NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

BSW Five Year Commissioning Plan (Strategy)

2026/27 to 2030/31

Working Draft 15 January 2026 V1.1

Contents

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.

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 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.

1. 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. Whilst we are currently three systems, we have a shared mission: to help people live healthier lives, tackling unfair differences in access and outcomes, and making the best use of every pound we spend. By bringing our strengths together, we can go faster on the things that matter most for our communities.

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 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.
- **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.

2. Purpose & Scope

This plan will set out how we intend to deliver our strategy for the five-year period, from 2026/7-2030-31 and clearly articulate how the commissioning intentions will deliver on the agreed outcomes and the path to delivery with clearly set out targets and trajectories.

In developing these paths to delivery, the commissioning plan will:

- Consider the ICB's integrated needs assessment and baseline mapping of current performance and quality of care to describe our commissioning intentions to improve population health outcomes and ensure equitable access to healthcare in line with the outcomes and priorities described in the ICB's five-year Commissioning Strategy.

- Provide clarity for healthcare providers and other partners on how the ICB intends to allocate resources, and what outcomes will be achieved as a result,
- Translate national and local strategic priorities into local action
- Demonstrate how partners will practically work together to improve health outcomes
- Describe the financial framework that will be used to support financial sustainability and value for money.

The plan will demonstrate also how the ICB Embed 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.

3. Strategic Commissioning Overview

The Model ICB Blueprint marked the first step in a programme of work to reshape the purpose, role and functions of integrated care boards (ICBs), laying the foundations for delivery of the 10 Year Health Plan and following the announcement of a significant reduction in the operating costs for ICBs from 2026/27. This strategic commissioning framework supports ICBs in commissioning NHS services as well as others with this function – regional NHS teams currently and in future some providers, to understand 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, the ICB are accountable for creating the best value for the public from their NHS budget. ICB's should consider how the budget should be spent within their population to secure high quality accessible healthcare now and in the future and ensure that the health services they plan, and commission uphold the rights and values outlined 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 and the 4th purpose of ICBs to support wider socioeconomic development.

Strategic commissioning comprises four stages:

1. **Understanding the context** – ICBs 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.

4. BSW Context

4.1 Summary of BSW Integrated Needs Assessment

This section provides a high-level summary of the Integrated Needs Assessment (INA) for BSW. It draws together key messages from the three place-based JSNAs (B&NES, Swindon and Wiltshire), system-wide analysis of the health and care economy, and baseline performance using the BSW Outcomes Framework. The full INA (including detailed place-level needs, segmentation, and supporting analysis) can be accessed separately and should be read alongside this Medium Term Plan.

4.1.1 Local context and population health needs (JSNA summary) *[section being reviewed and updated incorporating further detail and feedback from public health leads]*

Across BSW, JSNA evidence highlights generally good health outcomes overall, but substantial variation by place and neighbourhood. Swindon has a younger and more diverse population profile and the greatest concentration of deprivation. B&NES and Wiltshire have older population profiles, with rurality creating additional access barriers (transport, distance, connectivity and digital exclusion). Wider determinants (housing affordability, employment, education, transport and community infrastructure) shape both need and inequality, and this is compounded for inclusion health groups and people living with long-term conditions.

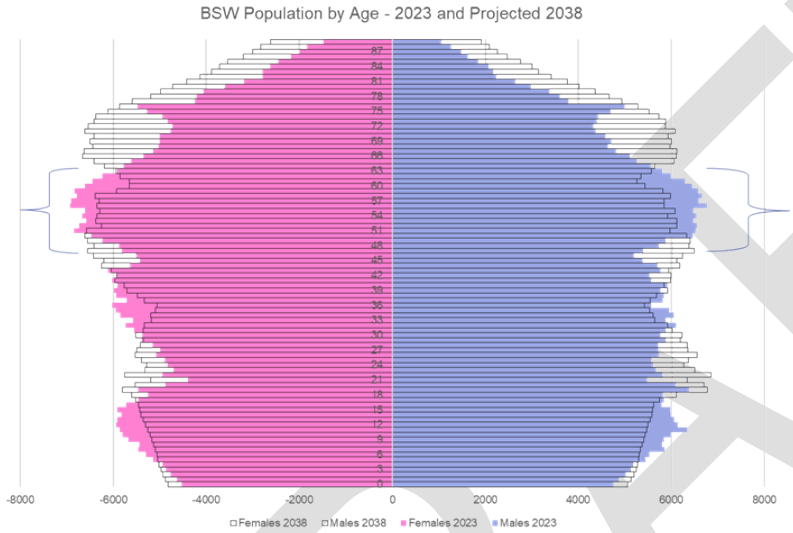
While we recognise a wider set of Core20PLUS inclusion groups, deprivation and ethnicity are two of our key inequality dimensions where we have the strongest and most consistent data across BSW. They also frequently intersect, for example, a higher proportion of our CORE20 population are in the Asian ethnic group, relative to the other deprivation deciles. This suggests we could benefit from targeting some of our inequalities work where ethnicity and deprivation intersect.

The JSNAs also highlight the growing burden of long-term conditions and multi-morbidity, rising demand linked to frailty, and sustained pressures 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/obesity and alcohol-related harm, with risk and outcomes strongly patterned by deprivation and place.

4.2 Health and Care Economy: Key Messages from the BSW Case for Change

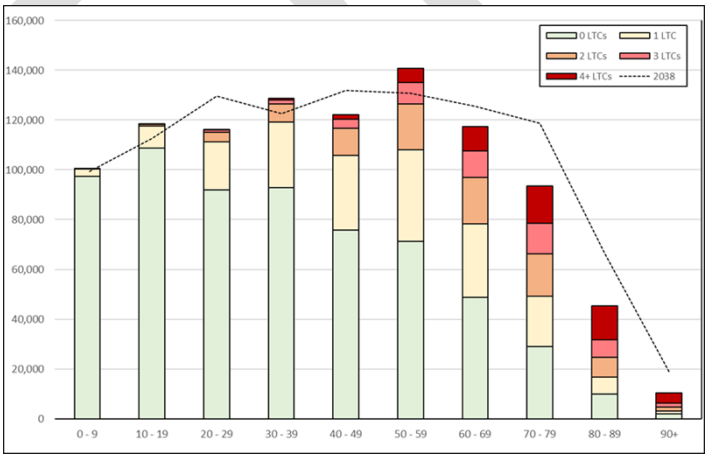
The system context is shaped by demographic change, increasing complexity, and constrained capacity. The case for change shows that:

1) Our population is ageing, and this will materially increase need:



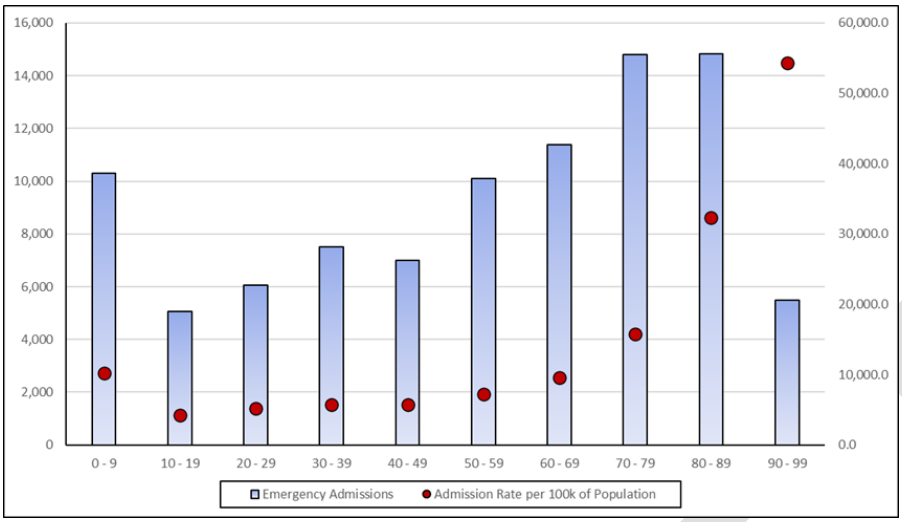
This figure provides the demographic context and supports the case for shifting investment and delivery models towards prevention, earlier intervention, and community-based support.

2) More older people means more multi-morbidity:



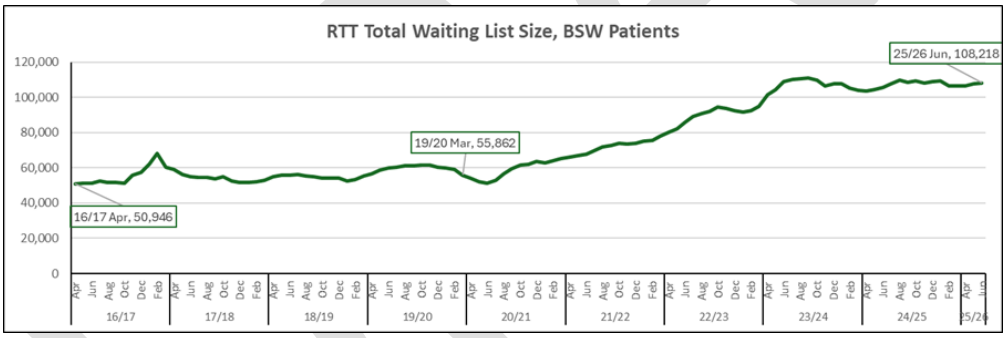
This illustrates the growth in long-term condition burden and the implications for proactive, coordinated care (particularly for people living with frailty and multiple conditions).

3) Demand pressures will increasingly show up in urgent care and acute bed capacity:



Without change, pressures on already stretched acute beds, ambulance dispatch and ED attendances will rise. Together, these reinforce why the Medium Term Plan must deliver the "hospital to community" shift, with integrated neighbourhood delivery and improved flow. These figures help connect the INA evidence base to urgent and emergency care priorities and the need for prevention and proactive community support to reduce avoidable crisis activity.

5) Access and waiting times remain a significant challenge across services:



This supports the MTPF expectation that systems address access and productivity alongside transformation.

4.3 Baseline Mapping of Current Performance

The Integrated Needs Assessment is anchored in the BSW Outcomes Framework, which provides the shared baseline for performance, variation and inequalities. For this summary we use three headline outcomes that together capture length of life, quality of life, and avoidable crisis/system pressure:

- Life expectancy and Years of Life Lost (YLL): establishes the baseline for premature mortality and highlights where preventable death and inequality gaps are greatest.

- Healthy life expectancy and Healthy Years of Life Lost (HYLL): provides the baseline for quality-of-life impact and identifies where people are spending more years in poor health.
- Emergency bed days: provides a system pressure proxy and highlights where urgent, reactive care use is concentrated and where proactive, integrated community support should have the greatest impact.

Outcome	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		↑

Implications of the 10 Year Plan (10YP) and Medium Term Planning Framework ("MTPF- delivering change together")

Taken together, the Integrated Needs Assessment evidence base supports the MTPF direction of travel and the three shifts:

- **Sickness to prevention:** tackling preventable risks and improving early intervention, particularly in communities experiencing the poorest outcomes.
- **Hospital to community:** strengthening neighbourhood and community delivery so people receive proactive, coordinated support and reliance on urgent reactive care reduces.
- **Analogue to digital:** improving data, segmentation and outcomes measurement so commissioning can target highest-need cohorts and track impact consistently.

4.4 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 challenges faced by the BSW System, we have in place an Integrated Performance Dashboard to provide oversight of the key operational standards, including those outlined within the NHS Oversight Framework (NOF) which is reported on both an ICB and Provider basis.

BSW ICS faces many of the same challenges as a system as other parts of the NHS, and although progress has been made across many performance standards, we face particular challenges, and benchmark as an outlier for Urgent and Emergency care and some elements of Elective care. We have identified improvement opportunities in the following areas:

Urgent & Emergency Care

- Ambulance Cat 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 which needs to be addressed.
- 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 26/27- 28/29.
- 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

- RTT – The system is improving RTT 18 week and 52 week performance in line with 25/26 plans though RUH are not meeting plans. BSW will be challenged to meet constitution standard of 92% 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 28/29.
- Cancer services- 28 day faster diagnosis & 62 day referral to treatment performance below target and national average for the System and Acutes, although challenging robust plans are in place to meet the MTP plan targets.
- Diagnostics- Athough 6 week performance is in line with region and currently performing better than national, a significant improvement is required to meet the MTP plan targets and the national standard of 1% by March 29.

Mental Health & Learning Disabilities

- Talking Therapies – Completed Courses of Treatment: Numbers of courses completed is below plan and fair shares (not benchmarked). Service development will be needed in the MTP to improve the number of adults receiving a course of treatment in Talking Therapies.
- Dementia Diagnosis rate is in line with region though substantially below national performance and target, a significant improvement is required to meet the national standard.
- CYP Access (age 0 to17, 1+ contacts) BSW are bottom quartile for CYPMH Access rate per 100,000 and improvement is required.

Primary Care & 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 and unscheduled care.
- 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:

- 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.

4.5 Quality

Quality is defined in statute as having three dimensions: safety, clinical effectiveness and patient experience and is a shared goal that requires system commitment and action to ensure that we provide the highest quality health and care services.

BSW System Quality is based on these principles:

• Collaboration, trust and transparency
• Transformation
• Equity and equality

The use of the Juran Trilogy Model of quality planning, quality control and quality improvement will be central to the planning and delivery of care. This is described within the BSW Quality Assurance and Improvement Framework (QAIF) and sets out the vision for quality through the application of the National Quality Board (NQB) guidance (further strategy publication due in 2026). The QAIF also sets out our governance arrangements for monitoring our quality priorities, including the use of agreed performance and quality assurance metrics and patient and service user reported outcomes and experience.

In practice this means that the system will deliver care that is safe, effective, well led, sustainably resourced and equitable. Our commitment includes the need to shape and

design the delivery of services by working with local communities, ensuring engagement with children, young people and adults that use local services (experts by experience), alongside health and care professionals and the voluntary sector. We will continue to monitor quality and safeguarding standards via metrics and agreed outcomes framework.

The care experience of the population will be positive through responsive, caring and personalised delivery and measured through a variety of feedback tools including patient and colleague surveys, Friends and Family Test (FFT) and review of patient and service user concerns, complaints and compliments to identify real time trends and themes for shared learning.

A collective reporting and shared learning approach will be achieved through existing governance structures and improvement networks and Communities of Practice, for example, Patient Safety Specialists; System Mortality Group oversight (including LeDeR oversight); Infection Prevention and Management Collaborative (with a focus on the continuous reduction in avoidable healthcare associated infections i.e., Clostridium Difficile infections and E Coli blood stream infections), vaccination delivery and communicable disease management); Medicines Optimisation and Safety (including oversight of antimicrobial stewardship and antimicrobial resistance), Digital transformation / clinical safety oversight and BSW Local Maternity and Neonatal System.

Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plans (PSIRP)

PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There are four key principles fundamental to the effective delivery of PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learn from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system function and improvement.

The BSW Patient Safety Specialists Community of Practice has worked collaboratively to support the implementation of the PSIRF and PSIRPs across all commissioned provider services. Following a recent internal audit of ICB quality assurance processes, monitoring of provider Patient Safety and Incident Response Plans (PSIRP) will be further strengthened as part of quality planning and quality control, via formal contractual governance oversight and BSW system shared learning and improvement group.

Quality Governance

The integral relationship with BSW System Quality Group (SQG) will be essential in ensuring:

- Positive system assurance, via quality control and improvement processes, that statutory duties are being met, concerns and risks are being effectively mitigated, and improvement plans are having the desired effect
- Confidence in the ongoing quality improvement of best practice pathways, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation are being addressed, utilising a person-centred approach to care delivery and outcome reporting
- A vehicle for wider thematic learning and improvement
- A clear governance structure, as described in BSW Quality and Improvement Framework, to recognise early warning signs and instigate a rapid quality review process and monitoring of quality improvement plans where statutory duties and contractual quality requirements are not being met
- Use of Equality Quality Impact Assessments (EQIA) to evidence the impact of transformation plans
- Horizon scanning for evidence-based research guidance and innovation, together with robust processes for timely response to new and emerging national guidance.

Quality Focus:

Maternity and Neonatal Services

Following concerns raised by families who have experienced adverse events in some maternity services in England, Baroness Amos was appointed to lead a rapid, independent investigation into maternity and neonatal system issues across England. In Dec 2025, after having engaged with families, staff, community organisations and MPs, Baroness Amos published her initial reflections on what she had heard to date and outlined the approach that will be taken for the investigation and next steps.

BSW maternity and neonatal service providers have not been identified for inclusion in the planned site visits, however learning from this national review will be incorporated into BSW current and future service planning and quality monitoring.

The Maternity Outcomes Surveillance System (MOSS) has recently been launched nationally and locally. This early safety signal system monitors outcomes and processes at a Trust site level to prompt rapid safety checks and initiate early interventions when unusual patterns occur within Trusts providing maternity care. Initial measures will be for term stillbirths and term neonatal deaths.

Additional tools are planned to be launched throughout Quarter 4 (January-March 26) and beyond, and will be further developed as part of ongoing quality planning, assurance and improvement monitoring including:

- A regional heat map/dashboard for risk assessment across maternity services. this will include safety indicators for each maternity provider and identify variations that signal need for additional review and assurance.
- A national inequalities dashboard.

- Daily Maternity Situation (OPEL) reporting to support provider, system, regional and national identification of need for mutual aid. BSW LMNS is exploring the potential for the data submitted to be visible through Single Health Resilience Early Warning (SHREWD) Database for BSW.
- NHS England Maternal Care Bundle. An evidence based practice focusing on 5 elements of care, namely, venous thromboembolism (VTE), neurology, obstetric haemorrhage, mental health and pre-hospital and acute care.

Infection Prevention Management

The BSW Infection Prevention and Management Collaborative will continue to support and inform infection prevention standards and practices across the current BSW system, whilst cluster arrangements are finalised. This will ensure continued surveillance of healthcare associated infections, provision of clear guidance aligned to evidence based practice (including AMR and AMS) and provision of monitoring and improvement tools aimed at continuously reducing the incidence of avoidable infections, which can have a significant impact on priorities such as Urgent and Emergency Care and Planned Care.

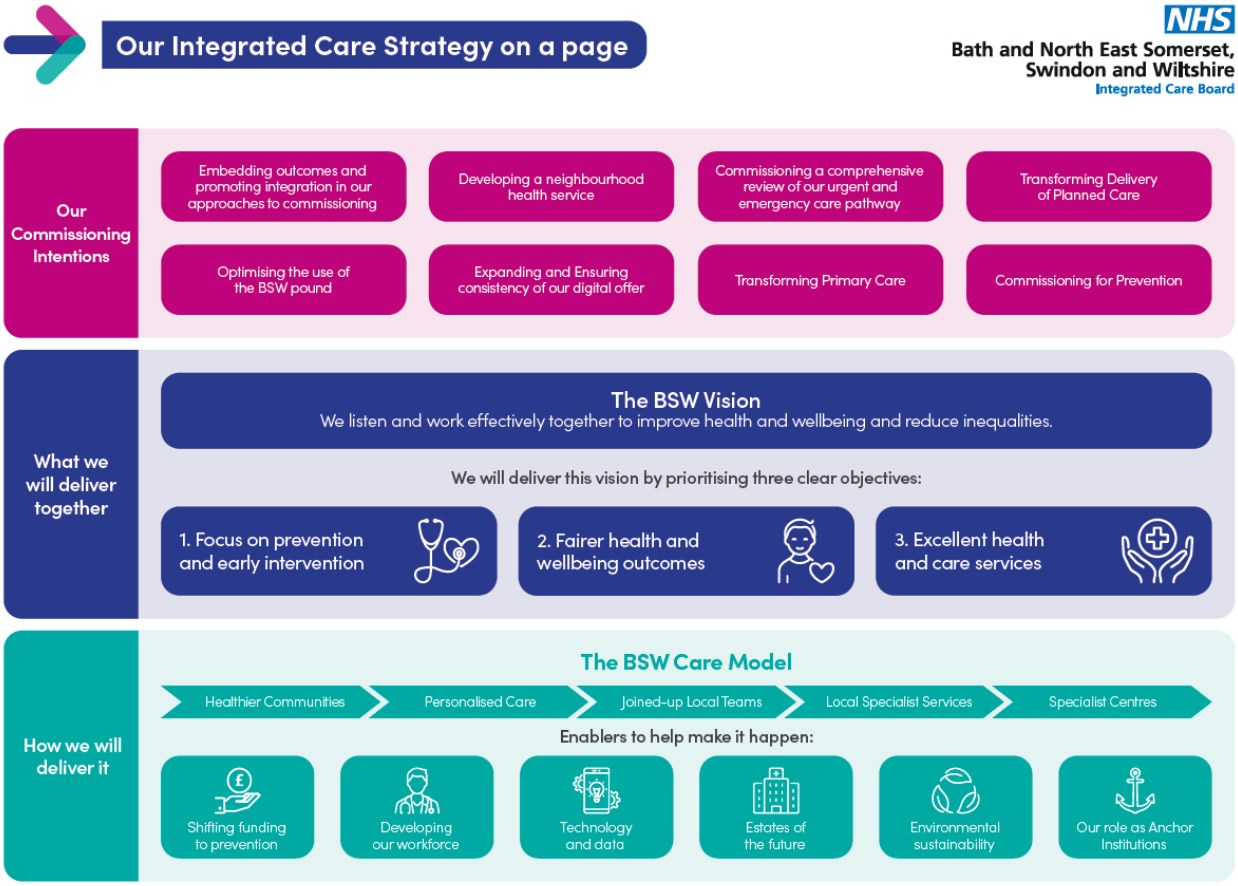
Urgent and Emergency Care (UEC)

Improving safety and experience of care within UEC pathways is central to meeting planning priorities, therefore quality planning, quality control and quality improvement oversight for UEC will include use of defined UEC metrics and a requirement to report against a UEC outcomes framework. Following the publication of Principles for Providing Patient Care in Corridors (NHSE 11th Dec 2025), providers will continue to review and report against their organisation's SOPs to ensure compliance to these principles, recognising the priority aim of eradicating corridor care completely as soon as possible.

All Age Continuing Care

BSW ICB will continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation while meeting statutory NHS Continuing Healthcare duties. The ICB will prepare for full transition to AACC Data Set v2.0 and its digital infrastructure by March 2027, replacing the current quarterly collection to improve monitoring

5. Vision, Aims and Strategic 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:

1)Hospital to Community:

- Shifting care delivery from acute settings to neighbourhood-based services
- Establishing Neighbourhood Health Centres as integrated hubs

2) **Sickness to Prevention:**
    - Tackling wider root causes of ill health (e.g., housing, employment, air quality)
    - Embedding genomics and predictive analytics in screening and prevention
3) **Analogue to Digital**:
    - The NHS App becoming the central platform for care navigation and self-management
    - AI, robotics, and shared care records driving efficiency and personalisation

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.

6. 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 aim to set out a roadmap for how we will continue this work, whilst aligning with the Ten Year Plan. However, they are deliberately strategic in nature, and we will be setting out in more detail over the rest of the planning round how we will put these into action.

These intentions have been developed in dialogue and discussion with stakeholders over the recent weeks, and we know that they are widely supported. There is a real 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 as long as possible. This will help us improve outcomes for our population, which is a commitment we have already made as part of developing our BSW Outcomes Framework.

In BSW, we are facing a significant financial challenge and we know that resolving that challenge can only be done through collective action, and by delivering on the three shifts set out in the Ten Year Plan. This means resetting the way that we are working 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.

6.1 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 this 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 helping us shift from organisational-led planning and delivery of care, into working in a way that supports delivery of better outcomes through integrated pathways.

Population health management will underpin this shift. By linking data, evidence and clinical insight, we will identify the groups and neighborhood's where outcomes are poorest, target resources to those with greatest need, and design services that prevent ill health, reduce inequalities and support people to stay 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.

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/PCN 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 (BCF/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.
- **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, informed by a completed Frail t-ED (GIRFT) review (including recommendations for RUH and GWH) and work to scope direct access to acute frailty teams and reduce variation and duplication across providers.
- **Consistent discharge standards across partners:** Work is underway to develop a system wide “Leaving Hospital” framework so providers operate to the same standards and processes, including a clear approach to patient choice and consideration of legal requirements for people with restricted options.

- **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 (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 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.

What it means for the Three shifts

Sickness to Prevention:

- **Commissioning decisions anchored in outcomes and prevention impact:** 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:** 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":** embed outcomes and integration expectations across an increasing number of contracts and pooled arrangements (including ICBC and BCF/Section 75), aligning providers around shared outcomes and integrated pathways.
- **Single set of place expectations:** use outcomes-based alignment across place governance (ICAs / neighbourhood plans) so partners work to a consistent set of priorities and measures, reducing duplication and unwarranted variation.

Analogue to Digital

- **Outcomes data as a core requirement:** 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.

Place analytics for decision-making: 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).

6.2 Developing a Neighbourhood Health Service

Neighbourhood Health is the organising approach through which BSW will plan, align and commission services at the scale that best reflects how people live their lives and experience care. It is not a single programme or prescribed model. Instead, it provides a shared commissioning and partnership framework that brings together the NHS, Local Authorities, the VCSE sector and communities around agreed priorities, outcomes and population groups at neighbourhood level. This approach supports a shift from reactive and fragmented care towards earlier intervention, prevention and more coordinated support, particularly for people with complex or long-term needs. Engagement with local people and communities is integral to shaping priorities and services.

Neighbourhood Health Plans are the primary mechanism for delivery. They align partners, commissioning intent and outcomes within defined neighbourhoods, providing a shared understanding of population need, inequalities and priorities. These plans are outcomes-focused, informed by population health insight, and enable more targeted and locally responsive commissioning while remaining aligned to system-wide priorities and the BSW Outcomes Framework.

Delivery of Neighbourhood Health in BSW is underpinned by the Integrated Community-Based Care (ICBC) contract. From April 2025, the ICBC contract establishes a community-based partnership to support more joined-up, preventative and personalised care across the life course. Over time, this will enable more care to be delivered in or near people's homes and neighbourhoods, supported by integrated working across community services, local authorities, primary care and the VCSE sector.

As part of this transformation, a stepped care model is being developed with partners. This includes a digital front door and single point of access for patients and professionals, with access to same-day urgent support seven days a week. Integrated Neighbourhood Teams form a core component of the model, bringing together community health professionals, GP and practice colleagues, local authority practitioners and VCSE partners. These teams will initially focus on priority cohorts at highest risk of hospital admission, while developing preventative approaches as the model matures. The digital front door, single point of access and Integrated Neighbourhood Teams are expected to go live from April 2026 and develop progressively over the following one to three years. Over time, access to outpatient services and diagnostics closer to home will also expand, supported by digital tools such as the NHS App.

Alongside the ICBC contract, BSW will develop new single-neighbourhood and multi-neighbourhood contracting arrangements with general practice over time. These arrangements are intended to support neighbourhood delivery and a more unified approach across partners, while existing GP contracts remain in place during transition. Further detail on these arrangements is set out elsewhere in this plan.
From a commissioning perspective, Neighbourhood Health strengthens Place as the level at which joint commissioning, governance and alignment are most effectively brought together. This includes the use of pooled budgets and joint arrangements, such as the Better Care Fund and Section 75 agreements, to support integrated delivery across organisational boundaries. Over time, further ICB budgets may be delegated at place level to support more targeted local investment.

Neighbourhood Health also provides the framework through which wider system reform is integrated locally, including national prevention and early intervention priorities and reforms across primary care, community services, urgent and planned care. The approach is intentionally flexible, recognising variation in population, geography and maturity across BSW, while operating within a shared strategic framework. Neighbourhood arrangements will continue to evolve over the five-year period, supported by outcomes-based assurance and system governance.
For local people and communities, Neighbourhood Health is intended to improve access, experience and outcomes through more joined-up, proactive and preventative support shaped around neighbourhood need. For the workforce, it provides clearer shared purpose, stronger collaboration and more sustainable ways of working across organisational boundaries.
In line with the NHS Ten Year Plan, BSW's ambition is to deliver care as locally as possible: digital by default where appropriate, delivered at home or in neighbourhood settings wherever feasible, and in hospital settings only where necessary.

Progress to date:

- In year 1 of the ICBC contract, the foundations for integrated neighbourhood teams,

the digital front door and single point of access have been put in place. Partnership development with the VCSE sector is underway and key care pathways are being reviewed, and services harmonised to ensure equal access across BSW. New workforce models and roles are being developed to support neighbourhood health including navigator roles that will support people to access the right services for their needs. INTs will be live across BSW by April 2026.

- The development of a 10-year Integrated Estate Plan for Community Based Services is underway, supporting the longer-term shift towards neighbourhood delivery models and care closer to home, with further investment in neighbourhood hubs planned from 26/27.
- Ongoing monitoring of investment in VCSE-delivered services, with an ambition to increase the proportion of spend to 5% by start of 2027/28 where this supports neighbourhood priorities, prevention and inequalities reduction.
- VCSE partners deliver approximately £5.6m of services through the Better Care Fund across the three localities, contributing to prevention, reablement, wellbeing and inequalities reduction.
- Collaborative working with Local Authorities and provider partners across BSW to ensure new social care and education reforms align with health reform to reduce duplication and maximise efficiencies, supporting system coherence.
- Development of a Population Health Improvement Plan aligned to national Neighbourhood Health requirements, triangulating finance, workforce and quality considerations to support deliverability and phasing.
- Early development of Integrated Neighbourhood Teams, supported by a developing neighbourhood outcomes approach that includes population-level indicators such as urgent care utilisation and emergency bed days for the most complex population cohorts.
- Progress on priority population cohorts and prevention-focused pathways, including Hypertension - General Practice pathway transformation to receive more hypertension case finding, Community Blood Pressure Checks and Outreach Health Checks, Health Coaching and Community Empowerment
- Development of an integrated weight management model that supports adoption and implementation of new drug-based treatments as well as non-medical support (healthy eating programmes, exercise management, psychological support)
- Monitoring and implementation of a programme for systematic development of integrated, risk stratified, MECC enabled pathways across Community, Primary and Acute services, aligning with GIRFT
- Delivery of the system wide clinical frailty strategy
- Strengthening of community vaccination infrastructure to support access, prevention and population coverage.

Key Workstreams

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

- Neighbourhood Health services will continue to be developed through the following strategic workstreams, recognising local variation in pace and maturity:
- Develop locality-based Neighbourhood Health Plans that define shared priorities and outcomes and commissioning intent for each population working jointly with general practice, planned and proactive care. Population segmentation and

population health management insight will inform these plans. ICAs will work with Health and Wellbeing Boards to develop plans and initiatives that tackle the wider determinants of health and create connections between community assets and health outcomes.

- Embed Integrated Neighbourhood Teams as the visible organising structure for neighbourhood delivery, with local flexibility in form and phasing. This includes early consideration of children and young people, prevention and wider determinants of health from the outset and aligning with wider system reform programmes including the Families First Partnership Programme. This includes consideration of children and adults with learning disabilities and autistic people as priority cohorts within neighbourhood planning and delivery. This will be supported by continued engagement with service users, the VCSE sector and targeted population cohorts.
- Building on the ICBC contract as the delivery vehicle for Integrated Neighbourhood Teams (INTs), supported by the wider community stepped care model, and working in collaboration with wider partners including PCNs, local authorities and the VCSE, to embed the six initial core components of the Neighbourhood Health Service.
- Strengthen joint commissioning and shared accountability across ICB and Local Authorities through the Better Care Fund and other pooled budget arrangements, ensuring alignment with neighbourhood priorities.
- Collaborative development of Neighbourhood-level outcome measures and evaluation methods with providers, including acute, VCSE and local authority partners aligned to the BSW Outcomes Framework, the ICBC outcomes framework and focused on learning and improvement.
- Using the opportunity and capacity that wider primary care offers (including community pharmacy, optometry, dentistry) to improve access, support urgent care, deliver prevention and reduce health inequalities in local neighbourhoods.
- Supporting stronger relationships between providers and local populations to build trust and encourage active participation in health decisions.
- Work with primary, secondary care and wider partners to deliver a transformation in outpatient referral, diagnostic and treatment pathways which will lead to a year-on-year increase in outpatient activity in community and neighbourhood settings beginning with priority pathways and helping people to access care closer to home.

What it means for 3 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 continued expansion of vaccination, screening and proactive case finding, informed by population need and neighbourhood insight. Over time, neighbourhood teams will increasingly use genomic approaches to help identify patients at risk of developing long term conditions.

Hospital to Community

Neighbourhood Health provides a clear direction of travel towards more care being delivered in community and neighbourhood settings, where this improves outcomes and experience. The stepped care model will support people with easy access to advice and support through the digital front door and single point of access, which will also co-ordinate strengthened urgent and planned care services, enabling more people to be treated in

their own homes and where they live. People who need more specialist support will receive this in the community unless it is required in an acute setting. Integrated neighbourhood teams (our teams of teams) will bring together partners to share information, expertise, advice and provide coordinated and joined up care, supporting more people to remain at home. This will be supported by joint commissioning approaches and appropriate use of community and neighbourhood infrastructure, recognising that models and pace of change will vary locally. On a phased basis, the number of integrated care centres / 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

Neighbourhood Health will be supported by progressive improvement in digital access and information sharing across settings, enabling more joined-up care, improved population insight and better engagement with local communities, in line with wider system digital strategy. Through the ICBC contract, a digital front door for patients will be live from April 2026 enabling them to have easy access to information, make referrals and request support. The digital front door will support a single point of access for both patients and professionals and will be fully integrated with the NHS app which will be the future route for patients to manage their care digitally. 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 will be expanded. Professionals will also have access to all diagnostic tests for their patients.

6.3 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) pathways 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 (UTC's) 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) -– Undertake a comprehensive review of existing SDEC pathways, along with peer-to-peer learning and implementation of profiles on the Directory of Services Commissioning a comprehensive review of our UEC Pathway
- Frailty Strategy / Pathways / Frail t-ED (GIRFT) - Embedding 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 SFT -– In line with national recommendations, the capital works are underway
- Hospital at Home maximisation - Embedding outcomes and promoting system integration in our approaches to commissioning to provide equity of services
- Hear and Treat and See and Treat - Commissioning a comprehensive review of our UEC Pathway. BSW have good Hear & Treat rates compared to other systems, work in place to maintain this and further work to increase See & Treat rates
- Mental Health vehicles & 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
- Maximisation of Care Coordination Centre which is led through Community Delivery Group and sub-contracted by HCRG to Healthhero

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.
- Systemwide 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 @ Home for other pathways, for example paediatrics.
- 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 strategy and pathway 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.

What it means for 3 shifts

Sickness to Prevention

- Signposting for patients and public to encourage self- care and prevention

Hospital to Community

- Increase the use of services in the Community Pharmacy, Optometry and Dentistry to reduce pressure on hospitals
- Commissioning Hospital @ Home for pathways like paediatrics

Analogue to Digital

- Use digital technologies to enable a more streamlined pathway for patients and utilise tools such as remote monitoring.

6.4 Transforming Delivery of Planned care

The NHS Elective Reform Plan set out a clear requirement for transformation for planned care services. This is key to ensuring we are delivering the Referral to Treatment 18 week target by March 2029, but also as part of our wider commitment to invest more in prevention and keep people well outside of hospital.

A key focus will be to ensure a partnership between primary, community and secondary care so that most people are managed in neighbourhoods, avoiding unnecessary attendances and keeping hospital capacity focused on complex care. We will explore options for radical change in service delivery or recommissioning with a specific focus on ENT, gastroenterology, respiratory, urology and cardiology as priority services set out in the elective reform guidance. We will also consider fragile services in BSW such as dermatology. We will do this in collaboration with BSW Hospitals Group to confirm these are the right services to look at first, as we also explore options for contracting models.

Across all of our planned care services, we will need to make the most of the available digital technologies to enable a more streamlined pathway for patients, and to move away from a traditional referral approach to a joint approach between primary and secondary care. We will seek to put these arrangements in place in line with the national direction of travel, working with primary and secondary care colleagues to agree this. The ICB has a plural market of acute, independent sector, and community/primary care based alternatives to hospital care.

The ICB will work with all providers to ensure common application of clinical standards and practices, enabling choice whilst also reducing referral rates where clinically appropriate. We will embed these requirements as part of our contracts and be clear on our expectations with regards to a reduction in long waits, removal of variation in performance and better management of system demand.

We have also heard from our engagement work that we need to review our diagnostic provision and make sure that our strategy works towards making our facilities as accessible as possible to the public.

Progress to date

- We have opened up three new diagnostic centres (in Bath, Swindon and Salisbury) providing services such as such as X-rays, MRI and CT scans, blood tests, ultrasounds and endoscopies, in the community.
- Reduced waiting times so that no-one in BSW will wait longer than 65 weeks by March 2025
- Increased activity across the footprint using the independent sector
- Improved access to diagnostics, delivering planned reductions in diagnostic waiting times
- Commissioned and developed new capacity at Sulis Hospital
- Commenced work on pathway transformation in core areas
- Implemented a Community Pharmacy Blood Pressure Check Service, including supporting VCSE with outreach clinics
- Developed a New Medicines Service
- Integrated dashboard for elective for BSW
- Discharge Medicines Service

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

Key Workstreams

- Commission services that enable a radical change in service delivery or recommissioning for ENT, Respiratory, Cardiology, Urology, Dermatology and Gastroenterology. This will require a whole system focus, creating end-to-end pathways that make best use of primary care, community and secondary care expertise at the right point in the care pathway.
- Ensure that delivery models support earlier access to elective intervention and address the disproportionate impact of long waiting times on Children and Young People.
- A shift away from a traditional referral approach to a joint approach between primary and secondary care and we will implementing nationally mandated changes to Advice and Guidance to create a ‘discuss with’ rather than ‘refer to’ model.
- Embed clinical standards and practice in our contracts e.g. GIRFT so that we ensure patients are able to access the right service for their needs, and we reduce the number of procedures of limited clinical value at all providers. .
- Straight to test pathways for clinically appropriate patients, with the 10 largest specialties by volume (all specialties by 2029).
- Right sizing our diagnostic provision to ensure we make best use of all available capacity (including CDCs) and to enable delivery of redesigned care pathways and using future capital to invest in more diagnostic capacity to support our neighbourhood health ambitions.
- Commission new or improved pathways that support faster diagnosis of cancer – including addressing current inequalities in uptake of screening across our population and making best use of new AI and digital tools.
- Begin scoping for genomic screening integration and workforce training
- Transformation to an all-age needs-based Neurodiversity pathway through our ICBC Programme, VCSFE waiting well support and National ADHD Service Development Programme.

- Transformation of CYP community pathways including sleep and neuro-disabilities through our ICBC programme.
- Commission new or improved pathways that support faster diagnosis of cancer – including addressing current inequalities in uptake of screening across our population.

What it means for 3 shifts

Sickness to Prevention

We will deliver the Referral to Treatment 18-week Referral to Treatment (RTT)target by March 2029 through maximising capacity within all our commissioned services and investing in preventative services to keep more people well outside of hospital. This will include developing new care pathways that provide earlier access to specialist provision in our communities, linked with our neighbourhood health ambitions.

Through straight to test pathways and increased use of community diagnostics, enabling earlier diagnosis to prevent deterioration, and enabling more people to be managed in community settings.

The delegation of screening commissioning to ICBs affords the opportunity to consider how and where our screening offers are provided. We will work with partners across our system to ensure that service provision continues to reflect population health needs and we maintain strong levels of uptake in core screening programmes. We will ensure that commissioned activity provides sufficient capacity for us to act rapidly where people require further intervention, with the intention to increase the number of people treated with lower grade cancers.

Hospital to Community

Through integrated care pathways, we will maximise the expertise that exists in primary, community and secondary care so that a greater proportion of the care pathway is delivered in a community setting. This will avoid the need for people to travel to hospital settings and ensuring that specialist capacity is focused on the most complex care. We will align delivery with our neighbourhood health and needs, with tailored offers that reflect population health needs.

We will continue to commission capacity from a range of providers, maintaining our commitment to supported patient choice in BSW. We will require all partners to work within our integrated care pathways so that people can be confident that they will receive the same level of service wherever they choose to receive treatment

Analogue to Digital

In line with national guidance, we will use digital technologies to enable a more streamlined pathway for patients and move away from a traditional referral approach to a ‘discuss with rather than refer to’ model. We expect that this will provide operational efficiencies, ensuring that face-to-face capacity is used for those people with more clinically complex needs. This new model will be deployed across all providers.

We will ensure that signposting to enable active waiting for patients is delivered through the NHS App, so that more people have easy access to information about how they can self-manage whilst they wait for interventions – improving outcomes and engagement.

We will work with the BSW Hospitals Group to ensure that opportunities to improve productivity through application of AI are maximised.

6.5 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.

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.
- In addition, a further £5m has been set aside to support mitigations of ambulance demand. The schemes are being developed using the same protocols.
- 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. (£10m from year 1). 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

What it means for 3 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 change in how resources are deployed with the rate of expenditure growth increasing into services outside of hospitals, including digital to manage impact on hospitals

6.6 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.

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.

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.

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, 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.
- Expansion of national and local product incubation of the Federated Data Platform. Products include Cancer360, PLICS, Shared 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 3 shifts:

Sickness to Prevention:

- Promoting early intervention to address issues before they escalate, improving long-term outcomes.

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

Analogue to Digital

- Digital Transformation and GPIT
- Prioritised digital inclusion through targeted outreach and training

6.7 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.

We recognise 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.

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.

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.
- 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 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.

What it means for the 3 shifts:
Sickness to Prevention:

- Promoting early intervention to address issues before they escalate, improving long-term outcomes.
- Utilising population segmentation to identify patients before they experience negative health outcomes to stay well and stay at home

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
- Align ICA priorities with emerging neighbourhood health plans

Analogue to Digital

- 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
- Prioritised digital inclusion through targeted outreach and training

6.8 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 funding for 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. Building on tobacco dependence and cardiovascular risk, we 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.

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/SW averages), understanding local variation (including PCN-level variation), and targeting action to narrow inequalities (Core20 deprivation gap, SMI and LD), 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/LA 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, strengthening community-based prevention and earlier intervention closer to home.

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, 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 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.
- **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.

What it means for the 3 shifts:

Sickness to Prevention:

- **Shift 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.

- **Commission end-to-end prevention pathways:** align funding to outcomes and equity across tobacco, cardiometabolic risk (hypertension→CVD), healthy weight, harmful alcohol and medicines safety—spanning identification through relapse prevention.
- **Use every setting as a prevention touchpoint (examples):** utilise 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:

- **Deliver prevention closer to home through neighbourhood and community models:** grow VCSE and community delivery in trusted settings and use neighbourhood teams to provide earlier intervention for high-need cohorts and communities.
- **Integrate NHS and Local Authority prevention into a single pathway (hospital → community):** Align 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.
- **Strengthen place and neighbourhood leadership and alignment (examples):** strengthen 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:

- **Measure and manage prevention as outcomes-led commissioning:** agree a core prevention indicator set (with inequalities breakdowns) and require providers to improve data capture where gaps exist so impact can be tracked consistently.
- **Target population health management using place analytics:** build place-level analytics capability to identify high-need cohorts/geographies and target prevention investment and outreach.
- **Digital inclusion by design:** ensure prevention offers are “digital-first where appropriate” with inclusive non-digital routes, supported by targeted outreach, training and accessible communications.

7. Strategic Commissioning Capabilities

The Strategic Commissioning Framework (2025) describes that ICBs will need the following to be successful in their role as strategic commissioners:

- capability in strategic leadership and partnership working with other commissioners, providers, local government and service users to co-design services and improve population outcomes
- effective and broad multidisciplinary clinical and professional leadership embedded in how they work to drive cross-organisation improvements
- access to high quality data analysis, sustained and meaningful engagement with people and 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.
- triangulating demand analysis with
- an ability to involve people and diverse communities and understand their experiences through asset-based approaches that facilitate co-production and empower community-driven solutions
- strong relationships with their 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
- an ability to use 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
- to develop a shared understanding with providers of current and future delivery costs, ensuring each investment improves access, care quality, efficiency and outcomes
- 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 26/27, 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.

8. 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.

We have been making progress with delivery of 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 developments, there has also been a number of wider developments that further the 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 26/26 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. The fund should not be used to plug recurrent deficits, support additional capacity or support business-as-usual delivery, temporarily prop up unsustainable services, fund activity growth without system redesign, or create additional net recurrent cost to the system baseline.

All proposals to the fund should align to a set of principles as follows:

1. Non-recurrent, enabling investment-one-off spend that unlocks future benefit (e.g. digital, estates reconfiguration, capability build, transition costs).
2. Clear line of sight to recurrent benefit-benefits realised in FY 2025/26 and beyond, such as:
3. Cash-releasing savings
   - Capacity release (clinical and managerial)
   - Avoided cost growth for the three BSW acute providers (ability to take costs out)
   - Productivity improvements

4. System-level impact, preference for proposals that:

   - Cross organisational boundaries
   - Reduce duplication or variation
   - Improve whole-pathway performance rather than single-service optimisation

5. Deliverability within the funding window-spend profile achievable within agreed timelines, dependencies understood and manageable, accountable leadership and delivery capability in place, scalability or reusability, solutions that can be scaled, replicated, or reused across the system or in future years are prioritised.

9. 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.

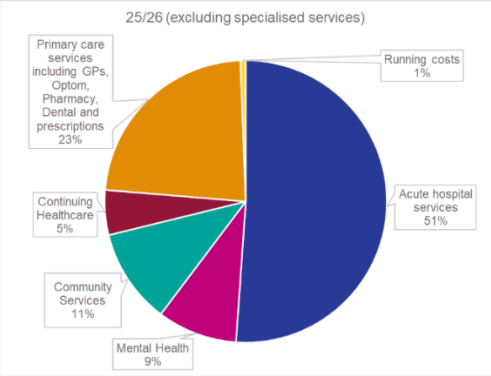
Addressing the overspend whilst continuing to meet the needs of our population will require changes to the services that we currently commission. This may mean ceasing some services, significant changes to existing services or adding new services.

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.

10. 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
- All staff feeling valued and having access to high quality development and careers
- Using resources wisely to reduce duplication, enhance efficiency, productivity and share learning

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.

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

In BSW, we have developed a Primary Care and Community Delivery Plan that sets out how we plan to transform care for our population. As part of our plan, we have commissioned our Integrated Community Based Care Contract including community Integrated Neighbourhood Teams (INTs). This aligns to the new national ambition set out for Neighbourhood Health. Our five - year workforce plan will be informed by the required workforce needs of the ICBC contract and the commissioned HCRG stepped care model. This will also draw in the workforce needs of wider partners including PCNs, local authorities and the VCSE.

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.

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. We recognise that each Primary Care sector operates under nationally negotiated contracts and frameworks, which provide consistency and clarity across England.

As part of our workforce plan, we will work jointly to support primary care to improve recruitment, training, retention and job satisfaction across all of the primary care workforce.

We will use data and intelligence to understand supply pipelines into roles such as community pharmacy and optometry in urgent care navigation, ensuring patients can access timely advice and treatment closer to home.

Mental Health

The BSW Mental Health Strategy 2025 – 2030 commits to improvements in commissioned services so we achieve good mental health for the people living in our area.

Workforce is identified as a key enabler of this strategy, and we are committed to make our area an excellent place to work in mental health. We know our key challenges include national shortages of mental health care professionals which is replicated in BSW, high staff turnover and in turn high vacancy rates and heavy reliance on agency staff to fill vacancy pressures in the clinical workforce. The temporary nature of their relationship with service users means they can't always provide consistency of treatment and interventions which impacts upon people accessing our services.

Our workforce plan will encompass these known challenges and BSW mental health providers will progress a number of actions to expand and develop the workforce including: Clinical associate psychology trainees, Talking Therapies workforce expansion through low and high intensity trainee , Apprenticeships ,Overseas recruitment ,Training for professionals to enhance their work with service users, Connect 5 Training, Oliver McGowan Mandatory Training, Cross provider training programmes and Recruitment of mental health professionals in primary and urgent and emergency care. Success will be measured by a bi-annual improvement forum where providers will share and commit to

measurable actions to improve recruitment and retention and optimise staff skills and wellbeing.

Learning Disabilities Autism and Neurodivergence (LDAN)

Our workforce plan will encompass the following priority areas:

- Workforce requirements for the new Kingfisher unit and outreach team provided by Avon and Wiltshire Mental Health Partnership NHS Trust. Building on the existing dedicated workforce workstream that has been part of the programme and has included use of the Aspire Nursing Programme and training of Advance Clinical Practitioners (ACP's). The intention is to continue to support and offer and consider how this can be implemented within community settings as part of the ICBC transformation priorities.
- Development of new all age Neuro Diversity pathway with HCRG and requirement for a needs-based approach including our VCSE partners
- Expansion in numbers of LDAN keyworkers
- ICBC Transformation work of LDAN Community Services (HCRG) including development of existing workforce to support autistic people without a learning disability and meeting the forensic needs of people with LDAN as part of community-based services – linked to ICBC outcomes.
- Upskilling of mainstream mental health services (inpatient and community) to meet the specific needs of autistic people with co-morbid mental illness.

Urgent and Emergency Care

The workforce plan will respond to the review of the UEC pathway including the review of workforce requirements for delivery of Urgent Treatment Centres and to support the shift from MIUs to UTCs. It will also reflect any expansion of Hospital @Home for other pathways, such as for children, and will outline the implied workforce requirements.

Analogue to digital

The ICB published a 5-year Digital Strategy in September 2024 that is now being refreshed in light of the ten-year plan publication and the shift from analogue to digital. We will commission in a way that ensures digital is the default for access, information and follow-up.

Our workforce plan will need to respond to the increasing need for a suitably skilled and competent workforce across a range of cyber professions to support the ambitions of the NHS ten-year plan. We know that filling specific digital roles is a challenge across BSW due to competition from other employers and skills gaps in our existing workforce. The ICS Cyber Strategy outlines how the expansion of relevant professional apprenticeships will take place to respond to the increasing workforce required and this will be incorporated into our five-year workforce plan.

11. 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).

Healthcare is more than ever, dependent on digital solutions for the prompt, safe and effective delivery of data and information to those that need it, be they staff, patients or their carers.

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"*

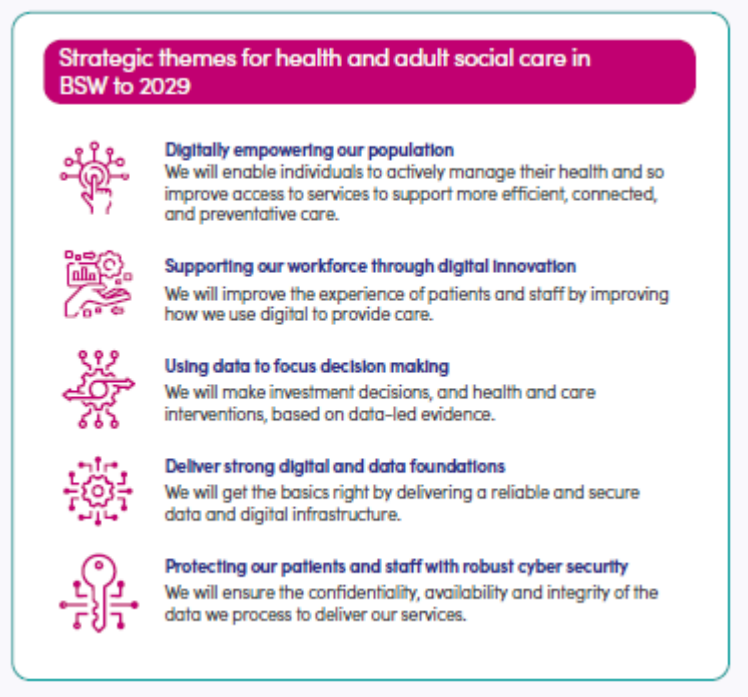


Figure 1. BSW Digital Strategic Themes to 2029

12. Infrastructure Strategy

Infrastructure is a critical enabler for delivering the transformational changes set out in the BSW Integrated Care Strategy. We aim to provide a modern, fit-for-purpose estate with seamless digital connectivity, designed for efficiency, sustainability, and flexibility to support high-quality care closer to home. As the third largest cost after workforce and medication, infrastructure must be financially sustainable and optimally utilised.

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 and is underpinned by six priorities:

- Empowered decision making
- Transformative digital solutions
- Workforce excellence
- Building a greener future
- Informed infrastructure spending
- Building a better future together

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.

Summary of NHS Bath and North East Somerset, Swindon and Wiltshire ICB CDEL Allocation	26/27 £m	27/28 £m	28/29 £m	29/30 £m	Total £m
Operational Capital (CDEL)	41.56	43.50	44.39	45.26	174.72
Primary Care BAU Capital (GPIT/MIG)	1.88	1.88	1.89	1.89	7.53
National Programme - Primary Care Utilisation Fund	0.75	0.75	0.75	0.75	3.00
Strategic Primary Care Fund	3.00	3.14	3.21	3.27	12.61
Total	47.19	49.27	50.23	51.17	197.86

Funding sources will include annual ICB capital allocation, national NHS capital programmes, Section 106 and CIL contributions, local authority borrowing, private sector partnerships, charitable funds, and capital disposal receipts (estimated £10.1m, with 50% reinvested locally).

Data-led decision making is central to our approach for planning and prioritising investment. We will use key planning tools to model demand and capacity across acute, community, mental health and primary care settings, ensuring that our estate strategy is evidence-based and aligned to population needs. This includes applying advanced

modelling techniques to forecast future service requirements and identify opportunities for co-location and optimisation.

Alongside this, we will maintain a robust categorisation of our estate into Core, Flex and Tail assets, enabling us to target investment where it delivers greatest value, improve utilisation of existing facilities, and plan disposals to release capital for reinvestment. These actions will ensure that decisions on infrastructure are transparent, data-driven and support the delivery of our strategic objectives for prevention, equity and care closer to home.

The development of our infrastructure plan is shaped by several critical dependencies that influence both timing and scope. Population growth and housing development across BSW will significantly impact demand for health and care services. Forecasts indicate an additional 62,000 residents and 57,000 new homes by 2038, with the most substantial growth in the over-60 population. This demographic shift requires close alignment with Local Plans and proactive engagement with local authorities to secure developer contributions through Section 106 and Community Infrastructure Levy agreements.

Clinical service transformation is another key dependency. Our infrastructure requirements are informed by ADEPT modelling, which supports the ‘left shift’ of care from acute hospitals into community settings. This approach demands flexible, modern facilities that can accommodate integrated neighbourhood teams and deliver care closer to home, reducing pressure on acute sites while improving patient experience.

Digital enablement underpins the success of our infrastructure strategy. The delivery of the BSW Digital Strategy, including shared electronic patient records, virtual wards, and remote monitoring will be essential to optimise estate utilisation and support new models of care. Investment in digital connectivity and space for virtual consultations is therefore a critical dependency.

Workforce expansion also influences infrastructure planning. The NHS Long Term Workforce Plan requires modern facilities for recruitment, retention, and training, alongside spaces that promote collaborative working and staff wellbeing. Without sufficient physical capacity, workforce productivity improvements cannot be achieved.

Finally, sustainability commitments and governance frameworks shape our approach. Compliance with the NHS Net Zero Building Standard and delivery of the BSW Green Plan depend on system-wide investment and external factors such as National Grid upgrades to support electrification. Governance arrangements, including the implementation of the BSW Capital Investment Framework and Investment Panel, ensure prioritisation and affordability. In addition, the forthcoming end of the Great Western Hospital PFI contract in 2029 requires early planning to manage transition and mitigate operational risk.

The National Programme, with indicate allocations to BSW capital provides investment opportunities over four years (2026/27–2029/30) to support constitutional standards and the ‘left shift’ of care into community settings. This indicative multi-year settlement enables strategic investment across six programme areas, with our total allocation over this period set out in the following table:

Note: This table will be completed with numbers once we have confirmed BSW allocations by the National Team and Region, so this is included as a holding position.

Summary of NHS Bath and North East Somerset, Swindon and Wiltshire ICB CDEL Allocation	26/27 £k	27/28 £k	28/29 £k	29/30 £k	Total £k
National Programme Estates Safety Fund					
National Programme Diagnostics Schemes					
National Programme UEC Schemes					
National Programme Mental Health, Learning Disability and Autism Schemes					
National Programme Community Schemes					
National Programme Elective Scheme Completion					
Total Value of PDC for Proposed Schemes					

We are developing a capital pipeline scheme that will be integral to delivering the ICB's strategic objectives across the following themed areas:

- **Diagnostics**: Expanding CDCs and replacing outdated equipment improves access to timely tests and supports elective recovery by reducing waiting times. Locating diagnostics in community settings aligns with the ambition to deliver care closer to home and tackle health inequalities.

- **Urgent and Emergency Care**: Investments in Model EDs, UTCs, and SDEC units enhance patient flow and reduce A&E waiting times, directly supporting constitutional standards. Ambulance hubs and home-based UEC care strengthen system resilience and integrated neighbourhood services.

- **Mental Health, Learning Disability & Autism**: Developing NMHCs and MHEDs ensures people in crisis receive care in therapeutic settings, reducing inappropriate hospital admissions and out-of-area placements. Crisis accommodation supports personalised care and parity of esteem for mental health.

- **Community Health Services**: Estate and digital upgrades increase capacity for proactive care and multidisciplinary working, supporting prevention and early intervention.

- **Elective Care**: Completing surgical hubs and day case units addresses the elective backlog and improves productivity, supporting RTT standards.

- **Primary Care Estates**: Upgrading GP premises creates additional clinical space, supports workforce expansion, and facilitates integrated care delivery within neighbourhoods. Strategic estate investment replaces outdated buildings and co-locates services with local authority and community partners.

Collectively, our schemes will enable the left shift of care from acute hospitals to community and primary care settings, improve access and reduce waiting times, address health inequalities, support digital transformation and workforce productivity, and deliver sustainability goals by embedding NHS Net Zero principles in all new developments.

Infrastructure priorities are fully aligned with the objectives of the Integrated Care Strategy: Prevention and early intervention, fairer health outcomes, and excellent health and care services.

Delivery will be supported by the BSW Capital Prioritisation Framework, categorising investments into three bands: Band 1 for major schemes attracting national funding, Band 2 for ICS-funded small projects, and Band 3 for local minor capital expenditure. Our plans underpin these priorities and will be refreshed annually to maintain alignment with evolving clinical and population needs.

Devizes Integrated Care Centre (opened 2023) and Trowbridge ICC (completion 2026). Community Diagnostic Centres in Bath, Swindon, and Salisbury. Sulis Orthopaedic Centre supporting elective recovery are current examples of where we are delivering against our vision as well as significant investment into Primary Care during 2025/26 to increase clinical capacity.

13. 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 conducted a number of engagement sessions with members of the public across BSW to gather input and involving several distinct groups, including Patient Participation Groups, senior citizens from Black and Minority Ethnic (BAME) communities in Bath, refugees and asylum seekers in Swindon, the Muslim community in BaNES, and representatives from the Gypsy, Romany, Boater, and Traveller communities in Wiltshire and Bath. Discussions with these groups focused on three key national shifts underway nationally in health and care.

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

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.

The ICB's work in this area against its Legislative Duties is also found in Appendix 4.

14. 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. The framework shall provide a robust, evidence-based approach to monitoring progress

and addressing inequalities. It enables the Integrated Care System (ICS) to align its priorities with measurable and actionable goals, ensuring that our efforts translate into meaningful change for our communities. 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.

15. 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, 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 (on the ICB / system if the risk does materialize)	Mitigating Action
NQ2, Ambulance to Hospital handover delays (Ambulance Improvement) impact on system's ability to meet targets	20	5	4	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
Fin05, 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
PCC9, PCC2, PCC1 Planned care and cancer wait times, capacity impact on system's ability to meet targets	16	4	4	GWH, RUH, SFT run recovery projects; ICB close monitoring and oversight
ICBCorp01, Organisational change impacts on ICB's capability to deliver its functions	16	4	4	ICB / cluster change programme: capabilities mapping exercise to identify essential roles and high-risk loss areas; business continuity plans
#74, 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
Various risks re specific ICB activities and operations 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	average 15			Mitigations focus on close collaboration with providers and on close monitoring of finances
BAF01, Urgent and Emergency Care, insufficient capacity across the entire system pathway 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	15	3	5	UEC strategy, oversight of SWAST contract, focus on infection prevention and control, oversight of out-of-hospital capacity

Risk	Risk Score (LxI)	Likelihood	Impact (on the ICB / system if the risk does materialize)	Mitigating Action
BAF02, 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	16	4	4	Providers activity plans and recovery plans, close monitoring via contract meetings, increased use of CDC capacity
BAF03, 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
BAF04, 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
BAF06, 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
BAF07, 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
BAF09, 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

16. Governance

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

During the business year 2025/26, the BSW ICB's governance and decision-making arrangements will ensure appropriate decision-making and oversight and assurance with regards to the approval, implementation and delivery of the plan. 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 the plan and its delivery, risk monitoring and assurance that risks are managed, and commissioning decisions where the value of the commissioned services contracts reach the relevant threshold per the BSW ICB's SoRD and Scheme of Financial Delegations (the BSW ICB Board is the decision-maker for the most high-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. The intention is to have in place cluster governance and decision-making arrangements. While these arrangements have not been finalized at this point in time, we anticipate the following as relevant forums for decision-making, oversight and assurance with regards to the delivery of the plan – to note that this is indicative only at this point in time and may be 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
  - TBC: Place 'boards' may play a role in the oversight and assurance of the plan and its delivery where intentions have particular local / place implications

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

We will report regularly to the ICB board on progress against the priorities set out here.