

# In-Common BSW, Dorset and Somerset Board meeting

Mon 11 May 2026, 09:30 - 11:30

Virtual via Teams



## Agenda

09:30 - 09:50  
20 min

### 1. Formalities

#### 1.1. Welcome, apologies and quorum

Verbal Chair

#### 1.2. Declarations of Interest

Verbal Chair

#### 1.3. Minutes

Enclosures for approval Chair

(a) Minutes of public BSW Board held on 18 March 2026 (for approval by BSW Board)

(b) Minutes of Part 1 Dorset Board held on 12 March 2026 (for approval by Dorset Board)

(c) Minutes of Part A Somerset Board held on 26 March 2026 (for approval by Somerset Board)

📎 01.3 NHS BSW ICB Board Minutes Meeting in Public Draft 180326.pdf (9 pages)

📎 01.3 NHS Dorset ICB Board draft minutes Part 1 120326 V1LB.pdf (7 pages)

📎 01.3 NHS Somerset ICB Board Part A draft minutes of meeting 26 March 2026 V1.pdf (14 pages)

#### 1.4. Action Logs

Enclosures for approval Chair

(a) Action log from public BSW Board held on 18 March 2026 (for approval by BSW Board)

(b) Action log from Part 1 Dorset Board held on 12 March 2026 (for approval by Dorset Board)

(c) Action log from Part A Somerset Board held on 26 March 2026 (for approval by Somerset Board)

📎 01.4 NHS BSW ICB Board 25-26 Public Action Tracker 280426.pdf (1 pages)

📎 01.4 NHS Dorset ICB Board Part One Action Log for 120326.pdf (1 pages)

📎 01.4 NHS Somerset ICB Board Part A Decision and Action Log 260326.pdf (1 pages)

## Standing Items

09:50 - 10:00  
10 min

### 2. Cluster Chair's Update

Verbal Chair

10:00 - 10:20  
20 min

### 3. Cluster Chief Executive Officer's Update

Enclosure for noting Jonathan Higman, ICB Cluster Chief Executive Officer

📎 03 Cluster Chief Executive Officer Board Report 110526.pdf (24 pages)

## Items for Decision

10:06/05/2026 15:44:22  
Teresa Louise

**10:20 - 11:10 4. Governance Arrangements**

50 min

*Enclosure for approval*

*Alison Henly, Chief Officer Strategic Finance and Resources*

(a) Scheme of Reservation and Delegation (SoRD)

(b) Standing Financial Instructions (SFIs)


(c) Cluster Committees - Terms of Reference


(d) Functions and decisions map


(e) Appointment of Deputy Chair

 04 Cluster Governance Arrangements 110526.pdf (5 pages)

 04 x Appendix 1 DRAFT Scheme of Reservations and Delegations 110526.pdf (10 pages)

 04 x Appendix 2 DRAFT Standing Financial Instructions 110526.pdf (26 pages)

 04 x Appendix 3a DRAFT Cluster Board ToR v0.1 110526.pdf (9 pages)

 04 x Appendix 3b DRAFT Audit Committee ToR v0.1 110526.pdf (13 pages)

 04 x Appendix 3c DRAFT Joint Finance and Resource Committee ToR v0.1 110526.pdf (9 pages)

 04 x Appendix 3d DRAFT Joint Quality and Population Engagement Committee ToR v0.1 110526.pdf (9 pages)

 04 x Appendix 3e DRAFT Joint Population Health and Commissioning Committee ToR v0.1 110526.pdf (9 pages)

 04 x Appendix 4 Functions and decisions map 110526.pdf (1 pages)

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

**Closing Items**

**11:10 - 11:15 5. Any Other Business**

5 min

*Verbal*

*Chair*

**11:15 - 11:20 6. Key Messages and Review of Part 1 meeting**

5 min

*Verbal*

*Chair*

**11:20 - 11:20 7. Date and Time of next meeting**

0 min

*Verbal*

*Chair*

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

Trent, Louise  
06/05/2026 15:44:22

# **DRAFT** Minutes of the BSW Integrated Care Board - Board Meeting in Public

Wednesday 18 March 2026, 10:30hrs  
Virtual Meeting – via MS Teams Town Hall

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## **Members present:**

Cluster Chair, Rob Whiteman  
Cluster Chief Executive, Jonathan Higman  
Primary Care Partner Member, Dr Francis Campbell  
NHS Trusts & Foundation Trusts Partner Member Acute Sector, Cara Charles-Barks (*absent 11:30-12:30hrs*)  
Non-Executive Director (NED) for Audit and Governance, Dr Claire Feehily  
Non-Executive Director for Finance, Paul Fox  
Non-Executive Director for Public and Community Engagement / Deputy Chair, Julian Kirby  
Cluster Chief Officer Strategic Finance and Resources, Alison Henly  
Deputy - Local Authority Partner Member – Wiltshire, Emma Legg (*until 11:45hrs*)  
Cluster Chief Medical Officer, Bernie Marden  
Cluster Chief Nursing Officer, Shelagh Meldrum  
Local Authority Partner Member – Swindon, Sam Mowbray  
Non-Executive Director for Remuneration and People, Suzannah Power  
Cluster Chief Officer for Population Health Improvement, Dr Amanda Webb  
Non-Executive Director for Quality, Ade Williams

## **Regular Attendees:**

ICB Chief Delivery Officer, Rachael Backler (RB)  
CEO, BaNES Council, Sophie Broadfield  
ICB Chief of Staff, Richard Collinge (RCo)  
ICB Chief Finance Officer, Gary Heneage (GH)  
Cluster Place Director, Wiltshire, Caroline Holmes  
ICB Chief Nurse, Gill May (GM)  
Deputy CEO, AWP, Matthew Page (MP)  
ICB Associate Director of Governance, Compliance and Risk  
ICB Corporate Secretary

## **Attendees:**

BSW ICB Head of Digital Transformation – for item 10b

## **Apologies:**

Local Authority Partner Member – Wiltshire, Lucy Townsend (LT)  
Cluster Chief Officer for Commissioning and Place, David Freeman (DavF)  
Cluster Place Director, Swindon, Gordon Muvuti (GMu)  
NHSE South West Managing Director (System Commissioning Development), Rachel Pearce (RP)  
Cluster Place Director, Somerset, David McClay (DMcC)  
Cluster Place Director, BaNES, Lucy Baker (LB)

## **1. Welcome and Apologies**

- 1.1 The Chair welcomed members, officers and observing members of the public to the meeting of the BaNES, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) held in public. A

special welcome was given to Cluster Executives, who joined this meeting now as voting members of the BSW ICB Board, and to the Cluster Place Directors who joined as attendees and non-voters.

1.2 The above apologies were noted. The meeting was declared quorate.

## **2. Declarations of Interest**

2.1 The ICB holds a register of interests for all staff and Board members. None of the interests registered were deemed to be relevant for the meeting business. There were no other interests declared regarding items on the meeting agenda.

## **3. Minutes from the ICB Board Meeting held in Public on 22 January 2026**

3.1 The minutes of the meeting held on 22 January 2026 were approved as an accurate record of the meeting.

## **4. Action Tracker and Matters Arising**

4.1 There were no actions recorded upon the tracker. There were no matters arising not covered by the agenda.

## **5. Questions from the Public**

5.1 A number of questions had been raised in advance of the meeting concerning myalgic encephalomyelitis (commonly known as ME) services in BSW, and GP services in Wichelstowe.

5.2 The ICB Chief Nurse and Cluster Place Director for Wiltshire read out the questions raised and the ICB's response. The full record of the questions and responses would be made available upon the ICBs website following the meeting.

## **6. BSW ICB Chair's Report**

6.1 The Chair welcomed Sophie Broadfield, the CEO of BaNES Council, to her first Board business meeting as a participant. The Board were also advised of the resignation of Pam Webb as the VCSE Partner Member of the Board. The Board composition item was later on the agenda, though the Cluster CEO advised that place roles were also being considered in support of the move into cluster arrangements and then into merger, to ensure a strong engagement and involvement of the voluntary sector within each of the six places. Voluntary sector partner input into health and care discussions was valued, bringing a wealth of local knowledge and that different perspective.

6.2 The Chair acknowledged that this was the last Board meeting for Rachael Backler, Gary Heneage, and Gill May, noting his thanks for their commitment and service to the ICB and local population. On behalf of the Board, the Deputy Chair wished to commend the departing Executives for their assertion, assurance, personal response, and impressive people working. Best wishes were offered for their next chapters and challenges ahead.

6.3 The Chair advised that discussions continued with regards the deciphering of cluster and place arrangements, to bring clarity on accountability and delegations. Thanks were recorded to colleagues and members for the support during this move to the new cluster

arrangements, noting the cluster was learning and developing as it proceeded against the available guidance and requirements.

- 6.4 The Chair referred to the current operating context and events in Iran, and the impact this was having on inflation and interest rates, and the cost of living. The financial envelope for the NHS remained as was for 2026-27, the Chancellor had advised that any potential medium-term headroom would be prioritised elsewhere. The role of the ICB was to change, using commissioning to transform care, moving to left shift and a greater prevention focus, using digital as an enabler where possible. The NHS 10 Year Plan was being embedded, bringing that focus to make available resources work.

## 7. Cluster Chief Executive's Report

- 7.1 The Board **received and noted** the Cluster CEO's report as included in the meeting pack.
- 7.2 The Cluster CEO provided a contemporary update, raising the following:
- A session was held on 17 March 2026 between ICB CEO's and the national team, primarily to discuss the neighbourhood health guidance and system archetypes, and how national, regional and ICB colleagues will work together. The session had further set the context of the strategic role of ICBs and the ambition to enable ICBs to shift from that short-term management to a longer-term NHS plan management, developing that strategic commissioner capability, outcomes approach, neighbourhood health, and interaction of ICBs and providers through Integrated Health Care Organisations. The strategic commissioning development programme was to go live June to September.
  - The alignment of strategy to each Health and Wellbeing Board was fundamental, recognising the importance of the place roles and direction. The legislation was to form later in the year regarding statutory accountability of connections between the NHS and Health and Wellbeing Boards.
  - The CEO report presented a positive message on dental services across BSW following the recent focus on urgent dental access. The focus was to now shift to routine access of dental care with a broader target, developing a sustainable dental network.
  - The Special Educational Needs and Disabilities (SEND) reform referenced in the Government's School White Paper would bring a focus on improving SEND services, to be led by the local authorities, with the NHS to play its part through the local area partnership boards. The Cluster Place Director for BaNES, Lucy Baker, was leading on this on behalf of the cluster, with six place plans to be developed and shared through local authority and ICB governance in due course.
  - NHS England was to transfer direct commissioning functions to ICBs from April 2027 (pending parliamentary approval), which would include vaccination and screening, and health and justice commissioning. Commissioning Hub based arrangements would be developed at regional level to create 'pan regional services'. Those currently delegated services were hosted by Somerset ICB, with this to be enhanced to include these additional delegations.
  - Gratitude to Gill May, Rachael Backler and Gary Heneage were echoed, thanking them for their professionalism during the Executive consultation and restructure phase of the ICB transition. They continued to guide the system through the planning round, leaving a legacy for the cluster to now take forward and deliver.
  - A national advert had been published for the Cluster Place Director for Bournemouth, Christchurch, and Poole (BCP) role that remained vacant. Becky Whale had been appointed as the interim Place Director for BCP whilst recruitment to the substantive position was underway.

- The wider staff change programme and consultation had been launched earlier that morning.
- 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 asked each ICB to provide an assurance statement. Submission of the statement had been 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.

To reflect the current position of the cluster, point (c) from NHS England's suggested wording of "have fully assessed" amended to "are in the process of assessing".

### 7.3 The Board discussion noted:

- Local authority colleagues recognised that there was a cohort of children and young people that deserved improved and joined up services, with the SEND reform, and the Governments' engagement and the wiping of the deficit on the dedicated schools grant at 90% welcomed. However, the challenge to honour those required responsibilities at pace was acknowledged. SEND local reform plans for each place were being developed with ICB colleagues, to submit within the next six weeks.
- The development of strategic commissioning capabilities and responsibilities was a significant task, with the use of incentives and new funding flows to developed alongside supporting guidance. The ICBs would continue to work alongside partners at a place and cluster level to address health issues and those wider determinants across our populations.

7.4 The Board ratified the decision of the Chair and CEO to submit the Board Assurance Statement to NHS England as referenced in the report.

## 8. Cluster Governance

### 8a. ICB Boards and Cluster Board Composition, and Cluster Governance Structure

8.1 The proposals for the composition for each ICB Board and the Cluster Board were shared in the supporting paper, noting this would be in place for the transition period until the ICBs formally merge, expected for April 2027. The three ICB's would operate as one under the cluster arrangements, whilst remaining individual legal entities. Legal advice had been sought to ensure delegation from the ICB Board to the Cluster Board were taken as far as possible, whilst remaining compliant, to aid this transition phase. The Cluster Chair was

cognisant that the three ICB Boards would need to meet to consider those items that could not be delegated, such as approval of an ICB's organisational budget or approval of Annual Report and Accounts, though this would be infrequent.

- 8.2 The Joint Transition Committee reviewed and discussed these proposals, recommending these on to each ICB Board for approval.
- 8.3 The Senior Independent Director role would be considered by the Cluster Chair once the non-executive appointments process for the cluster was complete, alongside that of Board Committee Chairs.
- 8.4 The Board **approved** the proposed composition of each ICB Board, and of the Cluster Board, approved the proposed cluster governance model, and agreed that the BSW ICB Constitution be amended to reflect this ahead of submission to NHSE for approval.

#### **8b. Joint Remuneration Committee Terms of Reference**

- 8.5 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 through the in-common Remuneration Committee arrangements, with the Committees recommending these to each Board for approval, noting these would create a supportive and agile accountability framework.
- 8.6 The Board **approved** the new Joint Remuneration Committee Terms of Reference, noting these would come into effect 1 April 2026.

#### **9. BSW ICB Quality and Outcomes Committee**

- 9.1 The draft minutes from the BSW ICB Quality and Outcomes Committee (QOC) meeting held on 3 March 2026 were shared for information. The Non-Executive Director (NED) Quality and Chair of the QOC advised that the Committee had been cognisant of the emerging cluster ambition and changing population health model that would need to form around strategic commissioning and left shift move against the demands and pressures. The Chair was keen to ensure the legacy of the committee and the organisation was not lost in this transition phase and implementation of cluster arrangements, particularly the focus on population health for the BSW geography. The performance metrics captured the legacy of the unique strengths and innovative work in train to pass on to the cluster. The Committee had debated and sought assurance on those reports received on population health, health inequalities and stroke services. The Chair wished to also commend the work of the Executives during this challenging time.

#### **9a BSW Quality Exception Report**

- 9.2 The Board **noted** the BSW Quality Exception Report, which provided a comprehensive overview of key quality, safety, and performance issues across BSW.
- 9.3 The ICB Chief Nurse highlighted the following areas:
  - Assurance was given to the Board that all three BSW maternity providers were to submit complaint plans in support of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. The Chief Nurse had signed these off on behalf of the ICB following review with the BSW Hospital Group CEO.

Each had also achieved >90% compliance with the NHS England Saving Babies' Lives Care Bundle and continued work towards meeting the >95% stretch targets. BSW maternity services remained in a good position.

- In response to the national report on corridor care risks, the three acutes had developed internal plans to mitigate associated risks, minimising the need to use corridors or temporary care areas. Region would maintain oversight of this.
- BSW remained in a good position nationally and regionally with regards its infection prevention and control performance – with BSW featuring in the higher quartile of delivery.

9.4 The Cluster Chair acknowledged the good practice in place across BSW to be shared across the cluster.

#### **9b. BSW Statement on Health Inequalities**

9.5 The Cluster Chief Officer for Population Health Improvement advised that the production of the Statement was an annual statutory requirement that ICBs must use when collecting, analysing, publishing, and acting on information about health inequalities. This was a snippet of the detailed data and reports held and produced by the BSW Intelligence Hub, used to drive the systems approach to reducing health inequalities and its commissioning decisions. The BSW Outcomes Framework previously shared with the Board supported this, embedding that inequalities focus, to identify those areas of unwarranted variation, using ringfenced funds to address inequalities and engage with the population for better access and outcomes.

9.6 Significant work was underway to bring together the operating model with the commissioning intentions, outcomes framework and place level approaches. This direction of travel would ensure commissioning was based on the needs of the population, supported by data at place and neighbourhood level. Baseline steps were being taken to bring together the best from each ICB.

9.7 The Board discussion noted:

- It was fundamental to the strategic commissioning role to utilise these tools and data at the forefront to design services and approaches to meet the needs of our communities.
- Health inequalities would be weaved into neighbourhood plans, using the various data sources of the local authorities and third sector organisations to make this real and tangible at place level to bring in line with the commissioning intentions and to prioritise as part of the place plans.
- Business continuity plans in place during the significant organisational change process would ensure Executives and applicable staff maintained oversight of quality, risks and the quality agenda. The ways of working were to be merged to bring out the best from each organisation. Colleagues were also to actively engage with providers to encourage that sharing of concerns and issues immediately.
- The Audit Committee had discussed and reflected on the need to define the 'managerial grip' risk during this period of complex transition. This was not a risk currently recorded upon the register, and it was one that should be recognised across all three organisations. in this time of heightened risk. The Committee wished to highlight this to the Executive for consideration within the guidance of the Risk Management Framework. The Cluster CEO advised that a similar conversation had taken place at the Transition Programme Board. The transition risk register would continue to be maintained separately

for the time being, recognising it was perhaps too early in the transition phase to bring the three risk registers together as one cluster risk register, though assurance was given that it was an area of work to progress. A report on consolidation of these registers would be brought back to the Transition Programme Board when appropriate.

## **10. BSW ICB Finance and Infrastructure Committee**

- 10.1 The NED for Finance, and Chair of the Finance and Infrastructure Committee (FIC) advised of business covered during the February and March committee meetings. The Committee had requested that the cost improvement plans (CIPs) be fully populated to inform the delivery of the medium term plan (MTP), elements of the acute plans were not yet confirmed. The Committee was aware that acute services and urgent and emergency care (UEC) reviews were planned to inform change and transformation, with timelines to be set. The scale of change needed for the system over the next three years was significant. Thanks were duly noted to Gary Heneage and Rachael Backler for their able support to the Committee and the NEDs, particularly during the planning process and the early stages of the organisational change.
- 10.2 The minutes from the meetings held on 4 February 2026 and 4 March 2026 were shared for information.

### **10a. BSW ICB and NHS ICS Revenue Position**

- 10.3 The Board **noted** the report and the month eight financial position of the system.
- 10.4 The ICB Chief Finance Officer (CFO) provided a further update on the financial position of the ICB and Integrated Care System (ICS) highlighting the following:
- At month 10, all organisations had moved their forecast positions.
  - The most likely forecast for the system was a deficit of £25m. The Group was now presenting a £48m deficit, offset by the ICB's significant upside of £23m.
  - Month 11 reporting was indicating the system was on track against the revised trajectories, though noting this was reliant on a strong elective performance in month 12 from the Group.  
There was no clawback on Elective Recovery Funds, therefore if there was a shortfall from the Group in month 12, the ICB would need to recognise the upside within its own position to land the forecast.
  - There had been a possible risk to quarters one to three of Deficit Support Funding due to the deficit position, though this was considered minimal with clawback no longer expected.
  - The deficit position would require repayment to NHS England, though this was not expected for 2026-27, therefore had not been included within the current MTP submission. If the system was to meet the plan over the next two years, it was understood this deficit would be written off, further accentuating the need to focus on de-risking 2026-27 plans.

### **10b. BSW Digital Strategy**

- 10.5 The ICB Head of Digital Transformation joined the meeting for this item, presenting the BSW Digital Strategy, produced in collaboration with system digital and IT leads in response to the publication of the NHS 10 Year Plan and the strategic ambition of moving from analogue to

digital, addressing local clinical priorities, and population and workforce need. The Strategy confirmed the focus areas for BSW against the five key strategic themes, setting out the roadmap against identified actions and priorities. Capacity, resources and financial pressures had been identified as challenges and risks to delivery and the significant change required, with investments to align to ensure every pound counted. IT and digital were to be seen as enablers to support the workforce in that required culture change and development of new ways of working. This strategy sat alongside the BSW Cyber Strategy as approved by the Board at its November meeting. The cluster would bring together the best practice, strategies, and digital infrastructure of the three organisations to adopt and take forward collectively.

- 10.6 The ICB Finance and Infrastructure Committee endorsed this strategy at its February meeting, recommending it to the Board for approval.
- 10.7 The Board **approved** the BSW Digital Strategy 2026 to 2029, and noted the roadmap, risks, and success measures across the five strategic themes.

## 11. **BSW ICB Commissioning Committee**

- 11.1 The NED for Public and Community Engagement, and Chair of the Commissioning Committee advised that the Committee had considered the future cluster arrangements in relation to commissioning, and the need to still have a space to include partners to engage and contribute to design of services. Though there was more work to do to improve compliance and delivery, colleagues were commended for bringing it all together into a coherent and understandable Plan.
- 11.2 The draft minutes from the meeting held on 10 February 2026 were shared for information.

### 11a **BSW Performance Report**

- 11.3 The ICB Chief Delivery Officer (CDO) presented the latest BSW performance report, acknowledging the forthcoming amendments to the oversight regime as the role of region and the ICB change. Though tiering was to continue, region had already commenced practice of oversight with providers direct.
- 11.4 UEC challenges continued for the system, though there had been a de-escalation of the extreme pressures seen over the winter period. The impact of those challenges continued to be visible in the current data against ambulance handovers and the four hour performance. An improvement against the 28 and 62 day cancer referral targets and diagnostics had been seen, though these remained below plan. AWP had worked through the issues logged against the talking therapies service with ICB and regional colleagues, with good progress now recorded.
- 11.5 The Cluster Chair advised that BSW had received a positive mention in the dispatches of the Dorset ICB Board. The monies held for transformation were seen as a positive step, maximising the value of funds, and an incentive to be bold, with it encouraged to consider this across the Cluster. Efforts were still needed to deliver the collective strategy and required savings.
- 11.6 The Board **noted** the report for assurance purposes.

## **11b. BSW ICB 5 year Strategic Commissioning Plan**

- 11.7 The Board signed off the Plan at its meeting in private in February ahead of submission, it was presented in this meeting in public for the record. The Plan had been further refined since the first draft ahead of the submission, with thanks noted to all colleagues who had contributed and helped bring the document to life.
- 11.8 The Board **noted** the BSW ICB Five Year Strategic Commissioning Plan and endorsed the implementation of the Plan.

## **12. BSW ICB Audit Committee**

- 12.1 The NED Audit and Chair of the Audit Committee advised that the Committee had considered the risk environment in the round across all areas as transition to cluster arrangements progressed. The proposed updates to the committee terms of reference were considered, ensuring these aligned with Dorset and Somerset to enable in-common meetings under the revised governance structures during transition. The external audit was progressing well, despite ICB colleagues being part of the organisation change process and the impact to capacity. A good source of organisation memory would be maintained through internal audit with KPMG to continue as the ICBs internal auditors and counter fraud specialists. Internal audit reports were received against prescribing and the risk management framework, both rated as 'significant assurance with minor improvement opportunities'. The required production and submission schedule of the Annual Report and Accounts 2025-26 were noted, and the review points included for the Audit Committee and the ICB Board.
- 12.2 The NED Audit wished to commend Gary Heneage, Rachael Backler and their teams for the positive position of the ICB during this difficult year.

## **13. Any other business and closing comments**

- 13.1 There being no other business, the Chair closed the meeting at 12.14hrs.

**Next ICB Board meeting in public:** *Cluster arrangements to be confirmed*

Trent Louise  
06/05/2026 15:44:22

**Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset  
Thursday 12 March 2026 at 10.15am  
in Committee Room 1, County Hall, Colliton Park, Dorchester, DT1 1XJ and via MS  
Teams**

<b>Members Present:</b>		
	Rob Whiteman (RW)	Cluster Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	Dawn Dawson (DD)	Deputy Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member (nominated deputy)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Alison Henly (AH)	ICB Interim Chief Finance Officer (and ICB Cluster Chief Officer Strategic Finance and Resources)
	Jonathan Higman (JH)	ICB Cluster Chief Executive Officer
	Karl Hoods (KH)	ICB Non-Executive Member
	Bernie Marden (BM)	ICB Cluster Chief Medical Officer
	Shelagh Meldrum (SM)	ICB Cluster Chief Nursing Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW) (virtual)	GP Alliance Chair, Primary Care Partner Member
	Adrian White (AW)	ICB Non-Executive Member
	Dan Worsley (DW)	ICB Non-Executive Member
<b>Invited Participants Present:</b>		
	Laura Ambler (LA)	Corporate Director for Wellbeing, BCP Council
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Paula Bennetts (PB) (virtual)	Programme Director, Dorset VCSA
	Sam Crowe (SC)	Director of Public Health, Dorset Council
	David Freeman (DF)	ICB Deputy Chief Executive Officer (and ICB Cluster Chief Officer for Commissioning and Place)
	Dean Spencer (DSp)	ICB Chief Operating Officer (and ICB Cluster Place Director, Dorset)
<b>In attendance:</b>		
	Liz Beardsall (LB)	ICB Head of Corporate Governance
	Helen Crook (HC) (for item ICBB26/023)	ICB Programme Manager, Transformation Delivery
	Jane Ellis (JE)	ICB Chief of Staff
	Leah Gallon (LG) (for item ICBB26/023)	Associate Director, Health Innovation Wessex
	Hester McLain (HM)	Director of System Co-ordination, NHS England South West
	Marianne Storey (MS) (for item ICBB26/023)	Dorset Women's Community Interest Company Lead
	Louise Trent (LT) (minutes)	ICB Governance Support Officer
	Amanda Webb (AWe) (virtual)	ICB Cluster Chief Officer for Population Health Improvement

<b>Public:</b>		
	There was 1 member of the public present. The meeting was also available via livestream.	
<b>Apologies:</b>		
	Lucy Baker	ICB Place Director for Bath and North East Somerset
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member - member
	Rob Carroll (RC)	Director of Public Health, BCP Council
	Aidan Dunn (AD)	Chief Executive, BCP Council (nominated deputy for ICB Local Authority Partner Member – BCP) - member
	Millie Earl (ME)	Leader of BCP Council
	Dawn Harvey (DH)	ICB Chief People Officer
	Caroline Holmes (Cho)	Place Director for Wiltshire
	Catherine Howe (CH)	Chief Executive, Dorset Council – participant
	Nick Ireland (NI)	Leader Dorset Council and ICB Local Authority Partner Member - member
	David McClay	ICB Place Director Somerset
	Gordon Muvuti (GM)	Place Director, Swindon
	Rachel Pearce (RPe)	Managing Director (System Commissioning Development), NHS England South West
	Andrew Rosser (AR)	Chief Finance Officer, SWASFT - participant

**ICBB26/019 Welcome, apologies and quorum**

The Chair declared the meeting open and quorate and welcomed the new cluster executives to the meeting. There were apologies from Lucy Baker, Matthew Bryant, Rob Carroll, Aidan Dunn, Millie Earl, Dawn Harvey, Caroline Holmes, Catherine Howe, Nick Ireland, David McClay, Gordon Muvuti, Rachel Pearce and Andrew Rosser.

**ICBB26/020 Conflicts of Interest**

There were no conflicts of interest declared.

**ICBB26/021 Minutes of the Part One meeting held on 15 January 2026**

The minutes of the Part One meeting held on 15 January 2026 were agreed as a true and accurate record.

**Resolved: the minutes of the meeting held on 15 January 2026 were approved.**

**ICBB26/022 Action Log from the Part 1 meeting held on 15 January 2026**

The action log was considered, and approval was given for the removal of completed items.

**Resolved: the action log was received, updates noted, and approval was given for the removal of completed actions.**

**Standing Items**

**ICBB26/023 Board Story – Women’s Health**

The NHS Dorset Programme Manager, Transformation Delivery, Dorset Women’s Community Interest Company Lead and the Associate Director, Health Innovation Wessex

presented the Women's Health Board Story. The story highlighted the programme's aims, approach, structure, engagement, and delivery of a co-produced online resource, new clinical pathways and training for clinicians.

*L Ambler joined the meeting.*

The Board welcomed the Board Story and discussed the historical bias in health research and the need to apply the user-led approach to other conditions affecting women. There was ongoing work with Wessex Health Partners and plans to expand website content to cover more conditions.

The Board enquired about the different engagement undertaken with older women and the risk of digital exclusion at all ages. The team had strong links with the Ageing Well Network and had reached digitally excluded groups through non-digital means. There had been wide engagement with schools and youth clubs to ensure broad representation.

There was a need for adequate resources, particularly for LARC within GP practices, with the risk that current funding levels may not support continued delivery and the programme team was supportive of the importance of fair resource allocation.

The Board noted the difficulty with measuring outcomes versus outputs and the positive impact of the programme. Consideration of how to sustain the programme's achievements as the system transitioned to new cluster arrangements would be required, with the potential to consciously plan for the integration and support of successful initiatives.

**Resolved: the Board noted the Women's Health Board Story.**

**ICBB26/024 Cluster Chair's Update**

The Cluster Chair updated the Board on the context of the challenging economic environment and tight fiscal framework that there could be low expectation of additional NHS funding and a requirement for local accountability in delivering financial targets. As the organisation moved into new a new cluster model, there would be the requirement to determine which workstreams and governance arrangements would be managed at cluster level and which would be managed at place. It would be important to take the opportunity to transform how resources were used to be a platform for neighbourhood health and to support the leftward shift.

**Resolved: the Board noted the Chair's update.**

**ICBB26/025 Cluster Chief Executive Officer's Report**

The Cluster Chief Executive Officer presented his CEO's report.

Work was underway with the Local Authorities for the Special Educational Needs and Disabilities (SEND) improvement plans with coordination being undertaken across the cluster with the importance of alignment with health and local authority responsibilities and timelines recognised.

There would be upcoming delegation of direct commissioning responsibilities to the ICB in April 2027 which would including health and justice, vaccination, immunisation and screening which were currently held by NHS England. This would potentially require the establishment of a commissioning hub for the Southwest.

Trent, Louise  
06/05/2026 15:44:22

The Electronic Health Record (EHR) development across Dorset had received approval with a go-live target date of April 2028. This marked a significant system-wide change and would require substantial work over the coming years.

There had been a significant and unexpected delay in the Coast building at University Hospitals Dorset with completion being postponed. It was anticipated that there would be clarity on the timelines by the end of March but that this would delay beyond July. Work was underway to address the implications for the Clinical Services Review and to assess the impact on service delivery and the requirement for ongoing community communication.

The ICB was entering a period of significant organisational change with the impact of voluntary redundancies and the launch of a consultation on new structures for staff. There was now a complete Executive Team in place. It was confirmed that there were plans for stakeholder communication in relation to leavers and interim arrangements as this progressed. The Board recognised the loss of valuable colleagues and talent through the process.

The Board Assurance Statement for NHS England had been signed off by the Chair and Chief Executive on behalf of the Board, with a caveat against risks linked to the running cost reductions with clear mitigations for how changes to the ICB's functions would be delivered, as this had not been fully assured at the point of sign off. The Board ratified the submission of this statement.

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

**ICBB26/026 Board Assurance Framework**

The NHS Dorset Deputy Chief Executive Officer presented the Board Assurance Framework (BAF).

This had been received at the February ICB committee meetings. Previous plans to redevelop the BAF had been paused due to the organisational change, and it continued to be maintained in the current format with ongoing monthly review of the risks. The cluster arrangements would provide the opportunity to reset the BAF during transition with using best practice and learning from the three cluster organisations to develop.

**Resolved: the Board approved the Board Assurance Framework.**

**ICBB26/027 Committee Escalation Reports**

Key areas of focus, progress and challenges from the committee escalation reports were presented from the December meetings. Highlights included:

**Finance and Planning Committee:**

Additional meetings had been held for the Electronic Health Record and the Medium Term Plan submission and the usual business meetings had received the New Wareham Surgery Full Business Case (FBC) and the Community Dental Services Contract Direct Award with all relevant matters escalated to the Board.

**Outcomes Committee:**

The Futurecare programme had provided positive updates with effective monitoring and mitigations seen across the reporting time. Integrated Neighbourhood Teams (INTs) was at an earlier stage of development and it would be important to ensure robust outcome metrics and reporting were in place as this matured.

**People Committee:**

Trent Louise  
06/05/2026 15:44:22

There were no significant issues for escalation to the Board at this time, however the impact of the staff wide consultation and of the Voluntary Redundancy were not yet known. Consideration would be required for where the people agenda would be sit in the future governance arrangements.

**Quality and Commissioning Committee:**

Discussion had included the challenge with monitoring quality and safety at the cluster level and the areas of best practice from NHS Dorset that could be considered going forward. Updates had included the national roll-out of the Dorset Hydration Project, the positive BCP Council SEND inspection, Pharmacy First and the positive work in relation to the reopening of Yeovil Maternity Services.

**Resolved: the Board noted the Committee Escalation Reports.**

**Performance and Planning**

**ICBB26/028 Integrated Performance Report**

The NHS Dorset Chief Operating Officer presented the Integrated Performance Report.

The Board welcomed that operational performance had not declined as the financial position had been recovered. Elective performance was strong, particularly in cancer performance across Dorset, with all cancer metrics being rated 'green'. There had been significant reductions in long waiters with the anticipation that there would be no patients waiting over 65 weeks by year end. The 18 week position had been variable during winter and had now reduced during March.

There was strong delivery of Mental Health targets and good performance in dental. Urgent and Emergency Care had been challenged during February but was seeing improvements in March. Ambulance response times had been continually improving and had achieved the under 30 minute target time. Handover delays had seen a significant improvement across the southwest with the introduction of the Trusted Handover protocol.

Although improved dental performance was welcomed, it was noted that Healthwatch was received ongoing reports of patients unable to access urgent dental appointments with the requirement for improved signposting for appointment availability and potential resource reallocation to routine dental care.

It was clarified that there was ongoing public engagement to influence appropriate use of services with campaigns including social media and the importance of reliable alternatives to emergency departments. The need for joined-up regional campaigns and community engagement was noted with the move to cluster arrangements.

*Louise Bate left the meeting.*

**Resolved: the Board noted the Integrated Performance Report.**

**ICBB26/029 Medium Term Planning**

The NHS Dorset Interim Chief Finance Officer introduced the report on Medium Term Planning.

This had been considered at an Extraordinary Board meeting, along with the Board Assurance Statements, prior to submission. The plan set out a £2.1b budget for 2026/27 with a break-even objective and an ICB efficiency programme to target £55.3m in savings. Capital allocations and how this would be used to support infrastructure had been

considered. The plan had been through in-depth discussion at the Finance and Planning Committee prior to Board approval. This had included the need for immediate action from month one to achieve efficiency targets with avoidance of late delivery of savings. It would be important to have rigorous financial governance and forecasting to maintain financial resilience.

It was clarified that the investment in neighbourhood health programmes with the national expectations for 1–2.5% investment would be discussed as part of the detailed budgets and external investments in the part two meeting.

**Resolved: the Board noted the Medium Term Planning report.**

### **Items for Decision**

#### **Governance Approvals**

**ICBB26/030**

#### **Board and Cluster Board Composition and Cluster Governance Structure**

The Chair introduced the Board and Cluster Board Composition and Cluster Governance Structure. The previously circulated report set out the proposed memberships for the three individual ICB Board and Cluster Board, as well as the proposed committee governance structure for the cluster

The Cluster Board would be the cluster's main decision-making and assurance body with delegated authority from the three organisational Boards. The individual ICB boards would be retained prior to merger but would retain only those the items that could not be delegated to the Cluster Board which included the Annual Report and Accounts approval and potentially some decisions on the merger. To reflect this reduced remit, the individual ICB Boards would have a reduced membership.

The Cluster Board would meet bi-monthly and would include six executives, seven non-executives, and members from local authority partners, FT partners, primary care and the voluntary sector plus a Healthwatch participant. Development sessions would be planned.

It was clarified that the appointed chief officers and executives were joint appointments across the cluster with the 'host' employment being in their original organisation until full organisational merger.

**Resolved: the Board approved the recommendations for the Board and Cluster Board Composition and Cluster Governance Structure.**

**ICBB26/031**

#### **Governance Arrangements – Terms of Reference and Constitution**

The Head of Corporate Governance introduced the previously circulated paper seeking the Board's approval for the proposed Terms of Reference for the cluster's Joint Remuneration Committee and amendments to the ICB's constitution to reflect the new executive structure.

The Board approved the terms of reference and constitution changes, noting that further iterations were anticipated as the governance model evolved.

**Resolved: the Board approved the Terms of Reference for the cluster's Joint Remuneration Committee and amendments to the ICB's constitution.**

### **Items for Noting/Assurance/Discussion**

**ICBB26/032**

There were no items for Noting/Assurance/Discussion.

**Items for Consent**

**ICBB26/033** There were no items for consent.

**ICBB26/034 Questions from the Public**  
There were no questions from the public.

**ICBB26/035 Any Other Business**  
There was no further business discussed.

**ICBB26/036 Key Messages and review of the Part 1 meeting**  
  
The Board acknowledged thanks to all staff, in particular exiting Dorset ICB staff, Board members and outgoing executives.

**ICBB26/037 Date and Time of Next Meeting**  
The next formal meeting of the ICB Board was to be confirmed.

**ICBB26/038 Exclusion of the Public**  
The Board resolved 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, publicity of which would be prejudicial to the public interest.

Signed by:

Rob Whiteman, ICB Cluster Chair

Date:

Trent Louise  
06/05/2026 15:44:22

Minutes of the **Meeting of NHS Somerset Integrated Care Board (ICB)** held at **Wynford House, Lufton Way, Yeovil** on **Thursday 26 March 2026**

Present:	Paul von der Heyde Suresh Ariaratnam	Deputy Chair Non-Executive Director (Chair of Primary Care Commissioning Committee)
	Dr Rebecca Duffy Christopher Foster	Primary Care Partner Member Non-Executive Director (Chair of Finance Committee, Remuneration Committee and Somerset People Board)
	David Freeman	Cluster Chief Officer for Commissioning and Place
	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 Peter Lewis	Cluster Chief Executive Chief Executive, Somerset NHS Foundation Trust (Trust Partner Member)
	Dr Bernie Marden Shelagh Meldrum Grahame Paine	Cluster Chief Medical Officer Cluster Chief Nursing Officer Non-Executive Director (Chair of Audit Committee)
	Duncan Sharkey (virtual)	Chief Executive, Somerset Council (Partner Member)
Apologies:	Lucy Baker	Cluster Place Director for Bath and North East Somerset
	Caroline Holmes	Cluster Place Director for Wiltshire
	Dean Spencer	Cluster Place Director, Dorset
	Becky Whale	Interim Cluster Place Director for Bournemouth, Christchurch and Poole
	Rob Whiteman	Chair, NHS Bath & North East Somerset, Swindon and Wiltshire (BSW) ICB; NHS Dorset ICB; NHS Somerset ICB
In Attendance:	Alison Bell Charlotte Callen	Director of Public Health (Participant) Executive Director of Communications, Engagement and Marketing (Participant)
	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)
	Katherine Nolan Jade Renville	SPARK Somerset, VCSE sector (Participant) Executive Director of Corporate Services and Affairs, NHS Somerset and Somerset NHS Foundation Trust (Participant)
Secretariat:	Steph Lower	NHS Dorset ICB Deputy Head of Corporate Governance (minutes)

Trent Louise  
06/05/2026 15:44:22

**ICB 20/26 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 21/26 PUBLIC QUESTIONS [\(PLEASE SEE APPENDIX 1\)](#)**

Five public questions had been received.

In relation to the stroke questions, Mr Smith noted the last public meeting was over 2 years ago and urged the Board to hold a further public meeting in Yeovil, emphasising the importance of public debate and transparency given the significant impact on local residents.

The Chair thanked Mr Smith and noted the comments made.

**ICB 22/26 REGISTER OF MEMBERS' INTERESTS**

The ICB Board received and noted the register of members' interests, which reflected the position as at 17 March 2026.

The Deputy Chair had been appointed to the role of Chair of the Hospitals Group at BSW and requested his interest be updated accordingly. He would be leaving the ICB on 31 March 2026.

**Action: Corporate Governance**

**ICB 23/26 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**

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

**ICB 24/26 MINUTES OF THE MEETING HELD ON 29 JANUARY 2026 AND ACCOMPANYING ACTION SCHEDULE**

The minutes of the meeting held on 29 January 2026 were **approved** as a true and accurate record.

The action schedule was reviewed and all actions were complete.

**Resolved:** The Board **approved** the minutes of the meeting held on 29 January 2026 and **noted** the accompanying action schedule.

**ICB 25/26 DEPUTY CHAIR'S INTRODUCTION**

The Deputy Chair thanked everyone for attending the meeting which marked an important milestone being the final meeting of the Board in its current form, with the new cluster arrangements expected to take effect from 1 April 2026.

He thanked everyone for their continued support, commitment and engagement, recognising the willingness to engage constructively, to understand different perspectives and to work through challenges collaboratively which had been central to Somerset's progress.

It was an exciting time for those involved in taking the cluster work forward and it was essential to continue to maintain the strong collaboration that existed across the Somerset system.

The Deputy Chair advised that he would shortly be moving to another part of the cluster as the Chair of the BSW Hospitals Group which covered the Royal United Hospital (Bath), Great Western Hospital (Swindon) and Salisbury General Hospital. He wished those continuing in their roles every success and to those moving on all the best for the future.

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

**ICB 26/26 CLUSTER CHIEF EXECUTIVE'S REPORT**

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

Trent Louise  
06/05/2026 15:44:22

The Chief Executive recorded his thanks to the Chair for his support, wisdom, composure and commitment throughout his tenure, not only to himself but the people of Somerset. This would be a significant part of his Somerset legacy and would be equally valuable as the Chair moved to his BSW role. He also paid tribute to the contributions of the non-executive directors and the Executive Director of Corporate Affairs for whom this would be the last meeting.

The above signified the pace and scale of change currently underway and the paper later on the Part A agenda set out the proposed cluster governance and board arrangements which would continue to evolve as work progressed.

Following an interview process, Becky Whale had been appointed to the final Place Director role (Bournemouth, Christchurch and Poole area) and had taken up the role from Tuesday 24 March 2026.

A key area of focus for the cluster executive team was the 45 day staff consultation launched last week on the significantly revised structures to bring the three organisations together across the cluster. The executives were committed to hearing colleagues' views on the proposed structures and how they might be improved or developed.

The CEO report included a request to endorse an assurance statement to NHS England regarding the readiness to operate as a cluster following the use of the Chair and Chief Executive delegated authority to submit the statement. The statement submission had been deferred to enable sufficient clarity on the proposed structure to provide the required assurance, however this was caveated in recognition of the risks in reshaping the organisation and running at half the running costs/staffing. The Board endorsed this assurance statement.

NHS England had confirmed arrangements for the delegated commissioning of the health and justice services, together with vaccinations and screening which would transfer to ICBs from 1 April 2027. The national intention was to establish an office of pan-ICB commissioning in each of the seven NHS regions which would be responsible for the commissioning of those services across all ICBs in the area. It was being explored whether the existing South West commissioning hub could be expanded to take on those responsibilities as a cluster. Consideration was being given as to whether the cluster would expand its current responsibilities to be the host for these arrangements on behalf of the three ICB clusters in the South West. This would be subject to the caveats of ensuring the right expertise and resources to enable delivery. This was a substantial undertaking with an overall commissioning budget of just under £2bn for these services across the South West region.

It was encouraging to see the recently published Neighbourhood Health Framework. There would be a need to determine which frameworks and levers could be used to incentivise and support the development of neighbourhood health services. Further work was needed to clarify the respective roles of the Somerset Board and Health and Wellbeing Board in supporting the development of the wider neighbourhood agenda.

There had been national guidance on talking therapies and dental services. The dental guidance was welcomed following a strong focus on urgent dental provision over the past year. The update guidance would support additional work in Somerset to strengthen routine dental access and provision.

The SEND reforms were announced recently and there would be substantial work to be undertaken with local authority partners to develop six draft plans across the cluster to bring back to the new cluster Board through the appropriate governance route.

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06/05/2026 15:44:22

## Voluntary, Community, Faith and Social Enterprise (VCFSE) presentation

K Nolan presented a VCFSE update which highlighted examples of voluntary sector-led partnerships, working with system partners to improve neighbourhood health and wellbeing, including collaboration across adult mental health services.

She described how community-led activity could be enabled by providing support and space for local groups to design and deliver what mattered to them, using pilots to demonstrate 'what good looked like'.

Board members were encouraged to stay curious and engaged, noting that updates were shared via the voluntary sector newsletter, webinars and the website and that many sessions were open to attend.

To inform future investment in the voluntary sector, the need to strengthen how the impact and value for money was evidenced was highlighted. This would require clearer outcomes, common metrics (where feasible) and a practical approach to measuring social value, recognising that evaluation may start with a pilot cohort rather than attempting to measure everything at once.

The Board discussed the need for effective communication and learning across a complex, multi-layered governance structure, ensuring this flowed through the cluster leadership and across the six places. There was also discussion on whether additional cluster-level insight could be developed to complement place-based intelligence, whilst recognising that meaningful measures were often those that were visible and measurable locally.

The presentation would be circulated to Board members.

### **Action: Corporate Governance**

## Emergency Planning, Resilience and Recovery (EPRR) Annual Report 2025

Jade Renville introduced the EPRR Annual Report for 2025.

Following a rigorous assessment process including review by NHS England, Somerset ICB Board was confirmed as *substantially compliant*, providing strong assurance to the Board.

The report also summarised ratings for key partner organisations noting they were also *substantially compliant*. These ratings related specifically to the NHS core standards for EPRR covering governance, plans and testing arrangements for incidents.

Areas of good practice were highlighted including the strength of system collaboration that enabled the collection of robust evidence to support the EPRR assurance.

Thanks were recorded to Public Health colleagues for the joint leadership of the Somerset Local Health and Care Resilience Forum and for supporting exercises and action planning.

The Board acknowledged the increasing uncertainty and the need to ensure that EPRR arrangements remained sustainable given the limited specialist capacity.

The Board discussed the need to maintain effective place-based relationships and arrangements (including for major events) alongside a cluster-level approach to share learning and provide mutual support.

It was noted the proposed future operating model (subject to the consultation) would result in a single EPRR team supporting multiple place partnerships and that structures would need to enable both local co-ordination and cluster oversight. The resourcing challenge would require careful design of relationships, escalation routes and on-call arrangements.

Trent Louise  
06/05/2026 15:44:22

Links to the System Co-ordination Centres were also referenced to ensure wider resilience and co-ordination across the cluster and region.

**Resolved:** The Board **noted** the Cluster Chief Executive's Report and approved the 2025 EPRR Statement of Compliance as presented.

**ICB 27/26 ELECTRONIC RESOLUTIONS (APPROVED/ENDORSED SINCE THE LAST BOARD MEETING)**

The Board noted the following approval which had taken place since the 29 January 2026 Board meeting:

- constitutional changes relating to the ICB executive accountabilities moving to the cluster executives on 18 March 2026 were approved via e-mail on 5 March 2026.

**ICB 28/26 NHS Somerset Medium Term Plan Overview 2026-27 – 2027-28: Final Submission and Board Assurance Statement.**

Alison Henly presented the NHS Somerset Medium Term Plan Overview 2026-27 – 2027-28: Final Submission and Board Assurance Statement.

Key points to note included:

- The plan being presented, was discussed and supported at the Finance Committee and the recent extraordinary Board discussion which supported Somerset's draft submission on 12 February 2026.
- The plan was slightly different from previous years. There was not a system control total and therefore the plan was a standalone ICB plan, with Somerset Foundation Trust submitting separately. Collaborative work continued to produce the plans, and the contract value and activity and performance assumptions underpinning the ICB plan were in line with the Trust's plan, showing consistency in the assumptions and it was noted that the NHS England assurance process had noted good triangulation between the ICB and Trust plans.
- Thanks were recorded to the teams both within the ICB and Trust for their hard work in getting to a high quality plan for the residents of Somerset.
- Financial allocations had been received covering the period 2026/27 – 2028/29 (with a further year for capital) to enable Somerset to set out longer term planning assumptions. The paper outlined the financial, workforce and performance priorities set against these.
- It was a challenging plan with a focus on improving productivity and tackling waste, by taking tough decisions on how to prioritise resources to best meet the needs of Somerset's population.
- The financial plan sets out the route to delivering a balanced financial plan for each of the 3 years and a capital plan over the 4 years of the plan. Approximately £2M per year strategic capital allocation had been received, which would need to be prioritised to support the ambitions to deliver the left shift.
- Corresponding performance plans had been submitted which flagged the areas where there were improving plans in order to reach the performance standards over the 3 years.
- One area to flag was in relation to routine dental activity, which would continue to be a priority focus. The plans submitted were not compliant and work continued at pace within the ICB to enable more access to the Somerset population to commissioning more activity by working with current dental providers and procuring more capacity. This was reflected in an improvement to this performance area being submitted in the plan alignment submission on 18 March.
- In addition, workforce plans had been submitted for primary care and a specific one on the VCSFE workforce for mental health services.
- The report showed the assurance statement for each of the areas considered and highlighted the amendments made to those statements to reflect the discussion that took place at the extraordinary Board meeting on 10 February 2026.

Trent Louise  
06/05/2026 15:44:22

**Resolved:** The Board **approved** the NHS Somerset Medium Term Plan Overview 2026-27 – 2027-28: Final Submission and Board Assurance Statement.

## **STRATEGIC FOCUS**

### **ICB 29/26 STROKE RECONFIGURATION**

David McClay presented the report on the Stroke Reconfiguration.

Key points to note:-

- There were two go-live options under consideration – one which would see Dorset County Hospital go live at the end of May with Musgrove Park Hospital (MPH) remaining as is, or both sites going live together in August. A decision between these options would be taken on 15 April 2026.
- As set out previously, recruitment challenges (including consultant vacancies arising from retirements) was a limiting factor for MPH's readiness to go live. Mitigation plans were in place however full provision was not expected until August. As a result, the service would not be able to deliver the full model until that point.
- A meeting had recently taken place to review progress and confirm the immediate priorities for delivery and risk management.
- There was ongoing work with SWASFT colleagues as a key dependency for implementation and ongoing operations.
- The Board noted the pre-hospital video triage pilot was currently being evaluated by SWASFT. The pilot was not on the critical path for go-live but was seen as a potential reassurance measure.

For context, the programme had been established to secure the best possible outcomes for patients by improving access to high-quality care and the right clinical expertise. As the programme moved into delivery, the clinical case for change remained strong.

Given the level of public interest, the proactive engagement approach would continue with valued stakeholders and the local population to ensure transparency and timely communication.

Progress, risks and mitigations would continue to be reported through the established programme governance and Board processes.

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

*Members of the public left the meeting.*

### **ICB 30/26 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT – THE MIRACLE CURE; GET SOMERSET MOVING** **Objectives: 1, 2, 4, 6 and 7**

Alison Bell presented the Director of Public Health Annual Report which focused on physical activity.

Key points to note included:-

- Physical activity was chosen as the report's theme due to its broad health benefits, low cost and potential to address widening health inequalities in Somerset.
- The report detailed the impact of physical activity on reducing risks of chronic diseases, improving mental health and supporting healthy ageing, with a particular focus on the 20% of adults in Somerset who were highly inactive and on children not meeting activity guidelines.
- Somerset's physical activity was around the national average, but this was still sub-optimal with only about 65% of adults and 50% of children meeting recommended activity levels.
- Short-term priorities included increasing activity among adults over 50, medium-term priorities focused on reducing health inequalities and

Trent Louise  
06/05/2026 15:44:22

- long-term priorities aimed to embed activity across the life course.
- The Board discussed potential barriers such as cultural norms, screen time and infrastructure and highlighted the need for positive messaging, cross-sector collaboration and organisational leadership to model and support active behaviours.
- Recommendations included reinvigorating partnerships, embedding activity in commissioning and using system levers.
- It was planned to refresh the Get Somerset Moving Strategy to strengthen engagement and commitment to enable the change.

The Board noted the update on the previous year's DPH annual report on smoking.

Key highlights included:-

- Actions taken across enforcement.
- Partnerships with local business and health and care settings supporting the development and implementation of smokefree policies.
- School resources for smoke and vape free environments had been showcased as best practice.
- Community campaigns had increased digital and in-person engagement.
- Since April 2025 the Smokefree Somerset service had supported 1,457 smokers to achieve a 4-week quit which was a significant increase from the previous year.

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

## DECISION ITEMS

### ICB 31/26 CLUSTER GOVERNANCE ARRANGEMENTS

#### Board, Cluster Board and Cluster Committee Structure

The Chief Executive Officer presented the Board, Cluster Board and Cluster Committee Structure report.

The report set out the proposed cluster board composition and new committee structure arrangements. The three existing ICB Boards would remain in place until formal merger but would delegate most decision-making to the new cluster board and only meet as required. The proposals had been supported by the cluster Transition Committee and the two other ICB Boards within the cluster.

Strong emphasis was placed on ensuring that place-based arrangements remained central. Whilst some detail was still being developed, it was agreed that appropriate practical arrangements should be established as quickly as possible recognising that the precise format would evolve over time. Further discussion would take place in Part B under the paper relating to the future of Somerset place-based arrangements.

Concerns were raised regarding public health input to the proposed future membership arrangements, highlighting that public health had a statutory advisory role to the NHS and local authorities. There was a request for assurance that the new cluster Board would continue to receive effective public health advice and input.

It was agreed that a discussion would be held off-line to confirm how public health advice and representation would be maintained within the proposed governance arrangements including options for ensuring appropriate assurance and impact. The need to balance representation with the practicalities of Board size and the transitional nature of the arrangements was recognised.

**Action: J Higman**

It was noted that the Constitution and membership requirements may change by April 2027 in line with forthcoming legislation including the potential implications of the new Health Bill.

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06/05/2026 15:44:22

There was a need to clarify how the wider Healthwatch and public feedback would be linked into decision-making with Healthwatch participation on the Board limited to a single regular participant. The value of attendance at this level was emphasised, particularly in ensuring strong links between system discussions and local resident feedback were maintained.

There would be a need to clarify a nomination approach/process to achieve a single Healthwatch and single VCSE participant on the cluster Board.

**Resolved:** The Board **approved** the recommendations set out in the report with the caveat of an off-line discussion with DPH.

#### Joint Remuneration Committee Terms of Reference

The Remuneration Committee Chair presented the Joint Remuneration Committee Terms of Reference report.

The Remuneration Committees of the three cluster ICBs had been meeting regularly in-common for more than six months.

The proposed Terms of Reference for the Joint Committee had been supported by the three Chairs and by each of the Remuneration Committees,.

While there was a significant degree of commonality, members who had attended those meetings would recognise that there had been the need to consider matters specific to individual ICBs, as the existing Terms of Reference were not identical. The proposal therefore set out a more comprehensive framework of responsibilities and duties, including ICB-specific items where required.

**Resolved:** The Board **approved** the Joint Remuneration Committee Terms of Reference.

### **GOVERNANCE, PERFORMANCE AND ASSURANCE ITEMS**

ICB 32/26

#### **ICB PRIORITY PROGRAMME REPORT AND BOARD ASSURANCE FRAMEWORK 2025-26 – QUARTER 4**

Jade Renville presented the ICB Priority Programme Report and Board Assurance Framework (BAF) 2025-26 – Quarter 4.

The need to align risk management systems and reporting across the three organisations within the cluster was outlined, aiming for a common framework for risk reporting and assurance.

Operational pressures remained the highest risks within Somerset ICB with transition-related risks also highlighted in the BAF.

Efforts were underway to shift neighbourhood work from a health-dominated focus to a broader, collaborative approach, with ongoing strategy development.

In terms of overall progress in the programmes, there had been positive movement although outcomes were not yet where they needed to be. There remained challenges with 'discharge to assess' which reflected a wider theme across the cluster.

Looking ahead, following the move to a single electronic health record across Dorset and Somerset, realising the full benefits would require streamlined clinical pathways and there was a need to be clear on 'what next' including what would sit with provider collaboratives, strategic commissioning, what would sit across Dorset and Somerset and if anything, what would sit at cluster level.

Trent Louise  
06/05/2026 15:44:22

In terms of the cluster transition work, it was important to ensure that voices from across primary and secondary care remained heard throughout the work.

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

**ICB 33/26**

**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 assurance reports from the Quality Committee, Finance Committee and System Assurance Forum which covered the period 1 April 2025 to the end of January 2026.

The Board noted the following:

- The Quality Committee had received an update on maternity services noting the ongoing system pressures following the temporary closure of YDH maternity and neonatal services.
- The committee had picked up a report on actions taken during the Covid pandemic and highlighted the need to ensure the actions weren't lost moving forward.

Key highlights included:-

- Within urgent and emergency care, there were no areas for concern to be flagged, although a number of areas which were not achieving their planned level of performance continued to be tracked.
- Patients in hospital with no criteria to reside had seen deterioration which reflected operational pressures. The report detailed the actions which had been taken since the last update and the areas of continued improvement focus which were being taken forward.
- There were no areas of concern to be flagged within elective care although updates were provided on the number of people who were waiting longer than 52 and 65 weeks for treatment and the 28 day faster diagnosis pathways . Attention was drawn to the 28 day faster diagnosis performance where improved performance was being seen in the head and neck pathways.
- There was a decline in talking therapies performance in July, following a period of improvement. This area related to no more than 10% of patients waiting more than 90 days for their second treatment. The actions being taken to bring performance back on track were detailed in the report and the mental health team continued to work closely with Somerset FT on the actions being taken. Tracking of the actions taken would be updated in the next report.
- The System Assurance Forum met on 19 February and the notes were appended to this report.
- There was a continued workforce focus at Somerset FT, with overall workforce number and agency usage showing as below planned levels.
- Primary care workforce had not grown in line with Somerset's plans and further work was happening to understand the drivers behind this.
- The ICB and Trust were on track to deliver a balanced financial position in the current financial year.
- Somerset Council was projecting a slight surplus of £0.1m this year.
- Attention was drawn to the underlying position which had seen a further deterioration of £0.3m this month, linked to the delivery of the CIP programme. This would put further pressure on the system moving into 2026/27 but has been factored into the plan presented earlier in the meeting.

Trent, Louise  
06/05/2026 15:44:22

- The venous thromboembolism (VTE) assessment rate was below the national standard. There were known data quality issues and it was agreed a post meeting note update would be provided including a timeline update.

**Action: B Marden**

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

## **ICB 34/26 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: this was the final meeting in its current format.

Key points to note included:-

- a review of the external auditor's completed audit plan for the 2025-26 audit cycle and agreement to the plan following detailed scrutiny.
- receipt of draft plans from the internal auditors, noting positive progress and direction of travel reflected in those plans.
- Strategic Commissioning Committee: there had been no meeting since the last Board.

### **System Group Reports:**

- Somerset Board: there had been no meeting since the last Board with the next meeting planned for Tuesday 31 March.
- Children, Young People and Families: focus on special educational needs and disabilities (SEND).

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

## **ICB 35/26 ANY OTHER BUSINESS**

There was no other business.

## **ICB 36/26 ITEMS TO BE DISCUSSED AT THE CONFIDENTIAL MEETING**

- Minutes of the confidential meetings 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

## **ICB 37/26 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 38/26 CLOSE AND DATE OF NEXT MEETING**

The meeting closed at 12.45pm. In light of the move to the new cluster governance arrangements, the next meeting would take place as required and would be confirmed accordingly when arranged.

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06/05/2025 15:44:22

**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:

Trent, Louise  
06/05/2026 15:44:22

## APPENDIX 1

### ICB XX/26 PUBLIC QUESTIONS

#### 1. From D Mallinson

What is the ICB's specific policy for supporting Shared Care Agreements for families in Somerset who have utilized 'Right to Choose' for ADHD and Autism? Furthermore, how is the ICB ensuring that children and adults are not financially penalised or left without medication due to a lack of local commissioning for these agreements?

#### Response from Shelagh Meldrum:

NHS Somerset supports shared care prescribing with 'Right to Choose' providers where the prescribing recommendations are in line with NICE guidance and the NHS Somerset formulary. The specialist's responsibilities under shared care are contractually enforceable with NHS providers but sometimes are difficult to enforce depending upon the contractual arrangements made with the Right to Choose provider by the host commissioning ICB.

NHS Somerset's Shared Care Protocols are found on our website and as autism isn't a disease to be treated, there are no medications used "for" autism – all autistic patients requiring shared care of appropriate drugs for comorbid conditions should be prescribed on an appropriate clinical basis:

[Shared Care and PGDs - NHS Somerset ICB](#) ADHD SCP can be found here. [Neurodivergence - NHS Somerset ICB](#) local information can be found here. [NHS Somerset Formulary](#) information on formulary approved drugs can be found here.

Shared care agreements are down to individual practices to agree to deliver. They need to be assured that the staff looking after the patients have the required competencies to deliver the care and that they have the capacity to take this care on as it is outside of the core contract.

If a patient requires medication:

- Where shared care is accepted the GP will prescribe medication
- Where shared care is not in place, the patient will either continue to be prescribed medication by the Right to Choose Provider or if the Right to Choose Provider is unable to prescribe medication, the patient will be referred into local services delivered by NHS Somerset NHS Foundation Trust, so there is no lack of local commissioning arrangements with regards to medication.
- ADHD will follow a shared care agreement with Somerset NHS Foundation Trust (SFT) but will not include prescribing under 'Right to Choose' or from a private provider. If medication becomes unavailable, patients will be referred to secondary care for review.

#### 2. From R Beaver, Quicksilver Community Group

I refer to Item 6 of the current agenda, Stroke Reconfiguration Update.

Reference is made to a meeting with reps from the Quicksilver group. As a member of the group, I would like to express our gratitude to those who gave up their time to meet us and give additional information.

We were updated on the PHVT pilot and the possible improvements in door to needle time which would have a positive impact on call to needle time.

Trent Louise  
06/05/2026 15:44:22

We were referred to potential door to treatment initiatives adopted in Northumbria noted in the DMBC where claimed improvements of 26 minutes were achieved. However, at the time of our meeting, we understand that these, have not been tried at MPH, and the Senior Stroke Consultant could not give a confident indication that such a level of improvements could be achieved. More worryingly there was no indication if such practices would or could be adopted at DCH where most patients would go instead of YDH. SWAST also described a current PHVT pilot with Dorchester Hospital, although no estimate of the level of improvement could be given. We were also told that no agreement has yet been given that this would be taken forward beyond the pilot or extended to Somerset in respect of patients impacted by the closure of YDH HASU.

SWAST data for cat 2 stroke callouts in 2025 for patients to MPH, DCH and YDH showed very similar mean handover times for MPH and YDH, and a reduction of 9 minutes for DCH which could reflect the PHVT pilot. Taking the most optimistic scenario with both these mitigations there could be a total of 35 minutes saved in call to needle time.

SWAST 2025 and SSNAP data showed that currently of the 1526 Somerset stroke patients taken to either YDH or MPH only 55% get treatment within 3 hours of the call for an ambulance.

The closure of YDH HASU will lead to additional travel times identified in the Geospatial Evidence pack in the DMBC. When this is added the 3-hour call to needle time reduces to 45% for all 1526 Somerset patients, and specifically for the 524 patients redirected the figure reduces to 28%. This performance for what amounts to about a third of the entire population is very worrying.

If the 35 minutes savings are achieved for the redirected patients 64% would have call to needle time within 3 hours. This would be a significant improvement.

In the current report it is proposed that the closure of YDH HASU is to be delayed while recruitment and mitigation plans are progressed. This is very reassuring.

Please can you confirm that this delay will extend until the mitigations initiated have been fully tried, tested, validated, confirmed, reported, and embedded by DCH and SWAST.

I ask that the evaluation report is not only received by the board but fully shared with the public, and progressing the closure of YDH HASU only considered if it is reliably demonstrated that there is significant improvement in call to needle time at least close to the national expectation.

#### **Response from David McClay:**

We welcomed the opportunity to discuss the modelling with representatives of the Quicksilver Community Group. We explored the challenges of modelling the change proposed. We've also reviewed the modelling assumptions contained in the DMBC and following discussion with clinical and modelling leads, we have confidence in the assumptions we have made in the case.

South Western Ambulance Service NHS Foundation Trust has recently announced that ambulances across the South West reached heart attack and stroke patients 38 minutes faster this winter across the South West region. Average response times for category 2 patients, which includes strokes, has improved from 72 minutes to 34 minutes between 2023 and 2026, despite a 22% increase in demand. I'll update on the PVT under item 6.

We are exploring whether the feasibility to phase the introduction of the new model with Dorset County Hospital going live ahead of Musgrove Park Hospital and I'll update more on that later on the agenda.

For clarity, the decision to close the HASU Unit at Yeovil has been made, these current considerations are in regard to the phasing of the implementation.

Trent Louise  
06/05/2026 15:44:22

When we met we outlined our approach to measuring the implementation of the new model against the Sentinel Stroke National Audit Programme (SSNAP) data, this will take place once the full model has been implemented and will report quarterly.

**3. From R Tostevin, Quicksilver Community Group**

I refer to Item 6 on the Agenda, the Stroke Reconfiguration Update.

Reference is made to a recent Joint Stroke Coordination Board, where “colleagues from Somerset Foundation Trust advised of a set-back in their plans to grow their Consultant workforce at Musgrove Park Hospital. And that this had 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 reconfigured stroke service to start 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.

The Stroke Update goes on to state that a joint Executive meeting between the Trusts and the ICB to discuss the Go/No Go criteria, was due to be held yesterday (25 March 2026) with a verbal update to be provided at this Board meeting today.

“In the Stroke update’s Impact Assessments report, we’re told 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 Joint Stroke Coordination Board.

Given the ongoing public concern about the pending closure of Yeovil HASU – and its impact on hundreds of Stroke patients currently served by YDH, isn’t it time to call time on the closure. And instead, for the JSCB to work constructively with staff at BOTH MPH and YDH, to deliver the excellent emergency stroke treatment at BOTH hospitals, that ALL patients deserve across the county?

**Response from David McClay:**

Thank you also for your ongoing interest and commitment to this issue. Both teams at Musgrove Park Hospital and Yeovil District Hospital have been working on implementing the change and just to reconfirm that there will still be continued provision of the Acute Stroke Unit at YDH.

We don’t intent to go over the Business Case again, but we are seeking to pool expertise at the two HASUs to improve outcomes - that’s in line with national best practice and has the support of the National Clinical Director for Stroke on his visit last summer.

Trent Louise  
06/05/2026 15:44:22

**BSW Integrated Care Board - Board Meeting in Public Action Log - 2025-26**

Updated following meeting held on **18/03/2026**

**OPEN actions**

Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
18/03/2026	No actions recorded - and no remaining open actions.					

Trent Louise  
06/05/2026 15:44:22

## Action Log – ICB Board Part One: Public

Presented on: 11 May 2026

Minute/Ref	Action	Owner	Timescale	Outcome	Remove?
<b>Actions from meeting of 12 March 2026</b>					
There were no actions from the meeting held on 12 March 2026					

Trent Louise  
06/05/2026 15:44:22

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
<b>ACTIONS CLOSED SINCE LAST MEETING</b>							
ICB 22/26	26/01/2026	Register of Members' Interests	To update the entry for the Deputy Chair who had been appointed to the role of Chair of the Hospitals Group at BSW and would be leaving the ICB on 31 March 2026.	Corporate Governance Team	Updated on Civica Declare 23/04/26.	Complete	23/04/2026
ICB 26/26	26/01/2026	Cluster CEO report	Circulate the VCFSE presentation	Corporate Governance Team	Presentation circulated via e-mail on 08/04/2026	Complete	08/04/2026
ICB 31/26	26/01/2026	Cluster Governance Arrangements	Off-line discussion to be held to confirm how public health advice and representation would be maintained within the proposed governance arrangements.	J Higman	The CEO has discussed this with the Chair and agreed that DPH representation on the Cluster Board will be followed up as part of the nomination process for the Council representatives on the Cluster Board. Further work is also underway to ensure strong partnership working between the Council Public Health teams and the new ICB cluster Population Health Improvement Directorate. This is being led by the Chief Officer for Population Health Improvement.	Complete	23/04/2026
ICB 33/26	26/01/2026	Integrated Board Assurance Dashboard and Exception Report	To provide a post meeting note update (including timeline) on the VTE assessment rate which was below the national standard.	B Marden	Post meeting note circulated via e-mail on 01/05/2026.	Complete	01/05/2026

Trent Louise  
06/05/2026 15:44:22

<b>Report to:</b>	NHS BSW, Dorset & Somerset ICB Legacy Board In Common	<b>Agenda item</b>	03
<b>Date of Meeting:</b>	11 May 2026		

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

<b>Report classification</b>	Not Confidential
<b>ICB body corporate</b>	NHS BSW, Dorset & Somerset ICB Legacy Board in Common
<b>ICS NHS organisations only</b>	BSW, Dorset & Somerset NHS
<b>Wider system</b>	BSW, Dorset & Somerset ICS

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

Previous consideration by:	Date	Please clarify the purpose

**1 Purpose of this paper**  
 This report provides the Board in Common with an update on the latest strategic developments across the NHS and more locally the developments within the Cluster.

**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:

- DHSC announcement on the Neighbourhood Health Framework
- NHS England announcement on Neighbourhood Health Centre Guidance
- NHS England announcement from the national CEO regarding recent Industrial Action
- NHS England announcement on the next steps for 26/27 Planning and Priorities

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

### **3 Legal/regulatory implications**

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

### **4 Risks**

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

### **5 Quality and resources impact**

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

### **6 Confirmation of completion of Equalities and Quality Impact Assessment**

Not applicable.

### **7 Communications and Engagement Considerations**

This report is published for public information and includes updates and the latest news from the NHS England.

### **8 Statement on confidentiality of report**

OFFICIAL, for public release.

Trent, Louise  
06/05/2026 15:44:22

## 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 BSW, Dorset and Somerset Legacy Boards and Integrated Care Systems.

### 2. Strategic Update – National & Regional Context

2.1. **DHSC announcement on the Neighbourhood Health Framework.** On 17 March the DHSC published its framework for Neighbourhood Health (<https://www.gov.uk/government/publications/neighbourhood-health-framework>). Neighbourhood health puts the person at the centre of how the NHS will deliver their health and care by organising services so they can work together to serve a defined population. This includes the services that people rely on close to home and on the high street, such as GPs and community services and, where appropriate, urgent care, diagnostics and outpatients. This also includes local authority-commissioned services, such as adult and children's social care and public health services.

The framework tasks ICBs and other providers to consider how they can plan neighbourhood health services. These services should complement and build upon local plans to transform the wider scope of public services, and support investment in local places and community regeneration. Health is an important contributor to that agenda, and the framework reflects the 3 principles that guide the government's approach to public sector reform. These principles are to:

- Integrate services so that they are organised around people's lives
- Improve long-term outcomes for people through a focus on prevention, relying less on expensive crisis management
- Devolve power to local areas, which understand the needs of their communities best, with services that are designed with and for people, in partnership with civil society and the impact economy

2.2. **NHS England announcement on Neighbourhood Health Centre (NHC) Guidance.** On the 16 April, NHS England published guidance on Neighbourhood Health Centre development (which should be read in conjunction with the DHSC Neighbourhood Health Framework above) ([NHS England » Neighbourhood health centre guidance for regions and integrated care boards](#)). Neighbourhood health is a central pillar of the government's 10 Year Health Plan and represents one of the most significant shifts in the organisation of health and care services since the creation of integrated care systems. Its purpose is to improve access to general practice, bring care closer to home, reduce unnecessary reliance on hospitals, and support a fundamental shift from reactive treatment to prevention, proactive care and integrated multi-disciplinary working. NHCs are a key physical and operational tool to support the neighbourhood health model, alongside care delivered in people's homes, digitally and in general practice, pharmacies and other community settings. They will be the place to go for most health needs in every

community. This approach also reflects the government's wider public service reform principles: shifting from reactive services to prevention, integrating services around people's lives, and devolving power to local areas in partnership with communities and civil society.

As part of the [Autumn Budget](#), the Government set out its plans in more detail – which confirmed it would deliver 250 NHCs by 2035, with 120 of those by 2030. These will comprise a mixture of upgrades to existing buildings and new build centres, with the balance between the two to be informed over time by local need, value for money and deliverability. New build schemes are expected to be funded through a combination of public capital and public private partnerships (PPPs), with around 20% funded through public capital and the remainder through PPP routes.

This investment in NHCs will support improved access to general practice, service transformation and a more strategic reshaping of the community and primary care estate and put us well on the way to our longer-term goal of a centre in every community supported by a combination of new capital investment, disposals and repurposed estate.

NHC estate proposals for upgrading, repurposing or building new centres should build on and be informed by the service changes ICBs are committing to deliver over 2026/27 and beyond in their planning submissions, including improved access to general practice, enhanced support for people with complex needs and the shift of appropriate activity out of acute settings. There should be a clear line of sight between neighbourhood health ambitions, clinical strategies, service redesign plans and the estate solutions proposed to enable them.

**2.3. NHS England announcement from the national CEO regarding recent Industrial Action.** On 13 April the national CEO for NHS England, Sir Jim Mackey, wrote to thank all staff for their efforts managing the latest round of the BMAs Industrial Action. He noted that “early indications show that you have, again, managed to maintain high levels of service and protect patient care through this latest strike – the latest data indicating that c 95% of elective activity has been maintained. That is a huge achievement so please pass on my thanks to all involved”. ([NHS England » Letter from NHS England's Chief Executive thanking staff for their efforts in managing the latest round of British Medical Association industrial action](#)).

**2.4. NHS England announcement from the national CEO regarding the next steps on planning and priorities for 2026/27.** On 1 Apr 26, Sir Jim Mackey, wrote to highlight the need to maintain the momentum, energy and discipline on delivery generated in the last year and equally apply it to shaping a more sustainable future model. He noted that the NHS is now very close to delivering our key operational imperatives on referral to treatment (RTT) and urgent and emergency care (UEC) while balancing the books. It was also genuinely encouraging to see this reflected in last week's British Social Attitudes survey which showed that, while we still have a long way to go, our patients have seen and felt a big improvement this year after two terrible years. The Cluster ICB has been requested to outline how it will enhance and augment our plans to describe

better how, as commissioners and providers, we intend to deliver our ambitions, with particular emphasis on:

- What strategic commissioning means in the local system and how we intend to develop this over the next 3 years
- How we intend to develop neighbourhood care, what our strategic ambition is and how this links to our key challenges
- Whether we would like NHS England to agree changes to financial flows and/or payment systems to help deliver this and, specifically, what these changes are
- Whether there is anything further NHS England need to do at the centre to help accelerate the pace of change locally, including getting out the way where necessary

The Cluster ICB will submit a single, system-wide strategic commissioning narrative, building on existing plans and setting out how commissioners and providers will work together over the next three years. The response is being developed using existing MTP and 5-year Commissioning Plans as the starting point and to challenge and co-design our stretch goals through the Board Development workshop on 7 May. This approach is intended to create a shared view of our NHS modernisation ambitions and agree clear goals, actions and delivery intent. Outputs from the workshops will be used to shape a single, coherent and jointly owned system response which will be submitted by 15 May. Details of the NHS England SW Region response to the plans that have already been submitted are included later in this report. (<https://www.england.nhs.uk/long-read/1-april-2026-next-steps-on-planning-and-priorities-for-2026-27/>)

**2.5. Annual Assessment of ICBs.** On 22 April NHS England has published the supporting guidance for the [2025/26 annual assessment of integrated care boards \(ICBs\)](#). This year's guidance sets out a streamlined, approach, reflecting the evolving role of ICBs and recent changes across the system. It provides details on the areas the annual assessment will cover, as well as information on timing and process, and is intended to support regional teams and ICBs in preparing for the 2025/26 assessment cycle.

### **3. Local Update - NHS BSW, Dorset and Somerset Legacy Board in Common and Cluster ICB**

**3.1. New Board in Common and Cluster Governance.** In accordance with NHS England statutory guidance, each legacy ICB must maintain their own ICB Board – we refer to these as 'legacy Boards' – as each ICB remains a legal entity until merger, these Boards are to remain. Each ICB website is still to display details of these legacy Boards until merger.

Legacy Boards will meet infrequently, and now in-common rather than having to hold three separate Board meetings. There are several powers that these legacy Boards will maintain – such as approving delegations to other committees, terms of reference, budgets, and annual reports. This Board in Common, happening today, is the first of this kind of meeting.

In parallel to this, we are establishing a Joint Committee – we refer to this as the ‘Cluster Board’ – the legacy Boards will delegate most powers/responsibilities down to this Cluster Board, enabling most business to be conducted collectively at cluster level, Changes to the constitution of the three ICB Boards, to support the development of the cluster joint committee, have been confirmed by NHSE. The first full Cluster Board meeting is to be held on 15 June 2026.

**3.2. Cluster ICB Transition and Staff Consultation.** The 45-day formal staff consultation on the proposed new structures for the Cluster was launched 18 March and ended on 1 May. While this process signals a major organisational shift, our shared commitment to the people and communities we serve remains unchanged. This consultation is about planning for the future as one team, developing the skills we need to succeed; building a high performing strategic commissioning organisation that can make bold, long-term decisions and achieve more for our communities. The aim for the consultation has been to hear colleague views on the team structures and engage colleagues in how we are going to work differently and build the skills and capabilities for the ICB to be successful in our new role.

Our role is to make sure we deliver the maximum value for every pound we spend, while using our commissioning skills to redirect resource and redesign the service. To do this ICBs need to change and be different. We need to build our technical commissioning skills while working collaboratively to deliver an NHS that is fit for the 21st Century.

Our three ICBs are now entering a significant new phase in this transition. We must continue to deliver our statutory functions while also evolving into a more streamlined, strategic commissioning organisation.

Our new cluster brings together our three Integrated Care Boards to work as one strategic commissioning organisation. Working together means we can share what we do best, learn from each other, and deliver care that is more consistent, more efficient, and more responsive to the people we serve.

We have already made the first steps in our transition; we have one shared executive team with the skills and experience to lead our new cluster as we develop into a high performing strategic commissioning organisation. We have also developed a new Target Operating Model that provides a clear blueprint for how our new organisation will work.

Following reflection by the Executive team outcomes of the formal consultation, including the final structures, will be published on 1 June and soon after that the recruitment and selection process will begin.

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.

**3.3. Second Tranche of Voluntary Redundancy.** To support the need to reduce overall running costs and fairly afford colleagues ‘agency’ in decisions that affect them, shortly after the formal staff consultation was launched, a second tranche of voluntary redundancy was offered to staff. The window for the second tranche closed on 26 April 2026 and the additional applications will now be considered against our set criteria.

**3.4. Medium Term Planning.** In line with the NHS Medium Term Planning Framework, all three legacy ICBs submitted their final medium-term plans to NHS England South West Region on 12 February.

Regional colleagues have provided three separate summary letters in response to the submissions of the final Medium-Term Plans for 2026/2027 – 2028/2029, and the five-year Strategic Commissioning Plan. We are required to publish these at Board and copies are at Appendix 1.

### **3.5. Focus on Place**

**3.6. Bath and North East Somerset (B&NES).** In Bath and North East Somerset, our commissioning focus is on translating a well-established shared neighbourhood vision into delivery - building on strong foundations of partnership. The B&NES vision was co-developed by the Integrated Care Alliance (ICA) and Health and Wellbeing Board and has been formally endorsed by the Board. Planning in B&NES must navigate what is genuinely distinctive about the locality: significant hidden deprivation sitting alongside overall affluence, a large student population across two universities of around 46,000 people, rural isolation and high housing costs driving insecurity for settled communities. Planning will build on particular strengths in comparatively mature health and social care integration and well established voluntary and community sector networks. The B&NES ICA is actively progressing its three priority areas:

- Children and Young People's Emotional Health and Wellbeing and Support for Children and Young People Not in Education or Training with a stakeholder planning event in July and a system summit in November co-produced with young people and aligned to the 2026 Schools Health and Wellbeing Survey. This work is being aligned with active locality plans around Best Start in Life, Families First Partnership Programme, SEND reform and Pride in Place.
- Integrated Neighbourhood Teams - building on the successful frailty multidisciplinary team test-and-learn pilot, which confirmed that community-based anticipatory care can reduce duplication and prevent avoidable admissions.

Through neighbourhood health planning, footprints for Bath, Keynsham and Somer Valley are being progressed for formal Health and Wellbeing Board agreement. In April, senior system leaders joined the first of a three-part neighbourhood health workshop series, with a Better Care Fund (BCF) strategic steer agreed to build on B&NES strong existing community foundations with a focus on coaching roles and coordination functions, treating patients and their carers holistically. BCF planning for 2026/27 is progressing in close partnership with the local authority ahead of the May national deadline.

**3.7. Swindon.** In Swindon, our strategic commissioning work reflects the particular character of our population: a young, diverse and growing community with concentrated deprivation in some areas, a strong presence of many diverse backgrounds and nationalities - communities with specific health access needs, and the highest rate of children in care in BSW. Our Neighbourhood Health vision, developed through ICA and Health and Wellbeing

Board working sessions in early 2026, sets out an approach deliberately designed for this context, moving away from one-size-fits-all models to address fragmentation, social isolation and cultural barriers as primary concerns. The Swindon ICA is actively progressing its three agreed priority areas:

- Children and Young People's Health Improvement Summit planned for June at New College Swindon, co-produced with young people through Change Makers and Youth Voice, with outputs to include agreed priorities and a post-summit action plan governed through the Health and Wellbeing Board.
- Targeted CYP oral health pathway pilot, live in Core20 communities<sup>1</sup>, with early positive results and a three-month review underway.
- Self-harm deep dive analysing activity in the year prior to hospital attendance, identifying the highest-risk cohort as white females aged 15 to 19, to inform commissioning and prevention strategy.

In April, senior system leaders from across Swindon joined the first of a three-part neighbourhood health workshop series, with a BCF strategic steer centred on a single trusted person, a community connector or social prescriber, as the practical mechanism for preventing people falling between services and treating loneliness and isolation as health issues. Neighbourhood footprint proposals, based on three Integrated Neighbourhood Teams mapped to primary care networks, are being progressed for Health and Wellbeing Board agreement. A key piece of work underway is developing a clear narrative for how these NHS footprints and Swindon Borough Council's community hub model, which are structurally distinct, will work effectively alongside each other in practice to deliver a joined-up experience for residents. Better Care Fund delivery for 2025/26 remains stable, with planning for 2026/27 actively underway ahead of the May national deadline.

**3.8. Wiltshire.** In Wiltshire, our strategic commissioning work is centred on developing a locally grounded Neighbourhood Health Plan, in close alignment with the Health and Wellbeing Board and our Integrated Care Alliance partners. The Wiltshire Neighbourhood Health vision has been formally endorsed by the Health and Wellbeing Board and reflects what is genuinely distinctive about the county: a widely dispersed population across rural villages, market towns and urban centres, with military families, agricultural communities, travelling communities and people in custodial settings, where rurality, transport and digital exclusion compound barriers to access. The opening this month of the new Trowbridge Integrated Care Centre (TICC), a £16 million investment bringing health and care services together under one roof in one of Wiltshire's most deprived communities, marks a significant milestone for integrated care in the locality and is part of a campus model offering neighbourhood health services across the town.

The Wiltshire ICA is actively progressing its three agreed priority areas:

<sup>1</sup> The most deprived 20% of the national population, as identified using the Index of Multiple Deprivation (IMD).

- Children and Young People's Emotional Health and Wellbeing Strategic Partnership Group, which is developing bid-ready prevention pilots across Community Connections, Social Communication Needs and Someone To Talk To workstreams.
- Ageing Brilliantly Community of Practice, which is bringing health, social care, voluntary sector and university partners together around frailty and falls prevention.
- Integrated Neighbourhood Teams, where learning from the Wiltshire Neighbourhood Collaboratives programme, nationally recognised for innovation in reducing health inequalities, is being systematically integrated into neighbourhood plan design.

In April, senior system leaders from across Wiltshire joined the first of a three-part neighbourhood health workshop series, producing agreed priority population statements and a BCF strategic steer focused on investment in technology and equipment to support people to remain independent at home for longer, alongside strengthening community-based connectors and notice-takers who can identify need before it reaches crisis. Better Care Fund planning for 2026/27 is progressing with Health and Wellbeing Board and local authority partners, ahead of the national May submission deadline.

**3.9. Dorset.** Dorset Place is in the early stages of developing its place-based partnership arrangements. A programme of design workshops is supporting the refresh of the Dorset Health & Wellbeing Strategy, alongside further consideration of the design, governance and purpose of a strengthened partnership model. There is growing momentum to align leadership and delivery across system partners, with early activity focused on collaborative working at neighbourhood level and clearer links between place-based priorities and system-wide strategies.

The ICB continues to play an active role in Dorset Place, including participation in Dorset Council-led workshops to inform the revision of the Local Plan. This work has focused on identifying sites for housing, employment, traveller provision and renewable energy, helping to ensure health and care considerations are embedded within future spatial planning.

A joint piece of work commissioned by Dorset Council's People and Health Scrutiny Committee is also underway, focusing on All-Age Continuing Care and joint funding arrangements. This aims to improve consistency, equity and joint accountability, and to optimise the use of collective resources across children's and adults' services.

Dorset Place remains part of the first wave of the National Neighbourhood Health Implementation Programme (NNHIP), with recent visits by national leaders providing positive feedback and recognising Dorset's strong partnership approach to neighbourhood working.

Dorset Council has published Dorset's Best Start Local Plan 2026–2029, setting out a whole-system approach to improving early childhood outcomes, with a focus on prevention, reducing inequalities and the first 1,001 days. The plan brings together health, education, early years, Family Hubs and voluntary sector partners to provide more coordinated, place-based support for children and families.

Dorset Council is working with partners on its SEND Reform Plan which requires us to demonstrate effective partnership delivery in response to the Schools White Paper. Each local area partnership must submit a SEND Reform Plan to the Department for Education by 19 June 2026 which has been signed off by the Partnership Board and signed off by the Local Authority and the ICB. Before that, Dorset Council must submit a draft to the DfE by 15th May. This is a big important piece of work in relation to an ambitious reform agenda, which has significant financial implications for councils as well as outcomes for children. To deliver this relies on very strong partnership working. Progress has also continued on delivery of the key worker service, supporting children, young people and families with complex needs to navigate services more effectively.

A robust NHS response to the meningitis B outbreak in the Weymouth area saw thousands of prophylactic antibiotics issued alongside a rapid vaccination programme, achieving high uptake rates. No further cases beyond the original three have been identified, demonstrating the effectiveness of the coordinated local response.

A new Youth Service has also launched at Dorset County Hospital for young people aged 11–25 with long-term health conditions and/or frequent Emergency Department attendance without a specific medical diagnosis, delivered by Dorset Youth as a two-year pilot, with the first referral now received.

**3.10. Bournemouth, Christchurch and Poole (BCP).** Work is progressing to formalise arrangements for the BCP place-based partnership, with a first meeting expected by the end of quarter one. This will provide an anchor point for place-based delivery, around which partners will convene. In parallel, work has commenced on the development of neighbourhood health plans, and a joint paper will be presented to the place-based partnership and Health and Wellbeing board around neighbourhood plan and integrated neighbourhood teams. This is aligned to national guidance and timelines. Linked to this, activity is underway to explore the feasibility of a neighbourhood health centre within the Boscombe Towns Fund regeneration programme.

The refreshed BCP Health and Wellbeing Strategy is scheduled for review and approval at the next Health and Wellbeing Board in June, following completion of public consultation. The strategy has been co-produced with system partners and is centred on four strategic priorities: Starting Well, Mental Wellbeing, Living and Ageing Well, and Healthy Neighbourhoods and Communities. This will provide a clear framework for place-based delivery around which all partners can align.

Several key focus areas are progressing at pace, aligned to national timelines. The BCP SEND Reform Plan is being co-produced with partners following extensive stakeholder engagement and will be submitted in June. This will provide a clear roadmap for delivering improvement in the offer for children, young people and their families. The 2026/27 Better Care Fund Plan has been jointly developed by health and social care and will be submitted in May. It retains a strong focus on intermediate care, to prevent admission and reduce hospital length of stay, alongside a focus on prevention and earlier intervention. Following submission, there is an intention to immediately commence development of the 2027/28

plan, which will align more fully with emerging neighbourhood delivery models. Work is also progressing on a refreshed Homelessness Delivery Plan and the emerging BCP Growth Plan, with full partner engagement.

Work continues to ensure system preparedness for the final transfer of services on the UHD hospital sites later this year with the next review gateway scheduled for June. This is focused in two areas:

- Realising the impact of large-scale transformation to better manage acute demand and reduce hospital delays, thereby creating capacity on acute sites. This builds on outputs and benefits realisation from existing programmes including FutureCare, Neighbourhood development, Mental health transformation and the recommendations from the Vista report centred on strengthening out of hospital provision, plus
- Development of a tactical risk management plan to ensure that service transfers are safe and supported by all partners.

**3.11. Somerset.** We have actively engaged with the national Primary Care Network (PCN) primary care pilot through Frome and Mendip, working closely with local partners to test and refine approaches that support neighbourhood working. Improving the primary–secondary care interface has been a key focus of the pilot, and with Frome and Mendip as the pilot sites this has enabled a strong focus on addressing cross-boundary issues, which will be particularly valuable as we move into cluster working.

Through participation in the National PCN pilot programme, we have developed a clearer, evidence-based understanding of the operational impact on practices, alongside wider system benefits in improving access, continuity and multidisciplinary team integration. This work has also highlighted the challenges in establishing consistent metrics across primary care, particularly in relation to variation in data capture and interpretation across different settings.

Digital transformation has also been a key enabler across both sites. This has included the introduction of online registrations, reduced administrative burden and improving efficiency, as well as automated filing of results. Ambient voice technology has also been adopted by both PCNs, alongside the implementation of clinical safety officers to support safe and effective use of digital tools.

Now in the final year of the pilot, both PCNs are sharing their insights and learning across the local system, including through the Big Tent event, and incorporating learning from other pilot sites, supporting spread and adoption. They have made a significant contribution to identifying and addressing primary–secondary care interface and pathway challenges, helping to drive practical improvements locally. This learning has been shared across the system and has also been fed into national discussions, helping to shape emerging general practice contract and neighbourhood models and inform future contractual development, ensuring Somerset's experience is influencing both local delivery and national policy.

Implementation of the reconfigured Somerset stroke service is progressing, with a strong focus on clinical safety and system readiness, including whole system risk assessments. Estates works at Dorset County Hospital (DCH) are on track for completion by the end of April 2026, enabling the opening of the expanded Hyper Acute Stroke Unit (HASU) in the first week of June 2026, subject to final clinical assurance. Workforce requirements for DCH are expected to be fully in place by the end of May, and joint clinical pathways and Standard Operating Procedures between Somerset NHS Foundation Trust and DCH are being finalised. Digital interoperability has improved, including access for DCH to the Somerset Integrated Digital eRecord, supporting safe cross-system working.

At Musgrove Park Hospital (MPH), estates and ward improvements remain on schedule for completion by the end of August 2026, with full implementation of the new countywide model expected in the first week of September 2026. Workforce plans across Somerset sites are expected to be fully met by this point, alongside the introduction of patient transport arrangements to support timely repatriation to Yeovil District Hospital (YDH). While redevelopment plans at YDH have been delayed due to updated fire safety requirements, a feasible alternative solution to enhance the rehabilitation environment has been agreed. The System-wide risk assessments, ongoing development of the pilot for Pre-Hospital Video Triage with SWASFT, and phased communication planning will be in place to ensure the service transition is safe, well-managed and clearly communicated ahead of full go-live.

Urgent dental care activity remains a key system priority and continues to be monitored nationally as an indicator of dental access improvement work. In Somerset, there are early signs of improvement linked to targeted interventions such as UDA rate uplifts and service mobilisation with 3 new dental provider contracts being enabled recently; however, delivery remains variable across providers, with full assessment dependent on year-end data. National reform is shifting the focus toward a more integrated, whole-system dental model, with Somerset transitioning from a predominantly urgent care offer to a more balanced urgent, complex and routine care pathway. Continued contract management, workforce stabilisation and system-wide planning will be critical to sustaining access and improving performance.

NHS Somerset is leading the development of a mobilisation plan to support delivery of the Somerset Frailty Strategy, in line with NHS Operational Planning guidance, working in partnership with general practice, primary care and wider system partners. The plan will align with the ICB's strategic commissioning intentions and neighbourhood health framework and set out a clear, system-led approach to mobilise the Somerset Neighbourhood Frailty Model. It will support consistent and equitable implementation across all neighbourhoods working in collaboration with all system partners, with a focus on improving population health outcomes and reducing inequalities, and act as a use case for new ways of neighbourhood working in the County.

Somerset NHS Foundation Trust (Somerset FT) reopened perinatal services on 21 April 2026 and confirmed that the Board has agreed that all essential criteria had been met. A robust communication plan was shared with all stakeholders, detailing plans for relaunch.

During the week running up to the relaunch, Somerset FT established a tactical operational call with all relevant stakeholders, meeting three times day. To monitor capacity, demand, workforce and acuity across maternity and neonatal services (Somerset/Dorset). The ICB has been attending the calls, to support any system actions (nil required to date).

Somerset FT has developed a new data dashboard (which records activity in real time), and Safety Oversight Framework. Both tools will support maternity and neonatal services to maximise service delivery (workforce, resources and clinical space) and ensure safety and quality of services.

Since the relaunch of services on 21 April 2026, there has been a steady increase in the number of pregnant women/birthing people accessing maternity services at YDH. The organisation is expecting a decline in the number of women/birthing people accessing maternity services at DCH and MPH.

There have been no concerns identified with the Special Care Baby Unit (SCBU) relaunch. Activity in the unit is being monitored via tools detailed above. At the time of writing there was one baby in SCBU receiving care.

Somerset FT will be collating feedback from service users, and this will be shared via social media/newsletters.

Trent, Louise  
06/05/2026 15:44:22

Appendix 1:  
**NHSE SW Regional responses to BaNES, Swindon and Wiltshire, Dorset and Somerset Integrated Care Board (ICB) submissions of the final Medium-Term Plan for 2026/2027**

To: Jonathan Higman, NHS BSW  
Integrated Care Board

NHS England  
South West Region  
South West House  
Taunton  
TA1 2PX

22 April 2026

Sent via email

Dear Jonathan,

BaNES, Swindon and Wiltshire Integrated Care Board (ICB)

Acceptance Status: Accepted with conditions

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year- Strategic Commissioning Plan**, and to set out next steps. Thank you for the extensive work across the organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years does not end with acceptance of the plan; as the focus moves to delivery, foundational work will continue as you work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

Trent, Louise  
06/05/2026 15:44:22

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

- Compliant with Conditions

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. We will review progress against these plans with you through our Regional governance arrangements which include System Delivery Stocktake meetings, System Mid Year Review meetings, Provider Oversight meetings, Tiering and other performance and delivery meetings, to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

We are aware that the data collection template for “Percentage of clinically urgent appointments seen on the same day” for the 2026/27 period is not expected until after the main planning round has concluded. With that in mind please note specific discussions may be needed around this area following issue of this letter.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely,



Sue Doheny Regional  
Director

**Copy to:**

Alison Henly, Cluster Chief Officer Strategic Finance and Resources

David Freeman, Cluster Chief Officer for Commissioning and Place

Trent, Louise  
06/05/2026 15:44:22

## Annex One

Below is the outcome of your full submission and the compliance against the key ambitions within the three years until 2028/29:

Programme	Measure Name	26/27 Plan	Target/Baseline	27/28 Plan	Target/Baseline	28/29 Plan	Target/Baseline
Learning Disabilities and Autism	Adult 12-month admission rate per million population	36.8	28.9	32.9	36.8	28.9	32.9
Learning Disabilities and Autism	Longest Lengths of Stay	42.9	53.3		42.9		
Learning Disabilities and Autism	Percentage of AHCs delivered to patients aged 14+ on the GP Learning Disability Register	75.0	74.4	77.0	75.0	79.0	77.0
Learning Disabilities and Autism	Reliance on MH inpatient care - adults with autism	8.0	8.0	0.0	8.0	0.0	0.0
Learning Disabilities and Autism	Reliance on MH inpatient care - adults with LD	8.0	8.0	0.0	8.0	0.0	0.0
Learning Disabilities and Autism	Reliance on MH inpatient care - LD&A - under 18	5.0	8.0	0.0	5.0	0.0	0.0
Learning Disabilities and Autism	Under-18 12-month admission rate per million population	51.8	62.2	46.6	51.8	41.4	46.6
Mental Health	Access to CYP Mental Health Services	13,830.0	13,829.0	14158.1	13829.0	14489.1	13829.0
Mental Health	Access to MHSTs in schools and colleges	2,982.4	2,465.0	3310.5	2982.4	3641.5	3310.5
Mental Health	Access to Specialist Community Perinatal Mental Health Services	1,115.0	1,115.0	1125.0	1115.0	1135.0	1115.0
Mental Health	Active inappropriate adult acute mental health OAPs	0.0	8.5	0.0	0.0	0.0	0.0
Mental Health	Average LoS for Patients in Adult Acute and PICU MH Beds	39.1	40.4	38.0	39.1	36.8	38.0
Mental Health	Average LoS for Patients in Older Adult Acute MH Beds	128.6	137.2	122.7	128.6	112.9	122.7
Mental Health	Completed courses of treatment	10,200.0	10,545.0	10700.0	11222.0	11250.0	12033.0
Mental Health	CYP with mental health waits over 104 weeks	0.0	0.0				
Mental Health	Individual Placement Support access	832.0	832.0	919.0	919.0	967.0	967.0
Mental Health	NHST coverage of total pupils/learners	79.9	77.0	90.6	100.0	100.0	100.0
Mental Health	NHS talking therapies - reliable improvement	69.0	69.0	70.0	70.0	71.0	71.0
Mental Health	NHS talking therapies - reliable recovery	51.0	51.0	52.0	52.0	53.0	53.0
Community	Community waiting list % 18 weeks or less		78.0		79.0		80.0
Primary Care	Pharmacy First Consultations	118,806.0	113,732.0	128342.0		133302.0	
Primary Care	Urgent dental appointments	41,218.0	54,455.0	41218.0	54455.0	41218.0	54455.0
Diagnostics	Diagnostic Tests - Activity - All Tests	453,618.0	427,970.0	459432.0	472795.0	458059.0	479106.0
Diagnostics	Diagnostics % waiting 6 weeks or over	8.4	8.4	5.3	5.5	1.0	1.0
Cancer	Cancer % treated within 31 days of DTT	94.1	94.0	96.0	96.0	96.1	96.0
Cancer	Cancer % treated within 62 days of referral	77.8	80.0	82.6	82.5	85.1	85.0
Cancer	Cancer FDS % within 28 days	80.0	80.0	80.5	80.0	80.0	80.0
Elective RTT	RTT % within 18 weeks	72.2	71.8	79.7	78.9	92.4	92.0
Elective RTT	RTT waiting list size	100,158.0	105,754.0	93646.0	81530.0	87688.0	57250.0

Specific issues that require ongoing review and/or further system action are:

CONDITIONS PLACED ON 18 MARCH PLAN ACCEPTANCE			
Plan area / Metric	Outstanding Issues	Conditions	Success Criteria & timescales
Finance	While BSW ICB has submitted a breakeven plan for all three years, the demand management schemes remain insufficiently mature. Failure of these schemes to deliver as planned would present a material risk to both the financial and operational plans.	Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay. Strengthen demand management design and reporting: Continue to develop and implement demand management schemes so they are fully operational, with reporting that is more granular (e.g., by pathway/specialty, intervention, timeline, owner, and quantified impact).	In Q1
Community Waits	Further information required relating to ICB focus on <18 and 52+ week waits, and triangulation of financial shift to support delivery.	Agreed for inclusion of waits from Swindon on the overall trajectory and system position for community waits, inclusive of ND.  Also, confirmation of what services will need including within the current view provided to ensure we have an inclusive view of all waits within BSW.	In action, for monthly review

LD	CYP admissions not aligned with per million benchmarking of 2 rather than 5. Current position is lower than 5 so an EoY ambition of 5 would be a backwards step	ICB must continue to work with providers to ensure CYP per million target can be met	Plans shared and agreed in Q1
Talking Therapies Completed courses of Treatment	No change to Feb submission. System remains 3% below in 26/27 rising to 7% below in 28/29	Further improvement in years 2 and 3 in order to meet the ambition by end 28/29. The ICB to return with a sustainable plan for delivery of Talking Therapies, which may include procurement, by the end of Q2.	Plans shared and agreed by Q2
MHCYP access	No changes to February submission, whilst achieving baseline ambition in 26/27 there is no further growth in activity in years 2 and 3. Expectation to see expansion in delivery of MHSTs	Plan for further growth in years 2 and 3 of plan. Triangulation between MHST expansion plans and CYP access trajectories is expected, with revised plans to be provided in Q1.	Plans shared and agreed by Q1

Trent, Louise  
 06/05/2026 15:44:22

To: Jonathan Higman, Cluster CEO  
Somerset Integrated Care Board (ICB)

NHS England  
South West Region  
South West House  
Taunton  
TA1 2PX

22 April 2026

Sent via email

Dear Jonathan

Somerset Integrated Care Board (ICB) Acceptance

Status: Accept with Conditions

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year Strategic Commissioning Plan** and to set out next steps.

Thank you for the extensive work across the organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years does not end with acceptance of the plan; as the focus moves to delivery, foundational work will continue as you work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

- Compliant with Conditions

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. We will review progress against these plans with you through our Regional governance arrangements which include System Delivery Stocktake meetings, System Mid Year Review meetings, Provider Oversight meetings, Tiering and other performance and delivery meetings, to ensure that there is oversight, alignment across organisations, and transparent governance.

We are aware that the data collection template for “Percentage of clinically urgent appointments seen on the same day” for the 2026/27 period is not expected until after the main planning round has concluded. With that in mind please note specific discussions may be needed around this area following issue of this letter.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely,



Sue Doheny  
Regional  
Director

**Copy to:**

David Freeman, Chief Officer for Commissioning and Place  
Alison Henly, Chief Officer Strategic Finance and Resources  
Shelagh Meldrum, Chief Nursing Officer and Director of Operations  
David McClay, Place Director Somerset

Trent, Louise  
06/05/2026 15:44:22

## Annex One

Below is the performance outcome of your full submission and the compliance against the key ambitions within the three years until 2028/29:

Programme		ICB	Provider	View		Engli South	
Multiple selections		SOMERSET	All	ICB	Provider		
Programme	Measure Name	26/27 Plan	Target/Baseline	27/28 Plan	Target/Baseline	28/29 Plan	Target/Baseline
Learning Disabilities and Autism	Adult 12-month admission rate per million population	30.0	27.9	27.9	30.0	21.4	27.9
Learning Disabilities and Autism	Longest Lengths of Stay	16.7	28.6	16.7	16.7		
Learning Disabilities and Autism	Percentage of AHCs delivered to patients aged 14+ on the GP Learning Disability Register	75.0	70.6	76.0	75.0	76.5	76.0
Learning Disabilities and Autism	Reliance on MH inpatient care - adults with autism	4.0	4.0	0.0		0.0	
Learning Disabilities and Autism	Reliance on MH inpatient care - adults with LD	7.0	7.0	0.0		0.0	
Learning Disabilities and Autism	Reliance on MH inpatient care - LD&A - under 18	1.0	1.0	0.0	1.0	0.0	0.0
Learning Disabilities and Autism	Under-18 12-month admission rate per million population	9.0	9.0	9.0	9.0	9.0	9.0
Mental Health	Access to CYP Mental Health Services	10,324.0	8,240.0	10456.0	8240.0	11076.0	8240.0
Mental Health	Access to MHSTs in schools and colleges	2,641.0	1,315.0	3591.0	2641.0	4211.0	3591.0
Mental Health	Access to Specialist Community Perinatal Mental Health Services	645.0	640.0	650.0	640.0	655.0	640.0
Mental Health	Active inappropriate adult acute mental health OAPs	0.0	3.0	0.0		0.0	0.0
Mental Health	Average LoS for Patients in Adult Acute and PICU MH Beds	63.9	65.5	62.3	63.9	60.7	62.3
Mental Health	Average LoS for Patients in Older Adult Acute MH Beds	78.8	86.2	76.8	78.8	74.9	76.8
Mental Health	Completed courses of treatment	6,582.0	6,980.0	7514.0	7436.0	7983.0	7978.0
Mental Health	CYP with mental health waits over 104 weeks	0.0	0.0				
Mental Health	Individual Placement Support access	551.0	551.0	609.0	609.0	641.0	641.0
Mental Health	MHST coverage of total pupils/learners	72.8	72.1	91.8	91.3	100.0	100.0
Mental Health	NHS talking therapies - reliable improvement	69.1	69.0	70.0	70.0	71.0	71.0
Mental Health	NHS talking therapies - reliable recovery	51.1	51.0	52.0	52.0	53.0	53.0
Community	Community waiting list % 18 weeks or less	84.4	78.0	84.4	79.0	84.4	80.0
Primary Care	Pharmacy First Consultations	79,060.0	79,058.0	80244.0		81448.0	
Primary Care	Urgent dental appointments	34,754.0	33,152.0	34754.0	33152.0	34754.0	33152.0
Diagnostics	Diagnostic Tests - Activity - All Tests	295,956.0	284,942.0	313378.0	310063.0	315634.0	312668.0
Diagnostics	Diagnostics % waiting 6 weeks or over	6.3	6.3	4.2	4.2	1.0	1.0
Cancer	Cancer % treated within 31 days of DTT	94.6	94.0	96.1	96.0	96.2	96.0
Cancer	Cancer % treated within 62 days of referral	81.0	80.0	82.5	82.5	86.0	85.0
Cancer	Cancer FDS % within 28 days	80.0	80.0	80.1	80.0	80.1	80.0
Elective RTT	RTT % within 18 weeks	74.8	74.8	83.2	83.2	92.1	92.0
Elective RTT	RTT waiting list size	57,756.0	59,843.0	47683.0	49462.0	37539.0	39001.0

Specific issues that require ongoing review and/or further system action are:

CONDITIONS PLACED ON 18 MARCH PLAN ACCEPTANCE			
Plan area / Metric	Outstanding Issues	Conditions	Success Criteria & timescales
Finance (including workforce plan triangulation)	Somerset ICB has submitted a breakeven plan in line with requirements. Plans are aligned across the Somerset system and progress is being made towards signing contracts in line with the timetable. Acceptance of the ICB's plan is subject to the following condition:	Contract closure and approvals: Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay.	Contracts to be signed without delay

Trent, Louise  
06/05/2026 15:44:22

To: Jonathan Higman CEO – NHS Dorset  
Integrated Care Board (ICB)

NHS England  
South West Region  
South West House  
Taunton  
TA1 2PX

22 April 2026

Sent via email

Dear Jonathan

NHS Dorset Integrated Care Board (ICB)

**Acceptance Status: Accepted with conditions**

I am writing in response to the submission of **your final medium-term plan for 2026/27–2028/29** and your **five-year-Strategic Commissioning Plan**, and to set out next steps.

Thank you for the extensive work across the organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years does not end with acceptance of the plan; as the focus moves to delivery, foundational work will continue as you work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

- Compliant with Conditions

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. We will review progress against these plans with you through our Regional governance arrangements which include System Delivery Stocktake meetings, System Mid Year Review meetings, Provider Oversight meetings, Tiering and other performance and delivery meetings, to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

We are aware that the data collection template for “Percentage of clinically urgent appointments seen on the same day” for the 2026/27 period is not expected until after the main planning round has concluded. With that in mind please note specific discussions may be needed around this area following issue of this letter.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely,



Sue Doheny Regional  
Director

**Copy to:**

Alison Henly, Chief Officer Strategic Finance and Resources David  
Freeman, Chief Officer for Commissioning and Place  
Dean Spencer, Place Director, Dorset

Trent, Louise  
06/05/2026 15:44:22

## Annex One

Below is the performance outcome of your full submission and the compliance against the key ambitions within the three years until 2028/29:

Programme		ICB	Provider	View			
Multiple selections		DORSET	All	ICB	Provider		
Programme	Measure Name	26/27 Plan	Target/Baseline	27/28 Plan	Target/Baseline	28/29 Plan	Target/Baseline
Learning Disabilities and Autism	Adult 12-month admission rate per million population	24.8	35.6	21.7	24.8	18.6	21.7
Learning Disabilities and Autism	Longest Lengths of Stay	11.1	32.4		11.1		
Learning Disabilities and Autism	Percentage of AHCs delivered to patients aged 14+ on the GP Learning Disability Register	75.1	71.6	75.7		76.1	75.7
Learning Disabilities and Autism	Reliance on MH inpatient care - adults with autism	5.0	5.0	0.0		0.0	
Learning Disabilities and Autism	Reliance on MH inpatient care - adults with LD	13.0	13.0	0.0		0.0	
Learning Disabilities and Autism	Reliance on MH inpatient care - LD&A - under 18	0.0	2.0	0.0		0.0	0.0
Learning Disabilities and Autism	Under-18 12-month admission rate per million population	28.6	64.3	14.3	28.6	7.1	14.3
Mental Health	Access to CYP Mental Health Services	8,142.0	8,136.0	9218.0	8136.0	9339.0	8136.0
Mental Health	Access to MHSTs in schools and colleges	1,821.0	1,620.0	1885.0	1821.0	2120.0	1885.0
Mental Health	Access to Specialist Community Perinatal Mental Health Services	721.0	720.0	742.0	720.0	769.0	720.0
Mental Health	Active inappropriate adult acute mental health OAPs	1.0	2.0	0.0	1.0	0.0	0.0
Mental Health	Average LoS for Patients in Older Adult Acute and PICU MH Beds	59.7	48.6	54.9	59.7	49.6	54.9
Mental Health	Average LoS for Patients in Older Adult Acute MH Beds	111.4	139.0	102.7	111.4	90.3	102.7
Mental Health	Completed courses of treatment	9,839.0	12,235.0	10452.0	12235.0	11183.0	12235.0
Mental Health	CYP with mental health waits over 104 weeks	0.0	0.0				
Mental Health	Individual Placement Support access	777.0	776.0	856.0	856.0	899.0	898.0
Mental Health	MHST coverage of total pupils/learners	77.1	76.4	92.0	91.5	98.5	100.0
Mental Health	NHS talking therapies - reliable improvement	69.0	69.0	70.0	70.0	71.0	71.0
Mental Health	NHS talking therapies - reliable recovery	51.0	51.0	52.0	52.0	53.0	53.0
Community	Community waiting list % 18 weeks or less	53.0	78.0	56.0	79.0	58.7	80.0
Primary Care	Pharmacy First Consultations	98,260.0	96,126.0	123637.7		139155.3	
Primary Care	Urgent dental appointments	42,960.0	52,857.0	48330.0	52857.0	53700.0	52857.0
Diagnostics	Diagnostic Tests - Activity - All Tests	446,123.9	427,968.0	468253.0	466124.0	479111.7	473570.0
Diagnostics	Diagnostics % waiting 6 weeks or over	9.7	1.0	6.4	1.0	1.0	1.0
Cancer	Cancer % treated within 31 days of DTT	95.5	94.0	96.0	96.0	96.0	96.0
Cancer	Cancer % treated within 62 days of referral	80.0	80.0	82.7	82.5	85.0	85.0
Cancer	Cancer FDS % within 28 days	80.0	80.0	80.2	80.0	80.3	80.0
Elective RTT	RTT % within 18 weeks	73.0	72.9	80.1	80.1	92.1	92.0
Elective RTT	RTT waiting list size	90,581.0	95,351.0	88295.0	76177.0	85276.0	56953.0

Specific issues that require ongoing review and/or further system action are:

CONDITIONS PLACED ON 18 MARCH PLAN ACCEPTANCE			
Plan area /Metric	Outstanding Issues	Conditions	Success Criteria & timescales
Finance	Dorset ICB has submitted a breakeven plan including DSF of £5.642m and £0.25m risk reserve monies. The ICB's savings plan represents 2.6% which is credible and achievable (2025/26 forecast is 3.8%) and is made up of £30.8m (2.0%) and additional schemes of £24.5m. Planned savings have increased by £7.1m since the December submission reflecting additional work to achieve breakeven and support UEC and elective growth in providers. 100% of schemes have been identified and 16.1% of schemes are assessed as high risk. Plans are broadly aligned across the Dorset system and there is a process and timelines in place to ensure signing of contracts and escalation route as	Contract closure and approvals: Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay.	Without delay

	appropriate. Acceptance of the ICB's plan is subject to the following condition:		
Elective Referral to Treatment (RTT)	Advice and refer is likely to impact positively on waiting list reduction whilst negatively on RTT performance. This needs to be factored in.	As part of preparation for planning 2027/28, model in an estimated impact on waiting lists through reduced clock starts due to advice and refer.	From October 2026 onwards
Mental Health Talking Therapies	Over national target for completed courses of treatment but note below current 2025/26 baseline. System (ICB and DHC) reviewed and confirmed they believe they are compliant with technical guidance, meet fair shares requirement and want to focus on quality and outcomes while delivering all three targets which means will not meet baseline (redline) for completed courses of treatment. NHSE different interpretation of the technical guidance and national red line to not reduce below current activity,	We note the position set out in Matthew Bryant and Jonathan Higman letter of 25 March 2026 and welcome the system's focus on sustainable achievement of both quality outcomes. NHSE clarification of the Technical Guidance is that where ambitions are being met in the baseline period this refers to ambitions individually. Completed courses of treatment must continue to increase year on year from baseline. This has been confirmed in correspondence with the mental health team throughout the planning process. We note the link to finances set out in the letter, however, on delivery of the baseline may risk access to the Autumn statement funding. The ICB and DHC are required to review the position, and confirm how they will get to a baseline compliant plan within 4 weeks.	By 5 May 2026
Dental	Plans do not currently meet urgent dental target. The system is modelling and developing new services which will increase capacity routine and urgent. System have Executive grip.	No conditions required and non-compliance accepted	N/A
Community Waits	Plans do not currently meet community waiting list requirements with long waiting times and lists for paediatric neurodiversity.	No formal conditions requested and non compliance accepted. To support local patients, the ICB is asked to work with providers towards an improved position from the one submitted.	Improvement in year performance meetings

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<b>Report to:</b>	NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB Boards meeting in common	<b>Agenda item</b>	04
<b>Date of Meeting:</b>	11 May 2026		

<b>Title of Report:</b>	Cluster governance, and appointment of Deputy Chair
<b>Report Author:</b>	Anett Loescher, BSW ICB Associate Director of Governance, Compliance and Risk
<b>Board / Director Sponsor:</b>	Rob Whiteman, Cluster Chair Jonathan Higman, Cluster CEO
<b>Appendices:</b>	1 – Scheme of Reservations and Delegations (SoRD) 2 – Standing Financial Instructions (SFI) 3 – Terms of Reference for: <ul style="list-style-type: none"> <li>• Cluster Board</li> <li>• Audit Committees (in common)</li> <li>• Strategic Finance and Resources Committee</li> <li>• Quality and Population Engagement Committee</li> <li>• Population Health and Commissioning Committee</li> </ul> 4 – Functions and Decisions map

<b>Report classification</b>	
<b>ICB cluster</b>	x

<b>Purpose:</b>	<b>Description</b>	<b>Select (x)</b>
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	x
Noting	For noting without the need for discussion	

<b>Previous consideration by:</b>	<b>Date</b>	<b>Please clarify the purpose</b>
Transition Committee	5 February 2026	Consideration and recommendation of proposals to the Boards
NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB Boards	March 2026	Endorsement of proposed committee structure

<b>1 Purpose of this paper</b>
In March 2026, NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB Boards approved the proposed cluster governance model which had been designed in alignment with the target operating model and the functions / duties that the ICBs and the cluster are required to discharge. Following that approval, the governance documentation in appendices 1 to 4 has been developed, forming the Governance

Handbook for the Cluster. Together with the ICBs' Constitutions, the Governance Handbook determines the cluster's governance and decision-making framework.

Key point – Scheme of Reservations and Delegations (SoRD), and Standing Financial Instructions (SFI):

- The Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB each need to formally approve and adopt the SoRD and SFI. This will bring the SoRD and the SFI into effect for each of the ICBs, and will enable governance and decision-making arrangements that are virtually identical across the three ICBs.

Key points – ICB Boards and Cluster Board:

- While NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB remain legal / corporate entities in their own right, they each must retain a Board and must not form a single joint Board.
- The Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB (the ICB Boards) form a joint committee – the Cluster Board – under sections 65Z5 and 65Z6 of the NHS Act 2006 (statutory guidance [NHS England » Arrangements for delegation and joint exercise of statutory functions](#) applies), and delegate the majority of their responsibilities and powers to that Cluster Board. The ICB Boards meet only to transact the business that they cannot delegate to the Cluster Board. The SoRD reflects this.
- It is important to recognise and acknowledge that the Cluster Board is a joint committee of the ICB Boards, it is not the joint Board of the ICBs.
- 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.

Key point – Committees:

- Audit Committees (in common), Strategic Finance and Resources Committee, Quality and Population Engagement Committee, and Population Health and Commissioning Committee are formally established by the NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB Boards, as committees of those Boards. The Committees are not established by, and nor do they function as, committees of the Cluster Board.

This construct satisfies the requirements of legislation and statutory guidance for ICB governance, and ensures that the ICB Boards can indeed retain accountability and assurance over the ICBs' discharge of their statutory functions, duties and responsibilities.

Key point – Audit Committees:

- While NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB remain legal / corporate entities in their own right, they each must retain an Audit Committee and must not form a single joint Audit Committee.

The Audit Committees can, however, meet in common and consider the ICBs' audit business in the round. To facilitate such in-common meetings, the ToR of the ICBs' Audit Committees have been aligned to the point of being identical. It is intended that each ICB Board adopts the proposed ToRs, establishing an Audit Committee for that ICB.

Key point – Remuneration Committee:

- The Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB approved the ToRs for a joint Remuneration Committee in March 2026. The ToR of the joint Remuneration Committee are therefore not included for approval.

Key point – Committees' sub-committees, Place governance:

- The Committees can themselves establish sub-committees / sub-groups, however they will not delegate any of their responsibilities to those sub-committees. The Functions and Decisions Map shows the anticipated sub-committees / sub-groups (in blue) which are still under development. Work has commenced to develop place governance arrangements also.

Assurance note:

- The cluster governance is designed to assure, during the year 2026/27, the delivery of the ICBs' legacy business, business as usual, and the transition both into cluster structures and towards merger. Chief Officers meet collectively and regularly as the Executive Management Meeting (EMM), the ICBs' overall decision-making body regarding the management of the organisations' day-to-day performance and delivery. The EMM is supported in this by the Senior Leadership Team (SLT) of each ICB. The SLTs are conceived as the custodian of the respective ICB's business as usual, and each SLT assures the EMM that the respective ICB continues to discharge its statutory functions through the delivery of agreed plans of work and activities.

Appointment of Deputy Chair for the Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB

- The ICBs' Constitutions stipulate that "The Deputy Chair is to be appointed from amongst the Non-Executive members by the Board, subject to the approval of the Chair. No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time". The Chair asks that the Boards appoint Ade Williams as the Deputy Chair of the Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB.

## 2 Summary of recommendations and any additional actions required

The Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB are invited to **approve**

- The Scheme of Reservations and Delegations (SoRD)
- The Standing Financial Instructions

- The Terms of Reference for:
  - Cluster Board
  - Audit Committees (in common)
  - Strategic Finance and Resources Committee
  - Quality and Population Engagement Committee
  - Population Health and Commissioning Committee
- The Functions and Decisions map

The Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB are invited to **note, and take assurance** from, the assurance note provided in this report.

The Boards of NHS BSW ICB, NHS Dorset ICB, and NHS Somerset ICB are asked to **appoint** Ade Williams as their Deputy Chair.

### 3 Legal / regulatory implications

The SoRD, SFI, Terms of Reference, and the governance and decision-framework that they establish together with the ICBs' Constitutions, comply with current legislation and statutory guidance for ICB governance; and respect specific limitations such as that Audit Committees must remain separate while the ICBs remain legal entities in their own rights. This specifically follows the advice of the ICBs' legal advisors, too.

### 4 Risks

Without formally approved and codified governance and decision-making arrangements, the ICBs and the cluster are unclear about who may make decisions, and where accountabilities lie. Consequences include paralysis in decision-making; inability to discharge functions, duties and responsibilities efficiently and effectively; lack of accountability; lack of transparency; and failures of governance.

### 5 Quality and resources impact

No additional financial resource is required to mobilise the committees per their ToRs, or to implement the overall governance and decision-making arrangements. Work is being delivered by existing governance teams.

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

n/a

### 7 Communications and Engagement Considerations

The cluster governance arrangements as determined via the ICBs' Constitutions and the documentation for approval today will be communicated internally, to ensure colleagues are clear about where responsibilities for decision-making, accountabilities, and assurance lies.

All documentation in appendices 1 to 4 will be published on the ICBs' websites, as the ICBs' Governance Handbooks.

**8 Statement on confidentiality of report**

The contents of this report can be shared publicly.

Trent, Louise  
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# NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board, NHS Dorset Integrated Care Board, and NHS Somerset Integrated Care Board

## Scheme of Reservations and Delegations

### 1. Introduction

This Scheme of Reservations and Delegations (SoRD) establishes the framework for the cluster arrangement between NHS Bath and North East Somerset, Swindon and Wiltshire (BSW), NHS Dorset, and NHS Somerset Integrated Care Boards, operating through the Joint Committee (the 'Cluster Board') established under sections 65Z5 and 65Z6 of the NHS Act 2006. Statutory guidance [NHS England » Arrangements for delegation and joint exercise of statutory functions](#) applies.

Sections 2 to 6 summarise at a high level the matters that are reserved to the ICB Boards, and the matters that are delegated to the Cluster Board and other committees.

Annex A – matters reserved to the individual ICB Boards.

Annex B – matters delegated to the Cluster Board.

Annex C – matters delegated to Committees.

Annex D – matters reserved to NHS England

Annex E – matters reserved to the ICB Chair

Each ICB Board adopts this SoRD; all three ICB Boards must approve changes and amendments to this SoRD.

**Summary:** The majority of functions and powers of each ICB Board are delegated to the Cluster Board and other joint committees of the ICB Boards, except those specifically reserved to the ICB Boards, see below. Each ICB Board remains accountable for all its functions and powers, including those that it delegates.

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## 2. Matters reserved to each ICB Board

ICBs are not permitted to delegate the following, and any decisions regarding the matters below are therefore reserved to each ICB Board:

- functions central to corporate governance of individual organisations –
  - maintenance of constitution and governance
  - preparation of annual reports
  - maintenance of proper accounts, and preparation of annual accounts
  - arrangements for conflicts of interest
  - arrangements for public involvement
  - powers to enter into agreements, to acquire and dispose of property, to accept gifts (incl. property to be held in trust for the purposes of the ICB)
- some regulatory and oversight functions –
  - notification of the Secretary of State of notifiable reconfigurations of NHS services
- functions that are required by NHSE to remain with individual ICBs
- functions that NHSE has delegated to the ICB, unless NHSE gives permission for on-ward delegation of such functions

Each ICB must retain decision-making in respect of its own NHS Continuing Healthcare and NHS funded nursing care functions, albeit that such decision-making need not be reserved to each ICB Board.

Each ICB Board remains accountable for the discharge of all the ICB's statutory functions and duties, including those functions (and decisions pertaining to those functions) that the ICB delegated.

Annex A details the matters reserved to each ICB Board.

### 2.2 Meetings of each ICB Board

Each ICB Board should meet annually as a minimum, or as required for decision-making on matters reserved and for discharging its accountability for the ICB's discharge of all its statutory functions and duties.

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### 3. Delegations to the Cluster Board

In summary, the ICB Boards delegate decision-making with regards to the following to the Cluster Board:

- Strategy and planning
- Capital and revenue spend
- Service commissioning and contracting
- Oversight
- Transition

Annex B sets out the matters delegated to the Cluster Board.

The Cluster Board has full authority to make binding decisions on behalf of the ICBs for all delegated functions, subject to:

- Compliance with statutory requirements
- Operating within agreed financial frameworks
- Reporting to individual ICB Boards on reserved matters
- During 2026/27 not taking any decisions that would materially change the operational plan that has been agreed by each Board without the explicit approval of that individual Board

The Cluster Board may

- establish non-decision-making sub-committees and / or working groups as it considers necessary
- determine the terms of reference for such sub-committees and groups, which must be reviewed annually
- receive reports and assurance from such sub-committees and groups

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#### **4. Delegations to the ICBs' Audit Committees**

While the ICBs remain legal corporate entities in their own rights, each ICB retains its own audit committee. The Audit Committees may meet in common.

With regards to each individual ICB, the Audit Committees will have authority for the following:

- Internal audit arrangements (appointment, oversight, planning)
- External audit arrangements, and non-audit services provided by the ICB's auditors
- Assurance of
  - governance arrangements incl. systems of control
  - arrangements for the management of strategic and operational risk
  - counter fraud arrangements
  - security management arrangements
  - information governance arrangements
- Financial reporting and annual accounts
- Oversight of losses and special payments

The Audit Committees' Terms of Reference are aligned to enable the Committees' meetings in common. The Terms of Reference describe the Committees' remits in detail.

Annex C summarises the decision-making powers and authorities of the Audit Committees.

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## 5. Delegations to the Joint Remuneration Committee

The ICB Boards establish a Joint Remuneration Committee with authority for the following:

- 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

The Terms of Reference describe the Committees' remits in detail.

Annex C summarises the decision-making powers and authorities of the Joint Remuneration Committee.

## 6. Other arrangements

Insofar as this is practical and does not impede on the ICBs' ability to remain compliant and to meet all statutory requirements placed on them, during 2026/27 the ICBs will align the following as much as possible to enable smooth day-to-day operations incl. operational decision-making:

- The ICBs' Standing Financial Instructions
- The ICBs' Schemes of Financial Delegations
- The ICBs' arrangements for conflicts of interest
- The ICBs' arrangements for managing and reporting risk
- Identified corporate policies, procedures and processes

## 7. Conflict management

Decision-makers must be alive to the possibility that actual or potential conflicts arise between the ICBs' individual interests while the ICBs remain legal corporate entities in their own right.

Papers and proposals that request decisions such as approval must therefore identify any such actual or potential conflicts.

Where this concerns decisions which are the prerogative of the Cluster Board, the Cluster Chair will consult with the individual ICB Boards to resolve the issue.

Final decision in such circumstances rests with the individual ICB Boards due to their continued responsibility and accountability as the individual ICBs' stewards.

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## 8. Review and amendment

This scheme shall be reviewed by the three ICB Boards six months after coming into effect, and updated as necessary to reflect:

- Changes in statutory requirements
- Evolution of cluster arrangements
- Lessons learned from operation

Changes to this scheme require approval by each of the three ICB Boards.

**Effective Date:** [To be confirmed following ICB Board approvals]

**Review Date:** Chair and CEO will keep this document under review and propose amendments to the ICB Boards as and when required

**Approval Authority:** The Boards of NHS BSW, NHS Dorset, and NHS Somerset ICBs

Trent, Louise  
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## Annex A – Matters reserved to each ICB Board

<b>Matters reserved to the ICB Board</b>
<b>Corporate governance matters</b>
Approve applications to NHS England for changes to the ICB's Constitution
Determination of the ICB's governance arrangements
Appoint and dismiss ICB Board committees, and approve the Terms of Reference (incl. membership and reporting arrangements) for such committees
Approve the ICB's Scheme of Reservation and Delegation (SoRD)
Approve the ICB's Standing Financial Instructions (SFIs)
Approve the ICB's arrangements for conflicts of interest
<b>Financial reporting and controls</b>
Approve the ICB's annual budget (incl. place budgets, delegated and pooled budgets and non-recurrent in-year allocations) and any material changes to it
Approve the ICB annual operating plan and any material changes to it
Approve the ICB's Annual Report and Accounts in accordance with NHSE guidance
<b>Internal controls</b>
Approve the ICB's counter fraud and security management arrangements
Approve the ICB's arrangements for the management of risk, incl. approval of the ICB's risk appetite, of arrangements for risk sharing and / or risk pooling with other organisations, and of the ICB's risk management framework and policies
Appoint the ICB's external auditors (on recommendation of the Audit Committee)
Approve the ICB's – <ul style="list-style-type: none"> <li>• Emergency Preparedness, Resilience &amp; Response (EPRR) Policy</li> <li>• Information Governance Framework</li> <li>• Risk Management Framework</li> <li>• Standards of Business Conduct Policy</li> <li>• Public involvement and engagement policy</li> </ul>
<b>Delegation of functions</b>
Authorise arrangements under section 65Z5 of the 2006 Act with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB.
Authorise arrangements under section 75 of the 2006 Act to enter arrangements with a local authority under which the local authority exercises specified ICB functions, or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund

## Annex B – Matters delegated to the Cluster Board

Matters delegated to the Cluster Board	
Decision area	Decision
Strategy	Approve the cluster's Population Health Strategy
	Approve the cluster's Commissioning Strategy
	Approve the cluster's Commissioning Intentions
Planning	Approve joint forward plans and joint capital plans for the NHS in the cluster
Finance	Approve capital spend over £10m (on recommendation from the Strategic Finance and Resources Committee)
	Agree to make capital grants over £10m available (on recommendation from the Strategic Finance and Resources Committee)
	Approve revenue spend over £10m (on recommendation from the Strategic Finance and Resources Committee)
Oversight	<p>Oversight of the ICBs' operations, and assuring the ICB Boards of:</p> <ul style="list-style-type: none"> <li>• competent and prudent management of activities and resources</li> <li>• sound planning, and performance monitoring</li> <li>• compliance with statutory and regulatory obligations</li> </ul>

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## Annex C – Matters delegated to Committees

<b>Matters delegated to the Joint Remuneration Committee</b>	
<b>Decision area</b>	<b>Decision</b>
Remuneration	Determine and approve all aspects of remuneration and conditions of service for the Cluster Chief Executive Officer, Cluster Chief Officers and other Very Senior Managers (VSM)
	For all ICB staff, determine each ICB's pay policy
	For all ICB staff, determine the arrangements for termination payments and any special payments.
<b>Matters delegated to the Audit Committees (in common)</b>	
<b>Decision area</b>	<b>Decision</b>
Internal / external audit	Approve the appointment of the head of internal audit
	Approve the annual internal audit plan and more detailed programme of work
	Approve the annual external audit plan
	Approve a policy for the engagement of external auditors to supply non-audit services and advise the ICB Board and Chief Executive on the contents of such a policy
Counter fraud	Approve counter fraud work plans
<b>Matters delegated to the Joint Strategic Finance and Resources Committee</b>	
<b>Decision area</b>	<b>Decision</b>
Strategy	Set the cluster's financial strategy
Policy	Approve the ICBs' Scheme of Financial Delegations

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## Annex D – Matters reserved to NHS England

<b>Matters reserved to NHS England</b>
The power to establish ICB
Approval of the ICB Constitution
Variation of the ICB Constitution <ol style="list-style-type: none"><li>where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and</li><li>where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).</li></ol>
Appointment and removal of the ICB Chair, subject to the approval of the Secretary of State
Determine the remuneration of ICB Chair
Approve the appointment, by the ICB Chair, of the ICB Chief Executive
Powers under the <a href="#">NHS England » NHS enforcement guidance</a> to direct the ICB when NHSE is satisfied that the ICB (a) is failing or (b) is at risk of failing to discharge its functions.

## Annex E – Matters reserved to the ICB Chair

<b>Matters reserved to the ICB Chair</b>
Appointment of the ICB Chief Executive (subject to approval of NHS England in accordance with any procedure published by NHS England)
Approval of appointment of partner members of the ICB Board
Appointment of Non-Executive members of the ICB Board
Approval of appointment of ICB Board's Deputy Chair

Trent, Louise  
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[insert: NHS Bath and North  
East Somerset, Swindon and  
Wiltshire / NHS Dorset / NHS  
Somerset]  
Integrated Care Board

Standing Financial Instructions

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06/05/2026 15:44:22

## Review Log

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1.0		Bath and North East Somerset ICB Board Dorset ICB Board Somerset ICB Board	Approval and adoption of SFI
1.1			

Trent Louise  
06/05/2026 15:44:22

# Contents

1	Purpose and statutory framework	4
2	Scope	5
3	Roles and responsibilities	6
3.1	Staff	6
3.2	The ICB Board	6
3.3	Accountable Officer	6
3.3	ICB Board Members, committee members and employees	8
3.4	Contractors and their Employees	8
3.5	Audit Committee	8
4	Annual operating plan and budget setting	9
5	Allotments	10
6	Budgetary Control and Reporting	10
7	Management accounting and business management	11
8	Income, banking arrangements and debt recovery	13
8.1	Income	13
8.2	Banking	13
8.3	Bank Accounts	13
8.4	ICB Corporate Credit Cards	14
8.5	Debt management	14
9	Financial systems and processes	15
9.1	Provision of finance systems	15
10	Procurement and purchasing	17
10.1	Principles	17
11	Staff costs and staff related non pay expenditure	18
11.1	Chief People Officer	18
12	Annual Reporting and Accounts	20
12.1	Annual report	20
12.2	Internal audit	20
12.3	External audit	21
13	Losses and special payments	22
14	Fraud, bribery and corruption (Economic crime)	23
15	Capital Investments & security of assets and Grants	24
15.1	Capital investments	24
15.2	Grants	25
16	Legal and insurance	26

## 1. Purpose and statutory framework

- 1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.
- 1.2 The purpose of these SFIs is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.
- 1.3 These SFIs help the Accountable Officer and Chief Officer Strategic Finance and Resources to effectively perform their responsibilities. They define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.
- 1.4 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the Chief Officer Strategic Finance and Resources must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the ICB's constitution, standing orders and scheme of reservation and delegation.
- 1.5 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

Trent, Louise  
06/05/2026 15:44:22

## 2 Scope

- 2.1 All officers of the ICB and all members of the ICB board and committees are within the scope of these SFIs, without exception or limitation. The term officer includes permanent employees, secondees, contract workers, hosted workers. If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the ICB Audit Committee for referring action or ratification.
- 2.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.
- 2.3 Any reference to an enactment is a reference to that enactment as amended.
- 2.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

Trent Louise  
06/05/2026 15:44:22

## 3 Roles and responsibilities

### 3.1. Staff

3.1.1. All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisation's property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity and value for money in the use of resources; and
- conforming to the requirements of these SFIs.

### 3.2. The ICB Board

3.2.1. The ICB Board exercises financial supervision and control by:

- formulating the financial strategy;
- requiring the submission and approval of budgets within approved allocations/overall income;
- defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
- defining specific responsibilities placed on members of the ICB Board and employees as indicated in the Scheme of Reservations and Delegations, and in the Scheme of Financial Delegations.

### 3.3. Accountable Officer and Chief Officer Strategic Finance and Resources

3.3.1. The ICB constitution provides for the appointment of the Chief Executive by the ICB Chair. The Chief Executive is the Accountable Officer for the ICB and is personally accountable to NHS England for the stewardship of the ICB's allocated resources.

3.3.2. The ICB Chief Officer Strategic Finance and Resources reports directly to the ICB Chief Executive and is professionally accountable to the NHS England regional finance director.

3.3.3. The Chief Executive will delegate to the Chief Officer Strategic Finance and Resources the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts, ensuring that annual report, annual accounts and the governance statement are signed;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded,;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- ensuring that the ICB meets the financial targets set for it by NHS England;
- ensuring that planned budgets are approved by the Board;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- developing the funding strategy for the ICB to support it in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- ensuring that all Board members – executive members, partner members and non-executive members – and all ICB officers are notified of and understand their responsibilities within the SFIs;
- ensuring that specific responsibilities and delegation of authority to specific job titles are confirmed;
- provide financial leadership of the ICB;
- identify key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions.

3.2.4 The Chief Officer Strategic Finance and Resource will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

Trent, Louise  
06/05/2026 15:44:22

### 3.3. ICB Board Members, committee members and employees

- 3.3.1. All members of the ICB Board and employees, severally and collectively, are responsible for
- the security of the property of the ICB
  - avoiding loss
  - exercising economy and efficiency in the use of resources
  - conforming with the requirements of the ICB's Standing Orders, Standing Financial Instructions, Scheme of Reservations and Delegations, and Scheme of Financial Delegations
- 3.3.2. For all members of the ICB Board, committees and any employees who carry out a financial function, the form in which financial records are kept and the manner in which these individuals discharge their duties must be to the satisfaction of the Chief Officer Strategic Finance and Resources.

### 3.4. Contractors and their Employees

- 3.4.1. Any contractor or employee of a contractor who is empowered by NHS Somerset ICB to commit the organisation to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

### 3.5. Audit Committee

- 3.5.1. The Board and Accountable Officer will be supported by the ICB's Audit Committee, which provides proactive support to the Board and the Accountable Officer by advising on:
- the management of key risks;
  - the strategic processes for risk;
  - the operation of internal controls;
  - control and governance and the governance statement;
  - the accounting policies, the accounts, and the annual report of the ICB;
  - the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

Trent, Louise  
06/05/2025 15:44:22

## 4 Annual operating plan and budget setting

- 4.1. The Accountable Officer will compile and submit to the ICB Board an annual operating plan which considers financial targets and forecast limits of available resources.
- 4.2. Prior to the start of the financial year the Chief Officer Strategic Finance and Resources will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the ICB Board.
- 4.3. The Chief Officer Strategic Finance and Resources shall monitor financial performance against budget and plan, periodically review them, and report to the ICB Board. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.
- 4.4. The Accountable Officer is responsible for ensuring that information relating to the ICB's accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.
- 4.5. Budgets will:
  - be in accordance with the aims and objectives set out in the plan
  - accord with activity and workforce plans
  - be prepared within the limits of available funds
  - identify potential risks
  - be allocated additional funding as it is received in year
- 4.6. Annual budget books will be produced for discussion and agreement with appropriate budget holders.
- 4.7. All budget holders must provide information as required by the Chief Officer Strategic Finance and Resources to enable budgets to be compiled.
- 4.8. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Accountable Officer, subject to any authorised use of virement.
- 4.9. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Accountable Officer, as advised by the Chief Officer Strategic Finance and Resources.

Trent Louise  
06/05/2026 15:44:22

## 5 Allotments

5.1. The Chief Officer Strategic Finance and Resources will:

- periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the ICB's entitlement to funds.
- prior to the start of each financial year submit to the ICB Board for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve.
- regularly update the ICB Board on significant changes to the initial allocation and the uses of such funds.

## 6. Budgetary Control and Reporting

6.1. The Chief Officer Strategic Finance and Resources will devise and maintain systems of budgetary control. These will include:

- regular financial reports to the ICB Board and relevant committees in a form approved by the ICB Board containing:
  - income and expenditure to date showing trends and forecast year-end position
  - balance sheet and cash flow statement
  - capital project spend and projected outturn against plan
  - explanations of any material variances from plan
  - details of any corrective action where necessary and the Accountable Officer's and/or Chief Officer Strategic Finance and Resources view of whether such actions
  - are sufficient to correct the situation
- the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible:
  - investigation and reporting of variances from financial, workload and manpower budgets
  - monitoring of management action to correct variances
  - arrangements for the authorisation of budget transfers

6.2. Each Budget Holder is responsible for ensuring that:

- they sign off their budget, as approved through the approved annual plan, at the start of the year, and any additional in-year allocations, and help provide accurate forecasts of out-turn during the course of the year;
- any likely overspending or reduction of income which cannot be met by a requirement is not incurred without the prior consent of the ICB Board ;

Trent Louise  
06/05/2026 15:44:22

- the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;
- no permanent employees are appointed without the approval of the Accountable Officer other than those provided for within the available resources and manpower establishment as approved by the ICB Board;
- they participate in finance training to develop the skills and knowledge necessary to discharge their financial management duties;
- they use the ICB's finance systems as required;
- where matters of financial control risk are identified, they are communicated to the ICB finance team as a matter of urgency;
- they are accountable for their budgets and financial performance;
- they take responsibility for ensuring that new members of staff are paid the correct salary and for making sure that final payments to and from employees are correct;
- ensuring that the prices paid for goods are correct, represent value for money, that procedures are followed to prevent fraud and that all invoices are appropriately authorised and that the goods and services received are correct;
- aware of the ICB's medium term plan and the impact of in year commitments on future years' planning assumptions;
- they are available to work with the auditors and respond to questions or recommendations.

6.3. The Executive Team is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Operating Plan and a balanced budget.

6.4. The Accountable Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

## 7 Management accounting and business management

7.1. The Chief Officer Strategic Finance and Resources is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

7.2. The Chief Officer Strategic Finance and Resources will delegate the budgetary control responsibilities to budget holders through a formal documented process.

7.3. The Chief Officer Strategic Finance and Resources will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long-term financial health for the ICB and the NHS within the ICB's footprint;

- that budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- that the implementation of financial and resources plans supports the NHS 10-year plan objectives.

7.4. In addition, the Chief Officer Strategic Finance and Resources has financial leadership responsibility for the following statutory duties:

- the duty of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year:
  - local capital resource use does not exceed the limit specified in a direction by NHS England;
  - local revenue resource use does not exceed the limit specified in a direction by NHS England;
- the ICB's duty to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the ICB's duty, in conjunction with NHS trusts and NHS foundation trusts, to achieve any joint financial objectives set by NHS England for the ICB and the trusts.

7.5. The Chief Officer Strategic Finance and Resources and any senior officer responsible for finance within the ICB will promote a culture where budget holders and decision makers consult finance in key strategic decisions that carry a financial impact.

Trent, Louise  
06/05/2026 15:44:22

## 8. Income, banking arrangements and debt recovery

### 8.1 Income

8.1.1. An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

8.1.2. The Chief Officer Strategic Finance and Resources is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider; and
- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks.

### 8.2 Banking

8.2.1. The Chief Officer Strategic Finance and Resources is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

8.2.2. The Chief Officer Strategic Finance and Resources will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and
- the ICB has effective cash management policies and procedures in place.

### 8.3 Bank Accounts

8.3.1. The Chief Officer Strategic Finance and Resources is responsible for:

- The ICB's bank accounts
- ensuring payments made from the ICB's bank accounts do not exceed the amount credited to the account except where arrangements have been made
- reporting to the ICB Board all arrangements made with the ICB's bankers for accounts to be overdrawn.

8.3.2. The Chief Officer Strategic Finance and Resources will prepare detailed instructions on the operation of bank accounts which must include:

- the conditions under which each bank account is to be operated
- those authorised to sign cheques or other orders drawn on the ICB's account

8.3.3. The Chief Officer Strategic Finance and Resources must advise the ICB's bankers in writing of the conditions under which each account will be operated.

## 8.4 ICB Corporate Credit Cards

8.4.1. The Chief Officer Strategic Finance and Resources is responsible for agreeing ICB Corporate Credit Card cardholders and credit limits.

## 8.5 Debt management

8.5.1. The Chief Officer Strategic Finance and Resources is responsible for the ICB debt management strategy. This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB Board every 12 months to ensure relevance and provide assurance;
- accountability to the ICB Board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders;
- responsibility to appoint a senior officer responsible for day to day management of debt;
- approval of write-off of balances below £250 where the Chief Officer Strategic Finance and Resources, or their deputy, is satisfied that there is no realistic prospect of recovery or it would not be cost effective to take further recovery action;

8.5.2. Debtors' balances of £5 or below will automatically be written off in line with NHS England Best Practice.

8.5.3. Amount below £250 written off following approval of the Chief Officer Strategic Finance and Resources or Deputy Chief Officer Strategic Finance and Resources , or any automatic write-offs below £5 will be reported to Audit Committee on at least an annual basis.

Trent, Louise  
06/05/2026 15:44:22

## 9 Financial systems and processes

### 9.1 Provision of finance systems

- 9.1.1. The Chief Officer Strategic Finance and Resources is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.
- 9.1.2. The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.
- 9.1.3. As part of the contractual arrangements for ICBs, officers will be granted access where appropriate to the Integrated Single Financial Environment (“ISFE”). This is the required accounting system for use by ICBs. Access is based on single access log on to enable users to perform core accounting functions such as transacting and coding of expenditure/income in fulfilment of their roles.
- 9.1.4. The Chief Officer Strategic Finance and Resources will, in relation to financial systems:
- promote awareness and understanding of financial systems, value for money and commercial issues;
  - ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing
  - ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
  - enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
  - ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
  - ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
  - ensure that risk is appropriately managed;

Trent, Louise  
06/05/2026 15:44:22

- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and
- where another health organisation or any other agency provides a computer service for financial applications, the Chief Officer Strategic Finance and Resources shall periodically seek assurances that adequate controls are in operation.

Trent, Louise  
06/05/2026 15:44:22

## 10 Procurement and purchasing

### 10.1 Principles

- 10.1.1. The Chief Officer Strategic Finance and Resources will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.
- 10.1.2. The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR), the Health Care Services (Provider Selection Regime) Regulations 2023, the Procurement Act 2023 and associated statutory requirements whilst securing value for money and sustainability.
- 10.1.3. The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.
- 10.1.4. The ICB must have a procurement policy which sets out all of the legislative requirements.
- 10.1.5. All revenue and non-pay expenditure must be approved, prior to an agreement being made with a third party that enters a commitment to future expenditure.
- 10.1.6. All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.
- 10.1.7. Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.
- 10.1.8. Undertake any contract variations or extensions in accordance with Public Contracts Regulation (PCR) 2015, the Health Care Services (Provider Selection Regime) Regulations 2023, the Procurement Act 2023, and the ICB procurement policy.
- 10.1.9. Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit Committee.

Trent, Louise  
06/05/2026 15:44:22

## 11 Staff costs and staff related non pay expenditure

### 11.1 Deputy Chief People Officer

- 11.1.1. The Deputy Chief People Officer will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.
- 11.1.2. Operationally, the Deputy Chief People Officer will be responsible for;
- defining and delivering the organisation's overall human resources strategy and objectives; and
  - overseeing delivery of human resource services to ICB employees.
- 11.1.3. The Deputy Chief People Officer will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.
- 11.1.4. Where a third-party payroll provider is engaged, the Deputy Chief People Officer shall closely manage this supplier through effective contract management.
- 11.1.5. The Deputy Chief People Officer is responsible for management and governance frameworks that support the ICB employees' life cycle.
- 11.1.6. The Deputy Chief People Officer is responsible for:
- specifying timetables for submission of properly authorised time records and other notifications;
  - making payment on agreed dates;
  - agreeing method of payment.
- 11.1.7. The Deputy Chief People Officer will issue instructions regarding:
- verification and documentation of data;
  - the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
  - maintenance of subsidiary records for superannuation, income tax, social security, and other authorised deductions from pay;
  - security and confidentiality of payroll information;
  - checks to be applied to completed payroll before and after payment;
  - authority to release payroll data under the provisions of the Data Protection Act;
  - methods of payment available to various categories of employee and officers;
  - procedures for payment to employees and officers;
  - procedures for the recall of cheques and bank credits;
  - pay advances and their recovery;
  - maintenance of regular and independent reconciliation of pay control

- accounts;
- a system to ensure the recovery from those leaving the employment of the ICB of sums of money and property due by them to the ICB.

Trent, Louise  
06/05/2026 15:44:22

## 12 Annual Reporting and Accounts

### 12.1 Annual report

12.1.1 The Chief Officer Strategic Finance and Resources will ensure, on behalf of the Accountable Officer and ICB Board, that:

- the ICB is in a position to produce its required monthly reporting, annual report and accounts that meet the requirements set out in DHSC and NHSE guidance and directions; and
- the ICB, in each financial year, prepares a compliant report on how it has discharged its functions in the previous financial year;

12.1.2. An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the board has taken to implement any joint local health and wellbeing strategy.

12.1.3 NHS England may give directions to the ICB as to the form and content of an annual report.

12.1.4 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

### 12.2 Internal audit

12.2.1. The Chief Executive, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Officer Strategic Finance and Resources to ensure that:

- all internal audit services provided under arrangements proposed by the Chief Officer Strategic Finance and Resources are approved by the Audit Committee, on behalf of the ICB Board;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards

Trent-Louise  
06/05/2026 15:44:18

(PSIAS);

- the ICB internal audit charter and annual audit plan must be endorsed by the ICB accountable officer, Audit Committee and Board;
- the Head of Internal Audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
- the Head of Internal Audit should attend Audit Committee meetings and have a right of access to all Audit Committee members, the Chair and chief executive of the ICB.
- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

## 12.3 External audit

12.3.1. The Chief Officer Strategic Finance and Resources is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;
- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and
- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

Trent, Louise  
06/05/2026 15:44:22

## 13 Losses and special payments

- 13.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.
- 13.2 The Chief Officer Strategic Finance and Resources will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.
- 13.3 A loss refers to any case where full value has not been obtained for money spent or committed. Examples of types of losses which cannot be treated as business as usual are cash losses, bookkeeping losses, fruitless payments and claims waived or abandoned.
- 13.4. Special Payments relate to the following;
- any compensation payments;
  - extra-contractual or ex-gratia payments; and
  - any payment made without specific identifiable legal power In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.
- 13.5 NHS England has the statutory power to require an ICB to provide NHS England with information. The information is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.
- 13.6 As part of the compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:
- details of all exit packages (including special severance payments) that have been agreed and/or made during the year;
  - that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made; and
  - adherence to the special severance payments guidance as published by NHS England.
- 13.7 All losses and special payments (including special severance payments) must be reported to the ICB Audit Committee and NHS England, noting that ICBs do not have a delegated limit to approve losses or special payments.
- 13.8 For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide.

Trent, Louise  
06/05/2025 13:44:22

## 14 Fraud, bribery and corruption (Economic crime)

- 14.1. The ICB is committed to identifying, investigating and preventing economic crime.
- 14.2. The ICB Chief Officer Strategic Finance and Resources is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the board and the Audit Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the ICB Board.
- 14.3. These arrangements should comply with the NHS Requirements the [Government Functional Standard 013 Counter Fraud](#) as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.
- 14.4. In line with their responsibilities, the Accountable Officer and Chief Officer Strategic Finance and Resources shall monitor and ensure compliance with guidance issued by the NHS Counter Fraud Authority and NHS England on fraud and corruption
- 14.5. The ICB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by Government Functional Standard 013 Counter Fraud
- 14.6. The Local Counter Fraud Specialist shall report to the Chief Officer Strategic Finance and Resources and shall work with staff in the NHS Counter Fraud Authority in accordance with the Government Functional Standard 013 Counter Fraud.
- 14.7. The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the ICB.
- 14.8. The ICB's Anti-fraud, -bribery and -corruption policy sets out the ICB's approach, processes and procedures to prevent, identify and investigate fraud, bribery or corruption.

Trent, Louise  
06/05/2026 15:44:22

## 15 Capital Investments & security of assets and Grants

### 15.1 Capital investments

15.1.1 The Chief Officer Strategic Finance and Resources is responsible for:

- ensuring that at the commencement of each financial year, the ICB prepares a plan setting out their planned capital resource use;
- ensuring that the ICB exercise its functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the Chief Officer Strategic Finance and Resources is responsible for ensuring there are processes in place to ensure that a business case is produced.

15.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;
- authority to enter into leasing arrangements.

15.1.3 Advice should be sought from the Chief Officer Strategic Finance and Resources or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

15.1.4 For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.

15.1.5 ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives; and
- comply with NHS England policies and directives and with this standard

15.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

## 15.2. Grants

15.2.1 The Chief Officer Strategic Finance and Resources is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

15.2.2 All revenue grant applications should be regarded as competed as a default position, unless there are justifiable reasons why the classification should be amended to non-competed.

Trent, Louise  
06/05/2026 15:44:22

## 16 Legal and insurance

- 16.1 So that the ICB has appropriate oversight and manages appropriately any legal cases threatened or instituted by or against the ICB, the Chief Officer Strategic Finance and Resources will ensure that the ICB has in place arrangements for the:
- engagement of solicitors / legal advisors;
  - approval and signing of documents which will be necessary in legal proceedings; and
  - identification of officers who can commit or spend ICB revenue resources in relation to settling legal matters.
- 16.2 The Chief Officer Strategic Finance and Resources will ensure that the ICB has in place appropriate insurance, noting that ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer.

Trent, Louise  
06/05/2026 15:44:22

# BSW, Dorset and Somerset ICBs Cluster

## DRAFT Cluster Board – Terms of Reference (ToR)

### Contents

1.	Introduction.....	1
2.	Responsibilities and duties.....	1
3.	Benchmarking and guidance.....	<b>Error! Bookmark not defined.</b>
4.	Authority .....	1
5.	Accountability and reporting .....	2
6.	Membership.....	2
7.	Quorum .....	3
8.	Meeting frequency and conduct .....	4
9.	Decision making .....	5
10.	Equality, Diversity and Inclusion.....	5
11.	Secretariat and administration.....	5
12.	Review.....	6
	Appendix I: Revision History .....	7

Trent Louise  
06/05/2026 15:44:22

## **1. Introduction**

- 1.1. Under sections 65Z5 and 65Z6 of the NHS Act 2006, the NHS Bath and North East Somerset, Swindon and Wiltshire (BSW), NHS Dorset, and NHS Somerset Integrated Care Boards (the ICBs) establish the Cluster Board as a joint 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 Cluster Board
  - 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 Boards of the NHS BSW, NHS Dorset and NHS Somerset Integrated Care Boards delegate to the Cluster Board decision-making with regards to the following:
  - a. Strategy and planning
  - b. Capital and revenue spend in line with the Standing Financial Instructions and Scheme of Financial Delegations
  - c. Service commissioning and contracting in line with the Standing Financial Instructions and Scheme of Financial Delegations
  - d. Oversight of the ICBs' operations, incl. the competent and prudent management of activities and resources; sound planning, and performance monitoring; and compliance with statutory and regulatory obligations

## **3. Authority**

- 3.1 The Cluster Board has full authority to make binding decisions on behalf of the ICBs, subject to:
  - Compliance with statutory requirements
  - Operating within agreed financial frameworks
  - Reporting to individual ICB Boards on reserved matters
  - During 2026/27 not taking any decisions that would materially change the operational plan that has been agreed by each Board without the explicit approval of that individual Board.
- 3.2 The Cluster Board 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;

Trent, Louise  
06/05/2026 15:44:22

- Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Cluster Board must follow any procedures put in place by the respective ICB for obtaining professional advice;
- The Cluster Board 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 section;
- Create non-decision-making sub-committees and / or working groups of the Cluster Board and determine the terms of reference of such groups in accordance with each ICB Board's Constitution, Standing Orders and SoRD.

## 4. Accountability and Reporting

- 4.1 The Cluster Board is accountable to the BSW ICB, Dorset ICB and Somerset ICB Boards.
- 4.2 The Cluster Board will keep the ICB Boards apprised of business transacted, and refer to the ICB Boards any matters reserved to the Boards.
- 4.3 On behalf of the Cluster Board, the Chair may report about other issues and matters within the Cluster Board's remit that in the Cluster Board's view require the attention or decision-making of the individual ICB Boards.
- 4.4 The Cluster Board receives scheduled assurance reports from any sub-groups that it establishes, in a format that is determined by the Cluster Board and enables it to obtain the assurances that it seeks.

## 5. Membership

- 5.1 The following are members of the Cluster Board who have voting rights and decision-making powers:
- The BSW, Dorset and Somerset ICBs' Joint Non-Executive Chair
  - The 6 BSW, Dorset and Somerset ICBs' Joint Non-Executive Directors
  - The BSW, Dorset and Somerset ICBs' Joint CEO
  - The BSW, Dorset and Somerset ICBs' Joint Chief Officer Strategic Finance and Resources
  - The BSW, Dorset and Somerset ICBs' Joint Chief Medical Officer
  - The BSW, Dorset and Somerset ICBs' Joint Chief Nursing Officer
  - The BSW, Dorset and Somerset ICBs' Joint Chief Officer for Commissioning and Place
  - The BSW, Dorset and Somerset ICBs' Joint Chief Officer for Population Health Improvement
  - The Primary Care Partner Member of the BSW ICB Board
  - The Primary Care Partner Member of the Dorset ICB Board
  - The Primary Care Partner Member of the Somerset ICB Board
  - Six members from Local Authority – one from each LA in the cluster geography

Trent Louise  
06/05/2026 15:44:22

- Four members from acute hospitals – one from each acute hospital in the cluster geography
- One member from the VCSE sector

5.2 The following are regular attendees of the Cluster Board. They will inform and advise the Cluster Board, but have no voting rights or decision-making powers:

- One representative from Healthwatch
- The Associate Non-Executive Director (Digital)

When determining the membership of the Cluster Board, active consideration will be made to diversity and equality.

Members are expected to make every effort to attend all Cluster Board meetings.

5.3 The Cluster Board Chair may determine one of the other Non-Executive members of the Cluster Board as deputy chair.

5.4 Only the above members and regular attendees of the Cluster Board have the right to attend Cluster Board meetings.

5.5 In addition, the Chair on behalf of the Cluster Board may invite ad-hoc and, in view of agenda items, such individuals to Cluster Board meetings as are considered necessary to enable the Cluster Board'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 Cluster Board papers, and they will not have voting rights or decision-making powers.

5.6 The Cluster Board Chair may ask any or all of those who normally attend Cluster Board meetings, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.7 In the case of absences:

- In the absence of the Cluster Board Chair and the Cluster Board's deputy chair, the remaining members present determine one of their number as Chair of the meeting.
- Where a Cluster Board 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.
- Where a regular attendee of the Cluster Board is unable to attend a meeting, a suitable representative may be agreed with the Cluster Board Chair.

## 6. Quorum

A quorum shall be 15 members, including:

- Either the Chief Executive or the Chief Officer – Strategic Finance and Resources;
- Either the Chief Medical Officer or the Chief Nurse Officer;
- At least one independent Non-Executive Director;

d. At least one Partner Member

- 6.2 If any member of the Cluster Board 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.
- 6.3 In the event of difficulty in relation to achievement of the quorum, independent Non-Executive Members who are not members of the Cluster Board may be co-opted as members for individual meetings. The Chair of the Audit Cluster Board cannot be co-opted.
- 6.4 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 Cluster Board.

## **7. Meeting frequency and conduct**

- 7.1 The Cluster Board will normally meet monthly, and otherwise as required. Additional meetings may be convened on an exceptional basis at the discretion of the Cluster Board Chair.

The ICB Boards, Cluster Chair or Cluster Chief Executive may ask the Cluster Board to convene further meetings to discuss particular issues on which they want the Cluster Board's advice.

- 7.2 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 Cluster Board's decision making by email, should this be required to expedite an urgent decision.
- 7.3 The Cluster Board conducts its business in accordance with relevant codes of conduct, good governance practice, including the Nolan principles of public life, the Standards of Business Conduct Policies, Standing Financial Instructions, SoRD and other relevant policies / guidance on good and proper meeting conduct for NHS organisations.
- 7.4 All Cluster Board 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.
- 7.5 The Cluster Board 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.

## **8. Decision making**

- 8.1 Decisions are normally arrived at by consensus.
- 8.2 Where consensus cannot be reached, the Chair will move to a formal vote. The quoracy rules apply. Only members of the Cluster Board 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.
- 8.3 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 Cluster Board.

## **9. Equality, Diversity and Inclusion**

- 9.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

## **10. Secretariat and administration**

- 10.1 The Secretariat for the Cluster Board is provided by the Governance Team. The Secretariat will ensure that:
- a. The Cluster Board'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 Cluster Board 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 Cluster Board members.

## 11. Review

11.1 The Cluster Board 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 202x] (when Board approved)

**Review date:** [Month 202x] (as set by Board)

**Contact:** [ cluster shared gov inbox]

Trent Louise  
06/05/2026 15:44:22

## Appendix 1: Revision History

Version	Date	Approved by	Type of changes
V1.0		BSW ICB Board Dorset ICB Board Somerset ICB Board	Approval of ToR and formal establishment of the Cluster Board

### 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.

Trent Louise  
06/05/2026 15:44:22

## Appendix 2: Members and attendees, status April 2026

### Members:

- The BSW, Dorset and Somerset ICBs' Joint Non-Executive Chair – Rob Whiteman
- The BSW, Dorset and Somerset ICBs' Joint CEO – Jonathan Higman
- The 6 BSW, Dorset and Somerset ICBs' Joint Non-Executive Directors –
  - Christopher Foster
  - Caroline Gamlin
  - Suzannah Power
  - Adrian White
  - Ade Williams
  - Dan Worsley
- The BSW, Dorset and Somerset ICBs' Joint Chief Officer Strategic Finance and Resources – Alison Henly
- The BSW, Dorset and Somerset ICBs' Joint Chief Medical Officer – Bernie Marden
- The BSW, Dorset and Somerset ICBs' Joint Chief Nursing Officer – Shelagh Meldrum
- The BSW, Dorset and Somerset ICBs' Joint Chief Officer for Commissioning and Place – David Freeman
- The BSW, Dorset and Somerset ICBs' Joint Chief Officer for Population Health Improvement – Amanda Webb
- The Primary Care Partner Member of the BSW ICB Board – Francis Campbell
- The Primary Care Partner Member of the Dorset ICB Board – Forbes Watson
- The Primary Care Partner Member of the Somerset ICB Board – Rebecca Duffy
- Six members from Local Authority – one from each LA in the cluster geography –
- Four members from acute hospitals – one from each acute hospital in the cluster geography –
  - Cara Charles-Barks, CEO Hospital Group (BSW)
  - Matthew Bryant, Joint CEO Dorset County Hospital and Dorset HealthCare FT
  - Siobhan Harrington, University Hospitals Dorset FT
  - Peter Lewis, CEO Somerset FT
- One member from the VCSE sector – tbc

### Attendees:

Healthwatch – Kevin Peltonen-Messenger; Kim Sadler (deputising for one another)

Trent Louise  
06/05/2026 15:44:22

**[Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board]  
[Dorset Integrated Care Board]  
[Somerset Integrated Care Board]**

**DRAFT Audit Committee – Terms of Reference (ToR)**

**Contents**

1. Introduction.....1

2. Responsibilities and duties.....1

3. Authority .....6

4. Accountability and Reporting.....7

5. Membership.....7

6. Quorum.....8

7. Meeting frequency and conduct .....9

8. Decision making .....10

9. Equality, Diversity and Inclusion.....10

10. Secretariat and administration.....10

11. Review.....11

Appendix 1: Revision History .....12

Appendix 2: Members and attendees, status April 2026 .....12

Trent Louise  
06/05/2026 15:44:22

## 1. Introduction

- 1.1. The Audit Committee (the committee) is established by the Integrated Care Board as a non-executive committee of the Board in accordance with the 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 ICB Board in accordance with the ICB's Constitution and Scheme of Reservations and Delegations (SoRD)
  - are published on the ICB's websites, as part of the ICB's Governance Handbook.

## 2. Responsibilities and duties

- 2.1. The purpose of the Audit Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB including:
  - Financial governance
  - Corporate governance
  - Risk management
  - Internal and external audit.

The duties of the Committee will be driven by the organisation's objectives and the associated risks.

The committee will seek assurances from Board Committees regarding the scrutiny and oversight of the strategy and risks to achievement of the Strategic Objectives within the Board Assurance Framework and Corporate Risk Register, escalating these to the Board as necessary.

The committee is responsible for the oversight of the delivery of internal and external audit programmes. An annual programme of business for internal audit and counter fraud will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

The Committee will assure the Board on the appropriateness and effectiveness of the external audit, internal audit and counter fraud services, their respective fees, findings and co-ordination between audit providers.

The Committee will act as Audit Panel to oversee the procurement for future external, internal and counter fraud service provision.

The Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

2.2. The Committee's responsibilities and duties are as follows:

### **Integrated governance, risk management, and internal control**

- 2.2.1. Review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.
- 2.2.2. Ensure that financial systems and governance are established which facilitate compliance with The Department of Health and Social Care's (DHSC) Group Accounting Manual.
- 2.2.3. Review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks. Review the ICB's risk management framework and policies, and recommend these to the Board for approval.
- 2.2.4. Have oversight of system risks where they relate to the achievement of the ICB's objectives.
- 2.2.5. Ensure that the ICB acts consistently with the principles and guidance established in His Majesty's Treasury (HMT) Managing Public Money.
- 2.2.6. Seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- 2.2.7. Identify opportunities to improve governance, risk management and internal control processes across the ICB and recommend to the ICB Board for approval the ICB's
  - risk management arrangements including relevant policies
  - counter fraud and security management arrangements including relevant policies
  - Standards of Business Conduct.

### **Internal audit**

- 2.2.8. Ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:
  - a. considering the provision of the internal audit service and the costs involved, appointing the Head of Internal Audit, and considering any questions of resignation by or dismissal of the Head of Internal Audit.
  - b. reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.

Trent Louise  
06/05/2026 15:44:22

- c. considering the major findings of internal audit work, including the Head of Internal Audit Opinion (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources.
- d. ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- e. monitoring the effectiveness of internal audit and carrying out an annual review.

## External audit

2.2.9. Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- a. act as the audit panel and conduct the tender process for external audit provision; make recommendations to the board about the appointment, reappointment and removal of the external auditor, and the remuneration and terms of engagement of the external auditor;
- b. discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- c. discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee;
- d. reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;
- e. Approving the annual external audit plan and ensure that it is consistent with the scope of the audit engagement;
- f. Approve a policy for the engagement of external auditors to supply non-audit services and advise the ICB Board and Chief Executive on the contents of such a policy.

2.2.10. The committee will, at least annually, separately meet the external and internal auditors, without management, to discuss matters relating to its remit and any issues arising from the audits.

## Other assurance functions

2.2.11. Review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

2.2.12. Review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

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06/05/2026 15:44:22

- 2.2.13. Review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.
- 2.2.14. To keep under review the adequacy and effectiveness of the ICB's policy framework and corporate registers for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- 2.2.15. Review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:
- a. reports on and recommendation to any providers who supply financial services to the ICB (including NHS Shared Business Service, NHS Business Services Authority, NHS South, Central and West Commissioning Support Unit, NHS Digital and Capital Primary Care Support England)
  - b. reviews and reports issued by arm's length bodies or regulators and inspectors, e.g. National Audit Office, Select Committees, NHS Resolution, CQC
  - c. reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

### **Counter fraud**

- 2.2.16. Assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet the NHS requirements of the [Government Functional Standard GovS 013:Counter fraud](#) and shall review the outcomes of work in these areas.
- 2.2.17. Review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.
- 2.2.18. Ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.
- Be responsible for ensuring that the counter fraud service submits an Annual Report and the Counter Fraud Functional Standard Return (CFFSR) Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS requirements of the Government Functional Standard GovS 013:Counter fraud – management of counter fraud, bribery and corruption activity.
- 2.2.19. Report concerns of suspected fraud, bribery and corruption to the NHS Counter Fraud Authority.

### **Information Governance (IG)**

- 2.2.20. Receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.
- 2.2.21. Review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.
- 2.2.22. Receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.
- 2.2.23. Provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

### **Financial reporting**

- 2.2.24. Monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
- 2.2.25. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided and are consistent with the principles and guidance established in HM Treasury's Managing Public Money.
- 2.2.26. To receive reports on all losses and special payments (including special severance payments).
- 2.2.27. Review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on and challenging where necessary:
  - a. the wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the committee
  - b. consistency of, changes in and compliance with accounting policies, practices and estimation techniques
  - c. responses to the external auditors from ICB officers responsible for governance
  - d. the methods used to account for significant or unusual transactions where different approaches are possible
  - e. whether the ICB has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the external auditor
  - f. the clarity and completeness in the ICB's financial reports and the context in which statements are made
  - g. unadjusted misstatements in the Financial Statements
  - h. significant judgements and estimates made in preparing of the Financial Statements
  - i. significant adjustments resulting from the audit
  - j. letter of representation
  - k. qualitative aspects of financial reporting explanations for significant variances.

Trent Louise  
06/05/2026 15:44:32

Where the committee is not satisfied with any aspect of the proposed financial reporting by the ICB, it shall report its views to the ICB Board.

## **Conflicts of Interest**

- 2.2.28. The Chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.
- 2.2.29. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective, including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

## **Management**

- 2.2.31. Request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 2.2.32. The committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.
- 2.2.33. Receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

## **3. Authority**

- 3.1 The Committee is authorised by the Board to
- a. Investigate any activity within its terms of reference;
  - b. Seek any information it requires within its remit, from any employee of the ICBs or any member of each ICB Board;
  - c. Commission reports required to help fulfil its obligations;
  - d. 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;
  - e. 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;
  - f. Create sub-groups of the Committee and determine the terms of reference of such sub-groups in accordance with each Board's Constitution, Standing

Trent Louise  
06/05/2026 15:44:22

Orders and SoRD. The Committee may not delegate any decision-making powers to such groups.

## **4. Accountability and Reporting**

- 4.1. The Committee is accountable to the ICB Board.
- 4.2. After each meeting of the Committee, the Committee Chair reports to the Cluster Board about the business transacted, and any concerns that the Committee wishes to escalate.
- 4.3. Reporting will be through the form as specified by and agreed with the Cluster Board, and may take the form of the Committee's minutes, exception or highlight reports, or dedicated reports produced by the Committee.
- 4.4. 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 the Cluster Board or individual ICB Boards.
- 4.5. 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.
- 4.6. A report will be written annually on the Committee's business during that year, and this will form part of the ICB's Annual Report. Specifically, the report will comment on:
  - the fitness for purpose of the assurance framework
  - the completeness and 'embeddedness' of risk management in the organisation
  - the integration of governance arrangements
  - the appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements
  - the robustness of the processes behind the quality accounts

## **5. Membership**

- 5.1. The following are members of the Committee who have voting rights and decision-making powers:
  - 3 Non-Executive Directors, one of who will chair the committee

- 5.2. The Committee Chair shall be independent and therefore may not chair any other committees.
- 5.3. Members will possess between them knowledge, skills and experience in accounting, risk management, internal / external audit, and technical or specialist issues pertinent to the Committee's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.
- 5.4. Neither the Chair of the Board nor employees of the ICB may be members of the Committee.
- 5.5. The following are regular attendees of the Committee. They will inform and advise the Committee, but have no voting rights or decision-making powers:
- The ICB Chief Officer Strategic Finance and Resources
  - The ICB Chief Nurse Officer
  - The Chair of the Joint Strategic Finance and Resources Committee
  - Internal Auditors
  - External Auditors
  - Security Management Specialists
  - Local Counter Fraud Specialists
- 5.6. Only the above members and regular attendees of the Committee have the right to attend Committee meetings.
- 5.7. 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.
- 5.8. 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.
- 5.9. In the case of absences:
- In the absence of the Committee Chair, the remaining members present determine one of their number as Chair of the meeting.
  - ICB non-executive members cannot nominate a deputy to attend the committee on their behalf.
  - Where a regular attendee of the Committee is unable to attend a meeting, a suitable representative may be agreed with the Committee Chair.
- 5.10. Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Committee, with the exception of any items which relate directly to a review of their performance.

## **6. Quorum**

- 6.1. A quorum shall be 2 members.

- 6.2. 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.
- 6.3. 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.
- 6.4. 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.

## **7. Meeting frequency and conduct**

- 7.1. The Committee will normally meet quarterly, and otherwise as required. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.
- 7.2. The ICB Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- 7.3. 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.
- 7.4. The Committee normally holds its meetings in private.
- 7.5. The Committee conducts its business in accordance with relevant codes of conduct, good governance practice, including the Nolan principles of public life, the Standards of Business Conduct Policies, Standing Financial Instructions, SoRD and other relevant policies / guidance on good and proper meeting conduct for NHS organisations.
- 7.6. All Committee members are bound by the Standing Orders and other relevant policies of the ICB. All members and those in attendance must declare any actual or potential conflicts of interest. This is recorded in the meeting minutes.
- 7.7. The Committee will apply the 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.

## **8. Decision making**

- 8.1. Decisions are normally arrived at by consensus.
- 8.2. 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.
- 8.3. The Chair may have a casting vote if members are equally divided on an issue.
- 8.4. 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.

## **9. Equality, Diversity and Inclusion**

- 9.1. Members must demonstrably consider the equality and diversity implications of decisions they make.

## **10. Secretariat and administration**

- 10.1. The Secretariat for the Committee is provided by the Governance Team. The Secretariat will ensure that:
  - The Committee's forward plan is maintained and kept current with the Chair and the relevant executive lead.
  - 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.
  - Members' and regular attendees' attendance at meetings is monitored, and the Chair is informed if members do not meet the minimum expectations re attendance.
  - 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.
  - Management of conflicts of interest including ensuring correct handling of declarations.
  - 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.
  - The Chair is supported to prepare and deliver reports to each Board.
  - The Committee is updated on pertinent issues/ areas of interest/ policy developments.
  - Action points are taken forward between meetings, and progress against those actions is monitored.

- Governance advice is available and easily accessible for Committee members.

## 11. Review

- 11.1. 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 202x] (when Board approved)

**Review date:** [Month 202x] (as set by Board)

**Contact:** [ cluster shared gov inbox]

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06/05/2026 15:44:22

## Appendix 1: Revision History

Version	Date	Approved by	Type of changes
V1.0		BSW ICB Board Dorset ICB Board Somerset ICB Board	Approval of ToR and formal establishment of the Committee

### 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.

## Appendix 2: Members and attendees, status April 2026

### Members:

Three Non-Executive Directors:

Dan Worsley (Chair)  
Suzannah Power  
Caroline Gamlin

### Attendees:

The Chair of the Joint Strategic Finance and Resources Committee: Adrian White

The ICB Chief Officer Strategic Finance and Resources: Alison Henly

The ICB Chief Nurse Officer: Shelagh Meldrum

Internal Auditors

External Auditors

Security Management Specialists

Local Counter Fraud Specialists

### Observers:

Two Non-Executive Directors:

Suresh Ariaratnam  
Julian Kirby

Associate NED: Karl Hoods

# BSW, Dorset and Somerset ICBs Cluster

## DRAFT Joint Finance and Resources Committee – Terms of Reference (ToR)

### Contents

1.	Introduction.....	1
2.	Responsibilities and duties.....	1
3.	Authority.....	3
4.	Accountability and Reporting.....	3
5.	Membership.....	4
6.	Quorum.....	5
7.	Meeting frequency and conduct.....	5
8.	Decision making.....	6
9.	Equality, Diversity and Inclusion.....	6
10.	Secretariat and administration.....	6
11.	Review.....	7
	Appendix 1: Revision History.....	8
	Appendix 2: Members and attendees, status April 2026.....	8

Trent Louise  
06/05/2026 15:44:22

## 1. Introduction

- 1.1. The Joint Finance and Resources 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 purpose is to contribute to the overall delivery of the ICBs' objectives by providing oversight and assurance to the Boards on the development and delivery of a robust, viable and sustainable system financial plan. This includes oversight of the financial performance of the ICBs.

The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

- 2.2 The Committee's key responsibilities and duties are as follows:

### Finance

- 2.2.1 To set the cluster's financial strategy. Provide oversight, and obtain assurance, that the strategy is delivered and achieves its aims and objectives.
- 2.2.2 To receive financial plans (annual, medium-term) and annual budgets, and recommend them to the ICB Boards for approval.
- 2.2.3 To provide oversight and assurance on the cluster ICBs' financial delivery against the Medium-Term Financial Plans and approved budgets.
- 2.2.4 To scrutinise commissioning and contract activity in relation to financial performance against the Medium-Term Financial Plans, by seeking assurance from providers on activity undertaken to meet contracted outcomes, based on the activity levels within provider contracts.
- 2.2.5 To provide oversight and assurance on capital expenditure in line with the financial strategy and joint capital plans (with providers).
- 2.2.6 To receive regular reporting on activities that significantly impact on financial delivery, including but not limited to All Age Continuing Care, medicines management, key transformation programmes.

2.2.7 Approve and regularly review the ICBs' Scheme of Financial Delegations.

### **Procurement and Contracting**

2.2.8 To provide assurance to the Cluster Board on investment decisions in line with the Scheme of Financial Delegations. Specifically:

- Support all contracts with a value exceeding £10m before formal authorisation and award.
- Through review of reports from the Procurement and Contracting Oversight Groups, ensure that due process was undertaken for appointing a provider for contracts with a value exceeding £10m before recommendation to the Cluster Board for authorisation and award.

2.2.9 To seek assurance on the financial aspects of the Provider Selection Regime, in line with national guidance and the delegated financial limits.

The committee's remit is limited to assurance and scrutiny of the process, governance, and outcomes of the Provider Selection Regime, aligned to the financial strategy.

The Population Health and Commissioning Committee will have oversight of the Provider Selection Regime in relation to outcomes-based commissioning. The Strategic Finance and Resources Committee may meet with the Population Health and Commissioning Committee as required.

2.2.10 To receive a regular report from the Contracting and Procurement Oversight Group, to provide the committee with assurance on contracting activity and to provide the committee with sight of early warning indicators.

### **Investments**

2.2.11 To receive a regular report from the Investment Panel, to provide the committee with assurance on affordability of proposed investments.

### **Resources**

2.2.12 To provide oversight and assurance on the cluster's people resources, including equality, diversity and inclusion, and people resources relating to transition and merger including related costs.

2.2.13 To provide oversight and assurance on digital resources in relation to the financial strategy.

The Audit Committees will retain oversight and assurance of governance and compliance pertaining to cyber security, information governance and data protection.

2.2.14 To provide oversight and assurance on estates and assets in relation to the financial strategy.

### **Risk**

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2.2.15 Regularly review strategic and principal operational risks (as held on the Board Assurance Framework/s (BAF) and Corporate Risk Register/s) which relate to finance, procurement and contracting.

2.2.16 Obtain assurance that these risks are appropriately managed, and assure the Cluster Board, and where required: the ICB Boards, thereof. If the Committee cannot assure the Cluster Board / the ICB Boards, it will make the Cluster Board / the ICB Boards aware of the fact and the reasons for it.

### **3. Authority**

3.1 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.
- Meet with the Population Health and Commissioning Committee and the Quality and Population Engagement Committee as required.

### **4. Accountability and Reporting**

4.1 The Committee is accountable to the BSW ICB, Dorset ICB and Somerset ICB Boards.

4.2 After each meeting of the Committee, the Committee Chair reports to the Cluster Board about the business transacted, and any concerns that the Committee wishes to escalate.

4.3 Reporting will be through the form as specified by and agreed with the Cluster Board, and may take the form of the Committee's minutes, exception or highlight reports, or dedicated reports produced by the Committee.

4.4 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 the Cluster Board or individual ICB Boards.

4.5 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.

- 4.6 A report will be written annually on the Committee's business during that year, and this will form part of the ICB's Annual Report.

## 5. Membership

- 5.1 The following are members of the Committee who have voting rights and decision-making powers:
- 3 Non-Executive Directors, one of who will chair the committee
  - The Chief Executive Officer
  - The Chief Officer Strategic Finance and Resource
  - The Chief Officer for Population Health Improvement.
- 5.2 The following are regular attendees of the Committee. They will inform and advise the Committee, but have no voting rights or decision-making powers:
- Non-Executive Chair of the cluster's in-common Audit Committees
  - 2 Place Non-Executive Directors

When determining the membership of the committee, active consideration will be made to diversity and equality.

Members are expected to make every effort to attend all committee meetings.

- 5.3 The Committee Chair may determine one of the other Non-Executive members of the Committee as deputy chair.
- 5.4 Only the above members and regular attendees of the Committee have the right to attend Committee meetings.
- 5.5 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.
- 5.6 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.

In the case of absences:

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.

## 6. Quorum

- 6.1 A quorum shall be 3 members, including one Non-Executive Director and one Chief Officer.
- 6.2 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.
- 6.3 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.
- 6.4 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.

## 7. Meeting frequency and conduct

- 7.1 The Committee will normally meet monthly, 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.

- 7.2 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.

- 7.3 The Committee normally holds its meetings in private.

- 7.4 The Committee conducts its business in accordance with relevant codes of conduct, good governance practice, including the Nolan principles of public life, the Standards

of Business Conduct Policies, Standing Financial Instructions, SoRD and other relevant policies / guidance on good and proper meeting conduct for NHS organisations.

- 7.5 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.
- 7.6 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.

## **8. Decision making**

- 8.1 Decisions are normally arrived at by consensus.
- 8.2 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.
- 8.3 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.

## **9. Equality, Diversity and Inclusion**

- 9.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

## **10. Secretariat and administration**

- 10.1 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.

## 11. Review

11.1 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 202x] (when Board approved)

**Review date:** [Month 202x] (as set by Board)

**Contact:** [ cluster shared gov inbox]

Trent Louise  
06/05/2026 15:44:22

## Appendix 1: Revision History

Version	Date	Approved by	Type of changes
V1.0		BSW ICB Board Dorset ICB Board Somerset ICB Board	Approval of ToR and formal establishment of the Committee

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## Appendix 2: Members and attendees, status April 2026

### Members:

Three Non-Executive Directors:

Adrian White (Chair)

Suzannah Power

Christopher Foster

The Chief Executive Officer: Jonathan Higman

The Chief Officer Strategic Finance and Resource: Alison Henly

The Chief Officer for Population Health Improvement: Amanda Webb

### Attendee:

The Chair of the cluster's in-common Audit Committees: Dan Worsley

### Observers:

2 Place Non-Executive Directors:

Suresh Ariaratnam

Paul Fox

Associate NED: Karl Hoods

# BSW, Dorset and Somerset ICBs Cluster

## DRAFT Joint Quality and Population Engagement Committee – Terms of Reference (ToR)

### Contents

1.	Introduction.....	1
2.	Responsibilities and duties.....	1
3.	Benchmarking and guidance.....	<b>Error! Bookmark not defined.</b>
4.	Authority .....	3
5.	Accountability and reporting .....	4
6.	Membership.....	4
7.	Quorum .....	5
8.	Meeting frequency and conduct.....	6
9.	Decision making .....	6
10.	Equality, Diversity and Inclusion.....	7
11.	Secretariat and administration.....	7
12.	Review.....	7
	Appendix I: Revision History .....	8

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06/05/2026 15:44:22

## **1. Introduction**

- 1.1 The Joint Quality and Population Engagement Committee (the Committee) is established by the BSW, Dorset and Somerset Integrated Care Boards (ICBs), as a Committee of their respective Boards in accordance with each ICB's Constitution.
- 1.2 The Committee applies the dimensions of quality set out in the National Quality Board's Shared Commitment to Quality, and is concerned with all services that:
  - Are commissioned by the NHS (either the ICBs or NHS England)
  - Are jointly commissioned by the NHS and local authorities, regardless of whether the ICB acts as principal, lead or co-commissioner
  - Are commissioned by local authorities from NHS and non-NHS providers.
  - Provide Health related care and support to the population served by the Cluster
- 1.3 The Committee is an assurance committee and has no executive powers. The Committee has the powers and authorities as delegated in the SoRD and specified in these terms of reference.
- 1.4 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 will
  - a. gain, and provide to the ICBs and the Cluster Board, assurance that the ICBs are delivering their functions in a way that secures the continuous discharge of the ICBs' statutory duties:
    - as to improvement in quality of services
    - as to reducing inequalities
    - to promote involvement of patients
  - b. gain, and provide to the ICBs and the Cluster Board, assurance that the ICBs meet and comply with the statutory requirements to make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives (if any), are involved (whether by being consulted or provided with information or in other ways)—
    - i. in the planning of the commissioning arrangements by the ICBs,

Trent Louise  
06/05/2026 15:44:22

- ii. in the development and consideration of proposals by the ICBs for changes in the commissioning arrangements where the implementation of the proposals would have an impact on—
  - the manner in which the services are delivered to the individuals (at the point when the service is received by them), or
  - the range of health services available to them, and
- iii. in decisions of the integrated care board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

2.2 In order to do so, the Committee will:

- a. Gain, and provide to the ICBs and the Cluster Board, assurance that there is an effective system of quality governance and internal control that supports the ICBs and the cluster to effectively deliver their strategic objectives and provide sustainable, effective, safe high-quality care.
- b. Agree and put forward the key quality priorities that are included within the ICBs and / or the cluster's strategy and annual plan/s, including priorities to address variations and inequalities in access to, and in provision and outcomes of, health and care services.
- c. Gain, and provide to the ICBs, assurance that there are robust processes in place for the effective surveillance and management of the quality of services that are planned, commissioned and delivered by the B/D/S ICBs.
- d. Regularly review strategic and principal operational risks (as held on the Board Assurance Framework/s (BAF) and Corporate Risk Register/s) which relate to quality and population engagement.
- e. Obtain assurance that these risks are appropriately managed, and assure the Cluster Board, and where required: the ICB Boards, thereof. If the Committee cannot assure the Cluster Board / the ICB Boards, it will make the Cluster Board / the ICB Boards aware of the fact and the reasons for it.
- f. Regularly consider reports and intelligence from all relevant sources on patient experience of commissioned services, recommend to the ICBs remedial actions to address concerns as may be required, and take assurance that learning is identified, shared and embedded.  
Reports and intelligence may include reports from the System Quality Group; reports on incidents, never events, complaints and claims; Serious Case Reviews; Adult Learning Reviews; Domestic Homicide reviews; reports from Local Safeguarding Partnerships, Safeguarding Adult Boards and Safer Community Partnerships, Prevention of Future Deaths reports; mortality report/s.
- g. Oversee and scrutinise the ICBs' response to all relevant (as applicable to

quality) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC), NHS England (NHSE) and other regulatory bodies/external agencies (e.g. Care Quality Commission, National Institute of Clinical Excellence). Gain, and provide to the ICBs and the Cluster Board, assurance that relevant action is taken to disseminate, implement and embed these both within the ICBs where ICB statutory functions and duties are concerned, and across all relevant stakeholder sites.

- h. Gain, and provide assurance to the ICBs and the Cluster Board, regarding the robustness and effectiveness of the ICBs' arrangements for discharging their statutory responsibilities for
- i. safeguarding adults and children.
  - ii. infection prevention and control.
  - iii. equality, diversity and inclusion as it applies to people accessing and using commissioned health and care services that are.
  - iv. medicines optimisation and safety.
  - v. Continuing Health Care (CHC), Funded Nursing Care (FNC), and mental health aftercare (s117, deprivation of liberties)

To do so, the Committee will consider, and approve for publication where required, relevant regular and annual reports.

- i. The Committee will highlight to the ICBs and the Cluster Board any areas of concern or unsatisfactory redress, and recommend the implementation of remedial action by the ICB Chief Nurse Officer.

### 3. Authority

#### 3.1 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.

- Meet with the Population Health and Commissioning Committee and the Strategic Finance and Resources Committee as required.

## 4. Accountability and Reporting

- 4.1 The Committee is formally accountable to the BSW ICB, Dorset ICB and Somerset ICB Boards. It will regularly report to the Cluster Board.
- 4.2 After each meeting of the Committee, the Committee Chair reports to the Cluster Board about decisions taken, assurances received, and any concerns that the Committee wishes to escalate.
- 4.3 Reporting will be in the form as agreed with the Cluster Board, and may take the form of the Committee's minutes, of exception or highlight reports, or dedicated reports produced by the Committee.
- 4.4 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 the Cluster Board, the ICBs' boards, or accountable officers.
- 4.5 The Committee receives scheduled reports from any sub-groups that it establishes, and from the ICBs' / the Cluster's quality function, in a format that is determined by the Committee and enables it to obtain the assurances that it seeks.

## 5. Membership

- 5.1 The following are members of the Committee who have voting rights and decision-making powers:
- 4 Non-Executive Directors, one of who will chair the committee
  - The B/D/S ICBs Joint Chief Nursing Officer (CNO)
  - The B/D/S ICBs Joint Chief Medical Officer (CMO)
  - The B/D/S ICBs Joint Chief Officer for Commissioning and Place

Members are expected to make every effort to attend all committee meetings.

- 5.2 The Committee Chair may determine one of the other Non-Executive members of the Committee as deputy chair.

- 5.3 The following receive a standing invitation to attend Committee meetings. They may inform and advise the Committee, but have no voting rights or decision-making powers:

- The CEO

- The Chief Officer Population Health and Improvement
- The Deputy Chief Nursing Officer
- The Deputy Director Safeguarding, SEND and LeDeR
- The Deputy Director All Age Continuing Care
- The Director of Communications, Engagement and Population Insight
- The Chief Pharmacist
- The Chief Clinical Information Officer
- One Patient Safety Partner

5.4 Only the above members and regular attendees of the Committee have the right to attend Committee meetings.

5.5 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.

5.6 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.

5.7 In the case of absences:

- a. 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.
- b. Where a regular attendee of the Committee is unable to attend a meeting, a suitable representative may be agreed with the Committee Chair.

## 6. Quorum

6.1 A quorum shall be 4 members, including one Non-Executive Director and either the Chief Medical Officer or the Chief Nurse Officer.

6.2 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.

6.3 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.

6.4 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.

## **7. Meeting frequency and conduct**

- 7.1 The Committee will normally meet bi-monthly. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

The Cluster Board, 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.

- 7.2 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.
- 7.3 The Committee normally holds its meetings in private.
- 7.4 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.
- 7.5 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.
- 7.6 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.

## **8. Decision making**

- 8.1 Decisions are normally arrived at by consensus.
- 8.2 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.

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.

## 9. Equality, Diversity and Inclusion

9.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

## 10. Secretariat and administration

10.1 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.

## 11. Review

11.1 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 202x] (when Board approved)

**Review date:** [Month 202x] (as set by Board)

**Contact:** [ cluster shared gov inbox]

Trent Louise  
06/05/2026 15:44:22

## Appendix 1: Revision History

Version	Date	Approved by	Type of changes
V1.0		BSW ICB Board Dorset ICB Board Somerset ICB Board	Approval of ToR, formal establishment of the committee

### 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.

## Appendix 2: Members, status April 2026

### Members

4 Non-Executive Directors:

Caroline Gamlin, Chair

Ade Williams

Suzannah Power

Christopher Foster

Chief Nurse Officer: Shelagh Meldrum

Chief Medical Officer: Bernie Marden

Chief Officer for Commissioning and Place: David Freeman

### Observers

Place NED (Somerset): Grahame Paine

Place NED (BaNES): Paul Fox

Place NED (BCP): Karl Hoods

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06/05/2026 15:44:22

# BSW, Dorset and Somerset ICBs Cluster

## DRAFT Joint Population Health and Commissioning Committee – Terms of Reference (ToR)

### Contents

1.	Introduction.....	1
2.	Responsibilities and duties.....	1
3.	Authority.....	3
4.	Accountability and Reporting.....	3
5.	Membership.....	4
6.	Quorum.....	5
7.	Meeting frequency and conduct.....	5
8.	Decision making.....	6
9.	Equality, Diversity and Inclusion.....	6
10.	Secretariat and administration.....	6
11.	Review.....	7
	Appendix 1: Revision History.....	8
	Appendix 2: Members and observers.....	8

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## 1. Introduction

- 1.1. The Joint Population Health and Commissioning 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 purpose is to contribute to the overall delivery of the ICBs' objectives by providing oversight and assurance to the Boards on the delivery of the ICBs' Population Health Strategy through strategic commissioning.

The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

- 2.2 The Committee's key responsibilities and duties are as follows:

### Strategy and outcomes

- 2.2.1. Oversee and assure the development of the cluster's Population Health Strategy. Recommend the Population Health Strategy to the Cluster Board for approval.
- 2.2.2. Obtain assurance on the delivery of the Population Health Strategy, and on progress towards achieving its stated aims, objectives, and outcomes.
- 2.2.3. Oversee the Outcomes Framework, and obtain assurance (incl. through deep dives) that outcomes are being delivered as planned and intended.

### Commissioning

- 2.2.4. Oversee and assure the development of the cluster's Commissioning Strategy, and the cluster's annual Commissioning Intentions. Test the Commissioning Strategy's and the Commissioning Intentions' capability to deliver the neighbourhood health framework, and novel population health delivery and contracting models.
- 2.2.5. Recommend the Commissioning Strategy and Commissioning Intentions to the Cluster Board for approval.

- 2.2.6. Obtain assurance that the cluster's Commissioning Strategy and Commissioning Intentions remain aligned with, complement, and drive the delivery of, the Population Health Strategy.
- 2.2.7. Test, and obtain assurance, that the intended commissioning at cluster and place will deliver all intended population Health outcomes as stated in the Population Health strategy and the Outcomes Framework.
- 2.2.8. Through regular assurance reports from its sub-groups, obtain assurance that the cluster fully delivers its Commissioning Intentions as planned, fully implements and follows the commissioning cycle, and applies appropriate levers to incentivise providers' delivery of outcomes.

### **Place**

- 2.2.9. Oversee and assure the development and application of a maturity framework for place, which sets criteria and thresholds to assess places' readiness to operate autonomously.
- 2.2.10. Receive and scrutinise assessments (against the maturity framework) of places' readiness to operate. Make recommendations to the ICB Boards for delegations of functions from the ICBs to place. Monitor, and obtain assurance on, places' exercise of the delegated functions.
- 2.2.11. Through regular reports from Place Boards, obtain assurance on the performance and progress of place, incl. delivery of the neighbourhood health framework through place commissioning intentions, and progress with implementing population health delivery and contracting models.

### **Public involvement**

- 2.2.12. Obtain assurance that the ICBs comply with and discharge their statutory duty to involve the public in
  - a. the planning of the commissioning arrangements by the ICBs;
  - b. the development and consideration of proposals by the ICBs for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them;
  - c. decisions of the ICBs affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

### **Risk**

- 2.2.13. Regularly review strategic and principal operational risks (as held on the Board Assurance Framework/s (BAF) and Corporate Risk Register/s) which relate to finance, procurement, and contracting.
- 2.2.14. Obtain assurance that these risks are appropriately managed, and assure the Cluster Board, and where required: the ICB Boards, thereof. If the

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Committee cannot assure the Cluster Board / the ICB Boards, it will make the Cluster Board / the ICB Boards aware of the fact and the reasons for it.

### **3. Authority**

3.1. 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.
- Meet with the Strategic Finance and Resources Committee and the Quality and Population Engagement Committee as required.

### **4. Accountability and Reporting**

4.1. 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.

4.2. 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.

4.3. 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.

4.4. 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.

4.5. 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.

4.6. A report will be written annually on the Committee's business during that year, and this will form part of the ICB's Annual Report.

## 5. Membership

5.1. The following are members of the Committee who have voting rights and decision-making powers:

- 4 Non-Executive Directors, one of who will chair the Committee
- The B/D/S ICBs Joint Chief Medical Officer
- The B/D/S ICBs Joint Chief Nurse Officer
- The B/D/S ICBs Joint Chief Officer for Commissioning and Place
- The B/D/S ICBs Joint Chief Officer for Population Health Improvement
- TBC - The B/D/S ICBs Joint Chief Officer Strategic Finance and Resources

5.2. The following are observers of the Committee, who have no voting rights or decision-making powers:

- Place NED (Somerset)
- Place NED (Wilts)
- Place NED (BCP)

5.3. When determining the membership of the committee, active consideration will be made to diversity and equality.

5.4. Members are expected to make every effort to attend all committee meetings.

5.5. The Committee Chair may determine one of the other Non-Executive members of the Committee as deputy chair.

5.6. Only the above members and regular attendees of the Committee have the right to attend Committee meetings.

5.7. 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.

5.8. 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.

5.9. In the case of absences:

- 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.

- 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.
- Where a regular attendee of the Committee is unable to attend a meeting, a suitable representative may be agreed with the Committee Chair.

## 6. Quorum

- 6.1. A quorum shall be 5 members, including 2 Non-Executive Directors and 2 Executive Directors.
- 6.2. 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.
- 6.3. 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.
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**Review date:** [Month 202x] (as set by Board)

**Contact:** [ cluster shared gov inbox]

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06/05/2026 15:44:22

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## Appendix 2: Members and observers

### Members

4 Non-Executive Directors, one of who will chair the Committee

Christopher Foster, Chair

Ade Williams

Adrian White

Caroline Gamlin

The B/D/S ICBs Joint Chief Medical Officer: Bernie Marden

The B/D/S ICBs Joint Chief Nurse Officer: Shelagh Meldrum

The B/D/S ICBs Joint Chief Officer for Commissioning and Place: David Freeman

The B/D/S ICBs Joint Chief Officer for Population Health Improvement: Amanda Webb

TBC - The B/D/S ICBs Joint Chief Officer Strategic Finance and Resources: Alison Henly

### Observers

Place NED (Somerset): Grahame Paine

Place NED (Wilts): Julian Kirby

Place NED (BCP): Karl Hoods

# Cluster Functions and Decisions Map from Q1 2026 / 27

NHS BSW ICB Board

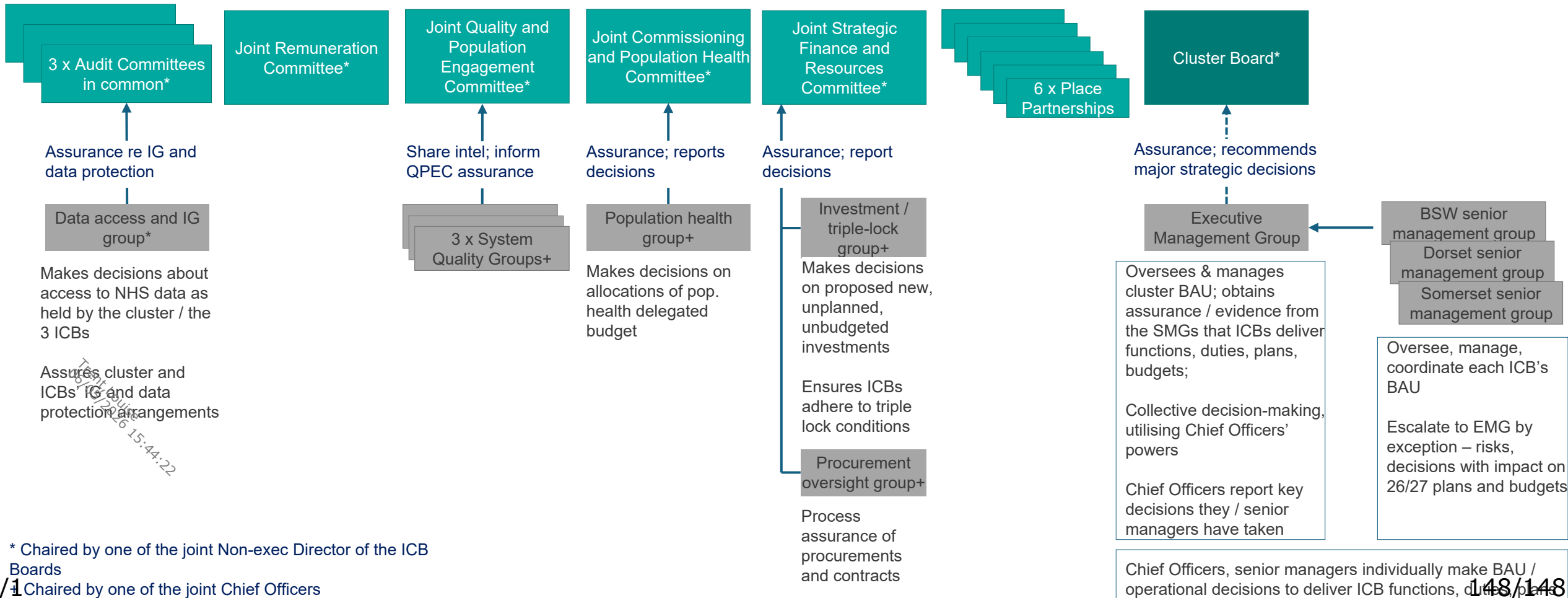
NHS Dorset ICB Board

NHS Somerset ICB Board

Remain in place for as long as ICBs exist; establish joint committees / in-common committees and delegate powers to them

## Committees

- Obtain from management, and provide to the three boards, assurance that the ICBs discharge their statutory functions and duties
  - Make decisions as delegated to them from the three ICB Boards



\* Chaired by one of the joint Non-exec Director of the ICB Boards

1/1 Chaired by one of the joint Chief Officers