REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: H
DATE OF MEETING:	27 March 2025	
REPORT TITLE:	NHS Somerset 2025/26 Operational Plan Overview – 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	

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 Finance Committee supported the submission on 19th March 2025.

REPORT TO COMMITTEE / BOARD

Summary and Purpose of Paper

The enclosed paper provides an update summarising the NHS Somerset Integrated Care System operational planning submission for the 2025/26 financial year due to be submitted on 27th March 2025.

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

- Summary of NHS Somerset Financial Position 2025/26
- Summary of NHS Somerset Performance Position 2025/26
- Summary of NHS Somerset Workforce Position 2025/26

Introduction

In late January 2025, NHS England published 2025/26 priorities and planning guidance and supporting information including productivity/efficiency benchmarking data. Other linked document and information was shared with systems, including: -

- One year revenue and capital allocations for 2025/26 and supporting guidance,
- NHS financial framework (business rules), revenue finance and capital guidance documents,
- Better Care Fund framework and planning requirements,
- Plan submission guidance,
- NHS Payment Scheme 2025/26 consultation,
- NHS Standard Contract 2025/26 consultation,

The timetable included a headline planning submission to regions on 27th February 2025 and full plan submissions on 27th March 2025, including board sign off plans and board assurance statements ahead of the full submission to NHS England.

2025/26 Priorities

Reduce the time people wait for elective care
improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement.

Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026.

Improve A&E waiting times and ambulance response times compared to 2024/25
with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26.

Improve patients' access to general practice
Improving patient experience, and improve access to urgent dental care, providing 700,000 additional urgent dental appointments.

Improve patient flow through mental health crisis and acute pathways
reducing average length of stay in adult acute beds and improve access to children and young people's (CYP) mental health services, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019.

Ways of working whilst delivering these priorities

Drive reform:
- ICBs and providers to focus on:

- reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
- making full use of digital tools to drive the shift from analogue to digital addressing inequalities and shift towards secondary prevention

Live within the budget allocated, reducing waste and improving productivity.

- ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other partners. This will require prioritisation of resources and stopping lower-value activity

Maintain focus on the overall quality and safety of our services, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of 'Three-year delivery plan', and continue to address variation in access, experience and outcomes

Address inequalities and shift towards prevention

ICSs must explicitly agree local ambitions and delivery plans for vaccination and screening services and services aimed at addressing the leading causes of morbidity and mortality such as cardiovascular disease and diabetes.

ICBs and provider trusts are expected to work together to reduce inequalities in line with the Core20PLUS5 approach and ensure plans reflect the needs of all age groups, including CYP.

NHS England will continue to prioritise prevention and proactive care as part of effective population health management through the GP contract, including increasing the focus on the prevention of cardiovascular events by supporting GPs to treat more people to target levels of blood pressure and lipid control.

Making the shift from analogue to digital

We expect that:

- all providers proactively **offer NHS App-first communications** to patients (with due regard to digital inclusion), by default through the NHS Notify service
- all GP practices have enabled all core NHS App capabilities.
- all systems adhere to the **'Federated Data Platform (FDP) First'** policy, connecting their own digital and data infrastructure to the FDP. NHS England will support adoption of the FDP to 85% of all secondary care trusts by March 2026
- all providers shift to the national collaboration service **NHS.Net Connect** where feasible
- all systems **complete planned electronic patient record (EPR) system procurements and upgrades**, and all trusts without an EPR continue to work to procure and implement one as quickly as is safely possible
- deploy the **Electronic Prescription Service** wherever possible
- all providers integrate systems with the **NHS e-Referral Service**
- all providers achieve and maintain compliance with the **NHS MultiFactor Authentication** and act to strengthen their cybersecurity
- all systems **mitigate against digital exclusion**, including by implementing the framework for NHS action on digital inclusion

Financial Reset

- Systems must develop plans that are **affordable** within the allocations set, exhausting all the opportunities to improve productivity and tackle waste (and take decisions on how to prioritise resources to best meet the health needs of their local population.
- Most **ringfenced** budgets are released. **Service Development Funding (SDF)** is rolled into core allocations. Further detail is set out in the Revenue finance and contracting guidance.
- Providers will need to **reduce their cost base by at least 1%** and **achieve 4% overall improvement in productivity** before taking account of any new local pressures or dealing with non-recurrent savings from 2024/25. This represents a step change across all services.
- ICBs and providers must demonstrate that all **productivity and efficiency opportunities** have been exhausted before considering where it is necessary to reduce or stop services, taking account of each organisation's own legal duties.
- In deciding how to prioritise resources to best meet the health needs of their local population, ICB and provider boards are expected to **explicitly consider both the in-year and medium-term quality, financial and population health impacts** of different options using the **Principles for Local Prioritisation**. Plans should reflect the needs of all age groups and explicitly children

Living within our means, reducing waste and maximising productivity

As part of reducing unwarranted variation and exhausting all possible realistic in-year productivity and efficiency opportunities, ICBs and providers must:

- **Reduce spend on temporary staffing and support functions**
  - achieving close to **100% delivery of planned core** capacity before accessing premium capacity, including the use of agency and premium bank rates, waiting list initiatives, and insourcing arrangements, managing to tariff prices as a guide
  - **reducing agency expenditure**, as far as possible as part of optimising cost and productivity. **As a minimum all systems are expected to deliver a 30% reduction based on current spending** with further reductions over the Parliament
  - **reducing bank use**, with all systems expected to deliver **a minimum 10% reduction**. Bank rates should be optimised as far as possible with collaborative arrangements in place across and between systems conducting a robust review of establishment growth and reduce spend on support functions to April 2022 levels

- **Improve procurement, contract management and prescribing**
  - working to accepted operating models and commercial standards, making full use of the **consolidated supplier frameworks** agreed through NHS Supply Chain
  - **optimising medicines value** and improving the adoption of and compliance with best value frameworks in medicine and procurement
  - **reducing unwarranted variation in prescribing**, implementing the guidance on 'Low value prescribing' & ensure that patients are prescribed the best value biological medicine where a biosimilar medicine is available.
  - **reducing unwarranted variation in all age continuing care spend and placement pricing** through standardised complex care specification(s), improved sharing of placement data and integrated 'at scale' commissioning practices

- **optimising energy value**. Trusts are expected to procure energy through the new national contract developed with Crown Commercial Services (CCS) and use green plans to identify and achieve savings from sustainable energy funding

- **Drive improvements in operational and clinical productivity**. Providers are expected to:
  - develop plans that **address the activity per WTE gap** against the pre-Covid level
  - **avoid duplication and low-value activity**, including a renewed focus on minimising inappropriate spend against evidence-based intervention (EBI) procedures. Commissioners are expected to work with providers to ensure that payment depends on meeting the relevant criteria
  - **systematically implement all elements of the People Promise** to improve the working lives of all staff and increase staff retention and attendance and **implement the 6 high impact actions to improve equality, diversity and inclusion.** The evidence is clear that engaged, motivated staff improve productivity and patient outcomes

Key Messages - Financial Plans 2025/26

The settlement for 2025/26 will mean a challenging ask for local systems, requiring systems to increase efficiency and reduce their cost base.

- Base growth of c.4.4%, comprising a cost uplift factor of 4.15%, a general efficiency requirement of 2.0%, and affordable activity growth.
- A consistent convergence policy will apply against ICB, specialised and primary medical care allocations in the range of +/-0.5%.
- All elective recovery funding has been allocated, there will be no national funding for overperformance. Commissioners will be able to set limits on elective payments to providers.
- Asking systems and providers to review their fixed payments to better understand contract values relative to actual activity and efficiency opportunities. Non-elective prices increased to support this exercise. But actual change in contract values should be carefully managed and take account of commissioner and provider financial implications.
- As in 2024/25, systems will be set plan limit positions and where necessary allocated support funding to reach breakeven. Revenue and capital incentives and penalties and repayment rules will continue to apply.
- Transfer of a significant proportion of service development funding into ICB allocations without ring-fences to support systems to make flexible decisions about the utilisation of their resources.

System Underlying Position – assessment of 2024/25 exit position

The system assessment of the exiting run rate deficit based on the final 2024/25 financial plan (submitted on 29 September 2024) was £69.752m. The system has revised this assessment as it gets closer to the end of the 2024/25 financial year, which has worsened the underlying position (ULP) by £3.764m. The bridge from 2024/25 outturn to the most recent assessment of the system ULP is set out in table 1 below:

Table 1: System Exit Underlying Position 2024/25

2025/26 Planning	2025-26 NHS Somerset £'000
2024/25 Outturn	-
NR 24/25 CIP / QIPP	40,546
N/R Budget Flexibility	6,000
IT Contract Extension (EHR Delay)	(3,500)
ERF Income Benefit	5,000
Removal of N/R Funding	18,000
Additional N/R Uncommitted Allocations	1,500
SFT - HCDD - Ustekinumab	(594)
GPDA / Hearing Aids	1,000
Learning Disabilities	1,800
ULP Exit 24/25 per Updated MTFP (Sep-24)	69,752
Movements to ULP	
GP Prescribing	2,000
Triple Lock - NBT FIT Testing	226
Triple Lock - Hybrid Closed Loops	385
NR Pay Funding 24/25	(2,337)
SFT Recurrent CIP Improvement	(500)
SFT Baseline Provider Costs	3,990
Opening 25/26 ULP	73,516

2025/26 ICB allocations

Table 2 summarises the ICB Total Allocations for 2025/26.

Table 2: ICB Total Allocations for 2025/26

	2025/26 Financial Plan £'000
Sources of Funds	
Core Programme Allocation	1,172,856
Core Programme Net Growth 25/26	44,180
Delegated Commissioning - Primary Medical Care	128,171
Delegated Commissioning - Pharmacy, Optom and Dental	57,066
Delegated Commissioning - Specialised Commissioning	1,580,830
Running Costs	8,515
Running Costs - Collaborative Commissioning Hub	246
Discharge Fund	5,126
Service Development Funds (SDF)	27,751
Elective Recovery Fund (Core & Additional)	40,596
Covid Testing	892
Total Sources of Funds	3,066,229

COVID-19 testing funding - As in 2024/25, ICBs have received fixed allocations for commissioning COVID-19 testing services for their populations, comprising PCR testing services and LFD hospital-based testing services.

Discharge funding - The 2025/26 allocation has been calculated based on the 2024/25 allocation of £500m. In respect of Somerset ICB has received an allocation of £5.1m, with an additional allocation of £5.5m allocated to Somerset Council.

Charges to Overseas Visitors (CEOV) and UK cross-border emergency care - An adjustment is to ICB baselines based on the 2023/24 actual cost, updated for the 2025/26 CUF and general efficiency requirement.

Elective Recovery Fund (ERF)

- Commissioners will continue to have access to elective recovery funding in 2025/26.
- There is no additional funding available for elective activity beyond that included in ICB allocations.
- Elective recovery funding in 2025/26 will be distributed as follows:
  - Core elective recovery funding will be separately identified in ICB allocations and distributed on a fair share basis
  - Additional elective recovery funding will be based on:
    - Month 8 forecast outturn
    - Less the component associated with 23/24 overperformance adjustments
    - Plus a calculation of impact of TIF schemes yet to start
    - ERF additional element scaled down (c90.4%)
- For Somerset this has resulted in a total allocation of £40.6m to support elective recovery.

NHS England has reserved the right to adjust elective recovery funding allocations in 2025/26 if final data is materially different to the forecasts on which the allocation is based or material data issues are identified

- The baseline for monitoring ERF has moved from 2019/20 to 2023/24.
- The National team have confirmed the funding applied delivers 118% of the 2019/20 baseline.

Service Development Fund (SDF)

- The Government's Mandate to the NHS and the 2025/26 priorities and operational planning guidance set out the need for reform and improvement to productivity to deliver on the Government's goals for the NHS.
- To support local systems to deliver, most ringfences have been removed to improve system flexibility on where to allocate resources.
- In relation to SDF, this means that for 2025/26 most SDF bundles will move into ICB core programme allocations. Where funding has been transferred into ICB core programme allocations this is no longer ringfenced and there are no additional performance requirements beyond those set out in the 2025/26 priorities and operational planning guidance.
- The remaining unallocated SDF includes: cancer alliances; IT & technology; 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 4.4%. It should be noted that these are assumptions and not binding requirements (except for MHIS).

Table 3: ICB core programme base growth

	Base growth (%)
CUF	4.15%
BAU productivity	-2.00%
Net CUF	2.15%

Elective activity - RTT	0.0%
Elective activity - Non-RTT	2.1%
Non-elective activity	4.0%
A&E activity	2.9%
Maternity activity	1.6%
Ambulance activity	0.0%
Community activity	0.0%
MHIS activity	4.4%
FNC total growth	11.2%
CHC total growth	8.8%
Excluded drugs total growth	8.8%
BCF total growth	5.2%
CNST growth	4.6%
Total base growth	**4.4%**

Elective Referral to Treatment (RTT) growth of 0% included in base allocations. This is because the funding to support elective activity is contained in the elective recovery fund (ERF).

Ambulance growth is funded but is being held centrally in line with the revised national commissioning approach so doesn't appear here. This will be allocated in year, once plans have been agreed.

The Mental Health Investment Standard funding increase is in line with base growth (4.4%)

Included within growth allocation is funding for the cost uplift factor (CUF) that is detailed in table 4 below. Total indicative pay cost change is valued at 4.72% for 2025/26. This reflects the fact that allocations for 2025/26 include a nominal 2.8% for pay, and then allows a 0.1% increase for pay drift. It is expected that any pay award above 2.8% would result in further uplift in ICB allocations.

Table 4: Cost uplift factor (CUF)

Cost	Estimate	Cost weight	Weighted estimate
Pay	4.72%	70.45%	3.33%
Drugs	0.83%	2.34%	0.02%
Capital	2.39%	7.35%	0.18%
Unallocated CNST	0.31%	2.09%	0.01%
Other	3.51%	17.76%	0.62%
Total			4.15%

A **consistent convergence policy** has been applied across ICB core programme, ICB primary medical care and Specialised Commissioning allocations based ICB's distance from target calculated using a weighted allocation formula. The weighted allocation formula is based on a complex assessment of factors such as demography, morbidity, deprivation and the unavoidable

cost of providing services in different areas. Convergence is set on a system's distance from target based on the below parameters:

DfT	Convergence
> 2.5%	(0.50)%
0 - 2.5%	taper
zero	-
0 - (2.5)%	taper
< (2.5)%	0.50%

For Somerset ICB, our distance from target at our recurrent 24/25 baseline is 4.39% over the weighted allocation formulae, which has resulted in a £6.0m convergence adjustment being applied in 2025/26.

2025/26 Application of Funds

Table 5 summarises the ICB Total Application of Funds for 2025/26.

Table 5: ICB Total Application of Funds for 2025/26

	2025/26 Financial Plan £'000
Total Sources of Funds	3,066,229
Applications of Funds	
Prescribing	100,660
Delegated Commissioning - Primary Medical Care	128,171
Delegated Commissioning - Pharmacy, Optom and Dental	52,066
Delegated Commissioning - Specialised Commissioning	1,580,830
Primary Care Programmes	22,655
Acute Services	948,409
Mental Health	12,752
Community and Partnerships	46,640
Continuing Care and Funded Nursing Care	61,458
Running Costs	8,761
Managed Programmes & Savings Schemes	33,094
Investments & Service Development Funds	44,868
Other Commissioning	25,865
Total Application of Funds	3,066,229
Variance	0

Financial Commitments

- The **Mental Health Investment Standard** (MHIS) for ICBs will grow in line with base growth (4.4%), with adjustments made to recognise the transfer of mental health SDF funding.
- The NHS minimum contribution to the **Better Care Fund** (BCF) will increase by 1.7%, with the full amount of the equivalent value reflected in the minimum contribution to adult social care (3.9%).

- Flexibilities will be introduced to the **dental services ringfence** where ICBs (i) deliver additional urgent care in line with the Government's manifesto commitment, and (ii) improve dental access more broadly (further details to be set out in additional guidance to ICBs).

Productivity and Efficiency

- Given the challenging financial and operational context, the approach to planning needs to be different and with a key focus on ensuring productivity and efficiency opportunities are fully reflected in plans.
- To support this, packs have been shared with NHS organisations describing quantified opportunities for improving productivity. These are a guide to help set the scale and priority of opportunities, which should be assessed alongside local insight, data and delivery capacity.
- The opportunities assessed cover:

Acute clinical & operational productivity	Efficiency (all providers where relevant)	Efficiency (system level)
• Non-elective admissions	• Temporary staffing	• All age continuing healthcare
• A&E and SDEC	• Secondary care medicines	• Primary care prescribing
• Elective admissions	• Corporate services	
• Outpatients	• Commercial spend	
• Other acute activity		

- These packs are not a comprehensive list of productivity and efficiency opportunities. Further opportunities will need to be considered, alongside testing what could be maximised in plans for 2025/26.

Capital

Table 6: NHS Somerset's capital plan for 2025/26:

NHS Somerset Capital Plan Summary		2025/26 £'000
	Provider Capital Envelope Funding	36,376
	Stroke CDEL Transfer to Dorset	(1,844)
	Additional Expected Allocation Fair Shares	8,143
		42,675
	5% over programming	2,134
	Total Envelope Available to ICS	44,809
	Capital Expenditure Schemes	Total
Internal	Backlog Maintenance	6,649
	essential facilities improvement works	1,885
	Infrastructure	352
	Replacement Medical Equipment	4,874
	Rolling IT Programme	3,732
	DIGITAL	3,504
	Service redesign enabling works	17,635
	SHS	180
	SSL	80
	Sundry Equipment	250
ROU	Lease Building Additions	2,010
	Leased Equipment additions	300
	Leased Vehicle Additions	252
	Lease remeasurements	3,106
		44,809
MES	MES	375
Donated	Donated Assets	1,412
PDC	TIF Elective Recovery PDC	3,000
	Biddable monies	53,507
	DIGITAL EHR	17,422
	Total ICS Planned Capital Expenditure	120,526

Does not include the capital incentive for delivering a breakeven plan position 25/26.

Table 7 summaries the national programme indicative allocations to NHS Somerset for 2025/26:

National Programme - NHS Somerset	System Indicative Allocation (£'000)
Return to Constitutional Standards	43,500
Diagnostics Schemes	500
Electives Schemes	28,000
UEC Schemes	15,000
Estates Safety	7,797
Mental Health - Reducing Out of Area Placements	1,189
Primary Care Utilisation Fund	1,021
TOTAL	53,507

The system is proposing to submit a break-even financial plan, as per national expectations.

System Efficiency Savings Programme 2025/26

The system efficiency programme within the proposed full financial plan submission is expected to deliver £91.9m of savings, 6.2% of the total NHS Somerset ICB allocation:

Table 10: System efficiency savings programme 2025/26

25/26 Savings Programme	Total £'000	Recurrent £'000	Non Recurrent £'000
ICB - 4%			
Acute - Out of County	(4,051)	(4,051)	
Prescribing	(4,008)	(3,006)	(1,002)
Continuing Care	(2,330)	(2,330)	
Primary / Community / Other Services	(3,721)	(3,528)	(193)
Running Costs	(796)	(796)	
Unidentified	(835)		(835)
Total ICB 4%	(15,741)	(13,711)	(2,030)
		87.1%	12.9%
SFT - 4%			
Community services reconfiguration	(5,000)		
Outpatient pharmacy / medicines mgmt	(2,100)		
Agency - reduction in premium	(5,700)		
Corporate services (exc merger benefits)	(6,000)		
Estates efficiencies	(2,600)		
Acute bed review	(1,920)		
Productive care - Medical specialties	(2,605)		
Productive Care - Clinical support services	(2,000)		
Productive care - Mental Health	(1,800)		
Productive care - Families	(1,500)		
Productive care - Surgical	(2,500)		
Non pay efficiencies	(1,500)		
Private patient income growth	(300)		
Unidentified	(11,425)		
Total SFT 4%	(46,950)	(30,518)	(16,433)
		65.0%	35.0%
Other Savings			
Other ICB Savings	(861)	(361)	(500)
ERF Benefit	(9,000)	(9,000)	
Other ICB Budget Flexibility	(5,000)		(5,000)
SFT Merger Savings	(1,296)	(842)	(454)
SHS	(1,601)	(1,601)	
Bed Escalation Capacity	(1,200)		(1,200)
In-year Allocations	(1,500)		(1,500)
N/R Benefits			
24/25 ERF	(4,000)		(4,000)
24/25 Additional Revenue Bonus	(4,400)		(4,400)
24/25 SFT Spec Comm	(240)		(240)
24/25 ICB Hub	(100)		(100)
Total Savings Programme	(91,889)	(56,033)	(35,856)
%		61.0%	39.0%

% of ICB Allocation	6.2%

System exit underlying position 2025/26

The system continues to assess its underlying deficit financial position, and its initial assessment of the exit 25/26 underlying position is £42.8m, which if delivered, has improved from the opening 25/26 ULP of £73.5m:

Table 11: System exit underlying position 2025/26

Underlying Position Exit 25/26	NHS Somerset £'000
Final Plan Position	**-**
N/R Allocation	
National Financial Framework - Achieving 24/25 Plan	8,143
N/R Pay - Other Income Support	856
N/R Cost Pressures/Investments	
IT Extension	(3,600)
Reinstate Contingency	2,052
N/R CIP/Benefits	
N/R 4% QIPP / CIP 35%	18,463
Other N/R QIPP / CIP	8,200
Other N/R Benefits	8,740
Exit 25/26 Underlying Position	**42,854**

System Risk and Mitigations

Table 12 below details the systems initial assessment of risks and mitigations it will need to manage to deliver the 2025/26 plan:

Table 12: System Risk and Mitigations

Risks and Mitigations 2025/26	NHS Somerset £'000	Comments	ICB £'000	SFT £'000
Risks				
Elective Care Programme	(6,000)		(3,000)	(3,000)
Prescribing	(3,000)		(3,000)	
Continuing Healthcare	(1,500)		(1,500)	
Winter	(2,000)		(400)	(1,600)
System Cost Improvement Programme	(13,262)	ICB High Risk & SFT Unidentified	(1,837)	(11,425)
Flexibility in Ringfenced Budgets	(5,000)		(5,000)	
Safety Investments	(500)	Mitigated in Contingency below		(500)
Total Risks	(31,262)		(14,737)	(16,525)
Mitigations				
Contingency - Safety Investments / Winter UTCs	1,300	Remainder of uncommitted Contingency released	0	1,300
N/R Investment Reserve	0	No N/R Investment Reserve in plan	0	0
Total Mitigations	1,300		0	1,300
Net Risk Position	(29,962)		(14,737)	(15,225)

Performance

The system is proposing to submit a plan to deliver all key performance with the exception of RTT 52-week wait compliance. The urgent and emergency care plans are predicated on delivery of a reduction in the number of patients in hospital with No Criteria to Reside and the elective plans predicated on delivery of the identified productivity improvements and closing the elective activity funding gap. Somerset ICB is aiming to agree a region-wide approach and working closely with other Systems to agree a set of principles to underpin elective modelling. The aim is fairly distributing elective funding and in turn equalise waiting times across our population.

Included in Appendix B is a summary of the key performance indicators included within the Operational Activity and Performance Plan.

Workforce

Table 8 details the Somerset Foundation Trust workforce plan, which shows:

- 0.5% decrease in total workforce, from 12,614 WTE (M10 2024/25 position) to 12,555 WTE (planned M12 2025/26 position).
- 2.64% increase in substantive staffing, from 11,872 WTE (M10 2024/25 position) to 11,948 WTE (planned M12 2025/26 position).
- 10.42% reduction in in Bank staffing, from 554.44 WTE (M10 2024/25 position) to 496.69 WTE (planned M12 2025/26 position).
- 41.49% reduction in Agency Staffing, from 188.45 WTE (M10 2024/25 position) to 110.26 WTE (planned M12 2025/26 position).
- Growth in clinical, non-medical staff groups (e.g. Nursing, Allied Health Professionals, Health Care Assistants)
- Growth in clinical, medical staff groups (e.g. Consultants, Speciality and Associate Specialist Doctors, Resident Doctors)
- Decrease in non-clinical staff groups

Table 8: Somerset Foundation Trust workforce plan

	Month 10	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
	WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Phased WTE	Bank & Agency Reduction
Total Non Medical - Clinical Substantive Staff	7,580.50	7,741.72	7,759.16	7,795.08	7,801.03	7,776.70	7,927.40	7,904.26	7,922.98	7,931.56	7,922.86	7,946.48	7,875.18	
Total Non Medical - Non-Clinical Substantive Staff	3,153.49	3,049.00	3,028.42	3,002.22	2,986.14	3,044.30	2,913.62	2,894.96	2,886.50	2,894.39	2,872.67	2,831.58	2,879.06	
Total Medical and Dental Substantive Staff	1,127.30	1,166.58	1,167.01	1,171.00	1,168.77	1,140.90	1,149.27	1,163.22	1,163.60	1,164.61	1,168.65	1,170.29	1,175.97	
Total WTE Substantive Staff	11,871.94	11,975.19	11,972.48	11,986.17	11,973.81	11,979.78	12,008.17	11,980.33	11,990.96	12,008.44	11,982.06	11,966.23	11,948.09	
Bank Staff	554.44	503.71	501.77	485.93	496.21	514.74	476.84	512.33	496.69	468.75	496.69	496.21	496.69	-10.42%
Agency Staff (including, agency and contract)	188.45	139.78	138.99	135.70	135.07	133.26	133.26	118.43	117.37	114.24	110.26	110.26	110.26	-41.49%
Total WTE all Staff	12,614.83	12,618.67	12,613.24	12,607.81	12,605.09	12,627.78	12,618.27	12,611.09	12,605.02	12,591.43	12,589.01	12,572.70	12,555.04	

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

- 1.5% increase in Total Workforce from current position (M10 24/25) to April 2026, including 3.0% GPs and 6.5% Practice Nursing growth.
- Flat trajectory for Administrative and Non-Clinical roles

Table 9: Primary Care workforce plan

	Baseline	Plan	Plan	Plan	Plan	Change from March 2025 to March 2026	
	Staff in post outturn	Q1	Q2	Q3	Year Ending		
	Year End	As at the end of	As at the end of	As at the end of	As at the end of		
	31/03/2025	30/06/2025	30/09/2025	31/12/2025	31/03/2026		
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	WTE	%
Total Workforce	2191.31	2193.35	2200.10	2213.10	2223.10	31.79	1.5%
Total GPs	404.20	405.50	410.50	413.50	416.50	12.30	3.0%
Total Nurses	238.25	239.05	240.65	249.65	253.65	15.40	6.5%
Total ARRS Funded Roles	336.76	336.70	336.85	337.85	340.85	4.09	1.2%
Total Direct Patient Care roles	251.90	251.90	251.90	251.90	251.90	0.00	0.0%
Total Administrative and Non-Clinical Staff	960.20	960.20	960.20	960.20	960.20	0.00	0.0%

Symphony Healthcare Services staff may need to be incorporated into SFT final plan (historically excluded, due to subsidiary status), we are still seeking final clarity, so may be adjusted from Primary Care figures.

Recommendations and next steps

The Integrated Care Board is asked to approve the NHS Somerset Integrated Care System operational planning submission for the 2025/26 financial year.

Following Integrated Care Board approval budget holders will be asked to sign off budget books.

Board Assurance Statement

Integrated Care Boards (ICBs) are asked to respond to the statements at Section A, ensure that the completed document is signed off by both by ICB Accountable Officer and Chair. Additionally, there is also a series of statements that ICBs should share with their providers, which will assist in assuring ICBs in terms of the process for provider Trusts.

The purpose of the Board Assurance Statements are to provide assurance that all considerations around finance, workforce, activity have been addressed whilst ensuring that the ambitions for 2025/26 can be met and that quality of patient care is prioritised.

A copy of the NHS Somerset Board Assurance Statement is included in Appendix A.

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 £3,066,229,000 for the 2025/26 financial year as at the time of the planning submission, which includes as the Principal Commissioner, £1,580,830,000 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.

Board Assurance Statement **Appendix A**

Integrated Care Boards (ICBs) are asked to respond to the statements at Section A, ensure that the completed document is signed-off by both by ICB Accountable Officer and Chair. Additionally, there is also a series of statements that ICBs should share with their providers, which will assist in assuring ICBs in terms of the process for provider Trusts.

The purpose of the Board Assurance Statements are to provide assurance that all considerations around finance, workforce, activity have been addressed whilst ensuring that the ambitions for 2025/26 can be met and that quality of patient care is prioritised.

The information provided will be used by regional and national teams to inform assurance conversations.

Section A: ICB Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the plans for 2025/26 that form the basis of the system's (ICB and partner trusts) submissions to NHS England. This included review of the partner trusts Board Assurance returns.	Yes	
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	
A robust quality and equality impact assessment (QEIA) informed development of the ICB's and wider system's plans and these have been reviewed by the Board.	tbc	QEIAs will be carried out as detailed efficiency plans are completed.
Plan content and delivery		
The Board is assured that the system's plans address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	

The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered across the system and are reflected in the plans of each system partner organisation.	Yes	
The Board is assured that any key risks to quality linked to the system's plan have been identified and appropriate mitigations are in place.	Yes	The 3 key risks are i) elective recovery, delivering the programme within the funding available, ii) the system contingency is partly committed to known issues, meaning in year pressures will need to be managed within current envelopes, and iii) the system does not have a transformation fund, therefore any funding needed to pump prime change would need to be found through additional efficiencies.
The Board is assured of the deliverability of the system's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes	

ICB CEO/AO name	Date	ICB Chair name	Date
Jonathan Higman	27/03/2025	Paul Von Der Heyde	27/03/2025

Section B: Provider Assurance **(will be completed after Trust Board)**

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.		
The Board has reviewed its quality and finance governance arrangements, and put		

in place a clinically led process to support prioritisation decisions.		
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.		
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.		
The organisation's plan was developed with appropriate input from and engagement with system partners.		

Assurance statement	**Confirmed (Yes / No)**	**Additional comments or qualifications (optional)**
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.		
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.		
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.		
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.		

Section C: Plan Overview

It is expected that ICBs will get board approval for their plans. The document that is signed off by the board should be submitted as part of the full submission to NHS England. There is no set template for this document, but it is expected that it will cover the following areas:

- A high-level summary of what has been submitted as part of the finance, workforce and performance submission; ***(purpose of paper to give ICB Board assurance of this)***
- An overview of transformation and major savings opportunities; ***(Outlined in System Efficiency Savings Programme 2025/26 section)***
- An overview of the system's plans to improve the quality of services including experience and outcomes (this should include an overview of how the system has used data to develop these plans); ***(System quality group established to oversee quality of services in Somerset)***
- An explanation of the approach to reducing health inequalities, including how this will be monitored throughout the year; ***(Further work to take place once approach to Elective Service redesign is clearer)***
- Key decisions that have been made as part of the planning, including prioritisation and EQIAs that have been completed in relation to these decisions; ***(Further work to be undertaken once detailed programmes emerge),*** and
- Risks to delivery of the plan and mitigations. ***(Outlined in Risk and Mitigations section)***

Appendix B

Summary of the key performance indicators included within the Operational Activity and Performance Plan

Domain	Operational Planning Metric	Target (If Known)	Latest Position (Provider)		Latest Position (Commissioner)		By Mar-26 (& In-Year Milestone, If Applicable)		Compliance (Current View)
							Provider	Commissioner	
Outpatients	EM42 - RTT Time to first Appointment	>=72% in March 2026 nationally Provider minimum 5% improvement	73.8%	02-Mar-25	72.5%	02-Mar-25	80.3%	78.4%	Compliant
Elective Care	EM20 - New RTT pathways (clock starts)	No Target	115,596	YTD Jan-25	-	-	177,638	-	No Target
	EB3A - RTT waiting list (all age)	Reduction in Waiting List	59,061	Jan-25	69,360	Jan-25	53,426	65,500	Compliant Plan
	EB39 - RTT waiting list (children, <18 years)	Reduction in Waiting List	4589	09-Mar-25	5168	02-Mar-25	4,060	4,715	Compliant Plan
	EB40 - RTT % of waiting list >52 weeks	<1% of total waiting list by March 2026	2.4%	Jan-25	2.1%	Jan-25	1.5%	1.5%	Non Compliant Plan
	EB24 - RTT % of children waiting >52 weeks	<1% of total waiting list by March 2026	2.9%	09-Mar-25	2.6%	02-Mar-25	1.9%	1.9%	Non Compliant Plan
	EB40 - RTT % of waiting list <18 weeks	65% - nationally Provider minimum 5% improvement	61.75%	Jan-25	62.54%	Jan-25	67.3%	67.9%	Compliant Plan
	EB41 - RTT % of children (<18 years) waiting <18 weeks	No Target	58.8%	09-Mar-25	59.3%	02-Mar-25	65.5%	64.2%	Compliant Plan
Cancer	EB27 - Faster Diagnosis - % of people waiting <28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	Improve to 80% by March 2026	75.77%	Dec-24	75.51%	Dec-24	80.6%	80.8%	Compliant Plan
	EB35 - 62 Day Combined Standard - % of patients receiving a first definitive treatment for cancer within 62 days	Improve to 75% by March 2026	71.00%	Dec-24	71.43%	Dec-24	75.1%	75.1%	Compliant Plan
	EB38 - 31 Day Standard - % of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat / earliest clinically appropriate date	No Target	93.68%	Dec-24	92.19%	Dec-24	91.3%	92.9%	No Target
	EB34 - % of Lower GI Suspected Cancer referrals with an accompanying FIT result	No Target	-	-	79.36%	Dec-24	-	80%	Compliant Plan
Diagnostics	EB26 - Diagnostic test activity	Increase	182,983	YTD Jan-25	214,413	YTD Jan-25	279,492	312,087	No Target
	EB28 - Diagnostic 6-week waits	No Target	-	-	71.82%	Jan-25	-	93.18%	No Target

Domain	Operational Planning Metric	Target (If Known)	Latest Position (Provider)		Latest Position (Commissioner)		By Mar-26 (& In-Year Milestone, If Applicable)		Compliance (Current View)
							Provider	Commissioner	
Non- Elective Activity	EM11 - Total Non-Elective Admissions - zero LOS	No Target		YTD Jan-25	-	-	1% Growth	-	No Target
	EM11 - Total Non-Elective Admissions - >1 Day LOS	No Target		YTD Jan-25	-	-	1.5% Growth	-	No Target
	EM11 - Total Non-Elective Admissions - >7 Day LOS	No Target		YTD Jan-25	-	-	1% Growth	-	No Target
	EM11 - Total Non-Elective Admissions - >1 LOS (>65 Yrs)	No Target	-	-		YTD Jan-25	-	1% Growth	No Target
	EM15 - Same day Emergency Care	No Target		YTD Jan-25	-	-	2.4% Growth	-	No Target
Urgent & Emergency Care	EM42 - Average handover time	To Deliver: <=45 minutes Amb Response Time	43.4	Feb-25	-	-	29.5	-	Under Review by SWAST
	EM13 - A&E 4-hour performance (All Types - Type 1 & Type 3)	78%	72.8%	Feb-25	-	-	78.2%	-	Compliant Plan
	EM13d - Percentage of attendances in A&E over 12 hours	<2% of A&E Attendances	7.5%	Feb-25	-	-	2.0%	-	Compliant Plan
Beds	EM30 - G&A Adult & Paediatric Bed Occupancy	No Target (Local, 92%, 95% of Time)	95.2%	Feb-25	-	-	93%	-	No Target
	EM30 - G&A Adult & Paediatric Beds (Core & Planned Escalation)	No Target	998	Feb-25	-	-	966	-	No Target
	ET5 - Virtual Ward occupancy	80.0%	-	-	50.3%	Feb-25	-	80.0%	Compliant Plan
Discharges	EB43 (NEW) - Non elective LOS - Acute	Reduction	7.7	YTD Jan-25	-	-	7.1	-	Compliant
	EB44 (NEW) - Combined elective / non-elective LOS - (community)	No Target	-	-	TBC	TBC	-	TBC	No Target
	EB45 (NEW) - Percentage of patients discharged on discharge ready date	86.6% (National Average)	81.0%	Jan-25	80.6%	Jan-25	86.6%	86.6%	No Target
	EB46 (NEW) - Average delay (exclude zero delay)	6.1 (National Average)	7.5	Jan-25	8.0	Jan-25	6.1	6.1	No Target

Domain	Operational Planning Metric	Target (If Known)	Latest Position (Provider)		Latest Position (Commissioner)		By Mar-26 (& In-Year Milestone, If Applicable)		Compliance (Current View)
							Provider	Commissioner	
Mental Health	EA4 - NHS Talking Therapies for anxiety & depression - number of adults and older adults receiving a course of treatment and those achieving reliable recovery	50%	-	-	50%	Dec-24	-	50%	Compliant Plan
	EA4 - NHS Talking Therapies for anxiety & depression - number of adults and older adults receiving a course of treatment and those achieving reliable improvement	68%	-	-	68%	Dec-24	-	68%	Compliant Plan
	EA5 - Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Zero by Mar-27	0	Sep-24	0	Sep-24	1	1	No Target
	EH15 - Women accessing specialist community perinatal health services	10% of 2016 Birth Rate	-	-	660	Dec-24	-	640	Compliant Plan
	EH9 - Access to Children and Young People's Mental Health Services	National: +345k CYP by 2026 Somerset: +7473	-	-	7570	Nov-24	-	7,768 Mar-26	Compliant Plan
	EH35 - Number of people accessing Individual Placement & Support	528 (NHS Set Target)	-	-	578	Dec-24	-	528	Compliant Plan
	EH37 - Average Length of Stay for adult acute beds	Reducing average LOS (Reduction from baseline)	64.7 Days	Nov-24	-	-	60.3 Days	67.0 Days	Compliant Plan
Learning Disability & Autism	EH32 (New) EK1c - Reliance on mental health inpatient care for people with a learning disability	Minimum of 10% reduction	-	-	7	Dec-24	-	8	Compliant Plan
	EH33 (New) EK1c - Reliance on mental health inpatient care for autistic adults	Minimum of 10% reduction	-	-	7	Dec-24	-	5	Compliant Plan
	EK1 - Children <18 Years who are autistic or have a learning disability (or both) and are in in-patient care	Minimum	-	-	0	Q2 2024/25	-	1	No Target
	EK3 - Learning disability registers and annual health checks delivered by GPs	75%	-	-	On track for 75%	Q3 2024/25	-	75.0%	Compliant Plan

Domain	Operational Planning Metric	Target (If Known)	Latest Position (Provider)		Latest Position (Commissioner)		By Mar-26 (& In-Year Milestone, If Applicable)		Compliance (Current View)
							Provider	Commissioner	
Primary care	ED19 - Appointments in General Practice	No Target	-	-	3,106,868	YTD Jan-25	-	3,741,647	No Target
	ED22 - % of resident population seen by an NHS dentist - adults	No Target	-	-	29%	Q2 2024/25	-	30%	No Target
	ED23 - % of resident population seen by an NHS dentist - children	No Target	-	-	47.0%	Q2 2024/25	-	47%	No Target
	ED24 - Units of dental activity delivered	No Target	-	-	45.7%	YTD Jan-25	-	50%	No Target
	ED26 - (New) - Count of Pharmacy First consultations	No Target	-	-	33,416	YTD Nov-24	-	65,856	No Target
Community	ET8 - Urgent Community Response (UCR) referrals	180.0 per 100,000 pop by Mar-26	-	-	176.2	Jan-25	-	180.1	Compliant Plan
	ET9 - Community services waiting list - over 52 weeks	No Target	-	-	8	Feb-25	-	0	No Target
	ET10 - Attended Community Care contacts	No Target	-	-	-	-	-	856,769 (0.1% Growth)	No Target