primary, community, mental health, acute and social care. We will support the development of accountable provider networks, including through Integrated Health Organisations and other appropriate partnership and contracting arrangements, giving providers the scale, capability and incentives to take shared responsibility for clinical, quality and financial outcomes.




We will use a range of commissioning and contractual approaches where they add value, including alliance arrangements, risk-sharing agreements, population-based models and outcomes-based incentives. Our objective will be to align accountability and risk across pathways and create the conditions for transformation, rather than relying solely on transactional contract management.

Collaboration does not remove commissioner accountability. Where providers do not deliver agreed standards or outcomes, we will use proportionate intervention, remedial action, pathway redesign and, where necessary, decommissioning to protect patients and secure better quality, outcomes and value.

## 4. HOW - Strengthening Delivery at Place through Partnerships

The following commitments set out how participating ICBs will work differently together. They describe the shared direction and disciplines that will support delivery, while detailed activity will sit in a shared implementation plan.

1. Neighbourhood health, prevention and population health

We will make neighbourhood health a central organising principle for strategic commissioning. We will use population health management to identify need and risk earlier, target prevention and early intervention, and coordinate care around people and communities. We will support consistent integrated neighbourhood models while retaining flexibility for local need and existing partnerships.

2. Quality, safety, outcomes and inequalities

Quality, safety and outcomes will be integral to every commissioning decision. We will use clinical outcomes, patient safety, patient and carer experience, inequalities data and quality intelligence alongside activity and financial information. We will address unwarranted

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variation and ensure pathway transformation improves quality as well as access, productivity and financial sustainability.

3. Best-practice pathways and Modern Service Frameworks

We will provide collective leadership for Modern Service Frameworks, using them to develop and commission consistent best-practice pathways. We will use evidence, outcomes and shared learning to reduce unwarranted variation and accelerate adoption of effective models of care.

4. Modern commissioning and contracting

We will commission around population need and whole pathways. We will support accountable provider networks, including through Integrated Health Organisations and other appropriate partnership and contracting arrangements. We will use alliance arrangements, risk-sharing agreements, population-based models and outcomes-based incentives where they add value. Where providers do not deliver agreed standards or outcomes, we will retain proportionate intervention, remedial action, pathway redesign and, where necessary, decommissioning.

5. Place, local government and joint commissioning

We recognise that delivery happens at place and through neighbourhoods. We will use upper-tier local authority geographies as a common basis for collaboration where appropriate and develop joint commissioning arrangements supported by shared assumptions about population need, demand, capacity, investment and outcomes. We will work jointly across prevention, safeguarding, SEND, all-age continuing care and wider health and care integration.

6. Cost, value and productivity

We will develop a shared approach to understanding service cost, value and productivity, enabling more consistent decisions about investment, disinvestment and pathway redesign. This will include common principles for costing, benchmarking and understanding the true cost of services.

## 5. HOW - DELIVER: Our initial collective priorities

**Neighbourhood health and frailty**

Our first collective delivery priority will be implementation of the urgent and emergency care and planned care strategy through a consistent approach to neighbourhood health and frailty. We will focus on a common population cohort and core model, adapted to local need, with neighbourhood teams identifying risk earlier, proactively managing rising need and providing coordinated alternatives to hospital care.

We will prevent avoidable deterioration and hospital attendance, provide rapid community alternatives to admission, support early discharge and reduce length of stay. We will consider how primary care and neighbourhood contracting arrangements can support this model, including relevant opportunities arising from emerging neighbourhood and Integrated Health Organisation policy.

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### Focused programme of collective commissioning work

Alongside neighbourhood health and frailty, we will agree a focused programme where common challenges and shared learning can produce accelerated impact. Initial areas for consideration will include:

- dentistry access and outcomes
- ADHD and wider neurodevelopmental pathways
- all-age continuing care, including continuing healthcare demand pressures

Detailed scopes, outcomes and milestones will sit in the shared implementation plan rather than expanding this compact.

### ACCOUNT: Implementation and collective accountability

Each participating ICB will translate this compact into clear commissioning intentions, an agreed approach to provider contracting and a transparent position on demand and capacity assumptions. These will be brought together through a shared implementation plan with named leadership, milestones and outcome measures.

Participating ICB Chief Executives will collectively sponsor this compact. Each ICB Board will determine appropriate local governance and Chair involvement. Progress will be assessed against agreed outcomes, measures and milestones, with collective support and intervention where delivery is off track.

The compact's outcomes, measures and reporting arrangements will align with the developing national approach to system assessment and reporting, supporting rather than duplicating wider accountability arrangements.

## 6. SIGN: Our collective undertaking

By signing this compact, each ICB commits to collective action that improves access, quality and outcomes, reduces inequalities and accelerates the development of sustainable, neighbourhood-based health and care.

| Integrated Care Board | Chief Executive | Date |
|---|---|---|
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## Appendix A - ICB Statutory Accountability

| Area | ICB accountability / activities |
|---|---|
| **Strategic commissioning** | Assess population need; determine priorities; plan services; commission services to meet reasonable requirements; set outcomes/specifications; contract and performance-manage commissioned services. |
| **Population health & inequalities** | Understand population health needs; reduce inequalities in access and outcomes; population health management; prevention; address unwarranted variation; work with Directors of Public Health/local authorities. |
| **Quality & patient safety** | Secure continuous improvement in quality; oversee quality of commissioned services; patient safety; quality surveillance; respond to systemic quality concerns; use commissioning levers where quality is inadequate. |
| **Safeguarding – adults** | Ensure the ICB meets its statutory safeguarding responsibilities; provide safeguarding leadership and expertise; work with local authorities, police and providers; participate in Safeguarding Adult Boards/processes and reviews; assure safeguarding within commissioned services. |
| **Safeguarding – children** | Fulfil NHS safeguarding duties for children; provide appropriate safeguarding leadership/expertise; participate in local multi-agency safeguarding arrangements; ensure commissioned providers meet safeguarding requirements; contribute to child safeguarding practice reviews. The 2022 Act framework specifically requires safeguarding responsibilities to receive appropriate executive leadership within ICBs. |
| **Looked-after children / children in care** | Ensure appropriate health arrangements, assessments and services for children in care and care leavers; provide designated professional leadership; work jointly with local authorities. |
| **SEND** | Meet NHS duties for **Special Educational Needs and Disabilities**, including partnership with local authorities, contribution to Education, Health & Care processes/plans, commissioning appropriate health provision and providing designated medical/clinical officer arrangements. |
| **NHS Continuing Healthcare (CHC)** | Assess eligibility; make eligibility decisions; commission and fund packages; undertake reviews; manage Fast Track CHC; resolve disputes/appeals; ensure compliance with Standing Rules and the National Framework. Critically, **the ICB retains ultimate statutory responsibility even where elements are delivered by another organisation**. |
| **NHS-funded Nursing Care (FNC)** | Determine eligibility; fund the NHS nursing contribution for eligible care-home residents; review eligibility/rates and ensure appropriate governance. ICBs are the statutory bodies responsible for CHC and FNC. |
| **EPRR – Emergency Preparedness, Resilience & Response** | Maintain emergency preparedness and business continuity; have appropriate Accountable Emergency Officer arrangements; plan/test responses; coordinate NHS partners; participate in Local Health Resilience Partnerships; respond to major incidents and assure provider preparedness. |
| **EPRR provider assurance** | Monitor commissioned providers against EPRR contractual/core standards, lead local assurance and consolidate system assurance. NHS England's 2026/27 process continues to place ICBs in the lead role across their local health resilience partnership. |

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| **Business continuity & system resilience** | Ensure the ICB can maintain critical functions during disruption and understand/coordinate resilience across commissioned services, including cyber, workforce, infrastructure, utilities, supply chain and other disruptions. |
| **Infection prevention & control / health protection** | Ensure appropriate commissioning and system arrangements for infection prevention/control and work with UKHSA, local authorities and providers on outbreaks and health protection incidents. |
| **Primary medical care** | Commission/manage relevant general practice functions; contracts; access; quality; capacity; estates/workforce implications; primary care transformation and development. |
| **Pharmacy, dentistry & optometry** | Exercise the relevant delegated/direct commissioning responsibilities for pharmaceutical, dental and ophthalmic services and ensure appropriate access, quality and provision. |
| **Medicines optimisation** | Ensure safe, effective and cost-effective use of medicines; prescribing governance; formulary arrangements; medicines optimisation; controlled-drug governance interfaces and appropriate pharmaceutical advice. |
| **Mental health** | Commission mental health services; meet parity-of-esteem responsibilities; crisis pathways; community services; children and young people's mental health; ensure appropriate provision for people with severe mental illness. |
| **Learning disability & autism** | Commission appropriate services; reduce inappropriate institutional care; support community provision; address inequalities and premature mortality; ensure appropriate care for people with learning disabilities and autistic people. |
| **Children & young people's services** | Assess and commission against the specific needs of children and young people; work with local authorities and other partners; address CYP needs explicitly within the Joint Forward Plan. |
| **Maternity & neonatal** | Commission safe maternity/neonatal pathways; oversee quality and outcomes; address inequalities; support maternity and neonatal improvement arrangements. |
| **End-of-life / palliative care** | Commission appropriate palliative and end-of-life services for the population and ensure reasonable access and integration across settings. |
| **Rehabilitation / community services** | Ensure adequate community health, rehabilitation and intermediate-care capacity as part of the overall commissioning duty. |
| **Patient choice** | Enable legally applicable patient choice and ensure commissioning arrangements support patients' rights to choose. |
| **Patient & public involvement** | Involve the public in planning, commissioning and significant service changes; demonstrate how engagement influences decisions. |
| **Complaints / individual rights** | Maintain arrangements for complaints concerning ICB functions/commissioned responsibilities and ensure patients can exercise relevant statutory rights. |
| **Research** | Promote/facilitate research and use research evidence when exercising ICB functions. |
| **Innovation** | Promote innovation in the provision of health services and use commissioning to support adoption of effective innovation. |
| **Workforce, education & training** | Have regard to education/training needs; support workforce planning and development across commissioned services. |

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|---|---|
| **Digital / information governance** | Ensure appropriate information governance, confidentiality, data protection, records, cyber resilience and lawful information sharing; use data to support commissioning and population health. |
| **Integration with social care** | Promote integration between NHS, social care and health-related services where it improves quality or reduces inequalities; establish appropriate joint commissioning arrangements. |
| **Section 75 / pooled arrangements** | Enter into and govern appropriate pooled-budget/joint commissioning arrangements with local authorities while retaining accountability for NHS statutory functions where applicable. |
| **Financial stewardship** | Operate within revenue and capital resource limits; deliver financial balance; ensure effective, efficient and economical use of resources; maintain appropriate financial controls. |
| **Governance & conflicts** | Maintain constitution, committees, schemes of delegation, standing financial instructions, registers of interests, conflict-management arrangements and appropriate Board capability. |
| **Joint Forward Plan** | Produce and maintain the statutory Joint Forward Plan with NHS trusts/foundation trusts, setting out how statutory duties and population priorities will be delivered. |
| **Triple Aim** | Consider the impact of decisions on **population health and wellbeing + quality of services + sustainable/efficient use of NHS resources**. |
| **NHS Constitution** | Promote the NHS Constitution and take account of NHS constitutional rights, pledges and principles. |
| **Net zero / environment** | Have regard to statutory climate/environmental responsibilities when exercising functions. |
| **Annual report & public accountability** | Produce statutory annual reporting demonstrating how the ICB has exercised its functions and discharged key duties. |
| **NHS England accountability** | Provide information and assurance to NHS England and be subject to NHS England's assessment of ICB performance and discharge of statutory functions |

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| **Report to:** | Cluster Board – Meeting in Public | **Agenda item** | 5 |
| **Date of Meeting:** | 16 November 2026 | | |
| **Title of Report:** | Strategic Commissioning Intentions 2027/28- 2031/32 | | |
| **Report Author:** | Rebecca Kendall, Deputy Director of Strategic Planning and Outcomes Delivery | | |
| **Board / Director Sponsor:** | David Freeman, Cluster Chief Officer of Commissioning and Place | | |
| **Appendices:** | 1: Strategic Commissioning Intentions FINAL DRAFT | | |

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

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

| **Previous consideration by:** | **Date** | **Please clarify the purpose** |
|---|---|---|
| Joint Population Health and Commissioning Committee | 4 September 2026 | Approve the approach to the development of the Strategic Commissioning Intentions |
| Commissioning Intentions Task and Finish Group | 17 September – fortnightly | Development of Strategic Commissioning Intentions |
| Cluster Executive Team Meeting | 13 October 2026 | Discussion |
| BSW, Dorset & Cluster ICB Board Development Session | 15 October 2026 | Discussion |
| Cluster Executive Management Group Meeting | 10 November 2026 | Discussion |

## 1 Purpose of this paper

The purpose of this paper is to share the Final Draft of the Strategic Commissioning Intentions with Board members for their review and approval.

The Strategic Commissioning Intentions set out the commissioning priorities and expectations for providers over the next five years and establish the framework through which the Cluster will operate as a strategic commissioner. They signal the changes commissioners intend to make to improve population health outcomes, reduce health

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inequalities, support delivery of the NHS 10 Year Health Plan and ensure the sustainability of health and care services

The document has been developed following approval of the approach by the Joint Population Health and Commissioning Committee in September 2026 and through extensive engagement with the Commissioning Intentions Task and Finish Group. The draft intentions were discussed at the Cluster Executive Team and subsequently reviewed at the Board Development Session in October 2026.

Feedback from these discussions has been incorporated, including strengthening the focus on neighbourhood health, prevention and population health, sustainable services, value-based commissioning, quality and the role of strategic commissioning.

## 2 Summary of recommendations and any additional actions required

The Board is asked to: formally approve the Strategic Commissioning Intentions for publication and implementation.

- Endorse the three strategic commissioning themes of Neighbourhood Health and Place-Based Working, Population Health Improvement and Prevention, and Sustainable Services.
- Support the phased delivery approach, recognising that the Strategic Commissioning Intentions provide the overarching direction while more detailed commissioning, contracting and implementation plans will be developed during 2027 and shared in early 2028.
- Support ongoing engagement with partner providers, local authorities, clinicians, voluntary sector organisations, communities and people with lived experience as detailed plans are developed.
- Delegate authority to the Chief Officer of Commissioning and Place to make minor amendments prior to publication where required.

## 3 Legal/regulatory implications

Systems are to develop and share with partners Commissioning Intentions for the year ahead.

## 4 Procurement

The Strategic Commissioning Intentions do not, in themselves, constitute procurement decisions or commit the organisation to specific procurement activity. They establish the strategic direction and future commissioning expectations for providers across the Cluster.

As the individual commissioning intentions progress into delivery and implementation phases, the most appropriate procurement and provider selection approach will be determined on a scheme-by-scheme basis. This may include use of the Provider Selection Regime (PSR), the Procurement Act 2023, direct award processes, contract variations, provider collaboration arrangements, competitive procurement exercises, or other lawful commissioning approaches, depending on the nature of the service, market conditions, value, complexity and statutory requirements.

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| The Procurement and Commercial Team will be engaged throughout the development of each initiative to ensure compliance with relevant legislation, governance requirements, value for money principles and transparency obligations. Formal procurement advice, recommended procurement routes, timelines and governance approvals will be developed and presented through the appropriate decision-making processes as individual commissioning programmes reach the procurement or provider selection stage. |
| The above has been checked with Andy Squire, Head of Procurement, with agreement of the approach and that further advice and guidance is not applicable at this stage. |

| | |
|---|---|
| P&C Name | Advice sought from Andy Squire |
| P&C Signature | N/A |

## 5 Risks

A key risk is that the full Integrated Needs Assessment will not be available in time to inform the publication of Part 1 Strategic Commissioning Intentions. This will be mitigated through the use of existing population health intelligence, performance data, strategic planning assumptions and stakeholder insight, with Part 2 providing a mechanism to refine and update commissioning intentions as further intelligence becomes available

Ensuring meaningful stakeholder engagement across all three systems is also a key risk, maintaining alignment with evolving national policy and financial planning assumptions, and developing a focused set of priorities that remain achievable within existing workforce and financial constraints. These risks will be managed through the proposed governance arrangements and ongoing executive oversight.

## 6 Quality and resources impact

Quality Impact Assessments are undertaken as part of proposed service changes. Commissioning Intentions are set within the context of the financial framework seeking to enable the three shifts set out in the 10yr Plan.

| | |
|---|---|
| Finance sign off: | Alison Henly, Chief Finance Officer |

## 7 Confirmation of completion of Equalities and Quality Impact Assessment

The Equality and Quality Impact Assessment will be updated as part of the annual planning review of the Medium Term Plan of which the Strategic Commissioning Intentions are part of.

Equality Impact Assessments are undertaken as part of proposed service changes.

## 8 Communications and Engagement Considerations

Engagement activity will support both Part 1 and Part 2 development. The process will focus on co-designing future commissioning approaches with Place teams, providers, local authorities, clinicians, voluntary sector partners and communities.

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| Engagement will ensure that strategic ambitions are understood, tested and refined while supporting provider and market preparedness for future commissioning, contracting and service delivery changes |

| 9 | Statement on confidentiality of report |
|---|---|
| This report is not classified as confidential. | |

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# Strategic Commissioning Intentions 2027/28- 2031/32

## 1. Introduction

1.1. The purpose of this paper is to share the Final Draft of the Strategic Commissioning Intentions with Board members for their review and approval.

## 2. Report

### *Background*

2.1. The NHS is increasingly moving towards a strategic commissioning model that focuses on improving population health, reducing health inequalities, delivering better outcomes and ensuring long-term financial sustainability. National policy, including the NHS 10 Year Health Plan, places greater emphasis on prevention, neighbourhood-based care, integration and outcome-focused commissioning. At the same time, health and care systems continue to face significant challenges including rising demand, workforce pressures, financial constraints and unwarranted variation in outcomes and access to care. These challenges require a more strategic approach to how services are planned, commissioned and transformed.

2.2. The Strategic Commissioning Intentions set out the Cluster's commissioning priorities and expectations for the provider market over the next five years. They establish the framework through which the Cluster will operate as a strategic commissioner, providing a clear direction of travel for how resources, services and partnerships will be aligned to improve population health outcomes, reduce health inequalities, support delivery of national priorities and ensure the long-term sustainability of health and care services.

2.3. Prior to the establishment of the Cluster ICB, separate five-year Commissioning Intentions were developed across the statutory ICB footprints. This resulted in 198 individual commissioning intentions across BSW (57), Dorset (101) and Somerset (40), reflecting local priorities and approaches.

2.4. As the Cluster matures, a more consistent and coordinated commissioning approach is required to address shared population health challenges, improve outcomes and maximise the value of available resources. The development of a single set of Cluster-wide Strategic Commissioning Intentions provides a common framework for commissioning and signals a shift from commissioning individual services in isolation towards strategic, outcome-based commissioning focused on prevention, population need, collaboration and value. The intentions provide early clarity to the market, providers and partners on the future direction of travel, enabling planning, investment and transformation activity to begin now while more detailed commissioning intentions are developed through the Cluster's Integrated Needs Assessment and stakeholder engagement processes.

### *Strategic Approach*

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2.5. As members are aware we have taken a two phased approach to the development of the Commissioning Intentions which was approved by Joint Population Health and Commissioning Committee on 4 September 2026, the approach was as follows:

- **Part 1** (October / November 2026) – Set out and engage on our strategic ambitions, building on the strategic commissioning ambitions set out with system partners.
- **Part 2** (January 2027) – Plan for detailed Strategic Commissioning Intentions, utilising intelligence from our Integrated Needs Assessment and taking account of outputs of current NHS policy that is being consulted upon (e.g. Single Neighbourhood / Multi-Neighbourhood Providers).

2.6. A task and finish group was established to develop the strategic commissioning intentions, including Subject Metter Expert representatives from each directorate and place.

### *Engagement*

2.7. Our refreshed commissioning intentions build on the work undertaken in 2026/27 across all three ICBs which were informed through engagement and listening to the views and experiences of local people over many years.

2.8. They have also been informed through the Board Development Session held in October 2026 where draft strategic commissioning intentions were shared for feedback. The table below sets out the feedback themes and actions taken.

| 'You Said' | 'We did' | 'We will develop in Part 2' |
|---|---|---|
| There needs to be a stronger focus on prevention, early intervention and shifting resources upstream. | Strengthened the prevention ambition throughout the document, including explicit commitments to shift investment towards prevention and community-based care, prioritise early intervention, improve healthy life expectancy, and move resources towards Children & Young People and the 65+ population. | Refine through part two with detailed intentions. |
| We need a stronger emphasis on population health, outcomes and reducing inequalities. | Strengthened the focus on outcomes, embedded population health management within commissioning actions, and included clear commitments to tackle unwarranted variation and reduce health inequalities. | Need to incorporate deliverable outcomes in part two as part of our SMART objectives. |
| The role of neighbourhoods, communities and VCFSE organisations should be more prominent. | Enhanced the neighbourhood health intention with commitments to Integrated Neighbourhood Teams, community-led models of care, stronger VCFSE involvement, and greater use | Need to understand impact of our commissioning intentions on VCFSE market through actions being developed within neighbourhoods. |

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| | | |
|---|---|---|
| | of lived experience in service design and delivery. | |
| The document should better explain the role of the ICB as a strategic commissioner. | Strengthened the strategic commissioning narrative, setting out how the ICB will use commissioning levers, contracts, investment decisions and outcomes-based approaches to improve population health and system sustainability. | Refine through part two with detailed intentions. |
| Greater clarity is needed on delivery, accountability and how success will be measured | Refined commissioning actions and success measures for each intention. | Develop specific milestones, outcome indicators and measures of success that can be tracked over time. |
| We should be more ambitious about transforming services and changing models of care. | Included commitments to outcomes-based commissioning, integrated provider models, neighbourhood health providers, new contracting approaches, digital transformation and redesign of key pathways. | Refine through part two with detailed intentions. |
| Partnerships across the system need to be more visible. | Strengthened references to provider collaboratives, alliances, community partners, local authorities, VCSE organisations and neighbourhood teams working together to deliver integrated outcomes. | Refine through part two with detailed intentions. |
| Greater visibility of:<br>• Mental Health and Neurodiversity<br>• Children and Young People | • Included neighbourhood mental health centres within the neighbourhood health ambition and prioritised reductions in children's waiting times through neurodiversity pathway redesign.<br>• Established CYP as one of the first population cohorts for outcomes-based commissioning, strengthened prevention ambitions for CYP, and included specific actions on neurodiversity and dental waiting times. | Refine through part two with detailed intentions. |

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| • End of Life Care<br><br>• Hospital flow and discharge arrangements. | • End-of-life care considerations have been incorporated within the wider neighbourhood and population-based care model and will be developed further through the detailed commissioning intentions in Part 2. | |

2.9. We will continue to engage as we develop plans, driven by the engagement cycle and ten principles of working in partnership with people and communities. For new areas of work, we will continue to routinely carry out Equality Impact Assessments to ensure our engagement is appropriate and accessible for all.

### *Next steps*

2.10. The timeline below shows the next steps in the development of the detail commissioning intentions.




2.10 We will regularly engage with the Executive Management Team throughout this period.

## 3. Conclusion

3.1. The Strategic Commissioning Intentions represent an important step in establishing a consistent strategic commissioning approach across BSW, Dorset and Somerset Cluster ICB. They provide clarity to providers regarding the direction of travel for commissioning and investment decisions while creating the framework through which the Cluster will

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deliver improved outcomes, tackle health inequalities and support sustainable services over the coming years.

3.2. Board members are asked to:

- Approve the Strategic Commissioning Intentions
- Note the next steps for progression to the Part Two of detailed delivery planning.

**Author's name and title: Rebecca Kendall, Deputy Director of Strategic Planning and Outcomes Delivery**

**Date: 3 November 2026**

| APPENDICES | |
|---|---|
| **Appendix 1** | **Commissioning Intentions FINAL DRAFT** |

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# Commissioning Intentions- Part 1

*Strategic commissioning intentions*

BSW, Dorset, Somerset Cluster Board

November 2026

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

## FINAL DRAFT




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# National & Local Context

- National policy increasingly expects health and care systems to improve outcomes through prevention, community-based support and stronger partnership working. At the centre of this ambition is neighbourhood health, supported by deep analysis of population health and care needs, reform of payment and contract models and a shift in the NHS architecture to create different commissioning and provider models.
- This agenda is reinforced by the Government's wider commitment to devolution and the transfer of greater influence and decision-making to local areas. As responsibility increasingly shifts towards places and communities, there is a growing expectation that public services will work together around shared priorities, align resources more effectively and take collective responsibility for improving outcomes for local populations.
- Across our Cluster of ICBs, we have begun our journey of transformation in health and care services, with clear strategies and plans aimed at improving performance, restoring financial balance and beginning the three shifts. As part of our launch as a Cluster ICB we carried out a co-design process with system leaders and agreed several stretching ambitions that are now being used to shape our cluster population health strategy and have been used to inform the development of our Commissioning intentions.
- Through committing to these ambitions, in the next 3-5 years we will:
  - Rebuild our system around people, place, communities and prevention, abolishing the current arrangements and historical pathways
  - End hospital as the default setting for care, using acute settings only where they add greatest value.
  - Dismantle legacy pathways, behaviours and power structures that currently lock resource into low-value activity

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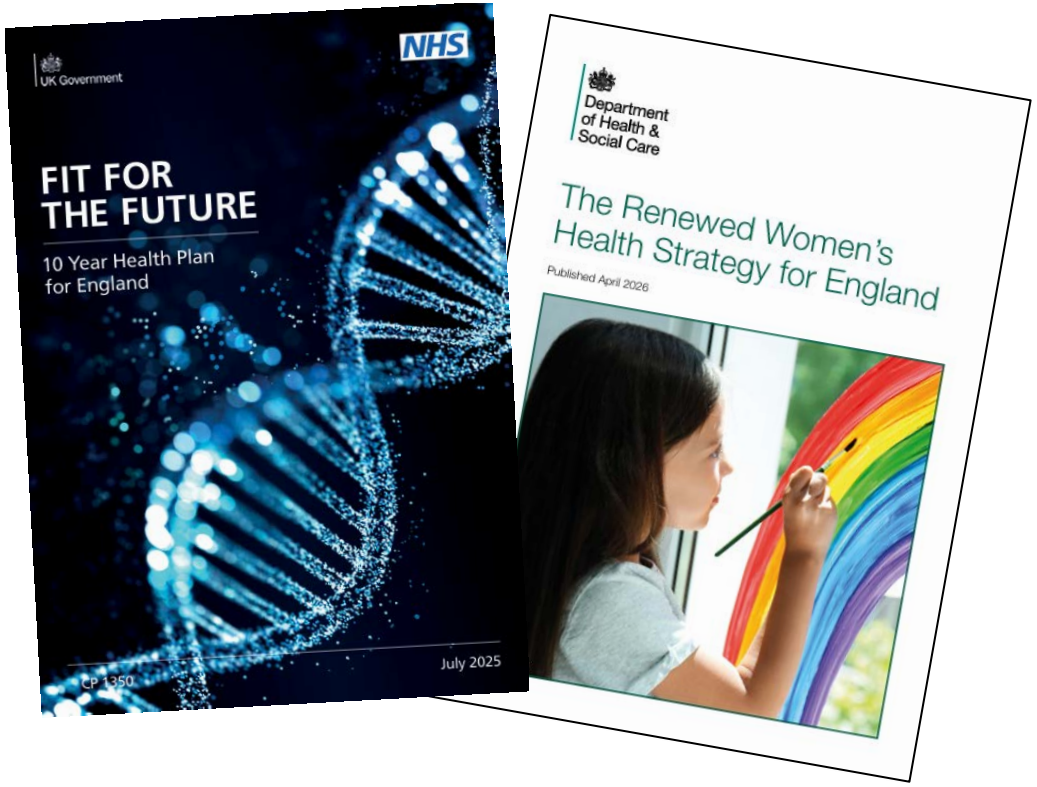
- **This is not a marginal adjustment to today's model. It is a decisive move to a system that is commissioned, funded and organised around outcomes for defined populations.**



# Why *Strategic* Commissioning Intentions?

Commissioning intentions need to be informed by a detailed population health needs analysis. This work is underway but will take time to complete; therefore, by developing **strategic** Commissioning Intentions in the interim (*commissioning intentions Part 1*), we are seeking to:

- **Signal to the provider market our intentions to shift to a radically different model of care** – based on populations, not services
- **Set out the long-term ambitions for the cluster** to give the market early notice of likely changes so organisations can begin planning.
- **Be clear that this is a step towards fully detailed commissioning intentions** (*part 2*) which will be informed by population health intelligence, performance, stakeholder engagement and financial planning, and will identify where investment, transformation and disinvestment are required to deliver the greatest value and impact.

Historically commissioning intentions have been produced in September/October to provide six months notice to changes expected in contracts from the following April. To ensure that our ambition through Strategic Commissioning is achieved through continuous improvement, we are moving away from the notion that commissioning changes always have to start in April (start of the financial year) – in fact, contracts can be varied at any point in-year, provided contractual notice periods are followed.

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We have developed our Strategic Commissioning Intentions in 2 parts:

- **Part 1 (October 2026 / November 2026)** – Setting out our strategic ambitions, building on the strategic commissioning ambitions set out with system partners and giving details where these are already available
- **Part 2– (January 2027)** – the details Commissioning Intentions, utilising intelligence from our Integrated Needs Assessment and taking account of outputs of current NHS policy that is being consulted upon (e.g. Single Neighbourhood / Multi-Neighbourhood Providers).

Whilst the full Integrated Needs Assessment is still being developed, Part 1 will focus on already shared ambitions & targets, existing population health intelligence, strategic planning assumptions, and stakeholder insight. Part 2 will refine and update commissioning intentions with more detail as the Integrated Needs Assessment becomes available.

# Introduction to the Strategic Commissioning Intentions

Our commissioning intentions set out how Bath, Swindon and Wiltshire, Dorset and Somerset ICB Cluster will work with partners and communities to deliver better health and care for local people over the next five years.

They build on the ambitions of the NHS 10 Year Health Plan, Medium Term Planning Framework and our medium-term strategic priorities, focusing on prevention, early intervention, and care that is joined up around people's needs.

We recognise the pressures across the system: growing demand, financial challenge, and variation in access and outcomes, and we don't have funds available to maintain our current ways of working. Our intentions respond to this and the predicted population changes nationally, regionally and across our cluster ICB but also the opportunities to work differently.

As a strategic commissioner we will drive care and investment towards prevention, reduce unwarranted variation, and create the conditions for effective collaboration across organisations and sectors, ensuring services deliver better outcomes, reduce inequalities, improve people's experience of care and make the most effective use of public resources.

Our refreshed intentions are not a list of targets – they are a commitment to shift from hospital care to community care delivered through empowered Integrated Neighbourhood Teams (INTs) and collaboration across acute organisations and other sectors. Marking a shift away from institution led planning and into outcome-based commissioning, in areas where service transformation can achieve greater effectiveness on a broader scale.

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This document sets our Strategic Commissioning Intentions which signals providers to changes we are intending to make, clearly articulating:

- Why this matters
- What changes will happen from April 2027
- What this means for the market, and
- How we will monitor success

This document will be supported with the strategic plan, detailed prioritised commissioning and contractual intentions which will be shared with providers in January 2027.

# Engagement

We know that if we want to make positive, lasting change to health and care services across out cluster, we need to listen to, and work alongside, people and communities.

Our refreshed commissioning intentions build on the work undertaken in 2026/27 across all three ICBs which were informed through engagement and listening to the views and experiences of local people over many years.

We will continue to engage as we develop plans, driven by the engagement cycle and ten principles of working in partnership with people and communities

A Board workshop was held in October where draft strategic commissioning intentions were shared for feedback, and they have been reviewed to reflect this.

For new areas of work, we will continue to routinely carry out Equality Impact Assessments to ensure our engagement is appropriate and accessible for all.

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# Strategic commissioning

We have set out that the funds we have available are not enough to maintain our current way of working. This in part reflects legacy contracts, models of care focussed on hospitals, underdeveloped coordination of services in the community.

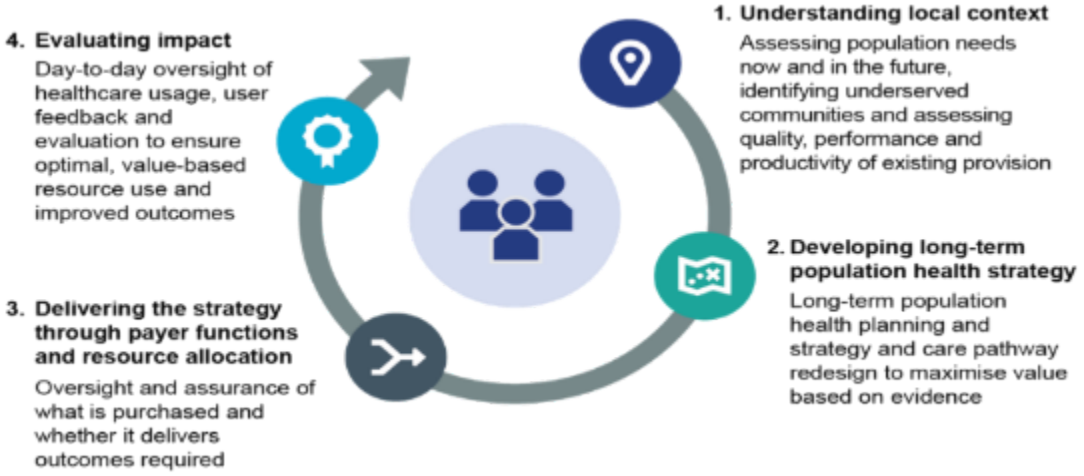
We will build on the work undertaken in 2026/27 to correct this through exploring our current ways of working with providers to shift funding into place-based outcome led delivery that is more equitable, and patient centred ensuring the best health value for public money. This will support us to deliver our commitment to improve the experience and outcomes of our local people.

## Quality

Quality is the foundation of our strategic commissioning and is central to every decision we make. We are using the National Quality Strategy to inform our processes for this. National and regional quality assessment, planning, monitoring and improvement tools are specific elements to the framework and building blocks for how we understand, specify, commission and assure care.

Quality is not an additional consideration or layer of assurance; it is integral to what we commission, the outcomes we seek and the experience we expect people to have.

These principles will be embedded throughout the commissioning cycle. We will set clear expectations for quality, outcomes and experience, use transparent measures to understand impact and variation, and act through commissioning and system governance where improvement is needed. People and communities will have a meaningful voice in shaping and evaluating the services we commission.

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# Strategic commissioning

## New contract models

We will move from commissioning and managing individual providers in isolation towards commissioning provider collaboratives, alliances and networks that can collectively deliver integrated outcomes for our population.

We will increasingly commission services through integrated neighbourhood, place and pathway-based models, encouraging providers to work collectively and take shared responsibility for outcomes, quality and financial sustainability. Subject to national policy, we will implement new Multi-Neighbourhood Provider (MNP), Single-Neighbourhood Provider (SNP) and Integrated Health Organisation (IHO) arrangements, commencing development of two IHO contracts in 2027/28. We will also use the findings of our market review to support partnership working, networked delivery and provider collaboration where this improves patient outcomes, resilience and value.

We will expect providers to work collaboratively through neighbourhood, place and provider partnership arrangements, taking collective responsibility for delivering improved outcomes, reducing health inequalities and making best use of available resources.

Providers will be expected to contribute to integrated delivery models, share accountability for pathway performance and demonstrate how collaboration is improving quality, sustainability and value for our population.

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## Value based commissioning

As commissioners, we will deliver value-based commissioning by directing resources towards interventions that achieve the greatest improvement in outcomes and reduce health inequalities. We will use population health intelligence and evidence to target investment where need is greatest, improve equitable access to care, and maximise the value of every pound spent for our population.

We will focus on commissioning pathways, outcomes and population health improvements rather than individual organisational performance, encouraging providers to work together to improve quality, access, productivity and resilience across the system, while maximising social and personal value by reducing inequalities, supporting healthier communities, and improving the wider outcomes that matter most to local people.

## Modern Service Frameworks

A set of national Modern Service Frameworks are being published. These frameworks will provide evidence-based descriptions of best practice, expected outcomes, clinical standards and service models across major service areas.

Many of these will align directly with our commissioning intentions priorities, such as neighbourhood health, planned care, urgent and emergency care, mental health, cancer, maternity, and children and young people's services.

We will work with providers to incorporate the requirements, priorities and guidance in a collective approach, with the potential to inform contracting, planning, outcome measurement and future quality standards. This process will ensure that our local services meet the national requirements and asks and will be consistent with emerging best practice or other national policy drivers.

# Our intentions- we will commission for:

Following engagement the intentions have been reviewed, with alignment to three key areas of focus:

1. **Neighbourhood and Place Health-** we will see services to serve defined populations at neighbourhood level, with person centred care delivered closer to people's homes. This will include integration of primary, community and social care amongst other health and wellbeing organisations and draw on the expertise and unique perspectives of VCFSE organisations.

2. **Population Health Improvement and Prevention-** we will see a shift of resource and focus to preventative solutions and care, reducing unwarranted variation to achieve equitable health outcomes for our population. Proactive care and early intervention will also feature to achieve best value and outcomes for patients. Focus on defined populations will reduce health inequalities.

3. **Sustainable Services-** during 2027/28 we will address services facing performance, access, quality, workforce or financial challenges, working with providers to redesign care, improve productivity and reduce unwarranted variation and low impact interventions (Evidence Based Interventions focus). Our aim is to secure sustainable, high-performing services that deliver the greatest value for our population and make the best use of public resources.

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## Assumptions

There are currently a small number of assumptions built into the commissioning intentions. These include:

- The delivery of quality, performance and finances in line with the Medium Term Plans.
- A phased approach to transition funding will be adopted to protect the system from instability.
- New contracting models currently in development will be available for use in 2027/28.
- Planning guidance to provide a mechanism for delivering the "left shift" via resource reallocation across the system, including from existing secondary care contracts, which avoids provider destabilisation.

The BSW, Dorset and Somerset Cluster Strategic Commissioning Intentions aim to be ambitious, allowing for further detail to be incorporated in line with the Integrated Needs Assessment, whilst setting out key metrics for those to be delivered in 2027/28.

# 1. Neighbourhood Health and Place Based Working Intentions

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# Neighbourhood Health and Place Based Working

## Our Strategic Commissioning Intentions:

- We will commission integrated neighbourhood models that bring services closer to home, enable proactive population health management and reduce dependency on hospital-based care through multidisciplinary and community-led approaches.

## Why this matters:

- Delivering the hospital to community shift through achievement of the targets in the neighbourhood health framework will support patients in the most appropriate setting, keeping them out of hospital where possible. Better integration of health and social care and partners with collaborative working will reduce fragmentation and system complexity for our populations, focussing on the support required rather than provider boundaries.

### What will happen from April 2027:

- Commission integrated neighbourhood teams-implementation of INTs (number to be agreed) across cluster by 2028/29.
- Support integrated community-based models of care- with neighbourhood CYP and frailty models in place, fully utilised within 2 years, and Neighbourhood Health centres established, to include local mental health provision, by 2030.
- We will require providers and partners to demonstrate how elective care services are redesigned around neighbourhoods, with explicit plans to shift appropriate elements of elective pathways into community and neighbourhood settings, improve access, reduce waiting times, avoid referrals where clinically appropriate and support patient self-management.
- Neighbourhood health providers lead on the delivery of Modern Services Frameworks starting with CVD ambitions 1-8.
- Strengthen end of life care, transforming services to offer sustainable, responsive and personalised care
- Strengthen the role of VCFSE and community partners.
- Strengthen the voice of the population and individuals with lived experience and service user experience.

### Provider contributions to delivery:

- Active participation and contribution to neighbourhood-based models of care.
- Delivery of services through Single Neighbourhood Provider, Multi- Neighbourhood Provider and Integrated Health Organisation contracts.
- Better integration with other health and social care providers including VCFSE organisations.
- Organisation of care around populations, with joined up resources leading to a higher proportion of care delivered within community settings.
- Movement of operational and financial resource into neighbourhoods.
- Evidence measurable improvements in outcomes and experience in population served.

### How we will measure success:

- Achievement of the targets set out in the Neighbourhood Health Framework
- Reduce bed days through:
  - Reduced non-elective admissions.
  - Reduced length of stay
- Reduction in hospital-based consultant led outpatient services, including a reduction in referrals through increased use of Advice and Guidance
- Improved patient experience assessed through collaborate and integrate.
- More people supported to remain independent at home.
- Increased patient activation, with patients reporting empowerment and a feeling of ownership over their health
- Improved quality of life for people supported through neighbourhood teams utilising QALYs and other measures.
- End of life patients have care plans in place which address symptom management and preferences for a good death. People will die in their preferred place wherever possible.

## 2. Population Health Improvement and Prevention

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# Shift investment towards prevention and population health improvement

## Our Strategic Commissioning Intentions:

- We will use our commissioning levers to reduce unwarranted variation in outcomes, target resources towards communities with the greatest need, and shift investment towards prevention, early intervention and proactive care, improving healthy life expectancy and reducing health inequalities

## Why this matters:

- Taking care of the health of our population through better prevention and reducing inequalities will lead to better patient outcomes, and an increase in healthy life years and independence.

### What will happen from April 2027:

- Developing a single view of population health that is used to support commissioning intentions and provider delivery, using a common set of population health, deprivation and outcomes data and intelligence to identify inequalities and target commissioning interventions where need is greatest.
- Prioritise investment in prevention, early intervention and proactive care models that improve healthy life expectancy and reduce demand for hospital based acute services.
- Use the NHS Standard Contract to embed clear expectations on health inequalities, population health improvement and equitable service delivery.
- Embed in provider contracts reporting requirements to identify unwarranted variation and outcomes segmented by inequality groups
- Identify and escalate risk relating to Quality and Safety standards of service and care delivery to improve as defined by National Quality Board Framework.
- Shift the percentage of spend in hospital, with a focus on outcomes for Children and Young People and 65yrs+ moving resource into preventive support for these populations utilising a phased approach to transform funding pathways.

### Provider contributions to delivery:

- Use population health management intelligence to identify, understand and address unwarranted variation in access, experience and outcomes across different population groups.
- Build routine reporting and review of outcomes, access segmented by inequality groups with the intent to report on existing standards.
- Undertake variation analysis and implement improvement plans where inequities are identified.
- Increase investment in prevention, outreach and proactive care programmes.
- Strengthen partnerships with primary care, local authorities, community services and the voluntary sector to redesign pathways and improve consistency of care.
- Ensure governance arrangements include oversight of inequalities, quality and population outcomes.
- Demonstrate how service redesign contributes to improved outcomes, prevention and reduced demand on acute services.

### How we will measure success:

- Reduced unwarranted variation between geographies
- Reduced variation between general population and target cohorts narrowing health inequality gaps (for target outcomes) for our most deprived and underserved populations.
- Improved uptake of prevention, screening and early intervention services.
- Providers routinely using and reporting segmented population-level data to identify and address inequalities.
- Measurable improvements in population health outcomes with a particular focus on healthy life expectancy, with providers demonstrating year-on-year progress against agreed equity indicators.

# 3. Sustainable Services

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# Models of Acute and Maternity Services

### Our Strategic Commissioning Intentions:

- We will determine the future model for acute and maternity services, driven by comprehensive review of services and pathways and best practice.

### Why this matters:

- Following national maternity reviews and instability in the local maternity offer, a full maternity pathway review and future model of care will ensure that services are safe, effective, equitable and sustainable.
- Acute service remodelling will support greater integration between acute, community and primary care, mental health and maternity services. This will reduce fragmentation and duplication, support right care right place right time, and improve sustainability of services and patient experience.

### What will happen from April 2027:

- Initiation of the review of maternity services across the cluster, reflecting national requirements as set out in the Ockenden and Amos reports, including development of a cluster wide Maternity and Neonatal Voices model
- Initiation of a comprehensive acute services review, starting with the BSW footprint.
- Supporting the implementation of an acute services review in Dorset

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### Provider contributions to delivery:

- Working with the ICB to understand service delivery and equity through data and insights
- Work collaboratively across organisations and sectors to develop clinically sustainable and evidence based future service models
- Market opportunities for maternity and neonatal voices models
- Benchmark services against national best practice, clinical standards and comparable high-performing systems
- Ensuring acute services are delivering only the care that cannot be delivered outside of a specialist setting

### How we will measure success:

- Clinically and publicly supported future model agreed and implemented.
- Improved patient outcomes and safety.
- Reduced unwarranted variation across services.
- Sustainable workforce and service resilience.
- More care delivered closer to home.
- Improved maternity outcomes and experience.
- Better access to urgent, acute and maternity services.
- Financially sustainable services that meet future population need including those services commissioned by SW Collaborative Commissioning Hub

# High-quality sustainable services to meet the needs of the population

## Our Strategic Commissioning Intentions:

- We will commission clinically sustainable, high-quality and financially responsible services that deliver improved outcomes, reduced variation and better experiences for our population. We will work with providers to redesign fragile services around population need, evidence-based care and long-term sustainability, ensuring resources are focused on interventions that deliver the greatest value and impact.

## Why this matters:

- There are known issues within service provision and delivery which are creating poorer patient outcomes. Focus on these as priority areas will create tangible benefits for our population, improving the quality and effectiveness of services. Improved understanding the population cohorts and usage and designing improvements around patient need rather than existing pathways or organisational boundaries will deliver sustainable impacts will deliver better value healthcare for our population through focussing resource where it is most needed and best delivered.

## What will happen from April 2027:

- Understand the needs of the 1% top users to embed proactive care aiming to reduce demand on same day emergency care services.
- Understand the contributing factors and any commissioning gaps adding to delayed discharge.
- Improve access to dentistry through targeted commissioning and market development.
- Reduce the time children are waiting with an initial focus on neurodiversity and dental waiting times through pathway redesign and capacity optimisation.
- Work in partnership with Local Authorities to deliver SEND Reform requirements.
- Eliminate inappropriate out-of-area Mental Health, Learning Disability and Autism placements through strengthened community-based provision.
- Reviewing and recommissioning planned care pathways:
  - Dermatology, Maxillofacial, Outpatients – patient initiated follow ups and multidisciplinary teams,
  - Maximise digital opportunities through pathways and back office functions.
  - Maximise the delivery of activity in accordance with ICB Clinical Policy criteria
  - Review and implement recommendations set out in the Modern Service Frameworks as they are published

## Provider contributions to delivery:

- Services will be delivered to improve clear population health outcomes, moving the focus from activity and organisational boundaries to quality and equity of care.
- Proactive identification and support for high-intensity users which maximise community-based care and prevention/secondary prevention
- Improve access to services through pathway redesign, capacity optimisation and innovation
- Additional measures to evidence health improvements in focus cohorts
- Working more across organisational boundaries utilising shared agreements or subcontracting arrangements
- Reduction in interventions and care which have lower clinical value.

## How we will measure success:

- Reduction in the percentage of patients in acute beds classified as NCTR
- Fewer same day urgent care episodes by end of 2027/28 (2025/26 baseline).
- 50% reduction in incidence of crisis in manageable condition over the next 3 years in priority cohorts.
- 50% reduction in delivery of care outside of clinical policy criteria
- Improved clinical outcomes and patient experience measures.
- Reduced unwarranted variation between providers and places.
- Improved access and reduced waiting times.
- Greater delivery of care in community and non-acute settings.
- Improved health outcomes for disadvantaged populations.
- Reduction in number of inappropriate out of area specialist hospital admissions
- Financially sustainable services operating within agreed resources.
- Stronger provider collaboration and pathway integration.

# Deliberately Digital

## Our Strategic Commissioning Intentions:

- We will commission safe, inclusive and interoperable digital services that empower people through the NHS App, provide professionals with joined-up patient information, and use AI responsibly to enhance the services we offer to patients, improve outcomes, access, patient and clinician experience and workforce productivity.
- Through better use of digital services, we will enable providers and commissioners to identify care gaps, reduce unwarranted variation, target interventions more effectively, and guide pathway management, while ensuring accessible alternatives remain available for those who cannot or choose not to use digital services.

## Why this matters:

- Digital transformation of healthcare services is key to delivering improved access for patients, improving the productivity of our workforce and improving the financial sustainability of our services, as highlighted in the government's 10 Year Plan for Health. We expect that all service transformation articulated within these commissioning intentions are designed through a digital first approach, which appropriately balances both the opportunities of digital transformation but also, the risks of digital exclusion.

### What will happen from April 2027:

- Specify mandatory requirements for interoperability, accessibility, cyber security, clinical safety and information governance in all relevant procurements and contracts.
- Standardise core digital access functions across general practice and priority pathways, including online consultation, booking, messaging and patient self-service.
- Require every digital pathway across providers to include assisted-digital support and a clearly defined non-digital route.
- Consolidate duplicative solutions and require suppliers and providers to optimise their solutions to simplify the route to provide the best care for all patients, harnessing all the new new digital means (predictive modelling, AI processing etc), evidence adoption, digital usability and accessibility, service user experience and benefits realisation.
- Ensure providers have the capability to assess and deliver assurance on digital clinical safety, through the contracting process.
- Require providers via contracting levers to deliver electronic prescribing.

### Provider contributions to delivery:

- Adopt common digital standards by ensuring systems are interoperable, secure with up to date cyber security plans, accessible and compliant with information governance and clinical safety requirements.
- Deliver a consistent digital experience for patients through standardised online access, booking, communication and self-service functions across services.
- Maintain inclusive access to care by providing assisted-digital support and clear non-digital alternatives for all digital pathways.
- Maximise value from digital investment by reducing duplication, increasing adoption, and demonstrating measurable benefits for patients, staff and the wider system.
- All providers must show how they are improving efficiency through new technology and automation. Any AI tools trialled must follow national guidance and meet required safety and effectiveness standards.

### How we will measure success:

- 80% of providers including General Practice offer the agreed core digital access functions: online consultation, appointment request or booking, messaging, repeat prescriptions and record access.
- 80% of new or renewed contracts that involve a DHT include the agreed interoperability, accessibility, cyber security, clinical safety and information-governance requirements, with compliance reviewed at least annually.
- At least three priority pathways achieve a 15% reduction from their 2026/27 baseline in avoidable telephone contacts, manual transactions or administrative handling time.
- Establish a baseline measure of user experience and digital literacy across agreed priority digital pathways, analysing results by relevant inclusion characteristics.
- Reduce the gap in digital uptake between the highest- and lowest-using population groups while retaining assisted and non-digital access in every commissioned pathway.
- People will have uncomplicated access to medications and information, including providers.

# Delivering national and local priorities

The following section sets out the national and local requirements we expect providers to deliver in 2027/28.

**National Guidance** [updated guidance to be added when available]

- National Operational Planning Guidance- link to be added once published
- NHS England Reforming Elective Care for Patients
- NHS England Urgent and Emergency Care Plan
- NHS England: Fit For the Future: 10 Year Health Plan for England
- NHS England Neighbourhood Health Guidelines
- NHS England statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

**Finance Requirements**

- Deliver in-year financial balance- eradicate underlying system deficit by end of three-year financial plan – focus on underlying run-rate improvement through recurrent cash releasing savings delivery.
- Deliver Recurrent Cost Improvement Plans (CIPs)
- 2% year on year productivity gains for 3 years
- Deliver corporate cost reductions per head of population
- Effective utilisation of cash and capital both strategic and operational
- Implement new best practice tariffs, incentivising left shift.

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**Workforce Requirements**

In line with the 10 Year Plan we are committed to moving from 'how many staff do we need to maintain our current care model', to a sustainable NHS workforce based on the workforce we need, where they should be deployed and with the skills they need to deliver better care for our local population. This will be achieved by:

- Creating the right culture, working collaboratively to drive efficiencies, make best use of our collective resources and reduce unnecessary cost
- Building a workforce fit for the future by developing a strategic workforce plan, influenced by the 10 year workforce plan, clinical pathways and the transformation programmes of work
- Using the strategic workforce plan to:
  - Better manage the supply and demand needs of our health and care workforce
  - Drive changes in the needs from a temporary workforce, reducing bank and agency usage
  - Bring teams and services together to consolidate and make best use of skills and resources across our geography
  - Make best use of digital and AI technology where appropriate.

# Examples of detailed commissioning intentions

Within phase 2 we will further develop how these intentions will be embedded. **Examples** are included below.

| Portfolio alignment | Commissioning intention | Outcomes | Delivery scale | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|---|---|
| Neighbourhood/ Urgent and Emergency Care | Review the top 1% users for Urgent and Emergency Care and embed alternative measures to reduce their UEC attendances | People are cared for in an environment appropriate to their presentation.<br>Improved patient flow and care availability for those who need it. | Place: BaNES, BCP, Dorset, Somerset, Swindon and Wiltshire | | | | | |
| Urgent and Emergency Care | Improve patient flow to reduce the number of patients with No Criteria to Reside in hospital beds | People can access the care they need, with bed availability for those requiring acute hospital-based care.<br>Reduced instances of harm from hospital acquired infection, falls and pressure ulcers.<br>Improved patient experience and retained independence. | Place: BaNES, BCP, Dorset, Somerset, Swindon and Wiltshire | | | | | |
| Children and Young People/ Mental Health | Improve access to support and diagnosis for CYP with neurodevelopmental symptoms. | Children and young people are able to meaningfully engage in education with a reduced number NEET.<br>Reduction in self harm and mental health crisis in CYP. | Neighbourhood and multi-neighbourhood | | | | | |
| Children and Young People/ Neighbourhood | Improved access for CYP to dental services | Children have access to primary dental care and advice on good oral hygiene and prevention of tooth decay. There are less instances of children requiring hospital treatment which could have been prevented with earlier intervention. | Neighbourhood | | | | | |
| Planned Care | Reviewing opportunities to change the outpatient model of delivery | People have timely access to the advise and diagnostic stage of their pathway, maximising the ability for this to be delivered locally and through neighbourhood models | | | | | | |

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# Progress we are already making

NHS

| Progress so far… |
|---|
| ✓ We have a Board-level Chief Officer for Population Health Improvement who is also a practicing GP |
| ✓ Our Integrated Community Based Contract (with IS provider HCRG) is an innovative outcomes-based contract worth ~£160m p/y serving the whole BSW population |
| ✓ Dorset is part of the National Neighbourhood Implementation programme and will be launching initial INTs during 2026/27 |
| ✓ Somerset has been part of the national Neighbourhood accelerator pilots and has seen demonstrable shifts in access and outcomes |
| ✓ Somerset's pioneering Open Mental Health service, launched in 2019, is neighbourhood care in action |
| ✓ The Dorset Insights & Intelligence Service (DiiS) and BSW's outcomes-based data platforms are major innovations, unique across ICBs – they are shaping our work to build a comprehensive integrated postcode level data insights platform |
| ✓ The B&NES Community Wellbeing hub model jointly commissioned between health and social care providing a single front door to 40 VCFSE partners with physical basis in our acute and community hospitals as a foundation for neighbourhood working. |
| ✓ In Dorset, the Dorset Healthcare AFT application (pending approval) will further enable integration of community, mental health and primary care services at neighbourhood level, strengthening delivery of INTs and population-based care models. |

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|---|---|---|---|
| **Report to:** | Cluster Board – Meeting in Public | **Agenda item** | 6 |
| **Date of Meeting:** | 16 November 2026 | | |

| | |
|---|---|
| **Title of Report:** | Delivering Population Health Improvement through Place-Based Partnerships and Neighbourhood Health |
| **Report Author:** | David Freeman |
| **Board / Director Sponsor:** | David Freeman |
| **Appendices:** | Appendix A: Place Development Programme Progress Overview |

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

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

| Previous consideration by: | Date | Please clarify the purpose |
|---|---|---|
| Population Health & Commissioning Committee | October 2026 | Discussion / Assurance regarding proposals for a structured approach to place and neighbourhood development. |

## 1 Purpose of this paper

This paper brings together an update on the development of place-based partnerships and neighbourhood health as part of the ICB's Place Development Programme.

The objective of place development is not to establish new structures for their own sake but to improve population health outcomes, reduce health inequalities and support delivery of the ambitions of the NHS Ten Year Plan.

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|---|
| The paper provides an overview of the integrated programme, the benefits it aims to deliver and current progress across each place footprint. It also recognises that place-based partnerships and neighbourhood health are complementary elements of a single transformation programme. |

| 2 | Summary of recommendations and any additional actions required |
|---|---|

The Board is asked to:

- Note the progress made in the development of place-based partnerships and neighbourhood health arrangements across the Cluster.
- Support the continued role of the Integrated Care Board as a system convenor, strategic leader and enabler of place and neighbourhood development.
- Note that successful delivery of the programme requires shared ownership and collective leadership from all partners across health, care, local government and the voluntary sector.
- Receive future progress reports through the Population Health and Commissioning Committee, including reporting on population health outcomes, neighbourhood development and place maturity.

| 3 | Legal/regulatory implications |
|---|---|

The programme supports delivery of the NHS Ten Year Plan through its three strategic shifts: prevention, community-based care and digital transformation. It contributes to the ICB's statutory duties to improve population health, reduce inequalities and work in partnership with local authorities, providers, primary care and voluntary sector partners. The approach aligns with national policy promoting neighbourhood health, place-based leadership and delegated decision-making closer to local communities.

| 4 | Procurement |
|---|---|

No procurement decisions are being sought through this report. The paper does not seek approval for additional investment and focuses on maximising value from existing resources through greater integration, earlier intervention, partnership working and improved targeting of support. Therefore, Procurement Act 2023 and Provider Selection Regime considerations are not applicable at this stage.

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

| | |
|---|---|
| P&C Name | n/a |
| P&C Signature | n/a |

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| 5 | Risks |
|---|---|

Key risks identified within the programme include:

- Lack of shared ownership across partner organisations.

- Partners focusing on organisational priorities rather than population outcomes.
- Variation in maturity across places.
- Pace of neighbourhood development insufficient to meet national expectations.
- Organisational and financial pressures diverting focus from transformation.
- Lack of clarity between Cluster, Place and Neighbourhood responsibilities.
- Failure to demonstrate measurable benefits.

Mitigations include shared governance arrangements, common outcomes frameworks, targeted support, accelerated Integrated Neighbourhood Team development, clear accountabilities and regular performance reporting.

## 6 Quality and resources impact

Quality, Patient Experience and Safeguarding: Expected benefits include improved health outcomes, earlier intervention, reduced health inequalities, better patient and carer experience, more coordinated care and stronger community support. Residents should experience more care closer to home, improved continuity and better coordinated support across services.

Finance: This paper does not seek approval for additional investment. The programme seeks to maximise the value derived from existing resources through integration, prevention and targeted support. Successful implementation is expected to improve productivity, reduce avoidable demand and support future investment in prevention.

Workforce: Development of Integrated Neighbourhood Teams will bring together primary care, community services, mental health, social care, acute providers, public health and VCSE partners to deliver coordinated care and prevention.

Sustainability/Green agenda: No specific sustainability impacts are identified within this paper; however, increased community-based care and reduced avoidable hospital activity may contribute indirectly to sustainability objectives.

| Finance sign off: | n/a |
|---|---|

## 7 Confirmation of completion of Equalities and Quality Impact Assessment

An Equality and Quality Impact Assessment has not been presented with this paper. However, reducing health inequalities is a core objective of the programme and forms part of the proposed outcomes framework, with measures including healthy life expectancy and inequality indicators. Any future service changes arising from programme implementation will be subject to appropriate EQIA processes.

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| 8 | Communications and Engagement Considerations |
|---|---|

Successful delivery depends on strong engagement with local authorities, NHS organisations, primary care, public health, social care, VCSE partners and local communities.

Community and partner engagement is a key element of place development and neighbourhood health, with several places already demonstrating strong stakeholder involvement and co-production approaches.

Future communications should focus on shared ownership of the programme and communicating benefits for local populations.

| 9 | Statement on confidentiality of report |
|---|---|

This report is suitable for publication and public discussion. It contains strategic programme and progress information and does not contain commercially sensitive, personal or confidential information. Based on the content provided, there are no reason for withholding the report from publication.

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# Delivering Population Health Improvement through Place-Based Partnerships and Neighbourhood Health

## 1. Introduction

National policy increasingly expects health and care systems to improve outcomes through prevention, community-based support and stronger partnership working. At the centre of this ambition is neighbourhood health, supported by mature place-based partnerships capable of convening organisations and communities around shared outcomes.

This agenda is reinforced by the Government's wider commitment to devolution and the transfer of greater influence and decision-making to local areas. As responsibility increasingly shifts towards Places and communities, there is a growing expectation that public services will work together around shared priorities, align resources more effectively and take collective responsibility for improving outcomes for local populations. Place-based partnerships provide the vehicle through which this locally-led approach can be realised, ensuring decisions are made closer to the communities they affect and that interventions reflect local need and opportunity.

The Board has previously discussed the development of place-based partnerships and received a paper on neighbourhood health. The purpose of bringing these together in this update report is to recognise that they represent two components of the same transformation programme.

Place-based partnerships provide the leadership, governance, accountability and resource alignment required to improve outcomes for local populations. Neighbourhoods provide the means through which those ambitions are delivered through integrated teams, proactive care and community-led action.

Neither can succeed in isolation.

Without strong place partnerships, neighbourhoods risk becoming disconnected service initiatives without strategic direction or sustainable investment. Without mature neighbourhoods, place partnerships lack the practical mechanisms required to deliver measurable improvements in population health.

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The Place Development Programme therefore seeks to develop both simultaneously, creating the leadership, partnerships and delivery capability necessary to improve outcomes for local communities. In doing so, it will help position Places to take on a greater role in shaping and coordinating local services,

whilst ensuring neighbourhoods become the primary mechanism through which improvements in population health, prevention and health inequalities are delivered.

## 2. Strategic Context

Neighbourhood health forms a central component of the NHS Ten Year Plan and underpins the three strategic shifts:

- From treatment to prevention
- From hospital to community
- From analogue to digital

At the same time, national policy increasingly recognises that the greatest opportunities for improving health outcomes lie beyond healthcare services alone. Progress requires coordinated action across public services, communities and the voluntary sector to address wider determinants of health including housing, employment, education, transport, social support and community resilience.

This reinforces the importance of Place as the level at which organisations can align resources, develop shared priorities and collectively take responsibility for improving outcomes for local populations.

## 3. A Vision for Place

The vision is that over time each Place becomes the primary partnership through which population health improvement is planned, coordinated and delivered.

Place Partnerships will provide:

- Local leadership
- Collective accountability for outcomes
- Alignment of organisational priorities and resources
- Oversight of population health improvement
- Engagement with local communities and stakeholders

Neighbourhoods will become the primary delivery mechanism through which partners improve outcomes for defined populations.

Integrated Neighbourhood Teams will bring together primary care, community services, mental health, social care, acute providers, public health and the voluntary and community sector to deliver coordinated care, earlier intervention and stronger preventative support.

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Together these arrangements create a coherent model through which strategic ambition is translated into practical delivery and measurable population benefit.

## 4. Why This Matters

The programme is ultimately about improving outcomes for local people rather than redesigning organisational arrangements.

Success will mean:

- More people living healthy and independent lives for longer
- Earlier intervention before needs escalate
- Reduced health inequalities
- Fewer avoidable hospital attendances and admissions
- Better experiences for patients and carers
- More coordinated support around individuals, families and communities
- Greater value from the collective investment made by public services

The development of place partnerships and neighbourhoods is therefore an enabler of improved health outcomes, not an objective in itself.

## 5. Expected Benefits and Outcomes

The approach is expected to deliver benefits across three key domains relevant to all partners in the place and neighbourhood eco-systems: population health, citizen experience and system sustainability.

### 5.1 Population Health Benefits

The programme will support:

- Improvements in healthy life expectancy
- Reduction in health inequalities between communities
- Increased uptake of prevention and early intervention
- Improved outcomes for people with frailty and complex needs
- Better management of long-term conditions
- Improved identification and support for people approaching end of life
- Stronger community resilience and social connectedness

### 5.2 Benefits for Residents and Communities

Residents should experience:

- Better coordinated care across services
- More care delivered closer to home
- Greater continuity of support

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- Improved access to community-based services
- More personalised care planning
- Increased involvement in decisions affecting their health and wellbeing
- Stronger community support networks

5.3 System Benefits

The programme will contribute to:

- Reduced emergency admissions
- Reduced avoidable attendance at Emergency Departments
- Reduced avoidable outpatient activity
- More effective use of resources across the system
- Reduced duplication across organisations
- Greater investment in prevention
- Improved collaboration and collective stewardship across partners

## 6. Current Progress

A significant amount of groundwork has already been completed, though the pace of change varies across our 6 place footprints.

Progress includes:

- Development of the place-based partnership frameworks
- Creation of place maturity approaches
- Clarification of future governance and delegation arrangements
- On going commitment to ensure outcomes-based approaches are fully linked to oversight and assurance
- Establishment of Place Partnership arrangements
- In parallel, a Cluster-wide assessment of neighbourhood health maturity has been completed against the national Integrated Neighbourhood Team maturity framework

Importantly, all Places have established key foundations for neighbourhood working whilst identifying opportunities to accelerate development in:

- Integrated Neighbourhood Team capability
- Primary and secondary care integration
- Elective pathway redesign
- Population health management capability
- Consistent adoption of best practice across Places

National feedback recognised a number of strengths already in place across the Cluster whilst highlighting opportunities to further accelerate development and reduce variation.

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## 7. High-Level Implementation Roadmap

At its meeting in October, the Population Health and Commissioning Paper considered proposals for bringing a more structured and co-ordinated approach to supporting the development of place and neighbourhoods across the Cluster. The work covers three horizons – or phases – to focus effort and resources in the right places.

Phase 1: Building the Foundations (2026/27)

*Focus*
Establishing the governance, leadership and delivery foundations required for future scale-up.

*Key Deliverables*

- Strengthened Place Partnership Boards
- Clear accountabilities between Cluster, Place and Neighbourhood levels
- Agreement of a common population health outcomes framework
- Baseline assessment of neighbourhood maturity
- Acceleration of proactive care initiatives
- Initial focus on frailty, care homes, housebound patients and end-of-life care
- Establishment of partnership development support and improvement networks

Phase 2: Scaling Delivery (2027/28)

*Focus*
Expanding neighbourhood delivery capability and embedding Place leadership arrangements.

*Key Deliverables*

- Fully operational Integrated Neighbourhood Teams across all Places
- Greater use of shared analytics and population health management
- Increased delegation and local decision-making
- Stronger alignment between NHS, local authority and voluntary sector priorities
- Delivery of neighbourhood interventions for long-term conditions and prevention
- Increased consistency and sharing of best practice across Places

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Phase 3: Embedding Population Health Improvement (2028/29)

*Focus*
Mature Place Partnerships leading sustained population health improvement.

*Key Deliverables*

- Mature neighbourhood health arrangements operating across all Places
- Demonstrable improvement in population health outcomes
- Reduction in unwarranted variation between communities
- Stronger community involvement in planning and delivery
- Place Partnerships functioning as the primary forum for coordinating local health and wellbeing improvement

## 8. Measures of Success

The success of the programme will be judged by outcomes rather than organisational milestones. The outcomes framework includes three levels of measurement, which will be used to inform and track the progress and place and neighbourhood health improvements:

*Population Health Outcomes*

- Healthy life expectancy
- Health inequality indicator
- Smoking prevalence
- Obesity prevalence
- Physical activity levels
- Preventable mortality
- Screening and vaccination uptake
- Patient activation and wellbeing measures

*Neighbourhood Health Outcomes*

Measures aligned to national expectations include:

- Reduction in emergency admissions for people with frailty
- Reduction in bed days for frail and housebound residents
- Reduced admissions from care homes
- Increased identification of people approaching end of life
- Reduced emergency admissions for people approaching end of life
- Improved long-term condition outcomes
- Increased completion of diabetes care processes
- Reduced avoidable outpatient activity for children and young people
- Improved urgent and emergency care performance.

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*Partnership and System Development Measures*

- Place maturity scores
- Integrated Neighbourhood Team maturity scores
- Progress against development milestones
- Adoption of common outcomes frameworks
- Levels of collaborative decision-making
- Evidence of resource alignment and joint planning
- Delivery against neighbourhood scaling objectives

## 9. Role of the Integrated Care Board

Place and neighbourhood development is a shared responsibility across the entire system. Its success depends upon leadership from: local authorities; NHS provider organisations; Primary care; Public health; Social care; Voluntary, Community and Social Enterprise partners; and Local communities.
The Integrated Care Board has a unique role as system steward and convenor. It cannot deliver this programme alone, but it can create the conditions under which success becomes possible.

The ICB will therefore seek to:

- Convene partners around a shared ambition
- Finalise the outcomes framework
- Align investment and incentives using new contract and payments models
- Support collaboration and organisational development
- Create enabling governance arrangements
- Help remove barriers to integration
- Provide oversight and assurance of delivery
- Support the spread of learning and innovation across Places

## 10. Risks and Mitigations

| Risk | Potential Impact | Mitigation |
|---|---|---|
| **Lack of shared ownership across partner organisations** | Neighbourhood health becomes perceived as an NHS programme rather than a collective endeavour | Shared governance, jointly agreed outcomes and active leadership involvement from all partners |
| **Partners focus on organisational priorities rather than population outcomes** | Collaboration weakens and transformation stalls | Confirm a Place-level outcomes frameworks with collective accountability for delivery |
| **Variation in maturity across Places** | Uneven delivery and outcomes | Place maturity framework, peer support and targeted development interventions |

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| Risk | Potential Impact | Mitigation |
|---|---|---|
| **Pace of neighbourhood development insufficient to meet national expectations** | Reduced ability to improve outcomes and system performance | Accelerate Integrated Neighbourhood Team development and proactive care models; seek to be part of national trailblazer programmes |
| **Organisational and financial pressures divert focus from transformation** | Reduced momentum and delayed benefits realisation | Align programme priorities with operational challenges and statutory objectives |
| **Lack of clarity between Cluster, Place and Neighbourhood responsibilities** | Duplication and slower decision-making | Clear operating model and delegated accountabilities |
| **Failure to demonstrate measurable benefits** | Reduced confidence from partners and stakeholders | Robust outcomes framework and regular performance reporting to Boards and Partnerships |

## 11. Recommendations

The Board is asked to:

1. Note the progress made in the development of place-based partnerships and neighbourhood health arrangements across the Cluster.
2. Support the continued role of the Integrated Care Board as a system convenor, strategic leader and enabler of place and neighbourhood development.
3. Note that successful delivery of the programme requires shared ownership and collective leadership from all partners across the health, care, local government and voluntary sectors.
4. Receive future progress reports through the Population Health and Commissioning Committee (PHCC), including reporting on population health outcomes, neighbourhood development and place maturity.

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# Appendix A: Place Development Programme Progress Overview

All six Places have now commenced implementation of the Place Development Programme, establishing the foundations required to support neighbourhood health, population health improvement and the wider ambitions of the NHS Ten Year Plan.

While individual Places are progressing at different rates and are responding to differing local circumstances, all have demonstrated progress in developing Place-Based Partnership arrangements, strengthening neighbourhood health planning and identifying priority cohorts for proactive intervention.

## Place Development Programme Heat Map (October 2026)

| Place | Partnership Development | Neighbourhood Design | Population Health Focus | Community & Partner Engagement | Delivery Readiness |
|---|---|---|---|---|---|
| **Bath & North East Somerset** | □<br>First meeting established and governance in place. | □<br>Three neighbourhoods defined with steering groups operating. | □<br>1% cohort analysis underway and care home pilot commencing. | □<br>Strong VCSE engagement and Community Wellbeing Hub involvement. | □<br>Delivery cohorts being finalised. |
| **BCP** | □<br>Strong partnership working evident but formal neighbourhood governance still developing. | □<br>Geography consultation ongoing and INT model in development. | □<br>Advanced work on high-risk frailty cohort and care planning model. | □<br>Strong alignment with housing, SEND and homelessness programmes. | □<br>Operating model not yet fully implemented. |

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| Place | Partnership Development | Neighbourhood Design | Population Health Focus | Community & Partner Engagement | Delivery Readiness |
|---|---|---|---|---|---|
| **Dorset** | □<br>Place Partnership framework emerging. | □<br>Nine neighbourhood footprints agreed. | □<br>1% cohort identification nearing completion. | □<br>Strong stakeholder engagement with PCNs, MPs and Healthwatch. | □<br>Launch phase approaching. |
| **Somerset** | □<br>Mature system-wide partnership arrangements already evident. | □<br>Neighbourhood development focused through Frailty Strategy. | □<br>Strong alignment between frailty programme, inequalities funding and 1% approach. | □<br>Extensive partner engagement across Somerset. | □<br>Delivery activity already underway. |
| **Swindon** | □<br>Formal Place Board and governance model now agreed. | □<br>Framework development continuing. | □<br>Early population health focus around mental health inequalities. | □<br>Strong commitment to co-production and community involvement. | □<br>Transitioning from planning into delivery. |
| **Wiltshire** | □<br>Place Board development progressing through ICA structures. | □<br>Comprehensive planning programme and mobilisation support in place. | □<br>1% testing underway through shared care record and MDT model. | □<br>Strong system-wide engagement through neighbourhood workstreams. | □<br>Neighbourhood plans nearing implementation. |

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## Overall Cluster Assessment

| Domain | Overall Position |
|---|---|
| Partnership Development | □ Establishing and maturing |
| Community & Partner Engagement | □ Strong |
| Neighbourhood Design | □ Largely complete |
| INT footprints | □ Agreed or proposals in consultation phase |
| Population Health Management | □ Emerging |
| Operational Delivery | □ Moving from design into implementation |
| Measurable Outcomes | □ Early stage |

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| **Report to:** | Cluster Board – Meeting in Public | **Agenda item** | 7 |
| **Date of Meeting:** | 16 November 2026 | | |

| | |
|---|---|
| **Title of Report:** | Performance Dashboard (Contracted Activity and Associated Performance) |
| **Report Author:** | Mark Harris, Director of Strategic Commissioning Delivery |
| **Board / Director Sponsor:** | David Freeman, Chief Officer for Commissioning and Place |
| **Appendices:** | Appendix 1, Integrated Performance Report - Summary<br>Appendix 2, Activity Dashboard |

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

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

| Previous consideration by: | Date | Please clarify the purpose |
|---|---|---|
| Procurement and Contracting Oversight Group | 19/10/26 | Discussion/Assurance |
| Joint Population Health and Commissioning Committee | 21/10/26 | Discussion/Assurance |

## 1 Purpose of this paper

The purpose of this paper is to provide assurance of the contracting oversight of providers commissioned. The focus is on the activity commissioned and within contracts, with NHSE now responsible for overall provider performance against national standards. However, the two aspects are clearly linked.

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| This Procurement and Contracts Oversight Group and Joint Population Health and Commissioning Committee have received and discussed a fuller version of this report; which also set out the developments to be undertaken as next steps in using the intelligence available to ensure that there is clearer mapping of those alert, advise, assure topics with contract review discussions with our providers. |

## 2 Summary of recommendations and any additional actions required

*The Board is asked to:*

- Note the report and the link with NHSE mid-year reviews and associated recovery actions.

## 3 Legal/regulatory implications

Links to NHS Oversight Framework and NHSE Medium Term Plan requirements of commissioners and providers.

## 4 Procurement

No identified procurement considerations.

| | |
|---|---|
| P&C Name | |
| P&C Signature | |

## 5 Risks

Some performance aspects are shown within individual ICB risk registers which are maintained at ICB level. This is being reviewing for consistency, and the output of this reporting process will inform those risks and the updates against them.

## 6 Quality and resources impact

Not considered in detail for this iteration of the report.

Linking with financial positions of contracts identified as a next step for discussion within Procurement and Contracts Oversight Group.

| | |
|---|---|
| Finance sign off: | |

## 7 Confirmation of completion of Equalities and Quality Impact Assessment

No EQIA completed.

## 8 Communications and Engagement Considerations

No communication and engagement considerations at this stage.

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## 9 Statement on confidentiality of report

This report is not confidential.

## 1. Introduction

1.1. This report provides a summary of the contracting oversight and actions in response to the contracted activity from the ICB Cluster main providers.

1.2. Contracts with providers are subject to scrutiny through Contract Review Meetings (CRMs) informed by the activity and performance information that is produced monthly. ICB Place Directors chair the CRMs holding responsibility for the relationship and oversight of the acute providers within their geography and are represented in NHSE meetings with providers relating to their performance against key national standards.

1.3. The flow supporting the oversight of contracted performance is represented below.




1.4. The ICB Cluster and Individual providers have been subject to a mid-year review with NHSE based on Month 4 (July 26 positions). Information related to performance positions, drivers and actions is drawn from both the both recent CRM and those mid-year (H2) review meetings.

1.5. Provider positions represent that activity and performance for ICB Cluster ICBs only. ICB targets represent the total target from all activity commissioned which will include both local Independent Sector Providers and non-local providers where the ICB is not the lead commissioner.

1.6. Within the BSW ICB, the three acute providers operate collectively as a group, however as they remain individual legal organisations, there are individual contracts and contract review meetings with each provider.

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## 2. Summary of Performance against contract

2.1. Note: References to baseline represent the planning round starting point of the previous year's forecast activity, whereas plan represents the activity set

out in the Medium-Term Plan and contracted from the provider for the current year.

2.1.1. Overall, as a cluster, we're seeing 1.5% growth on baseline across all elective activity combined, although we're under plan by 0.6%, with the largest variation to plan observed for the BSW area.

2.1.2. BSW are 5.4% under plan across all Points of Delivery with the biggest variation to plan seen in follow-ups (-8.2%)

2.1.3. Across outpatients, Dorset are currently seeing 14.7% more activity than planned at ISPs, with observed baseline growth of 1.1%

2.1.4. Dorset County Hospital are showing an activity reduction in first attendances of 6.7%, with variation to plan at -14.8%

2.1.5. All ICBs are showing reduced activity in elective ordinary admissions, with highest variation to plan noted at Somerset Foundation Trust

2.1.6. There is growth in day case admissions, although the majority of providers are under plan, excluding GWH with over delivery of 6.2%

2.2. Overall, as a cluster, we're seeing 2.7% growth in front door demand, and higher levels than expected year-to-date, with the largest growth and variation to plan observed for BSW

2.2.1. BSW are 2.8% above plan with significant growth observed at GWH (7.6%).

2.2.2. Dorset are seeing growth in demand, although year-to-date activity volume remains in line with expected levels.

2.2.3. Front door demand at Somerset Foundation is reduced on baseline and is therefore 1.7% under plan.

2.2.4. Overall, non-elective admissions are within plan, across the cluster, with growth in zero-day spells offset by a 2% drop in 1+ day Length of stay spells.

2.3. Significant growth in zero-day spells could be mainly attributed to increased streaming for Same Day Emergency Care attendances, captured as zero-day spells – This is the case at the RUH, where we are seeing significant growth in GP direct admits, who are streamed to additional SDEC capacity.

2.4. Appendix 1 shows the Executive Summary of the Integrated Performance Report, with the associated Alert, Advice, Assure performance areas. The majority of performance reported relates to the position at Month 4 (July 26).

2.5. Appendix 2 shows the Activity versus plan (as set out in the agreed Medium-Term Plan for that provider). The Cluster ICB and ICB summary form the exception reporting element of the report for committee escalation (alert section).

## 3. Contractual response

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3.1. Through a combination of the regular contract review meetings and the mid-year reviews carried out by NHSE with providers, recovery actions have been set in detail by providers across elective care, diagnostics, cancer and urgent care. These recovery plans will from a contractual perspective, be overseen

through ongoing Contract Review meetings and provider oversight by NHSE, with progress reported through the flow set out in section 1.3 above.

3.2. Alongside the provider recovery responses, the ICB as commissioner is focused on work to :-

3.2.1. Reduce avoidable urgent care demand through proactive support for the highest risk 1% population cohort (as set out in the Cluster Winter Plan).

3.2.2. Maximise alternatives to admission through neighbourhood and care co-ordination and enhanced work on no criteria to reside.

3.2.3. Review elective system capacity to identify any opportunities to offer patients choice of an alternate provider.

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# Cluster Integrated Performance Report (IPR)

[Link to IPR Power BI Report]

October 2026

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



# ICB Executive Summary

Overview of latest position for Operating Plan National Priority Metrics where we have data for all ICBs.

hover over the information button for the definition of ICB level reporting

Last Refreshed Date: 30/09/2026

DiiS Data Intelligence & Insight Service

## Referral to Treatment and Planned Care

| Metric | Organisation | Cluster Total | | | BSW ICB | | | Dorset ICB | | | Somerset ICB | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance |
| Cancer 62 day standard % | Jul 26 | 68.2% | 73.7% | -5.5% | 68.4% | 74.4% | -6.0% | 64.7% | 73.5% | -8.9% | 72.5% | 72.9% | -0.5% |
| Cancer 31 day standard % | Jul 26 | 90.6% | 93.6% | -3.0% | 88.6% | 92.6% | -4.0% | 92.9% | 94.3% | -1.4% | 90.4% | 93.8% | -3.4% |
| Cancer 28 day faster diagnosis standard % | Jul 26 | 77.1% | 80.4% | -3.2% | 76.1% | 80.5% | -4.4% | 76.4% | 79.3% | -2.9% | 80.0% | 81.9% | -1.9% |
| Diagnostics (DM01) % waiting over 6 weeks | Jul 26 | 15.6% | 13.4% | 2.2% | 12.4% | 10.9% | 1.5% | 18.6% | 11.9% | 6.7% | 15.9% | 19.3% | -3.3% |
| Referral to Treatment waiting within 18 weeks % | Jul 26 | 66.1% | 66.5% | -0.4% | 66.2% | 67.6% | -1.4% | 66.0% | 64.9% | 1.1% | 66.2% | 67.2% | -1.0% |
| Referral to Treatment waiting over 52 weeks % | Jul 26 | 1.51% | 0.83% | 0.68% | 1.32% | 0.68% | 0.64% | 1.23% | 0.88% | 0.35% | 2.21% | 1.00% | 1.21% |

## Primary Care and Community

| Metric | Organisation | Cluster Total | | | BSW ICB | | | Dorset ICB | | | Somerset ICB | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance |
| Community waiting list over 52 weeks | Jul 26 | 4,817 | | | 79 | | | 4,738 | 4,945 | -207 | 0 | 0 | 0 |
| Community waiting list % within 18 weeks | Jul 26 | 78.4% | | | 80.3% | | | 65.0% | 51.7% | 13.3% | 92.5% | 84.4% | 8.1% |
| Improved patient experience of access to general practice | Sep 26 | | | | 76.3% | | | 78.1% | | | 72.4% | | |
| Clinically urgent appointments seen on the same day % | Jul 26 | 77.6% | 77.2% | 0.4% | 79.8% | 75.0% | 4.8% | 71.4% | 80.0% | -8.6% | 82.5% | 76.5% | 6.0% |
| Number of urgent dental appointments | Aug 26 | 8,999 | 9,113 | -114 | 3,594 | 3,278 | 316 | 3,692 | 3,518 | 174 | 1,713 | 2,317 | -604 |

## Mental Health and Learning Disability

| Metric | Organisation | Cluster Total | | | BSW ICB | | | Dorset ICB | | | Somerset ICB | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance |
| NHS Talking Therapies reliable improvement % | Jul 26 | 67.6% | 69.0% | -1.4% | 68.0% | 69.0% | -1.0% | 68.0% | 69.0% | -1.0% | 67.0% | 69.2% | -2.2% |
| NHS Talking Therapies reliable recovery % | Jul 26 | 44.0% | 51.0% | -7.0% | 46.0% | 51.0% | -5.0% | 42.0% | 51.0% | -9.0% | 43.0% | 51.1% | -8.1% |
| Individual Placement Support access | Jul 26 | 1,700 | 1,864 | -164 | 585 | 607 | -22 | 535 | 706 | -171 | 580 | 551 | 29 |
| Inappropriate adult acute out-of-area placements | Jul 26 | | | | 4 | 2 | 2 | 4 | 3 | 1 | 4 | 0 | 4 |
| CYP mental health inpatients with LD and/or Autism | Aug 26 | 7 | 8 | -1 | 4 | 6 | -2 | 2 | 1 | 1 | 1 | 1 | 0 |
| Adult mental health inpatients with LD / LD and Autism | Aug 26 | 46 | 32 | 14 | 11 | 10 | 1 | 16 | 15 | 1 | 19 | 7 | 12 |
| Adult mental health inpatients with Autism | Aug 26 | 43 | 20 | 23 | 20 | 9 | 11 | 13 | 6 | 7 | 10 | 5 | 5 |

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*Variance is the difference between the latest performance and the target. Red variance means the metric is off target, green variance means the metric is meeting its target.*

# Provider – Alert, Advice and Assure Summary

October 26

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



# Provider Executive Summary

Overview of latest position for Operating Plan National Priority Metrics where we have data for all Providers.

Last Refreshed Date: 30/09/2026

DiiS Data Intelligence & Insight Service

## Referral to Treatment

| Metric | Organisation | GWH | | | RUH | | | Salisbury FT | | | DCH | | | UHD | | | Somerset FT | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance |
| Referral to Treatment waiting over 52 weeks % | Jul 26 | 2.52% | 0.77% | 1.75% | 0.38% | 0.93% | -0.55% | 0.40% | 0.00% | 0.40% | 1.62% | 0.74% | 0.88% | 1.15% | 0.99% | 0.16% | 2.69% | 1.10% | 1.59% |
| Referral to Treatment waiting within 18 weeks % | Jul 26 | 57.9% | 61.0% | -3.1% | 70.6% | 70.4% | 0.2% | 71.0% | 70.9% | 0.2% | 60.0% | 66.3% | -6.3% | 66.8% | 65.2% | 1.5% | 64.9% | 65.6% | -0.7% |

## Planned Care

| Metric | Organisation | GWH | | | RUH | | | Salisbury FT | | | DCH | | | UHD | | | Somerset FT | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance |
| Diagnostics (DM01) % waiting over 6 weeks | Jul 26 | 6.3% | 3.7% | 2.6% | 13.4% | 13.7% | -0.3% | 15.3% | 10.8% | 4.5% | 19.8% | 22.2% | -2.4% | 15.0% | 7.7% | 7.3% | 16.9% | 19.6% | -2.7% |
| Cancer 28 day faster diagnosis standard % | Jul 26 | 76.9% | 82.5% | -5.6% | 73.4% | 78.8% | -5.3% | 79.5% | 79.9% | -0.4% | 78.7% | 80.0% | -1.3% | 75.3% | 78.3% | -2.9% | 81.2% | 82.3% | -1.1% |
| Cancer 31 day standard % | Jul 26 | 89.2% | 93.6% | -4.4% | 96.1% | 93.4% | 2.7% | 92.9% | 92.5% | 0.4% | 91.1% | 94.2% | -3.1% | 93.6% | 96.0% | -2.4% | 89.8% | 94.4% | -4.6% |
| Cancer 62 day standard % | Jul 26 | 66.2% | 72.5% | -6.2% | 68.0% | 74.3% | -6.3% | 71.4% | 78.3% | -6.9% | 61.4% | 80.1% | -18.7% | 64.6% | 75.6% | -11.0% | 73.5% | 75.1% | -1.6% |
| Patients discharged on discharge ready date % | Aug 26 | 82.0% | 81.7% | 0.3% | 84.5% | 86.3% | -1.8% | 89.3% | 83.2% | 6.1% | 90.6% | 90.5% | 0.1% | 84.8% | 87.0% | -2.2% | 83.8% | 82.9% | 0.9% |

## Urgent and Emergency Care

| Metric | Organisation | GWH | | | RUH | | | Salisbury FT | | | DCH | | | UHD | | | Somerset FT | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance | Value | Target | Variance |
| A&E attendances waiting over 12 hours % | Aug 26 | 15.6% | 12.1% | 3.5% | 11.2% | 7.7% | 3.5% | 4.2% | 4.0% | 0.2% | 8.9% | 8.7% | 0.2% | 4.8% | 7.1% | -2.3% | 2.4% | 8.0% | -5.6% |
| Beds occupied by no criteria to reside patients % | Aug 26 | 18.8% | 10.0% | 8.8% | 23.2% | 10.0% | 13.2% | 17.2% | 9.0% | 8.2% | 18.7% | | | 24.5% | | | 22.1% | | |
| A&E attendances waiting within 4 hours % | Aug 26 | 67.4% | 79.2% | -11.8% | 67.8% | 70.5% | -2.7% | 67.3% | 78.6% | -11.3% | 76.9% | 78.3% | -1.4% | 70.9% | 70.0% | 0.9% | 73.0% | 78.1% | -5.1% |

| Metric | Organisation | SWASFT | | |
|---|---|---|---|---|
| | Month | Value | Target | Variance |
| Average category 2 ambulance response (mins) | Aug 26 | 37.68 | 25.22 | 12.46 |

*Variance is the difference between the latest performance and the target. Red variance means the metric is off target, green variance means the metric is meeting its target.*

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# Cluster Integrated Performance Report (IPR)

[Link to IPR Power BI Report]

October 2026

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



# BSW, Dorset and Somerset Cluster - Activity Vs Plan Monitoring | ICB Summary

Cluster-wide monitoring of elective and UEC activity across inpatient outpatient and A&E PODs, against annual plans submitted via the 2026/27 MTP submission

*For elective activity metrics, ICB totals are based on commissioned activity for ICB registered patients only. For UEC activity metrics, ICB totals are based on acute system totals, for that ICB, regardless of commissioner*

*Reporting as at Month 5*

| | BSW ICB | | Dorset ICB | | Somerset ICB | | Cluster | |
|---|---|---|---|---|---|---|---|---|
| **Activity Metric** | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan |
| **Elective Care** | | | | | | | | |
| Consultant-led first outpatient attendances | 4.4% | -1.3% | 4.8% | 1.9% | 4.1% | -2.2% | 4.5% | -0.2% |
| Consultant-led follow-up outpatient attendances | -0.8% | -8.2% | -0.2% | 2.4% | 3.1% | 3.7% | 0.3% | -0.7% |
| ***Total consultant-led outpatient attendances*** | ***1.1%*** | -5.8% | ***1.1%*** | 2.2% | ***3.5%*** | 1.7% | ***1.6%*** | -0.6% |
| Day case spells | 1.7% | -1.7% | 5.2% | 6.6% | -3.3% | -4.6% | 1.5% | 0.3% |
| Ordinary spells | 1.5% | -2.4% | -11.6% | -8.6% | -6.0% | -8.5% | -5.6% | -6.4% |
| ***Total elective admissions*** | ***1.6%*** | -1.8% | ***3.1%*** | 4.8% | ***-3.6%*** | -5.0% | ***0.7%*** | -0.4% |
| **Urgent and Emergency Care** | | | | | | | | |
| Zero-day non-elective spells | 6.3% | 6.4% | 4.4% | 1.6% | 0.0% | 5.7% | 4.6% | 4.3% |
| 1+ day non-elective spells | -1.3% | -5.6% | -3.3% | -5.8% | -0.6% | 0.1% | -1.9% | -4.4% |
| ***Total non-elective admissions*** | ***1.8%*** | -0.8% | ***-0.2%*** | -2.8% | ***-0.4%*** | 1.7% | ***0.6%*** | -1.1% |
| A&E Attendances - Type 1 | 11.3% | 7.9% | 9.1% | 6.7% | -3.6% | 7.0% | 6.8% | 7.2% |
| A&E Attendances - Other type attendances | -8.9% | -10.4% | -10.4% | -13.2% | 3.0% | -10.7% | -5.2% | -11.5% |
| ***Total A&E attendances*** | ***5.6%*** | 2.8% | ***2.6%*** | 0.1% | ***-0.7%*** | -1.7% | ***2.7%*** | 0.5% |

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# BSW, Dorset and Somerset Cluster - Activity Vs Plan Monitoring | Provider Summary

Cluster-wide monitoring of elective and UEC activity across inpatient outpatient and A&E PODs, against annual plans submitted via the 2026/27 MTP submission

*All activity metrics are based on acute totals, regardless of commissioner (Acute Trust total)*

| Activity Metric | Great Western Hospital | | Royal United Hospital | | Salisbury District Hospital | | Dorset County Hospital | |
|---|---|---|---|---|---|---|---|---|
| | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan |
| **Elective Care** | | | | | | | | |
| Consultant-led first outpatient attendances | 10.2% | 2.6% | 4.7% | -2.5% | 4.0% | -1.0% | -6.7% | -14.8% |
| Consultant-led follow-up outpatient attendances | -2.5% | -3.6% | 6.8% | 27.9% | -18.4% | -53.5% | -2.3% | -6.7% |
| ***Total consultant-led outpatient attendances*** | ***2.3%*** | -3.3% | ***2.7%*** | -1.6% | ***-0.3%*** | -2.7% | ***-0.1%*** | -8.8% |
| Day case spells | 4.2% | -5.1% | -6.3% | 0.1% | 2.7% | 5.0% | 3.5% | 1.5% |
| Ordinary spells | 8.3% | 6.2% | 7.0% | -1.5% | -0.1% | -4.0% | 5.9% | -3.2% |
| ***Total elective admissions*** | ***7.3%*** | 5.3% | ***6.2%*** | -1.6% | ***1.7%*** | -3.0% | ***5.5%*** | -3.7% |
| **Urgent and Emergency Care** | | | | | | | | |
| Zero-day non-elective spells | -1.0% | -0.9% | 19.1% | 19.9% | -6.8% | -8.0% | -5.5% | -8.2% |
| 1+ day non-elective spells | 2.4% | 0.6% | -3.1% | -8.5% | -3.8% | -9.4% | 1.5% | -1.5% |
| ***Total non-elective admissions*** | ***1.0%*** | 0.0% | ***6.0%*** | 2.7% | ***-5.0%*** | -8.9% | ***-1.7%*** | -4.5% |
| A&E Attendances - Type 1 | 32.8% | 29.1% | 3.5% | 2.2% | 0.5% | -5.8% | 5.1% | 1.6% |
| A&E Attendances - Other type attendances | -18.2% | -20.2% | | | 14.6% | 15.3% | -0.4% | -3.0% |
| ***Total A&E attendances*** | ***7.6%*** | 4.8% | ***3.5%*** | 2.2% | ***4.8%*** | 0.3% | ***2.5%*** | -0.5% |

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# BSW, Dorset and Somerset Cluster - Activity Vs Plan Monitoring | Provider Summary

Cluster-wide monitoring of elective and UEC activity
across inpatient outpatient and A&E PODs, against annual

*All activity metrics are based on acute totals, regardless of commissioner (Acute Trust total)*

*Reporting as at Month 5*

| Activity Metric | University Hospitals Dorset | | Somerset FT | | BSW ISPs | | Dorset ISPs | | Somerset ISPs | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan | % Growth | % Var vs Plan |
| **Elective Care** | | | | | | | | | | |
| Consultant-led first outpatient attendances | -4.1% | 1.3% | 4.8% | 0.6% | -2.5% | -3.6% | 6.8% | 27.9% | -18.4% | -53.5% |
| Consultant-led follow-up outpatient attendances | 1.6% | -1.1% | -2.8% | -3.8% | 3.5% | 1.5% | -10.8% | 7.4% | 6.7% | 88.7% |
| ***Total consultant-led outpatient attendances*** | ***-5.3%*** | 0.7% | ***3.4%*** | 3.4% | ***1.3%*** | -0.4% | ***-4.6%*** | 14.7% | ***-2.3%*** | -1.4% |
| Day case spells | -10.8% | 7.4% | 6.7% | 88.7% | -9.4% | -10.9% | -15.4% | 0.0% | -9.5% | -5.2% |
| Ordinary spells | 6.7% | -2.2% | 1.6% | -0.4% | 4.1% | 2.0% | -8.7% | 2.4% | -13.9% | -8.0% |
| ***Total elective admissions*** | ***2.8%*** | -3.3% | ***1.1%*** | -1.4% | ***0.0%*** | 0.0% | ***-14.4%*** | 0.4% | ***-10.2%*** | -5.6% |
| **Urgent and Emergency Care** | | | | | | | | | | |
| Zero-day non-elective spells | 8.7% | 5.9% | 0.0% | 5.7% | | | | | | |
| 1+ day non-elective spells | -4.9% | -7.3% | -0.6% | 0.1% | | | | | | |
| ***Total non-elective admissions*** | ***0.4%*** | -2.1% | ***-0.4%*** | 1.7% | | | | | | |
| A&E Attendances - Type 1 | 10.5% | 8.6% | -3.6% | 7.0% | | | | | | |
| A&E Attendances - Other type attendances | -19.1% | -21.9% | 3.0% | -10.7% | | | | | | |
| ***Total A&E attendances*** | ***2.6%*** | 0.3% | ***-0.7%*** | -1.7% | | | | | | |

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| | | | |
|---|---|---|---|
| **Report to:** | Cluster Board – Meeting in Public | **Agenda item** | 8 |
| **Date of Meeting:** | 16 November 2026 | | |

| | |
|---|---|
| **Title of Report:** | Thirlwall Inquiry: Implications and Required Actions for Cluster Maternity and Neonatal Services |
| **Report Author:** | Jo Hodson & Vicky Garner, Heads of Quality – Maternity, Women, Children and Young People |
| **Board / Director Sponsor:** | Shelagh Meldrum Chief Nursing Officer |
| **Appendices:** | |

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

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

| **Previous consideration by:** | **Date** | **Please clarify the purpose** |
|---|---|---|
| Executive Management Group | 20 October 2026 | Discussion |
| Joint Quality and Population Engagement Committee | 29 October 2026 | Discussion |

## 1 Purpose of this paper

The aim of this paper is to request the Cluster Board to discuss noting it's implications and course of action

## 2 Summary of recommendations and any additional actions required

The Cluster Board is asked to:

1. Discuss and note the implications of the Thirlwall Inquiry.
2. Receive assurance regarding actions being taken in response to NHS England's requirements and any gaps identified through local assurance processes.

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| |
|---|
| 3. Note that future implementation activity may require additional resources and investment, which will be brought forward through appropriate governance routes as national requirements and local priorities become clearer |

| 3 | Legal/regulatory implications |
|---|---|
| NHS Oversight Framework (tbc) | |

| 4 | Procurement |
|---|---|
| Not applicable | |
| Procurement to detail the advice provided in this instance and the guidance to ensure compliance, governance and value for money | |
| P&C Name | n/a |
| P&C Signature | n/a |

| 5 | Risks |
|---|---|
| The Thirlwall Inquiry highlights risks to neonatal safety, safeguarding and quality of care where concerns regarding patient safety, staff conduct or clinical practice are not recognised, escalated and acted upon promptly. There is a risk that organisational culture, governance arrangements or ineffective speaking-up and escalation processes could hinder the identification and management of emerging concerns. Variation in implementation across providers may also result in inconsistent compliance with national requirements, requiring robust oversight and assurance across the Cluster. Emerging national expectations may have workforce, governance and resource implications, and ongoing clarity regarding local and national accountability arrangements will be required to support effective delivery of the Inquiry recommendations. | |

| 6 | Quality and resources impact |
|---|---|
| Resource Impact:<br>Workforce:<br>• To be confirmed<br><br>Finance:<br>• No immediate financial approval is sought.<br><br>Future resource requirements may emerge from implementation of recommendations. | |
| Finance sign off: | n/a |

| 7 | Confirmation of completion of Equalities and Quality Impact Assessment |
|---|---|

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| |
|---|
| EQIA not required at this stage. The paper supports improvement in patient safety, safeguarding, bereavement care and organisational culture. |

| 8 | Communications and Engagement Considerations |
|---|---|
| A communications and engagement plan has been designed to enable clear and robust engagement with staff, partners organisations, key stakeholders and patients and their families. | |

| 9 | Statement on confidentiality of report |
|---|---|
| This paper can be shared | |

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## 1. Situation

The Thirlwall Inquiry examined events associated with neonatal care at the Countess of Chester Hospital NHS Foundation Trust and the wider response of NHS organisations and regulators. The Inquiry identified significant concerns relating to patient safety, organisational culture, safeguarding, data surveillance, leadership accountability and governance.

The Cluster Board is being briefed on the Inquiry findings and the implications for maternity and neonatal services across the Cluster footprint. The paper outlines the actions required in response to NHS England's recommendations and the arrangements being established to provide oversight and assurance of their implementation.

## 2. Background

The Cluster ICB includes six maternity and neonatal services providers over seven sites:

- Dorset County Hospital NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Somerset NHS Foundation Trust (Yeovil District Hospital and Musgrove Park Hospital sites)
- University Hospitals Dorset NHS Foundation Trust

The Inquiry identified several key themes:

**Patient Safety Must Override Organisational Reputation** - The Inquiry found repeated examples where concerns raised by clinicians were not acted upon promptly and where organisational considerations took precedence over patient safety.

**Deliberate Harm is a Safeguarding Issue** - A major theme throughout is that concerns regarding possible deliberate harm by a healthcare professional must be managed through safeguarding processes immediately, before certainty or proof has been established.

**Culture Matters** - The Inquiry highlights the importance of fostering environments where staff can raise concerns safely, concerns are listened to and leadership responds proportionately and transparently.

**Data Must Be Used Proactively** - The Inquiry identified missed opportunities to identify emerging patterns through mortality, outcome and clinical surveillance data and recommends strengthened systems for monitoring and escalation.

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The Inquiry made 17 recommendations focused on safeguarding, mortality surveillance, data systems, neonatal safety and security, bereavement care, investigations, managerial accountability and regulatory oversight. Many of the recommendations link in with the urgent work currently being undertaken through the Maternity and Neonatal Care 10-Point Plan and must remain as a top priority for the NHS.

From an ICB safeguarding perspective, the Thirlwall Inquiry reinforces the need for immediate, confident escalation of any concern relating to potential deliberate harm, unexplained deterioration or patterns of clinical anomalies. Safeguarding processes must be triggered at the earliest point, with clear thresholds, multi-agency involvement and protection for staff raising concerns. The ICB must strengthen oversight of provider safeguarding arrangements, including culture indicators, Local Authority Designated Officer referrals, Sudden and Unexpected Death in Children compliance, training, and data-driven triggers for escalation. These elements should be incorporated into Cluster and Place governance to ensure safeguarding is fully embedded within maternity and neonatal safety assurance.

## 3. Assessment

The findings of the Inquiry have significant implications for maternity, neonatal and safeguarding services across the Cluster.

While the Thirlwall recommendations provide a clear direction of travel, national implementation requirements continue to evolve. NHS England issued a response to the Thirlwall Inquiry on 22 September 2026, setting out a number of immediate priorities for the Trusts and ICBs.

NHS England has requested that all Trust and ICB Boards review the Thirlwall Inquiry findings and seek assurance that robust safeguards, oversight arrangements and a culture of speaking up are in place. Immediate priorities include:

1. Reviewing the findings of the Thirlwall Inquiry and seeking assurance that effective systems, processes and organisational cultures are in place to prevent, identify and respond to patient safety concerns. This includes promoting a culture of professional curiosity where Board members and staff feel empowered, supported and confident to raise concerns, challenge decisions and escalate risks without fear.
2. Reinforcing application of the Sudden and Unexpected Death in Children (SUDIC) process for all sudden and unexpected deaths.
3. Strengthening bereavement care in line with the National Bereavement Care Pathway as set out in the NHS Medium Term Planning Framework (October 2025).

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4. Ensuring compliance with neonatal insulin storage and access requirements as set out in the GIRFT neonatology guide to safe insulin use.
5. Confirming that staff and Board members meet safeguarding training requirements and understand escalation pathways.

Local assurance activity, including provider self-assessment against NHS England's immediate actions, is being coordinated through the Neonatal Operational Delivery Network (ODN) to identify gaps, assess implementation risks, and support delivery across the Cluster. The Neonatal ODN will collate and provide feedback on provider self-assessments to the ICB Head of Quality for Maternity, Neonates and Children and Young People (CYP). The initial returns are due to be shared with the SW ODN and ICB by 1 December 2026.

Accountability for the ongoing monitoring and oversight of improvement actions between the ICB and NHS England is not yet clearly defined however the ICB Chief Nursing Officer and Chief Medical Officer are clear that oversight and assurance sits jointly with them.

Areas requiring continued oversight and assurance include organisational culture, safeguarding arrangements, workforce wellbeing, and the consistency of implementation of improvement actions across providers. Robust governance arrangements will be required to ensure identified risks are appropriately monitored, improvement actions are delivered, and assurance is maintained across the cluster.

**Deliverability**

The Cluster ICB is developing joint maternity and neonatal governance arrangements to oversee provider assurance, risk management and implementation of actions arising from the Thirlwall Inquiry and other maternity and neonatal improvement programmes. These arrangements will align with emerging NHS England and Neonatal Operational Delivery Networks' assurance processes, supporting a coordinated approach, reducing duplication and facilitating shared learning across the Cluster. Providers must demonstrate that their internal governance routes do not delay safeguarding referral or investigation. The ICB will require assurance that providers have clear thresholds, decision-making guidance and escalation pathways for concerns relating to staff behaviour, clinical anomalies or unexplained harm.

## 4. Recommendation

The Cluster Board is asked to:

- Discuss and note the implications of the Thirlwall Inquiry for maternity, neonatal and safeguarding services across the Cluster.

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- Receive assurance regarding actions being taken in response to NHS England's requirements and the ongoing identification any gaps identified through local assurance processes.
- Note that future implementation activity may require additional resources and investment, which will be brought forward through appropriate governance routes as national requirements and local priorities become clearer.

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# Committee Summary Report

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| **Reporting Forum** | In Common Audit Committee | **Meeting date** | 24 September 2026 |
| **Presented to:** | NHS BSW, NHS Dorset and NHS Somerset Cluster Board – 16 November 2026 | | |

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| **Business considered** | The In Common Audit Committee considered the following business:<br>• Information Governance and Data Group Terms of Reference<br>• Information Governance Update, Data Security and Protection Report<br>• Single Tender Waivers<br>• Internal Audit Reports for BSW, Dorset and Somerset<br>• External Audit Updates for BSW, Dorset and Somerset<br>• Counter Fraud/Anti-Crime Service Reports for BSW, Dorset and Somerset |
| **Decisions made** | The In Common Audit Committee approved / agreed / endorsed / supported:<br>• Agreed that the Information Governance and Data Group progress in shadow form and deferred the approval of the Terms of Reference until the cluster risk approach, which included information governance, had been clarified. |
| **Recommendations to the recipient** | • To note full discussion on progress towards a cluster risk management approach that preserved the responsibilities of the three statutory bodies and clarity on the respective roles of the Board, Committees, and executive management in risk oversight.<br>• To note the discussion on the inherited information governance, cyber security and technology position, and closure of compliance gaps (Dorset).<br>• To note the discussion under the Dorset Internal Audit Progress report on the approach to All Age Continuing Care audit work with the potential to consider cluster themes.<br>• To note the discussion under the External Audit Update on the requirement to keep the future external audit arrangements under review due to merger uncertainty. |
| **Escalations, for consideration and action** | None at this point in time |
| **Assurances** | The In Common Audit Committee assured itself, and assures the Cluster Board, that the ICBs / the cluster<br>• Assurance on the operation of the three statutory risk registers during the transition year with further work underway for the cluster position. |

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# Committee Summary Report

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| **Reporting Forum** | Joint Strategic Finance and Resources Committee | **Meeting date** | 26 October 2026 |
| **Presented to:** | NHS BSW, NHS Dorset and NHS Somerset Cluster Board – 16 November 2026 | | |

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| **Business considered** | The **Joint Strategic Finance and Resources Committee** considered the following business:<br>• Financial Report for the Cluster – Month 6<br>• Corporate Risk Register Q2<br>• All Age Continuing Care Update<br>• Collaborative Commissioning Hub M5 Finance Reports<br>• Procurement and Contracts Oversight Group Report<br>• Committee Forward Plan |
| **Decisions made** | The **Joint Strategic Finance and Resources Committee** approved / agreed / endorsed / supported:<br>• Approved previous meeting minutes.<br>• Noted financial, risk and commissioning reports.<br>• Closed completed actions.<br>• Agreed further assurance updates where required. |
| **Recommendations to the recipient** | • Improve reporting of key risks, assurances and matters requiring Board attention. |
| **Escalations, for consideration and action** | • Maintain oversight of procurement and contracting arrangements to support strategic commissioning and commissioning flexibility. |
| **Assurances** | The **Joint Strategic Finance and Resources Committe**e assured itself, and assures the Cluster Board, that the ICBs / the cluster<br>• Financial plan remains on track.<br>• Key financial and operational risks are being actively managed.<br>• All Age Continuing Care Update recovery actions and governance arrangements are in place.<br>• Specialised Commissioning remains forecast to break even.<br>• Procurement and governance arrangements provide effective oversight. |

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|---|---|---|---|
| **Report to:** | Cluster Board – Meeting in Public | **Agenda item** | 9.2.1 |
| **Date of Meeting:** | 16 November 2026 | | |

| | |
|---|---|
| **Title of Report:** | Cluster Finance Report – Month 6 2026/27 |
| **Report Author:** | Scott Sealey, Cluster Deputy Chief Officer Strategic Finance and Resources |
| **Board / Director Sponsor:** | Alison Henly, Cluster Chief Officer Strategic Finance and Resources |
| **Appendices:** | 1 – Cluster Finance Report |

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

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

| **Previous consideration by:** | **Date** | **Please clarify the purpose** |
|---|---|---|
| Joint Strategic Finance and Resources Committee | 26 October 2026 | Assurance |

## 1 Purpose of this paper

To present to the Cluster Board the Cluster Finance Report for Month 6, which includes the position for each of the three separate ICBs - NHS BSW, NHS Dorset and NHS Somerset.

## 2 Summary of recommendations and any additional actions required

The Cluster Board is asked to note for assurance purposes the month 6 financial position of the cluster and each of the three separate ICBs – NHS BSW, NHS Dorset and NHS Somerset.

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

| 4 | Procurement |
|---|---|
| No issues identified | |
| Procurement sign off | |

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

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

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

| 8 | Communications and Engagement Considerations |
|---|---|
| No issues identified | |

| 9 | Statement on confidentiality of report |
|---|---|
| No issues identified | |

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# Cluster Financial Position

Month 6 – September 2026

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




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# Cluster Financial Position – Month 6

Finance and Use of Resources

| Revenue Financial Position - Surplus/(Deficit) | Year to Date (M6) | | | 2026/27 | | | Monthly YTD Change | Net Risk Position | Monthly Risk Change |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £'m | Actual £'m | Variance £'m | Plan £'m | Forecast £'m | Variance £'m | £'m | £'m | £'m |
| NHS BSW ICB | 1,159.0 | 1,159.0 | 0.0 | 2,312.7 | 2,312.7 | 0.0 | 0.0 | (6.8) | 11.7 |
| NHS Dorset ICB | 1,072.1 | 1,072.1 | 0.0 | 2,144.2 | 2,144.2 | 0.0 | 0.0 | (14.8) | (3.7) |
| NHS Somerset ICB | 1,623.9 | 1,623.9 | 0.0 | 3,275.9 | 3,275.9 | 0.0 | 0.0 | (0.6) | 7.8 |
| **Cluster** | **3,854.9** | **3,854.9** | **0.0** | **7,732.7** | **7,732.7** | **0.0** | **0.0** | **(22.2)** | **15.8** |
| **Cluster NHS Providers - Variance** | **(52.0)** | **(88.1)** | **(36.1)** | **0.5** | **0.5** | **0.0** | **(14.1)** | | |

| Savings Programme | Year to Date (M6) | | | 2026/27 | | | Monthly YTD Change |
|---|---|---|---|---|---|---|---|
| | Plan £'m | Actual £'m | Variance £'m | Plan £'m | Forecast £'m | Variance £'m | £'m |
| Cluster | 101.7 | 97.9 | (3.8) | 207.4 | 207.4 | 0.0 | (0.9) |
| *Of which: Recurrent* | *84.9* | *84.1* | *(0.8)* | *173.7* | *173.7* | *0.0* | *0.1* |

**Summary**

- At Month 6, all cluster ICB's have a breakeven year-to-date position and are forecasting to deliver a balanced outturn position this financial year.
- Across the cluster there are year to date pressures highlighted against Continuing Care (£13.4m - net of LD), GP Prescribing driven by No Cheaper Stock Obtainable (NCSO) Price Concessions (£4.3m) and ADHD/ASD right to choose assessments (£4.9m).
- The latest reported net risk position is £22.2m – an improvement of £15.8m this month driven by additional savings mitigation included against Continuing Care (£10.9m) and a reduction in the ICB Cost of Change risk (£5.0m).
- There is a year-to-date shortfall of £3.8m included against the cluster Savings Programme at Month 6, however the total savings are forecasted in line with plan.
- NHS Providers within the cluster currently have an adverse year-to-date position of £36.1m driven by shortfalls in cost improvement programmes and operational pressures – this position is a further deterioration of £14.1m this month due to adverse in-month deterioration against Som FT (£6.6m), GWH (£4.0m) and RUH (£3.4m).

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# Cluster Workforce – Month 6

| Month | 6 |
|---|---|

| | M01 | M02 | M03 | M04 | M05 | M06 | 25/26 M12 | YTD M06 | Variance |
|---|---|---|---|---|---|---|---|---|---|
| Nurse | 179.7 | 170.0 | 167.0 | 164.2 | 155.8 | 136.1 | 187.2 | 136.1 | -51.1 |
| Admin | 777.2 | 666.9 | 669.3 | 647.5 | 619.7 | 556.8 | 804.8 | 556.8 | -248.0 |
| **Contracted WTE** | **956.9** | **836.9** | **836.3** | **811.7** | **775.4** | **692.8** | **992.0** | **692.8** | **-299.2** |
| | | | | | | | | | |
| Nurse | 172.4 | 164.6 | 163.0 | 156.8 | 139.9 | 133.8 | 179.3 | 133.8 | -45.5 |
| Admin | 738.5 | 653.5 | 656.3 | 626.8 | 562.7 | 538.4 | 789.3 | 538.4 | -250.9 |
| **Worked WTE** | **910.9** | **818.1** | **819.3** | **783.6** | **702.6** | **672.2** | **968.6** | **672.2** | **-296.4** |
| | | | | | | | | | |
| Agency | 22.1 | 22.1 | 23.1 | 23.1 | 28.6 | 15.6 | 22.1 | 15.6 | -6.5 |
| Secondments Out | -6.8 | -5.8 | -6.8 | -6.8 | -6.2 | -6.2 | -10.8 | -6.2 | 4.6 |
| Secondments In | 11.6 | 11.6 | 10.6 | 10.6 | 10.6 | 9.6 | 9.6 | 9.6 | 0.0 |
| **Total:** | **26.8** | **27.8** | **26.8** | **26.8** | **33.0** | **19.0** | **20.8** | **19.0** | **-1.9** |
| Total: | **937.7** | **846.0** | **846.2** | **810.4** | **735.6** | **691.2** | **989.4** | **691.2** | **-298.2** |

The consolidated workforce across the cluster stands at 691 WTE at Month 6. This is a reduction of 298 WTE this financial year.

M6 actual WTE number is 7 WTE above the forecasted WTE position.

| Cluster WTE Projection | M01 | M02 | M03 | M04 | M05 | M06 | M07 | M08 | M09 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | 937.7 | 846.0 | 846.2 | 810.4 | 733.5 | 684.5 | 674.3 | 671.2 | 668.1 | 634.0 | 634.0 | 634.0 |
| Actual | 937.7 | 846.0 | 846.2 | 810.4 | 735.6 | 691.2 | | | | | | |
| Variance | 0.0 | 0.0 | 0.0 | 0.0 | 2.1 | 6.7 | | | | | | |

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

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

# Cluster Risks and Mitigations – Month 6

The cluster has a deficit net risk position of £22.2m at Month 6. This position has improved by £15.8m this month.

This positive in-month movement is driven by:

- Reduction in Cost of Change risk by £5.0m with the cluster WTE continuing to reduce per projection.
- Total Prescribing risk has reduced by £2.2m and reflects the forecasted annual cost impact of the increase in NCSO and CatM drug prices. It should be noted that our forecast outturn position has increased to £9.2m this month.
- Further £10.9m of CHC mitigations have been included this month to align the forecasted savings from their recovery plan.
- An additional risk against ADHD/ASD right to choose assessments have been included this month. This is over and above the £8.2m pressure included within the cluster M6 position.

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| Risks and Mitigations 2026/27 | Cluster £'m | RAG | Monthly Change £'m |
|---|---|---|---|
| **Risks** | | | |
| NHS 111 & Out of Hours | (0.7) | R | 0.5 |
| Other Risk (Cost Risk, CSU, Weight Management) | (1.4) | R | 0.2 |
| Continuing Healthcare / PHC | (13.9) | A | 0.1 |
| Prescribing | (19.2) | A | 2.2 |
| ICB Cost of Change | (4.8) | A | 5.0 |
| Elective Care Programme | (4.2) | A | 1.5 |
| NHS Contract - UEC | (3.0) | A | 0.0 |
| Community Contract - HCRG | 0.0 | A | 2.5 |
| Winter | (0.6) | A | 0.0 |
| Home Office | (1.0) | A | 0.0 |
| ADHD Right to Choose | (3.6) | A | (3.6) |
| **Total Risks** | **(52.3)** | | **8.5** |
| **Mitigations** | | | |
| N/R Investment Reserve / Transformation Fund | 7.9 | G | (0.1) |
| Contingency | 5.1 | G | 0.0 |
| Partial mitigation of N/R transition stranded costs | 0.0 | G | (3.0) |
| Other Mitigations (Income, IAPs, Weight Management) | 1.0 | G | (2.5) |
| CHC/PHC eligibility and package reviews | 13.3 | A | 10.9 |
| Acute demand management programme | 2.7 | R | 2.0 |
| **Total Mitigations** | **30.0** | | **7.3** |
| **Net Risk Position** | **(22.2)** | | **15.8** |

# Committee Summary Report

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| **RReporting Forum** | Joint Population Health and Commissioning Committee | **Meeting date** | Wednesday 21st October 2026 |
| **Presented to:** | NHS BSW, NHS Dorset and NHS Somerset Cluster Board – 16 November 2026 | | |

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| **Business considered** | The **Joint Population Health and Commissioning Committee** considered the following business:<br>• SNP/MNP contract model development and consultation response.<br>• Procurement and Contract Group Exception Report.<br>• Place Highlight Reports from all six Places.<br>• Place Development Update and Place Vision.<br>• Performance and outcomes reporting.<br>• Quarterly Risk Report.<br>• Population Health Sub-Committee Terms of Reference. |
| **Decisions made** | The **Joint Population Health and Commissioning Committee** made the following decisions:<br>• Noted and endorsed the SNP/MNP consultation response and future.<br>• Noted the Procurement and Contract Group Exception Report.<br>• Agreed future Place reports should be more consistent and exception focused.<br>• Supported further development of Place operating models.<br>• Endorsed continued refinement of performance reporting.<br>• Approved the Population Health Sub-Committee Terms of Reference. |
| **Recommendations to the recipient of this report** | None at this time. |
| **Escalations, for consideration and action** | The **Joint Population Health and Commissioning Committee** noted the following escalations:<br>• Strategic decisions required on SNP/MNP contracting arrangements.<br>• Ongoing provider performance and activity risks.<br>• Capacity and prioritisation risks linked to retained ICB functions.<br>• Provider readiness to assume devolved responsibilities.<br>• Transition and organisational change risks. |
| **Assurances** | The **Joint Population Health and Commissioning Committee** assured itself that<br>• Progress continues with proposed neighbourhood based delivery models.<br>• Performance oversight and contract management processes are strengthening.<br>• Place based risks are being actively monitored and managed. |

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| | • Place development plans are under review to ensure deliverability.<br>• Performance and outcomes reporting is improving.<br>• Mortality and population health concerns are being monitored through established governance routes.<br>• Risks remain actively managed while a unified cluster risk framework is developed. |

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# Committee Summary Report

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| **Reporting Forum** | Joint Quality and Population Engagement Committee | **Meeting date** | 21 September 2026 |
| **Presented to:** | NHS BSW, NHS Dorset and NHS Somerset Cluster Board – 16 November 2026 | | |

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| **Business considered** | The Joint Quality and Population Engagement Committee considered the following business:<br>• Children and Adults Safeguarding Annual Reports for 2025-26<br>• Children Looked After Annual Reports for 2025-26<br>• Child Death Review Summary Report for 2025-26 – noting the full pan Dorset/Somerset and BSW reports would be brought to the December meeting<br>• Infection Prevention Management Annual Reports for 2025-26 |
| **Decisions made** | There were no items for decision at this meeting. |
| **Recommendations to the recipient** | There were no recommendations. |
| **Escalations, for consideration and action** | There were no escalations to the Board. |
| **Assurances** | The Joint Quality and Population Engagement Committee noted that all the annual reports listed above provided assurance that statutory duties had been met across 2025-26. Reports evidenced robust governance structures, designated professional leadership, compliance with mandatory reporting requirements and strong multi-agency partnership working. |

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# Committee Summary Report

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| **Reporting Forum** | Joint Quality and Population Engagement Committee | **Meeting date** | 29 October 2026 |
| **Presented to:** | NHS BSW, NHS Dorset and NHS Somerset Cluster Board – 16 November 2026 | | |

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| **Business considered** | The Joint Quality and Population Engagement Committee considered the following business:<br>• Corporate Risk Register – Q2 risks for Quality and Patient Safety<br>• Cluster Quality and Patient Safety Report<br>• Summary report from the System Quality Groups and escalations to the Regional Quality Group<br>• Patient and Population Insights report<br>• Thirlwall Inquiry : implications and required actions for cluster maternity and neonatal services<br>• Learning from Lives and Deaths Learning Disabilities and Autism backlog recovery plan<br>• Safeguarding Update<br>• Committee Forward Plan |
| **Decisions made** | There were no items for decision at this meeting. |
| **Recommendations to the recipient** | None at this time. |
| **Escalations, for consideration and action** | The patient and population insights themes report demonstrated the importance of triangulating population insights with data to both inform commissioning decision making, and measure impact and outcomes.<br><br>The findings and recommendations of the Thirlwall inquiry were presented and discussed with commitment to the actions required and support for further consideration at Board. |
| **Assurances** | The Joint Quality and Population Engagement Committee assured itself, and assures the Cluster Board that:<br>• Sustained improvements had been seen in a number of areas including the de-escalation of Somerset maternity services and paediatric services at Yeovil District Hospital from Intensive to Enhanced oversight, alongside the de-escalation of non-emergency patient transport from enhanced to routine surveillance. There would be continued monitoring to ensure improvements were sustained.<br>• Progress was being made in terms of recovery of the LeDeR notification backlog and the development of a consistent cluster-wide approach. |

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