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BSW Five Year Strategic Commissioning Plan

January 2025

Purpose of session

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- Present a draft of the BSW Five Year Strategic Commissioning plan (strategy), prior to the sign off of the final plan (extraordinary board 10th February)
- Provide feedback and endorsement -Health and Wellbeing Boards required to endorse as part of the requirement for the planning submission on 12 February 2026 for the NHS Medium Term Planning Framework (published on 24 October);
- Outline the remaining work in finalising the plan prior to the February planning submission
- Describe the timeline for the planning process to achieve the final submission on 12 February

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Introduction & Context

Purpose of the Five Year Strategic Commissioning Plan

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Three strategic shifts

- The commissioning plan set out in this paper sets out the ambition of BSW ICB to further **transform health services over the next five years**, working as part of the wider ICB cluster.
- Takes forward the work previously set out in the **BSW ICP strategy**, and articulated in our **BSW Care Model**, and now incorporates the ambitions articulated in the **NHS Ten Year Plan**.
- Our plan adds further detail to our **commissioning intentions** (approved by the Board last year) for **transforming a range of key services that will deliver the three shifts.**
- The quantification of these shifts, which will be estimates only, is being completed in line with our already established **Outcomes Framework**,
- **Delivering on these outcomes** will drive the **delivery of our intentions** and be the key metrics by which we will evaluation success.

Work we have undertaken to date

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Developed strategic commissioning intentions and engaged upon them with key partners

Developed in collaboration with ICB portfolio and commissioning leads to further develop the commissioning intentions and delivery milestones and timescales

Alignment to the 10-year plan has been central to identify ambitions and opportunities for BSW

Integrated Needs Assessment

updated our population demographic and demand forecast work

Reviewed progress against the BSW Care Model and our associated clinical strategies.

Developed with a cluster approach based on the national guidance

Strategy on Page

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Our Commissioning Intentions

- Embedding outcomes and promoting integration in our approaches to commissioning
- Developing a neighbourhood health service
- Commissioning a comprehensive review of our urgent and emergency care pathway
- Transforming Delivery of Planned Care
- Optimising the use of the BSW pound
- Expanding and Ensuring consistency of our digital offer
- Transforming Primary Care
- Commissioning for Prevention

What we will deliver together

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

We will deliver this vision by prioritising three clear objectives:

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

How we will deliver it

The BSW Care Model

Healthier Communities → Personalised Care → Joined-up Local Teams → Local Specialist Services → Specialist Centres

Enablers to help make it happen:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as Anchor Institutions

Informing our Commissioning Intentions

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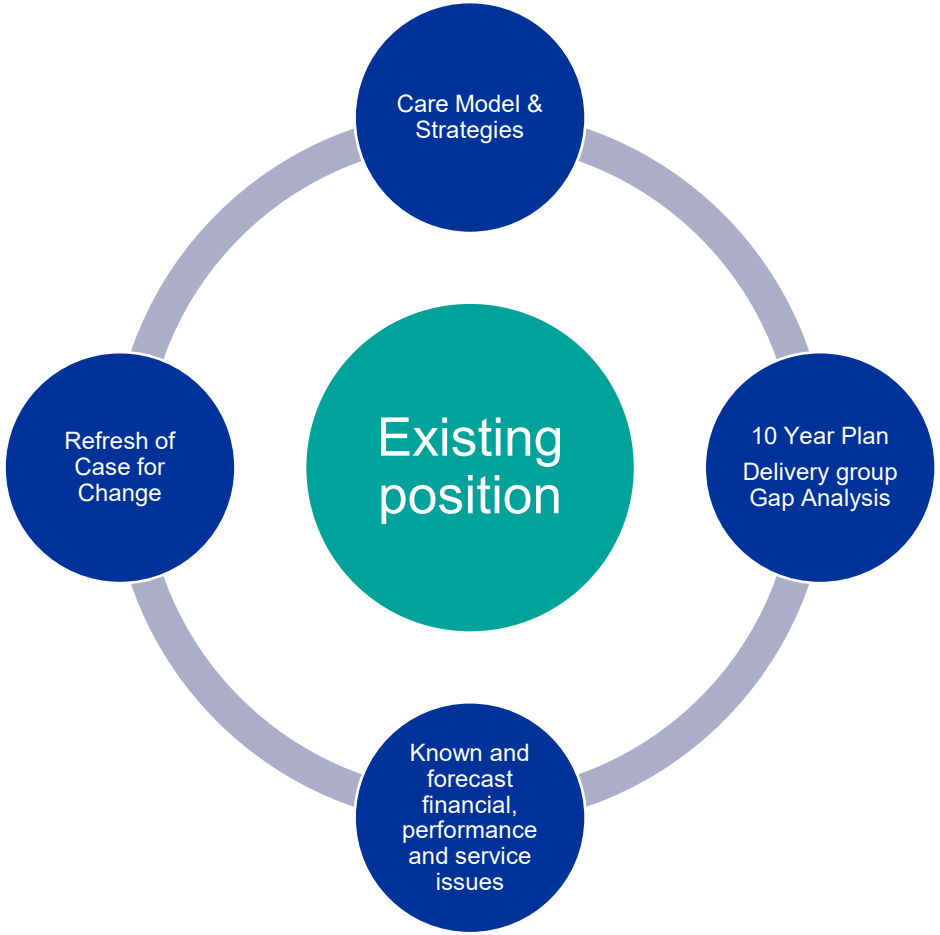

Commissioning Intentions

5 Year Strategic Intent and Ambition :
Direction and outcome improvements linked to rationale and Care Model and10 Year Plan

3 Year Commissioning Intentions :
Specific actions and measurable impacts

1-2 Year Contracting and Procurement Intentions :
Detail that impacts contracts
Planned procurements and management of expiring contracts

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Summary of Five Year Strategic Commissioning Plan

What our Integrated Need Assessment Tells Us

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- **Rising demand from an ageing population**: The number of people over 60 in BSW is set to grow by 35% in 15 years, driving higher A&E attendances, ambulance dispatches, and pressure equivalent to needing a new 20-bed ward each year.
- **Growing waiting lists:** Elective, community, and mental health backlogs have surged post-COVID, with over 100,000 people on acute waiting lists and 25,000+ on community lists, while neurodiversity and autism waits have quadrupled.
- **Workforce shortages and morale**: GP numbers have stagnated despite population growth, dental access is limited, and staff morale is flat or worse compared to pre-pandemic levels.
- **Financial pressures**: Rising costs and efficiency targets mean BSW faces difficult trade-offs to remain financially sustainable, with full details pending from Finance.
- **Health outcomes in major diseases**: While preventable mortality benchmarks well nationally, cancer, cardiovascular, and respiratory outcomes still trail, underscoring the need for earlier detection and proactive intervention.
- **Digital**: Digital tools and data offer scope to improve efficiency, patient experience, and proactive care, but maturity and investment vary across organisations.
- **Health inequalities**: Outcomes remain unequal across gender, age, ethnicity, and deprivation, with deprived groups experiencing longer waits, lower vaccine uptake, and higher risk of serious illness.

What Our Mapping of Current Performance Tells us

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1

Urgent & Emergency Care

- Improved ambulance handovers (now within 45 minutes) but increased A&E demand.
- A&E 4-hour performance remains in lowest national quartile.
- High numbers of patients delayed beyond discharge-ready date; flow improvements required.

2

Elective Care:

- RTT improving overall but RUH off-plan; significant challenge to meet 92% by 2029.
- Waiting list growth (+3.3%) is a national outlier; requires ~50% reduction.
- Cancer 28-day and 62-day performance below target
- Diagnostics strong vs national but substantial improvement needed to meet 1% by 2029.

3

Mental Health & Learning Disabilities:

- Talking Therapies course completions below plan; service development required.
- Dementia diagnosis rate below national standard.
- CYP MH access rates in bottom national quartile; expansion needed.

4

Primary & Community Care:

- Dental activity (routine & urgent) below plan; needs uplift to meet targets and support contract reform.Need to increase availability of GP and same-day appointments; digital triage rollout key.

5

Effectiveness & Experience of Care:

- Infection rates need improvement to reduce bed closures and support patient flow.

What Our Engagement on the 10 year plan told us

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We held an extensive local conversation on the NHS Ten year plan with our communities. The themes identified in this conversation as well as other engagement we have carried out with our communities are central to this plan and include:

Prevention & Early Intervention
- Strong support for prevention but differing views on delivery.
- Calls for better school-based health education, nutrition & physical activity programmes.
- Need for long-term VCSE funding and targeted outreach.
- Concerns about affordability of healthy food and unintended impacts of increased screening.

Access & Navigation
- Low awareness of pathways (esp. weight management, frailty).
- Desire for clearer signposting, self-referral routes and eligibility information.
- Transport & rural access challenges; request for mobile/closer diagnostic services.
- Frustration with poor hospital–GP coordination; need for joined-up referrals/discharge.
- Digital vs Face-to-Face

Support for shared care records & digital tools.
- High concern about digital exclusion (older & disadvantaged groups).
- Preference for face-to-face for complex issues.
- Ongoing worries about cyber security & data privacy.
- Workforce & Infrastructure Concerns about staffing shortages and ability to deliver new models (Hospital at Home, CDCs, TICC).Questions about feasibility in rural areas.

Communication & Cultural Sensitivity
- Need for clearer, jargon-free communication.
- Demand for translation services & culturally sensitive care.
- Behavioural & Social Factors
- Learned behaviour driving A&E attendance despite alternatives.
- Emotional/psychological support and stigma important in weight-related discussions.

Service Design Feedback (Trowbridge ICC)
- Support for care closer to home.
- Requests for extended MIU hours, local maternity options, short-stay beds.
- Mixed views on whether new facilities = improved care or just new buildings

1. Embedding Outcomes & Promoting Integration

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Embed System Outcomes Framework in Contracts:

- Embed **outcomes into our contracts with an increasing number of providers**
- Require providers to **demonstrate contribution to outcomes metrics and national best practice** on patient-reported outcomes and address inequalities.
- Underpin this with a **new financial framework** where partners collect and develop outcome data (e.g., dementia care).
- Incentivise providers to collaborate and shift care from hospital to community.
- Enhance integration of physical and mental health pathways in community settings.

Underpin population health management to identify groups and neighborhoods where outcomes are poorest:

- Strengthen **population health intelligence at place level** to guide investment and disinvestment within pooled budgets, using PHM segmentation to target high-need cohorts and geographies.
- Support equitable uptake of **high-value prescribing** (e.g., CVD) by linking **outcomes data to prescribing data** and using BI tools to identify areas of low uptake.
- Commission services to **maximize access for identified populations**, ensuring equity and reducing health inequalities across Pharmacy, Optometry, Dental, and medical pathways.
- **Integrate PHM into Pharmaceutical Needs Assessment (PNA)** to improve **access to safe, high-quality community pharmacy services** aligned with population needs.
- **Apply PHM in dental procurement processes** to ensure **accessible, safe, and quality dentistry services** that reduce health inequalities.
- Leverage **high-quality data and insights to drive strategic care** through NHS App, AI frameworks, and workforce training.
- Ensure **funding flows reflect population health need, not historical activity**, by adding **contractual clauses** for improved data quality, completeness, and linkage of data, evidence, and clinical insight.

2. Develop a Neighbourhood Health Service (1)

Develop a neighbourhood health service:

- **Develop locality-based Neighbourhood Health Plans** that define shared priorities and outcomes for each population. We will do this by shifting from organisation-led to place-led planning and align funding across community, primary, mental health, VCSFE and acute partners.
- Explore **development of a Mental Health Community Neighbourhood Service** to strengthen mental health support in schools, perinatal and child and adolescent services to build resilience and intervene earlier.
- **Strengthen joint commissioning and shared accountability across ICB and Local Authorities** through pooled budgets, shared outcomes, and integrated assurance.
- Align BCF, prevention, inequalities and population health management (PHM) workstreams under a **single Neighbourhood Health delivery framework.**
- **Neighbourhood-level outcome measures** and evaluation methods will be developed collaboratively with providers, including acute, VCSE and local authority partners.
- Commission Community Pharmacy as a key provider in our primary care offer, by using the opportunity and capacity that CP affords, to improve access, support urgent care, deliver prevention and reduce health inequalities.
- Commission services in primary care within other sectors e.g. urgent care, mental health, neighbourhood health rather than separately.

2. Develop a Neighbourhood Health Service (2)

Expanding and embedding Integrated Neighbourhood Teams, supported by renewed engagement with service users, the VCSE sector and targeted population cohorts:

- We will implement Neighbourhood Health Plans through Health and Wellbeing Boards, aligning each with local JSNAs and system outcomes.
- We will commission neighbourhood mental health teams which includes VCSE partnerships and school-based services so people are supported earlier and more locally.
- The next phase of ICBC implementation will enable the embedding of INTs as the visible organising structure for neighbourhood delivery, incorporating children and young people, prevention and wider determinants from the outset.
- We will expand Neighbourhood Health beyond the contract to include civic and community levers such as housing, education, employment and local infrastructure and progress the INT scope in line with this contract to include prevention and early intervention alongside clinical care.
- Using the opportunity and capacity that Community Pharmacy affords, we will improve access, support urgent care, deliver prevention and reduce health inequalities and expand outreach dental to underserved and discrete communities.

3. Review Urgent and Emergency Care Pathway

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We will undertake an end-to-end review of the currently commissioned UEC pathway. Using the outcomes of this review we will seek to:

- **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.
- **Review impact of CYP UEC scheme**s including the Healthier Together App and the Paediatric ARI Hubs
- **Hospital @ Home will be commissioned for other pathways**, for example paediatrics, end of life and increased step up
- **Review of Urgent Treatment Centres**, to support the shift from MIUs to UTCs.
- **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.
- **Align locality-commissioned Neighbourhood Health and ICA priorities to reduce duplication**.
- **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** so people remain connected to their support networks and local teams.
- **Commission mental health community rehabilitation, and crisis alternatives** reserving inpatient beds for the most complex needs

4.Transform Delivery of Planned Care

- Commission services that enable a **radical change in service delivery or recommissioning for ENT, Respiratory, Cardiology, Urology and Gastroenterology.**
- **Digitally enabled, patient-led outpatient model Advice and Guidance with specialty level Single Point of Access** before referral, complemented by direct access to diagnostics.
- **Straight to test pathways for clinically appropriate patients**, with the 10 largest specialties by volume (all specialties by 2029)
- 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.
- **Redesign the pathway for primary care to reduce need for referral to treatment**, that only those things required to do by specialists are done by specialists.
- A shift away from a **traditional referral approach to a joint approach between primary and secondary care** and we will implement nationally mandated changes to Advice and Guidance to create a 'discuss with' rather than 'refer to' model across all specialties through our Referral Redesign Programme.

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5. Optimising use of the BSW pound

A New Financial Framework:

- 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 at neighbourhood level.
- We will drive transformation, integration and the shift from sickness to prevention. We will do this by **focusing on eliminating waste by expanding the use of preventative approaches, improving productivity, ensuring alignment of services with needs and incentivising partnership working through different contracting models.**
- 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**.

6.Expanding Our Digital offer

- We will 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. This may require providers ensure they use subcontractors that are also going to engage.

- We will avoid system proliferation and commission consistency of the **Integrated Care Record** ensuring that providers will **flow relevant data into the ICR and use the care planning functionality** it contains.

- **Providers will make use of existing systems across BSW** rather than introduce new disparate solutions to the system architecture. We will do this through the **Integrated Care Record, Single EPR, AWP EPR review and our ICBC contract**.

- We will require **providers to state how they will collectively reduce digital exclusion**, for example this may involve outreach work into disadvantage communities.

- We will commission 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, meet clinical safety & cyber requirements and be evaluated to evidence benefits.

- **Patient empowerment-** Services will be designed in a way that allow **patients to take greater control of their own management** through using wearables, remote monitoring and virtual support.

7. Commissioning for Prevention and Population Health

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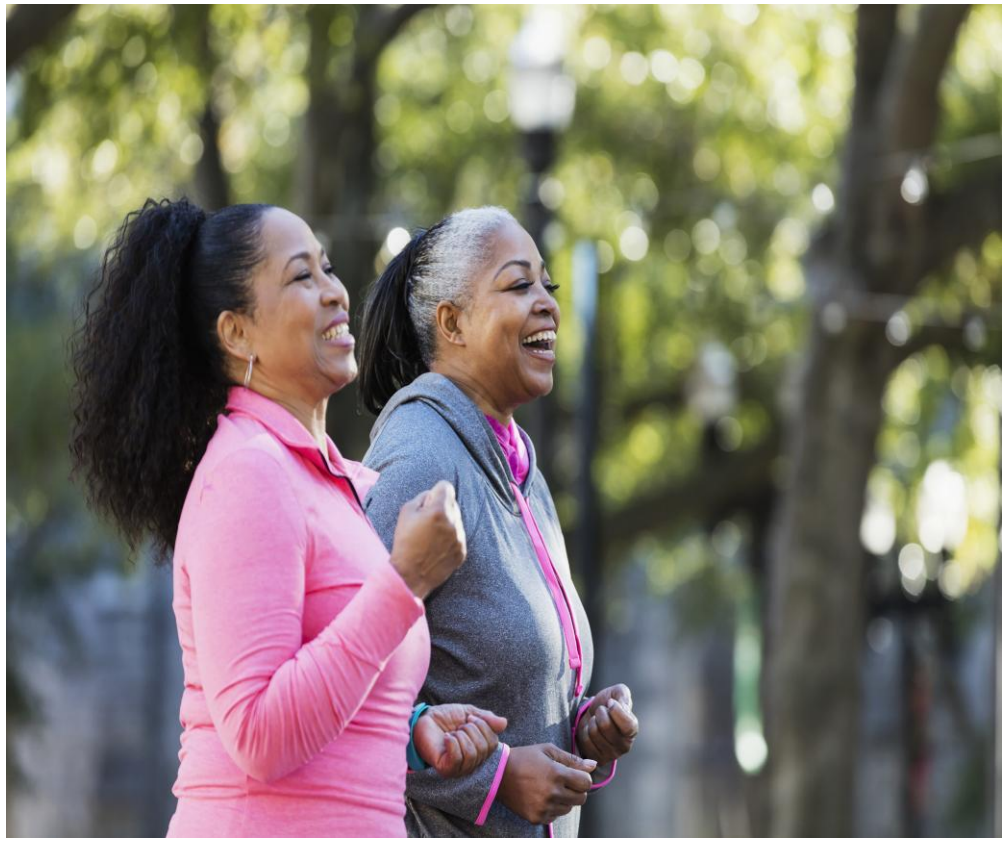
- Establish a **system-wide baseline of prevention spend** across NHS, Local Authority and VCSE partners and set a **multi-year ambition to increase the proportion of total resources** invested in prevention. We will do this by:
- Commission **coherent prevention pathways for major modifiable risk factors**, i.e tobacco, obesity, harmful alcohol use, polypharmacy, cardiovascular and metabolic risk, ensuring alignment from early identification through to treatment and maintenance.
- We will commission services in a way that **maximises access where populations have been identified**, to ensure equitable access and reduced health inequalities.
- Use the **opportunity and capacity that Community Pharmacy affords**, to improve access, support urgent care, deliver prevention and reduce health inequalities.
- We will commission providers to **proactively target patients with problematic polypharmacy**, and **reduce incentivizing interventions** where problematic polypharmacy is an outcome
- Require **early identification, escalation and learning processes across contracts** to build a preventative safeguarding culture.
- Make **neighbourhoods the focal point for prevention** by aligning NHS, VCSE and Local Authority partners around shared outcomes, expanding Wellbeing Co-ordinators and social prescribing.
- Utilise **Community Pharmacy as a key mechanism of the community** to deliver prevention.
- Implementation of the **vaccination strategy** to allow **all providers access to all vaccines at the most appropriate point** for the patient
- Grow the role of VCSE role by building on the **5 % ICBC investment requirement to deliver measurable prevention outcomes and scale trusted, community-led approaches** that tackle inequalities.



8. Transforming Primary Care

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- Commission **same-day services for clinically urgent patients** (face-to-face, phone, online) to meet 90% target.
- Ensure **all GP practices deliver 2025/26 and 2026/27 contracts**, including full access via multiple channels and online consultation availability during core hours.
- Improve **patient experience of GP access using PREMs** for year-on-year improvements.
- Expand **Pharmacy First and introduce prescribing-based services in community pharmacies** with outcome-based frameworks and PGDs.
- **Rebase dental contracts** to commission additional capacity for residents.
- Accelerate **digital-by-default** in primary care, supporting ambient voice tech and NHS App integration.
- Require **collaboration** across general practice, community pharmacy, dental, mental health, VCSE, and hospices **to design neighbourhood services for local needs** (frailty, deprived populations).
- Commission **outcome-based frameworks to incentivise proactive care at home and MDT collaboration**, reducing non-elective admissions and bed days.
- **Redesign planned care pathways** to reduce referrals and commission community-based specialist clinics, expanding CDC access and **formalising integrated pathways.**

Other Key Activities

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- De-commissioning programme
- Accountability framework
- Analysis of existing contracts and block arrangements
- Leveraging specialist networks
- Transformation/innovation fund-pathway improvement
- Engagement with patients and communities

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Next Steps

- Reviewing and refining a more concise version of the 5-year plan, incorporating Board feedback, and NHSE feedback on our first planning submission and commissioning intentions
- Translating and quantification of the commissioning intentions into activity plans, including aligning this with the ambitions set out in our BSW Outcomes Framework and our ICBC Outcomes Framework
- Ongoing work for activity, finance and workforce plans ahead of the February submission
- Finalise detailed delivery plans
- Socialisation of the plan with Integrated Care Alliances
- Endorsement of the 5 year plan by all three Health and Wellbeing Boards in BSW.
- An EQIA to be completed on the Integrated planning process and agreed by QOC on 2nd February 2026
- Detailed proposals to be agreed for key transformation projects to be agreed as part of the protected transformation fund and summarised in the plan

Timeline for Full Submission

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Full Submission 12th Feb 2026

Check & Challenge System Planning Exec
23rd Jan

Final Submission for Provider Plans to ICB
29th Jan

Extraordinary QOC (EQIA)
2nd Feb

Draft plans to Execs
2nd Feb

Finance & Investment Committee
4th Feb

Papers 6th Feb

Extraordinary Board
10th Feb

NHSE Submission
12th Feb

NHSE meeting 12th Jan

HWB Endorsement (5 year Plan)
29 Jan Wiltshire
3 Feb Swindon
5 Feb BaNES

Submission includes:
3 Year finance plans (4 year for capital)
3-year workforce plans
3 Year Activity and Performance
Integrated medium-term plan template
Board Assurance Statements
5 Year Plans (Trust delivery plan or ICB Strategic Commissioning Plan/PHIP)
3-year Ambulance operational plans

Provider Board sign off
SFT- 10th Feb
GWH- 5th Feb
RUH- 4th Feb

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Appendix 1: National Planning Requirements

Summary

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- On 24 October 2025 NHS England published the Medium Term Planning Framework- delivering change together 2026/27 to 2028/29, which introduces a shift away from short-term operational focus toward long-term, locally-led improvement across the NHS.
- Seeks to empower local innovation through a revised operating model and financial regime, supporting major improvements in neighbourhood health services, digital transformation, and quality of care;
- Key national priorities include:
  - **Financial discipline:** 3% real-terms revenue growth and 3.2% capital funding, with all systems to achieve balance or surplus by 2029 and deliver at least 2% annual productivity gains.
  - **Operating model:** Empowering Integrated Care Boards (ICBs) and providers to deliver integrated, prevention-focused care through eight strategic themes: local integration, neighbourhood health, prevention, digital transformation, quality improvement, patient experience, workforce and leadership renewal, and embedding genomics and research.
  - **Operational delivery:** 15 national success measures will underpin performance monitoring through the NHS Oversight Framework, supported by new technical guidance and productivity tools.

The Medium term planning framework required us to be ambitious

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The **Medium Term Planning Framework (MTPF)** is an ambitious document. Over the next 3 years it will return the NHS to much better health – with waiting times dramatically reduced, access to local care restored to the level patients and communities expect, and unnecessary bureaucracy slashed so that savings are poured back into frontline services and staff.

Building on the 10YHP it sets out how the NHS can deliver the three shifts and sets out the new way of working:

Hospital to Community	Sickness to prevention	Analogue to digital
• Accelerating progress on Neighbourhood Health • Same-day appointments for urgent cases in general practice • Increasing community service capacity and productivity • Greater use of community pharmacy • 700k extra urgent dental appointments a year	• Tackling obesity, including continued rollout of weight loss medicines and weight management services • Supporting the target of a 25% reduction in CVD-related premature mortality • Implementing opt-out models of tobacco dependency services • Reducing antibiotic use and polypharmacy	• Making full use of the NHS App to communicate with and support patients to better access and manage the care and services they need • Using the NHS Federated Data Platform to improve care through better use of data • Deploying AI tools like ambient voice technology and digital therapeutics

These shifts will be supported by:

1. Transforming our approach to quality, including setting out what good looks like in key clinical areas and rolling out data-led monitoring, starting in maternity services
2. A new Operating Model for the NHS which provides clarity on roles and accountabilities, and offers greater freedom and flexibilities for those performing well
3. A new financial regime which distributes funding more fairly and ensures payment schemes support new models of care, including the shift to community
4. A renewed approach to improving productivity, reducing unwarranted variation, transforming pathways and maximising the use of technology to speed up processes.

Planning Architecture-how the plans fit together

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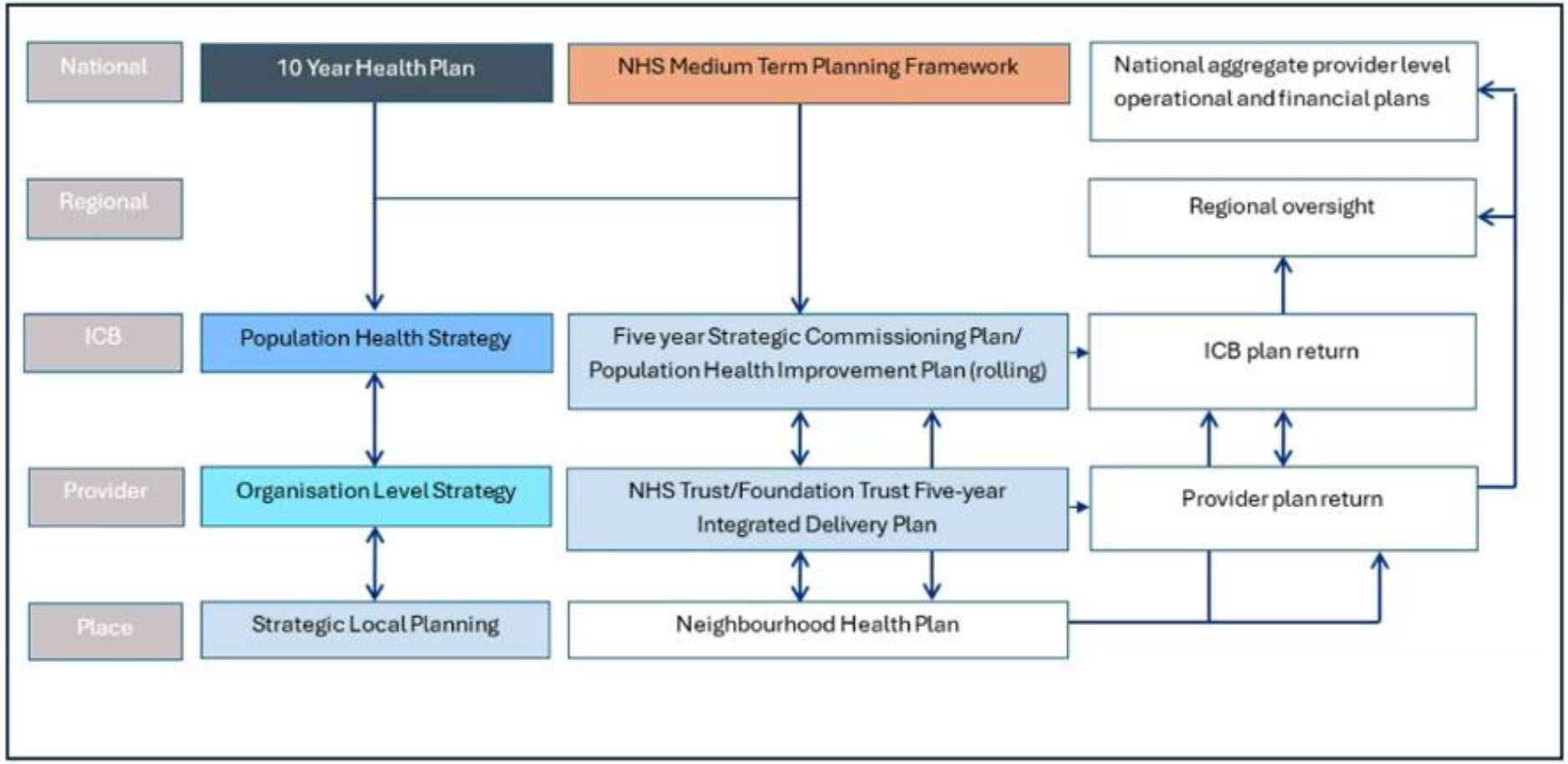
5-year plans will be collected at an organisation level at the full plan submission stage (early February).

The ICB plan will replace the functions of the JFP as well as setting out the strategic commissioning plans.



National Guidance on Five Year Plan Content

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Outline for ICB 5-year Strategic Commissioning Plan / Population Health Improvement plan (PHIP)

1. Executive summary	• Overview of the ICB's Commissioning Strategy including vision and desired outcomes • How the Strategic Commissioning plan will seek to deliver the outcomes and key points of the plan
2. Health economy / Population health context	• Summary of integrated needs assessment and baseline mapping of current performance and quality of commissioned services • High level analysis of population health need now and in the future, the health and care economy and the implications of 10YHP and objectives in MTPF- delivering change together for the development and commissioning of provision. • Assessment of the quality, performance and productivity of existing provision and improvement opportunities including relevant benchmarking and clear identification of underserved communities

3. Commissioning intentions for 2026/26 – 2030/31	• A methodology/framework to set out priority commissioning intentions over the five-year period
	• Each priority/commissioning intention as a minimum should include:
	  ◦ defined outcomes and metrics
	  ◦ clear milestones and delivery timescales
	  ◦ delivery scale (e.g., neighbourhood, place, ICB, pan-ICB — potentially one or more levels)
	  ◦ governance arrangements

4. Finance	• An overview of the financial ambitions over the 5 years • Evidence of the financial rigour applied in decision making and the maintaining of long-term financial sustainability
5. Workforce	• An overview of the ICB and system workforce plans over the 5 years • A description of how supply and demand challenges will be met, and how ICB is supporting system collaboration in workforce planning
6. Transformation and new care models	• A description of the organisations approach to transformation • Summary of how the organisation will co-ordinate and work with all partners to deliver major transformation programmes including embedding digital transformation and enabling the 'left shift' by supporting the shift of resources from acute to community services and increasing community and neighbourhood health capacity • Description of new care models to maximise value for patients and taxpayers aligned to 10YHP and how the ICB will embed these models
7. Enablers	• Key enablers for the plan, how they will be resourced, any dependencies that have been considered in the development of the plan and how they will be aligned to support the plan. The key enablers could be: digital, data and technology; estates and facilities; workforce

8. Risk and mitigations	• Risk model
	• High-level risk analysis including:
	  ◦ assessment of likelihood
	  ◦ financial and non-financial impact
	  ◦ mitigating actions which should be implementable internally without the need for external resource i.e. additional funding from the centre