Bath and North East Somerset,
Swindon and Wiltshire Together

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

Implementation Plan Refresh 2025/26

Appendix 1 – Companion Document

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Introduction

The Bath and North East Somerset, Swindon, and Wiltshire Integrated Care System (BSW Together) is committed to delivering high-quality, equitable, and sustainable health and care services to our communities. This companion document serves as an appendix to our Implementation Plan Refresh for 2025/26, providing more detail on our plans and the outcomes we aim to achieve.

This document outlines our plans across various service areas, including maternity and neonatal services, children and young people, learning disabilities and autism, mental health, primary and community care, urgent and emergency care, planned care, pharmacy and medicines, workforce, digital transformation, estates and facilities, and procurement.

Our approach is underpinned by an Outcomes Framework designed to indicate whether our interventions are impacting on the measures that we believe are the most important for our population.

The document, and the Implementation Plan refresh, come at a point in time when we are engaging in conversations with our patients and the public about what matters to them, to inform the NHS Ten Year Plan, to be published later this year. We will need to review our priorities in the light of the Plan. We are also currently developing our approach to how we define and measure our impact, including the new Outcomes Framework and we will need to continue to refine our approach

This companion document is primarily intended to ensure that we have a shared understanding of the collective work undertaken, and we hope it is useful to allow stakeholders to gain a deeper understanding of our strategic direction and the concerted efforts we are making to transform health and care services in Bath and North East Somerset, Swindon, and Wiltshire.

BSW outcomes framework

The Outcomes Framework is a tool designed to define the outcomes that are of value to our population. It will enable the measurement of the effectiveness of our activities and interventions in delivering improved health outcomes for the population. The framework shall provide a robust, evidence-based approach to monitoring progress and addressing inequalities. It enables the Integrated Care System (ICS) to align its priorities with measurable and actionable goals, ensuring that our efforts translate into meaningful change for our communities.

The framework was developed through a comprehensive and collaborative process:

- Consultation: As part of the ICS strategy development, extensive engagement with stakeholders, including local authorities, healthcare providers, and community representatives, ensured diverse perspectives were considered.
- Review of Existing Metrics: Outcomes from the previous Implementation Plan were evaluated. Challenges, such as a lack of recent data, insufficient segmentation by place or population characteristics, and irregular reporting, were identified as areas for improvement.
- Checklist Criteria: A structured checklist was used to select outcome metrics that are:
    - Can be split by place
    - Segmented by deprivation, ethnicity, age, and sex.
    - Reported frequently (at least quarterly) with a maximum reporting lag of three months.
    - Benchmarked nationally or locally for comparability.
- Indicator Bundles: Recognising the complexity of health outcomes, we developed bundles of indicators (generally two per outcome) to address gaps where a single metric could not meet all criteria. This approach ensures both national benchmarking and locally relevant insights.
- Placeholders - There are areas of our ICS strategy with important outcomes that we cannot currently measure. Therefore, we have developed placeholders which we will develop metrics for. These metrics will be added to the outcome framework as they are developed, and data is available to measure them.

By embedding this Outcomes Framework into our refreshed Implementation Plan, we ensure a structured, equitable, and transparent approach to improving health outcomes across our communities. The table below outlines both the key and contributory outcomes.

Outcomes Framework

	National indicator (benchmarks available)	Local indicator - can be segmented by age (CYP and adult), gender, ethnicity, deprivation, SMI and PLD.
Key Outcomes		
1	Life expectancy at birth	Years of life lost
2	Healthy expectancy at 65	Average age entering frailty
3	Emergency bed days	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	Admissions for self-harm
9	Population employment inactivity	
10	Staff Survey engagement score	
11	ICS organisation leavers rate	
12	Percentage of patients reporting they have a care plan Percentage of patients reporting 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	GP reported smoking prevalence
16	Obesity prevalence	GP reported obesity prevalence
17	Physical inactivity prevalence	
18	Admissions for alcohol specific conditions	Admissions for alcohol specific conditions

19	MMR vaccination rates	MMR vaccination rates
	Flu vaccination rates	Flu vaccination rates
20	Hospital admissions for dental decay	Hospital admissions for dental decay

Contributory Outcomes – Placeholders	
A	Quality of dementia care
B	Percentage reporting an MSK condition/ GP reported MSK prevalence
C	Apprenticeship or T-level take up as a proportion of BSW H&C employees
D	Social Value quantified benefits of our contracts (using Social Value Portal)
E	Carbon emissions of our providers
F	Percentage of patients with a long-term condition with a Shared Decision Making conversation
G	Numbers completing CollboRATE (Patient Reported Shared Decision Making) and percentage scoring 9+
H	Percentage referred to social prescribing services
I	Number of patients with an open Personal Health Budget
J	Numbers completing IntegRATE (Patient Reported experience of Integration) and percentage scoring 8+
K	Percentage ICS resource invested in prevention
L	Personal Wellbeing (life satisfaction, feeling worthwhile, happiness, anxiety).
M	Admissions for substance misuse
N	Percentage of children who feel they have healthy ways to manage difficult feelings
O	Percentage of adults who feel lonely
P	Average health gain from elective interventions

Prevention

Why is it important?

Investing in prevention is essential for delivering high-value care, improving population health, reducing future demand on services, and tackling health inequalities. By focusing on early identification and intervention, we can help people live longer, healthier lives while ensuring resources are used where they have the greatest impact.

Prevention spans across primary, secondary, and tertiary levels:

- Primary prevention focuses on reducing risk factors and promoting healthier behaviours, such as encouraging physical activity, reducing smoking and alcohol consumption, and ensuring access to vaccinations and screening programs.
- Secondary prevention involves early detection and timely intervention, which can prevent conditions from worsening. This includes routine screenings, health checks, and targeted support for at-risk populations.

Tertiary prevention aims to manage and mitigate the impact of existing conditions, ensuring better outcomes for individuals while reducing avoidable hospital admissions and long-term complications.

Our long term goals

- **Shifting the Balance Toward Prevention -** Our goal is to prioritise prevention over treatment, ensuring people stay healthier for longer. Over time, this means increasing investment in self-care, community, and primary care services to reduce reliance on hospital-based care.
- **Embedding Prevention at Every Level** We aim to strengthen primary, secondary, and tertiary prevention by preventing ill-health before it starts (e.g., tackling obesity, increasing physical activity, reducing smoking rates), detecting ill-health early through improved screening, case-finding, and proactive outreach and slowing disease progression by integrating prevention into long-term condition management.
- **Tackling Health Inequalities -** Health outcomes should not be determined by where people live. Our focus is on targeted prevention efforts for disadvantaged communities, expanding access to early intervention services in physical and mental health and addressing wider determinants of health, including housing, employment, and transport.
- **Supporting Children and Young People** Children and young people represent a third of our population. Investing in early years prevention will secure long-term health benefits by increasing the proportion of healthy-weight children. Embedding mental health support in education and community settings and ensuring environments support active lifestyles.
- **Creating Health-Promoting Places -** Recognising the role of environment in health, we will work with partners to: Improve air quality and access to green spaces, promote active travel and healthier communities, Ensure safe, warm, and secure housing for all.

During 2024/25, we achieved the following:

- **Treating Tobacco Dependency Service -** Now in its second year of implementation, this service has been integrated into acute in-patient care, mental health services, and maternity settings, ensuring that high-risk populations receive targeted, evidence-based interventions to quit smoking.
- **Weight Management Strategy -** A structured, system-wide strategy has been under development to tackle obesity and its long-term health impacts. This will embed early intervention, behavioural support, and multi-disciplinary care pathways.
- **Hypertension Case Finding and Management** - A comprehensive approach to improve early detection and optimise management of hypertension was developed.
- **Mental Health Prevention: A Case for Change** for focusing on early intervention in children and young people at risk of or affected by Adverse Childhood Experiences (ACEs) has been supported.

What is the impact of this work?

While some initiatives are already delivering benefits, others lay the groundwork for future improvements in population health, service demand, and health inequalities.

- By reducing smoking prevalence, we are reducing the risk of long-term respiratory and cardiovascular conditions, decreasing hospital admissions, and contributing to better long-term quality of life.
- Implementing the weight management strategy will reduce obesity related conditions such as type 2 diabetes, cardiovascular disease, and musculoskeletal disorders.
- Increased case finding and optimising management of hypertension will improve cardiovascular health outcomes and reduce the incidence of heart disease, strokes, and cardiovascular disease (CVD) related deaths.
- Acting on the case for change for mental health will identify ill-health early, slow or stop disease progression, and ensure parity between physical and mental health.
- Moving from reactive treatment to prevention will reduce demand for services.
- Targeting high-risk groups improves health equity and system sustainability.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Implement hypertension case finding and management programme	✓	✓
Focus on improving uptake, outcomes and addressing inequalities in Treating Tobacco Dependence Services	✓	
Implement weight management strategy	✓	✓

Develop mental health prevention business case against allocated prevention funding	✓	

What are we doing to address inequalities?

- Treating Tobacco Dependence data is segmented by deprivation and ethnicity. We have identified low uptake in Core20 and ethnic minority populations. A workshop has been held to deep dive into this and instigate a quality improvement programme to address this.
- The gap between estimated and reported prevalence of hypertension for Core 20 and ethnic minority populations is greater than for the general population. A key part of our business case is targeted case finding in these populations working collaboratively between community pharmacy and VCFSE partners.
- The Case for Change for Mental Health Prevention emphasises early intervention for children and young people at risk of or affected by Adverse Childhood Experiences (ACEs). Recognising that the impact of ACEs is amplified by experiencing inequalities, our business case will focus on addressing these disparities

Inequalities

Why is it 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. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population. PLUS refers to ICS chosen population groups experiencing poorer that average health access, experience and/or outcomes, who may not be captured within the Core20 alone. 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

Our long term goals

- Embedding fairer health and wellbeing outcomes in everything we do - make tackling health inequalities everyone's responsibility, addressing health inequalities is embedded in the work of all our Delivery Groups.
- Implementing the Core20PLUS5 Framework - We will target the most deprived populations (Core20) and priority groups (PLUS) while improving outcomes in maternity, mental health, respiratory disease, cancer diagnosis, and cardiovascular health for adults and in asthma, diabetes, epilepsy, oral health and mental health for children and young people.
- Strengthening Data-Driven Action - We will improve data collection and analysis to identify, track, and reduce health inequalities. Our new outcomes framework includes metrics that can be segmented by age, gender, ethnicity and deprivation.
- Prioritising Children and Young People - focusing on healthy weight, mental health, and early intervention, ensuring prevention starts early.
- Addressing Wider Determinants of Health - Working with partners to improve housing, employment, transport, and environment, tackling root causes of health disparities.
- System-Wide Accountability - We will hold partners accountable, align funding with reducing inequalities, and ensure a joined-up approach across BSW.

During 2024/25, we achieved the following:

- 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.
- Embedded inequalities in the work of each of our Delivery Groups. This is described in the sections on 'What are we doing to address inequalities?' at the end of each section

What is the impact of this work?

Our place-based projects are delivering measurable improvements in health, wellbeing, and access to services for diverse communities across BSW. The impact can be seen across multiple domains:

- Improved Health and Wellbeing - Mental health improvements for children with SEND, new parents, carers, and LGBTQ+ individuals, increased self-esteem and confidence, reduced depression and anxiety in targeted communities and enhanced wellbeing in CYP through improved physical activity and diets, particularly in Core20 areas.
- Greater healthcare engagement among ethnic minority groups and LGBTQ+ communities. Improved service user experiences of neurodiversity assessment pathways (pilot evaluation). Increased awareness and uptake of cancer screening and other preventive health interventions.
- Tackling Health Inequalities Prevention of homelessness, with improved individual health outcomes, enhanced oral health in children and young people with learning disabilities and autism (LDAN), better understanding of end-of-life care needs in people experiencing homelessness. Improved engagement with the farming community and military personnel, addressing specific health needs through qualitative insights.
- Addressing Wider Determinants of Health - Essential furniture provided to individuals in need. Increased energy security, helping people manage energy use and keep homes warm, reducing the impact of fuel poverty on health. Safer, healthier communities, promoting greener spaces and active lifestyles.
- Future impact - Many projects are laying the groundwork for long-term change, with anticipated improvements in physical and mental health outcomes to be measured in future evaluations. By embedding equity, prevention, and targeted support, these initiatives are making a meaningful difference in people's lives while strengthening system-wide resilience and sustainability.

The impact on the actions to address health inequalities embedded in each of the Delivery Groups plans are described in the relevant section.

How we are going to achieve this'	Year 1 (25/26)	Year 2 (26/27)
Continue investment in place-based projects with an increasing focus on outcomes demonstrating inequalities	✓	✓
Build our outcomes framework and use this to enhance monitoring of impact of work to address inequalities.	✓	✓
Increase impact of Delivery Group plans on inequalities	✓	✓

What are we doing to address inequalities?

- Funding place-based projects to tackle inequalities identified by our Integrated Care Alliances in B&NES, Swindon, and Wiltshire.
- Embedding addressing inequalities in the work of each of our Delivery Groups as described in each individual chapter.

Local Maternity and Neonatal Services

Why is it important?

To achieve the BSW Vision it is important that promotion of a healthy start to life begins from pre- conception and continues with a healthy pregnancy, birth and neonatal care as the building blocks for a healthy life.

Pregnancy care offers an opportunity for health promotion that can not only impact on the pregnant person/mother's health but also the baby and the wider family's health

The Local Maternity and Neonatal System in Bath and North East Somerset, Swindon and Wiltshire (BSW LMNS) brings together maternity and neonatal care providers within BSW, the ICB, Maternity and Neonatal Voices Partnership (MNVP) Leads and other partners including public health nursing early years and regional representative from NHS England and the Health Innovations Network, Regional Neonatal Operational Delivery Network representatives. They to work collaboratively to provide excellent health care services, focusing on improving health and wellbeing outcomes through effective perinatal quality surveillance and improvement activities.

The LMNS is a mandated provision for the ICB and is embedded within the BSW ICB Nursing and Quality Directorate.

Working collaboratively reduces variation across BSW and supports sharing learning from incidents (in line with the Patient Safety Incident Response Framework). It supports consistency of advice and services across our system and enables effective cross service working to improve experiences for service users.

A focus on prevention and early intervention includes personalised care to improve service users experience and supports informed decision making by parents. BSW LMNS represents maternity and neonatal at related ICB delivery groups including Population Health, Inequalities, Prevention and Quality Assurance and Outcomes Committee.

Our long term goals

- National Three-Year Plan for Maternity and Neonatal Services recommendations to be implemented by 2026.
- NHS 10 Year Health Objectives plan to be produced (once document published)
- Review/Evaluation of Maternal Mental Health provision in collaboration with Mental Health Delivery Group.
- Review/Evaluation of impact on outcomes of Perinatal Pelvic Health provision
- Continue focus on reduction of inequalities of outcomes related to ethnicity and indices of deprivation for pregnant and birthing people and neonates.

During 2024/25, we achieved the following:

We have continued to listen to pregnant women / birthing people and their families to improve maternity and neonatal services. Our Maternity and Neonatal Voices Partnership team and Maternity and Neonatal Senior Independent Advocate (Pilot role) ensure that the service users voices are represented at all our BSW maternity and neonatal providers and the BSW Local Maternity and Neonatal System at a strategic level, including learning from adverse events. Service improvements are co-produced with users, including multilingual maternity and neonatal videos and antenatal parent preparation mapping to support standardised provision.

We have continued to support preventative initiatives to reduce ill health, inequalities, stillbirths, neonatal deaths, and parent-baby separation. This includes tobacco dependency treatment, support for those experiencing pregnancy-related loss and trauma, and perinatal pelvic health services. Workshops with community groups, including the boating community, South Asian families, and care-experienced parents, have informed improvement actions to enhance access and experience. Maternity providers are improving ethnicity and deprivation data recording to monitor care inequalities. Anti-racism training has been provided to 600 maternity and neonatal staff, with additional training through Black Maternity Matters quality improvement projects.

We have continued to grow, retain and support our maternity and neonatal workforce with a significant reduction in vacancies, increased staffing investment, and lower turnover rate. To attract and retain local workforce we focused on ensuring there is a career development pathway that includes opportunities for apprenticeships, increased work experience for health and care students, and enhanced support for newly qualified midwives and staff. There is a plan in place to support additional provision of trained speciality neonatal nurses.

We have continued to focus on safety and quality of maternity and neonatal services in line with national recommendations and best practice, implementing NHS England's Saving Babies' Lives Care Bundle and the Clinical Negligence Scheme for Trusts to support safe outcomes for mothers and babies. Learning is shared across providers to proactively reduce adverse events. We have started assessing estate requirements and funding needs while advancing neonatal care improvements through the PERIprem optimisation project with the Health Innovation Network.

What is the impact of this work?

- Reduction in number of women smoking during pregnancy. Over the past 7 years, the rate of women smoking at the time of birth has reduced from 10.8 in 2017/18 to 6.6% in 2023/24.
- Maternal Mental Health - Treatment measures using a measure of PTSD demonstrate that most people accessing the service are symptom free following treatment with qualitative feedback also being overwhelmingly

positive. Staff across a range of different services including military medical staff, health visiting staff, primary care staff report improved knowledge of identification and referral criteria for maternal mental health following training provided by the OCEAN team.

- The perinatal pelvic health services have completed 550 assessments of pelvic health for women providing advice/ interventions and referrals to specialist clinics where required and demonstrating postnatal patient satisfaction of 98%.
- The stillbirth rate in BSW is below the national average.
- Promotion of heathy behaviours in pregnancy contributes to longer term impact on health for the BSW children and adult population.
- Improved service provision supported by hearing the voices of service users, including migrants, South Asian communities and care experienced parents to be heard within the LMNS and inform service improvements, policy and strategy reducing inequalities and improving access to services.
- Separation of mother and babies who require neonatal care is meeting the target for below 5% of all babies born from 37 weeks of pregnancy across our maternity and neonatal providers. This is achieved by a variety of improvement activities including provision of additional supported care by neonatal and maternity staff on maternity wards in “Transitional Care areas”. This reduces stress and anxiety for parents, supporting them to care for their babies and supports infant feeding.
- We have improved the number of pre-term babies who are born in the right place for their stage of pregnancy and continued to improve the numbers of babies receiving interventions that optimise their neurodevelopment and health.

What we are aiming to achieve next

1. To work collaboratively with maternity and neonatal providers to achieve the recommendations of the Three-Year Delivery Plan for maternity and neonatal services including implementation of tools for identification and management of the deteriorating patients.
2. To continue to focus on meeting stretch targets for NHS England Saving Babies Lives Care Bundle and revised Care Bundle targets (when published) and to achieve compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 7.
3. To implement single maternity digital system across all three maternity providers
4. Power BI dashboard for maternity and neonatal oversight for perinatal quality surveillance to be reviewed and rebuilt once maternity digital system is in place within maternity providers. This will include data on

What we are aiming to achieve next

ethnicity and deprivation and will support oversight of perinatal quality surveillance for BSW ICB.

5. To implement the national maternity incentive voucher scheme to further reduce smoking in pregnancy and to continue full implementation of treating tobacco dependency in pregnancy.
6. To reduce inequalities in outcomes for service users who have poorer outcomes, particularly those related to ethnicity, deprivation, disabilities and other social determinants of health.
7. Continue to fund the MNVP model to ensure service user experiences drive service improvement within maternity services
8. To participate in national evaluation of Maternity and Neonatal Independent Senior Advocate role.
9. To review the Continuity of Carer, offer across BSW against national guidance.
10. To identify opportunities for cross system working to improve service user experience and support efficient processes for maternity care
11. To have a continued focus on safe and timely triage processes within maternity services including self-help via triage application and triage passport.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Implement maternity digital system across BSW Maternity providers	✓	
For all maternity providers to be compliant with Saving Babies Lives Care Bundle to reduce stillbirths, neonatal deaths and brain injuries.	✓	
To standardise maternity support worker training and competency assessment across BSW maternity providers	✓	
Power BI System LMNS dashboard refresh once maternity digital system implemented across BSW maternity providers to provide enhanced perinatal Quality and Safety surveillance	✓	
Implement maternity digital system across BSW Maternity providers	✓	

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
For all maternity providers to be compliant with Saving Babies Lives Care Bundle to reduce stillbirths, neonatal deaths and brain injuries.	✓	
To standardise maternity support worker training and competency assessment across BSW maternity providers	✓	
Reduction of stillbirths and neonatal deaths		✓
To understand outcomes filtered by ethnicity/deprivation and other social determinants of health (to drive improvement actions to reduce equalities		✓
To reduce incontinence in later life by effective identification and early management of perineal and pelvic floor injuries relating to pregnancy and birth		

What are we doing to address inequalities?

- Continuing reviewing data/outcomes for women/birthing people from global majority/seldom heard groups. i.e. Black/Asian Women, Care leavers, GRTBS communities and working on functions to ensure co-production can occur and service user voices can occur within maternity services ensuring individuals within groups with higher levels of deprivation.
- Continuing to work with partner agencies/VCSE organisations/MNVP to ensure coproduction can occur which is representative of service user/population needs.
- Continue work with gypsy, Roma, traveller, boating and showman communities to provide service improvements/accessibility to service that is reflective of population needs.
- Work with education providers/provider organisations to ensure anti racism training is embedded within maternity providers to ensure a positive culture is present
- Ensure services are accessible in community areas by continuing to fund care closer to home, i.e. women's health hubs/maternity hubs/HV services.
- Ensure women and birthing people have access to accurate, accessible information in a range of languages/formats
- To continue to review staffing and education models and review WRES data to ensure staffing/training is in line with population needs.
- Continue to transform triage processes to ensure women and birthing people have access to timely assessment when they are concerned.

Enhancing outcomes for women in areas of high deprivation/seldom herd groups.

- Continue to review antenatal education across BSW to ensure the digital/face to face offer is reflective of population needs
- Create a BSW maternity dashboard to improve data collection processes which will inform health inequalities work and therefore impact those in areas of high deprivation ensuring resources are targeted
- Continue to work with specialist groups to support transformation including infant feeding/BFI, healthy start, maternal mental health, perinatal pelvic health and oral health
- Support providers to work with health innovations network and regional initiatives for quality improvement i.e. outpatient management of hypertension and Prevention and Management of Perineal Injury.

Children and Young People (CYP)

Why is it important?

Children and Young People make up a third of the BSW population. The Health and Social Care Act 2022 defines babies, children and young people as aged 0-24 years, and requires ICBs to set out steps to address their needs. Getting it right for children will create a healthier, more confident, better empowered population and investing in children's health will reverse ill health and prevent adult health decline.

Our long term goals

1. **Working together – delivering our Statutory Functions**

   Work effectively as an integrated partnership to address inequalities, to design neighbourhood health provision for babies, children and young people, shifting care to our communities to raise the healthiest-ever generation of children.

2. **Delivering on the ICP Strategy**

   Securing the commitment of the multiple agencies that make up our integrated care, education and support systems to deliver equitable access, timely identification of need and follow up action, though personalised care to improve experience and outcomes for babies, children and young people

3. **CYP Pathways for childhood and adulthood**

   Deliver the BSW model of care of babies, children and young people, their parents, carers and families, to meet need and transform to a 'waiting well' model across community provision

   Ensure access and clear pathways for babies, children and young people who need specialist paediatric expertise

   Deliver services designed with CYP, with strong and visible lived voice embedding by default to better meet need.

   Focus on improving Transitions processes including Preparing for Adulthood (PfA) workstreams

4. **ICS Operational priorities**

   Embed improvements through online and digital support so that reactive care services are used to respond sudden or urgent clinical and to manage increases in demand including during winter.

5. **Governance, oversight and Engagement**

   Inclusion of children and young people appropriately across ICB commissioned services, aspiring to joint commissioning to deliver integration.

During 2024/25, we achieved the following:

- Rollout of Paediatric Early Warning System (PEWS)
- Continued to use the CYPCore20PLUS5 framework to deliver a targeted approach and drive data-led improvement in population health and inequalities in partnership across BSW.
- We have worked with our Local Authority partners to roll out a BSW Asthma Friendly Schools Initiative, ensuring students with asthma receive the best care possible in school as part of the National bundle of care for children and young people with asthma.
- Contributed to delivering the BSW model of care for babies, children and young people, parents, carers and families through the recommissioning of Integrated Community Based Care (ICBC)
- Commissioned VCSE and mobilised the 12-month Youth Worker service pilot in our acutes, supporting CYP with long term conditions and emotional wellbeing. 60 CYP have been supported in first four months.
- Embedded Mental Health Champions in all three Acute hospitals, facilitating greater join up between CYP physical and mental health teams and drive cultural change to better recognise the needs of children
- Mobilising an RUH expansion clinic which will support the CYP aged 12-17 in B&NES who are living with Complications of Excess Weight (CEW).
- Carried out a review of CYP experience in our Emergency Departments, making recommendations for change and supporting Acute hospital settings to make improvements.
- Rolled out BSW-wide Acute Respiratory Illness (ARI) Hubs for CYP during the 2024/25 winter period.
- Effective partnership working to develop and deliver the SEND agenda across BSW.
- Worked with the Elective Care Board to focus on children leading to reduction of 52+week waits

What is the impact of this work

Working together – delivering our Statutory Functions

Effective integrated delivery of our Special Educational Need and Disabilities duties has resulted in a range of service developments such as the pilot of Neuro Developmental pathways, joint commissioning of services regarding early intervention and prevention; plus, positive and constructive feedback following a national thematic review and SEND inspection.

Delivering on the Integrated Care Partnership Strategy

Focus on health inequalities for children and young people through adopting CYPCORE20PLUS5 has led to the Population Health Board partnership child focused funded health inequalities projects.

Setting our intentions for future commissioning for CYP within the ICBC has established the platform for mobilising into the first year of the contract, ensuring a safe transition to new provider. This builds the foundations for the long-term transformation we need to see for CYP in BSW.

CYP Pathways for childhood and adulthood

Laying the foundations for better service delivery for CYP, for example PEWS enables consistency in how deterioration in children is recognised. Evidence from the BSW YW Pilot and CEW Clinics will establish an evidence base for future working for our most vulnerable CYP.

Ensuring clarity in our offer to support children and young people's emotional wellbeing. Continued working with Mental health teams.

ICS Operational priorities

Improved experience for CYP and their families/carers, improved working relationships and focus on CYP within Acute hospitals and, supporting the demand management agenda (e.g. supporting emergency departments through the YW Pilot and ARI Hubs)

Governance, oversight and Engagement

Building on the foundations of the work of the BSW CYP Programme we have engaged with partners, refreshed the CYP programme and set priority areas for 2025/6.

What we are aiming to achieve next

1. Safe landing of ICBC and collaboration to achieve delivery of community provision and new model of care for CYP across BSW ensuring oversight of our commissioned children's services
2. To support and enable BSW ICB's vision for children with special educational needs and disabilities, working in partnership to discharge our statutory duties for SEND and improve outcomes.
3. Deliver an integrated holistic offer for CYP by further embedding CYP appropriately across ICB governance, workstream and delivery group activity.
4. Build on good practice and follow the evidence on what works to support emotional health and wellbeing of our most vulnerable CYP, for example through supporting trauma service and securing ongoing funding for BSW YW.
5. Managing CYP urgent demand by delivering CYP ARI Hubs in 2024/25 and ensuring timely winter planning for CYP for 2025/26.
6. Partnership working to focus on and respond to the health needs of our 0–24-year population
7. Design and deliver services that meet the needs of BSW CYP and reflect their experience by having visible CYP voice engagement and coproduction.

8. Supporting elective and community service recovery and planning to increase capacity and needs led 'waiting well' initiatives to support CYP on waiting lists for services

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Services for children who need urgent treatment and hospital care will be delivered as close as possible to home. Over the next five years, paediatric waiting times in acute, community, and surgical care will improve through pathway transformations that optimise clinical capacity.	✓	
Through our work to improve outcomes for children with long term conditions, we are focussing on reducing health inequalities by understanding differences for our Core20PLUS5 populations	✓	✓
To address significantly poorer outcomes for care experienced children and young people, we will tackle issues affecting access and equity of care.	✓	✓
We will fulfil our statutory safeguarding responsibilities under 'Working Together to Safeguard Children' (2023) and respond to the local safeguarding children partnership priorities; This includes strengthening multi-agency collaboration between local authorities, police, and integrated care boards (ICBs) to ensure shared responsibility for protecting children. By 2028, we will ensure the health needs of all vulnerable children are identified and met.	✓	✓
Co-creation of community services for CYP as part of the ICBC procurement including family health hubs and joined up neighbourhood teams	✓	
The Special Education Needs and Disabilities (SEND) of children and families will be prioritised across the ICS. We will implement SEND reforms across the three Local Authorities, addressing weaknesses identified in Local Area Inspections within mandated timeframes.	✓	✓

What are we doing to address inequalities?

CYPCore20PLUS5 is a framework for everything we do. This supports equitable access to, experience of, and outcomes from the services we deliver as a System.

By defining our PLUS categories at a BSW and local level, we have broadened the scope of how our most vulnerable CYP are considered in all planning and activity.

Aligned with our Implementation Plan refresh (2024-26) we are continuing to advocate and prioritise CYPCore20PLUS5 to ensure parity with adults across internal and System partners. This includes representing CYP at local inequalities groups and collaborating to support better integration between healthcare inequalities and work to improve the core (wider) determinants of health.

For 2025/26 we are working with our Strategic Intelligence team to explore routine reporting for babies, children, and young people. Strategic Intelligence Team are now undertaking exploring the creation of a dedicated Core20 Workspace, which will bring together various reports and datasets, including those linked to the CYPCore20PLUS priorities. There is also planned a wider update to the current BSW Population Insights tool, which will provide another source of relevant CYP information.

Learning Disability, Autism & Neurodivergence (LDAN)

Why is it important?

People with learning disabilities, autism, and neurodivergence experience significant health inequities, often due to a lack of understanding and insufficient reasonable adjustments in services. The 2022-23 LeDeR report found that the median life expectancy for individuals with learning disabilities was 62.9 years, with 42% of deaths deemed preventable. It is essential to ensure that neurodivergent individuals receive the tailored support, autonomy, and healthcare access they need to thrive and lead fulfilling lives.

What are our long term/transformational goals?

Over the next five years, transformation efforts will continue to prioritise health equity, crisis prevention, and integrated community-based support. The completion of the Kingfisher Unit will introduce a regional inpatient service that is fully adapted to the needs of neurodivergent individuals, including an outreach model to prevent unnecessary admissions. Improvements to the Dynamic Support Register will enable real-time identification of individuals at risk, ensuring early and personalised interventions. Collaborative commissioning approaches with specialist provider collaboratives will support the transformation of mental health and neurodivergence pathways. There will also be increased investment in supported housing, employment initiatives, and self-directed support, enabling neurodivergent individuals to live independent and fulfilling lives.

During 2024/25, we achieved the following:

Throughout 2024/25, efforts have focused on improving inpatient care, prevention, and neurodevelopmental support. The upcoming **Kingfisher, a specialist mental health unit**, set to open in 2026, will provide individualised care that reduces reliance on long-term hospital stays. The closure of **The Daisy Unit** has allowed resources to be redirected into strengthening community-based services. The **BSW LDAN Practice Forum** has provided a structured approach to preventing unnecessary hospital admissions, while the **Digital Dynamic Support Register (DSR)** will improve risk identification and care coordination. The **Keyworker Service**, initially a pilot, is now a permanent function, ensuring timely and holistic support for neurodivergent young people at risk of crisis admissions. We continue to reduce the number of people who are admitted to an inpatient unit and the length of stay for those people who do require inpatient care and support.

Education-based interventions have been expanded, with the **PINS Initiative** equipping 40 schools with strategies to support neurodivergent students. The **Children and Young People HCRG Waiting List Initiative** has enhanced access to ADHD and autism assessments, streamlining processes and reducing delays. Additionally, the adoption of a **Right to Choose** framework ensures that neurodivergent individuals and their families can access timely and appropriate

diagnostic pathways. **Annual Health Check** uptake has increased due to proactive engagement and more accessible information for individuals and families.

What is the impact of this work?

Many of our projects cross financial years and the benefits will be realised in 2025/26 and beyond.

These initiatives have contributed to shorter hospital stays, earlier interventions, and a shift towards person-centred, community-based care. Improved pathways for ADHD and autism assessments have reduced waiting times, creating a more responsive system that respects individual choice and need. Increasing the uptake of Annual Health Checks has supported earlier identification of potential health concerns, improving overall well-being. Sensory resources in inpatient settings have enhanced accessibility and inclusivity, ensuring neurodivergent individuals experience healthcare environments that cater to their needs. The overall impact is an approach that prioritises dignity, autonomy, and meaningful support, fostering greater independence and improved quality of life.

What we are aiming to achieve next

For 2025/26, key objectives include reducing inpatient admissions by **10%** through strengthened discharge planning and improved community-based alternatives. Efforts will also focus on reaching a **75% uptake in LD Annual Health Checks**, facilitated through proactive engagement and collaboration with primary care and voluntary sector organisations. Expanding **neurodevelopmental pathways** to include adults will ensure more equitable access to assessments and ongoing support as part of the ICBC programme. Delivery will be monitored through data-driven approaches, multi-agency collaboration, and embedding digital tools such as the **Reasonable Adjustment Digital Flag**, ensuring services remain accessible and responsive to neurodivergent individuals' needs.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Completion of The Kingfisher and implementation of the new clinical model including an outreach service.	✓	
ADHD Adult Pathway	✓	
Implementation of LD Screening service	✓	
Digital DSR solution	✓	
Embedding Lived Experience in Service Design	✓	

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Reasonable Adjustment Digital Flag		✓
All Age Neurodivergent (ADHD and Autism) Pathway		✓
Transformed LDAN Community services that is needs led and focuses on early intervention and prevention		✓
Expanding the Keyworker service into Adults		✓
Building on PINS work with Education and LA Partners increase ND Awareness in schools to improve the school experience of children who are Neurodiverse.	✓	
Working with NHSE and LA Partners increase the housing stock for people with a learning disability, autism or are neurodivergent		
Work with the Department for Works and Pension and local employers to ensure young people and adults who have a learning disability and/or are neurodivergent are supported to get work experience and gainful employment.		
Work with our service providers (police, fire, criminal justice, etc.) to meet the needs of people with a learning disability and/or are neurodivergent		

What are we doing to address inequalities?

The LDAN programme is actively reducing disparities for Core20Plus5 populations by ensuring local, learning disability and autism inpatient services, minimising out-of-area placements and keeping individuals connected to their support networks. The expansion of Annual Health Checks and increased access to screening programmes are addressing physical health inequalities and reducing preventable deaths. There is a strong focus on housing security, meaningful employment, and inclusive support services, ensuring neurodivergent individuals receive the personalised and practical assistance they need to thrive. Embedding lived experience perspectives in decision-making ensures that service design is inclusive, strengths-based, and fully aligned with the needs of neurodivergent individuals.

Mental Health

Why is it important?

Ensuring provision of high quality, evidence based, sufficiently resourced and configured (i.e. integration across services/providers) mental health services is essential to the BSW population and the health and social care ecosystem. Supporting mental health generates positive impact to the individual, their networks, but also communities and the economy (i.e. completion of higher education, gaining/sustaining employment).

Global reports demonstrate that up to 20% of the population experience mental health needs, with rates impacted by contextual factors such as deprivation. Among the BSW population of 980,000 people, more than 100,000 have been diagnosed with dementia, depression or serious mental illness. Around 3,500 have more than one of those conditions.

Achieving parity of esteem (equality between our physical health and mental health provision) is a long-standing commitment, one we are on our journey towards and therefore must hold a strong profile and focus towards.

Whilst significant improvements and developments to the mental health offer and delivery status across BSW have been made we have access rates, waiting lists and outcomes below national target for key service lines/areas of delivery.

Importantly people engaged and involved across BSW have informed us about the status of their mental health, areas of success and good practice regarding their experiences in accessing services and how they would like us to continue to transform services – see the BSW Mental Health Strategy *(add hyperlink)* for further information

Our long term goals

Foundations for the future

- Co-production of the delivery plan – to function as a “container” for system partners strategic commitments.
- Development of key service lines/areas: CYP trauma integrated pathway, Talking Therapies, Community MH service 2+ contacts, in-treatment/service waits.
- Implementation of key programmes of work: Inpatient Quality Improvement Programme (inclusive of Community rehabilitation).
- Full pathway and service reviews, setting corresponding development plans and/or commissioning intentions: Memory/Dementia, CYP (inclusive of s75/jointly commissioned services).
- Service level ROI and outcome evaluation informing right sizing and shaping our commissioned provision (undertaking will span the 5 years of the delivery plan).

Transforming our care models – 2027-2028

- Developing our specifications - integrated model of community-based mental health provision (adults and children)

- ‘Right-sizing’ inpatient mental health capacity (adults) to deliver improved pathways
- Implementation of next steps from phase pathway, service reviews and right sizing/shaping evaluation.

Partnerships for the future – 2029-2030

- Formalisation of contractual arrangements to achieve the best contractual model to achieve and sustain an excellent service offer, establishment of an all-age mental health provider collaborative

During 2024/25, we achieved the following:

Key Locality Commitments – compliance status:

- Co-production of the BSW All Age Mental Health Strategy: see pages 77-78 of the embedded strategy for assurance and summary of the engagement and co-production reach.

SMI Physical Health Checks

- A BSW improvement group working in partnership with VCSE sector colleagues to increase the uptake of Annual Health Checks. Pilot model of post check support for those with annual review findings of concern/out of range is demonstrating positive update. This will impact on positive health behaviour change and/or engagement with further assessment/commencement of treatment in the short term, and in the longer term will impact positively on mortality rates.
- **AWP SMI PHC team now well established and operating to undertake 85% of [eligible] secondary care case load annual health checks.**
- The team take a MECC approach and actively promote and support service user vaccine uptake.

iThrive model

- Now embedded across the BSW CYP MH pathways/providers as the operational and pathway structure. Supporting effective integrated working across providers and informing a tiered pathway structure.

New access model as per Community Mental Health Framework requirements

- Access target operating above operational planning trajectory rate. Transformed metric for Sep 24 = 5,420 against Plan of 3,300
- 24/25 was year 3 of mobilisation and saw good development to the operational compliance with national standards – BSW now being compliance across all PCNs regarding transformation, therefore enabling recognition of access flowing through the integrated multi-agency service model**.**

Roll out a new care planning approach

- Programme of work, coproduced name “*Your Team Your Care Your Plan*”, fully mobilised at system level. Progressing at AWP Trust footprint, with initial

pilots in BNSSG. Learning and refinement of model (with BSW direct oversight) has led to delayed role out. Anticipated operational introduction to BSW in Q1 25/26).

Procurement of Community Mental Health

- Currently in mobilisation phase with service due to go live 1st April 2025.

Full-Service Review (FSR) for Talking Therapies

- FSR completed, improvement recommendations approved and translated by AWP into an improvement action plan which is in progress.
- Enhanced investment approved to expand workforce.
- BSW Talking Therapies Development Group mobilised to support and oversee improvement action plan.
- Requirement to engage and deliver against improvement plan and operational plan trajectory formalised in SDIP.
- **Mobilisation of our Wave 12 MHSTs in Wiltshire from January 2025 -** intention that these will be fully operational (training programme completion) by Q4 25/26.

What is the impact of this work?

- Greater access to community mental health (CYP and adults)
- In depth understanding and improvement of the BSW Talking Therapies. Workforce growth (through substantial investment). Actions set to support sustained improvement to outcomes achieved through service intervention. Clear delivery parameters formally set with the provider.
- Greater oversight and improvement processes established for MH acute flow: strategic flow forums established with multi-agency membership, multi-agency discharge events held regularly for Adults, CYP and Eating Disorders, system escalation protocol established (under current review to ensure optimisation for seasonal pressures) and AWP Acute Care Flow programme progressing implementation of multiple workstreams including transfer of care hubs, s136 and s140 pathways/policy development.
- Procurement completed for Third sector community mental health service provision.
- Improved after care post – SMI physical health checks
- People can call 111-2 (operational/fidelity to national service specification/operational standards) 24/7.
- B&NES Place of Calm – estates purchase and operational in year.
- Dementia diagnosis rate – steady and sustained improvement with a greater number of people being assessed and supported post diagnostically.

- Full compliance with the transformed service criteria at PCN level across BSW, enabling recognition of access rates.
- BSW All Age Mental Health Strategy final draft in final stage of approval.

What we are aiming to achieve next

Implement the National Quality Improvement Programme for Mental Health across all BSW wards (to run from April 2024 until March 2027)

- Completed (submitted to NHS E) and implementation is in progress to plan. Transformation lead appointed and in post. Programme Board commenced. Key workstreams mobilised and progressing to plan.
- A key workstream within the IPQI is development of a community rehabilitation pathway. The initial stage of this for BSW is reduction of out of area specialist hospital/locked rehabilitation admissions, with individual needs met through a local offer – whilst we develop our community offer we have enhanced our local rehabilitation ward bed based by 6 beds, avoiding out of area admissions and supporting repatriation [enabling more informed discharge planning] for those placed out of area.

Implementation of Phase 3 & 4 of Right Care Right Person in partnership with Police colleagues. – in progress. System level MOUs in place, updated regarding the mobilisation of each phase.

- System forums in place and ongoing to support and oversee the mobilisation. MH delivery group overseeing role out.

Implementation of the Fully Enhanced Model for NHS 111-2

- Operational and compliant with national specification April 2024.

Procurement of Swindon Crisis House

Further deployment and development of Older Adult roles to support dementia diagnosis to achieve 66.7% rate by end 2024/25.

Implementation of BSW Mental Health Strategy

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Implementing the National Quality Improvement Programme for Mental Health across all BSW wards	✓	✓
Roll out a new care planning approach from Q3 2024/25 to support CMHF delivery. Anticipated operational introduction to BSW in Q1 25/26	✓	
Deliver a Full Service Review (FSR) for Talking Therapies to achieve revised national standards (currently being	✓	

finalised as part of operational planning guidance within NHSE) – FSR to be completed by end Q2 2024/25, with new model to be commissioned from April 2025		
Implementing Phase 3 & 4 of Right Care Right Person in partnership with Police colleagues	✓	
Mobilizing Wave 12 MHSTs in Wiltshire. From January to October 2025	✓	
Implementation of the Fully Enhanced Model for NHS 111-2	✓	
B&NES Place of Calm (capital funding ready to be deployed)	✓	
Procurement of Swindon Crisis House	✓	
Further deployment and development of Older Adult roles to support dementia diagnosis to achieve 66.7% rate by end 2024/25	✓	
Implementation of BSW Mental Health Strategy following its approval via Board and sub-committees. On schedule and in process for ICB Board endorsement January 25	✓	
Transformational Activity 1: Foundations for the future – 2025-2026	✓	
Transformational Activity 2: Transforming our care models – 2027-2028		
Transformational Activity 3: Partnerships for the future – 2029-2030		

What are we doing to address inequalities?

Tackling health inequalities is a core priority in our Implementation Plan for the coming years. Our key focus areas include:

- Parity of esteem – Ensuring equal access to and improved health outcomes for both physical and mental health care.
- Reducing premature morbidity – Addressing the higher early mortality rates among individuals with a SMI diagnosis.

Reducing MHA detentions – Lowering the rate of detentions among Black and Core20 populations to fewer than 100 per 100,000 people

Primary Care

Why is it important?

The ICB has delegated responsibility for commissioning of all primary care services since April 2023 under section 65Z5 of the NHS Act (as set out in Health and Care Bill 2021). In BSW, our ambition is to realise the benefits of delegation in the way in which we can deliver care locally and to form stronger place-based partnerships. Key opportunities with delegation include:

- The ability to be locally responsive to population health needs and commission services accordingly
- A tailored approach working with partners to respond to health inequalities and ensure a focus on preventative care
- Transformation and pathway integration – greater ability to integrate these services into local transformation and system working both within the place and system agendas and to incorporate these services more fully into a local primary care strategy
- The ability to develop closer relationships which can then support increased partnership working at all levels further integrating care delivery in Primary Care Networks
- The opportunity to build a more integrated clinical leadership model which reflects the wider primary care system
- The ability to involve the wider primary care services in developing approaches to quality improvement and supporting wider primary care resilience.

Our long term goals

- Building on the programme to deliver modern general practice and targeted support to identified practices, moving the aim to being high impact patient contacts optimising the value of each episode of care to support Practices to create the "highest efficiency" model (in terms of outcomes).
- Reviewing the commissioning for frailty (including Transferring Care in Older People in Wiltshire) to align with BSW Frailty Programme including Care Home support through INTs and Primary Care Networks and domiciliary dental care.
- Strengthening partnerships between primary care, community services, and urgent care providers to improve patient flow and reduce demand on GP appointments.
- Workforce – develop and implement a primary care workforce strategy for all primary care contractor groups.

During 2024/25, we achieved the following:

- Update on the Primary Care Access Recovery Plan – reported to ICB Board Nov 23 https://bsw.icb.nhs.uk/document/bsw-icb-board-meeting-in-public-paper-pack-21-november-2024/ (ICBB/24-25/074)
- In February 2024 the Government issued a plan to recover and reform NHS dentistry, recognising the impact of COVID on dentistry was devastating and whilst the first full year from COVID (2023/2024) had shown some improvement, there are still issues with access. Working with the South West Collaborative Commissioning Hub and collaboratively with the other six ICBs, we have implemented the key deliverables of the National Plan, including the local decision to uplift the UDA value to £30, and £35 in Core20 PLUS5 areas; and the New Patient Premium.
- The team have worked with Business Intelligence ICB colleagues to build a dental power BI dashboard to better understand units of dental activity delivery and trend analysis, including year-to-date and month by month delivery as well as developing informed plans for delivery.

What is the impact of this work?

The national Primary Care Access Recovery Plan (PCARP) for recovering access to primary care was developed to look at ways to improve patient experience when it comes to accessing services, as well as making a difference for those working within general practice.

The NHS Dental Recovery Plan focuses on growing the workforce, improving access to right care, and preventing poor oral health.

BSW has made good progress with the delivery of the PCARP and is in a strong position regionally. Our headlines of achievement (as reported to ICB Board November 2024) are:

- Second highest ICB in SW for % Face to Face primary care appointments being offered
- Third highest ICB in SW for Appointments within 14 days
- Third highest GP staff FTE per weighted 10,000 patients
- Second highest % P9 Patient Registrations via NHS App
- Second highest % practices with prospective records access enabled
- First highest ICB in SW % of practices offering patients to book / cancel appointments online
- Telephony project is ending with most practices now on a cloud solution that meets the national specification
- All but two practices are live with the ‘Register with a GP surgery’ pathway
- 0.5% reduction in ‘Did Not Attend’ primary care appointments from October 2023 to August 2024, equivalent to 2,400 appointments per month.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Improve patient experience of access to GPs	✓	
Improve access to urgent dental care	✓	
Put in place action plans by June 2025 to improve contract oversight, commissioning, and transformation for GPs to tackle unwarranted variation.	✓	
Reduce tooth extraction for children under 10	✓	
Deliver domiciliary outreach dental service	✓	✓

What are we doing to address inequalities?

- Establish dental access hubs in areas with significant access challenges, particularly targeting underserved populations.
- Work with BCYP in reducing hospital admissions for tooth extractions due to decay in children and young people from Core20 populations.
- Commissioning primary care services for Core20Plus5 populations (including asylum, refugee, and Entitled People cohorts).
- Work with UEC and ISG to learn from UEC attendances, particularly among Core20PLUS populations, and understand why individuals sought urgent care and take meaningful action based on this learning.
- Work with Vaccination Programme to increase Covid and flu vaccination uptake among Core20 and ethnic minority populations through targeted outreach, improved accessibility, and community engagement strategies.

Community Care

Why is it important?

Community care is one of the cornerstones of the 2025/26 national planning guidance. Our plans support the delivery of the 6 core functions of a neighbourhood based model of care (NHS England » Neighbourhood health guidelines 2025/26) which are:

- Population health management
- Modern General Practice
- Standardising community health services
- Neighbourhood Multi-Disciplinary Teams (MDTs)
- Integrated intermediate care with a 'Home First' approach
- Urgent Neighbourhood services

Our ambition is not only to treat people, but also to prevent them from getting ill in the first place. We aim to support people to live longer, healthier lives through helping them to make healthier lifestyle choices and treating avoidable illness early on. The Primary and Community Delivery Programme supports delivery of the national planning requirements, the BSW Implementation Plan and the BSW Integrated Care Strategy. Within 2025/26, the Primary and Community Delivery Programme will encompass the delivery of community transformation under the new ICBC contract.

The six priorities in the primary and community care delivery plan are as follows:

- Adopt a scaled population health management approach by building capacity and knowledge, and using this to underpin transformation at every stage
- Deliver enhanced outcomes and experiences for our adults and children by evolving local teams
- Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets
- Increase personalisation of care through engaging and empowering our people
- Improve access to a wider range of services closer to home through greater connection and coordination
- Support access to the right care by providing co-ordinated urgent care within the community.

The plan is supported by a number of enablers including technology and data, estates, environmental sustainability, anchor institutions, commissioning, workforce and shifting funding to prevention.

Our long term goals

- Work with new community provider to deliver the long-term transformation priorities as set out in the ICBC contract
- Design neighbourhood specific care to meet community needs by embedding population health management approaches and personalised care

- Improve prevention and early intervention by empowering citizens, strengthening local partnerships and shifting resource into communities to deliver a truly values-based approach to provision
- Focus on transformation of key pathways such as hypertension, weight management, diabetes, frailty, EOL)
- Enhance the outcomes and experience of adults and children with complex long-term conditions through joined up neighbourhood teams and harmonisation of services
- Improve access by extending the range of local specialist services, advice and guidance and make better use of existing services
- Deliver the right care at the right time and support effective service delivery by providing a coordinated approach to crisis and urgent care

Within our ICBC programme our initial transformation focus (pending more in-depth planning post initiation of contract from April 1st 2025:

Projects/workstreams	Description	Start
Pre-programme governance	Establishment of transformation governance and PMO Defining overall objective, high-level expected benefits, projects, project leads and resource requirements	Feb '25
Programme initiation	Creating programme documentation (including programme and stage plans, PID, benefits realisation plan), briefing project leads and SME resource.	Mar '25
Baselining, benchmarking and benefits	As-is performance and process baselining exercise, culminating in recovery planning where required. Completing the benefits realisation plan.	Feb '25
BSW all-age Single Point of Access (phase 1)	Designing operational blueprint (RIVIAM referral management platform, triage, flow etc.), workforce model, care coordination pathways and initial Digital Front Door (Website, SMS, Apps).	Apr '25
Integrated Neighbourhood Teams	Operational blueprint and workforce redesign, establishing preventative approaches training, population health management	Apr '25
Partnerships & engagement	Development of partnership strategy, engagement networks established (VCFSE, service user, provider partners), Development of VCFSE input into ICBC	Apr '25
Digital Transformation	Digitisation of operational processes, standardisation of EPRs, implementation of systems to create efficiencies and improve performance / quality of service.	Apr '25
BSW all-age Single Point of Access (phase 2)	RIVIAM Patient and referrer portal, digitisation of forms / assessment, chatbot website integration	Apr '26
ICBC Estates Strategy	Stakeholder engagement, estate mapping and prioritisation, blueprint design, implementation	Apr '25
Harmonisation across BSW	Redesigning back office and corporate support through standardisation of policies, procedures, processes and systems. Care pathway redesign – move away from service lines to care pathway approach	Apr '25

Areas which will have the greatest impact in delivering reductions in unplanned hospital attendances are prioritised for harmonisation and earliest transformation. For adult community service, these include:

- Reactive care – with a particular focus on supporting pan-system improvement in patient flow through Care Coordination, Hospital@Home, community hospitals and urgent care response
- Planned care – focusing particularly on those pathways that contribute to urgent care demand, including respiratory, frailty, dementia and falls
- Neighbourhood development – co-design and development of the blueprint for integrated neighbourhood teams, to be rolled out across BSW, informed by and aligned with population health needs

Critical enablers, which will be developed and implemented in 2025/26 include:

- A BSW wide Single Point of Access, supported by digital transformation to enable rapid referral and self-management
- Wider digital transformation through development of improved digital systems and processes to support care and treatment

During 2024/25, we achieved the following:

- Successfully awarded the new ICBC contract
- Reduced waiting times so that no-one in BSW will wait longer than 52 weeks by March
- Implemented the Primary and Community Group to ensure assurance and oversight
- Commenced work on pathway transformation in core areas

What is the impact of this work?

- Reduced waiting times across the footprint for community services

What we are aiming to achieve next

All workstreams will contribute to maintaining demand at 24/25 levels through specific actions to reduce activity for the most complex population cohorts (working definition CMS segments 4 and 5):

- **Acute ED attendances**

Segments 4 and 5 – 1.8% reduction per year

Segments 1-3 – limited growth to 0.7% per year

This equates to 9190 attendances per annum, which is 25 attendances per day.

- **Emergency bed days (10% reduction overall)**

Segments 4 and 5 - 1.2% per year

This equates to 5456 bed days per annum, which is 15 bed days per day.

- **Ambulance Dispatches (17% reduction overall)**

Segments 4 and 5 - 1.8% per year

This equates to 1331 fewer ambulance conveyances per annum, or 4 per day.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Optimise practice use of Community Pharmacy hypertension offer	✓	
Hypertension Case Service Pilot	✓	
Redesign the Weight Management pathway across BSW		✓
Standardise implementation of Hybrid Closed Loops (NICE TA943) provision required as part of the NHSE constitution.	✓	
Reduce risk complication patients with T2DM < 40 years.		✓
Achieve a system wide view and definition of Frailty, the corresponding services and the health outcomes and value added for BSW		✓
BSW End of Life Care Alliance Programme of delivery to report to PCCDG	✓	
Implementation of ICBC contract with associated transformation priorities	✓	✓

What are we doing to address inequalities?

- Improving access for all patients across BSW to support reductions in waiting times and earlier intervention
- Increased access to services in the community including self-referral pathways and digital patient facing support
- Development of an integrated weight management model that supports adoption and implementation of new drug-based treatments as well as non-medical support (healthy eating programmes, exercise management, psychological support).
- Through ICBC, working in partnership with HCRG to ensure that transformation is targeted at areas of highest inequality through better use of population health management data

Urgent and Emergency Care

Why is it important?

Urgent and Emergency Care are essential services that play a specific part in supporting patients to receive the right care, by the right person, as quickly as possible to improve their health outcome. Effective patient flow through the Health and Social Care system is a key enabler to providing safe and effective Urgent and Emergency Care services.

The delivery group is responsible for the implementation and coordination of agreed transformation commitments which are shared priorities across BSW. All partners have a commitment to deliver timely and efficient access to safe care and treatment. The UCFDG provides oversight for the BSW Urgent Care and Flow Improvement Plan, delivery against key priority areas and ensuring robust system flow metrics.

The Urgent and Emergency Care team also provide the System Coordination Centre (SCC) providing a central function between NHS England and all providers across BSW

Our long term goals

Reduction in the overall number of ED attendances, both walk-ins and ambulance conveyed patients through increased use of 'out of hospital' and community-based services, as well as treatment on scene. This includes the use of alternative pathways, such as virtual wards (Hospital @ Home), the Care Coordination Centre, primary care, Urgent Treatment Centres, Urgent Community Response (UCR) service and community pharmacies.

More effective flow through inpatient acute and community hospital settings by reducing the average length of stay for patients and reducing the number of non-criteria to Reside (NCTR) patients. With an improvement in flow throughout the acute hospitals, this will allow for a reduction in ambulance handover delays at E.Ds.

During 2024/25, we achieved the following:

Flow – Increasing the number of patients discharged home on pathway 1 with assessments being completed outside of an acute environment. Developed a BSW Care Transfer Hub terms of reference that includes an escalation process to support out of area patients.

Hospital @ Home (Virtual Wards) – increased system capacity in addition to acute and community inpatient hospital beds. This resulted in a reduction in the number of ED attendances and hospital admissions, allowing people to receive care and treatment in their own home.

Care-Coordination – ambulance navigation to the most appropriate pathway reducing acute hospital ED attendance and subsequent admission by utilising other pathways away from acute. Latest monthly data, December 2024), demonstrates that Care Co-ordination received 2049 referrals with 1821 patients being directed to out of hospital pathways. The ambulance conveyance rate for patients through Care Co was 11%.

Demand Management – out of hospital capacity to support delivery of NCTR and discharges.

What is the impact of this work?

- Hospital@Home has circa 175 beds supported by the four teams across BSW. This supports reduction in ED attendance and hospital admissions. Latest data demonstrates occupancy at 83% with Swindon & Wiltshire improving utilisation rates which will be reflected in next month's data. Cumulative acute bed impact from April to date is 558.
- Work is underway to further increase utilisation with support from Dorothy House Hospice for RUH H@H and remote monitoring support from Medvivo for GWH H@H.
- Care Co-ordination has reduced attendances at Emergency Departments and subsequent admissions through reviewing calls from SWASFT via the ITK or from Paramedics on the Scene.
- Work is underway scoping possibilities for supporting the NHS 111 Category 2 calls to SWASFT as part of the system response to delayed handover times.

What we are aiming to achieve next

- System Flow Programme – focus is the interface between acute and community
- 7 day working across UEC pathways
- Acute Improvement Programmes to include SDEC and streaming and redirection including Acute Frailty - system wide frailty pathways that will have oversight at the Primary Care and Community DG
- Ambulance Improvement Group

*Delivery plans for all these targets will be with system partners through the key projects listed above.

- Revise the future model of care for urgent care to support more patients being cared for closer to home under a non-elective strategy
- Integrated pathways across primary, urgent and secondary care and diagnostic centres to improve access and prevent multiple presentations at multiple services
- Future capital opportunities to develop and support services
- Consideration of workforce opportunities across the system and all partner organisations
- Reduce the reliance on escalation capacity and additional beds in response to managing demand across the pathways and system

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)

Reduction of handover delays at acute trusts to ensure that we can deliver reduced delays in category 2 response times	✓	
Increased use of SDEC services across each site to ensure that patients can be seen, treated and discharged within 12 hours of arrival leading to improved outcomes	✓	
Optimisation of UTCs and ensuing that patients are streamed and redirected appropriately	✓	
Reductions in LOS by increase the % of patients discharged before or on day 7 of their admission in line with existing NHSE guidance Align the BCF schemes to ensure support reductions in LOS.	✓	
Increase frailty at the front door services reducing admissions of the frail elderly and increase on the day discharge	✓	
Reductions in delays in hospital through the Flow Programme, by implementing best practice at the interface of acute and community, supporting 7 day working and improvements in processes.	✓	

What are we doing to address inequalities?

Over a three-month period Healthwatch will be undertaking face to face questionnaires supplemented by a digital campaign through social media to understand the UEC demands in the three ED departments. The outcomes from this work will enable us to understand patients' awareness, use and accessibility of UEC services across the ICB area. This will provide intelligence that will be utilised for focused communications to raise awareness of alternative services for hard to reach communities and also understand future provision and demand of UEC services for the populations within the ICB.

This will improve urgent and emergency care access to all communities providing safe and effective services by adopting a learning approach to better understand access for Core 20+ population. There will also be work undertaken to connect the Delivery Groups with UCFDG to ensure a positive impact on population groups e.g. under 18's Core 20+ population.

Planned Care

Why is it important?

Across BSW, almost 2000 people are waiting > 1 year for an appointment. We know that there is continued variation in provision across our footprint and we need to address this 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 deteriorate 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 we ensure that our diagnostic pathways are as rapid as possible to enable early diagnosis and intervention to support recovery.

Our long term goals

- Develop Elective Strategy aligned with the development of the Group Model across BSW
- Develop and implement workforce transformation plans aligned with the elective strategy, including:
- New roles to support early and improved access (e.g. nurse specialists)
- New diagnostic roles to support community diagnostics expansion
- Co-produce plans to address fragile services, including public consultation and engagement
- Deliver 92% 18-week RTT by March 2029
- Develop additional surgical and diagnostic capacity
- Increase NHS productivity across a range of services
- Use digital solutions to improve efficiency and patient experience
- Further develop Advice and Guidance services

During 2024/25, we achieved the following:

- Reduced waiting times so that no-one in BSW will wait longer than 65 weeks by March 2025
- Increased activity across the footprint using the independent sector
- Improved access to diagnostics, delivering planned reductions in diagnostic waiting times
- Commissioned and developed new capacity at Sulis Hospital
- Commenced work on pathway transformation in core areas

What is the impact of this work?

- Reduced waiting times across the footprint for elective and cancer
- Delivery of Elective Recovery Fund ambitions
- Expanded range of offers available to our population to enable timely access and choice

What we are aiming to achieve next

- Ensure that greater than 65% of people on our waiting list wait 18 weeks or less for treatment across all three providers – this will be delivered through:
- Reviewing first to follow up ratios for all specialties and ensuring that clinic templates are in line with GIRFT guidance
- Meeting and sustaining an 85%-day case activity rate across all providers
- Maximising the use of Advice and Guidance across the system with 30% of outpatient referrals offered advice and guidance
- Implementation of new diagnostics capacity across the system through expansion of Community Diagnostics Centre facilities to support earlier diagnosis for cancer and non-cancer related conditions, as well as reducing reliance on outsourced diagnostics capacity. This will be realised through moving to 6 day working for 12 hours per day to provide better access to services across the system
- 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

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	✓	
Eliminate waits of over 65 weeks for elective care by March 2025 (except where patients choose to wait longer or in specific specialities)	✓	
To achieve 5% PIFU of all outpatient attendances by March 2025	✓	

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 19/20 baseline by March 2025	✓	
Increase the proportion of all outpatient attendances that are for the first appointments or follow-up appointments attracting a procedure tariff to 46% across 24/25	✓	
Increase productivity and meet the 85%-day case and 85% theatre utilisation expectations using GIRFT and moving procedures to the most appropriate setting	✓	
Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	✓	
Deliver diagnostics activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	✓	
Cancer 62-day standard. Total patients seen and of which those seen within 62 days – 70% by March 2025	✓	
Cancer 28 day waits (faster diagnosis standard)	✓	
Number of people referred onto a non-specific symptoms pathway	✓	
Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result	✓	

What are we doing to address inequalities?

- Improving access for all patients across BSW to support reductions in waiting times and earlier intervention
- Improving access to diagnostics to support earlier intervention for people with suspected cancer – reducing mortality across all populations
- Providing new diagnostics capacity in our communities so that people can access services closer to their homes

Pharmacy & Medicines

Why is it important?

It is the first time Medicines and the provision of healthcare services by Pharmacy have had a specific focus in our Implementation Plan although both been present as cross-cutting themes. BSW ICB is committed to ensuring the safe, effective, and sustainable use of medicines across the health and care system. Over £300m is spent on medicines within the ICS and our overarching vision is to spend that resource to maximise the value for our population with the best overall outcomes we can. Medicines are the most common healthcare intervention and contribute to our prevention strategy. When used strategically Pharmacy and medicines can help enable our left shift approach, supporting our population from needing higher acuity care.

Over the next five years, we will continue to drive improvements in medicines optimisation, equity of access, and cost-effectiveness, aligning with national policy, clinical best practice, and local population health needs.

A new Pharmacy & Medicines Delivery Group is being established to provide a more transparent and coherent system-wide governance route for our oversight and assurance of medicines transformation activity across BSW. This collaborative ensures our work prioritises a value-based approach with medicines supporting the key strategic priorities and aligns to improving outcome

Our long term goals

1. Deploy secondary care FP10 electronic prescribing to support safe and effective transfer of care from secondary care to primary care
2. Pharmacy Workforce:
    a. Scale up trainee pharmacist and pharmacy technician pipeline to meet community pharmacy and general practice need
    b. Develop system-level consultant pharmacist roles in key areas such as cardiovascular disease as enabler to whole-system transformation, research and innovation
3. Develop a clinical effectiveness framework to support the uptake and prioritisation of medicines and devices that provide best population value

During 2024/25, we achieved the following:

BSW ICB has an experienced Medicines Optimisation team that works collaboratively with region, national teams and other medicines teams in provider partners across the system. This year we have taken some time to review the function and form of the team to better align to the modern approach of and ICB and that restructure will conclude in 24/25.

Alongside this structural review, important work has continued which includes:

- A review of the medicines governance approach has been undertaken with a new oversight and assurance framework has been approved for implementation by March 2025 as an enabler for whole-system medicines optimisation.
- A system-wide medicines approach to align CIPP savings relating to medicines across BSW to ensure transparency and collaboration on opportunities.
- A more rigorous 'bottom-up' budget setting approach was used where clarity was achieved over what were cost-saving schemes versus what was a business-as-usual approach.
- Continued strategic switching initiatives in primary care, prioritising highest value first, saving over £1m in year.
- We continue to deliver against the quality schemes aligned to the NHSE medicines optimisation opportunities
- Work towards reducing the Pharmacist vacancy rate across general practice and community pharmacy by increasing the uptake of pharmacist trainees across all Pharmacy settings in BSW
- BSW ICB has supported the delivery of the Pharmacy First across 100% of community pharmacies and contraception supply from 30% of pharmacies. In addition, 5 community pharmacies have been commissioned as prescribing 'Pathfinder sites' as an enabler for the future long-term condition management from a community pharmacy setting
- Improved uptake and switching rates across all new biosimilar medicine opportunities, generating over £1m of savings in 2024/25.
- Biosimilar workstream has been supported by strategic workforce development of prescribing pharmacists in fragile services such as Gastroenterology, Dermatology and Neurology in alignment with the NHS Long Term Workforce Plan
- Secured funding for a first BSW ICS Community Pharmacy Research Liaison Project to increase our engagement in clinical research of underserved communities through Community Pharmacy

This work has laid strong foundations for the coming year.

What is the impact of this work?

1. Over £2.5 m from switch initiatives in primary (generics) and secondary care (biosimilars)
2. In 2024 a BSW acute trust was the first in the UK to switch patients to Natalizumab biosimilar.
3. Over 50% increase in the number of clinical appointments through Pharmacy 1st vs 2023/24

4. BSW contraception supply service from community pharmacy went live
5. Pathfinder community pharmacy pilot launched with 5 pharmacies prescribing in minor illness and hypertension
6. Pharmacist trainees coming into system increased from 18 in 2021 to 41 in 2025
7. BSW ICB benchmarks in top quartile for NHSE 16 meds optimisation primary care opportunity areas

What we are aiming to achieve next

For our 25/26 objectives, we want to ensure the following:

1. The Pharmacy & Medicines Delivery Group is fully established with a Pharmacy and Medicines Strategy co-created in partnership with stakeholders and communities
2. The Medicines Assurance Framework is embedded in our governance to give visibility and support planning, performance and accountability.
3. The ICB develops a value-based decision-making framework to support the uptake of medicines and devices that support prevention of serious illness and provide the best value for our communities
4. The ICB collaborates with acute trusts to improve the uptake of biosimilar medicines and to be top 10% in class in uptake rates of new biosimilar medicines
5. The mobilisation of an innovative single trainee lead employer for all Pharmacy trainees from July 2025
6. Continue to support community pharmacy to optimise uptake of the national Pharmacy First scheme and hypertension case-finding, to reduce health inequality and inequity of access to care
7. That BSW ICB takes a proactive approach to partnership working with Industry and the Health Innovation Networks to improve the uptake and spread of innovative practice across the ICS
8. We will work with PCNs to reduce problematic polypharmacy, to improve outcomes for patients while decreasing medicines waste.
9. We will use our proactive medicines system approach across our practices to support more strategically, prioritising areas of greatest opportunity with medicines, focusing resource to maximise outcomes for our population.
10. Explore case for change to transition from analogue to digital to improve patient experience, including secondary care to community pharmacy electronic prescribing

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Improve Biosimilar Uptake Rate	✓	✓
Expansion of Biosimilar Pharmacist prescribing Model of Care	✓	✓
Deploy a fully automated population medicines optimisation dashboard solution to provide real-time information for both primary and secondary care users, enhancing decision-making and efficiency	✓	
Embed Clinical Effectiveness and reinvestment process to support value-based care	✓	
Continue to improve use and access to Community Pharmacy Pharmacy 1st and minor illness services	✓	✓
Improve blood pressure checking rates and hypertension case-finding through pharmacy	✓	✓
Improved treatment to target of people with diagnosed hypertension	✓	✓

What are we doing to address inequalities?

- Work with community pharmacy to improve equity of access to sexual health and contraception support for previously underserved communities
- Optimise Community Pharmacy role in Hypertension case-finding and develop commissioned hypertension prescribing service, collaborating with VCFSE partners to target case finding in our Core20plus populations
- Progress a business case to enable bilingual and easy-read medicines labels across all pharmacy sites that supply medicines across BSW
- Continue working with Health Innovation West of England and system partners to reduce unnecessary prescribing and improve medication review rates of opioid medicines
- Use Pharmacy premises to improve research engagement with underserved communities to improve access to clinical research

Workforce

Why is it important?

Over 35,000 people work in health and care in BSW across a wide range of professions, in a variety of settings and across multiple employers.

We have a highly skilled, dedicated and committed workforce across our ICP area. However, gaps in the health and social care workforce will be one of the key barriers to improving services in BSW over the coming years.

Our priority is to improve both recruitment and retention of staff across BSW by creating a culture in which our workforce enjoy satisfying careers, feel valued and are able to make their best contribution. We will do this by focusing on the following four ambitions:

- Creating inclusive and compassionate work environments that enable people and organisations to work together
- Making BSW an inspiring and great place to work
- All staff feeling valued and having access to high quality development and careers
- Using resources wisely to reduce duplication ,enhance efficiency, productivity and share learning

Our long term goals

- Identifying and modelling the necessary supply and roles to deliver the most effective and productive workforce model for BSW, reducing long standing skills gaps and enabling care delivery closer to the community inc. roll out of Community Diagnostic Hubs
- Skill mix review for multi-disciplinary teams to optimise quality, personalised care and maximising the Care hours per patient day (CHPPD) for inpatient services
- Enhanced utilisation of digital solutions such as the automation of administration and passporting of training
- In collaboration with NHSE Workforce transformation activities required for BSW community and primary care programmes and using the Community Services Optioneering tool to support.
- Specific Workforce Planning redesign activities to support and enable increased productivity, reduced workforce spend and required reductions in headcount.
- Organisational development enabling new ways of working as part of integrated models of care.
- Securing strategic education partnership able to optimise innovative training solutions.

- Successful implementation and evidence for workforce inclusion with improvements in workforce representation and career progression.

During 2024/25, we achieved the following:

- Roll out of Calderdale workforce transformation tool against 4- 5 agreed projects focused on creating new ways of working and improved productivity. – delivered 3 cohorts of training. And the following projects.
- Successful roll out of Oliver McGowan Training for all system partners with highest level of compliance in the Southwest and on track to meet set training targets for eligible staff, to date 10,500 staff have been trained in Tier 2 and 1,900 in Tier 1.
- Working with region and local partners to develop sustainable and affordable models for an increasingly grow our own training model and collaborative apprenticeship opportunities. Apprenticeship network with levy sharing process in place with quarterly monitoring via internal dashboard
- Project funded by Department of Education for supporting numeracy skills across Wiltshire that has resulted in 40 colleagues being enrolled to gain a new maths qualification that will enable career progression and over 75 numeracy engagement events for staff offering support and coaching for numeracy skills.
- Continuing to build strategic partnerships with education partners for employer led models of education that increasingly attract from local communities and train a workforce with future focused skills. SFT leading procurement of HCSW apprentices for the system.
- Completion of recruitment, and roll out, of health and care ambassadors across partners offering one point of contact for school and employment engagement.
- Successful completion of a bespoke leadership programme co designed with Skills for Care for 30 domiciliary care registered managers with successful evaluation and with the intent to form a leadership advisory group.
- Completion of care covenant programme for supporting employment for looked after children. Outputs developed a tool kit and an awareness raising lived experience digital recording for supporting managers and the workplace.
- Funding secured for leadership capacity as part of DWP Work Well bid for Health and Work integration, scoping work across each locality completed with a view to co design a work and health strategy for supporting people who are economically inactive into employment, focus on mental health and musculoskeletal.
- Extension of NHSE funded project for increasing diversity in research project. Mobilisation of a research network with over 100 research active staff members, 3 workshops for research active staff trained in cultural competence, recruitment of new research champions, community

engagement mapping and new website resource completed with BSW Research Hub for engaging with communities and health inequalities

- Coordination of workforce planning and reduction in temporary staffing as part of leading the regional programme of work, resulting in a substantial reduction in use of NHS agency.
- Programme of work within Training Hub for supporting primary care workforce development inclusive of wellbeing programmes, apprenticeship support, placement coordination, ARRS roles support, practice manager development project and careers support for signposting careers in general practice.

Oversight of workforce inclusion programmes across NHS and with wider partner involvement. Inclusive of NHS Equality Delivery System duty with a focus on annual health checks for people with learning disabilities and PAL and complaints services.

What is the impact of this work?

- Workforce transformation such as project deployed using the Calderdale Framework to support the delegation of healthcare activities for improved workforce effectiveness and integrated care experiences.
- To date in total 12,400 eligible staff trained in Oliver McGowan Mandatory Training on Learning Disabilities and Autism training impact on quality of care and health inequalities.
- Addressing health inequalities through anchor organisation principles for accessing employment and skills/training pathways
- Population health benefits by upskilling the workforce in new skills, awareness and behaviours reflective of new models of care.
- Addressing workforce inequalities
- Improved workforce efficiency

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Reduction of Agency staffing usage/spend	✓	✓
Reduction of bank usage and controls	✓	✓
Removal of all off-framework agency usage: • No off-framework agency usage for RGN's and medical roles	✓	✓
Recruitment for hard to recruit roles /Fragile Services	✓	✓

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Scaling of People Services	✓	✓
E-Rostering and Medical and AHP E-Job Planning	✓	✓
Skill mix review for multi-disciplinary teams to optimise quality, personalised care and maximising the Care hours per patient day (CHPPD) for inpatient services	✓	✓
Workforce transformation for care closer to the community and supporting anchor organisation principles	✓	✓
Improved staff satisfaction, retention and inequalities	✓	✓

What are we doing to address inequalities?

- Increasing diversity in research aligned with Core20Plus5 populations.
- Anchor organisation principles for skills and employment as a way of addressing health inequalities for our populations.
- Staff training in raising awareness and tools for health inequalities and prevention

Digital

Why is it 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 outlined above.

The DH and NHSE announced the development of a ten-year health plan that focusses on three big shifts.

- moving care from hospitals to communities
- making better use of technology
- focussing on preventing sickness, not just treating it

Our long term goals

- Embed the benefits of EPR convergence across providers
- Increased information sharing through ICR
- Normalise adoption of digital solutions that use AI ensuring existing IG and Clinical Safety processes are matured to deal with the increased complexity.
- Improvement in cyber security especially assurance of 3rd parties' suppliers building on the NHS DTAC process
- Ensure community digital transformation take place as detailed in the new community contract.
- Work with NHSE to ensure all patient facing digital tool are integrated with the NHS App wherever possible to create a single digital front door
- Better develop our system data architecture, including to support population health management
- Consider how our teams work together more formally across the system to ensure efficient and effective delivery of Digital services
- Embed our PHM tools and data into use for the benefit of our populations
- To have established a systematic approach to modelling and evaluation which informed our major decisions
- To be applying advanced analytical techniques (including AI) to help solve some of our key problems. To support this, grow the capability of our team to do more advanced analytics

During 2024/25, we achieved the following:

Single EPR - The EPR programme is now in the implementation phase following the confirmation of support from the NHSE national team. This will bring our 3 acutes onto a single system creating consistency and providing a single point of acute integration going forwards.

Integrated Care Record - The ICR programme has increased the number of connected partners to the shared care record and increased the benefits derived from the record through increasing utilisation. Use of the record is now triple what it was only 2 years ago.

NHS App - Increased usage of patient facing digital tools focusing on adoption of NHS App uptake and usage, evidenced by national NHS App reporting. Over the past 12 months we have seen a 100% increase in repeat prescribing via the NHS app with over 100,000 repeat prescriptions via the NHS app in a single month. Patients are now logging into the NHS App more than ever with nearly 1 million logins across BSW last month.

BSW ICB currently (as of Nov 24) has 59% of patients 13+ registered with the NHS app this is higher than both the regional average (57%) and the national average (58%)

GP Telephony - Cloud based telephony has been deployed across practices in BSW with over half of practices receiving a new telephony system this will ultimately reducing patient telephone wait times and increasing satisfaction.

Independent Prescribing - The ICB have worked closely with community pharmacy and have already successfully deployed Cleo solo in a number of pharmacies to enable community pharmacy to prescribe digitally for the first time ever, given a much better patient experience and taking pressure of other service such as GP surgeries.

Cyber Security - We have continued to ensure strong cyber security is in place with increased board awareness and increased system wide working including the creation of a system wide Cyber Tactical Advice Cell (CTAC) and ICS wide cyber exercises.

Future Connectivity - The ICB has been part of the Future Connectivity programme and has successfully trailed the use of Starlink (low earth orbit satellites) to provide backup and mobile connectivity. This will enable us to ensure GP practices can stay open even in the event of a local connectivity outage and give us the ability to provide full IT access to any location within a few hours.

Population Health Analytics - The ICB team has supported the Population Health Board with analysis to drive forward the focus on Hypertension. The analysis supported development of the business case and is now working on evaluating the impact of the various actions.

Advanced Analytics - Following the ICB re-structure establishing teams with expertise in Modelling & Data Science and Evaluation, focusing on using more advanced analytical techniques to support with ICB and ICS decision making. Initial

focus has been in supporting Urgent Care with planning for Winter and on reviewing priority schemes.

What is the impact of this work?

The impact of these activities is multi-faceted:

- Keeping our patients and systems safe from cyber-attack by protecting their data or keeping organisations running
- Promoting the NHS App as the single digital front door, reducing pressure on other service like GP Practices by enabling those that can use digital freeing up capacity for those that have more complex needs.
- Improving patient access to services
- Enabling better decision making through access to analytical insights or timely medical records
- Providing innovative new ways of working through access to data and digital solutions
- Supporting the development of Hypertension and other priority population help work – driven by data and analytics – will ultimately help improve outcomes for our populations
- Using advanced analytical techniques to help us predict the impact of initiatives and evaluate if they're working will help us make better decisions about how to spend our money. For example, in vesting in schemes which are helping to manage emergency demand.

What we are aiming to achieve next

As a system we will work together to support individual provider activities associated with EPR maturity and convergence. Specifically, the AWP business case, the acute group EPR migrations, and HCRG community transition.

We will grow the ICR and develop a business case for its future. This will result in more partners, improved functionality, greater use (views), and increased benefits (identified in annual evaluation).

We will procure a remote monitoring solution for Hospital at Home at the end of the existing contract.

Community

- Mobilisation of our new ICS wide community contract, which has significant digital ambitions and investment including a fully digital front door. We are keen to work with NHS England to develop the community aspects of the NHS App.

AI tools

- Further explore the use of AI tools in various setting to understand the benefits and productivity these can bring; we have active plans in place to explore for the following:-

- AI Scrip tools in GP Practice (active pilot in place with ICB supporting on IG and Digital Clinical Safety)
- Team Premium Inteligent Recap (part of NHSE trail)
- Copilot 365 (part of NHSE trail)
- User of primary care TPP DNA predictor
- We also plan to continue to develop our AI governance including continued review of our ICB Generative AI policy as AI capability expand even further.

Cyber

- Continue maturing our ICS cyber capabilities with the recruitment of an ICS wider cyber manager and a refresh of our ICS Cyber strategy including learning from our ICS wide cyber exercises. The ICB Head of IT is also a member of the national Cyber Reference Group and we have expressed an interest to work with NHSE on 3rd party supplier assurance.
- Ensure all machines are migrated from Windows 10 to Windows 11 before October 2025 when Microsoft support ends.
- Ensure all our endpoints are configured in line with industry best practice (CIS 2.0 level 1 framework) with any exceptions agreed by the SIRO
- Completion of new DSPT CAF toolkit

Infrastructure

- Mobilisation of our new HSCN contract ensuring all sites (including primary care) have gigabit capable connectivity so they have the connectivity to meet future needs.

Data

- As a pilot site for the Federated Data Platform, to continue to on-board System products and tools to support BSW work
- To continue to support development of the South West Secure Data Environment for Research project

Population Health and Outcomes

To support the effective mobilisation of the new ICBC contract including ensuring population health data and approaches are well-embedded and that outcomes reporting is effective and well used to develop and embed the BSW Outcomes Framework

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Approved business case for ICR future	✓	
New contract for Hospital at Home remote monitoring	✓	

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
EPRs live across acute group		
NHS Cyber Manager In post	✓	
Gigabit HSCN to all sites	✓	
Community contract mobilisation	✓	
Community contract digital optimisation (7 year plan)		✓
Embed use of PHM in Community contract	✓	✓
Support to FDP and SDE	✓	✓
Establish BSW Outcomes Framework	✓	
Embed systematic approach to modelling and evaluation of BSW business cases	✓	

What are we doing to address inequalities?

Developing a data infrastructure approach that supports PHM and enables the ICS to identify and support populations with proactive care with a specific lens of inequality. These include the Graphnet ICR and the ICB data warehouse.

A significant amount of reporting and analysis has been developed to support health inequalities including against the CORE20PLUS5 and the NHS England Statement on Health Inequalities. Focused bit of work has also been undertaken with each BSW Delivery Group to help them understand health inequalities for the populations they support.

We are working with NHSE to improve NHS App reporting to enable us to identify digital exclusion and will continue to ensure that existing non digital access route are maintained, enabling those that can use digital to free up capacity to help those with more complex needs.

Estates and Facilities

Why is it important?

BSW aspires to have high-quality estate across its system with seamless IT connectivity across locations, designed for maximum efficiency that enables our workforce to deliver effective and high-quality care.

Estate is one of the key enablers to deliver the truly transformational changes that BSW ICS seeks to achieve to deliver outstanding care and support healthy communities.

Estate is our third largest cost after workforce and medication, so it must be financially sustainable and utilised well. We are improving the way we use our estate by removing organisational barriers to ensure we share our assets and spaces to increase utilisation across all settings to maximise the use of our investments.

Our long term goals

- Technologies will allow patients to access sophisticated diagnostics within community settings as part of an integrated service. Virtual spaces for virtual consultations with professionals reducing the need to come into buildings, physical spaces for face-to-face consultations in different locations where these are necessary, including the patients' own home, which will help to transform service delivery.
- Funding constraints inevitably create risks to achieving this vision, but it is important to have a clear aspiration for the future BSW estate. We must work as a system to prioritise our investments going forward to ensure they provide the most value for money and benefit for our population.
- Our workforce will be able to work across different locations, consolidating back-office functions and changing the way that we work, reducing unwarranted variations in provision of estate services.

Delivery

The way we use estate needs to transform and become more flexible to the changing needs of services and service delivery, which will be supported by technology to enable us to deliver care at the right place for the needs of our population.

Our estate will be flexible and provide sufficient access and capacity in the right place, with the highest standards in sustainability, with a low carbon footprint.

Estate is our third largest cost after workforce and medication, so it must be financially sustainable and utilised well. We are improving the way we use our estate by removing organisational barriers to ensure we share our assets and spaces to increase utilisation across all settings to maximise the use of our investments.

We are currently drafting our ICS infrastructure strategy, which will set out our approach to achieving this; by ensuring the key enablers such as digital, workforce and estates play an integral role in the annual planning process and service redesign.

What will be different?

Our future estate will be shaped and informed by the changes to our care model, to deliver better patient, staff and visitor experience and to significantly improve the way we deliver services in the future enabling us to dispose of ageing buildings that are no longer fit for purpose and invest in sustainable new solutions to enable the delivery on integrated care such as the Devizes Integrated Care Centre (opened in 2023) and the Trowbridge Integrated Care Centre (currently under construction). We will also further utilise the existing public, community and third sector estate, working

closely with our Local Authorities colleagues to support the one public estate agenda.

Technologies will allow patients to access sophisticated diagnostics within community settings as part of an integrated service. Virtual spaces for virtual consultations with professionals reducing the need to come into buildings, physical spaces for face-to-face consultations in different locations where these are necessary, including the patients' own home, which will help to transform service delivery.

Funding constraints inevitably create risks to achieving this vision, but it is important to have a clear aspiration for the future BSW estate. We must work as a system to prioritise our investments going forward to ensure they provide the most value for money and benefit for our population.

Our workforce will be able to work across different locations, consolidating back-office functions and changing the way that we work, reducing unwarranted variations in provision of estate services

How will it be delivered?

Our vision for our future infrastructure is ambitious and will require commitment from us all to work differently. It will also require significant resources, in terms of capital and revenue investment, informed by population health data and data toolkits (such as the Activity Driven Estate Planning Tool (ADEPT)).

Delivery of our infrastructure strategy will be undertaken through a delivery plan, which will outline key actions we need to take to support achievement of our vision. Each enabling function will take the lead for delivery of actions within its respective area (i.e. digital, estates and workforce). The infrastructure delivery plan will be refreshed on an annual basis. We will be doing more in the future to look at the governance arrangements for these enabling groups and reviewing how they are structured to better align the use of resources.

What we are aiming to achieve next

Our vision for our future infrastructure is ambitious and will require commitment from us all to work differently. It will also require significant resources, in terms of capital and revenue investment, informed by population health data and data toolkits (such as the Activity Driven Estate Planning Tool (ADEPT)).

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- Activity Driven Estates Planning Tool (ADEPT) programme complete

- Ratification of BSW ICS infrastructure strategy
- Complete the construction of Trowbridge Integrated Care Centre
- Deliver BSW ICS infrastructure strategy delivery plan

Plan for the next 12 months:

Actions	Milestone
Activity Driven Estates Planning Tool (ADEPT) programme complete	March 2025
Ratification of BSW ICS infrastructure strategy	July 2025
Complete the construction of Trowbridge Integrated Care Centre	December 2025
Deliver BSW ICS infrastructure strategy delivery plan	July 2025 – March 2026

*Note that the above list reflects the current position at the time of publishing.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Activity Driven Estates Planning Tool (ADEPT) programme complete	✓	
Ratification of BSW ICS infrastructure strategy	✓	
Complete the construction of Trowbridge Integrated Care Centre		
Deliver BSW ICS infrastructure strategy delivery plan	✓	

What are we doing to address inequalities?

Our future estate will be shaped and informed by the changes to our care model, to deliver better patient, staff and visitor experience and to significantly improve the way we deliver services in the future enabling us to dispose of ageing buildings that are no longer fit for purpose and invest in sustainable new solutions to enable the delivery on integrated care such as the Devizes Integrated Care Centre (opened in 2023) and the Trowbridge Integrated Care Centre (currently under construction). We will also further utilise the existing public, community and third sector estate, working closely with our Local Authorities colleagues to support the one public estate agenda.

Procurement

Why is it important?

Effective procurement ensures timely access to medical supplies, equipment, and medications, enabling uninterrupted care. A robust supply chain is also critical for managing emergencies like pandemics.

ICBs and the regional system operate within tight budgets. Strategic procurement optimises spending, reduces waste delivers cost improvement plans, and avoids overstocking or shortages of essential items, improving overall resource allocation.

ICBs aim to improve population health. Efficient supply chains equitably distribute resources across communities and foster collaboration among providers, suppliers, and organisations, enhancing service delivery.

Procurement ensures quality medical products, promotes access to innovative technologies, and supports better diagnostic and treatment outcomes.

ICBs contribute to NHS sustainability goals by adopting green procurement practices and ensuring resilience in the supply chain for future healthcare needs.

Procurement ensures adherence to NHS and UK legal, ethical, and safety standards, promoting transparency and accountability in spending.

Modern supply chain management supports digital healthcare solutions, such as telemedicine and electronic health records, while leveraging procurement analytics for better decision-making.

Our long term goals

The aim of the procurement function is very simple and is based on a continuous cycle of improvement that is focused on

Patient Journey – ensuring product is in the right place at the right time.

Demand Management / Efficiency – ensuring we use our resources across the ICS in an efficient way as well as looking to remove and manage efficient demand through reducing wastage in the supply chain.

Reducing Variation – using our analytics systems to have informed evidence-based discussions to remove variation and standardise.

Collaboration – formalised across the ICS cluster, with NHS Supply Chain and other partners.

Value Creation – ensuring we unlock value for each organisation in the BSW ICS cluster.

Staff Development – building and delivering a capable, professional, high-performing and proactive workforce.

During 2024/25, we achieved the following:

- Community services tender re procured for new contract to go live on the 1 April 2025
- Record year of cost improvement delivery from procurement for the 3 acute trusts of £9m
- Procurement of a new Electronic Patient Record for the acute hospitals
- Supported the procurement of equipment and consumables for the commissioning of the Sulis Elective Orthopaedic centre which supports waiting list reduction and improve patient choice
- Worked with the Acute hospitals, community and ICB to improve formulary standardisation on wound care working with NHS Supply Chain and colleagues in neighbouring ICB.
- Standardised and rationalised hearing aids suppliers and items across the Acute Hospitals to release £280k of benefits.
- Understanding of our scope 3.1 supply chain emissions base lined for the 3 acute trusts

What is the impact of this work?

- **Cost Improvement -** £9m savings towards the overall ICB efficiency plan agreed for 2024/25
- **Demand Management –** Reduction and removal of variation from products stocked, driving standardisation and rationalisation of product range and ultimately stock optimisation opportunities.
- **Capacity** – supported the trusts in ways to increase capacity to support the delivery of elective recovery.
- **Standardisation of elective implants** – reduction down to 2 main providers for hips and knees across the region driving resilience and efficiencies through best possible pricing and aggregation of system wide volumes along with the wider south west

What we are aiming to achieve next

Streamlining procurement Services to make the most of collaboration

- **Objective**: drive value from a shared procurement service.
- **Action Plan**: Implement further projects through centralised and collaborative purchasing to reduce costs, negotiate long-term vendor contracts for essential technologies, and ensure equitable distribution across regions to enable effective CIP delivery and cost and efficiency improvement as well as innovation for improving patient experience.

Ensure right product right time at the right place

- **Objective**: Procure resources where that good response times and reduce risk of cancellations through having the right product available when needed
- **Action Plan**: Focus on supply chain logistics to ensure the right products are stocked with improved resilience and ability to share across the region.

Sustainable and Resilient Workforce Support

- **Objective**: Focus procurement on sustainable products and solutions to support NHS carbon reduction targets while improving staff experience.
- **Action Plan**: Implement green procurement practices, such as sourcing from environmentally responsible suppliers, and procure flexible workplace tools like e-rostering systems.

Ensure procurement is an effective enabler and partner for the delivery of the ICB plan

- **Objective:** Ensure timely access to essential medical supplies, equipment, and medications to improve patient care, particularly in critical areas like diagnostics, elective procedures, and emergency care.

Action Plan: Establish long-term supplier agreements to ensure consistent delivery. Use data-driven tools to forecast resource needs and automate inventory management. Leverage NHS procurement frameworks and share resources across trusts to reduce costs. Fully Implement e-procurement systems for transparency and efficiency. Source environmentally friendly products to support NHS Net Zero targets while maintaining care quality.

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Optimisation of Stock at all Acute Trusts meaning wastage is reduced and resilience improved	✓	✓
Identify carbon footprint of procurement and deliver improvement as part of the green plan and system plan		✓

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Working with NHS Supply Chain identify opportunities based on value-based procurement and patient pathway improvements working with our clinical team to improve efficiency and experience. Rather than just price.		✓
Improve the resilience of the supply chain across the region to better cope with supply disruption and stock out from suppliers.		
Clearer identification of spend drivers to support divisions to make informed decisions through improved analytics	✓	
Investigate consolidated logistics centre to supply per procedure to each Trust.		
Delivery of an improved value creation plan to deliver and improved plan of efficiency		