

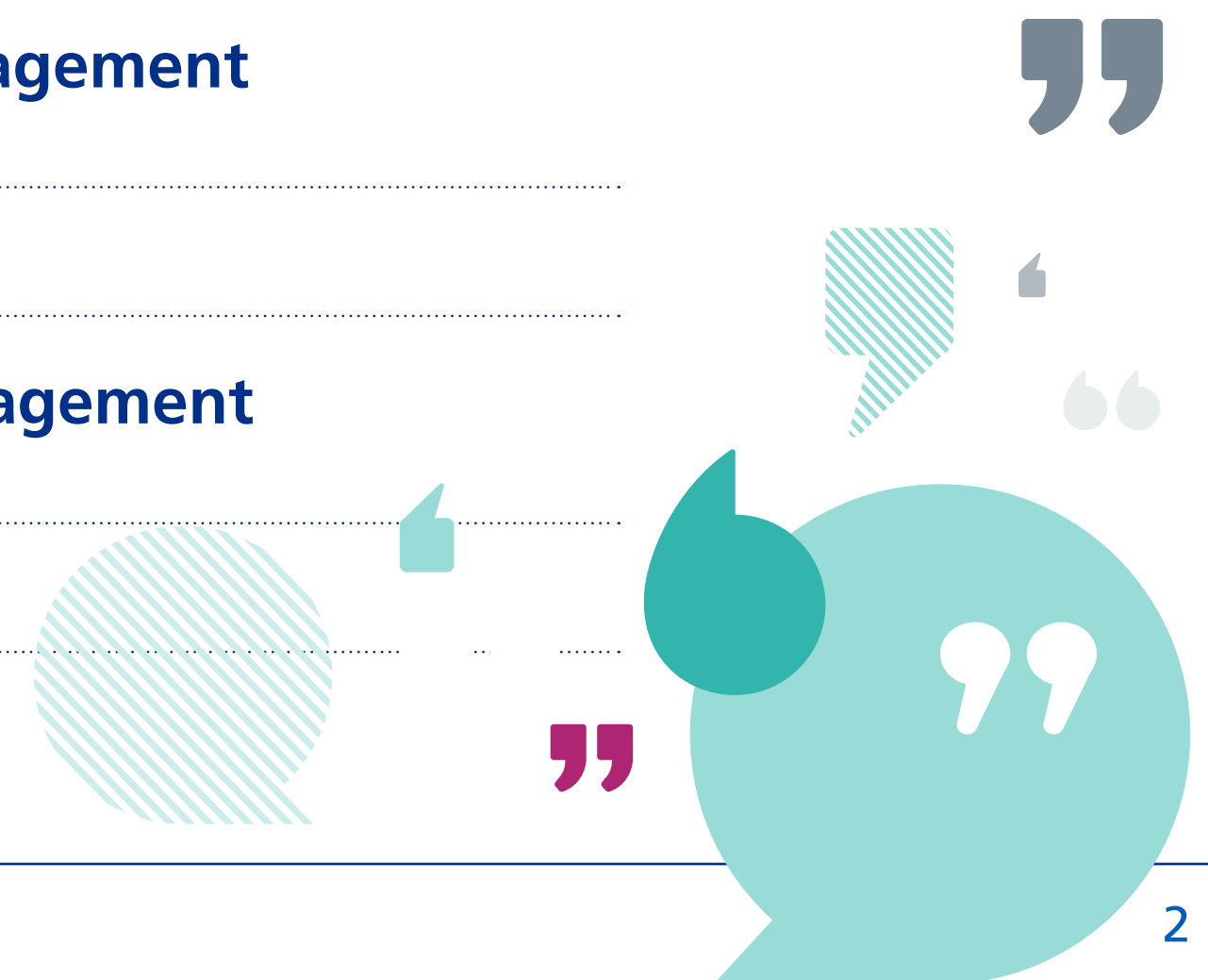
5 Year Strategic Commissioning Plan

2026/27 – 2030/31



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1. Foreword

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.



Rob Whiteman CBE

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 supporting the expansion of community pharmacy as an integral part of the out of hospital system.

In addition, we want to continue 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**
- **Preventing sickness - not just treating it.**



1. Foreword

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, Faith, and Social Enterprise (VCFSE) 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.

Our Cluster:

We will:

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

Our cluster size: 3,928.84 total square miles



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

2. Introduction to the plan

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

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

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

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

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

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, Voluntary, community, faith and social enterprise (VCFSE) partnerships, health and wellbeing boards, and ongoing public engagement so local insight shapes decisions.

Jonathan Higman



Vision, purpose and strategic context

Local feedback in action: You said, We Did



- ▶ Drawing on public and patient feedback gathered through our 10 Year Health Plan engagement, Somerset's Big Conversation 2025 engagement roadshow and our Engagement Insights Report 2025, people told us they support care being delivered closer to home when it is safe, reliable and properly supported.
- ▶▶ This is reflected in this plan's strategic direction to strengthen neighbourhood health services, develop integrated neighbourhood teams and shift appropriate care from hospital into community settings, while keeping safety, equity and local access at the forefront.

Get to know the cluster

2.6 million people live across Bath and North East Somerset, Swindon and Wiltshire, Dorset and Somerset.

We've got:

- Dispersed rural areas
- Large coastal communities
- Big urban centres
- 10% of our population is made up of our Armed Forces community.



Our primary care services



219
GP practices

across



373
community pharmacies,



57
Primary Care Networks (PCNs)

with



213
optometry services

and



208 Patient Participation Groups (PPGs)



367
dental practices



1
ambulance trust

South Western Ambulance Service NHS Foundation Trust covers the whole cluster. It's likely we'll keep lead commissioner arrangements for the South West.

Our provider trusts



5 acute hospitals (planned and urgent care)



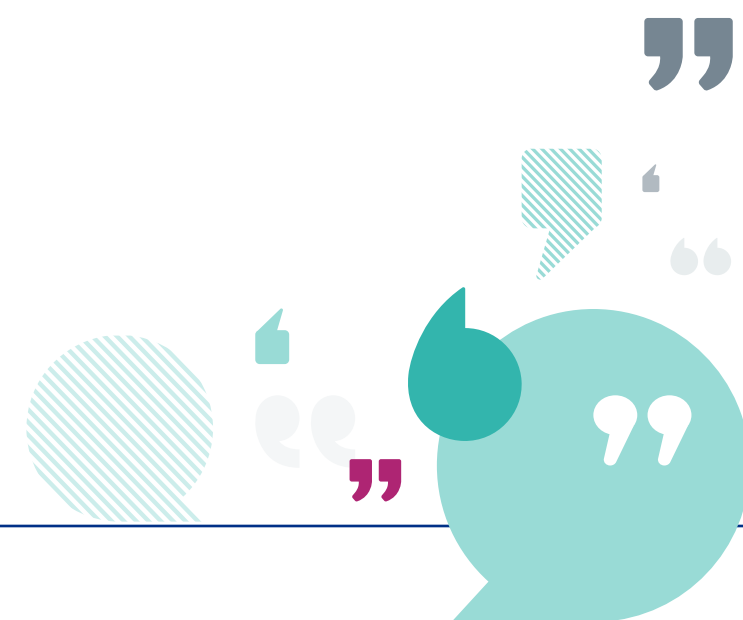
3 mental health trust



3 community providers



1 combined acute, community and mental health trust



2. Introduction to the plan

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 Voluntary, community, faith and social enterprise (VCFSE) partners working as one team.

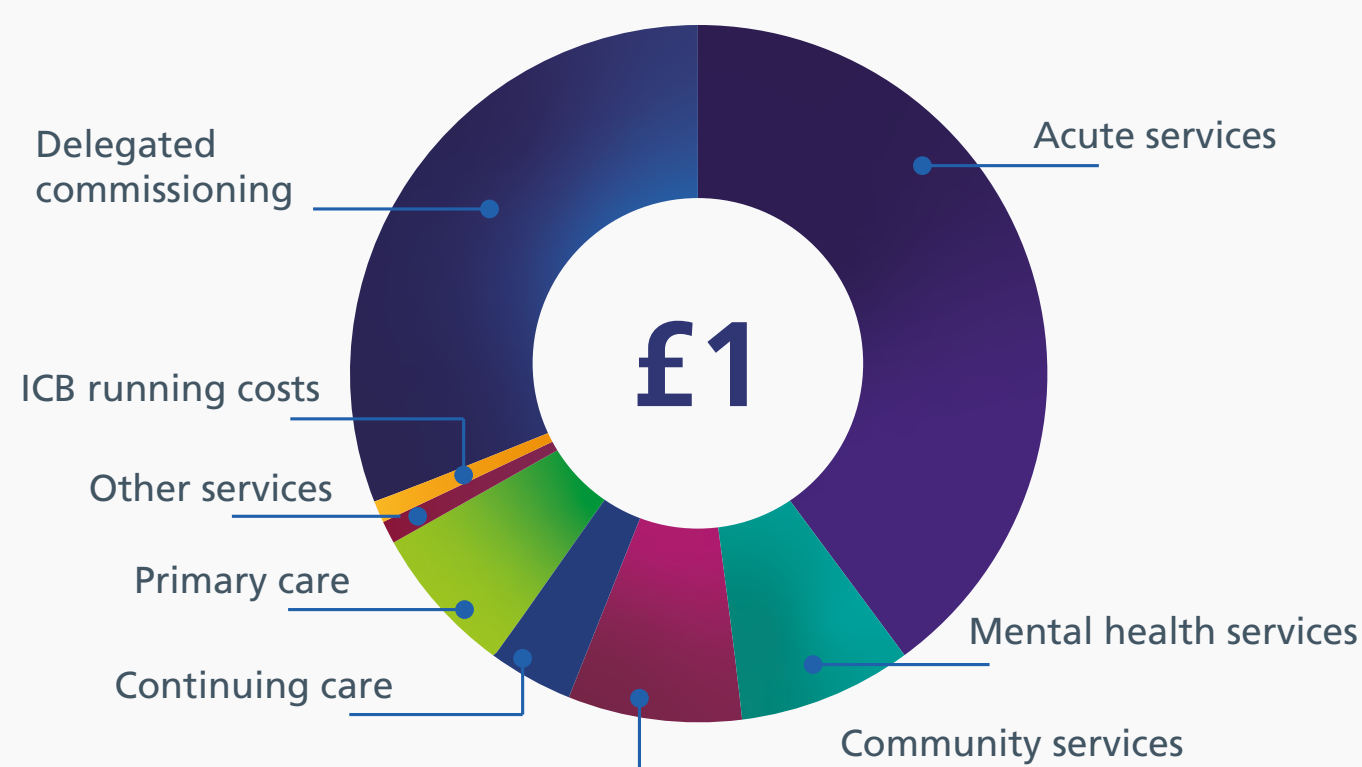
- **Improve urgent and emergency care by strengthening the community front door.** We will redesign same day and out of hours access, develop single points of access, and recommission Integrated Urgent Care (IUCS) so more needs are met safely at home.
- **Transform planned care pathways.** We will expand 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.** System wide 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 non digital routes open.** Shared care records, modern Electronic Patient Records (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.

Our finances

Our combined budget allocation for **2026-27 is £7.8bn** cluster (subject to change). We want to ensure the money we spend delivers the greatest value for our population. Here's how we spend every pound:

- Acute services..... 40p
- Mental health services..... 8p
- Community health services..... 8p
- Continuing care services..... 4p
- Primary care services..... 7p
- Other commissioned services..... 0.7p
- ICB running costs..... 0.4p
- Delegated primary and specialised commissioning (including primary medical services, dental, pharmacy and ophthalmic services)..... 31p



2. Introduction to the plan

- **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.

Understanding population need and demand

Local feedback in action: You said, We Did

- ▶ Across all three engagement routes – the 10 Year Health Plan engagement, Somerset’s Big Conversation 2025 roadshow and our Engagement Insights Report 2025 – people repeatedly highlighted how important timely access to care is, particularly at points of high demand.
- ▶▶ In response, this plan places a strong emphasis on improving access across primary and community care, addressing capacity pressures and reducing unwarranted variation so people can get help when they need it.



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.



* Bristol and North East Somerset
** Bournemouth, Christchurch and Poole



3. Purpose and Scope

Somerset's 5-year strategic Commissioning Plan sets out how we will use our collective resources to improve health outcomes, tackle inequalities and deliver high-quality care for our population until 2031.

It provides a clear line of sight from the needs of our communities and national NHS priorities through to the services we commission, the changes we will make and the results we expect to achieve.

Our plan:

- Describes our vision and priorities – informed by population health needs, our understanding of local inequalities, and the voices of people who use services, carers and communities.
- Highlights the transformation programmes we will pursue to meet the requirements of the NHS 10-year Plan, which seeks to: shift care from hospital into communities, move from treating sickness to prevention and making a shift from analogue to digital.
- Sets out our commissioning intentions for providers across the system. It describes the changes we expect in services, models of care

and contracts, and forms the basis for our dialogue and agreements with NHS trusts, primary care, local authorities, the voluntary and community sector and independent providers.

- Outlines how we will use our resources – including funding, workforce, digital and estates to deliver those priorities within our financial envelope.
- Describes our governance, assurance management of key risks, and how progress will be monitored and reported. In addition, it details how we will work with partners to deliver shared outcomes. In doing so, it provides a coherent framework for improving outcomes, experience and value for money for the people of Somerset.

Vision, purpose and strategic context **Local feedback in action: You said, We Did**

▶ Feedback gathered through our 10 Year Health Plan engagement, Somerset's Big Conversation 2025 engagement roadshow and the Engagement Insights Report 2025 consistently highlighted the value people place on continuity and trusted relationships with staff.

▶▶ This feedback is reflected in this plan's focus on workforce stability, continuity of care and neighbourhood-based service models that support relationship-based care, particularly for people with ongoing or complex needs.



4. Strategic Commissioning

Strategic commissioning is an ongoing, evidence-based process where we plan, purchase, monitor and review services over the longer term to support in the improvement of population health, reducing health inequalities and ensuring people in Somerset have fair access to high-quality care.

As strategic commissioners, NHS Somerset is responsible for getting the best value from the NHS budget by deciding how money is spent across our population, now and in the future, while making sure services uphold the rights and values set out in the NHS Constitution.

We will work alongside our key strategic partners, including but not limited to local government and Voluntary, Community, Faith, and Social Enterprise (VCFSE) sectors 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.

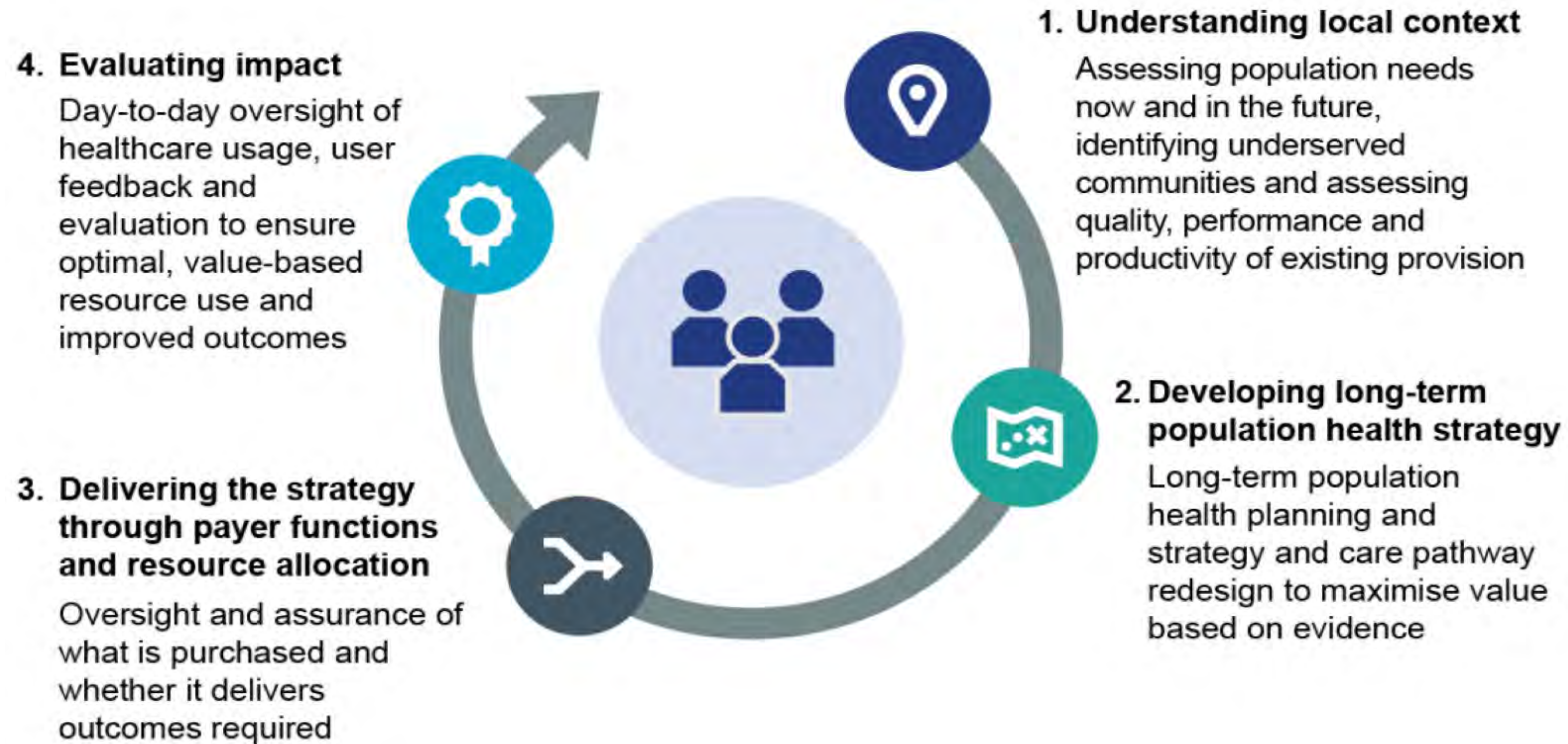
Strategic commissioning comprises 4 stages:

- **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.
- **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.

- **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.
- **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. Strategic Commissioning



5. Context – State of Somerset

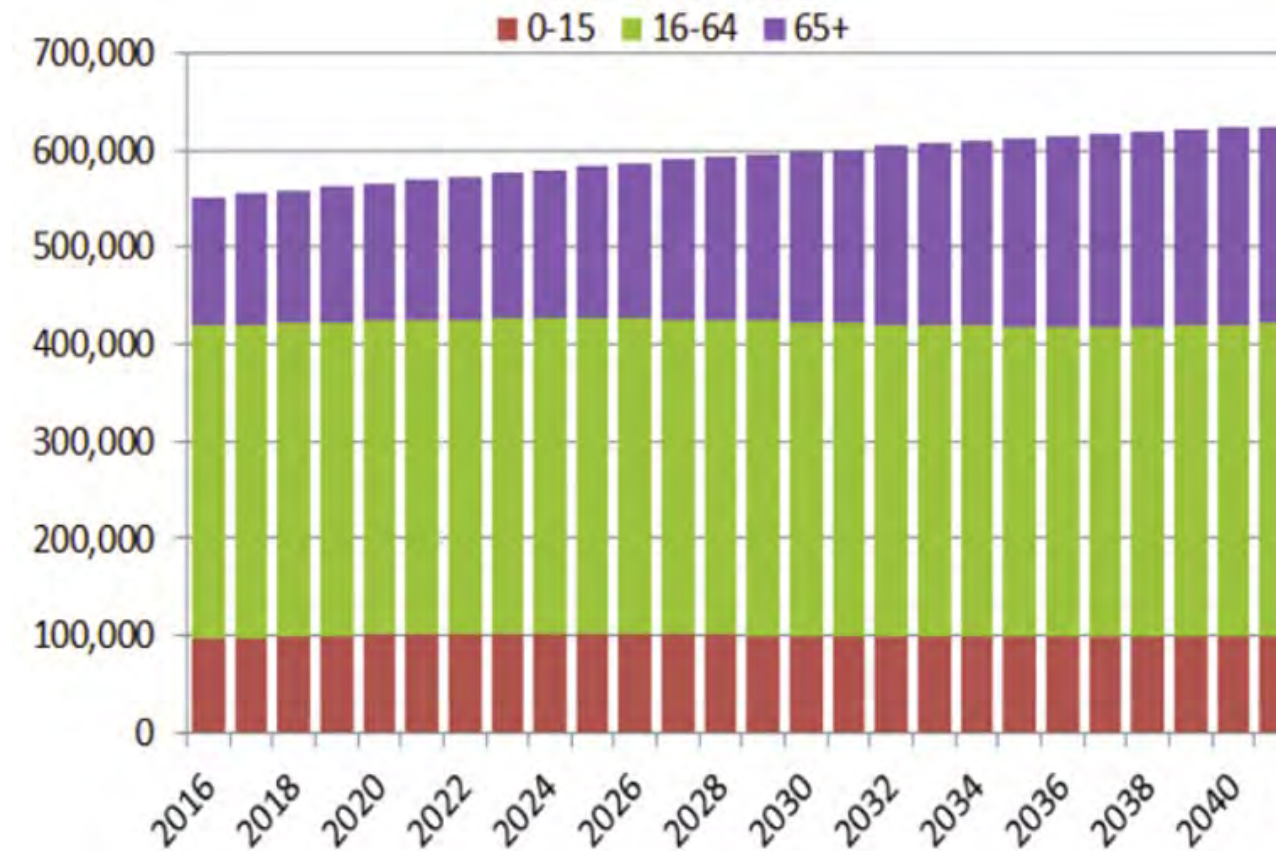
Population health summary of Somerset¹

Somerset’s Joint Strategic Needs Assessment is hosted online at <https://healthysomerset.co.uk/somerset-jsna/> and provides more detail. Key issues in Somerset which drive the key health needs and outcomes include the older population, the rurality and inequalities within an overall longer lived and less deprived population.

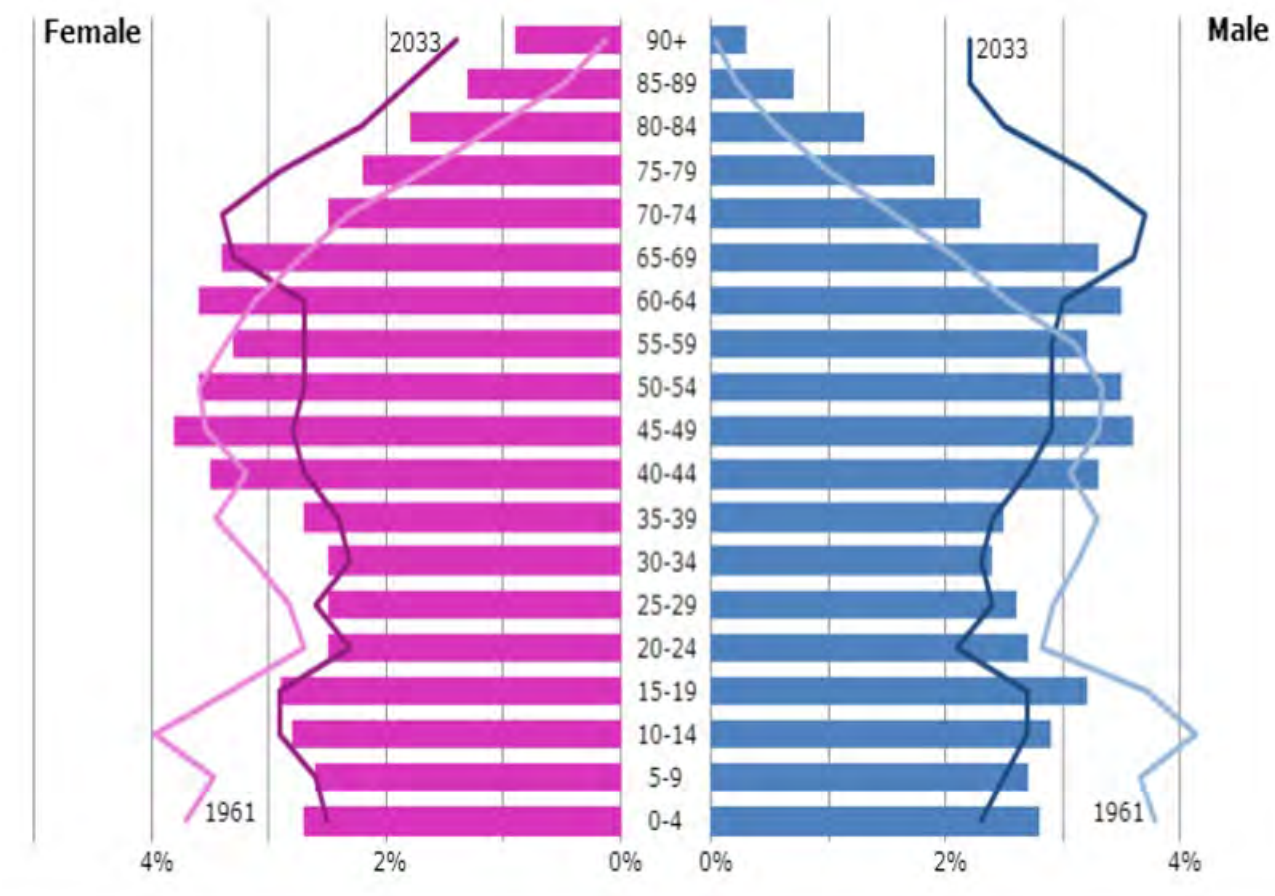
Age

Somerset has a population of 588,328 (ONS mid-year 2024). In the 2021 census, Somerset has a much older average age than found in England with 1 in 4 of the population being over 65. Similar to the England picture, birth rates are declining. Key drivers for population age patterns are a net inward migration of those in the early retirement age group and outward migration of younger adults seeking work and education opportunities. Over the next 25 years to 2041, the main growth in the population is within this over 65 age group and the number of those aged 85 is expected to more than double. The outcome of this demographic picture is a high dependency ratio, which will continue to increase over time, making it essential we attract a economically active working age population and keep them in good health for longer

Population Projections by Age - Somerset, 2016-2041



< Population change. Source Somerset JSNA <https://healthysomerset.co.uk/somerset-jsna/>



This also has implications for the amount of people that need support from health and care services, where and how they will live as well as the workforce needed to support those needs. For example, the number of people living with dementia is expected to increase 48% from 2025 to 2040.

5. Context – State of Somerset

Rurality

Somerset covers 3,452 square kilometres (1,333 square miles), one of the largest counties in England. The county is rich in environmental assets including 64Km of coastline, the Somerset Levels, Exmoor National Park, 4 designated National Landscape areas and 39 national and local nature reserves.

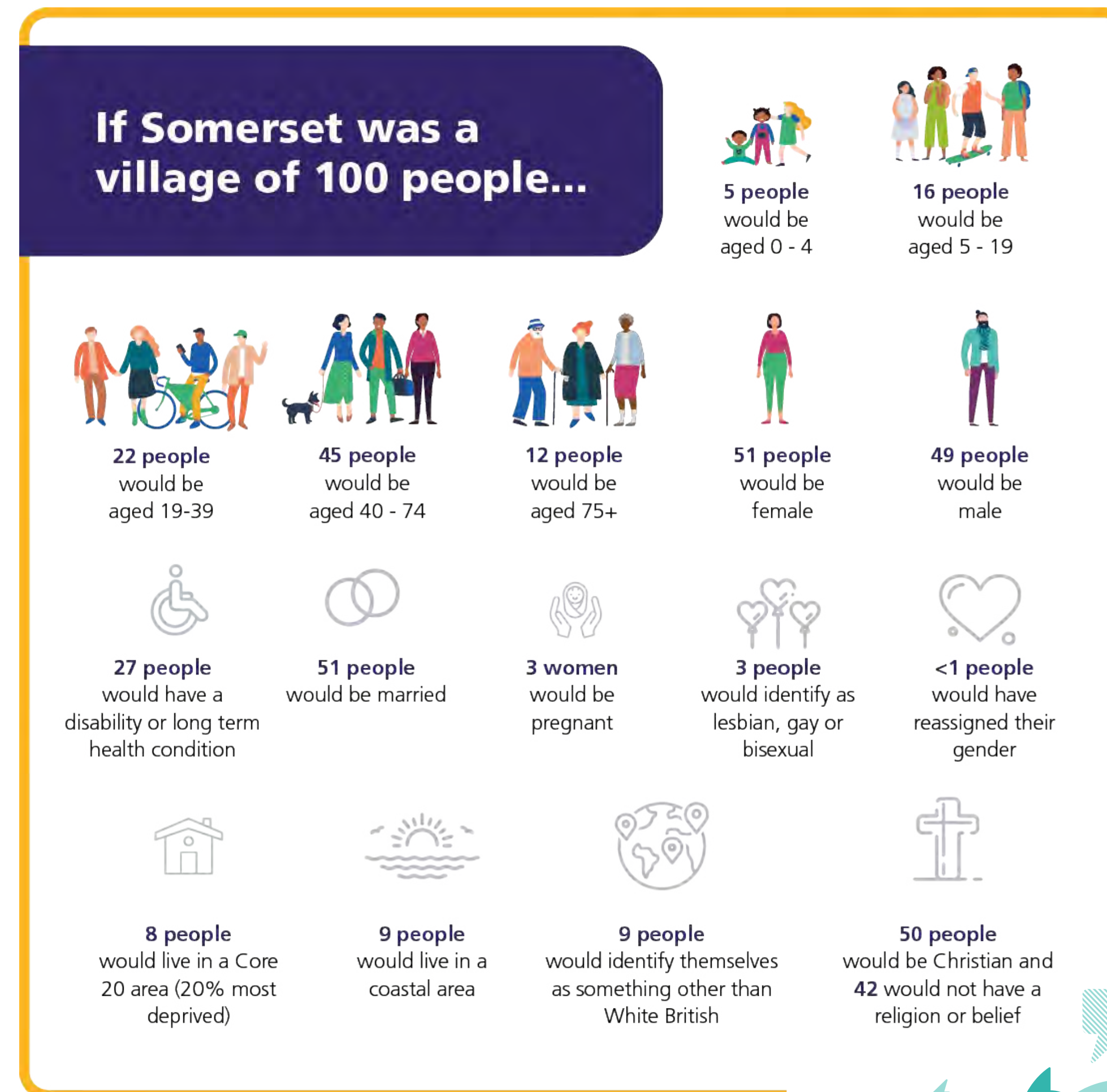
Much of Somerset’s distinctiveness comes from its rurality, with 48% of the population living in areas described as ‘rural’ by the Office for National Statistics compared to 18% in England. The vast natural assets of the county present significant opportunities for good quality of life however, they also shape some of the issues that can negatively influence on residents’ health and wellbeing and access to services, particularly related to social isolation and loneliness.

Taunton is the largest urban area with a population of approximately 70,000 people. The rural population has a slightly older profile than seen in the rest of Somerset. In rural areas, lack of mains gas and poorer public transport bring challenges of fuel poverty and barriers to access services.

Deprivation and diversity

Census 2021 data shows Somerset remains predominantly White, but diversity is increasing. The majority, 96%, identified with a White ethnic group, 8.5% were born outside the UK, about half identify as Christian. Within our school aged population, Polish, Portuguese and Romanian are leading non UK origins and languages.

For a group of 100 people in Somerset, this illustration gives an indication of the proportion with various protected and other important characteristics.



5. Context – State of Somerset

Somerset has less deprivation than the England average. Approximately 10% of the Somerset population fall into the England Core 20 most deprived group. The most deprived population groups in Somerset tend to be younger and are found in urban areas. This pattern can mask under-diagnosis and increased burden of disease in more deprived groups from conditions which become more common as you age. An example of this can be seen with hypertension diagnosis with overall lower rates in the CORE20 group but higher diagnosis at each age level.

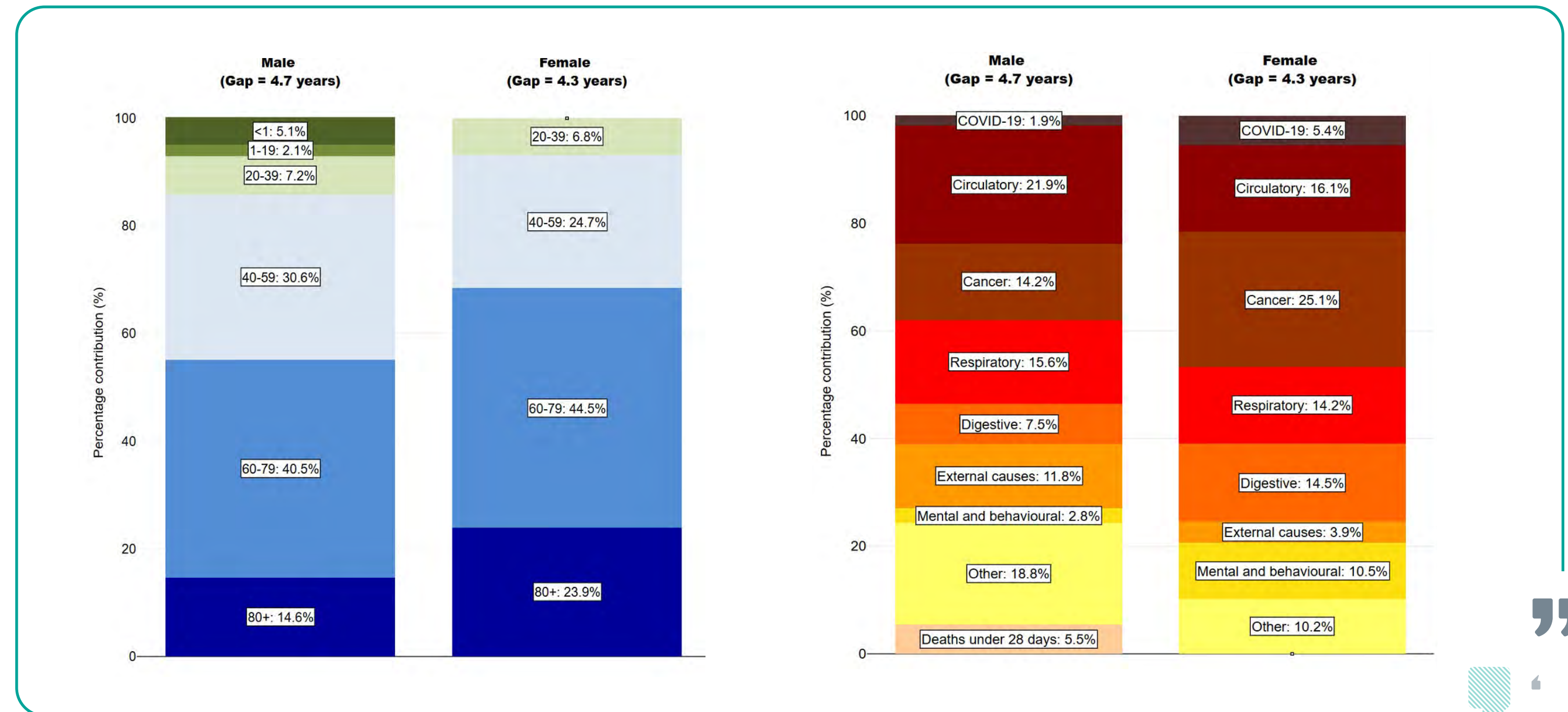
There is a lot of rural deprivation which is not as extreme and tends to be within an older population but exacerbated by those issues of poor transport, access to services and digital exclusion, especially in the west of Somerset and coastal areas.

Life expectancy

Post COVID, life expectancy has dropped for males with females remaining fairly static. Healthy life expectancy has dropped even further. However life expectancy in Somerset is still above the national average being about 4 months longer for males and 8 months longer for females. The gap in life

expectancy for the most deprived quintile is just over four years (males 4.7 years, females 4.3 years) although this is much smaller than seen in England as a whole (males 8.4 years, females 6.8 years). This gap can be seen to be caused by much younger deaths in the more deprived population groups.

Below: Breakdown of the life expectancy gap between the most and least deprived quintiles of England by age group and by cause of death, 2022 to 2023 Source OHID Segment Tool <https://analytics.phe.gov.uk/apps/segment-tool/>



5. Context – State of Somerset

In addition to communities of place, many other inequalities also exist for communities of identity. Groups who have protected characteristics under law and inclusion health groups (such as the homeless population and people with drug and alcohol dependence etc), often experience social exclusion and multiple disadvantage as well as very stark inequalities in health and access to healthcare that are unjust and need specific attention.

Healthy life expectancy

Despite the overall longer life expectancy in Somerset, on average, people in Somerset live a significant period of their life (approx. 17 years) in poorer health that they perceive limits their activities of daily living. On average people aged 65 will have 8-9 years unhealthy life ahead of them. Longer life, but lived in poorer health, is not a circumstance that most people would welcome and it significantly challenges local health and social care services as well as having a potential impact on the economic prosperity of the county through lost productivity.

Whilst it is helpful to consider overall averages in Life Expectancy and Healthy Life Expectancy, these do mask significant variation within the population, with people living in the 20% most deprived areas in Somerset and people with protected characteristics or from inclusion health groups being at increased risk of poorer health.



Integrated care and pathways Local feedback in action: You said, We Did

▶ Using insight from the 10 Year Health Plan engagement, Somerset's Big Conversation 2025 roadshow and our Engagement Insights Report 2025, people told us that care works best when services feel joined up and communication is clear, especially when moving between teams or settings.

▶▶ This has informed this plan's commitment to integrated models of care, clearer pathways and stronger coordination across primary, community, acute and voluntary sector partners.



5. Context – State of Somerset

Chronic issues

Rates of chronic conditions which tend to be more common in older age groups are higher in Somerset than the England average, reflecting Somerset's older population structure. Across Somerset, rates of chronic conditions are lower in more urban PCNs although this reflects more a younger population rather than reduced need.

> **Table 1.** Long term condition prevalence in Somerset by PCN and compared to England average. Source QOF March 2025

Mental health

Although recorded mental health issues are around national levels, deaths from suicide are higher than the national average. It is estimated that whilst about 3 out of 4 people with physical illness receive treatment, only 1 in 4 people with mental health problems do.

PCN Area	Atrial Fibrilat'n	CHD	Hyper-tension	Pre diabetes	Obesity	Cancer	COPD	De-mentia	De-pression	Mental Health	Osteo-porosis
ENGLAND	2.2	3.0	15.2	7.4	11.2	3.8	1.9	0.8	11.5	1.0	0.4
SOMERSET	3.3	4.0	18.7	9.3	11.7	5.4	2.3	0.9	14.6	0.9	1.2
W. Somerset	4.7	5.3	23.8	12.4	13.3	6.9	2.8	1.2	13.1	0.9	1.1
S. Somerset West	3.9	4.6	22.0	10.3	12.1	6.3	2.4	1.1	15.3	0.9	1.3
CLICK	4.0	4.6	21.6	12.0	15.0	6.4	2.4	1.1	15.1	0.9	2.1
North Sedgemoor	4.0	4.9	20.8	12.0	13.1	6.3	2.9	1.0	13.3	0.9	1.9
Rural Practice Net.	3.5	3.9	19.8	10.0	10.6	6.2	2.1	0.9	14.5	0.8	1.2
Taunton Deane	3.2	3.9	19.1	10.6	11.5	5.8	2.4	1.2	15.4	0.9	1.9
W. Mendip	3.4	3.9	18.3	9.6	10.0	5.4	2.1	1.0	14.3	1.2	1.6
Frome	2.9	3.5	18.9	9.2	11.5	4.7	1.9	1.0	14.1	1.0	0.9
Mendip	3.1	3.7	17.6	9.5	11.9	5.3	2	0.8	14.8	0.8	0.5
Bridgwater	2.6	3.7	16.8	6.6	11.1	4.5	2.4	0.7	14.5	0.7	0.7
Taunton Central	2.9	3.4	16.5	8.3	10.5	4.8	1.9	0.8	14.1	0.8	1.3
Tone Valley	2.8	3.4	16.5	7.3	11.9	4.8	2.3	0.9	15.6	1.1	0.9
Yeovil	2.7	3.3	16.2	7.5	11.8	4.2	2.1	0.9	16	1.0	0.7

Table 1.

5. Context – State of Somerset

Children and young people

Health indicators for children and young people in Somerset present a mixed picture, with infant mortality similar to the England average, fewer low birth weight babies than the national average, and similar oral health in five-year olds. Of particular concern are our rising proportions of children who are overweight or obese. Reception age proportion of children overweight is rising and higher than average, in year six levels are similar to England but still rising. There are more concerning indicators among older children and adolescents. Admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) and young people (15-24) are significantly above the England averages and emergency admissions for intentional self-harm are significantly worse than nationally despite recent improvements.



Digital, data and technology

Local feedback in action: You said, We Did



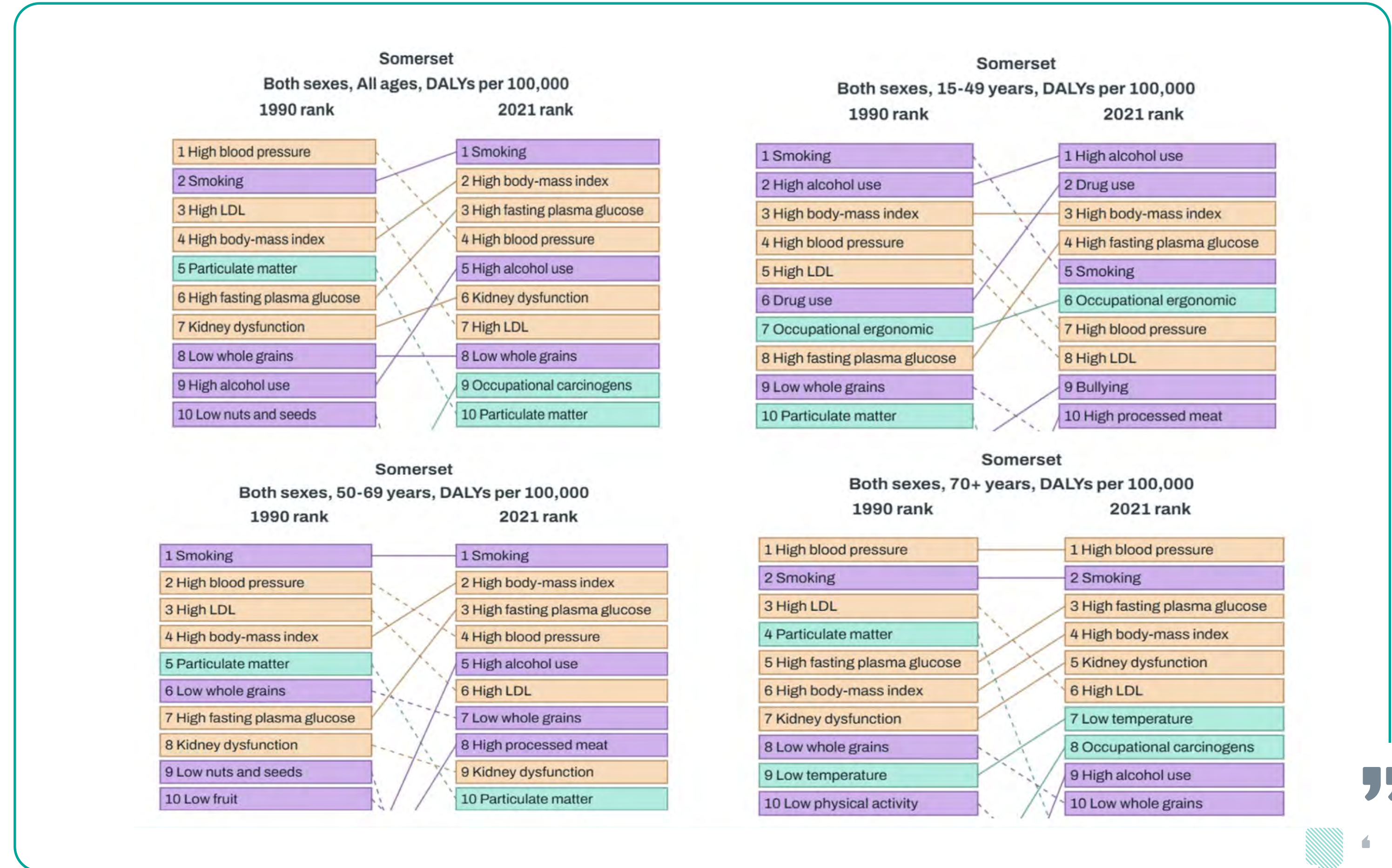
- ▶ Public and patient feedback from our 10 Year Health Plan engagement, Somerset's Big Conversation 2025 engagement roadshow and Engagement Insights Report 2025 shows broad support for digital tools that make access and communication easier, alongside clear concern about digital becoming the only route to care.
- ▶▶ This feedback shapes this plan's approach to digital transformation, prioritising inclusive design, maintaining non-digital access routes and reducing the risk of digital exclusion.

5. Context – State of Somerset

Factors causing ill health and premature mortality

According to Global Burden of Disease data, the top five factors most influencing the major conditions above and causing poor health and premature mortality in Somerset across the whole population are smoking, obesity (High body mass index), pre-diabetes, (high fasting plasma glucose), high blood pressure, and high alcohol use. It is important to note the importance varies of factors at different stages of life. Whole population statistics like this will also mask impact of conditions for vulnerable groups so should not constrain action on other issues, targeted to specific populations.

Figure. Risk factors for major conditions in Somerset. Source Somerset JSNA <https://healthysomerset.co.uk/somerset-jsna/> using Global Burden of Disease website



5. Context – State of Somerset

Key issues with whole population impact include:

Smoking: rates in Somerset are falling and this is likely to be a less important risk factor in general. As smoking levels in the population as a whole decline we need to ensure groups with highest levels, those with mental illness, those who use substances, the homeless and those living in more deprived neighbourhoods, are not lost in the general improvements.

Pre-diabetes: Diabetes is likely to be a major health issue in Somerset and burden on the healthcare system. Over the next 20 years is it estimated that the number of adults in Somerset with diabetes will rise from 40k to 50k. Progression from pre-diabetes to diabetes can be reversed and so it is important detect early stages of diabetes through screening as this often causes no symptoms.

Overweight: Obesity and overweight is increasing in both children and adults and adults and will also influence future rates of type two diabetes. Overweight and obesity rates are worsening in adults with 2 /3 adults overweight or obese, similar to the England average. Childhood overweight and obesity is also worsening for reception and Y6 children in Somerset.

High Alcohol Use: Alcohol use is increasing in Somerset and is reflected in poorer outcomes and hospital admissions. Rates of harm are generally trending up.

Hypertension: Diagnosed hypertension levels are some of the highest in England reflecting the older population. However, half of those with hypertension remain unprotected with 1 in 3 undiagnosed and 1 in 3 of those diagnosed not having their blood pressure reduced to target.

Prescribing: improve patient's clinical outcomes by increasing primary care prescribing to ensure medicines optimisation. Supporting primary care providers to deprescribe harmful medication, or medication that is no longer necessary and prescribe the most cost-effective way to make Somerset's budget go further.

Prevention, wellbeing and population health

Local feedback in action: You said, We Did



- ▶ Through our combined engagement activity – including the 10 Year Health Plan engagement, Somerset's Big Conversation 2025 roadshow and the Engagement Insights Report 2025 – people consistently supported a stronger focus on prevention and early help to support independence and wellbeing.
- ▶▶ This is reflected in this plan's commissioning intentions to strengthen prevention, early intervention and community-based support, particularly where this can help reduce inequalities and avoid crisis.

5. Context – State of Somerset

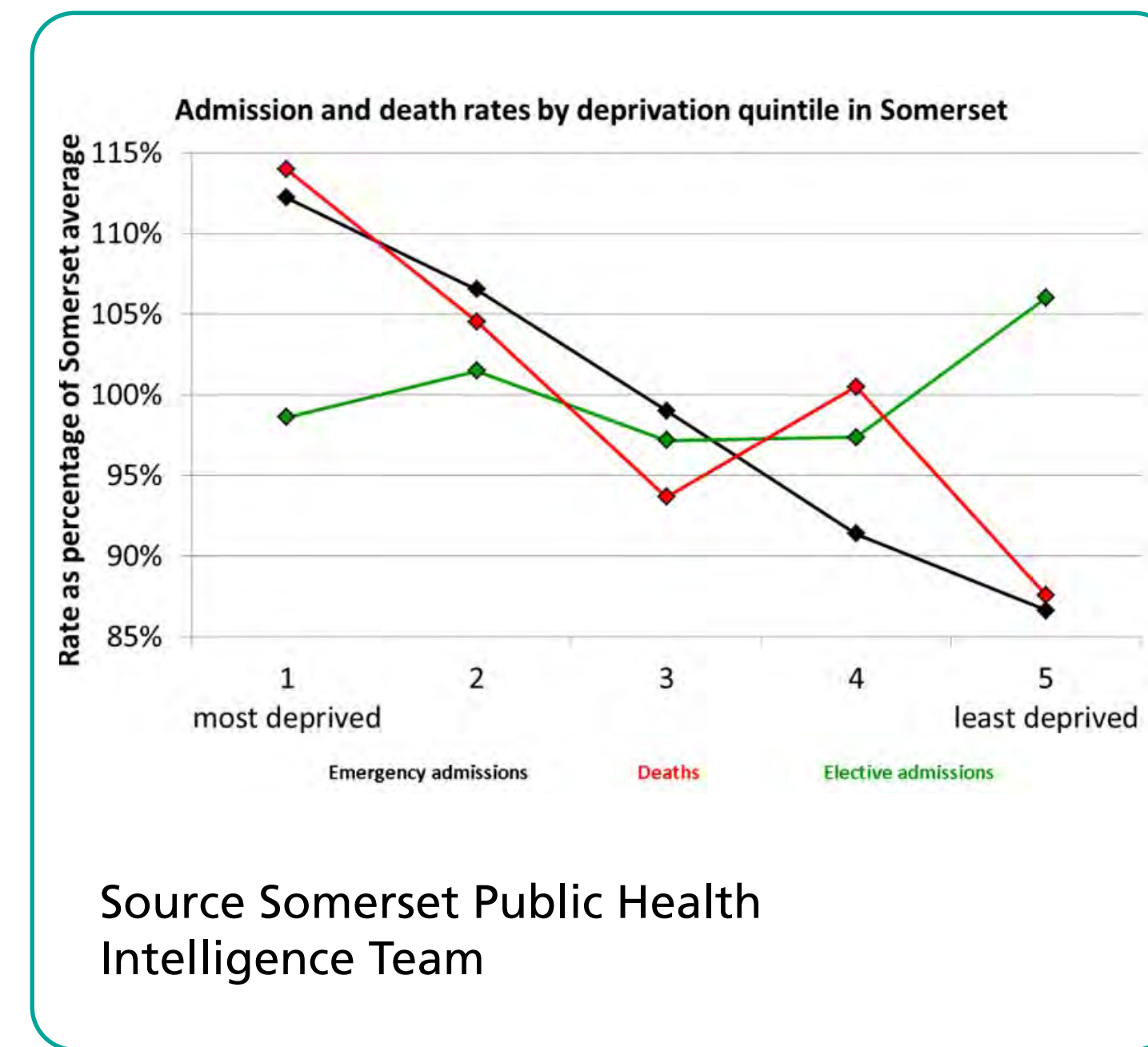
Healthcare inequalities

Many risk factors for major conditions are more prevalent in those in CORE20 groups, Somerset data shows people living in CORE20 areas are more likely to be obese, a current smoker, have diabetes, have chronic kidney disease and have hypertension. Promoting healthy lifestyle within the local population requires change to the environment to ensure that healthy options are easy options. We also need to consider accessibility of services. People in CORE20 groups in Somerset are less likely to have their diabetes, hypertension or cholesterol levels treated to target.

Data on cancer stage at diagnosis for Somerset shows that people living in more deprived areas are much less likely to have their cancers diagnosed at an early stage, an eight-percentage point gap between most to least deprived quintiles, with

likely implications for prognosis. To encourage screening uptake, especially in younger populations opportunities need to be made more easily accessible, especially for those not easily able to access healthcare during traditional 9-5 working hours. Cancer screening rates in Somerset are generally high, but across all main programmes at national level, inequalities are seen with those in more deprived areas being less likely to access screening. It is likely that the Somerset picture is similar although we do not have local data to confirm this.

The impact of inequalities on usage of healthcare is apparent in secondary care access. Those living in more deprived areas are more likely to present as emergency cases via urgent care. This effect is clearly shown in the graph below, demonstrating the inverse care law operating in Somerset.



5. Context – State of Somerset



Voluntary, Community, Faith and Social Enterprise (VCFSE).

Insights and challenges from Somerset’s VCFSE sector report on the shifting landscape of public services in England, shaped by systemic shocks and budget cuts, has intensified structural inequalities and health challenges. These challenges underscore the need for financial stability, strategic thinking, and continuity of service provision from a diverse range of service providers.

In Somerset, creating robust public sector-VCFSE relationships are critical for community resilience and maintaining, supporting and developing a successful and sustainable VCFSE sector for the future.

The sector faces increased demands, with most organisations planning to expand services. However, increased demand for services has been accompanied by funding challenges, with competition for resources and difficulties in securing funding. The top financial risks include short-term funding, increased premises costs, and demand exceeding capacity.

Although resources are limited, optimism remains high ensuring financial stability and sustainability requires strategic partnerships and improved funding conditions to meet the sector’s evolving needs. Commitment remains to work with the local VCFSE sector and further strengthen relationships and collaborative working.



5. Context – State of Somerset

Summary

The major conditions which impact Somerset residents are similar to the rest of England and are driven by behavioural factors or conditions with good potential for avoidance through adoption of healthier lifestyles, early detection and treatment. However, it is also clear that those in CORE20 groups are carrying a greater burden of those risk factors. We need efforts in Somerset to co-produce support for those in more deprived areas like parts of Bridgwater, Highbridge, Yeovil, Taunton and Minehead addressing barriers to access and ensuring these populations receive equitable healthcare.

The older age profile of the population which means higher levels of chronic and older age-related conditions now although data suggests sizeable proportions of the population are undiagnosed. In the future as the older 65 years plus portion of the population increases, there will be considerable growth in numbers with older age-related conditions, e.g. dementia, falls, frailty and a future need to consider how

to manage multi-morbidity and support people living with ill health in older age. Early detection of pre-existing conditions can ensure early treatment and reduce complications. The west of Somerset and South Somerset West areas stand out in this regard with an older population profile.

Homogeneity of the population in terms of languages spoken and cultural background pose less of a demand on service design than geographic spread of the population across the rural setting. There is a pattern of younger urban deprivation along with poorer mental health and older more affluent but isolated residents with more physical older age-related conditions which impacts on understanding health outcomes, service design and delivery. There is a need to invest in housing both to address fuel poverty but also explore technology adaptations and remote delivery where appropriate which may enable to older rural population to live independently for longer.

Geography, access and inequality

Local feedback in action: You said, We Did



- ▶ Feedback gathered through the 10 Year Health Plan engagement, Somerset's Big Conversation 2025 engagement roadshow and our Engagement Insights Report 2025 highlighted how geography, transport and practical access affect people's ability to use services, especially in rural and coastal areas.
- ▶▶ This feedback informs this plan's place-based approach to commissioning, neighbourhood working and action to address practical barriers that can drive inequality.

6. Activity and Performance Overview

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 Somerset System, we have in place a Performance Dashboard to provide oversight of the key operational standards as outlined within the NHS Oversight Framework (NOF) which is reported on both an ICB and Provider basis.

Our activity plans include the following annual growth assumptions: TBC

- **A&E attendances and Emergency Admissions: +1%**
- **Elective Referrals: -3%**
- **Elective Activity: +TBC% (this is still being worked through, and will share ASAP)**
- **Cancer Demand: +2.4%**

There are several areas where Somerset ICB needs to deliver performance improvements in order to achieve the operational standards as set out in the Medium Term 26/27 to 28/29 Plan:

Elective Care

- **RTT to 18 Week Waits:** Whilst we have reduced the duration of wait for elective services, we do not meet the RTT constitutional standard. We need reduce the waiting list to 37,359 to achieve 92% of patients waiting less than 18-weeks for their first definitive treatment by March 2029 by increasing NHS and non-NHS elective activity
- **Independent sector providers (ISPs)** continue to play an important role in meeting the health needs of Somerset's population and the system is already reliant on ISP capacity across a range of elective pathways

Urgent and Emergency Care

- **Ambulance Handovers >45 Minutes:** We have seen a significant improvement during 25/26 of lost ambulance handover hours as well as improving ambulance response times but need to go further during 2026/27 and eliminate those exceeding 45 minutes
- **A&E 4-hour Performance (All Age and Children <16 Years):** A&E 4-hour performance at Type 1 A&E Departments remains consistently lower than the operational planning ambitions set out for 26/27, 27/28 and 28/29
- **No Criteria to Reside / Patients Discharged on Discharge Ready Date:** We continue to have a high number of patients in Somerset's Acute hospitals and in Intermediate Care Beds who have No Criteria to Reside (are in hospital after their discharge ready date). To achieve improved hospital flow, to reduce bed occupancy and to improve length of stay we need to reduce the number of occupied beds with No Criteria To Reside to less than 13% and reduce the average duration of delay to 6 days

6. Activity and Performance Overview

Primary and Community Care

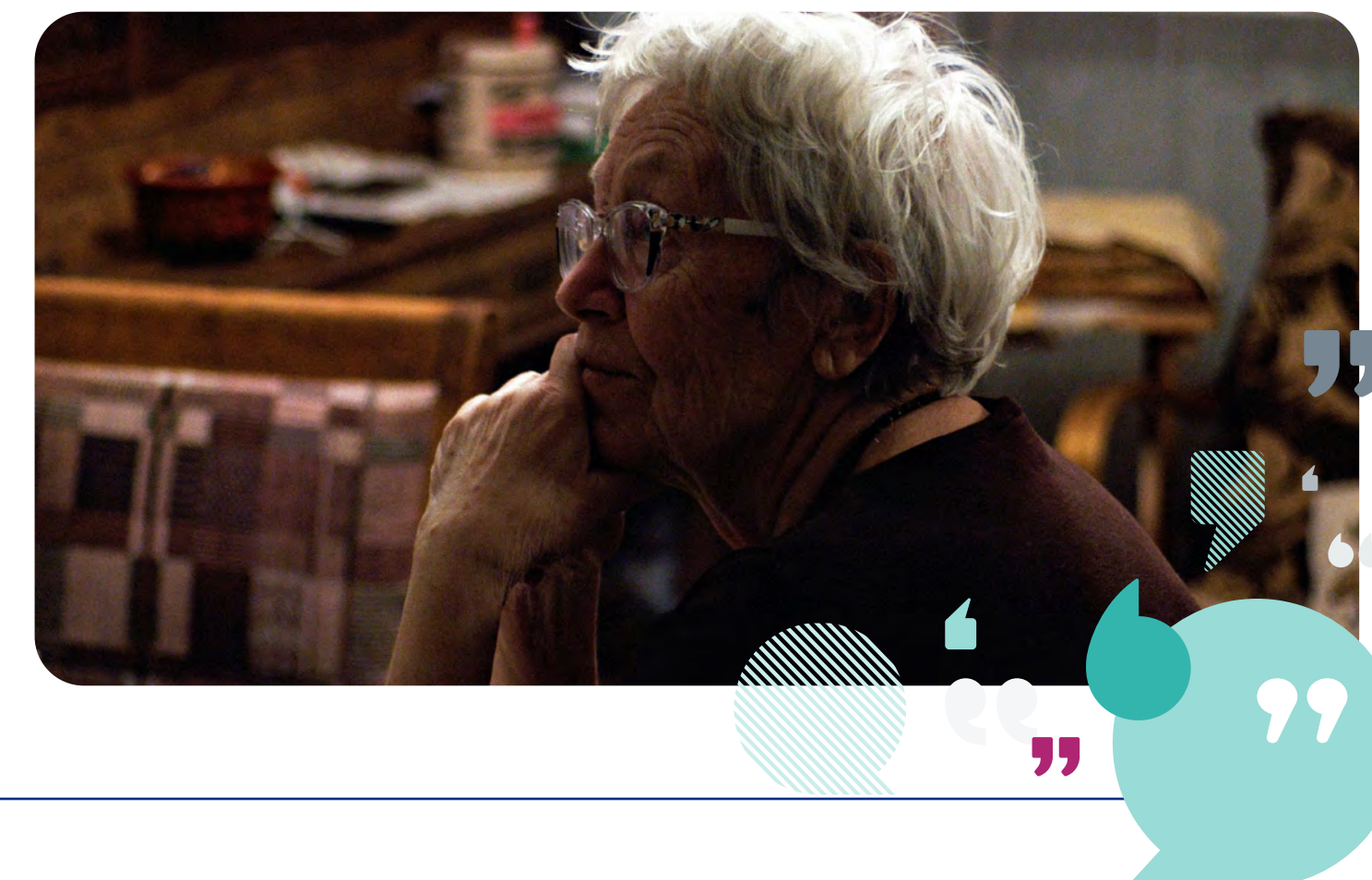
- **Dental Activity:** To achieve improved dental access we need to deliver increased routine and urgent dental activity inline with the Somerset ICB ambitions (urgent dental activity is nationally mandated and routine dental activity is a locally set recovery plan)
- **Community Services Waiting Times:** Somerset Foundation Trust has made significant improvements in waiting times for community services during 25/26. As our main Provider is an Integrated Acute, Community and Mental Health Trust, Neurodiversity Waits for adults and children are excluded as included instead within the Mental Health Minimum Data Set. However, improving neurodiverse waiting times remains a key priority and performance will continue to be tracked throughout the operational planning period
- **NICE technologies:** Support primary and secondary care to adopt and innovate new technologies and drugs. Identify Get It Right First Time (GIRFT) gaps and opportunities to improve outcomes and efficiency. Commission trust providers to rapidly adopt newly launched biosimilar medication. Where safe to do so, support the move of more prescribing from secondary care to primary care.

Mental Health, Neurodiversity and Learning Disabilities

- **Talking Therapies:** Talking Therapies provide treatment for adults experiencing common mental health challenges such as anxiety and depression. Somerset needs to increase the number of adults receiving treatment in Talking Therapies. The service will expand gradually over the next 3 years as the service recruits and trains new staff and explores evidence-based digital interventions.
- **Coverage of Mental Health Support Teams (MHSTs):** Somerset ICB will expand its school-based mental health support over the next three years. This will require recruiting and training new workforce, reconfiguring existing services and engaging with new schools.
- **Dementia diagnosis:** Somerset ICB needs to improve the dementia diagnosis rate during 2026/27. Receiving a diagnosis of dementia helps people, and their families/carers, to adjust to the condition, support as well accessing certain financial benefits.

Care Markets

Somerset 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.



7. Quality and Safety

As an Integrated Care System (ICS), we have a statutory responsibility to continuously improve the quality of services commissioned and delivered across all partners.

This duty is supported by a clear governance framework, robust assurance processes, and a culture of learning and improvement that spans acute, community, mental health, and independent providers.

Our Quality Assurance and Improvement Framework (2025–2027) sets out the principles, objectives, and escalation processes that underpin this work. It provides a structured approach for monitoring quality, identifying risks, and driving improvement in line with national guidance and the NHS Planning Framework. Key components include defined outcome measures, performance dashboards, and regular reporting to the ICB Quality Committee, the central governance body for quality oversight. Escalation routes to the ICB Board, System Quality Group, and regional and national quality boards ensure transparency and accountability. This framework will be reviewed against this plan to maintain prioritisation and support the development of a cluster outcome-based commissioning model.

To embed equity and inclusion, we have strengthened processes to ensure Equality Impact Assessments (EQIAs) are integral to commissioning and service redesign. A dedicated EQIA Panel, with executive clinical oversight, provides assurance that proposed changes are assessed for their impact on equity and quality. This approach helps identify and mitigate risks while ensuring decisions reflect the needs of underserved communities.

Patient safety remains a core priority. We maintain a strong infrastructure through weekly review meetings, quality improvement forums, and executive decision panels, enabling timely action on emerging risks. Our systems continue to mature following the implementation of the Patient Safety Incident Response Framework (PSIRF), which strengthens learning from incidents and promotes a just culture across the system. We also invest in capability-building through system-wide quality improvement training, compliance with the patient safety syllabus, and induction programmes that reinforce statutory and contractual responsibilities.

Alongside this, we further strengthen our approach through the Patient Safety Partner role, which brings a patient-centred, objective and lived-experience perspective. This role constructively influences and challenges our safety policies and practices, ensuring patient voice remains integral to our system.



7. Quality and Safety



Clinical and care professional leadership is embedded at every level, ensuring decisions are informed by frontline expertise. This is supported by the CNO and CMO-led Clinical and Professional Care Support Leadership Programme, which brings together health, care, and community professionals to shape a more integrated, equitable, and person-centred system. The programme fosters collaboration, builds trust, and aligns priorities across organisational boundaries, enabling leaders to drive cultural change and co-design solutions that improve outcomes for local populations.

To strengthen assurance, quality metrics have been incorporated into the Integrated Board Assurance Exception Report. These metrics are monitored

using Statistical Process Control (SPC) methodology, helping us distinguish between common and special cause variation and focus improvement efforts where they will have the greatest impact. Recent examples include venous thromboembolism (VTE) assessment, healthcare-associated infections, initial health assessments for children looked after (CLA), and mental health carers' assessments.

Finally, the quality function ensures that quality and safety insight remains integral to the commissioning and contracting processes. The methodology for quality oversight and assurance will be clarified in line with National Quality Board guidance and other relevant frameworks, ensuring a risk-based and proportionate approach.



8. Vision, Aims and Strategic Objectives



Our purpose (why we exist)

All ICBs have a statutory responsibility to improve population health, tackle health inequalities, support wider socio-economic development and enhance value for money. Through visionary commissioning we will support the achievement of the ambitious from a new health service set out in the 10-year health plan.



Our vision (what we want to achieve)

In delivering our purpose, we want to make substantial, tangible impacts in two key areas over the next five years:

- Increasing the healthy life expectancy of the population we serve, with a focus on reducing health inequalities.
- Implement the three 'shifts' of the ten-year plan by radically redesigning how we deliver healthcare to the people that need our services, moving away from a model dominated by acute hospitals to one that focusses on 'neighbourhoods', primary and community care.

8. Vision, Aims and Strategic Objectives

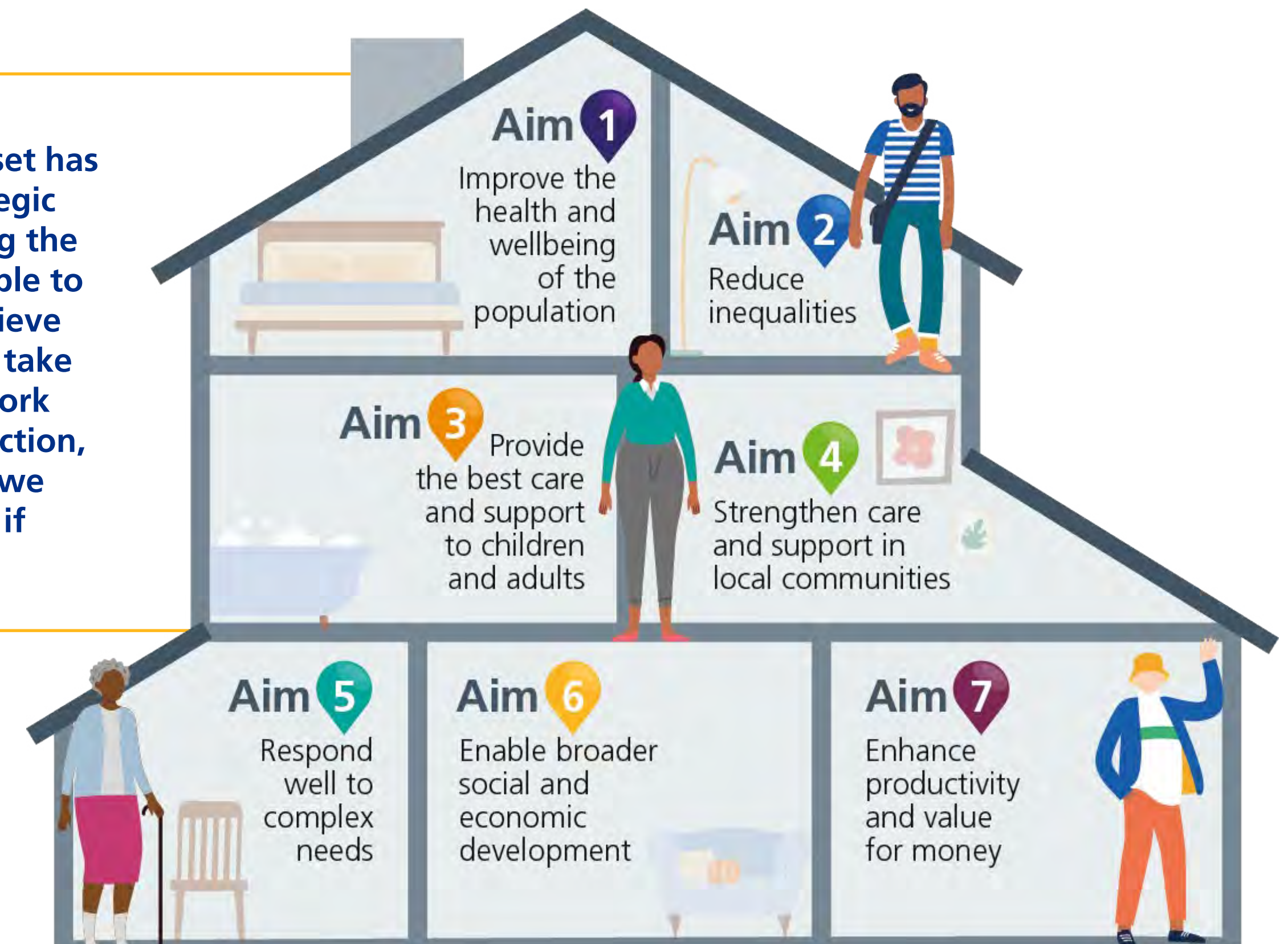
Our key priorities

In the near term, our priorities are to:

- Become a single, effective and unified strategic commissioning organisation, giving proper attention to how we build an inclusive culture that underpins our new organisation and how we challenge the established norms and traditional ways of working.
- Develop a clear population health improvement strategy which will set the guiding vision for our future commissioning decisions and the way we (re)allocate resources over time.
- Build our capabilities in data/insight and evaluation, learning from what has been proven to work elsewhere, and finding new ways of engaging with and learning from the people that use our services.
- Develop and embed the way we work, both across the cluster and our six 'Places'.

In Somerset we want people to live healthy independent lives, supported by thriving communities with timely and easy access to high quality and efficient public services when they need them.

Working together, Somerset has identified seven key strategic aims, focused on achieving the ambition of enabling people to live healthier lives. To achieve these aims we all need to take some action now. If we work together, take collective action, and support one another we can go much further than if we work alone.



8. Vision, Aims and Strategic Objectives

We are, through our Integrated Care Partnership Strategy and Joint Forward Plan, committed to healthier lives, thriving communities, and care that is integrated, digitally enabled, and delivered close to home.

Aligned with the NHS 10-Year Health Plan, we are focusing on three key shifts:

- Hospital to Community- creation of the Neighbourhood Health Service bringing care closer to or in patient's homes where possible, supporting people to feel more in control of and manage their own care. Making greater investment in out of hospital care.
- Analogue to Digital - make the NHS the most digitally accessible health system in the world - including creating and giving patients access to a single patient record, expanding the utility of the NHS App and expanding the use of digital tools.
- Sickness to Prevention - halve the gap in healthy life expectancy between the richest and poorest regions through a range of prevention activities including a focus on tobacco use, expanding free school meals and an expansion of access to weight loss medication.

Engagement, assurance and monitoring

Local feedback in action: You said, We Did



▶ Across our 10 Year Health Plan engagement, Somerset's Big Conversation 2025 roadshow and the Engagement Insights Report 2025, people told us they understand the need for change but want reassurance that decisions will improve access and outcomes locally.

▶▶ This feedback underpins this plan's commitment to ongoing engagement, transparency and monitoring, including showing how feedback has influenced priorities and how progress will be tracked and shared.

9. Commissioning Intentions

Our priorities for 2026/27*

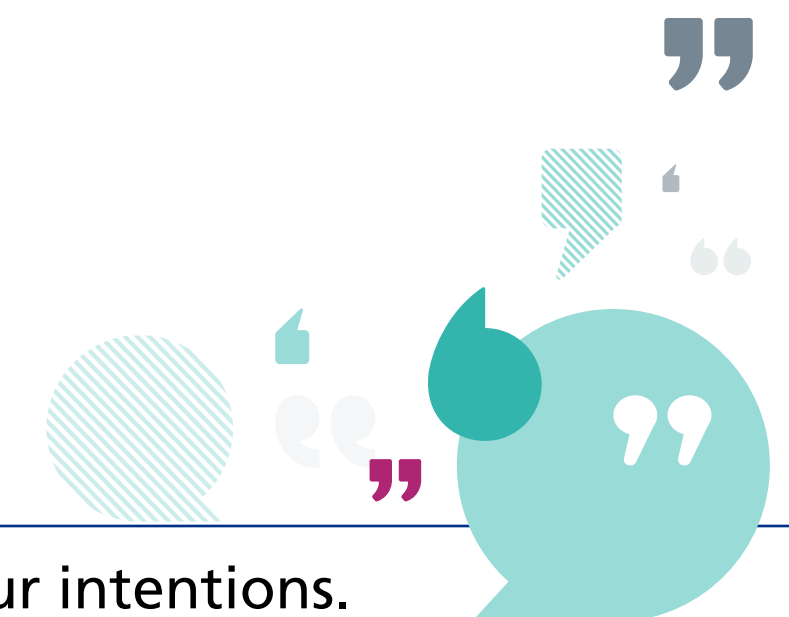
We want to begin commissioning differently to address the three shifts of the 10 Year Health Plan.

To do this, we have identified a number of areas where we will change how we incentivise delivery across the system. This will enable us to be more purposeful in how we work together as a system to deliver tangible benefits and address healthcare inequalities - we may make funding available to support this.

- The development of a Cluster-wide Outcomes Framework that will deliver over time an improvement in HLE for Somerset residents with short term tracker metrics to know we're on track.
- The introduction of tools and platforms that enable providers within the system to collaborate more effectively, central to this will be the transformation in how we use data through the Somerset Linked Data Platform, The Dorset DiS and utilisation of FDP capability as advanced in BSW.

- Utilising national contracting capability such as the MNP and SNP neighbourhood contracts. We are keen to encourage partnership working through the delivery of shared outcomes and purpose. They will be a mechanism to deliver our Neighbourhood Health Improvement Plan (once agreed).
- Standardising outcomes through a focus on addressing health inequalities. Our early focus will be on the development of a county-wide model for Frailty which will be co-produced and act as template for INTs to adopt within their neighbourhood. Over time we expect INTs to have greater autonomy over priority setting.
- Reforming financial flows through new payer models and incentivising the proactive care of population cohorts. We will also work closely with Somerset council to identify opportunities to improve the effectiveness of pooled funding via Section 75 agreements. This will start by building on progress on unpicking the existing Better Care fund arrangement.

- Increasingly commissioning at scale across the Cluster. For 2026/27 this will focus on recommissioning the front end of our Integrated Urgent Care service (IUCS) and working with providers to determine the scope of integration that will deliver the greatest value
- Elective care – commission a model for outpatients that tests new ways of working and moves away from normal payment methods and ways of delivering services.
- Neighbourhood based Peri-operative care model to control front door into elective services and reduce unnecessary treatment as well as variation and healthcare inequalities.
- Commission cancer front door model on a risk share basis
- Advancement of a non-medical model of healthy weight.
- Improving children's mental health.



9. Commissioning Intentions

26/27 will be a transition year where a strong focus will be placed on:

- Merging our commissioning capabilities across the 3 cluster organisations and developing a plan to bridge that combined capability to that detailed in the national Commissioning framework.
- Running alongside that will be the following changes:

Developing a Neighbourhood Health and Care Service

Somerset will continue to develop a neighbourhood-based model of health and care as a core delivery mechanism for achieving the three shifts set out in the 10 Year Health Plan: from hospital to community, from analogue to digital, and from sickness to prevention.

Our neighbourhood approach is underpinned by a clear set of shared principles, co-created across the system, which provide a common language and direction for how we work together. These principles support stronger collaboration, clearer decision-making, consistency with local flexibility, better use of resources, and improved outcomes for local people.

Neighbourhoods provide the scale at which partners can best understand population need, address unwarranted variation, and deliver more proactive, personalised and preventative care. They enable decisions to be informed by local insight and data, while remaining aligned to system priorities and commissioning intent.

We have established a strong foundation for neighbourhood working across Somerset, including a local framework for Integrated Neighbourhood Teams (INTs), advanced population health analytics, and nationally recognised models of proactive care, particularly for people living with frailty. Building on this, our focus will increasingly be on embedding our neighbourhood principles into how services are planned, commissioned and delivered.

Integrated Neighbourhood Teams will operate as part of wider neighbourhood ecosystems, working alongside primary care, community services, local authority services, and VCFSE partners. While delivery models will reflect local context and assets, all neighbourhoods will be expected to work to a shared set of principles that promote collaboration, shared accountability and a consistent core offer for residents.

During 2026/27, the ICB will strengthen governance, clarify roles and responsibilities, and embed neighbourhoods within system planning, workforce and financial frameworks. This includes preparing for the national Model Neighbourhood Framework and ensuring neighbourhood priorities have clear routes into commissioning and investment decisions.

From 2026/27, neighbourhoods will increasingly shape how we commission and redesign services, starting with priority areas such as frailty, urgent community care and prevention. Our neighbourhood principles will guide this shift, ensuring that new commissioning approaches support local leadership, reduce inequalities, and make best use of collective system resources.



9. Commissioning Intentions

Improving access in Primary Care

We will ensure practices are delivering the GP contract including improving and providing good access whether by phone, online or walk in throughout core hours. This includes all patients knowing on the day how their request will be managed and increasing the number of people who can see their preferred healthcare professional.

We will provide support to transformation for primary care, and tackle unwarranted variation, including identifying and planning how to support those struggling to deliver access or other elements of the GP contract.

We will support meeting urgent demand through ensuring additional capacity is commissioned to meet demand out-of-hours and over surge periods including bank holidays and weekends.

We will embed pharmacy-first approaches, ensuring that local commissioning discussions utilise available pharmacy capacity to support primary care pressure, including expanding access to emergency contraception through community pharmacies.

We will increase access to NHS dental services and the proportion of Somerset residents that have received NHS dental care.

We want to develop an integrated neighbourhood model for community ophthalmology, supporting the transition towards a fully integrated neighbourhood delivery model. See chapter X for further details on our approach in Primary Care.

Commissioning a comprehensive review of our urgent and emergency care pathway

We need to develop a greater understanding of our population health data and the access requirements of our whole population both now and over the next 5-10 years. We will start this in early 2026 working with all system partners. We also need to engage differently with our population to understand when, why and how they currently use the range of services we have and better understand their experiences of care and our UEC Pathways. This “diagnostic” will inform how to achieve the commissioning intentions outlined below and be overseen by our UEC Delivery Board.

Our focus over the next year will be in ensuring performance across our UEC system is optimised in line with the medium-term planning guidance as well as starting the alignment of urgent care and same day urgent care services with a

neighbourhood approach, focusing on frailty initially, given consistent growth in demand. Through this acute emergency care can be protected for those that need it most and ensure our hospital stays are only as long as is clinically appropriate.



9. Commissioning Intentions



This will require the urgent care needs of patients as much as is appropriate to be delivered in the community, aligning with integrated neighbourhood teams. This will require maximising the use of alternative pathways to Emergency Department (ED) and community services including hospital at home, Urgent Community Response (UCR), District Nursing and intermediate care as well as ensuring treatments and diagnostics normally provided in hospital can be moved into our community. We will work with partners to ensure that the temporary closures to Urgent Treatment Centres (UTC's) are minimised. The Urgent and Emergency Care (UEC) clinical framework, which is currently in draft will help shape our ambition here. This work will start in 2026.

Avoidable ambulance conveyances must be reduced, and we will support the Ambulance Trust to ensure it meets its targets for achieving hear and treat and see and treat outcomes.

A Single Point of Access (SPOA) will be central to our system, ensuring where possible community management of our patient's urgent care needs are achieved, enabling the ambulance service and emergency departments to focus on the most urgent patient needs.

To enable all the above, care, service availability and performance need to become more consistent across days, evenings and weekends. Detailed plans for achieving this will need to be developed and will be aligned with neighbourhoods.

Achieving this vision will require optimisation of our IUCS provision and greater integration with our SPOA

Transforming Delivery of Planned Care

Through our system Elective Care Board we will agree required improvements and timeline to meet the performance commitments set out in the Medium-Term Planning Framework for elective care, cancer and diagnostics, ultimately leading to a return to the 92% RTT constitutional standard by 2029.

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 continue to push Advice and Refer as the first option for seeking support to patients.



9. Commissioning Intentions

The ICB has one main acute provider, and we will work with them to identify and act on opportunities to improve productivity and ensure timely access, with a focus on Outpatient opportunities from standardised clinic templates, patient initiated follow up appointments (PIFU) optimisation and reduction in low clinical value follow-ups, and an aim to achieve top quartile performance in all of these areas. There will be further work undertaken to maximising the benefit from Advice and Guidance, which will support patients in receiving the most appropriate care in the right place, in addition to delivering system efficiencies. We will also ensure the independent sector works as a supporting partner to NHS services, helping to deliver appropriate and timely care to those who can access it.

We already have a good network of Community Diagnostic Centres and Community Investigation hubs; we will work to ensure this capacity is used in the most effective way possible to maximise improvements to key pathways. We want to ensure that the commissioning framework makes the most of new capacity coming online such as the diagnostic centre at Bridgwater and the Yeovil Surgical Hub.



The Somerset system is already an exemplar for cancer self-referral, and we want to build on this work, rolling out to more tumour sites. We will explore different payment methods for self-referral and other innovative pathways such as single front door, straight to test and one-stop clinics where clinically appropriate, to begin to ensure the 'left shift' is incentivised.

We will continue to identify and work as a system on priority pathway improvements, for 2026/27 this will be in the following areas -

- MSK services
- Weight Management
- Peri-Operative Care
- Ophthalmology

We will plan for a new neighbourhood health approach for elective pathways inline with the model neighbourhood framework.

9. Commissioning Intentions

Women's and Children's Health

We want to develop Children and young people (CYP) transitions strategic oversight and collaboration through exploring opportunities for joint and/or aligned commissioning arrangements. This will be linked to the development of an outcomes-based framework which will include relevant outcome measures for this section of the population.

We will improve elective performance for our CYP population – including developing ringfenced CYP capacity or dedicated paediatric surgery days in either a day surgery or hub setting.

We will work with the Community Diagnostic Centre (CDC) to identify options to reduce the number of women on elective waiting lists. Linking to our work on women's health hubs we will ensure pathway developments in key areas such as the diagnosis and treatment of heavy menstrual bleeding and improved access and support for pelvic health issues.

We will ensure delivery of the Special Educational Needs and Disability (SEND) programme, including the alignment of strategic partnership, enhancing engagement and improving outcomes of the SEND cohort.

Mental Health, Neurodiversity and Learning Disabilities

We want to develop a sustainable model and delivery vehicle for VCFSE providers supporting Children and Young People with mental health needs. This includes establishing the relationships, insight, skills and structures needed for providers to collaborate with statutory services and other VCFSE providers, respond to opportunities and deliver high-quality CYP mental health support.

We want to ensure our population with Learning Disabilities and Neurodiversity receive timely diagnosis and care, improving waiting times to assessment and reducing the number of people with learning disabilities or autism in our specialist mental health hospitals.

We will conclude the pathway review and redesign of the dementia pathway in Somerset to deliver key pathway improvements identified during the review process through consultation and codesign with people with dementia, carers and system partners. This includes working with our cluster partners to identify opportunities for joint commissioning where this will enable consistency of offer and maximise value for money.

We will work with our system partners to implement the recommendations of the Modern Service Framework for Mental Health, once it is published later in 2026.

We will work with partners and service users to review our mental health crisis offer, including Emergency Department and community offers. We will seek access to national capital funding in line with the outputs of the review.

This will build on our existing Open Mental Health offering to include children and young people's mental health. This will apply learning from our existing Open Mental Health service for adults



10. Financial and Resource Planning

Somerset has a reputation for strong financial delivery and control and since 2020 has delivered all its financial targets across the system.

This follows a history of financial challenge in both Foundation Trusts (prior to merger) and the Clinical Commissioning Group (CCG), now ICB. Prior to the Covid-19 pandemic the system was developing plans to address a significant underlying deficit position and ongoing in year deterioration, and work had been undertaken to assess the causes of the deficit in Somerset.

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. Underpinning the ambitions of the 10-Year Health Plan and 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.

- The Medium-Term Planning Framework sets out performance targets and requirements for NHS organisations over the next three and five years, unlike previous annual planning rounds, Integrated Care Boards (ICBs) and providers must develop robust and realistic three- and five-year plans to deliver these priorities.
- The financial framework sets out next steps to deliver on the 10 Year Health Plan for England and aims to move away from short-term planning to a system that empowers local leaders to plan over the medium-to-long term, and which supports innovation to deliver long-term sustainability.
- The framework helps to bridge the gap between immediate pressure for recovery with deeper, but longer-term, reform. It does offer a path to recovery, but it is a narrow one with several big risks to navigate along the way, including a precarious financial position and potential unfunded costs to come alongside the need for additional private capital.



10. Financial and Resource Planning

NHS Somerset has set out the following financial planning principles to deliver the Medium-Term Planning Framework:

- **Stretching but credible triangulated plans** across Finance, Workforce and Activity - aligning income and cost projections with realistic activity baselines and workforce profiles
- **Financial plan aligns** with ICS strategy and 10YP and Commissioning Intentions e.g. clinical, workforce, digital, and estates - ensure all financial decisions support long-term service sustainability and health outcomes for population of Somerset
- **Eradicate underlying system deficit** by end of three-year financial plan – focus on underlying run-rate improvement through recurrent cash releasing savings delivery.
- **Annual financial balance** as individual organisations
- **The Commissioner will agree a contract** with the provider, with a financial envelope based on delivery of performance standards, including Elective activity requirement, UEC blended payment baseline for activity and identify funding for individual services previously covered by a block contract element. The Commissioner and the Provider should agree on the value of any funding differences and on whether those differences represent an underpayment or an overpayment. We will move towards target contract values in a managed way that considers challenges in aggregate and in the wider context of demand growth, service sustainability and identified efficiency opportunities
- **The Commissioner will manage demand** in line with the principles set out within the Strategic Commissioner Intentions. The Provider will deliver the activity in line with the performance set out within the agreed plan
- **Any service developments/changes need to be considered** within existing resources without additional funding or further impacting the underlying deficit
- **Shift resources upstream** to neighbourhood services
- **Increase the percentage of funding** for population health and prevention to reduce long-term demand
- **Use national funding** and create a transformation fund to support Analogue to Digital shift (Capital and Revenue)
- **The Commissioner will pass on the Cost Uplift Factor (CUF)** and the provider will be expected to deliver at least the minimum 2% efficiency deflator as required to deliver inflationary uplifts. All efficiencies to be underpinned by robust, evidence-based delivery plans
- **The Commissioner will maintain a contingency** of 0.5% to support unforeseen system pressures
- **The Provider will demonstrate its improvement** in Productivity on a quarterly basis, with continued use of benchmarking outputs (Productivity packs, Model Hospital, Getting It Right First Time (GIRFT) to identify unwarranted variation and prioritise high-impact interventions



10. Financial and Resource Planning

NHS Somerset ICB and Somerset NHS Foundation Trust are submitting balanced financial plans for the period 2026-2027 – 2028-2029.

The medium-term planning guidance and the multi-year settlement provides the foundation on which we can move away from annual to medium-term financial and delivery planning cycles. This approach enables:

- better alignment of incentives to enable more robust delivery
- a move to fairer distribution of funding across the NHS
- longer-term planning
- a new approach to capital

This new approach will be underpinned by far greater transparency of increasingly granular financial data – with NHS England committing to publish trust-level productivity statistics on a routine basis to provide transparency on performance.

We currently contract with several providers both within and outside of Somerset, with NHS contracts based on an aligned payment incentive arrangement, which includes fixed and variable elements, and Non-NHS contracts usually based on a payment by activity basis. Historically, the latter has driven a ‘treatment’ based approach to finances, whilst current financial and contractual frameworks don’t incentive outcome delivery or encourage shifting of costs. Our current contracts tend to have performance measures that are specific to them and don’t necessarily read across to other contracts. Existing performance measures also tend to be ‘process’ in nature.



10. Financial and Resource Planning



The vision for ICBs is to become strategic commissioners, moving resources into prevention and community capacity, tackling inequalities and commissioning for value (quality of care and optimal efficient cost).

Key to this will be ensuring we have processes for identifying opportunities for efficiency and improvement, robustly reviewing at system level and agreed opportunities being pursued. This will be via a financial and contracting system that promotes innovation and focuses on patient outcomes, to support providers and partners to take decisions and balance risk on a delegated basis (as agreed and supported by the ICB as strategic commissioner). To enable pump priming of the transformation needed to deliver these Commissioning Intentions we will set aside a non-recurrent fund building to 4.5% over the 5 year period.

We want our Neighbourhood teams, Integrated Health Organisation and providers at large to be incentivised to address health inequalities, particularly where these are geographical. We will use the integrated data platform to ensure we have a good understanding of our population health and where the left shift can deliver better value for money as well as outcomes for patients.

We expect to see different payment models in place that allow Integrated Health Organisation to commission services on behalf of the strategic commissioner (e.g. VCFSE sector or GP Enhanced Services). Key to this will be the agreement and incentivisation of the Outcomes framework. We are actively working with colleagues to co-design a new payment model for neighbourhood health, and will look to implement this in Somerset, via the Frailty pathway.



11. Workforce Strategy

Strategic Context: Delivering in a Volatile Landscape

This workforce section pulls together the Somerset 2035 vision for our workforce, and the 10 Year Health Plan, whilst recognising that workforce changes must be delivered within a challenging operational reality.

We face a financial emergency in the Local Authority potentially impacting on social care provision, ongoing financial constraints and operational pressures in the NHS, and a 'productivity penalty' of delivering care across a rural geography.

Crucially, we also recognise that we cannot simply recruit our way out of the current or future workforce challenges we have; we must become self-sufficient by growing our own workforce, building partnerships with local education providers, and incentivising young Somerset people to remain living, studying and working in Somerset.

Despite these challenges, we start from a position of strength. Our operational plans and Joint Forward Plans have largely delivered in recent years.

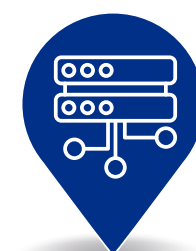
Our renewed focus is therefore on stabilising the current workforce whilst building the capacity needed for the three critical shifts: Hospital to Community, Analogue to Digital, and Sickness to Prevention.

Strategic Vision: Somerset 2035

Our strategic vision for our workforce is to move beyond siloed episodic working toward a future where:



People come first. We support patients and service-users holistically, focusing on the person rather than treating isolated illnesses, underpinned by a more 'generalist' and 'multiskilled' community workforce.



We collaborate, grounded in reality. Our health and care teams work in truly integrated ways, whilst acknowledging both the individual and collective operational, financial and capacity risks for organisations within our system.



We continue to develop Somerset as a "Place". We are investing in community-based teams, commissioning new and diverse care models, specifically expanding our Voluntary, Community, Faith and Social Enterprise (VCFSE) sector workforce through our "Volunteering for Health" strategy.



Staff are empowered. We are developing a culture defined by autonomy, trust, kindness, and respect, leading and supporting this through team coaching and system development initiatives.



Education is integrated. We are strengthening ties with local Further and Higher Education providers to improve access to training and drive local employability and self-sufficiency.