our SOMERSET
Together we care

Somerset **Five year Joint Forward Plan** refresh

2025 - 2030

PART OF THE INTEGRATED INTEGRATED HEALTH AND CARE STRATEGY FOR SOMERSET

Contents

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Foreword

Partners across Our Somerset – our Integrated Care System – have made significant progress in the way they work together to improve health and care services in our wonderful county. In Somerset, we want everyone who lives and works here to have healthy and fulfilling lives. We believe that by working together to harness our collective resources and expertise, we can provide earlier support to keep people well and deliver excellent, joined-up health and care services when they are injured or mentally or physically unwell.

The success stories included in the Our Achievements section of this plan stand as testimony to what can be achieved when we work together to break down organisational boundaries and focus on delivering responsive services that meet the needs of local people.

We know there remain significant challenges to overcome. We need to improve access to GP services and dentistry, continue to reduce waiting times for planned treatments and improve ambulance response times, 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 emerging 10-Year Health Plan:

- **Moving more care from hospitals to communities**
- **Making better use of technology**
- **Preventing sickness, not just treating it.**

None of our achievements, nor our aspirations for the future, would be possible without the dedication, talent and compassion of the inspirational people who work in our local health and care services – from across the statutory and the voluntary, community, faith and social enterprise (VCFSE) sectors – and I would like to thank them wholeheartedly for everything they do.

This updated Joint Forward Plan, covering 2025 to 2030, sets 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 March 2025, the Government has announced the abolition of NHS England and the requirement for integrated care boards to reduce their size by 50%. The impact of these changes is being assessed and will be reflected in future iterations of this plan.

Paul Von der Heyde

Chair: NHS Somerset
Deputy Chair: Somerset Board

Introduction

This is the third Joint Forward Plan published by Somerset Integrated Care Board (ICB) and is written in collaboration with partners in recognition of both our shared legal responsibilities and our desire to come together to create a delivery plan which delivers the entirety of our Integrated Care Strategy. For this reason, in Somerset, we have agreed to incorporate our local authority adult and children's social care partners.

It describes the priorities for the NHS in Somerset and articulates the steps that we will take over the next five years to deliver the actions required to achieve our vision for Somerset.

Due to the current national work taking place to establish a ten-year NHS Plan during 2025, and that the previous refresh of the Joint Forward Plan was published in the summer of 2024, this iteration is a more limited refresh. The focus is on the system's priority programmes, progress made in establishing these, and plans for further progress in the next year.

This JFP Refresh document should be read in conjunction with the context and drivers-for-change set out in the Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28) and the original Somerset Five Year Joint Forward Plan 2023 to 2028.

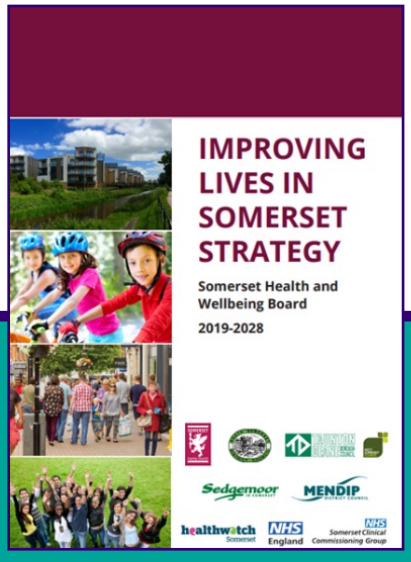
Improving Lives (2019 to 2028) Health and Wellbeing Strategy

Improving Lives is the Somerset Health and Wellbeing strategy. The strategy is owned by the Somerset Board and sets out how we will work to deliver improvements for our population. We take the Somerset Joint Strategic Needs Assessment (JSNA) into account when defining strategy and delivery of that strategy through our JFP.

The Improving Lives strategy has four strategic priorities. Our Integrated Care Strategy and Joint Forward Plan seek to deliver priority four of our county's strategic priorities.

4 Priorities

- A county infrastructure that drives productivity, supports economic prosperity and sustainable public services
- Safe, vibrant and well-balanced communities
- Fairer life chances and opportunity for all
- **Improved health and wellbeing and people living healthy and independent lives for longer.**



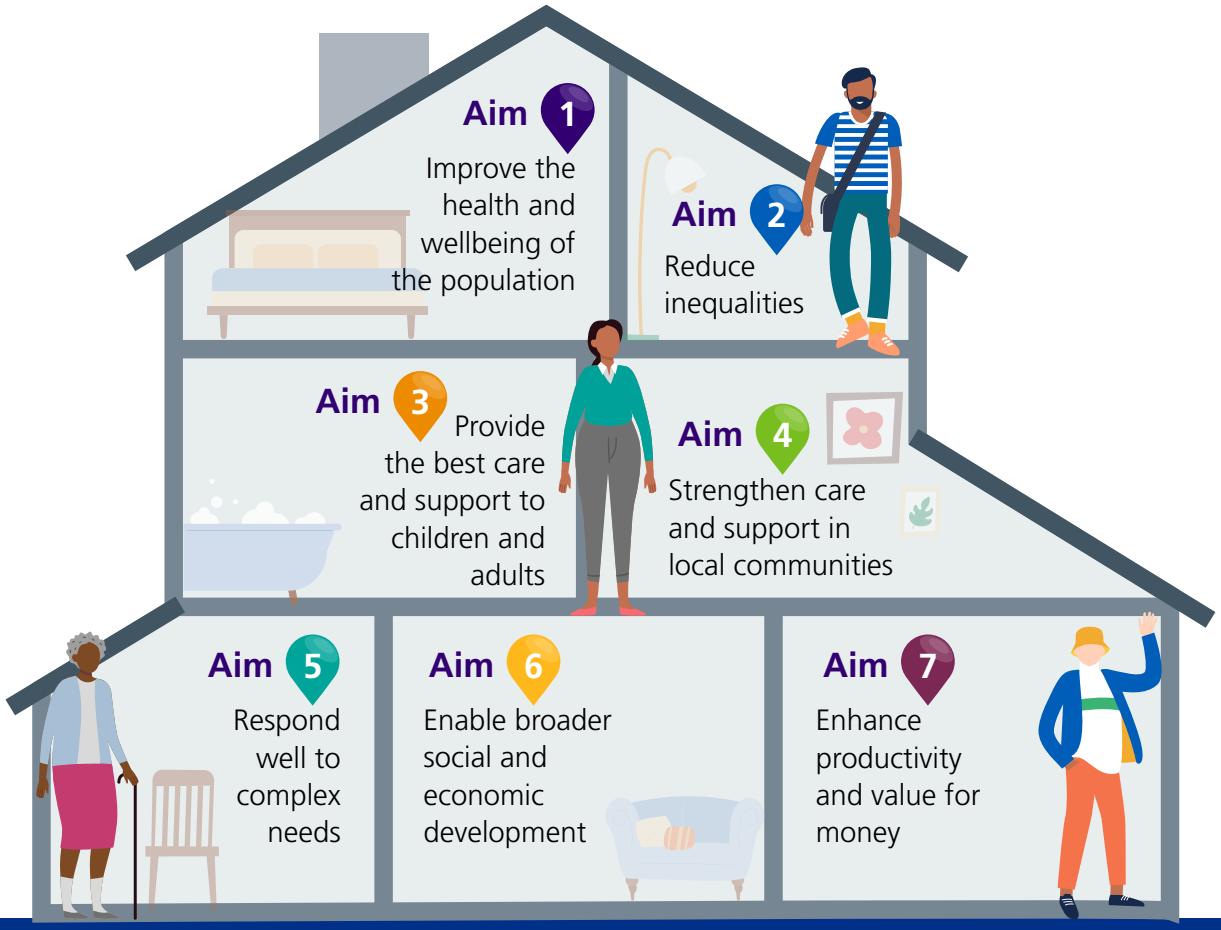
In Somerset, we have one Health and Wellbeing Board, which operates as a 'committee in common' with the Somerset Integrated Care Partnership (ICP), collectively known as the 'Somerset Board'.

As an Integrated Care System (ICS) we have set out how we will achieve our vision through our initial Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28).

Our vision for the Somerset health and care system is as follows:

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.



The Future of Healthcare: Preparing for the workforce of tomorrow

During the last year, over 200 NHS and Social Care staff across the Somerset system have supported our (2035) scenario planning work which is helping us consider the kind of workforce we will need to meet our vision, set out above. This work has provided important context for this plan including the development of four workforce principles we will work to:

- Community and people focused
- Innovation
- Valuing our workforce
- Collaboration

Year-on-year, our creative scenario planning approach will continue to help us test and assure this plan, ensuring we develop the skills and capabilities for Somerset's workforce of tomorrow.

How we have considered the views of people in Somerset

Public involvement is an essential part of making sure that effective and efficient health and care services are delivered with people and communities at the centre. By reaching, listening to, involving and empowering our people and communities, we can ensure that people and communities are at the heart of decision-making and that we are putting our population's needs at the heart of all we do.

Engagement work for previous versions of this strategy was done with the support of voluntary organisations, including Healthwatch, Spark Somerset, and health and care professionals. We are grateful for all the support. More recently, engagement work to inform our strategy and plans has been expanded in scope and scale – see below.

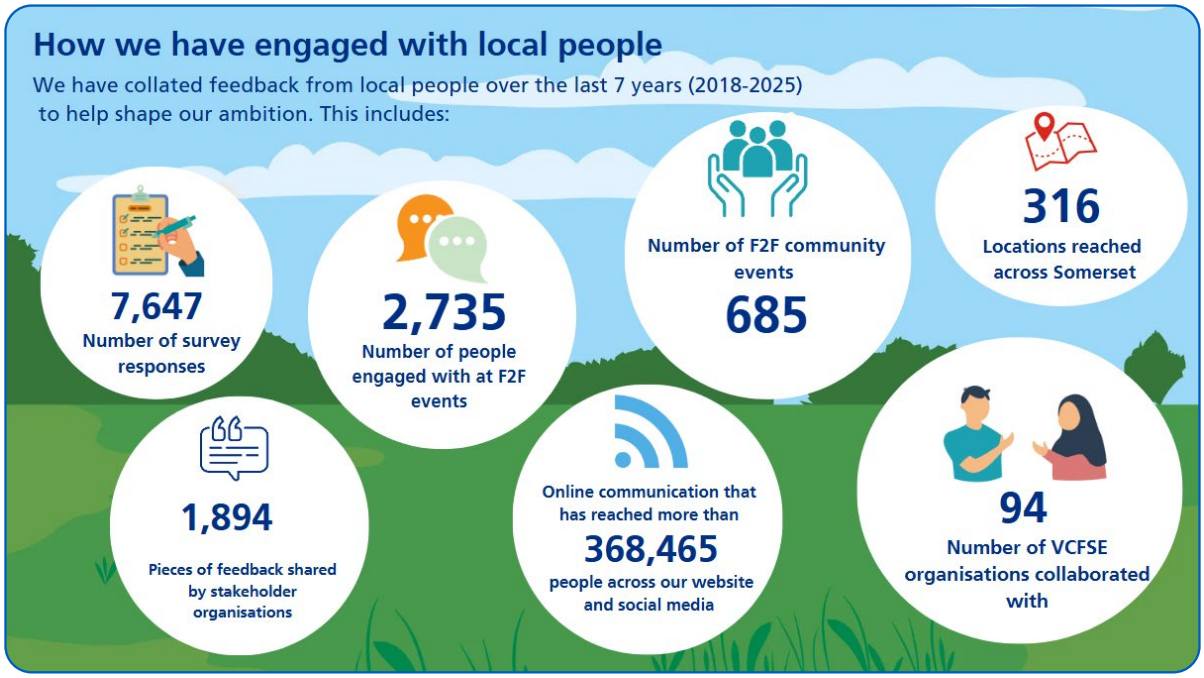
From May to October 2024, our Somerset's Big Conversation road-show engaged with people across Somerset.

Through Somerset's Big Conversation, which included marginalised groups, displaced people and refugees, we have gained a deeper understanding of the barriers to accessing healthcare, social services and community resources.

NHS Somerset's engagement team, working alongside other Our Somerset partners, held conversations with communities to discuss our strategy for health and care, posing broad questions to understand what matters most to them. We also used the events to take our public campaigns on the road, including our Take The Pressure Off hypertension initiative.

An online survey was developed and promoted, and an independent research specialist was commissioned to undertake analysis of insights gathered. These insights have also informed the development of this plan.

In total, we attended 26 community events, had 2021 conversations, carried out 982 blood pressure tests and 269 surveys were completed.



Change NHS – engaging communities on the 10-Year Health Plan

From November 2024 to February 2025, NHS Somerset led a major public and staff engagement project designed make sure the views of people in Somerset inform the Government's new 10 Year Health Plan.

The initiative, the biggest conversation about the future of the NHS since its creation, was part of the Government's Change NHS programme, in partnership with the Department of Health and Social Care and NHS England (NHSE).

The focus for the programme was the three key shifts that are expected to underpin the plan:

Moving more care from hospitals to communities

Making better use of technology

Preventing sickness, not just treating it.

Locally, the shifts align with the Our Somerset strategy and engagement work, run in partnership with Healthwatch Somerset, Somerset NHS Foundation Trust, Spark Somerset and other VCFSE partners. Project work included:

- **Raising awareness of the national and local online survey**
- **Social media and website updates**
- **Promoting the programme through established communications and engagement networks**
- **Holding workshops and engagement sessions in person and online with a wide range of people including Our Somerset leaders, local people at public libraries across Somerset and Talking Cafés run by Village Agents.**
- **Delivering engagement sessions with NHS Somerset teams**
- **Running drop-in 'Lunch and Learn' engagement sessions**
- **Providing communications resources to enable our colleagues to raise awareness of the national and Somerset engagement opportunities and our online survey**

Working with other health systems in the Southwest to share the responsibility of engaging with a diverse range of groups experiencing health inequalities, Somerset agreed to carry out focussed engagement with the following groups: armed forces, rural communities, children and young people and our VCFSE sector. This involved working closely with the relevant colleagues from across health and social care, as well as VCFSE sector partners to attend a range of events and venues, such as Veterans' Breakfasts, Rural Health Hubs, Markets, Community Support Groups and the Youth Parliament.

All feedback has been submitted to the national campaign, will be used as part of a Southwest regional analysis and in Somerset to help develop our strategy for local services.

Our achievements over the last 12 months

We have reviewed everything we said we would do in our previous Joint Forward Plan up to March 2025 (see Appendix 1). This section highlights some of the key achievements in Somerset over the last 12 months.

Our achievements over the last 12 months

Successful 'Take the Pressure Off' hypertension campaign

Throughout 2024, Our Somerset partners worked collaboratively on the successful 'Take the Pressure Off' campaign - an initiative dedicated to raising awareness of the importance of regular blood pressure monitoring.

Around 3 in 10 adults in Somerset have high blood pressure but it is thought 1 in 10 do not know it.

The campaign ran across workplaces, public spaces and events throughout Somerset. Just over 3,000 tests were carried out, resulting in more than 1,000 people discovering they had high readings and should seek medical assistance, while a further 1,000 people were made aware that they were at increased risk of hypertension.

The campaign supported wider messaging on the importance of a healthy lifestyle, with information provided on ways to easily and affordably improve lifestyle and fitness.

In a Somerset-based online survey about hypertension, run by NHS Somerset's engagement team:

- **44% understood the terminology of 'Hypertension' and/or 'High Blood Pressure' (with the majority recognising that high blood pressure causes health conditions and particularly raises the risk of heart attack and stroke).**
- **43% of people with high blood pressure began taking prescribed medication, with 19% making lifestyle changes and 19% searching more information and support**

Survey results show that the most common factors in causing hypertension were: smoking, diet (food choices, salt intake and alcohol), weight, exercise, stress and sleep.

The successful campaign is continuing throughout 2025. Working across Our Somerset, partners will deliver 'Take the Pressure Off' to more workplaces and a range of events while access to monitors will continue to be made available in public spaces.

In the pictures: Partners joined a nationwide effort to raise awareness of high blood pressure during 'Know Your Numbers Week' with a 24-hour blood pressure Test-A-Thon in September

Our achievements over the last 12 months

Supporting our Armed Forces community in Somerset

Around 50,334 people living in Somerset (9% of our population) make up our armed forces community including veterans, serving personnel and their families.

In May 2023, we signed the Armed Forces Covenant, recognising the value and service of the whole armed forces community and we undertook a consultation and engagement process to hear the views of our Armed Forces community and to better understand how we might be able to support them.

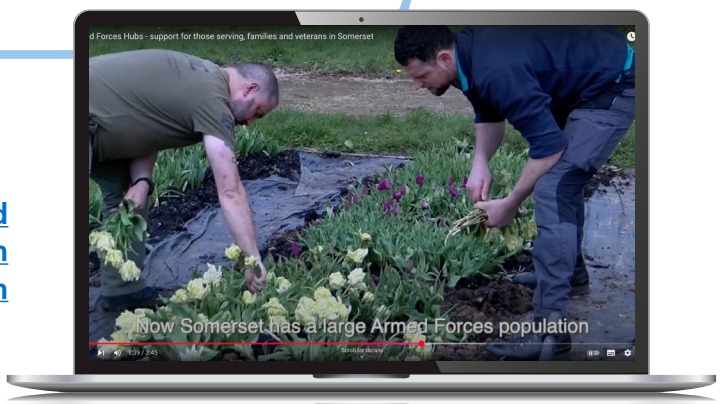
As part of the support we offer, we have two armed forces hubs, (in partnership with Ark at Egwood and Arc) based in Taunton and South Somerset. These hubs are open to all members of the Armed Forces community. They provide advice and support tailored to what the individual needs, covering anything from homelessness, support with mental health, help with accessing funding through military charities or with managing chronic pain.

Last year, we opened armed forces outreach services in Bridgwater and Yeovil where veterans, serving personnel and their families can have a brew and banter and meet Somerset NHS Armed Forces Link Workers, as well as representatives from many other agencies. We have since expanded our Armed Forces outreach service to include Wells and Highbridge and are due to further expand into Minehead and Chard soon. We also have the weekly breakfast club at Ark at Egwood, which regularly attracts about 30 veterans and their partners.

All GP practices in Somerset are now Royal College of GPs Veteran Accredited and we offer specialist training to all our GPs to help them better support our armed forces community.

"I've recently moved to Somerset and was happy to see 'are you a veteran or reservist' on the GP registration form. I don't know if it's luck or because I'm a veteran but I've been seen quickly by the neurologist for my MS and orthopaedics for my knee. Good work Somerset!"

Stace, Veteran.



See our armed forces hubs in action

Our achievements over the last 12 months

Support with the cost of living

Somerset Council has implemented several initiatives to support communities during the cost-of-living crisis. These include:

- **Household Support Fund:** Using monies from the Government's Household Support Fund, Somerset Council is supporting households struggling with essential needs in Somerset. The Household Support Fund provides short-term, urgent financial help to Somerset residents who cannot afford household essentials. Things like food and paying for prepayment meter energy bills: Apply for the Somerset Household Support Fund.
- **#Help4All:** Through Connect Somerset, this initiative puts key local voluntary, community and public services in one place to offer support for residents who are impacted by the increased cost of living: #Help4All.
- **Warm Welcome Spaces:** Many community groups in Somerset opened their space as a warm hub to help vulnerable people during the winter months. All Somerset libraries have also been designated as 'Warm Welcomes', where anyone in the community can spend time without needing to be a member. Every space will have something different to offer - whether it's free food, activities, support with wellbeing, or somewhere to access a computer. Find a Warm Welcome here: sparksomerset.org.uk/find-warm-welcome
- **The Somerset Local Pantry network:** The Somerset Local Food Pantry network pulls together local community-run projects that buy or collect surplus food to prevent it going to waste which is then available to Somerset residents for a small membership fee: The Local Pantry Network in Somerset.

The measures aim to provide immediate relief and long-term support to residents facing financial challenges due to the rising cost of living.

Our achievements over the last 12 months

Sloppy Slippers campaign to reduce trips and falls in Somerset

Falling at home is a common and serious issue, especially for older people and those with disabilities, who can end up in hospital after a fall. Falls are often due to lose, worn, or backless slippers, contributing to poor balance and gait.

Data shows that every year around 24,000 over-65s in the UK suffer a fall due to 'sloppy' slippers – with many ending up in hospital.

In a move to improve the safety and well-being of vulnerable adults in Somerset (which has one of the oldest populations in the country), NHS Somerset, in partnership with **Somerset Activity and Sports Partnership (SASP)**, launched our **"Sloppy Slippers"** campaign which ran from autumn 2023 to spring 2024 and involved:

- providing nearly 2,000 pairs of free, well-fitting, and supportive slippers to eligible adults
- providing nearly 5,000 advice leaflets
- holding 11 roadshows across Somerset, organised by SASP, where people could not only receive their free pair of slippers but also received information and support around falls prevention from a range of partners
- running an awareness campaign in the media, across social media, on buses and in newspapers
- offering strength and balance classes through SASP

North Petherton resident, Sylvia Selway, shared her experience:

"I've had a couple falls this year, which greatly affected my confidence. Since receiving these sturdy, comfortable slippers from the Sloppy Slippers campaign, together with attending strength and balance classes, I feel a renewed sense of safety and confidence in my daily life. It's a small change that's made a big difference."

Our achievements over the last 12 months

New Dads' Supporters programme

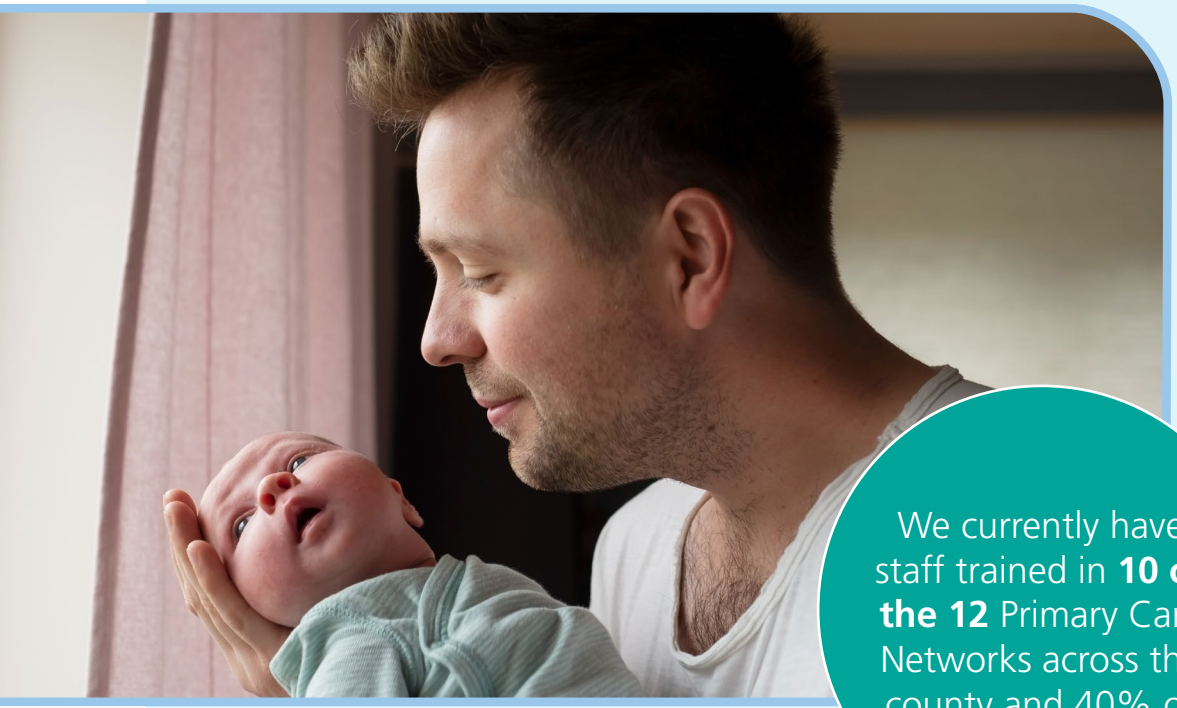
In Somerset, we believe that all men should be able to access the support and advice they need to be great Dads. Men across the UK have told us that services available during the periods before and immediately after birth do not regularly, significantly or substantially involve fathers, leaving many to feel ignored.

We want to change this and so have developed a "New Dads' Supporters programme".

We are training up staff in GP practices across the county to give men the opportunity to talk one on one about how they feel about being a new Dad; to ask whether they want any additional help and to share some really good parenting resources. If needed, we can help men access other services.

We currently have staff trained in 10 of the 12 Primary Care Networks across the county and 40% of GP practices, and we will continue to offer training to the rest.

Somerset is unique in offering this programme across the country and any man who feels they would find this helpful can ask their GP practice. Professionals working with families may also signpost men to the programme if they feel it might be of benefit.



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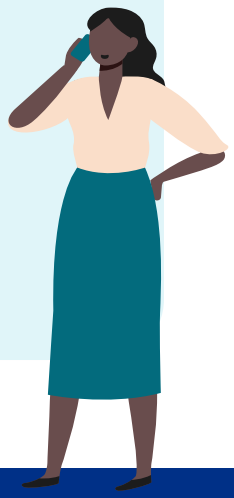


Our achievements over the last 12 months

Pharmacy First – 8,000 GP appointments freed up in first year

Since its launch on 31 January 2024, 95% of community pharmacies in Somerset are now taking part in the Pharmacy First programme, providing local people with a convenient alternative to GP appointments for seven minor conditions.

Over the past year, the initiative has freed up thousands of GP appointments in Somerset (over 8,000 in the first six months), providing local people with quick access to expert advice and treatment and allowing general practice teams to focus on more complex cases.

The service covers conditions such as sinusitis, sore throat, earache, infected insect bites, impetigo, shingles, and urinary tract infections (UTIs). Community pharmacists are experts in medicines and minor illness management, providing clinical advice and NHS medicines, including some antibiotics when necessary. They can offer consultations in a private room.

All participating pharmacies can be found here.

The Big Brush Club: Improving children's dental health in Somerset

Sadly, tooth decay is the leading cause of hospital admissions for young children, despite being largely preventable. To tackle this, NHS Somerset has funded the Big Brush Club for the last two years.

This supervised toothbrushing programme targets three- to five-year-olds in nurseries, preschools, and reception classes, encouraging them to brush their teeth with fluoride toothpaste daily at school and maintain the habit at home.

Delivered by At Home Dental, the Big Brush Club trains early years teachers and staff across Somerset to become Oral Healthcare Champions. These champions run daily five-minute fun sessions each day with their classes to instil good oral hygiene habits. Each participating school and early years setting is provided with toothbrushes and toothpaste, and supplies for use at home.

Parents and guardians are an essential part of this initiative and are provided with access to webinars and online advice on maintaining good oral health at home, helping to reinforce the lessons their child has learned through the supervised toothbrushing sessions.

The programme initially focused on areas of high deprivation, but due to its success and popularity, it has expanded to additional areas in the county. As of December 2024, 6,500 children across 156 nurseries and schools are being supported. By introducing positive oral health habits early, NHS Somerset aims to reduce health inequalities and improve the long-term dental health of children in the region.

Our achievements over the last 12 months

We Need to Talk About Death

Last year, NHS Somerset's LeDeR team commissioned a powerful film made with actors with learning disabilities to talk about death and dying, after we found that people with learning disabilities are often excluded from conversations around this important topic. The film was rolled out at a series of community workshops around Somerset, online, through national health and care organisations and in the media.

It aims to help remove the taboos that often arise around talking about death and dying and open up conversations with carers, family and friends.

LeDeR – Learning from the Lives and Deaths of People with Learning Disabilities and Autistic People – is a national programme that aims to improve access to health care, reduce health inequalities and reduce premature mortality for autistic people and people with learning disabilities.

In Somerset, the team noticed that often people with learning disabilities and autistic people were protected from conversations about death and dying. Often done with the best of intentions, this overprotection often meant that it was difficult for people to talk about what was important to them in terms of death, dying and bereavement. We wanted to work with a group of people with learning disabilities to identify what was important to them and encourage others to start a conversation. The film is a powerful resource for everyone, not just people with learning disabilities, to encourage them to engage with what can be a difficult subject – to watch it, click here.

Somerset also has a practitioner in the End-of-Life Care Education with a specific focus on supporting people with a learning disability. The post holder and team have carried out a range of initiatives to promote access to Treatment Escalation Plans and Advance Care Plans in this patient group.

The cast of the film during filming and on stage at a screening.

Our achievements over the last 12 months

‘Lifesaving’ Bleeding after Menopause Service marks first anniversary

The Bleeding after Menopause Service, that enables people to self-refer themselves for a vital womb cancer diagnostic test, rather than being referred by a GP, celebrated its first anniversary.

Patients can also be seen across Somerset, with appointments at community hospitals in Bridgwater, Minehead, South Petherton, Wellington, West Mendip (Glastonbury) and Wincanton.

In the first 12 months of running the service, 378 patients referred themselves, met the criteria for the service and were contacted by Somerset NHS Foundation Trust (SFT), which provides the service, within 24 hours for an appointment. The new service has resulted in 19 patients being diagnosed with cancer at an earlier point in time, helping to ensure there are more treatment options available to them.

Before the service was introduced, patients had to wait around 63 days to be seen by a hospital specialist, and then faced a possible wait of up to 48 days for a cancer diagnosis. Thanks to the new service, the wait to see a specialist has reduced to just five days, and most patients are getting a positive cancer diagnosis within 14 days of the referral or an all clear within nine days of the referral.

Mr David Milliken (pictured), a consultant gynaecological oncologist at SFT, said: “Our aim is to avoid any unnecessary delays and ensure patients have an appointment much sooner. It also has the added bonus of freeing up our GP colleagues to see patients with other conditions.”

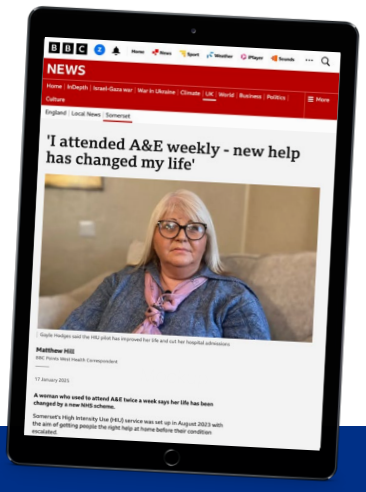
The service has attracted widespread media coverage and has been hailed as ‘lifesaving’ by patients.

Service results in huge fall in frequent users of Somerset’s A&Es

People who regularly attend Somerset’s emergency departments are getting additional help to find services that can better meet their needs. This is thanks to Somerset NHS Foundation Trust’s high intensity use (HIU) service, which was set up in August 2023 to monitor and provide support to those patients who frequently use the Accident and Emergency (A&E) department, helping to identify the unmet need and get people the right care in the right place.

The service has proven successful in its first year, with the number of attendances by this cohort of patients dropping by 58% in the first nine months. Since it launched, the service has supported a total of 141 people, who previously had 1,963 A&E attendances between them.

Following the HIU service’s involvement, their attendances fell to 1,189 – a reduction of 48% across all ages. The national standard (NHS Right Care) suggests aiming to make a 20 to 40% reduction, and the service in Somerset is comfortably achieving that in just its first year. The success of the service has been profiled in local and national media, with one user saying it had changed her life.



Our achievements over the last 12 months

Marking half a million patient tests through community diagnostic centres

Somerset's community diagnostic centres marked a major milestone in January 2025 when the 500,000th patient received a diagnostic test at one of the centres.

The national community diagnostic centre programme began in August 2021 with the aim of reforming diagnostic pathways, offering patients a wide range of diagnostic tests closer to home, and a greater choice on where and how they are undertaken, reducing the need for hospital visits, and often leading to faster access to treatment.

Somerset's community diagnostic centre programme offers 21 different diagnostic tests across a number of sites throughout the county and is run in a collaboration between Somerset NHS Foundation Trust (SFT), GP practices, and organisations from the independent sector.

The programme has created flagship diagnostic centres, including the Taunton Diagnostic Centre, which opened in September 2021, and was the first independent sector partnership of its kind in the UK.

The programme has also developed and launched specialist ophthalmology diagnostic facilities, which are the blueprint for how these types of centres would be provided across England.

An innovative partnership with Somerset's GP practices has been developed to provide a range of tests in the county's community diagnostic centres, which shows Our Somerset's commitment to investing in all partners within the health system, as well as using the experience, clinical skills and local knowledge they bring.

SFT is planning to open the largest community diagnostic centre, in Yeovil, in March 2025, which will further expand diagnostic capacity in the east of Somerset and will provide the facilities to develop new ways of diagnosing and caring for patients.

Community Diagnostic Centre staff celebrate the milestone

Our achievements over the last 12 months

New maternity and neonatal independent senior advocate pilot launched

In June 2024 we announced that Somerset was one of the areas piloting a new role developed by NHS England to support women, birthing people and their families as a result of feedback from those involved in maternity and neonatal investigations. The Maternity and Neonatal Independent Senior Advocate helps to ensure that the voices of those involved are listened to, heard, and acted upon by their maternity and neonatal care providers when they have experienced an adverse outcome any time during their maternity and/or neonatal care.

An adverse outcome is a serious incident or an outcome that has required or may require further formal investigation such as:

- A baby has died before they were born, after 24 weeks of pregnancy
- A baby has died in the days or weeks after they were born, up to 28 days
- The mother or birthing person has died
- The mother or birthing person had an unexpected or unplanned removal of their womb (within 6 weeks of giving birth)
- The mother or birthing person had an unexpected time of care in the critical or intensive care unit
- The baby was diagnosed with a brain injury, or a brain injury was suspected.

Advocates are independent from NHS Trusts, employed by integrated care boards to ensure impartiality. Since the pilot launched our advocate in Somerset has undertaken specialist training and been developing relationships with care providers to embed the role and support families navigating some of the complex investigation processes which follow an adverse outcome.

Somerset's Maternity and Neonatal Independent Senior Advocate, Jane Innes

Our achievements over the last 12 months

NHS Type 2 Pathway to Remission Programme

In June 2024, NHS Somerset launched a campaign to raise awareness of Type 2 diabetes, helping patients to understand the support they can gain from the free NHS Type 2 Pathway to Remission Programme. Somerset is one of 42 areas in the country offering this free programme which offers people aged 18-65, who have been diagnosed in the last six years, the opportunity to enrol in a 12-month digital or face-to-face behaviour change programme.

There are already over 30,000 people living with diabetes in Somerset, 90% of whom have Type 2 diabetes.

Those at risk may have no obvious signs that they have the condition, but public health experts have estimated there could be as many as 10,000 people in Somerset who are undiagnosed. Each year, between 2,000 and 2,500 people are diagnosed.

If people take no action to reduce their risk of developing Type 2 Diabetes it is estimated that by 2030 around 53,000 people in Somerset could have the disease.

This programme provides tailored and personalised help including:

- Three months of low calories soups and shakes to support initial weight reduction
- Education on lifestyle choices and healthy habits
- Advice on how to sustain weight loss through healthier eating.

Currently there are 118 people active on the programme and a further 184 people have already completed it.

Our achievements over the last 12 months

Helping our homeless communities access the healthcare they need

Life on the streets is tough. People in temporary accommodation, or sleeping rough, face huge barriers to accessing healthcare and often live in unhealthy conditions. This means many only live until their mid-40s, around 30 years less than the general population.

Our award-winning Somerset Homeless Nursing Service started in 2021. It has already helped around 2,000 people who are, or have been, homeless or living in temporary accommodation to access their health needs.

Somerset NHS Foundation Trust's Clinical Lead for the Homeless and Rough Sleeper Nursing Service, Karen George, said: "The team works with people who are marginalised in society and who have complex needs that are not just medical. The team consistently manages many challenges when working together with other services who are required to work within specific boundaries. Some of the normal ways of working that partner agencies have to follow are not always compatible with the lifestyle and needs of the homeless and rough sleeper community, so the flexible and determined approach of the Homeless and Rough Sleeper Team has been instrumental in providing vital support this community.

The service offers all aspects of nursing care from complex wound care, to blood samples and assessments. Having a holistic, patient centred approach to care and working alongside multiple agencies to help this marginalised group in our society access medical care.

Somerset Council continues to see unprecedented demand for Housing, Homelessness and Rough Sleeper services, with over 12,000 people on the housing register, a 16% increase in homeless applications and nearly a 25% increase of households living in temporary accommodation.

In response to the Everyone In campaign (2021), partners across Somerset formed the Somerset Homelessness Reduction Board (HRB). The Board work closely together to prevent homelessness and rough sleeping across Somerset and to provide a better future for people who have experienced homelessness or rough sleeping.
The impact of homelessness on people's health and life chances is huge, many face barriers in accessing services.

In March 2020, the government took the unprecedented step of asking councils to move all those, and those at risk of, sleeping rough into accommodation in a scheme known as 'Everyone In'.

A Somerset Homeless and Rough Sleeper Strategy was commissioned by the HRB to look at system changes and longer term solutions to tackle homelessness and rough sleeping.

Our achievements over the last 12 months

Supporting those with dementia and their families

SOMERSET DEMENTIA
Wellbeing Service

In Somerset, the number of over-65s being diagnosed with dementia is growing faster than the national average. As of November 2024, NHS England estimate that just over 10,000 people in Somerset have dementia.

We know what a stressful time it is for people and their families when they receive a dementia diagnosis but there is lots of support available to help people with dementia to live well. We want to ensure that when people receive a diagnosis in Somerset, they will be able to access the right support, quickly and easily.

Since 2023, we have been working with people living with dementia and their carers, the voluntary sector including Alzheimer's UK, Somerset NHS Foundation Trust and Somerset Council to help those living with dementia and their carers receive the help they need.

This includes:

- Having access to a Dementia Support Worker for everyone in Somerset with a diagnosis (provided by the Alzheimer's Society and funded by NHS Somerset). This helps ensure everyone diagnosed with dementia can be connected with support in the community and guided through their next steps.
- A Dementia Connect phoneline, 01458 251541, to connect people directly with the Dementia Support Workers team who can offer information and practical guidance to help people understand the condition, cope with day-to-day challenges and prepare for the future
- A Somerset Dementia Wellbeing Service website to connect people with local dementia services and resources.

Mental Capacity Act (MCA) liaison role

Learning identified via the LeDeR process (Learning from Lives and Deaths of People with Learning Disabilities and Autistic People) has shown that this group can experience delays in accessing health care or have poorer experiences of the care they do receive.

One of the reasons for this can be poor understanding and application of the Mental Capacity Act by professionals. In Somerset, we have appointed a Learning Disability nurse to work across our two acute hospital sites in Taunton and Yeovil to support professionals to access diagnostic pathways in a timely way.

This role is relatively new but, to date, has enabled a number of people with learning disabilities to access diagnostics on the colorectal pathway in a timely manner. We are currently piloting expanding this role to other care pathways.

Priority Programmes

The early years of our Joint Forward Plan were intended to prioritise transformational change with the aim to deliver short-term savings to address the challenging financial position. Within 2024/25 we have delivered the initial stages of this transformational change. The underlying financial deficit now stands at about £70 million, and plans have been developed to address this.

Priority Programmes

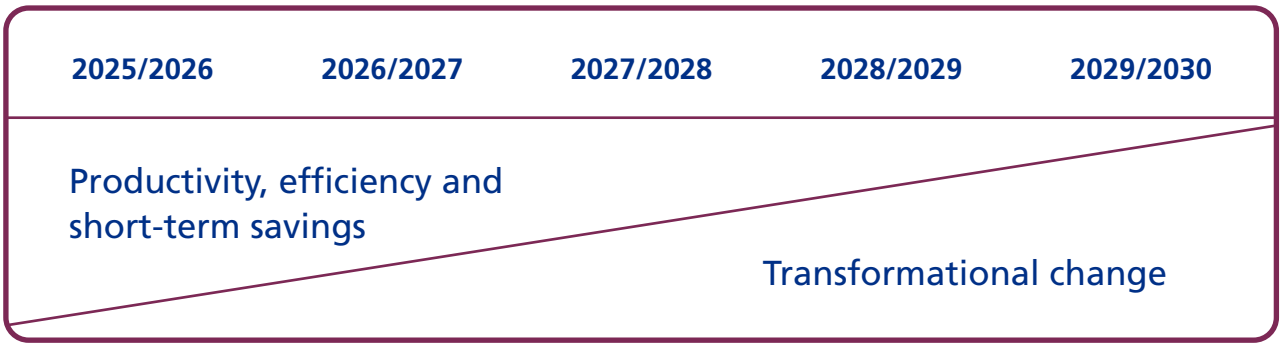
Our financial settlement for 2025/26 remains challenging, and as a system we will need to continue making savings. However, we need to see these pressures in context; headcount remains higher than before the pandemic, this coupled with the national focus on delivering more efficiency for the taxpayer, means that we need to make tough decisions to safeguard our future.

Somerset are also committed to modernising our services to deliver health and care needs in a way that meets the needs of our changing population. This will require us to adapt and align with the forthcoming NHS 10 Year Health Plan and the three 'shifts' underpinning it:

1. **Moving care from hospitals to communities**
2. **Making better use of technology**
3. **Focus on prevention of illness, not just treating it.**

We recognise that alongside short-term solutions to address our financial position, we will need to build the foundations which are required to deliver longer term transformational change for our population across Somerset.

In 2025/26 new approaches to the delivery of health and care services will be scoped to ensure that in the later period of this plan, we are able to deliver on the transformations required to produce long lasting change in Somerset.



Priority Programmes

In 2024/25 our Joint Forward Plan identified five key Priority Programmes of work as follows:

- **Priority 1: Finance & Resource Allocation**
- **Priority 2: Workforce**
- **Priority 3: System Flow**
- **Priority 4: Integrated Neighbourhood Working**
- **Priority 5: Population Health Transformation**

These priorities were set out to support the achievement of our seven strategic system aims. However, during the last 12 months we have not made as much progress in some areas for which we would have hoped – the update on each of these programmes can be found in appendix 1.

As such and given the on-going national conversations regarding the NHS 10 Year Health Plan, the system believes now is an opportune time in which to review these priorities and set about a new clear direction of travel. As such, moving into 2025/26 we will see the closing down of Finance and Resources with this moving into a newly scoped priority - Clinical Pathway Redesign. This shift does not detract from the system's commitment to providing services that are value for money but instead recognises the need for greater oversight of our finances and use of resources throughout each of our priorities. As such, finance moves to an enabling function with elements of this sitting across all our priorities, rather than being a standalone Programme of work.

Our new Priority Programme - Clinical Pathway Redesign – will be fully scoped during Q1 of 2025/26. In addition, further review of the existing Programmes will be undertaken, with any new streams of work under these priorities being identified using robust data analysis, known areas of opportunity across our system as well as recognising the wider determinants that support us in the management of Population Health. Somerset will be driven by designing services with people that provide value to the system; and be supported by an infrastructure with the capabilities to deliver the changes required. We will make robust use of quality impact assessments to know that decisions we make about any changes or ongoing programmes of work are appropriately risk assessed, monitored and evaluated.

Whilst we will have set Priority Programmes, both as a system and as individual organisations, there are many other projects we are undertaking or will be undertaking to improve outcomes for the people of Somerset and the health and care services they receive.

Priority Programmes

Priority 1:

Clinical Pathway Redesign

Why is it important?

Within Our Somerset, the county's Integrated Care System (ICS), we have numerous pathways for a wide range of patient conditions in which individuals are seeing inconsistent practice, resulting in varying experiences and outcomes. Undertaking a review of these clinical pathways and ensuring they are effective is important because they act as a structured guide for the Somerset system to deliver consistent, evidence-based care. Whilst full scoping of Priority One will take place through Q1 of 2025/26, we are clear on the outcomes we are seeking to achieve which include:

- **Optimisation of individuals outcomes, including improved experiences of moving through a service**
- **A reduction in the variations in practice allowing us to actively address known health inequalities**
- **Tackling our financial challenge with a drive to lower healthcare costs by streamlining treatment plans and identifying unnecessary interventions**
- **Greater collaboration with key system partners, including those in the voluntary and community sector**

Pathways for review will be identified and prioritised between 2025 – 2030 based on a triangulation of data which will help the Somerset system to identify areas of greatest opportunity, and will be backed by our already developed Clinical Principles ensuring services are of good quality, and provide the best outcomes for our population.

Priority Programmes

Priority 2:

Workforce

Why is it important?

Somerset's Integrated Health and Care strategy key principles identifies a number of requirements for a different approach to workforce in order to meet the changing needs of the population. As an ICS we will pursue an ambitious system-wide workforce strategy, to inform how our workforce will develop over the coming 10 years and beyond.

The success of the Health and Care Strategy requires our paid and unpaid workforce to have the right skills, behaviours and values in the right place at the right time, focused on a person-centred approach.

To achieve our One Workforce of the Future, we need to:

1. Foster a collaborative culture amongst health and care leaders in Somerset that enhances performance, builds inclusion, and attracts talent and investment
2. Design and deliver a long-term workforce strategy for the integrated care system, based on a thorough needs assessment, that enables the Government's '3 shifts' by:

Creating and maintaining an observatory for Somerset's workforce that enables us to build compelling business cases for change, and track progress.

Convening educational partners to stimulate / co-produce with the market so that it can provide for our collective future needs;

Developing and delivering a suite of people and workforce programmes to enhance supply, productivity, engagement, retention and integration; and,

Delivering tangible workforce improvements including oversight of the Somerset Health and Care Academy.

What are we going to do?

	2025/26	2026/27	2027/28 to 2029/30
Recruit (and train)	Work alongside educator-providers to develop new local qualification opportunities with education providers including access to apprenticeships.	Adopt new pathways and opportunities.	
	Increase the capacity and skillset of the educator workforce to support increased pipeline delivery.		
	Continue to develop enhanced, advanced and associate roles aligned to clear career pathways & service need.	Continue to develop enhanced, advanced and associate roles aligned to clear career pathways and service need.	

Workforce

	2025/26	2026/27	2027/28 to 2029/30
Retain	Using the evidence base around workforce retention, including evaluation of 24/25 retention schemes to define the 25-27 ICS Retention Strategy and interventions	Deliver actions and evaluate.	
	Conduct a test and learn approach to the programme before roll-out of core system leadership offer to include: A specific focus on: • Integrated Neighbourhood Working • AI (as part of the Digital Strategy) • NHSE Leadership Framework • Coaching (Team, Group, Systemic and 1:1) Initial high-level scoping of a Leadership Faculty.	Develop a System Leadership faculty as part of the Somerset Training Academy for Health and Social Care. Review of programmes.	
	Design a coordinated system approach to develop a career promotions strategy (aka Widening Participation)	Implementation plan developed and delivery started	
Reform	Design a coordinated system approach to develop a career promotions strategy (aka Widening Participation)	Implementation plan developed and delivery started	
	Implement agreed programme of work from Workforce 2035 (scenario planning)	Implement agreed programme of work from Workforce 2035 (scenario planning)	
	Implement the learning from the pilot work in Minehead into the final development of the Academy Business Plan and operating model	Open Somerset Health and Care Academy (2027)	
	Work and Health: Health Needs Assessment for Workwell produced & actions identified. Implement new requirements and review.	Review outcomes	
	Keyworker Housing Hub funding agreed, service scoped and Housing Hub operational by end 2026	Evaluation informs further developments.	
	Equality, Equity and Inclusion Plan year 2 actions to be defined	Equality, Equity and Inclusion Plan year 3 actions to be defined	Equality, Equity and Inclusion Plan year 4 actions to be defined

Priority 3:

System Flow

Why is it important?

The Problem:

The Somerset Integrated Care System and Somerset NHS Foundation Trust has a high number of patients in bedded care settings who do not meet the criteria for them to be there. This is across sectors – mental health, acute and intermediate care (community hospitals and care homes). This results in:

- Harm to patients as they are not in an appropriate setting for their needs, which in turn results in deconditioning, increased risk of harm and increased on going care needs
- Excess occupancy in bedded care services, causing inefficiency and increased safety risks
- Excess costs for all parts of the health and care system over the short and long term

In 2024/25 Somerset saw an improvement in mental health hospital delays. Somerset remains an outlier nationally with a level of No Criteria to Reside (NCTR) patients in acute beds of 21.8% compared with the national average of 13% (at 30 November, 2024).

The Strategy:

To ensure that patients are cared for in the right setting once their acute care needs (both physical and mental health) have been met. In the majority of cases this right setting will be in the patient's own home, potentially with support. It is however recognised that some patients will not be able to return home, either whilst they undergo a period of reablement or assessment for permanent care home provision.

Delivery of this strategy will result in a reduced cost base associated with acute bed capacity, intermediate care services and on-going care support provided by Somerset Council. [Note: work will be required to understand the counter factual because of the local demographics]

The Objectives:

1. To reduce and maintain the number of patients who do not meet the criteria to reside in an acute hospital bed at Somerset FT to no more than 10% of the general and acute bed base in 2025/26.

   As a linked objective to reduce the number of Somerset residents who do not meet the criteria to reside at non-Somerset based acute hospitals to similar levels.

   In simple terms, this means reducing the No Criteria to Reside number at Somerset FT to circa. 90 patients and maintaining it at that level or less.

2. To define the most appropriate metric to measure mental health delayed discharges and then agree, deliver and maintain a reduction that is appropriate given the demand and capacity for inpatient care.

System Flow

What are we going to do?

	2025/26	2026/27	2027/28 to 2029/30
System Flow	**Recommission Pathway 1 reablement service** Build upon learning from 2024/25 to ensure sufficient reablement capacity across all somerset geographies	Monitor and evaluate the Pathway 1 intermediate care model	
	Financial shift Support more people to recover in their usual place of residence, and less people within inpatient settings.	Continue the shift from inpatient to community focused recovery.	
	Inpatient Community Reablement We will use data insights and feedback to understand the future needs of people who require inpatient reablement in Somerset, including avoidance and improvement of Mental Health admissions.	We will develop and design a modernised inpatient reablement delivery model, and understand the resources required for future delivery. We will engage the people of Somerset in this design.	Continued engagement and progress to towards modernised inpatient reablement services across Somerset.
	Mature the new Transfer of Care Hubs model We will further optimise efficiency and strengthen person-led decision making in our transfer of care hub.		
	Supporting an improved hospital discharge We will ensure that hospital discharges are better planned and delivered for patients/relatives/carers.	Continue to build upon improvements using feedback from patients/relatives/carers.	
	Commission and implement a new Pathway 3 model of care We will ensure that people are able to be discharged to a care home close to their usual place of residence, and that they have the option to stay there, if they require a long-term care home placement.	Monitor and evaluate the Pathway 3 intermediate care model	
	Mental Health Discharge Build upon the 2024/25 learning to sustain the position whereby patients move out of mental health hospital-based care as soon as they are medically fit		
	Inpatient flow and length of stay (acute) Reducing variation in inpatient care and length of stay for key cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.		

System Flow

	2025/26	2026/27	2027/28 to 2029/30
Adult Social Care	**Work in partnership with our care provider market** We will work in partnership with our care provider market to ensure there are sufficient nursing places available to meet future demand, particularly for people living with dementia and other cognitive impairments		
	Development of viable care alternatives We will invest in the development of viable care alternatives to reduce and delay the need for long-term care (such as extra care housing and a range of reablement and community services).		

Priority Programmes

Priority 4:

Integrated Neighbourhood Working

Why is it important?

In its primary care strategy, Our Somerset has pledged to deliver on the Fuller Stocktake. To do this there will need to be a specific programme of systemwide work to develop those teams outlined within the Fuller Stocktake, which deliver care:

- to those with the most complex needs
- for same day urgent care

Following on from the Fuller Stocktake, in 2024 the government committed to three strategic shifts for the NHS, which are:

- hospital to primary care and community services
- analogue to digital
- treatment to prevention.

We will deliver this commitment via Integrated Neighbourhood Working in "A geographical area where there is a culture for multi-agencies and communities to co-design, co-create, co-deliver, work and learn together. Through this culture of collaboration, the community is supported to live the best and most fulfilling lives they can".

Additionally, Somerset has been selected as one of seven Integrated Care Board areas to work with selected Primary Care Network(s) to implement the changes required to deliver the major recommendations of the Fuller Stocktake. This work will support this programme and our local neighbourhood team development more broadly and enable the Somerset system to benefit from national support.

The Problem:

There are currently innovative approaches to the development of Integrated Neighbourhood Working (defined for the purpose of this work as PCN footprint) level in Somerset, however they are not developing within an overall framework that enables innovation to spread and for outcomes to be measured. It is also currently difficult to gauge the degree of resource utilisation across the county and there is a challenge for NHS services to consistently engage with council, VCFSE and other partners to take forward the vision of creating more 'resilient communities' that was set out in our overarching Health and Care Strategy.

What are the aims of this programme?

- To enable Integrated Neighbourhood Working to flourish across Somerset with clearly defined and measured outcomes and alignment of incentives that allow models to develop, but with local flexibility where necessary.
- To enable the NHS to meet population needs more effectively, and organise itself to better engage with other partners on the wider agenda of supporting the development of more resilient communities, enabling a shift in focus towards prevention.

What are the primary objectives of this programme?

- To develop a clear overarching vision that supports communities to design and implement a model of Integrated Neighbourhood Working – including clarity about the outcomes to be achieved, what features needs to be consistent across the system and what can be tailored to fit local (PCN) circumstances.
- To determine a set of clear outcome measures that reflect the strategic desire to support more people in their local geographies and avoid escalation to more acute (and higher cost) care settings, supporting the desire to move services from acute to community settings, in a 'left shift' of investment over time.
- Simplify the delivery of neighbourhood-based services to provide consistency and enable integration with the Integrated Neighbourhood Working model.
- To clearly evaluate existing models, determine what works and support roll out and spread.
- To streamline ICS work programmes ensuring alignment and support to the vision of Integrated Neighbourhood Working.
- To align financial and performance incentives to support this new model.
- To develop a clear offer that supports the cultural and behavioural elements of Integrated Neighbourhood Working.
- To support this work through a clear and prioritised infrastructure plan based on a risk assessment that facilitates the co-location of teams and supports integrated working, together with a financial strategy that supports the 'left shift' in investment over time.

What are we going to do?

	2025/26	2026/27	2028/29
Develop a Common Under-standing of Integrated Neigh-bourhood Working	**National Programme Engagement** Continue to work with the two Somerset PCNs taking part in the national PCN pilot programme led by Claire Fuller Work with the national team and local stakeholders to co-develop Somerset's Vision for neighbourhood health		
	ICS Work Programmes Review and prioritise commissioning intentions to support strategic commissioning in line with Integrated Neighbourhood Working at scale	Ongoing expansion of service delivery at neighbourhood level in line with commissioning intentions.	

Integrated Neighbourhood Working

	2025/26	2026/27	2028/29
Align Strategic Resources	**Governance** Develop and publish Integrated Neighbourhood Working maturity matrix for self-assessment and identification of need Promote enabler offer to support neighbourhood development against maturity matrix	Support the resourcing and OD needs of identified Integrated Neighbourhood Teams based on workforce planning and gap analysis.	
	Digital Neighbourhoods Programme Continue to review and align the digital neighbourhoods programme to apply a consistent, system-wide population health management approach in neighbourhoods Continued roll out of BRAVE AI as a risk stratification tool.		
	Workforce Support the resourcing and OD needs of identified Integrated Neighbourhood Teams based on workforce planning and gap analysis. Develop leadership programme to support OD needs of integrated neighbourhood teams at scale.		
Implement Test of Change Focus Area	Develop, test and implement integrated neighbourhood working model for frailty.	Cascade frailty test of change learning to support ongoing service development within commissioning intentions Refinement and evaluation of frailty test of change focus area.	
Develop Approach to Measurement	Continue to develop, refine and roll out evaluation methodology for existing and future Integrated Neighbourhood Working approaches in Somerset Develop and define overarching benefits realisation approach in accordance with integrated neighbourhood working principles.	Further expansion of benefits realisation approach to assess areas for improvement and/or scaling.	

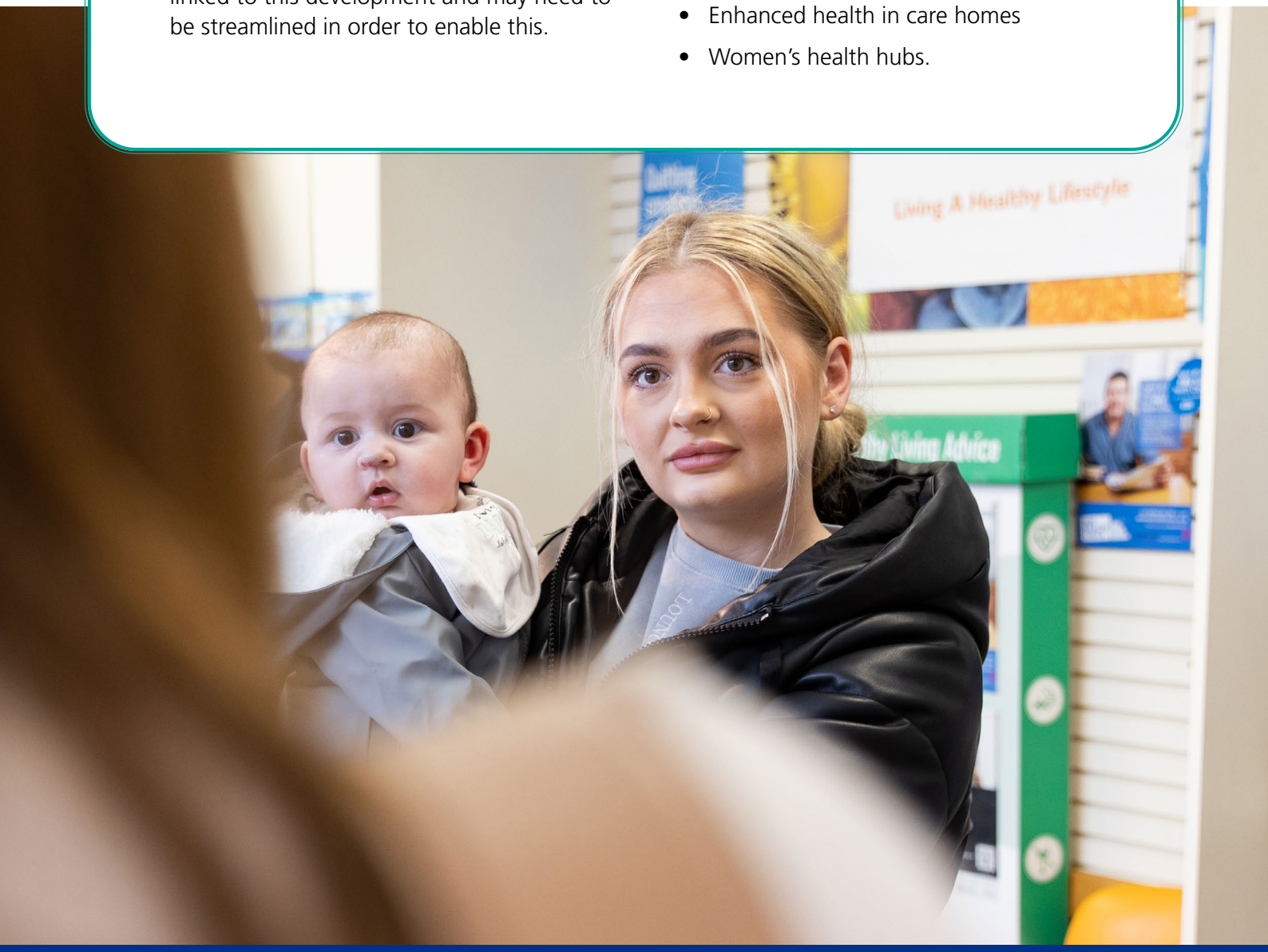
Key dependencies:

This programme of work has a number of key dependencies to other 'business as usual' activities. It is essential that there is close alignment to the work underway to support the future resilience of general practice together with the system plans to improve access to dentistry, community pharmacy and optometry. It also needs to work within an overall framework for building resilient communities, which Council colleagues will lead on.

There are a number of system-wide, ICB led programmes of work that also need to be linked to this development and may need to be streamlined in order to enable this.

These include:

- The rollout of the comprehensive model of Personalised Care through the enablers of social prescribing, health coaching, personalised care and support planning, personal health budgets and self-management and education
- Same day emergency care development
- Proactive care
- Long Term conditions
- Enhanced health in care homes
- Women's health hubs.



Priority Programmes

Priority 5:

Population Health Transformation

Why is it important?

We know that people living in Somerset with higher socioeconomic position have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. Health, care and unhealthy behaviours is one of the main focuses. It provides an opportunity to maximise our uptake of support for those with a long-term condition or mental health issue while also allowing our prevention programmes to help with modifiable risk factors.

We want to give more people in Somerset the life chances currently enjoyed by the few. Our people would be better off in many ways: in the circumstances in which they are born, grow, live, work, and age. This will require joined up and integrated working with our partners in health, social care, housing, police, education, fire and rescue, town and parish councils, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners and our employers.

By doing this, people in Somerset would see improved wellbeing, better mental health and less disability. Their children would flourish, and they would live in sustainable, cohesive communities which they are proud of and care about where they live.

What are we going to do?

	2025/26	2026/27	2028/29
Tackling Healthcare Inequalities	**Strengthening workforce** Established Community of Practice Local Health Inequalities toolkit being used to inform local decision making Continue to develop NHS Ambassador Programme	**Strengthening workforce** Established NHS Ambassador Programme	
	Data and Evidence Ongoing development of local health inequalities dashboard. Dashboard is used to inform tackling inequalities through integrated neighbourhood working locally and at scale Self-assessment evaluation of neighbourhoods in ability to respond to health inequalities and adopt population health methodology	**Data and Evidence** Evaluation of population health priority programmes and neighbourhood activity against aims	

Population Health Transformation

	2025/26	2026/27	2028/29
Tackling Healthcare Inequalities	**Tackling specific inequalities** Embed personalised care programme within existing programmes for people who experience multiple disadvantage		
Adopting Population Health Management approaches within neighbourhood working	**Alignment with Integrated Neighbourhood Working Priority:** Continue to differentially invest in general practice surgeries with higher level of inequality to target resource to areas of need. Delivery and self-assessment of population health management through Integrated Neighbourhood working	**Alignment with Integrated Neighbourhood Working Priority:** Ongoing expansion of population health as a primary focus for neighbourhood working and deliverables within	
Development of a Population Health Culture	Ongoing development of training programme Expand Health Ambassador Programme	Roll out of training programme Health Ambassador Programme expanded to all professionals	
Priority Population Health Programmes	Continued priority population health programme focus on: 'Take the Pressure Off' campaign to case-find and optimise treatment for individuals with hypertension. System-wide campaign to achieve smoke free by 2030	Embed population health prevention programmes within neighbourhoods	
Develop use of Data & Intelligence	Embed the use of integrated data within the Health and Care System to support the growth of Population Health Management Continue to develop skills and expertise required to support Population Health Transformation Further development and inclusion of additional data into the Integrated data function	Embed the use of integrated data within the Health and Care System to support the growth of Population Health Management Continue to develop skills and expertise required to support Population Health Transformation Further development and Inclusion of additional data into the Integrated data function	
Align Commissioning, Policies & Resources	All services commissioned consider healthcare inequalities Financial process and performance monitoring aligned to include and recognise health inequalities Business cases found to be effective in reducing health inequalities resourced through the redistribution of funding.		

Delivering this Joint Forward Plan

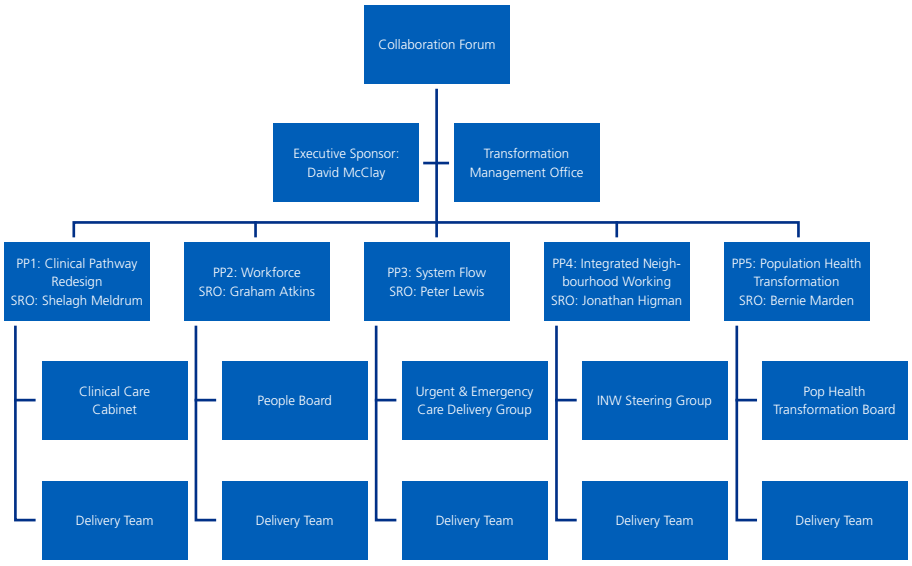
We are committed as partners to work together to deliver the commitments made within the Integrated Health and Care Strategy and taking forward the five priority programmes. Prioritisation of the actions within each priority programme has taken place to deliver early outcomes, including financial savings.

We have a strong track record of working together to improve the health and care services in Somerset. Overall accountability for the plan within Our Somerset, the county's Integrated Care System, rests with NHS Somerset (Somerset ICB). Our Somerset brings together all the organisations responsible for delivering health and care within our communities.

Governance and oversight for the delivery of this plan

The overall responsibility for delivery of this Joint Forward Plan rests with NHS Somerset ICB. The Collaboration Forum will be the committee that will oversee the delivery of the Joint Forward Plan on behalf of NHS Somerset.

- An Executive Sponsor will have overall responsibility for delivering the Priority Programmes, reporting into the Collaboration Forum
- Each Priority Programme will have:
  - A Chief Executive or executive level Senior Responsible Owner (SRO)
  - A transformation lead, identified from within the Somerset system to provide the expertise and knowledge to drive the programme forward.
  - A transformation manager working to deliver the programme
  - A delivery team comprised of colleagues from multiple organisations



To support the delivery of the five Priority Programmes a Transformation Management Office has been established to provide rigour, ensuring that there are clear mandates, work programmes and there is regular reporting through to the SRO and Collaboration Forum.

System partners are committed to identifying and releasing people to be able to lead these priority programmes.

Next Steps

This Joint Forward Plan sets out the priorities for Somerset and articulates the actions required to deliver our Integrated Health and Care Strategy in Somerset.

Throughout 2025/26 we will continue to prioritise the actions within each priority programme, to ensure they are aligned to deliver the next phase of benefits, including continued financial savings.

During 2025/26, we will align the re-refreshed Joint Forward Plan with any ambitions set out in the pending 10 Year Health Plan, updated NHS England planning guidance and any new policy announcements which may be made during its lifetime.

Development of system outcome measures

Our strategy, with its seven aims, is well established within Somerset. We recognise that to make this real, we need to define why we are doing what we are doing and whether we are heading in the right direction to achieve it.

Working with partners from across the system, we are:

- Defining the overall outcome we want to achieve through the delivery of our strategy and how we will measure it
- Defining why each aim is important and identifying a headline measure which will help us understand if we are delivering each aim. We will set:
    - Level 1 outcomes – what are we trying to achieve over the next 10-20 years?
    - Level 2 outcomes – what are we trying to achieve over the lifetime of the strategy (5 years)?
- Developing a suite of outcome measures - metrics or indicators which are used to evaluate our progress towards the outcome. We expect these to be different from our traditional performance Key Performance Indicators
- Developing the system wide baseline from which we will measure our progress.

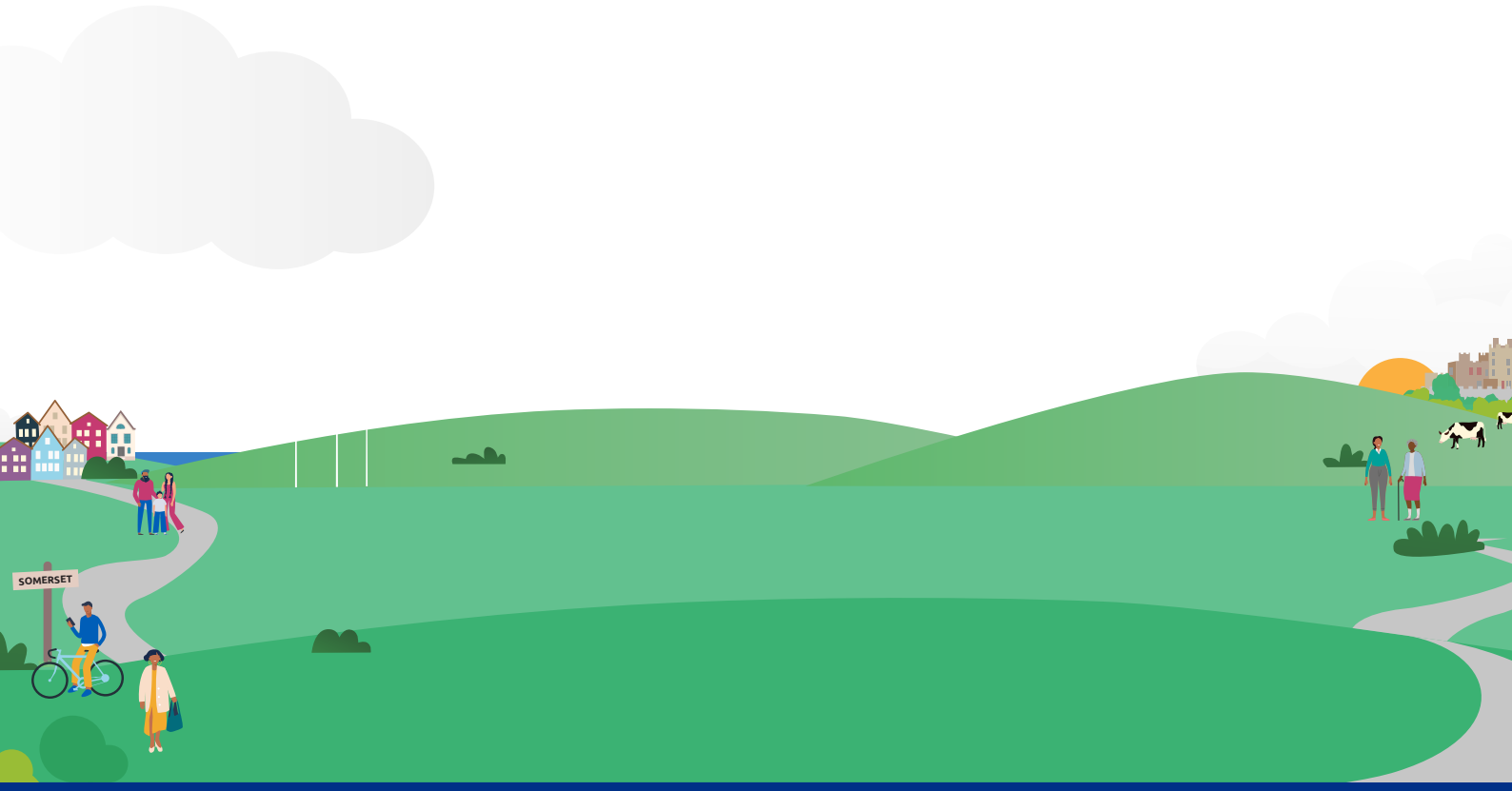
The new Transformation Management Office has recently developed the priority programme planning and reporting process and documentation to increase the focus on specific measurable outcomes. This work will continue to be embedded in 2025/26.

These outcomes and the metrics which support them will provide a future focus in our ICB Board Assurance Framework reporting. Progress made against initial measures of progress, set for the last year (2024/25), is reflected on, within Appendix 1.

Working with people and communities – Somerset's Big Conversation

Building on the successes and lessons learned from Somerset's Big Conversation in 2024 (see page 8), NHS Somerset is committed to evolving and expanding this initiative for 2025. This will involve deeper engagement with underrepresented groups to ensure voices are heard from across the Somerset population.

Somerset's Big Conversation 2025 will also place greater emphasis on demonstrating the impact of community feedback, providing updates on how insights are shaping health and care strategies. By fostering stronger partnerships with local organisations, community leaders and system partners, NHS Somerset aims to create a more inclusive, dynamic and impactful conversation, further embedding the principles of collaboration in the planning and decision-making processes.



our SOMERSET
Together we care

Somerset **Five year Joint Forward Plan** refresh

2025 - 2030

PART OF THE INTEGRATED INTEGRATED HEALTH AND CARE STRATEGY FOR SOMERSET