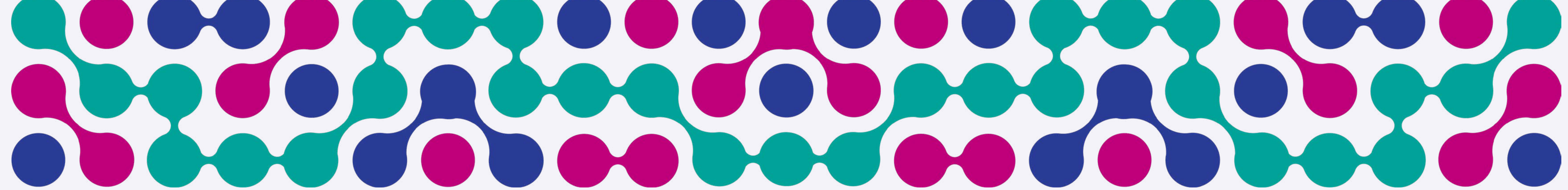
Bath and North East Somerset, Swindon and Wiltshire ICB

BSW Five Year Commissioning Plan

2026/27 to 2030/31



Welcome to our Cluster

Our purpose is to make sure we use every pound (and resource) in our system to deliver the greatest possible value for everyone we serve.

We will:

- Deliver a health system that is fit for the future.
- Improve the outcomes that matter most to people to improve their health and wellbeing.
- Direct our resources to where they make the biggest difference for everyone.
- Measure our success by focussing on measuring outcomes and quality relative to the resources used, rather than the volume of services provided.

Our cluster size:
3,928.84 total square miles

Swindon
B&NES*
Wiltshire
Somerset
Dorset
BCP**

* Bath amd North East Somerset
** Bournemouth, Christchurch and Poole

INTRODUCTION

Foreword by Cluster Chair

Rob Whiteman CBE, Chair NHS Bath & North East Somerset, Swindon and Wiltshire ICB, NHS Dorset ICB and NHS Somerset ICB.

It's a real privilege to introduce our new cluster, which brings together the collective strengths of NHS Bath & North East Somerset, Swindon and Wiltshire ICB, alongside NHS Dorset ICB and NHS Somerset ICB. By joining forces, we're combining the expertise, experience, and passion of three systems. Working together means we can share what we do best, learn from each other, and deliver care that is more consistent, more efficient, and more responsive to the people we serve. This is about planning for the future as one team; building a high-performing strategic commissioning organisation that can make bold, long-term decisions and achieve more for our communities as we move towards full merger in April 2027.

Many people in our communities live a significant part of their lives in poor health, and those in our most disadvantaged areas experience this earlier and more severely. This is not just a health issue; it affects families, communities, and the economic wellbeing of our region. We must act together to change this, doing this with kindness and compassion.

Our new cluster brings together our three Integrated Care Boards to work as one strategic commissioning organisation, ahead of our planned merger in April 2027. We need to plan for the long term, focusing on outcomes, and making sure every pound we spend delivers the greatest value for our population. It also means working differently, moving away from short-term fixes and towards evidence based and outcome-driven commissioning that tackles the root causes of ill health.

We know there remain significant challenges to overcome. We need to reimagine how we better support people in their communities; we will do this by building neighbourhood teams, working together with our partners across the NHS, local authorities, the voluntary and community sector and with the public. We want to improve access to GP services and NHS dentistry whilst at the same time continuing to improve access to mental health support, reducing waiting times for planned treatments and continuing the improvement we have seen over the past year in our ambulance response times.

We will make these changes supported by the latest technology and while creating a health and care system that is financially sustainable, with the workforce required to meet the care needs of our population. We also know that not everyone has the same experience, and those living in our most disadvantaged communities are least likely to receive the support they need to thrive. It is important to be clear that in the years covered by this plan, local partners will face difficult choices as a result of challenging financial positions, but we are committed to doing everything we can to deliver on the three key shifts set out in the Government's 10-Year Health Plan, moving more care from hospitals to communities, making better use of technology and preventing sickness - not just treating it.

None of our achievements, nor our aspirations for the future, would be possible without the dedication, talent and compassion of the inspirational people who work in our local health and care services – from across the statutory and the voluntary, community, and social enterprise (VCSE) sectors, and I would like to thank them for everything they do.

Our three ICB Strategic Commissioning Plans contain many shared ambitions and some locally set commissioning intentions. They set out the actions we will take to build on the solid foundations already laid and rise to the challenges we face.

At the time of finalising and publishing this, in February 2026, we are in a time of unprecedented change for the NHS. We are in a period of consultation with staff across our three ICBs as part of the government-led requirement

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to reduce our running costs by 50% ahead of our intended merger in April 2027. We have made some good first steps to work together, with Jonathan Higman appointed as our cluster chief executive in September 2025.

We also have a newly appointed cluster executive team, who are working hard to set us on the path to becoming a high-performing strategic commissioning organisation.

Alongside the changes to ICBs are the changes in NHS England and their merger with the Department of Health and Social Care. The NHS landscape is evolving, and we will continue to work with our partners, maintaining our focus on supporting our people and communities to live healthier lives.

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Cluster Introduction

Chief Executive Jonathan Higman, BSW ICB, Dorset ICB, Somerset ICB

I'm delighted to introduce our new cluster across Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, Dorset ICB and Somerset ICB. While we are currently three systems our cluster role and purpose are clear:

Our role is to transform our local NHS through exceptional commissioning and build an innovative health system fit for the 21st century that truly meets our communities' needs.

Our purpose is to make sure we use every pound (and resource) in our system to deliver the greatest possible value for everyone we serve. We will:

- Deliver a health system that is fit for the future.
- Measure our success by focussing on measuring outcomes and quality relative to the resources used, rather than the volume of services provided.
- Improve the outcomes that matter most to people to improve their health and wellbeing.
- Direct our resources to where they make the biggest difference for everyone.

The NHS 10 Year Health Plan focuses on three shifts, and this set the direction for how we commission services in the future:

- From hospital to community we will focus on delivering more joined up support close to home, with neighbourhood teams as the default place people get help.
- From analogue to digital we will focus on simple, secure digital tools like the NHS App and shared care records that make care easier to find, book and manage. We will look for digital innovation which will support people to live healthier lives.
- From sickness to prevention we will focus on earlier help to reduce the risks around smoking, high blood pressure, excess weight and harmful alcohol use, so fewer people reach crisis.

Most importantly, we will design our future services with people and communities, not for them. We will keep listening and work with people through neighbourhood plans, VCSE partnerships, health and wellbeing boards, and ongoing public engagement so local insight shapes decisions.

What we're already doing in common – our one shared approach

Across BSW, Dorset and Somerset, our plans point in the same direction. Together we will:

Commission for outcomes, not just activity. We will put outcomes frameworks into contracts and hold ourselves to reducing unwarranted variation and closing inequality gaps. This gives providers clear goals.

Build a Neighbourhood Health Service. Integrated neighbourhood teams (INTs) will wrap care around children and people with primary care, community services, local authority and VCSE partners working as one team.

Improve urgent and emergency care by strengthening the community front door. We will redesign same day and out of hours access, develop single points of access, and recommission Integrated Urgent Care (IUCS) so more needs are met safely at home.

Transform planned care pathways. We will expand advice and guidance and community based diagnostics; use data and clinical standards to reduce waits; and make follow-up more personalised and efficient.

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Focus prevention where it matters most. Systemwide tobacco dependence support, better hypertension case finding and treatment, integrated healthy weight support, targeted alcohol harm work and improved vaccination access are shared priorities.

Use data well. We will link up and responsibly use data across partners (e.g. Dorset's Intelligence & Insight capability, Somerset's Linked Data Platform, BSW's Outcomes and Intelligence Hub) and adopt national tools like the Federated Data Platform to target support and track impact.

Make digital the easy option and keep nondigital routes open. Shared care records, modern EPRs, NHS App integration, remote monitoring and inclusive digital support will be built into contracts and everyday practice.

Strengthen mental health and neurodiversity support. Earlier help in the community, crisis alternatives to inpatient care, dementia pathway improvements, and fair physical health checks for people with serious mental illness, are shared commitments across the cluster.

Improve support for children and young people. Speech and language, SEND reforms, family hubs, and fairer access to specialist care are shared areas of work so children get help earlier and closer to home.

Tackle dental access and oral health. We will stabilise the market, widen access – especially for vulnerable groups and strengthen prevention in schools and communities.

Align money to value. We will grow transformation funds, use pooled budgets (e.g., Better Care Fund) and outcome based payments to shift resources into prevention and neighbourhood care.

Invest wisely in estates and infrastructure. Modern, flexible spaces including community hubs, diagnostics closer to home, greener buildings will support the left shift and make access easier, especially in rural areas.

What's next

We are clustering now and intend to merge into a single strategic commissioning organisation by April 2027. This will help us plan at scale, reduce duplication and get the best value for our communities, while keeping decisions grounded in local needs. We will do this within the new NHS national framework, building the skills, data and market shaping capability that strategic commissioning requires.

Our promise is simple: we will keep people and communities at the heart of our commissioning intentions; we will measure the outcomes that matter; and we will work as one team across the 6 places in our cluster to deliver for our people and communities.

In BSW, we will continue to work as one system with the BSW Hospitals' Group, bringing together Great Western Hospitals, Royal United Hospitals Bath and Salisbury NHS Foundation Trust. This arrangement allows for unified leadership and a delivery model focused on improving quality, consistency and efficiency across acute services.

Through shared governance, joint decision making and collective use of resources, the Hospitals' Group has set out ambitions over the next five years through their Integrated Plan. This aligns to the ambitions at a cluster level and for our commissioning intentions.

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Purpose and Scope

This plan will set out how we intend to deliver our strategy for the five-year period, from 2026/7 to 2030-31.

It clearly articulates how the commissioning intentions will deliver the agreed outcomes, alongside the path to delivery with defined targets and trajectories.

The commissioning plan:

- Considers the ICB's integrated needs assessment and baseline mapping of current performance and quality of care. It then describes our commissioning intentions to improve population health outcomes and ensure equitable access to healthcare in line with our BSW Outcomes Framework.
- Provides clarity for healthcare providers and other partners on how the ICB intends to allocate resources, and what outcomes will be achieved as a result.
- Translates national and local strategic priorities into local action.
- Demonstrates how partners will practically work together to improve health outcomes.
- Describes the financial framework that will be used to support financial sustainability and value for money.

The plan will demonstrate also how the ICB embeds feedback and experience from patients, service users, people and communities to inform commissioning intentions and evidence partnership working across Public Health, local Government and the VCSFE sector to deliver on our agreed outcomes.

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Strategic Commissioning Overview

The recently published Strategic Commissioning Framework supports ICBs in commissioning NHS services by clarifying what strategic commissioning means in practice.

It updates the commissioning cycle and sets out the important enablers to support effective commissioning. We use the term 'strategic commissioning' to describe the updated approach to commissioning as presented in the framework.

Strategic commissioning is a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare.

As strategic commissioners, ICBs are accountable for securing the best value for the public from their NHS budget. They must consider how resources should be allocated to provide high-quality, accessible healthcare now and in the future, and ensure that the services they plan and commission uphold the rights and values set out in the NHS Constitution for patients, the public and staff.

ICBs will also work alongside government, including local government, to address the wider determinants of health, such as employment, in line with the government's health mission.

Strategic commissioning comprises four stages:

1. Understanding local context

CBs will use joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.

2. Developing long-term population health strategy

ICBs will focus on long-term population health strategy and planning and care pathway redesign. They will use national modern service frameworks and guidance to create the evidence base for new integrated models of neighbourhood care that maximise value, guiding the development of population health improvement plans.

3. Delivering through payor function and resource allocation

ICBs will understand and allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services to deliver the outcomes set out in the ICB strategy and population health improvement plan.

4. Evaluating impact

ICBs will rigorously evaluate the outcomes from commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence.

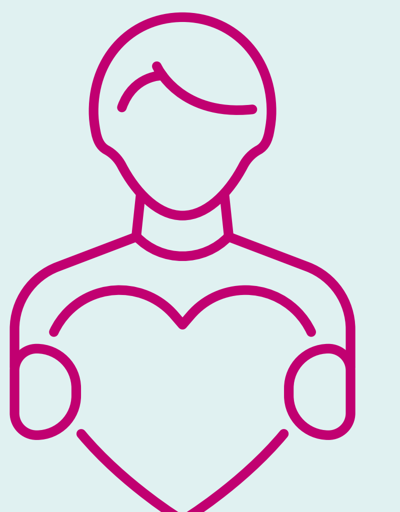
BSW CONTEXT

Summary of BSW Integrated Needs Assessment

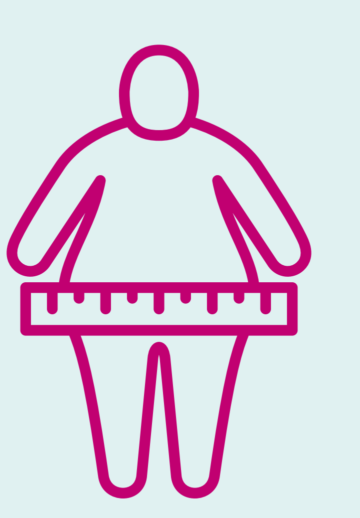
This section provides a concise summary of the Integrated Needs Assessment (INA) for BSW, drawing together key messages from the three place-based Joint Strategic Needs Assessments (JSNAs) and the system-wide Case for Change. It sets out the most significant drivers of need, inequality and demand across BSW and provides the evidence base that underpins the Medium Term Plan. The full INA, including detailed place-level needs, population segmentation and supporting analysis, should be read alongside this plan.

Local context and population health needs

3,000 children and young people live with 2 or more long-term conditions.



33% of year 6 children are overweight or obese.



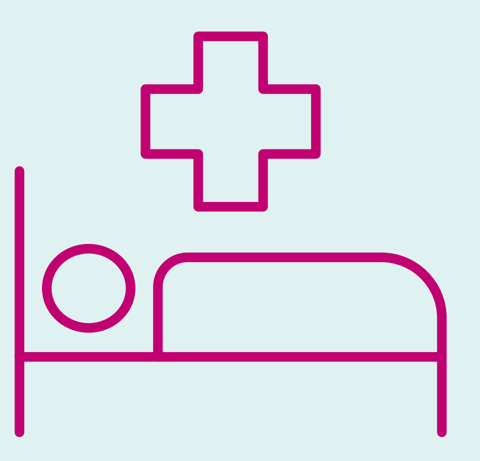
Under 18s acute hospital admissions for mental health conditions consistently higher than national average.

6% population growth in 15 years.

35% growth in the over 60 population.

£5m per year PbR cost pressure on Acute Inpatient, Outpatient and A&E activity through demographics alone.

115 additional acute bed demand in 5 years driven by demographic changes.



57% increase in adults over 65 requiring care in 15 years.

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Across BSW, overall population health outcomes compare favourably with national averages; however, this masks substantial variation by place, neighbourhood and population group. Swindon has a younger and more ethnically diverse population and the highest concentration of deprivation, while Bath and North East Somerset and Wiltshire have older population profiles, with rurality creating additional barriers to access related to transport, distance, connectivity and digital exclusion.

Wider determinants of health, including housing affordability, employment, education, transport and community infrastructure, are key drivers of both need and inequality across BSW. These factors intersect with deprivation and ethnicity, compounding disadvantage for some communities and contributing to poorer outcomes, earlier onset of long-term conditions and higher levels of preventable illness.

While a wider set of Core20PLUS inclusion groups are recognised locally, deprivation and ethnicity are the inequality dimensions where data is currently strongest and most consistent across the system, and where targeted action is likely to have the greatest impact.

The JSNAs also highlight the growing burden of long-term conditions and multi-morbidity, rising demand linked to frailty, and sustained pressure in children and young people's services, including SEND and mental health. Preventable risks remain key drivers of future ill health and demand, particularly smoking, excess weight and obesity, and alcohol-related harm, with risk and outcomes strongly patterned by deprivation and place.

Health and care economy – case for change

The system context is shaped by demographic change, increasing complexity of need and constrained capacity. BSW's population is ageing, with growth concentrated in older age groups over the next 15 years. This will materially increase demand for health and care services, particularly for people living with frailty and multiple long-term conditions and reinforces the need to shift investment and delivery models towards prevention, earlier intervention and community-based support.

Without changes to current models of care, demographic change alone will continue to drive sustained growth in demand for urgent and emergency care, acute bed capacity and ambulance services. These pressures sit alongside ongoing challenges in access and waiting times across hospital, community, mental health and dental services, and persistent workforce constraints across primary care, community services, mental health and social care.

Together, this evidence reinforces the need for the Medium Term Plan to deliver the hospital-to-community shift, strengthen integrated neighbourhood delivery, and reduce avoidable reliance on reactive, crisis-driven care.

Baseline outcomes and performance

The BSW Outcomes Framework provides the shared baseline for understanding performance, variation and inequality across the system. Three headline outcomes are used to inform our plans: life expectancy (and years of life lost), healthy life expectancy (and healthy years of life lost), and emergency bed days.

Oucome	Latest data date	BSW (latest data)	Benchmark (Average 6 peers ICBs)	Trend
Life Expectancy (Female)	2023	84.2	84.0	=
Life Expectancy (Male)	2023	80.8	80.3	=
Healthy Life Expectancy at 65 (Female)	2021-23	12.7	12.3	=
Healthy Life Expectancy at 65 (Male)	2021-23	11.4	11.1	=
Emergency Bed Days	9/24-9/25	43092		↑

Current performance shows BSW broadly in line with peer systems on life expectancy and healthy life expectancy, but with persistent inequalities between communities and a rising burden of poor health in later life.

BSW CONTEXT

Emergency bed days continue to increase, reflecting growing system pressure and highlighting where proactive, integrated community-based support has the greatest potential to improve outcomes and reduce avoidable demand.

Implications for the Medium Term Plan

Taken together, the Integrated Needs Assessment evidence base strongly supports the direction of travel set out in the Medium Term Planning Framework and the NHS 10 Year Plan, in particular the three strategic shifts:

From sickness to prevention
Tackling preventable risks and strengthening early intervention, particularly in communities experiencing the poorest outcomes.

From hospital to community
Eembedding integrated neighbourhood delivery and proactive support for people with complex needs, reducing avoidable crisis activity.

From analogue to digital
Improving data, segmentation and outcomes measurement to target resources more effectively and track impact consistently.

Activity and Performance

Integrated Health Boards and the wider NHS face significant challenges which include longer waiting times to access services and increased demand. To fully understand the pressures within the BSW system, we use an Integrated Performance Dashboard that provides oversight of key operational standards, including those set out in the NHS Oversight Framework (NOF). Performance is monitored at both ICB and provider level.

BSW ICS experiences many of the same system-wide challenges seen across the NHS. Although progress has been made against several performance standards, we continue to face particular pressures and benchmark as an outlier in Urgent and Emergency Care and in some elements of Elective Care.

We have identified improvement opportunities in the following areas:

Urgent and Emergency Care

Ambulance Category 2 response time and ambulance handovers: We have implemented a change in handover process at our acutes to ensure faster transfer of patients (within 45 minutes), which has significantly improved our handover times, although it has increased demand in A&E.

A&E 4 hour standard: BSW are performing nationally in the lowest quartile (Q2) for 4-hour performance at Type 1 A&E departments, and challenges remain in meeting operational planning ambitions set out for 2026/27- 28/29.

Non Criteria to Reside (NCTR): We continue to have a high number of patients in BSW Acute hospitals and in Intermediate Care Beds who are occupying a bed in hospital after their discharge ready date. To achieve improved hospital flow, we need to reduce the time between discharge ready date and the actual discharge date across all pathways.

Elective care

Return to Treatment (RTT): the system is improving RTT 18 week and 52 week performance in line with 2025/26 plans though RUH are not meeting plans. BSW will be challenged to meet the constitution standards of 92% patients waiting 18 weeks or less by 2029. The increase in the waiting list in year by 3.3% is a national outlier and the waiting list needs to reduce by almost 50% to 57,520 to support the 92% standard delivery by 2028/29.

Cancer services: 28 day faster diagnosis and 62 day referral to treatment performance are below target and national average for the System and Acutes, although challenging robust plans are in place to meet the MTP plan targets.

Diagnostics: although 6 week performance is in line with regional performance, a significant improvement is required to meet the MTP plan targets and the national standard of 1% by March 29.

BSW CONTEXT

Mental Health and Learning Disabilities
Talking Therapies: numbers of courses completed is below plan. Service development will be needed to improve the number of adults receiving a course of treatment in Talking Therapies.

Dementia Diagnosis: Our diagnosis rate is in line with regional performance though substantially below national performance and target. A significant improvement is required to meet the national standard.

Children and Young People (CYP): CYP Access (age 0 to 17, 1+ contacts) BSW are bottom quartile for CYP Mental Health Access rate per 100,000 and improvement is required.

Learning Disability: Number of people with a Learning Disability and / or autism admitted to an inpatient unit is slightly above plan.

Autism and Attention Deficit Hyperactivity Disorder (ADHD): Assessment waiting times for children, young people and adults remain long with increasing spend on NHS Right to Choose activity

Primary Care and Community care
Dental: Delivery of planned units of dental activity (regular and urgent) needs to increase to meet BSW ambitions and ensure we meet our nationally agreed targets, including the implementation of the dentistry contract reforms focusing on enhancing access to urgent/unscheduled care.

GP appointments: Ensuring there are sufficient GP appointments made available for patients including same day appointments is a priority to help reduce pressures on the urgent and emergency care system. The roll out of online triage systems across BSW also aim to support this.

Effectiveness and experience of care
Infection rates: Improving infection rates across all services is a priority to reduce closure of beds and support flow through patient pathways, improving patients experience of care.

BSW ICB is committed to actively managing the local health and care market to ensure services are sustainable, high-quality, and responsive to population needs. We will work closely with our Providers to support service resilience, innovation, and collaborative approaches, while identifying opportunities to address gaps or improve patient outcomes.

During 2026/27, we will strengthen our understanding of provider capacity, workforce pressures, and investment requirements, engaging providers in shaping future service models. Where appropriate, commissioning levers will be used to secure high-quality, cost-effective services that deliver equitable access and improved patient outcomes.

Quality

Quality in BSW is defined by safety, clinical effectiveness and patient experience. Our approach is anchored in collaboration, transformation, and equity, ensuring all partners contribute to delivering high quality, person centred care.

The Juran Trilogy underpins our quality planning, control and improvement, as set out in the BSW Quality Assurance and Improvement Framework (QAIF). This framework aligns with national guidance and sets out governance, metrics and patient reported outcomes to monitor quality across the system.

Over the next five years, we will ensure services are safe, effective, well led, sustainable and equitable. Communities and people with lived experience will shape service design, and experience data, such as surveys, Friends and Family Tests (FFT) and complaints, will drive continuous learning.

Shared learning will be strengthened through system governance and Communities of Practice in areas such as patient safety, mortality oversight, infection prevention, digital clinical safety and maternity services.

The Patient Safety Incident Response Framework (PSIRF) will continue to embed a compassionate, system based and proportionate approach to learning from safety incidents. The BSW Patient Safety Specialists Community of Practice will support consistent delivery of PSIRFs across providers. Monitoring of provider PSIRPs will be strengthened through contractual governance and shared learning groups.

BSW CONTEXT

The BSW System Quality Group (SQG) will continue to provide system wide assurance, ensuring statutory duties are met and risks addressed. Its role includes:

- Oversight of quality performance and improvement.
- Addressing inequalities and unwarranted variation.
- Supporting thematic learning.
- Triggering rapid review processes where early concerns emerge.
- Embedding Equality and Quality Impact Assessments (EQIAs).
- Ensuring timely adoption of new evidence and national guidance.

This governance ensures a consistent, transparent approach to quality across the system.

Quality Focus

Maternity and Neonatal Services

BSW will incorporate learning from national maternity reviews into local planning. The rollout of the Maternity Outcomes Surveillance System (MOSS) will strengthen early safety monitoring. Additional tools such as a regional risk dashboard, inequalities dashboard, maternity Operational Pressures Escalation Levels (OPEL) reporting and the NHS Maternal Care Bundle will support continuous improvement.

Infection Prevention and Management

The BSW Infection Prevention and Management Collaborative will maintain oversight of infection prevention standards, surveillance of healthcare associated infections and alignment with Antimicrobial Resistance (AMR) / Antimicrobial Stewardship (AMS) priorities. This will support the safe delivery of care.

Urgent and Emergency Care (UEC)

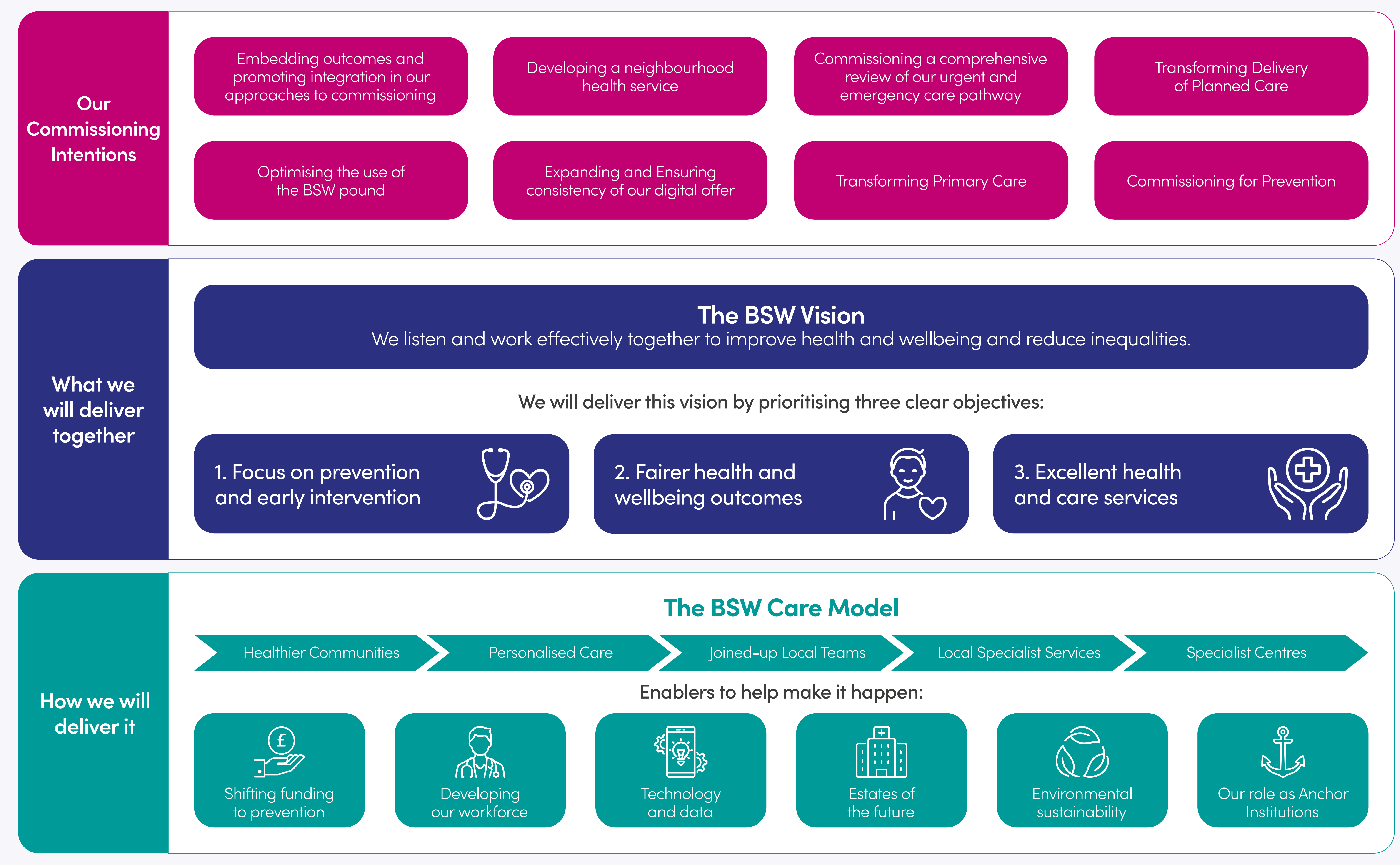
UEC quality will be monitored through defined metrics and a UEC outcomes framework. Providers will continue implementing national principles for corridor care, with a system wide aim to eliminate corridor care during the strategy period.

All Age Continuing Care (AACC)

The ICB will improve quality, consistency and efficiency in all age continuing care, ensuring statutory duties are met and variation reduced. Preparation will continue for full transition to the AACC Data Set v2.0 by 2027, improving oversight and assurance.

VISION, AIMS AND OBJECTIVES

Vision, Aims and Strategic Objectives



VISION, AIMS AND OBJECTIVES

Our Vision

We listen and work effectively together to improve health and wellbeing and reduce inequalities.

In July 2023, BSW published its first Integrated Care Strategy, setting out the ambitions of health and care partners to improve services for local people. This was also informed by the Health and Wellbeing Strategies set by each of our Local Authority Health and Wellbeing Boards. The Strategy set out a vision for the next five years, uniting partners behind three clear objectives:

1) Focus on prevention and early intervention
2) Fairer health and wellbeing outcomes
3) Excellent health and care services

Following this, we worked with partners to produce the first Implementation Plan demonstrating how we work together as a system and at place level to deliver our ICP Strategy through our Integrate Care Partnership 'BSW Together'. Aligning to the NHS 10-Year Health Plan, we are moving to a more ambitious tone and pace, focusing on the three key shifts: Hospital to Community, Sickness to Prevention and Analogue to Digital.

Our ICS Strategy from 2023-2028 describes our vision and ambitions for BSW in more detail. Our existing plans align to the 10 year plan though a shared emphasis on prevention, equity, and integrated care and both plans support transformation of outpatient and diagnostic services, with a common vision for personalised, community-based care.

To meet our aim of becoming more ambitious in tone and pace, we have identified that we need to reflect the NHS Plan's urgency and radical tone in our five year plan and embedded digital transformation, genomics, AI, and employment support to truly respond to these strategic shifts. The next section sets out our more detailed strategic commissioning intentions over the next five years.

COMMISSIONING INTENTIONS

Strategic Commissioning Intentions 2026/27-2030/31

Our strategic commissioning intentions set out how BSW ICB will commission to deliver the NHS Ten Year Plan as we move into a strategic commissioning role working across our BSW, Dorset, Somerset Cluster.

These intentions build on the work that we have already put in place across BSW to implement our BSW Care Model. They provide a roadmap for how we will continue this work, whilst aligning with the Ten Year Plan. They are deliberately strategic in nature; further detail on implementation will be developed and agreed throughout the planning round.

These intentions have been developed in dialogue and discussion with stakeholders and are widely supported. There is a strong commitment across our system to develop on the national vision of shifting care from hospitals into our communities and supporting our populations to stay well for longer.

This will help us improve outcomes for our population, in line with the commitments set out in the BSW Outcomes Framework.

BSW faces a significant financial challenge, and we recognise that addressing this can only be achieved through collective action and by delivering the three strategic shifts set out in the Ten Year Plan. This requires resetting how we work together across the system, including focusing our collective efforts on reducing unwarranted variation and narrowing inequalities in outcomes, so that all communities benefit equally from the changes we make.

As part of this reset, we will be clear about our expectations of providers and in turn, what they can expect from the ICB in its role, to support this, we will develop and agree a new accountability framework for the system so that all parties are clear on the roles and responsibilities that we are respectively undertaking.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve outcomes for our population over the next five years. We note that these are strategic commissioning intentions. They are structured thematically, not by provider as we are seeking to enable whole pathway change.

They also do not cover the entire range of work that is undertaken by the ICB or partners, this is set out in our BSW Implementation Plan and the Companion Document.

Links with BSW Outcomes Framework

Please refer to Appendix 1 for how the commissioning intentions align with the BSW Outcomes Framework and Inequalities Indicators.

1. Embedding outcomes and promoting integration in our approaches to commissioning

As part of delivering on our care model we developed a system outcomes framework that sets out the improvements in health, equity and quality of life that matter most to our population. This was approved by the BSW ICB Board earlier last year. We want to ensure that all providers are working in support of delivering improved outcomes.

For 26/27, we will embed our system outcomes framework in our contracts with an explicit ask of providers to demonstrate how they are contributing to relevant outcomes, delivering national best practice, acting on patient reported outcomes and reducing inequalities.

Coalescing around our Outcomes Framework is key to shifting from organisational-led planning and delivery of care, towards a way of working that supports delivery of better outcomes through integrated pathways.

Population health management will underpin this shift. By bringing together data, evidence and clinical insight, we will identify the groups and neighbourhoods where outcomes are poorest, target resources to those with greatest need, and design services that prevent ill health, reduce inequalities and support people staying well at home.

This also means having real discussions about value. We will identify where care can be delivered in a setting that adds greatest value for patients and populations, and where duplication or low-value services can be reduced. In doing so, we will explicitly prioritise action in communities experiencing the poorest health and greatest inequity and engage local communities in shaping these changes. This will therefore also require a comprehensive review of our services with a clear ambition to decommission services that are duplicative or not delivering value.

We will engage with local communities as we do this work making sure that we embed service user voices to co-produce service developments. This includes consistent consideration of health inequalities across all commissioning intentions, with outcomes monitored by deprivation, ethnicity and inclusion groups where data maturity allows.

Progress to date

We have made significant progress in this area to date through our portfolios of work supporting delivery of our overarching implementation plan. This has included:

BSW Outcomes Framework established and being embedded: The Outcomes Framework and interactive dashboard are in place and being rolled out through the Intelligence Hub, supporting consistent use of trends, benchmarking, place- and Primary Care Network-level variation, and inequalities segmentation, alongside guidance and training to support adoption.

Outcomes-led governance and deep dives: The Outcomes Framework is being used to structure Population Health Board deep dives and system performance conversations, bringing partners together around variation and inequalities and informing integrated pathway and commissioning work (e.g. dementia, with a focus on improving diagnosis rates and quality of care).

ICBC contract – outcomes-led integration: Our Integrated Community Based Care (ICBC) contract was commissioned using an ICBC outcomes framework (developed ahead of the BSW Outcomes Framework); it aligns closely and is being reviewed to strengthen alignment further. ICBC provides the delivery platform for integrated models across primary, community and acute care, with a consistent focus on outcomes and inequalities; this includes commissioning work underway for transformed LDAN pathways (reducing out-of-area placements) and embedding CYP early help requirements through ICBC aligned to neighbourhood health and Family Health Hubs.

Pooled funding (Better Care Fund/Section 75) strengthening integration and accountability: Through pooled funding arrangements we have strengthened integration and outcome accountability via joint ICB–Local Authority oversight, reporting against BCF metrics, shared performance dashboards and routine provider assurance/contract review, strengthening our ability to track impact, value for money and equity of access.

COMMISSIONING INTENTIONS

Neighbourhood and place governance aligned to outcomes: Neighbourhood governance and assurance is in place through Health and Wellbeing Boards, Integrated Care Alliances and the BSW Neighbourhood Health Working Group, bringing system partners together to support integrated delivery. The Outcomes Framework is embedded in Neighbourhood Health Plans to provide baseline outcomes and place-based inequalities insight to drive action on prevention, inclusion and equitable access.

Ageing Well / frailty integration: The BSW Ageing Well Strategy is in place and implementation is underway to deliver more integrated frailty pathways across acute and community settings. This work is informed by a completed Frailty Triage in the Emergency Department (Frail t-ED) review (Getting It Right First Time – GIRFT) which included recommendations for Royal United Hospitals Bath (RUH) and Great Western Hospital in Swindon (GWH). Further work is also underway to scope direct access to acute frailty teams and reduce variation and duplication across providers.

System-wide alignment to outcomes (primary care): Primary care priorities and metrics for 2025/26 have been explicitly mapped to Outcomes Framework indicators, strengthening shared focus on outcomes, prevention and inequalities.

Key Workstreams

Over the next five years we will deliver these intentions through the following workstreams:

Outcomes-based commissioning and contracting: Embed the BSW Outcomes Framework into an increasing number of contracts, including commissioning routes in primary care (GP, community pharmacy, optometry and dental), supported by a cluster-wide review of local enhanced/commissioned services (building on the recent BSW LCS review). The ICB recognises the need to identify and agree the proportionate approach to measuring and reporting outcomes for the VSCE sector in undertaking this ambition.

Align contract frameworks to transformation priorities: Continue to develop and refine the ICBC outcomes framework, strengthening its alignment to the BSW Outcomes Framework and ensuring it is mapped to, and used to track, transformation priorities.

Neighbourhood intelligence to inform joint commissioning: Use Neighbourhood Health data and impact assessment processes (IIA) to inform joint commissioning, capacity planning and prioritisation at place and neighbourhood level.

Partner and community insight built into decisions: Strengthen decision cycles by routinely incorporating provider and VCSE feedback, alongside performance and outcomes data.

Build the outcomes evidence base (Patient Reported Outcome Measures / PROMs and placeholder metrics): Strengthen contractual requirements for providers to collect, submit and use outcomes data, particularly patient-reported outcomes and other agreed measures, to address current gaps in the Outcomes Framework. This includes developing and implementing data collection for placeholder measures where data is not yet available (e.g. quality of care in dementia), alongside national best practice and inequalities reporting.

Use outcomes to drive collaboration: Use the Outcomes Framework as a practical mechanism to align providers around shared priorities and support collaboration in delivering the BSW care model.

Place-based Population Health Management (PHM) to guide investment and disinvestment: Strengthen population health intelligence and segmentation at place level to target high-need cohorts and geographies and to inform investment and disinvestment decisions within pooled budgets.

Value reviews and reducing duplication: Systematically review services for value and impact and decommission or redesign where services are duplicative or not delivering best value, reinvesting where this will improve outcomes and equity.

COMMISSIONING INTENTIONS

What it means for the Three shifts

Sickness to Prevention

Commissioning decisions will be anchored in outcomes and prevention impact, using use the BSW Outcomes Framework and place-based PHM segmentation to prioritise preventive investment, target high-need cohorts and geographies, and track disproportionate improvement for groups experiencing the poorest outcomes.

Evidence-led reinvestment will strengthen value reviews and disinvestment/reinvestment decisions so funding shifts towards interventions with the greatest prevention and inequalities impact.

Hospital to Community

Contracting and pooled budget levers to support “care closer to home” will embed outcomes and integration expectations across an increasing number of contracts and pooled arrangements, including Integrated Community Based Care (ICBC) and Better Care Fund (BCF) /Section 75. This will help align providers around shared outcomes and integrated pathways.

A single set of place expectations, using outcomes-based alignment across place governance (Integrated Care Alliance and neighbourhood plans) will enable partners to work to a consistent set of priorities and measures, reducing duplication and unwarranted variation.

Analogue to Digital

Outcomes data will be a core requirement, which will strengthen contractual expectations for outcomes measurement (including PROMs) and require development/collection of data for Outcomes Framework “placeholders” where gaps exist (e.g., quality of dementia care), improving the evidence base for commissioning.

Using place analytics for decision-making will build consistent place-level analytics capability to support targeting, monitoring and evaluation, alongside inclusive access approaches to avoid digital exclusion (with delivery actions set out in the Digital commissioning intention).

COMMISSIONING INTENTIONS

2. Developing Neighbourhood Health

Neighbourhood Health is BSW's integrated approach to planning and commissioning care in or around people's lives and homes and where they receive care. It provides a shared framework rather than a single programme, bringing together the NHS, Local Authorities, the VCSE sector and communities around agreed priorities, outcomes and population groups at neighbourhood level.

Its purpose is to shift care from reactive, fragmented provision to earlier intervention, prevention and coordinated support, especially for people with complex or long term needs and other key groups such as children and young people. Local engagement with our population is essential in shaping priorities and services' long term transformation plans.

Neighbourhood Health Plans bring this vision to life in local settings. They align partners around shared outcomes, population needs and inequalities, using population health insight to support targeted, locally responsive commissioning aligned with wider BSW priorities and the BSW Outcomes Framework.

Integrated Neighbourhood Teams (INTs) bring together community health, primary care, Local Authority and VCSE partners to provide coordinated, multidisciplinary support for people at risk of deterioration or hospital admission. Working as "teams of teams," they will align roles across organisations and strengthen joint decision making. Early priorities will focus on those at highest risk, using risk stratification to identify people with frailty, multiple long-term conditions, care home residents and housebound individuals.

Neighbourhood Health strengthens Place as the core setting for joint commissioning and governance, supported by pooled budgets such as the Better Care Fund and Section 75 agreements. Additional ICB delegated budgets may follow as neighbourhood models mature. The framework also supports the local delivery of wider system reforms across prevention, primary care, community services, urgent care and planned care. Its flexibility allows adaptation to local population differences while maintaining a shared strategic direction across BSW.

Delivery in BSW is underpinned by the Integrated Community Based Care (ICBC) contract led by HCRG Care Group, who are establishing integrated community partnerships to deliver more joined up, personalised and preventative care closer to home from birth to end of life. A stepped care model, including a digital front door and single point of access, will support same day urgent care and smoother navigation between services. Neighbourhood based contracting arrangements with general practice will evolve alongside the ICBC contract, with existing GP contracts maintained during transition.

From April 2026, the digital front door, single point of access for community services and INTs will go live, with more outpatient and diagnostic services shifting into neighbourhood settings supported by digital tools like the NHS App. Neighbourhood footprints will align with PCNs with agreed priority cohorts and standardised care planning and escalation processes. Over time, INTs will move from reactive demand management toward proactive, preventative neighbourhood working.

Neighbourhood Health is also the primary vehicle for reducing health inequalities. Working at neighbourhood level enables partners to identify variation in access, experience and outcomes. Population Health Management data insight, including Core20 deprivation, ethnicity and inclusion indicators will guide the development of proactive, preventative and integrated support.

We recognise that shifting care from acute to neighbourhood settings will also require a gradual rebalancing of resources, aligned to impact, workforce capacity and financial sustainability, overseen through place based governance and system assurance. Variation in provider maturity is recognised, and the ICBC contract and future GP arrangements are designed to support development over time.

COMMISSIONING INTENTIONS

Progress to Date

- Core infrastructure for INTs, the digital front door and single point of access has been established through the first year of the ICBC contract. VCSE partnerships are strengthening, pathways are being harmonised and new workforce roles such as navigators are being introduced. INTs will be live by April 2026.
- A 10 year Integrated Estate Plan is underway to support neighbourhood delivery, with neighbourhood hubs planned from 2026/27.
- VCSE investment is being monitored with a contractual commitment in the ICBC contract to increase spend from 4 to 5% by 2027/28. VCSE partners currently also deliver £5.6m of services via the Better Care Fund, supporting prevention and inequalities reduction.
- Collaboration with Local Authorities and providers is aligning social care and education reforms such as the Families First Partnership Programme with health reforms to reduce duplication.
- Progress on prevention pathways includes hypertension case finding, community health checks, health coaching, community empowerment and an integrated weight management model.
- The system wide frailty strategy has been delivered, and community vaccination infrastructure strengthened.
- Risk stratified Make Every Contact Count (MECC) enabled pathways are being developed across community, primary and acute care.

Key Workstreams

Neighbourhood Health Plans: Develop locality-based plans using PHM and risk stratification, working with Health and Wellbeing Boards to address wider determinants of health for adults, children and young people.

Embedding INTs: Establish INTs as the organising structure for neighbourhood delivery with flexibility in pace and scope; prioritise people with long term conditons in the first instance, also children, young people, people with learning disabilities and autistic people as teams mature.

ICBC Delivery: Implement the stepped care model and six core components of Neighbourhood Health with PCNs, Local Authorities and VCSE partners.

Joint Commissioning: Strengthen shared accountability through pooled budgets aligned with neighbourhood priorities.

Outcomes and Evaluation: Develop neighbourhood level outcome measures and evaluation aligned with the BSW and ICBC outcomes frameworks.

Wider Primary Care: Use capacity across pharmacy, optometry and dentistry to support access, urgent care and prevention.

Provider–Community Relationships: Build stronger relationships with local communities to increase trust and participation.

Outpatient and Diagnostics Transformation: Shift activity into community settings, expanding year on year.

What It Means for the Three Shifts

Sickness to Prevention

Neighbourhood Health supports a stronger focus on prevention and early intervention, aligned to national public health priorities and delivered through our neighbourhood teams and community stepped care model. This includes expanded vaccination screening and proactive case finding and use of PHM will drive earlier intervention. Over time, genomics will support earlier identification of people at risk of long term conditions.

Hospital to Community

More care will be delivered in neighbourhood and home settings. INTs will coordinate multidisciplinary support, reducing avoidable admissions. On a phased basis, the number of integrated care centres and neighbourhood hubs will be expanded across BSW, allowing patients to access several services as part of a "one stop shop" offer and professionals to share accommodation, increasing communication and multi-disciplinary working.

Analogue to Digital

The digital front door (from April 2026) will simplify access to support, integrated with the NHS App. Through the ICBC contract, the digital front door for patients will enable them to have easy access to information, make

COMMISSIONING INTENTIONS

referrals and request support. As part of our community and neighbourhood transformation, use of the integrated care record will increase 10% year on year, and remote monitoring will expand by 25% each year to support people with long term conditions and those cared for at home.

Professionals will also have access to all diagnostic tests for their patients. This will support the underpinning of digital enablement of Neighbourhood Health to positively impact on care delivery.

COMMISSIONING INTENTIONS

3. Commissioning a Comprehensive Review of our Urgent and Emergency Care Pathway

We know from a wealth of evidence - including our case for change, an ICB-led review into demand, and our recent engagement activities - that we need to ensure we have a sustainable urgent and emergency care (UEC) pathway that meets the needs of our current and future population. We have already made significant investments in some areas of our UEC pathway, including the development of Urgent Treatment Centres (UTCs) and Same Day Emergency Care (SDEC) services in our acute hospitals.

We have also commissioned BSW Community Health as part of our Integrated Community Based Contract (ICBC) contract to review the provision of some of our UEC services e.g. Minor Injury Units (MIUs) and virtual wards (Hospital at Home).

It is our intention to work with all partners to undertake a collective review of urgent and emergency care demand and capacity the whole pathway, with the aim of ensuring that we have a plan to deliver a pathway of care that is fit for purpose for our future population and the envisaged demand. This will need to include services that we jointly commission with other ICBs as well.

We will undertake this over the rest of this year, with the aim of identifying any gaps in our existing commissioning and including them in our detailed commissioning intentions for next year.

Progress to date

Same Day Emergency Care (SDECs): Undertaken a comprehensive review of existing SDEC pathways, along with peer-to-peer learning and implementation of profiles on the Directory of Services.

Frailty Strategy / Pathways / Frail t-ED (GIRFT): Embedded outcomes and promoting integration in our approaches to commissioning, developing a systemwide Frailty Strategy that all partners are signed up to.

Co-located Urgent Treatment Centre (UTC) at Salisbury Foundation Trust (SFT): In line with national recommendations, the capital works are underway.

Hospital at Home maximisation: Embedded outcomes and promoting system integration in our approaches to commissioning to provide equity of services.

Hear and Treat and See and Treat: BSW have good Hear and Treat rates compared to other systems, work in place to maintain this and further work to increase See and Treat rates.

Mental Health: Vehicles and service desk now in place with MH vehicles live from October 25.

Pharmacy First: Expansion with Pharmacy First referrals live from RUH and planned go live for GWH in Q3.

Enhanced ED: Validation via Healthhero Pilot undertaken Jan – Mar 25 which showed positive outcome. Healthhero commissioned from 24th October until end March 26 to run this service.

Care Coordination Centre: Maximisation of Care Coordination Centre which is led through Community Delivery Group and sub-contracted by HCRG to Healthhero.

Care Home Beds: Commissioned additional community hospital and spot purchase care home beds to support the system over Winter.

Over the next five years we will deliver these intentions through the following workstreams:

Key Workstreams

- Identify any gaps in our current commissioning by undertaking an end to end pathway review and including them in our detailed commissioning intentions for next year.
- System-wide engagement to develop pathways providing equity of service for patients across BSW. Strengthen community offers and dedicated specialist support to reduce preventable crisis attendances and admissions, learning from commissioning of inpatient, outreach and enhanced community offer in 25/26.
- Commission Hospital at Home for other pathways, for example paediatrics.

COMMISSIONING INTENTIONS

- Review of Urgent Treatment Centres, to support the shift from MIUs to UTCs, as well as implement co-located UTC at SFT and review of UTC at RUH with opportunity to relocate.
- Develop a fully joined up pathways for frailty patients.
- Strengthen the Place commissioning role in flow and discharge through the Better Care Fund and Section 75 agreements and use pooled funding to integrate intermediate-care capacity across NHS and social-care partners.
- Increase use of services in Community Pharmacy, Optometry and Dentistry, to support patient access and reduce pressures on general practice and UEC settings.
- Use our commissioning levers to end the use of inappropriate out of area placements for mental health so people remain connected to their support networks and local teams.
- Further the implementation of our mental health strategy, including commissioning mental health community rehabilitation, and crisis alternatives reserving inpatient beds for the most complex needs.
- Opening of new inpatient unit for people with a Learning Disability and/or autism to receive mental health care closer to home and provision of an outreach team to reduce preventable admissions.

What it means for the Three shifts

Sickness to Prevention

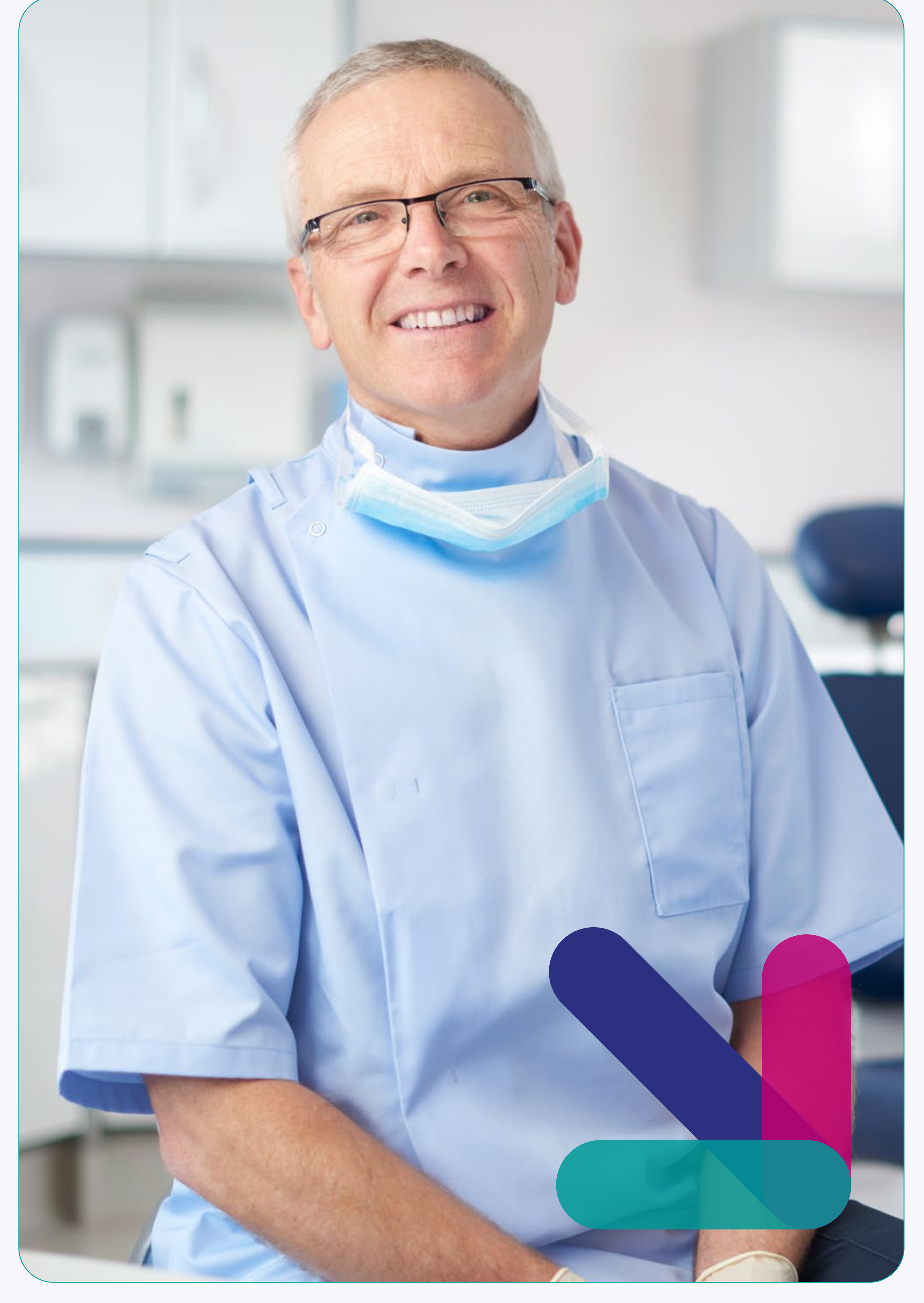
Signposting for patients and public will encourage self-care and prevention.

Hospital to Community

The shift will increase the use of services in the Community Pharmacy, Optometry and Dentistry and Commissioning Hospital at Home for pathways like paediatrics will reduce pressure on hospitals.

Analogue to Digital

The use of digital technologies to enable a more streamlined pathway for patients and utilise tools such as remote monitoring. It is anticipated that there will be a significant contribution of digital tools on increasing access to same-day or next- day scheduled care where clinically appropriate, positively impacting UEC performance.



COMMISSIONING INTENTIONS

4. Transforming Delivery of Planned care

The NHS Elective Reform Plan sets out a clear requirement for large scale transformation across planned care services. This transformation is vital to achieving the national Referral to Treatment (RTT) 18 week standard by March 2029 and is central to BSW's commitment to shifting investment and focus toward prevention, early intervention and community based support. Delivering elective care more effectively and more locally is essential for improving population health outcomes and for ensuring that specialist hospital capacity is reserved for those who genuinely need it.

A key priority for BSW is building a stronger and more integrated partnership across primary, community and secondary care. The ambition is for most people to be managed within neighbourhoods wherever appropriate, avoiding unnecessary hospital attendances and ensuring that acute services concentrate on complex and specialist care. To support this shift, BSW will explore opportunities for radical change in service delivery and recommissioning.

We are working with providers to agree the focussed priority list – our initial work suggests a focus on Ear, Nose and Throat (ENT), gastroenterology, respiratory, urology and cardiology in line with national elective reform priorities. Dermatology, which is recognised as a fragile specialty across the system, will also be reviewed early.

This work will be undertaken collaboratively with the BSW Hospitals Group, HCRG and Primary Care to ensure shared clinical leadership, robust analysis and alignment with system priorities.

Digital technology and new ways of working will be major enablers of a more streamlined and efficient elective care pathway. BSW will move from traditional referral models to a "discuss with" approach built on joint decision making between primary and secondary care, supported by digital platforms, improved advice and guidance pathways, and shared clinical tools. The ICB's mixed provider landscape, including acute hospitals, the independent sector and community based providers, offers flexibility that can be used to increase capacity and reduce delays.

However, waiting list analysis consistently highlights inequalities in access and outcomes. People living in more deprived communities, children and young people, and inclusion health groups wait longer on average for treatment. These disproportionate waits are linked to poorer outcomes and widening health inequalities. To address this, equity will be a core design principle for all pathway transformation work. BSW will focus on improving access, reducing unwarranted variation, and targeting pathways with the widest inequality gaps.

The ICB will also work closely with all providers to ensure consistent use of clinical standards, reduce inappropriate variation in practice and manage elective demand effectively. These expectations will be clearly embedded in contracts, with a focus on reducing long waits, improving performance and supporting equitable access.

Engagement with patients and communities has further emphasised the need for better access to diagnostics, which will shape future diagnostic strategy and capital investment.

Progress to Date

BSW has already made significant progress in modernising its elective care offer and expanding access:

- Three Community Diagnostic Centres are now open in Bath, Swindon and Salisbury, providing improved access to essential tests including imaging, pathology and endoscopy. These sites have already contributed to reduced waiting times and faster diagnosis.
- Long waits have reduced, and BSW is on track to ensure no patient waits longer than 65 weeks by March 2025, with continued progress toward achieving the 18 week RTT standard and 52 week waits in Community Paediatrics for ADHD and Autism.
- Independent sector providers are being used more effectively, helping ensure acute hospital capacity is prioritised for patients with complex clinical needs.
- A new Elective Orthopaedic Centre at Sulis Hospital has been commissioned, strengthening system capacity and improving access for people requiring joint replacement and other planned orthopaedic procedures.
- Pathway transformation work is underway in key areas such as ENT, dermatology and gynaecology, supported by regional and national funding programmes.

COMMISSIONING INTENTIONS

- Primary care–based initiatives, including Community Pharmacy Blood Pressure Checks, the New Medicines Service and enhanced discharge medicines support, are improving access and helping shift activity away from hospital.
- An integrated elective performance dashboard has been rolled out to provide clearer oversight of system-wide delivery.

This progress provides a strong platform for the next phase of planned care transformation, which will focus on wholepathway redesign, reducing inequalities and shifting a greater proportion of activity into community and neighbourhood settings. Pathway redesign, reducing inequalities and shifting a greater proportion of activity into community and neighbourhood settings.

Key Workstreams
Over the next five years, BSW will deliver its elective care ambitions through a focused set of workstreams:

1. Whole pathway redesign across priority specialties
BSW will commission services that support radical changes in ENT, respiratory, cardiology, urology, dermatology and gastroenterology (subject to confirmation with provider partners). These pathways will be designed to make the best use of primary, community and secondary care expertise, with clear roles at each stage of the pathway. A new all age ND pathway has been commissioned through the ICBC programme to address long waiting times for autism and ADHD assessments – moving to a needs based integrated offer.

2. Population health analysis to target interventions
Detailed insight, including Core20PLUS5 data will be used to identify where inequalities are greatest and where community based interventions can have the most impact.

3. Use of national and local evidence
Models of care will be informed by literature reviews, best practice guidelines and learning from regional improvement networks, ensuring redesigned pathways reflect proven approaches.

4. System-wide case for change development
Pathway redesign will be co-developed with providers, drawing on performance and workforce data, demand and capacity modelling, and risk assessments.

5. Pathway mapping and specification development
BSW will map existing patient journeys to identify duplication and opportunities for efficiency. This will underpin the creation of outcomes based service specifications and inform decisions on the most appropriate settings of care, ensuring that community diagnostic capacity and digital tools are fully utilised.

6. Commissioning approach to support primary care leadership
Where clinically appropriate, primary care will take a more prominent role in delivering planned care, while acute hospitals concentrate on specialist interventions.

7. Delivery partner to support rapid implementation
A specialist partner will support pathway redesign across three phases between 2026 and 2028, ensuring changes are delivered at scale and pace.

8. Implementation of a "discuss with" model
By October 2026, all specialties will be supported through advice and guidance, reducing unnecessary referrals and increasing collaboration between clinicians. Evaluation in 2027 will guide further commissioning decisions.

9. Embedding clinical standards and straight to test pathways
Clinical standards such as GIRFT will be embedded into contracts, reducing procedures of limited value and expanding straight to test pathways starting with the highest volume specialties.

10. Diagnostic strategy expansion
BSW will increase community diagnostic capacity, invest in equipment and explore mobile and third party options. Capital planning from 2026/27 will support additional Community Diagnostic Centres and permanent diagnostic facilities.

11. Cancer pathway improvement
Faster diagnosis pathways will be strengthened, including expanded screening, AI use in prostate cancer imaging and continued development of colon capsule endoscopy.

COMMISSIONING INTENTIONS

12. Genomics and neurodiversity:
BSW will begin integrating genomic screening and transforming both neurodiversity and CYP community pathways through ICBC and VCSE partners.

What It Means for the Three Shifts

Sickness to Prevention
BSW will achieve the RTT standard by expanding capacity, shifting resources toward prevention and improving early diagnosis. Straight to test pathways, increased community diagnostics and delegated screening commissioning will enable faster intervention and better outcomes, particularly for underserved groups.

Hospital to Community
More elective care will be delivered in neighbourhood and community settings through redesigned, integrated care pathways. General Practitioner with Extended Roles (GPwER) roles will expand, enabling more complex care to be managed outside hospital. Patient choice will remain a core principle, supported by a diverse provider market and consistent clinical standards across BSW.

Analogue to Digital
Digital pathways will improve efficiency and clinical collaboration. The NHS App will support active waiting and self management, and the use of the federated data platform and embedded AI-enabled tools for diagnostics will support earlier diagnosis, improvement of Did Not Attends (DNAs) rates whilst also streamlining care.

Digital-first pathways such as teledermatology will continue to expand, ensuring quicker access while maintaining equity.

COMMISSIONING INTENTIONS

5. Optimising use of the BSW pound

In order to support delivery of the above commissioning intentions, we need to move to a new financial framework across the system that prioritises investment in the left shift of care and prevention of ill health. As set out earlier in this document, returning the system to financial balance is a key part of our plan to ensure that we can continue to provide efficient and effective services.

Optimising use of the BSW pound also requires explicit consideration of equity, ensuring that resources are targeted where need is greatest and where investment can deliver the greatest improvement in outcomes and reductions in inequalities. Population Health Management insight and the BSW Outcomes Framework will be used to inform investment, disinvestment and prioritisation decisions, supporting a shift in resources towards prevention, neighbourhood services and communities experiencing the poorest outcomes.

The majority of our Provider contracts are mostly either fixed or item of service based. We will need to move to contracts that better support the type of change we are seeking to achieve in the areas described above, this could include alternative payment models that can be aligned to different outcomes, support transformation and incentivising whole pathway improvements or lead provider models (where appropriate) to incentivise collaboration with clear requirements to sub-contract with other providers, including VCSE.

We intend to align deficit support/transitional support funding paid to intra-NHS providers to service transformation and whole pathway improvement. Achieving this change is critical to returning to financial balance and allowing us to spend deficit support in ways that deliver more value for our population.

Progress to date

- As part of the 26/27 plan, we have ringfenced 0.6% (c.£12m) for investment in transformation and key enabler schemes. The schemes will be agreed through the Investment Committee framework process.
- As per the medium term plan the system will be breakeven in year two.
- Schemes are in place for prevention and health inequalities funding.

Over the next five years we will deliver these intentions through the following workstreams:

Key Workstreams

- We will drive equity and optimise the use of the BSW pound.
- The system must be financially sustainable by the end of year 2 with the ambition to eliminate the underlying deficit as deficit support funding and transitional support funding is removed.
- Our ambition is to generate an annual transformation fund of 3% for reinvestment in initiatives that support local commissioning priorities each year over the life of the plan. This will start at 0.6% and grow by 0.6% each year. (generating the required 3% non-recurrent surplus by year 5).
- We will make greater investment upstream in demand management schemes and agree a roadmap to move acute based services to more appropriate settings.
- We will commission for outcomes and value and will support a change in how resources are deployed with the rate of expenditure growth increasing into services outside hospitals, drugs and digital to manage the levels and impact of demand on acute. By year 5, we will aim to increase our contracts linked directly to outcomes from 5% to 25%.
- Collaboration will be incentivised with clear requirements to sub-contract with other providers, including the VCSE sector.
- Improved targeting of allocations based on the data from population health management to remove variation in provision and outcomes and align funding with need.
- Devise and set clear ROI criteria and critical success factors for all service expenditure including robust business cases to inform service changes.
- Identify two pathways or conditions areas where we can test new payment approaches.
- Support increase in High-Value prescribing equitably across the system.

COMMISSIONING INTENTIONS

What it means for the Three shifts

Sickness to Prevention

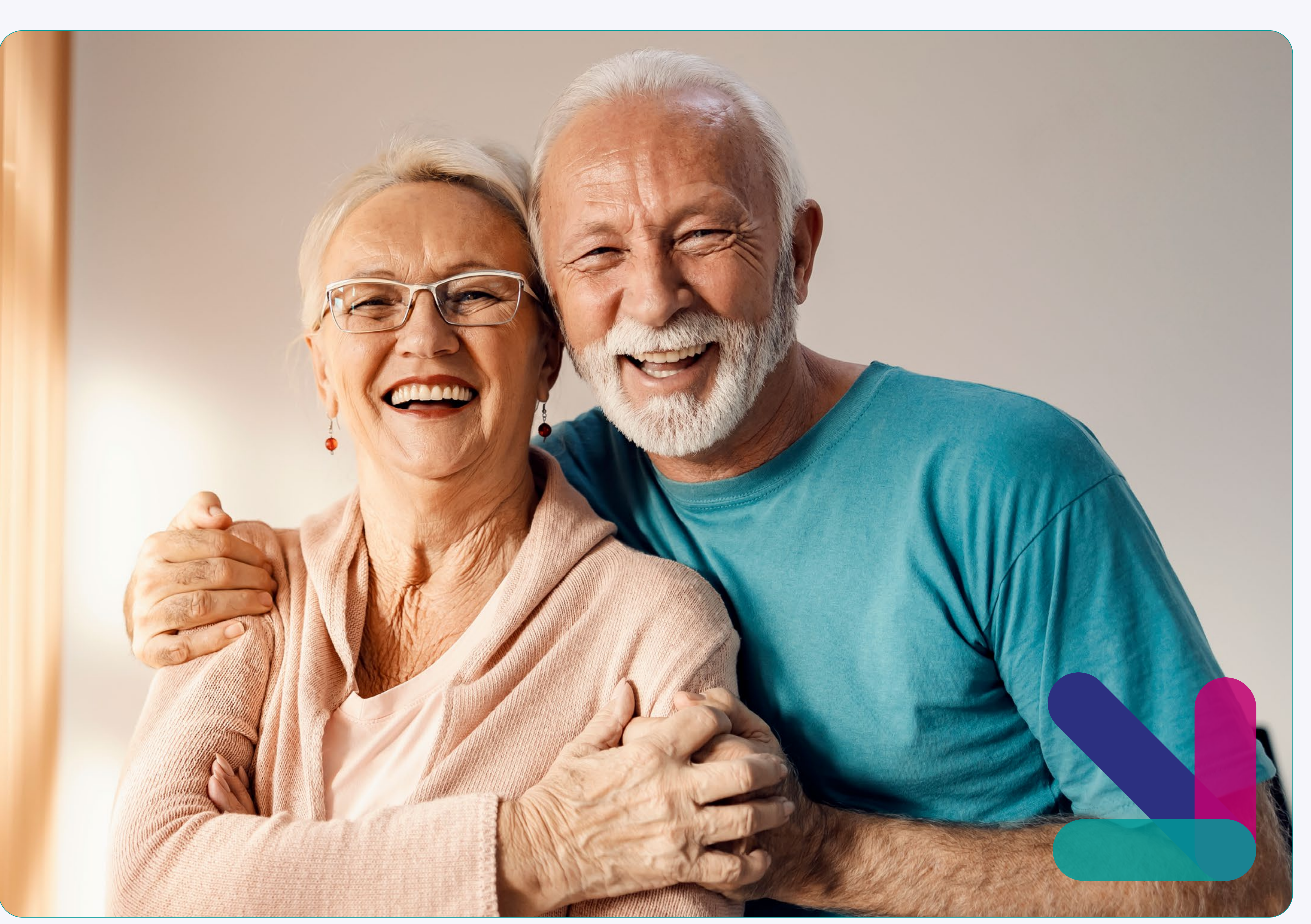
- Drive transformation, integration and the shift from sickness to prevention.
- Improved targeting of allocations based on the data from population health management to remove variation in provision and outcomes and align funding with need.

Hospital to Community

- Shift more care to the community using the new ICBC contract.
- Development of the annual transformation fund to reinvestment in initiatives that support local commissioning priorities.

Analogue to Digital

Support changes in how resources are deployed, with a greater rate of expenditure growth directed toward services outside of hospitals, including digital, to manage impact on hospitals.



6. Expanding and Ensuring Consistency of our Digital Offer

The ICB published a 5 year Digital Strategy in March 2023 that is now being refreshed in light of the ten year plan publication and the shift from analogue to digital. A National digital strategy is expected in 2026/27.

We will commission in a way that ensures digital is the default for access, information and follow-up, supported by inclusive alternatives to avoid digital exclusion. This includes expanding the use of the NHS App as a single digital front door, ensuring shared care records are accessible across providers, and embedding approaches such as patient-initiated follow-up and remote monitoring where clinically safe.

Digital transformation will be delivered in a way that actively mitigates the risk of widening health inequalities. Evidence shows that digital exclusion is more common in deprived communities, older people, some ethnic minority groups, people with learning disabilities and autistic people, and people with serious mental illness. Commissioning of digital services will therefore include explicit expectations on inclusive design, supported access and non-digital alternatives, ensuring equitable access to care and information. This means that we need to commission services that are aligned an integrated digital footprint, with a clear expectation that all providers will use the suite of national tools that are available such as the Federated Data Platform:

- Commissioning for responsible innovation, enabling providers to exploit new technologies, such as those that use AI, to deliver more efficient and safer pathways of care. Tools will be deployed in line with national guidance such as the Digital Technology Assessment Criteria (DTAC) and be evaluated to evidence benefits.
- Commission clear requirements for providers regarding digital exclusion and NHS app integration, e.g. outreach work into disadvantage communities, improved engagement with "Get Connected" groups, development of ICS digital inclusion roadmap.
- Commission the integration of the NHS App and a single digital front door, to ensure providers have contractual obligations to integrate with the NHS App once onboarding for the sector is available nationally.

Progress to date

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

Key Workstreams

- Extension of the deployment of the Integrated Care Record; new partners, use cases, data, infrastructure, and user interface.
- Implementation of Acute EPR programme in preparation for go live in 2027/28.
- Expansion of AI policies, guidance, training and governance within organisations to support AI adoption as part of overall digital roadmaps. Implementation of specific AI-enabled pilots in areas such as Ambient Voice Technology, administrative workflows, Referral triage and decision support, and others.
- Convergence onto single key cyber tooling across BSW Hospitals Group, Security Information and Event Management (SIEM) to sentinel clustering once available nationally, improvement in organisations' ICS cyber score.
- Working with partners and the public to increase uptake and usage of NHS App.

COMMISSIONING INTENTIONS

- Expansion of national and local product incubation of the Federated Data Platform. Products include Cancer360, Patient-Level Information and Costing System (PLICS), Shared Patient Tracking List (PTL) and ICS PHM.
- Consolidation of infrastructure across Hospitals Group and across ICB cluster.
- Transition away from bleeps for Hospitals Group (subject to business case approval), streamlining of community based acute services connectivity provision, single service management tool across Hospitals Group.
- Development of a plan to improve digital literacy offer across the Hospitals Group.
- Baselining exercise to understand capability and identify gaps in DDAT Digital Skills.
- Support providers to design pathways that allow patients to take greater control of their own health management through using wearables, remote monitoring and virtual support.

What it means for the Three Shifts

Sickness to Prevention
Promoting early intervention to address issues before they escalate, improving long-term outcomes. Digital transformation will drive measurable improvements in outcomes with any savings reinvested into frontline services delivering faster access and better patient experience.

Hospital to Community
Making health services more efficient, safer and provide a better patient experience so that patients can access support through the use of technology in their communities. Digital enablement of Neighbourhood Health will positively impact on care delivery.

Analogue to Digital
The implementation of embedded digital tools, platforms and AI will drive Digital Transformation and accelerate innovation, with digital inclusion achieved through targeted outreach and training in digital transformation.

7. Transforming Primary Care

Primary Care including general practice, community pharmacy, primary care dentistry, and optometry is central to the delivery of the NHS Ten Year Plan and the transformation ambitions of the new NHS operating model.

In BSW, Primary Care providers deliver the vast majority of patient contacts and are critical to enabling the shift from hospital to community, supporting prevention, and improving population health outcomes. Primary Care are key to delivering the neighbourhood health service vision, reducing unwarranted variation, and improving access and equity across all contractor groups. Our goal is therefore to enhance efficiency and integration across out of hospital care.

Primary care also plays a central role in reducing health inequalities, particularly through improving access, continuity and early intervention for communities experiencing the poorest outcomes. Evidence shows that people living in more deprived areas, some ethnic minority groups and people with serious mental illness or learning disabilities and autistic people experience greater barriers to accessing primary care leading to worse outcomes. Commissioning and transformation or primary care will therefore explicitly consider equity of access and outcomes alongside efficiency and integration.

Strengthening primary care is essential to delivering these ambitions, and work continues to address existing gaps in capability, operational pressures, and variation across contractor groups as we move towards cluster collaboration in partnership with our local providers. Understanding that each Primary Care sector operates under nationally negotiated contracts and frameworks, which provide consistency and clarity across England. However, in BSW we are committed to ensuring that these national arrangements do not constrain local innovation, improvement, or integration. This includes building on the ICBC contract and expanding Integrated Neighbourhood Teams (INTs) to deliver joined-up care across general practice, pharmacy, dental, and optometry, alongside community and mental health services.

To support this, we will ensure sufficient capacity for strategic commissioning within the ICB ensuring primary care has the visibility, influence and support required to deliver our ambitions across neighbourhoods, places and the wider system.

Progress to date

- Delivering modern general practice and targeted support to identified practices, focusing on high-impact patient contacts and efficient care models.
- 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.
- Developing and implementing a primary care workforce strategy for all primary care contractor groups.
- Contributing to implementing a system-wide, collaborative approach to the secondary prevention of cardiovascular disease by increasing case finding and optimising hypertension management.
- Creating additional capacity for urgent dental care across the system.
- Community services dental review.
- Ensuring all GP practices are transitioned onto a compliant online consultation product.
- Maximising community pharmacy services (inc. BP monitoring and contraception) and the use of prescribing qualifications to move services closer to home by expanding the roll out of Pharmacy First.
- Supporting the development of primary care clinical leaders, recognising that leadership capability will require sustained investment.

COMMISSIONING INTENTIONS

Key Workstreams

- Develop our approach to Integrated Neighbourhood Teams (covered earlier in this document) and ensure that primary care services are at the heart of emerging neighbourhood working for adults and children.
- This will include making sure that we are working together to put in place strategies for optimising the management of long-term conditions, improving frailty care and ensuring continuity of care.
- As part of this, we will engage with Primary Care on embedding Population Health Management as set out in the Neighbourhood Health Framework.
- All primary care providers will be engaged in development and maturation of Neighbourhood health models based on the needs of the population.
- We will utilise population segmentation to support signposting to the most appropriate location, developing multidisciplinary teams in at-scale urgent care hubs. This will be supported by a clearer system-wide approach to risk stratification, enabling INTs and PCNs to identify individuals at highest risk of poor outcomes or unplanned care, complementing population segmentation. This will allow GP practices to focus on the more complex patients and the low complexity to be managed by other health and social care professionals.
- We will develop Primary Care specific Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) to ensure a patient focus for outcomes regarding any interventions. This will identify any barriers to access as well as improve responsiveness to demand, leading to better health outcomes.
- We will commission approaches that enable patients to access care through multiple channels including telephone, online, NHS App, and walk-in supported by structured information and clear signposting. PCNs will be expected to lead improvement in access by optimising capacity, deploying multi-professional teams, and using digital tools effectively and appropriately. For example, online access for non-urgent queries, digital long term condition management to upload measures such as blood pressure and glucose readings.
- We will also strengthen the role of community pharmacy and optometry in urgent care navigation, ensuring patients can access timely advice and treatment closer to home. National requirements such as GP Connect functionality will be embedded, alongside initiatives like Pharmacy First, to reduce pressure on general practice and improve patient experience.
- We will commission urgent dental care services to continue to reduce the demand on other services, increasing activity in line with national targets.
- We will work jointly to support primary care to improve recruitment, training, retention and job satisfaction cross all primary care workforce. This will include specific support for emerging primary care clinical leaders, with a focus on capability, confidence and visibility within the wider system.

What it means for the Three Shifts

Sickness to Prevention

Promoting early intervention will address issues before they escalate, improving long-term outcomes and utilising population segmentation to identify patients before they experience negative health outcomes to stay well and stay at home. Using Risk stratification tools will support proactive identification and targeted support for those most likely to deteriorate.

Hospital to Community

Using patient experience to improve accessibility of the most appropriate service closer to the patients home e.g. Pharmacy First and online access. Aligning ICA priorities with emerging neighbourhood health plans, together with strengthened primary care capacity will improve the system's ability to manage demand in community settings.

Analogue to Digital

The development of digital services being used by providers e.g. AI transcription, triage and data processing, as well as use by patients, e.g. uploading health data digitally will support the shift from analogue to digital. Digital inclusion will be prioritised through targeted outreach and training which will support the acceleration of innovation.

COMMISSIONING INTENTIONS

8. Commissioning for Prevention

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.

Shifting from sickness to prevention, central to the NHS Ten-Year Plan and our BSW Care Model, requires a clear commissioning intention to fund value, not activity: moving resources from treatment to earlier, higher-impact prevention interventions that improve outcomes, cut inequalities and reduce avoidable demand.

We will commission end-to-end pathways for prevention utilising Population Health Management (PHM) methods. We will align commissioning with local authorities to coordinate coherent prevention pathways, ensuring continuity from early identification through to treatment and maintenance. and will selectively invest in high impact, major modifiable risk factors (tobacco, alcohol, obesity, cardiometabolic risk). Neighbourhoods will be a focal point, uniting partners around shared outcomes. This includes a commitment to increase the role of the VCSE sector as a commissioned delivery partner for prevention, through direct and pooled commissioning routes, building on existing Better Care Fund investment and neighbourhood level delivery.

Progress to date

Treating Tobacco Dependence (TTD): A system-wide commissioning model has been agreed to stabilise and scale TTD as a priority prevention and inequalities intervention from April 2026 (2026/27), including recurrent funding and a preferred Host Trust approach to standardise pathways, reporting and delivery across acute, maternity and mental health settings, with mobilisation underway.

Hypertension early detection and optimisation: We have developed a whole-system approach to improve early detection and optimise hypertension management, building delivery across general practice, community pharmacy and VCSE outreach with an explicit focus on reach into Core20PLUS communities and evaluation of impact.

Weight management pathway development: Work has progressed to develop an integrated weight management approach that brings together behavioural support and pathway redesign (and, where appropriate, the introduction of new treatment options) to improve access, reduce waiting times and support healthier weight outcomes, with an explicit focus on equity of access.

Alcohol-related admissions deep dive (in progress): The Population Health Board has initiated an outcomes-led deep dive into alcohol-specific admissions, with the first session completed and a second session planned to agree a focused set of partner-owned recommendations.

Early findings highlight the importance of using peer benchmarking (not just England / South West averages), understanding local variation (including PCN-level variation), and targeting action to narrow inequalities (Core20 deprivation gap, Severe Mental Illness and Learning Disability), with work underway to strengthen locally usable indicators and ongoing monitoring.

Targeted vaccination delivery: We have strengthened our Community Vaccination Hub model to improve targeted Covid-19 and flu vaccination uptake for priority groups.

BCF/VCSE prevention delivery infrastructure: VCSE partners currently deliver around £5.6m of BCF-funded services across BSW, contributing to prevention, reablement, wellbeing and inequalities reduction, with joint ICB/Local Authority oversight through BCF/Section 75 governance and structured locality engagement.

ICBC prevention levers: The ICBC contract includes prevention outcomes within its outcomes framework and an expectation to increase investment in the VCSE sector, complementing wider ICB commissioning and strengthening community-based prevention and earlier intervention closer to home.

COMMISSIONING INTENTIONS

Over the next five years we will deliver these intentions through the following workstreams:

Key workstreams

Deliver the BSW Prevention Strategy and Plan (Prevent–Reduce–Delay): Implement the agreed prevention approach across partners and places, embedding prevention consistently in neighbourhood, community and system delivery. The Prevention Strategy (2025–28) and Prevention Plan are currently in draft and will be finalised and ratified through 2025/26, enabling delivery from April 2026.

Baseline prevention spend and shift investment over time (2025/26): Establish a system-wide baseline for prevention spend across NHS, Local Authorities and VCSE, and agree a multi-year ambition to increase the proportion of total resources invested in prevention, governed through a prevention outcomes and inequalities framework aligned to the system outcomes framework to ensure investment shifts are evidence-led and deliver measurable impact.

Commission end-to-end prevention pathways (clear provider expectations): Commission and/or align whole pathways spanning identification, brief intervention, treatment, maintenance and relapse prevention, aligning funding to outcomes and equity with clear expectations for pathway leadership, collaboration and shared outcomes across providers, and optimising existing investment where possible.

Align prevention commissioning with Local Authorities (single pathway approach): Strengthen NHS - Local Authority partnership working so prevention services operate as a single pathway (e.g. smoking cessation and alcohol harm), with continuity across settings and clearer accountability for outcomes and inequalities impact.

Grow VCSE and community delivery (building on the 5% ICBC requirement): Expand community-based prevention delivery in trusted settings, building on the ICBC commitment to increase VCSE investment, targeting high-need cohorts and geographies to improve equity of access and measurable prevention outcomes.

Utilise all care providers in delivery of prevention: Providers such as Community Pharmacy have a key part to play in the delivery of prevention, widening access in harder to reach communities.

Focus on the highest-impact prevention priorities: Concentrate system effort on tobacco dependence, obesity, harmful alcohol use, polypharmacy (compliance and safety) and cardiometabolic risk, spanning identification through to relapse prevention. This includes scaling priority programmes such as hypertension expansion into broader Cardiovascular Disease (CVD) prevention, an integrated obesity/weight management pathway, optimised smoking cessation/TTD, improved vaccination uptake (including targeted flu and Covid-19 programmes), increasing the prescribing of high-value CVD medication, and the alcohol-related admissions deep dive actions as they are agreed, supporting the NHSE target to reduce CVD premature mortality by 25% over ten years.

Measurement and evaluation (provider contribution): Develop a consistent prevention measurement and evaluation approach, agree a core indicator set (including inequalities breakdowns), and, where data gaps exist, require providers to develop and implement outcomes data collection and reporting so prevention impact and value can be tracked over time.

Delivery Groups drive implementation and assurance: Delivery Groups are the mechanism for implementing prevention actions across the system, with each Delivery Group accountable for a defined set of prevention deliverables and for reporting progress and impact through system governance.

Integrated Care Alliance (ICA) prevention priorities: Each ICA across BSW has a focused priority on improving the emotional wellbeing of Children and Young people. These will continue to align with the prevention asks of the Families First Partnership Programme and Best Start in Life.

Providers as anchor institutions (coordinated system approach): Set a clear expectation that NHS providers act as anchor institutions - using their influence, assets and employment power to improve health and reduce inequalities - and coordinate this activity across the system so it adds value, avoids duplication and aligns with neighbourhood priorities and prevention outcomes.

COMMISSIONING INTENTIONS

What it means for the Three Shifts

Sickness to Prevention

- Shifting commissioning and investment upstream: establish the baseline prevention spend and a multi-year ambition to increase the proportion of resources invested in prevention, governed by a prevention outcomes and inequalities framework.
- Commissioning of end-to-end prevention pathways, aligning funding to outcomes and equity across tobacco, cardiometabolic risk (hypertension to CVD), healthy weight, harmful alcohol and medicines safety - spanning identification through relapse prevention.
- Using every setting as a prevention touchpoint, utilising community pharmacy to deliver key prevention interventions (e.g., BP checks, smoking cessation support, contraception/EHC where relevant) and implement the vaccination strategy so people can receive the right vaccines at the most appropriate point in their pathway.

Hospital to Community

- Delivering prevention closer to home through neighbourhood and community models, growing VCSE and community delivery in trusted settings and using neighbourhood teams to provide earlier intervention for high-need cohorts and communities.
- Integrating NHS and Local Authority prevention into a single pathway (hospital to community), aligning LA and NHS offers so needs identified in hospital are routinely followed through with timely referral into community-based support, reducing avoidable escalation and repeat use of urgent care.
- Strengthening place and neighbourhood leadership and alignment, strengthening community pharmacy leadership within neighbourhoods; link community-led approaches (including outreach) to pharmacy prevention services (e.g., BP checks); align ICA priorities with neighbourhood health plans.

Analogue to Digital

- Measuring and managing prevention as outcomes-led commissioning, though agreeing a core prevention indicator set (with inequalities breakdowns) and require providers to improve data capture where gaps exist so impact can be tracked consistently.
- Using targeted population health management supported by place-level analytics to identify high-need cohorts/geographies and target prevention investment and outreach.
- Embedding digital inclusion by design, ensuring prevention offers are "digital-first where appropriate" with inclusive non-digital routes, supported by targeted outreach, training and accessible communications.

COMMISSIONING INTENTIONS

Strategic Commissioning Capabilities

The Strategic Commissioning Framework (2025) sets out the capabilities ICBs will need to be effective strategic commissioners:

Strong strategic leadership and partnership working, collaborating with other commissioners, providers, local government and service users to co-design services and improve population outcomes.

Broad, multidisciplinary clinical and professional leadership embedded in everyday ways of working to drive improvement across organisational boundaries.

Access to high quality data analysis, sustained and meaningful engagement with people, and access to expertise to inform decision-making and target interventions. This will include having a greater understanding of how to identify geographical and demographic inequalities and what is working well locally and elsewhere, and greater use of technology in the solutions commissioned.

The ability to triangulate demand analysis with lived experience, involving people and diverse communities and understand their experiences through asset-based approaches that facilitate co-production and empower community-driven solutions.

Strong relationships with local government partners (including adult social care, children's services, housing and public health) within their footprint; to build a shared understanding of their population and work together to improve outcomes, tackle inequalities and develop neighbourhood health.

Capability in market management (including modelling impacts of shifts of activity between care settings by triangulating forecast demand analysis with needs based intelligence), contract management and procurement mechanisms to support a focus on quality, value for money and delivery of improved outcomes.

A shared understanding with providers of current and future delivery costs, ensuring each investment improves access, care quality, efficiency and outcomes.

The ability to develop the skills and capability of the workforce and effectively deploy it across the whole health and care system, to deliver effective strategic commissioning.

As an ICB and in our new role as strategic commissioners, we are committed to developing the skills and capability we need to fulfil this role.

From 2026/27, we will start changing this by working with providers to move funding towards local, outcome-based care. This means care will be fairer, more patient-focused, and give better value for public money.

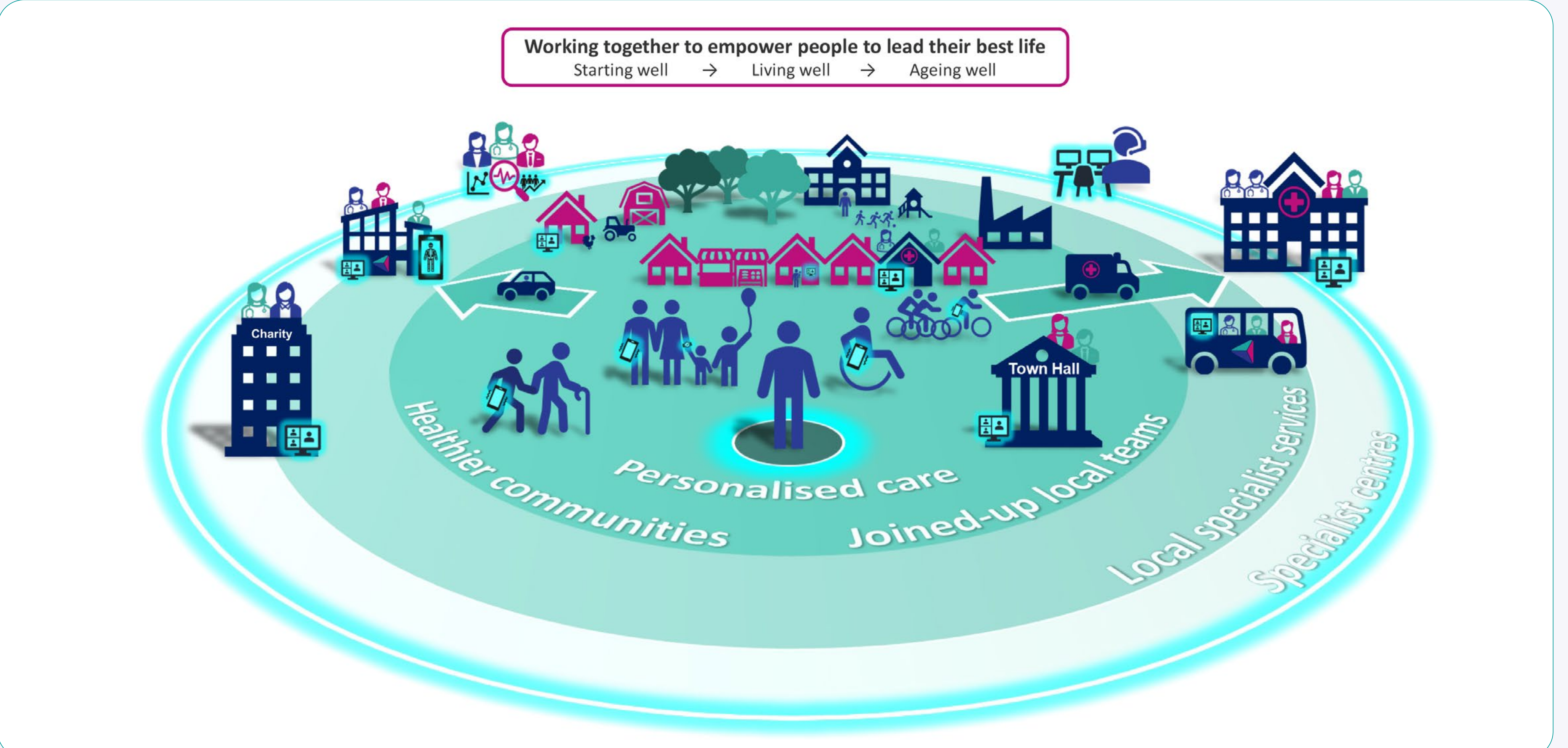
Our goal is to improve people's experience and health outcomes. To do this, we will move from planning based on historic activity and organisations, to commissioning based on needs and outcomes alongside activity.

TRANSFORMATION

Transformation

The BSW Care Model was developed following consultation and engagement with partners and the public during 2022.

This Care Model sets out how collectively as a partnership we agreed to transform the way in which care is delivered and organised in BSW.



TRANSFORMATION

We have made strong progress in delivering this care model, most notably with the procurement of an integrated community-based care contract (ICBC) that went live in April 2025 and the establishment of the BSW Hospitals Group in November 2024.

Alongside these milestones, a number of wider developments have also advanced implementation of the care model for specific pathways and populations.

BSW ICB will continue to lead and coordinate a system-wide approach to deliver major transformation programmes that enable sustainable, high-quality care and improved outcomes for our population. Central to this is the 'left shift', moving resources and care closer to home by transitioning from an acute-centric model to a community-based, preventative approach.

The key principles and actions to support this will include:

Collaborative System Leadership

- Work in partnership with NHS providers, local authorities, voluntary sector, and primary care networks to align priorities and resources.
- Governance structures that enable shared accountability and transparency.
- Integrated planning and delivery.
- Collaborative transformation plans that reflect local needs and national priorities.
- Coordinate workforce, digital, and financial enablers across organisations to support seamless implementation.

Resource Reallocation to Support Left Shift

- Identify opportunities to shift investment from hospital-based services to community and primary care based settings.
- Expand community capacity for proactive care, early intervention, and support for long-term conditions.

Population Health and Prevention Focus

- Use data-driven insights to target interventions that reduce health inequalities and avoid unnecessary hospital admissions.
- Embed personalised care models and strengthen social prescribing.

Continuous Engagement and Communication

- Maintain strong engagement with patients, carers, and communities to co-design services.
- Provide regular updates to stakeholders to ensure alignment and shared learning.

Through these coordinated efforts, BSW ICB will deliver transformation programmes that improve access, outcomes, and sustainability, while enabling the shift of care and resources from acute settings to community-based services.

In developing a more sustainable approach to transformation and enabling this 'left shift' we have recognised that a new approach is required to start changing the dialogue to shift of resources and ways of working to deliver major transformation.

To support this, a ring-fenced fund for Transformation has been created for BSW, for 26/27 this will be £11.6 million (0.6%) which will not be used for deficit reduction.

The purpose of the fund is to enable changes that cannot be funded through baseline allocations, removing structural barriers to efficiency, productivity, and quality and to create enduring benefits that release capacity, reduce avoidable cost, or materially improve outcomes in subsequent years. It must also enable better value from annual running costs.

TRANSFORMATION

The following initiatives have been agreed and will be subject to approval of detailed business cases:

Solution	Solution description	Strategic Commissioning Intentions Link
Hospital at Home expansion (+75 beds)	Recurrently expand Hospital at Home capacity by 75 beds (to ~20.6 beds/100k) to reduce avoidable emergency admissions for frailty/respiratory/cardiac cohorts.	6.2 Neighbourhood Health 6.3 UEC Opportunities
Care Coordination Centre expansion	Expanding this service beyond currently commissioning levels of c.65 referrals per day.	6.2 Neighbourhood Health 6.3 UEC Opportunities
Frailty	Implementation of BSW systemwide Frailty Strategy.	6.2 Neighbourhood Health 6.3 UEC Opportunities 6.7 Primary Care
Neighbourhood Development	Package of development measures essential to ensure early design and planning intention can be realised.	6.2 Neighbourhood Health 6.7 Primary Care
Acute Services Review (externally supported)	ICB to Commission an independent acute services configuration review to develop options, business cases and assurance-ready plans addressing workforce, estates, flow and variation. Link with Dorset Acute Services Review and to cluster opportunities.	6.3 UEC Opportunities 6.4 Delivery of Planned care 6.7 Primary Care
Linked finance-outcomes data	Build an integrated view of datasets of individual patient outcomes with financial activity (costed) data to target avoidable activity and variation.	6.3 UEC Opportunities 6.5 BSW Pound
Pathway reviews	Left shift activity acute to community. Contributing to cluster UEC demand/capacity work.	6.3 UEC Opportunities

KEY ENABLERS

Financial Plan

BSW ICB expects to receive in the region of £2.5bn of funding in 2026/2027 to provide a broad range of primary, secondary and specialised services for our population.

The BSW system comprising the ICB and the three main acute NHS providers within the geography (GWH, RUH and SFT) are currently spending more on the ongoing commitments for the system than the ongoing funding received to provide services for the population.

The system has managed to get to an overall breakeven position with additional non-recurrent national support funding for the last couple of years. This funding is expected to be withdrawn.

All NHS organisations have a statutory duty to not spend more than the funding they receive in a year. This means that recovery interventions will need to be undertaken to address the overspending to avoid a future deficit. On an ongoing basis c.5% more is being spent than we receive in funding.

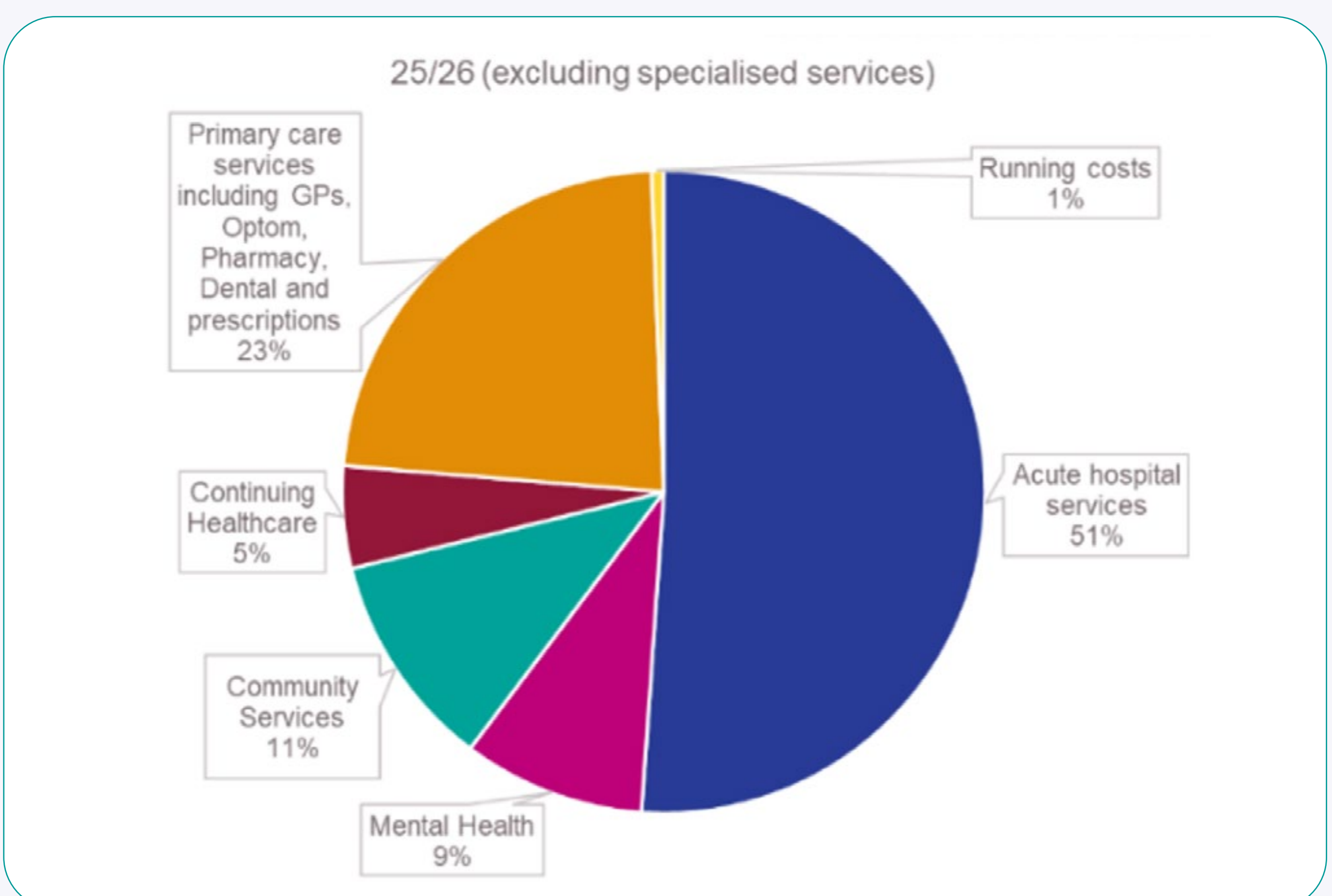
Addressing the overspend whilst continuing to meet the needs of our population will require changes to the services that we currently commission. This may mean ceasing some services, significant changes to existing services or adding new services.

The system is committed to meeting its financial statutory duties and returning to a break-even position and to a sustainable financial balance.

The system planned to deliver efficiency in 25/26 of £125m or 5.6%. Once we include productivity improvements, this increased to c.6.5%. This was a significant stretch for the system in the context of historical under-delivery of recurrent CIP schemes. Despite this high level of efficiency, the ongoing overspend is expected to remain at c.5% as we enter into 26/27.

The efficiencies delivered in 25/26 have failed to deliver the level of recurrent reductions in spend required or the productivity improvements to materially reduce waiting lists. Continued operational challenges connected with service demand have meant that both waiting lists and demand for non-elective services have exceeded planned levels. We have also continued to see higher levels than expected of patients occupying beds despite being medically fit for discharge.

The chart below indicates how the ICB planned to spend its resources for 25/26:



In addition to the funding that the ICB receives directly there is separate funding streams allocated to the BSW population to support specialised services. This funding is directed into the following areas of spend but the services are commissioned jointly for all ICBs across the South West.

The ICB commissions services from both NHS and Non-NHS provider organisations and currently c.40% of all service spend is with GWH, RUH and SFT. Not all hospital-based services are delivered with BSW, and patients regularly use providers in Bristol, Oxford, Gloucester and Southampton. More specialist provision is also used in London.

KEY ENABLERS

Workforce Plan

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.
- Ensuring all staff feel valued and have access to high quality development and careers.
- Using resources wisely to reduce duplication, enhance efficiency, productivity and share learning.

We will ensure that the equality, diversity and inclusion of our workforce improves and ensure that all providers of services comply with the minimum requirements of the Public Sector Equality Duty (PSED). As the published model blueprint indicates, the ICB's role is shifting to that of strategic commissioners with the aim of planning for the future of healthcare services, allocating resources and focusing on removing health inequalities and improving outcomes for the population we serve.

We will continue to build on the progress in reducing our use of and expenditure on temporary staffing in our NHS provider organisations as well as supporting initiatives to recruit into high cost and hard to recruit roles.

The ICB will continue to ensure that, where relevant, that workforce plans for NHS providers are triangulated across finance, activity and workforce. We will maintain relationships with NHSE and other arms lengths bodies to utilise provided tools and models as well as using relevant data and information to better inform and influence plans.

The BSW ICB Work and Health Partnership project will continue to build on its success in delivering the Work Well programme with its intent to support individuals with health conditions in overcoming barriers to employment.

Strategic workforce planning as part of commissioning

The workforce pay bill represents the largest proportion of commissioners' costs, and the way we commission our local workforce has a major influence on the local outcomes we achieve. Effective commissioning supports the development and supply of a well-trained and valued workforce. To achieve our aim of having the right workforce in the right place at the right time, service planning, financial planning and workforce planning must be formally aligned.

To enable this process BSW will develop a system of strategic workforce planning that assumes the following:

- Strong effective shared leadership at all levels with a focus on continuous improvement, financial balance, productivity, quality and outcomes.
- Commitment, support, participation and collaboration from everyone involved in the process including leaders at all levels, the workforce, people being supported, families, carers, communities, providers, commissioners and other professionals.
- Effective communication and information sharing, internally and externally, throughout the whole process.
- Shared responsibility and accountability for performance and delivery, with a positive appreciation for the contribution each party makes to the delivery of person-centred care and support.
- Alignment of strategic commissioning intentions to future workforce plans, supporting new models of care such as neighbourhood health.

KEY ENABLERS

BSW Strategic Vision for our Workforce

Over the next five years, BSW will develop workforce plans that aim to support and deliver the following priorities:

Hospital to Community
BSW will continue to implement the Primary Care and Community Delivery Plan and Integrated Community Based Care (ICBC) contract, including Integrated Neighbourhood Teams (INTs). Our workforce plan will reflect the needs of the ICBC contract, the HCRG stepped care model, and wider partners such as PCNs, local authorities and the VCSE. The focus will be on ensuring the right multidisciplinary workforce is in place to deliver neighbourhood based care.

Primary Care
Primary care is central to the NHS operating model and neighbourhood health ambition. We will support general practice, community pharmacy, dentistry and optometry to improve recruitment, retention, training and job satisfaction. Workforce planning will use data to understand supply pipelines, particularly into pharmacy and optometry roles to support urgent care navigation and timely access closer to home.

Mental Health
Delivering the BSW Mental Health Strategy (2025–2030) requires a sustainable, skilled workforce. Key challenges include national shortages, high turnover and reliance on agency staff. Our plan will support local providers to expand and develop their workforce through actions such as clinical associate psychology roles, Talking Therapies trainees, apprenticeships, overseas recruitment, skills development programmes and recruitment into primary and urgent care.

Learning Disabilities, Autism and Neurodivergence (LDAN)
The workforce plan will include requirements for the new Kingfisher unit and outreach team, the development of an all age neurodiversity pathway with HCRG and VCSE partners, the expansion of LDAN keyworkers, and the growth of community LDAN services, including support for autistic people without a learning disability and those with forensic needs. It will also prioritise upskilling mainstream mental health teams to better support autistic people with co morbid conditions.

Urgent and Emergency Care (UEC)
The workforce plan will support the redesign of the UEC pathway, including the shift from MIUs to UTCs, and workforce needs linked to expanding Hospital at Home services, including potential paediatric pathways.

Analogue to Digital
As the ICB updates its Digital Strategy, the workforce plan will support the shift to digital first access and care pathways. We will address shortages in digital and cyber expertise by expanding professional apprenticeships and developing skills across the existing workforce, aligned with the ICS Cyber Strategy.

Digital Strategy

To meet the current and future needs of our population we need to make significant changes in the way we deliver services.

Technology is an important enabler to make these changes. Digital solutions give us the potential to work differently, facilitating better, safer care and experience and more efficient and effective use of resources, both financial and time. Making better use of technology, also referred to as moving from analogue to digital, is a crucial element of plans to make the health service more efficient, safer and provide a better patient experience. Digital, Data and Technology across the ICS are also enablers for the other two shifts we are being asked to focus on (moving care from hospitals to the community, shifting from treatment to prevention).

The opportunity digital presents to the NHS and social care is recognised by the Government as one of the transformational shifts the NHS must make over the next ten years. The organisations of BSW have a shared aim to exploit this opportunity to the benefit of our patients, population, staff and organisations.

We have identified five strategic themes and agreed a set of principles that will ensure a consistent approach to delivering digital across all our organisations.

By delivering against the priorities identified within this strategy we will increase the digital maturity of our organisations, reduce our carbon impact, improve services for our patients and improve the working conditions for our staff.

Delivery is however not without risks. The BSW system is under financial pressure which impacts the ability to invest in digital technologies, and where national funding is available it is often capital where revenue funding is required. The capacity and resource to support the Digital, Data and Technological change is limited both within specialist teams and the frontline. The transition of NHS England into the Department of Health and Social Care and the ICB merge will also impact at a local level.

How we seize this digital opportunity will define the future of care in BSW. Encapsulated by our vision of:

“Working together to deliver innovative digital solutions that enhance patient outcomes, staff experience, and streamline healthcare services”

What Good Looks Like framework

The What Good Looks Like framework (WGLL) is directed at all NHS leaders, as they work with their system partners, and sets out what good looks like at both a system and organisation level. It describes how arrangements across a whole ICS, including all its constituent organisations can support success.

WGLL is included in the ICS design framework, the NHS Operational Planning and Contracting Guidance and A Plan for Digital Health and Social Care, reflecting the expectation that the standards in the WGLL framework will be used to accelerate digital and data transformation.

The WGLL framework has 7 success measures:

- Well led
- Ensure smart foundations
- Safe practice
- Support people
- Empower citizens
- Improve care
- Healthy populations

KEY ENABLERS

Infrastructure Strategy

Our Enabling Infrastructure Strategy (2025–2035) sets out our vision and objectives for reshaping and enhancing our estate and digital infrastructure over the next decade.

It aligns with the BSW Together Integrated Care Strategy and Primary & Community Care Delivery Plan. Delivering this vision requires significant investment for backlog maintenance and additional space, depending on the level of clinical transformation achieved. For 2026/27, the system has an operational capital envelope of £46.4m, supplemented by national programmes.

Delivering the three key shifts set out in the NHS Ten Year Plan; hospital to community, analogue to digital, and sickness to prevention, requires an estate and infrastructure platform that enables the new care model. Consistent with the Naylor Review, the form of our estate must follow the service strategy and not operate separately from it.

This means estates, digital infrastructure and capital investment must be considered at the same time as commissioning decisions, not afterwards.

Infrastructure is also one of the system's largest cost drivers, and capital availability is constrained. We therefore require a commissioning approach that ensures our estate is fit for purpose, digitally enabled, financially sustainable, and aligned to population need.

Over the next five years, we will embed estates and infrastructure as core commissioning levers, ensuring service transformation is supported by the right physical and digital environment. Our commissioning decisions will be underpinned by a system-wide, data driven approach to estate planning, utilisation, condition, carbon impact and affordability.

Our key commitments will be:

a) Make commissioning and estate decisions together
All major service redesigns, procurements, pathway changes, capital bids and disinvestment proposals will be required to demonstrate their estate, digital and infrastructure implications, including:

- Estate utilisation and co-location opportunities.
- Suitability, condition and backlog risk.
- Digital readiness and interoperability.
- Revenue impact and affordability.
- Disposal and reinvestment opportunities.
- Carbon and sustainability impact.

This aligns commissioning with the requirement for data-led and transparent infrastructure planning.
b) Use a single, system-wide infrastructure evidence base
We will use a unified estates dataset and common analytical approach to support consistent prioritisation and clear decision-making. This will include utilisation, condition, lifecycle cost, carbon, backlog, demand modelling and population need.

The SHAPE tool will be used systematically to ensure that community, primary care and neighbourhood infrastructure is located where it best meets population health need and reduces inequalities.

c) Prioritise estate investment that enables neighbourhood and community based care
Investment will focus on:

- Neighbourhood Health / Integrated Care Centres, community hubs and multi use spaces.
- Co-location of primary, community, mental health and VCSE services.
- Expansion of community diagnostics.
- Flexible estate models and shared booking systems.
- Repurposing underused or high-cost assets.
- Planned disinvestment from estate that no longer supports highvalue carevalue care value care.

This supports our capital prioritisation approach, disposal pipeline and the shift from acute to community settings.

KEY ENABLERS

d) Embed net zero principles into commissioning and procurement
To support the NHS ambition for a net zero health service, all relevant commissioning and procurement activity will incorporate environmental and carbon reduction requirements, including:

- Carbon Reduction Plans (CRPs) for all new contracts over £5m per annum, consistent with NHS England guidance.
- Net zero commitments for other procurements where proportionate.
- Compliance with the NHS Net Zero Building Standard for new builds and major refurbishments.
- Carbon impact assessments for major service changes.
- Sustainability weighted evaluation criteria where appropriate.

This ensures commissioning actively drives progress towards Net Zero and sustainable infrastructure transformation.

e) Align capital planning with commissioning priorities and affordability
Capital investment will be prioritised where:

- It directly enables delivery of commissioning intentions.
- It supports left shift, digital transformation or prevention.
- It improves equity of access.
- It delivers revenue savings or mitigates backlog costs.
- It forms part of an agreed disposal and reinvestment strategy.

Given constrained PDC and revenue consequences, all capital proposals must demonstrate affordability, value and alignment with our population health priorities.

f) Infrastructure investment supports equitable access to care, particularly for communities experiencing poorer outcomes
Estates and infrastructure play a key role in reducing inequalities in access, experience, and outcomes. The location, configuration, and quality of buildings affect how easily people can use services, whether care can be delivered closer to home, and how well new models of prevention, diagnostics, and integrated care can be implemented.

By aligning estate considerations with service design, the ICB can ensure investment supports fair access to care, particularly for communities with poorer outcomes.

This includes prioritising estate solutions that strengthen neighbourhood and community-based services, reduce travel barriers, support inclusion health groups, and improve the reliability and sustainability of core clinical infrastructure.

KEY ENABLERS

Engagement

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.

We held an extensive local conversation on the NHS Ten-Year Plan with our communities. During January and February 2025, we ran a series of engagement sessions across BSW to gather public input, involving a range of groups including Patient Participation Groups, senior citizens from ethnic minority communities in Bath, refugees and asylum seekers in Swindon, the Muslim community in BaNES, and representatives from Gypsy, Romany, Boater and Traveller communities in Wiltshire and Bath.

Discussions with these groups focused on the three key national shifts underway in health and care.

NHS Ten Year Plan: Feedback from patients and the public

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

The themes identified in this conversation as well as other engagement we have done with our communities are central to this plan include:

Prevention and early intervention

- Broad support for preventing illness rather than just treating it, but much debate about the best way of doing this.
- Improved health education in schools is widely believed to be the best route.
- More emphasis should be placed on nutrition and physical activity programs, subsidised where possible for disadvantaged communities.
- Calls for long-term funding for VCSE partners and better outreach to marginalised communities.
- Worries about affordability of healthy food, "nanny state" interference and unintended consequences of screening creating more patients the system would not be able to cope with.

Access and navigation of services

- Low awareness and unclear routes into services, particularly with weight management and frailty, were highlighted.
- People want clearer signposting, the ability to self-refer and better communication about eligibility criteria.
- Transport and rural access challenges were common concerns, with calls for mobile units and patients from rural areas highlighting the difficulty of attending Community Diagnostic Centres if they were situated away from town centres.
- There is frustration with poor coordination between hospitals and GPs. People want "joined-up" referrals and discharge processes.

KEY ENABLERS

Digital vs face-to-face care

- Strong support for shared care records and technology to improve efficiency, while there is criticism for what is seen as a disjoined approach between primary and secondary care.
- High levels of concern about digital exclusion for older or disadvantaged groups in terms of booking GP appointments and a preference for face-to-face appointments for complex issues.
- Cybersecurity and data privacy were raised as ongoing worries.

Workforce and infrastructure

- There were repeated questions about staffing shortages, pay and recruitment needed to deliver plans such as Hospital at Home, services at TICC, Community Diagnostic Centres and the hospital to community shift.
- Practical delivery concerns for rural areas and fears that plans may not be realistic.

Communication and Cultural Sensitivity

- Desire for clearer explanations of clinical terms and less use of jargon.
- Need for translation services and culturally sensitive care.

Behavioural and Social Factors

- Learned behaviour drives A&E attendance, even when alternatives exist.
- Emotional and psychological support needs were raised by many in relation to weight management discussions, alongside stigma concerns.

Service Design Feedback (mainly connected to Trowbridge Integrated Care Centre)

- Positive sentiment toward bringing care closer to home.
- Persistent requests for:
  - Extended opening hours for Minor Injury Units.
  - Local maternity options and short-stay beds.
- Mixed views on whether new facilities represent real service improvements or just "same services, new building."

We will continue to engage with our patients and local population on a regular basis, using a coproduction methodology that actively involves people and communities (based on Care Quality Commission's Framework for engaging with people and communities to address health inequalities (2025). By using both quantitative and qualitative insights to inform our integrated needs assessment, this will provide us with a comprehensive understanding of the lived experience of those receiving health and care support.

Areas of engagement that align with our commissioning intentions will include:

Developing a Neighbourhood Health Service: Place based engagement with communities to inform the development of Neighbourhood Health. Within this we will also be working closely with the Gypsy, Roma, Traveller and Boating communities as well as Veterans to gain a better understanding of how they view Neighbourhood Health and how to best to communicate the idea of Neighbourhood Health to them.

Commissioning a comprehensive review of our urgent and emergency care pathway: Expanding on the "Big A&E Survey" carried out in 2025, we will work on delivering further engagement activities to support the review of the currently commissioned UEC pathway.

Transforming Delivery of Planned care: Engagement work planned to support the development of the BSW Diagnostics Strategy to include Community Diagnostic Centres.

Transforming Primary Care: Working closely with our local Patient Participation Groups (PPGs) to gather feedback across Primary Care.

Commissioning for Prevention: Building on engagement work carried out at the end of 2025 on BSW Weight Management Services, we will look to codesign pathways and a system wide approach to compassionate language around weight management and obesity.

KEY ENABLERS

Improved access and outcomes for people with a Learning Disability and / or Autism (LDAN): People with lived experience have co-developed the LDAN vision as part of the transformation of end-to-end provision. This has included considerable input into the design and workforce of the new inpatient unit.

The ICB's work in this area against its Legislative Duties is also found in Appendix 2.

DELIVERY

Monitoring Delivery

We are committed to working together to deliver the intentions set out in this plan for BSW and using our agreed BSW outcomes framework indicators, performance reporting and our governance and assurance processes, we will track and monitor our progress.

The BSW 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.

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. By embedding this Outcomes Framework into our commissioning and contracting, we will ensure a structured, equitable, and transparent approach to improving health outcomes across our communities and by the end of the five year period we aim to see a measurable improvement in these outcomes.

As per the guidance set out for ICB's in the strategic commissioning framework, we will rigorously evaluate the outcomes from our commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence. We will monitor and evaluate the performance (quality, operational or financial) of the services we commission by:

- Understanding gaps or challenges in the achievement of agreed priorities or within individual commissioned services (such as those in the national planning priorities, for example, urgent and emergency care and elective care).
- Learning from and adapting services (including decommissioning and scaling successful innovations where appropriate).
- Ensuring quantitative metrics are triangulated with qualitative data, professional insight and regulatory intelligence to fulfil this function effectively (such as complaints, 'You and Your General Practice', Freedom to Speak Up, Patient Safety Incident Response Framework and safety incident data).

To support achievement of this and in meeting the national guidance, we will set up an evaluation approach by March 2027, supported by an intelligence function and working with other partners as appropriate. The approach will encompass both quantitative and qualitative data, including feedback from staff (ICB, provider and other partners), communities and people using services.

Risks and Mitigations

The ICB is committed to having a risk management culture that underpins and supports the business of the ICB, including its system function and responsibilities.

The approach seeks to embed robust, transparent, proportionate and responsive risk management in the ICB's activities and processes relating to the discharging of the ICB's functions, duties and responsibilities. The ICB's Risk Management Framework sets out the ICB's approach to risk management, key decision-makers with regards to risk management, the ICB's risk appetite and risk categories, and key processes to manage operational risks (held on the ICB's operational risk register) and risks to the ICB's ability to achieve its strategic objectives (held on the ICB's Board Assurance Framework, Board Assurance Framework (BAF)).

BSW ICB holds the following risks on its BAF and operational risk register which it deems to be relevant for this plan, and the ICB's ability to deliver it:

Risk	Risk Score (LxI)	Likelihood	Impact	Mitigating Action
Urgent and Emergency Care: insufficient capacity to meet demand and support flow, resulting in missed targets, high NCTR, insufficient flow, patient harm, and inability to shift resources from managing pressures into the transformation of care, impact on system's ability to meet targets; exacerbated by ambulance to hospital handover delays and resulting risks incl. patient harm, missed targets	20	5	4	UEC strategy, oversight of SWAST contract, focus on infection prevention and control, oversight of out-of-hospital capacity Close monitoring of contract performance; Acute UEC Programme focusing on front door, in hospital and discharge; Expansion of SDEC offers at RUH and SFT to avoid handover at ED
Financial delivery: financial cost pressures are not controlled, resulting in BSW overspending / breaching revenue or capital plan, not achieving statutory financial duties, and leading to intervention from NHSE including reduced local discretionary decision making, reduced capital resources, reduced opportunity to apply for additional funds, and loss of deficit support funding	20	4	5	Identify the root cause of BSW's strategic deficits, support from experienced consultant, financial recovery plans medium-term plan, efficiency pipeline for 2026/27 and beyond

DELIVERY

Risk	Risk Score (LxI)	Likelihood	Impact	Mitigating Action
Sufficiency of capital funding for the ICB and system: finite resource could be spent on schemes that don't support the delivery of system objectives or create revenue pressures which add to the system underlying deficit and ongoing savings requirements	20	5	4	Capital plan; close oversight and monitoring through ICB / ICB committees
Workforce: strategic workforce planning to support delivery of our current plans and strategies stalls, resulting in increased workforce gaps, negative impact on employee health and wellbeing, increased turnover, destabilization of the workforce pipeline; shift of strategic workforce planning out of ICB remit is a key driver of the risk	20	4	5	BSW approach to workforce planning that commits key partners / organisations to active involvement in health and care workforce planning and develop, implement a strategy / plan to utilise education and education providers for purposes of workforce planning and delivery.
Future of the BSW ICB: running cost reduction leads to ICB's inability to deliver statutory functions and short- to medium-term plans	20	4	5	Options for future footprint, functions and strategic objectives, programme plan to manage the change, plan/s to facilitate retention and delivery of as many strategic and planned objectives for the benefit of the BSW population as possible
ICB activities and operations: various risks across primary care (GP, dental, SW hub), urgent and emergency care and flow, planned care, mental health, s117 aftercare that all point to capacity and financial constraints as a risk to the ICB's ability to achieve delivery of in-year aims and objectives	Av. 15			Mitigations focus on close collaboration with providers and on close monitoring of finances
Organisational change: impacts on ICB's capability to deliver its functions	16	4	4	CB / cluster change programme: capabilities mapping exercise to identify essential roles and high-risk loss areas; business continuity plans
Single Electronic Patient Record: programme not delivered safely and on time could result in material operational disruption within the acutes and across the wider system	16	4	4	Acute Group has in place Board-led governance providing leadership and assurance against a set of readiness checkpoints that assess the various component parts of the EPR programme

DELIVERY

Risk	Risk Score (LxI)	Likelihood	Impact	Mitigating Action
Elective Care: system fails to deliver on the specific expectations set out in the elective care reform plan, leading to wait times / lists remaining high, loss of Elective Recovery Fund (ERF), continued increased demand for urgent and emergency care and primary care, continued operational systems pressures, impact to cancer wait times	16	4	4	Providers activity plans and recovery plans, close monitoring via contract meetings, increased use of CDC capacity GWH, RUH, SFT led recovery projects; ICB close monitoring and oversight
Prevention: no actions and incentives for residents to stay healthy, resulting in inability to prevent disease, injury or ill-health or avoidable complications associated with long-term conditions, leading to continuation of operational pressures and failure to deliver intended health outcomes	16	4	4	Prevention strategy incl. CYP / MH / frailty prevention, hypertension programme delivery and continuation beyond year 1, stronger prevention reporting and data
Health inequalities: efforts not focused on improving health inequalities and addressing unwarranted variation, resulting in little or no impact on the health and outcomes of those who are adversely affected by current ways of working	16	4	4	BSW inequalities strategy, Deliver 2025/26 inequalities commissioning model, inequalities dashboard
Wider determinants of health: failure to address wider determinants of health, leading to people not having the opportunities and means to stay healthy, resulting in continued high / increased demand for health and care services, operational pressures, inequalities of access and health outcomes	16	4	4	Medium Term Plan, system outcomes framework / reporting mechanisms
Children: failure to reduce prolonged waiting times for children's elective car will impact treatment delays, increase clinical complexities, higher treatment costs, breach NHS constitutional standards/reputational damage	12	3	4	Planning focus on CYP waits with parity to adults, CYP elective waits task and finish group established, waiting list validation, focus on Core20plus5 CYP cohorts
Neighbourhood Health: there is a risk that BSW will be unable to deliver a compliant Neighbourhood Health Plan by the national deadline for 2025/26. This may occur due to emerging national guidance still being issued, variable readiness and capacity across the three localities, dependency on HCRG for significant provider-led sections of the plan, and delays in agreeing neighbourhood footprints, governance arrangements and outcomes	3	3	1	Agreed BSW Neighbourhood Health Framework, system-level narrative to ensure alignment across the three localities and reduce duplication, ICA governance, provider responsibilities clarified, regular BSW Neighbourhood Health Working Group meetings, early engagement with Public Health, BI and JSNA leads, aligned communication channels with national and regional teams, defined submission governance route via HWBs HWB Chairs and local authority partners

Governance

Governance and oversight for delivery of this plan are set out below.

During 2025/26, the BSW ICB's governance and decision-making arrangements will ensure appropriate oversight, assurance and approval of the plan and its implementation. The relevant forums in the BSW ICB's governance arrangements are:

BSW ICB Board: approval of the plan.

BSW ICB Commissioning Committee: oversight and assurance of delivery, risk monitoring and assurance that risks are managed, and commissioning decisions where contract values meet the thresholds set out in the Scheme of Reservations and Delegations (SoRD) and Scheme of Financial Delegations (the ICB Board remains the decision-maker for the highest-value commissioning decisions).

BSW ICB Executive Management Group: day-to-day monitoring, operational decision-making in line with the BSW ICB's SoRD and Scheme of Financial Delegations, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes.

From 1 April 2026, BSW, Dorset and Somerset ICBs will closely collaborate as a cluster. Cluster governance and decision-making arrangements are still being developed, but the following forums are anticipated to play key roles in oversight and assurance of the plan (indicative and subject to change):

Cluster Board – approval of any material changes to the plan, decision-making with regards to very high-value commissioning decisions, decision-making with regards to novel or contentious commissioning models.

Joint cluster Committee for Commissioning – oversight and assurance of the plan and its delivery, commissioning decisions, risk monitoring and assurance that risks are managed.

Joint cluster Executive Group – day-to-day monitoring, operational decision-making, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes.

Place 'boards' – may play a role in the oversight and assurance of the plan and its delivery where intentions have particular local / place implications (TBC).

Oversight via Executive structures

The Cluster executive structure will have overall oversight of the commissioning intentions as set out in this plan. The Population Health Board will hold the oversight of the Population Health Improvement as part of this plan and our priorities in relation to outcomes and inequalities.

Accountability

Progress against the priorities in this plan will be reported regularly to the ICB Board.

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Appendix 1: Outcome Framework and Inequalities Indicators

Commissioning Intentions and Outcomes Framework Indicators:

	Strategic Commissioning Intentions							
Links to outcomes framework	Embedding outcomes and promoting integration	Developing a Neighbourhood Health Service	Commissioning a comprehensive review of our Urgent and Emergency Care Pathway	Transforming Delivery of Planned Care	Optimising the use of the BSW Pound	Expanding and Ensuring the consistency of our Digital Offer	Transforming Primary Care	Commissioning for Prevention
Key Outcomes								
Life Expectancy at Birth/ Years of Life Lost	✓	✓	✓	✓	✓	✓	✓	✓
Healthy Life Expectancy at Birth/ Healthy years of life lost	✓	✓	✓	✓	✓	✓	✓	✓
Emergency Bed Days	✓	✓	✓	✓	✓	✓	✓	✓
Contributory Outcomes								
Infant Mortality/ Pre-term births (YLL from child deaths)	✓							✓
<75 mortality/ Years of life lost - CVD	✓			✓			✓	✓
<75 mortality/ Years of life lost – Cancer	✓			✓			✓	✓
<75 mortality/ Years of life lost – Liver Disease	✓			✓			✓	✓
<75 mortality/ Years of life lost – Respiratory	✓			✓			✓	✓
Dementia Diagnosis Rate/ GP recorded dementia	✓	✓					✓	✓
Premature mortality/ Years of life lost – SMI	✓						✓	✓
Admissions for self-harm	✓		✓					✓
Population employment inactivity	✓							
Staff Survey engagement score	✓							
ICS organisations leaving rate	✓							
Percentage of patients reporting they have a care plan/ care plan is helpful/ no. care plans recorded on Integrated Care Record	✓	✓	✓			✓	✓	
Percentage of deaths in hospital	✓		✓				✓	
School readiness	✓							✓
Smoking prevalence	✓	✓		✓			✓	✓
Obesity prevalence	✓	✓		✓			✓	✓
Physical inactivity prevalence	✓	✓		✓			✓	✓
Admissions from alcohol specific conditions	✓	✓	✓	✓			✓	✓
MMR/ Flu vaccination rates	✓						✓	✓
Hospital admissions for dental decay	✓						✓	✓

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Appendix 1: Outcome Framework and Inequalities Indicators

Commissioning Intentions and Outcomes Framework Indicators:

	Strategic Commissioning Intentions							
Links to outcomes framework	Embedding outcomes and promoting integration	Developing a Neighbourhood Health Service	Commissioning a comprehensive review of our Urgent and Emergency Care Pathway	Transforming Delivery of Planned Care	Optimising the use of the BSW Pound	Expanding and Ensuring the consistency of our Digital Offer	Transforming Primary Care	Commissioning for Prevention
Placeholders								
Quality of dementia care	✓	✓					✓	✓
Percentage patients reporting a MSK condition/ GP reported MSK prevalence	✓	✓					✓	
Apprenticeship/ T-level take up in H&C	✓				✓			
Social value quantified benefits	✓				✓			
Carbon emissions of our providers	✓				✓			
% patients with LTC with SDM conversation	✓	✓		✓			✓	
No. CollaboRATE (SDM)/ % scoring 9+	✓	✓		✓			✓	
No. IntegRATE/ % scoring 8+	✓	✓		✓			✓	
% referred to social prescribing	✓	✓		✓			✓	✓
No. patients with Personal Health Budget	✓	✓					✓	
% ICS resource invested in prevention	✓	✓			✓			✓
Personal Wellbeing	✓	✓						✓
Admissions for substance misuse	✓		✓					✓
% children with healthy ways to manage difficult feelings	✓	✓						✓
Percentage adults who feel lonely	✓	✓						✓
Average health gain from elective admissions	✓			✓				

Outcome Framework Indicators and Inequalities in Common

Links to outcomes framework	Inequalities in outcomes
Key Outcomes	
Life expectancy at Birth/ Years of life lost	Core20, SMI and PLD have higher rates of years of life lost
Healthy life expectancy at 65/ Healthy years of life lost	Core20 has higher rates of healthy years of life lost. Data still in development for SMI and PLD
Emergency Bed Days	Core20 population, SMI and PLD have higher emergency bed days
Contributory Outcomes	
Infant Mortality/ Pre-term births (YLL from child deaths)	Numbers are too small to analyse inequalities
<75 mortality/ Years of life lost - CVD	Core20, SMI and PLD have higher rates of years of life lost from CVD
<75 mortality/ Years of life lost – Cancer	Core20, SMI and PLD have higher rates of years of life lost from Cancer
<75 mortality/ Years of life lost – Liver Disease	Inequality data is being accessed for this indicator
<75 mortality/ Years of life lost – Respiratory	Core20, SMI and PLD have higher rates of years of life lost from Respiratory
Dementia Diagnosis Rate/ GP recorded dementia	Recorded dementia in 65+ is lower for Core20 and BAME populatins
Premature mortality/ Years of life lost – SMI	Core20, SMI and PLD have higher years of life lost in SMI
Admissions for self-harm	Core20, SMI and PLD have higher rates of admissions for self-harm
Population employment inactivity	Inequality data is not available for this indicator

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Links to outcomes framework	Inequalities in outcomes
Contributory Outcomes	
Staff Survey engagement score	Inequality data is not available for this indicator
ICS organisations leaving rate	Inequality data is not available for this indicator
Percentage of patients reporting they have a care plan/ care plan is helpful/ no. care plans recorded on Integrated Care Record	Core20 and PLD have lower numbers of care plans on the ICR
Percentage of deaths in hospital	Core20 and BAME populations have higher percentage or deaths in hospital
School readiness	Inequality data is being accessed for this indicator
Smoking prevalence	Core20, SMI and PLD have higher smoking prevalence
Obesity prevalence	Core20, SMI and PLD have higher obesity prevalence
Physical inactivity prevalence	Inequality data is being accessed for this indicator
Admissions from alcohol specific conditions	Core20, SMI and PLD have higher rates of admissions for alcohol specific conditions
MMR/ Flu vaccination rates	Inequality data is being accessed for this indicator
Hospital admissions for dental decay	Core20 and SMI have higher rates of admissions for dental decay in <19s
Placeholder indicators	We do not have inequality data yet for placeholder indicators

Appendix 2: Statutory Functions

1. Describing the health services for which the ICB proposes to make arrangements
Our 5-year Commissioning Plan describes the priorities that we are working on in order to better meet the needs of our population. This includes our strategic commissioning intentions which describe our main priorities as commissioner and allow our providers to better understand our approach to commissioning and contracting. This has been developed for the BSW ICB, working in conjunction with our colleagues across the BSW, Dorset, and Somerset Cluster.

In turn, our BSW operational plan quantifies our activity, finance and performance plans over the next three years. This allows us to have a collective understanding of the funding, activity and performance that we are planning to meet the requirements set out in the national NHS planning guidance.

We are committed to engaging with our public and stakeholders in line with our statutory duties as and when we undertake major service change, as well as on an ongoing basis. This is covered in more detail in our Implementation Plan.

2. Duty to promote integration
The duty to promote integration requires consideration of securing integrated provision across health, health-related and social care services where this would reduce inequalities in access to services or outcomes achieved. This duty is considered in the work that we do across all of our services, including through our Delivery Groups and in our Integrated Care Partnerships and Locality Commissioning Groups.

Working together across our Integrated Care System and now our ICB cluster, to promote integration is a key part of our work, and this is set out through our ICP strategy and within our Implementation Plan. Integrated approaches are particularly important for people with complex or additional needs who rely on coordinated input across physical health, mental health, community and social care services to avoid fragmented or crisis driven care.

In promoting integration, the ICB will continue to work jointly with local authorities to meet statutory responsibilities for individual patient commissioning such as section 117 aftercare under the Mental Health Act which includes coordinated commissioning, funding and oversight arrangements to support continuity of care across health and social care. Where individuals are not eligible for full NHS funding, joint working may be supported through appropriate partnership and joint funding arrangements. The duty to promote integration requires consideration of securing integrated provision across health, health- related and social services where this would reduce inequalities in access to services or outcomes achieved. This duty is considered in the work that we do through our Delivery Groups and in our Integrated Care Partnerships and Locality Commissioning Groups. Working together across our Integrated Care System to promote integration is a key part of our work, and this is set out through our ICP strategy and within our Implementation Plan.

3. Duty to consider wider effect of decisions
We are committed to exercising our duties in a way that properly takes into consideration the 'triple aim'. This means ensuring that we consider the effects of our decision in relation to healthcare services on the health and wellbeing of our population, the quality of services that we provide and the efficiency and sustainability of resources.

Our commitment to delivering the triple aim is set out through our 5-year Commissioning Plan and also our BSW ICP Strategy. In developing these plans, we have also considered a wide range of data and made sure that the priorities that we have identified meet the triple aim. This has been documented in our Integrated Needs Assessment. Our success in meeting the triple aim will be demonstrated through our monitoring against delivery of the actions included in this plan and the achievement of the system outcomes we have put in place through our BSW Outcomes Framework.

For each decision of sufficient scale or impact, we take a business case through our decision-making forums. This case has to include an assessment of the financial impact,

but crucially it must also describe and assess the impact of the decision on the quality of our services and the equalities for our population. Each case must set out a case for change in terms of the benefits it will bring to patients, and the options that we have considered.

4. Implementing any JLHWS
BSW is a complex system, but partners are committed to working together to jointly implement a set of health and care priorities that take into account the joint local health and wellbeing strategies. We came together in 2023 to write and publish our ICP Strategy, which describes our three strategic objectives and the nature of the challenges that we want to collectively tackle. We know that our three places have different challenges and this includes different inequalities and issues to tackle – but as an ICS, we know that we have opportunities to resolve these challenges by working together at scale, supported by the ICB Board.

As part of developing our 5-year commissioning plan, we have documented our Integrated Needs Assessment which draws together the JSNAs supplemented by our own analysis of the challenges facing our local population. In future, we will be working across our cluster to make sure that we are using our collective resources in the way that creates the most value for our population and tackles our collective challenges most effectively.

Our Integrated Care Alliances are a key part of the way that we work in BSW. These are our places, and our alliances at place-level demonstrate our commitment to reducing inequalities and improving outcomes for our residents and patients. This approach will be consistent in future as we work across our larger Cluster, as place will continue to be an important.

5. Financial duties
The ICB has established Standing Financial Instructions and a Scheme of Financial Delegation which set out how it ensures that it fulfils its statutory duty to carry out its functions effectively, efficiently and economically. These are part of the ICB's control environment for managing the organisations financial affairs as are designed to ensure regularity and propriety of financial transactions.
The ICB has a legal obligation to live within the financial allocations that it receives each year. This is both for revenue and capital.

The ICB produces an annual operating plan which is agreed by the ICB Board and sets out how the ICB will deliver on its financial priorities and duties. The ICB is required to appoint an auditor in accordance with the Local Audit and Accountability Act 2014 to audit its accounts for a financial year.

Financial performance is assured by the Finance and Infrastructure Committee with the control environment being assured by the Audit Committee. This is supported by an internal audit and counter fraud service.
Financial recovery requirements are supported by a dedicated Financial Recovery Board.

An Investment Panel operates to assure all system investment over £50k as part of a triple-lock process involving the ICB, Providers and NHSE.

6. Duty to improve quality of services
Quality is a shared goal that requires system commitment and action in order to ensure that we provide the highest quality health and care.

System Quality is based on these principles:

- Collaboration, trust and transparency.
- Transformation.
- Equity and equality.

In practice this means that the system will deliver care that is safe, effective, well led, sustainably resourced and equitable. The care experience of the population will be positive through responsive, caring and personalised delivery.

BSW now has an established System Quality Group (SQG) that meets bi-monthly, chaired by BSW ICB Chief Nursing Officer.

The National Quality Board (NQB, 2021) risk response and escalation sets out the three levels of quality assurance and escalation process. This has been set out in the BSW SQG TOR to support system understanding and reporting processes. The approach is providing the required level

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of support needed at system level to understand level of risk, mitigations needed and priorities for improvement, for those organisations or pathways with risks identified. This has been enhanced by the utilisation of dynamic risk assessment and management, for example across UEC and flow pathways.

A credible and focused quality strategy and assurance framework aimed at enhancing our understanding of quality and safety across the ICS is being finalised following workshop in early 2025 and will be signed off by Quality and Outcomes Committee in March 2025. The assurance framework sets out a defined governance, risk and response process, and is aligned to the national quality standards and regional NHSE quality forums.

To support this assurance framework, an agreed set of BSW Quality Assurance (QA) metrics has been developed with support from the BI Team, and now informs the BSW integrated performance and quality dashboard and reporting to both BSW Executive Management Meeting, Quality Outcomes Committee and BSW System Quality Group.

All providers have implemented Patient Safety Incident Response Framework (PSIRF) and have credible Patient Safety Incident Response Plans (PSIRPS) and updated relevant policies to incorporate the changes. All provider organisations who are required to have Patient Safety Specialist (PSS) with level 3/4 accredited training have supported colleagues to attend the training, with the first cohort of PSS's expected to graduate in Q4 24/25. During Q4 of 24/25 BSW ICB will be collaborating with providers to assess providers current maturity with the delivery of PSIRF, this work is being supported by Health Innovation Network West of England.

In 2024 – 26, the BSW system will be recognised as a thriving and empowering patient safety learning system. All system partners will commit to working collectively to ensure the appropriate oversight is in place to maximise the opportunities of sharing insight, participating in collaborative Improvement, and learning, to continuously improve patient safety for everybody living in BANES, Swindon, and Wiltshire. A collective approach will be achieved through already existing improvement networks and Community of Practices, for example, Patient Safety Specialists, LeDeR and BSW Local Maternity and Neonatal System, and if required, through the development of new improvement networks to align to shared improvement priorities. West of England Health Innovation Network (WEHIN) will be an important partner to help BSW system adopt and optimise continuous improvement and learning. The integral relationship with BSW System Quality Group (SQG) will also offer further opportunity to share learning and ensure further opportunities for:

- Positive assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having the desired effect.
- Confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation are being addressed.
- System efficiency for thematic learning and improvement.

Learning from reviews, audits and wider system insight is used to inform commissioning and quality improvement activity. In doing so, the ICB has regard to relevant statutory guidance, including that issued under the Autism Act 2009 and the Down Syndrome Act 2022, where this informs service design, accessibility, reasonable adjustments and quality assurance. This approach supports the identification and reduction of avoidable harm and unwarranted variation, particularly for people who require additional support or reasonable adjustments.

During 24/25 BSW has successfully mobilised the BSW mortality group, as well as introducing a UEC and flow safety group and a BSW oversight and learning group. All acute providers across BSW are also participating in the pilot to implement Martha's rule:

1. All staff in NHS Trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.

2. All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about a patient's condition.

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3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist Trusts.

All Provider critical care outreach teams are active participants in the Community of Practice (COP) facilitated by WEHIN. The COP's aim is to support teams delivering Martha's Rule and Identify and share good practice across the region and create a safe space for lead clinicians to ask questions. All providers are submitting data to the national team as part of the pilot programme.

This includes consideration of how commissioned services identify and respond to the needs of people who may be at increased risk of poorer experience or avoidable harm if care is not accessible or appropriately adjusted. The ICB will take account of the Mental Health Act 2025, which modernises the statutory framework for detention and treatment of people in mental health crisis, ensuring commissioning and oversight arrangements align with national guidance as it is issued.

7. Duty to reduce inequalities
Strategic Objective 2 sets out our work to achieve fairer health and wellbeing outcomes in detail.

The Health and Social Care Act 2022 described the duties as to reducing inequalities.

In exercising its commissioning, planning, prioritisation and resource allocation functions, the ICB applies this duty consistently across strategy development, service design, contract management and performance oversight.
The Act requires each integrated care board to have regard to the need to a) reduce inequalities between persons with respect to their ability to access health services, and b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services, including effectiveness, safety and experience.

NHS England's Statement on Information on Health Inequalities sets out national expectations for how ICBs should collect, analyse and use information on access, experience and outcomes to identify unwarranted variation and inform targeted action, aligned with Core20PLUS5 and medium-term planning expectations.

In reducing inequalities, the ICB recognises that variation in access and outcomes may arise from factors beyond deprivation alone, including communication needs, accessibility of environments and information, availability of reasonable adjustments and pathway design with anticipatory consideration of accessibility and communication needs at the point of commissioning and service design. These considerations inform commissioning decisions alongside population health data.

During 2025/26, BSW has achieved this in the following ways:

- Inequalities priorities embedded into all ICS Delivery Group plans, supported by structured reviews and Action Learning Reviews to align commissioning, delivery and outcomes and to support shared learning across the system.
- Health inequalities funding used to support place-based programmes, with 27 projects commissioned for 2025/26 through collaborative, place-based prioritisation processes, targeting inequities in access, experience and outcomes.
- Continued progress towards Core20PLUS5 goals, with delivery focused on populations experiencing the greatest gaps in access and outcomes.
- Development of the Outcomes Framework, shifting focus from activity to health outcomes and wellbeing, with segmentation by inequality groups to identify differential access and outcomes. A dashboard has been developed to guide targeted investment, planning and assurance.
- Inequalities are embedded as a core consideration across commissioning intentions within the Medium-Term Plan, informed by the System Outcomes Framework and Core20PLUS5 priorities.

Delivery of the duty to reduce inequalities is overseen through formal system governance, with routine reporting and assurance through the Population Health Board and the Quality Outcomes Committee.

The Population Health Board's purpose is to provide strategic oversight and accountability for the

implementation and delivery of the Core20PLUS5 and Core20Plus5CYP Health Inequalities programme, and for BSW's Health Inequalities and Prevention Programme. The Population Health Board advises the ICB on how the prevention and health inequalities agendas can be integrated with the ICB's and BSW's strategies and plans. The Population Health Board has established three sub-groups to support this purpose:

- Population Health Management Intelligence Forum, with system leadership from Director of Public Health for Wiltshire.
- Health Inequalities Strategy Group, with system leadership from Director of Public Health for Swindon.
- Prevention Strategy Group, with system leadership from Director of Public Health for Bath and North East Somerset.

8. Duty to promote involvement of each patient
The ICB focuses on Personalised Care and making this business as usual, building relationships between people, professionals and the wider community to allow people more choice and control over the way their care is planned and delivered. We will continue to plan utilising the comprehensive model of personalised care support improved health outcomes:

Patient choice, ensuring the Accessible Information Standard is met so that everybody has access to information they can understand and is able to communicate the things that are important to them. We will look at evidence to demonstrate active choice conversations are regularly being held e.g. Ask me 3, BRAN- Benefits, Risks, Alternatives, Do Nothing It's ok to ask, What Matters To You which encourages people to ask key questions, so they are better supported to make a decision about care, support or treatment options.

Shared decision making: Plan for decision making initiatives embedded in pathways with a shared understanding of what good looks like. Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a person to reach a joint decision about their treatment and agrees outcomes wanted.

Personalised care and support planning: Looking at opportunities to develop further, measuring impact and outcomes for shared learning. People are central in developing and agreeing their personalised care and support plan, including deciding who is involved in the process. There will be a focus on proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing.

Hospital passports are widely used for people with a learning disability and/or autism to reduce risk across partners and ensure people and families only have to tell their stories once. This includes recognising that some people may require adapted approaches to involvement, such as accessible information, supported communication or involvement of carers or advocates, to enable meaningful participation in decisions about their care. Social prescribing and community-based support (links to 3rd sector): Social prescribing is a key component of Universal Personalised Care. It is an approach that connects people to activities, groups, and services in their community to meet the practical, social, and emotional needs that affect their health and wellbeing. We plan to improve selfcare through people with:

- One or more long term conditions.
- Who need support with low level mental health issues.
- Who are lonely or isolated.
- Who have complex social needs which affect their wellbeing.

There will be access to social prescribing link workers to co-produce a personalised care and support plan to support people to take control of their health and well-being. Supported self-management: Supported self-management means increasing the knowledge, skills, and confidence a person has in managing their own health and care by putting in place interventions. We will focus on how we can build on the use of evidence-based interventions such as peer support, self-management education and health coaching that can slow disease progression, reduce early mortality and reduce costs.

PHBs: The use of Personal Health Budgets will be explored

further to allow for greater flexibility in meeting personal health needs. There will be a particular focus for those who have the following care needs:

- Adults and children who receive NHS continuing healthcare funding.
- Care funded jointly by NHS and social care.
- A learning disability.
- Those with mental health needs.
- End-of-life care services.
- Wheelchair services.

Also please refer to the engagement and involvement sections of the plan.

9. Duty to involve the public

There are three strands to our system approach to engagement and involvement:

1. Maximising the opportunities to undertake engagement and involvement with our partners and communities jointly with partner organisations.

2. A devolved approach where all colleagues recognise their individual role in engaging and involving stakeholders and our local populations.

3. Adoption and implementation of the 10 elements of statutory guidance on involvement.

Our approach to ensuring that all parts of our population our able to engage and be involved will be informed by our local Joint Strategic Needs Assessment (JSNAs) and population health management data so that we are able to focus on communities where we know there are poorer health and wellbeing outcomes. This approach supports inclusive engagement by taking account of groups who may face barriers to traditional engagement methods, ensuring that involvement activity is representative and accessible.

We plan to develop a BSW engagement portal and citizens panel, to make use of different approaches to achieving more effective interaction between services and communities.

We will also create an engagement advisory panel, acting as a cohort of experts by experience, to inform our thinking and planning, and ensure that senior leaders are directly, regularly, and fully in touch with our population.
The work to bring these initiatives together will be captured in the ICB People and Communities Involvement Strategy.

10. Duty to enable patient choice

Each ICB must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them. We will remain compliant with the legal regulations for choice whilst also developing the elective strategic ambition to network our provision for best deployment to reduce waiting times and reduce inequities in access and associated inequalities.

The BSW Referral services currently comprise of two services: BSW Referral Service and SARUM Referral Service – a separately commissioned referral services for SARUM area (South Wiltshire) GP Practices. BSW referral services interface between GP practices and secondary care, to facilitate patients making informed choices about where to go for consultation and possible treatment. The main objective of the service is to provide a smooth journey from referrer to provider and ensure that patients are offered appropriate patient choice of healthcare provider ensuring that they are seen in the 'right clinic, first time'. This process therefore reduces the burden on both referrers and providers and supports the patient journey. Patient choice is also promoted and publicised on the ICB website.

Over the next year we will continue to develop our elective co-ordination activities to both ensure capacity across the system is used to provide in-system mutual aid, and to ensure patients have the best information available to inform choice decisions.

We have implemented our Right To Choose provider accreditation process and accredited two providers with two further providers in process of being accredited. Further work is being undertaken to refine the documentation and approval process.

We have ensured all of our providers have mobilised the Digital Mutual Aid process, and co-ordinated a system response to the Patient Initiated Mutual Aid programme (Phase 1).

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11. Duty to obtain appropriate advice
Each ICB must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in the prevention, diagnosis or treatment of illness and the protection or improvement of public health. Where decisions affect population groups with specific or additional needs, the ICB will seek relevant professional, clinical or experiential advice, proportionate to the decision being taken.

BSW ICB will follow this approach in seeking advice, including from local authority partners, through formal governance arrangements and other appropriate means:

1. Clearly identify the issue requiring advice with specific objectives outlined for the advice being sought.

2. Determine the type of advice needed most appropriate for the objectives and issue, whether in prevention, diagnosis or treatment of illness, or the protection or improvement of public health. That could be legal, financial, technical, strategic, clinical or other types as required.

3. Determine the potential sources of appropriate advice, drawing from experts either inside or outside the system.

4. Work to understand the most appropriate advice source from those selected based on expertise, experience, credibility, and alignment to the ICB vision.

5. Establish formal contact with sources of advice against a clear brief, explaining the issue. Following ICB procurement practices where applicable, asking for experience, expertise, qualifications, availability, any conflicts of interest, and rates where any of these are unknown.

6. Evaluate advice received, determining the relevance and applicability, together with the effectiveness in addressing the issue.

7. Consider seeking second opinion or further advice as appropriate.

Advice may be deemed ongoing or on-demand. On-going advice may be incorporated in permanent representation to governance mechanisms associated with ICB as required, for example with specialist clinical or legal advice supporting local policy formulation according to best practice.

BSW ICS is fortunate to feature clinical networks, alliances, public health, social care, clinical senates, academic institutions, as well as having access to regional networks including NHSE SW.

All ICBs have varying demographics, and it is therefore important for BSW ICB to be able to seek the most appropriate advice for its partners and population.

12. Duty to promote innovation
The UK Life Sciences Sector Plan 2025, sets out the strategic intent for life sciences and biomedical innovation over the next decade, emphasising stronger translation of research into patient impact. The ICB will promote innovation in the provision of health services (including in the arrangements made for our provision). We will promote local innovation, build capability for the adoption and spread of proven innovation and work with Health Innovation Networks (HINs) and other local partners, such as the University of Bath. We will support the identification and adoption of new products and pathways that align with our population health needs and address health inequalities.

HINs bring together the NHS, industry, academic institutions, third sector organisations and local partners to ensure that innovations, improvement, and best practices benefit more patients faster, and they offer a natural partner to help ICBs foster and grow an innovation culture. In 2024/25, the ICB has developed closer working relationships with the HIN. This has included:

- Developing a more strategic approach to the role of the ICB in facilitating and supporting HIN programmes across the ICS (both nationally mandated and locally co-designed programme work, such as Black Maternity Matters).
- Collaborating around opportunities for innovation in our medicine's optimisation programme.

- Supporting the development of the West of England and South West Life Sciences Cluster by providing leadership insights.

The role of the BSW ICB Research and Innovation lead will be a key focus for the development of a meaningful programme of innovation culture and activity which aligns to the strategic priorities of BSW ICB. This capacity will focus on how we can build on these assets and accelerate identifying and embedding innovations in BSW as part of the strategic commissioning cycle.

When innovation is embedded within ICBs, commissioners can generate evidence through live service delivery, identify opportunities for innovation and adapt rapidly. Therefore in 2026/27 we will develop a more structured approach including:

- We will champion a mindset of curiosity, learning, and iteration. By aligning innovation to strategic priorities, it will be purposeful and accountable. Embracing innovation requires cultural change.
- Commission with an innovation lens by maximising the opportunities for commissioning decisions to consider relevant research evidence and opportunities for innovation.
- Creating governance structures that embed innovation appraisal into business case processes
- Working with the Life Sciences sector and HINs to support early adoption and spread of innovation.
- Embed evaluation into all transformation projects through the use of evaluation frameworks (e.g. logic models, realist evaluation, cost-benefit analysis) as standard parts of programme design.
- Participate in real-world pilots or pathfinder projects with structured evaluation support.

13. Duty in respect of research

In line with the Health and Care Act 2022 ICBs have a statutory duty to support, facilitate and use research that is relevant to the health service. This duty builds reflects the NHS Constitution's commitment to research as a core NHS function. This duty aims to embed research into NHS planning, commissioning, and service delivery so that patient care is informed by robust evidence and contributes to broader improvements in health outcomes. In practical terms, BSW ICB must actively encourage research activity and the application of research findings across the health system. This may be done by:

- Considering research evidence in commissioning decisions.
- Encouraging NHS providers to participate in relevant NIHR research.
- Promoting the use of evidence in clinical practice and decision-making.
- Helping to support and sustain research infrastructure or partnerships where feasible.

For BSW ICB this is a unique opportunity to help support and facilitate research across the BSW ICS to the benefit of our population and to disseminate successful research within BSW into the wider NHS. Research in this context includes all research benefitting health and care outcomes such as advancing health and care operations, management, and leadership, as well as clinical trials. Some of the ways in which the ICB aims to support research include:

1. Fostering collaboration: Identifying all partners connected to BSW ICS which are either involved, aspire to be, or would benefit from connection with research including academic institutions. Bringing together health and care professionals, researchers, and patients to collaborate and understand contemporary issues, facilitating a more integrated approach to research.

2. Enabling funding: ICB can help to coordinate the enablement of funding to support research projects. This can help to incentivise researchers to conduct studies aligned to system priorities and can help coordinate necessary resources.

3. Providing and supporting with data collection: BSW ICB can provide support for data collection and analysis. This can help researchers to access the data they need to conduct their studies and can ensure that data is collected and analysed in a consistent, ethical, well-governed and reliable way.

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4. Encouraging and facilitating patient involvement: BSW ICB can work to involve patients in research projects, mindful of existing inequalities evident in the conduct and application of research.

5. Supporting research governance: BSW ICB can play a key role in ensuring research is conducted in an ethical and transparent manner. We can provide guidance on research governance. This is currently supported via our relationship with the BSW Research Hub (funded via NIHR for the system). Delivery in the previous period includes:

- BSW ICB leading a BSW Research & Innovation Forum inviting all partners and stakeholders within BSW to quarterly sessions to network, share opportunities and learning. This is providing a key conduit in and out of the system for research and innovation related matters.
- Following the appointment of an R&I Lead, we began the implementation of a co-created Research & Innovation Approach for BSW, mindful for alignment with ICB cluster partners.
- Further developing the role of the Research Engagement Network (REN) including establishing a well-attended BSW Diversity in Research forum and community pharmacy research engagement
- Strengthening relationships with key partners including HIN, ARC West and ARC Wessex, neighbouring system leads. This includes

Our next steps for the coming period include:

- Continuing the implementation of the short-term objectives from our BSW Research & Innovation Approach focusing on the enablers and aligning our objectives with cluster partners.
- Embedding and integrating the new BSW Research & Innovation Lead role into ICB planning and strategy to optimise the development of R&I into all programme work, where relevant.
- Using ICB levers to ensure equitable access to research for underserved populations. We will build the reach and scope of our Research Engagement Network (REN) activities as we transition through cluster arrangements, aligning with cluster partner RENs through 2026/27 and seeking additional funding for programme work to continue.
- Responding to the NHSE mandate of all ICBs to report research metrics from March 2026.
- Integrate research into governance structures by embedding research impact measures in business case templates, investment decisions, and service reviews.
- Support the strategic commissioning cycle by building pathways within health learning system informed by research, local data, evaluation, and innovation.

By fostering a collaborative approach to research, BSW can help to improve patient outcomes and better leverage research potential to deliver the ICS strategy more efficiently. In 5 years', time, the system should see a more effective, aligned (as section 3.2 of the guidance), systematic and comprehensive approach to research.

14. Duty to promote education and training

- The ICB has previously worked in partnership with a range of universities and colleges. The partnerships support workforce supply routes, new role development, post registration skills and access to education expertise to inform BSW workforce priorities. As stated in the model ICB Blueprint this will now sit with Providers.
- There is a commitment to apprenticeships with system partners working together for maximising the impact of apprenticeship routes for entry levels roles and career development. The plans include a well-established levy sharing process for non-levy paying partners in mutually supporting workforce development in new roles as nursing associates and advanced clinical practitioners. As stated in the model ICB Blueprint this will now sit with Providers.
- There is a system wide oversight of clinical placements and education capacity so that trainees can access high quality placements across health and care sectors. This work has included a focus on expanding clinical placements in primary and social care in line with enabling neighbourhood health models of care.
- Partners have committed to the passporting of statutory and mandatory training thereby, supporting movement across organisation boundaries and efficiency of training resources.
- The ICB leads the Training Hub responsible for the supporting education and training in primary care for example, expansion of clinical placements, enabling training programmes and workforce planning.

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15. Duty as to climate change
The ICB recognises that the climate emergency is a health emergency.

The Health and Care Act 2022 places a statutory duty on NHS organisations to contribute to achieving net zero and to mitigate the impact of climate change on health and care services. We are committed to embedding environmental sustainability into all aspects of our planning, commissioning, and delivery of care.

Our approach is set out in the BSW Together Green Plan 2025–2028, approved by the ICB Board in November 2025. This plan builds on our previous progress and sets out how we will deliver sustainable healthcare and achieve net zero in line with national NHS targets:

Net Zero Targets

- For emissions we control directly, reach net zero by 2040, with an 80% reduction by 2028–2032.
- For emissions we can influence, reach net zero by 2045, with an 80% reduction by 2036–2039.

We will work collaboratively with partners, local authorities, and communities to create a greener, healthier future. Our actions focus on ten priority areas:

Our 10 Priority Areas for Action

1. Workforce and System Leadership – Embed sustainability into leadership, governance, and workforce training so that every colleague understands their role in achieving net zero.

2. Care Model Transformation – Shift towards preventative, out-of-hospital, digitally enabled care models that reduce emissions and improve health outcomes.

3. Digital Transformation – Harness digital technology to improve care delivery while minimising the environmental impact of IT infrastructure and devices.

4. Medicines and Medical Gases – Reduce emissions from prescribing and anaesthetic gases, promote low-carbon alternatives, and cut medicines waste.

5. Estates and Facilities – Decarbonise NHS buildings, improve energy efficiency, and embed net zero design in new developments.

6. Travel and Transport – Support active travel, public transport, and transition to zero-emission vehicles across our fleet and workforce.

7. Food and Nutrition – Promote healthy, local, and seasonal food options, reduce food waste, and improve sustainability in catering.

8. Supply Chain and Procurement – Align with the NHS Net Zero Supplier Roadmap, prioritise sustainable products, and deliver social value through procurement.

9. Adaptation – Ensure our healthcare system is resilient to climate change by planning for extreme weather and embedding climate risk into business continuity.

10. Green Spaces for Health – Enhance biodiversity and create therapeutic green spaces across our estate to support wellbeing and nature recovery.

For full details of our commitments and actions, please refer to the BSW Together Green Plan 2025–2028.

16. Addressing the particular needs of victims of abuse
The BSW ICB Chief Nurse and the ICB safeguarding team are representatives on all three safeguarding partnerships, including the Violence Reduction Unit (VRU) in B&NES locality, Swindon Community Safeguarding Partnership and Wiltshire Community Safeguarding Partnership. Community Safety Partnerships (CSPs) VRU's have an explicit role in evidence based strategic action on serious violence and these partnership meetings will be the driver for delivering the serious violence duty (SVD) and safeguarding Statutory Duties. The ICB, as a Specified Authority, will work with Relevant and Specified Authorities to collaborate on a multi-agency approach to prevent and reduce serious violence.

BSW ICB, as a statutory safeguarding partner, is committed to working in collaboration with Police and Local Authorities to ensure the people across our area are safeguarded. Safeguarding means protecting people's health, wellbeing and human rights; enabling them to live free from harm,

abuse and neglect. It is an integral part of providing high-quality health care. This is achieved through partnership working with all statutory and VCSE agencies across our area via the Safeguarding Partnership Boards, Domestic Abuse and Sexual Violence Boards, Community Safety Partnerships and the Health & Wellbeing Boards. Effective safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances. The ICB is working with partners to support strategic planning in the prevention and reduction of violence in our local communities. This includes collating and analysing health data from NHS Accident and Emergencies, strengthening links with primary care networks and sharing of intelligence.

Safeguarding children, young people and adults is a collective responsibility. Children, young people and adults live in families and local communities; these can be sources of support and safety or of danger and risk. Our approach to safeguarding and protecting our community is focused around where people live and with whom – it's an approach which has 'Think Family, Think Community' at its heart working with and for our communities.

The ICB discharges its responsibilities in line with the statutory requirements of Section 11 Children Act 2004, Working Together to Safeguard Children (2023), the Mental Capacity Act 2005, the Care Act 2014 the Domestic Abuse Act 2021 and the Serious Violence Duty 2021. The Safeguarding Accountability and Assurance Framework (SAAF) identifies core duties across the lifespan of safeguarding for individuals working in providers of NHS-funded care settings and NHS commissioning organisations. Our safeguarding team provide safeguarding leadership through expert safeguarding advice and expertise and engagement in sub-groups, audit processes and learning from significant incidents and statutory learning processes such as Safeguarding Child Practice reviews, Domestic Homicide Reviews, Safeguarding Adult reviews and Child Death Overview Panel.

Domestic Abuse

We will continue to ensure services are appropriately commissioned and developed to specifically address the needs of victims of abuse within existing funding allocation and ensure services are appropriately commissioned and developed which focus on early intervention and prevention.

The ICB will further improve the effectiveness of the multi-agency approach to support victims, working with partners to tackle perpetrators and prevent domestic abuse in accordance with the requirements of the Domestic Abuse Act 2021.

Sexual Violence

The ICB will consolidate the commissioning of the non-recent service abuse service which will include holistic assessment and care for children referred whenever there is an allegation of non-recent sexual abuse.
Access to sexual assault referral centres (SARC's) has been further developed with the commissioning of the Swindon and Wiltshire Sexual Violence Therapeutic Service and we will seek work with partners to further develop services across BSW.

Child Sexual Abuse

BSW ICB in collaboration with partners undertook a piece of work in 2024 to review the existing pathways of support and resources for those who had experienced sexual violence, audited awareness and understanding of sexual abuse within ICB service providers and completed a review of clinical records. In 2024, The Child Safeguarding review panel published 'I wanted them all to notice' which makes recommendations to improve earlier identification, response and support to sexual abuse. It contains recommendations for commissioning to provide services for the assessment of people presenting a risk of sexual harm and commissioning of services to respond to the health needs of sexual abused children. The Victims and Prisoners Act 2024 has provided legislation to underpin the duties of ICBs to collaborate in the commissioning and provision of services for Sexual abuse, Domestic abuse and Serious Violence, including a local strategy based on a local needs assessment.

In 2024/25 we have continued to lead on developing practice, policy and procedure which safeguards unborn and under 1's across all our system with partners with a focus on prevention and early intervention. The delivery of the ICON programme is part of the BSW Under 1's programme works to reduce injury and harm to our most

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vulnerable population. Abusive head trauma in children aged under one, accounts for 200 deaths in the UK a year and 24 out of every 100,000 hospital admissions.

The impact is significant and long lasting for families, for children who survive there are significant costs across health and social care to meet the lifelong care needs of these children.

Organisations are now working towards establishing ICON within their delivery of care, with the aim for the five contact points to be implemented by June 2025 and awareness for ICON conversations within Children's Wards, Emergency Departments, Minor Injury Units and Out of Hours Services. We have also worked with wider partners and have training progressing within police, social care and have plans to extend this to early years partners and wider community resources.

We continue to work with our partners using our population data to develop a serious violence strategy, developing multi-agency interventions to support victims of abuse to deliver excellent health services and focus on prevention and early intervention.

Serious youth violence is an increasing concern amongst the multi-agency safeguarding system and partners contribute to the ongoing planning and implementation of strategies alongside and through the serious violence duty to try and mitigate the risks to the young people, their families and networks. Into 2024-26 BSW will work with providers to develop a package of training which recognises the needs of victims and survivors that is trauma-informed and recognising the impact of Adverse Childhood Experiences, reasons for distrust in authorities and designing appropriate responses to better support people to access the support they want and need.

We will ensure health elements of the pathways for victims of abuse are linked to the broader ICB health inequalities agenda, addressing inequalities – supporting the most vulnerable and identifying and addressing inequality of risk.

17. Addressing the particular needs of CYP
In line with our statutory duties under the Health and Care Act 2022, and building on the ambitions of the NHS 10 Year Health Plan for England, we have identified our vision and priorities for babies, children, and young people across BSW.

Our nominated Executive lead for children and young people, alongside our Chief Nurse who is lead for special educational needs and disabilities (SEND)and Safeguarding, champion the needs of babies, children and young people, ensuring visible board-level leadership and focus. We have a well-established partnership Children and Young People's Delivery Group which focuses on how the needs and health and wellbeing outcomes of babies, children, young people and families can be met and improved.

BSW ICB is working in collaboration with each Local Authority and system partners to respond to the latest health and social care reforms including the Families First Partnership Programme, Neighbourhood agenda and the awaited SEND reforms.

In addition, we note the following key objects:

1. Emotional Wellbeing and Mental health support is available for children and young people who need it, when they need it

2. The most vulnerable children and young people are well supported, including those in and leaving care, as well as those who need to be kept safe

3. Children are ready to start education and educational attainment gaps are addressed

4. There are better links between health and care services and schools

5. Ensuring CYP waiting for elective care including autism and ADHD assessments are supported to 'wait well' and those with additional support needs are appropriately prioritised

6. Improving experience of CYP and families who may need to attend our hospitals. Providing acute respiratory illness hubs for CYP in local communities during Winter.

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7. Embedding integrated neighbourhood teams as part of the ICBC programme for CYP will deliver joined-up, integrated support for children and families.

8. We remain committed to meeting the needs of children and young people with special educational needs and disabilities (SEND) in partnership with our Local Authorities and Parent Carer Forums. We are also committed to implementing the health elements of future SEND reforms and national and local SEND and Alternative Provision Improvement Plans.

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Appendix 3: Glossary

A&E – Accident and Emergency Department (interchangeable with ED)

ACP – Advanced Clinical Practitioner

ACM – Acute-Centric Model

AACC – All-Age Continuing Care

ADHD – Attention Deficit Hyperactivity Disorder

ADEPT – Advanced Data Exploration and Processing Tool

ASR – Acute Services Review

AI – Artificial Intelligence

ARADD – Alcohol-Related Admissions Deep Dive

ASC – Adult Social Care

AMR – Antimicrobial Resistance

AMS – Antimicrobial Stewardship

ANP – Aspire Nursing Programme

AVT – Ambient Voice Technology

BAF – Board Assurance Framework

BAME – Black and Minority Ethnic Groups

BSF – Behavioural and Social Factors

BAU – Business As Usual

B&NES – Bath & North East Somerset

BCF – Better Care Fund

BPC – Blood Pressure Checks

BPS&SIOT – Baseline Prevention Spend and Shift Investment Over

BSW – Bath and North East Somerset, Swindon and Wiltshire

C&CS – Communication & Cultural Sensitivity

CDEL – Capital Departmental Expenditure Limit

CHC – Continuing Health Care

CHS – Community Health Services

CCC – Care Coordination Centres

CDC – Community Diagnostics Centres

CDG – Community Delivery Group

CDS – Community – Driven Solutions

CIP – Cost Improvement Programme

COI – Cross Organisation Improvements

COVID – Coronavirus Disease

CPF – Capital Prioritisation Framework

CPD – Continuous Professional Development

CQC – Care Quality Commission

CS – Clinical Standards

CSA – Coordinated Systems Approach

CSL – Collaborative System Leadership

CM – Contract Management

CPI – Cancer Pathway Improvement

CRP – Carbon Reduction Plans

CT – Computerised Tomography

CTAC – Cyber Tactical Advice Call

CVD – Cardiovascular Disease

CYP – Children and Young People

DCC – Direct Clinical Care

DDaT – Digital Data and Technology

DfE – Department for Education

DFP – Digital First Pathways

DHCS – Department of Health and Social Care

DIR- Digital Inclusion Roadmap

DMS – Demand Management Schemes

DNA – Did Not Attend

DoLS – Deprivation of Liberty Safeguards

DPC – Delivery of Planned Care

DSC – Directory of Services Commissioning

DSE – Diagnostic Strategy Expansion

APPENDICES

DST – Digital Strategic Themes
DS – Digital Strategy
DT – Digital Transformation
DTAC – Digital Technology Assessment Criteria
DWM – 'Discuss With' Model
ECH – Extra Care Housing
ED – Emergency Department (interchangeable with A&E)
EHCH – Enhanced Health in Care Homes
EHCP's – Education and Health Care Plans
EHR – Electronic Health Record
EIA – Equalities Impact Assessment
EIS – Enabling Infrastructure Strategy
EMG – Executive Management Group
ENT – Ear, Nose and Throat
EOC – Elective Orthopaedic Centre
EPR – Electronic Patient Record
ERF – Elective Recovery Fund
ERP – Elective Reform Plan
ESD – Early Supported Discharge
FCP's – First Contact Practitioners
FDP – Federated Data Platform
FFT – Friends and Family Trust
FHH – Family Health Hub
FNC – Funded Nursing Care
FS – Frailty Strategy
Frail t-ED – Frailty Triage in the Emergency Department
GCG – 'Get Connected' Group
GIRFT – Getting It Right First Time
GP – General Practitioner
GPIT – General Practice Information Technology
GPwER – General Practitioner with Extended Roles
GWH – Great Western Hospital
H@H – Hospital at Home
HCL – Hybrid Closed Loops
HCRG – Health Care Resource Group
HEAT – Health Equity Assessment Tool
HEDO – Hypertension Early Detection and Optimisation
HEE – Health Education England
HEI – Higher Education Institutiion
HG – Hospitals Group
HLE – Healthy Life Expectancy
HVLC – High Volume Low Complexity
IA&O – Improved Access & Outcomes
ICAS – Integrated Care Alliances
ICB – Integrated Care Board
ICBCC – Integrated Community – Based Care Contract
ICR – Integrated Care Record
ICS –Integrated Care System
ICF – Investment Committee Framework
IEP – Integrated Estate Plan
IIA – Integrated Impact Assessment
IP – Implementation Plan
IPD – Integrated Planning and Delivery
IPMC – Infection Prevention and Management Collaborative
IETS – Initial Education and Training Standards
IHG – Inequalities in Healthcare Group
IMD – Index of Multiple Deprivation
ICA – Integrated Care Alliance
INA – Integrated Needs Assessment
INT – Integrated Neighbourhood Teams
IUCS – Integrated Urgent Care
IVDU – Intravenous Drug Users
JSNA – Joint Strategic Needs Assessment

APPENDICES

LA – Local Authority
LAHWB – Local Authority Health & Wellbeing Boards
LD – Learning Disability
LDA – Learning Disability and Autism
LDAN – Learning Disability, Autism and Neurodivergence
LE – Life Expectancy
LFOD – Linked Finance Outcomes Data
LoS – Length of Stay
LTC – Long Term Conditions
M&E – Measurement and Evaluation
MCA – Mental Capacity Act
MCB – Maternal Care Bundle
MD – Monitoring Delivery
MDT – Multi-disciplinary Team
ME – Myalgic Encephalomyelitis also known as Chronic Fatigue Syndrome
MECC – Making Every Contact Count
MH – Mental Health
MHA – Mental Health Access
MHSDS – Mental Health Services Data Set
MIU – Minor Injury Unit
MIG – Medical Interoperability Gateway
MOSS – Maternity Outcomes Surveillance System
MRI – Magnetic Resonance Imaging
MSK – Musculoskeletal
MTP – Medium Term Plan
NCTR – Non-Criteria to Reside
ND – Neighbourhood Development
NEWS 2 -National Early Warning Score
NEWTT – Newborn Early Warning Trigger and Track
NHP – Neighbourhood Health Plan
NHS – National Health Service
NHSE – NHS England (merged with NHSI 01/07/22)
NOF – NHS Oversight Framework
NICE – National Institute for Health and Care Excellence
OD -Organisational Development
ODT – Outpatient and Diagnostics Transformation
OF – Outcomes Framework
ONS – Office for National Statistics
OOH – Out Of Hours
OPEL – Operational Pressures Escalation Levels Framework
OT – Occupational Therapist
PA – Programmed Activities
PAU – Paediatric Assessment Unit
P&EI – Prevention & Early Intervention
PCBI – Primary Care – Based Initiative
PCE – Primary Care Estates
PCL – Primary Care Leadership
PCN – Primary Care Network
PCR – Provider – Community Relationships
PCSP – Personalised Care Support Planning
PDC – Proportion of Days Covered
PF – Pharmacy First
PH – Public Health
PHA – Population Health Analysis
PHB – Personal Health Budget
PHM – Population Health Management
PLA – Place Level Analytics
PLD – Provider Level Data
PLICS – Patient-Level Information and Costing System
PM – Pathway Mapping
PMB – Post Menopausal Bleed
PPM – Patient Participation Group
PRD – Prevent Reduce Delay

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PREMs – Patient Reported Experience Measures

PROMs – Patient Reported Outcome Measures

PPS – Pharmacy Prevention Services

PSED – Public Sector Equality Duty

PSIRF – Patient Safety Incident Response Framework

PT – Prevention Touchpoint

PTW – Pathway Transformation Work

PR – Pathway Reviews

QAIF – Quality Assurance and Improvement Framework

RI – Rapid Implementation

ROI – Return On Investment

RRSLS – Resource Reallocation to Support Left Shift

RTT – Referral to Treatment

RMF – Risk Management Framework

RUH – Royal United Hospital

SCF – Strategic Commissioning Framework

SDEC – Same Day Emergency Care

SDF – Service Design Feedback

SDUC – Same Day Urgent Care

SEND – Special Educational Needs and Disabilities

SFD – Scheme of Financial Delegations

SFT – Salisbury Foundation Trust

SHAPE Tool – School Health Assessment and Performance Evaluation

SIEM – Security Information and Event Management

SLT – Speech and Language Therapy/Therapist

SMI – Severe Mental Illness

SoRD – Scheme of Reservations and Delegations

SQG – System Quality Group

SRO – Senior Responsible Officer

STP – Straight to Test Pathways

SWG – System-Wide Engagement

SWIEB – System-Wide Infrastructure Evidence Base

SWP – Strategic Workforce Planning

TICC – Trowbridge Integrated Care Centre

TTD – Treating Tobacco Dependence

TVD – Targeted Vaccination Delivery

TYP – Ten Year Plan

UEC – Urgent and Emergency Care

UTC – Urgent Treatment Centres

VCSE – Voluntary, Community and Social Enterprise

W&I – Workforce & Infrastructure

WMPD – Weight Management Pathway Development

WPC – Wider Primary Care

Additional Roles Reimbursement Scheme (ARRS)
The Additional Roles Reimbursement Schemewas introduced in England in 2019 as a key part of the government’s manifesto commitment to improve access to general practice. The aim of the scheme is to support the recruitment of 26,000 additional staff into general practice.

Advanced Clinical Practitioner (ACP)
Advanced Clinical Practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master’s level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients. (As per Health Education England HEE definition).

Armed Forces Covenant
The Armed forces Covenant is a promise by the Nation that those who serve or have served and their families are treated fairly. The Armed Forces Covenant is a part of the NHS Constitution. In relation to healthcare the Covenant states that the Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live and that Veterans should receive priority treatment where it relates to a condition that results from their service in the Armed Forces, subject to clinical need.

APPENDICES

Artificial Intelligence (AI)
Artificial Intelligence (AI) is the use of a non-human software package to interpret brain imaging, even if the imaging is also subsequently interpreted by a radiologist.

BLISS
Bliss is a UK-based charity for infants. Bliss supports the families of babies in neonatal care and works with health professionals to provide training and improve care for babies.

BRAVE AI
A risk assessment tool that helps health professionals identify individuals who are at risk of going to hospital next year but who may otherwise go under the radar.
The tool works by using clever computer algorithms (machine learning AI) to look for patterns in registered patients' records, the technology assesses an individual's risk of unplanned hospital admission in the next year. Those individuals identified can then be invited to take part in a holistic assessment so that local, integrated neighbourhood teams of health and care professionals (nurses, pharmacists, therapists, health coaches, social prescribers, and doctors) can work together to develop a personalised care and support plan, based on what matters to the individual.

Call before you Convey
A single point of access for 111, ambulance, primary care and rapid response referrals to an emergency medicine physician for triage/remote consultation so people can be treated by skilled paramedics at home, or in the most appropriate setting outside hospital whenever it is safe to do so.

Care Quality Commission
Independent regulator of health and social care in England, who make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

Carer
A person (commonly the patient's spouse, a close relative or friend) who provides on-going, unpaid support and personal care at home.

Commissioners
Funding bodies of NHS services.

Continuing Health Care (CHC)
Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as NHS continuing healthcare which can be provided in a variety of settings outside hospital, such as in your own home or in a care home.

Core20Plus5
Core20PLUS5 is a national NHS England approach to inform action 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.

CT angiogram
Uses a CT (computerised tomography) scanner to produce detailed images of both blood vessels and tissues in various parts of the body.

CT scan
A CT (computerised tomography) scan X-rays the body from many angles. The X-ray beams are detected by the scanner and analysed by a computer. The computer compiles the images into a picture of the body area being scanned. These images can be viewed on a monitor or reproduced as photographs.

Direct clinical care (DCC)
Refers to the time a doctor spends on direct patient contact and/or management. DCC is work directly related to preventing, diagnosing, or treating illness, including emergency work carried out during or arising from on-call work.

Deprivation of Liberty Safeguards (DoLS)
The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

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Education and Health Care Plans (EHCP's)
Where a child requires additional support that goes beyond what a school, college, or nursery can typically deliver from their own budgets or staffing then they may need an Education Health and Care Plan (EHCP). An EHC plan is a legally binding document outlining a child or teenager's special educational, health, and social care needs. The document has to list all of the child's special educational needs, provision to meet each of the needs and that provision has to be specific, detailed, and quantified. The plan names the school/setting which is to provide the provision and the plan is legally enforceable ultimately through Judicial Review.

FOREST
Enhanced Parent Pathway, now known as the FOREST team, which provides a more targeted midwifery and health visiting offer.

Funded Nursing Care (FNC)
NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.

Further Faster Programme
The work brings together clinicians and operational teams with the challenge of collectively going 'further and faster' to transform patient pathways and working to reduce unnecessary appointments and improve access and waiting times for patients.

Getting It Right First Time (GIRFT)
GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Healthwatch
The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch organisations are a statutory service commissioned by local councils as part of the Health and Social Care Act 2012.

Hybrid Closed Loop (HCL)
HCL technologies are the next phase of technical advancement linking continuous glucose monitoring (CGM) and insulin pump technology to provide people living with type 1 diabetes with support 24 hours a day. Sometimes referred to as an 'artificial pancreas'.

Herts Urgent Care (HUC)
A social enterprise providing NHS services who specialise in both primary care and urgent care services. HUC currently provides the Somerset NHS 111 service.

Hospital @ Home
Enabling people to receive acute care and treatments in home surroundings with support from a team of health and care professionals.

Liberty Protection Safeguards (LPS)
LPS (Formerly DoLS) rooted firmly within the Mental Capacity Act 2005 (MCA) and all the key principles of the MCA will be about safeguarding the rights of people who are under high levels of care and supervision, but lack the mental capacity to consent to those arrangements for their care.

Long Term Plan
The NHS long Term Plan launched in January 2019.
It sets out a plan for the NHS to improve patient care and health outcomes in the future.

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Mental Health Services Data Set (MHSDS)
The Mental Health Services Data Set (MHSDS) is a PATIENT level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for PATIENTS who are in contact with Mental Health Services. The Mental Health Services Data Set covers Mental Health Services located in England, or located outside England but treating PATIENTS commissioned by an English Integrated Care Board, NHS England specialised commissioner or an NHS-led Provider Collaborative. As a secondary uses data set, the Mental Health Services Data Set re-uses clinical and operational data for purposes other than direct patient care, and defines the data items, definitions and associated value sets to be extracted or derived from local information systems.

Multi-disciplinary
A team or service which is composed of staff from different healthcare professions with specialist skills and expertise. The members work together to ensure patients receive comprehensive, coordinated treatment.

NEWS 2
National Early Warning Score. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

Ockenden Maternity Review
This Review has been established by NHS England in May 2022, following significant concerns raised regarding the quality and safety of maternity services at Nottingham University Hospitals NHS Trust (NUH) and concerns of local families. This review replaces a previous regionally led review after some families expressed concern and made representation to the SoS at DHSC.

One Public Estate (OPE)
One Public Estate is an established national programme delivered in partnership by the Office of Government Property (OGP) within the Cabinet Office and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners.
Population Health Management (PHM) Population Health Management will be a core enabler and function of integrated care systems in helping drive a data led focus on person-centred care. It can help local integrated teams to reduce health inequalities and offer targeted proactive, personalised, and preventative healthcare for every community.

Sessions
A term used to describe a junior doctor's time. One session represents half a day.

SIDeR
Somerset Integrated Digital e-Record
A shared care record system, which gives an overview of patients health and social care information in one digital record. This combined information is not stored anywhere and is read-only. Only an audit trail remains once the page has been closed. This makes it easier and quicker for care professionals, to access the right information at the right time to provide patients with the right care without the need for patients to repeat their past medical information to each doctor or carer that they see and will provide more time to talk about what is important to them.

Social Prescribing
Social prescribing is a key component of Universal Personalised Care. It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. In social prescribing, local agencies such as local charities, social care and health services refer people to a social prescribing link worker. Social prescribing link workers give people time, focusing on 'what matters to me?' to coproduce a simple personalised care and support plan, and support people to take control of their health and wellbeing.

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SWAG Cancer Alliance
The Somerset, Wiltshire, Avon & Gloucestershire Cancer Alliance is the forum to bring providers and commissioners together with patients, to co-design services to optimise pathways, ensure effective integration and address variation, and are the vehicle that leads the activity required at a local level. The Cancer Alliance puts clinical leaders across primary, secondary, and tertiary care in the driving seat for improving quality and outcomes across cancer pathways, based on shared data and metrics. Continuing to deliver the strategy and its programmes will require committed leadership, smart choices around investing to save, and a firm intent to try new approaches and test new models of care.

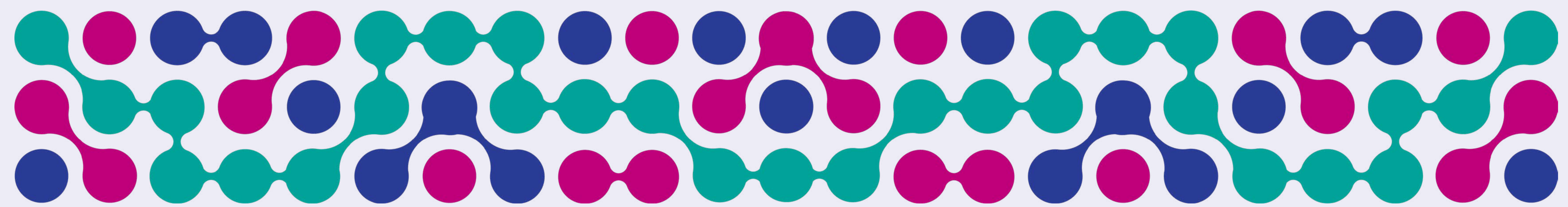
Telemedicine
The remote diagnosis and treatment of patients by means of telecommunications technology.

Treatment Escalation Plan (TEP)
A Treatment Escalation Plan is a tool which records and communicates the personalised and realistic goals of treatment. It should reflect the values and preferences that are important to the person receiving care if their condition should deteriorate.

Trusts
In the context of the UK's National Health Service (NHS), trusts are organisational units, e.g., hospital trusts, community trusts, primary care trusts or combinations thereof. In this report it usually refers to hospitals.

Urgent Community Response (UCR)
Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and hydrated.

Virtual Wards (Hospital @ Home)
Virtual wards (also known as hospital at home) allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most. Just as in hospital, people on a virtual ward are cared for by a multidisciplinary team who can provide a range of tests and treatments. This could include blood tests, prescribing medication or administering fluids through an intravenous drip. Patients are reviewed daily by the clinical team and the 'ward round' may involve a home visit or take place through video technology. Many virtual wards use technology like apps, wearables and other medical devices enabling clinical staff to easily check in and monitor the person's recovery.



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