Bath & North East Somerset Council

Improving People's Lives

To: All Members of the Health and Wellbeing Board

Chief Executive and other appropriate officers
Press and Public

Dear Member

Health and Wellbeing Board: Thursday 7th May 2026

Please find attached a **SUPPLEMENTARY AGENDA DESPATCH** of late papers which were not available at the time the agenda was published. Please treat these papers as part of the agenda.

Papers have been included for the following items:

14. **UPDATE FROM INTEGRATED CARE BOARD (ICB) (Pages 3 - 24)**

Yours sincerely

Corrina Haskins
for Chief Executive

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Neighbourhood Health: Progress Update and INT Footprint Approval

Paper reference	HWB-2026-05-NH01
Meeting	Bath and North East Somerset Health and Wellbeing Board
Date	7 May 2026
Author	Emma Higgins, Head of Combined Place Team, BSW ICB
On behalf of	Lucy Baker, Place Director, B&NES, BSW ICB
Status	Final for Board consideration
Purpose	To approve: INT neighbourhood footprints for B&NES. To note: neighbourhood health programme progress; Workshop 1 outputs; national Stage 1 requirements and B&NES priorities; BSW £1.5m investment for INT development.
Companion documents	See Appendix A for Full List

1. Executive Summary

Bath and North East Somerset has made substantial progress in developing its neighbourhood health model since the Health and Wellbeing Board endorsed the B&NES locality vision in January 2026. This paper sets out that progress, presents the outputs of the first neighbourhood health (NbH) planning workshop held in April 2026, and brings forward for Board approval the proposed neighbourhood footprints for B&NES around which Integrated Neighbourhood Teams will be developed.

The Board is asked to approve three neighbourhood footprints: Bath, Keynsham and Somer Valley. These are proposed as provisional administrative containers, and are also aligned to Community Services operational footprints, which will be refined through locality working in 2026/27 and subject to a formal review at a later stage. Approval of the footprints is a national Stage 1 requirement under the National Neighbourhood Health Framework[1], published March 2026. Further detailed planning will take place to confirm the detail of the geographical make up of the neighbourhood footprints with all Place partners prior to a further update to the HWB in September 2026. The concept of hub and spoke models within the largest neighbourhoods is also being developed. B&NES are also co-developing footprints across Children and Young People's services including the potential to align neighbourhood footprints with School Cluster conversations as part of our joint response to the SEND reforms.

The paper updates the Board on the BSW-wide £1.5m investment programme approved to support INT development across all three localities. B&NES's indicative share is approximately £265,000, to be confirmed once final footprints across BSW are agreed.

B&NES is progressing well in NbH planning. The governance architecture is in place, the vision has HWB endorsement, and the Community Health integrated teams went live on 1 April 2026. The task now is to move from strategic intent to delivery, with named accountability and the footprints agreed by this Board providing the governance foundation.

[1] https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

The BSW Locality Neighbourhood Health Plan Framework will be updated to reflect the National Neighbourhood Health Framework (March 2026), the Renewed Women's Health Strategy for England [2], and the new Neighbourhood Health Centre guidance [3]. The updated framework will set out the national Stage 1 requirements alongside B&NES's own priorities, as identified through the ICA and HWB vision process.

Board recommendations

1. Approve the three proposed neighbourhood footprints for B&NES (Bath, Keynsham/ Saltford and Somer Valley) as footprints for Integrated Neighbourhood Team development, subject to the conditions set out in Section 6. Note further detailed geographical planning to follow across adult and CYP pathways with the concept of hub and spoke delivery models to be explored.
2. Note the progress made in the neighbourhood health programme across B&NES and BSW since January 2026.
3. Note the outputs of Workshop 1 (People and Prevention, 16 April 2026) and confirm that the B&NES Locality Planning Group should develop these into full plan content.
4. Note the national Stage 1 requirements and B&NES's current position against each, as set out in Section 5.
5. Note the indicative B&NES share of the BSW £1.5m INT development investment (approximately 3/17ths, to be confirmed), and the intended outcomes of that programme.
6. Note and endorse the proposed BSW locality plan development methodology, including: Lucy Baker as named Place Director lead for the B&NES plan; the section-level accountability framework governing organisational contributions; the NHS Futures platform as the shared resource environment.

Contents

[2] https://assets.publishing.service.gov.uk/media/69df5d7261d2e8e9b9e42d2e/renewed-womens-health-strategy-for-england-web-accessible.pdf
[3] https://www.england.nhs.uk/publication/neighbourhood-health-centres/

2. Background and Policy Context

2.1 The National Neighbourhood Health Framework

The National Neighbourhood Health Framework was published jointly by the Department of Health and Social Care and NHS England on 17 March 2026. It sets the national direction for neighbourhood health and establishes a minimum floor of Stage 1 requirements for 2026/27, alongside five national goals with specific 2029 targets.

The framework makes a significant and deliberate change to governance architecture: the Health and Wellbeing Board is now the body that agrees the neighbourhood health plan, agrees neighbourhood geographies (footprints), and agrees local goals and metrics. This is a formal decision-making role, not simply an oversight function. The framework is explicit that this change in the HWB's role takes effect from 2026/27, with the formal Stage 2 plan agreed by HWBs for implementation from April 2027.

The five national goals, against which all ICBs will be held to account, are:

Goal	Aim	Key metrics by March 2029
Goal 1	Improve health outcomes for high-priority cohorts	10% reduction in non-elective admissions and bed days for frailty, care home and housebound cohort. 10% increase in end-of-life identification. 10% improvement in QOF outcomes for CVD, diabetes, COPD, mental health and dementia. 10% reduction in paediatric outpatient appointments for under-16s.
Goal 2	Improve access to general practice	90% of clinically urgent patients seen same day by March 2027. Routine access and patient satisfaction baselines established in 2026/27.
Goal 3	Improve experience of planned care	25% outpatient diversion rate by March 2027 for ten or more high-volume specialties. 10% reduction in secondary care follow-up appointments by March 2027.
Goal 4	Better urgent and emergency care performance	82% four-hour A&E standard by March 2027, rising to 85% by 2029. Flat or reducing non-elective admissions for high-priority cohorts. Reduction in category 3 and 4 ambulance conveyances for frailty, care home, housebound and end-of-life patients.
Goal 5	Improve patient and staff satisfaction	95% of people with complex needs to have an agreed care plan by 2027. New patient and staff experience measures to be developed during 2026/27.

2.2 Women's Health Strategy

The Women's Health Strategy for England, and its associated implementation guidance, sets out commitments relevant to neighbourhood health planning, including improving access to services for women, addressing health inequalities experienced by women in deprived communities, and embedding women's health hubs within local service models. The BSW Neighbourhood Health Plan Framework will be updated to reflect these commitments explicitly. For B&NES, this includes ensuring that neighbourhood teams are designed to address the specific health needs of women across the priority cohorts, including SMI (where B&NES has the highest excess mortality in England), self-harm in young women, and carers (the majority of whom are women).

2.3 Neighbourhood Health Centres

The government is investing in 250 new or repurposed Neighbourhood Health Centres by 2035, with 120 by 2030. Wave 1 in 2026/27 focuses on repurposing existing NHS estate in areas of highest deprivation. The B&NES approach to neighbourhood estates, including the use of available

community spaces and the community hub model, will need to be considered alongside the national Neighbourhood Health Centre pipeline once detailed archetypes guidance is published. The Board should note that binding estates decisions should not be made ahead of that guidance.

2.4 The BSW Neighbourhood Health Vision and Local Planning

BSW ICB published its shared Neighbourhood Health Vision in February 2026. The vision uses a layered model of six components: community assets and prevention at the base, through first contact care, Integrated Neighbourhood Teams, specialist community services, and shared enabling foundations. Each locality has subsequently grounded this shared vision in its specific context.

The B&NES locality vision was developed and endorsed by the ICA and Health and Wellbeing Board following the joint workshop on 29 January 2026. This HWB endorsement provides the statutory governance anchor required by the national framework.

The BSW Locality Neighbourhood Health Plan Framework will be updated rapidly, to reflect the National Neighbourhood Health Framework (completed), the Women's Health Strategy, and the Neighbourhood Health Centre guidance. The updated framework will be shared with Locality Planning Groups and HWBs as the organising structure for Stage 2 plan development.

3. BSW Neighbourhood Health Programme: Progress Update

3.1 Programme Overview

BSW ICB has been developing neighbourhood health planning since 2024, with earlier groundwork dating to 2022. The overall assessment is that BSW is progressing well when compared across the country; the strategic architecture is in place, governance foundations are established, and the 2025 Community Services contract provides a community delivery vehicle that few systems have in equivalent form.

3.2 Key Milestones Achieved Since January 2026

- Early work by B&NES to population the initial NbH Plan for B&NES has provided detailed information that will feed into the revised planning approach.
- The BSW Neighbourhood Health Vision was published in February 2026, providing a shared system-level reference point across all three localities.
- Community Health INTs went live on 1 April 2026, establishing Community Health INTs and a community services single point of access (SPA) across all three BSW localities. The INTs provide a 24/7, 365-day service. The SPA triages calls and refers to the correct INT.
- Workshop 1 of the BSW Neighbourhood Health Workshop Series was delivered on 16 April 2026 in Trowbridge, covering the People and Prevention layer of the neighbourhood health model. All three localities participated, with locality-level outputs recorded for use by Locality Planning Groups.
- The BSW National Neighbourhood Health Framework Analysis was completed (March 2026), providing a gap analysis against the national framework and a prioritised set of actions for plan development.
- VCSE organisations are being actively included and integrated into locality planning and development.
- Population Health Management cohort identification is live and actively informing INT design, BCF planning and priority-setting across all three localities.
- The frailty MDT test-and-learn piloted in B&NES has been evaluated positively and is informing BSW-wide rollout.

3.3 BSW Self-Assessment Against National Stage 1 Requirements

The table below shows BSW's self-assessment against the national framework Stage 1 requirements. Wiltshire has an externally validated position from the national Health Integration Partnership. B&NES and Swindon ratings are BSW self-assessment using the same framework. No locality is rated red against any requirement.

Requirement	B&NES	Notes
Lead development of the neighbourhood health plan		ICA-agreed vision; HWB-endorsed January 2026.
Define neighbourhood outcomes and metrics		Data strong; not yet a shared set of metrics driving decisions at neighbourhood level. Scheduled for workshop 2
Agree neighbourhood footprints	 action today	Proposed (Bath, Keynsham, Midsomer Norton); this paper seeks HWB agreement.
Embed community engagement and co-design		ICA and HWB workshops, VCSE integration, vision co-production all in place.
Develop INTs for frailty, end of life, MLTCs and CYP		Community Health INTs live from 1 April 2026; team of teams model being co-designed.
Plan neighbourhood approach to elective pathways		BSW-level workstreams active; not yet integrated into the B&NES locality plan.
Confirm use of BCF pooled funding		BCF stable and aligned; not yet used explicitly as a transformation lever. Informed by Workshop 1 outputs and further work in 26/27.
Confirm data-sharing arrangements		Integrated Care Record active across organisations; specific agreements for new INT data flows to be confirmed.
Confirm organisational ownership of deliverables		ICA and HWB governance models agreed; named accountability for individual deliverables to be agreed through the locality development group.

Green: requirement met or well in hand. Amber: partially in place; targeted action required. No locality is rated red against any requirement across BSW.

4. Workshop 1 Outputs: B&NES

4.1 Overview

Workshop 1 of the BSW Neighbourhood Health Workshop Series was held on 16 April 2026 at Trowbridge Civic Centre. The workshop focused on the first two layers of the BSW six-layer neighbourhood health vision: community assets and prevention, and first contact care. The B&NES group worked in three sub-groups on priority populations, a neighbourhood footprint discussion, and a BCF breakout, before coming together for a locality sharing session.

The full workshop outputs are shared in Companion Document 1. They’re owned by the B&NES Locality Planning Group, which is responsible for reviewing, refining and incorporating them into the emerging Neighbourhood Health Plan.

The BCF strategic steer is important to note – the B&NES workshop group worked through a case study of Frank, a 73-year-old man awaiting hip surgery, to identify what the system cannot see, what participants would do differently, and how BCF investment should be directed. The agreed direction for confirmation as the formal B&NES BCF strategic steer is:

> *Commission and fund a coordinated, holistic offer around planned and elective care that treats the patient and their carer as a single unit, reducing handoffs and embedding a coaching rather than doing approach. BCF should explicitly fund the in-between space: carer hubs, coaching roles and coordination functions that sit between formal health interventions. B&NES has strong existing VCSE and community foundations, including village agents, that should be reviewed, expanded and better coordinated through BCF investment rather than replicated from scratch.*

5. B&NES Neighbourhood Health Plan: Stage 1 Requirements and Local Priorities

5.1 National Stage 1 Requirements

The National Neighbourhood Health Framework sets out the following Stage 1 requirements for 2026/27. The Board is asked to note B&NES's current position against each requirement and the actions planned to address gaps.

Stage 1 Requirement	B&NES position and planned action
Agree a plan to reduce non-elective admissions and bed days by increasing urgent, rehabilitation and reablement capacity.	BCF Home First and Urgent Community Response are active. HCRG ICBC contract includes NEL reduction obligations. Explicit locality-level plan required: to be developed through the Locality Planning Group and BCF 2026/27 planning process.
Agree a plan for tackling unwarranted variation and improving GP access.	BSW shared GP access principles developed. Primary care commissioning moving to Place level within the cluster. Locality-level GP access plan to be completed and included in the Stage 1 Localuty NbH plan.
Agree neighbourhood footprints for INT development.	This paper seeks HWB approval of proposed footprints: Bath, Keynsham and Midsomer Norton.
Agree plans to establish INTs for high-priority cohorts, including how devolving care budgets could work locally.	Community Health INTs live from 1 April 2026. Team of teams model being co-designed. Budget devolution approach to be developed as plans develop – this will be informed by national learning.
Start planning a neighbourhood approach to elective pathways, including contribution to RTT and how a devolved outpatients commissioning budget would work.	BSW-level workstreams active with BSW Hospitals Group and ICB Planned Care team. Integration into the B&NES locality plan required: action for Locality Planning Group. To be informed by workshops 2 and 3.
Confirm plans to meet 18-week community waits and eliminate 52-week community waits.	Monitored via ICBC contractual meetings. Targets to become INT performance indicators once the full model is live.
Confirm how ICB and local authority intend to use BCF pooled funding in line with BCF guidance.	BCF 2026/27 planning process is active. Submission deadline 19 May 2026. HWB Chair and Chief Executive sign-off required as a national condition – this has been delegated by HWB to DASS and Place Director.

Continue Red Tape Challenge implementation.	ICB-led. B&NES to confirm local status in Locality Plan.
Confirm organisational ownership of planned deliverables.	ICA and HWB governance models are established. Named accountability for individual deliverables to be documented through the Locality Planning Group.
Confirm data-sharing arrangements for patient identification and evaluation.	Integrated Care Record is active across all organisations. EoLC and ReSPECT forms are held. Specific data-sharing agreements for new INT data flows to be confirmed.

5.2 What B&NES Has Said Is Important: Local Priorities

In addition to the national minimum requirements, the B&NES locality vision and workshop process have identified a set of locally grounded priorities that will be incorporated into the Neighbourhood Health Plan. These priorities were identified through the joint ICA and HWB workshop in January 2026 and developed further in Workshop 1 in April 2026.

- SMI premature mortality: B&NES has the highest excess under-75 mortality rate for adults with severe mental illness in England. This is a ranked national outlier and must be a named priority within the B&NES neighbourhood health plan, with a specific INT design element for this cohort.
- Children and young people: B&NES ranks sixth lowest nationally for KS2 attainment among free school meal eligible pupils and has consistently above-average hospital admission rates for self-harm in the 10 to 24 age group. CYP emotional health and wellbeing must be treated as a central neighbourhood health priority, not a parallel programme.
- Whole-family approaches: the workshop was clear that treating family members separately is less effective than a needs-led approach to the whole family. This includes working-age adults with long-term conditions who care for others, and families where a child's needs are the entry point to multi-agency support.
- Community assets and VCSE investment: the B&NES Community Wellbeing Hub integrates over 300 VCSE partners and is a significant asset that distinguishes B&NES from other localities. This must be sustained and strengthened, not treated as an add-on. BCF investment should coordinate existing community foundations rather than replicate new provision.
- Deprivation and health inequalities: the Core20 communities in Twerton, Foxhill and Whiteway experience substantially worse outcomes than surrounding areas. Neighbourhood health in B&NES must demonstrate measurable impact for these communities first.
- Prevention and the Be Well B&NES programme: the B&NES neighbourhood health model should align with and strengthen Be Well B&NES and other local authority prevention programmes from the outset. This integration is built into the vision and must be maintained as the plan develops.
- Housing as a determinant: housing insecurity in B&NES has exceeded national rates for the first time. Neighbourhood teams must be connected to housing support, and the Neighbourhood Health Plan should explicitly reference housing reform as a wider determinant.
- Reaching communities not currently being served: the four priority community profiles identified in Workshop 1 (housebound people, rough sleeping and associated groups, families with poor mental health, young carers) should be developed into full plan content by the Locality Planning Group.

5.3 Framework Updates to Come

The BSW Locality Neighbourhood Health Plan Framework will be updated in May to reflect:

- The National Neighbourhood Health Framework (March 2026), including explicit mapping of all five national goals with baselines and trajectories for B&NES.

- The Women's Health Strategy, with explicit inclusion of women's health priorities within the priority cohort design.
- Neighbourhood Health Centre guidance, once archetypes are published, to inform the B&NES estates approach.
- The HWB's strengthened decision-making role, including governance arrangements for Stage 2 plan development and approval.

The updated framework will be presented to the B&NES Locality Planning Group and to the ICA before returning to this Board for formal agreement as the basis for the Stage 2 plan.

6. INT Footprints: Seeking Board Approval

6.1 Why the Board Is Being Asked to Approve Footprints

The National Neighbourhood Health Framework is explicit: agreeing neighbourhood footprints is a Stage 1 requirement for 2026/27, and the HWB is the body that must agree them. Footprints are the geographic containers around which Integrated Neighbourhood Teams are developed and within which neighbourhood health plans are made operational. Without agreed footprints, the programme cannot proceed to the next phase of design, delivery or evaluation.

The Board is therefore asked to approve the proposed three-neighbourhood model for B&NES as the provisional administrative structure for INT development. They will be refined through locality working during 2026/27 and will be subject to formal review in 2028. Partners in B&NES are in agreement that the key success factor will be to establish clear and trusted ways of working together – this is more important that a ‘boundary’ line.

6.2 Proposed Footprints

Following the neighbourhood footprint discussion at Workshop 1 on 16 April 2026, and in alignment with the HCRG Community Health INT operational structure live from 1 April 2026, the proposed neighbourhood footprints for B&NES are:

Proposed neighbourhood	Notes
Bath	Covers Bath city. Contains the four Bath PCNs. Whether Bath operates as a single neighbourhood or is divided into two hubs by the river is an open question to be resolved through locality working. Population approximately 90,000.
Keynsham	Covers Keynsham and Saltford. Population approximately 20,000 depending on exact boundary definition. Alignment with HCRG INT footprints at approximately 45 to 50 percent of this area is a live challenge to be resolved.
Somer Valley	Covers Midsomer Norton, Radstock and the Somer Valley. Rural and market town character; hub-and-spoke model will be required to reach dispersed communities. PCN mapping to be confirmed. Population c70,000

Population increases forecast as part of the Local Plan have been taken into account as part of the neighbourhood footprint conversations.

6.3 Conditions and Open Questions

The Board is asked to approve these footprints, subject to the following conditions and with the following open questions to be resolved through locality working:

- PCN primacy: neighbourhood footprints do not override or replace PCN arrangements. General medical services contracts and PCN structures continue as the primary vehicle for GP and primary care provision. The neighbourhood model works with and around PCN footprints.
- Bath hub configuration: the question of whether Bath operates as one neighbourhood or is divided into two hubs, and what the hub model looks like in practice, will be resolved through the B&NES Locality Planning Group. The Board's approval today covers the Bath neighbourhood as a whole, pending this resolution.
- Somer Valley configuration: the question around Somer Valley configuration will be resolved through the B&NES Locality Commissioning Group. The Board's approval today covers the Bath neighbourhood as a whole, pending this resolution.
- ICA oversight: the Integrated Care Alliance with extended membership will serve as the pre-HWB forum for neighbourhood health decisions. The ICA brings together NHS, local authority, primary care, VCSE and community partners.
- 2028 review: footprints will be subject to formal review in 2028, informed by the maturation of neighbourhood working, national contract archetype consultations, and the evaluation of INT delivery against agreed outcomes.
- Patient choice: neighbourhood footprints are administrative containers for service delivery. They do not override patient choice. Residents will continue to access services based on their needs and preferences.
- Cross-boundary working: cross-boundary care access, where residents currently use services outside proposed footprint areas based on GP registration, will be managed through the operational INT arrangements and should not create barriers to care.
- Community engagement: communities and community organisations should be actively involved in refining the hub-and-spoke model within each neighbourhood. The footprints are a starting point for that co-design, not its conclusion.

6.4 Forum for Agreement

The footprint discussion has been through the B&NES ICA with extended membership as the pre-HWB forum. Workshop 1 on 16 April 2026 included a dedicated footprint breakout in the B&NES locality group, which confirmed broad agreement on the three-neighbourhood structure. The Locality Planning Group has been briefed and the ICA has been the forum for partner engagement. The Board is the appropriate decision-making body under the National Neighbourhood Health Framework.

7. BSW Investment: £1.5m for INT Development

7.1 The Programme

BSW ICB and has approved a £1.5m non-recurrent investment programme to support the development of Integrated Neighbourhood Teams across all three BSW localities. This positions BSW as one of a small number of systems with dedicated investment to support the transition from strategic intent to operational neighbourhood delivery.

The programme is designed to support the components of INT development that cannot be funded within existing operational contracts: co-design, workforce development, cross-partner infrastructure, and evaluation. It provides the transformation logic for the investment case alongside the ICBC contract and supports the INTs through developing new ways of working to address some of the most complex challenges in their area.

7.2 B&NES Indicative Share

The B&NES indicative share of the £1.5m programme is approximately £265,000. This allocation is based on the proposed proportion of neighbourhood footprints across BSW and will be confirmed once final footprints across all three localities are agreed and approved by their respective HWBs.

The funding is split into developmental costs (per footprint) and outcome delivery (population weighted). Therefore the £265,000 is an estimate and subject to change.

7.3 Intended Outcomes

The programme is intended to achieve the following for B&NES:

- Support co-design of the wider INT team of teams model, bringing together primary care, social care, VCSE and hospital partners around the HCRG Community Health INT foundation.
- Develop workforce capacity and capability for neighbourhood working, including community navigation, social prescribing link workers and population health management literacy.
- Establish neighbourhood-level population monitoring and early warning systems, drawing on PHM data already available within BSW. It also provides for additional Population Health Management resource, accessible by the Neighbourhood Teams.
- Strengthen VCSE integration into INT delivery, building on the established Community Wellbeing Hub and the extensive VCSE partnership networks in B&NES.
- Support community engagement and co-design within each neighbourhood, ensuring that neighbourhood health is designed with communities rather than delivered to them.
- Enable evaluation of the neighbourhood model against the national five goals and local B&NES priorities.
- Deliver an initial programme of integrated working to address the ‘excess demand’ of priority cohorts – taking a co-production and population health management approach.

The programme will be governed through the ICB Place team and the ICA (or successor group). Expenditure decisions will involve the B&NES Place Director and will be subject to ICB governance requirements.

8. Next Steps

8.1 Immediate: Following HWB Approval Today

- INT footprints confirmed: the Locality Planning Group will use the approved footprints as the organising structure for Stage 2 plan development, co-design with communities, and INT team of teams design.
- Footprint refinement: the Bath hub configuration and PCN mapping will be resolved through the Locality Planning Group.
- BCF 2026/27 submission: the formal strategic steer will be confirmed. Separately, the BCF 26/27 planning submission will be made with HWB Chair and Chief Executive sign-off required by 19 May 2026 (or delegated decision-making by the Place Director and Director of Adult Social Care).
- Section 75: pooling completion deadline is 30 September 2026. A new agreement model was published in 2025, which will be implemented in B&NES in 2026/27.

8.2 Workshop 2

Workshop 2 of the BSW Neighbourhood Health Workshop Series will cover layers three and four of the six-layer BSW vision: connecting people to neighbourhood support, and INTs and coordinated care. Workshop 2 outputs will feed into the Stage 2 plan development process. Workshop 2 will be organised by a task and finish group of partners, and aims to include outcomes development and the voice of people with lived experience.

8.3 Stage 2 Plan Development

HWBs must approve Stage 2 Neighbourhood Health Plans, for implementation from April 2027. The Stage 2 plan for B&NES will be developed through the Locality Planning Group during 2026/27 and will return to this Board for agreement.

The plan will be developed through a structured, co-produced methodology agreed by partners and taken through the ICA for partnership endorsement.

Lucy Baker, as B&NES Place Director, will lead the process and named leads will be agreed for each component which clearly coded to distinguish national requirements, BSW-wide commitments, and local B&NES priorities. A section-level accountability checklist will track content requirements, approval routes and deadlines throughout development so HWB members can be assured of the structure and content.

The Board is asked to endorse this methodology. The Board's role is active: providing strategic direction as content develops, formally agreeing neighbourhood geographies, and agreeing local goals and metrics. This is a plan the Board will help shape, not one that will arrive complete.

Questions about this paper should be directed to Emma Higgins, Head of Combined Place Team, BSW ICB (bswicb.combinedplace@nhs.net).

BSW ICB Combined Place Team | April 2026 | Version 1.0 | Draft for Board submission

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Appendix A: Companion Documents

The following documents are referenced in this paper and are available as companion documents. They are not appended but can be provided on request.

Document	Status and availability
B&NES Locality Vision	Endorsed by ICA and HWB, January 2026. Available from BSW ICB Combined Place Team.
BSW Neighbourhood Health Vision	Published February 2026. Available from BSW ICB.
BSW ICA Newsletter Issue 4 (Spring 2026)	Final draft. Covers BCF reform, neighbourhood health progress, all three localities. Available from BSW ICB Combined Place Team.
BSW Locality Neighbourhood Health Plan Framework v4	Current version. To be updated in 2026/27 to reflect the National Neighbourhood Health Framework and other national guidance. Available from BSW ICB Combined Place Team.
National Neighbourhood Health Framework	Published 17 March 2026. Available at GOV.UK.
BCF Guidance 2026/27	Published February 2026. Available at GOV.UK.
B&NES Population and Health Context	Document prepared for the Workshop1 event – brings together multiple sources of information. Available from BSW ICB.

Appendix B: National Neighbourhood Health Requirements in Full

Stage 1: Minimum Requirements for 2026/27

ICBs must confirm all of the following this year:

1. A plan to reduce non-elective admissions and bed days by increasing urgent, rehabilitation and reablement capacity, based on patient risk register analysis.
2. A plan to tackle unwarranted variation and improve GP access, ensuring core hours GMS contract requirements are met including new urgent access requirements.

3. Agreed neighbourhood footprints around natural communities for INT development.
4. Plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work locally.
5. A neighbourhood approach to elective pathways, including how the locality will contribute to RTT and how a devolved outpatients commissioning budget would work.
6. Plans to meet 18-week community waits and eliminate 52-week waits.
7. Confirmation of how ICBs and local authorities intend to use BCF pooled funding in line with BCF guidance.
8. Continued Red Tape Challenge implementation (primary/secondary care interface improvement).
9. Confirmed organisational ownership of planned deliverables.
10. Confirmed data-sharing arrangements for patient identification and evaluation.

Stage 2: HWB-Agreed Neighbourhood Health Plan (from April 2027, for 2027/28 implementation)

The plan must:

1. Provide a broad overview of how the three reform agendas will be delivered locally.
2. Set out how neighbourhood health supports wider local health outcomes goals and health inequalities reduction.
3. Confirm how objectives are informed by the JSNA and any other relevant assessments.
4. Confirm final neighbourhood geographies.
5. Confirm which organisations are responsible for which elements of delivery.
6. Confirm governance and operational partnership arrangements.
7. Confirm how other relevant initiatives align (Best Start, housing, mental health hubs, Pride in Place, employment support).

Once agreed with the HWB, the ICB incorporates the plan into its refreshed five-year strategic commissioning plan.

Source: National Neighbourhood Health Framework, DHSC and NHS England, 17 March 2026.

Appendix C: B&NES Workshop 1 Output Record

BATH AND NORTH EAST SOMERSET

Neighbourhood Health Workshop 1: People and Prevention

Workshop 1 Output Record | 16 April 2026 | Trowbridge Civic Centre

Status: Initial draft for review and use by the B&NES Locality Planning Group. Content is drawn directly from workshop outputs and captured notes. Sections marked [TO CONFIRM] require verification before wider circulation.

Purpose and Use of This Document

This document records the outputs produced by the Bath and North East Somerset locality group at Workshop 1 of the BSW Neighbourhood Health Workshop Series. It is structured to feed directly

into the B&NES Locality Neighbourhood Health Plan, using the BSW Plan Framework as the organising structure.

The content is an initial working draft. Each section is owned by the B&NES Locality Planning Group, which is responsible for reviewing, refining and incorporating these outputs into the emerging plan.

Section in this document	Destination in the BSW Plan Framework
Section A: Priority Population Statements	Sections 2b and 2c
Section B: Neighbourhood Footprint Position	Section 2a
Section C: BCF Strategic Steer	BCF Planning Process (26/27 and 27/28)
Section D: Community Profiles and Language	Sections 2b and 2e
Section E: Actions and Next Steps	Working group programme

Section A: Priority Population Statements

Three sub-groups worked in parallel on pre-assigned cohorts, then shared back within the B&NES locality group. The statements below are initial drafts for the locality planning group to refine.

Cohort 1: Children and Young People and Families

Local context

B&NES presents a distinctive and in some respects contradictory picture for children and young people. The area has significant pockets of deprivation concentrated in specific communities, including Twerton West, Foxhill North and Whiteway West, alongside wider affluence. This proximity creates particular challenges: children growing up in deprived neighbourhoods experience very different outcomes from peers nearby, and the gap is not closing. Hospital attendances for children with mental health presentations are higher than the national average, and crucially these are frequently not diagnosable mental illnesses but trauma-related presentations that cause young people to bounce between services without receiving sustained support. Educational inequalities are marked, with relatively poor attainment at KS2, a significant NEET cohort, and pressures from the pupil premium and SEND reform. B&NES also has specific population groups within CYP that require particular attention: Gypsy, Roma and Traveller communities face intersecting barriers across education access, healthcare, literacy and cultural awareness. The large student population creates a complex dynamic, with pressure on housing, services and primary care, and a disconnect between NHS and university services for the 18 to 24 cohort. Rural isolation affects some families in outer areas. All roads tend to lead to Bath in terms of service geography, creating access challenges for those without transport.

What neighbourhood health needs to do differently

- Create a navigation system for parents, families and children that operates through neighbourhoods rather than through GP surgeries alone. Families need somewhere to go that is not framed by a medical threshold.
- Apply the principle of no wrong door: any local service should be able to support someone to reach the right service for their needs, including through technology.
- Expand school-based and community hubs, and develop something specific for home-educated children who fall outside most existing provision.
- Provide a menu of available options at neighbourhood level so families know what exists before reaching crisis.

- Address SEND as a neighbourhood health priority through local integration of the White Paper commitments. Consistency is critical: families should not rely on parental tenacity to navigate the system. The neighbourhood model should offer early identification and a whole-family approach.
- Join the dots between adults and children. A needs-led approach to the whole family is more effective than treating each member separately, and is the basis for early identification.
- Align with 'best start in life' values through the neighbourhood model, with a deliberate focus on prevention rather than crisis response.
- Access to activities and schooling should be supported for populations with attainment gaps, including mixed-race communities and others experiencing educational inequalities.
- Mental health provision and access outside the school setting is needed, particularly for trauma-related presentations that do not meet clinical thresholds.

Key dependencies and gaps

- GRT communities require specific outreach across school and education access, healthcare, literacy and cultural awareness. Current provision is inconsistent.
- The 18 to 24 cohort, including students, sits in a gap between NHS and university services. Shared duty of care needs to be defined.
- SEND reform is creating resource and expertise pressures. Local integration of the White Paper is at an early stage.
- Home-educated children are not consistently within reach of neighbourhood services and require a targeted approach.
- Accessibility to criminality and county lines is a contextual risk for young people in certain areas that neighbourhood health must be aware of and connected to safeguarding responses.

Cohort 2: People with Long-Term Conditions (including Frailty)

Local context

B&NES has a growing older population with multimorbidity as a dominant feature of the LTC cohort. There are good opportunities for secondary and tertiary prevention in the at-risk group, for example around falls, medication optimisation and delay of dementia progression. Mental health links strongly to deprivation and there is a recognised need for earlier and lower-level mental health support in communities. Community pharmacy, GP and ED have maintained a degree of consistency and people seek care there as fragmentation in other services increases. Changing Futures is referenced as a programme demonstrating how to work well with complex needs and multiple organisations. BNSSG MINT teams are noted as an area of learning for neighbourhood-based approaches. Rivium Wellbeing Hub and possible IT solutions to make the team visible around the person were raised. GP access is already at or near maximum capacity due to enhanced access targets, which creates a direct tension with the ambition to shift community services towards proactive work.

What neighbourhood health needs to do differently

- Describe and learn from the experience and outcomes of high-priority areas: what is working now, what could be faster or better.
- Address the gap for those who are working age with long-term conditions, who are often missed between the frailty and younger adult service models.
- Empower self-management as a central offer, not an afterthought.
- Create more touchpoints for people to support wider health, including food, isolation and wellbeing, not just clinical need.
- Shift from reactive to proactive approaches, supported by a named coordinator and peer support, held together by a stewards group acting as a broker across organisations.

- Design with the VCSE as equal partners. Develop the trust required for this to work in practice.
- Determine how to use wider community assets to support prevention at secondary and tertiary level, including cross-generational approaches.
- Stop some of the focus on discharge to community services to free capacity for proactive work. The two cannot expand simultaneously without additional resource.
- Recognise that GP access is already at capacity due to enhanced access targets. Neighbourhood health must work around this constraint, not assume additional GP capacity is available.

Key dependencies and gaps

- Fragmentation of services means people fall through gaps, particularly in the third sector. Coordination beyond signposting is needed, not just reduction of everything.
- High users versus more working-age people at future rising risk: the system is focused on the reactive and needs to create capacity to support the proactive alongside.
- Consistency in areas of uncertainty drives activity. Services and commissioners need to agree risk and responsibility clearly.
- Roll-out of frailty work through NIC Aphin needs to be tracked as a learning resource for neighbourhood model design.
- Assets, supermarkets and care homes are potential touchpoints not currently used systematically.

Cohort 3: People Living in Areas of Deprivation

Local context

Deprivation in B&NES is concentrated but widening in its gap from surrounding affluence. The Indices of Multiple Deprivation are changing, with a growing divide between those in deprived areas and others. Housing affordability and location are increasingly determinants of deprivation, with transport and access to services playing a key role. Pressures on primary care are increasing due to poorer health outcomes in specific groups, including people with severe mental illness, unpaid carers and young carers. The student population is creating expansion of numbers locally and into different areas, with sub-standard housing and shortage. Worsening mental health in young people, including high rates of self-harm, is impacting on the deprivation picture. Digital exclusion is a key factor adding to challenge for this cohort. Inclusion health groups present within the deprivation cohort, including Travellers, Boaters, Veterans, homeless people, ethnic minority communities, migrants and people leaving prison. Intersectionality is important: these are not separate groups but overlapping identities with compound barriers.

Named places of concentration: Twerton West, Foxhill North, Whiteway West. Keynsham and Saltford (approximately 70,000 population), Somer Valley, Bath city (approximately 90,000 population, with the CYP/kids subset approximately 30,000 to 50,000) are the neighbourhood geography references noted in the session.

What neighbourhood health needs to do differently

- Make every contact count. Connect services both within the community and to manage risk collaboratively in the community. Enable early access to support. Challenge resource and co-ordination and ensure people are not overwhelmed.
- Support effective navigation and a clear sense of where to go. Develop in-reach into communities experiencing deprivation, building trust and peer support locally from existing assets.
- Develop from the PIP programme and capitalise on its success. Ensure information flow is optimised and journeys are mapped from the start.

- Need consistent commissioning to fund and build what is working locally and respect those working locally in the VCSE. Ensure Wayne's data is included in the picture.
- Work on two streams simultaneously: prevention and targeted intervention, overseen by the Primary Care Director.
- BCF should enable neighbourhood health delivery, including carers administration, discharge and care home admissions.

Key dependencies and gaps

- High numbers of self-funders accessing support at crisis point. Digital exclusion adds to this.
- Inclusion health groups are not consistently reached and require specific outreach strategies rather than mainstream service adjustments alone.
- SMI to mortality rate link requires early community-based mental health investment.
- People leaving prison require planned transition into neighbourhood-based support.

Cross-cutting Themes from Breakout 1.1

- Turn the NHS on its head: relationships and a Neighbourhood Health Service orientation, with the P+G+C Alliance playing a key role in delivery.
- The three questions that neighbourhood health must answer for B&NES: Where are our neighbourhoods? What are the populations of priority? How are we mobilising our community assets?
- Need consistent commissioning to fund and build what is working locally. VCSE partners must be respected and resourced, not consulted and ignored.
- Too many gaps, evidenced by pressure on GP, ED and pharmacy. Prevention and targeted intervention must run in parallel.

Section B: Neighbourhood Footprint Position

Status: The proposed three-neighbourhood model was agreed in principle at the workshop and confirmed in the locality sharing session. Further refinement is required through the LPG before progression to HWB.

1. Current picture and proposal

There is limited appetite in B&NES to over-focus on footprint boundaries as an end in themselves. The group's starting position is that some form of neighbourhood structure is required to organise delivery, but that it should be designed around outcomes rather than administrative lines. The emerging proposal, confirmed in the locality sharing session, is to work with three neighbourhoods:

- Keynsham and Saltford (approximately 20,000 to 70,000 population)
- Somer Valley
- The City of Bath (approximately 90,000 population, with Bath potentially split by river into two hubs, or organised around four PCNs)

These neighbourhoods are geographically large. B&NES expects to use a hub-and-spoke model within them, co-developed with partners and designed around where people actually go rather than service boundaries.

2. How far apart are we from agreement?

There is broad agreement on the three-neighbourhood structure. The main open questions are within Bath: whether it functions as one neighbourhood or is split by the river into two hubs, and how the four PCNs relate to neighbourhood arrangements. Alignment with HCRG Integrated

Neighbourhood Teams at approximately 45 to 50 percent of the Keynsham area population is a live challenge. Cross-boundary care access currently based on GP registration is a known complexity.

3. What would need to be true to close the gap?

- Agreement on whether Bath is one neighbourhood or two, and what the hub model looks like in practice.
- Clarity on how the four PCNs map onto the neighbourhood structure.
- Shared understanding that footprints do not override patient choice and will evolve as neighbourhood working matures.
- Engagement with communities and asset-based approaches to shape the model from the outset.

4. Possible solutions and mitigations

- Hub-and-spoke model within larger neighbourhoods, with strong outreach to rural and dispersed communities.
- Use practice benchmarks and natural population movements to understand flows rather than imposing boundaries.
- ICA with extended membership used as the pre-HWB forum to ensure inclusivity.
- Accept that neighbourhood delivery often means going to where people already are: shared facilities, trusted spaces and community presence matter more than rigid maps.

5. Forum for agreement before HWB

The pre-HWB conversation should go through the ICA with extended membership. HWB discussions should focus on who the population is, where people go for help, and how support joins up in practice, rather than structural boundary questions. Neighbourhood footprints will be refined through locality working groups and taken to the HWB for discussion and approval.

6. Known unknowns to hold and track

- Whether Bath operates as one or two neighbourhoods and what the hub model looks like in practice.
- How HCRG INT footprints align with the three-neighbourhood structure, particularly around Keynsham.
- Cross-boundary care access where residents currently use services based on GP registration outside proposed footprint areas.
- What residents actually need to understand about the model. The group noted that residents do not need to understand structural arrangements if services work seamlessly.
- Natural population movements and flows: these should inform rather than be overridden by boundary decisions.

Section C: BCF Strategic Steer

The B&NES locality group worked with the story of Frank, a 73-year-old man awaiting hip surgery, as the basis for its BCF breakout session. Three role cluster groups (VCSE perspective, social care and Frank himself, unpaid carer perspective) explored what the system cannot see, what they would want to do differently, and what is stopping them.

What the system cannot see about Frank's situation

- The precariousness of the home situation: Frank understands the physical challenges of his home but does not want to or cannot move house. Christine is not coping and he knows she will struggle, but does not want to say that in front of her.
- Frank is overwhelmed by the information he has been told to read. He wants to ask questions but has not had enough time to talk it through with someone.
- Gaps between the outpatient information system, the pre-operative process and the operation itself. Hospital time could be used better to prepare for renewal of needs.
- What could be done in the home as part of this process. Things are less good when planned without engagement with the family.
- Not just health: wider needs including reablement before surgery, clarity of what needs to happen and what to do if things do not go to plan.
- State and care needs assessment is not always carried out.
- The VCSE perspective: we will have understanding of Christine's anxiety and what this might say about family dynamics. Location of the house and community connection: who knows the family? This was a planned operation and early planning for discharge and family support was possible but did not happen. Whole-system lack of holistic understanding of family needs reads like an unplanned discharge because information flow was broken.
- The unpaid carer perspective: pain management, what to expect, what support is needed. What do I do if I need help and support? Why did no one explain this? Patient and carer did not feel able to ask for help.

What participants wanted to do differently

- Much more holistic and multi-agency pre-operative assessment that understood both sets of needs (Frank and Christine) and the impact each would have on the other.
- Non-judgemental conversation to alleviate Christine's perceived fear of what might happen if she suggests she is struggling to cope.
- MDTs looking at the whole population rather than the LTC cohort: engagement with acute colleagues, community and GP.
- Giving enough time and opportunity to explore the problems. Pre-appointment with reablement, making sure it is planned for.
- Triage questionnaire that could pick out some key indicators. Bring photos of your environment to pre-op.
- A compassionate community: knock on the door to see how they are doing, ask questions, provide information and advice.
- Act as advocates for the couple regarding discharge planning and carer support.
- Reach out to Christine's sister to provide support, with the person's permission.
- Do a financial health check.
- Wellbeing offer: phone call four to five weeks post discharge. Mobilisation pre-discharge needed.
- BCF: phone call and intervention. Phase assistant at home or you go there on the way home. Check meds, exercise understanding, practice. Someone to go to the place with them, but anxiety may make this easier to take on when out of hospital.
- Don't like outcome! Pre-op care assessment, discharge and care support plan. BCF should reduce handoffs to create a single shared record. Appropriate information. More person assessment, less paperwork and form.
- Carer should be involved. BCF to support carer and VCSE role. More movement from health and carers to include outcomes, holistic. Impact. Coaching, not just doing it for them.
- In-between carer hubs and coaching: can be funded by BCF. Need to review and expand.

BCF Strategic Steer: B&NES

AGREED DIRECTION FOR CONFIRMATION AS FORMAL STEER: Commission and fund a coordinated, holistic offer around planned and elective care that treats the patient and their carer as a single unit, reducing handoffs and embedding a coaching rather than doing approach. BCF should explicitly fund the in-between space: carer hubs, coaching roles and coordination functions that sit between formal health interventions. B&NES has strong existing VCSE and community foundations, including village agents, that should be reviewed, expanded and better coordinated through BCF investment rather than replicated from scratch.

The summing up from the locality sharing session confirmed that BCF discussions in B&NES were particularly helpful in opening up thinking around planned and elective care, and that the locality has strong existing community foundations that need coordination more than new provision. A key caution raised was the risk of coordinating the coordinators: BCF investment must be deliberate about what coordination is actually required in each neighbourhood, not simply add another layer. Owner to confirm formal steer: Lucy Lang. BCF 26/27 submission deadline: 19 May 2026.

Section D: Community Profiles and Language

Four sub-groups in Breakout 3 identified communities in B&NES that neighbourhood health is not currently reaching well enough, explored language, and considered VCSE and community reach.

Communities we are not reaching well enough

Who	Where	Notes and barriers
Those living alone with early dementia or memory problems		Seasonality: less fixed, not a condition. Hub and spoke approach needed. Equipment, diet, falls, transport barriers. Care home funded by the ICB. Co-ordinator role needed.
Those living in rural areas without transport	Community groups Young people without own transport, older people with diminishing mobility	
Boaters Canal dwelling population	River Avon, Kennet and Avon Canal	Cannot wait for all people to turn up: need to go to them.
Student population	Freshers, meningitis contacts	
Children not at school	Local authority	MH and neurodiversity
Adults with learning disabilities or autism	Mulder end. LD register, more not attending services	Dementia: die earlier, norm.
Children and families in poverty	Across B&NES	History of barriers to engagement with services. Range of diverse needs. ND may be a factor. Could use housing providers to reach.
Minority ethnic groups	Across district	Data quality issues. Poor experiences in maternity and mental health.
Veterans		PTSD and homelessness a factor.

Who	Where	Notes and barriers
People living with mental illness		
People in most deprived areas	Twerton, Whiteway, Coombe Down North, parts of Radstock, Keynsham	
Families in contact with care system		
People with learning disabilities		
Global majority communities	Spread, not typically in larger communities with appropriate support	Build the links and ask the communities. Who are the community leaders? (Fairfield House)
Those eligible for FSM, over-represented in high-risk inequalities groups	Some areas of higher concentration but widespread	Not just the children themselves. FSM as a proxy for other needs and issues.
Homeless and rough sleeping cohort, including women (high cost, unaffordable housing)	Particularly Bath centre, also hidden elsewhere, sofa surfers, temporary accommodation	Need to understand the cohort's notes and how they prefer to access services. Flexible assessment, fringe outreach. How to link to third-sector knowledge and data.
Traveller communities: Gypsy, Roma, Boaters, van-dwellers		
Those more socially isolated through rurality		
CYP who are NEET or post-18 NEET (higher risk)	Across the area, often hidden in family units	
18 to 24 including students		Disconnect between NHS and university services. Need shared duty of care.
Families previously on targeted pathway, including young carers	Across B&NES	History of barriers to engagement with services. Range of diverse needs. ND may be a factor. Housing providers could help reach.

Community profiles: named priorities from synthesis session

The B&NES group produced a community profiles synthesis chart identifying four priority community profiles for the locality plan:

Profile 1: Housebound people

Seasonality of need and the fact that housebound status is not a fixed condition but fluctuates. A hub and spoke approach is needed. Equipment, diet, falls prevention and transport barriers are the primary practical issues. Care home admission funded by the ICB is a downstream risk. A coordinator role was identified as critical. Language note: less jargon, drug terms should use brand names rather than clinical names. Mental health and housebound intersect, as do isolation and social isolation.

Profile 2: Rough sleeping and associated groups

Quite well identified and reached but lack of coordination means health outcomes are not also accessible. Lack of coordinated conversations is the primary gap. Language note: referral thresholds are a barrier.

Profile 3: Families with poor mental health

Intergenerational involvement required. Stigmatising and impact on venues: mainstream offer needed. Digital and language barriers. More VCSE involvement and peer leadership needed.

Profile 4: Young carers

Consistently missed across settings. Current blind spot. Issues across education, recording system consistency and transitions. Language and labels matter. Impact on more cared-for person. Excellent resources on supportive language exist and can be agreed. Data on volume of demand is a gap. Coordination is the primary system need. Schools can be first point of play, particularly around non-attendance.

Language: what works and what fails

Terms to avoid

Hard to reach, disadvantaged, jargon, threshold-based language (which leads to constant refusal), acronyms, health terms and medical language, names of drugs (use brand names), service names such as reablement and HFirst, referral and threshold as barriers, and non-stigmatising alternatives are needed throughout. Global majority communities: avoid much adapting of language and embrace technology. Frame conversations in the language best suited to the individual, agree terms of engagement with people, and use conversations in a more restorative way.

What works

Research through stories and clear language. Go to people and listen. Ask how people want to be referred to. Be responsive and take them on a journey. Use ASC work on community frontline work and case studies. 18 to 24 research from Urban Health regarding conversations about weight. Be aware of changes over time. Regardless of where you live. Understand challenges. What matters to you. Identifying needs over wants. Have we considered carers: who do you have to support you. Make sure you are using the Urban Health dictionary, frameworks UK guidance and university autism awareness guidance. Check content with relevant groups via multiple lived experience forums.

The jargon we use is excluding. Use of PDFs for people to fill in does not work. Work with faith communities. Work with peers and community champions. Shift the majority of people to a very simple platform process with no humans needed for eighty percent and save human interaction for the people who really struggle, the twenty percent. Bring professionals to community-favoured locations.

This document was produced by the BSW Combined Place Team following Workshop 1 on 16 April 2026, drawing on workshop output sheets and captured notes. It should be read alongside the B&NES Locality Vision, BSW Neighbourhood Health Plan Framework v5, and the BCF 2026/27 Guidance Briefing. Questions to Emma Higgins, Head of Combined Place Team.

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