11. Workforce Strategy

Delivering Three Strategic Shifts. We will reshape the workforce to deliver the 10 Year Health Plan mandates, adapted specifically for Somerset's rural geography.

Shift 1:
Hospital to Community (The Neighbourhood Health Service)

Strategic Goal: Deliver integrated services locally, reducing reliance on acute hospitals.

Somerset Action:

- Multi-skilled Community Roles: We will continue to develop the skills and capabilities of our community workforce, including more 'generalist' roles where appropriate. By equipping staff to handle a wider range of needs, we hope to reduce the necessity for multiple specialist visits to the same home.

Shift 2:
Analogue to Digital

Strategic Goal: A digital-first service that helps staff work smarter and empowers patients to take charge of their health.

Somerset Action:

- Bridging the Gap: We will improve the digital skills, capability and capacity of our clinical workforce, in order to support the development of new digitally-enabled systems and processes that are intuitive, safe, and enable transformation.

- We will explore the development of community-based Digital Health Navigator roles, to support the digitally excluded to access services.

Shift 3:
Sickness to Prevention

Strategic Goal: To close the gap between life expectancy and healthy life expectancy.

Somerset Action:

- Work and Health: We will target economic inactivity caused by long-term sickness by integrating employment support directly with health services.

- New Skills/Roles: We will expand and develop skills and roles relating to prevention and tackling inequalities, such as Health Coaches, Social Prescribers etc.

12. Digital, data and Technology Strategy

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.

We know there are opportunities to use data and technology in more innovative ways that will make it easier for people to live well and reduce the need for acute hospital care.

1. Technology and the smart use of data has improved our lives in many ways. We want to work as one system to review, develop and deploy solutions that will enable people to access care and support more effectively.

2. We want to ethically use data to support the delivery and development of services, and to find better ways of improving the health and wellbeing of our population.

Over the past few years, we've seen rapid technological advances - most notably in artificial intelligence (AI) - which presents us with new challenges and opportunities for innovation and transformation. With this pace of change we need to remain adaptable and outcomes focused. This system-wide vision and roadmap, underpinned by an agreed set of Principles and Enablers, recognises our need to stay agile in our approach. Instead of speculating about what might be possible in a multi-year strategy, we'll focus on delivering practical solutions using modern technologies that address the needs of our patients, residents and staff.

12. Digital, data and Technology Strategy

Our vision for doing things better

We will use technology and data to re-imagine how we will achieve better outcomes for the people of Somerset. Organisational boundaries will not stop us from creating holistic digital services to improve outcomes for our communities.

We will focus on breaking down the technological and cultural barriers that silo us into our respective organisations.

We will become a team of teams, building a single view of an individual through a digital lens. We will build common data platforms to enable data to flow safely and ethically across the Integrated Care System (ICS) partners.

We will place the people at the heart of the digital service development process, ensuring that the final product is tailored to meet their needs and preferences. We will offer an accessible, trusted set of digital services that help individuals find the right care and support for them.

Our three missions

We have three missions which aim to enhance health and wellbeing outcomes for our residents and patients. To deliver a positive impact we will need to tackle daily operational challenges related to accessing information and data.

Mission 1. Working together

Mission 2. Improving Lives

Mission 3. Navigating Support

12. Digital, data and Technology Strategy

Mission 1. Working together

The Somerset Health and Care Strategy wants to make people's lives better by improving teamwork across our health system. We aim to provide a seamless experience when people need information, support, or care. It should be easy and timely, no matter which organisation is helping.

To achieve this, we're using digital technology and data to help our teams across the ICS work together better. We have started to roll out a common knowledge sharing platform to help us share information and manage collaborative projects.

We've created communities of practice where colleagues can share best practices across our health and care system. This will help us come up with new ideas faster and ensure high-quality digital solutions everywhere.

Lastly, we've set up clear rules and governance for technology projects involving different partners. This will help us use common standards and create an agile eco-system to manage quality and risks.

12. Digital, data and Technology Strategy

Mission 2. Improving Lives

Over the past two years, as part of the Population Health Transformation Programme, Somerset has shifted its focus to the development of an integrated health and care data set.

This work is critical to enable a Population Health Management Approach and develop a deeper understanding of the drivers of population health and inequalities.

At the heart of this shift is a platform approach to population health analytics — one that treats data not just as an asset, but as a product, ready to be consumed, reused, and trusted. Traditional health analytics across a partnership often operate in project-based silos. Data is extracted, transformed, and analysed for a specific purpose, and then archived or abandoned. This results in duplicated efforts, fragmented insights, and low return on investment.

Somersets platform approach flips this on its head. Rather than building one-off solutions, we, at an ICS level, are investing in shared infrastructure — a linked data platform — designed to support multiple use cases, users, and partners over time.

This will enable:

- **Scalability:** Our platform will support many analytical products and services.
- **Reusability:** Once data is cleaned, linked, and modelled, it can serve multiple teams.
- **Security and Governance:** Centralised control ensures compliance across partners.
- **Innovation:** Common infrastructure reduces barriers to experimentation and iteration.

Our current partners include, Somerset GP Practices, Primary Care Network (PCN), Somerset Council, Somerset Foundation Trust, South West Ambulance Service Trust (SWAST), HUC (NHS 111 and GP out of hours provider), Hospices, Care Homes, Somerset Fire & Rescue, Somerset Active Partnership, Thrive (Village Agents), Housing Associations and local and national Charities.

Data will be shared anonymously with partners to support research and more effective commissioning of health and wellbeing services. When research indicates specific cases within a neighbourhood or GP practice, the platform will allow GPs to re-identify those patients to offer health interventions.

Ultimately it will give us one version of the truth across all partners and will allow new and existing population health tools to sit on top of it. Somersets Linked data platform will feed all partners at a local and national level, specifically it has been built in collaboration with the South West Secure Data Environment (SWSDE) and will feed our local Federated Data Platform (FDP) instance for comparisons with the national data sets.

This has not just been a significant partnership, information governance (IG) and technical challenge but has also required us to think about building capacity, resources and skills across the system. Newly formed communities of practice are being encouraged to share best practice and case studies. And partners across the system have been testing tools to maximise the usefulness of the canonical data set that will soon be available, including risk stratification software, inequalities dashboards, and integrations to support a more agile commissioning process.

12. Digital, data and Technology Strategy

Mission 3. Navigating support

The health and care landscape is complicated to navigate. This complexity can lead to confusion and frustration for those seeking care and/or support.

Many individuals find it challenging to identify the right services, understand eligibility criteria, or navigate between different providers whether that's across the NHS (which is complex in it's own right), the council, or the voluntary sector. And that's not taking account of the multitude of commissioned activities provided by commercial organisations such as opticians, domiciliary care providers and tele-care businesses. This issue is particularly acute for vulnerable populations, such as the elderly or those with chronic conditions, who often require multiple services across different parts of the system.

The work of this mission is to support residents, patients and providers access information quickly and easily so that they can make choices around what support they need to access, and from what part of the system.

Our objectives are

- Develop or implement digital services focused on supporting residents, patients and providers to be easily able to access the right support or information.
- Automate processes and information gathering to help inform decision-making by multi-disciplinary teams across the system.
- Sign-post to local offers; offering options for neighbourhood support. By building community intelligence on behalf of individuals and families wellbeing, we can improve efficiency and build capacity by leveraging our collective assets, resources, and capabilities. This shifts the focus from crisis response to enhanced early intervention and prevention.

13. Primary Care – Delivering the Three Shifts

Primary care will play a central role in delivering the three shifts set out in the 10 Year Health Plan: from hospital to community, from analogue to digital, and from sickness to prevention.

For 2026/27, the ICB will continue to evolve its approach to commissioning primary care, moving beyond a predominantly access and activity focused model towards one that increasingly incentivises proactive population health management, neighbourhood-based delivery and improved outcomes, while continuing to ensure delivery of national contractual requirements.

Primary care services including general medical services, community pharmacy, optometry and dentistry will be positioned as core components of integrated neighbourhood health and care systems, working collectively to reduce pressure on urgent and acute services, enable proactive and preventative care, address health inequalities and improve patient experience.

General Medical Services

We will continue to ensure that general practices meet the requirements of the GP contract, including improving access via telephone, online and walk-in routes throughout core hours. This includes ensuring that patients receive timely clarity on how their requests will be managed on the day and supporting continuity of care where clinically appropriate.

Alongside access improvement, we will focus on reducing unwarranted variation in delivery and experience across Somerset. This will include targeted support for practices and neighbourhoods experiencing sustained challenges, informed by population health data, access metrics and local intelligence.

From 2026/27, general practice will increasingly operate as part of Integrated Neighbourhood Teams (INTs), supporting the shift towards proactive, personalised and preventative care. Where appropriate, community pharmacy, optometry and dentistry will also be aligned with neighbourhood delivery models, supporting shared priority cohorts and contributing to integrated pathways. Neighbourhoods will increasingly influence how primary care capacity and capability are deployed, particularly for priority population cohorts.

Community Pharmacy

Community pharmacy will play an increasingly important role as an integral part of the out-of-hospital system, supporting access, prevention and system resilience. Building on Pharmacy First, the ICB will further develop community pharmacy services to support the management of acute presentations and long-term conditions, reduce avoidable demand on general practice and urgent care, and improve patient experience.

This will include developing and expanding community pharmacy prescribing services, aligned with neighbourhood priorities, to support timely treatment, medicines optimisation and proactive management of defined population cohorts. Community pharmacy will be aligned with integrated neighbourhood delivery models, contributing to shared pathways and outcomes while making best use of its accessibility and clinical expertise.

13. Primary Care – Delivering the Three Shifts

Optometry

We will further develop community ophthalmology, incorporating it within integrated neighbourhood delivery models, to support the transition from traditional activity-based pathways towards a more preventative, community-based approach. This will include closer alignment between optometry, general practice, community services and secondary care, reducing unnecessary referrals to hospital services and improving patient experience.

Dentistry

We will increase access to NHS dental services and the proportion of Somerset residents who are able to receive NHS dental care. This includes continued focus on urgent dental care provision and wider work to improve coverage, equity and sustainability of dental services. Dental commissioning will increasingly align with neighbourhood principles, supporting prevention, early intervention and improved population oral health outcomes.

Alignment with Urgent Care and System Access

All Primary care services will be central to the redesign of urgent and emergency care pathways, supporting a reduction in avoidable emergency attendances and unnecessary hospital admissions. This includes aligning same day urgent care and urgent community response with neighbourhood delivery, maximising alternative pathways to emergency departments, and supporting a Single Point of Access to enable community-based management of urgent care needs where clinically appropriate.

Care delivery and service availability will increasingly be expected to be consistent throughout weekdays, evenings and weekends, aligned with neighbourhood models of care.

Digital, Data and Commissioning Reform

Primary care will be a key contributor to, and beneficiary of, the system's investment in data and digital transformation, including the Somerset Linked Data Platform and federated data capabilities across the Cluster. National and neighbourhood-level contracting mechanisms will increasingly be used to support partnership working and shared accountability for outcomes.

13. Primary Care – Delivering the Three Shifts

Workforce, Estates and Enablers

Delivery of the primary care commissioning intentions will be underpinned by a realistic and phased approach to workforce, estates and digital enablement, recognising system-wide capacity and capability constraints. Rather than relying on workforce growth or new estate development, the ICB will focus on making better use of existing skills, assets and capacity across general practice, community pharmacy, optometry and dentistry, aligned to neighbourhood models of care. Neighbourhoods will act as the primary organising unit for deploying multidisciplinary teams, flexing skill mix, and targeting effort using population health insights. Digital and data capabilities will be used pragmatically to support prioritisation and outcome tracking.

Outcomes and Transition in 2026/27

2026/27 will be a transition year for primary care commissioning, reflecting the move towards greater Cluster-level working and neighbourhood-led delivery, while maintaining stability and resilience across primary care services. Progress will be tracked through a combination of access, activity and early outcome indicators, including improvements in proactive identification and management of frailty, reductions in avoidable urgent care utilisation, and improved consistency of access and experience across neighbourhoods. Alongside this, the ICB will continue to provide targeted strategic direction and support to maintain provider resilience and support organisational maturity, ensuring services remain sustainable while new commissioning approaches are embedded. These measures will contribute to the emerging Cluster-wide Outcomes Framework and inform future commissioning decisions.

For the purposes of this plan, primary care refers collectively to general practice, community pharmacy, dentistry and optometry, working alongside system providers across acute, mental health and community services, local authority and VCFSE partners within integrated neighbourhood models of care.

14. Neighbourhood model

Purpose

Neighbourhoods are the primary delivery mechanism for NHS Somerset's ambition to improve population health, reduce health inequalities and deliver the three strategic shifts set out in the NHS 10-Year Health Plan. This section sets out the strategic framework for neighbourhood working in Somerset. It is intentionally proportionate and enabling, providing sufficient clarity to guide commissioning and delivery while retaining flexibility as national guidance and system partnerships continue to mature.

The neighbourhood model aims to:

- Establish a clear and consistent strategic direction for neighbourhood working across Somerset
- Enable local leadership and collaboration within an agreed system-wide framework
- Strengthen the link between neighbourhood delivery, commissioning intentions and system outcomes
- Allow for phased development at a time of emerging national policy and evolving local partnership arrangements

National Context and Alignment

National policy indicates that neighbourhoods should operate at Primary Care Network (PCN) footprint, focus initially on people with the most complex needs, and adopt a population health management (PHM) approach supported by prevention, personalised care and digital enablement. National guidance also recognises variable starting points and the need for phased implementation.

The Somerset neighbourhood model has been developed to align with this direction while remaining adaptable.

Somerset Context

Somerset has established a strong platform for neighbourhood working, including:

- 13 PCNs providing a stable neighbourhood geography
- Advanced population health analytics and integrated data capability
- Well-established proactive care models, with an initial focus on frailty
- A single integrated NHS provider across acute, community and mental health services
- Strong local authority leadership in prevention, early help and community-based support

These strengths sit alongside known challenges, including an ageing population, rural geography, workforce constraints and variation in neighbourhood readiness. The neighbourhood model is therefore designed to be principles -led and outcomes-focused, rather than structurally prescriptive.

14. Neighbourhood model

Defining Neighbourhoods in Somerset

In Somerset:

- Neighbourhoods are aligned to PCN footprints
- Somerset operates as a single Place
- Neighbourhoods are the level at which partners can most effectively understand population need, address unwarranted variation and deliver proactive, personalised and preventative care

Neighbourhoods do not constitute new statutory organisations. They represent a way of working, bringing together NHS, local authority and voluntary, community, faith and social enterprise (VCFSE) partners around shared outcomes for a defined population.

Principles for Neighbourhood Working

All neighbourhoods will operate in line with a shared principles, developed through system collaboration:

- Person-centred – coordinated seamless care around individuals, families and communities through a whole life course approach
- Population-led – decisions informed by population insight, data and community intelligence
- Outcome focussed-measuring outcomes not inputs
- Preventative – care based on proactive support
- Collaborative – shared ownership across NHS, local authority and VCFSE partners
- Subsidiarity – decisions taken at the most local appropriate level
- Consistency with flexibility – a common core offer with scope for local adaptation
- Continuous learning – evaluation, improvement and shared learning across the system

Integrated Neighbourhood Teams

Integrated Neighbourhood Teams (INTs) are a key delivery component within neighbourhoods. INTs bring together primary care, community services, mental health, social care and VCFSE partners to support people with more complex needs.

Initial focus will be on people living with frailty, multimorbidity and high service utilisation.

INT configurations will vary by neighbourhood, reflecting local context, but all will:

- Use shared population health insight and risk stratification to identify priority cohorts
- Coordinate care and proactively manage risk
- Embed personalised care approaches, including social prescribing and health coaching

INTs operate as part of wider neighbourhood ecosystems rather than as standalone services.

14. Neighbourhood model

Phased Development and Maturity

Neighbourhoods in Somerset will develop through a phased maturity model, recognising that progress will not be linear and that neighbourhoods will start from different positions:

Phase 1 – Foundations and Integrated Practice

- Neighbourhood geography and leadership arrangements established
- Core services aligned with agreed ways of working
- Initial population insight and community engagement

Phase 2 – Population Health Management Enabled

- Consistent PHM approach embedded across neighbourhoods
- Risk stratification and cohort management in place
- Locally agreed priority outcomes identified

Phase 3 – Integrated and Intelligence-Led Practice

- Digital interoperability supporting integrated workflows
- Integrated pathways and joint workforce planning
- Services redesigned to reflect neighbour-hood need

Phase 4 – Delegated Delivery and Accountability

- Increased delegation of resources and decision-making
- Shared accountability for outcomes
- Neighbourhoods playing a defined role in shaping commissioning decisions

System governance will support assurance, consistency and shared learning across neighbourhoods.

Governance and Decision-Making

Governance arrangements for neighbourhood working will continue to evolve. The emerging approach includes:

- Neighbourhood-level leadership arrangements to support operational coordination and local problem-solving
- A Somerset-wide coordination to provide system alignment, resolve barriers and support learning
- Clear routes for neighbourhood priorities, risks and investment proposals to inform commissioning and planning decisions

This approach balances local autonomy with system oversight.

14. Neighbourhood model

Commissioning and Resource Alignment

Neighbourhoods will increasingly influence how services are planned, commissioned and delivered.

This includes:

- Defining a consistent core neighbourhood offer aligned to national requirements
- Using neighbourhoods as the primary unit for commissioning priority pathways, beginning with frailty
- Reforming incentives to better support prevention, proactive care and shared outcomes
- Aligning workforce, digital and estates planning to neighbourhood delivery models

The initial focus during 2025/26 and 2026/27 will be on strengthening foundations, with increased delegation and flexibility over time.

Measuring Progress and Impact

Neighbourhood progress will be assessed through:

- A basket of agreed population health, quality and experience measures
- A neighbourhood maturity framework
- Evaluation of priority pathways and test cases

Learning from early implementation will inform refinement of the model and support spread of effective practice.

Looking Ahead

The Somerset neighbourhood model sets out a clear strategic direction while avoiding over-specification. It establishes a coherent framework that can accommodate national policy development and local system maturity.

Over the five-year period of this plan, neighbourhoods will become the principal mechanism through which improved outcomes, reduced inequalities and more sustainable health and care services are delivered for the people of Somerset.

15. Estate and Facilities

The ICS Strategic Estates Group published the Somerset ICS Infrastructure Strategy in September 2024.

The ICS Estates Group involves representatives from the Police, voluntary sector and the wider public sector.

Part of the work of the group is to bring together all the strands of related work being taken forward elsewhere. This includes projects such as One Public Estate, where public sector organisations consider what efficiencies and sharing initiatives could be taken forward across the entire public sector estate, breaking down organisational boundaries to ensure that money is efficiently spent and kept within the public sector where possible. We are conscious of our role as public sector organisations, and the wider responsibilities that that entails. The Council has a specific remit for economic regeneration, but all ICS partners realise their responsibilities to the county as a whole, and their economic and social heft as large employers. The work of the ICS Estates Group, and of this strategy, moves beyond simply improving buildings and looks to the social good that we can engender from a more strategic approach to Estates planning.

We are also continuing conversations between public sector partners and the private sector regarding the development of Keyworker and affordable housing for the county, to attract and retain colleagues and to make sure that they and their families have good quality places to live, with affordable rents and purchase prices.

The Infrastructure Strategy sets out a framework through which the development of our estate and infrastructure will support the ambitions of the ICS, and builds on from the good work already underway, and makes the case for significant but necessary investment to ensure we have safe, compliant and future proofed infrastructure. A key aim of the Strategy is to set out our plans for the future, and how we intend to realise them. This includes both strategic and financial plans, but also the risks and issues which might prevent us from achieving our goals. These challenges, whether they be to do with our population or our finances, are important to understand to place our plans in context.

Many of our facilities across our public estate in Somerset, are old and inefficient. As we develop new buildings and renovate old ones, we will also be able to contribute to the Net Zero agenda more broadly by recognising the importance of an estate which promotes joined up and sustainable travel for patients. This emphasises the importance of working in partnership across our region and cluster to ensure our Estate Strategies are robust and enable system wide resilience.

Somerset ICS exists to help people live healthy lives, supported by thriving communities with timely and easy access to high-quality and efficient public services. Ensuring that we have good quality, accessible, local buildings and facilities to deliver public services is key to helping the ICS achieve its aims.

15. Estate and Facilities

The ICS ten-year vision is to create:

A thriving and productive Somerset that is ambitious, confident and focused on improving people's lives.

A county of resilient, well-connected, safe and strong communities working to reduce inequalities.

A county infrastructure that supports affordable housing, economic prosperity and sustainable public services.

A county and environment where all partners, private and voluntary sectors, focus on improving the health and well-being of all our communities.

Somerset NHS Foundation Trust delivers acute, community and mental health services for Somerset as part of the ICS, as well as delivering around a quarter of GP services for the county. Its clinical strategy seeks to improve the quality of the services that it provides.

The trust's model of care covers the entire pathway from living well through to inpatient care and describes how the trust will deliver better services at every level to keep people well for longer, out of hospital where possible, and making the most of their time.

The trust has identified a series of obstacles that impede effective service delivery, such as poor coordination between services, too much resource delivered through hospitals, and a lack of focus on illness prevention. Having identified these obstacles, there are now plans to overcome them through the programmes that the trust is delivering to achieve its strategic objectives. Many of the obstacles would be partially relieved with better buildings, and better use of existing buildings.

15. Estate and Facilities

As a result, the clinical and estates strategies are closely connected. We are clear that we won't be able to achieve excellent clinical services without an estate fit to deliver them from. Similarly, as we look to develop our estate, we are clear that it needs to change to meet the goals of the clinical strategy.

As part of the strategy to transfer services to the community where possible and to focus on essential services on the Musgrove Site the Trust developed two diagnostic centres including a community diagnostic centre in partnership with the independent sector and an ophthalmology hub.

The Trust delivers facilities from 70,000m2 of Community estates including 13 community hospitals (37,000m2), four dental access centres, sixteen community health buildings (14,000m2) and four principal mental health sites (17,000m2), with a further 14 smaller sites (2,000m2). The buildings comprise of a mix of inpatient provision, day units, residential provision and community team bases. In addition, community services are delivered from a wide range of other venues, including GP surgeries, under licence agreements. The current community and mental health estate is generally in good condition, operationally sound and safe after significant investment in the improvement of facilities for the people who access the sites. Investment has generally been used to enhance the environments and meet modern day standards.

We are conscious of the Council's role in enhancing the broader health of local communities. This goes beyond simply sharing Council or High Street buildings with health services. It also involves things like active travel – public transport, walking and cycling. Situating office hubs and customer locations will be key to this. The NHS Travel and Transport Strategy2 also details this partnership working approach and to include strategic direction in the next iteration of the Green Plans (current plans expire 2025). There is also a commitment in the strategy to reduce staff travel emissions by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles. This will also need to be considered when thinking of where staff work.

Perhaps the largest front-line Council estates class is the residential care estate. There are residential care sites that are being built now, and also legacy estate that is becoming out dated, meaning that over the next few years the nature of that estate will change significantly. The Council is currently building its fifth children's residential home, with plans to build seven. These are small (1-3 bed) units for children with high needs related to mental health and behaviour, with a clear relationship with NHS Children and Adolescent mental health service (CAMHS) services. The development of these smaller, more bespoke facilities for particular needs will be a hallmark of the changing residential care estate. There will also be investment is specific facilities for Children with disabilities, and young people leaving care.

15. Estate and Facilities

For adults, the residential care estate is primarily legacy stock, leased to providers. It is either becoming outdated or is being handed back by providers because they don't want it anymore. As a result, it is likely that there will be a shortage in residential care beds in the future, and a re-design of services towards home care and nursing care. The Council is exploring the potential for strategic partnering arrangements for residential care, using brownfield sites with a guaranteed number of places. The ICS will seek to understand the potential for further partnership arrangements and multi-organisational facilities and services in the future.

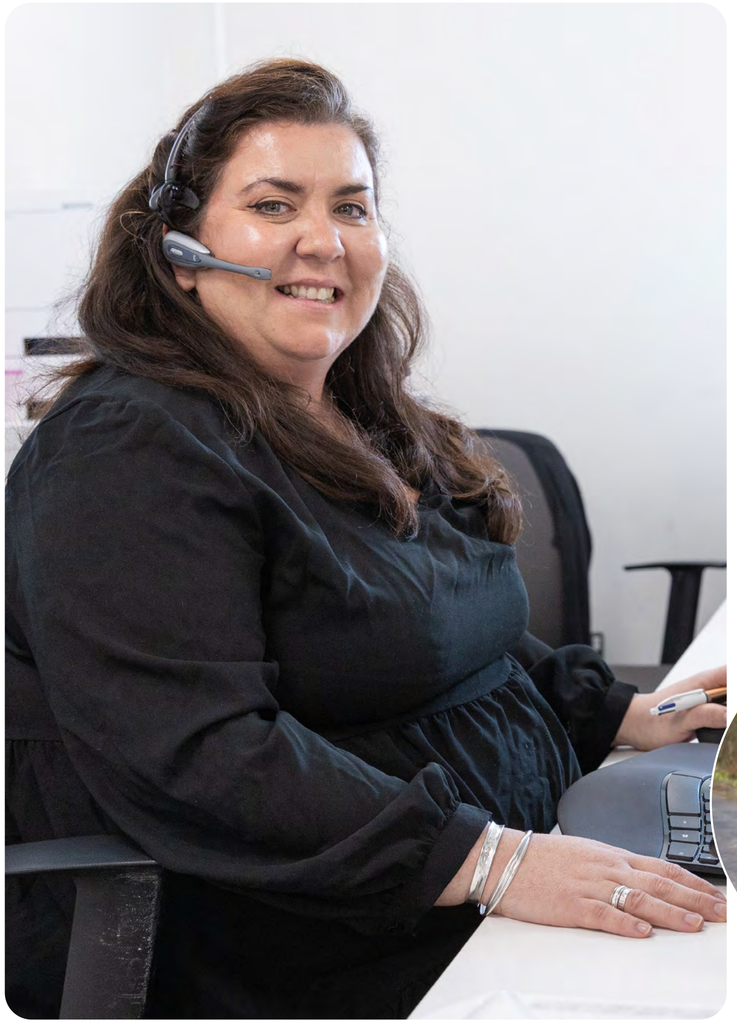
We will increase the focus on independent living in future, through the development of hubs for advice and low-level assistance. This will involve the greater use of libraries and community centres for low level health and wellbeing services. There will be a move away from new facilities, and towards existing things like high street facilities, which will avoid construction costs and remove any potential stigma about attending facilities and utilising services.

There are currently nine Family Hubs, which are bases for public health nursing teams, providing a range of family support and health and care services. These are in deprived areas, replacing Sure Start centres. There are also numerous pop-up clinics in place, and we intend to further develop these services in the coming years.

We will not abandon new facilities entirely. For example, the New Somerset Academy is emerging, to be delivered from the site of the old Bridgwater community hospital, and with a satellite centre in Minehead.

However, a lack of funding makes it difficult to move from ideas to delivery. Across the ICS we are exploring funding models, and the ability of partner organisations to borrow for capital investment, marry plans to revenue budgets, and develop business cases for new buildings.

16. Our commissioning skills / development needs.



Becoming a strategic commissioning organisation means that we will need to enhance our capabilities and skills in new and different areas.

To help with this, we will be supported by a nationally led programme of strategic commissioning capability development which we expect to commence from April 2026.

We expect the following skills and capabilities, detailed in the NHSE Strategic Commissioning Framework, to be important for our future success:

- System leadership and managing complexity
- Population health management, population segmentation and population health mangement
- Data, analytics and technology
- Citizen involvement/engagement and co-production capabilities
- Commissioning, finance and contracting
- Effective and broad multidisciplinary clinical and professional leadership
- Strategy and systems thinking
- Transformation and change management

We need people that are consistently innovating and collaborating in a spirit of continuous improvement, pushing the boundaries and with a passion for radically changing the way we care for our population.

17. Engagement

Engagement with the Somerset population provides insight that underpins the strategic commissioning cycle – informing service design, development and evaluation – and ensuring the needs of local people are at the heart of all we do.

The NHS Somerset communications, engagement and marketing team delivers continuous engagement through established networks and projects throughout the year.

Continuous engagement underpins how we plan, design and improve health and care services. We use a wide range of engagement techniques, both digital and in-person to actively listen to patients, carers, communities and partners through ongoing dialogue — including events, surveys, workshops, groups and established networks — so local voices shape decisions over time. This approach ensures insight is used throughout planning, delivery and evaluation, helping to build trust, address health inequalities and keep people at the heart of everything we do.

In the last 12 months, the team has undertaken two largescale pieces of public engagement, which are summarised below. Full information is provided within appendices 2 and 3. Findings from engagement is fed back to Board members and strategic commissioning teams to inform their work.

Somerset's Big Conversation 2025

This was large-scale engagement from May to October 2025, comprising an interactive roadshow, online activities, and bespoke involvement work with people more likely to experience health inequalities, for example from local CORE20PLUS5 communities. The team engaged with 3,947 people through nine different engagement approaches, covering digital and face-to-face activities. Engagement took place in over 50 locations across the county, and we analysed over 8,339 individual pieces of qualitative feedback.

17. Engagement

Key findings

1. GP access, continuity and communication remain a central priority

People strongly value their GP teams, praising compassion, professionalism and the quality of care once they are seen. At the same time, many described difficulty getting through on the phone, navigating online systems and securing timely appointments. People want primary care to remain local, familiar and with good continuity, supported by clearer, more reliable routes to access.

2. Community hospitals and UTCs play an important role in local, accessible care

People consistently highlighted the strengths of community hospitals – including calm environments, familiar staff and shorter travel distances that make services easier to reach. People valued having UTCs, clinics and rehabilitation closer to home. Concerns were raised about reduced UTC hours, uncertainty about future services and the impact of having to travel further when local options are unavailable. Overall, people want these local facilities protected and strengthened so care remains close to their communities.

3. Staff were widely praised, workforce pressures affect reliability and consistency

Across primary, community and acute services, people spoke with warmth about staff who are kind, skilled and go "above and beyond." Alongside this, workforce shortages can lead to delays, missed visits, reduced therapy and less predictable care. People want staff to have enough time and support to deliver the safe, reliable care they value.

4. Home-based care and reablement work well when services are reliable and joined-up

Many people appreciate recovering at home, valuing personalised care, familiar surroundings and support that helps them regain independence. This works best when visits are on time, communication is clear and therapy is consistent. Confidence drops when support is rushed or missing, so people emphasised the need for robust, well-coordinated home-first pathways.

5. Transport, rurality and distance influence people's ability to access care

Local clinics, community hospitals and outreach services were praised for reducing travel and helping people stay connected to care. For others, long journeys, infrequent buses and high transport costs made accessing services difficult, particularly in coastal and rural areas. People want more reliable, affordable options that reduce inequality and avoid missed appointments.

17. Engagement

6. Discharge and recovery pathways can work well, but are inconsistent

Positive experiences were described when discharge planning was clear, equipment arrived on time and follow-up care began smoothly. However, others reported gaps such as missing equipment, unclear communication or delays in starting home care and therapy. People want more consistent, well-coordinated transitions between hospital, community teams and home-based care.

7. Digital tools are helpful for some, but many still need non-digital options

People who are confident online appreciated using digital systems for quick tasks like prescriptions and simple queries. For others, especially those with limited digital confidence or poor connectivity, online forms felt confusing or inaccessible. People want a balanced approach where digital routes improve convenience without replacing the option to speak to someone directly.

8. Preventive support and early help are valued and seen as essential to staying well

People welcomed activities and services that help them remain independent, active and connected – including social prescribing, wellbeing groups and community-based support. They also described gaps in early intervention and difficulty finding information about help before issues escalate. People want more local, easy options to avoid unnecessary deterioration or crisis.

9. NHS dentistry is valued where available, but access remains extremely challenging

Most feedback on NHS dentistry focused on the difficulty of registering, long waits, cancelled appointments or travelling long distances, with many relying on private care they cannot afford. People want fair, local access to essential dental treatment. People praised the quality of NHS dental care and the reassurance of routine check-ups where they could access them.

10. Mental health support brings big benefits, but access needs to be earlier and more consistent

Compassionate mental health workers, supportive community groups and youth services were described as lifelines for many people. Yet long waits, high thresholds and limited local provision often meant help arrived too late. People want more timely, joined-up and inclusive mental health support for both adults and young people.

For full details, see Appendix 2 – Somerset's Big Conversation findings report

17. Engagement

Change NHS: 10 Year Health Plan engagement in Somerset

Between November 2024 and March 2025, the NHS Somerset engagement team engaged with people and patients across Somerset, visiting community groups and engaging in a wide range of locations, as well as talking to ICS colleagues about the three key shifts (see below) and hearing about people's experiences of healthcare services.

Summary of findings:

The feedback emphasises clearly that the public strongly values the NHS for being free at the point of use, universally accessible, and delivered by compassionate, hardworking staff. However, major challenges persist, and people note the need for inclusivity, proper investment, and careful coordination to ensure these shifts are successful and sustainable.

Shift 1. Moving care from hospitals to communities

Feedback from people in Somerset highlights strong support for more localised, accessible, and personalised care. Many see the move as beneficial in improving patient experience, reducing hospital strain, and enhancing recovery. However, concerns about rural transport, workforce shortages, and digital exclusion persist, with people fearing that these shifts may result in unequal access to services, particularly in underserved areas. There is a clear call for significant investment in community infrastructure, resources, and seamless coordination across care services to make this shift effective.

Shift 2. Analogue to digital

The shift is broadly supported for its potential to improve efficiency, communication, and patient empowerment. Many view digital tools, such as electronic records and virtual consultations, as positive changes. However, there are notable concerns regarding digital exclusion, particularly for older adults and rural populations, as well as fears about data privacy, cybersecurity, and the loss of human interaction in care. Ensuring that digital solutions are accessible, user-friendly, and inclusive, with alternatives for those unable to engage digitally, is seen as crucial for success.

Shift 3. Sickness to prevention

Focusing on early intervention, education, and addressing social determinants of health, is widely supported as essential for long-term health system sustainability. People appreciate the idea of prevention being more cost-effective and compassionate but worry about its funding and the potential neglect of urgent care needs.

For full information, see Appendix 3 – 10 Year Health Plan Engagement Report

17. Engagement

Current engagement work

Current engagement work includes:

- Engagement work with **local communities about reshaping community services**, especially in relation to those based in community hospitals, in partnership with Somerset NHS Foundation Trust.
- Public engagement on **views around data sharing** to support the system application for Section 251 approval for our Somerset Linked Data Platform. If approved, the platform will enable enhanced and proactive population health management work, in line with our responsibility as a strategic commissioner
- **Supporting the development of an ICS research strategy** and the current implementation of the second Research Engagement Network project.
- Currently developing **engagement support for patient transport and the refresh of the Somerset Adult Social Care strategy**.

18. Monitoring the plan

Current engagement work

We are committed to working together to deliver the intentions set out in this plan for Somerset, and using our agreed BSW outcomes framework indicators, performance reporting and our governance and assurance processes, we will track and monitor our progress. To support this, Somerset will develop an agreed Population Health Outcomes Framework (aligned to the NHS England approach) which sets out agreed metrics (and a way of monitoring progress against them) for the 5-year period. This will inform progress towards our overall objective of improving Healthy Life Expectancy (HLE).

The Somerset outcomes framework will be a tool designed to define the outcomes that are of value to our population. It will enable the measurement of the effectiveness of our activities and interventions in delivering improved health outcomes for the population. The framework shall provide a robust, evidence-based approach to monitoring progress and addressing inequalities. It enables the Integrated Care System (ICS) to align its priorities with measurable and actionable goals, ensuring that our efforts translate into meaningful change for our communities. By embedding this Outcomes Framework into our commissioning and contracting, we will ensure a structured, equitable, and transparent approach to improving health outcomes across our communities and by the end of the five-year period we aim to see a measurable improvement in these outcomes.

As per the guidance set out for ICB's in the strategic commissioning framework, we will rigorously evaluate the outcomes from our commissioned services, care models and proactive interventions.

This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence. We will monitor and evaluate the performance (quality, operational or financial) of the services we commission by:

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

18. Monitoring the plan

Current engagement work

We will address unjust health and healthcare inequalities by using an integrated data set to develop a greater understanding health and healthcare inequalities. We will begin this using the lens of frailty and embed this within our neighbourhood programme. By the end of the five-year period, we aim to see a measurable reduction in identified areas of health inequalities, as captured in the Population Health Outcomes Framework.

We will move resources to support health improvement and tackle inequalities. Key investments will include supporting delivery of:

- Population Health Transformation Programme
- Developing our population insight capability
- Neighbourhood Health and Personalised Care Development Programme
- Prevention initiatives to reduce risk of Cardio-Vascular disease (CVD) and early identification of cancers (particularly focussed on inequalities)

We will enable the left-shift through new strategic and agile commissioning methods. To support this, we will develop a greater range of tools that enable funding and value to better align, for a wider range of providers and partnerships to flourish in the county, and to empower people through increased involvement in their care. We will also harness efficiencies through greater economies of scale where feasible.

We will define required improvements and incentivise the system to ensures timely access to the care needed for our patients (in line with requirements set out in the Medium-Term Planning Guidance). We will ensure providers deliver key performance standards as part of our outcome's framework with associated incentives. We will have effective assurance measures in place for ensuring quality of services.

As an enabler we will strengthen joint commissioning and shared accountability across ICB and Local Authorities through the Better Care Fund and other pooled budgets.

We want to incentive understanding of healthcare inequalities and start to address where populations experience difference in access. We will explore new payments related to differential access rates and start to incentivise addressing these.

19. Risks and Mitigations

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

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

20. Governance

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

During the business year 2025/26, Somerset's ICB's governance and decision-making arrangements will ensure appropriate decision-making and oversight and assurance with regards to the approval, implementation and delivery of the plan. The relevant forums in the Somerset governance arrangements are:

- Somerset ICB Board – approval of the plan
- Somerset ICB Commissioning Committee – oversight and assurance of the plan and its delivery, risk monitoring and assurance that risks are managed, and commissioning decisions where the value of the commissioned services contracts reach the relevant threshold per the Somerset ICB's Scheme of Financial Delegations (the Somerset ICB Board is the decision-maker for the most high-value commissioning decisions)
- Somerset ICB Management Group – day-to-day monitoring, operational decision-making in line with the Somerset ICB's and Scheme of Financial Delegations, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes
- From 1 April 2026, BSW, Dorset and Somerset ICBs will closely collaborate as a cluster. The intention is to have in place cluster governance and decision-making arrangements. While these arrangements have not been finalized at this point in time, we anticipate the following as relevant forums for decision-making, oversight and assurance with regards to the delivery of the plan – to note that this is indicative only at this point in time and may be subject to change:
  - Cluster Board – approval of any material changes to the plan, decision-making with regards to very high-value commissioning decisions, decision-making with regards to novel or contentious commissioning models
  - Joint cluster committee for commissioning – oversight and assurance of the plan and its delivery, commissioning decisions, risk monitoring and assurance that risks are managed
  - Joint cluster Executive Group – day-to-day monitoring, operational decision-making, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes
  - TBC: Place 'boards' may play a role in the oversight and assurance of the plan and its delivery where intentions have particular local / place implications

Oversight via Executive structures

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

Accountability

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

Appendices

Appendix i: Statutory Commissioning Intentions Summary

Stream	Where we are now	Longer Term Aim	Priority for 2026/27	Implications for providers	Benefit - Metrics to be impacted
Commissioning Framework Development	Currently, Commissioning is mainly undertaken on a service basis which can perpetuate silo working. Good examples of co-design and outcome based models in Somerset Open Mental Health service (OMH) which can act as a template for wider application. More advanced forms of outcome-based contracts developed in BSW. Good integrated reporting and monitoring models in Dorset.	To have an integrated model of strategic commissioning that enables a clear join-up at Neighbourhood/Place/ Cluster levels. Also a framework that works for all partners within Somerset, providing Utilisation of the framework to deliver the 3 aims within the 10YP	1. Development with providers of a Population Health Improvement Plan at cluster level with associated Outcomes Framework. This will be underpinned by a review of financial incentives, quality requirements and a commitment to co-production with residents.	This will primarily affect NHS providers holding or seeking system, place or neighbourhood-level contracts, including acute trusts, community providers and primary care provider collaboratives. These providers will be expected to engage in the development and testing of outcomes-based commissioning approaches and contribute to defining how outcomes are measured and delivered. Over time all providers commissioned by the ICB will be expected to commit to Partnership working that prioritises population outcomes, prevention and personalised care over activity. Providers will need to demonstrate how their services contribute to agreed system priorities, work collaboratively across organisational boundaries, and adapt to commissioning arrangements that increasingly reward outcomes, value and integration rather than volume.	See measures outlined below, as likely to be overlap for this workstream

Stream	Where we are now	Longer Term Aim	Priority for 2026/27	Implications for providers	Benefit - Metrics to be impacted
Neighbourhood Development	Somerset has a draft framework for Integrated Neighbourhood Team (INT) development. Early thinking has been applied to a wider model of Neighbourhood Development spanning universal Council services, resilient communities and the VCFSE sector. A common vision and principles have been drafted.	To have vibrant, resilient communities within which health, care and wellbeing support is fully integrated and service delivery optimised and efficient.	Commissioning during the planning period will focus on establishing the conditions for effective neighbourhood-based working, reducing unwarranted variation, and managing demand through prevention and personalised care. This will include: 1. Strengthening neighbourhood governance and planning arrangements 2. Addressing variation in access to general practice and urgent community care and improving understanding of high-need cohorts to reduce non-elective demand, with frailty used as an early priority use case 3. Support delivery of national prevention and personalised care priorities 4. Strengthen digital and data-enabled planning, aligning workforce commissioning with national expectations to ensure readiness for the Model Neighbourhood Framework, informing commissioning intentions for April 2026 onwards.	This will primarily affect primary care, community health providers, mental health providers and VCSE partners, particularly those working in early neighbourhood priority areas. These providers will be expected to participate in integrated neighbourhood teams, support proactive care for defined populations, and work more closely with local authority services. Over time acute providers will increasingly be expected to align services to neighbourhood models, including supporting care closer to home, providing specialist input into neighbourhood teams, and adapting pathways to reduce avoidable hospital activity. All providers will need to operate as part of neighbourhood-based delivery models, with shared accountability for outcomes rather than siloed service delivery.	Improvement in Patient activation or self-management proxy (e.g. PAM) Improvement in Patient-reported experience Positive Staff experience of multidisciplinary working and autonomy (via staff survey or targeted neighbourhood feedback) Workforce stability in neighbourhood teams (e.g. sickness absence, retention or continuity of key roles) Increase in achievement of frailty metrics (e.g. % completed CGA and falls risk assessments) Reduction in non-elective admissions for priority cohorts (e.g. frailty) Reduction in falls for priority cohorts (e.g. frailty) Reduction in unplanned admissions for chronic ambulatory care Reduction in prescribing for priority cohorts

Stream	Where we are now	Longer Term Aim	Priority for 2026/27	Implications for providers	Benefit - Metrics to be impacted
Population Health & Prevention	The ICB has an established Pop Health & Prevention Programme that has funded a number of successful interventions to combat health inequalities and improve prevention capacity. A recent example is the 'know your numbers campaign' and the Homelessness Service	Is to develop a culture of prevention, pop health management and a focus on reducing health inequalities in all our commissioning activity. Through this the win is to grow the % spend within Somerset on prevention and have a greater focus on improving long term health outcomes	1. Continued work on Hypertension and CVD. 2. Obesity and healthy weight pathway redesign. 3. Full programme of work on Core20Plus5 in line with Outcome Framework	Active participation within the Population Health Transformation programme and through 26/27 a requirement to embed the Outcome framework within provider contracts for future years.	Improvement across Core 20+5 metrics (all age, and CYP) and legal statement metrics Improved ethnicity recording (primary care, Acutes, community, ASC) is key to understanding our population needs Increase in the proportion of people diagnosed with hypertension who are optimised. Reduction in prevalence of smoking Reduction in prevalence of smoking at time of delivery Increase in preventative healthcare uptake for homeless population/inclusion health groups eg. vaccinations/screening etc
Primary and Community Based Provision	Primary care has a central role within Integrated Neighbourhood Teams (INTs). Somerset has good models of GP access within the patch, however experience is variable. Nationally, dental access is a challenge, good progress has been made within the County to improve access, but significant work remains	Over time, and subject to contracts, primary care services will work in partnership with other agencies to deliver personalised care to those most in need and to offer on-the-day services in the most effective way. Clinical leadership, local engagement and good data and digital provision at a local level are critical enablers of success.	1. We will reduce the variation in on-the-day access times for people to General Practice, and develop models of integrated on-the day-access including MIU and UTC provision in certain areas. 2. 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. 3. We will embed pharmacy-first approaches. 4. We will increase access to NHS dental services and the proportion of Somerset residents that have received NHS dental care. 5. We will develop an integrated neighbourhood model for community ophthalmology.	This will mainly affect primary care, community health providers and relevant specialist services, with a focus on strengthening community-based pathways for long-term conditions and personalised care. Providers will be expected to work more closely across traditional boundaries, align workforce and skills to neighbourhood delivery, and expand proactive, preventative and self-management approaches. Over time acute providers will be expected to redesign pathways to support a sustained shift of activity into primary and community settings, including greater use of advice and guidance, shared care models and neighbourhood-based follow-up. All providers will need to demonstrate a reduction in avoidable hospital use and increased contribution to community-based, personalised models of care.	Primary care - GPAD data only - same day care, count of appointments vs plan Primary care - patient experience (patient survey) Dental - Urgent dental access and routine appointments Pharmacy first - operational planning metrics Community services contacts (+ selected measures reported vis CSDS) Neurodiverse WL - Adults & Children Community Services WL UCR referrals / 2 hour referrals / contacts Hospital at home - caseload / occupancy

Stream	Where we are now	Longer Term Aim	Priority for 2026/27	Implications for providers	Benefit - Metrics to be impacted
Urgent and Emergency	Patient experience is inconsistent with some people experiencing good timely access to same day care whilst others feel the need to shop-around between their GP, ED, NHS 111 and local Urgent Treatment Centre	To have a seamless model of same-day urgent care that is available when local residents need it.	1. We will engage with providers during early 25/26 to undertake a diagnostic exercise that will determine our commissioning priorities for Urgent and Emergency Care. 2. In certain neighbourhoods we will look to commission an integrated same-day urgent care offer for people that better utilises existing GP and UTC capacity. The initial areas of focus will be Frome and Shepton.	Support from all providers required to complete the diagnostic through provision of data, feedback and experiences. New ways of working may result including integrated working with primary care for example in relation to the UTC's	A&E attendances - by minors/majors UTC attendances Drill through at locality, condition, age SDEC attendances Emergency admissions zero, >1 day LOS Excess bed days Avg LOS NCTR
Acute Service Configuration	Nationally leading model of Integrated provision within the County however scope for strategic planning application to acute service provision and consideration of scale and quality.	Opportunity to strategically plan acute provision across the Cluster to improve safety, continuity and quality.	1. Implementation of the Stroke Reconfiguration Business Case from May 26. 2. Review the output of the Dorset Vista programme and seek to replicate a version at Cluster level, delivering a clearer strategic plan for acute provision within Somerset.	Providers will need to monitor the implementation of the revised stroke pathway to ensure that the clinical pathway is operating effectively including TIA and outpatient clinics. Shared protocols, escalation pathways and performance oversight arrangements need to be in place and regularly monitored. Providers must participate in strengthened governance structures for monitoring patient outcomes, pathway performance and continuous improvement across the system.	No of stroke admissions per month, and Average Length of Acute Stay per month % of Patients admitted to an acute stroke unit within 4 hours of hospital arrival % Patients scanned within 20 minutes of hospital arrival % Patients seen by stroke consultant within 1 hour Number of eligible patients receiving thrombectomy Number of Ischaemic stroke patients, and Number of Ischaemic stroke patients thrombolysed per month

Stream	Where we are now	Longer Term Aim	Priority for 2026/27	Implications for providers	Benefit - Metrics to be impacted
Outpatients	Somerset has a growing range of self-referral pathways into outpatient services. The introduction of Cinapsis has improved clinical communication over patient management options.	To improve the responsiveness of cancer diagnosis and treatment provision, for non-cancer pathways and seek to replace existing routine referrals with community-based models and MDT working between clinical teams.	1. Commission a model for outpatients that tests new ways of working and moves away from normal payment methods and ways of delivering services. 2. Neighbourhood based Peri -operative care model to control front door into elective services and reduce unnecessary treatment as well as variation and healthcare inequalities. 3. Commission cancer front door model on a risk share basis	1. Will require continued change to outpatient working but is an essential part of the required improvements in RTT performance and the wait to first OPA. 2. Potential expansion and further change to existing peri-operative care service. 3. Cancer front door model currently in place but requires sustainable commissioning to support continued achievement of cancer targets. Likely further expansion of self-referral pathways.	Advice and Refer - track progress and impact on OP WL Diversion rate Non-admitted waiting list size RTT 1st OPA 18 week performance New to Follow up appt ratio Reduction in OP FU appt Above - by specialty?
Women & Children's Health	Somerset has an established partnership arrangement to oversee the development of children's services. There is a shared CYP strategy. There is scope to develop the governance arrangement to support increased accountability of outcomes, and enable creative innovation. There is a range of work taking place within the Women's Health portfolio - including working with SFT and primary care to develop pathways and improve the experience of women in Somerset. A programme of work has been developed and is being overseen by the Women's Partnership Board.	There is an opportunity to align and combine the strategic commissioning of Women's and CYP health and wellbeing services across the County to better ensure that support to Women, Children and Young People are optimally coordinated and person-centred.	1. Develop CYP transitions strategic oversight and collaboration through exploring opportunities for joint and/or aligned commissioning arrangements. 2. 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. 3. 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. 4. Engage in delivery of the SEND programme, and associated service development to address health inequalities	Implication for providers are: 1. active engagement regarding the development, implementaton, and monitoring of children' services and the associated outcomes; 2. potential discussions regarding the flexibility of provision to meet the complex needs of indiviudal children / personalisation; 3. demand management modeling to support early intervention and appropriate referral model. 4 . Increases in the demand in SEND, particularly ND assessments, therapy services, support for health services in schools / alternative provision	Track Core 20+5 CYP measure / legal statement measures for CYP CYP elective activity and waiting list A&E 4-hour performance for paediatrics (<16 years) PICU

Stream	Where we are now	Longer Term Aim	Priority for 2026/27	Implications for providers	Benefit - Metrics to be impacted
Mental Health, LD and Autism	There has been significant development, improvement and expansion of mental health services over the last ten years, with particular focus on the community offer. There are opportunities to further develop the urgent and emergency mental health offer and improve integration with the community offer, which will promote prevention, early intervention and an holistic approach bringing together medical need and the wider social determinants. Demand for ADHD, autism and dementia diagnosis, and associated pre-and-post support is rapidly rising and waiting lists are growing.	To streamline the pathway for people experiencing an urgent mental health need and ensure robust integration with community mental health services, as close to home as possible. To improve waiting times for dementia, autism and ADHD assessments and associated pre-and-post diagnostic support	1. Implementing the recommendations of the new Modern Service Framework for mental health (including severe and enduring mental illness) when published in 2026. 2. We will develop the model for MH Emergency Departments (Crisis Assessment Centres), working with partners in VCFSE as appropriate, which will support attendees to access the most appropriate support in the event of a crisis, and seek access to national capital funding accordingly, in line with NHS England specification	Respond to the Modern Service Framework Access to capital funding to make any site based improvements. Review of service delivery locations for CMHS and mental health crisis/urgent care staff. Ongoing pathway development work across VCFSE and statutory partners. Pathway improvement work across dementia, autism and ADHD	Reduction in LOS Reduction of ED attendances for mental health need Increase in use of community crisis alternatives Reduction in waiting times for MH, dementia, ADHD and autism services Neurodiverse waiting list MH Delayed discharges / lost occupied bed days Delivery of operational plans for MH/LD measures
Pathway Improvement	These pathways have been identified as being priority projects for the elective care board. The focus is on reducing demand into secondary care by streamlining the referral process and offering alternative provision in the community.	To commission and incentivise pathways which are streamlined. Increase provision within the community as a means of avoiding need for referral to acutes.	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	MSK, Weight and Ophthalmology are 3 key high volume elective pathways for providers. Work on these remains a key area for elective recovery and improvement and will likely be necessary to support reaching RTT and long wait targets. Peri-operative care remains an ongoing programme to support reduced variation/ improved optimisation in surgical pathways with potential for change to neighbourhood model of delivery.	Elective WL size, RTT performance and activity reported by specialty

Appendix ii: Delivering our Statutory Functions

This section of our Plan describes how we have delivered our legal requirements as set out by NHS England.

Describe the Health Services for which the ICB proposes to make arrangements

Our 5 year Strategic Commissioning Plan explains how the ICB seeks to arrange health services to meet the future needs of the people living in Somerset.

Detailed information about services can be found on our websites:

- NHS Somerset Integrated Care Board
- Somerset NHS Foundation Trust
- Somerset Council
- South Western Ambulance Service NHS Foundation Trust

The combined information in this plan and on our websites fulfils our duty to describe the current and planned health services to meet the needs of the people living in Somerset.

The NHS is also responsible for responding to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease such as Covid or a major transport accident. This is referred to as emergency preparedness, resilience and response (EPRR). The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded services, to show that they can deal with such incidents while maintaining services.

The ICB is known as a Category 1 responder which means we must:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans and business continuity management arrangements
- make information available to the public, including warning and informing in the event of an emergency
- co-operate with and share information with other local responders.

We coordinate the activities of all providers of NHS funded healthcare to plan for and respond to emergencies. The ICB has an Accountable Emergency Officer (AEO) for EPRR, who is responsible for discharging the ICBs responsibilities around EPRR and providing assurance to the board.

Duty to Promote Integration

Integration

For Somerset, integration and collaboration is a key priority. We want to support people to live independently in their own homes for longer and take a joined-up approach to improving outcomes across health, social care, and housing. In simple terms, it refers to the bringing together and joining up of services and support, processes, and ways of working which improve outcomes for local people and local services. Integration relates to several important interdependent domains:

- The person: Integrating care and support around what matters most to the person and their life situation and enabling people to engage with resources in their local community. We believe that integration and person-centred care are closely linked.
- Services: Integrating health and care services where this will improve outcomes for local people and make better use of local resources
- Systems: Integration of governance, commissioning, or provider functions where this brings about a more efficient and effective use of public money and better outcomes for local people.

The Somerset health and care community acknowledge that structural and process change needs to be accompanied by cultural change. This is fostered by ensuring we are always listening to the people we service and making sure they are at the heart of our strategic plans and service development. This is also achieved by enabling teams to work together, to form trusting, psychologically safe joint working arrangements in which different perspectives can be considered and shared. It involves enabling culture change using IT, training and support and most importantly through leading by example.

Better Care Fund

The Better Care Fund (BCF) within Somerset is a joined-up plan between health and social care. The work under the BCF is strengthened further within the county through our Joint Commissioning Steering Group with oversight by the Somerset Board. The plan contains some key areas of joint working including intermediate care services, carers services, community-based schemes, Disabled Facilities Grant related schemes and home care or domiciliary care.

Pharmacy, Ophthalmic and Dentistry Services

Since April 2023, NHS Somerset has been responsible for the commissioning of community pharmacy, optometry and dental services, in addition to its preexisting responsibility for the commissioning of services in general practice. Whilst this has created some short-term challenges, the benefits of having greater autonomy and strategic focus for the entirety of primary care services provides opportunities for a more cohesive approach to service transformation and clinical pathway development.

NHS Somerset is fully committed to the wider integration of the four areas of primary care service delivery, alongside community and secondary care teams. The benefits of this comprehensive approach are clearly articulated within the Fuller Stocktake Report (Dr Claire Fuller, May 2022), and further underpinned as a key part of an effective Integrated Care System in The Hewitt Review (Rt Hon Patricia Hewitt, April 2023).

NHS Somerset fosters a collaborative approach to primary healthcare service delivery, encouraging general practice, community pharmacy, optometry, and dentistry to work cooperatively to ensure that care is effectively delivered by the most appropriate healthcare professional. The development of

integrated care pathways ensure that patient care delivery is efficiently coordinated and sufficiently comprehensive to meet the needs of the individual. The successful delivery of this model of care is predicated on the seamless sharing of patient information between healthcare professionals, supported by a robust integrated digital information platform.

Throughout 2026/27, NHS Somerset will continue to build on this model of integrated primary care, supporting with the training and education of professionals across different sectors; supporting public awareness campaigns regarding access to, and the benefits of the new models of care; supporting quality improvement initiatives to ensure the continuation of high standards of care, and; supporting investment in areas of integration that provide the biggest benefit to communities across Somerset.

Example: NHS Pharmacy First

Following the launch of the NHS Pharmacy First Advanced Service on 31 January 2024, general practice is now able to refer eligible patients to participating community pharmacies for advice and treatment of seven minor healthcare conditions (acute otitis media, impetigo, infected insect bites, shingles, sinusitis, sore throat and uncomplicated urinary tract infections). NHS Somerset has ensured that these referrals are sent via an integrated digital platform, which securely transfers care from general practice to the community pharmacy of the patient's choosing. Following a consultation with the pharmacist, a record of the consultation (including any medications supplied by the pharmacist) is electronically returned to the general practice for inclusion of the patient's GP record. This integrated care pathway helps to ensure that patients experiencing one of the seven common conditions can conveniently access safe, high-quality healthcare services delivered by a highly trained healthcare professional, whilst simultaneously reducing the demand for appointments in general practice for patients who are in greatest need. By November 2024, Community Pharmacies across Somerset had supported 15,000 patients to access an urgent care consultation for one of the seven minor health conditions via this service.

Duty to Have Regard to Wider Effect of Decisions

In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the triple aim of: (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.

In making decisions about the provision of healthcare, the ICB is guided by the 'triple aim'. Our Joint Forward Plan describes the priorities that have been identified to support the delivery of our strategic aims, which are aligned to the aims of Somerset NHS Foundation Trust, and Somerset's Health and Wellbeing Board 'Improving Lives Strategy', ensuring that as a health and care system we have a common set of aims and objectives that explicitly reflect this 'triple aim'.

Decision-making and oversight are underpinned by our Constitution and Governance Handbook, which are adapted to reflect evolving national guidance and local accountability requirements.

Financial Duties

Living Within Our Means

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 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. Work had been undertaken to assess the causes of the deficit in Somerset, with a recent refresh in 2023 confirming that the following factors remained key:

- True structural costs, predominantly the unavoidable inefficient cost of sub-scale services which are necessary to ensure appropriate provision and access across the geography of Somerset and Private Finance Initiative costs at SFT.
- Challenges in recruitment and retention has led to premium-rate workforce costs to cover gaps in substantive.
- Workforce availability to support sustainable primary care services.
- Inefficiencies created by the existence of sub-scale and duplicate services which are not attributable to geographical necessity and could therefore be eliminated through redesign.
- Historic non-delivery of recurrent efficiency savings and reliance on non-recurrent solutions to achieve in year balance.
- The productivity and cost impacts of underutilised and expensive estate.
- In some areas corporate services costs which benchmark highly compared with other systems and organisations.
- Resources not being used to achieve best value as a consequence of historic investment and/or underinvestment decisions.

In 2023/2024, the NHS returned to a national financial framework which reintroduced a funding allocation based on fair shares for each system and a trajectory for return to this value from the system position.

The national and regional expectation for Somerset, as for all systems, is to plan for and deliver aligned financial, workforce and service sustainability in the medium to long term, implementing such changes as are necessary to ensure this is achieved through wise and affordable use of resources.

NHS Somerset will deliver all its financial duties in 2025/26. The system has an assessed exit underlying financial deficit at 2025/26 in the region of £67m, which is £24m worse than at plan largely due to less recurrent cost improvement plan being delivered.

This analysis of drivers and value of the Somerset deficit provides useful context and baseline information for future planning but does not generate solutions. Factors driving the deficit are not necessarily the same as solutions to achieve balance and improve value for money, although there will be significant overlap.

What we are seeking to achieve for our population:

Our strategic financial aim as set out in the overall system strategy from 2022 is:

'To live within our means and use our resources wisely to create a sustainable system'.

This strategy sets twin objectives at both organisational and system level of affordability and value for money, which align well with both the overall Somerset system strategy and with regulatory and statutory expectations at that point in time:

- Understanding and managing the interdependent and iterative relationship between the financial strategy, the emerging clinical and care model for Somerset and other enabling strategies is key to delivering a coherent and cohesive plan. The financial strategy and plan are shaped by

the vision for services and the constraints and opportunities of workforce, infrastructure, and community assets. Financial constraints and opportunities inform and affect choices on delivery of the service vision.

- Under the new financial framework, regulatory and statutory expectations for both the system as a whole and individual partners are focussed on managing within the nationally determined allocation for our population and maximising the productive use of our resources, obtaining best value for every pound spent and optimising our use of workforce, infrastructure, and community assets.

In both contexts, expectations and detail are still emerging but we have sufficient information already to plan and make early decisions and progress, confident that we are pursuing the right direction.

Living Within Our Means

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.

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 CUF uplift, 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, GIRFT) to identify unwarranted variation and prioritise high impact interventions.

NHS Somerset ICB and Somerset NHS Foundation Trust submitted draft plans on the 17th December 2025. The system overview of the two-year financial plan for 2026/28 for the draft submission is shown in the table below:

Draft Submission Financial Position	2026-27 £'m	2027-28 £'m
NHS Somerset ICB	+5.0	0.0
Somerset NHS FT*	+16.2	+14.6
NHS Somerset	**+21.2**	**+14.6**

In 2026/27, both NHS Somerset ICB and Somerset NHS FT submitted a deficit plan position with a combined forecasted financial gap of £21.2m.

In 2027/28 NHS Somerset ICB is submitting a balanced financial plan position, with Somerset NHS FT submitting a deficit plan of £14.6m.

The system are working through the following steps to close the deficits for final submission on 12th February 2026 and extend the medium-term financial plan to 2028/29:

- Jointly refresh deconstructing the block assessment with Somerset FT for 2025/26 based on actual activity and confirm value of adjustment to Acute element of contract value for 2026-29
- Continue to work with Out of County NHS Acute providers to finalise contract values for 2026-29
- Review 2028/29 revenue allocations and growth expectations once released to extend financial plan to three-year model
- Overlaying impact of Strategic Commissioning Intentions across all financial years

Our ambition is to return both organisations to recurrent financial balance by the time we exit the 2028/29 financial year.