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. These plans will be subject to EQIAs and business cases as part of our normal governance processes.

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	Number of Care Plans recorded on Integrated Care Record
	Percentage of patients reporting care plan is helpful	
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 CollaboRATE (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

Indicative Alignment of Indicators to Delivery Groups

		Local Maternity & Neonatal	Children & Young People	Learning Disability, Autism & ND	Mental Health	Primary Care	Community Care	Urgent & Emergency Care	Planned Care	Pharmacy & Medicine	Workforce	Digital
1	Life expectancy at birth / Years of life lost			✓	✓	✓		✓				
2	Healthy expectancy at 65 / Average age entering frailty					✓	✓			✓		
3	Emergency bed days		✓	✓	✓	✓	✓	✓				
4	Infant mortality/ Pre-term births / Years of life lost from child deaths	✓	✓									
5	Under 75 mortality rates for major conditions / Years of life lost for major conditions					✓		✓		✓		
6	Dementia diagnosis rate / GP recorded dementia prevalence				✓	✓						
7	Premature mortality in adults with SMI / Years of life lost with SMI				✓							
8	Admissions for self-harm		✓									
9	Population employment inactivity										✓	
10	Staff Survey engagement score									✓	✓	
11	ICS organisation leavers rate										✓	
12	Percentage of patients reporting they have a care plan / Number of Care Plans recorded on Integrated Care Record / Percentage of patients reporting care plan is helpful	✓	✓			✓	✓					✓
13	Percentage of deaths in hospital						✓	✓				
14	School readiness		✓									
15	Smoking prevalence / GP reported	✓	✓			✓	✓		✓			
16	Obesity prevalence / GP Reported	✓	✓			✓	✓		✓			
17	Physical inactivity prevalence	✓	✓			✓	✓		✓			
18	Admissions for alcohol specific conditions	✓	✓			✓	✓		✓			
19	MMR vaccination rates / Flu vaccination rates		✓			✓	✓					
20	Hospital admissions for dental decay					✓						

Working in Partnership with People and Communities

Why is it important?

Ensuring that the voices of local people are listened to is so much more than a statutory obligation. Without these views, we cannot develop and deliver services that truly reflect the needs of the people we serve.

Local people and communities possess a unique perspective on the local health and care system, along with a real-world view of how services are delivered within our communities. It is essential that we listen to these insights as we plan for the future.

This Implementation Plan reflects the engagement we have undertaken over the last year and signals our intent to build upon the relationships and networks we have developed.

What we are aiming to achieve next

- Create a legacy for 10 Year plan engagement work – this is the start of our relationships and we will re-engage when the plan is published
- Work with our partners to share insights and opportunities to engage across communities and networks, recognising that there are many existing and trusted channels that will help us reach seldom heard groups
- Focus on CORE20PLUS5 groups - looking at the most effective ways to reach people and gain their insights and feedback to inform our work
- Work collaboratively with our system partners to deliver evidence-based campaigns i.e. hypertension, community-based care, vaccination etc that address health inequalities and support behaviour change.
- Continue to build patient and public forums, working to increase the diversity of group members and attendees via active recruitment to seldom heard groups.
- Proactively use the insights we gather so that we are a ‘listening’ organisation that understands the views, opinions and ideas of people and communities.
- Continue to be outward-facing, reaching out to where people live, work and spend time to have conversations about health and care
- Support the use of lived experiences to inform plans, programmes and projects
- Continue to work with our highly engaged network of Patient Participation Groups and support and encourage them in their work.

What difference will we make?

- Engagement and involvement best practice is embedded at every level so that accountability for our duties is at the heart of our work
- Maximise the shared expertise and commitment to engagement and involvement across our wider system
- Learn by hearing from people's lived experiences
- Better understanding of the people and communities we serve, reflected in the care and support that is available

Prevention

Why is it important?

Prioritising the focus on prevention is essential for delivering high-value care, improving population health, reducing future demand on services, and tackling health inequalities. Early identification and intervention help people live longer, healthier lives while ensuring resources are used where they have the greatest impact. Prevention spans:

- Primary - reducing risk factors and promoting healthier behaviours.
- Secondary - early detection and timely intervention.
- Wider determinants – addressing social, economic and environmental factors that shape health.

Our long term goals

- **Shifting the Balance Toward Prevention -** Prioritise prevention over treatment by reprioritising funding into self-care, community support, and primary care to reduce reliance on hospital-based care.
- **Embedding Prevention at Every Level -** Strengthen the focus on prevention at all levels - tackle obesity, physical inactivity, and smoking, enhance screening, case-finding, and proactive outreach and integrate prevention into long-term condition management.
- **Tackling Health Inequalities -** Focus on targeted prevention for disadvantaged communities, expanding early intervention in physical and mental health and addressing wider determinants of health.
- **Supporting Children and Young People -** Secure long-term health by increasing the proportion of healthy-weight children, embedding mental health support in education and community settings and promoting active environments. **Creating Health-Promoting Places -** Improve air quality, access to green spaces, active travel options and housing conditions in collaboration with partners.

What we are aiming to achieve next

- Further increasing focus of activities on prevention, including where resources allow, increasing investment.
- Implement system wide hypertension case finding and management programme, ensuring more people are diagnosed and supported earlier.
- Moving our mental health prevention case for change into a full business case.
- Work to address inequalities in access and outcomes to Treating Tobacco Dependency Services.
- Launch our weight loss strategy, supporting individuals and communities to achieve and maintain a healthy weight.

- Delivery Groups are the mechanism for implementing system-wide action on prevention, ensuring that initiatives are embedded within service delivery.
- Coordinate action through the Prevention Strategy Group, which will lead deep dives with each Delivery Group and review overall progress towards ICS strategy goals.

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 by Core20 and ethnic minority populations in accessing smoking cessation services. 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 service initiatives 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 services 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.

What we are aiming to achieve next

- Continue with our annual grant award process to support in place-based projects with a more targeted focus on Core20plus5 clinical areas.

- Delivery Groups are the mechanism for implementing system-wide action on inequalities, ensuring that initiatives are embedded within service delivery.
- Overall coordination of inequalities action will happen at a system level. The Inequalities Strategy Group will organise deep dives with each of the Delivery Groups to deep dive into their targeted inequality actions.
- The Inequalities Strategy Group will review whether the whole of our actions achieves the ambition set out in the Core20plus5 frameworks and if not identify gaps for future years.
- Build our outcomes framework dashboard which includes metrics that can be segmented by age, gender, ethnicity and deprivation. This will enable a more targeted focus on reducing inequalities in the outcomes we have identified that matter.

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) service user representatives and other partners including public health nursing, early years and regional representative from NHS England, Health Innovations Network and Regional Neonatal Operational Delivery Network representatives. They work collaboratively to provide excellent health care services, focusing on improving health and wellbeing outcomes through improvement activities and effective perinatal quality surveillance.

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 for maternity and neonatal 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
- Continued focus on reduction of inequalities of outcomes related to ethnicity and indices of deprivation and other protected characteristics for pregnant and birthing people and neonates.

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 and to progress the development of business plans for full neonatal digital EPR system.
4. A 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 ethnicity and deprivation and will support oversight of perinatal quality surveillance across BSW ICS.
5. To seek 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. **(Prevention Priority)**
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, including breast feeding rates in areas of deprivation and low uptake.
7. Continue to ensure service user experiences drive service improvement within maternity services
8. To participate in national funded pilot evaluation of Maternity and Neonatal Independent Senior Advocate role.
9. To review the Continuity/Consistency of Care 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	✓	
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?

- To review the maternity smoke free offer including TTD with a focus on uptake and quit rates in the Core20Plus populations.
- Continuing review of data/outcomes for women/birthing people from global majority/seldom heard groups. i.e. Black/Asian Women, Care leavers, GRTBS communities.
- Continuing to work with partner agencies/VCSE organisations/MNVP to ensure coproduction can occur which is representative of service user/population needs including those from areas of deprivation.
- 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 support care closer to home.

- 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.

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. **(Prevention Priority)**
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	✓	✓

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

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. **(Prevention Priority)** 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	✓	
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. There is representation from the LDAN Team across Delivery Groups. The expansion of Annual Health Checks through co-produced easy read communications and increased access to screening programmes, paying attention to our core 20 and ethnic minority communities we 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 2025-2030 - Bath and North East Somerset, Swindon and Wiltshire ICB) 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, development and implementation of the CYP mental health prevention investment business case **(Prevention Priority),** 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

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 (Prevention Priority).

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 – Supporting developments towards equality access to and improved health outcomes for both physical and mental health care through

joint work and advocation for parity of esteem across programme delivery groups.

- 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 Transforming 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.
- Contribute to implementing a system-wide, collaborative approach to the secondary prevention of cardiovascular disease by increasing case finding and optimising hypertension management, with a focus on the GP Contract, QOF, and Locally Commissioned Services to enhance optimal hypertension management, supporting Community Pharmacy in delivering the national blood pressure service in collaboration with the VCFSE sector and a pilot

programme testing blood pressure checks in dental practices (**prevention priority).**

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	✓	✓
Improve both the quantity and quality of blood pressure checks through outreach initiatives	✓	✓

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

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 **(prevention priority),** 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, 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 end of life care, 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

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 (**Prevention Priority)**	✓	
Hypertension Case Finding **(Prevention Priority)**	✓	
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. Deliver a Frailty pathway.	✓	
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 (e.g. Integrated Neighbourhood Teams) 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 Emergency Departments (ED's).

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 **(prevention priority)**

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 recognize that to ensure that people receive timely advice, guidance and support to enable them to access the right elective pathway for their needs, and 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 with primary and secondary care providers
- Make best use of our commissioned capacity across BSW to enable timely access

What we are aiming to achieve next

- Ensure that more than 65% of people on our waiting list wait less than18 weeks 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

- Implementation of our new Elective Orthopaedic Centre to provide ringfenced capacity for people needing orthopaedic treatment
- 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% To deliver a 5% improvement in patients having their first appointment within 18 weeks across BSW by March 2026	✓	
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 2026 *national standard*	✓	
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 2026	✓	
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 2026 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 – 75% by March 2026	✓	

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
80% of Cancer patients to be diagnosed in 28 days (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?

- Continue to embed Treating Tobacco Dependency services within in-patient services and taking a continuous quality improvement approach to increasing uptake, numbers of people supported to quit smoking and addressing inequalities in outcomes.
- Embed Health inequalities reporting in elective performance, and complete quarterly reviews of local waiting list data to address disparities related to inequality, deprivation and Core20PLUS5.
- Develop actions to address the most relevant local issues for patients so that we mitigate the current gap in length of time waiting for people from Core20 areas compared with those people in the general population.

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

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 **(Prevention Priority)**
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 **(Prevention Priority)**	✓	✓
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.

- Strengthen the health and wellbeing agenda to support staff in managing their own health and reducing the risk of disease progression (secondary prevention)

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	✓	✓
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?

- 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 tools are integrated with the NHS App wherever possible to create a single digital front door. We will also look at increasing uptake and utilisation of the NHS App to empower patients in managing long-term conditions and preventing disease progression **(Prevention Priority)**
- 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

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 Intelligent 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	✓	
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.

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.
- Explore how we work collaboratively with VCSE groups to support the needs of our population through sharing our estate and improving utilisation across the system.
- Prioritise action around disposing of ageing buildings that are no longer fit for purpose and investing in sustainable solutions in areas of greatest inequality.

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)).

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.

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.

- 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

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.

Prevention - building prevention criteria into tenders – with additional points for providers that offer upstream services

Reducing Inequalities - the Procurement Delivery Group will ensure that all commissioning and contracting decisions actively contribute to reducing health

inequalities by embedding inclusive and equitable practices throughout the procurement process. This includes supporting suppliers who are committed to workforce diversity, community engagement, and delivering services that meet the needs of underserved populations (Core20PLUS5).

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	✓	✓

How we are going to achieve this	Year 1 (25/26)	Year 2 (26/27)
Identify carbon footprint of procurement and deliver improvement as part of the green plan and system plan		✓
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		