Bath and North East Somerset,
Swindon and Wiltshire Together

Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW Together)

Implementation Plan

2025/26

FOREWORD

The Integrated Care Partnership in Bath and Northeast Somerset, Swindon and Wiltshire (BSW) was set up in July 2022. The Partnership brought together statutory and voluntary sector organisations with a joint mission to improve health and wellbeing and tackle inequalities.

Since then, significant progress has been made in the way we work together and some of our achievements are set out in this document.

2024/25 has been a year of significant change for BSW, along with many other health and care systems in the country. While we have had to deal with considerable operational and financial challenges, we have also seen areas of development including the introduction of a new BSW Integrated Community Based Care Programme and the formation of the BSW Hospitals Group.

This means that we are making great progress with the implementation of our BSW Care Model – there is more to do but we are confident that through working as partners we will continue to make the right steps to improve outcomes and reduce inequalities for our patients and residents.

The next 12 months will be an exciting time in BSW where there will be a renewed focus on community services, embracing the concept of 'neighbourhood health' focused squarely on the needs and experience of patients . The planning and preparation in place puts BSW in a good position to support local communities and the hardworking staff who care for them.

This updated Implementation Plan covering 2025-2027 sets out the actions that BSW will take as a system to jointly address the most pressing priorities, building on the solid foundations already laid.

We are expecting a new ten year plan for the NHS this year, and we will reflect on that plan and consider any potential changes to our ICP strategy and our implementation plan in due course.

INTRODUCTION

Introduction

In July 2023 BSW published its first Integrated Care Strategy, setting out the ambitions of health and care partners to improve services for local people.

This was also informed by the Health and Wellbeing Strategies set by each of our Local Authority Health and Wellbeing Boards. The Strategy set out a vision for the next five years, uniting partners behind three clear objectives.

These are:

- Focus on prevention and early intervention
- Fairer health and wellbeing outcomes
- Excellent health and care services

Following this, Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) worked with partners to produced the first Implementation Plan demonstrating how we work together as a system and at place level to deliver our ICP Strategy.

This is our third annual refresh of that Plan carried out with the input of partners and covers our intentions from 2025 to 2027. Whilst focussing on implementation of our strategy, this plan also takes account of the annual planning guidance which NHS England issues to all ICBs and makes the link between our immediate objectives and the longer term outcomes that we are seeking to deliver collectively. The purpose of the Implementation Plan to give BSW local populations, partners and stakeholders a clear picture of the programmes of work we will be delivering and the outcomes that we are seeking to achieve to support the health and wellbeing of our population.

We are in the middle of a national and local conversation on the NHS Ten year plan, which includes engagement with our communities. During January and February 2025 we conducted a number of engagement sessions with members of the public across BSW to gather input and involving several distinct groups, including Patient Participation Groups, senior citizens from Black and Minority Ethnic (BAME) communities in Bath, refugees and asylum seekers in Swindon, the Muslim community in BaNES, and representatives from the Gypsy, Romany, Boater, and Traveller communities in Wiltshire and Bath.

Approximately 150 people attended these events and shared their views. Discussions with these groups focused on three key national shifts underway nationally in health and care: better use of technology, transitioning more care from hospitals to communities, and prioritising illness prevention over treatment. These themes are central to this Plan, and relevant feedback from our engagement sessions has been included.

Given the ongoing national conversations regarding the NHS Ten Year plan, we have sought to take a light touch approach to this refresh, although we have aimed to be more concise in our articulation of our priorities. More information on our work, our achievements and our aims for the future is contained within our more detailed Companion document. The ICB's work against its Legislative Duties is also found in the Companion document.

NHS Ten Year Plan: Feedback from patients and the public

- Broad support for 'Hospital at home' (virtual wards).
- Enthusiasm for 'Pharmacy First' (this community pharmacists to supply some prescription-only medicines, where clinically appropriate.
- Concerns over digital exclusion.
- Concerns over access to Community Diagnostic Centres.
- Belief that NHS will improve in the future.

INTRODUCTION

About BSW

The health and care needs of people living in Bath and Northeast Somerset, Swindon and Wiltshire are changing, with more people living longer, often with multiple long-term conditions.

The profile of the population varies greatly across the ICB. For example, whilst **BSW has areas of affluence, Swindon is ranked as the 98th most deprived area out of 151 Local Authority areas in England** but some smaller areas are in the 10% most deprived in the country.

BSW serves a combined local population of 940,000.

It has a complex and extremely varied demographic structure and geography which poses challenges to the delivery of health and social care.

Approximately 103,000 people from ethnic minority communities live in BSW (All Age MH Strategy, 2024). Swindon has significantly more residents from a black and ethnic minority group:

18.5% in Swindon, compared to **7.8% in BANES** and **5.6% in Wiltshire** . In all three areas the largest ethnic group after 'White British' is 'Asian/British/Asian (ONS, 2021).

The health needs of local people varies across our area. Here's a snapshot and some areas of concern:

- **180,000 people** in BSW have some form of **Mental Health condition**.
- In BSW **5.56% of the population has diabetes** yet 20% of the COVID deaths were in people with diabetes.
- **156,000 people** in BSW have 3 or more **long-term conditions**.
- **85,000 people** in BSW a**ged 65+ on 10 or more prescriptions**. This is nearly 1 in 2.85.
- The percentage of **people with a learning disability living in residential care often away from home is greater than the national average** increasing isolation.
- **60375 people live in the 20% most deprived areas.** This is 6.5% of the population.

Children and young people account for 30% of our population. While most child health indicators are better than the national average, many children have difficult living circumstances across the system:

- **1 in 4 children** do not achieve a good level of development at the end of Reception.
- **1 in 10** children are **living in poverty**.
- **1 in 200** children are **in care**.

National statistics show an increase in mental ill health in children and young adults, with 83% of this group saying that the pandemic has made their mental health worse. Across BSW, **acute hospital admissions for mental health conditions in under 18s are consistently higher than the national average**, ranging from 500 to 800 per 100,000 population each year, with rates highest in Swindon.

Future challenges

- The **BSW population is projected to grow by 6%** over the next 15 years, meaning there will be an **extra 60,000 by 2038**.
- **The number of people aged under 60 will remain stable**; all of this growth is in the over 60s, meaning a 35% growth in our 60+ population.
- **Multi-morbidity increases with age**. These population changes mean that there will be a**n additional 32,000 people with two or more long term conditions** by 2038.
- It currently costs **£340 million to provide acute, inpatient, outpatient and A&E services in BSW**. Because of demographic changes alone in 15 years this will increase to £410 million a year.

JOURNEY AND ACHIEVEMENTS

Developing our care model – our journey

Over the past four years we have been working with clinicians, staff, patients and carers to develop our health and care model.

The five main components of the model are:

1. Personalised care
Health and care professionals working together will support people with long-term physical and mental health conditions and complex needs to live well with their health conditions and take charge of their own care.

2. Healthier communities
We want people in every community across BSW to have the information, education, resources and support available so they can live their best life.

3. Integrated local teams
Local teams involving the NHS, community services, social and care workers and the third (voluntary) sector will work together in teams to provide what local people need.

4. Local specialist services
In the future, much more specialist health and care support will be available closer to where you live. Clinics that take place in hospitals today will be available in places like local health centres and on your local high street.

5. Specialist centres
Our hospitals will focus more on specialist care. Routine appointments and treatments will happen in community locations, online or over the phone. Hospitals will be for complex treatment and people who are seriously ill or injured. With less routine care happening at hospitals, specialist care will be less disrupted than it is today.

In this Plan we set out our recent progress in implementing our care model. This includes our new community contract with HCRG Group, our Integrated Care Alliances, our Hospitals' Group Model and our new diagnostic centres.

"The NHS needs to do more to join up the heath service and social care otherwise people get stuck in hospital because they don't have care at home."

Ten Year Plan workshop participant

Our care model

JOURNEY AND ACHIEVEMENTS

Some of our achievements across BSW in 2024

Transforming community services

The ICB's landmark decision to appoint HCRG Care Group as the lead partner for BSW ICB Integrated Community Based Services (ICBC) portfolio from April 2025 marks the start of a new and innovative approach to commissioning and delivery services in the community.

A new focus on community services means BSW can transform care and support for people at every stage of their lives with a focus on prevention and early intervention that will help people to manage their health proactively and stay healthier for longer.

Local people can expect to receive more health and social care in or near their homes, in a more joined up and streamlined way, embracing the concept of neighbourhood health.

Developing our All Age Mental Health Strategy

Working with partners, we have recently agreed our All Age Mental Health Strategy, recognising the growing number of both children and adults facing mental ill health.

The Strategy sets out a transformation roadmap for developing person-centred mental health services over the next five years, from pregnancy and birth, through childhood, adulthood and older adults.
The Strategy commits to ensuring timely access to high quality services for everyone and that people's voices and experiences are at the heart of how services are transformed.

Improving services through digital

BSW population's use of the NHS App continues to grow. In October BSW hit over 100,000 repeat prescriptions in a month and more than one million logins to the app.

While BSW know that digital is not for everyone, this does show that people value the app and growth in usage is strong.

Getting to know our communities

During 2024, BSW have gone further to reach directly into communities to understand their health needs through initiatives such as outreach to the Wiltshire Farming Community at the Salisbury Livestock Market.

BSW know that this outreach resulted in people getting much-needed, urgent medical care which they might not otherwise have sought – this support the essence of BSW to make a genuine difference to people's lives.

Improving our facilities

BSW have been able to invest in the facilities that house health and care services, with the green light given for Trowbridge Integrated Care Centre in November.

Capital investment in 'bricks and mortar' projects like these is not always easy to come by and along with the new community diagnostic centre in Swindon, and new builds at our acute hospitals, BSW are breathing new life into the fabric of our NHS.

JOURNEY AND ACHIEVEMENTS

Our hospitals' group model

"Working together, learning together, improving together"

In 2024, the Boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust agreed to form a Group, the purpose of which is to collectively provide high quality care for our population.

Through working as a Group, we can improve patient care and how we use our resources and help us to develop our ambitions to become anchor institutions. This follows years of increasingly close working as a provider collaborative called the Acute Hospital Alliance.

Our three Trusts have long acknowledged that we can achieve far more by collaborating than by operating independently. This includes working collaboratively with the ICB, local authorities and other partners, to deliver the priorities set out in the Integrated Care Strategy.

We are currently developing our leadership team and have appointed Cara Charles-Barks as Chief Executive of each of the three Trusts, and of our Group.

We are now setting up a Joint Committee and establishing a governance structure and operating model for our Group.

The key issues that have our immediate focus include:

- Improving access to **urgent and emergency care**, with a particular focus on reducing delays to ambulance crews safely handing their patients over to us
- Implementing a new shared **Electronic Patient Record**, so that patient records are shared between Trusts which helps ensure healthcare providers have instant access to accurate, up-to-date patient information, helping clinicians make decisions about patient care.
- Responding to the national **elective care** improvements outlined by the Government in January 2025 which will help patients get faster access to planned care

Becoming a Group also puts us in a better position to address some of our system challenges, make a shift away from a traditional acute hospital model to focus on prevention and primary and community care.

Over time, the care we deliver will reach new heights of excellence, transforming both patient outcomes and staff experiences. Our ambition is to set a standard of exceptional care across our system, eliminating variation and consistently achieving outstanding results.

JOURNEY AND ACHIEVEMENTS

Our new model for integrated community based care

At the centre of our care model is our ambition to develop integrated health and care services at neighbourhood and community level, so people have access to the support they need as close to home as possible.

From April 2025 HRCG Care Group will lead an innovative community based care partnership with the NHS, local authorities and charities that will transform care and support by providing more joined up health and social care in or near people's homes. We will be focused on delivering better outcomes for the people of BSW against the three objectives agreed in the BSW Integrated Care Strategy:

Focus on prevention and early intervention

By providing more services and support that catch illnesses and health conditions early to help people stay well and live independently for longer.

Fairer health and wellbeing outcomes

The new contract will ensure that services will be provided to meet the needs of local people, wherever they live.

Excellent health and care services

By developing thriving community-based services, we will reduce pressure on GPs and hospitals, helping reduce waiting times , joining up care pathways and making sure people get the right care, in the right place, at the right time.

We are going to transform care by:

- Building neighbourhood teams to support the health and care needs of specific communities utilising population health management approaches.
- Providing an all age single point of access for urgent clinical needs so people get the right care in the right place.
- Implementing family child health hubs to help join up care.
- Improving care pathways to help people avoid being admitted to hospital.
- Providing more specialist support in communities and primary care so people get care closer to home.
- Providing more specialist advice and support for people with a learning disability, autism or neurodiversity.

Underpinned by:

- Building a sustainable and innovative workforce so that we attract and keep enough of the right staff.
- Harnessing digital innovation to make the most of modern technology to improve health and care.
- Shifting funding and capacity into more community based care.

INTEGRATED CARE ALLIANCES

How we work in BSW – our Integrated Care Alliances

Role

BSW is made up of three 'places': Bath & North East Somerset, Swindon and Wiltshire.

In each area, health and care organisations work together as Integrated Care Alliances (ICAs) and are integral in delivering the vision on the ICB and the wider system.

As collaborative partnerships, ICAs bring together health, care, Local Authority, voluntary, and community sector organisations to improve outcomes, reduce inequalities, and promote the health and wellbeing of local populations.

ICAs focus on the integration of services to ensure residents receive joined-up, high-quality care that meets their needs.

By operating at a local level, ICAs are able to respond to the specific challenges and strengths of their communities while contributing to wider system goals.

Purpose

By working together, ICA partners ensure that services are:

- **Person-centred:** Seamless and accessible, enabling residents to receive the right care, in the right place, at the right time.
- **Focused on prevention:** Promoting early intervention to address issues before they escalate, improving long-term outcomes.
- **Aligned to tackle inequalities:** Addressing health disparities and ensuring equitable access to care for all parts of the population.
- Each ICA works in alignment with the Joint Strategic Needs Assessments (JSNAs), Health and Wellbeing Strategies, and the BSW Integrated Care Strategy. This ensures their priorities reflect both local population needs and system-wide ambitions.

Core responsibilities

- **Health and Care Strategy:** Develop local strategies to improve outcomes, informed by data and partner expertise.
- **Service Transformation:** Oversee integrated service delivery, quality, and resource use to meet local needs.
- **Tackling Inequalities:** Identify and address health disparities through targeted programmes.
- **Population Health Management:** Use data to design services that improve health and reduce inequalities.
- **Resource Alignment:** Oversee budgets, including the Better Care Fund, to support shared priorities.
- **Community Connections:** Link health and care services with voluntary and community partners for locally rooted support.

Governance and Accountability

ICAs operate as key components of the BSW ICS, providing a forum for senior decision-makers from NHS, local authority, and community partners to collaborate effectively. Each ICA is established as a formal partnership with robust governance arrangements.

Decisions are made collectively, with members working towards shared goals that benefit local populations. Regular reporting ensures accountability to the Integrated Care Board (ICB) and relevant sub-committees, local Health and Wellbeing Boards, and partner organisations.

What This Means for Our Residents

ICAs ensure that health and care services are more integrated, making them easier to navigate and more effective in meeting the needs of local populations.

Their focus on prevention, tackling inequalities, and using shared resources means better long-term outcomes and fairer access to services for everyone.

INTEGRATED CARE ALLIANCES

Priorities for our ICAs

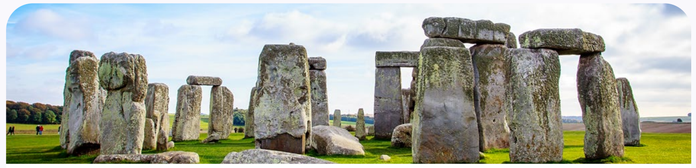
Below we highlight three key programme areas for each ICA in 2025/26, aligned with the goals of prevention, reducing inequalities, and excellent care. These priorities represent a focus within the broader scope of ICA activities, which encompass extensive efforts to improve outcomes, tackle local challenges, and deliver the Integrated Care Strategy.

B&NES Priorities

- **Children and Young People (CYP) emotional health and wellbeing;** Developing resources on emotional health and wellbeing support, to include training tools and sustainable model of delivery, for use by colleagues working with CYP in the community.
- **Addressing the needs of 18-25 year olds;** who are not in education, training or employment, to access support and experience to develop healthy lives.
- **Integrated Neighbourhood Teams;** expanding and extending the current model in partnership with primary care and the ICBC service. Initially focussing on frail individuals.

Swindon Priorities

- **CYP emotional health and wellbeing;** offering practical support for families waiting for mental health appointments.
- **Children's Oral Health;** prevention of avoidable dental extractions in CYP. Aiming to support families with high levels of dental decay and previous extractions.
- **Working together to support all adults not in employment or training;** helping them build healthy lives. Improving health outcomes by creating pathways for employment and skills development, fostering long-term opportunities for growth and wellbeing.



Wiltshire Priorities

- **CYP emotional health and wellbeing;** development of a work plan following a comprehensive schools survey and the March joint Wiltshire Summit on improving CYP Emotional Wellbeing.
- **Children's Oral Health;** a multiagency approach to improving CYP oral health including training programmes, a dental health equity audit and other priority actions. Aiming to reduce avoidable CYP dental extractions.
- **Integrated Neighbourhood Teams;** working alongside the ICBC service to further progress and develop the Wiltshire Collaboratives, integrating the approaches.

OUTCOMES FRAMEWORK

BSW System Outcomes Framework

Why do we need an Outcomes Framework?

The way we deliver health and care across Bath and North East Somerset, Swindon and Wiltshire (BSW) is changing. We know that delivering more care is not the same as delivering better care.

What truly matters is the impact that services have on people's health, wellbeing and quality of life. That is why we have developed the system Outcomes Framework.

It is a way to ensure that every decision we make and every pound we spend delivers the best possible outcomes for our communities.

What is the BSW System Outcomes Framework?

Our Outcomes Framework is a set of clear, measurable goals that help us track how well our health and care system is meeting the needs of local people.

Instead of just measuring activity, like the number of hospital appointments, we focus on real world improvements such as are people living healthier, longer lives? Do patients feel supported in managing their conditions? Are we reducing inequalities in health across different communities?

By focusing on what truly matters to individuals, families and communities, we can work together to improve the health and wellbeing of everyone in BSW.

We have identified 20 indicators for which national data is available, as well as supplementary local outcomes that will allow us to further segment these outcomes by age (CYP and adult), gender, ethnicity, deprivation, SMI and PLD. More detail on this can be found in the Companion Document.

How we developed the framework?

We created the BSW System Outcomes Framework through a collaborative process building on feedback we received about our initial outcomes work. This included reviewing the existing data and evidence, identifying key areas where we can make the biggest impact; developing a structured approach – ensuring that selected outcome measures are clear, measurable and meaningful; testing and refining – learning from real-world use and continuously improving how we measure success.

We recognise that some important outcomes cannot yet be measured due to data limitations. When this is the case, we have either identified a proxy indicator to use while we develop an outcome measure and/or included them as placeholders in our companion document. Over time we will work to improve data collection and reporting enabling us to track these outcomes more effectively in the future.

For each outcome we have identified a national metric and a local metric. The national metric provides the opportunity to benchmark BSW to other ICBs and Local Authorities. The local metric enables more frequent and timely reporting and segmentation by place and inequalities groups. This provides the opportunity to monitor trends and explore inequalities.

What next?

The 2025/26 Implementation Plan marks the next phase of embedding the Outcomes Framework into everything we do. This is just the beginning – our framework will continue to evolve, ensuring we remain focussed on delivering the best possible health and care for all.

By continuously improving how we measure success, investing in better data and keeping outcomes at the heart of our decision making, we will drive meaningful change for our communities.

OUTCOMES FRAMEWORK

Outcomes Framework

	National indicator (Local indicator if different)
Key Outcomes	
1	Life expectancy at Birth (Years of life lost)
2	Healthy expectancy at 65 (Average age entering frailty)
3	Emergency bed days
Contributory Outcomes	
4	Infant Mortality/ Pre-term births (Years of life lost from child deaths)
5	Under 75 mortality rates for major conditions (Years of life lost for major conditions)
6	Dementia Diagnosis Rate (GP recorded dementia prevalence)
7	Premature mortality in adults with SMI (Years of life lost with SMI)
8	Admissions for self-harm
9	Population employment inactivity
10	Staff Survey engagement score

Continued on next page...

OUTCOMES FRAMEWORK

Outcomes Framework

	National indicator (Local indicator if different)
Contributory Outcomes	
11	ICS organisation leavers rate
12	Percentage of patients reporting they have a care plan/ care plan is helpful (Number of Care Plans recorded on Integrated Care Record)
13	Percentage of deaths in hospital
14	School readiness
15	Smoking prevalence
16	Obesity prevalence
17	Physical inactivity prevalence
18	Admissions for alcohol specific conditions
19	MMR vaccination rates/ Flu vaccination rates
20	Hospital admissions for dental decay

OUR STRATEGIC OBJECTIVES

Our strategic objectives – Overview

We have four strategic objectives agreed across the system. As part of developing our Implementation Plan this year, we have taken on board feedback from stakeholders that we need to be targeted in our priorities. We have therefore set out five key priorities and two enablers. These are the things that we believe will make the most difference for our local patients and citizens in the coming years and ensure that we deliver on our strategic objectives.

Strategic Objectives	Key Priorities
1. Focus on prevention and early intervention	**1.** Increase our focus on prevention, improve timeliness of access and expand diagnostic and preventative care
2. Fairer health and wellbeing outcomes	**2.** Reducing healthcare inequalities in our localities and our system
3. Excellent health and care services	**3.** Implement the vision set out in the NHS elective reform plan by redesigning our elective services, improving access and outcomes for our population **4.** Improve our urgent and emergency care services providing the right care at the right time in the right place
4. Financial recovery and sustainability	**5.** Deliver our medium term financial plan and return to financial balance
Enablers	
 **Workforce**	 **Digital**

OUR STRATEGIC OBJECTIVES

Strategic Objective: Focus on prevention and early intervention

Priority 1:
Increase our focus on prevention, improve timeliness of access and expand diagnostic and preventative care.

Why is this important?

Helping people to manage their lives to prevent ill health, ensuring they can access care closer to home and earlier in their care are key aspects of our BSW Care Model. This includes a focus on prevention for children and young people. By prevention and early intervention we can help people live longer, healthier lives and ensure our resources are used where they have the greatest impact. Through using data and local knowledge about our population we can personalise care and target our efforts on those who need it most.

What have we achieved in 24/25?

We have made progress on number of important initiatives:

- Prevention is a key system priority. This includes our approach to mental ill health prevention and our weight loss strategy helping people to maintain a healthy weight.
- Our Treating Tobacco Dependency Service is being embedded across our acute, mental health and maternity services, helping people to quit smoking.
- We developed an approach to improve early detection and optimise management of hypertension, laying the foundations for better cardiovascular health outcomes.
- We have strengthened our Community Vaccination Hub model, ensuring targeted Covid 19 and flu vaccinations for priority groups.
- We have opened up three new diagnostic centres (in Bath, Swindon and Salsbury) providing services such as such as X-rays, MRI and CT scans, blood tests, ultrasounds and endoscopies, in the community.
- We have awarded the contract for integrated community services to HRCG Care Group.

What are we doing next?

- Delivery Groups are the mechanism for implementing actions across the system. Each Delivery Group will take responsibility for delivering targeted prevention actions, including those linked to hypertension, weight management and mental health prevention.
- Through this work we are ensuring prevention remains a key system priority. This includes implementing our hypertension case management service, developing our approaches to mental health prevention and launching our weight loss strategy, supporting individuals and communities to achieve and maintain a healthy weight.
- We are increasing access to primary care including dental services as well as working to ensure that good oral health is maintained for our CYP.
- We will further reduce the number of people who smoke by expanding our stop smoking services across partner organisations.
- Developing our work in anchor institutions.
- We will form integrated neighbourhood teams with greater focus on earlier intervention.
- Boosting our uptake of vaccinations.
- We are planning to further expand our community diagnostic centres offering.

What difference will we make?

- Reduction in smoking and obesity prevalence.
- Increase in Personal Wellbeing scores and decrease in admissions for self-harm.
- Reduction in under 75 mortality and years of life lost from Cardiovascular Disease.
- Increase in percentage of patients reporting they have a care plan.
- Improved life expectancy through early diagnosis of disease.
- Maintenance of high levels of flu vaccination rates.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Fairer health and well being outcomes

Priority 2:
Reducing health inequalities in our localities and our system.

Why is this important?

Inequalities are unfair and avoidable differences that can impact health across different communities driven by factors such as education, housing, employment, ethnicity and access to health services and programmes.

Core20PLUS5 is a national NHS England approach to reduce healthcare inequalities at both national and system level. Core20 refers to the most deprived 20% of the national population. PLUS refers to ICS chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone. '5' refers to five clinical areas of focus which require accelerated improvement.

1. Maternity
2. Severe mental illness (SMI)
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension

Across BSW these include people (children and adults) from ethnic minority, gypsy, Roma and traveller and rural communities, homeless people and people living with severe mental illness.

What have we achieved in 24/25?

- Invested £1.7 million in 35 place-based projects that tackle inequalities in Core20Plus population and the wider determinants of health that lead to these.
- Through the Maternity Delivery Group targeted projects to reduce inequalities have been delivered, including: Improving accessibility to maternity services for Gypsy, Roma, Traveller, Boating, and Showman communities, ensuring services reflect population needs and co-producing 12 "Hello Baby" maternity and neonatal videos, supporting parents through pregnancy and birth, with subtitles available in 10 different languages.
- Through the Babies, Children and Young People Delivery Group, the CORE20PLUS5 framework has been used to identify the most vulnerable children and young people in our communities. The Strategic Intelligence Team is supporting to integrate reports and datasets, enabling the Delivery Group to track health outcomes and pinpoint areas for improvement.

What are we doing next?

- Investment of a further £1.7 million in place-based projects with a more targeted focus on Core20plus5 clinical areas. We will report on the impact of this investment in 25/26.
- Each Delivery Group has developed a specific priority in conjunction with the Inequalities Strategy Group in relation to reducing inequalities for 25/26. We will be measuring progress against completion and impact of these priorities (see Companion document for further detail).
- We are also working to increase our understanding of our population health data in respect to health inequalities.

What difference will we make?

- Reduced inequalities in infant mortality and pre-term births.
- Increase percentage of children who feel they have healthy ways to manage difficult feeling in Core20plus populations.
- Improved personal wellbeing scores (life satisfaction, worthwhile, happiness, anxiety) in Core20plus populations.
- Reduction in adults who feel lonely always, often or some of the time in Core20plus populations.

Example

The Salisbury Livestock Market pilot brought together health and wellbeing services in a setting familiar to the farming community. By providing health checks, mental health advice, and signposting to local services, the pilot helped to break down barriers to healthcare access in this often hard-to-reach group.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Excellent health and care services

Priority 3:
Implement the vision set out in the NHS elective reform plan by redesigning our elective services, improving access and outcomes for our population.

Why is this important?

Across BSW, almost 2000 people are waiting more than a year for an appointment, which is too long and which we are working to address. We know that there is continued variation in provision across our footprint and we need to address this too so that we secure the best possible health and care outcomes for our population.

We also need to ensure that we are providing timely access for people to elective care so that they do not get worse whilst waiting.

Alongside improving access to planned care services, we also need to ensure that we continue to provide early access to cancer services and that our diagnostic pathways are as rapid as possible to enable early diagnosis and intervention to support recovery.

What have we achieved in 24/25?

- Reduced waiting times so that no-one in BSW will wait longer than 65 weeks by March 2025.
- Increased elective activity so that more people have had access to treatment.
- Improved access to diagnostics, delivering planned reductions in diagnostic waiting times.
- Commenced work on pathway transformation in core areas.

What are we doing next?

- Implementation of new diagnostics capacity across the system to support earlier diagnosis for cancer and non-cancer related conditions.
- Prioritise service redesign of the five specialities identified in the NHS Elective Reform Plan: Cardiology, ENT, Gastroenterology, Respiratory and Urology.
- Cutting waiting times further by:
  - Reviewing 'first to follow up ratios' for all specialties so that patients only get a second outpatient consultation if they really need it and ensuring that we are following best practice guidance.
  - Meeting and sustaining an 85%-day case activity rate across all providers so as many patients as possible do not need an overnight hospital stay.
  - Maximising the use of advice and guidance whereby GPs can get expert input from a consultant before referring a patient to an outpatient appointment.
  - Further roll out of Robotic Process Automation (RPA) across outpatient services to support efficient booking processes.
  - Implementation of Patient Engagement Portal (PEP) to enable patients to manage their own outpatient appointments and booking.

What difference will we make?

Improved health gain from elective interventions through the following:

- Ensuring that greater than 65% of people on our waiting list wait 18 weeks or less for treatment across all three providers.
- Improving access to diagnostics to support earlier intervention for people with suspected cancer – reducing mortality across all populations.
- 30% of outpatient referrals from GPs benefit from advice and guidance from a specialist consultant.

Example

The Sulis Elective Orthopaedic Centre (part of the Royal United Hospitals Bath family), opened in late 2024, provides capacity for 3,750 orthopaedic NHS patients every year across BSW and beyond. Facilities at the Centre will include two new modular theatres, additional inpatient beds, and the conversion of two existing theatres to laminar flow theatres.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Excellent health and care services

Priority 4:
Improve our urgent and emergency care services providing the right care at the right time in the right place.

Why is this important?

Over the past year we have continued to see an increase in demand for urgent and emergency services and high levels of pressure on our ambulance service, emergency departments and acute hospitals.

It is important that people needing emergency or urgent care are treated swiftly and appropriately and to do this we need to make sure they are treated in the right place, with access to care as close to home as possible.

This means utilising the most appropriate primary care setting for each patient; such as a consultation within community pharmacy rather than GP practice where appropriate.

What have we achieved in 24/25?

- Increased the number of 'virtual ward' beds so that more people can be treated in their own homes.
- Through our Care Coordination approach, diverting patients to out of hospital services when appropriate.
- Worked to decrease the number of patients in hospital beds who no longer need to be there for medical care.
- Improved the way we work together across the system so that systems and processes are not causing unnecessary delays.

What are we doing next?

Reduction in emergency bed days through doing the following:

- Identify more opportunities to divert patients (when appropriate) away from urgent and emergency care services through urgent care response, expanding our care co-ordination approach and other care pathways closer to home.
- Improve and expand our 'hospital at home' service.
- Expand our Same Day Emergency Care offer in our hospitals.
- Further improvement work to reduce our acute mental stay and discharge patients when they are clinically ready.
- Ensure universal access to mental health support through patients ringing 111 and choosing option 2.
- We will be opening a new mental health unit for people with a learning disability or autism in early 2026.

What difference will we make?

- Reduction in the overall number of people attending emergency departments.
- Increase in the number of people being treated in virtual ward settings rather than in hospital to avoid a further 30 hospital admissions a month.
- Decrease ambulance journeys to hospital via the Care Co-ordination approach by a further 25 a month.
- Discharging people from hospital more quickly so freeing up 152 beds in 25/26.

Example

In 24/25 we worked to increase numbers of GP referrals to pharmacies, and the growing number of consultations (65,000K in October 2024). BSW has the second highest rate of GP referrals per 100K population in England.

OUR STRATEGIC OBJECTIVES

Strategic Objective: Financial recovery and sustainability

Priority 5:
Deliver our medium term financial plan and return to financial balance.

Why is this important?

Ensuring that we can live with our means is an important priority because this demonstrates that we are using our funding wisely, and to deliver the best value for our population.

It is part of delivering on the triple aim of high quality, efficient services that deliver improved outcomes for our population. This is a key duty of ICBs, hospitals and the wider health system. As with all other health systems across the NHS, we are facing increasing demands for our services with a population which is growing older and in greater need and have to manage this within our allocated resources.

What have we achieved in 24/25?

In the financial year 24/25 we submitted a deficit budget. Over the past year we have developed a medium term financial plan across our NHS partners to set out how we are going to return to financial balance. This has involved identifying opportunities for partnership working to increase our scope for delivering savings through collaboration.

What are we doing next?

For 2025/26, we continue to face significant underlying deficit challenges in the order of £100m, which have been mitigated from a series of one-off measures and deferrals of spending commitments through 2024/25.

Tackling these challenges will require us to continue to postpone, mitigate and minimise new spending against planning commitments and against the underlying demographic and demand challenges across our ICS population.

Our delivery approach seeks to address this credibly and robustly. We will:

- Build on our delivery progress with substantive efficiency savings and cost controls.
- Aim once again for stretching levels of further efficiency, transformation and cost containment savings in 2025/26 and 2026/27. These will amount to £89m of in-year savings delivery in 2025/26, including £75m of new full-year efficiency programmes, built up across organisation-level transactional savings; continuing productivity drive across planned care; and benefits delivery from a range of continuing system-wide programmes.
- Work together across the system to make best use of our capital and our pooled funds, as appropriate.

These stretching levels of delivery will mitigate the underlying deficit in 2025/26 . The delivery plan then aims to reach the stability of full financial balance in 2026/27.

What difference will we make?

- Release funds to invest in secondary prevention, reducing waiting lists and improving outcomes.
- Greater levels of productivity and efficiency.
- Reduced regulatory oversight.

ENABLERS

Our enablers: Workforce

Why is this important?

The health and care workforce is its greatest asset but also presents the biggest challenge.

Workforce and skills shortages have an impact on how we deliver many of our services now and for the future. We need to ensure that we have the right workforce so that we can recruit and retain a talented workforce that are able to thrive with rewarding careers.

What have we achieved in 24/25?

- Roll out of a workforce transformation tool for identifying new skills and ways of working needed in health and care settings.
- Successful implementation of Oliver McGowan Mandatory Training on Learning Disability and Autism Training.
- Reduction in the usage of NHS temporary staffing.
- Extension of a NHSE project for increasing diversity in research with the set up of a research network with over 100 active members.
- In partnership with Skills for Care completion of leadership programme for domiciliary care registered managers.
- A range of primary care workforce development programmes.
- Implementation of a new toolkit for supporting employment of care leavers aged between 16-25 years.

What are we doing next?

- Reducing our use of and expenditure on temporary staffing.
- Recruitment to high cost and hard to recruit roles.
- Development of an integrated work and health pathway for supporting people with long term conditions access to good work.
- Implementation of workforce models for enabling new models of care closer to neighbourhoods and communities.
- Improving the equality, diversity and inclusion of our workforce.

What difference will we make?

- Look for opportunities to work more closely with our social care and other partners.
- Removal of all expensive off-framework agency usage.
- Reduction in use of temporary staffing.
- Improved workforce planning efficiency.
- Improved staff satisfaction.
- Workforce models built around the needs of communities.
- Reduction in population employment inactivity.
- Improved staff survey engagement scores and reduction in ICS organisation leavers rates.

Example

During the year we delivered a Department of Education funded project for supporting numeracy skills across Wiltshire with individual staff gaining a new maths qualification and engagement events for staff offering support and coaching for numeracy skills.

Through this 40 individuals gained new maths qualifications to support career development.

"The NHS should do more to invest in staff, they are definitely its most important asset."

Ten Year Plan workshop participant

ENABLERS

Our enablers: Digital

Why is this important?

Making better use of technology, also referred to as moving from analogue to digital, is a crucial element of plans to make the health service more efficient, safer and provide a better patient experience. Digital, Data and Technology across the ICS are also enablers for the other two shifts we are being asked to focus on (moving care from hospitals to the community, shifting from treatment to prevention).

What have we achieved in 24/25?

- The Electronic Patient Record (EPR) programme is now in the implementation phase. This will bring our three acutes onto a single digital system creating consistency and supporting our increasing collaboration.
- We have increased the number of partners using our shared care record and increased its use, meaning that health staff have access to a single set of records for patients.
- We have increased the usage of the NHS App.
- We have increased cloud based telephony within GP practices which reduces patient waiting times and increases satisfaction.
- We have continued to ensure strong cyber security is in place with increased system wide working including the creation of a system wide Cyber Tactical Advice Cell (CTAC) and ICS wide cyber exercises.

What are we doing next?

- We are refreshing our digital strategy to take account of the national priority of moving from analogue to digital, and ensure we have a joined up approach to population health management.
- We will carry out further work to explore the use of AI tools in various setting including primary care to understand the benefits and productivity these can bring.
- We will continue maturing our ICS cyber capabilities and refresh our ICS Cyber strategy including learning from our ICS wide cyber exercises.
- We will be working to expand the use of the NHS App, and look for further opportunities to use electronic means of communication.

What difference will we make?

- Use of the NHS App is currently at 59%. We aim to increase it to 75% by 26/7.
- Logins to the App are currently at 1 million a month. We aim to increase this to 1.5 million. Log-ins are even more important than uptake in that they show people are actively using the App.

Example

Example: We piloted an innovative satellite solution to address connectivity challenges in rural GP sites. The “office-in-a-box” system ensures seamless internet access during outages or in temporary medical locations.

A live test in November at a site with a planned outage tested the solution in a real-life situation. After the test, the GP partner commented: “Virtually indistinguishable from the normal setup. We wouldn’t have known it was a satellite connection”.

“I’m more than happy to use the NHS App. It makes ordering repeat prescriptions so easy”

Ten year Plan workshop participant

MEASURING PROGRESS

We are committed to working together to deliver the priorities within this Implementation Plan. Overall accountability for the plan rests with BSW Integrated Care Board.

The Board brings together partner trusts and primary care with wider system partners including our three local authority partners.

Governance and oversight for the delivery of this plan is as follows:

Delivery via ICS Delivery Groups

Our Delivery Groups have overall accountability for delivering the priorities set out here.

Each Delivery Group has a Senior Responsible Officer and we are working to align clinical leadership to these groups and make sure that these groups contain the right representation from across our partnership.

Oversight via Executive structures

We will be expanding the remit and membership of our System Planning and Delivery Executive group in 2025 to ensure it is more representative of our partnership. Population Health Board will continue to carry out oversight of our priorities in relation to outcomes and inequalities.

Accountability via BSW Integrated Care Board

We will report regularly to the Board and our Integrated Care Partnership on progress against the priorities set out here.

Oversight of ICA Priorities will also be reported via the Board for completeness, however our local Health and Wellbeing Boards have the primary role in overseeing delivery of ICA priorities.

Bath and North East Somerset, Swindon and Wiltshire Together

Published March 2025