NHS Somerset Integrated Care Board (ICB) Part A

Thu 26 March 2026, 09:30 - 13:00

MR1-3, Wynford House, Lufton Way, Lufton, Yeovil, BA22 8HR

If you are unable to attend, please notify Steph Lower (stephanie.lower@nhsdorset.nhs.uk)

Paul von der Heyde
Deputy Chair

Objectives:
1: Improve the health and wellbeing of the population
2: Reduce health and social inequalities
3: Provide the best care and support to children and adults
4: Strengthen care and support in local communities
5: Respond well to complex needs
6: Enable broader social and economic development
7: Enhance productivity and value for money

Agenda

09:30 - 09:55
25 min

1. INTRODUCTORY ITEMS

1.1. Welcome, Apologies for Absence and Public Questions

Verbal *Deputy Chair*

1.2. Register of Interests and Declarations of Interest relating to items on the agenda

Enclosure for noting *Deputy Chair*

- 01.2 Register of Members' Interests as at 17 March 2026.pdf (2 pages)
- 01.2 Declarations of Interest for ICB Board as at 17 March 2026.pdf (5 pages)

1.3. Minutes of the meeting held on 29 January 2026 and accompanying Action Schedule

Enclosure for approval *Deputy Chair*

- 01.3 Part A Minutes, Decision and Action Log 29 January 2026.pdf (2 pages)
- 01.3 x Part A draft Minutes of Meeting 29 January 2026 V1.pdf (11 pages)
- 01.3 xx Part A Decision and Action Log 290126.pdf (1 pages)

BUSINESS ITEMS

09:55 - 10:05
10 min

2. Deputy Chair's Introduction

Verbal *Deputy Chair*

10:05 - 10:20
15 min

3. ICB Cluster Chief Executive's Report

Enclosure for noting *Jonathan Higman, Cluster CEO*

- 03 CEO Somerset ICB Board Report 260326.pdf (13 pages)
- 03 x Appendix 1 January-February 2026 CE&M spotlight 260326.pdf (9 pages)

3.1. Emergency Planning, Resilience and Recovery Annual Report 2025

Enclosure for approval *Jade Renville, Director of Corporate Affairs/Accountable Emergency Officer (for the reporting period)*

03.1 EPRR Self Assessment Update Report Summary 2025 260326.pdf (6 pages)

10:20 - 10:25
5 min

4. Electronic Resolutions (Approved/Endorsed since the last Board meeting)

Verbal *Deputy Chair*

- Approval of Constitution changes relating to ICB executive restructure (via e-mail)

10:25 - 10:40
15 min

5. NHS Somerset Medium Term Plan Overview 2026/27 – 2028/29: Final Submission and Board Assurance Statement

Enclosure for approval *Alison Henly, Chief Officer Strategic Finance and Resources*

05 Final Medium Term Plan Overview 202627 202829 submission v2 Part A 260326.pdf (20 pages)
05 x ICB Board Assurance Statement 260326.pdf (43 pages)

10:40 - 10:50
10 min

Break

STRATEGIC FOCUS

10:50 - 11:25
35 min

6. Stroke Reconfiguration

Enclosure for discussion *David McClay, Place Director, Somerset*

06 Stroke Reconfiguration Update 260326 v6F 260326.pdf (3 pages)

11:25 - 11:45
20 min

7. Director of Public Health Annual Report - The Miracle Cure; Get Somerset Moving

Enclosure for discussion *Alison Bell, Director of Public Health*

Objectives: 1, 2, 4, 6 and 7

07 Director of Public Health Annual Report 2025 260326.pdf (3 pages)
07 x Appendix 1 Director of Public Health Report 260326.pdf (20 pages)

DECISION ITEMS

11:45 - 12:10
25 min

8. Cluster Governance Arrangements

8.1. Board, Cluster Board and Cluster Committee Structure

Enclosure for approval *Deputy Chair*

08.1 Board, Cluster Board and Governance Structure 260326.pdf (10 pages)

8.2. Joint Remuneration Committee Terms of Reference

Enclosure for approval *Christopher Foster, Remuneration Committee Chair*

08.2 Joint Rem Comm Terms of Reference 260326.pdf (3 pages)
08.2 x Appendix 1 Joint Rem Com ToR 120326.pdf (9 pages)

GOVERNANCE, PERFORMANCE AND ASSURANCE ITEMS

12:10 - 12:30
20 min

9. ICB Priority Programme Report and Board Assurance Framework 2025-26 - Quarter 4

Enclosure for discussion *Alison Henly/David McClay/Jade Renville*

Linked to the following System Group Reports:

- Collaboration Forum - (Jonathan Higman) - no meeting since the last Board
- Population Health Transformation Board - (Bernie Marden) - no meeting since the last Board
- People Board - (Christopher Foster) - no meeting since the last Board

09 ICB Priority Programme Report and Board Assurance Framework 2025-26 - Quarter 4 report 260326.pdf (6 pages)
09 ICB Priority Programme Report and Board Assurance Framework Q4 25-26 v3 final 260326.pdf (19 pages)

12:30 - 12:50
20 min

10. Integrated Board Assurance Dashboard and Exception Report from the System Assurance Forum

Enclosures for assurance *Alison Henly, Chief Officer Strategic Finance and Resources*

Linked to the following ICB Assurance Committee Reports:

- Quality (Caroline Gamlin) - enclosed
- Finance (Christopher Foster) - enclosed
- System Assurance Forum (Alison Henly) - enclosed

10 Exception Report Quadrant_January_26.pdf (22 pages)
10 x Quality Committee Chair report 260326.pdf (4 pages)
10 x Finance Committee Chair Report 260326.pdf (2 pages)
10 x System Assurance Forum Chair Report 260326.pdf (2 pages)

12:50 - 12:55
5 min

11. Other Key meeting Reports:

Enclosures for assurance *Committee Chairs*

ICB Assurance Committee Reports:

- Audit (Grahame Paine) - verbal update as meeting held 19 March 2026
- Strategic Commissioning (Suresh Ariaratnam) - no meeting since the last Board

System Group Reports:

- Somerset Board (David McClay) - no meeting since last Board
- Children, Young People and Families (Shelagh Meldrum) - enclosed

11 Key Meeting Reports 26 March 2026.pdf (2 pages)
11 CYP & Families Partnership Board - report to Board - Mar26.pdf (2 pages)

12:55 - 13:00
5 min

12. CLOSING ITEMS

12.1. Any Other Business

Verbal *Deputy Chair*

12.2. Items to be discussed at the confidential meeting:

- Minutes of the confidential meeting held on 29 January 2026 and 10 February 2026
- Chief Executive's Part B update
- Electronic Resolutions (Approved/Endorsed since the last Board meeting)
- Somerset Health and Care Academy - Heads of Term delegation
- Budgets and Programmes 2026-27
- Transition Update
- Place-based governance arrangements for Somerset

12.3. Withdrawal of the press and public:

To resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public

interest.

12.4. Close and Date of Next Meeting:

- Thursday 28 May 2026 (to be confirmed pending new cluster governance arrgts)

REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: 01.2
DATE OF MEETING:	26 March 2026	
REPORT TITLE:	Register of Members’ Interests	
REPORT AUTHOR:	Steph Lower, NHS Dorset Deputy Head of Corporate Governance	
EXECUTIVE SPONSOR:	-	
PRESENTED BY:	Paul von der Heyde, Chair	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☒
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☐ Objective 1: Improve the health and wellbeing of the population
- ☐ Objective 2: Reduce inequalities
- ☐ Objective 3: Provide the best care and support to children and adults
- ☐ Objective 4: Strengthen care and support in local communities
- ☐ Objective 5: Respond well to complex needs
- ☐ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

N/A

REPORT TO COMMITTEE / BOARD

Where a member of the NHS Somerset Integrated Care Board (ICB Board) has an Interest, or becomes aware of an Interest, which could lead to a conflict of interests in the event of the Board considering an action or decision in relation to that Interest, the Interest must be considered as a potential conflict and must be declared.

The Register of Members’ Interests is part of the mechanism through which the NHS Somerset ICB Board will ensure the integrity of their decision-making processes.

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Board members are also required to orally declare at each meeting specific Interests in respect of items on the agenda.

The Register as presented reflects the position as at 17 March 2026.

The Board is asked to **Note** the Register of Members Interests and to make any further declarations where appropriate.

Board members are reminded that any new or relinquished Interest should be advised to the Board, and updated on the electronic database, within 28 days of becoming known.

Board members should also update the electronic database on a regular basis (every three months or sooner) ensuring that the date of last sign-off is appropriately recorded.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	An open and transparent approach to identifying and disclosing potential conflicts of interest supports a culture that promotes and encourages equality and fairness in the conduct of all NHS Somerset ICB Board business.
Quality	N/A
Safeguarding	N/A
Financial/Resource/ Value for Money	N/A
Sustainability	N/A
Governance/Legal/ Privacy	The ICB is required to demonstrate that appropriate arrangements are in place to declare and manage all potential conflicts of interest.
Confidentiality	N/A
Risk Description	Failure to ensure disclosure of Members' Interests would potentially lead to a challenge of decisions made by the NHS Somerset ICB

REGISTER OF INTERESTS

ICB Board as at 17 March 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Provider Description	Date Arose	Date Ended	Date Updated	Decision Making Groups
Suresh	Ariaratnam	ICB Non Exec Director	Non-Financial Professional	Advisory Council Member	British Library	National library of the UK	01/12/2022			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Non-Financial Professional	Trustee	Literature Works South West	Charitable arts organisation	08/02/2021			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Financial	Non-Executive Director Member, Transformation Committee Member, Mental Health Legislation Assurance Committee	NHS Dorset HealthCare University	Providing integrated healthcare services	01/09/2022			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Financial	Beneficiary owner	Sprung Sultan	Literary and talent agency	01/07/2007			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Non-Financial Professional	Trustee	The Trussell Trust	A Non-Governmental Organisation (NGO) and charity that works to end the need for food banks in the UK	30/05/2023			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Non-Financial Professional	Trustee	Theatre Royal Bath	A charitable arts organisation	20/05/2019			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Non-Financial Professional	Deputy Lieutenant	Somerset Lieutenancy	Community engagement	02/04/2024			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Suresh	Ariaratnam	ICB Non Exec Director	Non-Financial Professional	Director	Norland College	Educational	01/09/2024			ICB Board,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Somerset People Board,Strategic Commissioning Committee
Alison	Bell	Director of Public Health	Non-Financial Professional	Director of Public Health	Somerset Council	Unitary authority which governs the district of Somerset	01/01/2025			Primary Care Commissioning Committee,Somerset System Quality Group,Primary Care Operational Group,ICB Board,Strategic Commissioning Committee
Alison	Bell	Director of Public Health	Indirect	My spouse is employed in a national emergency planning role for UKHSA	UKHSA	UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases, and environmental hazards, to keep all our communities safe. This is an arms length body of HMG	16/01/2025			Primary Care Commissioning Committee,Somerset System Quality Group,Primary Care Operational Group,ICB Board,Strategic Commissioning Committee
Charlotte	Callen	Exec Director of Communications Engagement and Marketing	Indirect	Charles Callen (Brother) is a GP	Cranleigh Gardens Medical Centre, Bridgwater	GP Practice	05/09/2022			ICB Board,Management Board,Population Health Transformation Board
Rebecca	Duffy	Primary Care Partner Member	Non-Financial Professional	I am currently employed as a sessional GP at Mendip Country Practice. I was the Senior Partner until stepping down from partnership at the end of November 2025.	Mendip Country Practice	Provide primary medical care under General Medical Services contract.	01/01/2010			ICB Board
Rebecca	Duffy	Primary Care Partner Member	Financial	I work as a GP Appraiser for the NHSE South West Appraisal Team conducting annual NHS appraisals for GPs working in the region.	NHS England – South West Appraisal Team	Manage NHS appraisals for doctors, directly linked to doctors revalidation with the GMC.	01/09/2018			ICB Board
Rebecca	Duffy	Primary Care Partner Member	Financial	I am a Non-Executive Director for the Somerset GP Support Unit.	GPSU	Company owned by all of general practice in Somerset who provide support services to support the delivery of patient care across Somerset.	01/05/2025			ICB Board
Rebecca	Duffy	Primary Care Partner Member	Financial	I work for Severn PGME School of Primary Care as a medical educator. I have been a GP Trainer since 2009, I facilitate on various 'train the trainer' courses for GP and multiprofessional educational and clinical supervisors, and deliver additional tutorials to GPs in training and their trainers to support the development of communication skills where this is required.	Severn PGME School of Primary Care	Post graduate medical education, training GPs and their trainers.	01/11/2018			ICB Board
Rebecca	Duffy	Primary Care Partner Member	Non-Financial Professional	I am the Treasurer of the Clinical Socirty of Bath, a medical education charity linked to the Royal United Hospitals Bath.	Clinical Society of Bath	Supporting medical education for doctors and dentists in and around Bath.	01/11/2019			ICB Board

REGISTER OF INTERESTS

ICB Board as at 17 March 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Provider Description	Date Arose	Date Ended	Date Updated	Decision Making Groups
Christopher	Foster	ICB Non Exec Director	Non-Financial Personal	Chair	Churches Funeral Services Trust (also known as Churches Funerals Group)	An advisory group to co-ordinate policy in connection with the pastoral and administrative aspects of funeral services at cemeteries and crematoria	01/04/2022			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Christopher	Foster	ICB Non Exec Director	Non-Financial Personal	Council Member (Director and Trustee)	The Cremation Society of Great Britain	A registered charity	09/08/2022			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Christopher	Foster	ICB Non Exec Director	Non-Financial Professional	Non-Executive Director and Trustee	Royal Hospital for Neurodisability	The RHN is experienced in working with people with a range of neurological conditions and brain injury	01/04/2022			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Christopher	Foster	ICB Non Exec Director	Indirect	Spouse is Parish Councillor	Nunney Parish Council	A local authority that makes decisions on behalf of the people in the parish and has an overall responsibility for the well-being of its local community	05/09/2022			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Christopher	Foster	ICB Non Exec Director	Non-Financial Personal	Treasurer and Committee Member	Nunney Community Association	Set up to raise money for the benefit of the inhabitants of Nunney	13/03/2022			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Christopher	Foster	ICB Non Exec Director	Indirect	Spouse is a member of the Somerset Council Standards Committee.	Somerset Council	Maintenance of standards in service of elected Councillors in local government.	03/06/2024			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Christopher	Foster	ICB Non Exec Director	Indirect	Spouse is Chair of Trustee of Open Story Tellers, based in Frome Somerset.	Spouse	A charity offering a day care service to people with a learning disability, so that everyone finds a voice to tell their story.	09/12/2024			ICB Board,Audit Committee,Finance Committee,Primary Care Commissioning Committee,Remuneration Committee,Somerset People Board,Quality Committee
Caroline	Gamlin	ICB Non Exec Director	Non-Financial Personal	Member	Deafinate Matters CIC	Supporting those with hearing loss and/or communication difficulties living in Somerset	01/09/2021		04/06/2024	ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Caroline	Gamlin	ICB Non Exec Director	Non-Financial Professional	Member of ICB Audit Committee	NHS Somerset ICB Audit Committee	Responsible for commissioning health and care services and bringing organisations together to work as one integrated care system (ICS), for Somerset	01/07/2022		04/06/2024	ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Caroline	Gamlin	ICB Non Exec Director	Financial	Paid through a contract for services for Responsible Officer appraisals, up to 6 a year	NHS England	Leading the NHS in England to deliver high quality services for all	01/09/2021		04/06/2024	ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Caroline	Gamlin	ICB Non Exec Director	Non-Financial Personal	Volunteer	PromiseWorks	Local charity providing Mentors for young people in Somerset	01/06/2021		04/06/2024	ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Caroline	Gamlin	ICB Non Exec Director	Financial	Company holds a small parcel of agricultural land, 1.7 acres	Director of Rhyneside Ltd	land management	01/04/2024		04/06/2024	ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Caroline	Gamlin	ICB Non Exec Director	Non-Financial Professional	Appointed Governor representing NHS Somerset ICB	Somerset Foundation Trust	Provider of NHS services in Somerset	01/04/2023		04/06/2024	ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee

REGISTER OF INTERESTS

ICB Board as at 17 March 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Provider Description	Date Arose	Date Ended	Date Updated	Decision Making Groups
Caroline	Gamlin	ICB Non Exec Director	Indirect	Husband is a Director	Pier Health, Weston Super Mare, North Somerset	Designed to deliver the very best in primary care for the patient population across Weston-Super-Mare, Worle and local villages in North Somerset	07/07/2025			ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Caroline	Gamlin	ICB Non Exec Director	Non-Financial Professional	Non Executive Director	SW specialised services commissioning committee	Overseeing the commissioning of specialised services on behalf of the SW ICBs	02/06/2024			ICB Board,Audit Committee,Primary Care Commissioning Committee,Quality Committee,Remuneration Committee,Strategic Commissioning Committee
Judith	Goodchild	ICB Board - Healthwatch (Participant)	Non-Financial Professional	Public Governor	Somerset NHS Foundation Trust	To deliver joined up community, mental health and acute hospital care	31/05/2011		05/03/2025	ICB Board,Primary Care Commissioning Committee
Judith	Goodchild	ICB Board - Healthwatch (Participant)	Non-Financial Professional	Chair (Date Commenced: TBC)	Healthwatch Somerset	Local health and social care champion	01/04/2023		05/03/2025	ICB Board,Primary Care Commissioning Committee
Alison	Henly	CFO and Director of Performance and Contracting	Non-Financial Professional	Interim CFO for NHS Dorset ICB	NHS Dorset ICB	NHS Dorset ICB	08/04/2025			ICB Board,Audit Committee,Finance Committee,Management Board,Primary Care Commissioning Committee,Somerset Assurance Forum (SAF),Population Health Transformation Board,Collaboration Forum,Strategic Commissioning Committee
Alison	Henly	CFO and Director of Performance and Contracting	Non-Financial Professional	Cluster Chief Officer Strategic Finance and Resources NHS Bath and North East Somerset, Swindon and Wiltshire ICB NHS Somerset ICB NHS Dorset ICB	Cluster	ICB	01/01/2026			ICB Board,Audit Committee,Finance Committee,Management Board,Primary Care Commissioning Committee,Somerset Assurance Forum (SAF),Population Health Transformation Board,Collaboration Forum,Strategic Commissioning Committee
Jonathan	Higman	Chief Executive	Non-Financial Professional	Partner Member	Health Innovation South West	To help transform the way our health and care systems in the South West identify, adopt and spread innovation to transform lives, improve population health, and drive economic growth	23/03/2022		02/04/2025	ICB Board,Finance Committee,Management Board,Somerset People Board,Remuneration Committee,Somerset Assurance Forum (SAF),Collaboration Forum,Quality Committee
Jonathan	Higman	Chief Executive	Non-Financial Professional	Somerset ICB Representative	NIHR ARC South West Peninsula (PenARC) Management Board	To improve lives and the quality of health and social care in South West England through applied research	01/04/2022	25/09/2025	02/04/2025	ICB Board,Finance Committee,Management Board,Somerset People Board,Remuneration Committee,Somerset Assurance Forum (SAF),Collaboration Forum,Quality Committee
Peter	Lewis	ICB Board - Trust Partner Member	Non-Financial Professional	Chief Executive of Somerset NHS Foundation Trust	Somerset NHS Foundation Trust	To deliver joined up community, mental health and acute hospital care	01/07/2022			ICB Board,Somerset People Board,Somerset Assurance Forum (SAF),Collaboration Forum
Peter	Lewis	ICB Board - Trust Partner Member	Non-Financial Professional	Director and Management Board Member	Yeovil Strategic Estates Partnership Project Company	TBC	01/07/2022			ICB Board,Somerset People Board,Somerset Assurance Forum (SAF),Collaboration Forum
Bernard	Marden	Chief Medical Officer - Somerset ICB	Non-Financial Professional	Associate Member (non-voting) of Board	Sulis Hospital Bath (Wholly owned subsidiary of RUH Bath NHS Foundation Trust)	Helping people get better, faster with state-of-the-art hospital treatments, innovative rehabilitation and other healthcare services	01/09/2022		15/04/2025	ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Information Governance Records Management and Caldicott Committee (IGRMCC),Somerset Assurance Forum (SAF),Somerset System Quality Group,Population Health Transformation Board,Collaboration Forum,Primary Care Operational Group,Strategic Commissioning Committee,Contract Oversight Group (COG)
Bernard	Marden	Chief Medical Officer - Somerset ICB	Indirect	Brother is Consultant Gastroenterologist and Clinical Lead	RUH Bath NHS Foundation Trust	Major acute-care hospital in the Weston suburb of Bath, England	01/09/2022		15/04/2025	ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Information Governance Records Management and Caldicott Committee (IGRMCC),Somerset Assurance Forum (SAF),Somerset System Quality Group,Population Health Transformation Board,Collaboration Forum,Primary Care Operational Group,Strategic Commissioning Committee,Contract Oversight Group (COG)

REGISTER OF INTERESTS

ICB Board as at 17 March 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Provider Description	Date Arose	Date Ended	Date Updated	Decision Making Groups
Bernard	Marden	Chief Medical Officer - Somerset ICB	Non-Financial Professional	Chair	South West Paediatric Critical Care Operational Delivery Network	One of ten Paediatric Critical Care Operational Delivery Networks in England	01/09/2022		15/04/2025	ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Information Governance Records Management and Caldicott Committee (IGRMCC),Somerset Assurance Forum (SAF),Somerset System Quality Group,Population Health Transformation Board,Collaboration Forum,Primary Care Operational Group,Strategic Commissioning Committee,Contract Oversight Group (COG)
Bernard	Marden	Chief Medical Officer - Somerset ICB	Non-Financial Professional	Member	NHSE South West Digital Transformation Portfolio Board	TBC	01/04/2023		15/04/2025	ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Information Governance Records Management and Caldicott Committee (IGRMCC),Somerset Assurance Forum (SAF),Somerset System Quality Group,Population Health Transformation Board,Collaboration Forum,Primary Care Operational Group,Strategic Commissioning Committee,Contract Oversight Group (COG)
Bernard	Marden	Chief Medical Officer - Somerset ICB	Indirect	Wife is directly employed by the organisers of Glastonbury Festival	Glastonbury Festivals	The largest greenfield music and performing arts festival in the world	01/09/2022		15/04/2025	ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Information Governance Records Management and Caldicott Committee (IGRMCC),Somerset Assurance Forum (SAF),Somerset System Quality Group,Population Health Transformation Board,Collaboration Forum,Primary Care Operational Group,Strategic Commissioning Committee,Contract Oversight Group (COG)
Bernard	Marden	Chief Medical Officer - Somerset ICB	Non-Financial Professional	Somerset ICB Representative	NIHR ARC South West Peninsula (PenARC) Management Board	To improve lives and the quality of health and social care in South West England through applied research	26/09/2025			ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Information Governance Records Management and Caldicott Committee (IGRMCC),Somerset Assurance Forum (SAF),Somerset System Quality Group,Population Health Transformation Board,Collaboration Forum,Primary Care Operational Group,Strategic Commissioning Committee,Contract Oversight Group (COG)
David	McClay	Chief Officer for Strategy Digital and Integration	Indirect	Wife is a Teacher	The Blue School, Wells	A coeducational, secondary school located in Wells, Somerset	17/05/2023		13/03/2025	ICB Board,Management Board,Somerset People Board,Somerset Assurance Forum (SAF),Population Health Transformation Board,Collaboration Forum,Information Governance Records Management and Caldicott Committee (IGRMCC),Strategic Commissioning Committee,ICS Digital Board
Shelagh	Meldrum	Chief Nursing Officer	Non-Financial Professional	Specialist Advisory for the CQC Integrated Care System inspection team	CQC	The independent regulator of health and social care in England	20/10/2023		09/05/2024	ICB Board,Finance Committee,Management Board,Primary Care Commissioning Committee,Quality Committee,Somerset Assurance Forum (SAF),Somerset System Quality Group,Collaboration Forum,LMNS Programme Board,Strategic Commissioning Committee,Contract Oversight Group (COG)
Katherine	Nolan	ICB Board - SPARK Somerset, VCSE sector (Participant)	Non-Financial Professional	Chief Executive (Date Commenced: TBC)	SPARK Somerset	Providing information, advice, training and support to the voluntary and community sector in Somerset	01/04/2023			ICB Board,Somerset People Board,Collaboration Forum
Grahame	Paine	ICB Non Exec Director	Non-Financial Professional	Chair of Trustee Board	SPARK Somerset	To provide information, advice, training and support to the voluntary and community sector in Somerset	10/03/2022		04/06/2024	ICB Board,Audit Committee,Finance Committee,Quality Committee,Remuneration Committee,Somerset Assurance Forum (SAF)
Grahame	Paine	ICB Non Exec Director	Non-Financial Professional	Trustee	Festival Medical Services	FMS is a 'not for profit' registered charity staffed by volunteers, delivering professional medical services at events throughout the country	26/03/2022		04/06/2024	ICB Board,Audit Committee,Finance Committee,Quality Committee,Remuneration Committee,Somerset Assurance Forum (SAF)

All Interests have been declared in line with the Conflicts of Interest Policy

REGISTER OF INTERESTS

ICB Board as at 17 March 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Provider Description	Date Arose	Date Ended	Date Updated	Decision Making Groups
Grahame	Paine	ICB Non Exec Director	Non-Financial Professional	Chair of Trustee Board	Amica Care Trust	Amica Care Trust provide nursing, dementia, residential care and companionship, as well as day care and respite care.	30/09/2025			ICB Board,Audit Committee,Finance Committee,Quality Committee,Remuneration Committee,Somerset Assurance Forum (SAF)
Jade	Renville	Executive Director of Corporate Affairs	Non-Financial Personal	Director (Chair of Trust from January 2023)	Richard Huish Multi-Academy Trust (Voluntary Capacity)	An independent charitable organisation originally established by Richard Huish College to support local schools	01/09/2019		02/04/2025	ICB Board,Information Governance Records Management and Caldicott Committee (IGRMCC),Management Board,Collaboration Forum
Jade	Renville	Executive Director of Corporate Affairs	Indirect	Father is Director and Owner	Renvilles Costs Lawyers	Providers of legal costs services in the region	01/08/2003		02/04/2025	ICB Board,Information Governance Records Management and Caldicott Committee (IGRMCC),Management Board,Collaboration Forum
Jade	Renville	Executive Director of Corporate Affairs	Non-Financial Professional	I am Joint Director of Corporate Affairs/Services across Somerset NHS Foundation Trust as well as Somerset ICB	Somerset NHS Foundation Trust	NHS Provider	06/07/2024		02/04/2025	ICB Board,Information Governance Records Management and Caldicott Committee (IGRMCC),Management Board,Collaboration Forum
Duncan	Sharkey	ICB Board - Local Authority Partner Member	Non-Financial Professional	Chief Executive	Somerset Council	Unitary authority which governs the district of Somerset	03/10/2022		18/02/2025	ICB Board,Somerset People Board,Somerset Assurance Forum (SAF),Collaboration Forum
Paul	Von Der Heyde	Chair Somerset ICB	Non-Financial Professional	Chairman of Board	PAPAA Enterprises Limited	The virtually dormant trading subsidiary of Psoriasis and Psoriatic Arthritis Alliance	01/11/2021		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Non-Financial Professional	Chairman of Board of Trustees	Psoriasis and Psoriatic Arthritis Alliance	A National charity focused on advice to those suffering from the condition	01/11/2021		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Non-Financial Professional	Chairman of Trustees	Worshipful Company of Furniture Makers Charitable Fund	A charity supporting those employed or who have been employed in the furniture and furnishing industry and their connections providing grants and donations to cover welfare, education or excellence needs	01/11/2021		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Financial	Director and shareholder	Herswell Coaching and Consulting Limited	A management consulting and behavioural advice business	01/11/2021		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Indirect	My wife is a fundraiser. I have no direct relationship with the Centre and am not engaged in the fundraising or other activities.	Conquest Centre	A disabled riding enterprise based in Norton Fitzwarren	01/11/2021		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Non-Financial Professional	South West Social Mobility Commissioner	South West Social Mobility Commission	A commission established with the support of Exeter University and chaired by its Chancellor, Sir Michael Barber, to understand and improve the social mobility within the population of the South West of England	01/01/2023		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Financial	Trustee and Adviser	Howlands Furniture Limited Group	A fine office furniture manufacturer, classic residence furniture and property letting group based in High Wycombe	01/11/2021		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Non-Financial Professional	Chair	NHS South West Region People Board	NHS	27/03/2024		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Financial	Director of the Company	A&F Howland (Wycombe) Limited	operates in the high quality meeting room and executive furniture market trading as William Hands	01/10/2024		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Financial	I have become a non executive director of this British furniture maker.	Burbdige & Son Limited	Design and manufacture of fitted kitchen and bathroom furniture	01/01/2025		06/05/2025	ICB Board,Finance Committee,Remuneration Committee,Quality Committee
Paul	Von Der Heyde	Chair Somerset ICB	Financial	Appointed Director of the Company in a non-executive capacity	Howlands (Furniture) Limited	This is the holding company for a group which carries out both high quality and value office furniture and property management based in High Wycombe.	03/12/2025			ICB Board,Finance Committee,Remuneration Committee,Quality Committee

All Interests have been declared in line with the Conflicts of Interest Policy

REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **01.3**
DATE OF MEETING:	**26 March 2026**	
REPORT TITLE:	**Minutes of the ICB Board Meeting held on 29 January 2026 and accompanying Action Schedule**	
REPORT AUTHOR:	**Steph Lower, NHS Dorset ICB Deputy Head of Corporate Governance**	
EXECUTIVE SPONSOR:	**Jonathan Higman, Cluster Chief Executive**	
PRESENTED BY:	**Paul von der Heyde, Chair**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☒
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☒ Objective 5: Respond well to complex needs
- ☒ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

N/A

REPORT TO COMMITTEE / BOARD

The Minutes are a record of the meeting held on 29 January 2026. They are presented to the ICB Board, together with the accompanying Action Schedule, and are published in the public domain through the NHS Somerset website, to provide clarity and transparency about the discussions and decisions made, and to ensure the principles of good governance are upheld.

The NHS Somerset ICB Board is asked to **Approve** the Minutes of the meeting and accompanying Action Schedule and to confirm that the Chairman may sign the Minutes as a true and correct record.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	N/A
Quality	N/A
Safeguarding	N/A
Financial/Resource/ Value for Money	N/A
Sustainability	N/A
Governance/Legal/ Privacy	The Minutes are the formal record of the meeting and are presented together with the accompanying Action Schedule.
Confidentiality	N/A
Risk Description	N/A

Minutes of the **Meeting of NHS Somerset Integrated Care Board (ICB)** held at **Wynford House, Lufton Way, Yeovil** on **Thursday 29 January 2026**

Present:	Paul von der Heyde	Deputy Chair
	Dr Rebecca Duffy	Primary Care Partner Member
	Dr Caroline Gamlin	Non-Executive Director and Deputy Chair (Chair of Quality Committee)
	Alison Henly	Cluster Chief Strategic Finance and Resources/Chief Finance Officer and Director of Performance and Contracting
	Jonathan Higman	Cluster Chief Executive
	Peter Lewis	Chief Executive, Somerset NHS Foundation Trust (Trust Partner Member)
	Dr Bernie Marden	Cluster Chief Medical Officer/Chief Medical Officer
	Shelagh Meldrum	Cluster Chief Nursing Officer/Chief Nursing Officer and Director of Operations
	Grahame Paine	Non-Executive Director (Chair of Audit Committee)
	Duncan Sharkey (virtual)	Chief Executive, Somerset Council (Partner Member)
Apologies:	Suresh Ariaratnam	Non-Executive Director (Chair of Primary Care Commissioning Committee)
	David Freeman	Cluster Chief Officer for Commissioning and Place
	Rob Whiteman	Chair, NHS Bath & North East Somerset, Swindon and Wiltshire (BSW) ICB; NHS Dorset ICB; NHS Somerset ICB
	Christopher Foster	Non-Executive Director (Chair of Finance Committee, Remuneration Committee and Somerset People Board)
In Attendance:	Graham Atkins	Chief People Officer (Participant)
	Alison Bell (virtual)	Director of Public Health (Participant)
	Charlotte Callen	Executive Director of Communications, Engagement and Marketing (Participant)
	Alex Cameron (for item ICB 10/26)	Associate Director of Communications, Engagement and Marketing
	Carmen Chadwick-Cox (for item ICB 11/26)	Deputy Director of Strategic Commissioning
	Judith Goodchild	Healthwatch (Participant)
	Hester McLain	Director of System Coordination, NHS England South West
	David McClay	Cluster Place Director, Somerset/Chief Officer for Strategy, Digital and Integration (Participant)
	Gordon Muvuti (virtual)	Cluster Place Director Swindon
	Katherine Nolan	SPARK Somerset, VCSE sector (Participant)
	Jade Renville (part)	Executive Director of Corporate Services and Affairs, NHS Somerset and Somerset NHS Foundation Trust (Participant)
	Dean Spencer	Cluster Place Director, Dorset
	Kate Smith (for item ICB 12/26)	Associate Director of Strategic Programmes
	Kat Tottle (for item ICB 10/26)	Engagement and Insights Lead Officer
	Teri Underwood (for item ICB 09/26)	Armed Forces Programme Lead
	Amanda Webb (virtual)	Cluster Chief Officer for Population Health Improvement
Secretariat:	Steph Lower	NHS Dorset ICB Deputy Head of Corporate Governance (minutes)

ICB 01/26 WELCOME AND APOLOGIES FOR ABSENCE

The Deputy Chair welcomed everyone to the meeting. Apologies were noted as above and the quoracy of the meeting was confirmed.

ICB 02/26 PUBLIC QUESTIONS (PLEASE SEE APPENDIX 1)

The Deputy Chair shared that nine public questions had been received regarding the planned stroke service changes. As communicated to those who had submitted questions, he explained responses would not be provided during the meeting as the information sought was already detailed in the decision-making case and appendices.

A member of the public expressed disappointment at the lack of immediate answers and highlighted the ongoing concerns and questions that required answers.

The Deputy Chair acknowledged the concerns raised and reiterated the Board's commitment to continued engagement. A dedicated meeting would be held with individuals to address the further issues raised. The questions would be published in the Part A minutes for public transparency.

Members of the public left the meeting.

ICB 03/36 REGISTER OF MEMBERS' INTERESTS

The ICB Board received and noted the register of members' interests, which reflected the position as at 13 January 2026. The following amendments were requested:

- Rebecca Duffy – update 'senior partner at Mendip Country Practice' to 'employed as a salaried GP'.
- Shelagh Meldrum – update job title to Chief Nursing Officer

Action : Corporate Governance

ICB 04/26 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

There were no declarations of interest relating to items on the agenda.

ICB 05/26 MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2025 AND ACCOMPANYING ACTION SCHEDULE

The minutes of the meeting held on 27 November 2025 were **approved** as a true and accurate record subject to the following:

- Amend the minutes to show Katherine Nolan as in attendance.

Action : Corporate Governance

The action schedule was reviewed and all actions were complete.

Resolved: The Board **approved** the minutes of the meeting held on 27 November 2025 and **noted** the accompanying action schedule.

ICB 06/26 DEPUTY CHAIR'S INTRODUCTION

The Deputy Chair gave some introductory remarks which included the following:

- Recognition of the continued efforts and focus of colleagues.
- The continued importance of collaborative working.
- The positive Somerset Board workshop held recently where thoughts and opportunities were shared regarding developing neighbourhood working.
- Congratulations were given to those individuals appointed into the key cluster* leadership roles along with recognition of the ongoing change process which would affect colleagues across the organisations.

Resolved: The Board **noted** the Deputy Chair's Introduction.

* *Somerset ICB is coming together as a cluster with Bath and North East Somerset, Swindon and Wiltshire (BSW) and Dorset ICBs.*

ICB 07/26 CLUSTER CHIEF EXECUTIVE'S REPORT

The Board received and noted the Cluster Chief Executive's report.

Key points included:

- Despite a challenging backdrop, including the resident doctors' industrial action and flooding incidents, the winter plans in Somerset had held up well. Ambulance response times had been maintained during the winter months, although there were ongoing operational pressures, particularly in the acute sector.
- The system was on track to deliver its financial outturn for this year. The first draft plans were submitted in December. Finalised plans due to be submitted on 12 February.
- Confirmation of the cluster executive team following interview/appointment processes. Two of the three vacant Place Director roles had since been filled with Lucy Baker appointed as the Place Director for Bath and North East Somerset and Caroline Holmes as the Place Director for Wiltshire. An external recruitment process would be undertaken for the remaining Place Director for Bournemouth, Christchurch and Poole.
- There was a challenging timeline between now and the end of March 2026 for the next phase of organisational change.
- The independent review into mental health conditions, attention deficit hyperactivity disorder (ADHD) and autism was welcomed and would help inform Somerset's next phase of work.
- The Government's response to the NHS dentistry contract consultation, which sets out its immediate high-level changes and further commitment to fundamentally reforming the dental contract, was welcomed.

  The Chief Executive had recently attended dental practice openings in Wellington, Chard and Swindon, noting the latter was working with a local school providing targeted oral assessment support for children. This had been rolled out to 40,000 children in the area and would be good learning to take forward across the cluster.

Resolved: The Board **noted** the Cluster Chief Executive's Report.

ICB 08/26 ELECTRONIC RESOLUTIONS (APPROVED/ENDORSED SINCE THE LAST BOARD MEETING)

There were no electronic resolutions to note.

ICB 09/26 FOCUS ON: ARMED FORCES PROGRAMME PROGRESS

Teri Underwood presented the armed forces programme progress update.

Key points to note included:

- The programme had grown from two to four link workers and expanded outreach services from two to ten.
- Additional services remained in demand with the programme now serving approximately 50,000 armed forces community members in Somerset.
- The programme demonstrated the effectiveness of neighbourhood working and personalised care using a small financial investment, along with the creative approaches to building and maintaining trusted relationships with veterans, which was a significant key enabler.
- The team acted as a single point of contact, facilitating access to services and supporting individuals often with complex needs.
- Reference was made to the Jumpstart Programme which was a weekly youth club for 8-18yr old children from armed forces families which provided group and one-to-one mentoring. The programme is successful with

demand exceeding capacity and would be considered for expansion to other parts of the county.
- Joined up services were key to improving outcomes, not only for the armed forces programme but for other services.

Sam Sheppard, Armed Forces Link Worker shared a case study of a veteran with PTSD and alcohol dependence, illustrating the challenges of accessing siloed services. Through regular contact, multi-agency meetings and referrals to appropriate services, the team facilitated holistic support, improved engagement and addressed their physical and mental health needs.

The Board discussed the importance of measuring the economic and social value of the programme, the challenges in collecting relevant metrics and the potential to apply the personalised approach to other communities such as those in rural or agricultural settings.

K Tottle and A Cameron joined the meeting.

The Somerset Armed Forces Strategic Forum was an effective cross-sector network and Board members were encouraged to attend a meeting.

T Underwood and S Sheppard left the meeting.

Resolved: The Board **noted** the armed forces programme progress report.

ICB 10/26 SOMERSET'S BIG CONVERSATION
Objectives: All

Charlotte Callen, Alex Cameron and Kat Tottle presented the findings from Somerset's Big Conversation and the Engagement Insight report.

The extensive public engagement undertaken to inform service design, the key themes raised by the public and the importance of co-designing future NHS services with the community to maintain trust and relevance were highlighted.

The shift from historically engaging with a relatively small group to a broader population was welcomed and would help inform priorities such as strategic commissioning.

The Board noted the diverse engagement methods used. The engagement aimed to capture feedback from a wide demographic, particularly those experiencing health inequalities.

The Somerset Insights Report was a comprehensive evidence base, combining feedback from multiple sources including Healthwatch and Foundation Trusts. The report aimed to provide a single baseline for future planning and to ensure that engagement was not seen in isolation but as part of a continuous feedback loop.

The top 10 feedback themes aligned with the 10 Year Health Plan three key shifts and showed that people significantly valued care that is local, joined-up reliable, kind and accessible in a way that helps people stay well and feel heard.

Key pressures and concerns included access, waits and uncertainty, fragmented systems and inequitable access.

There was a clear call for 'you said – we did/we will' and the Board discussed the need to ensure that changes were communicated back to the public to demonstrate how their input had shaped decisions.

The Board also discussed:

- The maturity of public dialogue in balancing what is wanted with realistically what can be delivered.
- The challenge of translating feedback into future-focused plans.
- The need to avoid duplication of engagement across organisations.
- Getting engagement right and working alongside our communities on

service changes.
- The importance of framing questions effectively.
- Seeking learning from other industries that had tackled similar challenges.
- Recognition that empowering communities could reduce reliance on statutory services. Alison Bell offered an off-line conversation to incorporate public health and behavioural science approaches.
- Acknowledgement that standardisation did not work for all cohorts and there was a need to balance long-term digital ambitions with meeting current access needs.

Resolved: The Board **endorsed** the recommendations as set out in the Somerset's Big Conversation Report.

C Chadwick-Cox joined the meeting.

ICB 11/26 DRAFT STRATEGIC COMMISSIONING INTENTIONS
Objectives: All

David McClay and Carmen Chadwick-Cox introduced the draft strategic commissioning intentions.

The requirement to submit strategic commissioning plans was outlined, noting the current draft aligns with the 10 Year Health Plan, and was structured to ensure consistency with the intentions for BSW and Dorset ICBs. The document had been refined following system partner feedback.

There was a query whether the draft was sufficiently outcome-focused and a suggestion that more emphasis be placed on improving continuity of care and measuring outcomes rather than processes. The Board noted the full narrative document contained more detail on quality, but further enhancements would be made to the document to address the points raised.

The Board discussed the importance of co-producing commissioning frameworks with the voluntary sector, for example, incorporating learning from the ongoing work with children and young people's mental health services. There was agreement on embedding these insights into the strategic framework.

The discussion highlighted the need for alignment across clusters and the integration of data and insights to inform decision-making. The Board acknowledged the challenge of balancing national policy requirements with local needs and the importance of ongoing adaptation as more data became available.

Following incorporation of the feedback received from the Board, the commissioning intentions would be brought back to the extraordinary February Board meeting for approval along with the medium-term planning submission.

K Smith joined the meeting.

Resolved: The Board **noted** the draft Strategic Commissioning Intentions.

C Chadwick-Cox left the meeting

ICB 12/26 INTERMEDIATE CARE: 12-WEEK TEST AND LEARN EVALUATION

David McClay and Kate Smith introduced the intermediate care: 12-week test and learn evaluation.

The test and learn aimed to set the direction for the delivery of more locally driven health and care in Somerset with the concept of supporting people to receive their post-hospital reablement in the 'right bed' (which for most people would be in their own home), thereby making experiences for people better as well as improving flow through hospitals.

The Somerset Management Board was supportive of the recommendation to extend the test and learn period from 12 weeks to 12 months.

The presentation highlighted changes that had taken place and summarised the 12-week findings, including that people preferred recovering at home after a hospital stay. More certainty was needed regarding care visit timings

The Board discussed the measurement of outcomes including bed occupancy, re-admission rates and the impact on primary care. The sequencing of the changes was clarified and there was acknowledgement of the need for more detailed data to provide assurance and inform future decisions.

The importance of monitoring equity in access to care and the significant role of the voluntary sector in supporting intermediate care was discussed.

There was a need to ensure the commissioning of the right capacity in the right place and the extended test period could enable more extensive progress.

Continued communication to system partners particularly within general practice and neighbourhood communities to ensure collaboration and understanding of the changes was key.

The Board supported extending the test period to 12 months to capture more data and feedback, allowing the changes to be tested under varying system flow conditions.

Resolved: The Board **noted** the report.

K Smith left the meeting.

ICB 13/26 INTEGRATED BOARD ASSURANCE DASHBOARD AND EXCEPTION REPORT FROM THE SYSTEM ASSURANCE FORUM 1 APRIL 2025 TO 30 NOVEMBER 2025

The Board received the integrated board assurance dashboard and an exception report from the System Assurance Forum (SAF) and noted the following:

- Quality - the ongoing work on the VTE (venous thromboembolism) risk assessment and looked after children initial assessments were highlighted, noting improvements and the need for continued attention.
- Performance - efforts continued to reduce waiting times and improve diagnostic pathways with actions taken to address delays and maintain commitments to timely treatment.
- There had been a decline in talking therapies performance in July following a period of improvement. This related to no more than 10% of patients waiting more than 90 days for their second treatment.
- The overall people workforce summary was favourable, although the bank shifts and general practice workforce remained below target.
- Finance – the cost improvement programmes were on track, although underlying financial challenges remained. The Board discussed the need for efficient use of resources and the importance of aligning commissioning intentions with financial realities.
- Future funding for the voluntary sector remained challenging, impacted by traditional grants and funding no longer being available.

Resolved: The Board **noted** the report.

ICB 14/26 OTHER KEY MEETING REPORTS

The chairs of the Board committees and system groups provided written and/or verbal reports of the most recent meetings, as follows:

ICB Assurance Committee Reports:

- Audit Committee: The Board noted the written report provided, in particular the focus on cyber security.

- Strategic Commissioning Committee: The Board noted the written report provided.

System Group Reports:

- Somerset Board – David McClay provided a verbal update regarding the recent workshop which included a focus on neighbourhood working.

- Children, Young People and Families – there had been no meeting held since the last Board. The next meeting would include a focus on special educational needs and disabilities (SEND) and this would be reported to the March Board meeting.

- Population Health Committee – there had been no meeting held since the last Board.

Resolved: The Board **noted** the other key meeting reports.

ICB 15/26 ANY OTHER BUSINESS

- The Board noted the invitation to Alison Henly from NHS England to undertake joint working on neighbourhood funding models.

- Katherine Nolan referred to her attendance at a recent launch meeting following Bridgewater South receiving £20M funding from the Government's Pride in Place programme which was aimed to improve some of its most deprived neighbourhoods. The funding could be spent on projects designed to increase social mobility, improve access to local services and encourage greater community spirit. This was seen as a great opportunity and there was a need to join up engagement efforts and ensure the strategic use of resources to maximise long-term benefits for the community.

- Thanks were given to Graham Atkins who was exiting as the ICB's Chief People Officer, for his contributions at the Board and wider organisation.

ICB 16/26 ITEMS TO BE DISCUSSED AT THE CONFIDENTIAL MEETING

- Minutes of the confidential meeting held on 27 November 2025
- Chief Executive's Part B update
- Electronic resolutions (approved/endorsed since the last Board meeting)
- Transition update
- Primary Care Workshop session

ICB 17/26 WITHDRAWAL OF PRESS AND PUBLIC

The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

ICB 18/26 CLOSE AND DATE OF NEXT MEETING

The meeting closed at 1pm. The next meeting will take place on Thursday 26 March 2026 at Wynford House, Lufton Way, Yeovil.

Objectives – Key:

Objective 1: Improve the health and wellbeing of the population
Objective 2: Reduce health and social inequalities
Objective 3: Provide the best care and support to children and adults
Objective 4: Strengthen care and support in local communities
Objective 5: Respond well to complex needs
Objective 6: Enable broader social and economic development
Objective 7: Enhance productivity and value for money

Chairman: Date:

APPENDIX 1

ICB 19/26 PUBLIC QUESTIONS

1. From R Beaver, Quicksilver Community Group

At the last ICB meeting I asked about the extended travel time for ambulances to take stroke patients from Yeovil and surrounding areas, to either MPH or DCH to receive time critical treatment in a HASU. The target is 90% receive treatment within 3 hours.

Using SWAST data my analysis showed that currently 85% and 70% respectively for BA20 and BA21 patients receive treatment within the 3 hour window when going to Yeovil HASU. However, this reduces by a further 50% if these patients were directed to MPH or DCH. This outcome is broadly similar with others who have done analysis on the SWAST data.

I shared this analysis with Somerset Foundation Trust including the assumption made in the modelling, and welcomed feedback, which I have not received.

I made an FOI request to SFT on 15th December for details of any analysis and modelling, (with assumptions). which they had carried out. I received a late response this Monday. I was merely referred back to the appendices in the DMBC. Given the response I have slightly altered the nature of the point I am making although my questions are the same.

The modelling in the appendices regarding ambulance timescales is all based on the **key assumption** that the time taken for a 3.00am Tuesday morning car journey is a proxy for a blue light ambulance.

I had hoped the response to my FOI would detail work underpinning the validity of this assumption specifically within Somerset and for those journeys which would be most critically impacted by the closure of the Yeovil HASU. I assume such work has not been done.

In contrast to this Somerset approach, Healthcare for London in planning a re-configuration of HASU provision undertook a detailed analysis and modelling of ambulance travel times to ensure that **wherever** someone lives in London they will be less than 30 minutes, in a blue-light ambulance, from one of the HASUs.

This included:

- Details of 4 million ambulance journeys over three years
- Sophisticated modelling software, **using real average journey times on roads**, to supplement the data from the Ambulance Service.
- Specific analysis to assess the impact **of the day of the week and rush hour on ambulance journey times.**

This contrast sharply in its detail and approach with the adoption in Somerset of a proxy indicator without validation from any real data.

In London the aim was for an upper level of a 30-minute ambulance journey time as part of the 3-hour window. Achieving this upper limit reflected an actual mean journey time 15.57 minutes.

In contrast here modelling indicates mean ambulance journey times for patients in BA20 and BA21 to MPH or DCH is between 42 minutes and 66 minutes with 90th centile times between 63 and 99 minutes. A far cry from the 30-minute upper-level aimed for in London.

I know you will say this is not London, and journeys are longer but the difference here is that you are closing a HASU and extending journey times.

My questions:

1. Has the Trust carried out any detailed modelling **using real data** to establish mean and 90th centile estimated journey times from Yeovil and its surrounding areas to MPH and DCH, including consideration **of real ambulance travel times during peak hours of the week and seasonal issues related to tourism etc**?
2. Has the Trust any evidence of **real category 2 ambulance journey** times from Yeovil to MPH or DCH? (Following a recent FOI request SWAST provided an average from BA21 to MPH of 55 minutes although no details of sample size – (this concurred almost exactly with the mean from my modelling)
3. Has the Trust carried out any credible analysis, **based on real data,** to indicate what proportion of stroke patients from Yeovil and surrounding areas will exceed the 3-hour treatment window, if the Yeovil HASU is closed and they are re-directed to MPH or DCH?
4. Has such data been presented to the Clinical Senate and endorsed by them as clinically safe?

Failure to use real data, and relying completely on a proxy indicator, as a basis to inform the critical decision to close the Yeovil HASU appears to be negligent in the extreme. and is surely counter to the legal responsibility of the Trust and ICB to ensure clinical safety

The closure of the Yeovil HASU needs to be stopped immediately to prevent the avoidable detrimental health outcomes for stroke patients in Yeovil and surrounding areas who will have additional delays to their time critical treatment.

2. From anonymised member of the public

Topic: - Clinical Safety

What proportion of stroke patients will exceed the safe treatment window (180 min call to needle) under the proposed travel times to Taunton and Dorchester?

3. From anonymised member of the public

Regarding the stroke reconfiguration my question is:

Has the clinical senate explicitly endorsed the clinical safety of adding one hour to ambulance journeys?

4. From M Jones

Under the new arrangements for stroke care my question is this:

How many additional ambulance hours per day will the new model require?

5. From J Davies

Following the Higman/Marden reconfiguration of stroke services my question is:

How does the proposal avoid widening inequalities for deprived rural or elderly populations?

6. From K Smith

Following the closure of the Yeovil Hospital HASU my question is:

Please provide modelling which included journeys where ambulance pick up of stroke patients is delayed during peak demand periods?

7. From M Davies

The Yeovil HASU closure will cause hundreds of additional ambulance journeys from Dorchester and Taunton, so my question is:

Have mitigations, private ambulances, been funded and guaranteed?

8. From G Smith

Please explain how the Somerset stroke reconfiguration complies with the statutory duties to improve quality and reduce inequalities and provide the evidence demonstrating net population health benefit?

9. From R Tostevin, Quicksilver Community Group

Speaking on BBC Radio Somerset a week ago (Thurs 22 January), the Health Secretary Wes Streeting told Emma Britton it was "*totally unacceptable"* for Category 2 patients (including stroke) to be waiting so long for an ambulance to reach them. In December 2024, people were waiting "about an hour, said Mr Streeting. Since then, South Western Ambulance response times have improved, according to the Health Secretary; "*down to just over half an hour. But there's still much more to do."*

"When I look at things like A&E waiting times particularly ambulance response times that's where I feel the particular pressure because I know the difference you can achieve with a faster response; if you're having a stroke "time is brain"; if you're having a heart attack, the faster we see you, the more likely we are to save you."

Wes Streeting was quoting the *"time is brain" mantra* of Juliet Bouverie (Stroke Association CEO). She has repeatedly stressed the critical need for immediate action when stroke symptoms are suspected.

In response to NHS England performance data (2023–2025) Ms Bouverie says: "Stroke is a medical emergency. The brain is losing 1.9 million neurons every minute without treatment. We cannot accept patients waiting hours for scanning or thrombolysis... the system must respond with urgency. Rapid treatment can be the difference between walking out of hospital or living with severe disability."(Quoted in Stroke Association media pack; multiple reports and HSJ articles)

In consideration of the above, last month I wrote to the ICB Chief Executive Jonthan Higman, requesting the following:

Full details of the ***clinical evidence, modelling and analysis*** used by Somerset ICB (and/or Somerset NHS Foundation Trust) to support the conclusion that longer Category 2 ambulance response and travel times for suspected stroke patients from BA20 and BA21 postcodes (and surrounding Yeovil area) would be outweighed by improved patient outcomes, if those patients were treated at Musgrove Park Hospital or Dorset County Hospital – if the Yeovil HASU closure goes ahead.

Can the Chief Executive advise when we might have sight of this information?

ICB ACTION/DECISION LOG							
Committee Name: ICB Board							
Item No or Type (Action/Decision/Issue/Risk)	**Date Raised**	**Item**	**Decision/Actions/Comment**	**Lead**	**Update**	**Status (Complete/Ongoing/ Approved/Endorsed)**	**Date Action Closed**
ACTIONS CLOSED SINCE LAST MEETING							
ICB 03/36	29/01/2026	Register of Members' Interests	To update the Register as follows:- - Rebecca Duffy – update 'senior partner at Mendip Country Practice' to 'employed as a salaried GP'. - Shelagh Meldrum – update job title to Chief Nursing Officer	Corporate Governance Team	23/02/26 Register updated accordingly.	Complete	23/02/2026
ICB 05/26	29/01/2026	Minutes of the meeting held on 27 November 2025	Amend the minutes to show Katherine Nolan as in attendance.	Corporate Governance Team	23/02/26 Minutes updated accordingly.	Complete	23/02/2026

Report to:	NHS Somerset ICB Board	**Agenda item**	03
Date of Meeting:	26 March 2026		

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

Report classification	Not Confidential
ICB body corporate	NHS Somerset ICB
ICS NHS organisations only	Somerset NHS
Wider system	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	
Noting	For noting without the need for discussion	

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

1 Purpose of this paper

This report provides the Board with an update on the latest strategic developments across the NHS and more locally the developments within the Cluster and Somerset. It also includes reflections on the system by partners and the key areas of focus.

2 Summary of recommendations and any additional actions required

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

- NHS England announcement on Talking Therapies
  NHS England announcement on Urgent Dental Care
- Heraeus bone cement supply chain disruption
- SEND Reform
- Direct Commissioning Delegation

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

3 Legal/regulatory implications

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

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

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

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

7	Communications and Engagement Considerations
This report is published for public information and includes updates and the latest news from the NHS England, Somerset NHS providers, Local Authority partners and Voluntary, Community and Social Enterprise.	

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

Chief Executive Officer Board Report

1. INTRODUCTION

1.1 This report provides the Board with an overview of the latest strategic developments across the NHS and more locally across the Cluster and Somerset Integrated Care System. It also includes reflections on the system developments during this reporting period.

2 SYSTEM PERFORMANCE OVERVIEW AND KEY ISSUES

2.1 In recent weeks the operational focus of the system has been on ensuring the safe management of the winter months and the risks associated with this. Demand across the urgent and emergency care services in Somerset remains high, with additional pressure being felt as a result of winter flu and norovirus which have had a significant impact on bed availability in the two acute hospital sites.

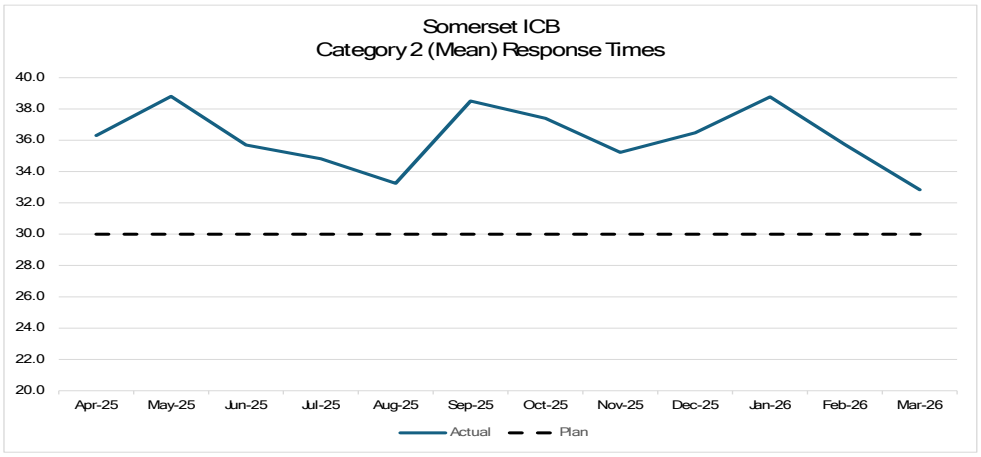
2.2 During the most recent period (January to February) there was a deterioration in performance across key urgent and emergency care metrics including ambulance handover times, ambulance response times and the number of patients waiting over 4 and 12 hours for admission within our emergency departments. However, performance has improved during March to date and is significantly better on many of these metrics than at the same time last year. The number of patients in hospital awaiting placement for on-ward care remains a key risk.

2.3 The year-to-date position on a number of the key metrics is demonstrated by the run charts below with further detail provided in the full performance report. It should be noted that the most recent points in the data presented below are unvalidated.

2.4 Following improvement earlier in the year, performance against the A&E 4-hour standard has deteriorated since late summer and for the year (to 12 March), Somerset NHS Foundation Trust performance was at 71.8% against the 78% national standard. This is also behind our locally agreed operational plan target of 78.7% in March (where performance month to date is 70.8%).

2.5 12-hour performance has deteriorated in January and February following improvement in November and the average ambulance handover times at hospitals in Somerset is 24.5 minutes for the year to date which benchmarks favourably against other systems and represents a significant improvement on the position this time last year.

2.6 Across the South-West Region Category 2 ambulance response times improved in February to 34.2 minutes and in Somerset was 35.9 minutes compared to 36.6 minutes during Quarter 3.

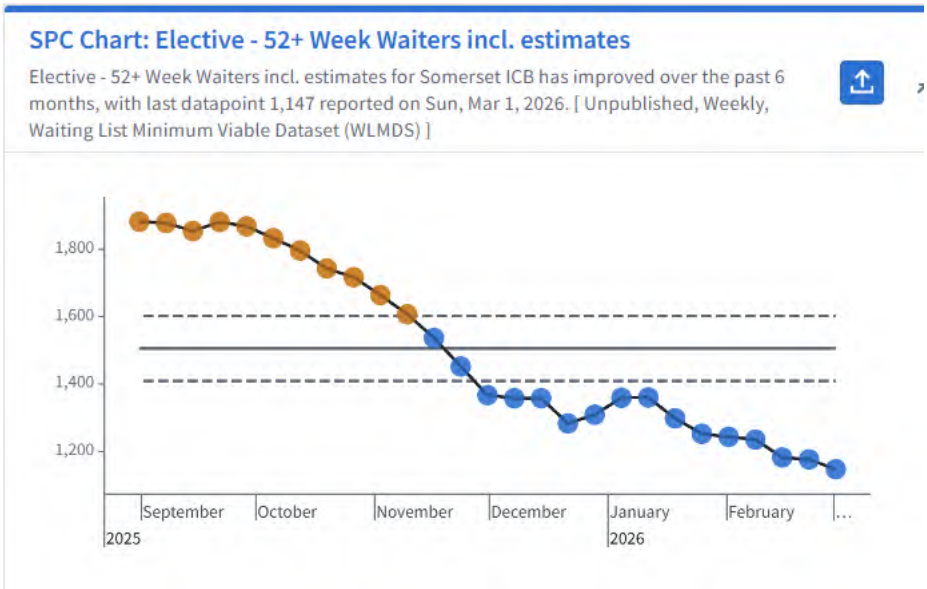


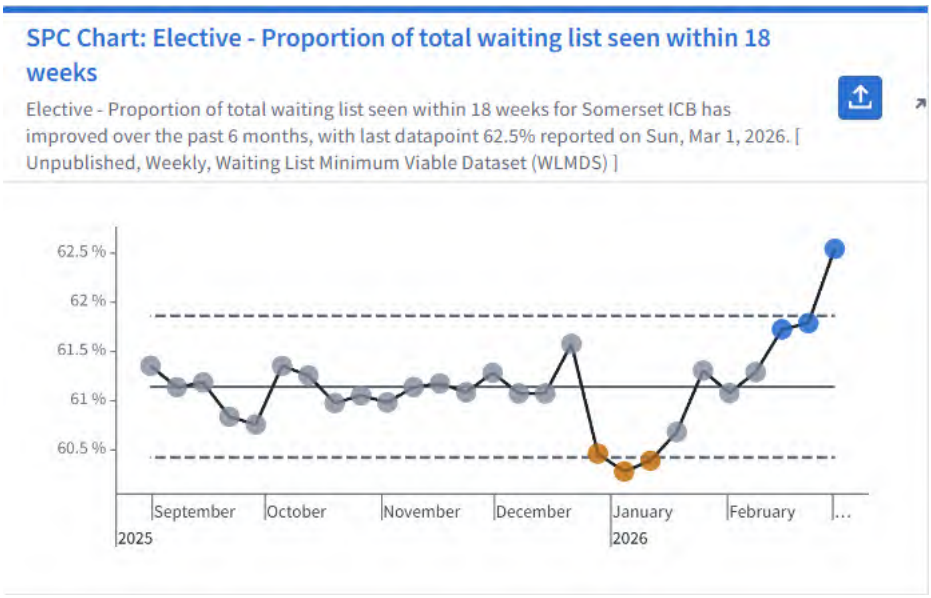
2.7 As part of the 2025/26 operational planning process the (planned) elective care priorities have reverted back to improving delivery against the 18-week referral to treatment target and reducing the proportion of people on the waiting list waiting over 52 weeks for treatment. At the end of January 2026 (latest reported month end position) there were 53,143 patients at Somerset FT and 64,571 Somerset residents waiting for elective treatment.

2.8 The most recent available data, covering the period to 1 March 2026, demonstrates an improvement in performance against the 18-week referral over the winter period. This stands at 63.3% for Somerset residents against the national standard of 65%.

2.9 A particular focus during this year has been on reducing the number of patients waiting over 52 weeks for planned treatment. At the most recent data point 2.0% of people on the Somerset waiting list had waited over 52 weeks. The agreed target is to reduce this to 1.5% by the end of March 2026. Additionally, Somerset NHS Foundation Trust is working to ensure that any patient waiting longer than 65 weeks receives treatment.

2.10 Work continues with Somerset FT on mitigating actions, following the good progress made earlier in the year and there is a particular focus in the final quarter of the financial year to increase the number of outpatient appointments and reduce waiting times for non-admitted care.





2.11 Work continues across the Somerset system to finalise the 2026/27 operational plan which is a 3-year plan spanning finance, operational performance and workforce, following feedback from the submission on the 12 February 2026. The Somerset plan was assessed as low risk and the only non-compliant metrics are access to routine dental treatment, Mental Health Support Teams and Talking Therapies with the latter 2 non-compliant in 2026/27 with the agreement on NHS England. The final submission is due on the 18 March 2026, and minimal changes will be made. Amongst other things commissioner ambitions for elective 18-week performance and overall waiting list have been published which include a 28,664 reduction in the overall waiting list size to get to 92% RTT performance by March 2029.

2.12 Alongside this on 12 February 2026 a 5-year strategic commissioning and 5-year (provider) delivery plan has been submitted.

3 STRATEGIC UPDATE – NATIONAL & REGIONAL CONTEXT

Department of Health and Social Care (DHSC) announcement – The National Cancer Plan for England

3.1 On the 4 February, the DHSC published the National Cancer Plan for England. The National Cancer Plan sets out how the NHS will improve cancer care so that three out of four people diagnosed with cancer survive for five years or more by 2035. The plan has been shaped by an extensive call for evidence exercise, held from 4 February to 29 April 2025. The more than 11,000 responses received have played an essential role in developing the plan. The complete plan can be found at this link: https://www.gov.uk/government/collections/national-cancer-plan-for-england

NHS England announcement on Talking Therapies

3.2 New analysis of NHS data shows that over 670,000 people were treated with NHS talking therapy care last year – nearly 70,000 more than pre-pandemic (12% increase on 2019) – with a record 83,000 accessing employment support through the service in 2025 to help them return to work (20% increase on 2024). In response, the NHS has launched a landmark new campaign urging those facing six common anxiety conditions to come forward for support by self-referring online at nhs.uk/talk.

3.3 NHS talking therapies provide people with practical skills and techniques to overcome a range of mental health conditions like OCD, social anxiety disorder, PTSD, panic disorder, body dysmorphic disorder, and phobias. Anyone can self-refer online without needing to see their GP or have an already diagnosed mental health condition. The new campaign puts a spotlight on six common mental health conditions, which are often mistaken or underplayed, and can be treated by NHS talking therapies.

NHS England next steps on Urgent Dental Care

3.4 On 23 February 2026 NHS England noted that, thanks to efforts from Integrated Care Boards and dental teams across England, overall access to dental care, including urgent care, has increased over the past year. This is reflected in Somerset with additional investment made to improve urgent dental access to those most in need and in areas of highest deprivation. In Somerset we have 25 providers in total now providing urgent care appointments.

3.5 New capacity has been commissioned across the country and strong progress has been made in creating a safety net for patients, in line with updated guidance on urgent and unscheduled care treatment.

3.6 Commissioners have supplemented this new capacity by also making progress in ensuring 111 and other access points are directing patients in pain and with other unscheduled need to services that can rapidly treat them.

3.7 Rightly the government's priority has been ensuring that this safety net is in place, but whilst many have benefitted from the new appointments, it is recognised, from feedback from clinical teams and commissioners, that for many patients the current definition of the national target, focused on clinically urgent care, is too narrow.

3.8 Many with the highest needs may initially require an urgent care appointment, but then their ongoing treatment cannot take place under the newly commissioned capacity. This risks patients who should be prioritised struggling to access care under the current arrangements.

3.9 To recognise and act on this feedback, on the advice of the Chief Dental Officer for England, the government has now confirmed that the 700,000 commitments will be broadened with immediate effect to all dental appointments measured

through courses of treatment. In Somerset, we have been allocated an additional 13,498 appointments in 2025/26. Currently we deliver approximately 19,362 Urgent Dental Care appointments per annum. Access to an appointment is commissioned via the NHS 111 and Smile Dental Triage Pathway. With the additional appointments we have sufficient capacity to meet the demand of the population with practices with an NHS contract.

3.10 In addition, two new dental practices have been mobilised to further increase urgent care provision across Somerset. Wellington Dental Care opened in October 2025 and a new practice in Chard opened in December 2025, bringing new NHS dental capacity to areas with historically limited access to services. We are actively looking at opportunities to increase access to urgent dental care.

3.11 Further details on urgent dental care published at this link: https://www.england.nhs.uk/long-read/broadening-the-700000-urgent-care-commitment/

Heraceus bone cement supply chain disruption

3.12 On 18 February 2026, NHS England notified ICBs and providers of significant disruption that has emerged in relation to the supply of bone cement products sold by Heraeus Medical. A packaging fault temporarily halted production at Heraeus' main production site. Whilst production has now restarted, product availability will be impacted. This is a global issue. NHS England has issued immediate guidance to hospitals to ensure trauma and urgent care can safely continue, enable the use of alternative suppliers where possible, and to support prioritisation of orthopaedic waiting lists based on patients' needs over the coming weeks.

3.13 Any stock already in hospitals is unaffected. The NHS is working closely with government and leading professional bodies to ensure safe and effective care can be provided while the supply is resolved. Alternative suppliers have already been identified and training for clinicians is being rapidly implemented. Further details are on the NHS website NHS England » Heraeus Medical – bone cement products

3.14 Somerset ICB and providers are working with Cluster, Regional and National colleagues to safely manage this situation.

SEND Reforms

3.15 On 23 February 2026, the government published the Schools White Paper, Every Child Achieving and Thriving and the Special Educational Needs and Disabilities (SEND) consultation document, SEND reform: putting children and young people first. The white paper outlines a vision for schools and SEND system reform to support every child to achieve and thrive.

3.16 The proposals aim to improve the lives of all children and young people by addressing challenges in education, including attainment, disadvantage SEND and attendance.

3.17 The proposed reforms to the SEND system in England aim to create a more consistent, inclusive, and accountable framework for supporting children and young people with additional needs to ensure every child can achieve their potential. ICBs will be working collaboratively with Local Authorities to respond to the reforms accordingly. Opportunities include jointly developing an Experts at Hand offer, which will require continued strong partnership working and co-production with local settings, health partners, and families.

Direct Commissioning Delegation

3.18 NHS England have written to ICBs on the plans for transferring NHS England's direct commissioning functions to ICBs from April 2027. The NHS England Executive and the Department of Health and Social Care (DHSC) have agreed that, subject to parliamentary approval of changes in primary and secondary legislation, the following NHS England commissioning functions will transfer to ICBs from April 2027:

- vaccinations, child health information services (CHIS) and almost all components of screening services
- health and justice services and sexual assault and abuse services, including sexual assault referral centres
- specified specialised services, including all previously delegated services and a small number of additional services identified as suitable
- primary care services, including all previously delegated services

3.19 In preparation for this, from April 2026 ICBs will be fully engaged with and leading the commissioning of these services, supported by NHS England's regional commissioning teams.

3.20 Further details on the direct commissioning delegations are available here: NHS England » Direct commissioning update

4 LOCAL UPDATE - NHS SOMERST ICB

ICB Cluster Executive Team Recruitment

4.1 Following the appointment of most of the new Executive Directors for the NHS Bath and North East Somerset, Swindon and Wiltshire, Dorset and Somerset ICB cluster, expressions of interest have been sought for an Interim Executive Place Director for Bournemouth, Christchurch, and Poole. This is while the substantive recruitment process is conducted. The interviews for this role took place on 6 March 2026, with an immediate start date. The duration of the interim role is dependent on the outcome of the full recruitment.

Cluster ICB Transition and Staff Consultation

4.2 While the change programme for the new Cluster has been on the horizon for nearly a year, the reality is fast coming into focus. The new Cluster Executive Team are working at pace to design the new structures for the Cluster. The formal consultation was launched on the 18 March 2026 for most staff.

4.3 A change process on this scale is hugely unsettling. The Cluster Executive Team recognise this, and significant well-being and support measures are in place for all staff. Work is also underway to manage the risks associated with the transition and implement new ways of working to enable the new ICB cluster to continue to deliver its statutory responsibilities together with its new focus as a strategic commissioner, with a significantly reduced workforce.

Somerset NHS Foundation Trust Three-Monthly Maternity Services Review Meeting

4.4 The ICB and NHSE Colleagues met with the Trust on the 25 February 2026.

4.5 The Trust presented progress on recruitment which was positive with 5 paediatricians recruited, 3 are now in post, one is commencing in post in March, and the final paediatrician commences in post in summer 2026. The Trust also presented positive news on the recruitment of midwives and specialist trained neonatal nurses.

4.6 The Trust presented that project groups are working at pace covering all of the safety criteria for re-opening and meeting regularly to assure progress. There was recognition in the meeting that the resource to deliver all of the priorities in Maternity Services remains stretched and the Trust Leadership Team continue to acknowledge this and provide additional resource to support.

4.7 There was recognition at our previous 3 monthly review that in order not to disrupt individual service user pathways to Dorset County Hospital and Musgrove Park Hospital(MPH) maternity services midwifery and neonatal nursing workforce modelling needed further refinement, alongside activity modelling, to plan how much resource would be required to return the Yeovil District Hospital unit, at what point. This modelling is in progress and the ICB are leading on a system risk assessment process to ensure that we are also considering risks outside of Somerset.

4.8 The next steps were discussed including:

- Completion of estates works by 10 March.
- Regular gateway meetings to review progress and sign off readiness to re-open.
- Implementation of an additional operational support structure approaching 21 April go live.

4.9 Planned re-opening remains set for the 21 April 2026.

Board Assurance Statement to NHS England

4.10 As ICBs finalise their future new operating structure in line with the revised running cost allowance and the direction set out in the Model ICB Blueprint, NHS England is asking each ICB to provide an assurance statement. BSW, Dorset and Somerset ICBs have been holding submission of the statement pending the development of the new organisational structures, so as to be assured that the ICBs are able to deliver all the functions within the revised running cost envelope. The draft structures are now available however the assessment of risk (point c) is underway and not yet complete. Submission of the statement was required ahead of the three ICBs' March Board meetings, therefore the Cluster Chair and Cluster CEO, in consultation with the non-executive members of the Joint Transition Committee, confirmed to the NHS England regional team that BSW, Dorset and Somerset ICBs:

a. have considered and understand the functions for which they are accountable under current legislation, under formal delegation from NHSE, and as described in the Model ICB Blueprint, with specific regard to:
   - the current national position on functions identified as 'review for transfer'
   - the good practice guides shared on Continuing Healthcare, Infection Prevention and Control, Safeguarding, Special Educational Needs, and Medicines Optimisation

b. are confident that the proposed 'To Be' structure enables the effective and efficient discharge of these functions within the £19 per head running cost allowance.

c. are in the process of assessing the risks linked to the running cost reduction and identifying clear, tangible mitigations for any changes to how the ICB's functions will be delivered.

4.11 To reflect the current position of the cluster we amended point (c) from NHS England's suggested wording of "have fully assessed" to "are in the process of assessing". We have just completed our draft structures ready to launch consultation on 18 March and are working through the actions to mitigate the cut over as a result of this and the changes resulting from colleagues starting to leave on voluntary redundancy. As this is work in progress, we are currently unable to provide full assurance that these risks are fully assessed.

4.12 The Board are asked to ratify the decision of the Chair and CEO to submit this statement.

Somerset Medium Term Planning

4.13 In line with the NHS Medium Term Planning Framework, Somerset ICB and our provider (Somerset NHS Foundation Trust) submitted their final medium term plans to NHS England South West Region on 12 February 2026. Our plans set out how we will deliver a balanced financial position and all of the required operational performance standards with the exception of Routine Dental access

and as agreed with NHS England Talking Therapies and Mental Health Support Teams which are both non-compliant in 2026/27 but are compliant from 2027/28.

4.14 This year saw the first time in many years that planning has moved away from an annual process to a medium term to enable commissioners and providers to undertake longer term planning which will better support our vision for integrated neighbourhood services and care closer to people's homes, whilst ensuring people can access specialist care when it is needed.

4.15 We are currently in the process of reviewing our feedback with NHS England whilst we work towards acceptance of our plans.

Early Cluster ICB Stakeholder Engagement

4.16 The success of our Cluster will hinge significantly on effective stakeholder engagement. To this end our Cluster Chief Executive, Jonathan Higman, supported by a small team, delivered an update briefing, in Westminster, to which all 25 Cluster MPs, and local elected representatives, were invited. This was the first time we have been able to provide a collective update on the future of the Cluster and hear from MPs about how they would like us to engage with them.

4.17 It was an incredibly productive meeting and allowed us to answer their questions about key priorities. We will continue working closely with our MPs, local elected representatives, and other stakeholders, as part of our wider stakeholder engagement.

5 COMMUNICATIONS AND ENGAGEMENT UPDATE

5.1 The Communications and Engagement Spotlight is attached as Appendix 1.

Appendices	
Appendix 1	Communications and Engagement Spotlight

Communications, Marketing and Engagement Spotlight

1 January - 28 February 2026

Welcome to our spotlight report, highlighting communications and engagement activity - during this time our focus has remained on supporting people to stay well and healthy.

We launched our RSV campaign reminding those people aged between 75-79 to get protected and preparations were well underway for the Spring Covid-19 vaccination programme. We raised awareness of medicines wastage, working with Frome Medical Practice, showcasing their pioneering initiative, which highlighted just how much of an impact local action can make. In February, we also worked with the BBC on a one-hour phone-in to mark a day of NHS focus for the broadcaster - helping to highlight how people can access the care they need.

We have continued to support the Somerset Linked Data Platform survey - gathering views and insight. Having analysed the findings from our Somerset's Big Conversation, we began sharing the outcomes report, with findings already being used to inform key projects across health and care.

Newsletter update

The January edition of Our Somerset newsletter was introduced by Laura Annandale, Head of Service at Somerset Council. The newsletter included information about cost-of-living support available to Somerset residents, how we are improving access to NHS dentistry, and helping to protect over-75s from serious lung infection through RSV vaccinations, the opening of Yeovil Diagnostic Clinic and a new x-ray machine for Minehead Hospital.

The February edition of Our Somerset newsletter focussed on the refresh of Somerset's Adult Social Care Strategy and how people can share their views. We celebrated Open Mental Health's recent Impact Report, highlighted an RSV vaccine campaign to protect over-75s and a campaign to encourage people to use the NHS Pharmacy First service. We also showed how Move 2 Independence is supporting local people after hospital stays.

You can find all editions of the newsletter on our websites:

Our Somerset and NHS Somerset

Social media highlights

NHS Somerset followers: 117,008

6,646 | 7,071 | 100,160 | 2,616 | 515

Our Somerset Followers: 2,666

1,347 | 898 | 421

Top 5 most engaging posts:

Protect against Norovirus carousel

- 22,850 reach
- 1,848 engagements
- 57 reactions
- 73 shares
- 1,708 other post clicks
- N/A link clicks

The Somerset Linked Data Platform

- 14,160 reach
- 881 engagements
- 102 reactions
- 14 shares
- 91 link clicks
- 651 other post clicks

Yellow weather warning for Somerset

- 25,112 reach
- 794 engagements
- 58 reactions
- 54 shares
- 91 link clicks
- 656 other post clicks

Symptoms for urgent dental NHS 111

- 28,821 reach
- 482 engagements
- 7 reactions
- 15 shares
- 4 link clicks
- 455 other post clicks

NHS Somerset website

- 21,000 active users
- Top pages: Homepage, Prescribing and medicines, Antimicrobial, Wellington Dental Care, Weight Management

Our Somerset website

- 1,500 active users
- Top pages: Pain Cafes in Somerset. Homepage, Blood pressure, Our Somerset Strategy, Falls prevention

Childhood vaccination schedule

- 6,896 reach
- 314 engagements
- 9 reactions
- 15 shares
- 219 link clicks
- 68 other post clicks

In this period we recieved 73 messages from the public via our channels

our SOMERSET Together we care

In the news

Maternity and neonatal investigations

In January, we supported the national 'Call for Evidence' - for women and families to share their experiences of maternity and neonatal care in England. The investigation is seeking to understand the full range of experiences of maternity and neonatal care, and responses will be used to inform the development of the national recommendations which will shape the future of maternity and neonatal services in England.

Read more

Bounce back in winter viruses

In January, we highlighted a nationally reported bounce back of winter viruses with a sharp rise in the number of patients in hospital with flu, Norovirus and Covid, and leading to increased pressure on our ambulance services. The report encouraged people to take up their flu vaccines when invited.

Read more Somerset County Gazette

Increased demand for NHS services

In January, we encouraged people to choose the right service for their health needs as demand for NHS services increase during the busy cold weather period. We asked people to help us by using NHS111 online, thier local community pharmacy, urgent treatment centres and Open Mental Health.

Read more

In the news

Views sought on new data system

In February, we shared information about the development of a 'Linked Data Platform' - a secure system that will anonymously link health and social care data to support population health management. We asked people in Somerset to share their views on the planned data system to help to predict health needs and develop tailored services that prevent illness and deliver targeted care.

Read more

Top health tips for February half-term

In February, we shared top tips on how to stay healthy and happy over the half-term - from ordering repeat prescriptions early and accessing mental health support, to making the most of local services like NHS 111 and community pharmacies.

Read more Wellington Weekly News

Launch of RSV vaccine campaign

In January, we encouraged over-75s to have their free RSV vaccine to protect themselves from getting ill and to keep them out of hospital. The virus spreads easily through coughs and sneezes and can hit older lungs much harder than expected. The RSV vaccine helps your body fight it off before it becomes serious.

Read more BBC News Somerset County Gazette

Campaign highlights

Medicines Management campaign

NHS Somerset has been encouraging patients to only order the medicines they need as part of an ongoing campaign to reduce unnecessary prescribing and medicines waste.

A pioneering initiative at Frome Medical Practice shows the difference local action can make. The practice's "Show Me Your Meds" campaign saved nearly £280,000 in just 12 months, reduced prescribing by more than 22,000 items, and helped prevent 122 tonnes of CO_2 emissions.

Read our news release here and the campaign case study of Marion and Sheila Gore (pictured opposite) here.

We've had excellent coverage for this campaign including from BBC Points West, BBC Somerset and BBC online, as well as local press.

NHS in focus at the BBC

In February, as part of the BBC's NHS Day, NHS Somerset worked with BBC Somerset to organise a one-hour phone in with Deputy Chief Medical Officer and Musgrove Park Hospital Cardiologist, Dr Tom MacConnell (*pictured right with programme host Emma Britton*), who highlighted what we are doing to make it easier to access the care people need, whether in our hospitals, getting a GP or NHS dental appointment or using our community pharmacists and urgent treatment centres.

"It was a great opportunity to hear directly from patients about some of the issues they have been facing when using health services in Somerset and for us to be able to help our communities understand more about the range of services we have that can support them," said Charlotte Callen, NHS Somerset's Director of Communications, Engagement and Marketing.

Campaign highlights

Winter campaign

During January and February, our winter campaign continued to focus on raising awareness of the impact of having flu, Covid, RSV and norovirus on the public and our staff and we continued to promote winter vaccinations including RSV, flu, Covid and HPV vaccines.

Read more on our website here and here.

Choose Well

We continued to help the public understand what services were open over the February half-term and continued to remind people to choose well to help relieve pressures on our frontline services including GPs, hospitals and our ambulance service.

Together with system partners we shared online and social media messaging around 111, Handiapp, urgent treatment centres, mental health support, pain cafes and community pharmacies.

Care on your doorstep

We have created a series of localised leaflets and are running a paid for social media campaign to help people understand where they can go for support with their health (rather than calling an ambulance or visiting A&E for non-emergency care).

The leaflets will be distributed to key areas of Somerset and offer information on frontline services in each area.

Campaign highlights

Supporting RSV, childhood and spring COVID-19 preparedness

During January and February, our communications focused on driving RSV vaccination uptake among over-75s, alongside supporting HPV school vaccination activity and wider childhood vaccination messaging. Preparations also began for the Spring COVID-19 vaccination programme.

RSV Vaccinations focus

We developed new, clear messaging to explain what RSV is, why it matters for over-75s, and how easy it is to get protected.

A comprehensive communications pack for GP practices and partners was produced, including posters, social media assets and TV screen materials for both over-75s and pregnant women/birthing people.

To extend reach to our desired audience (over-75s), **parish councillors across Somerset** were provided with posters and copy for local magazines.

Myth-busting Q&A videos with Nurse Kathy from Wincanton Health Centre addressed common questions to help reassure over-75s and their families/carers. These have generated 15,896 views and 54 positive reactions across digital channels.

A press release launching the RSV campaign resulted in coverage on BBC Somerset radio, BBC online, the Somerset Leveller and Somerset County Gazette. Sector engagement also continued through inclusion of RSV information in **Somerset Council's Care Sector Newsletter**.

Targeted digital adverts aimed at carers of over-75s reached 42,436 people and drove 133 clicks on a £50 budget. Website content has been updated ahead of eligibility changes coming into effect on 1 April.

Childhood and HPV Vaccinations

A **refreshed HPV vaccinations communications pack** has been produced and shared with GP practices. HPV communications supported school-based clinics. We created targeted social messaging showing the child vaccination schedule which **reached 6,885 parents** and generated **219 clicks for more information.**

Spring COVID-19 programme planning

Preparations are now underway for Spring COVID-19 communications, and our focus will be working alongside our cluster comms colleagues to find ways to complement and support messaging across each of our places.

Engagement highlights

Somerset Linked Data Platform

Partners across our Integrated Care System (ICS) continue to develop the Somerset Linked Data Platform (SLDP), a secure system that links anonymised health and care data to support population health management and help partners better understand and address health inequalities.

Engagement activity has continued across Somerset, with 53 events delivered so far. These have included online workshops, community group discussions and partner meetings. A public survey, open until 15 March 2026, also enables Somerset residents who cannot attend events to share their views or raise any concerns. Find out more here https://nhssomerset.nhs.uk/my-voice/our-work-with-people-and-communities/somersetlinkeddataplatform/

Feedback we have captured is informing how the SLDP is developed and communicated, including how information about the platform and the use of data is explained. This engagement is helping ensure the programme is developed in a way that is transparent, trusted and aligned with public expectations.

Key takeaways around the Linked Data Platform

Somerset's Big Conversation

Findings report due soon

During November and December, feedback from Somerset's Big Conversation 2025 was analysed, bringing together views from residents, communities, stakeholders and staff gathered through a wide range of engagement activity across Somerset. Analysis was undertaken using a robust AI Verification Framework, with clear governance, human oversight and quality assurance to ensure findings accurately reflected lived experience. The resulting insights consolidate public feedback on the NHS 10 Year Health Plan and its three key shifts: care closer to communities, increased use of digital approaches, and a stronger focus on prevention.

During January and February, work focused on finalising the Somerset's Big Conversation findings report, which will be shared very soon. The feedback gathered through the roadshow is already being used to inform the development of our strategy and support key projects across Somerset's health and care system, helping ensure future plans reflect what matters most to people and communities.

Sharing insight to inform change

Throughout 2025, people across Somerset shared their views and experiences of health and care services through engagement led by NHS Somerset and partners across Somerset. An insights report developed in November and December brought together learning from this activity, providing a consolidated picture of feedback in relation to the NHS 10 Year Health Plan and its three key shifts.

Work has continued throughout January and February to review engagement activity and findings reports to date, bringing together all available insight from people and communities. Findings from Somerset's Big Conversation have been used as part of this wider insight to inform key programmes across Somerset, including Somerset Council's refresh of the Adult Social Care Strategy, development of community services, plans to tackle frailty, consideration of improvements to wheelchair services, and research activity. This helps ensure that people's views, experiences and ideas continue to inform future health and care planning.

Ongoing system engagement highlights

- Currently have 3 live surveys
- Received 547 survey responses
- Received 5,654 pieces of feedback from surveys
- Held 1 PPG chairs meeting
- Held 1 stroke reference group meeting
- Held 2 engagement leads coordination meetings

REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **3.1**
DATE OF MEETING:	**26 March 2026**	
REPORT TITLE:	**EPRR Annual Report 2025**	
REPORT AUTHOR:	**Peter Osborne, Head of EPRR, Estates and Facilities**	
EXECUTIVE SPONSOR:	**Jade Renville, Director of Corporate Affairs (and AEO for the reporting period)** **Shelagh Meldrum, Chief Nursing Officer and Accountable Emergency Officer (AEO) from 18 March 2026**	
PRESENTED BY:	**To be received as part of the CEO Report**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☒
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☒
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☒

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☐ Objective 3: Provide the best care and support to children and adults
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- ☐ Objective 5: Respond well to complex needs
- ☐ Objective 6: Enable broader social and economic development
- ☐ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

The EPPR work programme is subject to ongoing discussion and monitoring via the Somerset system Local Health and Care Resilience Partnership and the annual self-assessment has been subject to check and challenge with NHS England. We report the position to the ICB Board annually for assurance purposes.

REPORT TO COMMITTEE / BOARD

Overview of the EPRR Legislative Requirements

The NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet. The purpose of the NHS core standards are to:

- Enable health agencies across the country to share a common approach to EPRR.
- Allow co-ordination of EPRR activities according to the organisation's size and scope.

- Provide a consistent and cohesive framework for EPRR activities.
- Inform the organisation's annual EPRR work programme.

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

NHS England has a statutory requirement to formally assure its own readiness and that of the NHS in England (NHSE) to respond to emergencies. This is achieved through the EPRR annual assurance process .

Providers and commissioners of NHS-funded services complete an annual assurance self-assessment based on these core standards to provide the requisite assurance. This assurance process is led nationally and regionally by NHS England and locally by ICBs.

The NHS core standards for EPRR cover 10 domains:

1. governance
2. duty to risk assess
3. duty to maintain plans
4. command and control
5. training and exercising
6. response
7. warning and informing
8. co-operation
9. business continuity
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

Organisations must have an appointed Accountable Emergency Officer (AEO) who is a board-level director and responsible for EPRR. Jade Renville was the Accountable Emergency Officer (AEO) for NHS Somerset in the reporting period.

Core Standards Assessment – NHS Somerset

The ICB has self-assessed itself against the EPRR core standards as 'substantially compliant'. The standards rated as 'partial' relate to the business continuity domain, and link to standard 49 Dat Security and Protection Toolkit (DSPT), and 53 third party supplier assurance. The ICB has an improvement plan following the DSPT audit by our auditors BDO which are linked to these two standards and so it was agreed to assess these standards as partial until the actions were complete, which at the time of writing of this report have now been completed.

At the check and challenge meeting with NHSE on 22 October this position was endorsed and they also commended the ICB on our thorough core standards submission. The NHS England Regional Team present the overall South West position to the National Team and this was approved by the end of 2025. The key areas highlighted as having made very good progress were:

- Developing our LHCRP and system partnerships across Somerset
- The programme of work relating to cyber threats and the testing and exercising carried out
- The system response to a number of significant incidents including the planning for industrial action and the Minehead coach incident.

Core Standards Assessment – Somerset NHS Foundation Trust

NHS Foundation Trusts are assessed against a total of 66 core standards with the additional domain of Chemical Biological Radiological and Nuclear (CBRN) planning being assessed. Of

the 62 core standards all were assessed as compliant, which reflects the huge amount of work carried out across the Trust over the last 12 months.

The Chemical Biological Radiological and Nuclear (CBRN) standard (which includes 12 separate standards) was assessed by South Western Ambulance Service NHS Foundation Trust and determined to be fully compliant.

As well as responding to live events, the Trust has conducted a significant amount of exercising and testing, with positive and well-attended engagement from colleagues. Maintaining this programme was a major achievement, given levels of operational pressure, which had wide-ranging reach across all parts of the organisation. The approach has also ensured that teams are actively engaged in their business continuity planning and how this links into operational pressures and escalation.

It is also important to note the effective operational plans that were enacted during incidents such as the response to the Minehead coach crash. Casualties and their families were supported both at Musgrove Park and the Minehead Community Hospital.

It was also clear that there continues to be exceptionally strong partnership working in Somerset across EPRR teams and through the Local Health and Care Resilience Partnership (LHCRP). Our teams work very closely and this clearly has a positive impact on both the planning and response to incidents.

Other providers

NHS Somerset has sought emergency planning assurance from the other key providers in addition to the formal assurance process carried out as follows:

- South Western Ambulance Service NHS Foundation Trust is assessed by Dorset ICB on behalf of the region and have confirmed SWASFT were rated as Substantially Compliant.

- HUC (formerly DevonDoctors) were assessed by Hertfordshire and Essex ICB as providers of NHS111 services and were rated as Substantially Compliant.

- Emed (formerly Ezec) Patient Transport Services have been assessed by BANES, Swindon & Wiltshire (BSW) ICB and rated as Substantially Compliant.

Governance

In addition to the annual assurance process, the EPRR leads for NHS Somerset, Somerset NHS Foundation Trust, Somerset Council and Public Health work very closely throughout the year to ensure that work programmes are aligned, and that we have ongoing assurance of system plans and readiness. This is coordinated through the Somerset Local Health and Care Resilience Partnership (LHRCP), which is co-chaired by the NHS Somerset AEO and Somerset Council Consultant in Public Health.

There is a framework of formal groups which provide assurance that plans and procedures are being monitored and maintained. In particular:

- The Somerset LHCRP provides a regular forum for partners in Somerset to come together and collectively agree and monitor our work programme, risk register and training and exercise schedule.
- The Somerset Health Protection Forum (chaired by Somerset Council Public Health) brings together system partners to manage the priorities associated with health protection and the communicable disease agenda.

- Participation in the Avon and Somerset Local Resilience Forum (LRF), and associated working groups, which coordinate all responders in emergency planning for the region.
- NHS England Regional Health Resilience Partnership (RHRP), which the AEO attends to maintain links with Somerset LHCRP.

The NHS Somerset system coordination centre (SCC) and EPRR teams have continued to work together so processes are well aligned and complement the management of system escalation pressures and how these can develop into business continuity or major incidents.

The ICB Board is asked to:

- Note the results of the assurance process for 2025 and the position of NHS Somerset and its partners.
- Note that the key policies have been reviewed and updated in advance of the forthcoming cluster restructure. It is important that these key documents are maintained whilst Somerset ICB remains as a legal entity
- Approve the ICB's statement of compliance for 2025 (Appendix 1)

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	Equality and Diversity is considered in focusing planning on vulnerable groups who may be at risk in the event of an adverse incident. During any incident the vulnerabilities of people affected are considered as part of the response. For example, during the pandemic response, people with vulnerabilities to the virus were identified on the shielded patient list and provided with additional support.
Quality	A key principle of EPPR planning is to ensure that controls and assurances are in place to manage the identified community risks and to minimise disruption and maintain the quality of services as far as possible.
Safeguarding	No safeguarding issues have been identified, but ensuring vulnerable people are identified and supported during an incident is a key part of an emergency response.
Financial/Resource/ Value for Money	Resources have been identified within the ICB budget for emergency planning and business continuity.
Sustainability	Minor changes from previous EPRR Policy, not affected by our Sustainability Plan.
Governance/Legal/ Privacy	The ICB's Legal duties in relation to Emergency Preparedness Resilience and Response (EPRR) are set out in section 4 of the Emergency Planning and Resilience Policy. Under the Civil Contingencies Act 2004, all NHS funded organisations are required to share information with other responders to maintain public safety. The ICB provides assurance of the system preparedness through the core standards self-assessment and the compliance is assessed by NHS England through the annual governance programme.
Confidentiality	N/A
Risk Description	There are no significant risks to identify in relation to the compliance position. Risks have been identified in relation to each local plan and linked to the Local Resilience Forum Community Risk Register where appropriate. Risk registers for the system are in pace as part of the work of the Local Health and Care Resilience Partnership (LHCRP).

EMERGENCY PLANNING RESILIENCE AND RESPONSE
SELF ASSESSMENT ASSURANCE AND
STATEMENT OF COMPLIANCE 2025

APPENDIX 1

1 INTRODUCTION

1.1 Emergency Preparedness Resilience and Response (EPRR) guidance, issued by the Department of Health and NHS England, requires NHS Somerset to plan for and respond to all declared major incidents as a Category 1 responder.

1.2 Under the requirements of NHS EPRR guidance NHS Somerset is required to:

- Have suitable and up to date incident response plans which set out how NHS Somerset would respond to and recover from a major incident / emergency which is affecting the wider community or the delivery of services; and
- Adopt business continuity plans to enable NHS Somerset to maintain or recover the delivery of critical services in the event of a disruption.

1.3 NHS Somerset is compliant in providing an EPRR structure through which:

- NHS Somerset can meet its obligations to all appropriate EPRR guidance and standards and the Civil Contingencies Act 2004
- The emergency preparedness, resilience and response roles and responsibilities of employees are defined
- An Incident Response Plan is maintained in order to implement an effective response to a major incident / emergency
- The reputation of NHS Somerset is not compromised
- NHS Somerset shares information with partner agencies to enhance co-ordination and co-operation
- A comprehensive business continuity management system is established and maintained, following the principles of PAS 2015 and ISO 22301
- NHS Somerset has identified those activities which are critical to the delivery of its responsibilities and applied systems to reduce the impact of a disruption to business continuity
- Business continuity plans are developed, tested and regularly reviewed to ensure that NHS Somerset can deliver an effective response to a disruption to service delivery
- An annual cycle of EPRR exercises are held to test the effectiveness of NHS Somerset's response to a business continuity disruption and major incident
- NHS Somerset annually reviews the business continuity management system and emergency preparedness with the aim of agreeing EPRR objectives and strategies to drive continual improvement

EMERGENCY PLANNING RESILIENCE AND RESPONSE
STATEMENT OF COMPLIANCE

1.4 The Integrated Care Board and the Director of Public Health can be assured that sufficient resources are in place to manage the business continuity management system and that Directorates have reviewed their plans and that desk top exercises are in place to test this. Assurance is also provided for emergency preparedness through the provision of an active training plan and work programme which are in place to ensure that NHS Somerset can deliver effective and robust support to the response to a major incident or business continuity disruption in line with our EPRR obligations. Our self-assessment position has been assured by NHS England EPRR team as Substantially Compliant.

REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: 05
DATE OF MEETING:	26 March 2026	
REPORT TITLE:	NHS Somerset Medium Term Plan Overview 2026/27 – 2028/29 – Final Submission	
REPORT AUTHOR:	Scott Sealey, Deputy Chief Finance Officer and Deputy Director of Performance & Contracting	
EXECUTIVE SPONSOR:	Alison Henly, Chief Finance Officer and Director of Performance and Contracting	
PRESENTED BY:	Alison Henly, Chief Finance Officer and Director of Performance and Contracting	

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PREVIOUS CONSIDERATION / ENGAGEMENT

The Finance Committee and ICB Board have been kept updated on the development of the Medium Term Plan 2026/27-2028/29. The Finance Committee recommended the final submission to the ICB Board on 10th February 2026, with an ICB Board Exceptional Part B meeting on 10th February 2026 giving final approval of the submission for 12th February 2026.

REPORT TO COMMITTEE / BOARD

Summary and Purpose of Paper

The enclosed paper provides an update summarising the NHS Somerset Integrated Care Board Medium Term Plan submission for 2026/27 – 2028/29 due to be submitted on 12th February 2026.

This report provides an analysis of financial performance across the following areas:

- Summary of NHS Somerset Revenue Position 2026/27 – 2028/29
- Summary of NHS Somerset Capital Position 2026/27 – 2029/30
- Summary of NHS Somerset Performance Position 2026/27
- Summary of NHS Somerset Workforce Position 2026/27

Introduction

On 24 October 2025 NHS England published the **Medium-Term Planning Framework - delivering change together 2026/27 to 2028/29**, which introduced a shift away from short-term operational focus toward long-term, locally led improvement across the NHS. The Framework underpinned the ambitions of the 10-Year Health Plan, seeking to empower local innovation through a revised operating model and financial regime, supporting major improvements in neighbourhood health services, digital transformation, and quality of care.

Medium-Term Planning Framework - delivering change together 2026/27 to 2028/29

• The Medium Term Planning Framework set out performance targets and requirements for NHS organisations over the next three and five years, unlike previous annual planning rounds, Integrated Care Boards (ICBs) and providers must develop robust and realistic three- and five-year plans to deliver these priorities,
• The financial framework set out next steps to deliver on the 10 Year Health Plan for England, to move away from short-term planning to a system that empowers local leaders to plan over the medium-to-long term, and which supports innovation to deliver long-term sustainability,
• The framework helped to bridge the gap between immediate pressure for recovery with deeper, but longer-term, reform. It offered a path to recovery, but a narrow one with several big risks to navigate along the way, including a precarious financial position and potential unfunded costs to come alongside the need for additional private capital to be decided upon at the Budget in November 2025;
• Alongside the framework, NHS England promised to publish at least 20 additional guidance and resource documents for ICBs and providers over the coming months, for areas from neighbourhood health to integrated health organisations, setting significant central direction,
• With 15 headline success measures over a three year-period, down from 18 in 2025/26 and 133 in 2022/23, the framework continued the recent trend of providing local leaders with greater focus to better enable delivery. However, it included many more requirements, albeit over a longer three-year period,
• Released five months before the next financial year, it also provided more time for local leaders to build its expectations into realistic plans. However, the framework went as far to inform planning, with further updates to be provided.

Medium Planning Framework – summary of the requirements for both providers and commissioners

- **Financial discipline and incentives**

The multi-year funding settlement at the Spending Review provides 3% real-terms increase in revenue and 3.2% in capital funding; providing the foundation to move away from annual financial and delivery planning cycle. Capital allocations alongside updated delegated limit guidance and technical guidance will be released later this autumn.

All ICB and Providers are expected to deliver financial balance or surplus each year (without deficit support by 2029). A 2% productivity gains per year for 3 years as a minimum to be delivered through getting the basics right in productivity improvements and harnessing the opportunities of digital and service transformation in Urgent and Emergency Care and Outpatients, which support the shifts.

ICB revenue allocations will move to 'fair sharing of resources' alongside a review of the broader NHS funding formulae. Alongside, the capital regime will be reformed to get better value from public and private capital.

Block contracts will be dismantled, with a new Urgent and Emergency Care (UEC) payment model for 2026/27, comprising a fixed element of the UEC payment model and a 20% variable payment and an incentive element of the UEC payment model to left shift with clinical, financial and operational groups. The reformed payment mechanisms and models will be set out in the 2026/27 NHS Payment Scheme, including proposed best practice tariffs to incentives transformation and new ways of working.

A financial model/incentive model for neighbourhood health as demand for acute service reduces is currently being developed with pilot sites, available for adoption in 2026/27.

- **Productivity**

The operating framework continues the focus on improving the productivity of the NHS. It highlights focuses on the following areas:

- **Technical efficiency** – reducing inpatient length of stay, improve theatre productivity and return to pre-COVID levels of activity per whole-time equivalent (WTE). This means delivering at a minimum the 2% annual productivity target,
- **Analogue to digital** – accelerate the shift to a digital-by-default across acute, community, mental health. Learning disabilities and autism services and primary care,
- **Metrices** – NHS England will publish trust-level productivity measures and incorporate these into the NHS Oversight Framework. This will include dedicated measures for community health services, addressing previously unwarranted variation,
- **Urgent and Emergency Care (UEC)** – shift to digital-first UEC model, using clinical prioritisation and scheduling to improve reducing available demand. Move away from traditional walk-in demand to models that support patients' access to the right care, in the right setting, at the right time, based on clinical urgency and individual needs. This includes expanding digital and telephony-based triage and booking mechanisms and increasing access to same-day or next-data scheduled care where clinically appropriate,
- **Outpatients** – shift to digitally enabled care by expending use of advice and guidance and digital triage and expanding PIFU, remote consultations and digital monitoring. This should deliver a reduction in outpatients follow-up activity (OPFU). Rather than a uniform national target, each ICB must:
  - Model required OPFU reduction to accelerate delivery of referral to treatment (RTT) and long-way targets, and then
  - Submit bespoke plans.

- **Operating Model** - the refreshed NHS operating model enables delivery of the10 Year Health Plan; focussing on empowering integrated local care to improve access and reduce hospital demand, while prioritising prevention, tackling health inequalities and enhancing patient experience. It focusses on eight areas as follows;

○ **Providing clarity on system roles–**every part of the system has a different role:

- **The centre–**sets national outcomes, codifies standards, builds shared platforms once and well and removes barriers,
- **Regions –** leadership interface, with a single line of sight across performance, finance, workforce and quality, responsible for both grip and for support,
- **ICBs –** strategic commissioners, moving resources into prevention and community capacity, tackling inequalities and commissioning for value (quality of care and optimal efficient cost),
- **Providers –** through a revitalised foundation trust process, are responsible for collaboration, productivity and quality, with earned freedoms for those who deliver and proportionate intervention where standards slip,
- **Integrated health organisations –**contracts will enable end-to-end redesigning of pathways, with efficiencies reinvested into better and more effective ways of working,
- **Neighbourhood teams –** will support communities and deliver proactivity support for people with facility and long-term conditions. They will provide urgent and acute community services, rehabilitation and prevention and support improves access to care, especially general practice. Their work will be enabled by digital tools and shared care records.

○ ***Unleashing local potential to deliver integrated care*** - setting out plans for ICBs to be strategic commissioners and taking an outcomes-based approach, with integrated health organisation who will not be new organisations they will work with the wider provider landscape to deliver high-quality care efficiently, including through sub-contracting arrangements and, where appropriate, delegation of commissioning. Blueprints for these will are being developed which include the contractual frameworks to support them. New oversight framework to show the public how organisations are performing with success being rewarded with greater local control.

○ ***Neighbourhood health at pace*** - taking immediate action on improving access and reducing unwarranted variation reducing unnecessary non-elective admissions and bed days from priority cohorts (frail, care home residents and ed of live) and shifting planned specialised care closer to home. Systems need to understand the current and projected total service utilisation and costs for high priority cohorts of those with moderate to severe frailty, living in care homes, housebound or at the end of life. Creating an overall plan to more effectively manage the needs of these high priority cohorts and significantly reduce avoidable unplanned admissions.

○ ***Sickness to prevention*** - ICBs need to ensure that their five-year commissioning plan reflection the need to continue to focus on prevention and early intervention. Specifically tackling obesity, rates of premature mortality linked to CVD, tobacco dependency and reduce exposure to antibiotics to meet thresholds set in recent guidance and addressing problematic polypharmacy to reduce avoidable harm.

○ ***Doing digital differently*** - the health service must become one that is digital by-default; a core element of this is through the NHS App including using AI triage and data drive pathways to guide patients to bookings through My NHS GP, giving patients one place to manage all appointments, referrals and interactions and facilitating access to targeted prevention services and expanding point-of-care testing in the community. Establish NHS Online, a new 'online hospital' to connect patients to expert clinicians from 2027.

- ***Transform approach to quality*** - NHSE have developed a new purpose and scope for the National Quality Board and are currently undertaking stakeholder engagement to inform the vision and strategy. The National Quality Board quality strategy (March 2026) will inform local improvement priorities.

Organisation will implement the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework, with trained patient safety specialists and partners in governance. The first three Modern Service Frameworks (CVD, serious mental illness, sepsis) will be adopted, with dementia and frailty to follow. National Care Delivery Standards will be applied to ensure consistent care quality.

Preparation for the Single National Formulary will continue, focusing on priority medicines savings. All-age continuing care services will transition to the AACC Data Set v2.0 by March 2027. Workflows will be redesigned to maximise use of digital systems and the NHS Federated Data Platform, eliminating duplicate paper processes.

The Paediatric Early Warning System will be in place in all relevant hospitals by April 2027. With best practice maternity resources will be adopted, including care bundles and bereavement pathways. The Maternity and Neonatal Inequality Dashboard will guide action on variation, supported by the Perinatal Equity and Anti-Discrimination Programme. The MOSS system will be operational across all trusts by November 2025.

- ***Understanding and improving the patient experience***- by the end of 2025/26, all providers will complete a patient survey cycle for waiting patients and collect near real-time feedback from at least five wards or departments before discharge.
- ***Reconnecting with our workforce and renewing and strengthening leadership and management***- every NHS board must use the 2025/26 staff survey findings to analyse free text comments, identify at least three areas with the greatest staff dissatisfaction and plan actions. As well as continuing to tackle discrimination, racism and sexual misconduct, including regularly assessing progress on the Sexual Safety Charter.

NHS England will publish a new Management and Leadership Framework during autumn 2025, setting a code of practice of standards and competencies for clinical and nonclinical leaders and managers at five levels from entry level to board. ICBs and providers should use these in recruitment and approval. A national curriculum and interactive online modules will be published in 2026/27.

- ***Embed Genomics, life sciences and research into care delivery***- All providers should meet the site-specific timeframes of the government's 150-day clinical trial set-up target. Progress should be reported to boards six-monthly. From April 2026, ICBs should proactively support clinical trials by following standards and guidance set out in Managing Research Finance in the NHS. Providers must deliver services in line with the NHS Genomic Medicine Service Specification from April 2026.

Guidance and Allocations

In mid-November 2025, NHS England published the following guidance and allocations to launch the next phase of medium-term planning:

- Revenue and Contracting Guidance,
- ICB revenue allocations for 2026/27 to 2027/28 and supporting guidance,

- Capital guidance and allocations for 2026/27 to 2029/30,
- NHS Payment Scheme 2026/27 consultation,
- NHS Standard Contract 2026/27 consultation,

The guidance included an initial timetable, noting a draft submission of operational plans (activity, workforce, finance) due in December and a final submission (including narrative) submission due in February. It was noted that the third-year revenue settlement was to follow, with the draft submission only including 2026/27 and 2027/28.

Key Messages - Financial Plans 2026/27 – 2028/29

Context
We have a three-year revenue settlement and four-year capital settlement, allowing us to now publish two years of allocations, with a third year to follow shortly, in support of the medium-term planning process.

The task is a stretching one; make significant improvements to elective and UEC performance, and shift care from hospitals to neighbourhoods alongside the other shifts, whilst delivering 2% annual productivity and eradicating deficit funding.

We are updating the financial framework to support an operating model based on clearer organisational accountability, with greater transparency of funding flows.

Funding and allocations
- ICB core programme allocation growth in 2026/27 is 2.7% based on cost uplift factor (CUF) of 2.03%, a general efficiency requirement of 2.0%, and activity/other cost growth. Convergence of up to +/-0.5%. CUF and allocations subject to change depending on pay decisions.

- Target allocations made fairer with 2.3bn increase to target quantum's (not actual). DSF moved into recurrent allocations for >2.5% under target systems. Annual convergence based on this revised DfT. No system is more than 2.5% underfunded on ICB core programme by 28/29. All ICBs within +/-2.5% of overall fair share by 28/29 excluding spec com.

- £6.3bn elective recovery funding has been moved into recurrent baseline allocations (ICB core and specialised) on a fair share basis. Further non-recurrent funding is allocated over the 3 years on a differential basis to enable delivery of diagnostic and elective performance standards.

- 2% general efficiency requirement in the NHSPS consultation and allocations. In addition, DSF will be withdrawn over time, and ICB funding based on successful delivery of £19/head cost of commissioning target (not reflected in 2.7% base growth figure above).

- Operational capital allocations are made at provider rather than system level. Different methodologies are used to calculate strategic capital allocations. Organisations in NOF segments 1 and 2 may reinvest prior-year surpluses as additional CDEL.

NHS Payment Scheme
- Move to blended payment approaches for UEC, including same day emergency care (SDEC) and other same day pathways, comprising a fixed payment, based on price x planned activity and a variable payment of 20% of prices for activity above or below the planned level.

- Continue to work on deconstructing fixed payments. Recommended maximum contract value change of 2.5% to manage change at commissioner/provider level.

- Elective payments remain on variable basis. Best Practice Tariffs to encourage shift to day case, outpatient procedures and support elective delivery.

- Helping “left shift” through UEC blended payment, working groups on neighbourhood payment models and UEC, development of MH and community currency models.

- Introduction of some non-mandatory guide prices for some ADHD and autism services

- Set prices by updating the 2025/26 pay award prices by applying the cost uplift (2.03%) and efficiency (2.0%) factors and an adjustment reflecting the change in MFF values (0.42%)

- Ophthalmology services – reduce the prices for simple cataracts by 20% and use the funding to increase the prices of other ophthalmology services, focusing on more complex procedures.

- Low volume activity (LVA) – continue to use LVA arrangements for almost all NHS provider/commissioner relationships with an annual value of less than £1.5m.

Financial framework and business rules

- System financial balance requirement replaced with ICB and NHS trust/FT breakeven requirements.

- Deficit Support Funding (DSF) is issued to organisations with deficit plan limits. No national provider surplus plan limits but surpluses will enable access to capital drawdown regime.

- MHIS is set at flat real for ICB core programme allocations.

Planning approach

- ICB and NHS trust boards must ensure they have a robust approach to risk management in place. Plans must have assessed risk and identified robust mitigations that are actionable within the control of the organisation.

- ICBs and NHS trusts will be expected to submit plans that show a mutual alignment of contract information and planning assumptions. NHSE will reject plan submissions that are not aligned, requiring local resolution and re-submission.

Business Rules

As part of the new NHS operating model, ICBs and NHS trusts/FTs are required to deliver financial balance as individual bodies.

NHSE have published updated NHS finance business rules guidance which will apply from 1 April 2026.The system financial balance requirement is replaced by ICB and NHS trusts/FT financial balance requirements. The system cumulative position is replaced by ICB cumulative position, with associated drawdown/repayment.

ICBs and NHS trusts will continue to be required to collaborate including when setting plans, as set out in the NHS Planning Framework shared in the summer.

System cumulative positions at 2025/26 year-end will be carried forward to form new ICB cumulative positions from 2026/27. Deficit repayments will be paused for two years with the opportunity for system cumulative deficits to be forgiven where the ICB maintains balance in each year alongside a history of strong financial management in recent years. Cumulative system surpluses will be carried forward to new ICB cumulative positions.

ICB Underlying Position – assessment of 2025/26 exit position

The ICB assessment of the exiting run rate deficit based on the final 2025/26 financial plan (submitted on 30 April 2025) was £21.281. The ICB has revised this assessment as it gets closer to the end of the 2025/26 financial year, which has worsened the underlying position (ULP) by £3.673m, as discussed at the Finance Committee. The bridge from 2025/26 outturn to the most recent assessment of the system ULP is set out in table 1 below:

Table 1: ICB Exit Underlying Position 2025/26

2026/27 Planning	Somerset ICB 2026/27 £'000
25/26 Outturn	**-**
N/R Allocation	
National Financial Framework - Achieving 24/25	8,143
N/R Pay - Other Income Support	856
N/R Cost Pressures/Investments	
IT Extension	
Reinstate Contingency	2,052
N/R CIP/Benefits	
N/R 4% QIPP / CIP 35%	2,030
Other N/R QIPP / CIP	8,200
ULP Exit 25/26 - per 25/26 Plan	**21,281**
R Allocation	
R Income Support	(1,366)
In-Year R Cost Pressures/Investments	
ADHD/ASD Right to Choose	2,000
Learning Disabilities	1,650
Continuing Care - Fast Track	3,000
Transporting Somerset	200
Maternity	400
CEWS	(610)
Named Patient	(601)
R CIP	
GP Prescribing - Diabetes Drug	(1,000)
Opening 26/27 ULP	**24,954**

2026/27 – 2028/29 ICB allocations

Table 2 summarises the ICB Total Allocations for 2026/27 – 2028/29.

Table 2: ICB Total Allocations for 2026/27 – 2028/29

	2026/27	2027/28	2028/29
	Financial Plan £'000	Financial Plan £'000	Financial Plan £'000
Sources of Funds			
Core Allocation	1,295,999	1,332,007	1,379,922
Delegated Commissioning - Primary Medical Care	131,479	133,459	135,420
Delegated Commissioning - Pharmacy, Optom and Dental	61,328	62,456	63,613
Delegated Commissioning - Specialised Commissioning	1,725,597	1,791,025	1,838,478
ICB Cost of Commissioning Adjustment	(12,536)	(12,787)	(13,044)
Running Costs	9,010	9,200	9,391
Service Development Funds (SDF)	2,754	2,405	4,117
Elective Recovery Fund	57,844	60,783	60,918
Capital Charges	9,845	15,412	5,582
Total Sources of Funds	**3,281,320**	**3,393,959**	**3,484,396**

ICB cost of commissioning (£19/head) - changes are transacted as a post convergence adjustment in all three years. This is a National calculation. ***Since the sign off discussion of the plan on 10th February 2026, NHS Somerset ICB has resolved the baseline issue that existed with the Cost of Commissioning Adjustment, which has resulted in £3.640m being returned to the ICB, reducing the adjustment to £12.536m.***

Elective Recovery Fund (ERF)
£5.5bn of elective funding will be added to recurrent ICB core programme allocations on a fair share distribution from 2026/27. NHS Somerset is below ERF fair shares funding in 2025/26, so has benefitted from an additional allocation of £16m to support performance improvements

Additional non-recurrent elective recovery funding will be added to ICB allocations in 2026/27 (£321m) and 2027/28 (£871m) on a targeted distribution to support all areas of England to meet the 6-week diagnostic and 18-week RTT access standards by 2028/29. The NHS Somerset non-recurrent allocation in 2026/27 is £1m, which increases to £4m in 2027/28 and 2028/29

Ambulance growth funding is initially held outside ICB allocations, as in 2025/26.

Service Development Fund (SDF)
£1.7bn of SDF funding recurrently into allocation baselines.

SDF included in table 2 relate to allocations for CYP complications of excess weight, innovation, hybrid closed loops and Mental Health services for Individual Placement Support, Talking Therapies and Mental Health Support Teams in schools (MHST).

The remaining unallocated SDF includes: cancer alliances; children's hospices; funding issued on a drawdown or reimbursement basis; funding that has been allocated for a specific purpose by government departments.

Base growth - Table 3 details the national assumptions underpinning ICB core programme base growth of 2.7% in 2026/27, 2.9% in 2027/28 and 3.2% in 2028/29. It should be noted that these are assumptions and not binding requirements (except for MHIS).

Table 3: ICB core programme base growth

	2026/27	2027/28	2028/29
CUF	2.03%	2.00%	2.00%
Productivity	-2.00%	-2.00%	-2.00%
Electives activity	2.0%	2.0%	2.0%
Non-Electives activity	2.4%	1.7%	3.1%
A&E activity	1.8%	1.7%	1.8%
Diagnostics activity	3.9%	3.7%	3.2%
Ambulance activity	0.0%	0.0%	0.0%
Maternity activity	2.0%	2.0%	2.0%
Community activity, NbH & Left Shift	6.2%	7.1%	7.5%
Mental Health activity	2.0%	2.0%	2.0%
ICB Other activity	2.0%	2.0%	2.0%
CHC/FNC total growth	4.7%	4.7%	4.7%
Prescribing total growth	0.1%	3.5%	3.3%
HCDs total growth	5.6%	5.5%	5.3%
BCF	4.4%	4.8%	4.7%
CNST total growth	8.0%	5.9%	5.5%
Total Base Growth	**2.7%**	**2.9%**	**3.2%**

The Mental Health Investment Standard funding increase is in line with base growth (2.7%) in 2026/27.

Included within growth allocation is funding for the cost uplift factor (CUF) that is detailed in table 4 below. Total pay cost change is valued at 2.1% for 2026/27. This reflects the fact that allocations for 2026/27 include a nominal 2% for pay and then allows a 0.1% increase for pay drift. It is expected that any pay award above 2% would result in further uplift in ICB allocations.

Table 4: Cost uplift factor (CUF)

	2026/27	2027/28	2028/29
Pay	2.10%	2.10%	2.10%
Drugs	0.58%	0.73%	0.70%
Other Operating Costs	2.20%	2.00%	2.0%
Unallocated CNST	0.52%	0.51%	0.47%
Capital	1.66%	2.04%	1.95%
Tariff Inflator (CUF)	**2.03%**	**2.00%**	**2.00%**

Table 5 shows the consistent **Convergence** parameters across ICB core, Specialised Commissioning and Primary Care Medical expected to deliver up to 0.5% when outside of the target range. For systems within the range a materially less convergence is applied.

Table 5: Convergence Parameters

DfT	Convergence
>3.0%	(0.50)%
0 - 3.0%	taper
zero	-
0 - (3.0)%	taper
<(3.0)%	0.50%

For NHS Somerset ICB, our distance from target at our recurrent 2025/26 baseline is 0.60% over the weighted allocation formulae, which has resulted in a -0.06% (£0.8m) convergence adjustment being applied against our core allocations in 2026/27. For 2027/28, our distance from target at our 2026/27 recurrent baseline has reduced to is 0.5% over the weighted allocation formulae, which has resulted in a -0.04% (£0.6m) convergence adjustment being applied in 2027/28. Our distance from target at our recurrent 2027/28 baseline has reduced further to 0.4% over the weighted allocation formulae, which has resulted in a -0.04% (£0.5m) convergence adjustment being applied in 2028/29. This is summarised in **table 6**.

Table 6: NHS Somerset ICB Convergence Adjustment 2026/27 – 2028/29

Somerset ICB Core Allocations	Distance from Target	Convergence Adjustment	
	%	%	£'m
2026/27	+0.60%	-0.06%	-0.8
2027/28	+0.50%	-0.04%	-0.6
2028/29	+0.40%	-0.04%	-0.5

Application of Funds 2026/27 – 2028/29

Table 7 summarises the ICB Total Application of Funds for 2026/27 – 2028/29.

Table 7: ICB Total Application of Funds for 2026/27 – 2028/29

	2026/27 Financial Plan £'000	2027/28 Financial Plan £'000	2028/29 Financial Plan £'000
Total Sources of Funds	**3,281,320**	**3,393,959**	**3,484,396**
Application of Funds			
Delegated Commissioning - Primary Medical Care	131,479	133,459	135,420
Delegated Commissioning - Pharmacy, Optom and Dental	61,328	62,456	63,613
Delegated Commissioning - Specialised Commissioning	1,725,597	1,791,025	1,838,478
Acute Services	792,015	799,155	804,006
Mental Health	139,439	145,258	151,874
Community and Partnerships	170,783	182,684	205,731
Prescribing	99,238	100,514	101,806
Primary Care	24,165	22,552	22,555
Continuing Care and Funded Nursing Care	66,198	67,986	69,821
Running Costs	9,010	9,200	9,575
Managed Programmes	19,951	36,969	38,161
Other Commissioning	42,117	42,702	43,355
Total Application of Funds	**3,281,320**	**3,393,959**	**3,484,396**
Variance	**0**	**0**	**0**

Financial Commitments

Better Care Fund

In 2026/27, the overall NHS minimum contribution to the BCF rises by 3.0% on average. Within this, the average rise is 4.4% for the NHS minimum contribution to ASC. ICB BCF minimum contribution values are published as part of ICB revenue allocations.

Government intends to reform the BCF from 2027/28 but indicative 2027/28-2028/29 values are provided in the revenue guidance for medium-term planning purposes.

Mental Health Investment Standard (MHIS)

ICB MHIS values for ICB core programme allocations will be set for 2026/27-2028/29 based on flat real growth each year.

ICB specialised MHIS will be set for 2026/27-2028/29 based on the mental health weighting of the delegated specialised services allocation.

ICB dental ringfence

The ICB dental services ringfence will continue to apply to the ICB POD allocation in 2026/27-2028/29, with a schedule issued on Futures to support planning.

Temporary staffing expenditure

Agency spend limits will be set for all NHS trusts/FTs in 2026/27-2028/29 to support removal of agency spend in 2029/30. Limits are set based on 25/26 M6 FOT, with reductions of 30% in 2026/27, 25% in 2027/28 and 25% in 2028/29.

Bank spend limits will be set for all NHS trusts/FTs in 2026/27-2028/29 to support a reduction on bank spend over the period. Limits are set based on 25/26 M6 FOT, with a reduction of between 7.5% to 15% in each year from 2026/27 to 2028/29 (varying dependent on starting position).

Deconstructing the fixed payments and move to UEC blended payment.
ICBs and trusts have completed work to deconstruct blocks and to review fixed payments as we move back to a rules-based framework for provider payment.

The payment scheme proposes that agreement is reached between NHS trusts and ICBs and that contracts should identify funding for individual services – including for services not funded on an activity basis and where payments for services are in excess of the unit price value of activity being undertaken.

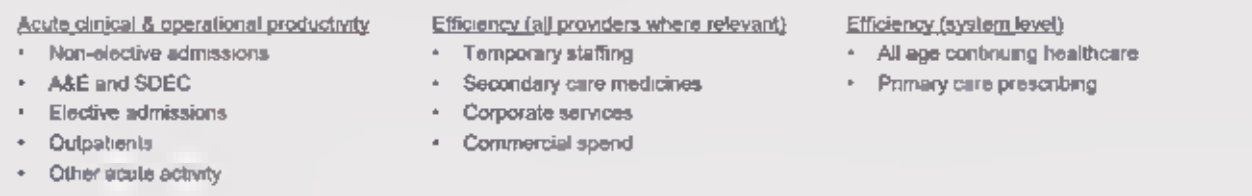
Differences in funding between baseline contract values and the combined value of these elements should be agreed, and a proposed approach to move towards target contract values in a fair way over time by setting an expectation that adjustments for funding differences should generally not exceed 2.5% of contract values. For 2026/27 the adjustments for funding differences will only be applicable to acute services (including delegated specialised commissioning) commissioned by ICBs.

Productivity and Efficiency

- The Medium Term Planning Framework sets a clear expectation for trusts to deliver a 2% annual productivity improvement and balanced plans should consider how this can be

delivered. All trusts should review their productivity performance and understand how to maximise opportunities for improvement.

- Productivity Opportunity Packs have been produced for all trusts to support this. These describe quantified opportunities for improving productivity that, if delivered, can contribute to delivering the annual requirement. The packs cover a range of areas for improvement and use the data held nationally to show variation.
- Opportunities are expected to cover the full planning period (2026/27 to 2028/29). The packs are a tool helping to set the scale and priority of opportunities in different areas, to be assessed alongside local insight, data and delivery capacity. Action taken to realise opportunities will be reflected in respective activity, finance and workforce plans.



- These packs are not a comprehensive list of productivity and efficiency opportunities.

Capital guidance and allocations for 2026/27 to 2029/30

Purpose

- Introduce a more transparent, devolved and rules-based capital system.
- Support delivery of the 10-Year Health Plan and Spending Review 2025 (SR25) priorities.
- Provide long-term certainty for planning and investment across the NHS.

Key features of the new regime

- 4-year firm settlement (£44bn capital) plus 5-year planning horizon to 2034/35.
- Three funding streams underpinning ~£10–11bn annual investment:
    1. Operational capital: provider-level allocations (85% depreciation / 15% CIR)
    2. Estates Safety: £750m per year (9-year programme, regionally led).
    3. Strategic capital: c.£5.5bnfor UEC, electives, diagnostics, MHLD&A , community, and primary care.
- Expanded freedoms and flexibilities for high-performing providers and ICBs.
- Simplified approvals: Treasury limit raised to £300m; faster delivery for schemes below threshold.
- Integration with the 10YHP's key shifts – hospital → community, analogue → digital, sickness → prevention.

Overall aim

- A stable, fair and accountable capital framework that empowers ICBs and providers to deliver sustainable improvement in NHS performance, productivity, and estates safety—while maintaining national affordability within the CDEL budget.

Operational Capital

Direct provider-level allocations (rather than via systems), consistent with the 10YHP and new operating model. Formula based on:

- 85% depreciation (scale of asset base)
- 15% critical infrastructure risk (adjusted for RAAC funding and early wave NHP schemes)

Redirect 5% of provider op-cap into ICB allocations to support ICBs' role in demand management and strategic investment.

Strategic Capital

- c.£5.5bn funding to support capacity growth & transformation across UEC, electives, diagnostics, MH, community, and primary care.
- Regions work with ICBs to develop strategic plans aligned to commissioning strategy – considering CDEL & RDEL affordability

Allocation approach:

- Diagnostics: formula based on performance data (pending adjustment for independent CDCs)
- UEC / Community / PC: weighted population with adjustments for health inequalities and building costs
- Mental Health: straight population, adjusted for building costs
- Frontline Digitisation flows on a regional basis, allocated by weighted population and digital maturity.
- Regional tailoring to target investment and meet commitments (e.g. OAPs, Crisis Centres), prior to confirmation of system allocations
- Regions and ICBs can move funding between the five indicative allocations, provided they put the indicative funding allocation into diagnostics and left shift or can justify not doing so.
- Plans should commit 100% for years 1–2, and ≥80% for years 3–4;We expect at least 80% of schemes to have a value over £1m, and will take a streamlined approach to approvals below £1m.

Estates Safety

£750m p.a. (4 years firm + 5 planning = £6.75bn total) to tackle Critical Infrastructure Risk.
Regional allocations based on CIR levels adjusted for RAAC (£500m–£900m per region)
Regions will be responsible for the allocation and prioritisation of funding.

- Regions are best placed to prioritise schemes, reflecting local estate intelligence and maximising value for money.
- Delivery will be overseen regionally, with clear accountability for outcomes and delivery.

Table 8: NHS Somerset ICB Capital plan for 2026/27 – 2029/30:

ICB Summary	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	4 Year Plan £'000
ICB - Capital Envelope Analysis					
ICB Core allocation	1,184	1,187	1,191	1,191	**4,753**
ICB Strategic Allocation	1,892	1,981	2,024	2,063	**7,960**
2025/26 Revenue Fair Shares Allocation Adjustment (business rules)	0	0	0	0	**0**
Total ICB Capital Allocation	**3,076**	**3,168**	**3,215**	**3,254**	**12,713**

National Programme Funding	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	4 Year Plan £'000
Utilisation and Modernisation Fund (UMF) Allocation	500	500	500	500	**2,000**

These allocations do not include the capital incentive for delivering a breakeven plan position 2025/26.

Table 9 Indicative Constitutional Standards Capital Schemes for NHS Somerset for 2026/27 – 2029-30:

ICB	26/27 £'000	27/28 £'000	28/29 £'000	29/30 £'000	Total £'000	Programme	New/Pre-Commitment
Somerset	4,000				4,000	Elective	Pre-commitment
Somerset	2,900				2,900	UEC	Pre-commitment
Somerset	2,796				2,796	UEC	Pre-commitment
Somerset	6,000	3,000			9,000	UEC	New
Somerset	3,000				3,000	UEC	New
Somerset	70	-	-		70	Diagnostics	New
Somerset	-	150	-	-	150	Diagnostics	New
Somerset	245	-	-	-	245	Diagnostics	New
Somerset	-	323	-	-	323	Diagnostics	New
Somerset	-	100	1,900	-	2,000	MHLDA	New
Somerset	272	200	116	93	681	MHLDA	New
Somerset	0	0	0	1,140	1,140	MHLDA	New
Somerset	1,250	750	750	750	3,500	Community	New
	20,533	**4,523**	**2,766**	**1,983**	**29,805**		

The ICB is proposing to submit a break-even Capital plan for 2026/27 – 2029/30, as per national expectations.

ICB Efficiency Savings Programme 2026/27 – 2028/29

The ICB efficiency programme (excluding Specialised Commissioning) has been updated due to the cost of commissioning adjustment and is now expected to deliver £50.7m of savings in 26/27, 3.3% of the total NHS Somerset ICB allocation:

Table 10: System efficiency savings programme 2026/27 – 2028/29

ICB Savings Programme (£'000)	2026/27			2027/28			2027/28		
	Total	Recurrent	Non Recurrent	Total	Recurrent	Non Recurrent	Total	Recurrent	Non Recurrent
Provider CIP - Intra System Deflator (2.0%)	(15,606)	(15,606)		(16,772)	(16,772)		(16,851)	(16,851)	
Provider CIP - Convergence	-			(341)	(341)		(203)	(203)	
Provider CIP - High Cost Drugs (Biosimilars)	(1,500)			-			-		
Provider CIP - SHS	(2,223)	(2,223)	-	(2,489)	(2,489)		-		
ICB - Acute - Out of County	(3,589)	(3,589)		(3,693)	(3,693)		(3,846)	(3,846)	
ICB - SWASFT (Pace of Change/Handovers)	(629)	(629)		(628)	(628)		(689)	(689)	
ICB - Primary Care incl. Prescribing	(6,559)	(6,559)		(2,426)	(2,426)		(2,451)	(2,451)	
ICB - CHC	(1,289)	(1,289)		(1,324)	(1,324)		(1,360)	(1,360)	
ICB - Community Health	(104)	(104)		(99)	(99)		(99)	(99)	
ICB - Mental Health	(332)	(332)		(346)	(346)		(418)	(418)	
ICB - Other Programmes	(1,141)	(147)	(994)	(1,034)	(542)	(492)	(1,044)	(549)	(495)
ICB - Learning Disabilities	(2,500)	(2,500)		(2,500)	(2,500)		-		
ICB - Running Costs - Growth Mitigation	(180)	(180)		(183)	(183)		(184)	(184)	
ICB - Cost of Commissioning	(12,536)	(12,536)		(251)	(251)		(257)	(257)	
ICB - Ringfenced Budgets	(2,500)		(2,500)	-			-		
Total CIP / QIPP ex Spec Comm	**(50,688)**	**(45,694)**	**(3,494)**	**(32,086)**	**(31,594)**	**(492)**	**(27,403)**	**(26,908)**	**(495)**
% of ICB Allocation ex Spec Comm	**-3.3%**			**-2.0%**			**-1.7%**		

ICB exit underlying position 2026/27

The ICB continues to assess its underlying deficit financial position, and its initial assessment of the exit 26/27 underlying position is £12.1m, which if delivered, has improved from the opening 25/26 ULP of £25.0m.

Table 11: ICB exit underlying position 2026/27

	NHS Somerset ICB 2026-27 £'000
Plan Position	**0**
Movements to ULP	
N/R Allocation	
National Financial Framework	7,727
N/R Cost Pressures/Investments	
ICB Cost of Commissioning	(4,000)
ICB Cost of Commissioning Provision	4,987
Reinstate Contingency / Recurrent impacts	2,900
Investment Reserve	(3,000)
N/R CIP/Benefits	
N/R QIPP / CIP	994
Other N/R Benefits	2,500
Exit Underlying Position	**12,108**

Risk and Mitigations

Table 12 below details the initial assessment of risks and mitigations it will need to manage to deliver the 2026/27 – 2028/29 plans:

Table 12: Risk and Mitigations

Risks and Mitigations	26/27 £'000	27/28 £'000	28/29 £'000
Risks			
Elective Care Programme	(5,000)	(5,000)	(5,000)
Prescribing	(1,800)	(1,800)	(1,800)
Continuing Healthcare	(2,500)	(2,500)	(2,500)
NHS Contract - UEC	(2,000)	(2,000)	(2,000)
Winter	(1,000)	(1,000)	(1,000)
CSU	(1,000)	(1,000)	(1,000)
System Cost Improvement Programme	(2,500)	(2,500)	0
ICB Cost of Change	(4,000)	0	0
Flexibility in Ringfenced Budgets	(2,500)	0	0
Total Risks	**(22,300)**	**(15,800)**	**(13,300)**
Mitigations			
Contingency	5,450	6,526	6,769
N/R Investment Reserve	3,000	3,000	3,000
Total Mitigations	**8,450**	**9,526**	**9,769**
Net Risk Position	**(13,850)**	**(6,274)**	**(3,531)**

The previous risk relating to the ICB Cost of Commissioning Adjustment (£4m) has now been removed.

Performance

The system is proposing to submit a plan to deliver all key performance except for:

- RTT 18-week waits: a compliant plan will be submitted, however there are risks to delivery during 26/27 due to the impact of the further roll-out of Advice and Refer. Modelling has been undertaken to predict the impact on waiting list size reductions on admitted / non-admitted performance and further work is being scoped to develop a specialty level simulation model for both admitted and non-admitted pathways. The plans for 27/28 and 28/29 are compliant and factor in productivity improvements and additional ERF funding to deliver additional elective activity; this is fairly distributed across our population to equalise waiting times

- RTT 52-week waits: this plan is non-compliant due to Somerset FT predicting a small number of >52 week waits (29 by March 2027) and plan to clear these residual long waits by March 2028. Somerset ICB is submitting a compliant plan with zero by March 2027

- Mental Health – Talking Therapies (Completed Courses of Treatment): Somerset FT have agreed with NHS England to not deliver the standard (actual 6,582 vs requirement of 6,980) in 2026/27 due to new appointments going through training during 26/27. The trajectory is compliant for 27/28 and 28/29. The Reliable Recovery and Improvement trajectories is compliant across all 3 years

- Mental Health – Mental Health Teams in Schools: the plan is non-compliant in 26/27 (72.8% vs national expectation of 77%), recovering in 27/28 and 28/29, with the agreement of NHS England

- Routine Dental – Somerset ICB has submitted a non-compliant plan for routine dental activity in each for 3-years (26/27, 27/28 and 28/29) and projected performance of 55.7% by March 2029 versus the national ambition of 96%. This projected performance has subsequently changed to 83% in the 18th March 2026 planning submission, following the announcement of and the anticipated benefits from the NHS dental quality and payment contract reforms. Somerset ICB remains a significant outlier both Regionally and Nationally. However, the Urgent Access trajectory is compliant

- Community Contacts: National expectation is 3% growth in Community Contacts which demonstrates 'left shift' from acute to community. However, the proposed plan does not factor in any growth across the 3-year period which aligns with the financial planning assumptions

- The urgent and emergency care plans, submitted by Somerset FT, are predicated on delivery of a reduction in the number of patients in hospital with No Criteria to Reside to 13% of occupied beds by March 2029

Workforce

The Primary Care workforce plan detailed in table 9 shows a:

- 4.34% increase in Total Workforce from March 2026 to March 2029, including 4.28% GPs and 7.5% Practice Nursing growth.
- -0.62% reduction in Administrative and Non-Clinical roles

Table 13: Primary Care workforce plan

	Baseline	Plan	Plan	Plan	Plan	Plan	Plan	Change from March 2026 to March 2029	
	Staff in post outturn	Q1	Q2	Q3	Staff in post outturn	Staff in post outturn	Staff in post outturn		
	Year End	As at the end of	As at the end of	As at the end of	As at the end of	As at the end of	As at the end of		
	31/03/2026	30/06/2026	30/09/2026	31/12/2026	31/03/2027	31/03/2028	31/03/2029		
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	WTE	%
Total Workforce	2236.88	2242.37	2247.02	2253.57	2281.65	2312.35	2333.85	96.97	4.34%
Total GPs	430.67	431.67	432.67	432.67	437.9	444.1	449.1	18.43	4.28%
Total Nurses	228.83	229.52	230.02	233.67	235.5	242.25	246	17.17	7.50%
Total ARRS Funded Roles	377.38	377.98	380.93	381.83	390.85	403.25	415.6	38.22	10.13%
Total Direct Patient Care Roles	251.7	251.9	252.1	253.1	261	270.35	280.75	29.05	11.54%
Total Administrative and Non-Clinical Staff	948.3	951.3	951.3	952.3	956.4	952.4	942.4	-5.9	-0.62%

The Non-NHS (VCFSE) Mental Health workforce plan detailed in table 10 shows a:

- 2.5% increase in Substantive Staff between March 2026 and March 2027

Table 14: Non-NHS (VCFSE) Mental Health workforce plan

Summary Staff WTE Detail	Expected Sign			CWTE053 Forecast Out-turn 31/03/2026 Year Ending WTE	CWTE054 Forecast Out-turn 31/03/2027 Year Ending WTE	CWTE055 Forecast Out-turn 31/03/2028 Year Ending WTE	CWTE056 Forecast Out-turn 31/03/2029 Year Ending WTE	Maincode / Subcode
Total Establishment WTE	+			132.27	135.36	135.36	135.36	HWTE001
Total Substantive Staff WTE	+			125.35	128.45	128.45	128.45	HWTE002
Total ARRS Substantive Staff Whole Number	+			0.00	0.00	0.00	0.00	HWTE003

Recommendations and next steps

The Integrated Care Board is asked to approve the NHS Somerset Integrated Care Board operational planning submission for the 2026/27 – 2028/29 financial year.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	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.
Quality	Financial decisions are made to deliver with regard to the best possible value for service users.
Safeguarding	No issues identified
Financial/Resource/ Value for Money	NHS Somerset Integrated Care Board has a confirmed revenue budget of £3,281,320,000 for the 2026/27 financial year as at the time of the planning submission, which includes as the Principal Commissioner, £1,725,597,000 for Delegated Specialised Commissioning.
Sustainability	No issues identified
Governance/Legal/ Privacy	The financial report details any constitutional standards required to be met by the NHS Somerset Integrated Care Board
Confidentiality	No issues identified
Risk Description	NHS Somerset Integrated Care Board must ensure it delivers the planned financial target.

REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **05**
DATE OF MEETING:	**26 March 2026**	
REPORT TITLE:	**NHS Somerset Medium Term Plan Overview 2026/27 – 2028/29 – Final Submission**	
REPORT AUTHOR:	**Scott Sealey, Deputy Chief Finance Officer and Deputy Director of Performance & Contracting**	
EXECUTIVE SPONSOR:	**Alison Henly, Chief Officer Strategic Finance and Resources**	
PRESENTED BY:	**Alison Henly, Chief Officer Strategic Finance and Resources**	

PURPOSE	DESCRIPTION	SELECT (Place an 'X' in relevant box(es) below)
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	X
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	
Discuss	To discuss, in depth, a report noting its implications	
Note	To note, without the need for discussion	
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	

SELECT (Place an 'X' in relevant box(es) below)	LINKS TO STRATEGIC OBJECTIVES (Please select any which are impacted on / relevant to this paper)
X	Objective 1: Improve the health and wellbeing of the population
X	Objective 2: Reduce inequalities
X	Objective 3: Provide the best care and support to children and adults
X	Objective 4: Strengthen care and support in local communities
X	Objective 5: Respond well to complex needs
X	Objective 6: Enable broader social and economic development
X	Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT
The Finance Committee and ICB Board have been kept updated on the development of the Medium Term Plan 2026/27-2028/29. The Finance Committee recommended the final submission to the ICB Board on 10th February 2026, with an ICB Board Exceptional Part B meeting on 10th February 2026 giving final approval of the submission for 12th February 2026.

REPORT TO COMMITTEE / BOARD
The enclosed power point provides a summary of the NHS Somerset Integrated Care Board Medium Term Planning ICB Board Assurance 2026/27 onwards support pack submission, which was submitted on 12th February 2026.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	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.
Quality	Financial decisions are made to deliver with regard to the best possible value for service users.
Safeguarding	No issues identified
Financial/Resource/ Value for Money	NHS Somerset Integrated Care Board has a confirmed revenue budget of £3,277,680,000 for the 2026/27 financial year as at the time of the planning submission, which includes as the Principal Commissioner, £1,725,597,000 for Delegated Specialised Commissioning.
Sustainability	No issues identified
Governance/Legal/ Privacy	The financial report details any constitutional standards required to be met by the NHS Somerset Integrated Care Board
Confidentiality	No issues identified
Risk Description	NHS Somerset Integrated Care Board must ensure it delivers the planned financial target.

Medium term planning

ICB Board Assurance 2026-27 onwards

Support pack v3.0

Updated for full submission

Presented by:
National Planning Team

1. Overview

Board assurance statements - overview

Board assurance statements have been created covering the key expectations and role of board outlined in the planning framework for the NHS in England (the planning framework) and cover the following areas:

- **Foundational activities:** acknowledgement and confirmation that the key planning actions outlined in the planning framework as part of Phase 1 have been conducted and reviewed.
- **Governance and leadership:** confirmation that appropriate decision-making structures are in place as well as key input and sponsorship at a senior and clinical level.
- **Plan development:** to provide assurance that plans have been developed in line with the standards outlined in the planning framework and the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 (MTPF), have been co-produced, are evidence based and align with national ambitions.

Additional set of statements covering some specific areas of assurance:

- **Productivity:** confirmation that all opportunities for productivity have been considered and are reflected in plans.
- **Risk:** confirmation that risk management is embedded throughout plan development with a specific emphasis on financial risk.
- **NHS standard contract & commissioning:** early assurance that processes are in place to enable contacts to be agreed and signed off in line with the national timetable and considerations are in place in terms of commissioning and plan alignment.
- **Workforce:** confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans.

Updates since first submission

- Changes to the board assurance statements are noted within the title section of each slide:
  - **No change:** Identical to first submission
  - **Updated:** Update to wording, including changes to reflect the expected position at the point of full submission. Any updates are marked in **bold text**.
  - **New:** Additional statements deemed suitable for full submission. These include additional assurance around plan alignment and the ambition of moving care from hospital to community.
- We have incorporated an additional field within each slide for you to record your assessment at first submission against your proposed assessment for full.
- Slides 4 and 5: Additional feedback and guidance around the assessment and completion of statements.
- Section 3: A summary list of all statements showing changes between first and full submission.

Assessment and completion

Maturity assessment descriptors

- For first submission it was acknowledged that boards would be at variable levels of maturity in terms of plan development and full assurance was not expected for all board assurance statements.
- Whilst we would expect to see a level of improvement between first and full submission, we recognise this may not always be possible and some statement assessments may remain static.
- The level of board assurance does not necessarily need to correlate completely with your numerical plan submission. Your assessment should focus on the maturity of your organisation indicating that despite the plan outcome you are assured that everything has been considered and put in place to get to the best possible plan position.

1. Embedded [Full Assurance]	2. Maturing	3. Developing	4. Not Embedded [No Assurance]
The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.	The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.	Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.	There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

Supporting Commentary

- If boards select a maturity assessment of 2-4, i.e. signalling an activity is not embedded, supporting commentary must be provided. The quality of commentary provided at first submission varied considerably.
- For full submission commentary should clearly outline the reason(s) why full assurance cannot be provided and the actions that will be taken to improve this and / or mitigations in place to manage. Organisations can also use this space to highlight any support they need.
- Responses should be succinct and to the point, cells will continue to be limited to 500 characters / approx. 80 words. Please avoid simply repeating the statement back or adding vague comments such as 'we will improve', 'we are becoming confident'.
- We've included some examples of both where responses were considered to fully address any concerns and where further assurance would be needed in slide 5.

Additional guidance and clarification

- Some statements at first submission were interpreted differently across organisations. We have provided some supporting information against relevant slides within this pack to provide additional clarity and to encourage consistency.

Supporting commentary: Examples of responses

Responses considered to demonstrate assurance	Responses where further detail is required
• ***Response includes the relevant actions that will be taken to improve assurance and demonstrates an understanding of the statement.*** • ***Risks and exceptions are clearly outlined.***	• ***Statement repeated back*** • ***Statement not fully addressed*** • ***N/A or random text included to pass validations*** • ***Scores of 2-4 do not cite exceptions***
"Continuous improvement is driven by cross-functional teams, governance structures, and staff engagement, supported by training, national initiatives, and new models of care. QI underpin methodology; Quality Improvement Movement and Core Care Record rollout are key in delivery. Data-driven insights, coproduction, and structured management underpin progress, though service-level data maturity remains a challenge. Maturity score: 3 due to need for consistent, robust outcomes data."	"The Board is increasingly becoming confident in a data-driven, clinically-led continuous improvement approach. The organisation systematically builds improvement capacity and capability, aligning plan with national and local performance indicators" *(Maturity assessment: 3)*
"During the Foundation Phase, the Board has been involved in setting our strategic direction and challenging assumptions, through provider collaborative work and financial recovery planning, and as part of Board seminars. An exceptional PIRC will review the first submission on 15 December 25. Further sessions are scheduled to ensure sufficient Board input into final submissions by 12/02/2026, allowing time for adjustments and sign-off."	"The Board have been kept up to date with plan development" *(Maturity assessment: 3)*
"Senior clinicians (Executive Medical Director, Chief Nurse, Clinical Directors) are engaged, but wider clinical leadership is not fully visible. Further work is planned around involvement of deputies, broader clinical groups, and a more developed clinical leadership culture. Clinical leaders need training, strengthened involvement in productivity/change programmes, and greater presence in Board deliberations."	"The Board confirms strong clinical and managerial leadership in the development of the plan - with engagement from the Chief Medical and Nursing Officers & Clinical leads." *(Maturity assessment: 3)*
"Productivity improvement aligned to temporary staffing and sickness reduction, with plans for delivering on e-Job Planning, e-Rostering implementation. The three-shifts lens has been applied to identify emerging examples of practice, stemming from speciality-led initiatives. The shifts are evident in learning development, staff wellbeing, pro equity, resourcing and commitment to our community approaches. There is scope with the wider system to take this further."	"The impact of the 10 Year Health Plan on the workforce is being considered in the development of plans, but is not yet fully developed." *(Maturity assessment: 3)*

Purpose of support pack

Board approval

- The boards of individual ICBs and providers are ultimately accountable for the development and delivery of their plans and have a responsibility to be assured in terms of the deliverability, credibility and affordability of the plans that have been agreed.
- There is a requirement that organisations' boards are involved in the development of the responses to the board assurance statements and provide final sign off against the board assurance positions and supporting commentary, prior to submission.

Purpose of support pack

- **Section 2. Board Engagement Pack**
    - This section takes the key elements from the board assurance sheet of the integrated template into an accessible presentation.
    - Organisations can use this section of the pack to interact with their board, develop responses and seek approval prior to submission.
    - This pack **should not be used for submission** and is an optional resource organisations may / may not wish to use.
    - Please be mindful when developing commentary responses that cells in the submission template will only accommodate 500 characters.

- **Section 3. A summary list of all board assurance statements and any changes from first submission.**

2. Board Engagement Pack

- Medium term planning 2026/27 onwards – Board assurance statements

Contents

Ref	Area of assurance	Summary description	Slides
2.1	Foundational activities	Acknowledgement and confirmation that the key planning actions outlined in the planning framework as part of Phase 1 have been conducted and reviewed.	9–10
2.2	Governance and leadership	Confirmation that appropriate decision-making structures are in place as well as key input and sponsorship at a senior and clinical level.	11–17
2.3	Plan development	To provide assurance that plans have been developed in line with the standards outlined in the planning framework and the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 (MTPF), have been co-produced, are evidence-based and align with national ambitions.	18–20
2.4	Productivity	Confirmation that all opportunities for productivity have been considered and are reflected in plans and justification where any identified opportunities cannot be fully delivered during this planning round	21–22
2.5	Risk	Confirmation that risk management is embedded throughout plan development with a specific emphasis on financial risk.	23–24
2.6	NHS standard contract & commissioning	Assurance that processes are in place to enable contacts to be agreed and signed off in line with the national timetable and considerations are in place in terms of commissioning and plan alignment.	25–29
2.7	Workforce	Confirm the impact of the 10 Year Health Plan on the workforce has been considered in the development of plans.	30–31
2.8	New statements	Additional statements deemed suitable for full submission. These include additional assurance around plan alignment and the ambition of moving care from hospital to community.	32–36

2.1 Foundational activities

No change "1. The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning."

Maturity Assessment 1-4	
First	Full
2	1

Notes / Additional Guidance

Feedback from first submission: Responses to this statement were less embedded than expected; therefore, it has been decided to retain it for full submission. Some responses indicated a misunderstanding of this statement to be more about the degree of board oversight/engagement, rather than the status of the foundational work.

Organisations may wish to refer to the core foundational activities listed in the planning framework:

- ❑ In collaboration with providers and partners perform a refresh of the clinical/organisational strategy as required to ensure they are updated to reflect changes in national policy (for example, the 10 Year Health Plan) or local context.
- ❑ Review organisational improvement capability.
- ❑ Establish appropriate governance structures and agree responsibilities and ways of working to support the integrated planning process, including engagement with patients and local communities. This should include working with providers.
- ❑ Assess population needs, identifying underserved communities and surfacing inequalities, and share with providers.
- ❑ Review quality, performance and productivity of existing provision using data and input from stakeholders, people and communities.
- ❑ Develop initial forecasts and scenario modelling for demand and service pressures.
- ❑ Generate actionable insights to inform service and pathway design with providers.
- ❑ Create outline commissioning intentions for discussion with providers.

Finance Committee and Board have been regularly updated on the phase one activities and the associated next steps .

Work is underway to refresh the clinical strategy

Commissioning intentions created, and communicated with key partners

Governance has been established by the ICB and all providers including system level.

2.2 Governance and leadership

Updated "2. The board can confirm strong clinical leadership **has been** involved in the development of plans."

Maturity Assessment 1-4	
First	Full
2	2

Board and management Board have multiprofessional clinical leads
CCPL - Cabinet (senior decision makers) and Reference Group
GP Provider Support Unit - primary care voice. Clinical reference group - pathway/service design
Priority Pathway Programme, CMO/CNO leadership to transform pathways.
CMO member - Op Planning group
CMO chairs frailty program
CNO/CMO chair COG and system triple lock
CNO and CMO attend system committees – Finance, Strategic Commissioning Collab Forum

Updated "3. The board can confirm that the **plans reflect** the consideration of population needs, underserved communities and inequalities.

Maturity Assessment 1-4	
First	Full
2	2

The assessment of population health needs and those of underserved communities form a key part of processes when developing plans. The JSNA forms the backbone of assessment of needs and is augmented with more specific needs assessment as required.

A good example of assessing the needs of underserved communities is in the development of proposals for the Inclusion Health Strategy and service, informed by a Homeless Health Needs Assessment Homeless Health Needs Assessment 2023.pdf

Updated "4. Robust quality and equality impact assessments (QEIA) **have been** undertaken and reviewed by the board to inform **the sign off** of the organisation's plan."

Maturity Assessment 1-4	
First	Full
2	2

The ICB's EQIA template and processes have been developed in line with NHSE guidance.

A high-level EQIA has been completed to support the medium-term plan and approved in principle by the ICB's EQIA panel and subject matter experts, as well as peer-reviewed by EQIA cluster leads across BSW and Dorset, prior to full sign off by the Board.

The assessment reflects current strategic intentions; however, as the plan comprises multiple programmes of work still in development, full detailed EQIAs will be carried out for each individual programme as they progress.

It is recognised that the potential risks, impacts and benefits identified within the EQIA may not be exhaustive.

The EQIA for the plan will be monitored via the Strategic Commissioning Committee as a sub committee of the Board and be bought back to the Panel if there are any new significant risks identified.

Notes
Feedback from first submission: This could include multiple QEIAs across several components of the plan.

Updated "5. The board **has played** an active role in setting direction, reviewing drafts, and constructively challenging assumptions – **rather than simply endorsing the final version of the plan.**

Maturity Assessment 1-4	
First	Full
2	1

As part of the planning process a series of Board/Finance Committee discussions and meetings have taken place for members to set clear direction, review early drafts, and challenge assumptions. This has been underpinned by work at our system forums to consider the planning assumptions and allocations collectively with our system partners and providers

Lower Steph 19/03/2026 16:32:50

No change "6. The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability."

Maturity Assessment 1-4	
First	Full
2	2

Connecting data from all ICS partners to have the ability to understand population need. Tested segmentation, risk stratification, and GIS tools

Working with commissioning and clinical colleagues to transform how service information is found

Piloted a knowledge sharing platform with colleagues across the ICS and track project and programme activities.

Agile training delivered across the ICS ensuring we have the right delivery mindset for continuous improvement.

Lower Steph 19/03/2026 16:32:50

No change "7. The board can confirm the organisation has the appropriate structures to work constructively across the system and that system working is effective."

Maturity Assessment 1-4	
First	Full
2	2

Established structures enabling constructive system working across our local health and care system. We operate an open book approach to finances, fostering transparency and trust between partners and underpinning collective decision-making. Our Board is representative of the breadth of our system, ensuring that diverse perspectives inform our governance and strategic direction. We have embedded a shared approach to planning and strategy development, for example, through our system collaboration forum, which provides a platform for partners to co-design priorities and agree collective actions. This is complemented by a range of underpinning system partnership groups. On this basis, the Board can confirm the appropriate structures are in place to work constructively across the system and that system working is effective. At the same time, we recognise that further work is required to continue strengthening the maturity of these structures, ensuring adaptability, and to enhance delivery, particularly as we move towards Clustering and Place based arrangements.

Lower Steph
19/03/2026 16:32:50

2.3 Plan development

No change "8. The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic."

Maturity Assessment 1-4	
First	Full
3	1

- The plan reflects the change in financial rules and allocations, and since the draft submission the ICB has completed several actions to confirm the plan is robust and deliverable. The ICB and Somerset NHS Foundation Trust have concluded the deconstructing the block exercise, we have assessed and transacted activity growth and additional capacity/funding needed to deliver performance improvements. The plan has been triangulated and there are no known differences, and the funding relating to strategic change in respect of stroke and urgent care has been transacted.

No change "9. The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent."

Maturity Assessment 1-4	
First	Full
2	1

- The plan reflects the change in financial rules and allocations, and since the draft submission the ICB has completed several actions to confirm the plan is robust and deliverable. The ICB and Somerset NHS Foundation Trust have concluded the deconstructing the block exercise, we have assessed and transacted activity growth and additional capacity/funding needed to deliver performance improvements. The plan has been triangulated and there are no known differences, and the funding relating to strategic change in respect of stroke and urgent care has been transacted.

2.4 Productivity

Updated “The Board **can confirm** that the organisation **has fully considered and incorporated** productivity opportunities into plans, **and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit non-compliant financial or performance plans or plans that do not deliver the 2% productivity improvement.”**

Maturity Assessment 1-4	
First	Full
2	2

Productivity analysis forms part of monthly reporting internally and is a regular item to the Finance Committee. The latest information from NHSE has been reviewed and the ICB pack has recently been received and any opportunities enacted. The expectation is that the majority of the opportunities will form a key part of the Trusts efficiency programme. We have reviewed and identified opportunities through our various system groups. It should be noted that the opening of the new surgical centre will not drive its full productivity benefit until existing theatres have been refurbished, which is a reason why SFT is not able to deliver 2% at plan.

Lower Steph 19/03/2026 16:32:50

Notes / Additional Guidance
The productivity opportunity packs have been provided to assist in identifying areas where improvement could be made but it is acknowledged that these do not cover the entirety of local opportunities.

2.5 Risk

No change “11. The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.”

Maturity Assessment 1-4	
First	Full
2	1

The ICB has a detailed risk management approach and financial risks are presented and discussed monthly at the Finance Committee. Financial risk, in the context of the 2026/27 and 2027/28 financial plan submission has been further reviewed and embedded into the final plan submissions. A contingency has been set aside within the plan to manage the financial impact of in year pressures, a source of funds is available to support the implementation of the left shift required in-year and any pump-priming developments.

Lower Steph 19/03/2026 16:32:50

Notes / Additional Guidance

Feedback from first submission: The response to this statement should be against the maturity assessment of your organisation’s overall approach to risk rather than the level of risk in plans. Some responses indicated a misunderstanding of this statement and gave a maturity assessment of 3 (developing) due to the risk level in the plan, although the organisation had a robust approach to managing risk.

2.6 NHS standard contract and commissioning

Updated "12. The board **can confirm** that the organisation has commissioned sufficient activity from its providers to meet expected performance trajectories."

Maturity Assessment 1-4	
First	Full
2	1

The ICB and Somerset NHS Foundation Trust have completed detailed work to inform the final submission to confirm sufficient levels of activity are commissioned in the plan to achieve the expected performance trajectories and ensure that these trajectories are robust and deliverable. The one area we are uncertain relates to the impact of Advice and Refer implementations, which will be further reviewed and assessed as we move into 2026/27.

Updated "13. The board can confirm **that the organisation has engaged with its providers** to ensure contract values used in planning submissions are **agreed** across (commissioner and provider) activity and financial plans."

Maturity Assessment 1-4	
First	Full
2	1

Contract values have been confirmed with Somerset NHS Foundation Trust and there is alignment and understanding of areas of difference to be resolved between draft and final plans. Contract offers have been made to inter system providers, ensuring enactment of any adjustments required based on the outputs of the deconstructing the block exercise. Discussions will continue with all providers between draft and final plans.

No change “14. The board can confirm that there is an effective process in place to manage the sign-off of contracts.”

Maturity Assessment 1-4	
First	Full
1	1

The sign off process for contracts is clear and the ICB has a strong track record of agreeing and signing contracts by the deadline.

Lower Steph
19/03/2026 16:32:50

No change “15. The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.”

Maturity Assessment 1-4	
First	Full
1	1

The Finance Committee will receive regular updates about contract signature and will escalate to the Board if necessary.

Lower Steph
19/03/2026 16:32:50

2.7 Workforce

Updated "16. The board can confirm the impact of the 10 Year Health Plan on the workforce **has been considered in plans**. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention."

Maturity Assessment 1-4	
First	Full
2	2

Somerset NHS Foundation Trust workforce plan reflects productivity improvement and financial balance (including necessary agency/bank reductions)

Primary Care workforce plan reflects changing admin staff requirements (reduction) based on digital enablement, and growth in clinical staffing

Mental Health plan includes growth of Education Mental Health Practitioner (EMHP) workforce, as per National directive

Lower Steph 19/03/2026 16:32:50

2.8 New statements

New “17. The board can confirm in the development of plans associated with the transition to a merged organisation, all constituent parts have been actively engaged and involved in the planning process.”

Maturity Assessment 1-4	
First	Full
n/a	n/a

n/a - Somerset not currently involved in merger

Lower Steph 19/03/2026 16:32:50

Notes / Additional Guidance
Only for organisations involved in mergers: Central East, Essex, Norfolk & Suffolk, North Central and West London, Hampshire and Isle of Wight, Surrey and Sussex & Thames Valley

New “18. The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the strategic commissioning plan.”

Maturity Assessment 1-4	
First	Full
n/a	2

Our five year strategic commissioning intentions cover how we plan to develop our neighbourhood health service in order to deliver the shift from hospital to community as outlined in the 10 year health plan. Each specific commissioning area has a section within the commissioning intentions and these include details of ambitions in each of these areas to move care from hospital to community.

New “19. The board can confirm that the ICB has worked with providers to ensure that their plans are fully aligned.”

Maturity Assessment 1-4	
First	Full
n/a	2

We can confirm that financial plans are fully aligned with our providers, alongside performance.

New "20. The board can confirm that the five year strategic commissioning plan is fully aligned with the numerical returns."

Maturity Assessment 1-4	
First	Full
n/a	2

We have begun the work to quantify the impact of our commissioning plans with a particular focus on 2026/27 as a transitional year. The ICB has included growth funding to support the left shift and other developments in 2027/28 and 2028/29, with the detail around the application of this to be determined.

3. Board Assurance Statements 2026-27

Full submission summary list

Summary list of statements at first and full submissions (1/2)

Ref	Category / Area for Assurance	Statement (First Submission)	Maturity Assessment (First)	Change	Statement (Full Submission)	Maturity Assessment (Full)
1	Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning.		No Change	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning.	
2	Governance and leadership	The board can confirm strong clinical leadership is involved in the development of plans.		Updated	The board can confirm strong clinical leadership **has been** involved in the development of plans.	
3	Governance and leadership	The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans		Updated	The board can confirm that the plans reflect the consideration of population needs, underserved communities and inequalities.	
4	Governance and leadership	Robust quality and equality impact assessments (QEIA) are underway or are planned to be undertaken and reviewed by the Board to inform development of the organisation's plan.		Updated	Robust quality and equality impact assessments (QEIA) **have been undertaken** and reviewed by the board to inform **the sign off** of the organisation's plan.	
5	Governance and leadership	The board is playing an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.		Updated	The board **has played** an active role in setting direction, reviewing drafts and constructively challenging assumptions– **rather than simply endorsing the final version of the plan**.	
6	Governance and leadership	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.		No Change	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	
7	Governance and leadership	The board can confirm the organisation has the appropriate structures to work constructively across the system and that system working is effective.		No Change	The board can confirm the organisation has the appropriate structures to work constructively across the system and that system working is effective.	
8	Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The Board is content that the phasing of the plan across two years is realistic.		No Change	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	
9	Plan development	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.		No Change	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	
10	Productivity	The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.		Updated	The board **can confirm** that the organisation **has fully considered and incorporated** productivity opportunities into plans**, and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit non-compliant financial or performance plans or plans that do not deliver the 2% productivity improvement.**	

Summary list of statements at first and full submissions (2/2)

Ref	Category / Area for assurance	Statement (First Submission)	Maturity Assessment (First)	Change	Statement (Full Submission)	Maturity Assessment (Full)
11	Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.		No Change	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	
12	Standard Contract & Commissioning	The board will ensure sufficient levels of activity are commissioned from its providers to achieve the expected performance trajectories.		Updated	The board **can confirm that** the organisation has commissioned sufficient activity from its providers to meet expected performance trajectories.	
13	Standard Contract & Commissioning	The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans		Updated	The board can confirm **that the organisation has engaged with its providers to ensure** contract values used in planning submissions are **agreed** across (commissioner and provider) activity and financial plans.	
14	Standard Contract & Commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.		No Change	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	
15	Standard Contract & Commissioning	The board can confirm that there is a timetable in place to ensure that the Board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the Board.		No Change	The board can confirm that there is a timetable in place to ensure that the Board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the Board.	
16	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.		Updated	The board can confirm the impact of the 10 Year Health Plan on the workforce **has been considered in plans**. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	
17	Governance and leadership	n/a		New	**The board can confirm in the development of plans associated with the transition to a merged organisation, all constituent parts have been actively engaged and involved in the planning process.**	
18	Plan development	n/a		New	**The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the strategic commissioning plan.**	
19	Plan development	n/a		New	**The board can confirm that the ICB has worked with providers to ensure that their plans are fully aligned**	
20	Plan development	n/a		New	**The board can confirm that the five year strategic commissioning plan is fully aligned with the numerical returns.**	

Thank You

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REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **6**
DATE OF MEETING:	**26 March 2026**	
REPORT TITLE:	**Stroke Reconfiguration Update**	
REPORT AUTHOR:	**Alison Rowswell, Director of Localities and Strategic Commissioning**	
EXECUTIVE SPONSOR:	**David McClay, Place Director - Somerset**	
PRESENTED BY:	**David McClay, Place Director - Somerset**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☒
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☒ Objective 5: Respond well to complex needs
- ☐ Objective 6: Enable broader social and economic development
- ☐ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

Regular briefings have been presented to Board during the implementation period. This briefing follows a detailed Infrastructure update presented to Board in November.

REPORT TO COMMITTEE / BOARD

Background

This paper provides an update on the stroke reconfiguration work that is currently being undertaken following a full statutory public consultation in early 2023. NHS Somerset Integrated Care Board (ICB) made a formal decision in January 2024 to provide Hyper Acute Stroke Units (HASUs) at Musgrove Park Hospital (MPH) in Taunton, Dorset County Hospital (DCH) in Dorchester, an Acute Stroke Unit (ASU) at both MPH and Yeovil District Hospital (YDH) and a Transient Ischaemic Attack (TIA) service seven days a week at MPH and five days a week at YDH. The decision was taken after full consideration of the Decision-Making Business Case (DMBC).

Current Position

The estates work is progressing well at both MPH and DCH. At MPH the 4 HASU beds are on target to be completed by the end of May 2026 with the rest of the ward reconfiguration to be completed in August 2026. The additional 4 HASU beds and 2 ASU beds at DCH are expected to be in place by May 2026. A plan for improving the Activities of Daily Living (ADL) kitchen and gym area is being developed thereby improving the rehabilitation offer at YDH.

The pathway work is continuing and a review of progress against pathways has been completed across both MPH and DCH. Areas being worked through ahead of go live include the digital offer, transport for stroke and mimic patients and pre-hospital video hospital triage (PVT) and progress continues to be made.

At the last Coordination Board colleagues from Somerset Foundation Trust advised of a set-back in their plans to grow their Consultant workforce at MPH, this followed the unsuccessful onboarding of a Consultant and forthcoming retirement of another. This reduction in clinical staffing affects the ability to deliver the required level of clinical safety for the new service from May. As a result, the planned go-live timeline will likely be delayed while recruitment and mitigation plans are progressed. Targeted nursing recruitment is underway for both MPH and DCH ahead of go live to support safe staffing levels ahead of the launch. There will be no changes to stroke services at Yeovil District Hospital until the new model is ready to start at Musgrove Park Hospital.

Monitoring of the Stroke implementation will be undertaken through the Sentinel Stroke National Audit Programme (SSNAP) data, which will provide valuable insights to inform efficiency and ongoing service improvement. In addition, a refresh of the EQIA will be completed to ensure that any potential impacts are fully assessed and addressed as part of the implementation process and a system risk assessment will be undertaken.

Representatives from the ICB, SWASFT and Somerset NHS Foundation Trust (SFT) met recently with the Quicksilver Community Group. The Quicksilver Community Group have undertaken some specific postcode modelling on travel times and this was discussed. We have reviewed the modelling provided by Quicksilver and thank them for their ongoing interest. We advised them that we believe their assumptions do not take into consideration improved door-to-needle times that would bring further clinical benefits for the whole population of Somerset. Following the system review, we remain satisfied that the modelling undertaken for the DMBC was robust. SWASFT also updated the group on the PVT pilot and improved pathways including straight-to-CT that are in operation at DCH. The group have shared a third set of modelling with us following that meeting. We have agreed to review this and will report back to them in due course.

The Board are also asked to note that Yeovil Town Council have publicly announced they are seeking legal advice to ascertain what they can do to stop the implementation of the reconfiguration of stroke services. The ICB have not been formally notified of any legal action or any further concerns by the Town Council. We remain committed to transparent engagement and to listening to the concerns of all stakeholders. We will continue to keep valued stakeholders including, Yeovil Town Council, informed during the implementation phase. We are in the process of arranging another meeting with Yeovil MP Adam Dance.

There is a joint Executive meeting taking place between the Trusts and the ICB to discuss the Go/No Go criteria on 25 March 2026 and a verbal update will be provided at the Board meeting.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	An EQIA has been completed as part of this service change – key points of note are that it delivers a 24/7 clinically sustainable service to the population of Somerset rather that the current in hours and out of hours variation. It delivers time critical interventions more quickly ie brain scan, within 1 hour, time to see a stroke specialist within 1 hour, door-to-needle time for stroke thrombolysis, proportion of patients receiving thrombolysis within 1 hour of hospital arrival, and proportion of patients admitted to the hyperacute stroke unit within 4 hours.
Quality	Quality of care to patients will be enhanced by units being able to recruit enough specialist stroke staff to deliver 24/7 consultant cover, and enough specialist nursing staff or therapists to meet the national standards for stroke care. In developing this model, the work strengthens the requirement of HASU Centres, supporting the 600 annual admission threshold to sustain stroke expertise (British Association of Stroke Physicians (BASP).
Safeguarding	Patients will be safeguarded in line with Trust policies.
Financial/Resource/ Value for Money	Work is being led and resourced by dedicated project teams at both SFT and DCH. Oversight is being provided by the Joint Stroke Co-ordination Board (JSCB). Cost of works are being held within each Trust, respectively.
Sustainability	N/A
Governance/Legal/ Privacy	Several requests were made to the Secretary of State to review the decision taken in January 2024 to implement the new model of hyper acute stroke services for the population of Somerset. However, the Secretary of State made the decision that the call-in requests did not meet the criteria for ministerial intervention and took the view that NHS Somerset is best placed to determine the needs of our local population. NHS Somerset welcomes these decisions. More recently, in September 2025, Minister of State for Health, Karin Smyth turned down a further call-in request.
Confidentiality	N/A
Risk Description	The stroke work being undertaken poses several risks and challenges, with risk owners and mitigating actions in place for all. Oversight of programme risks are maintained via the JSCB.

REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD**	**ENCLOSURE:**	**07**
DATE OF MEETING:	**26 March 2026**		
REPORT TITLE:	**Director of Public Health Annual Report – The Miracle Cure; Getting Somerset Moving**		
REPORT AUTHOR:	**Alison Bell DPH** **Pippa Simes, Public Health Specialty Registrar**		
EXECUTIVE SPONSOR:	**Bernie Marden, Chief Medical Officer**		
PRESENTED BY:	**Alison Bell**		

PURPOSE	DESCRIPTION	SELECT
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(Please select any which are impacted on / relevant to this paper)

☒ Objective 1: Improve the health and wellbeing of the population

☒ Objective 2: Reduce inequalities

☐ Objective 3: Provide the best care and support to children and adults

☒ Objective 4: Strengthen care and support in local communities

☐ Objective 5: Respond well to complex needs

☒ Objective 6: Enable broader social and economic development

☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

This report has been written following discussions with a range of colleagues working in physical activity, education, active travel and with partners across the system who are stakeholders in this provision. There has been and no requirement for public consultation on this topic as part of writing a DPH annual report

This report has been presented to Somerset Council Adults & Health Scrutiny, Children & Families Scrutiny and was endorsed by the Somerset Council Executive on 11th March 2026

REPORT TO COMMITTEE / BOARD

The production of an annual report on the health of the local population, is a statutory duty for Directors of Public Health (DPH). The annual report is a part of the DPH role to be an independent advocate for the health of their population and to provide leadership for its improvement and protection. Under section 73B (5) and (6) of the 2006 Act, the local authority's duty is to publish this report

The topic chosen for this 2025 annual report is Physical Activity, which Dame Sally Davies described as 'the miracle cure.' This topic was chosen in the context of a decline in the health status of our population and the widening of inequalities.

This report illustrates how physical activity can both prevent disease and help to manage conditions, as well as help older adults live independently for longer. It is not just physical activity that needs to be increased, but also time spent being sedentary needs to reduce.

The Board is asked to endorse the recommendations and for the NHS to support work across Somerset 'Get Somerset Moving.'

The 2025 report covers the vital importance of increasing physical activity in our population and reducing sedentary behaviour. It demonstrates that in recent decades lives have become less active and more sedentary for a range of reasons. There are enormous health and social benefits to increasing physical activity and work must be focussed throughout the different age groups in the Somerset population. Crucially work must go beyond discrete interventions for activity classes and begin to change how we live day to day to that being more active becomes the norm. There are also some groups who experience greater barriers to being active and these need to be addressed to reduce the differences in health outcomes across our population.

Recommendations

The report is structured around the life course and different cohorts that we must consider which demonstrates that physical activity can both prevent and manage health conditions.
The report identifies three priorities for getting the Somerset population more active:

Short Term – Ageing Well

The biggest priority currently is supporting adults over the age of 50 who are active for less than 30 minutes per week, to be more physically active and reduce sedentary behaviour so that they maintain strength and mobility into their later years

Medium Term – Reduce health inequalities

Focus on reducing inequalities in physical activity by targeting groups (using Sport England inequality matrix) at greater risk of inactivity. This includes communities in areas of deprivation and individuals with disabilities or protected characteristics who may face barriers to participation.

Long Term – Future Focus

The long-term priority is to ensure that physical activity is initiated and sustained across the life course and efforts should focus on groups where activity levels drop off or where participation doesn't start.

The overarching message is - Physical activity must be embedded in our lives, in our communities and in our futures. Physical Activity opportunities in a neighbourhood can and should unite communities to come together and get more physically active at minimal cost. Bringing the opportunity of enormous gain, both physically and mentally.

The **detailed recommendations** are listed within the report, these are designed to give the system partnership direction and a prioritisation framework

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	The needs of people within our population who have protected characteristics have been considered in the preparation of this report, however, as there is no decision to be taken, there is no equality impact assessment. How to reduce health inequalities in the uptake of physical activity will be a key part of developing an action plan to take forward the recommendations of this report.
Quality	Physical activity services do not have a standard approach to measuring quality
Safeguarding	Providers of physical activity opportunities are bound by statutory safeguarding duties
Financial/Resource/ Value for Money	No new funding is required to implement the majority of the recommendations. Influencing existing funding across the system in line with the recommendations, as well as seeking additional funding opportunities for physical activity should be the focus to have the greatest impact on the health and wellbeing of the population.
Sustainability	A key area of activity is to engage more of our population in active travel, which has the added benefit of reducing carbon emission and contributing to sustainability goals
Governance/Legal/ Privacy	No legal or procurement implications of this report
Confidentiality	Not confidential
Risk Description	If we fail to get the somerset population moving, longer term there will be increased demand for health and social care for people who are no longer able to live independently due to loss of strength, conditioning or mobility




‘The Miracle Cure’ Physical Activity for All

Somerset Annual Director of Public Health Report 2025

Somerset Council

Contents

Foreword

This is my first report as Director of Public Health for Somerset. Before choosing the topic for this report I reflected on the declining health status of our population and the widening inequalities we see in health status.

The declining health status of the population is in the context of free Universal access to healthcare. But we know that health is determined far more by the circumstances we live and work or study in than the health services we access. For this reason, I have focused this report on 'Physical Activity For All,' which was described by Dame Sally Davies as 'the miracle cure.' Physical activity does not mean going to a gym or running a marathon, it's just being active, each and every day. It's something we all can and must do.

This report takes a life course approach and looks at the benefits of physical activity at each stage of life and how we can address some of the barriers, to improving physical activity levels for all and reduce sedentary behaviour. It still staggers me that 20% of our adult population do less than 30 mins of physical activity in a week

It is with thanks I acknowledge the contribution of system partners to the production of this report and to Pippa Simes, for assisting in the production of the report.

Alison Bell
Director of Public Health, Somerset

Introduction

"If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat."
Dame Sally Davies, CMO 2010-2019

What is the report about?

This report explores the critical role of physical activity in improving health. It highlights the growing concern around sedentary behaviours, and the fact that physical activity levels remain below recommended guidelines in a significant proportion of the population. Physical activity is important at every stage of our lives, this report examines examines the evidence, current initiative and identifies priorities and recommendations for future action, at three key stages of life - Children and Young People, Working Age Adults and Older Adults –.

Why is it important?

Physical activity is a simple, low-cost way to develop, maintain and improve health and wellbeing. It can prevent and help to manage chronic diseases, as well as supporting independence.

In recent decades, increases in technology use, commuting and more sedentary lifestyles have contributed to declining activity levels. Even small changes in activity levels can improve health, especially for people at increased risk of poorer health, such as those with disabilities or long-term health conditions, people living in deprived areas or older adults.

Inequalities mean that some groups face more barriers that make it harder for them to access physical activity opportunities. This can impact initial engagement with physical activity and the chances of being able to maintain it long term. Tackling these barriers is crucial if we want to improve health outcomes and reduce the impact of preventable diseases in our population.

Active partnerships

The Somerset Active Sports Partnership (SASP) is a local, independent organisation funded by Sport England, Central Government grants, the NHS and Local Authority funding. It has a range of programmes and initiatives that promote health, well being and social inclusion through physical activity and works to create solutions to increase physical activity. The work of this partnership is not currently linked to Somerset's Health & Wellbeing Board.

The Benefits of Physical Activity

The benefits of physical activity are significant for all of us, both for physical and mental health. Physical activity reduces the chances of[1]:

Type 2 Diabetes	Cardiovascular disease	Depression & dementia	Joint pain	Cancers (colon/breast)
40%	35%	30%	25%	20%

Physical activity also improves mental health with reduced anxiety and risk of depression and reduces obesity and osteoporosis. Beyond this there are several other benefits of physical activity[2].

Physical health

Prevent and manage long-term health conditions and diseases.

Improves health and reduces risks for those with long-term health conditions.

Mental health

Happiness and self esteem are improved by feel good endorphins produced during physical activity. As a result, there is a reduction in anxiety and depression.

Individual development

Fosters personal worth and capability. Develops life skills (such as teamwork), self esteem and productivity. This leads to improved school readiness, educational attainment and social inclusion.

Social and community development

People connect through being active or through volunteering. This helps build stronger communities with social cohesion, increased sense of belonging and reduced loneliness.

Environmental impact

Contributes to a greener healthier environment, more sustainable living, cleaner travel, and places where people and nature can thrive together.

Economic development

There are opportunities for employment in physical activity and sports along with the benefits of healthy workforce being a more productive one.

Disabilities

Physical activity provides disabled people of all ages with the same benefits as those without disabilities. However, there are also additional and important benefits. People with disabilities are more like to have chronic health conditions and physical activity reduces the impact of these. It also reduces the risk of developing, or can help manage, secondary health complications. Additionally, with the right opportunities, the social benefits of physical activity can boost confidence and increase a sense of inclusion. Retaining independence and ability to carry out activities of daily living are vital and suitable and regular physical activity supports this.

Figure 1: Adapted from UK Physical Activity Guidelines

Health benefits at life stages with moderate or strong evidence[2]

Children and Young People

- Improved bone health
- Improved cardiovascular fitness
- Improved muscle fitness
- Improved weight status*
- Improved cognitive function
- Reduced rates of depression

Adults

- Reduced rates of stroke
- Reduced heart disease & high blood pressure
- Reduced type 2 diabetes
- Reduced cancers
- Reduced depression & anxiety
- Reduced dementia rates
- Improved cognitive function & sleep
- Improved weight status

Older adults

- Reduced falls
- Reduced frailty
- Improved physical function**

[1]Physical activity: applying All Our health Physical activity: applying All Our Health - GOV.UK
UK Chief Medical Officers' Physical Activity Guidelines UK Chief Medical Officers' Physical Activity Guidelines

* Weight status - being overweight or obese
** Physical function - Activities Daily Living such as bathing, eating, dressing, cooking

Moving More Built into Daily Life

Beyond the guidelines

It is possible to meet the physical activity guidelines but still spend many hours being sedentary. Sedentary behaviour - time spent sitting or lying whilst awake – is now recognised as a significant public health issue.

Why is it important?

Prolonged periods of sedentary time are associated with increased risk of cardiovascular disease, obesity, type 2 diabetes, some cancers and poor mental health outcomes, along with increased overall deaths of any cause[1].

Causes of sedentary lifestyles

Sedentary behaviours can result at work, school, at home and whilst travelling. Excessive time spent sitting or lying (in a buggy or car seat,) watching the television, using screens, driving, working at a computer or sitting reading) all contribute to sedentary behaviour. The increase in sedentary behaviour has been driven over the last 2-3 decades by several factors in societal behaviour including increased handheld devices and increased car usage.

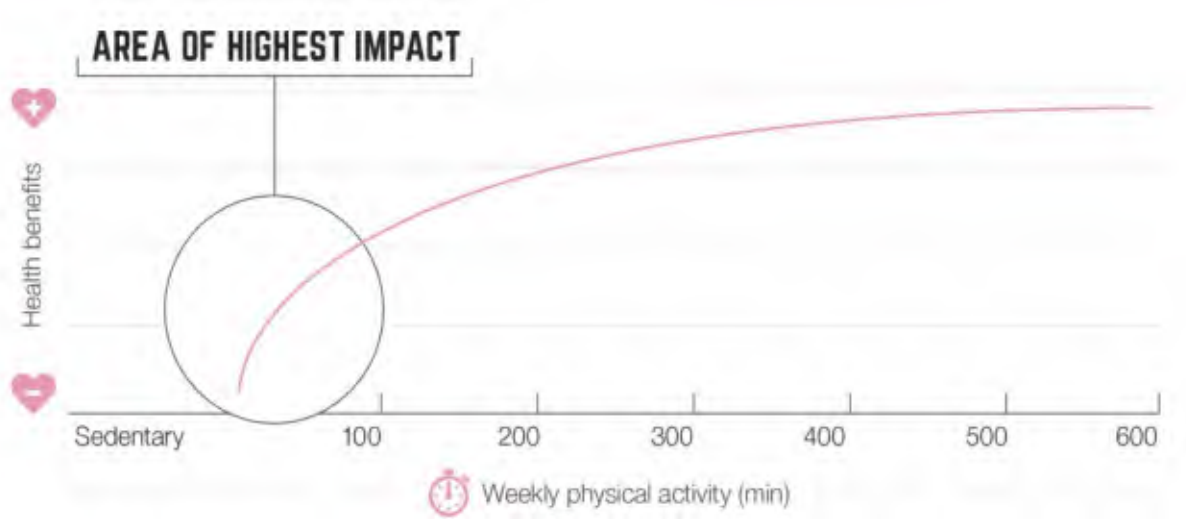
The reduction in green spaces and increase in busy roads have limited safe environments for children to play and walk to school. At the same time, the fear of crime can discourage people from walking in their communities, further reducing opportunities for physical activity.

What can help?

Interrupting sitting time with light movement (including standing) is simple but effective. Limiting screen time and promoting active play that involves running and jumping is key for young children. Schools can use movement breaks every 30-60 minutes and encourage active travel to school.

People of all ages are unaware of how sedentary their lives are and why this can cause them harm. We need to improve awareness and create a shift in everyday behaviours, so that movement becomes ingrained and regular. There is no minimum amount of physical activity to gain benefit when starting from a sedentary lifestyle and small changes can make a significant difference.

Figure 2: UK Chief Medical Officers' Physical Activity Guidelines



This graph shows the increase in health benefits as you increase weekly physical activity. There is no minimum amount of exercise that can yield health benefits, and the health gains are especially significant for those with the lowest levels of activity. The improvements per additional minute of physical activity will be proportionately greater in those who are doing the least [1].

Embedding movement

- Regular breaks (school, work or home) and move around every 30 minutes
- Active play for young children involving running and jumping
- Active travel - Walk more and take the stairs
- Stand up at work, on the bus or take a walk every time you have coffee break
- Active family time – children out of buggies, reduce screen time, encourage active chores, active games & outings,
- Fitness trackers help monitor activity levels and frequency of movement
- Stand or move around when on the telephone or during TV advert breaks
- Walk to the shops and carry shopping home

The Life Course Approach

Understanding the impact of being physically inactive influences health across our lives[1].

What is it?

The life course approach is a framework that recognises that physical activity plays a vital role in health from pre-birth right through to later years. It helps understanding and promoting physical activity as a lifelong process, that underpins health, independence and wellbeing.

Building blocks

During early development, babies learn to roll, move and crawl through active play. The acquisition of fine and gross motor skills establishes the foundations for capability (to walk and hold a pen independently), confidence and enjoyment of activity in childhood. Activities like climbing on play equipment or running through the park help to consolidate skills and enjoyment. If done regularly they help to embed behaviours and habits around activity that support long-term health.

In childhood, the growth of strong bones and muscles alongside motor competence is critical. Strengthening continues through adolescence and young adulthood. Around the age of 50, targeted strengthening activities become more vital to reduce the natural decline in muscle mass and bone density and sustain function into later life.

Benefits

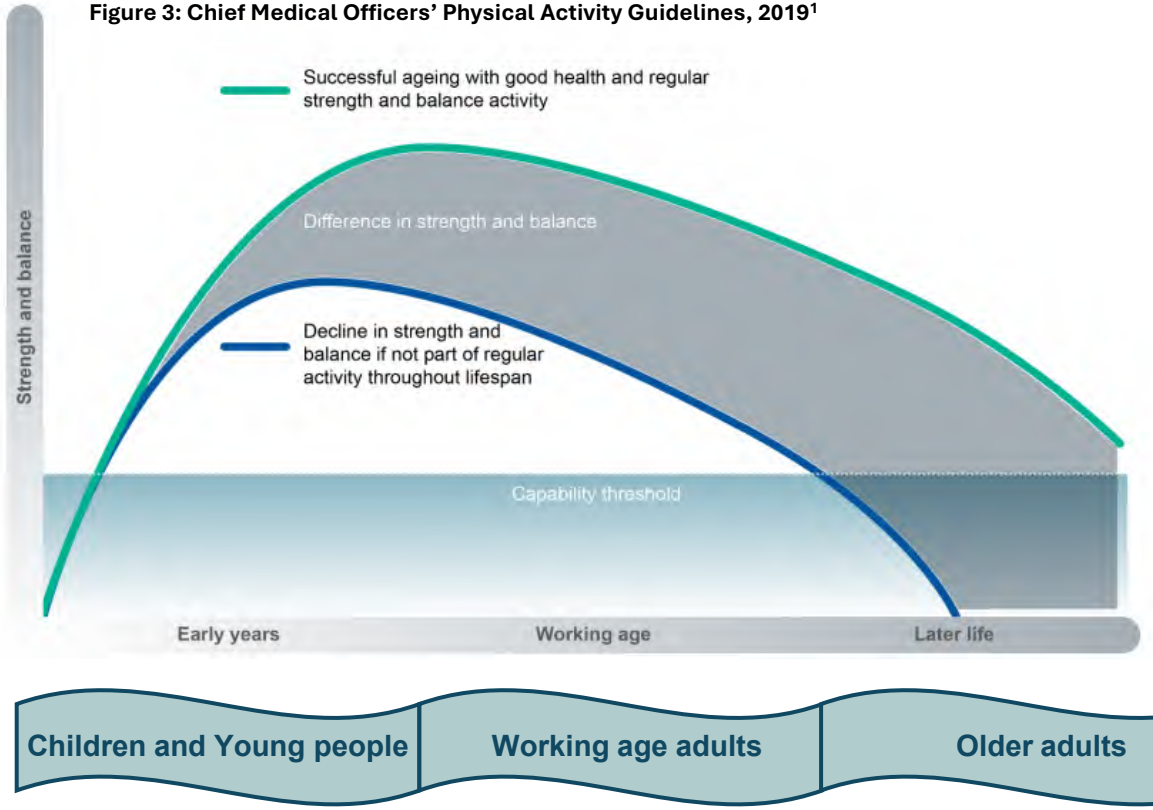
Across all stages, physical activity serves as a constant tool for prevention – reducing obesity and building bone strength in young people and lowering risks of cardiovascular disease, type 2 diabetes and cancers in adulthood. Later in life it prevents falls, broken bones and reduces the risk of dementia.

Physical activity is also central to the management of conditions such as diabetes, COPD, arthritis and mental health disorders and in older age it preserves mobility, independence, balance and strength, enabling people to carry out daily living activities independently.

Who benefits most?

Evidence demonstrates that the greatest gains are achieved by increasing activity in those least active (see Figure 2). Improvements at every stage produces significant immediate benefits and cumulative gain over time. Embedding this approach within communities so that physical activity increases in our daily living, throughout our lives and becomes a social norm, will ensure significant improved health outcomes.

Figure 3: Chief Medical Officers' Physical Activity Guidelines, 2019[1]



The Chief Medical Officer Physical Activity Guidelines (2019) uses the graphic above to demonstrate that physical function changes throughout the life course. As we age, regular activity helps to retain strength and balance and allows an individual to continue with day to day living. The capability threshold is the level of capability, below which, someone can no longer carry out usual daily living activities independently and therefore requires help or support. It is possible to see that by later in life there is a significant gap in strength and balance between those who have been more active and those who have not.

Regular physical activity throughout life is fundamental to our future health.

[1]UK Chief Medical Officers' Physical Activity Guidelines UK Chief Medical Officers' Physical Activity Guidelines

Children and Young People

Children and young people represent a crucial stage in the life course - physical activity begins from the earliest days of life and is a key building block of our future health and habits. Development of coordination and strength begins as babies and as children grow, movement shapes physical, social, and emotional development.

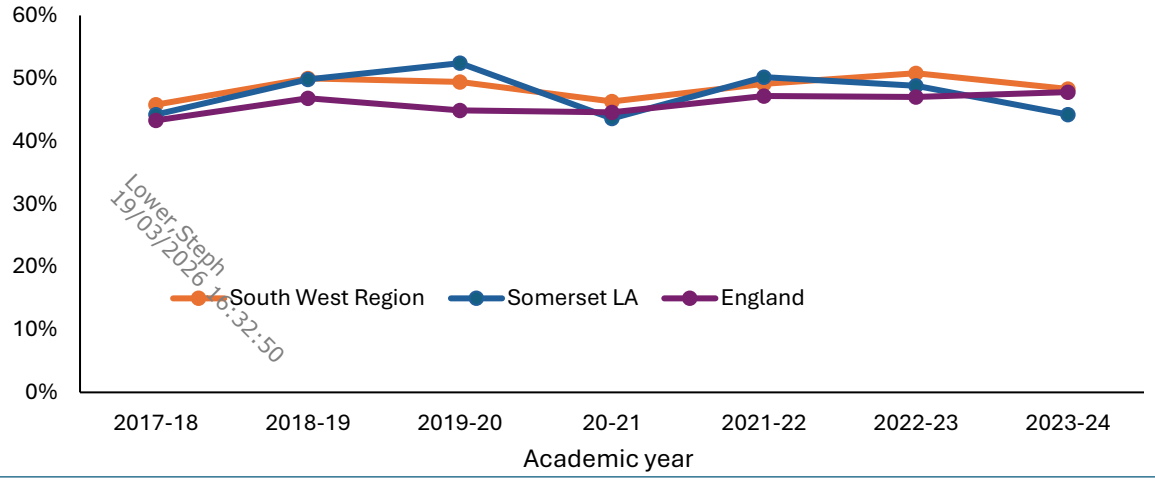
Guidance

The Chief Medical Officer's (CMO) guidance[1] on physical activity recommends the following for children and young people:

- Infants should **be active several times a day** and include tummy time.
- Toddlers and preschoolers should be active **180 mins per day**, (and include 60 minutes each day that are moderate to vigorous intensity for preschoolers).
- Children aged 5-18 should do MVP* activity for an average **60 mins per day** and this can include P.E, active travel, after school activities and sports to develop skills, muscular fitness, and bone strength.
- Children with **disabilities** should complete an average of **20 minutes physical activity per day** with strength and balance activities 3 times a week.
- **All children** - Time spent being sedentary should be minimised.

***MVP - Moderate to vigorous physical activity**

Figure 4: Children in Somerset reporting 60 minutes or more activity each day[2]

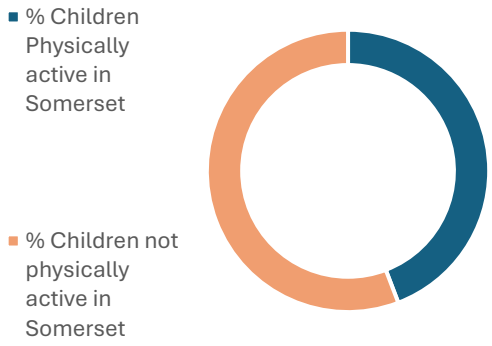


How active are children and young people in Somerset?

The Active Lives and Young People Survey (ALCYPS) completed by Sport England in 2024/5 found that 44.2% of 5–15 year-olds in Somerset met the 60 minutes per day recommendation[2].

This figure was lower than the average across the southwest region (48.3%) and lower (although not statistically significantly) than the national average (47.8%). The percentage has dropped in the last 2 years.

Figure 5: Active children in Somerset[2]

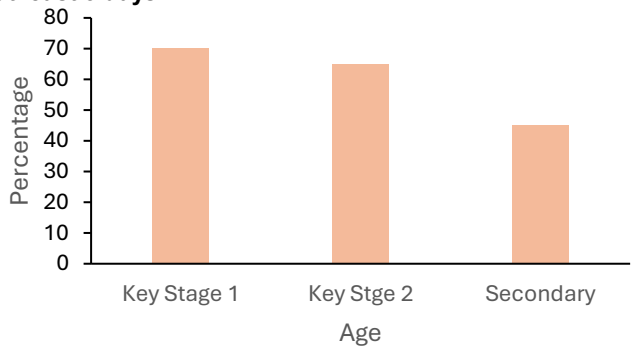


Whilst it is favourable to be broadly in line with national figures, the reality is that **more than half of young people** are not meeting the recommendations, and this is a significant concern.

Somerset Schools Survey

The 2023/4 data from the survey[3] shows how the percentage of children reporting being active 5 days a week reduces as children get older. Around half of children aged 8 report nothing stops them being physically active, but this drops to 30% in children aged 15.

Figure 6: Children reporting physical activity on at least 5 days[3]



Active travel

Somerset's rural geography affects travel patterns. Only around 50% of secondary age children walk to school and only 37-43% walk to primary schools.

Most children who are not walking, travel by car. Bus use is less than 10% in primary school children and is highest in secondary school age children (around 17%). Very few children travel by bike or scooter[3].

[1]UK Chief Medical Officers' Physical Activity Guidelines UK Chief Medical Officers' Physical Activity Guidelines
[2] Active Lives Children and Young People Survey – academic year 2024-25 Active Lives | Sport England
[3] Somerset School Health and Wellbeing Survey 2023 Somerset children & young people : Health & Wellbeing : Sshaws 2023 2021 Countywide Reports

Children & Young People: Barriers and Health inequalities

The benefits of activity for physical, social, and mental wellbeing are well known but despite this, stark inequalities exist in who can be active, even from early childhood. Differences in opportunities and experiences result from a mix of social, economic and environmental factors. Without early opportunities to develop key physical skills, confidence and enjoy movement with peers where they also learn social skills and feel a sense of belonging, they can become progressively more excluded from active lifestyles[1,2].

Key barriers

Confidence – many children and young people lack confidence to take part in physical activity which results from prior negative experiences or lack of earlier opportunities to develop skills. National and local evidence shows girls have lower confidence levels than boys.

Time - children are often only able to participate when parents or guardians can support it. Time pressures in families from work commitments are significant. Additionally, half of secondary age children spend more than 4 hours a day on a screen device and quarter of the cohort spend more than 6 hours a day.

Clothing – Children need to feel comfortable to participate in physical activity and this can be a particular barrier for girls, both in what they wear and the process of getting changed in school.

Disability – there are significant social and environmental barriers for disabled children to take part in physical activity. Assumptions and attitudes can make it difficult for disabled children to feel welcome or able to take part.

Cost – organised activities or sports cost money to take part in and may require clothing, equipment, or travel and parking costs. Evidence show that children from less affluent families are less likely to take part in sport.

Social factors – peer pressure and not feeling that they fit or are welcome is a barrier for children and young people, along with not having role models in their home environment.

Environmental factors – proximity of outdoor green space, parks, or leisure facilities that offer activities impact activity levels. Routes to school can be busy and perceived as not safe and reduce active travel. Children who do not attend school may do less activity outside of the home.

Safety - Somerset Schools survey 2023 around 25% of children (from different age groups) felt safe in the park.

The barriers for children and young people being active are not felt equally across communities. Sport England launched the 'Inequalities metric' and the 'Place Need Classification' so that individuals, groups, and areas with the most need are identified. The inequalities metric reflects the intersectionality of the different personal, social and economic characteristics that can influence activity levels and is built on the data from the Active Lives surveys. The metric shows that children and young people with at least two or more inequality characteristics are least likely to be active and that the key driver is not a specific characteristic, but instead how many different characteristics a person has. For children and young people those characteristics are;

- Disability
- Gender (being a Girl, or Other gender if secondary age)
- Socioeconomic disadvantage
- Ethnicity (being Asian or black)
- Lack of access to park/outdoor sports field (secondary school age).

The Place Need Classification helps identify where additional resources will have the greatest impact and combined two types of need: Sport and physical activity need (areas where people are less active and inequalities in participation are high) and secondly social need (where wider determinants reducing activity levels).

What can help?

Increasing opportunities and access to physical activity groups for children growing up in areas of socioeconomic disadvantage and those with disability.

Children and young people need role models within their community and opportunities to get involved where they feel comfortable to participate and build their confidence. However, it is also essential that activity is built into the everyday lives of young people from the beginning. Local and accessible parks and green spaces so that families can take young children to be active along with safer travel routes to school so that children can walk or cycle.

Improving awareness about the harms of sedentary behaviour and building more activity into the school day will help physical activity levels but also educate children about life long healthy habits.

Barriers reported by children[1]

"I don't feel confident"

"I am shy in front of other children"

"I don't have time"

"I don't know what to do"

[1]Active Lives Children and Young People Survey – academic year 2024-25 Active Lives | Sport England
Youth Sport Trust Youth Sport Trust - Youth Sport Trust

Children & Young People: Physical Activity in Somerset

Get Active Together

Get Active Together - Holiday Activities - Somerset Activity & Sports Partnership

This SASP programme provides an opportunity for children with disabilities to be active alongside their non-disabled siblings during school holidays. This allows families to spend valuable time together sharing fun experiences whilst also getting everyone moving. There are activities of all kinds, both indoor and outdoor, that are suitable for children from age 8-18.

Photos courtesy of SASP

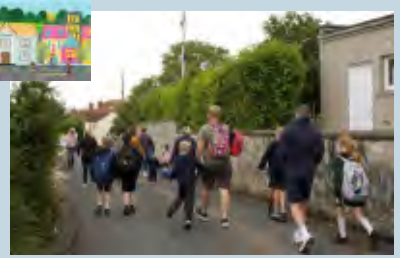
On Your Bike

The Climate and Working group for Burnham and Highbridge Town Council was formed in 2022 and one area of focus was active travel. With funding from Somerset Association of Local Councils (SALC) they partnered with 'On Your Bike' and offered sessions to local schools. Two schools took up the offer with over 1000 children taking part over multiple sessions learning to both enjoy cycling and how to maintain bikes safely.

Photos courtesy of St Joseph's RC Primary School, Burnham on sea.

School Streets

A national initiative to restrict road access outside schools, to reduce congestion, increase safety and encourage walking, wheeling* and cycling to school. The measures include road closures at school pick up/drop off times and reduced speed, traffic calming and improved cycle racks. In Somerset, a partnership between Somerset Council, SASP and Sustrans ~~is~~ has been developed to implement a trial of School Streets around Otterhampton Primary School in Bridgwater. Avon and Somerset Police also supported the initiative by encouraging active travel and bike marking



Photos courtesy of SASP

In Frome, the Town Council worked in partnership with the Walk Wheels Trust to implement the School Streets pilot scheme and after positive evaluation it has just been made permanent.

Research

The National Institute of Health Research has been carrying out the NAPSACC Study which has been researching physical activity in Early Years Education settings and Somerset was part of the pilot. The study has shown that activity levels are highest in children as they begin school, and also that inequalities in activity levels are reduced when children are active in education settings. Therefore, time spent in early years education and primary school are critical in developing long lasting habits for activity levels.

*Wheeling –use of bicycles, electric power-assisted and disability adapted cycles, wheelchairs and mobility scooters

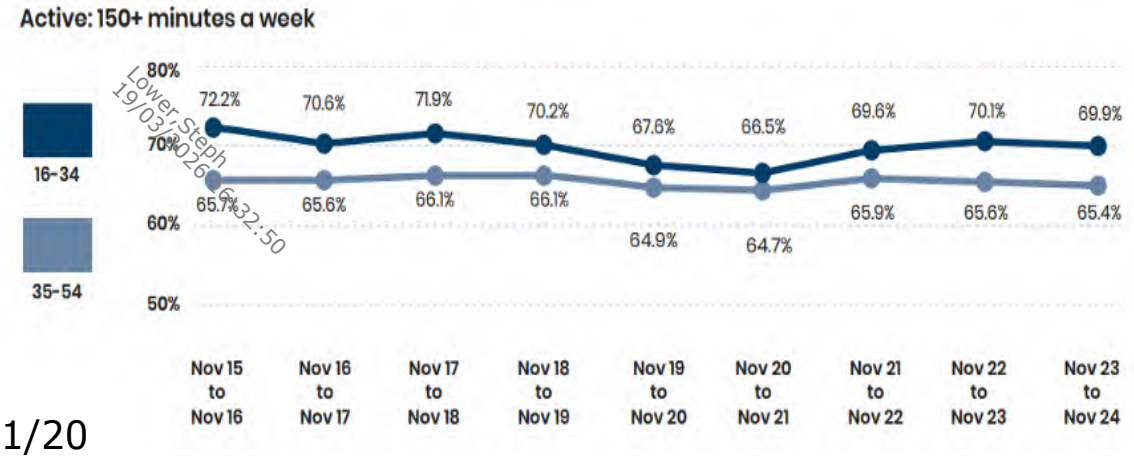
Working age adults

As young people transition into adulthood, patterns of physical activity shift for many people as work, caring responsibilities and competing demands reduce their physical activity levels.

Activity Recommendations

- The CMO guidance on physical activity for **working adults is 150 mins moderate intensity** or 75 minutes vigorous intensity per week. It is more beneficial if the physical activity spread out over 4-5 days.
- Activities to develop or **maintain strength in major muscle groups** such as gardening, carrying shopping, or resistance exercise should be done twice a week. Reducing sedentary behaviour is also crucial and long periods of inactivity should be broken up with light exercise.
- During pregnancy, individuals should continue to aim for 150 minutes moderate intensity activity per week, with choosing activities that reflecting pre pregnancy levels of fitness[1].
- Adults with disabilities are similarly encouraged to work towards 150 minutes of moderate intensity activity per week, adapted to individual ability and health needs.

Sport England Active Lives Survey national data suggests that currently activity levels in working age adults are relatively stable, albeit with a long-term slight decrease in the younger adult group (and a disruption for both groups during the pandemic). **Figure 7: Percentage of Adults in England who are active[1]**



Adults in Somerset

The Active Lives survey 2023/4 shows that 69% of adults in Somerset meet the 150 minutes of moderate intensity which is slightly higher than, but similar to, the national average of 67.4%. Therefore, **almost one third of adults** do not meet recommended levels of physical activity.

31% adults inactive	69% adults active

Only 13.3% adults in Somerset **walk** to work at least three days a week, which is significantly lower than the average across England of 18.6%

One in five adults in Somerset **do less** than 30 minutes of activity a week (similar to the national average)

Only 12.1% adults reported using cycling for travel and **only 45.7%** used walking for travel in the previous 12 months

Over half of adults in Somerset did not use any form of active travel in the previous 12 months

[1]UK Chief Medical Officers' Physical Activity Guidelines UK Chief Medical Officers' Physical Activity Guidelines
[2]Active Lives Adult Survey Nov 2023/24 Active Lives | Sport England

Adults: Barriers and health inequalities

The barriers for physical activity in adults of working age are varied and influenced by wider inequalities as they are not evenly distributed across the population.

Time Competing demands from work, family, and caregiving responsibilities, combined with long or irregular working hours, can make regular exercise difficult. These pressures can be more significant in lower-paid or insecure employment.

Accessibility and environment The availability of safe, convenient, and affordable facilities and activities is not equal. Poor local infrastructure (unsafe pavements or crossings and limited green space) can discourage activity as can concerns about safety due to busy roads. Areas with greater levels of deprivation can experience higher crime rates which can discourage opportunities to be physically active in the local environment.

Cost Financial constraints can limit access to many activities such as gyms, sports clubs, and organised activities. Additional costs from buying equipment and clothing, or travel and parking costs, can increase the expense of physical activity and widen inequalities.

Awareness & Confidence Understanding and awareness of the benefits, not just of physical activity but of reducing sedentary behaviour, is a significant factor in the motivation levels for adults. Lack of self belief, fear of injury and feeling out of place or inadequate can discourage participation. Awareness and confidence levels are influenced by social norms and are likely to be lower in communities with fewer active role models.

Disability and health Disabilities and long-term chronic conditions or pain can reduce capability and confidence resulting in lower physical activity levels. Negative attitudes and stereotypes can compound the barriers and restricts opportunities, which further perpetuates the inequalities by limiting access to physical, mental and social benefits of being active.

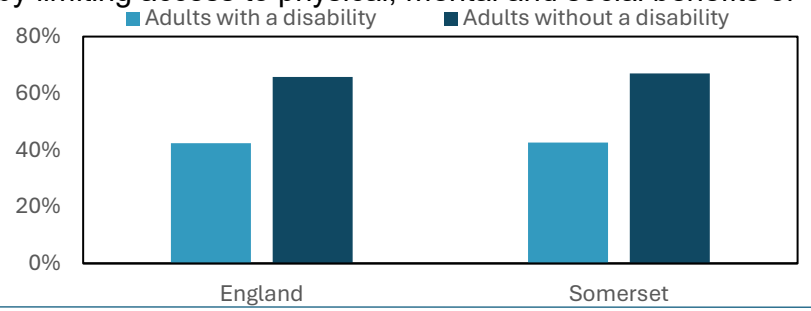


Figure 8: Adults with and adults without a disability who are active[1]

Sport England national data[2] shows women are less active than men, and that there is variation in activity levels by ethnic background. The Sport England inequalities metric for adults focuses on:

- Those with a disability or long-term health condition
- Those aged 65 and over
- Lower socioeconomic groups
- Asian, Black and Chinese adults
- Pregnant women
- Parents of children under one and
- Adults of Muslim faith

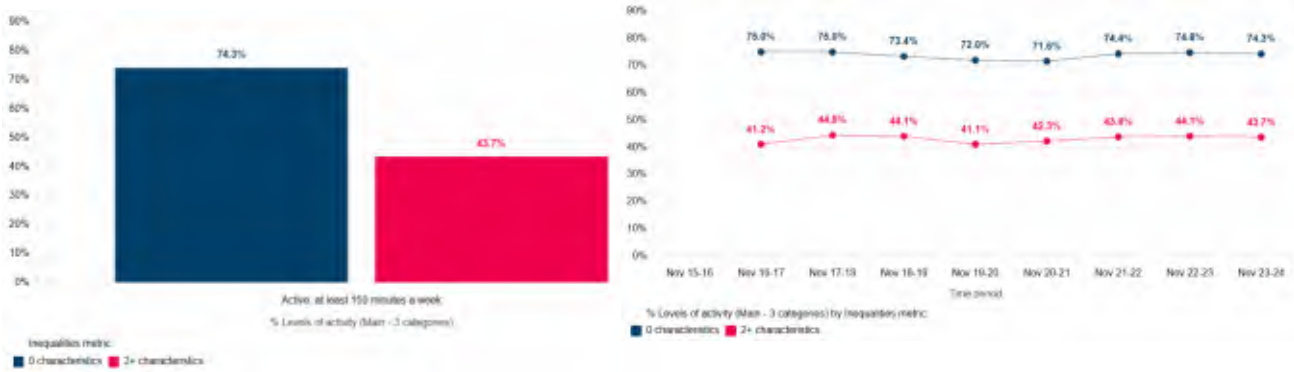
Locally, the data[2] shows that adults in deprived neighbourhoods are less likely to be physically active which aligns with the national picture. Significantly, the trend is for an increase in activity levels for those from higher socioeconomic groups and a decrease in the lower socioeconomic groups which means the gap is widening[2].

Perceptions

The Sport England Survey asked individuals about their own perceptions of physical activity and inclusion. Adults with a disability, those from lower socioeconomic groups and women were all more likely to report they feel physical activity is not inclusive.

As with children and young people, the intersectionality of different inequalities is evident and the difference in activity levels between groups of adults with no characteristics and 2 or more is significant[2].

Figure 9: Differences in activity levels between those with 2 characteristics on the inequalities metric and none[2].



What can help?

Making activity affordable and improving access within local communities is key. In Somerset, 32 out of the 339 neighbours are classified as the most deprived areas in England; this equates to around 8.5% of the Somerset population[3]. Improving local facilities and green spaces so that these communities have accessible opportunities is key, including provision for individuals with disabilities.

[1]Somerset Insights Hub Dashboard | Local Insight [2]Active Lives Adult Survey Nov 2023/24 Active Lives | Sport England
[3] Somerset Intelligence, Indices of Deprivation 2025 IMD 2025 - Somerset Intelligence

Working Age Adults: Physically Active in Somerset

ProActive

The Physical Activity Referral Scheme, launched in 2022 and delivered by SASP[1], helps people living with health conditions to become more active and gain confidence in a supportive environment to improve their physical and mental health. Individuals with a range of health conditions are referred by health care professionals and invited to 12 weeks of activity at a local provider. Find out more here.

4213 referrals between January 2023 - March 2025:

- **62%** completion rate
- **56%** improved balance
- **78%** had increased strength
- **63%** improved wellbeing

Courtesy of SASP

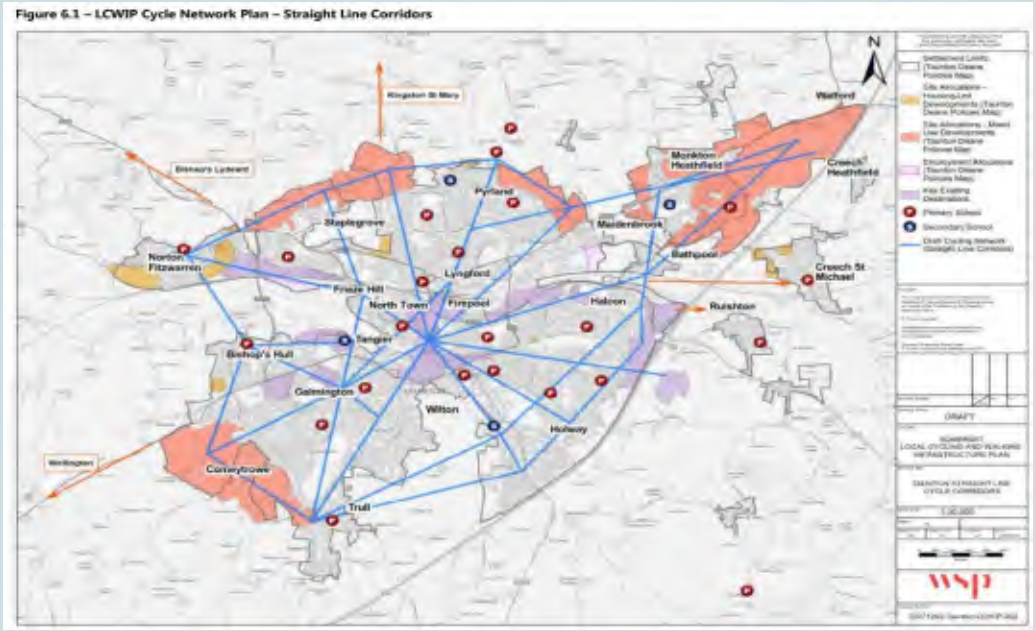
Active Travel

Increasing cycling and walking as modes of transport has been part of national plans since 2017. In 2020 the guidance (LTN 1/20) was published with standards for infrastructure (cycle lanes, junctions, crossings and places to secure bikes) so that future changes to infrastructure will make wheeling and walking safer and more accessible. Local cycling walking improvement plans (LCWIPs) were also started, and Somerset has LCWIPs in 8 towns across the region aiming to increase active travel.

Taunton LCWIP

Most of Taunton is accessible within a 30-minute walk or cycle but the LCWIP has found that routes are fragmented or unsafe and growth in housing developments has not always tied into active travel networks. The aims of the LCWIP are to create continuous corridors, safer junctions and ensure that further new developments incorporate infrastructure, making cycling and walking more accessible.

Figure 10: Taunton Local Cycling and walking infrastructure plan



[1] Somerset Activity and Sports Partnership Somerset Activity & Sports Partnership - Somerset Activity & Sports Partnership
[2] Cycle infrastructure design (LTN 1/20) Local Cycling and Walking Infrastructure Plans
[3] Local Cycling and Walking Infrastructure Plans Local Cycling and Walking Infrastructure Plans

Working Age Adults: Physically Active in Somerset

Strawberry line

Since 1980, the Strawberry Line Society, in partnership with landowners and the council, has been transforming the disused railway into a safe and accessible multi-use path. The route is being carefully developed to welcome walkers, cyclists, wheelchair users, mobility scooters (and in places equestrians) allowing increased accessibility. Each new stretch opened increases the opportunities for active travel, recreation and connection with nature. Work continues to extend the line, and eventually the path will provide a continuous route from Yatton right through to Shepton Mallet. The Strawberry Line is also fundamental to creating the 'Somerset Circle'– and around two thirds of the 76-mile route that is predominantly disused railway paths is already complete. The path allows free access to predominantly traffic free walk and cycle access that is used by many people.

Parkrun

There are eight Parkruns, including Junior ParkRun, across Somerset, offering excellent free and accessible opportunities to be physically active, volunteer and meet other people. The events are held in parks and open spaces with an emphasis on participation for all. Walking is encouraged. There are Parkruns at Shepton Mallet, Taunton, Cheddar, South Petherton, Bridgwater, Frome, Street, Minehead and Burnham & Highbridge. The social connection of being active alongside others reduces isolation and the weekly schedule helps to build a habit and offer long-term health benefits. It is volunteer-led, which helps build local community, and there is an inclusive and friendly culture making it more accessible. Cheddar Parkrun, for example, has been in place since 2021. A total of 519 volunteers have been involved, with just over 24,000 runs completed by a total of 7,386 individuals.

"Today I was celebrating my return to parkrun after a short hiatus, and today I brought my daughter with me to experience her first parkrun in the buggy, taking it in turns to push her with her big brother. 2025 has seen me do 17 parkruns pregnant, take 7 weeks off (volunteered for 3 of those weeks), and now I'm back taking it gently and hope to be back running in the Autumn. Parkrun was a huge part of my pregnancy journey, keeping me moving and I really valued my Saturday morning park walk once I found running too hard - parkrun really is for everyone." Maxine, June 2025

Photo courtesy of Cheddar Parkrun

Moving Mums

Becoming a parent can be a daunting and busy time, making physical activity low on the agenda. However physical activity is important during pregnancy and after childbirth. The social contact with peers is also especially important for supporting mental health in new mums. Confidence and logistics of childcare can reduce participation. Moving Mums is a free and supportive exercise programme run and designed by SASP, and the range of classes help women to build confidence and be active through gentle exercise that they can do with their baby or toddler with them.

The classes run by SASP include beginner walking/running classes, buggy walks and mum and baby swimming classes. Promoting physical activity in women is not just important to their individual health, but it is also crucial to increase role models to daughters because girls are less likely to enjoy and participate in activity.

Disability Activity Sessions

These are sessions that provide physical activity for adults with disability. This group is at risk of being less active than non-disabled adults.

The sessions are designed to be inclusive and fun so that everyone can take part and enjoy the social benefits alongside the physical ones.

The sessions currently run in Bridgewater and Yeovil and over a range of different activities such as new age kurling, balloon tennis and soft tip archery.

Photo courtesy of SASP

Older age adults

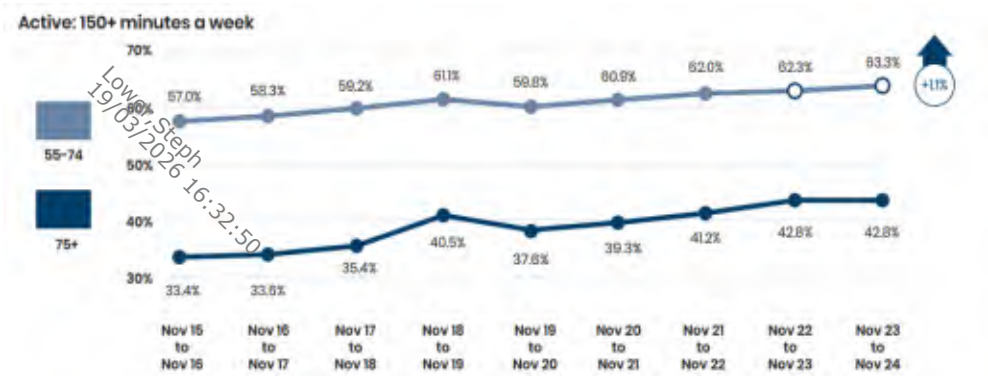
As we get older, maintaining an active lifestyle becomes ever more crucial for preserving health, independence, and overall quality of life. Physical activity continues to help prevent and manage health conditions in older age. The maintenance of mobility and function becomes vital to overall quality of life through remaining independence and reducing the risk of falls. Bone and muscle mass declines, and by age 65 some women have lost half of their bone mass. In addition, joints become less flexible and the range of motion for shoulders reduces. Combined with sight impairment and reduced balance, the risk of falls is significant and 30% of people over the age of 65 fall at least once a year.

Activity recommendations

- For older adults, the recommended level of activity is 150 mins moderate intensity aerobic activity (but should build up from the current level of activity).
- Weight bearing activities are essential to help maintain bone health and activities that improve balance should be done twice a week to reduce the risk of frailty, falling and fractures.
- Prolonged periods of sedentary time should be broken up with movement and there is increasing emphasis on the benefit of regular light activity. Even just standing has benefits[1].

The graph below shows that activity levels have risen in adults 55-74 and 75+ (6.4% and 9.4% respectively) over the last 8 years.

Figure 11: Percentage of active adults in England[2]



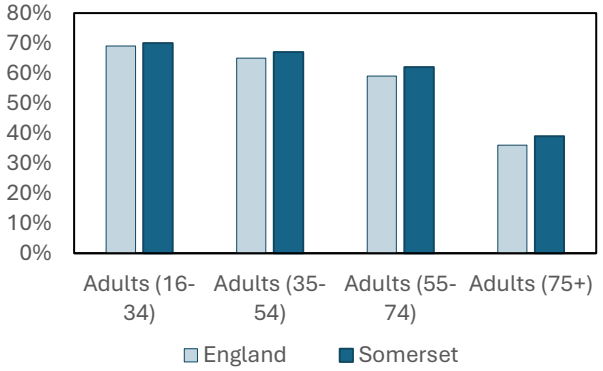
[1]UK Chief Medical Officers' Physical Activity Guidelines UK Chief Medical Officers' Physical Activity Guidelines

[2]Active Lives Adult Survey Nov 2023/24 Active Lives | Sport England

Current levels of activity

Although nationally there is an upward trend in physical activity in older adults, there is still a significant proportion of older adults who are not meeting the physical activity recommended levels. Somerset has an ageing population, and by 2033, a quarter of the population will be aged 65 or over. Maintaining independence among this cohort is vital to the functioning of our communities.

Figure 12: Physically active adults in England and Somerset[2]



Activity levels are in decline in adults as they get older, but there is marked drop after the age of 74.

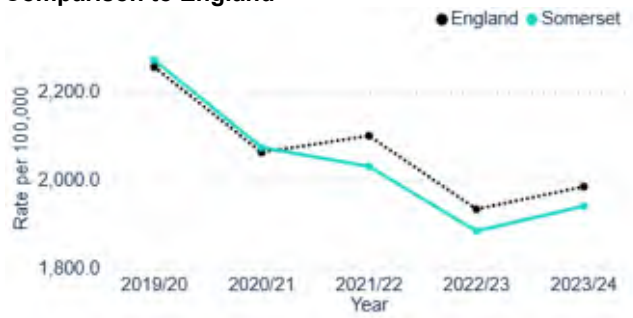
Inactive Adults in Somerset[4]

Falls

The Somerset Falls Health Needs assessment estimated that there are around 42,570 falls a year in people over the age of 65, in Somerset[3]. This results in physical injury and pain but also distress, and a loss of confidence and independence. The cost of falls to the NHS is £2.3 billion year and is estimated to be £8.5million per year in Somerset.

Somerset has seen a long-term drop in emergency emissions due to falls but crucially there was an increase in from 2022/3 onwards. This is a pattern also seen nationally.

Figure 13: Rate of emergency hospital admissions due to falls in adults (aged 65 + years over time in Somerset: Comparison to England[3]



Physical activity can reduce falls and resulting hip fractures by up to 68% and therefore engaging older adults in more activity is a priority.

[3]Somerset Council Falls Health Needs Assessment Falls Health Needs Assessment.pdf

[4]Somerset Insights Hub Dashboard | Local Insight

Older Adults: Barriers &health inequalities

"Knowledge, consumed through learning, is the Elixir of Life - the way we think about ageing is wrong; the new evidence from research lets us reimagine living longer and then realise the new paradigm and live longer better" — Muir Gray

The benefits of physical activity in later life are significant but so are the barriers to participate. The Somerset JSNA (2017)[1] described that chronic health conditions, decreased mobility, painful feet, falls and fear of falling, reducing confidence, are issues to overcome for older adults. These are more prominent in individuals who have had less active lives. Socioeconomic status can impact activity levels in older adults and Muir Gray[2] describes that those from more deprived backgrounds have shorter lives with a longer period where they are dependent on others.

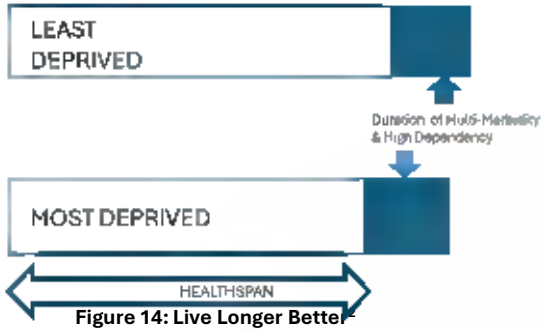


Figure 14: Live Longer Better

The National Live Longer Better[2] initiative has 3 main aims

- Increase healthy life expectancy and compress the period of dependency
- Reduce difference in health life expectancy between the most and least deprived groups in society
- Reduce need for health and social care

Recent research on factors affecting physical activity levels in this age group from low socioeconomic groups described the barriers and enablers based on the capability, opportunity and motivation for an individual[3].

Capability – Fitness, mobility and general health all influence how easy or difficult physical activity is. Individuals from lower socioeconomic groups are more likely to experience chronic health conditions and reduced fitness levels. Two in five older adults have a disability and 53% of those with disabilities are inactive[4]. Psychological capability - knowledge and awareness of activity benefits – is more common in higher socioeconomic groups, contributing to the difference in activity levels.

Motivation – Perceived health benefits and self-efficacy both encourage physical activity, while competing priorities can act as barrier. When physical activity becomes part of someone's identity, it is more likely to result in sustained commitment and behaviour change.

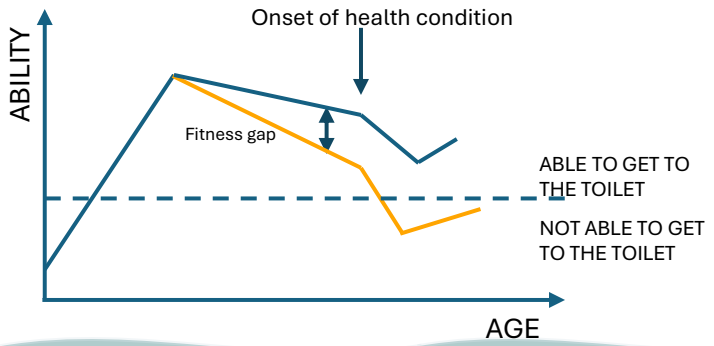
Opportunity - Environmental factors such as safety, traffic, crime rates and local infrastructure can support or hinder activity. Access to suitable local activities, along with green spaces and local community groups are important for older adults. In rural areas like Somerset, transport can be a barrier for older adults. Social support - whether physical, emotional or informational - also enables physical activity, with carers and community organisations playing a key role.

What can help?

We can't stop people getting older, but we can reduce the impact of ageing. Increasing activity levels in older adults and addressing health inequalities are key for physical and mental health in our older adults. Important areas to focus on are:

- Accessible activity options: Increase tailored strength, balance and mobility classes including chair-based or low impact activities for those with limited mobility or confidence.
- Integration into care: Embed physical activity into rehabilitation and chronic disease management in a way that is sustainable long term.
- Education and behaviour change: Raise awareness of the benefits of the activity, promote varied options, and reduce sedentary behaviour in daily life.
- Supportive environments: Ensure safe, well-maintained spaces, affordable local classes, transport access and opportunities for peer support to reduce isolation and boost motivation.

Figure 15: Effect on independence of physical activity habits[2]



Those who are less active are more likely to lose independence earlier or decline significantly when experiencing acute health challenges, whereas those who are more active retain better physical function for longer and are more resilient when they have health challenges.

[1]Somerset JSNA Joint Strategic Needs Assessments [2]Live Longer Better, Muir Gray LIVE LONGER BETTER - The Mission [3] Enablers and barriers to physical activity among older adults of low socio-economic status Enablers and barriers to physical activity among older adults of low socio-economic status: a systematic review of qualitative literature [4] Active Lives Adult Survey Nov 2023/24 Active Lives | Sport England

Older Adults: Physical Activity in Somerset

Somerset Health Walks

Somerset Health Walks - Somerset Activity & Sports Partnership & Health walks video

Health walks are organised by SASP and have been running in Somerset for many years with varying routes and levels. They provide an opportunity for individuals to get out and about, be physically active and improve their fitness alongside their general wellbeing. Often at the end of a walk the group will go to a café for a drink, providing additional chance for a chatting and connecting. Find out more here

The walks are run by volunteer walk leaders who receive training and ongoing guidance from SASP. The volunteers thoroughly enjoy helping others and benefit from the physical activity and engagement with others themselves.

Data collected April 2024 - March 2025 shows that:
There were **1,661** walks with **21,474** walk attendances
67% of walkers had at least one long-term condition
72% were aged 65 years or over
81% of walkers would recommend Somerset Health Walks, with high rates of satisfaction for aspects of the walk such as the information and meeting point, the walk level and duration and the accessibility.

Photos courtesy of SASP

Move 2 Independence (M2I)

Move 2 Independence - Somerset Activity & Sports Partnership

This work supports people after discharge from hospital who are at risk of losing independence without support. Hospitalisation can lead to loss of muscle strength, and this programme helps participants rebuild mobility and confidence to enable the activities of daily living (for example, eating, moving round the home, cooking, dressing and maintaining personal hygiene). This is vital as it enables independent living and reduces the chance of readmission to hospital.

During the period March 24-Sept 25 SASP M2I achieved:
82% uptake
97% either completed or made progress towards their goals
96% are aware of exercises to prevent falls
32% reduction in fear of falling

'This is such a good service. It has really helped me, thank you and I hope it can help other people too. It's so important.' Jenny

Photo courtesy of SASP

Strong and Steady

Stay Strong, Stay Steady sessions

AgeUK Somerset run gentle exercise classes for adults over 60 with two levels - 'Get Strong Get Steady' and 'Stay Strong Stay Steady' - across many locations in Somerset to cater for different starting points.

"Last year I had a nasty fall and a knee replacement operation. I was feeling wobbly and anxious when I was moving about. The balance class has restored my confidence and strengthened muscles to support my safe movement. I look forward to coming each week and do regular practice sessions at home. Michelle's kindness, understanding and sense of humour gives us all the encouragement we need and she is also very good at explaining what muscles we are using and how this will help our everyday movement.
The results have been amazing and culminated in a Bank Holiday walk up the steep path and along the headland at Brean Down! Sue, Nov '25

Photos courtesy Age UK Somerset

Priorities for Getting Somerset Active

The human body and mind thrive when they are active and engaging with others. If there was a drug that could reduce diabetes, hypertension, cardiovascular disease, cancer, obesity and mental health conditions, and allow us to live longer, there would be demand for it. Physical activity has this impact on health, and we need to market this and reduce barriers for those who cannot currently engage. Societal changes and behaviours mean that activity levels are much lower than recommended. It is essential that we find ways to embed physical activity back into everyday living and reduce sedentary behaviours. This means physical activity needs to feature in all aspects of life: in our homes, our local communities, our schools, our workplaces, as we travel, our retirement, as we socialise and spend leisure time.

SHORT TERM

Ageing well

The biggest priority currently is supporting adults over the age of 50 who are active for less than 30 minutes per week, to be more physically active and reduce sedentary behaviour so that they maintain strength and mobility into their later years. This will:

- Keep people independent for longer
- Prevent or delay the onset of frailty
- Reduce the risk of falls
- Prevent and mitigate social isolation and loneliness
- Lower future demand for healthcare services

MEDIUM TERM

Reduce health inequalities

Focus on reducing inequalities in physical activity by targeting groups (using Sport England inequality matrix) at greater risk of inactivity. This includes communities in areas of deprivation and individuals with disabilities or protected characteristics who may face barriers to participation. Action in these groups will:

- Address barriers and improve access and inclusion
- Support physical health and mental wellbeing through activity
- Reduce long-term risks of chronic conditions associated with inactivity
- Strengthen community resilience and social inclusion

LONG TERM

Future focus

The long-term priority is to ensure that physical activity is initiated and sustained across the life course and efforts should focus on groups where activity levels drop off or where participation doesn't start. This includes;

- Children and young people learning about and participating in physical activity to embed lasting healthy habits
- Teenagers whose activity declines during adolescence
- Working women who face barriers due to caring responsibilities and may have lower confidence in being physically active
- Promoting active travel to reach the 50% of children and adults who never walk or cycle to school or work

Physical activity must be embedded in our lives, in our communities and in our futures

Recommendations to the Somerset System to Get Somerset Active

Physical activity is not an optional extra –it is a fundamental component of good health at every age. Embedding movement into our homes, schools, workplaces and communities will enable Somerset residents to live healthier, more independent and more fulfilling lives.

Policy

- **Place-based approach** There is a need to create a system-wide partnership, accountable to the Health and Wellbeing Board, to drive a place-based approach to get Somerset moving at all stages of our lives.
- **Ageing well** There is a need to prioritise physical activity in older adults to promote healthier independent lives. Increase integration with health and care services whereby activity prescribing is routine and individuals most in need are supported.
- **There is a need to create a local environment that promotes physical activity and is inclusive.** This could mean prioritising the LCWIPs to create safer, more accessible communities and through the process of creating a new Local Plan, ensure the built environment invests in green spaces and recreation facilities, along with connecting into active travel infrastructure.
- **There is a need for a new tailored approach to disability and a m**ove beyond a one-size fits all approach and meet the physical activity needs of people with different disabilities.

Organisations

- **Increase active travel.** The Health and Wellbeing Board members could effect change as anchor organisations to lead the way in embedding active travel in employment.
- **Community.** Sports clubs and activities could be more inclusive and accessible, promoting participation not only for competition but for the health , wellbeing and the social benefits they bring. They could be used as vital spaces for building stronger, more connected communities and as a way of tackling loneliness.
- **Keep teenagers engaged** Support schools through initiatives to reduce the decline in activity levels of teenagers.

Communities and individuals

- **Building from the beginning** Ensure young people have positive early experiences of physical activity; interventions should be specifically targeted to areas of deprivation to increase opportunity.
- **Education and awareness** Evaluate campaigns that promote and encourage the importance of embedding physical activity in our everyday lives for health gain and then scale up interventions that work.
- **Where possible embed opportunities for increased physical activity into neighbourhood plans**.

Physical activity must be embedded in our lives, in our communities and in our futures

Acknowledgements

This report is the result of research using data and literature both locally and nationally on physical activity and sedentary behaviours, looking at the Public health outcome framework data, Active lives survey from Sports England data and data from SASP and the Youth Sports Trust. There has been a review of National guidance on physical activity along with local strategies such Somerset Moves and the work undertaken by Age UK.

A specific thankyou to the following people:
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Livvy Hartland
Kate Anderson
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Stuart Kennard
Tamara Bennett
Rosie Bennetts
Frederick Marais
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Item 8.1

Report to:	Somerset ICB Board
Date of Meeting:	26 March 2026

Title of Report:	ICB Boards and Cluster Board Composition and Governance Structure
Report Author:	Anett Loescher, BSW ICB Associate Director of Governance, Compliance and Risk Liz Beardsall, Head of Corporate Governance, Dorset ICB Jade Renville, Director of Corporate Services, Somerset ICB
Board / Director Sponsor:	Rob Whiteman, Cluster Chair Jonathan Higman, Cluster CEO

Report classification:	
ICB Cluster	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**
CEO, Chair, stakeholders	November and December	Engagement around composition of ICB Boards, Cluster Board, and 'place boards'
Transition Committee	5 February 2026	Consideration and recommendation of proposals to the Boards
NHS Dorset ICB Board	12 March 2026	Approved
BSW ICB Board	18 March 2026	Outcome awaited at time of circulation

1 Purpose of this paper

This paper sets out proposals for the composition for ICB Boards and Cluster Board, as envisaged for a transition period from April 2026 when the ICBs formally cluster. It is anticipated that these arrangements will be in place until the ICBs formally merge, which is currently expected for April 2027. At that point in time, legislation may also have changed and is likely to result in further changes to the composition of ICB boards.

Agreement on the composition of the ICB Boards is crucial because from it flows the composition of the Cluster Board, joint committees, and place governance arrangements.

The proposals in this paper are designed to:

- create a supportive and agile yet robust accountability, assurance and decision-making framework for the cluster as it evolves towards one organisation and strategic commissioner
- ensure that each ICB meets the statutory and regulatory requirements that apply to ICB governance while they remain as legal corporate entities throughout 2026/27.

2 Summary of recommendations and any additional actions required

The ICB Board is asked to

- approve the proposals for the composition of the ICB Boards and Cluster Boards.
- approve the proposed cluster governance model.

3 Legal/regulatory implications

The proposals in this paper are designed to be compliant with the Health and Care Act 2022 and relevant statutory guidance from NHS England, and to respect specific limitations such as that Audit Committees must remain separate while the ICBs remain legal entities in their own rights.

Any changes to ICB Board compositions will require formal amendments to each ICB's constitution, subject to NHS England approval.

Decision-making processes with regards to the proposals must follow constitutional requirements to avoid any defects in governance or legal challenge.

The ICBs' legal advisors have advised that NHSE's policy steer to primarily follow legislation when considering future governance arrangements may mean that ICBs operate at risk, and potentially unlawfully, if ICBs then choose to follow only the law and not NHSE statutory guidance regarding ICB governance. This is because NHSE statutory guidance has not been revoked and therefore is considered to still stand in full.

4 Risks

- Initial period of adjustment: as the organisations move into joint arrangements, it will be important for the Cluster Board to undertake development work early to support the formation of a strong and cohesive Cluster Board team.
- Stakeholder perception and trust: changes to governance structures, particularly Board composition, may raise concerns among partners and stakeholders about representation and influence.
- Risk of misalignment with national policy shifts: if NHS England guidance or statutory expectations evolve during the transition, proposed arrangements may need to be revisited, potentially delaying implementation.
- Risk of designing and implementing unlawful governance arrangements: mitigated by adhering to relevant legislation and NHSE statutory guidance.
- Capacity risk: the pool of governance subject matter experts continues to diminish, as colleagues have left the ICBs for new opportunities, are leaving imminently through Voluntary Redundancy, and potentially will leave in the next six months through Compulsory Redundancy. This will have real impact on the ability to establish and deliver strong governance arrangements, and on the ability to deliver a compliant merger.

5	Quality and resources impact
No additional financial resource is required to implement the proposed governance arrangements; work is being delivered by existing governance teams.	

6	Confirmation of completion of Equalities and Quality Impact Assessment
An EQIA is not required for this paper.	

7	Communications and Engagement Considerations
Chair and CEO will lead engagement with Board members, particularly around refreshed Board compositions and governance changes. Governance leads will support Chair, CEO and committee chairs with technical guidance and expert advice on Board composition, processes to recruit and appoint Board members, powers to delegate internally and externally, and implementation of agreed aligned governance arrangements.	

8	Statement on confidentiality of report
The contents of this paper are not confidential.	

ICB Boards and Cluster Board composition

1. Introduction

1.1. In September 2025 and November 2025, the Joint Transition Committee and the three ICB Boards respectively endorsed the proposed direction of travel toward cluster governance from April 2026, including joint committees and refreshed Board compositions. This paper, which was reviewed by the February Joint Transition Committee, builds on those initial recommendations. It sets out proposed compositions for the ICB Boards and Cluster Board, and a proposed governance structure. Cluster governance arrangements from April 2026, including compositions of ICB Boards and Cluster Board, are envisaged to be in place until the ICBs formally merge. A merger is currently expected for April 2027, at which point legislation may also have changed, potentially with implications as to how ICB boards must be constituted.

1.2 The following principles underpin the proposals contained in this paper:

- the cost saving mandate for ICBs applies to ICB Boards themselves.
- in order to be an effective decision-making and oversight body, and steward of the organisation, a Board should be relatively small in numbers and comprise through its members diversity of perspectives and an appropriate skills mix.
- no category of Board members on its own should be able to command a majority of votes and therefore be able to 'outvote' all other categories of Board members.
- the ICBs' individual boards' compositions is determined first, as this will in large parts determine the membership of the Cluster Board and of the committees in the proposed cluster governance arrangements.
- where significant delegation and autonomy is granted there will be suitably strong accountability, and a robust connection, through board members, between cluster and place.

2. Proposed ICBs' Boards composition

2.1 While they remain legal entities in their own right, the three ICBs must not form a single joint Board. Each ICB must retain a Board that meets the minimum statutory requirements of ICB Boards as set out in the Health and Care Act 2022 and NHSE statutory guidance:

- The Health and Care Act 2022 determines that an ICB Board must have as members an independent Chair, the CEO, a Partner Member FTs / Trusts, a Partner Member Local Authority, a Partner Member Primary Care.
- NHSE statutory guidance on Guidance on integrated care board constitutions and governance still applies, and so an ICB Board must also comprise a minimum of two non-executive members to Chair the Audit and Remuneration committees respectively.

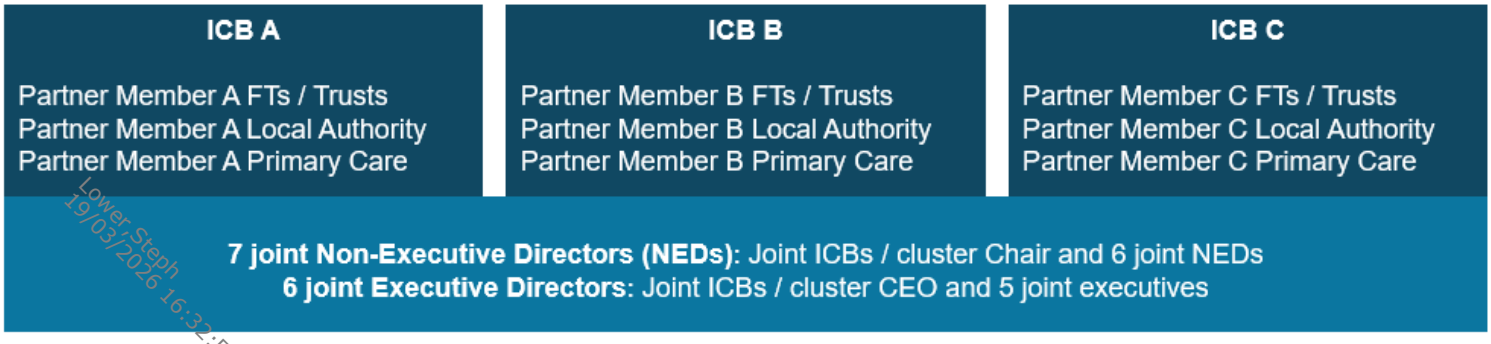
2.2 The ICBs' legal advisors strongly advise the ICBs to follow both the current legislation and NHSE statutory guidance – neither has been revoked or changed and must therefore be deemed applicable to ICBs. Non-compliance with either the legislation or the statutory guidance would put ICBs at risk of designing, implementing and operating unlawful governance arrangements. The proposals in this paper take account of this advice and meet the requirements of both legislation and statutory guidance.

2.3 It is proposed that while the BSW, Dorset and Somerset ICBs remain legal entities, their individual Boards are constituted in such a way as to meet the minimum requirements for ICB board composition as stipulated in legislation and NHSE statutory guidance. It is further proposed that these Boards then delegate the majority of their responsibilities and powers to the Cluster Board (see below) and meet only to transact the business that they cannot delegate to the Cluster Board, such as approval of an ICB's organisational budget or Annual Report and Accounts. At the same time, the ICB Boards remain fully accountable for all their functions including those that they delegate, and they must therefore be able to have appropriate oversight and assurance that and how the ICBs discharge all their statutory functions and duties.

2.4 Because of the very limited proposed remit, it is proposed that each individual ICB Board is kept small and comprises the following:

- 6 executive directors:
    - comprising the cluster CEO and the 5 cluster chief officers
- 7 non-executive directors (NEDs):
    - comprising the cluster Chair and 6 joint cluster non-executive directors (NEDs), including a joint NED Audit, a joint NED RemCom, and joint NEDs with the skills and capabilities to chair the anticipated joint committees with remits for strategic finance and resource; quality and resident engagement; commissioning and population health.
- The three statutory partner members (one jointly nominated, respectively, by FTs/Trusts; local authorities; and primary care in the respective ICB's area).

It is proposed that no regular participants are invited to these individual ICB Board meetings, given the very limited proposed remit of the Boards.



2.5 Each Board would thus comprise 16 members with voting rights. This proposed composition would equip each ICB with a board that meets the minimum statutory and mandatory requirements for ICB boards. The ICBs' Constitutions will need to be amended, and the amendments approved by NHS England, in order to bring this proposal into effect.

2.6 The nomination, selection and appointment of the joint Non-Executive Directors and of the partner members will follow the established processes as described in the ICBs' constitutions.

2.7 The Cluster Place Directors and Place Non-Executive Directors are not voting Board members and therefore are not included in the individual ICB Board memberships.

3. Proposed Cluster Board composition

3.1 It is proposed that the Cluster Board is established as a joint committee of the ICBs through which the ICBs exercise most of their functions jointly. The Cluster Board draws its membership from the three ICB Boards, and from the system, making use of the permissiveness around the appointment of non-ICB individuals to ICB committees.

3.2 A 'maximalist' approach to delegation from the three ICB Boards to the Cluster Board is proposed, so that the Cluster Board can function as a board and as the cluster's most senior oversight and decision-making forum.

3.3 In view of this significant remit, it is proposed that the Cluster Board comprises the following:

- 6 executive directors:
  - Comprising the cluster CEO and the 5 cluster chief officers
- 7 non-executive directors (NEDs):
  - Comprising the cluster Chair and the 6 cluster non-executive directors
- 6 members (local authority):
  - Comprising the 3 partner members (local authority) of the individual ICB boards, and 3 members from the local authorities that are not represented through the 3 partner members – with the intention that there is on the Cluster Board one member from a local authority for each place within the cluster geography.
- 4 members (FT/Trusts):
  - Comprising the three partner members (FT/Trusts) of the individual ICB boards, and a member from the fourth FT/Trust in the cluster; one of these members will bring knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
- 3 members (primary care):

- Comprising the three partner members (primary care) of the ICB boards
  - 1 member (VCSE sector)

3.4 The Cluster Board would thus comprise 27 members with voting rights who bring key sectors' perspectives to the Cluster Board. This is a large forum. However, Chair and CEO deem this composition appropriate to ensure representation of key stakeholders and to guide the cluster safely through the transition period towards merger.

3.5 It is proposed that HealthWatch are invited to nominate one individual to attend the Cluster Board as a regular participant. Regular participants are not voting members. However, they typically take part in discussions and inform business and decisions through their particular expertise and perspective; participants therefore hold significant influence. For the avoidance of doubt, HealthWatch and VCSE would not be participants of the individual ICB Boards, see section 2 above.

3.6 The Cluster Place Directors and proposed Place Non-Executive Directors (see below) are not voting Board members. They would not routinely attend the Cluster Board but would be invited to attend Board Development Sessions.

4. Place

4.1 A senior oversight, assurance and decision-making forum will govern each of the cluster's six places, the details of which are yet to be determined. Arrangements for place governance will reflect each Place's current arrangements and requirements and will be likely to evolve over time.

4.2 The Cluster Chair has requested that for the transition period from cluster to merger, the ICBs jointly appoint six place Non-Executive Directors (place NEDs), each to serve as the ICBs' / the cluster's ambassador at one place. The place NED roles will be focussed on fostering, brokering and nurturing key relationships between the ICB and stakeholders at the respective place. The place NEDs will work closely with the place directors. At the point of the ICBs' merger, the remit for place would transfer from the place NEDs to the joint NEDs who are voting members of both the ICBs' Boards and the Cluster Board (noting that at merger the ICBs' individual Boards would cease to exist).

4.3 To ensure balance on the Boards, the place NEDs would not be voting members of any of the ICB Boards or of the Cluster Board. There is no precedent for a governance construct where NEDs are appointed without being voting members of a board, other than the use of an Associate Non-Executive arrangement, usually used as a development opportunity for aspirant NEDs. To accommodate the arrangements for non-voting NEDs, the ICBs will mirror elements of the Associate NED model for the place NEDs – with a reduced portfolio and reduced remuneration for these roles.

5. Reporting between ICB Boards, Cluster Board and Place Boards

5.1 For the period that the ICBs remain legal entities in their own rights, the ICB boards remain fully accountable for all their functions including those that they delegate, and they must therefore be able to have appropriate oversight and assurance that and how the ICBs discharge all their statutory functions and duties.

5.2 The Cluster Board, although invested with significant powers and authorities through the delegations from the ICB Boards, is a joint committee of the ICB Boards and therefore is accountable to them.

5.3 The same is true for any place governance arrangements with delegated authorities from the ICB Boards, and all joint committees that the ICB Boards establish as part of the cluster governance.

6. Cluster governance arrangements

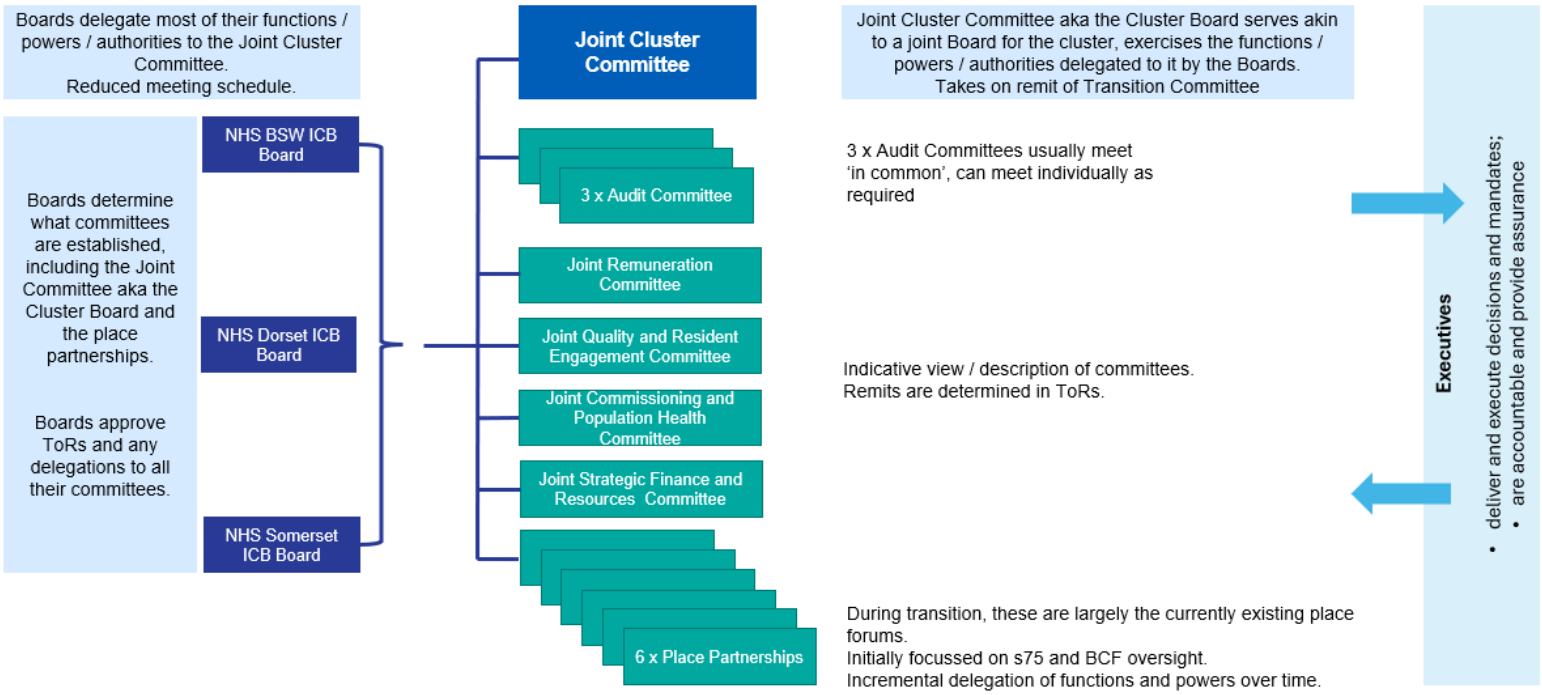
6.1 The target operating model was launched end January / early February. Under the 'form follows function' principle, the cluster governance model is now designed in alignment with the target operating model and the functions/duties that the ICBs and the cluster are required to discharge.

6.2 The model envisages that the ICB Boards are retained while the ICBs are legal corporate entities; however the Boards are expected to delegate the majority of their powers and authorities to the Joint Cluster Committee (the Cluster Board) and only transact the business that they cannot and must not delegate. See section 2 above, in particular point 2.3.

6.3 The ICB Boards will establish joint committees and delegate powers and authorities to them. It is envisaged that this will be the case for all but the Audit Committees, where it is proposed that the ICBs follow their legal advisors' strong advice to maintain one Audit Committee per ICB while the ICBs remain legal corporate entities in their own rights.

6.4 The below visualises the proposed cluster governance model. To note that the below shows neither the sub-groups that the committees are likely to establish, nor the interface between governance and management arrangements and structures.

6.5 The Board is asked to approve the proposed cluster governance model.



7. Key Decision Points and next steps

7.1 The next steps are:

- March 2026: ICB Boards to approve the proposed ICBs Boards and Cluster Board compositions, and the governance structure. Constitution amendments to be submitted to NHS England.
- April 2026: Cluster Board Development session to be held and cluster committees have inaugural meetings, in the form of development sessions where appropriate, including consideration of their respective terms of reference.
- May 2026: Cluster Board inaugural meeting and final Board approval of all cluster governance arrangements.

7.2 Subject to Boards' approvals and NHSE approval of constitution changes, governance leads will implement the changes to ICB boards, and work to establish the Cluster Board. Alongside this, work will continue on the cluster governance arrangements in anticipation of go-live in Q1 2026. This includes development of key governance documents and practical arrangements such as devising the meeting calendar. The workplan for the Governance and Legal workstream of the transition programme sets out the milestones and deliverables and aligns with the Readiness to Operate checklist that NHSE issued to ICBs just before the new year.

8. Recommendations

8.1 The ICB Board is asked to approve the proposed compositions for:

- the three individual ICB Boards

- the Cluster Board.

8.2 The ICB Board is asked to approve the proposed cluster governance model.

Item 8.2

Report to:	Somerset ICB Board
Date of Meeting:	26 March 2026

Title of Report:	Joint Remuneration Committee Terms of Reference
Report Author:	Anett Loescher, Associate Director of Governance, Compliance and Risk Liz Beardsall, Head of Corporate Governance
Board / Director Sponsor:	Cluster Chair
Appendices:	Appendix One: Joint Remuneration Committee Terms of Reference

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

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

Terms of Reference - Previous consideration by:	Date	Purpose
RemCom Chairs, Chief People Officers and Deputy Chief People Officers	16 January 2026	Shared by email for comment
In-Common Remuneration Committees	26 January 2026	Recommended to ICB Board for approval
NHS Dorset ICB Board	12 March 2026	Approved
BSW ICB Board	18 March 2026	Outcome awaited at time of circulation

1 Purpose of this paper

The ICB Board is asked to **approve**:

- the new Joint Remuneration Committee Terms of Reference to come into effect 1 April 2026.

2	Summary of recommendations and any additional actions required
The BSW, Dorset and Somerset ICBs are moving towards formal cluster arrangements, anticipated to commence from 1 April 2026. Governance arrangements for the cluster are being developed, including the creation of joint committees. Clustered ICBs are required to maintain a remuneration committee. The Joint Remuneration Committee Terms of Reference have been drafted in consultation with the three Remuneration Committee Chairs and leads. The Terms of Reference were reviewed by the in-common Remuneration Committees and recommended to the ICB Board for approval. The new Terms of Reference will be implemented from 1 April 2026.	

3	Legal/regulatory implications
Each ICB is required to have in place appropriate and effective governance and decision-making arrangements.	

4	Risks
Failures of governance – including the failure to have in place adequate and appropriate governance and decision-making arrangements – can have a significant impact on each ICB. Consequences of governance failures range from invalidation of decisions, reputational damage for each ICB, to NHSE applying its enforcement powers and protocols for failing organisations.	

5	Quality and resources impact
Quality and resources could be impacted by a lack of adequate governance and decision-making arrangements.	

6	Confirmation of completion of Equalities and Quality Impact Assessment
An EQIA was not undertaken because this activity does not relate to the arrangement of health and care services.	

7	Communications and Engagement Considerations
The approved Terms of Reference will be published on the website of each ICB as part of their respective Governance Handbooks.	

8	Statement on confidentiality of report
There are no issues of confidentiality relating to this report.	

Joint Remuneration Committee Terms of Reference

1. Report

Terms of Reference – for approval

1.1 Since August 2025 the Remuneration Committees of the three clustering ICBs (Dorset, Somerset and BSW) have been meeting on an in-common basis. In line with the move to joint governance arrangements for the cluster, the Remuneration Committees will move from in-common to joint arrangements from 1 April 2026.

1.2 New Terms of Reference (ToRS) for a Joint Remuneration Committee were developed in consultation with the Remuneration Committee Chairs and leads and were drafted with reference to all three sets of ToRS. The ToRS already had a high level of alignment and the approach taken was to maximise rather than minimise the committee's remit within the framework of the existing ToRS.

1.3 The new ToRs were reviewed by the in-common committees on 26 January 2026 and recommended to the Board for approval.

1.4 Once approved by all three ICB Boards, the new Joint ToRS will come in effect from 1 April 2026.

2. Conclusion

2.1 The ICB Board is asked to **approve**:

- the new Joint Remuneration Committee Terms of Reference to come into effect 1 April 2026.

Author's name and title: **Liz Beardsall, Head of Corporate Governance and Anett Loescher, Associate Director of Governance, Compliance & Risk**

Date: **3 March 2026**

BSW, Dorset and Somerset ICBs Cluster

Joint Remuneration Committee – Terms of Reference (ToR)

Contents

1. Introduction

1.1 The Joint Remuneration Committee (the Committee) is established by the BSW, Dorset and Somerset Integrated Care Boards (ICB), as a Committee of their respective Boards in accordance with each ICB's Constitution.

1.2 These Terms of Reference

- set out the membership, remit, responsibilities and reporting arrangements of the Committee
- are defined and agreed, and may be amended by, the respective ICB Boards in accordance with each ICB's Constitution and Scheme of Reservations and Delegations (SoRD)
- are published on the BSW, Dorset, and Somerset ICBs websites, as part of each ICB's Governance Handbook.

2. Responsibilities and duties

2.1 The Committee's main purpose is

- to exercise the functions of the ICBs relating to paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006; and
- to function as an advisory and assurance committee of each Board with regards to the ICB's respective discharge of its responsibilities as an employer.

2.2 The Boards have delegated the following functions to the Committee:

- Determination of remuneration and conditions of service
- Assurance that nominations, recruitment and appointments of the ICB's Board members follow due process
- Oversight and assurance of the ICBs' executive board members' performance for purposes of determining performance related pay or similar pay awards.

2.3 The Committee's responsibilities and duties are as follows:

2.3.1 For the Cluster Chief Executive, Cluster Executive Directors and other Very Senior Managers (VSM):

a. Determine and approve all aspects of remuneration and conditions of service including:
   i. salary, including any performance-related pay or bonus;
   ii. provisions for other benefits, including pensions and cars;
   iii. allowances under any pension scheme it might establish as an alternative to the NHS pension scheme;
   iv. arrangements for terminations and severance payments; and
   v. other allowances;

The Committee will ensure that any approvals from regulators and / or government departments (e.g. NHSE, HM Treasury) are sought as required.

b. For all ICB staff
    i. Determine each ICB's pay policy which may include the adoption of pay frameworks such as Agenda for Change, pension schemes, allowances, benefits, employee tribunal settlements;
    ii. Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate;
    iii. Ensure that each ICB has in place appropriate contractual arrangements with its employees.

Non-executive Board member remuneration will be determined by the national framework, with the Cluster Chair exercising limited discretion for any additional allowances. The Committee will not discuss remuneration or succession planning of the ICB Board's Independent Non-Executive Directors due to Committee members' conflicts of interests.

2.3.2 Performance and evaluation

a. Ensure that a framework is in place for the appraisal and performance management process for the Cluster Chief Executive and Cluster Executive Directors, take assurance that the process is undertaken, and consider its outcomes for the purposes of any pay review.

b. Consider matters relevant to the Cluster Chief Executive's, Cluster Executive Directors', and VSMs' continuation in post including any suspension or termination of their service as employees of the respective ICB, subject to the provisions of the law and their service contract.

c. Take assurance that a framework is in place for the appraisal and effectiveness review of non-executive, partner and other ordinary Board members, including for the robust and compliant application of the Fit and Proper Person requirements. The Cluster Chair leads the appraisal of the Cluster Chief Executive and of non-executive, partner and other ordinary Board members, and will consider action that may be required – this may include decision to terminate the term of office of a member of the Board or its Committees. For the avoidance of doubt, the Committee will not undertake appraisals of Board members.

2.3.3 Succession Planning

a. Ensure that succession plans are in place for all the ICBs' Board members, including mechanisms to ensure that the Boards have the right balance of skills, knowledge and perspectives to discharge their duties and functions. This includes undertaking an annual skills review of the Board.

The Cluster Chair will lead succession planning of the ICBs' Independent Non-Executive Directors.

b. Ensure that succession plans are in place for the Cluster Chief Executive,

Executive Directors and VSMs, taking into account the leadership needs of the organisations, existing challenges risks and opportunities, and the skills and expertise needed for the health economy in the future.

2.3.4 Nominations and appointments (Board and committees)

a. Assurance that nominations, recruitments and appointments of Board members follow due process,
b. Assure each Board and the Cluster Chair that in making any appointments to each ICB Board and its committees, due process is followed, and any statutory and regulatory requirements / expectations are complied with.

3. Benchmarking and guidance

3.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

4. Authority

4.1 The Committee is authorised to

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee of the ICBs or any member of each ICB Board;
- Commission reports required to help fulfil its obligations;
- Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the respective ICB for obtaining professional advice;
- The committee is invested with the delegated authority to act on behalf of each ICB Board. The limit of such delegated authority is restricted to the areas outlined in the Responsibilities of the Committee;
- Create sub-groups of the Committee and determine the terms of reference of such sub-groups in accordance with each Board's Constitution, Standing Orders and SoRD. The Committee may not delegate any decision-making powers to such groups.

5. Accountability and Reporting

5.1 The Committee is accountable to the BSW ICB, Dorset ICB and Somerset ICB Boards and reports to each Board on how it discharges its responsibilities.

5.2 After each meeting of the Committee, the Committee Chair reports to each Board about decisions taken, assurances received, and any concerns that the Committee wishes to escalate.

5.3 Reporting will be through the form as specified by and agreed with each ICB Board, and may take the form of the Committee's minutes, of exception or highlight reports,

or dedicated reports produced by the Committee.

5.4 On behalf of the Committee, the Chair may also report about other issues and matters within the Committee's remit that in the Committee's view require the attention or decision-making of each Board.

5.5 The Committee receives scheduled assurance reports from any sub-groups that it establishes, in a format that is determined by the Committee and enables it to obtain the assurances that it seeks.

5.6 A report will be written annually on the Committee's business during that year, an this will form part of the ICB's Annual Report.

6. Membership

6.1 The following are members of the Committee who have voting rights and decision-making powers:

- Five Non-Executive Directors
  - One of these Non-Executive Directors will chair the Committee. The chair will have the specific knowledge, skills and experience to chair the Committee.
  - The Non-Executive Chair of the Audit Committee cannot be a member of the Committee so as to maintain their independence to objectively scrutinise and assure the ICBs' governance arrangements.
  - The Cluster Chair may be a member of the Committee but cannot chair it.

6.2 The following are regular attendees of the Committee. They will inform and advise the Committee, but have no voting rights or decision-making powers:

- <insert lead / director-level HR / CPO role – in the immediate term: Deputy Chief People Officers>

When determining the membership of the committee, active consideration will be made to diversity and equality.

No individual should be present during any discussion relating to:

- any aspect of their own performance, pay (incl. benefits, severance etc), or conditions of service
- any aspect of the performance, pay (incl. benefits, severance etc), or conditions of service of others when it has an impact on them

Members are expected to make every effort to attend all committee meetings.

6.3 The Committee Chair may determine one of the other Non-Executive members of the Committee as deputy chair.

6.4 Only the above members and regular attendees of the Committee have the right to attend Committee meetings.

6.5 In addition, the Chair on behalf of the Committee may invite ad-hoc and in view of agenda items such individuals to Committee meetings as are considered necessary to enable the Committee's effective conduct of its business. Such additional attendees will only attend as requested and will not become regular attendees. They will not have a right to receive committee papers, and they will not have voting rights or decision-making powers.

6.6 The Committee Chair may ask any or all of those who normally attend Committee meetings, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6.7 In the case of absences:

a. In the absence of the Committee Chair and the Committee's deputy chair, the remaining members present determine one of their number as Chair of the meeting.
b. Where a Committee member is unable to attend, they should ensure that a named and briefed deputy attends the meeting in their place. Such deputies will count towards the quorum.
c. Where a regular attendee of the Committee is unable to attend a meeting, a suitable representative may be agreed with the Committee Chair.

7. Quorum

7.1 A quorum shall be three members (including the Chair or Deputy Chair of the committee), with representation from each of the three ICBs.

7.2 If any member of the Committee is disqualified from participating in an item on the agenda due to a declared conflict of interest, that individual no longer counts towards the quorum.

7.3 In the event of difficulty in relation to achievement of the quorum, independent Non-Executive Members who are not members of the committee may be co-opted as members for individual meetings. The Chair of the Audit Committee cannot be co-opted.

7.4 If the meeting becomes inquorate, and if members agree, the meeting may continue but cannot take decisions. Any decisions in principle must be ratified at the next quorate meeting of the Committee.

8. Meeting frequency and conduct

8.1 The Committee will normally meet twice during a business year, and otherwise as required. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

The ICB Boards, Cluster Chair or Cluster Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

8.2 A meeting is constituted when members attend face-to-face, via telephone or video conferencing, any other electronic means, or through a combination of the above. Quoracy rules apply in any case. For the avoidance of doubt, this provision applies to and facilitates the Committee's decision making by email, should this be required to expedite an urgent decision.

8.3 The Committee normally holds its meetings in private.

8.4 The Committee conducts its business in accordance with relevant codes of conduct, good governance practice, including the Nolan principles of public life, the ICBs' Standards of Business Conduct Policies, Standing Financial Instructions, SoRD and other relevant policies / guidance on good and proper meeting conduct for NHS organisations.

8.5 All Committee members are bound by the Standing Orders and other relevant policies of each ICB. All members and those in attendance must declare any actual or potential conflicts of interest. This is recorded in the meeting minutes.

8.6 The Committee will apply each ICB's Standards of Business Conduct Policy with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.

9. Decision making

9.1 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

9.2 Decisions are normally arrived at by consensus.

9.3 Where consensus cannot be reached, the Chair will move to a formal vote. The quoracy rules apply. Only members of the Committee may vote. Each member is allowed one vote, and a simple majority is conclusive on any matter.
The Chair may have a casting vote if members are equally divided on an issue.

9.4 If a decision is urgent and cannot wait for the next scheduled meeting, and an extraordinary meeting is not appropriate or possible, the Chair may conduct business via email ('out-of-meeting decision'). The Secretariat will undertake the process on behalf of the Chair. The quoracy rules as set out in these Terms of Reference will apply. All out-of-meeting decisions will be formally reported to the Committee.

10. Equality, Diversity and Inclusion

10.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

11. Secretariat and administration

11.1 The Secretariat for the Committee is provided by the Governance Team. The Secretariat will ensure that:

a. The Committee's forward plan is maintained and kept current with the Chair and the relevant executive lead.
b. Meeting agendas are agreed by the Chair with the support of the relevant executive lead, and meeting papers and materials are prepared and distributed in accordance with each ICBs Standing Orders.
c. Members' and regular attendees' attendance at meetings is monitored, and the Chair is informed if members do not meet the minimum expectations re attendance.
d. Records of members' appointments and renewal dates are up-to-date, and the Chair and the Board are prompted to renew membership and identify new members where necessary.
e. Management of conflicts of interest including ensuring correct handling of declarations.
f. Good quality minutes are taken in accordance with each ICBs Standing Orders and agreed with the Chair, and a record is kept of matters arising, action points and issues to be carried forward.
g. The Chair is supported to prepare and deliver reports to each Board.
h. The Committee is updated on pertinent issues/ areas of interest/ policy developments.
i. Action points are taken forward between meetings, and progress against those actions is monitored.
j. Governance advice is available and easily accessible for Committee members.

12. Review

12.1 The Committee will regularly review its performance, its membership and these terms of reference, and recommend to each ICB Board any amendments it considers necessary to ensure it continues to discharge its business effectively

Effective date: [Month 2026] (when Board approved)
Review date: [Month 2026] (as set by Board)
Contact: [cluster shared gov inbox]

Appendix I: Revision History

Version	Date	Approved by	Type of changes
V1.0		BSW ICB Board Dorset ICB Board Somerset ICB Board	Establishment of the Joint Committee and creation of ToR

Document control

The controlled copy of this document is maintained by the governance function for the BSW, Dorset and Somerset ICB cluster BSW ICB. Any copies of this document held outside of that area, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

REPORT TO:	**NHS Somerset Integrated Care Board ICB Board Part A**	**ENCLOSURE: 09**
DATE OF MEETING:	**26 March 2026**	
REPORT TITLE:	**ICB Priority Programme Report and Board Assurance Framework 2025/26 – Quarter 4**	
REPORT AUTHOR:	**Priority Programme Leads Kevin Caldwell, Head of Information Governance and Risk**	
EXECUTIVE SPONSOR:	**Jade Renville, Director of Corporate Services and Affairs David McClay, Chief Officer for Strategy, Digital & Integration Alison Henly, Chief Officer for Strategic Finance & Resources**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☒
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☒ Objective 5: Respond well to complex needs
- ☒ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

The Somerset System Board Assurance Framework (BAF) and priority programme reporting provides strategic oversight of progress toward meeting ICS strategic aims. The last update to the ICB Board was in November 2025. This report provides the quarter 4, 2025/26 update.

REPORT TO COMMITTEE / BOARD

Key changes and progress

This report provides the Board with strategic oversight of progress towards meeting the Integrated Care System's (ICS) strategic aims, including an update on the priority programmes and enablers which underpin the aims and the key risks and mitigations.

Pan-ICS Strategic Risks

Strategic risks provide a top-down view of the key high-level risks at a pan-ICS level that may impact on progress to meeting the ICS strategic aims. The current set of strategic risks are:

Workforce – If we do not have a workforce with the right skills and diversity available in the right places, at the right time, then we will be unable to effectively meet the health and care needs of our population. Current risk score: 20

Financial Achievement - If we do not improve and maintain the financial health of the Somerset system, then we will be subject to restrictions which will impact on our ability to deliver sustainable, continually improving services, resulting in worse outcomes for the people of Somerset. Current risk score: 20

Culture/Partnership Working - If system partners lack a set of shared values and behaviours, then the agreed operating model and ways of working will not prove effective, resulting in limited delivery of strategic aims and poorer outcomes for the people of Somerset.
Current risk score: 12

Innovation - If we fail to identify and maximise the opportunities presented through innovation, then we may miss chances to improve services, resulting in poorer outcomes for the people of Somerset. Current risk score: 12

Population Health - If we fail to improve the health and wellbeing of the people of Somerset, then existing service delivery models will be further stretched, resulting in exacerbating inequalities and worsening of healthy life expectancy. Current risk score: 16

Outcomes - If the Somerset system fails to transform delivery of health and care services, then current models of care will become unsustainable, resulting in poorer outcomes for the people of Somerset. Current risk score: 16

Population Demographics - If service transformation does not meet the future needs of the population of Somerset, then there is a risk of exacerbating inequalities, resulting in poorer outcomes for the people of Somerset. Current risk score: 12

Reducing Inequalities - If we fail to reduce inequalities for the population of Somerset, then there will be a worsening of healthy life chances and outcomes for disadvantaged groups among the people of Somerset. Current risk score: 15

Transition: There is a risk that the national ICB cost reduction programme and transition to ICB cluster arrangements will adversely impact the delivery of Somerset ICS strategic aims resulting in limited progress and a failure to deliver improvements in health and care for the population of Somerset. Current risk score: 16

Each strategic risk is allocated an executive 'owner' and overseeing committee to take responsibility for leading a system wide review and assessment of each allocated risk.

Corporate Risk Profile Across Statutory Organisations

Each system partner organisation within the ICS manages its own portfolio of risk. Although there are varying approaches to risk management across the system, the following summarises the latest available data aligned to priority programmes and strategic aims.

It should be noted that this data is publicly available in the respective organisation's reports.

There are currently 63 open active corporate level risks (rated at 15 or above) across Somerset NHS Foundation Trust, Somerset Council and Somerset Integrated Care Board.

Risks are currently rated:

Risk rating	Number of corporate risks at this level	Change since last quarter
25	3	+1
20	17	No change
16	28	+5
15	15	-1

Links to thematic overview of corporate risks

Finance

Financial risks form a significant component of the risk portfolio, with the two highest risks at organisation level being rated at 25. All organisations continue to carry significant financial risk, further amplified by the national requirement to significantly reduce running costs within NHS organisations during 2025/26. Although the net risk position of the system has reduced since quarter 1, risk remains. It is noted there remains deterioration in the system deficit underlying position.

Risks include:

ORG009 – Somerset Council – Medium term financial sustainability (25)
ORG011 – Somerset Council – Escalation in high needs budget pressures and cumulative deficit (25)
749 – Somerset ICB – Significant business impacts on Somerset ICB as a result of transition to cluster arrangements – (20)
764 – Somerset ICB – Risk that the NHS Somerset financial position for 2026/27 delivers a deficit position (16)
R1611 – Somerset NHS Foundation Trust (SFT) – Failure to secure necessary infrastructure – physical and digital (funding) (20)
R1789 – SFT – Unsafe premises and environment (20)
R2192 – SFT – Symphony Healthcare Services (SHS) not becoming self-sustaining (20)

There is risk for all priority programmes and strategic aims to be impacted due to the financial risks seen across the ICS.

Most relevant strategic aims:

- Enable broader social and economic development
- Enhance productivity and value for money

Outcomes

There remains significant risk across the ICS in relation to improving patient outcomes. Risk factors identified include increasing demand for services, waiting and referral times above prescribed targets and inability to meet statutory responsibilities.

Priority programmes impacted by these risks include redesign of clinical pathways, system flow, impacted by risks of increasing demand and 'no criteria to reside' (NCTR) activity and risks relating to neonatal and maternity services.

ORG002 – Somerset Council – Statutory responsibilities for children, families and education services (25)
ORG014 – Somerset Council – Statutory responsibilities for Social Care (16)
R0004 – SFT – Demand for services (15)
R0012 – SFT – Waiting times (20)
R0007 – SFT – Referral to treatment times (16)
542 – Som ICB – Patients facing delayed discharge whilst waiting for out of hospital care (20)

715 – Som ICB – Risk to care quality, safety, outcomes and experience for pregnant people and babies born in Somerset (20)
679 – Som ICB – Adult ADHD and autism assessment capacity issues impacting health services and patient care (20)

Most relevant strategic aims:

- Improve the health and wellbeing of the population
- Provide the best care and support to children and adults
- Respond well to complex needs
- Improve the health and wellbeing of the population
- Reduce inequalities
- Strengthen care and support in local communities

Workforce

Workforce continues as a further significant area of risk documented at corporate level across ICS system partners. A particular focus of risk is in relation to clinical workforce and retention and turnover of staff. As with financial risk, workforce risk may impact across all priority programmes and strategic aims. Risks relating to workforce and ICB transition continue to present challenges. For the clinical workforce, the impacts of changes in the agency market present risks to potential unsafe staffing levels.

222 – Somerset ICB - GP workforce is insufficient to meet the needs of the population (20)
647 – Somerset ICB – Risk that safety, quality and delivery will be affected due to workforce shortages (16)
691 – Somerset ICB – There is a risk that the reduction in staff within the Local Maternity and Neonatal system could impact assurance function (16)
ORG001 – Somerset Council – Health, Safety and Wellbeing (15)
R3673 – SFT – Potentially unsafe staffing levels on shifts due to collapse of agency market (20)
R2306 – SFT – Vacancies rates within trainee doctor workforce as a result of national shortage of trainees, Deanery allocations, and the structure of run throughs (16)

Most relevant strategic aims:

- Strengthen care and support in local communities
- Enable broader social and economic development
- Enhance productivity and value for money

Inequalities

Linked to improving health and wellbeing of the population, failing to make impact on reducing inequalities across the Somerset population remains a significant risk. A risk has been added in this quarter to reflect the challenges to accessing NHS dental services in Somerset. It should be noted that there are fewer defined risks at a corporate level which specifically focus on reduction of inequalities, which in itself could be a risk for delivery of the priority programmes.

285 – Somerset ICB – Patients will wait longer than the access waiting time required by the specific cancer standards (16)
624 – Somerset ICB – Children with familial hypercholesterolemia do not have access to screening and treatment (15)
765 – Somerset ICB – Access to NHS dental services in Somerset (16)
R1620 – SFT – Failure to achieve objecting of reducing healthcare inequalities (10)

Most relevant strategic aims:

- Reduce inequalities
- Provide the best care and support to children and adults

- Strengthen care and support in local communities
- Respond well to complex needs

Other thematic areas of risk

Currently the focus of corporate risk across all organisations in the ICS tends to be on reactive operational activity rather than on some of the more proactive measures which need to be taken as a system to progress towards risks relating to population health, population demographics, culture/partnership working and innovation. Further risks are acknowledged in the priority programme update relating to population health capacity programme capacity, which will impact further.

These areas align across all seven ICS strategic aims.

Transition

The planned change programme for the NHS continues to carry risk for Somerset and the strategic aims it holds. The strategic ICS transition risk articulates the risk to delivery of strategic aims across the ICS due to the planned ICB clustering, cost reductions and restructuring required. ICB corporate transition risks have been identified during the last quarter and added to the ICB risk register.

749 – Somerset ICB – There is a risk of significant business impacts on Somerset ICB as a result of the transitioning to cluster arrangements (20)
748 – Somerset ICB – Risk that workforce disengagement during transition may impact delivery of 2025/26 financial position (12)
484 – Somerset ICB – Transition to ICB clustering and organisational restructure impact on workforce training for Data Security and Protection Toolkit compliance (12)

Summary

This report presents a high-level overview of progress with priority programmes which are in place to support delivery of ICS strategic aims, and the risks and mitigations.
The Board are asked to review and discuss:

- Where there may be any gaps in assurance?
- What are the key areas of concern to the Board?
- What actions can the Board take to support?

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	There are no proposals or matters which affect any individuals with protected characteristics directly within this paper. Each priority programme is responsible for assessment of potential impacts on any people with protected characteristics.
Quality	Impacts to quality of service are considered and covered as part of priority programme development.
Safeguarding	N/A
Financial/Resource/ Value for Money	N/A
Sustainability	N/A
Governance/Legal/ Privacy	N/A
Confidentiality	N/A
Risk Description	N/A

ICB Priority Programme Report and Board Assurance Framework 2025/26

Summary

Ref	Exec Sponsor	Priority Programme	Overseeing Committee	Assessment at Q4	Trend
1	BM/SM	Clinical Pathways	Clinical Pathways Redesign Programme Group		⇨
3	PL	System Flow	Urgent and Emergency Care Delivery Group		⇨
4	DM	Neighbourhoods	Collaboration Forum		⇨
5	BM	Population Health	Population Health Transformation Board		⇨
Ref	**Exec Sponsor**	**Key Enabler**	**Overseeing Committee**	**Assessment at Q4**	**Trend**
6	AH	Finance	Finance		⇨

ICB – Priority Programme and Board Assurance Framework report

2025/26

Priority Programme:	**1 – Clinical Pathways Redesign**	**Programme SROs:**	**Bernie Marden Shelagh Meldrum**
Overseeing Committee:	**Clinical Pathways Redesign Programme Group**		
Strategic Aims:	(Please indicate which aim/s this programme supports) ☒ Aim 1: Improve the health and wellbeing of the population ☒ Aim 2: Reduce inequalities ☒ Aim 3: Provide the best care and support to children and adults ☒ Aim 4: Strengthen care and support in local communities ☒ Aim 5: Respond well to complex needs ☒ Aim 6: Enable broader social and economic development ☒ Aim 7: Enhance productivity and value for money		

Programme risk	**Title**	**Owner**	**Score/ Change**	**Appetite**
	Impact of ICB restructuring	-	16	Within tolerable appetite
	Changes required to contractual/financial arrangements	-	12	Within optimal appetite
	Capacity of operational staff to engage and implement	-	16	Within tolerable appetite
	Change fatigue across the system	-	12	Within optimal appetite
	Lack of meaningful service user involvement	-	12	Within optimal appetite
	Lack of co-design and service user involvement due to pace of change	-	12	Within optimal appetite
	Challenges in obtaining baseline data for clinical pathways	-	16	Within tolerable appetite
Corporate risk	A summary of ICS organisational risks impacting this programme is outlined in the covering report			

Narrative Overview:

Reporting period:	**Q3 and 4 (October 2025 – March 2026)**
Alert:	• Nothing to note at this time.
Assure:	**Paediatrics; Focus on UEC and Primary Care Models** • A communications campaign to promote the use of the HandiApp started at the beginning of December 2025 – end February 2026. • Data received indicates a positive impact, with increases observed in both new and returning users. A full learning review is being completed and learning can be shared. **Women's Health – Development of Women's Health Services** • Work continues to develop a comprehensive women's health service map and GAP analysis. • A women's health & wellbeing event took place in Glastonbury on 5 November 2025. • A second women's health event will be held in Minehead (June 2026) to include healthy relationships and starting periods. **Ophthalmology – Current Local Enhanced Services (LESs)** • The NHS Somerset Integrated Care Board and the Somerset Local Optical Committee have worked collaboratively to undertake a clinical review of the optometry local enhanced services, prioritising the acute community eyecare service. They are now progressing the review of the financial and contracting model, with rollout planned from October 2026/27. • There is an opportunity to utilise a digital referral platform, whilst a longer term, more functional solution is found a system meeting is scheduled to focus on the three national priorities, moving to communities, prevention and digital. **ADHD; Adults Service Redesign;** • Colleagues from SFT have met with the ICB to discuss proposals relating to the adults ADHD service model. • Further meetings have taken place to develop the proposal into a draft Business Case, including detailed costings which will require further review. • The team are working on developing a dataset that meets the commissioning and quality needs.
Advise:	**Measures** Additional data has been identified to support the paediatric pathway, however some challenges remain. **Paediatrics; Focus on urgent and emergency care and primary care models**

	The Business Case for a paediatric intermediate service is currently in development to determine next steps. **Weight management** The OPIP bid outcome was unsuccessful, the outcome was shared on 27 February 2026 and team are considering next steps. **Women's Health – Development of Women's Health Services** Work is ongoing to gather appropriate data sources to determine baseline data for the current women's health service provision in Somerset including analysis of gynaecology.

Key metrics:

Metrics	Target	RAG	Change to Previous month	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
No. of 111 Calls for Paediatrics received	TBC	TBC	↓	2350	2310	1890	1990	2040	1925	Data awaited	Data awaited	Data awaited
No. of 111 calls for paediatrics received that resulted in an ED attendance	TBC	TBC	↓	800	835	650	675	695	655	Data awaited	Data awaited	Data awaited
No. of 111 calls for the 7 most prevalent paediatric symptom groups that resulted in an ED attendance	TBC	TBC	↑	750	720	545	565	540	635	Data awaited	Data awaited	Data awaited
No. of attendances at ED and UTCs for the 7 most prevalent paediatric symptom groups	TBC	TBC	↑	255	290	185	180	175	200	Data awaited	Data awaited	Data awaited
No. of direct secondary care to optometry follow-up referrals	TBC	TBC		Metric under review - No data source available								
No. of direct new referrals optometry to secondary care	TBC	TBC										
% Reduction in GP referrals to secondary care (Ophthalmology Service - eRS data)	TBC	TBC	↓	811	847	752	874	818	847	1028	850	775
% Children diagnosed as obese	TBC	TBC		Metric under review, only Annual data available (outdated)								
% Adults diagnosed as obese	TBC	TBC										
ADHD - Total No. of people on the waiting list (Somerset FT)	TBC	TBC	↓	2028	2013	1981	1909	1830	1833	2125	2110	2080
ADHD – No. of people on the triage waiting list for 18+ wks (Somerset FT)	TBC	TBC	↓	1921	1917	1935	1898	1825	1816	2094	2100	2069
ADHD – No. of people on the assessment waiting list for 52+ wks (Somerset FT)	TBC	TBC	↑	1360	1401	1454	1444	1428	1455	1605	1649	1673
ADHD Right to Choose	TBC	TBC		Metric under review - No data source available								
Number of ring pessaries fitted	TBC	TBC				267			323			389
Number of referrals into Post menapausal bleed service	TBC	TBC		31	22	31	27	19	33	32	25	32
Number of patients seen in Post menapausal bleed service	TBC	TBC		90	68	91	139	68	82	116	79	47

Overall assessment of progress toward achieving priority programme measures for 25/26	
The current assessment of progress is rated Amber as some projects at early stages of development or awaiting further input to progress. Until these are fully scoped with robust plans, a degree of uncertainty remains around delivery timelines and outcomes.	

ICB – Priority Programme and Board Assurance Framework report 2025/26

Priority Programme:	3 – System Flow	**Programme SRO:**	Peter Lewis (SFT)
Overseeing Committee:	Urgent and Emergency Care (UEC) Delivery Group		
Strategic Aims:	(Please indicate which aim/s this programme supports) ☒ Aim 1: Improve the health and wellbeing of the population ☐ Aim 2: Reduce inequalities ☒ Aim 3: Provide the best care and support to children and adults ☒ Aim 4: Strengthen care and support in local communities ☒ Aim 5: Respond well to complex needs ☐ Aim 6: Enable broader social and economic development ☒ Aim 7: Enhance productivity and value for money		

Programme risk (risk scores 12 and above only)	**Title**	**Owner**	**Score/ Change**	**Appetite**
	If pathway waiting times are higher than target, **then** No Criteria to Reside (NCTR) and 21-day Length of Stay (LOS) trajectories will not be achieved, resulting in increased risk of deconditioning and harm to patients	System flow programme group and Intermediate Care Steering Group	12	
	If in-hospital process delays do not fall to the target level of 30 **then** NCTR trajectories will not be achieved, **resulting in** high acute bed occupancy, continued use of escalation beds & extended length of stay for inpatients.	Patient Flow Service Group Director, SFT	12	
	If the newly expanded pathway 1 resource is neither delivered or fully utilised, **then** NCTR trajectories will not be achieved, **resulting in** high acute bed occupancy, possible use of escalation	Strategic Lead for Older People Commissioning, Somerset Council and Pathway 1 Manager, SFT	16 ↑	

	beds and extended length of stay for inpatients.			
Corporate risk	A summary of ICS organisational risks impacting this aim is outlined in the covering report.			

Narrative Overview:

Reporting period:	**7/11/25 to 26/2/26 inclusive**
Alert:	Acute No Criteria to Reside (NCTR) was 21.9% against a target of 12.5% at the end of the last Board Assurance Framework (BAF) reporting period (6/11/25). This position has deteriorated. NCTR is currently 28% (as of 26/2/26) The high NCTR is on a background of increased front door activity, ward infection prevention control restrictions, high demand for supported discharge pathways and pathway 1 (P1) re-contracting processes being underway. Other drivers include continued in-hospital process delays and a misalignment of P1 capacity where demand is currently outstripping available capacity. 21% of NCTR at YDH is attributable to Dorset (26/2/26). Mental health NCTR increased in the last reporting period.
Assure:	The system flow programme team continue to meet weekly and are prioritising efforts to a. Offset P1 demand where feasible b. Scope out options to increase pathway 1 capacity in geographies where existing providers are unable to meet their contracted hours. Inpatient mental health patients ready for discharge now have allocated social worker practitioners. Workforce challenges are expected to be resolved by end Feb-26 and therefore delays in mental health inpatient units are expected to reduce in the next reporting period.
Advise:	The national Discharge Advisory Group met with the programme team on 25 February 2026.

Key metrics:

Metric	Current risk RAG	Change from previous reporting
Reduce NCTR (26/02/26)	**246 (28.0%) against a target of 108 (12.5%)**	Deterioration from 184
Reduce acute LOS (end dec-25 data)	**8.5 against a target of 7.0**	Deterioration from 8.0
Reduce community hospital LOS (Oct-25)	**38.4 days against a target of 30 days**	Deterioration from 35.6 days
A&E waits to 78% by March 2026 (Dec-25 data)	**70.2% against a target of 76.8%**	Deterioration from 70.5%
Average length of discharge delay (Dec-25)	**7.5 against a target of 6.1**	Improvement from 9.0
Overall assessment of progress toward achieving priority programme measures for 25/26		
No criteria to reside position remains off plan with a deterioration noted in the last reporting period.		

ICB – Priority Programme and Board Assurance Framework report 2025/26

Priority Programme:	**4 - Integrated Neighbourhood Working (INW)**	**Programme SRO:**	**David McClay**
Overseeing Committee:	**Collaboration Forum**		
Strategic Aims:	(Please indicate which aim/s this programme supports) ☒ Aim 1: Improve the health and wellbeing of the population ☒ Aim 2: Reduce inequalities ☒ Aim 3: Provide the best care and support to children and adults ☒ Aim 4: Strengthen care and support in local communities ☒ Aim 5: Respond well to complex needs ☒ Aim 6: Enable broader social and economic development ☒ Aim 7: Enhance productivity and value for money		

Programme risk	**Title**	**Owner**	**Score/ Change**	**Appetite**
	There is a risk to pace of delivery following the ICB and council restructures while portfolios change within teams, as the programme is reliant on matrix working.	D.McClay	9	
	If development of training opportunities for neighbourhood staff is delayed and/or under-resourced there is a risk that strong joint leadership and culture will not be develop, resulting in continued fragmentation across organisational boundaries.		8	Within optimal appetite
	If population health digital development is not aligned with neighbourhood development, then there is a risk that resource will be allocated inappropriately resulting in failure to achieve outcomes.	L.Laker	8	Within optimal appetite
Corporate risk	A summary of ICS organisational risks impacting this aim is outlined in the covering report.			

Narrative Overview:

Reporting period:	**Q3**
Alert:	**Objective 1 – Establish a strong foundation for Integrated Neighbourhood Working (INW) with strong local leadership and governance** • Good progress has been made since the last reporting period in establishing a way of working on Neighbourhoods that is inclusive of voluntary, community, faith and social enterprise (VCFSE), Council and health bodies. The health aspect of this has been supported by the National Association Primary Care (NAPC) following a commission by system partners. Whilst we have growing clarity on vision, principles and ways of working, there is more to do over coming months. The potential impact of moving to Cluster-wide commissioning presents both an opportunity to accelerate progress, but also a degree of uncertainty over the degree of consistency that may be required between neighbourhood working models across the Cluster. The approach will however become clearer over coming months.
Assure:	**Objective 1 – Establish a strong foundation for Integrated neighbourhood working with strong local leadership and governance** • CEO-level partnership discussions have been very productive with the focus on re-setting of the vision and underlying principles for end Mar 26. The first Neighbourhood Steering Group (CEO/Directors) met Feb 26 with the next meeting 21 Apr to sign off wider vision and principles and ways of working. • Agreement for funding for neighbourhood lead appointments to develop local leadership. Options are being explored for social financing. • Team Coaching (Affina Org Dev) for two neighbourhood teams (North Sedgemoor and South Somerset West PCNs) started delivery Oct 25. Outputs focussed on delivery for Q4. Sustainable programming of Team Coaching as a 'key enabler' has been developed. Additional system thinking/leadership development is being explored through the National Neighbourhood Health Implementation Programme. **Objective 2 – Strengthen proactive, population-based approaches to care through enhanced Population Health Management (PHM) and risk stratification**

	• The development of a population health management (PHM) approach in neighbourhoods is underway within the Population Health Transformation Programme. The Optum pilot projects could provide initial foundations for future risk stratification capability. The future Linked Data Platform will enhance to enable integrated neighbourhood working and will provide the catalyst for delivery of a frailty dashboard. Discussion is ongoing regarding delivery timelines – likely June 2026. **Frailty Strategy/Model and System Delivery.** To co-design, develop and implement the Somerset response to frailty for adults delivered through integrated neighbourhood working. • Frailty project is now progressing at pace. Frailty strategy/model co-designed with Local Authority, VCFSE, SFT and ICB now in final draft. Finalising of outcomes and metrics Mar 26. Review of current frailty contracts with opportunities for primary care focus on frailty delivery through the 2026/27 new (Somerset) funding framework. Delivery of frailty model as 'test case' for Neighbourhood working is a priority for strategic commissioning intentions for 2026. • It has been agreed that the GP Support Unit (GPSU) will develop an implementation approach as a test case for neighbourhood working. It is likely to be deployed in waves with detail of the Wave 1 support offer being worked through by the end of March with Wave 1 sites being onboarded during Q1 26/27.
Advise:	**Governance** • Governance processes through a proposed Neighbourhood Steering Group (ICB, SFT, Somerset Council, VCFSE, GPSU) will be confirmed once Cluster and Place realignment of integrated neighbourhood working is confirmed. **Outcomes and Metrics** • Future outcomes and metrics aligned to the Frailty Strategy/Model are currently being reviewed by the Frailty Steering Group.

Key metrics:

Metric	Current risk RAG	Change from previous reporting
Emergency admissions for people aged 65		No change
Admissions due to falls for people aged 65+		Declining trend. Frailty model in development which will include review of existing falls prevention services.
Unplanned admissions for chronic ambulatory care		Improvement with sustained reduction
Long term admissions to residential care homes and nursing homes for people aged 65+		No change Local Authority now six monthly

Overall assessment of progress toward achieving priority programme measures for 26/27	
The neighbourhood programme is currently assessed as Amber. Since the last BAF a System Frailty Strategy and Model has been developed. The agreed frailty model will be used as the 'test case' for strategic commissioning of frailty services through integrated neighbourhood working for 2026/27. With Cluster and Place changes there is an impact on the current pace of delivery.	

ICB – Priority Programme and Board Assurance Framework report 2025/26

Priority Programme:	**5 – Population health**	**Programme SRO:**	**Bernie Marden**
Overseeing Committee:	**Population Health Transformation Board**		
Strategic Aims:	(Please indicate which aim/s this programme supports) ☒ Aim 1: Improve the health and wellbeing of the population ☒ Aim 2: Reduce inequalities ☒ Aim 3: Provide the best care and support to children and adults ☒ Aim 4: Strengthen care and support in local communities ☒ Aim 5: Respond well to complex needs ☒ Aim 6: Enable broader social and economic development ☒ Aim 7: Enhance productivity and value for money		

Programme risk	**Title**	**Owner**	**Score/ Change**	**Appetite**
	If the Population Health Transformation Programme is not given appropriate resourcing then transformation may stall, resulting in deteriorating health and widening inequalities	Alison Henly	16	Within tolerable appetite
	Population Health Transformation Programme activity will not be successful if primary care capacity remains limited and misaligned, reactive urgent care may continue to take precedence over preventative interventions, increasing long-term system demand.	Bernie Marden	16	Within tolerable appetite
	The Population Health Transformation Programme is at risk of exhausting its funding without achieving its intended purpose, as there is currently no mechanism within the system to transition funding into business-as-usual (BAU) support.	Alison Henly	20	Outside tolerable appetite
Corporate risk	A summary of ICS organisational risks impacting this aim is outlined in the covering report.			

Narrative Overview:

Reporting period:	**Q3/Q4 (October 2025-March 2026**
Alert:	As of mid-February 2026, there is no NHS Somerset ICB capacity supporting the Population Health Transformation Programme, significantly limiting further programme delivery. • The health inequalities audit has collated relevant evidence and is preparing its report, providing a system-wide assessment of inequalities across access, outcomes, and experience of care. There is a risk that findings will not be progressed or implemented due to the absence of programme capacity. • At the most recent Population Health Board, decisions were agreed regarding the future ownership and oversight of individual projects, recognising that there will be no dedicated programme leadership going forward. • Funding for the homeless health inclusion service has been confirmed by the Population Health Board on a non-recurrent basis. The Board recognises the associated sustainability risks; however, given the current climate, no alternative funding option is available at this time. With the programme team ceasing in mid-February, the Health Inequalities Project Group will continue under performance leadership rather than reporting directly to the Population Health Board and will remain outside the Population Health Programme until the Target Operating Model (TOM) is finalised and appropriate governance arrangements are agreed. In light of preparations for the health inequalities audit and the discovery of related work across the system, the programme will also reconsider the group's structure to better coordinate and prioritise activity.
Assure:	A comprehensive handover document has been completed and will be shared with all relevant parties. All formal handover meetings have either taken place or are currently in progress. • Somerset NHS Foundation Trust (SFT) continues to pursue creation of a Population Health and Inequalities Strategy for the Trust and have held their first Population Health Board meeting • Hypertension Project: An updated data dashboard is in development to better reflect current activity. The project is transitioning from case finding to optimisation of care, having identified approximately 15,000 new cases of hypertension to date

	• Coastal Navigators Network (CNN): The project has been successfully handed over jointly to colleagues within the organisation and the Local Authority for ongoing oversight and continuation The Maldaba project continues to make strong progress.
Advise:	A significant proportion of programme funding continues to support recurring business as usual (BAU) activity, activity outside the original scope, or projects transitioning into BAU. Over the past three months, focus has been on maintaining delivery, capturing impact and learning, and supporting transition planning while longer-term funding options are explored.

Key metrics:

Metric	Current risk RAG	Change from previous reporting
M1 - Hypertension		**The issues the programme had previously with regards to the data have been resolved and we now have what is needed to measure progress**
M2 - Smoking cessation		**The programme is currently in discussion with the public health team regarding data provided for this metric**
M3 - Maldaba		**The issues the programme had previously with regards to reporting into the programme has been resolved and we now have what is needed to monitor**
M4 - Homeless Health Services		**Funding has been identified to continue to the primary care element of the homeless health service for a further year**
M5 - Population Health Ambassadors		**Now over 45 ambassadors in Somerset**
M6 - Focusing on MORE		**Capacity has been identified to continue the programme. Project has been accepted to present at national conference**
M7 - Governance and agreements in place to Expose Data		**Now signed – discussions to take place at board to decide new metric for success measure**

Overall assessment of progress toward achieving priority programme measures for 25/26	
Progress across all priority programme measures is now on track for the 25/26 period. Earlier challenges have been effectively addressed, largely due to the programme's strong leadership and clear strategic direction, which has ensured consistent focus and the rapid resolution of emerging issues. The programme is confident that any remaining challenges will be resolved. Current resource levels are sufficient, mitigation actions for minor risks are embedded, and forecast projections indicate that the programme will achieve its intended outcomes within agreed timeframes.	

ICB – Priority Programme and Board Assurance Framework report 2025/26

Key enabler:	**6 – Finance**	**Programme SRO:**	**Alison Henly**
Overseeing Committee:	**Finance Committee**		
Strategic Aims:	(Please indicate which aim/s this key enabler supports) ☒ Aim 1: Improve the health and wellbeing of the population ☒ Aim 2: Reduce inequalities ☒ Aim 3: Provide the best care and support to children and adults ☒ Aim 4: Strengthen care and support in local communities ☒ Aim 5: Respond well to complex needs ☒ Aim 6: Enable broader social and economic development ☒ Aim 7: Enhance productivity and value for money		

Strategic risk	**Title**	**Owner**	**Score/ Change**	**Appetite**
	Financial Achievement - If we do not improve and maintain the financial health of the Somerset system, then we will be subject to restrictions which will impact on our ability to deliver sustainable, continually improving services, resulting in worse outcomes for the people of Somerset	AH	20 No change	Outside tolerable appetite
Corporate risk	A summary of ICS organisational risks linked to the finance key enabler is outlined in the covering report.			

Narrative Overview:

Reporting period:	**Q3 (Oct – Dec 2025)**
Alert:	Nothing to note currently.

Assure:	• Detailed and appropriately challenging focus through ICB Finance Committee, including deep dives into:
	  ○ ICB financial health
	  ○ System savings programme
	  ○ Continuing Healthcare
	  ○ Primary care prescribing and high-cost drugs & devices
	• Weekly Finance Assurance Group (system level)

	• Audit Committee oversight of process and internal control • ICS Estates Group, System Performance Group
Advise:	The net risk position of the system has reduced since Q2, and is largely mitigated, with the system confident of delivering the in year financial position. The risk score of delivering financial balance in 2025/26 has been downgraded to 12, within risk tolerance. System deterioration in the underlying position (ULP) due to higher delivery of non-recurrent savings in year than planned. This will mean the ULP deficit starting point for 2026/27 will be higher than planned, which has impacted on the level of cost improvement plans needing to be included to submit a balanced plan, increasing its risk of delivery.

Key metrics:

Metric	Current risk RAG	Change from previous reporting
System forecasting to deliver balanced FOT		
Reduce system deficit ULP		
Workforce wte in line with workforce plan		
Deliver 30% reduction against the 2024/25 agency spend		
Transformation Plan developed to deliver cost reductions		

Overall assessment of progress toward achieving priority programme measures for 25/26	
Progress is currently rated Amber. Whilst delivery of the in year financial position has moved to green, the deterioration in the system deficit ULP is a concern	

REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **10**
DATE OF MEETING:	**26 March 2026**	
REPORT TITLE:	**Integrated Board Assurance Dashboard and Exception Report from the System Assurance Forum 1 April 2025 to 31 January 26**	
REPORT AUTHOR:	**Alison Henly – Chief Officer Strategic Finance and Resources**	
EXECUTIVE SPONSOR:	**Alison Henly – Chief Officer Strategic Finance and Resources**	
PRESENTED BY:	**Alison Henly – Chief Officer Strategic Finance and Resources**	

PURPOSE	DESCRIPTION	SELECT (Place an 'X' in relevant box(es) below)
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	
Discuss	To discuss, in depth, a report noting its implications	
Note	To note, without the need for discussion	
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	X

SELECT (Place an 'X' in relevant box(es) below)	Links to Strategic Objectives (Please select any which are impacted on / relevant to this paper)
X	Objective 1: Improve the health and wellbeing of the population
X	Objective 2: Reduce inequalities
X	Objective 3: Provide the best care and support to children and adults
X	Objective 4: Strengthen care and support in local communities
X	Objective 5: Respond well to complex needs
	Objective 6: Enable broader social and economic development
	Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT
Following discussion at the Finance Committee meeting, System Assurance Forum, People Board and the Quality Committee the enclosed paper provides a summary of escalation issues for quality and performance against the constitutional and other standards, for the period 1 April 2025 to 31 January 2026.

REPORT TO COMMITTEE / BOARD
The report provides an overview for the following areas: • Quality • Performance • Workforce • Finance The Board is asked to discuss the performance position for the period 1 April 2025 to 31 January 2026.

Impact Assessments – key issues identified (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	Equality and diversity are at the heart of Somerset ICB's work, giving 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 it, in its functions including performance management
Quality	Decisions regarding improvements against the performance standards are made to deliver regarding the best possible value for service users.
Safeguarding	We are dedicated to ensuring that the principles and duties of safeguarding children and adults are applied to every service user and that safeguarding is integral to service development, quality improvement, clinical governance, and risk management arrangements
Financial/Resource/ Value for Money	ICB revenue resource limit as of 31 January 2026 was £ 3,120,563,000 which includes Delegated Specialised Commissioning
Sustainability	Outline how you have considered the underlying objectives of the Somerset ICS Green Plan. This includes core work elements around sustainable healthcare, public health and wellbeing, estates and facilities, travel and transport, supply chain and procurement, adaptation and offsetting and digital transformation.
Governance/Legal/ Privacy	Financial duties of NHS Somerset not to exceed its cash limit and comply with relevant accounting standards.
Confidentiality	No issues are identified
Risk Description	NHS Somerset must ensure it delivers financial and performance targets

Integrated Board Assurance

Exception Report

January 2026

Performance declining
Performance Improving
Performance unchanged

National ambition **
Operational Plan *

Quality

Areas of Focus	Current Plan/Target	Performance
• SFT - Rate of acute hospital acquired pressure ulcers (category 2 and above) per 1000 bed days - (current position 1.33)	0	↓
• % of VTE assessments completed within 24 hours of admission (Acute setting)- (current position 84%)	95%	↓
• % of VTE assessments completed within 24 hours of admission (Community setting) - current position 86.9%)	95%	↑
• CLA (Children Looked After) Initial Health Assessments - (current position 42.9%)	90%	↑
• CLA (Children Looked After) Dental Checks - (current position 87.5%)	90%	↑
• Somerset Overall C.Diffs. Rate (current position 14)	12.25	↑

Performance

Areas of Focus	Current Plan/Target	Performance
• Type 1 A&E 4-hour performance (SFT)*	58.9%	↑
• All Types A&E 4-hour performance (SFT)*	77.0%	↓
• Adult G&A Bed Occupancy (SFT)*	94.7%	↓
• % of adult G&A beds occupied with NCTR patients	12.6%	↓
• Number of patients with No Criteria to Reside	108	↓
• Number of incomplete pahways (SFT)*	66,868	↑
• Referral to treatment - Patient waiting >52 weeks (ICB)	1,118	↑
• Referral to treatment - Patients waiting >65 weeks (ICB)	0	↑
• Diagnostics 6 week performance %	86.8%	↑
• 28 Day Faster Diagnosis Pathway - Breast cancer	77%	↑
• 28 Day Faster Diagnosis Pathway - Urological	77%	↓
• Talking Therapies 1st to 2nd treatment wait >90 days**	10%	↓
• Talking Therapies - patients seen <6 weeks **	75%	↔
• IPS (Individual Placement and Support) Access	528	↓

People

Areas of Focus	Current Plan/Target	Performance
• Workforce retention & attrition (SFT)	11.0%	↑
• Sickness absence (SFT)	5.15%	↓
• Agency WTE vs Plan (SFT)	110	↑
• Total General Practice & PCN Workforce vs Plan (Primary Car	2,223	↓
• Use of off-framework Agency shifts (SFT)	0	↑

Finance

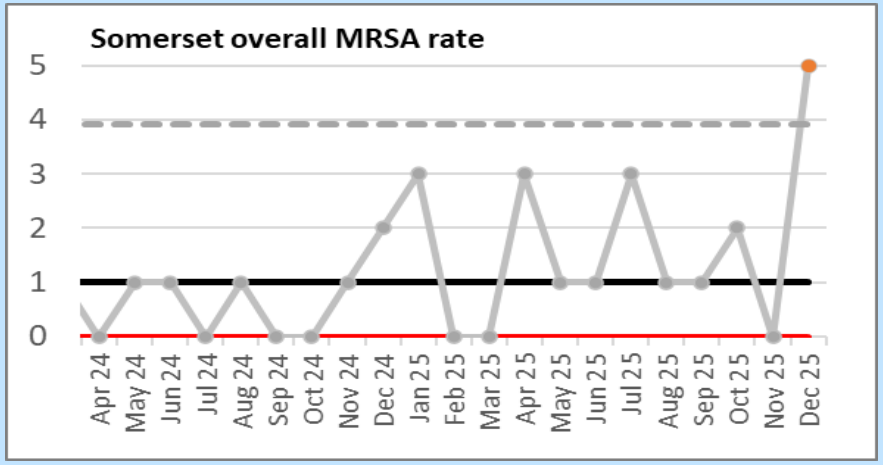
Areas of Focus	Current Plan/Target	Performance
• System underlying financial position	£42.8m deficit	↓
• System financial performance YTD & forecast vs plan (revenue)	Balanced	↑
• System financial performance YTD & forecast vs plan (capital)	Fully utilise	↑
• Agency workforce spend YTD & forecast vs plan	£17.7m plan/£22m cap	↑
• Bank workforce spend YTD & forecast vs plan	£32.5m plan/£32.5m cap	↓
• Savings Programme	£47m recurrent	↓
• Mental Health Investment Standard	£6.1m	↔
• Risks and Mitigations	£30m net risk	↑

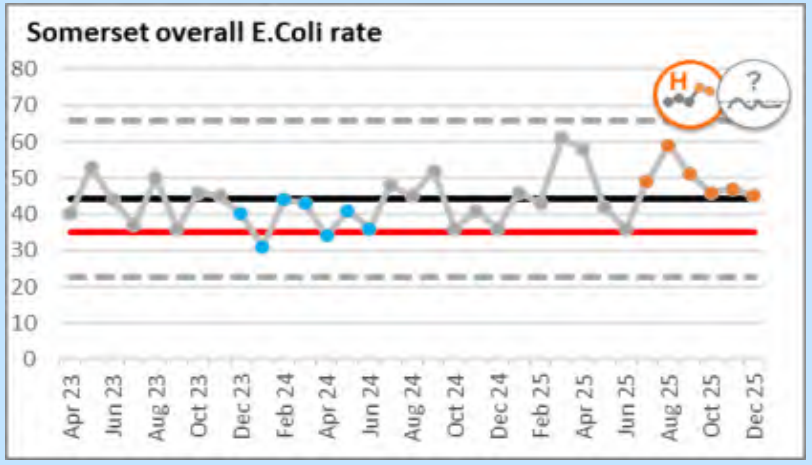
Quality Summary

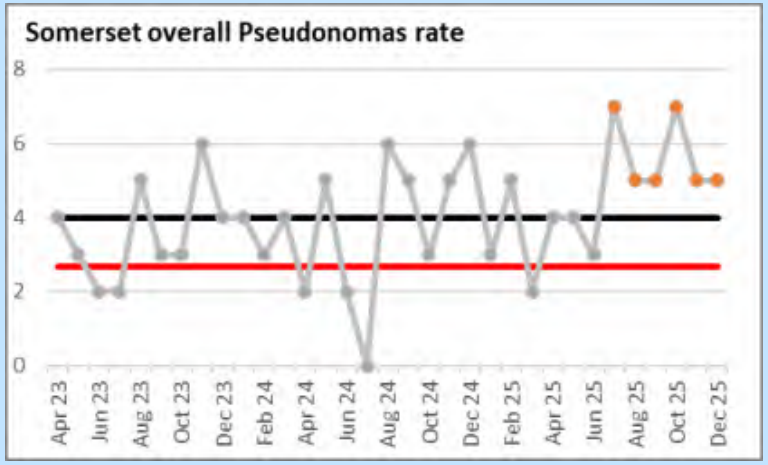
Quality Matrix

VARIATION \ ASSURANCE	P	?	F	No Target
H		Number of ligature incidents	CLA - Dental Checks	Rate of Falls per 1000 bed days - Acute
L				
same		Rate of community hospital acquired pressure ulcers (category 2+) /1000 bed days % of adult inpatients (acute) having nutrition screening <24 hours % of adult inpatients (community) having nutrition screening <24 hrs Somerset overall C.Diffs rate Somerset overall MSSA rate Somerset overall Klebsiella rate % 3rd & 4th degree tears for assisted birth	MPH - Rate of acute hospital acquired pressure ulcers (category 2 +) /1000 bed days YDH - Rate of acute hospital acquired pressure ulcers (category 2 +) per 1000 bed days SFT - Rate of acute hospital acquired pressure ulcers (category 2+) per 1000 bed days	Rate of Falls per 1000 bed days - Community Rate of Falls per 1000 bed days - MH Rate of PPH≥1500 ml per 1,000 births
H		% VTE assessments <24 hrs (community) Somerset overall E.Coli rate Somerset overall MRSA rate Somerset overall Pseudonomas rate	% of VTE assessments <24 hrs (acute) CLA - Initial Health Assessments	Number of carers who have been offered a carers assessment
L				

Quality Summary







MRSA

- Q3 reported 5 MRSA cases compared with a threshold of 0, which represents a breach.
- Counts have continued to increase from the April baseline, consistent with wider Southwest patterns and indicating structural pressures rather than seasonal factors.
- Somerset remains in the 4th national quartile, reflecting sustained poor benchmarking performance.
- Actions being taken include: strengthening MRSA decolonisation practices, ensuring full adherence to evidence-based protocols; improving discharge communication to reduce catheter-associated infection risks across care settings; and continued involvement in system infection escalation processes due to ongoing high rates.

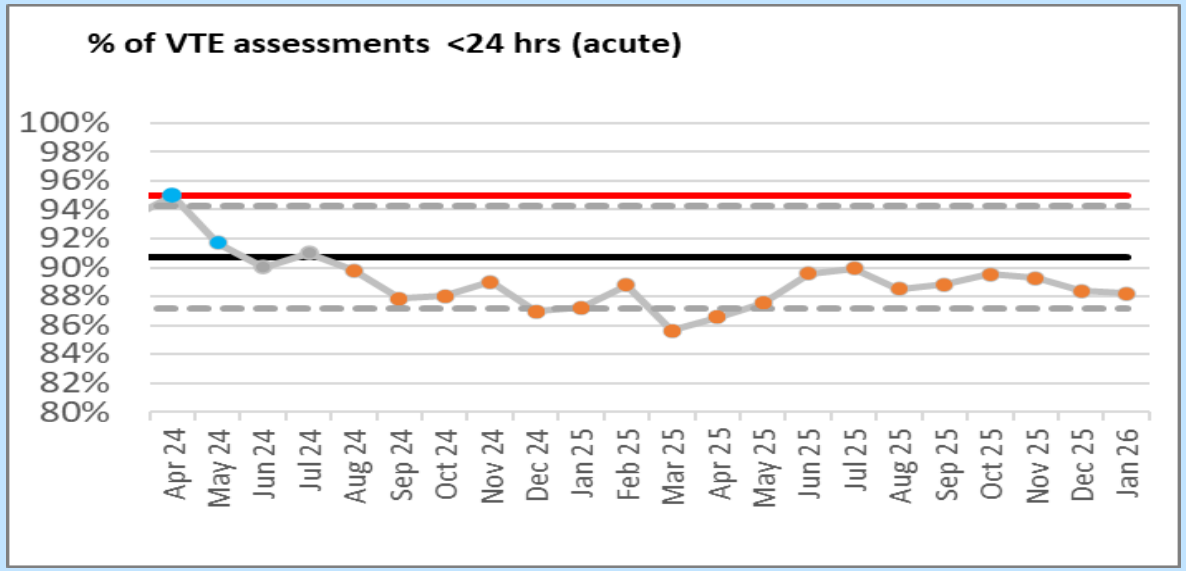
E.coli

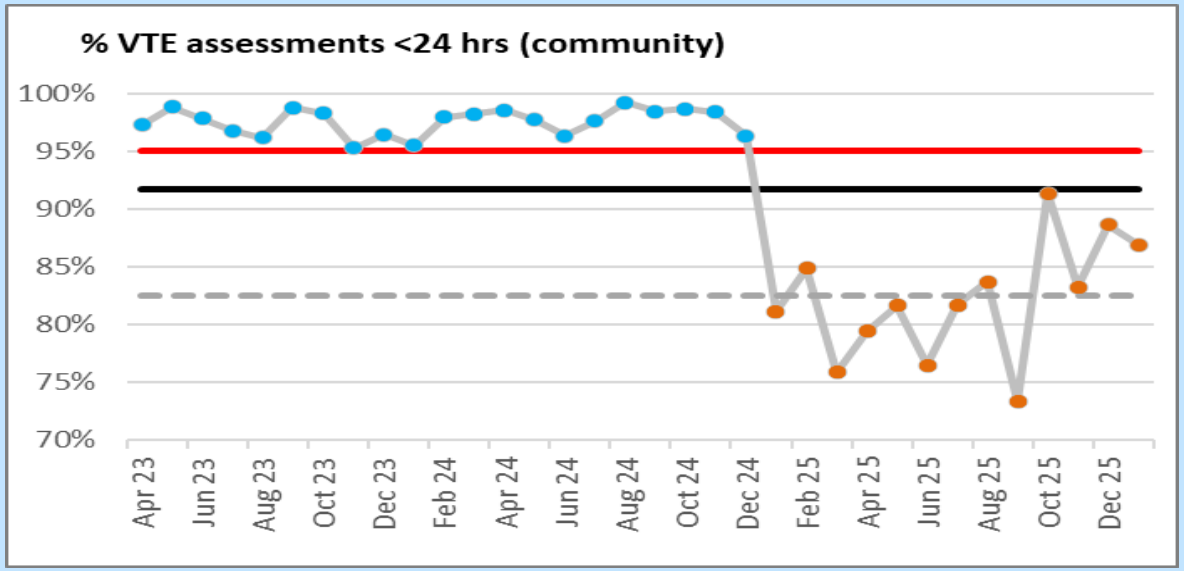
- Q3 recorded 98 E.coli cases compared with a threshold of 80, meaning the system is performing significantly above expected levels, although officially classed as no breach.
- Rates continue to rise steadily from the April baseline, mirroring trends across Southwest peers and pointing to wider system drivers.
- Somerset's national ranking has deteriorated to the 3rd quartile, and the system is now highest in the Southwest region.
- Actions being taken include: participation in the NHSE Southwest Hydration Project to improve hydration-related infection prevention; rolling out hydration and mouthcare programmes in care homes via LARCH and Continuing Care teams to reduce community-onset risk; and moving toward a risk-based, proactive approach to prevention as part of wider bloodstream-infection reduction activity.

Pseudomonas

- Q3 reported 7 Pseudomonas cases compared with a threshold of 6, resulting in a breach.
- Case numbers are rising from the April baseline, aligned with Southwest regional trends, and suggest system-level structural pressures.
- Benchmarking has worsened, placing Somerset at the top of national quartile 2 and again highest in the Southwest.
- Actions being taken include: incorporation into the wider bloodstream infection reduction programme, focusing on prevention across both acute and community settings; targeted activity to address system flow pressures and community-associated risks contributing to rising Pseudomonas rates; and strengthened IPM oversight, supported by regional escalation due to deteriorating benchmarking.

Quality Summary

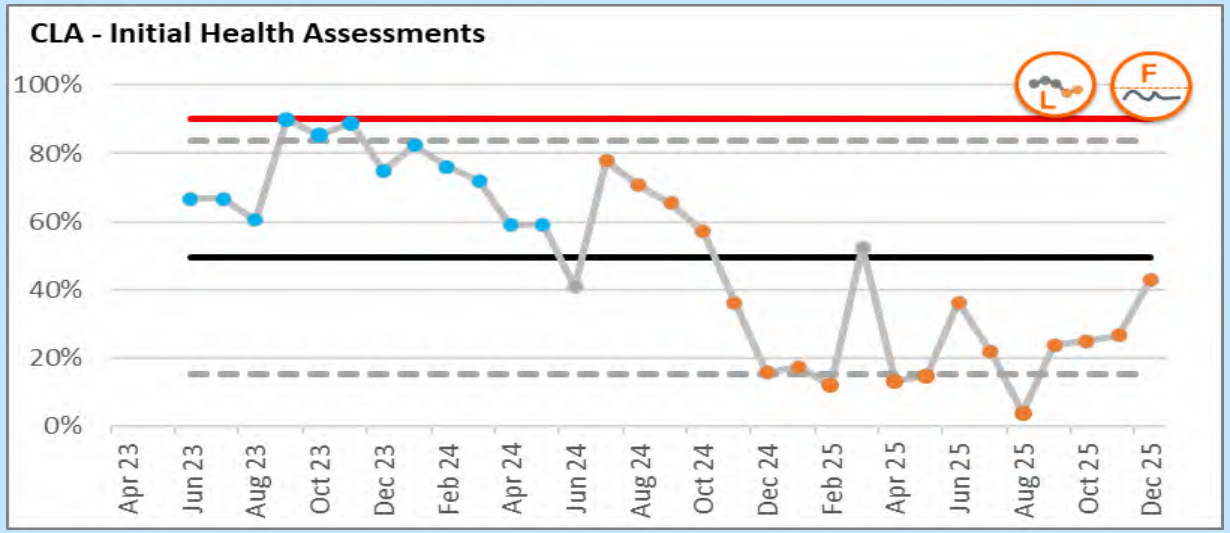


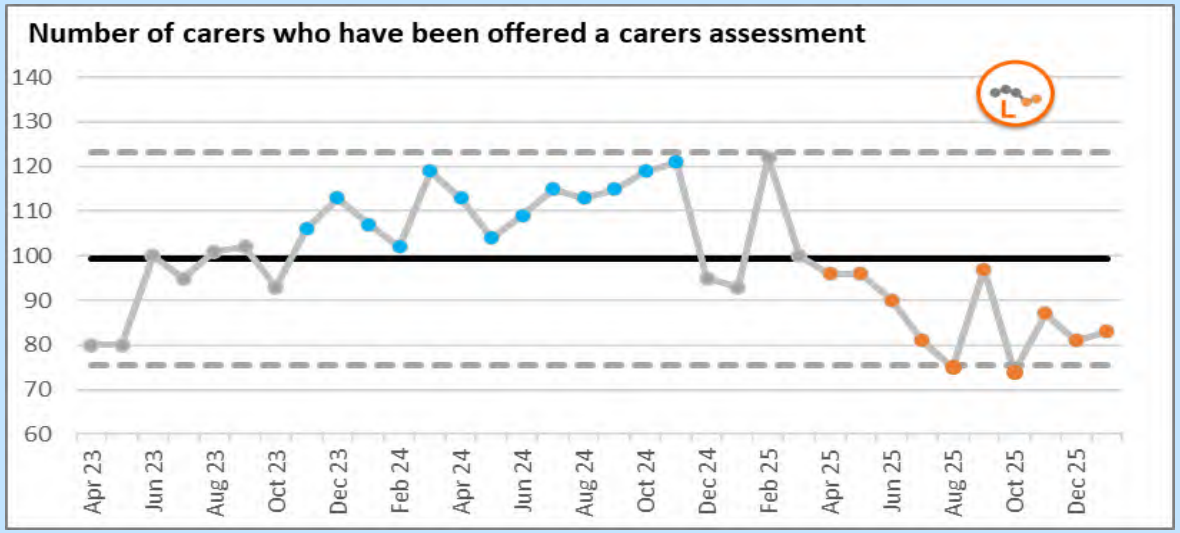


Venous thromboembolism (VTE) assessments

- Compliance continues to fall below the national standard: MPH at 88%, Yeovil at 75% and community hospitals at 89% (November data).
- A deep dive into VTE performance was presented at the January System Quality Group meeting.
- Confirmation was received that all adult inpatients must undergo a VTE risk assessment within 14 hours of admission. However, the ICB currently receives data showing completion within 24 hours rather than against the 14-hour standard.
- Data accuracy and standardisation remain key concerns, as differing data extraction processes across sites are leading to discrepancies. A formal request has been submitted to digital teams to standardise VTE data collection and enable reporting against the 14-hour requirement, though progress has been limited to date.
- The digital VTE assessment tool within the Better platform is now in use across YDH and SFT acute services, and Better is reviewing the potential introduction of mandatory fields to support compliance. Community services continue to use the RiO system. A pilot of the Better platform for mental health settings remains under consideration.
- Ratification of the SFT VTE policy remains outstanding

Quality Summary





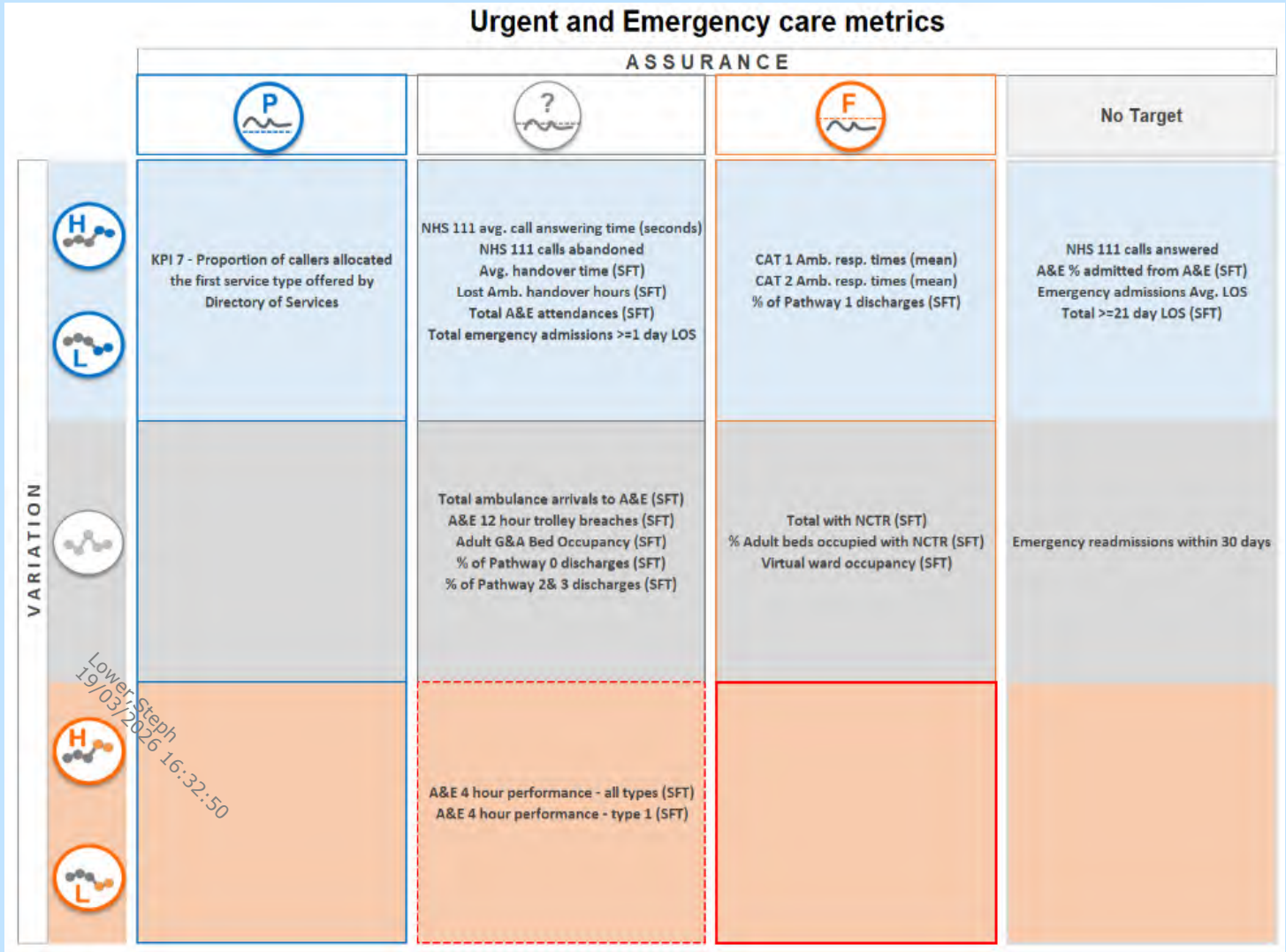
Children looked after (CLA) initial health assessments (IHA)

- November data indicates a modest improvement in IHA performance; however, overall compliance continues to fall below the required standard. This trend reflects both the implementation timeline of the revised IHA request form and the significant increase in children entering care during October 2025.
- Data from December 2025 and early 2026 shows a clear improvement in the timeliness of IHA requests as well as completion of assessments, although this progress is not yet fully reflected within the iBAR report.
- A multi-agency review of the IHA request form and overall IHA performance was undertaken in February 2026. It is evident that both the CLA Health Service and Children's Social Care teams have worked collaboratively and diligently to improve the timeliness of requests and the subsequent completion of IHAs. Minor refinements to the form were agreed, and a follow-up meeting has been scheduled for July 2026.

Number of carers who have been offered a carers assessment (Carers of people in mental health services)

- The number of carers who have been offered a carers assessment continues to fluctuate and has shown a downward trend for December. However, it is unclear whether this is a result of the recent change in funding and subsequent team and criteria changes (as outlined in the last report) or whether there has been an unexpected change in demand.
- Further discussions are planned with Somerset Council and Somerset FT to get a clearer understanding of the impact of the service change and the reason for the continued decrease.

Urgent & Emergency Care Matrix



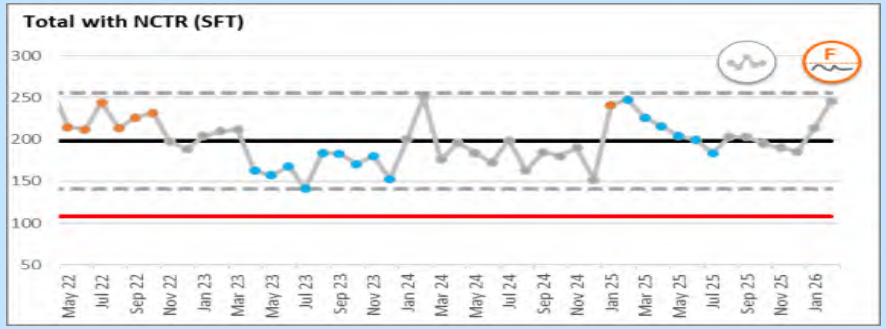
During February 2026, no urgent and emergency care metrics are demonstrating special cause concerning variation and consistently failing the plan/target.

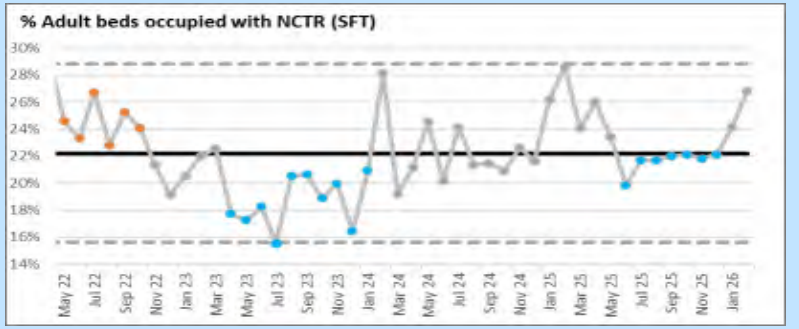
Those measures contained within the dotted red box have triggered special cause variation but have not consistently failed the 2025/26 Operational plan and if performance does not improve will be re-assessed as a metric with special cause concerning variation **and** not achieving the plan/target.

In addition, the following measures are kept under observation:

- A&E 4-hour performance, All Types (ED & UTC) – Somerset FT
- A&E 4-hour performance, Type 1 (ED) – Somerset
- Number of patients with NCTR – Somerset FT
- % Adult beds occupied (bed occupancy) – Somerset FT
- % Adult beds occupied with NCTR patients – Somerset FT
- Total ambulance arrivals to A&E - Somerset FT

Urgent & Emergency Care Performance Summary





Patients in hospital with No Criteria To Reside (NCTR) - the number of patients with NCTR at Somerset FT remains significantly above (higher) than plan. The average Adult G&A beds occupied by patients with NCTR in February was 25.5% against the revised trajectory of 16%, with 24.4% occupied beds at Musgrove Park Hospital and 27.3% at Yeovil District Hospital. As at26th February 2026 (latest weekly census date) there were 246 patients with NCTR against the revised trajectory of 137 (or 280% of occupied adult beds) which impacts on the performance of other UEC measures including ambulance handovers, 4-hour performance and G&A bed occupancy. The number of occupied acute beds is a variable figure day by day so reduction in the number of patients with no criteria to reside does not necessarily reflects in reduction in the proportion of occupied acute beds. Somerset FT is operating on approximately 5% less (-51) acute beds (adult G&A Beds) in February26 when compared to February 25, although continues to have a reliance on escalation capacity due to temporary core bed closures

One of Somerset ICS priority programmes for 2025/26 is System Flow; a multi-partner working Group meets weekly to review the detailed NCTR dataflows The data pack shared reports MPH and YDH acute hospital and Intermediate Care (Community Hospital and Care homes) delays by pathway and by locality which compliments other locality reporting to provide granularity at a geography level and identifies areas where there is increased demand and/or a shortfall in capacity

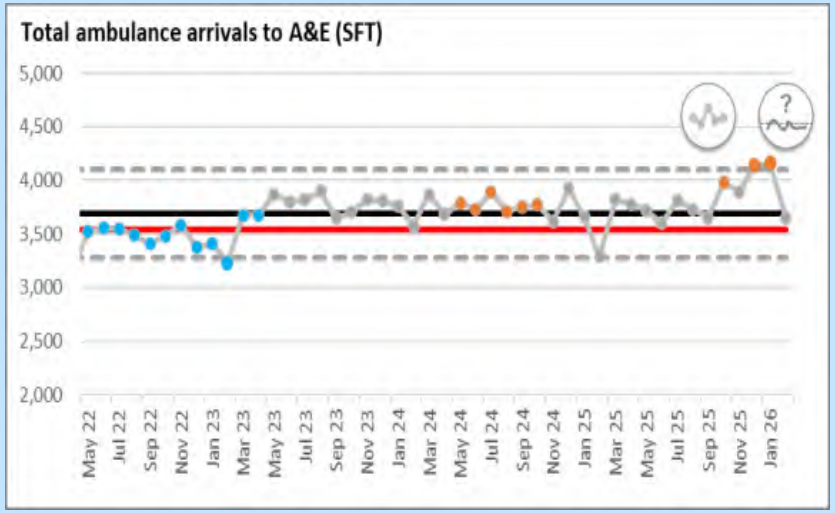
Key Achievements within last reporting period

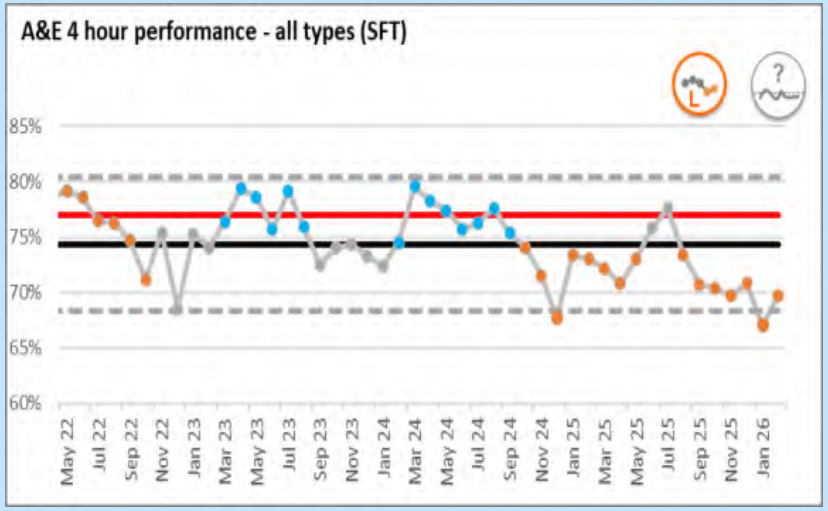
- The intermediate care test and learn has been presented to ICB Management Board, ICB Board and the Somerset Council Scrutiny Committee for Health and Adults. All groups were supportive of an extension of the test and learn till Sept-26. The extension will allow the changes to be stress tested under different system flow pressures, before making long term decisions about how intermediate care services are delivered in the future.

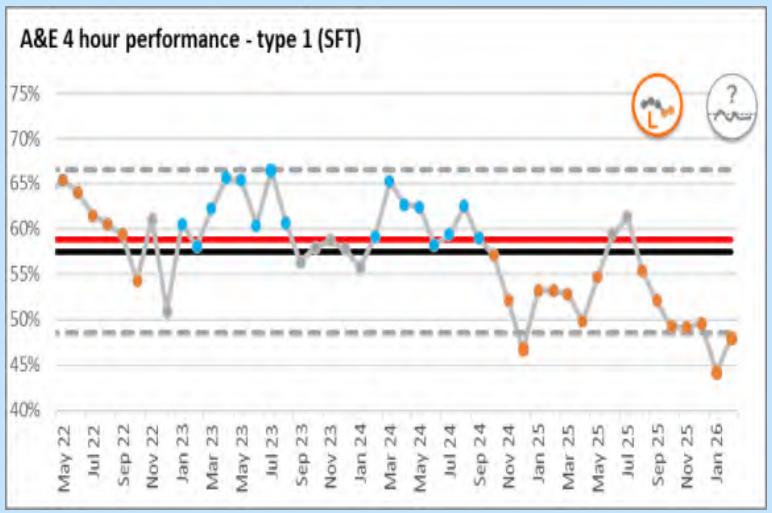
Areas of improvement focus for the next reporting period:

- Attempt to recover pathway 1 demand to as close to the target of 83 referrals per week – through education with referring teams and maximising P0 services.
- Somerset Council to work closely with the existing and incoming pathway 1 providers to manage the risks associated with the re-contracting transition. Particularly in high-risk geographies such as South Somerset and Taunton/West.
- Continue to work towards reducing the time to access a long-term care bed (Pathway 3)
- SFT Every Minute Matter Steering Group to support ward-based staff to reduce the in-hospital process delays
- ICB Exec support with Dorset delays (which current make up approximately 21% of the delays at Yeovil Hospital)
- Project support to Pathway 2 units, helping ward-based staff to recover LOS and NCTR improvements

Urgent & Emergency Care Performance Summary







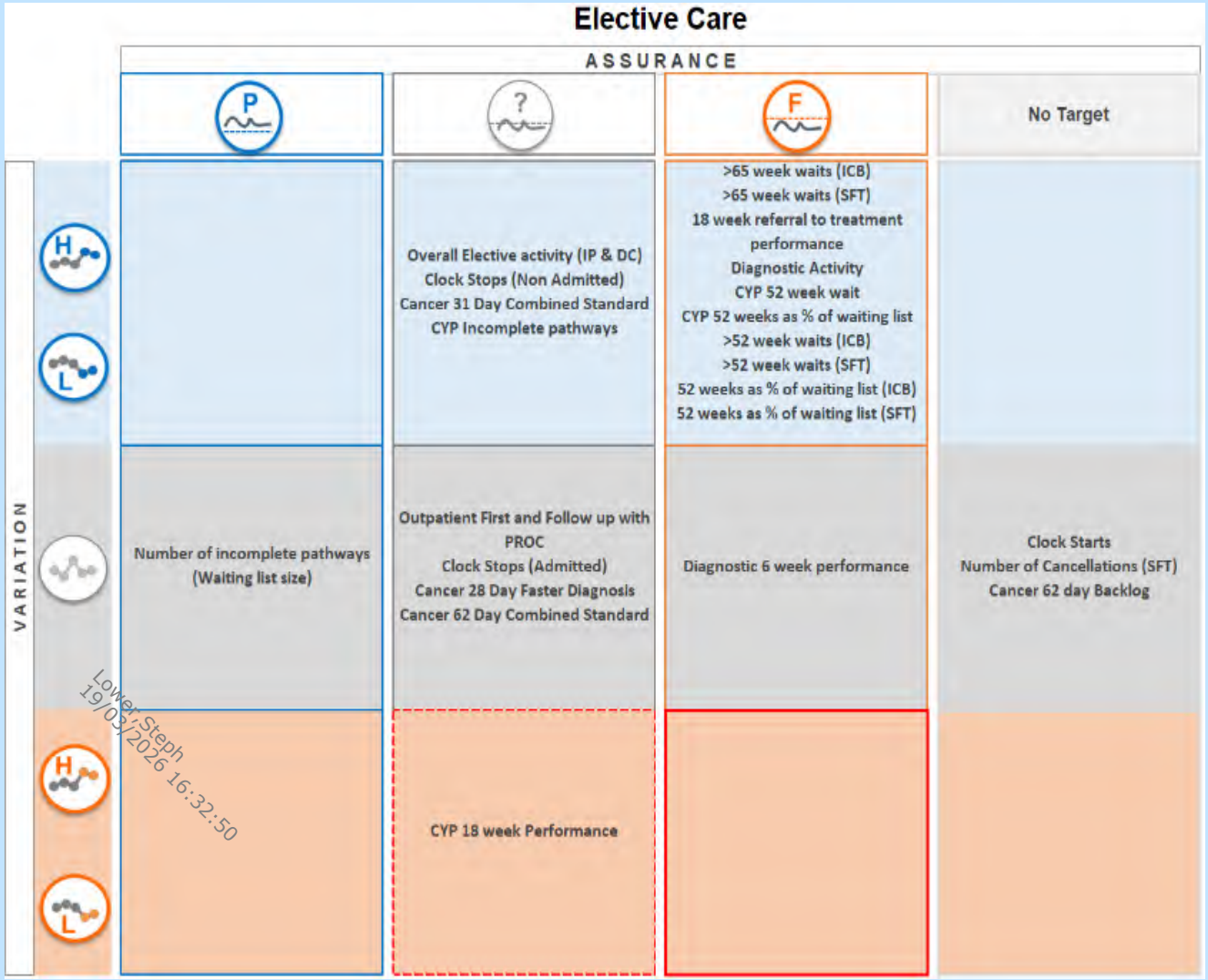
The number of ambulance arrivals to A&E have increased by 3.2% YTD, but during the period November to February by 9.3% and breached the upper control limit during this period. During this winter period MPH has seen growth of 5.1% and YDH a more significant 17.2%. Both sites have seen a significant improvement in ambulance handover performance during 2025/26, but a decline over the winter months when compared to earlier months in the year. The average handover time remains significantly better than plan with an average handover time in February at MPH of 19.8 minutes (against the plan of 30 minutes) and YDH, 27.8 minutes (against the plan of 34 minutes). Factors impacting upon handover performance include unprecedented levels of demand on particular days, compounded by high bed occupancy and NCTR and challenged flow out of the A&E department. A review of winter is underway to understand the increased demand with a workshop with System partners is planned for April 2026

The proportion of patients seen, admitted or discharged within 4 hours in A&E (Type 1 Emergency Departments) and in combined (All Types) Urgent Treatment Centres and Emergency Departments improved compared to January, with performance of 70.2% against the 77.0% plan, and Type 1 A&E performance was 48.0% against the plan of 58.9% (MPH 47.4% and YDH 488%). Type 1 performance has been challenged since August with a further deterioration from November when the lower control limit was breached due to the opening of the co-located UTC at YDH. Minor cases have been streamed to this new service and these cases are more likely to be seen, treated and discharged within 4-hours. The underpinning factors affecting flow out of the emergency department is the high level of patients with No Criteria To Reside and resulting high bed occupancy within the Acute Hospitals.

Focused actions to improve A&E performance include:

- Low acuity conditions to be booked to re-attend the next day. Trial started in January
- Recruitment underway for 2 consultant posts and Advanced Clinical Practitioner posts at the MPH site
- Successful recruitment for Frailty Same Day Emergency Care ACPs (Advanced Care Practitioners-trainee) and Specialty Doctor at YDH
- Paediatric Early Warning Score roll out at YDH
- Cross site actions include, recruitment of a Frailty Programme manager, role review for progress checkers/chaser, point of care testing is now live and the BARS (booking and referrals standards) workstream is progressing well

Elective Care Matrix



Any measures contained within the dotted red box have triggered special cause variation but have not consistently failed the 2025/26 Operational plan. Currently no measures overall are seen within this area or in the solid red line box.

In addition, the following measures are kept under observation:

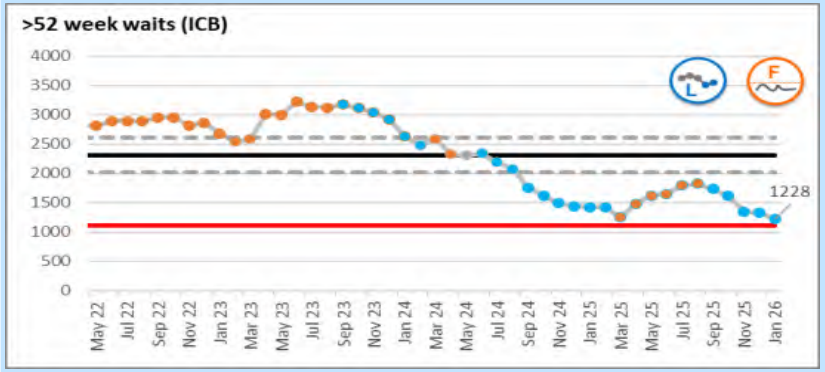
- **Referral to treatment Overall waiting list**
  We have reviewed this metric at a speciality level, and no specific area is flagging as not meeting the plan **with** special cause concerning variation, the waiting list continues to reduce and is better than plan.

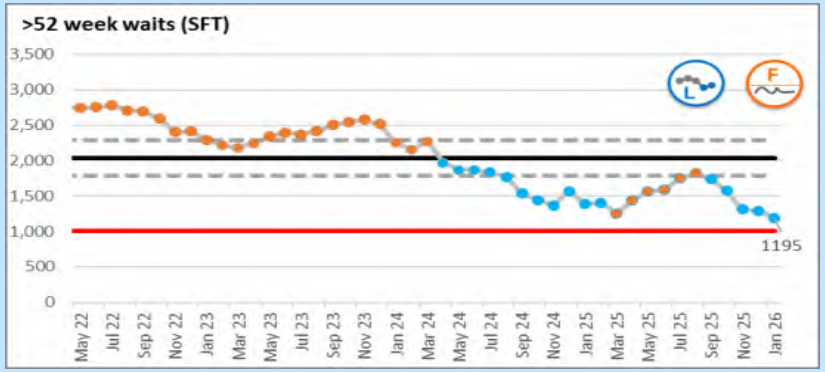
- **RTT 18-week Performance for Children and Young People**
  This metric has been flagged as “at risk” of special cause concerning variation with 4 data points below the mean however weekly data indicates this metric is improving with the overall waiting list and 18 week waits better than plan but 18 week performance worse than plan. We continue to monitor.

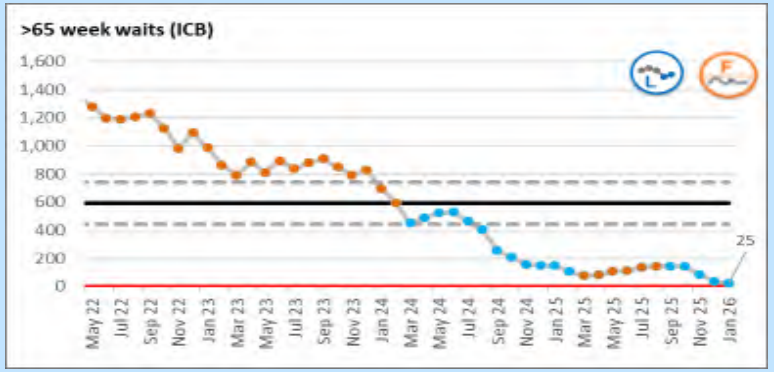
- **Cancer**
  28-day Faster diagnosis has seen improvements since October. We have reviewed this metric at a Tumour site level with no specific tumour sites showing special cause concerning variation. However Gynaecological and Lower Gastrointestinal pathways are showing a decline in performance

- **Diagnostics**
  Diagnostic 6 week performance has seen a deterioration with Endoscopy modalities, Echocardiography and DEXA Scan flagging special cause concerning variation.

Elective Care Performance Summary







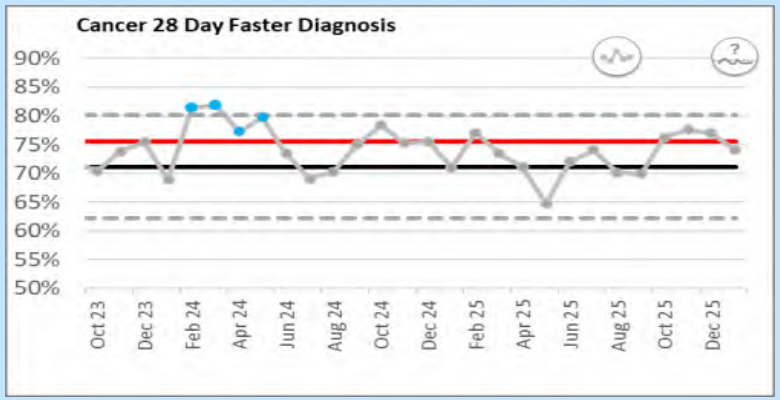
>52 week waits & 52 weeks as % of overall waiting list

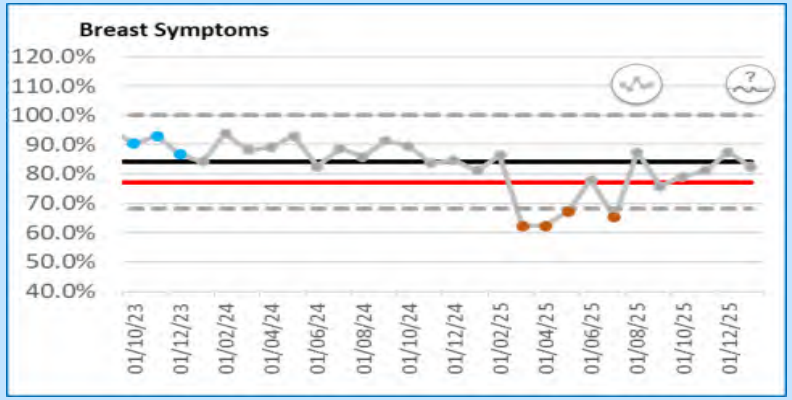
- Significant national focus remains on the clearance of long waits; with a commitment to eliminate 65 week waits by end ofMarch 2026 and to meet the 52 week wait 1% of waiting list ambition by 31 March 2026, alongside maintaining focus on 18-week delivery and managing the overall size of the waiting list.
- Progress on the reduction of the numbers of patients waiting > 52 weeks has slowed but continuesboth on a Trust and ICB basis. As at January 2026 the ICB is above a plan of 1,118 with 1,228 patients waiting longer than 52 weeks, representing 1.90% of the overall waiting list and reduction of 100 since December 2025.
- 87.9% of long waits are at Somerset FT with the remainder at other inter-system or out of area providers. As at January 2026Somerset FT are recording more breaches than their January plan (1,195 vs plan 1,003) Most long wait breaches are within Trauma and Orthopaedics (T&O), Urology, Upper GI, ENT and Gynaecology with Somerset FT increasing capacity in T&O due to insourcing and use of the Independent Sector, Urology with 2 x urologist returning from maternity leave and a recruitment of additional 2. Additional capacity is also being sought through internal waiting list initiative, weekend working and further utilisation of the independent Sector. Somerset FT also continue with RTT validation and monitoring reports for all RTT standards.
- Specialties that could pose a risk to the 52 week position include Maxillofacial, Weight management and Pain management which continue to be monitored.
- The Overall waiting list size continues to reduce following the implementation of Advice and Refer and remains below the level set out in the operational plan (64,571 vs plan 66,868) which will impact the proportion of long waiters

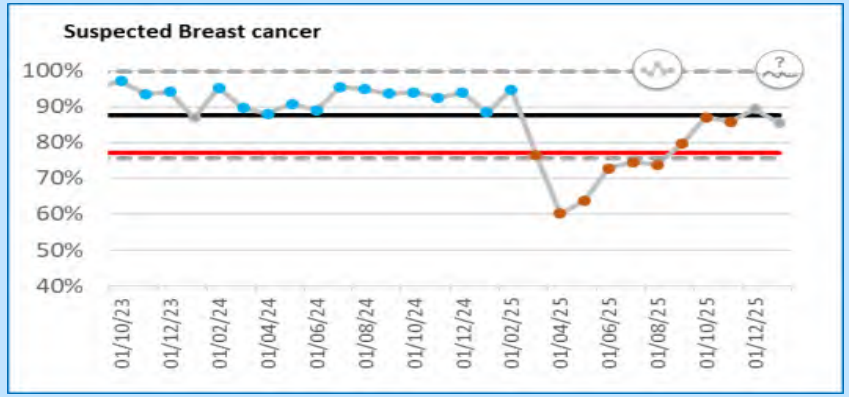
>65 week waits

- Although significantly reduced, Somerset ICB is tracking above the national ambition of 0 with 25 breaches remaining as of January 2026. 44% of breaches are at Somerset FT with the remaining breaches at providers outside of Somerset. T&O and General surgery make up 80% of the 65 week wait backlog
- In January 2026 Somerset FT had 18 breaches with a forecast of 18 breaches for the end of February 2026, all of which are clinically complex.
- Somerset FT continue to track patients waiting >65 weeks on an individual pathway basis.
- A risk has been identified in the Upper GI specialty and plans are being reviewed due to less than expected numbers of patients wanting to transfer to Yeovil or being appropriate to transfer to the Independent Sector.

Elective Care Performance Summary







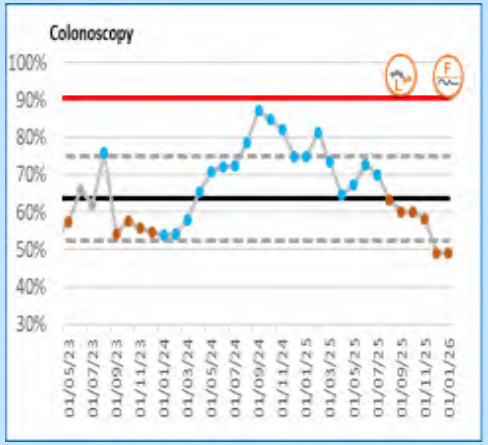
Cancer 28 day Faster diagnosis

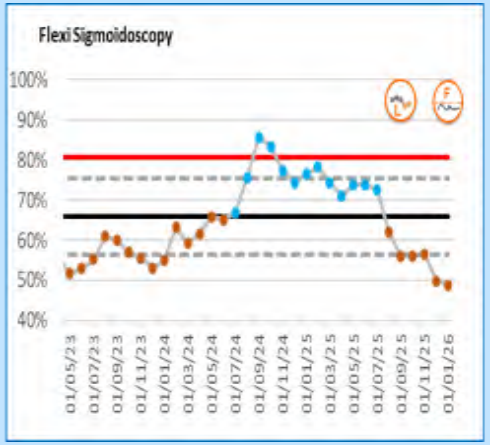
- Cancer 28-day Faster Diagnosis performance has not trigged special cause concerning variation but has been included due to Somerset FT moving into Tier 2 targeted support for cancer due to the decline in performance in May 2025. This was due to issues in the suspected breast cancer pathway, suspected lower gastrointestinal pathway and suspected head and neck cancer pathway. January 2026 has seen a slight decline to 74.08% vs plan of 75.5% on a Somerset ICB basis, whilst Somerset FT is driving a bulk of this performance which is at 76.1%, performance at Royal United Hospital Bath is impacting the overall ICB position which is at 65.6% for Somerset patients. The suspected breast and Head and neck cancer pathways have both seen improved performance since October 2025 with concerns remaining in the suspected Lower GI cancer pathway and Suspect Gynaecological cancer pathway at Somerset FT with Royal United hospital experiencing concerns in Skin and Lower Gastrointestinal suspected pathways

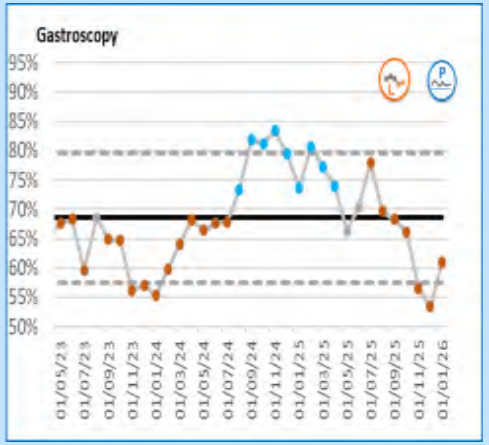
- Issues at Somerset FT include:
  - Delays in the diagnostic phase of the pathway, particularly in Endoscopy where Somerset FT have had endoscopy nurse vacancies affecting Lower GI suspected pathway
  - Increase in demand into the gynaecological pathway with delays in the administrative part of the process

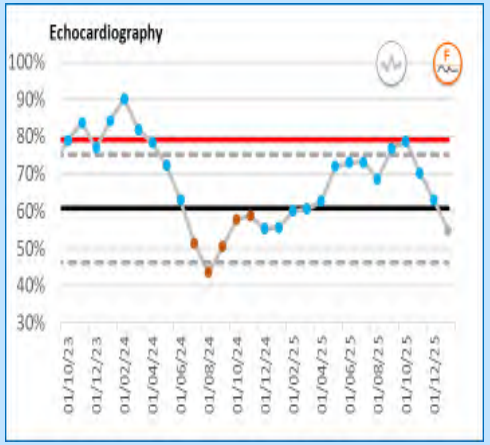
- Actions at Somerset FT to improve the position include:
  - In Endoscopy action include (but not limited to) recruitment to nursing vacancies with most now in post, increased capacity in CT Colon at Yeovil Diagnostic Centre (now open).
  - Colorectal team are revisiting the 100 days matter national challenge
  - Transfer of patients across MPH and YDH sites
  - Theatre demand and capacity under review for Hysteroscopy
  - Pilot will commence in March 2026 to rule out endometrial cancers within 72 hours
  - Continuation of benign one-stop/diagnostic insourcing which should release capacity for suspected cancer appointments.

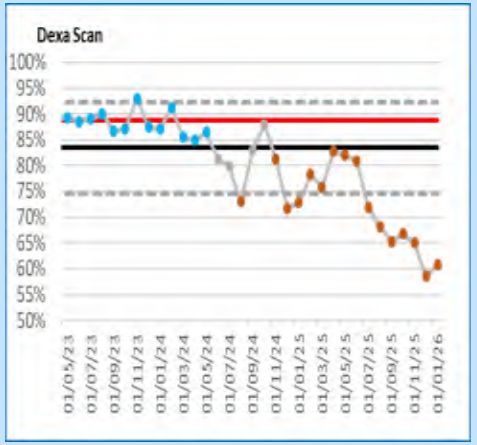
Elective Care Performance Summary











Diagnostic 6 week performance

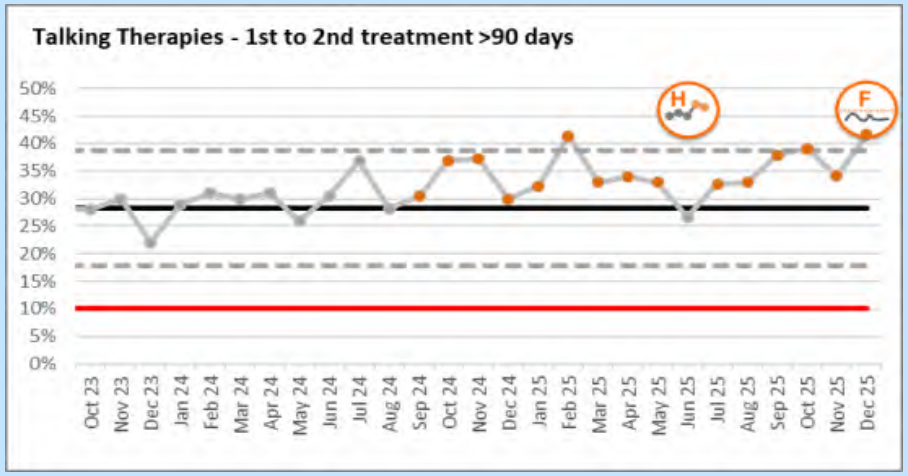
- Diagnostic Performance for the planning modalities has slightly improved to 74.6% but still below plan of 86.81%, whilst overall this metric is not flagging special cause concerning variation, Endoscopy and DEXA scan have been consistently performing below the mean and are now showing special cause concerning variation and Echocardiography showing a decline over recent months. Overall Endoscopy performance has slightly improved on an ICB basis is at 53.7% vs plan of 87.03% with Colonoscopy, Gastroenterology and Flexi Sigmoidoscopy performing below plan. DEXA Scan has improved in January performing at 60.8% vs plan of 88.73%.

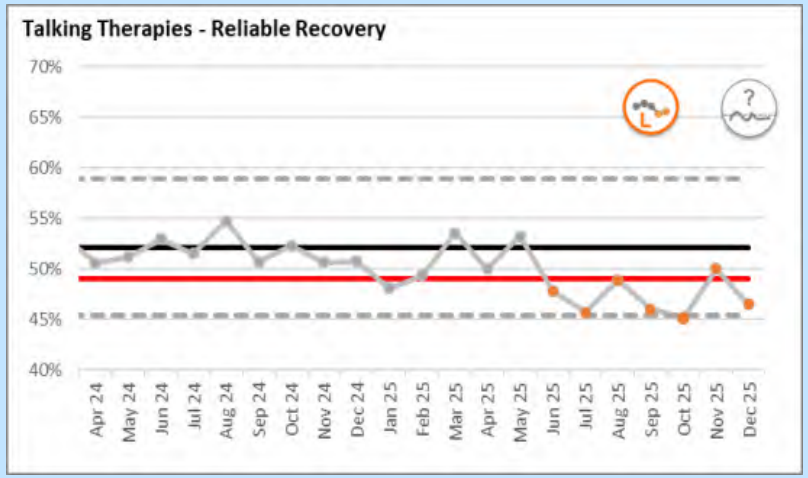
- The > 6 week waiting lists for the above mentioned modalities has reduced in January 2026 with the Endoscopy backlog at 1295 (-121) and DEXA Scan backlog at 362 (-24) and expected to continue to reduce in February

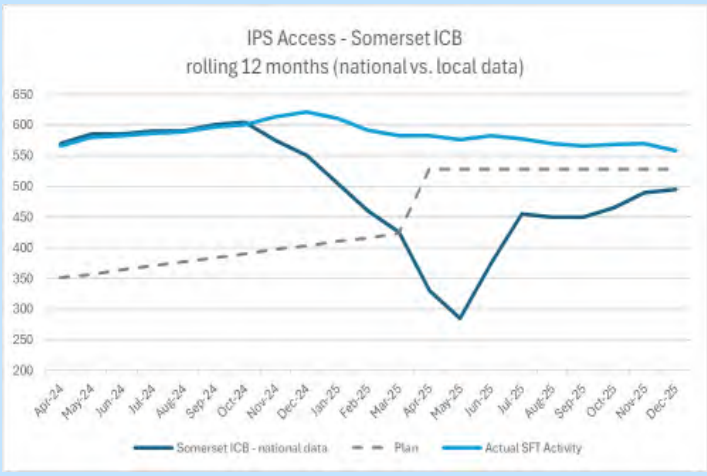
- Issues at Somerset FT include:
  - Endoscopy are experiencing capacity challenges due to nursing shortages and sickness, alongside vacancies in the booking team and booking system inefficiencies.
  - The DEXA team have also experienced challenges due to long term absences

- Actions at Somerset FT to improve the position include:
  - In Endoscopy actions include (but not limited to) recruitment to nursing vacancies and increased capacity from the Yeovil Diagnostic centre which has now opened.
  - In the DEXA service, a locum has now started in post, and an additional person has joined the team to increase capacity, and an additional locum is being sought
  - Moving forward completion of the Bridgwater diagnostic centre is due in June 2026
  - The current insourcing contract for Echo is being reviewed

Mental Health Performance Summary







Talking Therapies - 1st to 2nd treatment within 90 days

- The national ambition for this metric is that no more than 10% of patients should be waiting greater than 90 days for their second treatment. Performance in Somerset has seen further decline in December 2025 to 41% (equating to 150 patients) against the 10% threshold and is worse the National average of 22% and the regional average of 26%. Almost all cases are very complex and require highly skilled therapists.
- Actions to improve performance include work on the Step 2 offer which include courses, workshops and low intensity Cognitive Behavioural Therapy (CBT). Bespoke assessment training is also being offered to ensure people are on the right pathway. Over the longer term, our plan submission for 2026/27 includes expanding our group session offer to other conditions, such as endometriosis. Also implement two new digital solutions; one for assessment and one for digital therapy for PTSD which will free up capacity for treatments. Somerset is also recruiting additional staff to increase capacity - 5 trainees started in December in 2025, and a further 9 are to be recruited for the December 2026 intake. the increase in capacity will help the service to reduce the 1st to 2nd stage waits

Talking Therapies – Reliable Recovery

- This metric measures the proportion of patients that have moved from being a clinical case at the start of treatment to not being a clinical case at the end of treatment.
- National reporting for Reliable recovery is currently updated to December 2025 at 46% vs plan of 50%. Somerset FT which take almost all Somerset cases have reported a decline in December 2025 locally to 48% which is below plan.
- Actions to improve performance include recruitment of 3 additional therapists, productivity improvements over the last year moving from 9 hours patient facing time per week to 17.5 per week per WTE which will support reduction in the waiting list and waiting times

Individual Placement Support (IPS)

- A data quality issue has been identified, which has resulted in an incorrect decline in IPS Access being reported within national data dipping below the operational plan since March 25.
- As a result of the rules on how the data is refreshed, NHSE are unable to correct the nationally reported position
- Local reporting shows in 558 vs plan 528 in December 2025.

People Summary (Somerset FT Workforce)

Somerset FT Workforce Overview: For the 2025-26 financial year, Somerset FT is focusing on reducing temporary staffing spend and non-clinical / corporate workforce spend, whilst also reducing risks relating to key clinical (primarily Medical and Nursing) vacancies. Strong controls exist across the Trust to authorise both substantive vacancies, and for agency usage.

Workforce Turnover rate (SFT) and Sickness absence 12-month rolling (SFT):
- In January 2026 (M10), Turnover at SFT was 9.97%, lower than the planned 11.02%.
- No sickness data is yet available for Month 10 (January 2026), however Sickness in M9 at SFT was 5.15%, slightly higher than the planned 5.12%.

Total Workforce vs 2025/26 Operational plan (SFT) **WTE figures rounded to nearest integer*

2025/26 Operational Plan	Total Workforce	Substantive	Agency	Bank & Medical Locums
In Month Actual (WTE)	12,879	12,231	97	550
In Month Plan (WTE)	13,039	12,382	110	547
Variance to Plan (WTE)	-160	-151	-13	+3
Temporary Staffing (WTE) as a Percentage of Total Workforce			0.75%	4.27%

Ceasing use of Off Framework Agency contracts (SFT):
Throughout February 2026 there were 16 off-framework shifts used within the Trust. Compared to February 2025, however, there was a significant reduction (47 shifts in February 2025 to 16 shifts in February 2026).

People Summary (General Practice Workforce)

General Practice Workforce Overview: For the 2025-26 financial year, the General Practice & PCN workforce is planned to grow by 1.5% overall, with 6.5% of that growth coming through an increase in Nursing roles, and 3.0% of that growth coming through an increase in GP roles.

Total Workforce (Practice and PCN) at M10 vs. Operational Plan

Total Planned Workforce (WTE)	Total Actual Workforce (WTE)	Variance to Plan (WTE)	Monthly Change (WTE)
2223.1	2158.6	- 64.5	- 11.4

Detailed Practice & PCN Workforce (as of M10):

Role Category	Latest Month (WTE)	Monthly Change (WTE)
GPs	416.7	- 3.8
Nursing	230.5	- 1.3
Direct Patient Care (DPC)	584.4	0
Admin/Non-Clinical	921.5	- 6.3

Finance Summary

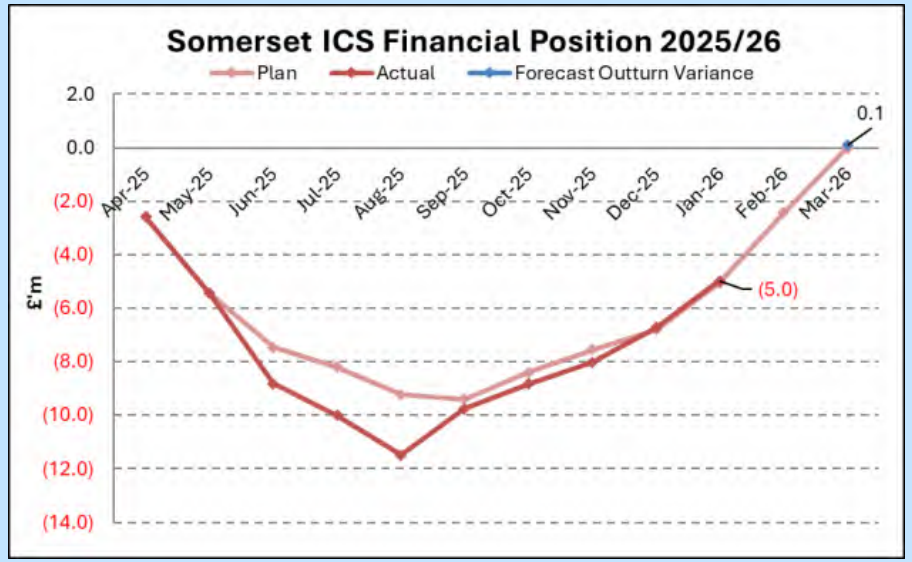
- **System underlying financial position – above plan**

As at month 10, the assessed underlying position at the end of 2025/26 remains at a £66.5m deficit.

- **System financial performance YTD & forecast vs plan (revenue) – below plan**

Performance against organisation-specific and system control totals									
£'m	Month 10			YTD Month 10			Forecast Outturn 2025/26		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
NHS Somerset ICB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Somerset NHS FT	(1.7)	(1.7)	0.0	(5.0)	(5.0)	0.0	0.0	0.0	0.0
Somerset Council*	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1
Somerset ICS	**(1.7)**	**(1.7)**	**0.0**	**(5.0)**	**(5.0)**	**0.1**	**0.0**	**0.1**	**0.1**

*Somerset Council forecast outturn relates to month 9 budget reporting, with monthly/year to date positions pro rated from forecast outturn



At month 10, Somerset ICS is showing a £0.1m favourable position this financial year. This is driven from the Somerset Council month 9 budget reporting that is forecasting a £0.1m underspent position in 2025/26. NHS Somerset is currently in a balanced year-to-date position and is forecasting to deliver a balanced outturn position for the 2025/26 financial year.

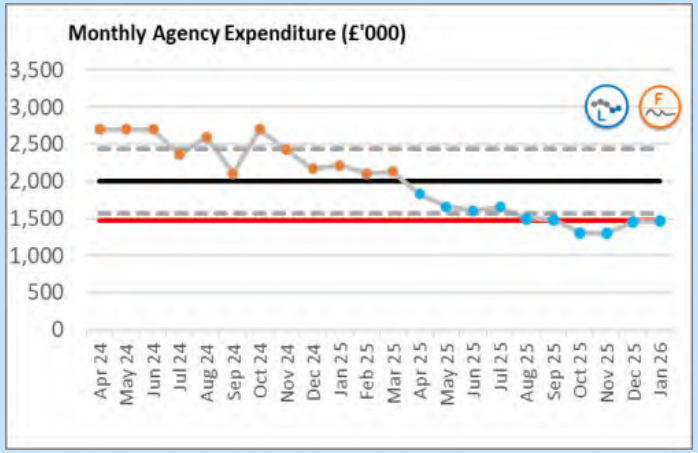
- **System financial performance YTD & forecast vs plan (capital) – below plan**

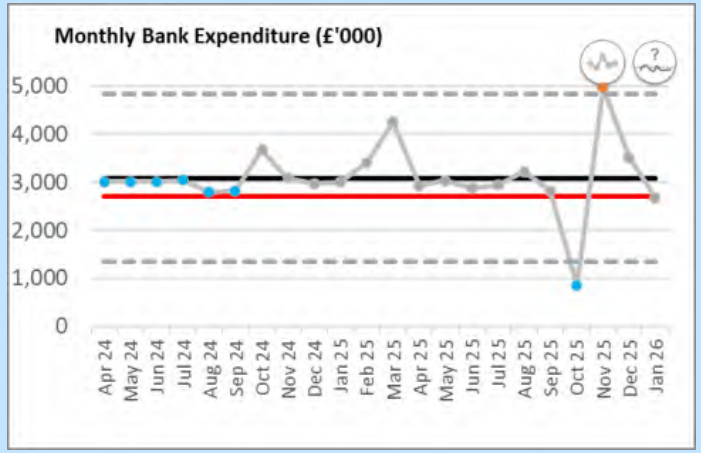
At month 10, NHS Somerset's capital scheme expenditure is currently £10.1m behind plan year-to-date, predominantly relating to backlog maintenance and the new theatre build. The system 2025/26 capital programme is forecasted to fully utilise our CDEL this financial year.

Finance Summary

- **Agency workforce spend YTD & forecast vs plan – below plan**

At month 10, spend is in line with plan this financial year. Total annual spend is also forecasted to be £0.2m below plan this financial year (£4.5m below cap).





- **Bank workforce spend YTD & forecast vs plan – above plan**

At month 10, there is an adverse £2.7m year-to-date overspend against plan. The forecasted outturn spend has been updated this month with an adverse position of £1.9m against plan/cap forecasted this financial year.

The charts opposite detail the monthly agency and bank expenditure since the start of the last financial year (the red target line is a 12th of the 25/26 plan)

- **Savings Programme – below plan recurrently**

NHS Somerset has total savings programme of £83.0m this financial year. At month 10, whilst NHS Somerset's year-to-date total savings programme is ahead of plan by £0.3m, the shortfall in recurrent savings has increased to £13.1m against plan. Forecasted shortfall in recurrent savings delivery is £16.8m against plan, a deterioration of £0.3m this month. No unidentified savings remain within the SFT savings programme, with only £0.2m of savings rated as high risk.

- **Mental Health Investment Standard (MHIS) – on plan**

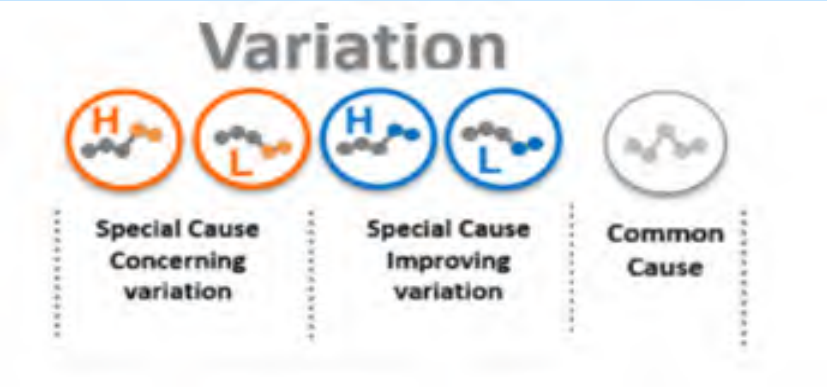
NHS Somerset are forecasting to comply with the requirements of the MHIS to increase MH spending rising by 4.93% (£6.1m) this financial year.

- **Risks and Mitigations – on target**

At month 10, NHS Somerset has an adverse net risk position of £2.3m - a reduction of £1.6m compared to last month. Included within our risk position are risks relating to system elective care programme and winter pressures.

APPENDIX - Guidance on the use of Making Data count SPC Charts and Matrix

SPC Variation Icons



- **Orange** indicates **concerning** special cause variation, requiring action.
- **Blue** indicates **improving** special cause variation, no action required.
- **Grey** indicates no significant change due to **common cause variation**

SPC Assurance Icons

- **Blue** indicates that you would consistently expect **to achieve** a target.
- **Grey** tells you that sometimes the target will be met and sometimes missed due to **random variation.**
- **Orange** indicates that you would consistently expect **to miss** the target.

REPORT OF THE ICB QUALITY COMMITTEE MEETING HELD ON 25 February 2026

1 ITEMS DISCUSSED

1.1 Somerset Foundation Trust maternity services
Somerset Foundation Trust paediatric services
System flow and winter planning
Quality report
Quality risk report
Feedback from System and Regional Quality Groups
System mortality update
Evidence based interventions activity update
Vaccination update
Quality assurance of independent sector providers and small contracts
Patient experience quarterly report, including TOFT report
Infection prevention management quarterly update

2 NEW ISSUES AND/OR NEW RISKS IDENTIFIED

2.1 The Committee noted emerging concerns regarding the **impact of indicative activity plans on patient experience**, highlighted through recent PALS and complaints activity. The Committee recognised the need for strengthened oversight of these impacts and noted that quality, contracting, commissioning, and performance colleagues are meeting regularly to monitor associated risks and ensure mitigations are developed and implemented.

2.2 The Committee noted emerging concerns regarding a series of **digital incidents** affecting information sharing during system and provider transitions. The Committee recognised the potential impact on patient safety and experience and agreed that this area requires strengthened monitoring and oversight as further assurance is sought from system partners.

2.3 The Committee received the quarter three **infection prevention and management** update and noted significant concerns with Somerset's performance on healthcare-associated infections. Assurance was taken from active improvement work, though progress is hindered by limited access to patient-level data. The Committee agreed that improved system-wide engagement and data access are essential, and supported actions to remove data barriers and develop a shared methodology to understand rising infection trends.

3 DECISIONS TAKEN BY THE ICB QUALITY COMMITTEE UNDER DELEGATED AUTHORITY

3.1 The Committee received an update on the **Toft Report** and noted that an updated action plan had been shared with the family. A small number of areas require final clarification, after which the action plan can be concluded, with ongoing pathway risks continuing under routine quality governance.

3.2 The Committee approved the updated **Complaints Policy**, noting that it has been streamlined to reflect current regulations and national guidance, with operational detail moved to a separate procedure document.

3.3 The Committee approved the **Adoption Strategy**, noting clear articulation of statutory responsibilities, strengthened governance, and a consistent health offer for children across the adoption pathway. The strategy focuses on improving outcomes, reducing inequalities, and ensuring timely assessments, robust medical advice and safe information sharing. The Committee was assured by the extensive consultation undertaken and acknowledged the strategy's potential national significance.

4 ITEMS REQUIRING ESCALATION TO THE ICB AND/OR OTHER SYSTEM BOARDS

4.1 The Committee received an update on **maternity services**, noting ongoing system pressures following the temporary closure of YDH maternity and neonatal services. Assurance was taken from continued improvement work, strengthened triage processes, established governance oversight and progress against the maternity improvement plan, with no triggers reported through the Maternity Outcomes Signal System (MOSS). A system-wide dynamic risk assessment is supporting planning for a safe relaunch of YDH services. The Maternity Incentive Scheme declaration remains paused pending CQC feedback, and the Committee was assured that preparations for the proposed relaunch are progressing appropriately.

4.2 The Committee received an update on **paediatric services**, noting ongoing impacts from the temporary closure of the YDH neonatal unit and that the contract performance notice remains in place. Assurance was taken from strong recruitment progress, improved senior clinical presence out of hours and the introduction of a new rota to ease pressure on medical teams. Work continues on the criteria and planning for the proposed YDH relaunch, with further assurance to follow once detailed plans have been reviewed. Overall, the Committee was assured by the positive momentum in workforce and rota improvements, while recognising areas where further assurance is still required.

4.3 The Committee received an update on **system flow and winter planning** noting significant winter pressures, particularly from norovirus, but took assurance from strong system collaboration, improved ambulance handovers, ongoing work to strengthen flow and discharge, and the

contribution of general practice and community services. Vaccination uptake supported overall resilience, though some pressures remain.

4.4 The Committee received the **Quality Report** and took assurance from continued improvements across a number of services, including strengthened performance in All Age Continuing Care, progress against the improvement plan for non-emergency patient transport, and aligned work to address ongoing challenges with delayed discharges. Assurance was noted regarding the planned introduction of revised key performance indicators for the wheelchair service and the strengthened joint oversight of a general practice provider's documentation backlog. The Committee also took assurance from progress within the 111 and out of hours provider, against its quality improvement plan, as well as ongoing action on children and young people's waiting times. Dental access pressures continue to be monitored, and the Committee welcomed the de-escalation of concerns regarding an at scale pharmacy provider following reinstated provision.

4.5 The Committee received assurance on continued progress in **system mortality** work, noting learning from recent Prevention of Future Death reports, improvements to pathways and falls prevention, and enhanced insight from the developing mortality dashboard. SHMI remains within expected limits, work on the David Fuller recommendations continues, and themes from Medical Examiner learning have been reviewed. The Committee also noted positive regional engagement and ongoing work on suicide prevention, premature mortality and future system arrangements.

4.6 The Committee received an update on **evidence based intervention** activity. Activity continues to centre on a small number of high-volume procedures, noting increases in certain procedures. The Committee noted the importance of continued adherence to policy criteria to support consistent and equitable access.

4.7 The Committee received an update on **vaccination** and took assurance from strong flu uptake, noting Somerset outperformed national and regional levels, though care home consent remains a focus. COVID uptake fell in line with national trends and RSV uptake was mixed. Planning continues for the spring booster and next winter's programme, with stable childhood immunisation rates and upcoming commissioning changes alongside increased GP practice participation.

4.8 The Committee received assurance the findings of the **quality assurance of independent sector providers and small contracts** self-assessment survey from strong compliance across smaller providers in key areas including DBS checks, mandatory training, quality reporting and incident processes. Some gaps were noted in safeguarding reporting, incident governance and workforce data, indicating a need for clearer guidance and improved future survey questions.

4.9 The Committee noted improving trends in patient transport and wheelchair service feedback, alongside positive CHC compliments and better maternity survey results within the **patient experience quarterly report**.

Key concerns centred on COVID-19 vaccination pathway complaints, persistent communication issues, rising cases linked to indicative activity plans and continued high levels of dental access complaints.

Reports for information for future Board agendas

4.10 Nil

5 CHAIR'S SUMMARY

5.1 I confirm that the summary above indicates the Committee's assurance in the matters listed and further work we expect; in particular the quality and safety report, and the detail provided in relation to risks, patient safety and quality of care.

5.2 The Committee will expect further updates on maternity and paediatric services, system flow and infection prevention, and the impacts of indicative activity plans and Care Coordination Hub processes.

Chair: Caroline Gamlin

Date: February 2026

REPORT OF THE FINANCE COMMITTEE MEETINGS HELD ON 10 FEBRUARY and 9 MARCH 2026

1 ITEMS DISCUSSED

1.1 ICB Planning Financial Submission (1)
Specialised Commissiong Financial (2)
Financial Performance (3)
Better Care Fund (4)
Contracts (5)
Risks (6)

2 NEW ISSUES AND/OR NEW RISKS IDENTIFIED

2.1 The Committee reviewed and supported 2 new risks to be added relating to 2026/27 (6).

3 DECISIONS TAKEN BY THE COMMITTEE/SYSTEM GROUP UNDER DELEGATED AUTHORITY

3.1 None.

4 ITEMS REQUIRING ESCALATION TO THE ICB AND/OR OTHER SYSTEM BOARDS

Items for Consideration/Decision

4.1 None.

Reports for Information for Future Board Agendas

4.2 None.

5 CHAIR'S SUMMARY

5.1 (1) The Committee supported in February the revised balanced ICB financial plan (revenue, performance and workforce plan for 3 years, capital plan for 4 years) for recommendation from the Committee to the ICB Board. Assurance was received that the contract envelope had been agreed with SFT.
(2) The Specialist Commissiong plan was also reviewed following agreement at the South West Joint Directors Group for submission.
(3) Updates for Month 9 and Month 10 confirmed 2025/26 financial performance on plan to deliver a balanced outcome for revenue and capital expenditure. Net risks continued to reduce in year with planned savings being achieved, albeit with disappointing levels of recurrent savings.

Continuing Health Care and Learning Disabilities were identified as ongoing risks into 2026/27 and a fuller consideration was agreed, particularly as the present LD pooled budget arrangement which ends on 31 August 2026.
(4) In March the committee reviewed the Q3 BCF position, noting some performance behind plan with an expectation of some improvement before year end. Delay in publishing the new BCF framework will necessitate continuation of the existing approach in 2026/27 with planning for better links with Neighbourhood Health beyond the transition year.
(5) Contract Extensions agreed by the Contracts Oversight Group were noted.
(6) Risks were reviewed. Two new risks were confirmed relating to the ICB financial position in 2026/27 and the possible financial impacts of transition. A further new risk was agreed relating to procurement risk of previously unknown companies seeking direct contracts.

Chair: Christopher Foster

Date: 17 March 2026

REPORT OF THE SYSTEM ASSURANCE FORUM MEETING HELD ON 19 February 2026

1 ITEMS DISCUSSED

1.1

Month 9 Financial Headline (1)
Operational Plan 2026/27 – 2028/29 Submission (2)
Elective Performance – RTT and long waits (3)
Referral Demand – Advice and Refer (4)
Diagnostic Performance (5)
Winter Resilience (6)
Neurodiverse Pathway (7)
Risks (8)

2 NEW ISSUES AND/OR NEW RISKS IDENTIFIED

2.1 None

3 DECISIONS TAKEN BY THE COMMITTEE/SYSTEM GROUP UNDER DELEGATED AUTHORITY

3.1 None

4 ITEMS REQUIRING ESCALATION TO THE ICB AND/OR OTHER SYSTEM BOARDS

Items for Consideration/Decision

4.1 None

Reports for Information for Future Board Agendas

4.2 None

5 CHAIR'S SUMMARY

5.1

(1) The Forum noted that the month 9 financial position and on plan to deliver a balanced financial position for 2025/26 in line with the plan
(2) The Forum reviewed the 2026/27 – 2028/29 Operational Plan, paying due consideration to the finance, workforce and performance delivery

(3) The Forum considered the performance delivery, risks and actions being taken in relation to RTT and long wait patients
(4) The Forum received an update on the progress across the system on implementing advice and guidance, with national benchmarking showing the strong performance in Somerset
(5) An update on diagnostic performance was noted, including risks and mitigating actions which are being taken
(6) The forum received an update on the winter resilience schemes employed and recognised the need to carry out a full evaluation on the benefit delivered
(7) An update on the focus on the considerations on the neurodiversity pathway was provided
(8) Risks were reviewed and noted

Chair: Jonathan Higman

Date: 17 March 2026

REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: 11
DATE OF MEETING:	26 March 2026	
REPORT TITLE:	Key Meeting Reports	
REPORT AUTHOR:	Non-Executive Directors and System Group Chairs	
EXECUTIVE SPONSOR:	Jonathan Higman, Cluster Chief Executive Officer	
PRESENTED BY:	Non-Executive Directors and System Group Chairs	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☒

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☐ Objective 2: Reduce inequalities
- ☐ Objective 3: Provide the best care and support to children and adults
- ☐ Objective 4: Strengthen care and support in local communities
- ☐ Objective 5: Respond well to complex needs
- ☐ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

N/A

REPORT TO COMMITTEE / BOARD

The Key Meeting Reports are a record of the most recent Board Committee and System Group meetings. They are presented to the ICB Board and are published in the public domain through the NHS Somerset website, to provide clarity and transparency about the discussions and decisions made, and to ensure the principles of good governance are upheld.

The Key Meeting Reports are provided for **Assurance.**

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	N/A
Quality	N/A
Safeguarding	N/A
Financial/Resource/ Value for Money	N/A
Sustainability	N/A
Governance/Legal/ Privacy	N/A
Confidentiality	N/A
Risk Description	N/A

REPORT OF THE ICS CHILDREN, YOUNG PEOPLE AND FAMILIES PARTNERSHIP BOARD MEETING HELD ON 10 FEBRUARY 2026

1 ITEMS DISCUSSED

1.1 SEND strategy
Children and young people's plan deep dive
Maternity and paediatrics update

2 NEW ISSUES AND/OR NEW RISKS IDENTIFIED

2.1 There continues to be uncertainty regarding the publication of the national SEND white paper, which has been subject to repeated delays. While this does not prevent local planning from progressing, it does create some ongoing ambiguity around future national expectations and potential policy changes. Senior oversight will help ensure that the partnership remains well-positioned to respond once formal guidance is released, while maintaining focus on the improvement activity already underway.

3 DECISIONS TAKEN BY THE PARTNERSHIP BOARD UNDER DELEGATED AUTHORITY

3.1 None

4 ITEMS REQUIRING ESCALATION TO THE ICB AND/OR OTHER SYSTEM BOARDS

Items for Consideration/Decision

4.1 There remain areas where governance arrangements across children and young people's services could be clearer, particularly in relation to how different partnership boards align and report. Work is underway to map these structures, and senior oversight will support the development of a more streamlined and transparent approach. Strengthening this framework will help ensure shared priorities are delivered consistently across the system.

4.2 Timeliness for Education, Health and Care Plans continues to be affected by workforce pressures, particularly within educational psychology services. Although mitigating actions are in place, overall demand continues to exceed capacity. Support from senior leaders will help ensure that sustainable workforce and delivery options are explored to meet statutory expectations.

4.3 The partnership continues to experience sustained pressure within neurodevelopmental pathways, with longer waiting times than desired. This remains an important area for collective focus, and further support from

system leadership will help ensure that capacity, pathway development, and improvement activity are progressed in a coordinated way.

4.4 Plans for the phased relaunch of maternity and paediatric services in Yeovil continue to progress, supported by improvements in recruitment. As preparations continue, it will be important for senior leaders to maintain oversight of key milestones and safety requirements to ensure confidence in service readiness and long-term sustainability.

4.5 In preparation for the forthcoming SEND inspection, partners are gathering evidence and ensuring staff are well briefed on shared priorities. Continued organisational support will help ensure that contributions are timely and that all teams are confident in describing their role in improving outcomes for children, young people and families.

4.6 New tools have been developed to help partners track progress against the Children and Young People's Plan. Embedding these approaches will take time, and support from senior leaders will encourage consistent participation across organisations, ensuring that reporting is reliable and that progress can be clearly demonstrated.

4.7 An update on the Family Hubs programme will be scheduled for a future meeting to ensure continued visibility of this important area of work. Given its links to early help and wider prevention activity, it will benefit from ongoing senior oversight to maintain alignment and momentum.

Reports for Information for Future Board Agendas

4.8 None

5 CHAIR'S SUMMARY

5.1 Progress was noted in preparation for the SEND inspection, development of the Children and Young People's Plan measurement tools, and the ongoing work to stabilise maternity and paediatric services in Yeovil. While several areas require continued focus appropriate actions are in place and senior oversight is being sought where system-level support is needed. On this basis, the Board can take assurance that the partnership is actively addressing its key priorities and risks, while maintaining clear sight of where further work is required.

Chair: Bernice Cooke, Director of Nursing and Deputy Chief Nursing Officer

Date: 9 March 2026