Wiltshire Council

AGENDA

Meeting: **Health and Wellbeing Board**

Place: **Kennet Room - County Hall, Bythesea Road, Trowbridge, BA14 8JN**

Date: **Thursday 20 July 2023**

Time: **10.00 am**

Please direct any enquiries on this Agenda to Max Hirst - Democratic Services Officer of Democratic and Members' Services, County Hall, Bythesea Road, Trowbridge, direct line or email Max.Hirst@wiltshire.gov.uk

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Voting Membership:

Cllr Richard Clewer (Chairman)	Leader of the Council and Cabinet Member for Climate Change, MCI, Economic Development, Heritage, Arts, Tourism and Health & Wellbeing
Gina Sergeant	Healthcare Clinical Professional Director (NHS BSW ICB)
Cllr Laura Mayes	Deputy Leader and Cabinet Member for Children's Services, Education and Skills
Dr Nick Ware/ Dr Catrinel Wright	GP Clinical Lead (Wiltshire Integrated Care Alliance)
Philip Wilkinson	Police and Crime Commissioner
Alan Mitchell	Chair, Healthwatch Wiltshire

Non-Voting Membership:

Kate Blackburn	Director - Public Health (DPH)
Dr Edd Rendell	Wessex Local Medical Committee –

	Medical Director
Dr Andy Purbrick	Wessex Local Medical Committee – Medical Director
Terence Herbert	Chief Executive Wiltshire Council
Stacey Hunter	Chief Executive NHS Salisbury Foundation Trust
Stephen Ladyman	Wiltshire Health and Care - Chair
Shirley-Ann Carvill	Wiltshire Health and Care – Interim Chief Executive
Kevin Mcnamara	Chief Executive or Chairman Great Western Hospital
Clare Thompson	Director of Improvement & Partnerships - GWH
Clare O'Farrell	Interim Director of Commissioning
Catherine Roper	Wiltshire Police Chief Constable
Alison Ryan	RUH Bath NHS Foundation Trust - Chair
Val Scrase	Regional Director B&NES, Devon and Wiltshire Community Services
Lucy Townsend	Corporate Director of People (DCS)
Emma Legg	Director of Adult Social Services
Marc House	Dorset and Wiltshire Fire & Rescue Service - Area Manager Swindon and Wiltshire
Sarah Cardy	VCSE Leadership Alliance Representative
Cllr Gordon King	Opposition Group Representative
Cllr Ian Blair-Pilling	Cabinet Member for Public Health and Public Protection, Leisure, Libraries, Facilities Management and Operational Assets
Cllr Jane Davies	Cabinet Member for Adult Social Care, SEND, Transition and Inclusion

Fiona Slevin-Brown	Place Director – Wiltshire, NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)
James Fortune	Avon and Wiltshire Mental Health Partnership
Maggie Arnold	Oxford Health (CAMHS)
Stephen Otter	South West Ambulance Service - Non-Executive Director
Laura Nicholas	South West Ambulance Service NHSE, SW Director of Strategic Transformation / Locality Director
Emma Higgins	Associate Director – Wiltshire ICA Programme and Delivery Lead

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Please see the agenda list on following pages for details of deadlines for submission of questions and statements for this meeting.

For extended details on meeting procedure, submission and scope of questions and other matters, please consult Part 4 of the council's constitution.

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AGENDA

1 **Chairman's Welcome, Introduction and Announcements***(Pages 7 - 8)*

The Chairman will welcome those present to the meeting.

- Procurement of Community Health Services

2 **Apologies for Absence**

To receive any apologies for absence.

3 **Minutes***(Pages 9 - 14)*

To confirm the minutes of the meeting held on 25 May 2023.

4 **Declarations of Interest**

To declare any personal or prejudicial interests or dispensations granted by the Standards Committee.

5 **Public Participation**

The Council welcomes contributions from members of the public.

Statements
If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named on the front of the agenda for any further clarification.

Questions
To receive any questions from members of the public or members of the Council received in accordance with the constitution.

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **(4 clear working days, e.g. Wednesday of week before a Wednesday meeting)** in order to be guaranteed of a written response**.** In order to receive a verbal response questions must be submitted no later than 5pm on **(2 clear working days, eg Friday of week before a Wednesday meeting)**. Please contact the officer named on the front of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

6 **BSW Integrated Care Strategy Implementation Plan Update***(Pages 15 - 210)*

To receive an update from David Jobbins regarding the implementation plan of the BSW Integrated Care Strategy.

7 **ICB Capital Plan***(Pages 211 - 220)*

To receive an update from Bina Kakad on the ICB Capital Plan.

8 **Update On The Transfer of Pharmacy, Optometry and Dental Services to BSW***(Pages 221 - 226)*

To receive an update from Jo Cullen on the transfer of pharmacy, optometry and dental services to the BSW.

9 **CYP Strategy***(Pages 227 - 238)*

To receive an update from Sadie Hall regarding the CYP Strategy.

10 **Better Care Plan - standing update***(Pages 239 - 272)*

To receive an update on developments relating to the implementation of the Better Care Plan.

11 **Healthwatch Wiltshire Annual Report***(Pages 273 - 300)*

To receive an annual report from Stacey Sims for Healthwatch Wiltshire.

12 **Date of Next Meeting**

The date of the next meeting is 28 September 2023.

13 **Urgent Items**

Any other items of business which the Chairman agrees to consider as a matter of urgency.

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

Stakeholder briefing: **Integrated Community Based Care programme**
Distribution: **HWB**
22 June 2023 - V1.8

This paper provides an overview of the Integrated Community Based Care programme that is being led by Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board in partnership with the three Local Authorities in BSW.

Summary

The Integrated Care System (ICS) has recently published its Integrated Care Strategy which describes the key priorities and ambitions for the ICS. An integral part of this is to increase the focus on prevention and early intervention, delivering this through the BSW Care Model and providing excellent community-based services for people in BSW.

Some of the existing contracts for community health services are expiring soon and this offers a unique opportunity for the ICB to plan and commission services for a future model of care. This future model will enable better integration of local services to meet the health needs of our communities, helping to address the challenges facing health and care services including increasing demand, workforce recruitment and retention, and financial sustainability.

The BSW Integrated Care Board (ICB) has established a programme of work called the Integrated Community Based Care Programme (ICBC) to lead the process of securing specific health community services from 2025 onwards. The ICBC is governed by a programme board made up of representatives from the ICB and each of the Local Authorities.

The ICBC programme will start with ensuring the immediate continuity of service provision for the people of BSW and the workforce for the financial year 2024/25. This allows sufficient time to ensure people and communities, clinicians, professional staff and providers of services are involved as appropriate in the process.

It is expected that the programme will be completed, with new contracts in place by April 2025. Decisions will be made by the BSW ICB and relevant Local Authorities in the coming weeks on their plans for ensuring continuity of service provision for 2024/25. The ICBC programme will work to complement and align with the concurrent programmes of work initiated by Wiltshire Council on commissioning Public Health Nursing Services, and the Bath & North East Somerset Council plans for Adult Social Work and Learning Disability services.

We will continue to keep you informed as the programme progresses. For further information please contact: bswicb.bsw-icbc@nhs.net

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Wiltshire Council

Health and Wellbeing Board

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 25 MAY 2023 AT KENNET COMMITTEE ROOM, COUNTY HALL, TROWBRIDGE.

Present:
Cllr Richard Clewer (Chair), Cllr Laura Mayes (Vice – Chair), Cllr Jane Davies, Cllr Gordon King, Cllr Ian Blair-Pilling, Cllr Tony Jackson, Alan Mitchell (HW), Gina Sargeant (ICB), Alison Ryan (RUH), Claire Thompson (GWH), Stephen Ladyman (WHC), Val Scrase (HCRG), Sarah Cardy (VCS), Emma Higgins (ICB), Kate Blackburn (Director - Public Health), Lucy Townsend (Corporate Director – People), Dr Edd Rendell (WLMC) and Dr Nick Ware (ICB).

Also Present:
David Jobbins (BSW ICB), Colonel Ricky Bhabutta (DPH), Helen Mullinger (WC), Lynn Gibson (CF), Sammer Tang (WC), David Bowater (WC), Ben Fielding (WC) and Max Hirst (WC).

27 **Chairman's Welcome, Introduction and Announcements**

Cllr Richard Clewer, Chairman of the Board and Leader of the Council, welcomed all attendees to the meeting.

Before the meeting began, each Member of the Board, other Councillors and officers who would be contributing to the meeting were given the opportunity to introduce themselves.

Cllr Clewer, through a chairman's announcement, informed Members of a Briefing Note in relation to the Wiltshire Pharmaceutical Needs Assessment, which was attached to the agenda. The Briefing Note provided an overview of the Market Exit Notification from Lloyd's in Sainsbury Pharmacy as well as an initial impact assessment of the closure by the Public Health Team.

A further point was raised that an additional Lloyd's in Sainsbury Pharmacy was closing in Melksham, highlighting the need to monitor staffing issues, and that although local efforts were being made to solve this, central support was needed.

As part of the briefing note it was recommended that the Board:

I. Acknowledge the closure of the Lloyd's pharmacy in Sainsbury in Chippenham from 18th April 2023.
II. Review the initial impact assessment for the closure of the Lloyd's pharmacy in Sainsbury, Chippenham and support the finding that this closure does not create a gap that could be met by an application offering to meet a need for, or secure improvements or better access to, pharmaceutical service.

III. Support the decision that a supplementary statement is not required to be issued as sufficient alternative local providers are available locally.
iv. Continue to monitor any future changes in pharmaceutical services within Wiltshire.

After which, it was resolved:

Decision:

To accept the Wiltshire Pharmaceutical Needs Assessment's recommendations.

28 **Apologies for Absence**

Apologies were received from:

- Tony Mears (Salisbury NHS FT)
- Lisa Hodgson (WHC)
- Niall Prosser (RUH)
- Shirley-Ann Carvill (WHC)
- Jo Howes (WCP)
- Jo Madeley (WC)
- Fiona Slevin-Brown (ICB)
- Jen Salter (WC)
- Philip Wilkinson (OPCC)
- Massimo Morelli (ICB)
- Barry Young (ICB)
- Catherine Roper (WP)
- Catrinel Wright (ICB)
- Catherine Symington (WHC)
- James Fortune (CAMHS)

29 **Minutes**

The minutes of the previous meeting of the Board held on 30 March 2023 were presented for consideration. After which, it was:

Decision:

To approve and sign the minutes of the previous meeting of the Health and Wellbeing Board held on 30 March 2023 as a true and correct record.

30 **Declarations of Interest**

There were no declarations of interest.

31 **Public Participation**

No questions were received.

32 **Public Health Nursing Services - Update**

Kate Blackburn, Public Health Consultant, presented an update regarding the Public Health Nursing Contract to the Board. The purpose of this report was to provide Health and Wellbeing Board with an update on the future delivery model for Wiltshire's Public Health Nursing (PHN) Services beyond April 2024.

During the item, the main points raised included, but were not limited to:

- The contract with HCRG Care Group to deliver the Wiltshire Children's Community Healthcare Service would expire on 31 March 2024.
- The ICB had recently clarified it was not able to progress a joint procurement process with Wiltshire Council at this time and the Council was not able to extend the current contract any further under procurement legislation. The options available since June 2022 had therefore evolved to:
    a. Single procurement of Wiltshire PHNS by Wiltshire Council or;
    b. Local Authority in-house PHNS.
- In June 2022, Cabinet was presented with these options for the service beyond April 2024 and agreed for PHNS to be part of a single procurement of a combined universal and specialist children's community health service for Wiltshire.
- However, there was commitment from both the Local Authority and BSW ICB to continue to work closely together to align Wiltshire's universal and specialist service specifications, and monitoring processes, to ensure services would continue to be joined up and seamless.
- The full report was included within the Agenda Pack.

Decision:

To accept the following recommended proposal:

The Board noted the future delivery model for Public Health Nursing Services.

33 **Healthwatch Wiltshire Priorities**

Alan Mitchell, Chair of Healthwatch Wiltshire, made a presentation of the Healthwatch Wiltshire Priorities to the Board.

During the item, the main points raised included, but were not limited to:

Following a priority setting process, involving volunteers and a short survey open to Wiltshire residents to give their views, the following priority areas were identified for Healthwatch Wiltshire to focus on over this next year:

i. Hospital Discharge and Care at Home/virtual wards.
ii. Children and Young People's Wellbeing.
iii. Mental Health and Autism.
iv. Access to GP services – continue follow up work.

It was also agreed to monitor dentistry and how the BSW ICS manages implementation of any changes now that it is taking on responsibility for dentistry.

The Board welcomed the focus on access and capacity issues surrounding GP Practices, and support was offered by numerous members in actioning the Survey. The full report was included within the Agenda Pack.

Decision:

To accept the following recommended proposal:

The Board notes Healthwatch Wiltshire's priorities for the year ahead.

34 **Better Care Fund**

Helen Mullinger, (Head of Commissioning Adults), presented the Better Care Fund End of Year Submission to the Board. The report provided the Board with an executive briefing of the end of year submission for BCF Wiltshire. It was noted that the template was required to be submitted to the BCF National Team, as well as that there was a requirement of BCF governance arrangements that the template be formally presented to the Health and Wellbeing Board, to provide accountability for the funding, information, and input into national datasets.

It was highlighted that all national conditions were met, the BCF were successfully enabling integrated working and that both the Department for Health and Social Care and Department for Levelling Up, Housing and Communities had highlighted the BCF as an integral programme for delivering Key Priorities in the NHS Long Term Plan.

The full report can be found in the Agenda Pack.

Decision:

To accept the following recommended proposals:

i. **The Board noted the end of year BCF submission 2022-23,**

ii. **The Board approved the delegated sign-off of the Better Care Fund Plan to the Chair.**

35 **Draft BSW ICS 5 Year Joint Forward Plan**

David Jobbins and Emily Higgins, Interim Deputy Director – Planning & Programmes, presented the Draft BSW ICS Implementation Plan 2023/24 to the Board.

During the item, the main points raised included, but were not limited to:

That Board members were asked to consider the Plan with particular reference on whether it took proper account of the Wiltshire JLHWS. It was further highlighted that this was an opportunity to give feedback to allow adaptation.

The BSW Vision was highlighted as three strategic objectives:

i. Focus on prevention and early intervention.
ii. Fairer health and wellbeing outcomes.
III. Excellent health and care services.

The BSW Strategy and this Implementation Plan aimed to bring together the key elements of what is aimed to be delivered and change through the three Strategic Objectives.

It was suggested that document was currently large, and that work would be done to condense the document.

The Board echoed the opportunity for engagement and feedback but stated that issues of deprivation were far different in Wiltshire to other areas, therefore it was important that the nuances were to be considered.

Decision:

To accept the following recommended proposals:

i. The Board considered the content of the Implementation Plan and provided feedback including responses to the Engagement Process questions made available at the meeting; and

ii. The Board contributed to the opinion the HWB would provide on whether the plan took proper account of the Wiltshire JLHWS.

iii. The Board delegated provision of the final opinion to the Chair, in consultation with the Corporate Director of People (Wiltshire Council) and the Wiltshire Integrated Care Alliance Director (BSW ICB), given that there was not another Health & Wellbeing Board prior to publication on June 30th.

36 **Break Out Groups**

The Board partook in informal break out groups to further discuss the implementation of the JLHWS, led by Emma Higgins and David Jobbins.

Three questions were put to the Board to give one-word answers as part of a Q and A using Slido:

What do you like about the Implementation Plan?

Comments included: Localism, Prevention, Ambitious, Inclusive, Comprehensive, Detailed

How useful do you think the plan is and how will it help us?

Comments included: Framework, Unsure, Vague,

What do you think is missing from or needs more focus in the plan?

Comments included: Resources, Timelines, Monitoring, Accountability, Neighbourhoods, SEND, Goals

It was noted that ICB's were being made to balance their budgets and the challenges that this would bring shouldn't be underestimated.

The Board appreciated the amount of useful information however, pointed to a need for more information on resources in the implementation plan, and the need to understand where the funding is to understand whether it was realistic.

The military population was highlighted as an anchor institution in Wiltshire, impacting without much notice and the need for cooperation going forward was expressed.

The timescale for incorporating the comments and updating the draft integrated care strategy was noted.

37 **Date of Next Meeting**

The next meeting is being held on 20 July 2023, starting at 10.00am.

38 **Urgent Items**

There were no urgent items.

(Duration of meeting: 10:00am – 11:30am)

The Officer who has produced these minutes is Max Hirst - Democratic Services Officer, of Democratic Services, direct line 01225 718215, e-mail max.hirst@wiltshire.gov.uk

Press enquiries to Communications, direct line 01225 713114 or email communications@wiltshire.gov.uk

Wiltshire Council

Health and Wellbeing Board

20th July 2023

Subject: BSW ICS Implementation Plan 2023/24

Executive Summary

I. Every Integrated Care Board (ICB) in England is required to produce a Joint Forward Plan (JFP) setting out how the ICB and NHS partners in each system will implement their Integrated Care Strategy and meet their legal duties to their population in 2023/24;
II. As part of this requirement ICBs and partner trusts are subject to a general legal duty in involve each Health and Wellbeing Board (HWB) in the geographical area with particular reference as to how the ICB proposes to implement the relevant Joint Local Health and Wellbeing Strategies (JLHWS);
III. In the BaNES, Swindon & Wiltshire (BSW) system partners have called the JFP the Implementation Plan for the BSW Strategy and present work across all partners rather than only NHS partners;
IV. The draft Implementation Plan was presented to the HWB on 25th May where it was discussed and considered by the members;
V. It was agreed that the HWB would delegate provision of the final opinion on the Plan to the Chair, in consultation with the Corporate Director of People (Wiltshire Council) and the Wiltshire Integrated Care Alliance Director (BSW ICB), given that there is not another HWB meeting prior to publication on June 30th;
VI. The finalised Plan is now being brought to the HWB to note changes from the draft and to note the agreed opinion.

Proposal

It is recommended that the Board:

i) note the finalised the 2023/24 BSW Implementation Plan; and
ii) note the opinion the HWB has provided that the plan takes proper account of the Wiltshire JLHWS.

Reason for Proposal

Following engagement the 23/24 Plan has been finalised and is brought to the HWB to note with the HWB opinion. The main changes are noted in the report.

David Jobbins
Interim Deputy Director – Planning & Programmes, BSW ICB

Wiltshire Council

Health and Wellbeing Board

20th July 2023

Subject: BSW ICS Implementation Plan 2023/24

Purpose of Report

1. Following informal consultation and engagement with stakeholders across BSW the finalised BSW ICS Implementation Plan is being presented to the Health and Wellbeing Board to note changes from the draft and to note the agreed opinion.

Relevance to the Health and Wellbeing Strategy

2. The Implementation Plan sets out how Integrated Care Partnership (ICP) members will work together through 2023/24 to support the delivery of the JLHWS.

Background

1. Our ICP (BSW Together) has produced a five year Integrated Care Strategy covering 2023 – 2028 called the BSW Strategy that brings together all system partners. This strategy will be refreshed annually.
2. Every Integrated Care Board (ICB) in England is required to produce a Joint Forward Plan (JFP) setting out how the ICB and NHS partners in each system will implement the strategy and also meet their legal duties to the local population. This Plan will also be refreshed on an annual basis through the life of the strategy.
3. In the BaNES, Swindon & Wiltshire system partners have agreed to call the JFP the Implementation Plan for the BSW Strategy and present the work across all partners rather than solely the NHS partners.
4. The draft Plan was presented to the Board at the 25th May HWB meeting.
5. Following engagement the Implementation Plan was amended prior to final publication on 30th June 2023.

Main Considerations

1. The wording of the HWB opinion, agreed through Chair's Action is as follows:
   In the opinion of the Wiltshire Health and Wellbeing Board, the BSW Implementation Plan for the Integrated Care Strategy takes proper account of the Wiltshire Joint Local Health and Wellbeing Strategy. We welcome the clear and strong alignment between the objectives, the detail on local implementation through Wiltshire Integrated Care Alliance and the opportunity to contribute to future refreshes of the plan, as well as the development of more detailed resource allocations and metrics to oversee quality and performance.

2. It should be noted that the Wiltshire place section in the Local Implementation Plans chapter has been maintained with the same wording as agreed with Wiltshire Integrated Care Alliance partners.
3. Following the engagement process the main changes to the 23/24 Plan are as follows:
    a. The length of the Plan was noted by a number of stakeholders. We have made considerable progress in reducing the length to below 140 pages. We will continue to work through how the Plan can be made increasingly user friendly through the life of the Strategy;
    b. All contributors have reviewed their sections to check their contributions are clear and understandable. This has made the narrative sharper and has contributed to reducing the size of the Plan overall;
    c. A specific Children and Young chapter has been created to bring together all partner activities for this part of our population in one location. This content has previously spread across the Plan which meant that messages and activities did not come across in a cohesive way; and
    d. We have worked to make the outputs and outcomes of the work as clear and tangible as possible so that stakeholders and our population will be able to see what has been delivered. As described in the outcomes chapter, there is still a lot of work to do on this and will be a particular focus of the 24/25 Plan refresh.

Next Steps

1. A framework for monitoring and assuring delivery against the plan as a whole will be developed during the year.
2. The final 2023/24 Plan has been published and made available on the BSW Together website.
3. We will be commencing the refresh process on both the Strategy and the Plan for 2024/25 in the coming months.

David Jobbins
Interim Deputy Director –
Planning & Programmes
BSWICB

Report Author:

David Jobbins, Interim Deputy Director – Planning & Programmes, BSWICB

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Bath and North East Somerset,
Swindon and Wiltshire Together

Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW Together)

Implementation Plan 2023

July 2023

Contents

Section 1

Introduction and purpose

Purpose of the Implementation Plan

The purpose of this plan is to enable our local populations, our partners, and our stakeholders to have a clear picture of the programmes and plans that will be delivered in support of our partnership strategy.

This Implementation Plan sets out how we and our partners, working together at system-level and in our places, Bath and North East Somerset, Swindon and Wiltshire (BSW), will deliver our Integrated Care Strategy over the period 2023 – 2028. This is our Joint Forward Plan that all Integrated Care Boards (ICB's) across England are required to produce for their respective systems.

This is the first time we are publishing an implementation plan, and this document focuses on plans for 2023/24 with a high-level vision for where we plan to be in 2028. The plan will be refreshed annually, and more detail will be added in future publications as to our plans and milestones for future years.

It is our expectation that both the plan and the process will mature through the five-year period of the Strategy so that the document becomes an increasingly comprehensive delivery plan which partner organisations and our local communities can use to understand and track our progress as a system.

Our system is made up of three distinct local areas – or Places – and a wide range of organisations which may operate at one or more of Neighbourhood, Place or System level. The name we have given to our Integrated Care System is BSW Together. The BSW Strategy, from which this Implementation Plan is derived, sets out what BSW Together aims to achieve for our population in the next five years and is informed by strategies and plans, including the three Health and Wellbeing Strategies, produced by partners.

The aim is that when these strategies and plans are seen together, they provide a coherent whole of what we aim to do and achieve.

The structure of the document reflects our intention for the plan to be a working document setting out our plan for the year in a digestible form as well as providing a summary of how the ICB will meet each of its legislative duties.

The structure gives a particular focus on how we are delivering our BSW priorities together through system activities, and our Place level priorities through our Place based local implementation plans. Both activities are supported by our enabling plans and our engagement work with our local communities. Assurance on delivery will be shared with our ICB Board on a six-monthly basis and published in our public meeting papers.

Section 1

Our Integrated Care Strategy on a page

Figure 1: Our Integrated Care Strategy on a page

Bath & North East Somerset
Joint Strategic Needs Assessment and Joint Local Health & Wellbeing Strategy

Swindon
Joint Strategic Needs Assessment and Joint Local Health & Wellbeing Strategy

Wiltshire
Joint Strategic Needs Assessment and Joint Local Health & Wellbeing Strategy

What we will deliver together

The BSW Vision

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

We will deliver this vision by prioritising three clear objectives:

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

How we will deliver it

The BSW Care Model:

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

Enablers to help make it happen:

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

Section 1

Our partnership vision and strategy

The Integrated Care Strategy, from which this Plan is informed, has built on the emerging priorities outlined in the following individual strategies that are either published or in development. Over the life of the strategy will build on and strengthen the links and synergies with all partners in order to most effectively deliver our strategic objectives.

Place Based Strategies

These include:

- Bath and North East Somerset (BaNES) Joint Local Health and Wellbeing Strategy (JLHSW)
- Swindon JLHSW
- Wiltshire JLHSW

Organisational Strategies

These include:

- NHS organisations (e.g., Trust strategies)
- Local Authorities (e.g., Local Plans, Air Quality Strategies, Economic Strategies)
- Voluntary, Community and Social Enterprise organisations
- Wider public sector (e.g., fire and police)
- Universities

Thematic Strategies

These include:

- Health Inequalities Strategy
- Primary Care Strategy
- Mental Health & Wellbeing Strategy
- Maternity Strategy
- Children & Young People Strategy
- Children Looked After Strategy
- Elective Care Strategy
- Urgent Care & Flow Strategy
- Acute Services Clinical Strategy
- End of Life Strategy

Enabling Strategies

These include:

- BSW Green Plan
- Financial Sustainability Strategy
- People Strategy
- Digital Strategy
- Infrastructure Strategy
- Quality Strategy
- Medicines Optimisation Strategy

Section 2

Working together to deliver our strategy

During 2023/24 we will be reviewing the effectiveness of both our governance and programme management arrangements with the aim of identifying where refinements should be made in order to drive both our partnership and transformation work forwards.

This process will help us to refine how we align the authority to lead with the responsibility and accountability for delivery across our system. This may result in delegation of resources and responsibilities to designated parts of our system.

Our Integrated Care Partnership (ICP)

The ICP is the statutory committee that sits within the local integrated care system and brings together a broad alliance of partners concerned with improving the care, health and overall wellbeing of the population. It is responsible for preparing the ICP strategy and is chaired by Cllr Richard Clewer, leader of Wiltshire Council.

There has been active participation in the ICP from a range of statutory and non-statutory organisations across BSW, however it is still a relatively small forum, and we need to further develop both the ICP's role within our integrated care system and the involvement opportunities that it can offer to stakeholders across BSW.

To achieve this the ICP will use its meetings throughout 2023/24 to bring together colleagues from our three places to focus on areas of common interest, and how we can evidence our progress towards a greater focus on prevention and early intervention.

BSW ICB

The Bath and North East Somerset, Swindon and Wiltshire ICB is a statutory body which brings together NHS organisations with local authorities and other partners to work to improve population health and establish shared strategic priorities. The ICB oversees how money is spent and makes sure that health services work well and are of high quality. It brings together hospitals, primary care, local councils, hospices, VCSE organisations and Healthwatch partners in our local places: Bath and North East Somerset, Swindon and Wiltshire. As an ICB, we have taken on the functions and broader strategic responsibility for overseeing healthcare strategies for the system from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group, which has now been dissolved

Acute Hospital Alliance

The BSW Acute Hospital Alliance (AHA) is a provider collaborative, made up of Salisbury NHS Foundation Trust, Royal United Hospital Bath NHS Foundation Trust, and Great Western Hospitals NHS Foundation Trust. The AHA aims to maximise delivery of benefits to the people of BSW helping them to live happier and healthier for longer. The collaborating Trusts will enable the delivery of excellent health and care services working closely with the Urgent and Emergency Care (UEC) and Elective Care programmes to deliver the BSW Care Model and ICP Strategy. As a provider collaborative, the AHA is committed to financial sustainability in BSW. In February 2023, BSW AHA was selected to be part of the first cohort of the NHSE Provider Collaborative Innovation Scheme. Membership of this scheme will drive delivery with tailored support and the opportunity to network and share learning and innovation with peers.

Section 2

Working together to deliver our strategy

Transformation Programmes

Table 1: Transformation programmes across BSW

Programme	Description
Prevention and Population Health Management	The BSW Prevention and Population Health Management Programme has two key areas of focus: To design and develop a coordinated approach across BSW to the implementation of initiatives which aim to support individuals to stay well and to prevent ill health. To develop the culture, tools and processes needed to embed a 'population health management' approach across BSW.
Children and Young People	The ambition of the Children and Young Peoples Programme is to nurture and value the health and wellbeing of all babies, children and young people, their families, and communities across BaNES, Swindon and Wiltshire to live happy, healthy lives, regardless of their circumstances, no matter where they were born, live and go to school, so we can close and prevent the inequality gap in their outcomes.
Integrated Community Based Care	The Integrated Community Based Care Programme is seeking to maximise the opportunity for transformational change in the way that services are delivered across the communities of Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW).
Mental Health Programme	To support people not just to survive, but to have opportunities to truly thrive and grow in a manner which supports them to make their unique contributions to our community.
Learning Disability and Autism	The three pillars in our programme are: 1. LDA/ND Pathways- including Community provision, keyworker programme, annual health checks and wellbeing. 2. Acute Care Pathway, Prevention and Oversight (ACPPO), including system escalation process and learning, Care education and treatment reviews, managing the dynamic support register, quality assurance. 3. North LDA Capital Delivery Programme- we have an exciting opportunity to lead on the provision of a new facility for individuals with a learning disability and/or autism who require support with their mental health.
Urgent and Emergency Care	The Urgent and Emergency Care Programme is focussed on ensuring the effective operation of the urgent and emergency care system across BSW.
Elective Care	The programme is focussed on ensuring that when individuals need to access health and care services in a planned way, these are accessible, joined up, efficient and effective, and delivered in a personalised way which recognises the desired outcomes and goals of the individuals concerned.

Section 2

Working together to deliver our strategy

Table 2: Enabling programmes across BSW

Programme	Description
Anchor Institutions	To fulfil our wider role as part of our local communities, helping to influence the health and wellbeing of our local populations.
Workforce Programme	Our priority is to improve both recruitment and retention of staff across BSW by creating a culture in which our workforce enjoy satisfying careers, feel valued and are able to make their best contribution.
Estates Programme	Realising the opportunity to create high quality estates with seamless IT connectivity across locations. We will design our facilities to ensure they are sustainable, of high quality, technologically enabled and in the right place.
Digital Programme	We will make the best use of technology and data to improve health and care for children and adults in BSW. We know that some people cannot access technology and we will make sure our services are always accessible for everyone.
Financial Recovery Programme	To ensure BSW is able to sustain financial balance and make the best use of its financial resources in the pursuit of the outcomes set out in the BSW Integrated Care Strategy.
BSW Green Plan Programme	An ambitious and cocreated system-wide vision and set of commitments to begin our journey towards delivering net zero health and care services in BSW.

Section 3

Ongoing engagement and involvement

There are three strands to our system approach to engagement and involvement:

- Maximising the opportunities to undertake engagement and involvement with our partners and communities jointly with partner organisations.
- A devolved approach where all colleagues recognise their individual role in engaging and involving stakeholders and our local populations.
- Adoption and implementation of the 10 elements of statutory guidance on involvement.

Our approach to ensuring that all parts of our population our able to engage and be involved will be informed by our local Joint Strategic Needs Assessment (JSNAs) and population health management data so that we are able to focus on communities where we know there are poorer health and wellbeing outcomes.

We also plan to develop a BSW Engagement Portal, Citizens Panel, form academic partnerships to make use of different approaches to achieving more effective interaction between services and communities and also to build a cohort of Experts by Experience to inform our thinking and planning. The work to bring these initiatives together will be captured in the ICB People and Communities Involvement Strategy.

Engagement for the Implementation Plan

We have engaged with key stakeholders to help inform the development of the strategy, including a well-attended stakeholder engagement event in December 2022. We collated feedback from attendees at this event and used this to inform the focus and structure of the strategy and subsequently this implementation plan.

Since developing a full first draft of the strategy in January 2023, we have engaged with members of the Voluntary Community and Social Enterprise (VCSE) Sector Alliance groups across Bath and North East Somerset, Swindon and Wiltshire and we will continue to work in collaboration with the sector at system, place and community level.

The strategy has also been presented to Health Overview and Scrutiny Committees, Health and Wellbeing Boards and Integrated Care Alliances (ICA) in each locality at both the draft and final version stages.

We have engaged with local Health and Wellbeing Boards on whether this plan aligns with their respective strategies, and their opinions are shown on the next page. The strategy and implementation plan will be refreshed annually, and this will provide a framework for ongoing engagement with partners and also our local communities. The record of engagement is shown in the Appendix.

Section 3

Ongoing engagement and involvement

Health and Wellbeing Board Opinions

BaNES Health and Wellbeing Board (HWB)

BaNES Health and Wellbeing Board has been asked to provide an opinion on whether the BSW Implementation Plan (the local version of the Joint Forward Plan) for the BSW Strategy takes proper account of the BaNES Joint Local Health and Wellbeing Strategy. We note that the BSW Strategy, from which this plan is derived, is focussed around the delivery of three Strategic Objectives which have been agreed across partners and were arrived at through a process of consideration of the priorities in the three local JLHWS, including the BaNES strategy, as part of a wider stakeholder engagement process. Themes from priorities in the BaNES Joint Local Health and Wellbeing Strategy flow well through the plan. The plan also includes a chapter pulling out key 2023/24 deliverables from the local implementation plans for each of the three place based Integrated Care Alliances. The BaNES section well reflects delivery of relevant parts of the BaNES JLHWS.

The BaNES HWB is therefore happy to confirm that the BSW Implementation Plan does take proper and appropriate account of the BaNES JLHWS. The BaNES Board welcomes the opportunity to continue to be engaged in and contribute to future refreshes of the implementation plan.

Swindon Health and Wellbeing Board

Swindon Health and Wellbeing Board has been asked to provide an opinion on whether the BSW Implementation Plan (the local version of the Joint Forward Plan) for the BSW Strategy takes proper account of the Health and Wellbeing Strategy. We note that the BSW Strategy, from which this plan is derived, is focussed around the delivery of three Strategic Objectives which have been agreed across partners and were arrived at through a process of consideration of the priorities in the three local health and wellbeing strategy, including that of Swindon, as part of a wider stakeholder engagement process. Themes from priorities in the Swindon Health and Wellbeing Strategy flow well through the plan. The plan also includes a chapter pulling out key 2023/24 deliverables from the local implementation plans for each of the three place based Integrated Care Alliances.

The Swindon Health and Wellbeing Board is content to confirm that the BSW Implementation Plan does take proper and appropriate account of the Swindon Health and Wellbeing board strategy. We welcome the opportunity to continue to be engaged in and contribute to future refreshes of the implementation plan.

Wiltshire Health and Wellbeing Board

In the opinion of the Wiltshire Health and Wellbeing Board, the BSW Implementation Plan for the Integrated Care Strategy takes proper account of the Wiltshire Joint Local Health and Wellbeing Strategy. We welcome the clear and strong alignment between the objectives, the detail on local implementation through Wiltshire Integrated Care Alliance and the opportunity to contribute to future refreshes of the plan, as well as the development of more detailed resource allocations and metrics to oversee quality and performance.

Section 4

Our population

Bath and North East Somerset, Swindon and Wiltshire has a combined population of around 923,000 people (BSW System Intelligence Report, 2021). Life expectancy across the three areas varies from 73 years to 91 years according to sex and geographical location.

There are further in life expectancy between places and neighbourhoods in BSW. For example, a female in Bathavon South, BaNES, can expect to live for 91 years, whereas a male from Trowbridge Central, Wiltshire, can expect to live for 73 years (BSW Partnership, 2021).

Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men (Department of Health and Social Care, 2022). Women in inclusion health groups often experience severely poor health outcomes. The Women's Health Strategy for England acknowledges that it is vital that we address these stark disparities and improve health outcomes for women in these groups.

In BSW, approximately 1 in 3 children do not achieve a good level of education at the end of reception, approximately 1 in 10 children are living in poverty and 1 in 200 are in care. So, although many childhood indicators are better than the national average in BSW, there are still many children that have difficult living circumstances.

According to the Index of Multiple Deprivation (IMD) (2019), Bath, North East Somerset, Swindon, and Wiltshire remains one of the least deprived parts in the country. However, this overall average masks pockets of deep deprivation and inequality within each area, including 14 neighbourhoods within the most deprived 10% nationally (2 in BaNES, 1 in Wiltshire, and 11 in Swindon). Swindon has a higher level of deprivation compared to Wiltshire and Bath and North East Somerset.

During the pandemic there have been disproportionate deaths from Coronavirus Disease 2019 (COVID-19) between those living in the most deprived areas and those living in the least deprived areas. Ethnicity also has a large and complex effect on health. In England, inequality is experienced when comparing ethnic minority groups and those from white ethnic groups, and between different ethnic minority groups (Robertson et al., 2021).

Nationally, the COVID-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population.

There are approximately 87,000 people from ethnic minority communities living in BSW (ONS, 2021). Swindon has significantly more residents from a black and ethnic minority group: 18.5% in Swindon, compared to 7.8% in BANES and 5.6% in Wiltshire (ONS, 2021). In all three areas the largest ethnic group after 'White British' is 'Asian/Asian British/Asian Welsh' (ONS, 2021).

Section 5

Our local implementation plans

The ICP and the three Health and Wellbeing Boards in BSW all have responsibility to set direction to improve health and reduce inequalities through the BSW Integrated Care Strategy and the three Local Health and Wellbeing Strategies respectively.

The Health and Wellbeing Boards need to consider the Integrated Care Strategy when preparing (or updating) their own strategy to ensure that they are complementary and to actively contribute to the development of the Integrated Care Strategy. The ICB will involve the Local Health and Wellbeing Boards in preparing or revising their forward plan.

The Integrated Care Alliances in BaNES, Swindon and Wiltshire have responsibility for oversight and assurance of the delivery of the relevant parts of the Integrated Care Strategy and the Local Health and Wellbeing Strategy.

This chapter sets out how partners across health and care are working together to provide accessible care nearer to where people live and enable us to build an approach rooted in prevention and early intervention to support our population to remain healthier and happier and as long as possible.

Section 5

Our local implementation plans

BaNES

Context

The Health and Wellbeing Strategy is a seven-year strategy that identifies four priorities for improving health and wellbeing and reducing inequalities for the Bath and North East Somerset (BaNES) population. These are:

- Ensure that children and young people are healthy and ready for learning and education.
- Improve skills, good work and employment.
- Strengthen compassionate and healthy communities.
- Create health promoting places.
- These priorities are directly informed by the intelligence collated in the BaNES Strategic Evidence Base (also known as the Joint Strategic Needs Assessment, or JSNA).

The strategy was developed by working closely with local partners from health, social care, the local authority, community and social enterprise groups. Residents of BaNES also played a key role in identifying priorities through public consultation.

The strategy and its implementation plan complement and align with other strategies and plans, such as the Economic Strategy, the Local Plan, and the BaNES Swindon and Wiltshire Integrated Care Strategy by setting out ambitions and a plan to improve health and wellbeing through the combined efforts of partners on the Health and Wellbeing Board. It is intended to also set high-level direction for the BaNES Integrated Care Alliance.

All of this work to date has been co-designed and collaboratively developed with people with lived experience and this engagement will continue across our programmes of work. We will continue to proactively keep an ongoing, meaningful dialogue with our communities including through our Your Health, Your Voice Panel, carers forum, and Third Sector Alliances.

How we are organised to deliver

Our ICA has embraced the opportunity for new ways of integrated working and closer alignment with partners. To achieve this and recognising the scale of our area and capacity of partners, we utilise existing local forum wherever possible to govern our locality joint working. This includes:

1. An Integrated Care Alliance and Locality Commissioning group that feed directly into the ICB Board and other sub-committees as required and works closely with our Health and Wellbeing Board.
2. An Alliance Delivery operational group – that holds the work of the locality in one strategic place, and is empowered to setup relevant task and finish groups as required to respond to any BSW wide transformation that needs a locality input, response or lead.
3. Health and Wellbeing Board sub groups that feed into specific themed work areas across our system. For example the BaNES Children and Young People sub group of the Health and Well Being Board feeds into the Children and Young People Programme Board of the BSW ICB.

Section 5

Our local implementation plans

By keying into existing structures we reduce duplication, maximise efficiencies, capacity, capability and skills. This enables us to use our resources to target joint working in a way that can be flexible in meeting our needs, standing up and standing down groups as needed.

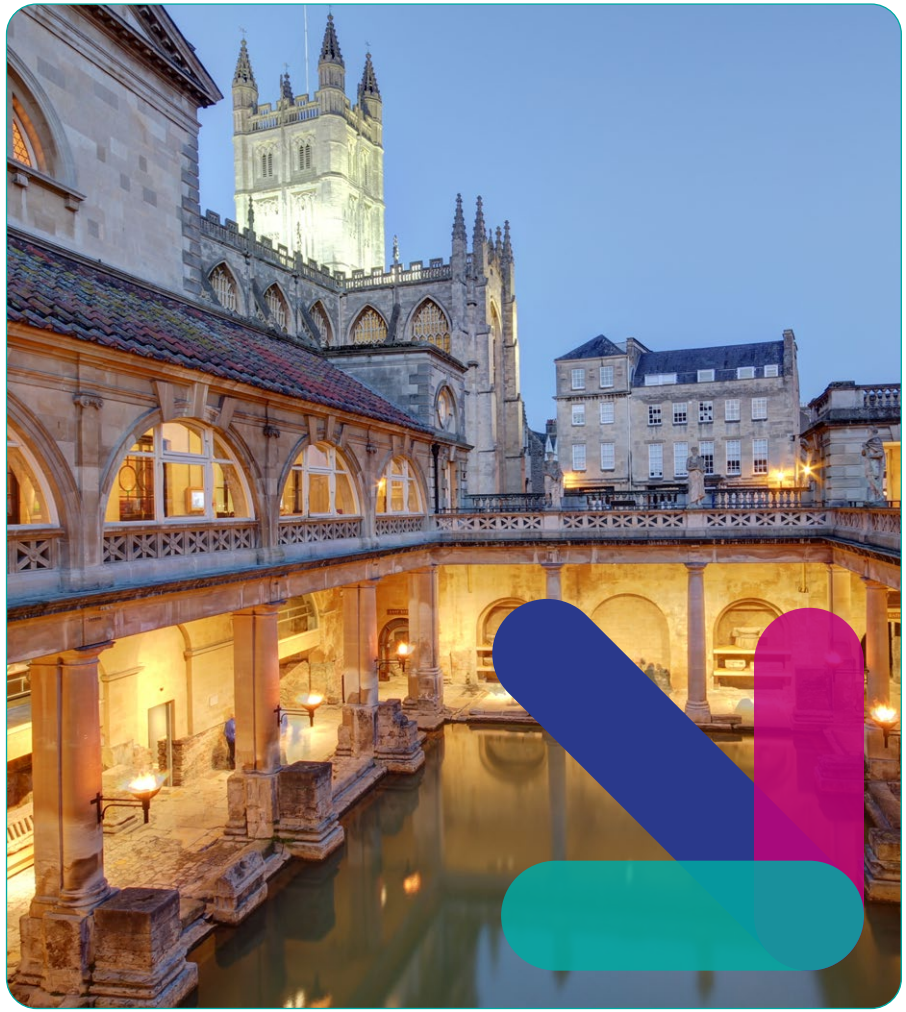
The Health and Wellbeing Board and the Integrated Care Alliance work alongside one another to ensure alignment of core objectives and strategic outcomes for the health and wellbeing of our population.

Our BaNES Integrated care Alliance (ICA) have identified priorities that respond directly to the BSW statutory functions and align with the priorities in our H&W Being strategy. The priorities directly correlate to the journey of transforming our care model.

Our delivery plan

Our Integrated Care Alliance (ICA) priorities are collaboratively developed across all our partners and reviewed annually.

Our current set of priorities, which respond to the Statutory functions of the BSW Integrated Care Board (ICB) and align with the aforementioned H&W priorities, have a two to three year timeframe to deliver given their scale. Our current priorities are set out on the next page alongside cross cutting themes.

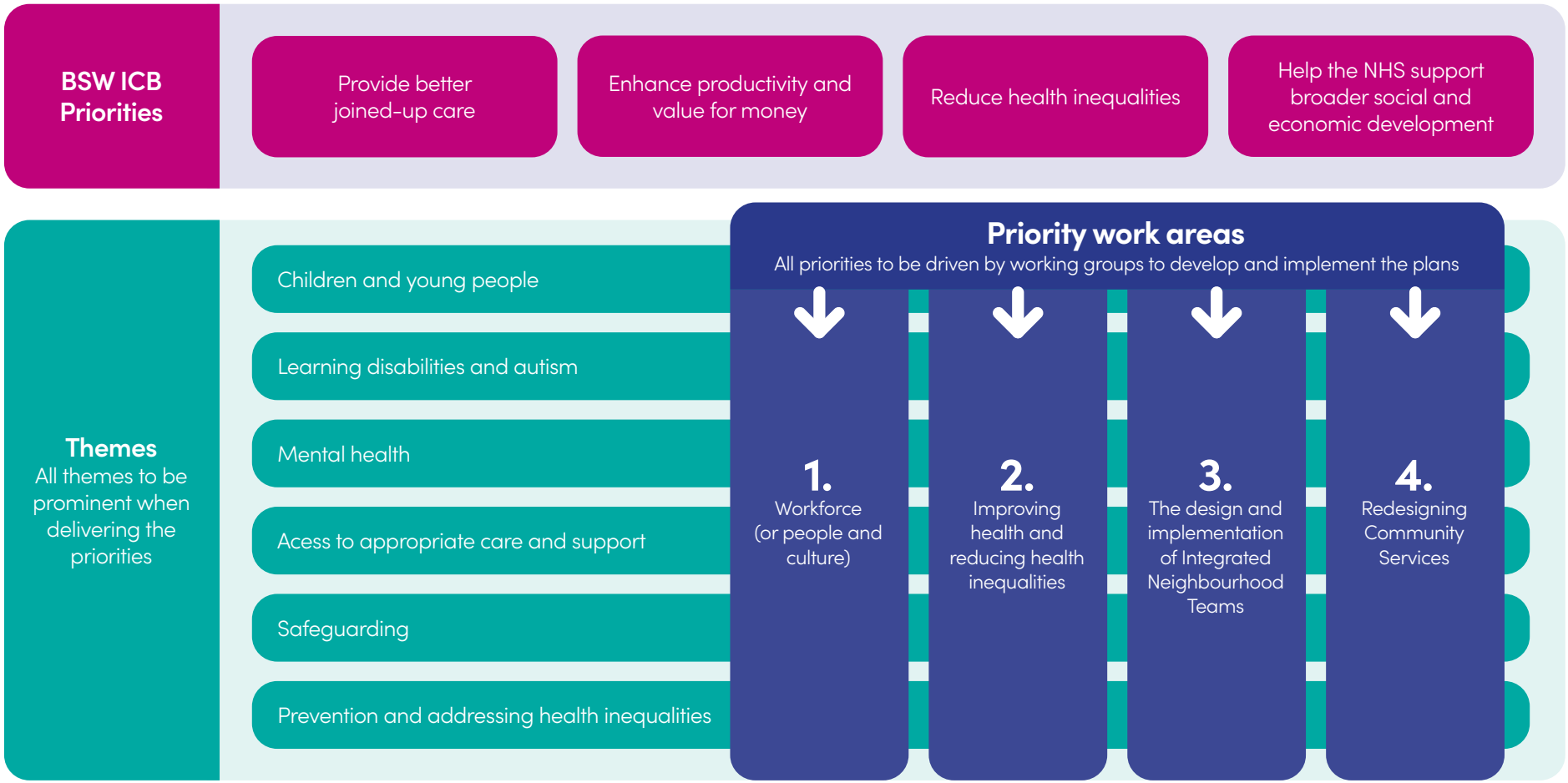


Section 5

Our local implementation plans

Priority work areas and themes

Figure 2: Priority work areas and themes in BaNES



Section 5

Our local implementation plans

1. Workforce culture and people

Our Integrated Care Alliance is comprised of Health and Care Professional Leadership that is diverse and fully inclusive of the broad range of professionals who work together across our system, beyond the traditional boundaries of health and care. Including Leaders from across the Third sector, Local Authority, Primary Care, our Acute Hospitals, Community provision, and all age Social Care. Our Leadership is committed to promoting ways of working and a culture that is creative, ambitious and innovative, to ensure we make improvements happen to best serve our population.

Examples of this included working with the BSW Academy on approaches to attract, widen access to and retain a workforce in Domiciliary Care, and to consider place actions to implement the recently commissioned work from the academy. At locality we are testing new models including United Care Bath- a joint initiative between the Council and Royal United Hospital.

Workforce milestones include:

- Between May and April and May 2023: Update on outputs from the work commissioned from the BSW Academy.
- Between May and September 2023: consider BaNES local response.
- Continued joint working across all sectors to consider new models of working in an integrated way to respond to opportunities, local needs and challenges. This will be a key enabler to attract, retain, and provide development opportunities to create a multi skilled sustainable workforce.

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Our local implementation plans

2. Improving health and reducing health inequalities

From the strategic base Strategic Evidence Base an emerging area of health improvement need on which to give focused attention is improving cardiovascular disease outcomes.

Over the coming months the scope of this work this will be agreed, identifying opportunities to make concerted efforts to drive improvements in areas such as tobacco control, the Health Check offer, whole system approach to weight management, alcohol use, and variation in high risk condition monitoring and intervention, taking a population health management approach.

We will take an approach to this work that aligns with and maximises benefit to other work programmes that benefit the population. In the next 12 months, we plan to do the following in relation to this area of health improvement:

- Work with colleagues to agree the scope of work.
- Develop an implementation plan.
- Secure sign up to the plan from the ICA and establish an implementation group.

What will be different for our population in 5 years' time

Cardiovascular disease outcomes will be improved.

In relation to reducing health inequalities, we are establishing a Health Inequalities Network in BaNES with dedicated resource to strengthen capacity and understanding about inequalities.

We are taking an evidence-based understanding of how inequalities impact on our population and will build on this with coordinated and planned action to prevent and tackle inequalities through activity at different levels including through wider determinants of health, health and wellbeing services, ill health prevention programmes, health care services, and social care programmes.

An example of this is the Community Wellbeing Hub (CWH). The CWH is made up of a partnership from the public, private and third sector organisations. It provides a "one-stop-shop" for wellbeing services for adults and their families. We have a hub and spoke model with a Central Wellbeing hub and a spoke in the Atrium of the Royal United Hospitals, Bath (RUH) to assist with discharge planning. The 'Culture' and ways of working is different and critical to implementation.

The approach is one of shared responsibility, and working practices and organisational boundaries removed, which enables the focus to be on the individual. The hub is an example pre-cursor of how we can utilise community assets to implement Integrated Neighbourhood Teams (INTs).

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Our local implementation plans

In the next 12 months we plan to do the following in relation to tackling health inequalities:

- By end of April 2023: Health Inequality network coordinator in post.
- By end of May 2023: Network posts in RUH and primary care (PC) in place May 23.
- Between April and September 2023: Community Investment Fund in place supporting universal and targeted schemes to support local people by addressing known inequalities including warm housing and help with cost of living increases.
- Establish governance and partnership arrangements to shape and oversee delivery of a health inequalities implementation plan.
- Establish a health inequalities network.
- Use Strategic Evidence Base to identify priorities and potential actions to address.
- Develop and be implementing a heath inequalities implementation plan that aligns with the BSW Health Inequalities (HI) Strategy.

What will be different for our population in 5 years' time
People from groups experiencing greater inequalities will see this reduce with improved access and outcomes.

3. The design and implementation of Integrated Neighbourhood Teams

Our delivery plan

- Designing and implementing Integrated Neighbourhood Teams is one of four priority work areas of the BaNES Integrated Care Alliance.
- For further detail see the BaNES Local Implementation Plan section.

How we are organised to deliver

- There is a BaNES Task and Finish Group (T&F) for Integrated Neighbourhood Teams attended by a range of partners, which reports to the BaNES Integrated Care Alliance.
- The leads for the BaNES INT T&F Group meets monthly with leads in Swindon and Wiltshire to share learning and develop synergies for INT working at a system level.
- The T&F Group uses an Improvement Together approach to facilitate a quality improvement and learning style to the design and development of INTs.
- The T&F Group will work and support a number of teams and services to test the emerging design principles and outcomes measures for INTs.

Section 5

Our local implementation plans

What we will do in the next twelve months

- By July 2023: Co-create a blueprint for the BaNES collaborative approach and Integrated Neighbourhood team model. This will include mapping of our current resources and community assets. Understand any gaps in resourcing.
- Develop an INT Maturity Matrix and associated outcome measures to enable teams to develop INT ways of working.
- From May 2023: collaborate with Community Frailty 12-month pilot to trial INT approach to working with 2 primary care networks (PCNs) in BaNES.
- Between August and October 2023: Identify at least 4 other teams and services - working with different scales of geography, population need, range of providers - to test the Maturity Matrix and outcome measures.
- By September 2023: Evolve the BaNES INT T&F Group into a Steering Group to oversee and assure the progress against agreed programme timescales.

What will be different for our population in 5 years' time

- Care will feel individualised as teams and services operating an INT approach will drive clinical practice and interventions based on population health need.
- Children and adults will experience more coordinated care, delivered together and including smaller local services and assets in their community to meet their health and care needs
- People will be proactively offered interventions to reduce their risk of long term conditions (LTCs) as teams and services start to utilise data predictively.

4. Redesigning Community Services

We have a transformational opportunity to consider the needs of our population and to design and shape our services and provision so that it is outcome focussed and meets the needs of individuals within the community in line with the BSW Care Model.

This will involve discussions to determine what we mean by left shift of resources and funding across our ICA and to understand where the opportunities are for place to drive delivery and where working at scale provides added value.

In addition, there are a number of cross cutting transformation priorities, which link across place and system. The key BaNES focus areas for these cross-cutting themes feature below.

Access to Care and Support

Home is Best is an umbrella programme of work being undertaken across multiagency partners in BaNES to deliver the espoused improvement in access to care and support for our local population.

This programme also feeds into and aligns with system wide work across the end-to-end health and social care pathway. The programme plan features on the next page.

Section 5

Our local implementation plans

Figure 3: Home is Best programme plan

Admission avoidance	Improve flow – home with informal support	Improve flow – home with additional support	Improve flow – bedded capacity
	ECIST review of BaNES community health and social care pathways – April 2023		
Urgent community two hour response – in place delivering above the trajectory.	Expansion of BaNES Wellbeing Hub to support RUH and community discharge through third sector provision – in place.	Reablement including art plus – review of pathways and demand and capacity.	Consolidate bed base – ward four business case and workforce plan – commenced.
BSW care co-ordination CCC with access to SWAST call stack and development of business case – BaNES linked into system wide plans.	Increased Individual Discharge Grants.	Home care – United Care Bath (UCB) ambition to increase care by 1,000 hours – commenced.	Focus on complex discharges including dementia amd delirium pathways.
BaNES Virtual Ward – RUH Hospital at Home in place – on track to deliver trajectory to go live May 2023 and hit trajectories by September 2023.	Introduce wellbeing checklist to start planning on admission.	Social care – reduce delays for Adult Social Care Assessment including use of trusted assessors – commenced.	Describe not prescribe – focus on ensuring patients are on the correct pathways– commenced.
		Reducing self funding and brokerage delays.	
Patient Outcomes Provide support, treatment and interventions closer to home. Reduce preventable admissions	**Patient Outcomes** Reduce length of stay and expedite discharge to support people returning to their normal place of residence.	**Patient Outcomes** Reduce length of stay and expedite discharge to support people returning to their normal place of residence or a placement to meet their needs.	**Patient Outcomes** Reduce length of stay and expedite discharge to support people returning to their normal place of residence or a placement to meet their needs.

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What we will do in the next twelve months

By end of May 2023: Our BaNES step up Virtual Ward will be operational and supporting patients to stay safely in their community reducing preventable hospital admissions.

By September 2023: Both our BaNES Step Up and Step Down Virtual Ward models will deliver the required capacity to meet the national trajectory.

By the end of April 2023: We will have conducted, with the support of the national Emergency Care Intensive Support Team, a further review of community health and social care pathways. This will build on the strong foundation we have developed together to reduce the Non-Criteria to reside position in our acute hospital and support people to return home or their usual place of residence.

By the end of April 2024: Our focus for the next 12 months will be the delivery of the Home is Best work streams as documented above with the initial priority of increasing community hospital flow. This will deliver improved patient flow across our system supporting patients to be in the best environment to lead happy and healthy lives.

By end of April 2023: our community wellbeing hub will be piloting in both our acute and community hospitals.
By July 2023: We will have increased care by an extra 600 hours through our United Care Bath (UCB) project.

By end of April 2024: Care through the UCB project would be increased by 1,000 hours.

By May 2023: We would have collaboratively developed the business case to secure funding for Ward Four – which provides additional community hospital beds. This will support our 'left shift' agenda to reduce reliance on acute hospital beds.

What will be different for our population in 5 years' time

- Care will feel individualised and personalised.
- People will be able to access the care they need, where and when they need it.
- We will reduce hospital admissions and support people to stay well in their local community.

We will continue to monitor access to other services including elective care and diagnostics to ensure our local population get the help they need when they need it linking in with the system wide Elective Care and Mental Health recovery plans.

Our plans include digital and technological transformation such as remote monitoring for people being supported by our Virtual Wards and realising the benefits of work to create an Integrated Care Record.

Section 5

Our local implementation plans

Themes
All of our ICA themes are a lens that we apply to everything that we do and also have been identified in our evidence base as key areas to improve outcomes for our local population. Below we have set out more detail around two of our themes: Children and young people and Learning Disabilities and Autism.

Children and Young People
Within BaNES our key priorities around supporting children, young people and families include:

Strengthening family resilience to ensure children and young people can experience the best start in life including:

- Provide intensive support for those eligible for free-school meals to improve school readiness.
- Confirm and measure pre-conception support including smoking cessation, preparing for parenthood and maternal mental health provision.
- Improved transition processes between children and young people and adult services (physical and mental health (MH) provision).

Reduce the existing educational attainment gap for disadvantaged children and young people including:
Provide intensive support for children eligible for free school meals and with Special Educational Needs and Disability (SEND) to help them achieve better outcomes at school.

Ensure services for children and young people who need support for emotional health and wellbeing are needs-led and tailored to respond and provide appropriate care and support (from early help to statutory support services). Our work will align with the BSW Children and Young People's Programme and we will continue to have a focus on Children Looked After and the Care Leavers Covenant. Further co-design of transforming the provision for children, young people and families across physical health and emotional wellbeing will continue with people with lived experience and staff from across our system.

Learning Disabilities and Autism
We will continue to collaboratively develop our local priorities for people with Learning Disabilities (LD) and Autism (ASD). These will align with system wide priorities including:

- Reducing the number of people cared for in an inpatient unit out of area.
- Introducing the national Key Worker programme in BaNES for people with LD and ASD to support people in their local community.
- Improving access to services including Autism diagnosis and support for children, young people and adults.
- Promoting and delivering improvements to the number of children, young people and adults who access their Annual Health Check and health screening programmes.
- Further work on our inclusive workforce agenda to offer opportunities for employment for these members of our communities.

Section 5

Our local implementation plans

Emotional Wellbeing and Mental Health
We will continue to work with people with lived experience, families, carers and supporters and our staff from all partners to further transform our offer for people to stay well with their emotional wellbeing and mental health.

Our areas of focus include:

- Expanding the community emotional wellbeing and mental health support offer as part of the continued implementation of the community mental health framework.
- Improving access to support including reduced waiting times for Talking Therapies and Child and Adolescent Mental Health Services (CAMHS).
- Delivery of the new Community Wellbeing House in Bath in conjunction with our third sector partners.
- Embedding emotional wellbeing and mental health support in our priority community workstreams such as Integrated Neighbourhood Teams, Virtual wards and Community Wellbeing Hub.

We will also build on work across safeguarding to ensure we have strong oversight of our most vulnerable communities and align this with work to reduce health inequalities for our local populations – addressing known areas including homelessness and rough sleeping and rural isolation.

Section 5

Our local implementation plans

Swindon

Context

Swindon has a population of nearly 223,000 which is projected to increase by about 5% between 2020-2030. Our Swindon population has a significantly lower healthy life expectancy than Wiltshire or BaNES. In terms of deprivation, Swindon ranks as the 98th most deprived area out of 151 upper tier authorities in England but some of the smaller areas are in the 10% most deprived in the country.

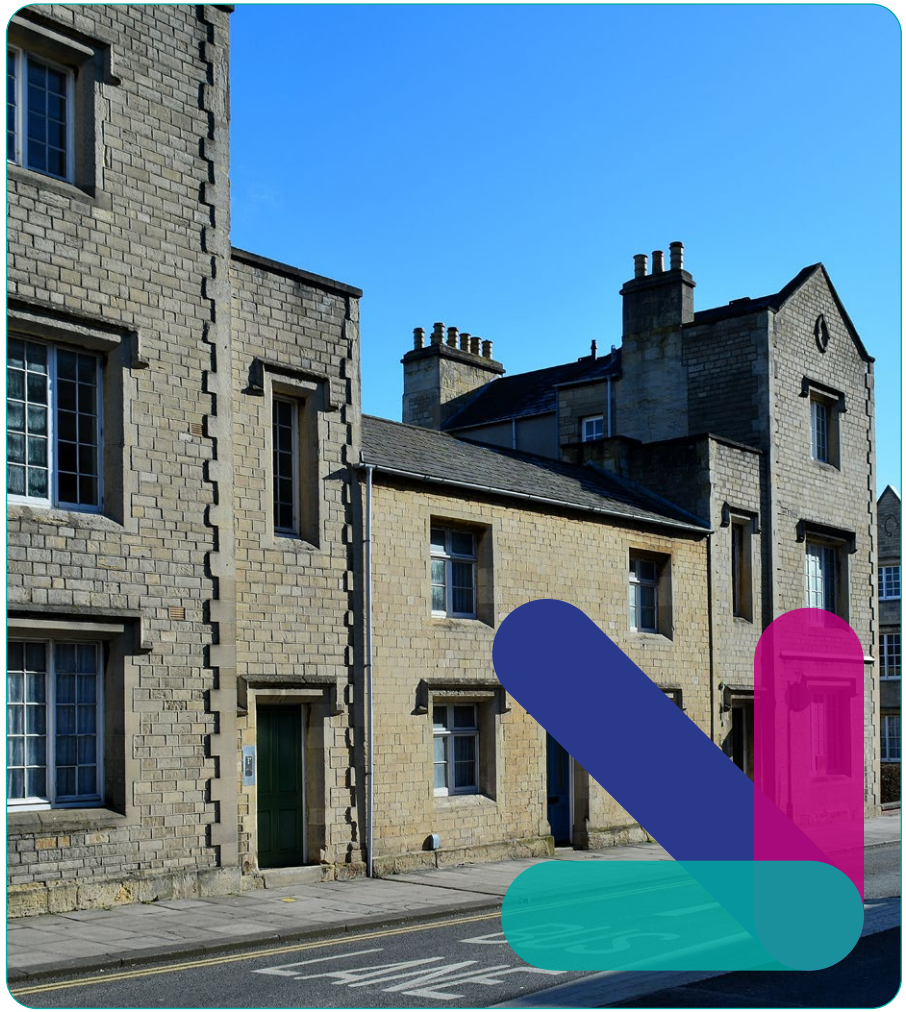
Tackling health inequalities and the impact of deprivation run through the heart of our ICA delivery plan which draws on the three clear priorities set out in the refreshed Health and Wellbeing Strategy for Swindon set out below. These priorities are:

- Improve mental health and wellbeing.
- Eat well and move more.
- Stop smoking and reduce alcohol.

These priorities also feed directly into the BSW Integrated Care Strategy.

Our Delivery Plan

Our delivery plan has been shaped by partners across our ICA. It is guided by a set of principles (set out below) and underpinned by ICP enablers. It blends with our joint Better Care Fund plan (the next iteration is 2023-25) which sets out specific priorities in more detail across health and care.



Section 5

Our local implementation plans

The principles guiding our plan are as follows. We will...

- Work together and take collective responsibility to ensure the system is fair and that everyone is contributing to solve even the most difficult problems.
- Ensure that we tackle inequalities following the Core20PLUS5 approach to reducing inequalities.
- Prioritise co-production and ensure people using our services have a clear voice in their design, development, and delivery.
- Listen, coordinate, and communicate effectively to avoid duplication and ensure people only have to tell their story once.
- Work in partnership across our third sector, health, and social care teams to provide joined up support that meets the needs of individuals.
- Ensure our colleagues, patients, carers, partners, and our communities experience meaningful participation in decision-making, in shaping our health & care services and delivering person centred care.
- Engage in meaningful co-production of all programmes, driven with a needs led lens.
- Listen and adapt based on views from our diverse communities.
- Ensure we have a JSNA evidenced health and wellbeing strategy.
- Focus on action and delivery.
- Not cost shift.
- Promote personalised care and involve unpaid carers and families - we will ensure carers receive carers assessments.

The three core segments in our Delivery Plan are set out below and in the following diagram. Each segment of the plan has developed a set of objectives, and these are set out below:

- Improving the care and quality of service delivery.
- Managing demand, capacity, and resource.
- Improving the wellbeing of our communities.

The three ICP objectives inform our plan, and our three health and wellbeing strategy priorities are specifically referenced within our health inequalities workstream, although the themes also run throughout our plan.

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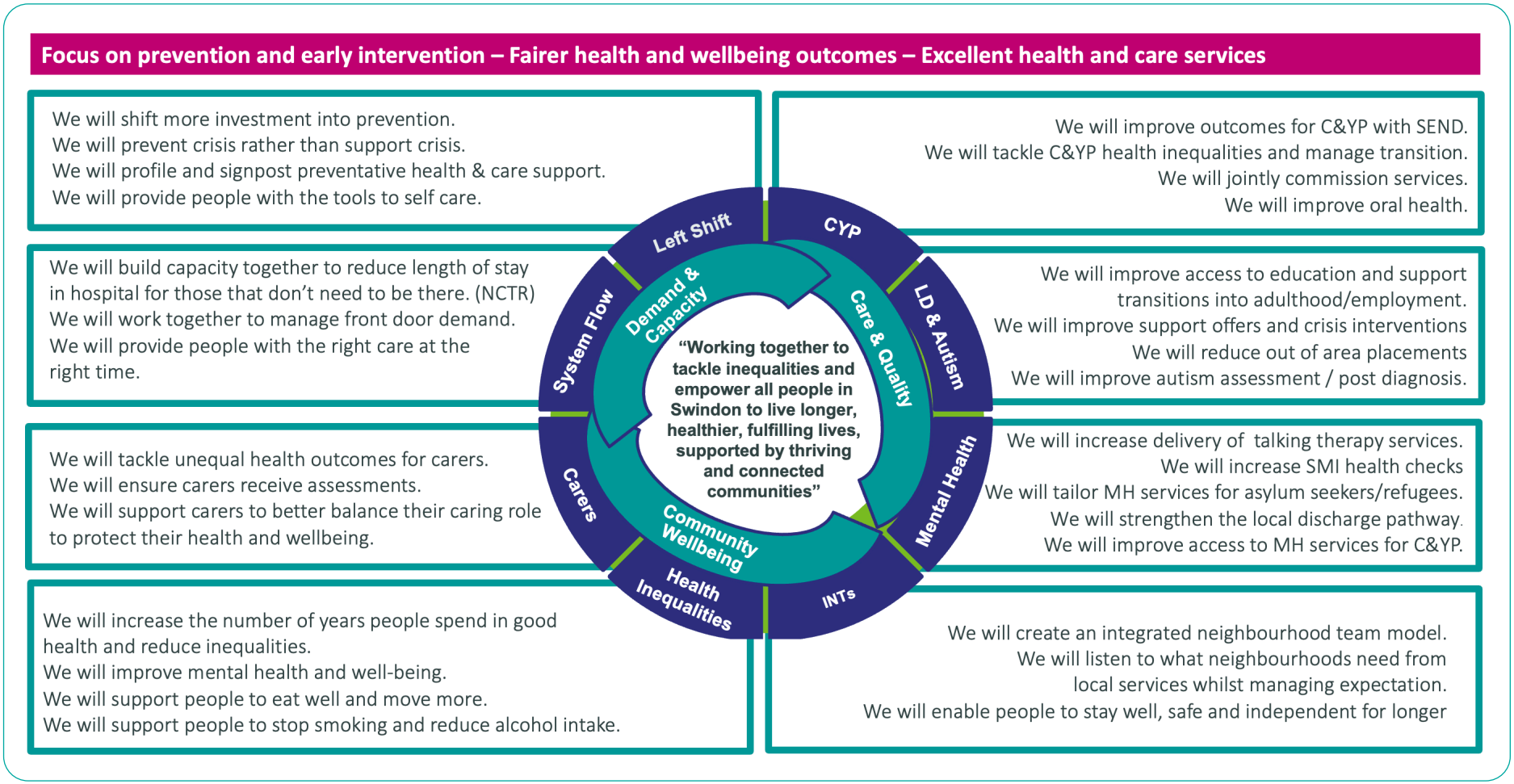
Swindon ICA - Our Vision and Delivery Objectives

Figure 4: Swindon ICA - Our Vision and Delivery Objectives



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How we are organised to deliver

Currently the ICA Delivery Plan is led through the ICA Delivery Executive Group (DEG) which is the engine room of the ICA.

Feeding into the DEG currently are a number of working groups, including the ICA Planning Group, Mental Health and Learning Disability and Autism (LDA) Forum and ICA Inequalities Group. Going forward, leads for the three priority segments will review governance required. The DEG will oversee the delivery plan and will report regularly into the ICA which in turn reports into the Swindon Health and Wellbeing Board.

The ICA Delivery Plan incorporates key ICB transformation programmes as follows:

- Community transformation and primary care development are aligned to our integrated neighbourhood teams work stream.
- Urgent and emergency care transformation is led through the demand and capacity work stream and locality planning group.
- The principles of business intelligence and population health management run through all of our work streams which are informed by data and modelling (a strong example of this is the demand and capacity modelling to support system flow).

A diagram illustrating our governance structure is set out on the next page.

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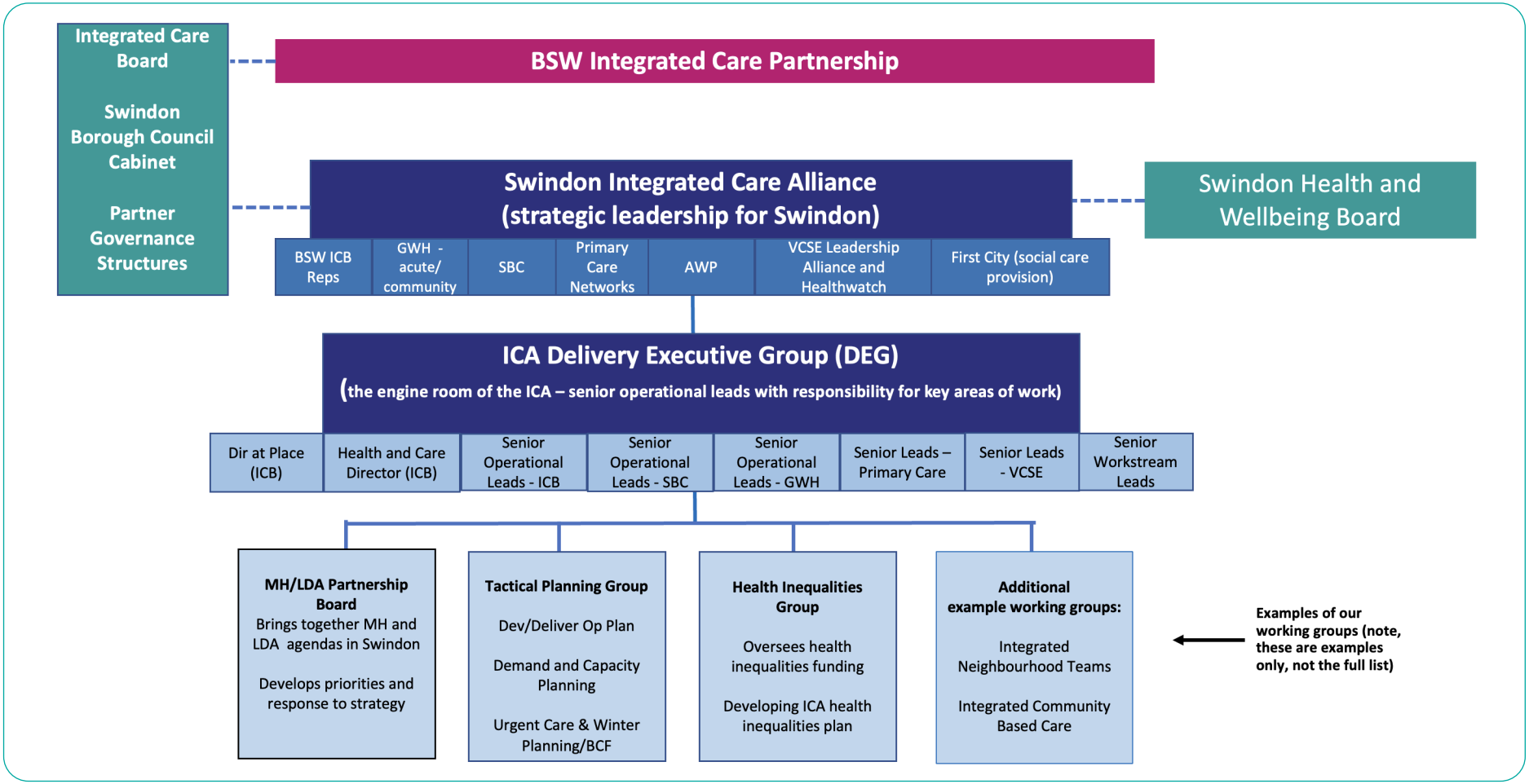
ICA - Governance and delivery model

Figure 5: Governance and delivery model



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What we will do in the next 12 months

Set out below are the core segments in our ICA Plan and the actions taking place to achieve our objectives in the next 12 months.

It is important to note that our plan is iterative; this is not the final version, and it will continue to evolve over the coming months and during its lifetime.

We are currently designing the outcomes framework for our delivery plan with key metrics that will enable us to measure the impact of our actions. These metrics are blended with core national metrics including those set out in the Better Care Fund.

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Swindon ICA 5 Year Delivery Objectives and Milestones

Table 3: Care and Quality

	CYP	Learning Disabilities and Autism	Mental Health
Milstones	We will improve outcomes for CYP with SEND. We will tackle CYP health inequalities and manage transition. We will listen and ensure a person centred approach. We will jointly commission services We will explore how to improve oral health for CYP.	We will improve access to education, and support transitions into adulthood and employment. We will improve support offers and crisis interventions. We will reduce out of area placements. We will improve autism assessment process and post diagnostic services.	We will increase delivery of talking therapy services. We will increase SMI health checks. We will tailor MH services for asylum seekers/ refugees. We will strengthen the local discharge pathway. We will improve access to mental health services for CYP.
Q1	Continue prep work for recommissioning of Children's Health Services Embed programme of work for Delivering Better Value Sign off of Joint Funding Guidance for CYP	Carry out Building the Right Support Peer Review – Jun23	Review SMI health check registers with primary care and the wider system We will hold a mental strategy workshop to determine how best to deliver mental health services Commission new model of CYP MH services for CAMHS/ TAMHS & MH Support Teams
Q2	Plan for recommissioning of supported living in support of transition planning Develop plan for implementation of national strategy for autistic children, young people and adults: 2021-2026		
Q3	Complete SSP project on self-neglect and exploitation Scope opportunities to improve oral health	Complete review of dynamic support process Launch BSW Autism Care Co-ordination pilot Carry out a review on how to improve LD assessment process and post diagnostic services	Family Safeguarding Model with MH becomes operational Commission new Wellbeing House Implement new primary care SMI health check model
Q4	Review opportunities for jointly commissioned SEND roles Complete review of market sufficiency	Monitor the improvement of the uptake of annual health checks	Implement revised BSW wide IAPT model

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Swindon ICA 5 Year Delivery Objectives and Milestones

Table 4: Community Wellbeing

	INTs	Carers	Health Inequalities
Milstones	We will create an integrated neighbourhood team model. We will listen to what neighbourhoods need from local services whilst managing expectation. We will enable people to stay well, safe and independent for longer (BCF).	We will tackle unequal health outcomes for carers. We will ensure carers receive assessments. We will support carers to better balance their caring role to protect their health and wellbeing.	We will increase the number of years people spend in good health and reduce inequalities. We will improve mental health and well-being. We will support people to eat well and move more. We will support people to stop smoking and reduce alcohol intake.
Q1	Identify pathfinder area(s) Workshop with frontline workforce (BCF milestone – TBC) Confirm key milestones for integrated community based care programme and update plan	Explore financial sustainability of Carers services Plan for re-procurement of Carers Services is in place	First meeting of reformed ICA Inequalities group
Q2	Integrated Neighbourhood Team Task & Finish Group formed which reports to ICA (BCF milestone – TBC)	Engage carers in development of Integrated Neighbourhood Team model	Publish the Health & Wellbeing Board Strategy and associated implementation plans
Q3	Initial integrated neighbourhood team model developed (BCF – TBC)	Integrated Neighbourhood Team know the carers in the pathfinder geography	Recurrent funding for inequalities work is identified and a recurrent process developed
Q4	Implementation of integrated neighbourhood team started (BCF – TBC) Year 2 milestones for integrated community based care programme planned		Inequalities projects are aligned with Integrated Neighbourhood Team model when appropriate

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Swindon ICA 5 Year Delivery Objectives and Milestones

Table 5: Demand and capacity

	System Flow	Left Shift
Milstones	We will build capacity together to reduce length of stay in hospital for those that don't need to be there. (NCTR) We will work together to manage front door demand. We will provide people with the right care at the right time. (BCF)	We will shift more investment into prevention. We will prevent crisis rather than support crisis. We will profile and signpost preventative health & care support.
Q1	Home First and Discharge hub 5 days a week Intermediate Care and Demand plan complete (BCF) Trusted Assessor for Care Homes in place 7 days a week Additional care managers in place to support discharges	£100k 'Community Investment' in Falls Prevention VCSE and Primary / secondary care to be invited to engage in system level working to shape the Integrated Community Care Programme Confirm key milestones for integrated community-based care programme and update plan
Q2	Home First and Discharge hub 7 days a week Complete winter plan Scope potential further elements of an ICA demand and capacity plan (primary care, voluntary sector for example) Confirm and plan winter respiratory clinics	New falls prevention capacity in place and being evaluated by PH and working with coordination hub VCSE and Primary / secondary care engaged in place-based shaping of Integrated Community Care Programme Identify left shift and what it means for Swindon – what does it look like now? - our vision for the future Deliver key milestones for integrated community-based care programme (TBC)
Q3	NHS @ Home (virtual ward) beds 65 (80% bed occupancy) Stand up winter respiratory clinics – TBC	Deliver key milestones for integrated community based care programme (TBC) Develop thinking and action plans to support the Swindon left shift vision
Q4	NHS @ home (virtual ward) beds 90 (80% bed occupancy)	VCSE and Primary / secondary care built into tender process for Integrated Community Care Programme Evaluation of impact of Left Shift investment in Falls Prevention Start to implement actions to deliver left shift change Deliver key milestones for integrated community-based care programme (TBC)

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What will be different for our population in 5 years' time

Together we have set out what will be different for our population by 2028 under the key segments of our plan and what we will do to achieve these changes.

At the heart of our plan is our Team Swindon vision which clearly sets out how we will work together to tackle inequalities and empower all people in Swindon to live longer, healthier, fulfilling lives, supported by thriving and connected communities.

Our next priority is to develop logic models for each of our priorities which will enable us to identify specific and measurable outcome measures of success for 5 years' time.

A spotlight on Integrated Neighbourhood Teams

To give a specific example of our work in Swindon, we have set out further detail on our project to design Integrated Neighbourhood Teams with partners.

INTs are a way of bringing together front line staff and community organisations that either support our local communities, or groups of people who have complex needs. In essence, it is a way of creating a "team of teams," that improves the experience of people and our communities and ultimately their health and wellbeing.

Figure 8 (right) gives a simple description of what will be different.

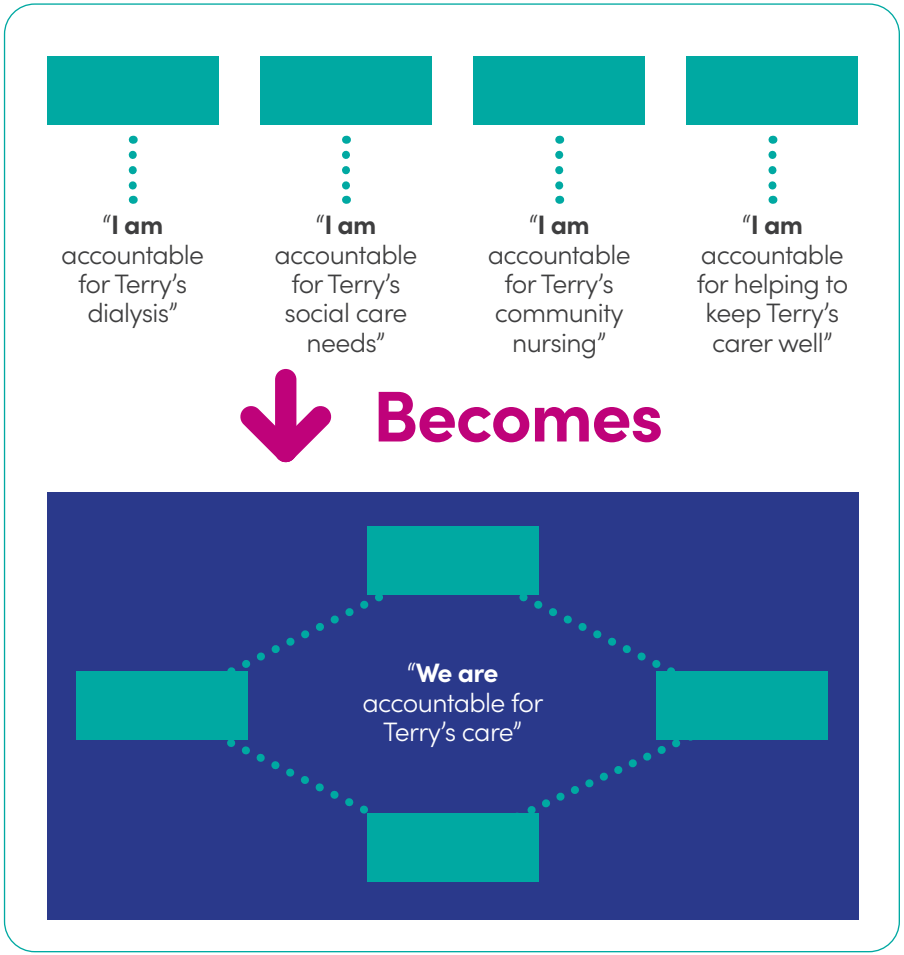

Figure 6: Our ambition for bringing together front-line staff and community organisations

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Developing an INT model is a key delivery vehicle for the BSW Integrated Care Strategy in Swindon. We will connect our local teams through a collaborative with a focus on personalised care, prevention, and fairer outcomes for our population.

Each Collaborative will connect partners from health and Social Care, VCSE, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire, and many Community Groups. The partners will offer their resources and share their assets to enable solutions to be developed that can tackle health inequalities and promote health and wellbeing within their local community. Community views and engagement will be the key to success.

We will start small, working in target area(s), to test out what is achievable. We will evaluate for the impact on left shift and the potential to implement at scale.

We will focus on developing a positive culture with strong collaboration. This will start with our approach which will focus on coproduction with our frontline workers and the populations they are working with.

We will learn from other areas where integrated neighbourhood working is further developed to support development of enablers.

What will be different for our population in 5 years' time

- Local population health and wellbeing outcomes will be improved from today's position, as people are empowered and equipped to design and deliver care and solutions with a preventative and early intervention approach.
- Care will feel individualised as teams and services operating an INT approach will drive clinical practice and interventions based on population health need.
- People will experience more coordinated care, delivered together and including smaller local services and assets in their community to meet their health and care needs.
- People will be proactively offered interventions to reduce their risk of long-term conditions as teams and services start to utilise data predictively.

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Wiltshire

Context

Wiltshire is a vibrant community of over 500,000 people living across our area in large towns, small towns, villages, and large areas of rurality, including across Salisbury Plain. Wiltshire is home to significant populations of current or former armed forces service personal and their families.

Our current population is 510,400, we are expecting our residents over 65 to increase by 43% by 2040 (representing about a third of our population) and our over 85 population will rise by 87%.

Although Wiltshire is one of the 'least deprived' local authorities in England, approximately 14,000 people currently live in areas that are considered 'most deprived' when compared nationally - this is about 3% of our population.

Life expectancy compares favourably at a national level, however the 2022 JSNA has identified female healthy life expectancy as an area of decline and people living in deprivation as a significant life and healthy life expectancy inequality gap. Figure 9 provides some high level key points and areas of focus from the JSNA.

Additional detail around all areas of focus can be found using this link www.wiltshireintelligence.org.uk/jsna
which takes you to the JSNA in full.

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Our Principles

Our planning has been shaped by partners across our ICA. It is guided by a set of Alliance Principles and Core Commitments which are below:

Life expectancy
In 2018-2020 the average life expectancy for females in Wiltshire is 3.6 years more than males, with females expected to live to 84.5 years and males 80.9 years in Wiltshire.

Healthy Life expectancy

Male - Within Wiltshire, male healthy life expectancy is above that of its statistical neighbours and the South West; meaning that the time males spend in a healthy life extends into their state pension age at 66.

Female - Wiltshire's female healthy life expectancy has been in continual decline and has dropped by 4.2 years over the past 4 years to 65.2 years and now sits below that of the region, whilst Wiltshire's comparators have remained largely stagnant.

Identifying inequalities in life expectancy in Wiltshire
Healthy life expectancy – in years (England).

The areas of deprivation in England have a large variation in healthy life expectancy at birth.

	Least deprived decile
Men	70.5 years
Women	70.7 years

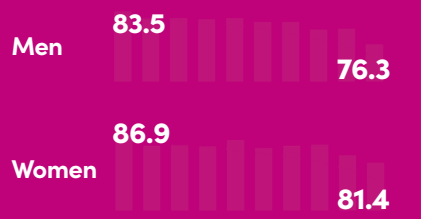
	Most deprived decile
Men	52.3 years
Women	51.9 years

Nearly 120,000 people in Wiltshire live in in the most deprived 5 deciles (half) of areas in England, and face these inequalities in their healthy life expectancy.

Life Expectancy - in years
Wiltshire deprivation deciles

	Least deprived decile
Men	70.5 years
Women	70.7 years

	Most deprived decile
Men	52.3 years
Women	51.9 years



This difference in life expectancy among the different deciles is likely to worsen as a result of the cost of living crisis.

All-age all-cause mortality – 2021

Diseases of the circulatory system	**26%**
Neoplasms (cancers)	**25%**
Diseases of the respiratory system	**9%**
Mental and behavioural disorders	**9%**
Codes for special purposes (mainly Covid-19)	**8%**
Diseases of the nervous system	**7%**
Diseases of the digestive system	**4%**
Other causes	**11%**

Figure 7: Extract from Joint Strategic Needs Assessment for Wiltshire (2022)

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Our Principles

Our planning has been shaped by partners across our ICA. It is guided by a set of Alliance Principles and Core Commitments which are below:

Diseases and ill health: Key focus areas

Sensitively promoting healthy behaviours to lower the risk of preventable conditions associated with lifestyle factors. These include:

Hypertension: 15.4% of people in Wiltshire had a recorded diagnosis of hypertension in 2020/21, higher than levels in South West (14.8%) and England (13.9%).

Diabetes: 7.2% of Wiltshire's population aged 17 and over were recorded as having diabetes in 2020/21, similar to the South West (6.9%) as well as England (7.1%)

Coronary heart disease: In 2020/21 3.4% of people in Wiltshire were registered as having coronary heart disease, comparable with regional (3.5%) and national levels (3.0%)

Strokes: 2020/21 prevalence data shows that 2.2% of Wiltshire's population were recorded as having experienced a stroke or transient ischaemic attack, broadly in line with levels reported regionally (2.2%) as well as in England (1.8%)

Disease prevention and health protection with a specific focus on

Early childhood vaccine coverage: Meningitis B vaccinations for 2 year olds, Dtap/IPV boosters (protecting against diphtheria, tetanus, pertussis and polio) and the second MMR vaccine (both for 5 year olds) were below the national coverage target of 95% in Wiltshire in 2020/21.

Cervical and breast cancer screening: Levels of screening in these areas has reduced in Wiltshire over the last 2 years as a result of the pandemic. For both metrics, uptake is consistently lower in the most deprived areas of the county.

Wiltshire's ageing population and age related conditions, particularly:

Dementia: In 2022, the dementia diagnosis rate in over 65 year olds in Wiltshire is estimated to be 58.5%, equivalent to around 4,300 people. This indicates that there are in the region of a further 3,000 people in older age groups in the county that are undiagnosed.

By 2030, it is estimated that almost 11,500 people in Wiltshire aged 65 and above will be living with dementia, driven primarily by an aging population and increased life expectancy.

Supporting good mental health and emotional wellbeing.

The prevalence of common mental health disorders is rising in Wiltshire

In 2020/21, almost a quarter (24.6%) of persons aged 16 and over in the county were estimated to have higher levels of anxiety. Whilst this is similar to the South West (23.4%) and England (24.2%), it represents a 6% rise compared with the previous year (18.3%).

Almost 44,000 people in Wiltshire (18 and over) had a recorded diagnosis of depression in 2020/21, equivalent to 11% of the adult population. Levels have been steadily rising since prior to 2016/17.

Rates of hospital admissions for self harm in Wiltshire are now at their highest level for five years

Hospital admissions relating to self harm in Wiltshire's overall population and the 10-24 year age group have increased annually since 2016/17. In 2020/21, admissions of this type (in both age ranges) were significantly higher than both the South West and England. Admission rates for both metrics in Wiltshire are notably higher in women and young females.

Figure 7: Extract from Joint Strategic Needs Assessment for Wiltshire (2022) (Continued)

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Locality Strategy

Using the findings of the JSNA (2022) to directly inform development, colleagues across our ICA in Wiltshire have co-authored a new Joint Local Health and Wellbeing Strategy (JLHWS) – this will be our locality plan for the next 5 years.

The JLHWS sets out 4 guiding priority themes for our work and these, together with our Alliance Principles and Core Commitments and the ICS Strategy priority objectives have set a clear pathway towards improving outcomes for and with our population, drawing on the combined resources and skills of our Alliance partners.

Figure 11 demonstrates at the highest level how the JLHWS and the ICS Strategy align with each other in scope and ambition, the clusters represent linked and related priority areas of work.

Localisation and connecting with our communities is seen as integral to our way of working across all themes and objectives and aligns with the ICS Vision of "Listening and Working Effectively together to improve health and wellbeing and reduce inequalities".

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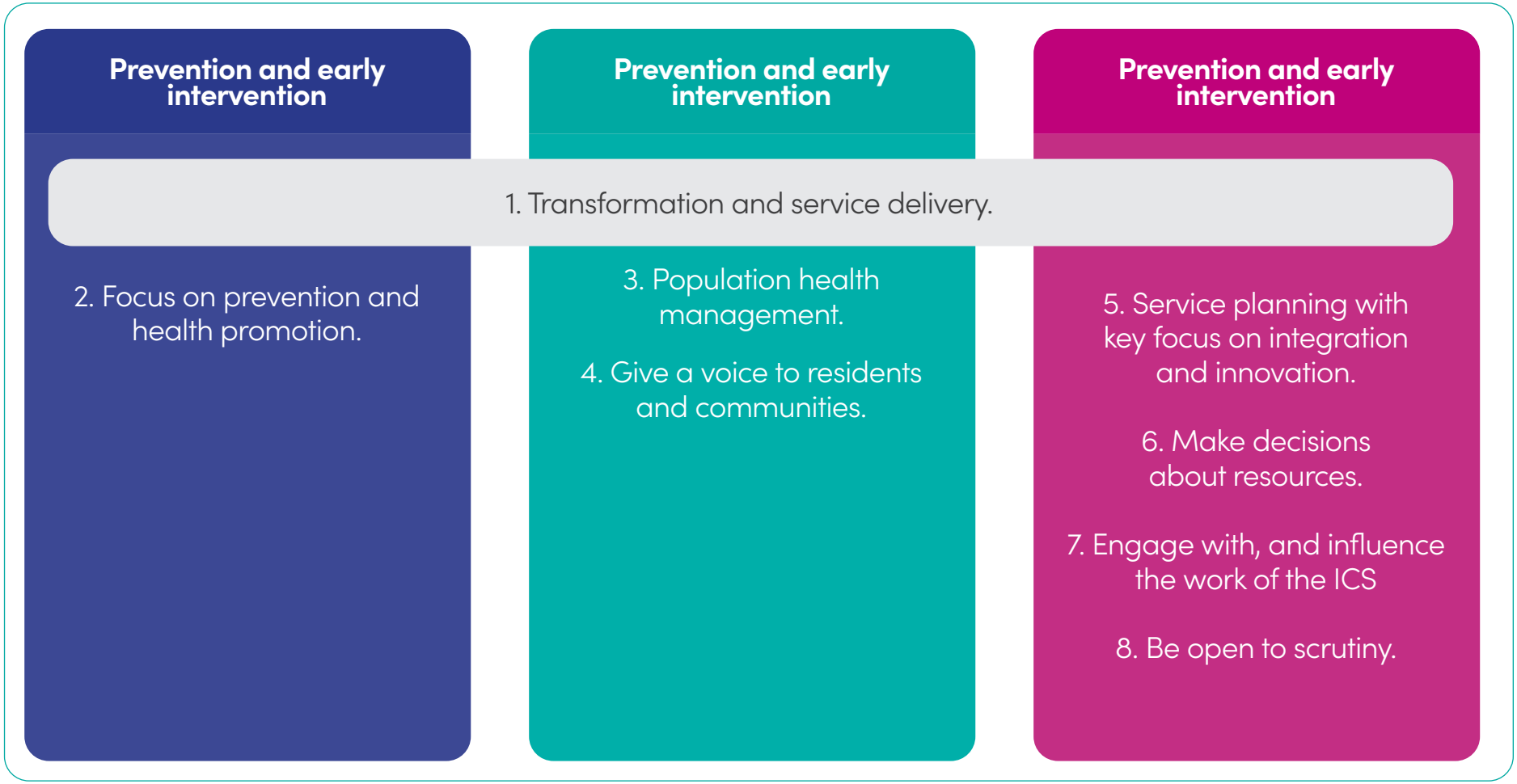
Locality Delivery Plans and Actions

Figure 8: Wiltshire Integrated Care Alliance Principles and Core Commitments



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The Joint Local Health and Wellbeing Strategy is so newly developed and agreed, that more detailed planning for milestones is still ongoing with key performance indicators and thresholds to be set and agreed upon for the Wiltshire locality. Alliance Partners, working as part of the Health and Wellbeing Board, have agreed on the actions in Table 6 as the priority deliverables against the strategy. Some programmes and key actions are already well established.

Figure 9: Joint Local Health and Wellbeing themes (purple) and ICS Strategy Objectives (green)

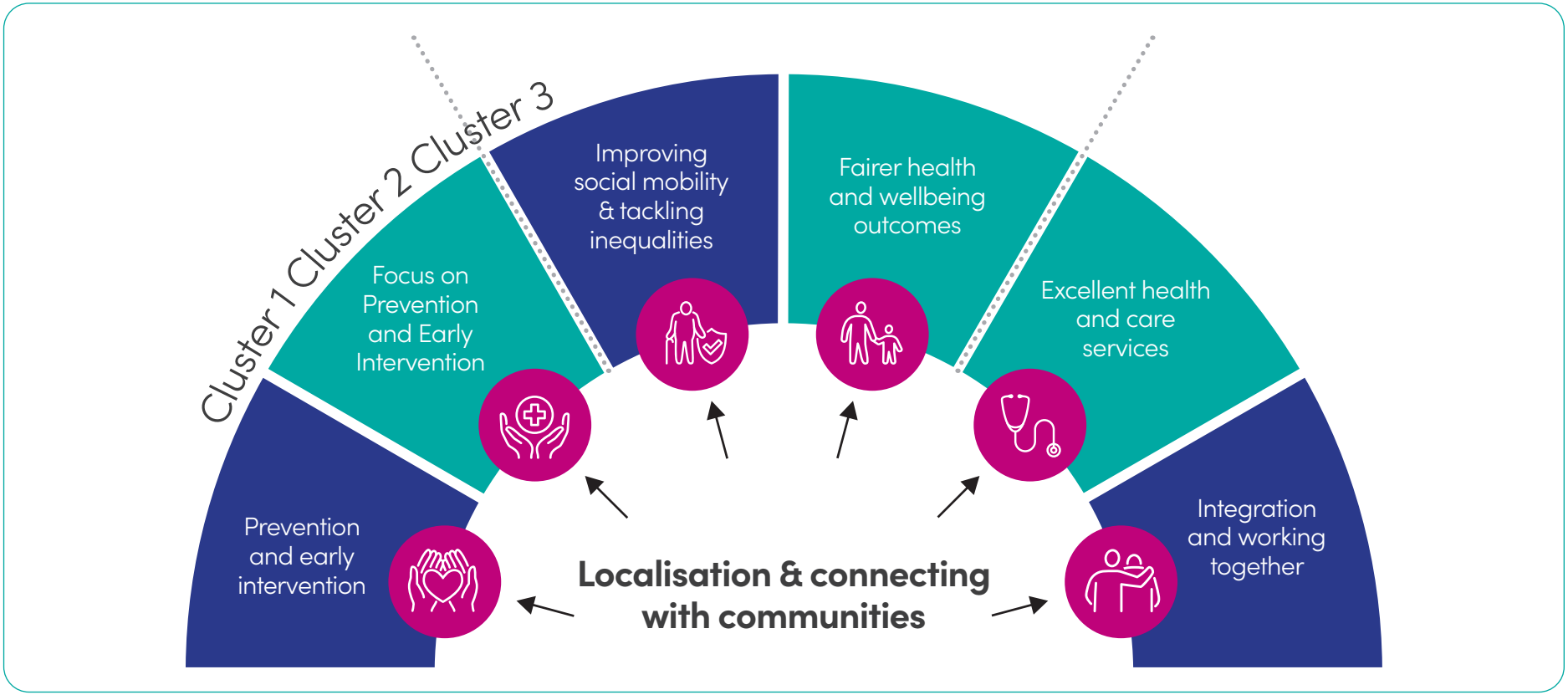

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Table 6: Extract from Joint Local Health and Wellbeing Strategy (2023) aligned to Cluster Groups

Theme	Cluster 1: Prevention and early intervention	Cluster 2: Improving social mobility and tackling inequalities	Cluster 3: Integration and working together
Joint Local Health and Wellbeing Strategy; Actions to achieve change	Lay the foundations for good emotional wellbeing whilst young – by developing a coordinated approach and promoting a core offer in early years settings and schools across Wiltshire. Empower individuals across the life course – in all schools, with working age adults and for the elderly – with advice focusing on healthy lifestyles, smoking cessation, alcohol and substance misuse. Prevent ill health - through increased uptake of screening, health checks and immunisations as well as tackling antimicrobial resistance through the best use of antibiotics. Adopt a proactive population health approach – rolling this out to new areas (such as moderate frailty) each year to enable earlier detection and intervention.	Promote health and care in all policies – including housing, employment and planning. This will include the development of sustainable communities, whole life housing and walkable neighbourhoods. Support healthy home settings – with action on fuel & food poverty, help to find stable well-paid work, mental health and loneliness and by increasing digital inclusion. Give children the best start in life – with a focus on the whole family, family learning, family help, parenting advice, relationship support, the first 1000 days/ early years and community health services. Target outreach activity – identifying particular groups to improve access to services and health outcomes and tackle root causes. Improve access through online services and community locations.	Provide integrated services at key stages in a person's life – including early years, special educational needs and disability, family help, whole life mental health and LDA, later life planning, end of life care, and increasing the provision of personal budgets and coproduction of services. Boost 'out-of-hospital' care, dissolving the divide between primary and community health services - through community multi-disciplinary teams, clustering services around primary care networks, and guaranteeing support to people in care homes. Enable frontline staff to work more closely together – planning our workforce needs together, developing case studies on front line cooperation, supporting shared records and IT & sharing estates wherever possible. Ensure carers benefit from greater recognition and support by improving how we identify unpaid carers. Improve join-up of services including specialised commissioning. Drive improvement through collective oversight of quality and performance, reconfigurations and recommissioning; overseeing pooled budgets and joint teams together – including the ICA transformation programme and Better Care Plan.

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Table 6: Extract from Joint Local Health and Wellbeing Strategy (2023) aligned to Cluster Groups (continued)

Theme	Cluster 2 (and linked to 1 and 3) Localisation and connecting with communities
Joint Local Health and Wellbeing Strategy; Actions to achieve change	Support local community action – through initiatives such as neighbourhood collaboratives allied to the development of Primary Care Networks, community based programmes and social prescribing, the community mental health model, area board activity. Pilot community conversations – starting with neighbourhoods in Wiltshire that have significant deprivation and roll these out gradually across the county. Consider the role that procurement can play in delivering social value and the way in which organisations can act as anchor institutions. Embed Healthwatch Wiltshire and VCSE voices in relevant decision-making structures; ensure the results of consultation are reflected in decision papers.

In addition to the actions set out above, the Alliance is engaged in delivering against national objectives in the NHS Long Term Plan (LTP) and Better Care Fund (BCF) Guidance. These, together with priorities identified by Wiltshire in pursuance of the BSW Health Inequalities strategy are reflected in our delivery structure.

How we are organised to deliver

Delivering all the actions in the JLHW Strategy will require intense effort across many parts of the Wiltshire system and Wiltshire ICA has a key part to play. Embracing the opportunities that partnership working and our Alliance now bring, a structure of ICA Partnership Subgroups and additional delivery programme structures across the locality has been established to help drive the change that the JLHW and ICS Strategies have set out, as well as ensuring delivery against national and local aims, improvement work and standards.

The Subgroups will embed links to ICS Programme Boards, acting as a key link with the wider system across BSW. Once fully operational, each group will own delivery against key national and local indicators for health and wellbeing improvement for the Wiltshire population. Membership of each group represents the broad Alliance partnership and engages the resources across our organisations.

The groups are accountable to the Wiltshire ICA Partnership Committee, with close relationships to the Health and Welling Board which monitors achievement against the JLHW Strategy.

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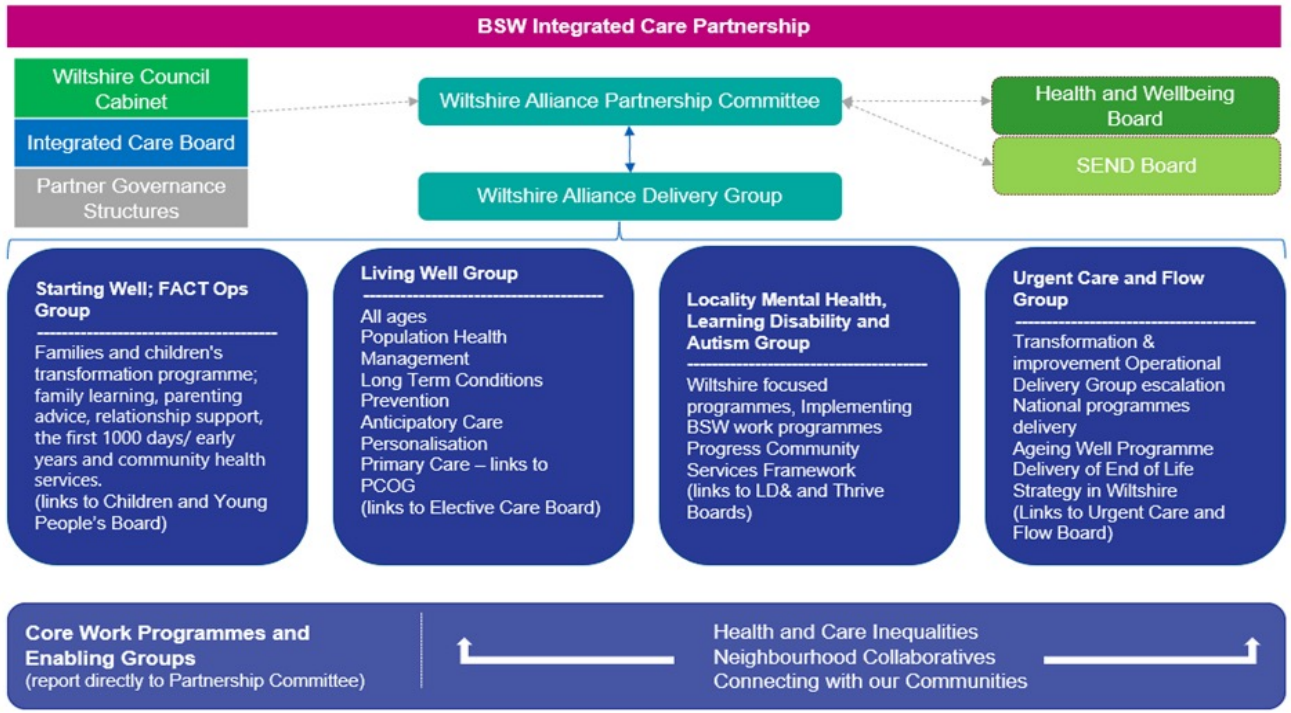
Figure 10 sets out the structure and relationships to other groups and programmes of work. This ensures maximised resources and limits duplication whilst affording a line of sight across the matrices in which we now function, both at neighbourhood, locality, and broader system. Each action to achieve change will have a link to one of the cluster groups for support, although we recognise that some actions will require broad-based effort and may not be 'owned' by one of the delivery sub-groups. The Health and Wellbeing Board will monitor progress against all actions.

Figure 10: Map of Alliance Partnership Committee and Delivery Sub Group Structure



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These groups will also connect directly via a 'Task Force Group' established for the purpose of support and delivery of the Community Transformation programme in Wiltshire.

Our delivery plan

The Alliance Partnership is focussed on achievement via it's Delivery Groups and key Transformation programmes.

Table 7, on the next page, sets out some key programmes of work and associated milestones and targets.

Each Delivery Group will, however, also be responsible for an agreed programme of work, which aims to reduce health inequalities and address the priorities identified in the JLHW and ICS Strategies.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 1; Prevention and early intervention	**Wiltshire Health Inequalities Group and Living Well** Wiltshire partners have established a Wiltshire Health Inequalities Group (WHIG) to coordinate Population Health Inequalities improvement across the NHS Core20PLUS5, BSW Reducing Inequalities Strategy and Salisbury Hospital 'Improving Together' work programme. Gypsy, Roma, Traveller and Manual Workers (specifically those in minority groups) have been identified as the Wiltshire Plus Groups. The planning phase of this group is ongoing. • July 2023 – agree and launch work programme The Alliance Living Well Delivery Subgroup has been established to support this work, as well as addressing priority improvements around Long Term Conditions and Anticipatory Care. Partnership working with VCSE sector colleagues will be essential in promoting prevention and co-production and reducing our health inequalities. **Adopting a proactive population health approach** Working through the Health and Wellbeing Board and the Living Well Delivery Group, over the next 12 months we will: • Develop a programme of work to delivery improvements in identified areas of unwarranted variation. • Population health management approach will be applied to areas such as moderate frailty, diabetes, deprivation, air quality, Cardiovascular disease (CVD), cancer, maternity and infant health, mental illness, end of life and chronic illness. **Childrens Community Health Services** In the next twelve months, we will recommission children's community health services, ensuring they are inclusive of a coordinated approach and core offer for emotional wellbeing in schools. **Public Health Nursing Services** Wiltshire Council is recommissioning Public Health Nursing Services in preparation for a new contract from 1 April 2024. The service leads on the delivery of the Healthy Child Programme to improve health and wellbeing outcomes for children, young people and families. Strong and effective integration and partnership with health, local authority and voluntary sector services is critical to the effective delivery of the service to ensure a joined-up and seamless experience for children and families. This is a key area of focus going for the new service.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 1; Prevention and early intervention	**Special Educational Needs and Disabilities (SEND)** The local area partnership is implementing an ambitious programme for children and young people with Special Needs and Disabilities in Wiltshire. The Partnership has been addressing the recommendations highlighted in the last Ofsted/CQC inspection as well as ensuring the domains in the new Local Area inspection framework are a focus alongside exploring innovative ways of ensuring children and young people with SEND can fully engage in all aspects of life and have the best chances during their adult lives. The Partnership is preparing for an inspection in 2023/24 and has completed a Self-Evaluation Framework identifying strengths and development areas. Wiltshire Parent Carer Council (WPCC) are integral to local developments, and we have strengthened our ability to ensure children and young people's voices are embedded into local service developments to improve the quality of provision and expand choice. Key developments have included the expansion of special school places and associated resource bases, the development of the Local Offer website, and the introduction of health advisors. **Empower individuals across the life course** Working through the Health and Wellbeing Board, over the next 12 months we will: • Evaluate the findings of the Safe Outside the Home pilot in Wiltshire. • Consider the findings of the latest pupil survey and the implications for work to reduce risky behaviour in schools. • Personal, Social, Health and Economic Education (PSHE) support materials will be rolled out as part of Healthy Schools and education on the risk of smoking and vaping. • We will review the impact of health coaches on delivering targeted work on healthy lifestyles and smoking cessation. • Implement a new whole life substance misuse service and evaluate its performance. **Prevent ill health - through increased uptake of screening, health checks and immunisations as well as tackling antimicrobial resistance** Working through the Health and Wellbeing Board, over the next 12 months we will: • Continue to support and work as partners to improve immunisation and screening uptake, in particular through local community engagement and addressing place level health inequalities. • Promote antimicrobial stewardship with the public and through professional networks.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 1; Prevention and early intervention	**In five years' time:** • Health and wellbeing outcomes for Gypsy, Roma, Traveller and Manual worker populations will have improved in line with targets (to be identified). • Health screening rates will be improved in line with targets (to be identified). • School age children will be able to develop improved emotional health and wellbeing. • We will take very opportunity to support residents in reducing risky health behaviours and improve self-care. • Children and young people with SEND will have improved outcomes and life experience. • There will be increased school attendance and a reduction in suspensions. • There will be reduced levels of obesity in our adult population. • There will be reduced substance misuse. • There will be herd immunity for a range of illnesses and early detection of illnesses. • Public and professionals understand the need to optimise use of antibiotics. • Health professionals will have a better understanding of predictors of disease and implement appropriate preventative and predictive capability.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 2; Improving social mobility and tackling inequalities	**Neighbourhood Collaboratives** The Neighbourhood Collaborative programme has been co-designed by Integrated Care Alliance partners to enable partnership working to flourish across services, organisations and community groups within neighbourhood areas loosely defined along Primary Care Network footprints. Once established there will be 12 to 13 Collaboratives across Wiltshire, connecting partners from health and Social Care, VCSE, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire and many Community Groups. The partners will offer resources and assets to tackle health inequalities, focus on prevention, improve outcomes, and promote health and wellbeing within their local community. Community views and engagement will be the key to success. This programme works closely with the Community Conversations work led by local authority with engagement of partners which focusses on working with our most deprived communities in Wiltshire to support and drive improvements those communities want to see. Over the next 12 months the programme will: • April 2023 – Pathfinder site launched • May 2023 – Onboarding Launch programme agreed and online portal established • June 2023 – Devizes and Chippenham, Corsham, Box areas commence launch, first pathfinder report • July 2023 – First Wiltshire Collaborative event; share learning; and Pathfinder report • By April 2024 - All neighbourhood areas will be on their collaborative journey and will have completed or commenced the Launch programme **Community Conversations** The community conversations programme has begun, with two pilot areas in North and South Wiltshire – starting with neighbourhoods in Wiltshire that have significant deprivation. We will roll these out gradually across the county. Over the next 12 months, we will: • Continue the community conversation pilots in Studley Green and Bemerton Heath and evaluate the early learning for other potential areas • The community conversation approach will have been rolled out to several other areas of deprivation in towns such as Chippenham, Melksham and Calne

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 2; Improving social mobility and tackling inequalities	**Connecting with our Communities (CWOC)** This programme is an 'enabler' of our work together. Once fully established, the CWOC group will have a 'helicopter view' of Alliance work and will provide a mechanism to support and guide meaningful community engagement throughout development, initiation and delivery of our transformation and service improvement work. It brings together organisations and people to share views, inform the development of our work and align our efforts around engagement and feedback with and from our residents. The group is responsible for ensuring best practice against the BSW People and Communities Strategy and is developing a work programme, which will launch in July 2023, having completed the work on a gap analysis and identified priority work areas. Our VCSE and Health Watch colleagues are welcome partners in this space and have joined us as full members of the ICA Partnership Committee and Health and Wellbeing Board. **Promote health in all policies – including housing, employment, and planning** Working through the Health and Wellbeing Board, over the next 12 months we will: • Publish a new Local Plan and Local Transport Plan outlining measures for the development of sustainable communities, whole life housing and walkable neighbourhoods • Develop health and care campuses that transform healthcare, employment and economic opportunities (e.g. HEAT project in Salisbury (Health Education and Technology)

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 2; Improving social mobility and tackling inequalities	**Support healthy home settings** Working through the Health and Wellbeing Board, over the next 12 months we will: • Expand provision of the warm and safe service. • Employment support team will help those with mental health or learning disabilities gain employment. • Area Board health and wellbeing champions and grants will undertake a range of activity to tackle loneliness, alongside measures in the adult social care prevention strategy. • ICA Partnership Committee members will attend an Area Board meeting. **Target outreach activity** – We will improve access to services for people who can or do not access them easily in the current way, improving health outcomes and tackle root causes. Working through the Health and Wellbeing Board, over the next 12 months we will: • Outreach to homeless, Gypsy, Roma, Traveller and boater communities and asylum seekers on screening and immunisations. • Finalise WHIG work programme in July (See Cluster 1 actions). • Promote take up of health improvement coaches and active health programmes. **In five years' time:** • Our children and families will be supported within their local area to access timely prevention-focussed help and support. • More children will achieve a good level of development before starting school. • Young people will be supported through a Transitional Safeguarding approach through adolescence into Adulthood. • There will be 13 fully operating, self-sustaining neighbourhood collaboratives, which are able to evidence their impact on improving local health and wellbeing outcomes and reducing inequalities. • Residents will be able to share their views and thoughts on our work and understand how their opinions can directly shape our work and priorities. • People will find services easier to access with increased co-location and online booking facilities. • Reduced digital exclusion and maximised opportunities technology can bring to improve equitable access to services. • It will be easier to move around local communities in a sustainable manner and vulnerable groups will be supported to access public transport as a wider determinant of health (identified as a priority area of improvement through the Health Inequalities Strategy work). • There will be fewer experiencing fuel poverty and the impact of fuel and fuel poverty will be reduced.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 3; Integration and working together	**Urgent Care and Flow Transformation.** A comprehensive programme of work across our Alliance is focussed on supporting people to remain in their own homes, improving flow across services and reducing unnecessary hospital admissions and delayed discharges. Over the next 12 month this programme will deliver: • Reduced Length of Stay in Care Homes (to achieve 28 days by July 2023). • Achievement of the 70% 2-hour Urgent Care Response target (by June 2023). • Delivery against Virtual Ward development targets, (reaching 136 'beds' by December 2023 and 180 by March 2024). • Reduced length of stay in community hospitals (to reach 35 days across all wards by July 2023). • Reducing hospital trust lengths of stay. • Maximising capacity of Home First services. • Complete Discharge Communications Project to improve patient, family and carer experience and reduce discharge delays (resources launching July 2023, full impact September 2023). • Increasing the number of people returning to their own home after a hospital admission (% increase to be confirmed (TBC) once modelling completed). • Implementing new End of Life care provision model, ensuring people are supported to die in the place of their choosing (launch new model October 2023). • Increased 0-day lengths of stay. • Same Day Emergency Care expansion.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 3; Integration and working together	**Community Services Transformation** Re-thinking the design and delivery of Community services across BSW is a key priority. Wiltshire Alliance is actively engaged in this process and will continue to shape and inform the work as it develops, ensuring we deliver the best possible future model of support for our residents. This programme relates to all of our Delivery Subgroups, a 'task force' group will be established from across the groups to ensure appropriate and agile collaboration, feeding work across our Alliance as needed, but acting as a single point of engagement and coordination. **Provide integrated services at key stages in a person's life** This work includes later life planning, end of life care, and increasing the provision of personal budgets and coproduction of services. Over the next 12 months we will: • Evaluate additional areas suitable for personal budgets. • Roll out later life plans to everyone over 85 and earlier cohorts as appropriate. • Implement the new End of Life care provision model, ensuring people are supported to die in the place of their choosing (launch new model October 2023). **Boost 'out-of-hospital' care, dissolving the divide between primary and community health services** We will achieve this through community multi-disciplinary teams, clustering services around primary care networks, and guaranteeing support to people in care homes. Over the next 12 months we will: • Review primary care commissioning arrangements and alignment with public health, pharmacy, optometry and dental services alongside local community and social care provision. • Prepare for delegation of specialised services and identify opportunities to improve integration with local services. • Identify opportunities to commission provision for military communities alongside that for spouses and families and local communities.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 3; Integration and working together	**Mental Health, Learning Disabilities and Autism** Linking closely with system-wide groups, this group leads the delivery and improvement work around these areas in Wiltshire. This Delivery group has been established for some time, with the focus on embedding the Community Services Framework and has included implementing the Severe Mental Illness (SMI), LD and Autism Register and increasing the number of Annual Health checks. An alliance of third sector partners has developed an access model, reducing waiting times and travel distances for people to seek support. This group is currently refreshing it's work programme in line with the ICS and JLHW Strategies, taking account of key national targets and requirements. It will be responsible for prioritising and delivering: • Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024. • Recover the dementia diagnosis rate to 66.7%. • By March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit. • Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services. **Services for Children** We will ensure good access to mental health support and services for all children, young people and their parent/carers and we will ensure our corporate parenting priorities are met. **Enable frontline staff to work more closely together** This will include planning our workforce needs together, developing case studies on front line cooperation, supporting shared records and IT and sharing estates wherever possible. Over the next 12 months we will: • Develop Wiltshire workforce plans as part of BSW strategy. • Enable NHS access to the social care record system as appropriate and increased shared records. • Develop Wiltshire estate plans as part of BSW strategy.

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Table 7: High Level Actions to Support JHHW Strategy and System Priorities Delivery

	Alliance Actions to Support JLHW Strategy
Cluster 3; Integration and working together	**Support for Unpaid Carers** We will ensure carers benefit from greater recognition and support by improving how we identify unpaid carers. Over the next 12 months we will: • Rollout training for GPs and other health professionals on recognising and referring to support unpaid carers, this will support our ongoing work in other areas to identify carers and offer support.
	In five years' time • Those of our residents requiring support to be discharged from hospital will experience timely, integrated care and enables as many people as possible to return to their own homes. • Access to NHS dentistry will be improved. • Primary care will be commissioned alongside other services locally. • Our colleagues will feel supported in their roles, and able to work with people across organisations, taking advantage of improved training, technology and integrated systems, able to focus on prevention and early intervention. • There will be clear career pathways in place for both health and social care and professional recognition across both. • Data is collected once and shared with those who need it. • Residents who experience mental health problems will be able to seek and receive timely support, locally to them – preventing deterioration. • People on the learning disability or autism will be better supported to access health care and support. • Performance is measured in a transparent and understandable way. • Unpaid carers know how to access support. • There is seamless provision in areas such as mental health. • The military covenant statutory responsibilities are fully delivered.

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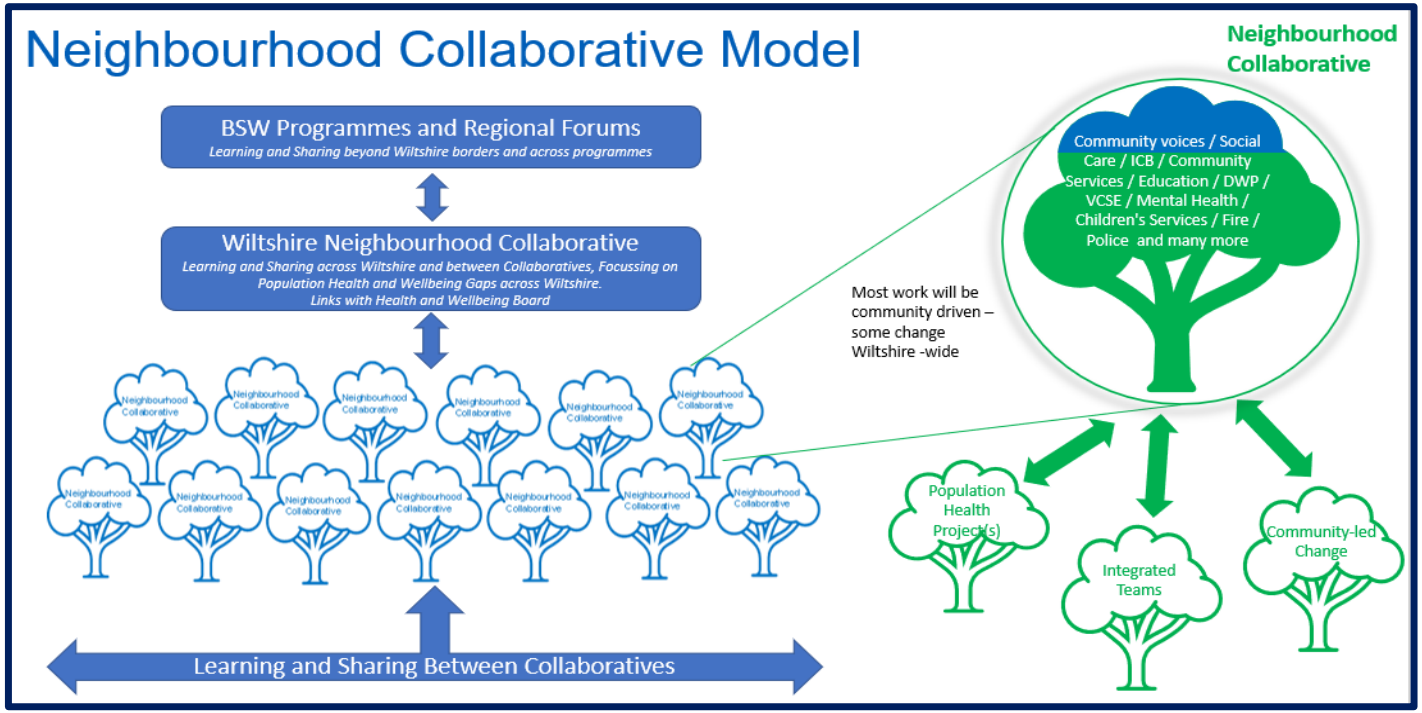
Spotlight on Wiltshire Neighbourhood Collaboratives

The Wiltshire Neighbourhood Collaboratives Programme is an example of how we are working together in partnership. In early 2022, Wiltshire ICA Partners recognised the right approach to improving health outcomes in our communities, is to work directly with them to do so – bringing together partner colleagues, organisations, partners, and residents in a new way. The concept of Neighbourhood Collaboratives was born from this work. Loosely defined by each of the PCN footprints, once established there will be 12 to 13 Collaboratives across Wiltshire.

Figure 11: The Neighbourhood Collaborative Model



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When the Fuller Stocktake was published, Alliance Partners recognised there is clear alignment between that review, and the Neighbourhood Collaborative model – so both areas of work are managed in an integrated way.

Integrated and explicit in the JLHWS (2023) for Wiltshire, each Collaborative will connect partners from health and Social Care, VCSE, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire and many Community Groups who will offer their resources and share their assets to enable solutions to be developed that can tackle health inequalities and promote health and wellbeing within their local community.

Community views and engagement will be the key to success.

The Wiltshire Collaborative will provide a forum for Neighbourhoods to share their learning, celebrate success, and in times of need, seek support. It will also offer a place to learn from best practice elsewhere and to collaborate on improvements Wiltshire-wide.

Each Neighbourhood Collaborative will be grown from the ground up, which means they may be structured differently to each other, and partner staffing models may look different depending on what works for each area. They will establish their own needs and priorities.

The pre-launch evolutionary work designed a structure to support collaborative development consisting of:

- A Readiness Review that provides a series of insights and questions to identify the strengths and growth areas across a Neighbourhood, informing the Collaborative plan.
- A Launch Programme, tailored to the individual Neighbourhood area based on the outcomes of the Readiness Review, bringing neighbourhood partners together to design and agree their work across six principle areas which underpin the model.
- A Toolkit which is a comprehensive set of resources linked to each principle area, that Collaboratives can use to support their work and embed the model.
- The ICA Partnership provides support, facilitation and system convening to the Collaboratives.

The six Principle Areas are:

- Partnership working
- Co-production
- Community-led approach for health & wellbeing
- Working as one using data analysis
- Enabling volunteers and staff to thrive
- Creating a movement for change

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How we are organised to deliver

Following the initial development work during 2022, a Steering Group was established in December to provide a means of driving the programme forward. The Group has brought colleagues together who have formed new relationships and links and will continue to develop, providing direction and support to the programme as it evolves. Now including more than twenty partners from across the county, it is demonstrating a shared enthusiasm for delivering new ways of working within local communities as it grows.

Governance for the Steering Group is through the ICA Partnership Committee, with regular updates to the Health and Wellbeing Board.

What we will do in the next twelve months

Over the next 12 months, the Collaborative programme aims to:

- Pathfinder Site (Melksham and Bradford on Avon):
  - February to April 2023 – Collaborative group in one neighbourhood on a 'fast track' launched to gather early learning to add to the initial pilot findings.
  - May 2023 - Engagement work with Collaborative cohort, focussing on prevention.
  - July 2023 - Start working directly with an identified group of patients.
  - September 2023 – Progress update.
  - December 2023 – Progress update.
- May 2023 – Onboarding Launch programme agreed and online portal established. Full programme pathway agreed (indicates place and pace of Collaboratives launching).
- June 2023 – Devizes and Chippenham, Corsham, Box areas commence launch, first pathfinder report.
- July 2023 – First Wiltshire-wide Collaborative event; share learning; and Pathfinder report.
- By April 2024 all neighbourhood areas will be on their collaborative journey at different points of maturity and will have completed or commenced the Launch programme. Initial impact results will be available for multiple collaborative areas.

What will be different for our population in 5 years' time

- Local population health and wellbeing outcomes will be improved from today's position, as people are empowered and equipped to design and deliver care and solutions with a preventative and early intervention approach.
- Care will feel individualised as teams and services operating an INT approach will drive clinical practice and interventions based on population health need
- People will experience more coordinated support, delivered in partnership and including VCSE local services and assets in their community to meet their health, wellbeing and care needs.
- People will be proactively offered interventions to reduce their risk of LTC's as teams and services start to utilise data predictively.

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Our Alliance will continue to deliver against our priorities, whilst evolving and refining our programme, targets, and pathway to the future. We are establishing a robust and trusting partnership which will grow and strengthen over time.

Our Health and Wellbeing Board and Alliance Partnership Committee will continue to monitor and manage progress against our commitments and to chart the course ahead, guided by our communities and our colleagues.

As a key action in the JLHW Strategy, we have committed to driving improvement through collective oversight of quality and performance, reconfigurations and recommissioning; overseeing pooled budgets and joint teams together – including the ICA transformation programme and Better Care Plan.

To support this, and the commitments set out in this plan, we are developing a dashboard of metrics and progress reporting for regular review by the Wiltshire ICA and in turn the Wiltshire Health and Wellbeing Board.

Section 6

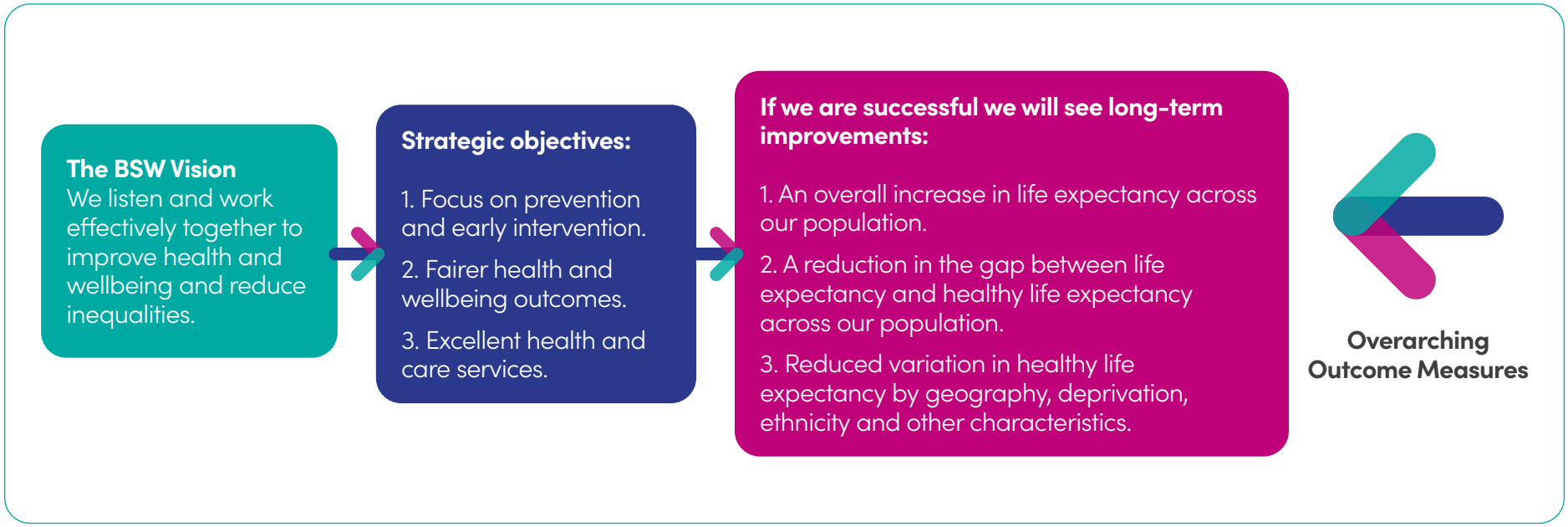
Our outcomes measures

What we will measure

We want to ensure that we have clear and effective ways to measure our progress against the commitments set out in the BSW Integrated Care Strategy over the next five years. Below we provide three overarching outcome measures and a short list of other key outcome measures we will use across a range of priority areas. It will be up to the three places and the transformation programme teams across health and care to ensure that more specific outcome and process measures are developed to deliver progress against the measures listed below for specific elements of our plans. Some of these are set out in the following chapters.

The measures outlined will require concerted and integrated working across multiple partners covering the wider determinants of health. The BSW Integrated Care Partnership (ICP) is therefore well-placed as a forum to monitor progress against the measures listed and agree how progress could be accelerated.

Figure 12: What we will measure



Section 6

Our outcomes measures

Figure 13: Logic model: Delivering and measuring our strategic objectives

Inputs

People & communities
- Joint Strategic Needs Assessments
- Inequalities Group
- BSW Health and Care Model
- Health & Wellbeing Boards
- Local Healthwatch

Workforce
- People Plan
- BSW Academy Strategy
- Clinical and Care Professional leadership

Organisation
- Integrated Care Strategy
- Integrated Care Alliance Plans
- Joint Local Health & Wellbeing Strategies
- 2022/23 Planning Guidance
- Forthcoming major conditions strategy

Activities

People & communities
- Care based transformation programmes
- Implementation of CORE20PLUS5 approach for adults and Children and Young People
- Local Authority public health programmes
- Elective recovery

Workforce
- BSW Academy development
- Development of multidisciplinary teams

Organisation
- Assessment of prevention vs treatment spend and plan for shift to former
- AHA provider collaborative development
- ICP to expand and agree focus/ infrastructure

Outputs

People & communities
- BSW Outcomes Framework
- Population health management (PHM) Priority cohort impacts
- Transformation programme aligned to Integrated Care Strategy objectives and JSNA population priorities

Workforce
- Clinical and Care Professional Leadership Framework
- Workforce plan and actions

Organisation
- AHA provider collaborative clinical strategy actions
- ICA strategy delivery at place level
- VCSE framework
- ICP subgroups and reporting structure

Outcomes (Long Term)

1. An overall increase in life expectancy across our population.

2. A reduction in the gap between life expectancy and healthy life expectancy across our population.

3. Reduced variation in healthy life expectancy by geography, deprivation, ethnicity and other characteristics.

Impacts

- Improved outcomes in population health and healthcare
- Reduction in inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Social and economic development

Section 6

Our outcomes measures

Overarching and contributing outcome measures

Below we outline the overarching measures we will use to measure progress on delivering the long term ambitions of the Integrated Care Strategy. These are ambitious and will take time to make progress against, so we therefore also outline a short set of contributing outcome measures that will help us to deliver progress against those that are overarching.

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
OVERARCHING OUTCOME MEASURES					
1. Life expectancy	If we are successful on shifting to a preventative approach and ensuring excellent health and care services then we would expect life expectancy across BSW to increase over time.	1 & 3	Office for National Statistics (ONS) Life expectancy and Healthy Life Expectancy data – annual LifeSpan Population and Person Insight Dashboard (https://apps.model.nhs.uk/report/PaPi)	Use ONS data for understanding recent and historic position at system, place and population segments Use LifeSpan to understand current position Look at how lifespan data maps to ONS data	Life expectancy to increase across demographics and in each place in BSW by 2028.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
OVERARCHING OUTCOME MEASURES					
2. The gap between healthy life expectancy and overall life expectancy	Our commitments to prioritise prevention are intended to ensure that people across BSW live healthier and for longer. If we are to be successful in achieving this then we would expect the gap between healthy life expectancy and overall life expectancy to reduce over time.	1	ONS Life expectancy and Healthy Life Expectancy data – annual Gap between HealthSpan and LifeSpan Population and Person Insight Dashboard (https://apps.model.nhs.uk/report/PaPi)	Use ONS data for understanding recent and historic position at system, place and population segments Use LifeSpan to understand current position Look at how lifespan data maps to ONS data	The gap between healthy life expectancy and overall life expectancy to have reduced across all three places in BSW by 2028.
3. Variation in healthy life expectancy by geography, deprivation, ethnicity and other characteristics	By adopting a targeted approach based on CORE20PLUS5, both for adults and children and young people, we expect to see a reduction in the variations between healthy life expectancy across different demographics of our population.	2	ONS Life expectancy and Healthy Life Expectancy data – annual	Use ONS data for understanding recent and historic position at system, place and population segments Use LifeSpan to understand current position Look at how lifespan data maps to ONS data	Variation in healthy life expectancy to have reduced.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
1. The share of health and care funding going towards preventative measures (self-care and community care) over the next five years We aim to increase this by year five and our ICP will monitor over time the degree to which this balance is shifting	A key ambition of our integrated care strategy is to prioritise investment into prevention over the coming five years. It commits partners across the ICP to work together to identify an accurate picture of funding and resourcing across BSW when it comes to self-care, community care and hospital care and then work towards achieving a shift in funding and resources towards the first two.	1	ICB and local authority spend To be determined in year one	Year one: To undertake an assessment of current balance of spending on treatment vs prevention funding assessment across ICB and LAs.	ICB and local authorities to have made a shift towards overall spend on prevention by 2028.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
2. Personal Wellbeing ONS4 scores (Life Satisfaction, Worthwhile, Happiness, Anxiety)	BSW is committed to prevention in both mental and physical health. To prevent poor mental health from arising we therefore intend to work together as partners to promote mental wellbeing across our population. Improved personal wellbeing ONS4 scores will help to demonstrate that mental wellbeing is improving among residents.	1	Office for National Statistics Available here	Year 1: Record Public Health Outcomes Framework (PHOF) position as baseline for next 5 years	Personal wellbeing scores across Life Satisfaction, Worthwhile, Happiness and Anxiety to have improved by 2028.
3. School readiness School readiness: percentage of children achieving a good level of development at the end of Reception	This may be subject to change.	1 & 2	Public Health Outcomes Framework Available here	Year 1: Record PHOF position as baseline for next 5 years	Percentage of children achieving a good level of development at the end of Reception to have increased by 2028.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
4. Smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy Smoking prevalence in adults Smoking prevalence age 15 years Smoking prevalence in adults in routine and manual occupations (18-64) Smoking in early pregnancy	There are strong links between levels of deprivation and rates of smoking, alcohol use and obesity. We therefore plan to prioritise action on each of the three areas to reduce health inequalities emerging over time.	1 & 2	Public Health Outcomes Framework	Year 1: Record PHOF position as baseline for next 5 years	Smoking prevalence (including in target groups) to have reduced by 2028.
5. Heavy alcohol use across BSW Admission episodes for alcohol-specific conditions			Public Health Outcomes Framework	Year 1: Record PHOF position as baseline for next 5 years	Heavy alcohol use to have reduced by 2028.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
6. Levels of obesity among both adults and children and young people Reception: Prevalence of overweight (including obesity) Year 6: Prevalence of overweight (including obesity) Percentage of adults (aged 18 plus) classified as overweight or obese	There are strong links between levels of deprivation and rates of smoking, alcohol use and obesity. We therefore plan to prioritise action on each of the three areas to reduce health inequalities emerging over time.	1 & 2	Public Health Outcomes Framework	Year 1: Record PHOF position as baseline for next 5 years	Levels of obesity among adults, children and young people to have reduced by 2028.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
7. Outcomes across the BSW population on the major causes of ill-health Cancers, cardiovascular disease (inc stroke and diabetes), chronic respiratory disease, dementia, mental ill health, musculoskeletal disorders	We want to take action to ensure that we are minimising the impact of the major causes of ill-health, and reducing variation in outcomes between demographics and places within BSW.	1, 2 & 3	Premature mortality <75 years Increase in 1 and 5 year cancer survival	Year 1: Use of existing data to agree baselines and trajectories for change Agree at programme and pathway the specific outcomes	Improved levels of diagnosis and outcomes for patients across the six major conditions. E.g. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%. From the Inequalities Strategy.

Section 6

Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
8. Shared decision making to ensure that individuals are supported to make decisions that are right for them.	One of the key ambitions of the integrated care strategy (and the BSW Care Model) is to support individuals to make informed decisions about their own care. We want to ensure that we make progress on this across primary, secondary and social care.	3	Primary care (GPPS): % people reporting they have **agreed a plan with a healthcare professional from their GP practice to manage their condition.** % people reporting they found this plan very or fairly helpful in managing their condition. Secondary care & social care(?) (CollaboRATE): Number of people completing CollaboRATE and proportion scoring 9+. http://www.glynelwyn.com/collaborate-measure.html	Action will be needed here around roll-out of CollaboRATE tool (or similar) across secondary care.	Should be doing this as part of our EDS at system and provider level. Data to be used to agree milestones.

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Our outcomes measures

Table 8: Overarching and contributing outcome measures

Headline outcome measure	Why we will measure this	Strategic objective achieved	Baseline data / Source	Short-term actions	Milestones
CONTRIBUTING OUTCOME MEASURES					
9. Telling your story once	If our commitment to working together as partners in a more integrated way are to be successful then service users should expect to not have to tell their own story multiple times to different organisations. We therefore intend to measure this over the coming years.	3	Number of people and number of partners (including MH providers) access the ICR Number of shared care plans recorded on the ICR and the **frequency in which these are accessed by multiple front line workers (including MH workers).** Number of people completing IntegRATE (http://www.glynelwyn.com/integrate.html) and proportion scoring 8+ (NB. This will require a process to collect and collate IntegRATE)."	As above, action will be needed here around roll-out of IntegRATE tool (or similar) across services.	
10. Listening to our workforce	In support of our work to support staff wellbeing and also to contribute to workforce retention initiatives.	3	Staff satisfaction scores	As above, action will be needed here around roll-out of IntegRATE tool (or similar) across services.	

Section 7

Strategic Objective 1: Focus on Prevention and Early Intervention

In this section:

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Strategic Objective 1: Focus on Prevention and Early Intervention

Introduction

Our ambition is to move towards a greater focus on prevention, and this needs to be wider than individual, subject specific, prevention programmes. Key things to be considered are:

- The need to articulate how we are using data and intelligence to inform decisions around how we target efforts and resources in the context that where there are inequalities there is increased risk.
- To hold central to our thinking that every time we intervene for a child we intervene for the future health and wellbeing of an adult as well.
- The need to involve communities and neighbourhoods because that is where the strategy starts.

We have a number of prevention initiatives underway and we are aiming to form a BSW Prevention Programme to develop a clear programme of work across the following three areas:

- Defined prevention programmes e.g. smoking cessation.
- Developing prevention and early intervention as a component within all BSW programmes.
- Ensuring all pathways of care incorporate prevention and early intervention to support the left shift in how we work.

Early intervention is a collaborative process through which a professional supports an individual to reach a decision about how best to meet their needs. We will encourage people to manage their own care as far as possible and empower them to do this with better information and support. For example, good management of diabetes at home will help to avoid emergencies.

We have set out a number of areas of focus within our BSW Integrated Care Strategy under this objective. This section sets out these areas of focus, and how we are going to deliver our joint commitments made within the strategy.

The next phase of this work in 2023/24 is to work through with our transformational programmes how the left shift to prevention and early intervention is fully incorporated into their work giving us a clearer picture of what our current prevention spend is and how primary, secondary and tertiary prevention can underpin all our pathways of care.

Focusing funding and resources on prevention rather than treatment

We have made the following commitments in our strategy:

- Partners across the ICP will work together to identify an accurate picture of funding and resourcing across BSW across self-care, community care and hospital care.
- We will aim to increase the share of health and care funding going towards preventative measures over the next five years.

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- We will aim to increase the share of health and care funding for babies, children and young people as we know that the needs of children are multifaceted and need a higher profile (See also section 10: Children and Young People).

We will come together as partners across the ICP to identify the proportion of funding spent on prevention. Initial measurements will be worked up through the Population Health Board and the Finance and Investment Committee which will report to the integrated care board and tested through engagement. We will use national definitions and metrics where practicable (e.g. UK Health Accounts).

We will endeavour to create a repeatable definition and prepare comparable figures year on year. By March 2024, we expect to have a common, recognised spend baseline for prevention.

We will take a similar approach to determine a spend baseline for babies, children and young people's services. This reflects our commitment to increase the spend on young people's services.

In developing medium term financial plans, we will increase weighting of new investment decisions in favour of the six prevention focus areas outlined in our strategy.

Successful implementation of financial sustainability plans will deliver improvements in the use of resources allowing reinvestment in prevention. All business cases will need to outline how they will address health inequalities across our population to proceed.

Intervening before ill-health occurs (primary prevention)

We have made the following commitments in our strategy:

Physical wellbeing

- We will increase the proportion of physically active adults.
- We will improve Personal Wellbeing ONS4 scores.
- We will reduce the proportion of adults considered overweight or obese.
- We will increase the proportion of children and young people who are healthy weight.
- We will further reduce the proportion of people in BSW who smoke.
- We will expand stop smoking services across partners.

Mental wellbeing

We will reduce the prevalence of mental health conditions.

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Physical wellbeing

Tackling obesity in adults and increasing the proportion of children and young people who are healthy weight.

Context

Currently much of our work on obesity is driven at a Place level and this is reflected in our current approach to this area of prevention work. The NHS recognises the complex and multi-factorial factors that contribute to both adults and CYP being obese or overweight and that local authorities (LAs) working in partnership have the lead role in delivering change. However, the NHS through its tier 3 and 4 weight management programmes and its interactions with patients has an important role to play and we will be looking at how we maximise the NHS contribution over the next year.

In Swindon in 2020/21 65% of all adults were classified as overweight or obese, higher than the England average of 63.5%, and 34% of children aged 10-11 and 24% of children in reception are classified as overweight or obese both of which are higher than rates for the South West and England. The percentage of physically active adults in Swindon is 70.5% which is above the England rate of 65.9%. Hospital admissions directly attributable to obesity rose from 2013/14 to 2018/19, mirroring a similar trend regionally and nationally.

In 2019/20 55% of adults in Bath and North East Somerset Council (BaNES) were classified as overweight or obese. For children, in 2021/22, 18.5% of Reception aged children and 28.9% of Year 6 aged children resident in BaNES were overweight or obese. In BaNES 70% of adults are physically active which has reduced from a peak of 80% in 2017/18. 49% of children and young people are physically active.

It is estimated 61.8% of Wiltshire's adult population are overweight/obese. In 2018/19, 20.8% of children of reception year age in Wiltshire were recorded as obese or overweight, slightly lower than proportions recorded in the South West as well as England. The Active Lives Children and Young People Survey estimates 53.7% of Wiltshire's CYP are physically active, whilst this is higher than the South West and England percentages, it is a significant proportion of the population or are not physically active.

Children Living with Excess Weight (CEW) is a priority cohort across BSW. Therefore, we will adopt a system-wide approach that recognises the need for localised adaptions due to the complex interplay between weight, eating, food poverty, access to healthy food, physical health, emotional wellbeing, mental health and inequalities and deprivation including food and fuel poverty across the BSW area.

Our delivery plan

In Swindon there are a range of programmes for adults and children to help reduce obesity, including implementing the 'Whole Systems Approach to Obesity ' using Public Health England (PHE) guidance, provision of programmes in early years and schools' settings, and a range of weight management offers.

Using a whole systems approach, we have mapped the key drivers of obesity in Swindon including addressing food poverty, physical inactivity, and the built environment and eating as a coping

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mechanism. Working in partnership with a range of stakeholders, we are developing action plans to tackle each of these key drivers.

In 2019 BaNES, initiated work on the 'Whole Systems Approach to Obesity' and extensive engagement and system mapping was completed with partners and stakeholders. The COVID-19 pandemic interrupted progress on this work and this is now being incorporated into a new BaNES Integrated Health Improvement Strategy which is under development.

This strategy will bring together our approach to physical activity, healthy weight, mental wellbeing, alcohol harm reduction, tobacco and food in BaNES. The Strategy is planned for completion in November 2023.

Wiltshire Public Health team intend to set up a stakeholder group with invested interests in the Whole Systems Approach to healthy weight.

How we are organised to deliver

The Public Health Directorate at Swindon Borough Council leads on implementing the whole systems approach to obesity. A systems network with a range of partnerships and organisations has been developed to support the implementation of the whole systems approach and to take forward actions to tackle each of the identified drivers of obesity. Our commissioned weight management services are also delivered in partnership with colleagues from the Council's Livewell Team and partners including schools, and Swindon Town FC Community Foundation.

Our programmes include Slimming World, Football Fans in Training and our pilot whole school programme 'School Nutrition and Activity Project in Swindon' (SNAPS).
In BaNES, the governance systems and structures for overseeing our work on healthy weight will be determined as part of development of the Integrated Health improvement Strategy.

Wiltshire Public Health team will be the core working group set up to undertake the day-to-day operations and seek to gain senior level buy in and engage relevant stakeholders in this work.

The BSW CYP Programme is now staffed with capacity to move forwards on this priority.

What we will do in the next twelve months

In Swindon, our key deliverables over the next 12 months are:

- Publication of our Whole Systems Approach to Obesity strategy (October 2023).
- Delivery plans developed for each theme of the whole systems approach to obesity (October 2023).
- Interim evaluation of SNAPS programme (October 2023).
- Review of national child measurement programme letters and support to parents (October 2023).
- Options appraisal for a child and family weight management programme (December 2023).
- Ongoing commissioning of tier 2 weight management services such as Slimming World and Football Fans in Training.

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In BaNES, our key deliverables over the next 12 months are:

- Integrated Health Improvement Strategy complete: November 2023
- Strategy partnership work launch: December 2023

In Wiltshire, our key deliverables over the next 12 months are:

- Delivery over the next 12 months will include the initial phases of the Whole Systems Approach (WSA) to Healthy Weight: Phase 1 – Set up core working group.
- Phase 2 – Building the local picture.
- Phase 3 – Mapping the local system.
- Develop end to end weight management pathway across the life course, ensuring equity in access to these services.
- Review food insecurity work in Wiltshire and identify unmet needs as part of WSA to healthy weight.
- Increase referrals to tier 2 weight management services including Healthy Us, and digital tier 2 weight management services in Primary Care.

For the CYP Programme

- Establish a Healthy Weight, Nutrition and Food Resilience workstream to enable a joined up BSW approach to supporting healthy weight, prevention and supporting children and families living with obesity and excessive weight.
- BSW expansion of specialist Children with Excessive Weight (CEW) Clinics – linking SW regional CEW Hub.
- Focus on inequalities and improving outcomes through CYPCORE20PLUS5.
- Link to adult healthy weight approach and diabetes prevention
- Link to food poverty and cost of living crisis.
- Whole systems approach and place based working and BSW ICA and Health and Wellbeing Boards.
- Learn from previous local weight management initiatives, scrutinise their outcomes and use our findings to shape future commissioned support, which is fun, engaging, motivational and effective.

What will be different for our population in 5 years' time

In Swindon, the vision for the Whole Systems Approach to Obesity is that "Together we will create an inclusive environment that supports everyone in Swindon to be a healthy weight." We want everything in our environment to help people increase their levels of physical activity, eat nutritious food and maintain a healthy weight.

In five years', time we want the environment in which our residents live to support them to achieve a healthy weight and for healthy weight will be a consideration in a range of policies and strategies.

In BaNES, this is to be determined as part of our Integrated Health Improvement Strategy Development. In Wiltshire, this will be a continuation of the phases mentioned above: For the BSW CYP Programme this will linked to the localities 5-year plans.

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Smoking cessation

Context

Smoking is uniquely harmful, causing damage not only to smokers themselves but also to the people around them. Smoking is one of the main causes of health inequalities in England, with the harm concentrated in disadvantaged communities and groups.

Smoking is an ongoing concern across BSW with current smoking prevalence at 9.7% in BaNES, 12.5% in Swindon and 11.7% in Wiltshire (PHOF), compared to an England average of 13.9%. 8.4% babies are born to mothers/birthing people who are smokers at the time of birth.

Costs of smoking across BSW can be illustrated through the ready reckoner: Action on Smoking and Health (ASH) ICB Ready Reckoner - ASH. It should be noted that smoking cessation activity takes place at both system and place level.

As the NHS Long Term Plan identifies, attending hospital is a potential point of intervention for more than the specific health condition someone attends for. It is an opportunity to have a conversation and make an offer of support for smoking, recognising that for many people tobacco is a dependency and not a lifestyle choice.

BSW has a strong record of working collaboratively to address smoking. The current Tackling Tobacco Dependency programme provides a plan for delivering the ambitions across the system. It also links the ambitions across inpatients, maternity and mental health whilst recognising that each area has different needs and will draw on topic specific evidence for delivery.

Our delivery plan

BaNES

In BaNES the strategic vision is to achieve a smokefree generation which will build healthier, more equal communities by reducing smoking prevalence, exposure to second-hand smoke and illicit tobacco. A Tobacco Control Needs Assessment was completed in early 2019 and informed the priorities outlined in our Smoke Free BNES Tobacco Control Strategy 2019 – 2024. The strategy plan sets out an ambition to reduce health inequalities by achieving a smoke free generation - 5% smoking prevalence by 2030, in line with national ambitions and local needs.

The strategy sets out how the local authority and its partners will seek to act in an evidence and needs based way in order make meaningful impact on:

- Prevention of uptake of tobacco use including relapse into tobacco use.
- Protection from the harm of smoking in existing smokers and from second-hand smoke.
- Increasing quit attempts and evidence-based support to quit.

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Swindon
Addressing smoking has been identified as a priority for Swindon as set out in Swindon's Tobacco Control Strategy 2023-2028, with ambitions to end smoking and tobacco use for good (signed off by local Health and Wellbeing Board and due to be published here when design complete).

The vision is for a smokefree Swindon where everyone lives a long and healthy life protected from the harm caused by tobacco. Delivery will occur across six priorities for Tobacco Control:

- Focus on health inequalities and target resources for those that need it most.
- Protect children and prevent young people from taking up smoking and vaping.
- Support a smokefree environment.
- Communicate hope and increase quit attempts.
- Reduce the availability and access to illegal tobacco and illegal nicotine vaping products in the community.
- Raise the profile of tobacco control and local services through marketing and communications programmes.

Wiltshire
In Wiltshire there is a gap in life expectancy for men of 5.5 years mapped between the most and least deprived areas, and 3.4 years for women. Tobacco is still the largest preventable cause of these differences.

Smoking has been identified as a cross cutting theme in the work to deliver the BSW Reducing Inequalities Strategy, and a core focus of the Wiltshire Health Inequalities Group.

The vision for a smokefree Wiltshire is where everyone lives a long and healthy life protected from the harm caused by tobacco. Wiltshire Council's Business Plan includes an aim to reducing smoking prevalence to 5% or less in line with the government's 2030 smokefree ambition.

Delivery will occur across 4 priority areas:

- Increase quit attempts and look to increase quit rates specifically in areas of highest deprivation across the county, expanding the use of E-cigarettes as a tool to becoming smokefree.
- Protect children and prevent young people from taking up smoking and vaping.
- Raise the profile of local services through marketing and communications programmes.
- Ensure smoking cessation pathways are designed around the individual, utilising evidence on behavioural insights to increase effectiveness of activity.

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BSW Providers
Each Acute Trust (Great Western NHS Foundation Trust, Royal United Hospital, Salisbury Foundation Trust) and Avon and Wiltshire Mental Health Partnership has recognised the importance of tackling tobacco dependency and are at different stages of service implementation.

The NHS Long Term Plan requires that everyone admitted to hospital will be offered NHS funded tobacco treatment services, including maternity and mental health inpatients. Funding has been provided by National Health Service England (NHSE) to ICBs for onward allocation to NHS Trusts for delivery. Full details of the programme are contained in the NHS Long Term Plan for Treating Tobacco Dependency Business Plan for BSW.

In addition to the NHS pathway and funding, Public Health funds support for pregnant smokers in the community maternity service.

How we are organised to deliver

BaNES
BaNES has an active and well-established Tobacco Action Network (TAN). The TAN oversees the delivery of the BaNES Tobacco Control Action Plan that drives delivery of the strategy and works collaboratively across all areas of tobacco control in BaNES.

Swindon
In Swindon, an evidence based whole systems approach to tobacco control (WSATC) was conducted with a range of partners, organisations, and service users in developing the Tobacco Control Strategy. The Strategy will be supported by a detailed annual action plan which will be agreed by all partners of the Swindon Tobacco Control Alliance (STCA).

Wiltshire
It has been agreed for a Wiltshire Tobacco Control Alliance to be established to oversee delivery of the tobacco control activity, reporting to the Wiltshire Health Inequalities Group. The Alliance will adopt a whole systems approach to tobacco control, involving a range of partners and will be guided through the delivery of an agreed action plan.

BSW Population Health Board

Local Authority Public Health leads support the delivery of the treating tobacco dependency (TTD) programme through chairing of the monthly BSW NHS Long Term Plan for Treating Tobacco Dependency network meetings.

The group is accountable to the ICS Population Health Board and provides updates on delivery and implementation at least annually. Executive level support and named senior clinicians from acute trusts are identified in project plans.

Smokefree working groups exist within each trust, with clinical lead support to ensure delivery of the TTD model and that it is embedded as a treatment pathway.

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What we will do in the next twelve months

- Focus on health inequalities and target resources for those that need it most (linked to local health inequalities activity).
- Increasing knowledge, awareness and skills in talking about e-cigarettes and vaping, particularly amongst those working directly with children and young people e.g. schools.
- Reduce the availability and access to illegal tobacco and illegal nicotine vaping products in the community.
- Raise the profile of tobacco control and local services through marketing and communications programmes e.g., Stoptober.
- Working together to support implementation of the NHS Long Term Plan (LTP) on Treating Tobacco Dependency including provision of support across inpatient, maternity and mental health services. BSW Tackling Tobacco Dependency Business Case is reviewed and agreed across the system for 23/24 delivery.
- Trust project plans are in place and resources identified for delivery (to include named leads, finance, etc).
- Recruitment and confirmation of system leadership for Treating Tobacco Dependency, with programme management support to work with Trusts to ensure delivery plans continue to be monitored and reporting back to NHS England as appropriate.
- Delivery of the TTD programme is fully embedded in the system and place inequalities workstreams to ensure integration of work across organisation and adequate finance resource is in place to achieve delivery of the programme.

What will be different for our population in 5 years' time

- Reduction in the inequality gap in smoking prevalence between those in routine and manual occupations and those with a Serious Mental Illness and the general population.
- Reduce the prevalence of smoking in the adult population towards the national ambition of 5% by 2030.
- Reduce the prevalence of women who smoke at the time of delivery towards the national ambition of below 5%.
- Reduce the prevalence of smoking in CYP.
- The BSW business case for TTD contains the implementation plan for the programme, with further detail on what NHS Trusts will deliver found here: NHS England » Guide for NHS trust tobacco dependence teams and NHS trust pharmacy teams.

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Mental Wellbeing

Context

Deprivation is one of the principle determinants of mental ill-health, and people from our deprived communities have greater levels of mental illness and poorer levels of wellbeing than those who live our more affluent areas. The Indices of Deprivation are:

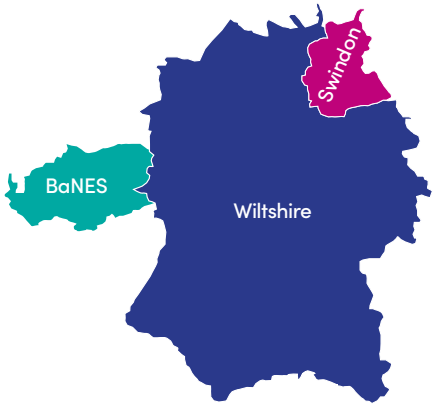
- Income.
- Employment.
- Education.
- Health.
- Crime.
- Barriers to housing and services.
- Living environment.

Although a large proportion of our population live in relatively less deprived areas, there are pockets of challenge across our communities that we will need to address if we are to support improvements in mental wellbeing and a reduction in common mental illness.

Overall Swindon has a far higher rate of deprivation than Wiltshire or BaNES. This is evident in lower income levels, greater levels of unemployment, poorer education attainment and challenges with housing. From a health outcomes perspective, people in Swindon have a lower life expectancy than people in BaNES or Wiltshire.

Children who are Looked After (CLA) are more likely to experience mental illness – both in childhood and into adult life – often driven by significant psychological trauma in early years. The number of Children Looked After in BaNES, Swindon and Wiltshire is reflected in the map below:

Figure 14: Number of Children Looked After in BaNES, Swindon and Wiltshire (2020).



Local Authority	Number of CLA (2020)
BaNES	**181**
Swindon	**301**
Wiltshire	**458**

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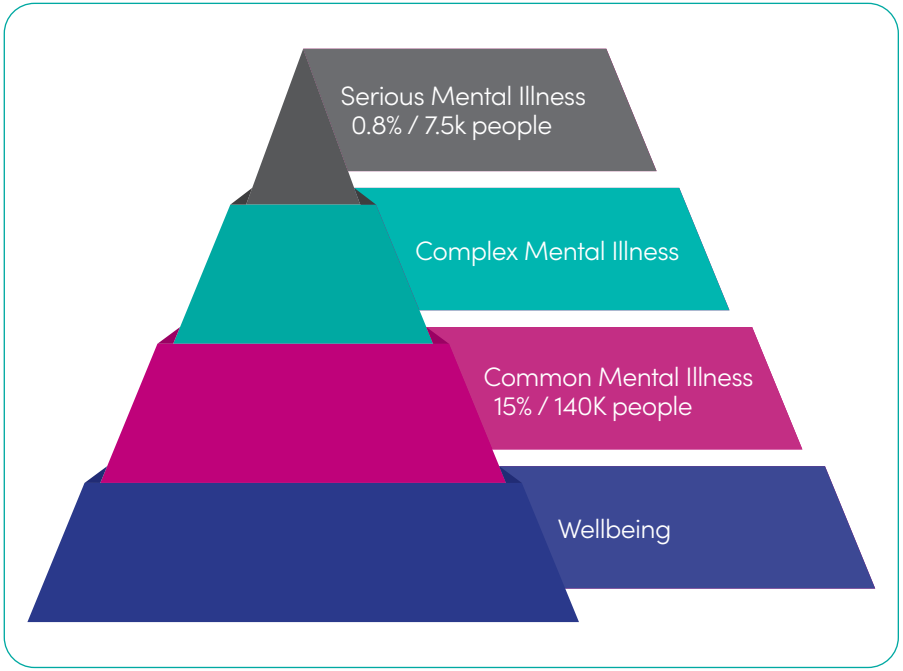
Taking action to improve the life chances for Children Looked After will have a positive impact on their immediate mental health and wellbeing but also demand for mental health services in later life. This cannot be achieved by health partners alone, but requires a concentrated effort between Local Authorities, health, community organisations and education providers. People with mental health needs can be broadly segmented into the following groups:

Figure 15: Broad groupings of people with mental health needs



Whilst the number of people with Serious Mental Illness is relatively consistent across BaNES, Swindon and Wiltshire, the number of people with Common Mental Illness is increasing in every geography. This is across both adult and children's services, and if we are to arrest this growth in future years, we need to have a more systematic and consistent approach to wellbeing that focuses on providing opportunities for people to access community based offers that support them to stay well in the community. The following groups are more likely to experience poor mental health:

- People from Black, Asian and Minority Ethnic (BAME) groups.
- People with physical disabilities.
- People with learning disabilities.
- People with alcohol/drug dependence.
- People in prison.
- People who identify as Lesbian, gay, bisexual, transgender, intersex, queer/questioning and others (LGBTQ+).
- People who are carers.
- People with sensory impairments.
- People who are homeless.
- People who are refugees or seeking asylum.

People with Serious Mental Illness(es) have a life expectancy 10 to 20 years lower than those who do not. This is generally not as a result of the illness itself, but as a result of challenges in accessing physical health service provision.

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Our older adult population is increasing, and similarly we need to respond to this with the right support to both people and their carers in order to reduce demand on both mental health and physical health services – across primary, secondary and tertiary care services.

The development of our Integrated Care Board affords us the opportunity to work together to address these health inequalities, with a collective and concerted effort to improve prevention and reduce mental ill health.

Our delivery plan

Our delivery plan to improve mental health and wellbeing is focused on increasing investment in early intervention and prevention initiatives, reducing demand for secondary mental health services and achieving a 'left shift' in provision. This will involve working through our ICAs to coordinate and develop thriving local communities, equipped to support people's mental health and wellbeing. Over the coming 5 years we will:

- Reinvest savings made in core mental health provision in targeted wellbeing initiatives, directing funding through our Third Sector Mental Health Alliance.
- Increase the number of people across our communities trained in mental health first aid.
- Expand and develop our Mental Health Support Teams (MHSTs) in schools and work with education providers to support delivery of their local mental health plans.
- Continue to increase the number of people with serious mental illness accessing annual physical health checks in primary care.
- Develop targeted support offers for people who are refugees or asylum seekers across our communities.
- Make best use of social prescribing and navigation support available in primary care.
- Make "every contact count" and follow the child through to adult mental health support.

How we are organised to deliver

Delivery of our plans will be overseen through Place based mental health groups, with strategic oversight provided through our Mental Health (Thrive) Programme Board. Core membership of these groups includes third sector, people with lived experience, secondary mental health and primary care partners.

What we will do in the next twelve months

Over the next twelve months we will:

- Improve access to community based mental health services with a no wrong front door approach delivered by our third sector mental health alliance partners, across BSW. Their service will 'walk alongside' and direct people to alternative offers in local communities. Achieve LTP target for Community Mental Health service provision (by Q4).
- Implement a new model for Children and Young People's mental health in Swindon, with this then operating as a blueprint from which we will develop similar services across our ICB footprint (Q3).

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- Improve our Talking Therapies provision, recruiting new staff to implement phase 1 of our plan to deliver national LTP metrics (by Q4)
- Reduce long lengths of stay in out of area placements, investing savings in new models of community rehabilitation (Rehab) and wider mental health transformation (by Q4)
- Implement a new GP Local Enhance Services (LES) for Physical Health Checks for people with SMI in order that they can be managed successfully in primary care (Q2)

What will be different for our population in 5 years' time

- More people who are supported through local offers as directed by primary care, social prescribing and third sector partners.
- A Talking Therapies service that achieves and exceeds LTP standards.
- Pathway based model of mental health provision that is constructed around population health needs from point of presentation to recovery.
- A measurable improvement in life expectancy for people with severe mental illness (SMI) in our population, achieved through earlier identification of physical health needs.
- Fully integrated care records that enable access for all staff regardless of sector.

Identifying ill-health early (Secondary Prevention)

- We have made the following commitments in our strategy: We will work to ensure the system has routine access to high quality secondary prevention data.
- Partners will work on joined-up prevention pathways; and
- We will improve uptake of cervical, breast and bowel cancer screening.

Long term conditions: Cardiovascular disease (CVD) and Diabetes

Context

We currently spend over £120m each year on events and complications because of diabetes and CVD. Issues to be addressed include identifying and engaging with patients with modifiable risk factors, or who have developed a condition, earlier in their care journey, developing robust, risk stratified systems and processes and optimising behaviours and medicines to achieve treatment targets.

Our delivery plan

Headlines of what we are aiming to achieve in 2023/24 are:

- Increased use of data to highlight differences in NHS Health Check invites and uptake, and treatment targets and care processes attainment, including by Health Inequalities cohorts.

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- Work with primary care to improve the identification and management of people with the risk factors for diabetes and CVD.
- Develop plans to increase focus on behavioural interventions.
- Care aligns with the BSW Care Model and through Integrated Neighbourhood Teams, moving to a population health approach to diabetes and CVD.

How we are organised to deliver

The core of delivery is through General Practice supported by Community Pharmacy and social prescribers to support behaviour change. Where required, care is provided by specialist diabetes services who in-reach into Primary Care.

As part of our work in 2023/24 we will agree system arrangements to provide oversight and co-ordination to these services.

What we will do in the next twelve months

- Agreed governance and priorities for Long Term Conditions across BSW by end of Q3.
- Dashboard to enable system wide visibility of key diabetes and CVD targets, with first draft by end of Q1, with further development into Q3.
- Utilisation of data to support uptake and attainment discussions to commence in Q2.
- Options and plans for sharing care between Practices and Community Pharmacy developed.
- Increased coordination between specialist diabetes services, planned from Q1.
- Plans developed for how patients with modifiable risk factors or new condition identified and receive support.
- Implementation of Diabetes Pathway 2 Remission (Low Calorie Diet Programme), to commence roll out from Q3.
- Increasing utilisation of diabetes digital Structured Education options for appropriate patients, to commence roll out from Q3.

What will be different for our population in 5 years' time

- Treatment will commence with a good understanding of each patient's individual behavioural risk factors and preferences.
- Specialist services are risk stratified, complexity based and aligned with the BSW Care Model.
- We will use the Population Health Management approach to diabetes and CVD care alongside Integrated Neighbourhood Teams to identify patients with unresolved risk factors and agree solutions.
- Ensure all clinicians involved in care of patients have the information required for effective shared care, with decisions being jointly agreed by clinicians and patients.
- Structured Education services at scale and scope to meet demand for patients to attend within one year of diagnosis.
- Remote delivery of care, using technology for a digital safety net.

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Our delivery plan

- To review stroke services and locality based provision against the requirements in the National Stroke Service model (www.england.nhs.uk/wp-content/uploads/2021/05/stroke-service-model-may-2021.pdf).
- To develop a needs led model for stroke, heart failure and cardiac rehabilitation that aligns with the BSW Care Model and is of sufficient scale and scope to maximise opportunities for independence and recovery.
- To develop provider led governance and leadership of Stroke and Rehabilitation (Rehab) services.

Cancer and Screening (cervical, breast and bowel)

Context

Provision in the BSW area is as follows:

- There is a single bowel cancer screening programme, commissioned by NHSE and delivered collaboratively by all three of our acute trusts.
- There are three breast screening services – the Wiltshire breast screening programme, covering most of Wiltshire plus Swindon; the Avon breast screening service, covering BaNES and part of West Wiltshire; and the Portsmouth service, covering the south of Wiltshire. Our trusts provide treatment for patients identified via breast screening.
- There are two labs supporting the cervical screening programme across BSW, at North Bristol and Berks and Surrey; samples are taken by GP practices; patients are then seen in colposcopy units and as required receive treatment in our acute trusts.

Our delivery plan

Alongside the ambitions of the cancer screening commissioners and providers, we actively assist with the uptake rates for cancer screening across our population, including for those groups or cohorts who typically are under-represented in terms of attendance.

What we will do in the next twelve months

There are a number of strands to the work being done to improve early diagnosis, including addressing the needs of those typically late to present.

- We will share with all practices and PCNs the learning and outcomes from projects that we have funded in primary care in 22/23 aimed at increasing early presentation and screening uptake.
- Targeted Lung Health Check (TLHC) –In 2023/24 we will submit bids to support expansion to cover the remaining parts of BSW population footprint in line with national TLHC opportunities.
- Bowel Cancer Screening Programme (BCSP) – to ensure sufficient capacity of trained staff to deliver the BCSP at all three trusts, as well as access to screening colonoscopies; BSW ICB will continue to engage in this process alongside our providers,

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and link with our community diagnostic centres (CDC) programme regarding provision of sufficient colonoscopy capacity.

- Non-specific symptoms (NSS) - We will explore expansion of the NSS pathway provision to cover the remaining 35% of BSW population.

What will be different for our population in 5 years' time

- More people taking up the opportunity of cancer screening for bowel/breast/cervical.
- Widespread roll-out of lung cancer screening building on existing lung cancer screening programme pilots (which include Swindon, and parts of Bath; with next phase expansion currently being planned by SWAG (Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance) and expected to include Salisbury and Trowbridge).
- Reduction in inequality of access/uptake of cancer screening.

Long term conditions: Respiratory

Context

Respiratory disease affects one in five people in England and is the third biggest cause of death. The NHS Long Term Plan identifies respiratory disease as a clinical priority and outlines how we will be targeting investment to improve treatment and support for people with respiratory disease, with an ambition to transform our outcomes to equal, or better, our international counterparts. Programme aims include:

- Ensuring patients get an early and accurate diagnosis.
- Improving medication optimisation.
- Increasing access to Pulmonary rehab services that are of appropriate scale and scope.
- Patients supported with behaviour risk factor reduction.
- Improving the treatment and care of people with community acquired pneumonia.

We recognise the need to work with local authority partners to improve air quality and the importance of local authority initiatives such as warm homes where we aim to work together to reduce the environmental risk factors for respiratory disease.

Additionally, there is a need to agree and set in place the necessary BSW respiratory programme, including prioritisation and oversight of adult and children respiratory plans.

Our delivery plan

- Progress Year 2 priorities as set out in the BSW Pulmonary Rehab Plan.
- Improve diagnosis process and monitor impact on diagnosis rates and prescribing patterns and expenditure.
- Expand pulmonary rehab into areas where not provided and increase provision in areas of health inequalities (see BSW 5-Year Plan).

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- Develop plans and understand assigned resources to enable reviews of inhaler prescribing, scope personalisation and behaviour risk factor reduction projects and scope community acquired pneumonia, if Commissioning for Quality and Innovation (CQUIN).

How we are organised to deliver

- Early Diagnosis through Primary Care and Community Diagnostic Hubs.
- Rehab through Community Service providers.
- No single group with an Executive Senior Responsible Officer coordinates respiratory priorities across localities and system.

What we will do in the next twelve months

- Agree system governance, priorities and assigned resources for respiratory programme.
- Continue to support the roll out of fractional exhaled nitric oxide (FENO) testing in primary care and monitor impacts.
- Business case for funding spirometry across BSW, with a view to supporting accreditation training and restarting services.
- Develop rehab workforce and service model alongside other rehab services, such as heart failure and utilising digital rehab offers.

What will be different for our population in 5 years' time

Patients presenting with respiratory issues are diagnosed correctly and treated appropriately.

- Pulmonary rehab available in format most appropriate to patient needs and preference within 90 days of referral.
- All Pulmonary rehab services accredited and compliant with National Asthma and chronic obstructive pulmonary disease (COPD) Audit Programme.
- Use of FENO testing for monitoring and dose adjustment.
- Treated combines behaviour risk factor reduction with medical interventions.
- Rates of community acquired pneumonia have reduced.
- Clear governance of respiratory within the ICS.

Slowing down or stopping disease progression (Tertiary Prevention)

We have made the following commitments in our strategy:

- We are working with our health and care professionals to connect them with the emerging joined up local teams in each neighbourhood to provide coordinated lifestyle, psychological and medical advice and support.
- Specialist services such as hospitals will work together with local authorities, VCSE organisations and neighbourhood teams to prevent, break or slow the chain of progression that results in poorer outcomes.

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Strategic Objective 1: Focus on Prevention and Early Intervention

Long term conditions: CVD event recovery

Context

This is an example of the tertiary prevention work in place in our system. Other parts of our plan focus on preventing CVD events, through earlier diagnosis, engaging with modifiable risk factors and treating patients to target. For those patients who have had a CVD event, such as a stroke or heart attack, or been diagnosed with heart failure, we will support them to regain independence, mobility and reduce the risk of future events. This is through a combination of timely treatment by experienced teams and a focus on rehabilitation.

How we are organised to deliver

Cardiac rehab is led by the three acute hospitals however further consideration needs to be given to scale and scope of provision to best meet patient need, particularly in the context of health inequalities. Heart Failure provision is organised through a combination of community and acute services, with different services models and rehab available across our system.

What we will do in the next twelve months

- Agree governance of CVD work.
- Provider led Stroke and Neuro Group will, from Q2, map the prevalence and outcomes data against current provision, with a view to agreeing priorities and optimum model.
- Scope creating a neuropsychology service for individuals on the stroke pathway, living in the community and in stroke rehabilitation beds across BSW, by end of Q3.
- Newly implemented Wiltshire Heart Failure service to be developed to agreed scale and scope, by end of Q4.
- Review scale, scope and service models of rehab services to emphasise individualised patient care and patient choice in physical and educational components of rehab, with robust data collection.
- Plan how to embed rehab into the wider multi-disciplinary team (MDT) to include nurses, physicians, dietitians, pharmacist, occupational therapy (OT), psychology practitioner to meet the full spectrum of patients physical and psycho-social needs.

What will be different for our population in 5 years' time

Scale and scope of cardiac rehab services to be reviewed, to ensure provision aligns with the BSW Care Model.

Wider determinants of health

We have made the following commitments in our strategy:

- We will increase green space, accessible for all to use, and promote greener transport.
- We will improve air quality, including by incentivising greener forms of travel.
- We will keep all of our residents in warm and decent homes, through investment in our social housing stock and both supportive and enforcement interventions in private sector homes.

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Strategic Objective 1: Focus on Prevention and Early Intervention

- We will prevent homelessness by engaging with vulnerable individuals at the earliest possible stage.
- We will prioritise social housing to those in greatest need to support their health and social care needs.

The wider determinants of health are a diverse range of social, economic and environmental factors which impact on children and adults mental and physical health. Also known as social determinants, they are influenced by the local, national and international distribution of power, wealth and resources which shape the conditions of daily life. Systematic variation of these factors constitutes social inequality.

They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasising the strong and persistent link between social inequalities and disparities in health outcomes.

The following list provides examples of wider determinants of health, which can influence health equity in positive and negative ways:

- Income and social protection.
- Education.
- Unemployment and job insecurity.
- Debt.
- Working life conditions.
- Food insecurity.
- Housing (including warm and decent homes) and access to basic amenities.
- The built and natural environment.
- Early childhood development.
- Social inclusion and non-discrimination.
- Access to affordable health services of decent quality.

Research shows that the wider determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that wider determinants of health account for between 30-55% of health outcomes. Utilising the wider determinants of health appropriately is fundamental for improving health and wellbeing and reducing longstanding inequities.

Variation in the experience of wider determinants (i.e., social inequalities) is considered the fundamental cause (the 'causes of the causes') of health outcomes, and as such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist. Addressing the wider determinants of health has a key role to play in reducing health inequalities. With the South West Region commitment to becoming the first Marmot region in England, BSW as a system has the moral imperative to deliver Prevention and Early Interventions through addressing the social determinants of health across the three Places.

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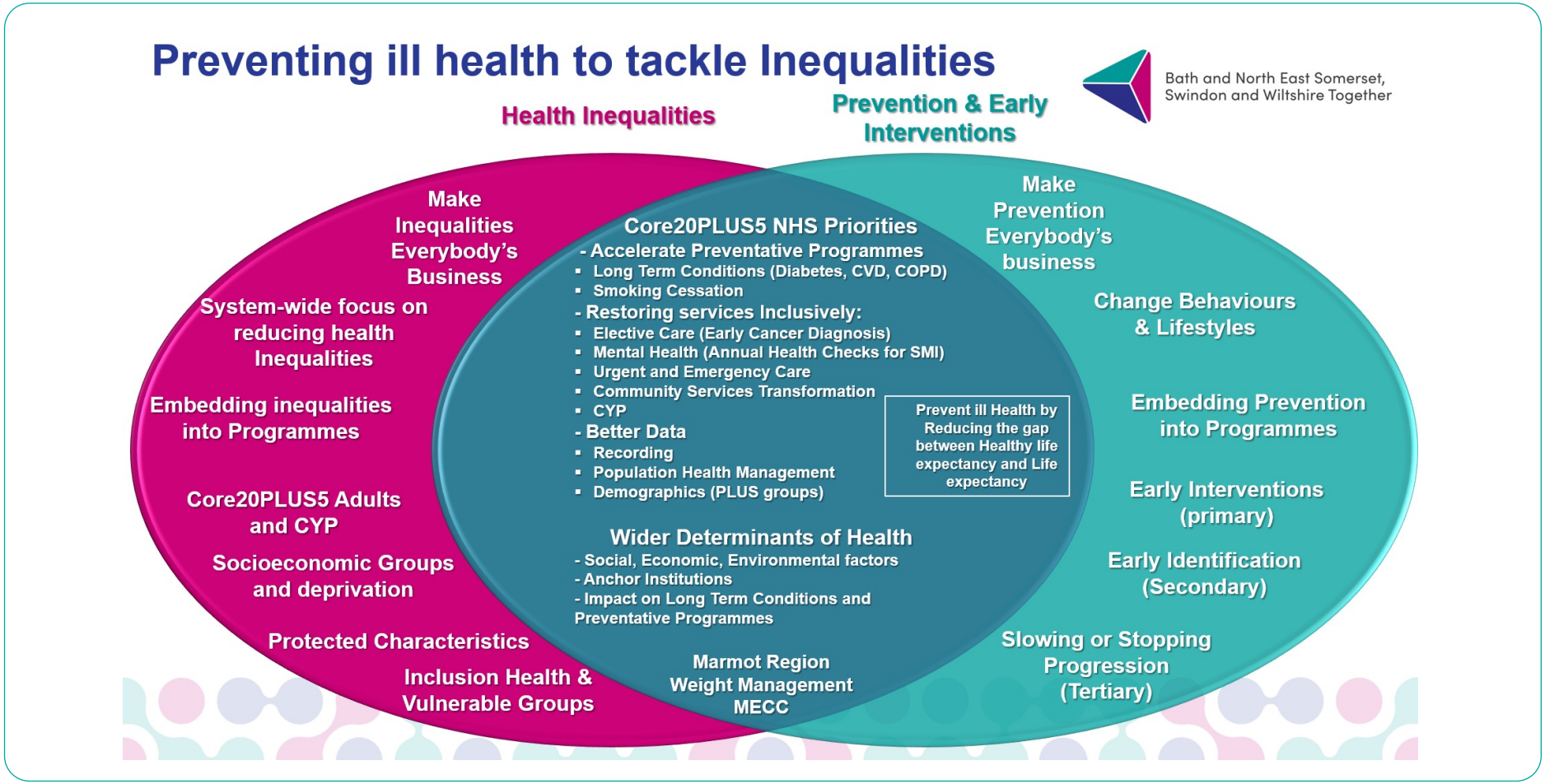
Strategic Objective 1: Focus on Prevention and Early Intervention

Preventing ill health to tackle inequalities

Figure 16: preventing ill health to tackle inequalities



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Strategic Objective 1: Focus on Prevention and Early Intervention

Our delivery plan

- Align and support delivery of the South West regional work to become a Marmot region.
- Ensure that the promotion of health and wellbeing and reducing inequalities are priorities embedded in key place strategies when they are refreshed/developed, including the Local Plan, Transport Strategy, Housing Strategy, and Economic Strategy.
- Support delivery of Strategy action plans, for example by taking leading roles as anchor institutions in promoting the social determinants of health through key levers such as good quality work and robust and inclusive pathways into work and including for those under-represented in the labour market and/or disadvantaged.
- Align health programmes/innovations such as "health on the high-street" with place based interventions such as Liveable Neighbourhoods and Healthy High Streets.

How are we organised to deliver?

- Establish a BSW wider determinants working group to support strategic discussions and action on wider determinants at a BSW footprint.
- Deliver through place-based programmes of work on specific strategies/plans, including through the Health and Wellbeing Strategy.

What we will do in the next 12 months?

- Utilise place-based strategies/plans that are being refreshed/developed as an opportunity to shape, promote and deliver healthy and sustainable places and reduce inequalities.
- Commit to supporting delivery of strategies/plans as anchor institutions and agree specific actions, outcomes and timescales to support delivery.

What will be different for our population in 5 years' time

- Establishing and harnessing the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact.
- All three acute hospitals in BSW achieve chartered anchor institution status by 2025.
- Increased number of local hires.
- Increased number of apprenticeships.
- Increased recruitment representative of local demographic data.
- Increased local vs. central spend where possible.
- Increased community use of NHS estates.
- Increased support for NHS staff to access affordable housing.
- Increase in accessible community green space.

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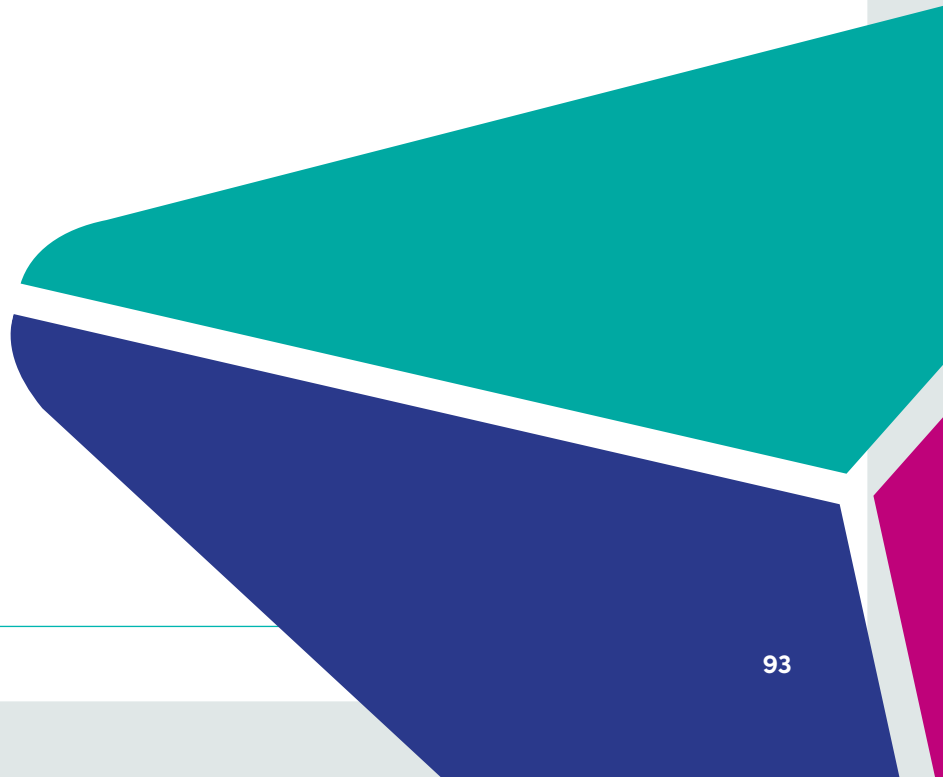
Strategic Objective 1: Focus on Prevention and Early Intervention

- Decreased carbon output through improved energy efficiency, increased sustainable travel options.
- Reduced waste and water consumption.
- Develop and support anchor collaboratives/networks (e.g., Avon and Wiltshire Mental Health Partnership (AWP), Local authorities, campuses, leisure centres).

Section 8

Strategic Objective 2:
Fairer Health and Wellbeing Outcomes



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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

Inequalities are unfair and avoidable differences that can impact health across different communities driven by factors such as education, housing, employment, ethnicity and access to health services and programmes.

Tackling health inequalities to guarantee fairer health and wellbeing outcomes across all sectors of our communities is a matter of fairness and social justice. Working with other partners across BSW, the aim for this plan is to make sure that tackling health inequalities becomes "everyone's business" and is embedded in all the work of the health and care organisations that make up the BSW Integrated Care Partnership.

Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities. In addition, BSW ICB has a legislative requirement to:

a) Reduce inequalities between people with respect to their ability to access health services.

b) Reduce inequalities between patients in respect to the outcomes achieved for them by the provision of health services.

The ICB has also the duty to have regard to the wider effects of decisions on inequalities. The duty to promote integration requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved.

Our commitments

- We will implement a CORE20PLUS5 approach for children and adults across BSW, as outlined in our Inequalities Strategy.
- We will embed inequality as "everybody's business" across the system.
- We will develop an inequalities hub within BSW Academy to host learning and development resources.
- We will work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and set out clear plans on how to close the inequality gaps.
- We will demonstrate action on inequalities that spans from system to place through joined up strategy and planning.

Our Delivery Plan

The BSW Inequality Strategy 2021-2024, first published in 2021, aims to provide a framework for system activity to reduce health inequalities. The strategy has been developed from key guidance and policy relating to reducing healthcare inequalities, as well as recognising the need for close partnership working with colleagues at a place level to address social, economic and environmental determinants of health (also known as 'wider determinants').

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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

This strategy aims to address inequalities across the life course, to include pregnancy, children and young people, adults and into old age.

The BSW Inequalities Strategy builds a foundation for a shared understanding of health inequalities as a system, bringing together existing strategy and local data and intelligence and focusing this on the CORE20PLUS5 population. This approach focusses on the 'core' 20% of most deprived areas, 'PLUS' communities at higher risk of inequality, and five key clinical focus areas.

For adults these are:

1. CVD
2. Maternity
3. Respiratory
4. Cancer
5. Mental Health

Smoking Cessation is included as a priority that cross cuts all five clinical areas for adults.

For children and young people, these are:

1. Asthma
2. Diabetes
3. Oral health
4. Epilepsy
5. Mental Health

PLUS groups are locally defined populations experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the core 20 alone and would benefit from a tailored healthcare approach.

PLUS groups were chosen based on local data, and for BSW are outlined below.

For adults, PLUS groups are:

- Bath and North East Somerset: Ethnic minority communities, Homeless and People living with severe mental illness (SMI).
- Swindon: Ethnic minority communities.
- Wiltshire: Routine and manual workers, Gypsy, Roma and Traveller communities and rural communities.

For Children and Young People, the BSW PLUS groups are:

- Children with Special Educational Needs and Disability (SEND).
- Children with excessive weight and living with obesity.
- Children Looked After (CLA) and care experienced CYP.
- Early Years (with a focus on school readiness).
- Children and Young People with Adverse Childhood Experiences (ACE; with a focus on delivering trauma informed services).

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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

For each locality, our CYP PLUS groups are:

- Bath and North East Somerset: children eligible for free school meals.
- Swindon: children from ethnic minority backgrounds.
- Wiltshire: children from Gypsy, Roma, Boater and Traveller communities.

The BSW Inequalities Strategy 2021-2024 provides a defined set of targets to deliver across three phases:

- Phase 1: Awareness Raising.
- Phase 2: Healthcare Inequality and Core20PLUS5.
- Phase 3: Prevention & the social, economic, and environmental determinants of health. This phase is covered in detail in other chapters of this plan.

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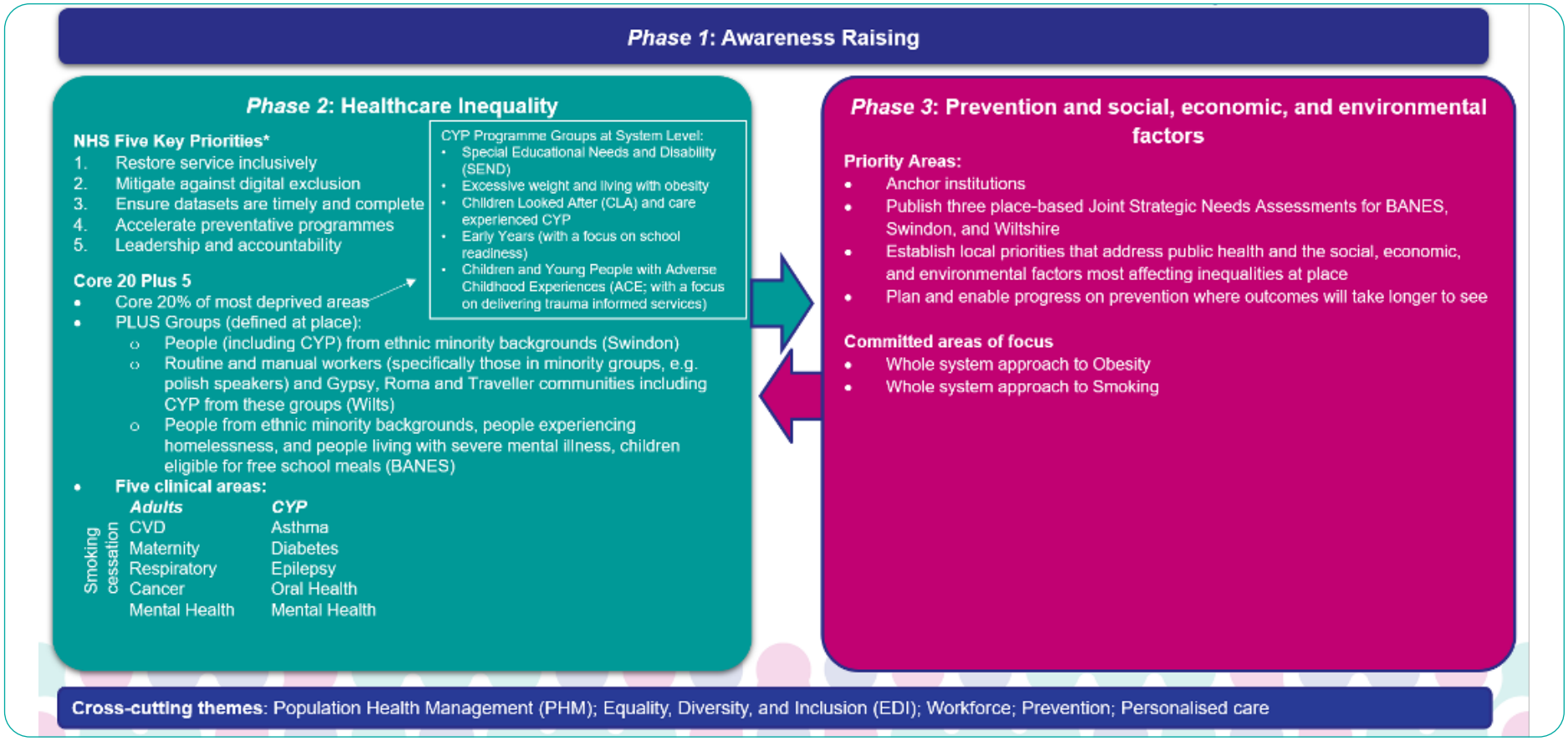
Strategic Objective 2: Fairer Health and Wellbeing Outcomes

The BSW Inequalities Strategy on a Page

Figure 17: The BSW Inequalities Strategy on a Page



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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

What we will do in the next twelve months

Phase 1 of the strategy implementation is currently underway and focuses on Making Inequalities Everybody's Business. This phase targeted ICS leaders to ensure Health Inequalities drivers and priorities were understood and addressed.

This area of work is strongly linked to the BSW learning and development agenda and collaboration with the BSW Academy has been instrumental in the development of an online Inequalities Hub that brings together a collection of resources that will enable all staff, partners, and communities to understand inequality and how BSW seek to address this. The table below outlines delivery plan for phase 1 and the ambitions for 2023-24:

Table 9: The BSW Inequalities Strategy delivery plan for phase 1 and ambitions for 2023-24

Action	Metrics and Milestones	Status
A training needs analysis will be undertaken outlining multi-disciplinary training pathways across all staff and learner groups; this analysis will identify the learning outcomes, intended audience, method of delivery and evaluation	Training Needs Analysis completed by **June 2022**	✓ **Complete**
BSW inequalities workshops will be delivered to inform and support colleagues and partners with their work on Health Inequalities	20 sessions delivered by **April 2024**	4 x workshops delivered (PCN) Local Knowledge and Intelligence Service (LKIS) workshops co-developed – Analysts Roll out with health inequalities (HI) posts at Place
The BSW Academy will support phase one through multi methods such as bite size e-learning modules, a seminar series, storytelling and showcasing of BSW examples for real world application	Inequalities online 'hub' online by **November 2022** and disseminated. Traffic to site to show increasing access from baseline to **April 2024**.	✓ **Complete** BSW Academy link

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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

Table 9: The BSW Inequalities Strategy delivery plan for phase 1 and ambitions for 2023-24

Action	Metrics and Milestones	Status
Collate resources to support PCN, ICS and Provider health inequalities Senior Responsible Officer (SRO) to access training and wider support offer, including utilising the Health Inequalities Leadership Framework, developed by the NHS Confederation	Resource library to be available and distributed by **December 2022**	✓ **Complete** Hosted on BSW Academy Resource review underway – feedback welcome!
A BSW Inequalities Communication Plan will be established to effectively map stakeholders and ensure inequalities is truly embedded in thinking across BSW	BSW Inequalities Communication Plan completed by **Quarter 3 2023-24**	
Inequalities will be represented across the system at planning groups and networks, coordinated through the BSW Inequalities Strategy Group	Full membership of the BSW Inequalities group established by **April 2022**	✓ **Complete**
The BSW Inequalities Strategy Group will collate action plans from relevant leads to clarify how inequalities are being addressed throughout the system and reported back to the BSW Inequalities Strategy Group	All thematic and organisation leads to deliver action plans as outlined by the BSW Inequalities Strategy by **September 2023**	**On track** To align with phase 2 implementation plan

Section 8

Strategic Objective 2: Fairer Health and Wellbeing Outcomes

What will be different for our population in 5 years' time

The successful delivery of this programme and the achievement of the high level outcomes in phase 2 and 3 will ensure that the gap between healthy life expectancy and life expectancy is on course to be reduced.

Phase 2 of the strategy focuses on embedding Core20PLUS5 for adults and CYP in the day to day work of the ICS to promote inclusive recovery of services and deliver ICS Strategic Objectives for prevention and early interventions as well as fairer outcomes.

The Implementation Programme at System level will focus on embedding inequalities and prevention across the BSW programmes with particular focus on data improvement, initially covering the following areas Mental Health, Elective Care, CYP, Community Services, Cancer, and UEC. Funds for better data will be non-recurrent with the ambition to transition into Business as Usual by 2025-26.

Another key feature of phase 2, is to take action to continuously improve BSW data on inequalities both at System and Place level. This includes routine use of postcode of residence and indicators of place, and improved ethnicity recording.

Phase 3 focuses on action around the social, economic and environmental factors, including a focus on anchor institution work. It also highlights the importance of primary prevention in areas such as smoking and obesity where there are strong associations with health inequalities.

Across both phase 2 and phase 3 activities within the health inequalities strategy there is synergy with many of the wider prevention actions that have been highlighted under our planned work on prevention and early intervention (strategic objective 1).

This contributes to delivery of the 'proportionate universalism' approach described by Marmot where action should be of sufficient scale and intensity to be universal but also proportionately targeted to reduce the steepness of the social gradient.

Work for example, on hypertension through our CORE20+5 approach drives us to consider how to deliver for our most deprived populations, and populations at greatest risk of health inequalities fastest, while also recognising that we need to work with all our population to flatten the gradient and improve health outcomes.

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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

The table below outlines the ambitions of BSW in reducing health inequalities by achieving the Core20PLUS5 targets for both adults and CYP.

Table 10: The BSW Inequalities Strategy delivery plan for phase 2 and 3 ambitions

Action	Metrics & Milestones
Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas (adults)	Increase in percentage of pregnant people on continuity of care (CoC) pathway in line with staffing trajectories
	Annual health checks for 60% of those living with severe mental illness and learning disabilities
	Increased uptake of COVID-19, flu and pneumonia vaccines in C20+ and people with COPD
	75% of cancer cases diagnosed at stage 1 or 2 by 2028
	Increase percentage of patients with hypertension treated to National Institute for Health and Care Excellence (NICE) guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas (CYP)	Reduce the percentage of children and young people with a reliever: preventor ratio greater than 1:6
	Reduce the number of asthma attacks as indicated by unplanned hospital admissions, presentations in ED, prescriptions of oral steroids
	Increased access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes
	Increase access to Epilepsy Special Nurses (ESNs) for CYP within the most deprived 20%, and CYP with LDA, within the first year of care
	Tooth extractions in hospital due to decay for children aged 10 years and younger
	Children and young people (ages 0-17) mental health services access (number with 1+ contact)

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Strategic Objective 2: Fairer Health and Wellbeing Outcomes

How we are organised to deliver

The Strategic Leadership and Accountability within the inequalities programme is guaranteed by a SRO in place, and an Executive Director with remit for inequalities within the ICB.

The Governance and oversight of Health Inequalities is provided by the Population Health Board. The Board oversees the delivery of the BSW Inequality Strategy as well as the deployment of the Health Inequalities funds to support the prioritisation of tackling Health Inequalities. The role of the Population Health Board will be to bring together all the elements of the inequalities and prevention agenda. Delivery will be embedded through all the BSW programmes and organisations.

The BSW ICB intends to make a five-year commitment to ringfence funds to support health inequalities of £2m per annum. This allocation is a minimum commitment for BSW at this stage.

The Hewitt report recommends that the spend that ICBs commit to prevention should increase over the next 5 years by a minimum of 1% of the total ICB budget and the Integrated Care Strategy identifies the need for resource to be moved to support prevention and early intervention.

Section 9

Strategic Objective 3: Excellent Health and Care Services

In this section:

Section 9

Strategic Objective 3: Excellent Health and Care Services

Excellent Health and Care Services – An Overview

This chapter discusses the work we are undertaking in health and care services across the BSW system to meet our commitments for the delivery of excellent health and care for our population.

It should be noted that the focus is on transformation and developmental work in those delivery areas specifically highlighted in the strategy and set out below.

Therefore, this section is not a comprehensive directory of all services provided and in no way means that areas not included are not important.

The chapter is structured in line with the commitment areas set out below. Service areas that are primarily Place-based are discussed in the local implementation plans chapter rather than in this chapter.

Our Commitments

Personalised Care

- Shared decision making to ensure that individuals are supported to make decisions that are right for them.
- Personalised care and support planning to ensure that facilitated conversations take place in which the individual, or those that know them well, is an active participant.
- Enabling choice, including legal rights to choice.
- Social prescribing and community-based support.
- Supported self-management to ensure people are helped to manage their ongoing physical and mental health conditions themselves.
- Personal health budgets and integrated personal budgets.

Joined up local teams / Neighbourhood teams

- Across BSW we will develop integrated, multidisciplinary teams that deliver health and care services around the needs of children and adults.
- We will review community services and put integrated teams at the heart of the way these services are provided in future.

Responsive local specialist services

- We will provide virtual ward services in BSW that will provide a range of interventions tailored to the needs of the children and adults to help prevent hospital admissions and to accelerate discharge from hospital.

BSW is committed to expanding community diagnostic facilities that will deliver additional, digitally connected, diagnostic capacity.

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Strategic Objective 3: Excellent Health and Care Services

High quality specialist centres

- The AHA is developing a clinical strategy that will set out the role hospitals will play in the delivery of urgent care services, management of long-term conditions and how they can improve quality and productivity for children and adults.
- The AHA partners are working together on the development of facilities in the Sulis Hospital in Peasedown St John which will play a critical role in reducing the waiting times for surgical procedures for the population of BSW.
- We will work with local communities, children and adults using services (who are experts by experience) and staff to shape the design and delivery of services.
- We will set clear quality standards and expected outcomes when commissioning health and care services for the population we serve.

Mental health and parity of esteem

- Personalised care: developing nuanced models of care that reduce unwarranted variation whilst paying attention to localised differences in our populations.
- Joined up local teams: we will accelerate place based integration of mental and physical health, through Integrated Neighbourhood Teams and primary care.
- Healthier communities: we will take a holistic approach to mental health by aligning more closely with our Joint local Health and Wellbeing Strategies.
- Local specialist services: we will work with our specialist mental health providers to ensure local specialist provision is accessible, responsive, financially sustainable and reduces the need for out of area care.
- Addressing inequalities: we will use data to inform our approach to targeted interventions in addressing inequalities.

Our Duty to Improve Quality of Services

Quality is a shared goal that requires system commitment and action in order to ensure that we provide the highest quality health and care.

System Quality will be based on these principles:

- Collaboration, trust and transparency.
- Transformation.
- Equity and equality.

In practice this means that the system will deliver care that is safe, effective, well led, sustainably resourced and equitable. The care experience of the population will be positive through responsive, caring and personalised delivery.

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Strategic Objective 3: Excellent Health and Care Services

Our Commitments

1. Set clear quality standards and expected outcomes when commissioning health and care services for the population we serve.

2. Have clear governance and accountability arrangements for collective monitoring of quality and safeguarding.

3. A shared commitment to delivering seamless pathways of care where the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation.

4. Develop a Just Culture which is open, transparent, and supports continuous improvement.

5. Work with local communities to shape the design and delivery of services.

Our Approach

Delivery of quality care in the system will be underpinned by:

- Key quality metrics that focuses on safety, effectiveness and experience, triangulated with performance data/ intelligence and professional insight.
- Focused on population health and system quality priorities across pathways/ settings with particular emphasis on reducing inequalities in access, experience, and outcomes.
- Identification of risks and issues to patient safety and quality and the strength of the mitigation at both an organisational and system level.
- Identification of collaborative and inclusive patient safety leadership, with a shared vision and values, driven by continual promotion of learning and aligned to a just and inclusive culture.
- Consistent and up to date guidelines and evidence; designed to protect the whole community; delivered in a way that enables continuous improvements in quality based on best evidence.
- Recognising and supporting the capability to deliver safe and effective services, ensuring the right number of people, who have the right mindset (supporting cultural change), skills set and tools to be able to fulfil their roles.
- Identification of collaborative and inclusive leadership, with shared vision and values; driven by continual promotion of learning and supported by a just and inclusive culture.
- Actively promoting co-production with people using services (experts by experience), the public and staff.

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Strategic Objective 3: Excellent Health and Care Services

PSIRF (Patient Safety Incident Response Framework)
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents to improve patient safety.

The ICB role during the preparation and transition to PSIRF includes:

- Collaborate in policy and plan development.
- Develop own systems as required.
- Sign-off policy and plan.
- Support collaboration between the different parts of the system as needed.
- Co-ordinate BSW Patient Safety Specialists Community of Practice.

BSW Integrated Care System (ICS) leaders recognise patient safety and quality as the organising principle of the ICS, and BSW's Chief Nursing Officer is the designated executive clinical lead for quality, patient safety and clinical and care professional leadership working in collaboration with the Chief Medical Officer for BSW ICS, and active engagement with BSW system constituent partnerships, and organisations to deliver two fundamental quality responsibilities:

1. To ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation.

2. To continually improve the quality of services, in a way that makes a real difference to the people using them.

This ensures patient safety and quality, oversight, assurance, and improvement are embedded at all levels, and delivers:

1. An effective System Quality Group (SQG) that meets bi-monthly.

2. A credible and focused strategy to improve quality across the ICS, this is currently in development, and we are working to have a set of BSW Quality Assurance (QA) metrics dashboard /framework by end of July (working with partners). The aim is for the framework to support measurement of the Implementation Plan, as well as providing assurance to the relevant ICB and system boards.

3. A defined governance, risk, and response process, linked to regional NHSE quality governance and wider forums.

4. A defined way to engage and share intelligence and improvement for quality through bi-monthly SQG.

This is illustrated in the diagrams on the following pages.

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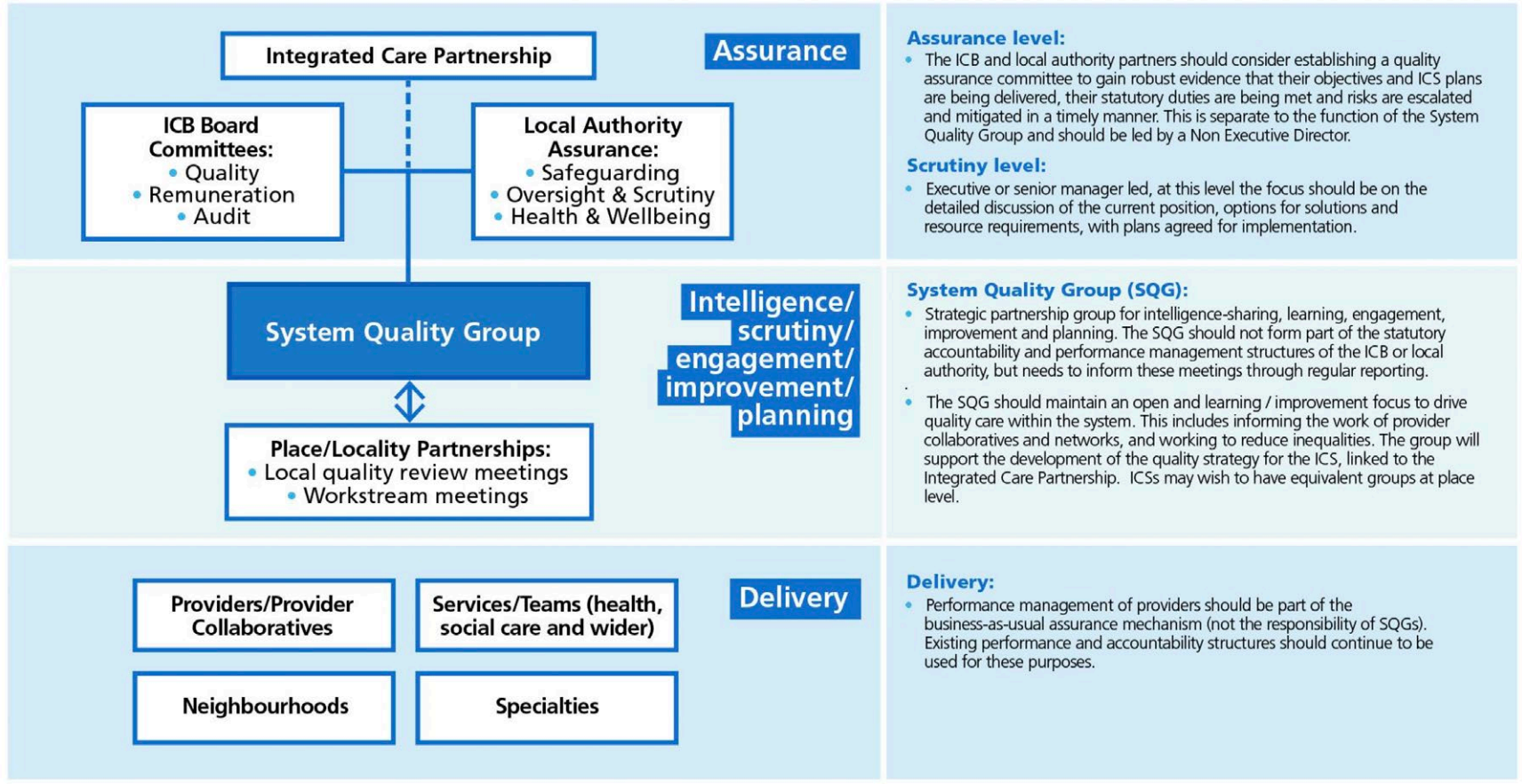
Strategic Objective 3: Excellent Health and Care Services

Quality governance in BSW ICS

Figure 18: Quality governance in BSW ICS

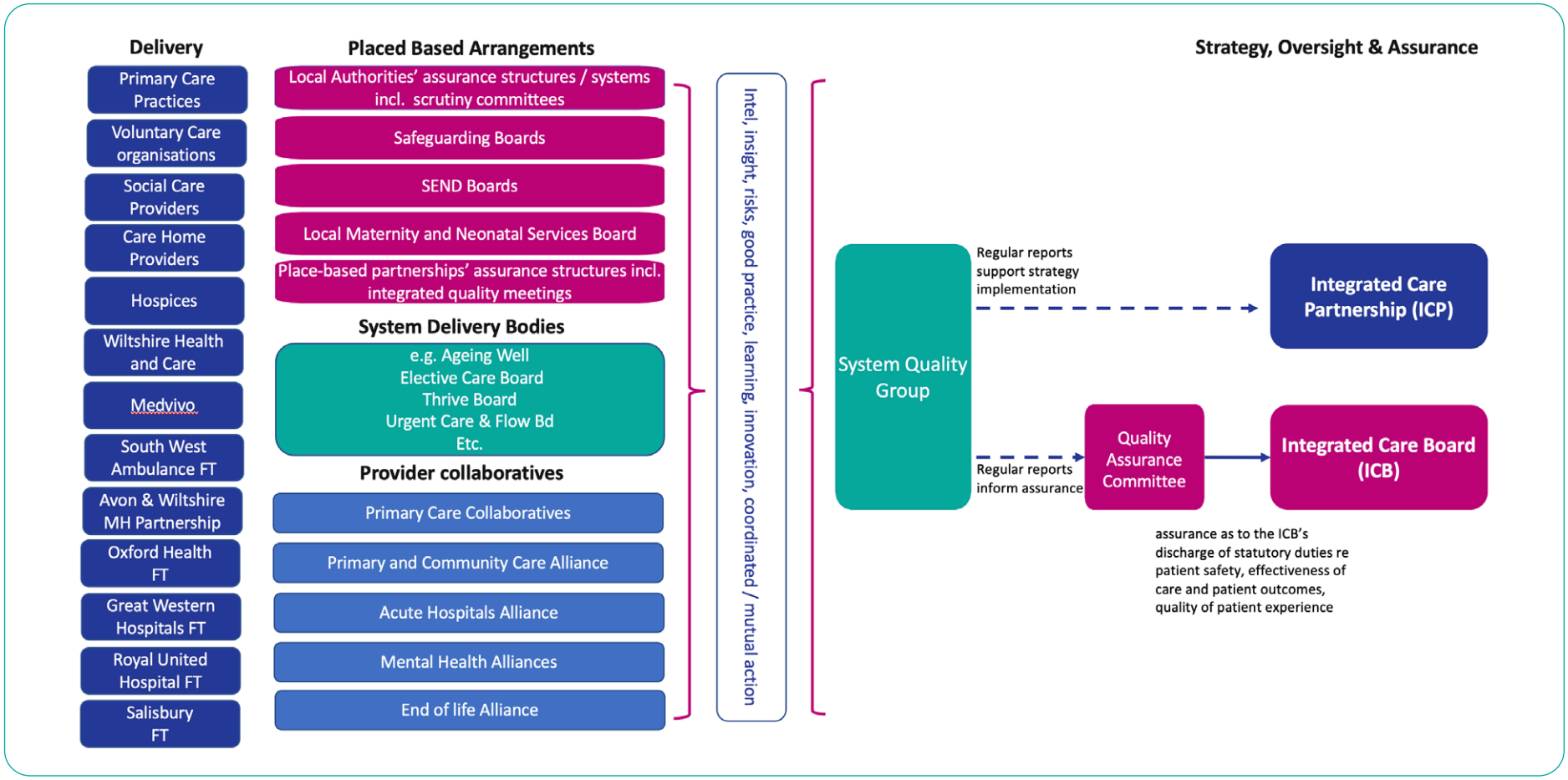


Section 9

Strategic Objective 3: Excellent Health and Care Services

Quality governance in BSW ICS

Figure 19: Quality governance in BSW ICS



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Strategic Objective 3: Excellent Health and Care Services

Quality Risk Response and Escalation in BSW ICS

Quality assurance, management of risk and the agreed level of escalation is decided as close to the point of care as possible. Provider assurance and risk management is the responsibility of the provider boards. BSW ICB's patient, safety and quality team are integral to relevant provider governance meetings to actively participate and support assurance discussions, risk management, decisions and improvement plan delivery. Using triangulation of relevant patient safety and quality information (Insight), as outlined in the table (below), informs learning and improvement:

Table 11: Patient safety and quality information (Insight) informs learning and development

Internal	External
Quantitative	**Quantitative**
Serious Incidents data and National Patient Safety Alert data	CQC inspection ratings data
Infection prevention and control data including HCAIs	Quality data in the System Oversight Framework (SOF)
Hospital mortality data	Quality data in the GP Quality and Outcomes Framework (QOF)
Freedom to Speak Up (FTSU) data	External Audit data
Integration Index (forthcoming 2022/23)	External benchmarking data
Staff Survey results data	Clinical Audits data
Workforce data – absence rates and turnover rates	NHS Digital data/intelligence on quality
Quality Accounts data	UK Health Security Agency (UKHSA) data/intelligence
Maternity reporting tool data on quality	External horizon scanning data
Quality data in Model Health System and the Quality Toolkit	Homicides/unlawful killings -historic and ongoing including action plans
Adult and child safeguarding	National surveys data – CQC patient surveys, HEE training surveys, GMC National Training Survey, GP patient survey (GPPS)
Local Authority data (e.g. ASCOF)	Public Health Outcomes Framework
Charity/voluntary organisation data	Friends and Family Test
Quality data in the Commissioning for Quality and Innovation Framework	
Workforce Race Equality Standard (WRES) data	

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Strategic Objective 3: Excellent Health and Care Services

Table 11: Patient safety and quality information (Insight) informs learning and development (Continued)

Internal	External
Quantitative	**Quantitative**
Complaints, PALS and concerns data	CQC Inspection reports, warning notices, related notifications
Quality Accounts information	HSCRF emerging concerns protocol
Speaking up reports from staff	HEE intensive support framework and Deanery reports
Serious Incident investigations and action plans	Professional regulators intelligence
Internal Audit reports and action plans	Oversight and Scrutiny Committees. Health and Wellbeing Boards
Internal reviews, recommendations and action plans	Central Alerting System (CAS) safety alerts
System Quality Groups/Quality Committees	Patient/service user websites, groups and forums
Staff feedback/survey information	Traditional media and social media
Mandatory and statutory training records	Getting It Right First Time (GIRFT) and RightCare reports
Staff professional development plans (PDPs)	Regulation 28 Prevention of Future Death reports
Maintaining High Professional Standards (MHPS)	Judicial review reports
Risk and issues registers	Safeguarding serious case reviews
Contractual and legal action	Charity Commission case reviews/reports
Quality impact assessments	Use of NICE Quality Standards
Healthwatch reports library	Independent Reviews

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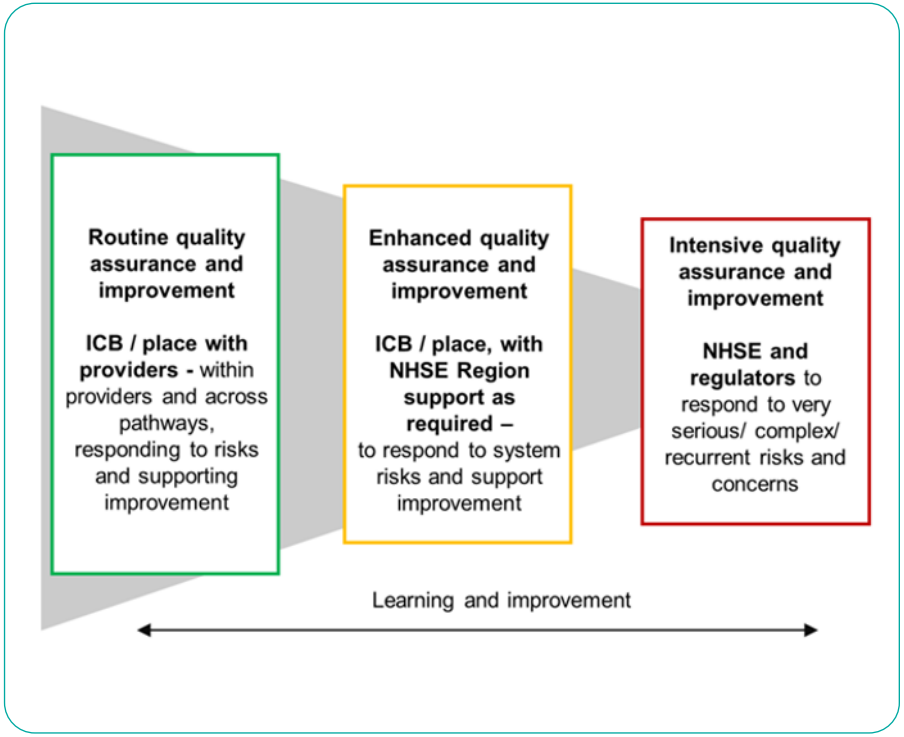
To support wider BSW system assurance, learning and development, the system has adopted the recognised National Quality Board (NQB) guidance (2021) for risk response and escalation and the three levels of quality assurance and support.

Figure 20: Overview of main levels of quality assurance and improvement



The move into enhanced assurance for health commissioned providers will be authorised by the ICB, and the move into intensive assurance by NHSE. However, the decision will need to reflect the risk profile and regulatory and accountability arrangements. Therefore, the role of System Quality Groups will be integral to decision making as they provide joined up quality intelligence and engagement, enable improvement and support to system risks. Where there is an emerging risk that is deemed to be a significant or immediate risk to quality, including safety, which is not being addressed in wider discussions and the need to rapidly share intelligence, diagnose, profile risks, and develop action/ improvement plans, the ICB or other key partners such as NHSE, regulators or Local Authorities will instigate Rapid Quality Review meetings, including the development of an improvement plan and if required additional Quality Improvement Groups to ensure the required actions are taken forward and improvements realised.

NHS Patient Safety Strategy and the introduction of the Patient Safety Incident Response Framework (PSIRF)

Through the introduction of the NHS Patient Safety Strategy (2019) and the aim of continuously improving patient safety, the new Patient Safety Incident Response Framework (PSIRF) will be implemented across all providers from September 2023, this will replace the Serious Incident Response Framework and prioritises compassionate engagement with those affected, advocates a coordinated data driven approach, and embeds a wider system of improvement. Through the Patient Safety Specialists Community of Practice, BSW will support all providers to adopt the new approach and continue to learn, develop, and improve patient safety across

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the system. BSW will also ensure providers collaborate to deliver the nationally recognised patient safety improvement programmes; maternity and neonatal safety improvement programme, medicines safety programme and mental health safety programme, as well as supporting safety improvement in priority areas such as safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.

Safeguarding

Context

Safeguarding children, children looked after, young people, care leavers, and adults is a collective responsibility. NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) as a statutory safeguarding partner is committed to working in collaboration with police and the local authority to ensure the people across Bath and North East Somerset, Swindon and Wiltshire are safeguarded. Safeguarding means protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care.

As part of the ICB duty to safeguard, a key area of focus is the protection of the victims of abuse and to prevent and reduce serious violence within our local communities. This is in line with the Serious Violence Duty which launched in December 2022.

The impact of abuse and serious violence on our children, children looked after, young people, care experienced young people, adults and communities is devastating and does lead to poorer health, social and mental health outcomes. Listening and responding to the voice of the child and the lived experience of risk and abuse in the population are pivotal to everything we do. By preventing abuse and neglect through promoting good practice, safeguarding will impact on the reduction of inequalities and enable the BSW population to live a life that is free from abuse and neglect.

Our delivery plan

The ICB will work as part of the three safeguarding partnerships to support strategic planning in the prevention and reduction of violence in our local communities. This will include collating and analysing health data from NHS Accident and Emergencies, strengthening links with primary care networks and sharing of intelligence. We will also ensure links with safeguarding professionals specialising in Prevent, Female Genital Mutilation and Modern Slavery to share insight and gain a fuller picture of what is happening locally.

To gain an insight into the causes of violence and the devastating consequences for members of our communities, BSW ICB will connect with local agencies such as education, probation, charity organisations and faith leaders. A primary focus will be engaging with our communities, and where consent is gained conducting interviews to hear the lived experience from victims of violence and/or their families. The lived experiences will be reflected in our Strategic Needs Assessment and local strategy.

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To assess readiness to tackle and prevent serious violence a training skills analysis will be completed to determine any training needs for healthcare professionals.

We will work as part of the specialist team to embed lessons learned from Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicides. We will engage with the local authority community safety partnerships to collate recommendations and disseminate these to healthcare staff in a variety of platforms such as staff training, safeguarding supervision and newsletters. Action plans and task and finish groups will drive any required changes to clinical practice. BSW ICB are committed to avoid preventable deaths wherever possible.

In the implementation stage, serious violence pathways will be collaboratively designed with partner agencies so frontline staff know who to inform and where to refer to ensure the safety of victims. We will work collaboratively with partner agencies to form an Early Help response to identifying and preventing where possible violent crime.

How we are organised to deliver

Each place alliance has a Designated Nurse for Safeguarding Children, Designated Nurse for Children Look after, Designated Professional for Safeguarding Adults, Designated Doctors for Safeguarding Children and Designated Doctors Children Looked after and care experienced young people, named GP for safeguarding and specialist nurses. They work in strengthening safeguarding systems and response across health, police and social care. Each alliance has a safeguarding partnership formed of the Police, Social care and ICB as Statutory partners and Corporate Parenting Boards/Panels with a clear focus on CLA and Care Experienced Young People.

What we will do in the next twelve months

- Undertake with partners a training analysis of healthcare staff requirements to meet Serious Violence Duty.
- Develop a learning framework for statutory reviews based on Social Care Institute for Excellence quality markers to disseminate the learning in a way that measures impact.
- We will continue to develop and deliver our strategic safeguarding and children looked after and care experienced young people children workplans.
- Continue leadership regarding the vulnerability of under 1's and work with partners to have differentiated system that improves outcomes for this vulnerable group.
- Use population health data to identify and understand emerging vulnerable groups and work with partners and systems to improve their outcomes.
- In partnership we will strengthen assurance of our vulnerable population placed in residential and therapeutic providers both within and out of area.

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What will be different for our population in 5 years' time

- BSW will have greater insight into the predictors of vulnerability from abuse and serious crime in order to improve outcomes for our population.
- We will demonstrate responsive commissioning to address inequality at an early stage and learn from the trauma of abuse.
- Through listening to the voice of children and adults including CLA the population will see improved high quality services with staff they feel are safe and trustworthy sources of help.

Medicines optimisation

Medicines Optimisation is an enabler to achieving the key elements of the Joint Forward Plan. Our strategy can be found here:

https://bsw.icb.nhs.uk/wp-content/uploads/sites/6/2022/05/202008-BSW-Medicines-Optimsation-Strategy-document.pdf

Personalised Care – Duty to Promote Involvement of Each Patient

Context

BSW Integrated Care System is committed to further implementing the comprehensive model of personalised care to establish:

- Whole-population approaches to supporting children and adults of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to children and adults with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health condition.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.

Personalised care is core to the delivery of our system strategy. Where individuals feel well informed about their care and are able to work in partnership with health and care professionals to manage their health and wellbeing, they are more likely to achieve better outcomes and have a better experience of care because their hopes, fears and expectations are being listened to.

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Our delivery plan

We will utilise the model and supporting tools to deliver this plan by focusing on the six, evidence-based components each of which is defined by a standard set of practices:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets

How we are organised to deliver

We are developing as integrated health and care neighbourhood teams within PCNs and at place to implement and monitor the comprehensive model of personalised care.

What we will do in the next twelve months

- We will develop further opportunities for self-management and self-care which will be promoted wherever possible in an appropriate way based on the individual's activation level.
- Plan to focus resources to further develop and fund the Personalised Care Health Coaching Programme and Personalised Care Ambassador.
- Within identified PCNs we will aim for people with 2+ long term conditions and low activation to have a personalised care worker (that is a core part of an integrated neighbourhood team) as their first and consistent point of contact.
- Integrated Neighbourhood Teams will include Social Prescribing Link Workers that can encourage access to community-based support. We will further develop social prescribing along the Compassionate Frome model.
- We will provide additional training to meet mandated requirements of all Personalised Care Additional Roles Reimbursement Scheme (ARRS) roles.
- Develop a network of workforce using a personalised care approach, starting with known ARRS roles and then expand. Extend training to this wider group in 2024 and beyond.
- Through other transformation programmes increase the scale of workforce using a personalised care approach.
- Promote Personal Health Budgets.

What will be different for our population in 5 years' time

Aligned to national ambition, we will aim for personalised care to benefit up to 5% of the population by 2024 and increase to 25% by 2028.

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Joined up local teams / Neighbourhood teams

Across BSW we are developing Integrated Neighbourhood Teams, bringing together different types of clinicians and professionals from a range of teams and organisations to provide more joined up care and support for children, families, and adults. This will ideally be in people's homes or otherwise as close to them as possible. The detail of what is being developed in each part of BSW is described in the earlier Local Implementation Plans section.

Primary Care

Context

The past few years have demonstrated the dedication of practice and Primary Care Network (PCN) teams in innovating and responding to the needs of their populations. In March 2023, BSW General Practice delivered 497,783 appointments, an increase of 7.4% on March 2022, 67% were face to face appointments, a testament to the incredible work of GP teams.

The Delivery Plan for Recovering Access to Primary Care (published 09.05.23) sets out how practices and PCNs can be supported to improve access. Recognising changes will require time and support – including freeing up workforce through changes to QOF (practices) and IIF (PCNs).

From April 2023, the ICB has taken delegated responsibility to secure the provision of Pharmaceutical Services (including Dispensing Doctors and Dispensing Appliance Contractors); General Ophthalmic Services; and Dental Services (Primary, Secondary and Community) for our population. Our local governance structures are still being established but will cover all primary care contractor groups.

How are we organised to deliver

In order to meet the needs of our child and adult population, our 87 GP Practices are working across BSW as 27 Primary Care Networks (PCNs). PCNs build on existing primary care services and enable greater provision of proactive, personalised, co-ordinated and more integrated health and care for people close to home. Across BSW we have:

- 148 Community Pharmacies (137 are 40 hours; 11 are 100 Hours) Jan 23.
- 503 Mandatory only contracts and 87 Domiciliary only General Ophthalmic Services contracts (Jan 23).
- 122 Dental Contracts (Jan 23).

What will we do in the next twelve months

Key targets for primary care include:

- Making it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within

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two weeks and those who contact their practice urgently are assessed the same or the next day according to clinical need.

- Implementing the GP Access Recovery Plan (working with community pharmacy) to improve patient experience, ease of access and demand management and accuracy of recoding appointments.
- Continue on the trajectory to deliver more appointments in general practice by the end of March 2024 (national).
- Supporting PCN with workforce planning and recruitment to continue to recruit Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024.
- Implement the GP Contractual Changes for 23/24.
- Working closely with NHSE and Public Health to deliver the SW Dental Development Sustainability Plan to recover dental activity to pre pandemic levels and deliver the key priorities from the local oral health needs assessments.
- We will focus on integrating community pharmacy clinical services which form part of the Community Pharmacy Contractual Framework, Pharmacy Integration Fund or GP Access Recovery Plan e.g., Community Pharmacy Consultation Service, Discharge Medicines Service (DMS), hypertension case finding, smoking cessation & contraception services to ensure utilisation of these services to their full potential.

What will be different for our population in 5 years' time

We will have the ability to be locally responsive to population health needs and commission services accordingly and have developed a tailored approach working with partners to respond to health inequalities and ensure a focus on preventative care.

We will have developed our ability to integrate all primary care services into local transformation and system working both within the place and system agendas and will have incorporated these services more fully into a local primary care strategy.

We will have developed closer working relationships with our local independent contractors across primary care which will have supported increased partnership working at all levels further integrating care delivery in PCN's; and build a more integrated clinical and professional leadership model which reflects the wider primary care system.

The wider primary care services will have developed approaches to quality improvement and support wider primary care resilience.

Community Pharmacy

The Community Pharmacy Contractual Framework (CPCF) 2019-2024 commits to a 5-year deal for community pharmacy to be more fully integrated in the NHS, providing a range of clinical services, be the first port of call for healthy living advice and for managing minor illness, and support managing demand in general practice and urgent care settings.

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As the NHS enters a period of recovery following the Covid pandemic, community pharmacy is well placed to support the system in opening up access to a range of clinical and preventative services and supporting actions to mitigate against health inequalities.

Community pharmacy is a key clinical provider in our primary care team. The GP Recovery Access Plan highlights the opportunity to maximise utilisation of community pharmacy clinical services to support system capacity and patient outcomes.

Our focus will be on integrating community pharmacy services which form part of the Community Pharmacy Contractual Framework, Pharmacy Integration Fund or the GP Access Recovery Plan. This includes:

- Referrals from NHS111, GP practices and Urgent & Emergency Care Settings to the Community Pharmacist Consultation Service (CPCS) to facilitate patients having a same day appointment with their community pharmacist for minor illness or an urgent supply of a regular medicine, improving access to services and providing more convenient treatment closer to patients' homes. The service is helping to alleviate pressure on other parts of the system, in addition to harnessing the skills and medicines knowledge of pharmacists. Currently around 4,000 CPCS consultations are provided every month across pharmacies in BSW. There is scope to increase this further and also implement the Common Conditions Service when nationally commissioned.
- Community pharmacy's role in preventing and reducing health inequalities, through the Hypertension Case Finding Service.
- Smoking Cessation and Contraception Services.
- Supporting safe transfers of care, and reduced hospital admissions / readmissions relating to medicines, through increased use of the Discharge Medicines Service (DMS).

What we will do in the next twelve months

- Develop a community pharmacy strategy and delivery plans to support integration and collaboration across the system.
- Focus on integrating community pharmacy clinical services which form part of the Community Pharmacy Contractual Framework, Pharmacy Integration Fund or GP Access Recovery Plan to support access, public health priorities and tackling health inequalities e.g. Community Pharmacy Consultation Service & Common Conditions Service, Hypertension Case Finding, Smoking Cessation & Contraception services and the Discharge Medicines Service, to ensure utilisation of these services to their full potential.
- Be part of national pathfinder work to scope the role of independent prescribing in community pharmacy.
- Workforce priorities as above.

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Urgent and Emergency Care

Context

Despite system responses and efforts over the last few years post the pandemic, across England hospitals are fuller and occupied by patients who are clinically ready to leave, patients are spending longer in Accident & Emergency (A&E) and patients are waiting longer for an ambulance response. This is no different in BSW:

- Average percentage of patients seen in A&E within four hours was 70.9%, fourth highest in the South West which had an overall average of 70.8%.
- The highest general and acute bed occupancy across the South West in 2022/23, average 96%.
- The average hospital handover time was 66 mins in 2022/23.
- Non criteria to reside position was the highest in the South West, around 36%.

Our BSW ICS Urgent and Emergency Care strategy is aligned to the national vision as we set out in 2021 a 5-year plan for "Ensuring people access the right care, in the right place, first time".

This vision is for adults, children and young people and their families.

Our delivery plan

Our delivery plan for recovering urgent and emergency care services has two main ambitions:

- Patients being seen more quickly in emergency departments, with the ambition to improve to 76% of patients being admitted, transferred, or discharged within four hours by March 2024 and further improvement in 2024/25.
- Ambulances getting to patients quicker, with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

In addition, we have set an ambitious target to achieve a reduction in no criteria to reside (NCTR) to 13%. This will be challenging to achieve.

To meet the ambitions, we will not only need to increase the size of the workforce but create and develop career opportunities including rotational posts. Improving conditions for staff and enabling people to work more flexibly to meet the needs of patients will be a key commitment.

How we are organised to deliver

BSW's Urgent Care and Flow Board (UCFB) has tasked the UEC tactical group to create a system wide UEC recovery plan that will outline the plans to deliver the ambitions in the recovery plan. There are 5 key areas of the plan.

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1. Increasing urgent and emergency care capacity
2. Increasing workforce size and flexibility
3. Improving discharge
4. Expanding care outside of hospital
5. Making it easier to access the right care

UEC tactical group has conducted a gap analysis against the recovery plan and system wide Winter Washup event was held on the 27th of April to reflect on lessons learnt during 2022/23 and what further actions and decisions and priorities need to be incorporated into our 2023/24 plans.

The gap analysis will identify which priorities will be delivered through our existing transformation workstreams (Discharge to Assess, Domiciliary Care provision, Care Coordination), Locality schemes, links with other boards (Virtual ward, Community Integrated Care, Thrive Board), and our other workstreams including Ambulance Handover, Directory of Services, Integrated Urgent Care, MIUs.

BSW's Urgent Care and Flow board and UEC tactical group representatives from each of BSW's localities, including primary care, mental health, social care. UCFB will provide monthly oversight and assurance of our delivery against the recovery plan and report back to the Integrated Care Board a. BSW's weekly UEC tactical with system partners will monitor progress against schemes to achieve our targets and plans.

What we will do in the next twelve months

- Care Coordination will be fully embedded in the system as single point of access for 999 and Care Home providers by Winter 2024.
- Same day emergency care (SDEC) capacity and provision will be increased in each of the 3 acute hospitals.
- Reduce the non criteria to reside numbers in acute and community beds to 13%.
- Providers will be required to implement electronic bed management systems by Summer 2023 and utilise A&E admission forecasting tool.
- Discharge Hubs will be rolled out in each of the 3 acute trusts 7 days week by September 2023.
- Phase 2 of our Domiciliary care work programme in 2023/24 will continue to develop the BSW strategic workforce plan for domiciliary care.
- Installation of a new, permanent X-Ray machine at Paulton in April 2023 which will reduce pressure on acute provision and support an improvement in 4-hour performance.
- Continue to increase referrals to community pharmacy for self-care / minor illness or urgent supplies of repeat medications through the Community Pharmacy Consultation Service.
- Minor Injury Unit (MIU) Transformation work programmes will continue and look at plans developing to co-locate Trowbridge MIU clinicians with local GP practice to improve minor illness offer.
- Work will continue to support the Home First approach across BSW, learning from the successful model implemented in

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Swindon during 22/23. This model for Swindon should be 7 days a week from June 2023.

- Care Coordination will be fully embedded in the system as single point of access for 999 and Care Home providers by Winter 2024.
- South Western Ambulance Service NHS Foundation Trust (SWAST) have 6 key priority workstreams to improve Category 2 response times, which include Category 2 segmentation, improved call answering, improving front line resource (Core and Private), Ambulance vehicle preparation hubs and reducing sickness over 2023/24.
- A strategic workforce plan with key priorities will be in place.

What will be different for our population in 5 years' time

- From Spring 2024 - Mental health support will also be universally accessible through 111 by selecting option 2.
- During 2024/25, expecting that system will continue to improve on A&E performance from 2023/24 back towards the 95% target. The community services review will be concluded and shape the direction of strategic direction of travel for our 3 local MIU services, walk in centre service provision and identify plans for Urgent Care treatment provision in the South of Wiltshire.
- Our ambition that by 2028, Emergency departments will be for the most acute and life-threatening conditions. With all patients being referred by a healthcare professional and no patient will be able to walk in without clinical triage first (including those attending community treatment centres and urgent treatment centres).

Virtual Wards

BSW NHS@Home (Virtual Wards) programme supports the delivery of the System urgent care and flow priorities.

Virtual wards (VW) provide a safe and efficient alternative to the use of an NHS hospital bed and offer a range of interventions for people in their own home or normal place of residence, providing an alternative to admission or enabling early discharge from hospital.

Our delivery plan

We have plans to significantly expand NHS@Home capacity across BaNES, Swindon and Wiltshire over the coming years.

The baseline position as at Q4 2022/23 is 87 virtual ward beds.

Table 12 sets out our profiled growth in capacity by Place for the coming year.

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Table 12: Virtual Wards profiled growth in capacity by Place

	2022/23	2023/24			
	Q4	Q1	Q2	Q3	Q4
BaNES	25	50	70	75	90
Swindon	30	45	60	75	90
Wiltshire	32	56	90	135	180
BSW ICB total	87	151	220	285	360

We have detailed implementation plans for 23/24 which include workforce expansion and development, enhancing clinical pathways to ensure consistency of access and offer, and improved utilisation rates. We expect through the development and effective use of the System Care coordination Centre the capacity available in VWs will be optimised and used equitably across the System.

How we are organised to deliver

Subject matter experts from across BSW make up our key delivery groups. Clinicians and operational professionals from all partners across health and care, including the voluntary sector, have been working together to co-produce a Standard Operating Procedure (SOP) for virtual ward delivery.

Alongside a BSW SOP for our NHS@Home Virtual Wards, each ICA (Integrated Care Alliance) in BSW has developed their own implementation plans to reflect local population needs.

What we will do in the next twelve months

Throughout England, ICBs have committed to achieving 40-50 virtual ward beds per 100,000 population by March 2024 in the two-year nationally funded Virtual Ward programme. This equates to 2,228 beds in the South West and 360 beds across BSW.

As detailed above we have a clear trajectory for expansion over the next 12 months.

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Community Diagnostic facilities

Context

In line with government guidance on developing community diagnostic centres, the BSW system has produced business cases for national funding for both capital and revenue funding. The cases set out the approaches for a community diagnostic system-based approach to meet the challenges of increasing diagnostic waiting times, health inequalities and reflecting the impact of geography.

The investments will:

- Provide additional activity over and above the diagnostic capacity currently being delivered at acute hospital sites.
- Provide some additional provision around primary care locations to fill in geographical gaps in delivery.
- All locations will be accommodated on community sites, not acute hospitals.
- Mobile units, using independent sector capacity, will be used to deliver much of the community activity; a number of these will be introduced on acute sites in advance of the spoke site developments to accelerate new diagnostic capacity.

Our delivery plan

- A key feature of the development of diagnostic services is the implementation of our Community Diagnostic Centre model, which includes a fixed hub site at Sulis Hospital alongside additional services (including mobile facilities) for imaging, endoscopy and physiological measurement in Swindon and Salisbury.
- This additional capacity and standardised approach to pathways will reduce waiting time, reduce backlogs and support delivery of elective pathway waiting time reductions in Year 1 and 2 and support the national ambitions for earlier diagnosis in cancer over the five-year period.

How we are organised to deliver

BSW has an established AHA, underpinned by a Committee in Common, operating as Board committees of each of the three trusts, with the requisite decision making powers. The AHA is discussed in more detail later in this section.

Each provider has their own clinical governance arrangements which flow to their respective boards and through the ICB quality mechanisms. Community Diagnostic Centre (CDC) activity will be governed in the same way, noting that as consistent system-wide pathways are developed, these will need to be agreed across all providers. The CDC clinical director (once appointed) will have responsibility for oversight and management of standardising clinical pathway arrangements.

To support CDCs being most effective, BSW aspires to having aligned technologies and improved system-level interoperability with clinical staff within the CDC having access to their local clinical information systems.

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What we will do in the next twelve months
Aspects of the CDC programme will go live in 23/24 contributing to diagnostic recovery, reducing the backlog and supporting elective delivery of the waiting time ambitions.

What will be different for our population in 5 years' time
This investment will facilitate additional activity over and above the diagnostic capacity currently being delivered at acute hospital sites.

The proposed model is designed to enhance the current offering of diagnostic testing services from existing, mostly fixed, sites. The implementation of the hub and spoke model will enhance diagnostic endoscopy services bringing them closer to people's home in the local area and with the core objectives being:

- The intent is to generate communities of practice with a networked range of diagnostic services which are efficient and equitable in their delivery.
- The enhanced facilities will provide a multi-functional approach to design, achieving a purpose-built, generic, flexible infrastructure for diagnostic endoscopic examinations, which will support one stop diagnostic pathways and reduce waiting lists.

Mental Health

Context
Improving the overall mental health and wellbeing of our population is a core component of our plan. Our three strategic priorities are reflected in our transformation ambitions, with our intention to make a radical change to mental health delivery over the next 5 years. This will move us away from a provider based model of provision to an integrated service model that is pathway based.

Although children and adults in BSW have relatively good mental health, pockets of deprivation drive poorer outcomes for people living in our most challenged communities. In mental health services, we remain challenged in our delivery of core mental health standards. Key issues are:

- Continued challenges in delivering improvements in Access and Recovery rates in our Talking Therapies services. Although progress has been made to integrate services and secure additional training we still fall short of the Long Term Plan ambition for our population. This is of concern given that the number of people with Common Mental Illness is increasing across BaNES, Swindon and Wiltshire.
- Challenges associated with ensuring early access to children and young people's mental health services, with a lack of consolidated early support provided by third sector partners across BaNES, Swindon and Wiltshire.

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- Continued high cost long term placements for people with severe mental illness, resulting in people having to travel out of area for extended periods of time affecting patient experience and outcomes, as well as causing financial pressure.
- Challenges in securing housing and ongoing care packages mean that a high proportion of our beds (c30%) are occupied by people who do not need to reside in an acute mental health environment.
- Pace of community services transformation, meaning that we are still working to an historic model of community provision.

Our delivery plan

Over the coming 5 years we will move away from a provider-based model of contracts to a model of pathway-based contracts that will bring together a range of organisations to deliver services from community to inpatient and back to community care again. This will require a fundamental shift in the way our services are organised, the way we share information and intelligence (through use of the Integrated Care Record and population health management tools) and the culture of our mental health system. We believe that in delivering this model of provision, we will make better use of community based services, reduce reliance on costly secondary mental health services and enable more people to live well in their communities with support from the people who know them best.

How we are organised to deliver

We have an established Third Sector Mental Health Alliance and have invested in a programme of organisational development to support their evolution from an alliance of providers to an integrated system partner. We intend that this Alliance will lead the connection with wider community groups, drawing in other organisations and making best use of grant based opportunities for the benefit of our population.

Our two principle secondary Mental Health providers – Oxford Health NHS Foundation Trust (CAMHS) and Avon and Wiltshire Mental Health Partnership NHS Trust are part of the design and development of our future model. We will continue to work with them and our Third Sector Alliance through our Mental Health Programme Board, which will have delegated responsibility for overseeing delivery and service development.

Our ICAs will take responsibility for working with community partners (in conjunction with Third Sector Mental Health Alliance colleagues) and primary care to increase local community-based provision.

What we will do in the next twelve months

In the coming twelve months, we will sustain our focus on addressing key challenges associated with access to services and outcomes for people with serious mental illness. Our priorities for the year ahead are outlined below:

Children and Young People's Mental Health Transformation

We will focus on implementing a range of new initiatives to increase first contact with children and young people's mental health services. This will include:

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- Increasing our digital offer to provide early help and support including an ambition to work with those who are digitally excluded.
- Commissioning a new model of service provision that integrates TAMHS (Targeted Mental Health Service), CAMHS and Mental Health Support Teams across Swindon.
- Appointing a single third sector lead for each Place who will be the connector for all community based provision who will work in partnership with Oxford Health NHS Foundation Trust as our secondary CAMHS provider.
- To appoint Mental Health Champions (in line with NHSE mandate) to improve mental health support provided to children and young people who present in crisis at A&E and develop a BSW Hospital based Youth Worker offer pilot to support young people, including with their Mental Health.
- Redesign our model of urgent response for children and young people, including supporting the redesign of the Paediatric front door at Great Western Hospital, Swindon (GWH).
- Continuing to support the roll out of assessment and liaison for paediatric inpatients with eating disorders (ALPINE) across Paediatric Departments to support targeted intervention for children with eating disorders.

Community Mental Health Services Transformation
Implementation of the new model of community mental health services, focusing on three elements:

1. Improving access to mental health support for people with Severe Mental Illness through new access models that provide immediate advice, support and signposting to community and secondary services as required at PCN level.

2. Reviewing and developing our secondary mental health service provision so that we provide timely therapeutic interventions as and when they are needed through redesigning our secondary mental health workforce and aligning this successfully with Primary Care Networks and ARRS investment.

3. Continued redesign of pathways of care for older adults, people with complex emotional needs (personality disorders), young people aged 16-25, people who need community based rehabilitation and people with eating disorders.

To support this work, we will continue to:

1. Work with AWP to support transfer from Care Programme Approach' (CPA) to an alternative model of care planning in line with the national Community Mental Health Framework mandate.

2. Embed new roles aligned with our workforce plan with a particular focus on developing and increasing the number of ARRS workers, making best use of Multi-Professional Approved Clinician (MPAC) roles and developing our healthcare support worker offer.

3. Making best use of the Integrated Care Record (ICR) and agreeing access to clinical systems for staff engaged in community service delivery across all sectors.

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We expect that with the implementation of our ambitions we will increase the numbers of people being treated within transformed services. Consequently, we anticipate a higher proportion of contacts within third sector provided services.

Eliminating out of area placements
In partnership with AWP, we have significantly reduced our out of area placements. This has been as a result of targeted work supported by system partners through the AWP led Right Care Programme.

During 2023/24 we will work to implement single-sex wards across BSW mental health services and focus on right sizing our bed base informed by population health needs. We will engage stakeholders and service users in this work.

During 2023/24, we will focus on:

- A pan-system review of Section 136 pathways, action plan to be co-developed with partners from Q1 2023/24 and to be delivered by Q4 2023/24.
- Further development and expansion of our NHS111 offer in order that we can deliver 'press 2 for Mental Health'.
- Deployment of a mental health response vehicle to reduce conveyance to A&E and improve crisis response. Data from early adopters Bristol, North Somerset and South Gloucestershire (BNSSG) shows that the impact of this is significant, in terms of both the overall ambulance pathway but also reducing the number of MH patients that present to A&E departments.
- Continued work to implement the 10 Discharge Priorities, in partnership with AWP and pan-system.
- Development of a further Wellbeing House in Swindon and securing long term estate for the Place of Calm in BaNES (capital funding provided by NHSE) to support admission avoidance and improve step down provision.
- Review and development of our Wellbeing House specifications to provide a consistent offer across BSW, including supporting people who may be 'No Fixed Abode' (NFA).

Dementia
We will continue to work with partners across our system to develop and deliver our Ageing Well programme in line with our BSW system strategy. In mental health services, a core component of this is the effective and timely diagnosis of dementia.

In 2023/24, we will focus on:

- Developing specialist Older People's Mental Health resource to work in primary care, using ARRS funding.
- Supporting primary care colleagues to record DDR in practices which is currently not consistent.
- Developing a diagnosing advanced dementia mandate (DiaDEM) model to support improving diagnosis of dementia in care homes.
- In our Virtual Wards programme, we will ensure that mental health expertise is available to support those who require additional support in the community.

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Perinatal
We will continue to develop the service further including:

- Establishing closer links with improving access to psychological therapies (IAPT) services in order that women identified through Maternal Mental Health Service provision (MMHS) are directed to this where clinically appropriate.
- Considering how best to support the needs of women with personality disorders during the perinatal period, aligned with our community services pathway development work.

IAPT
Our focus during 2023/24 will be:

- Implementing a consistent, BSW wide service model that is IAPT manual compliant.
- Starting our first phase of recruitment to training posts, providing additional capacity in year and beyond to meet nationally agreed trajectories (Q2 2023/24).
- Scoping digital offers and their use, with a plan to implement from 2024/25

We will embed our IAPT offer into the Community Mental Health Framework so that we make best use of not only IAPT but also wider services that would help meet individual needs.

Physical Health Checks for people with Severe Mental Illness (SMI)
Over the last 2 years, we have invested in additional service provision to support physical health checks for people with SMI.

We have confirmed that we will not be continuing this funding in 2023/24 and will instead have a primary care based model for those people on GP registers who are not open to AWP services, and for AWP to provide physical health checks for those people on their caseload. We anticipate that this will provide a more integrated service and will align with our community services framework ambitions. In addition to this service change we will:

- Work with primary care to review their individual registers of people with SMI. Early evidence from other systems (and our own) demonstrates that GP registers are not consistently updated. Data review and cleansing during Q1 2023/24 will be carried out in partnership with primary care – with the intention to ensure that we have an accurate register moving forward.
- Review recording to ensure that we are accurately capturing those people who have had both a full SMI check (all 6 elements) and those people who have declined parts of the check.

Long term, we will maintain our approach to providing health checks for people with SMI. We know that mental illness represents a key inequality in outcomes, with people with SMI typically dying 10-20 years earlier than those who do not. Our approach will ensure that we offer parity of esteem in primary care provision for people

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with SMI, and that we not only identify health needs but also act promptly on outcomes of health checks so that we provide wider physical health support to people with SMI.

What will be different for our population in 5 years' time
In five years' time, we expect that:

- All direction, intervention and community based support will be personalised to an individual's needs.
- We will have a vibrant and effective model of preventative care, with social prescribers working with third sector partners embedded in PCNs.
- People will be able to access Talking Therapies via a range of modalities (digital, face to face, group work) in line with national standards and our recovery rate will exceed 50%.
- Children and Young People will be treated in community hubs that will bring together primary care, third sector, Local Authority and secondary mental health services. These services will wrap around the young person and their family, working with them and education partners to provide earlier help and advice and risk support when required in line with the Anna Freud iThrive model.
- There will be a single front door for adult mental health services, with first contact provided by third sector partners who will support people to reach the right professional for their needs at the right time. Specialist provision will be drawn in as and when required.
- We will make best use of NHS111 and other emergency response, and where people (of any age) present in crisis their needs will be met by the most appropriate staff.
- Services will use interoperable records that allow multi-disciplinary input to records and enable supported transfers between services.
- Care planning will be strengths and goals based, personalised to the individual.

Learning Disability and Autism

Our delivery plan
BSW ICB continues to make improving care, experience and outcomes for children and adults with learning disabilities and autism a strategic priority. We have undertaken a collaborative refresh of this programme and our priorities for the next year include:

- Reducing the number of people who are in inpatient care. BSW ICB are the lead organisation for the new LDA capital build for the North of the South West patch covering the BSW, BNSSG and Gloucester footprint. This work covers the whole end to end pathway for people with a further focus on improving and expanding community provision.
- Delivering annual health checks for people with learning disabilities and autism. This builds on our improvement work during the last year, which provided additional resources for primary care and dedicated health checks in special schools.

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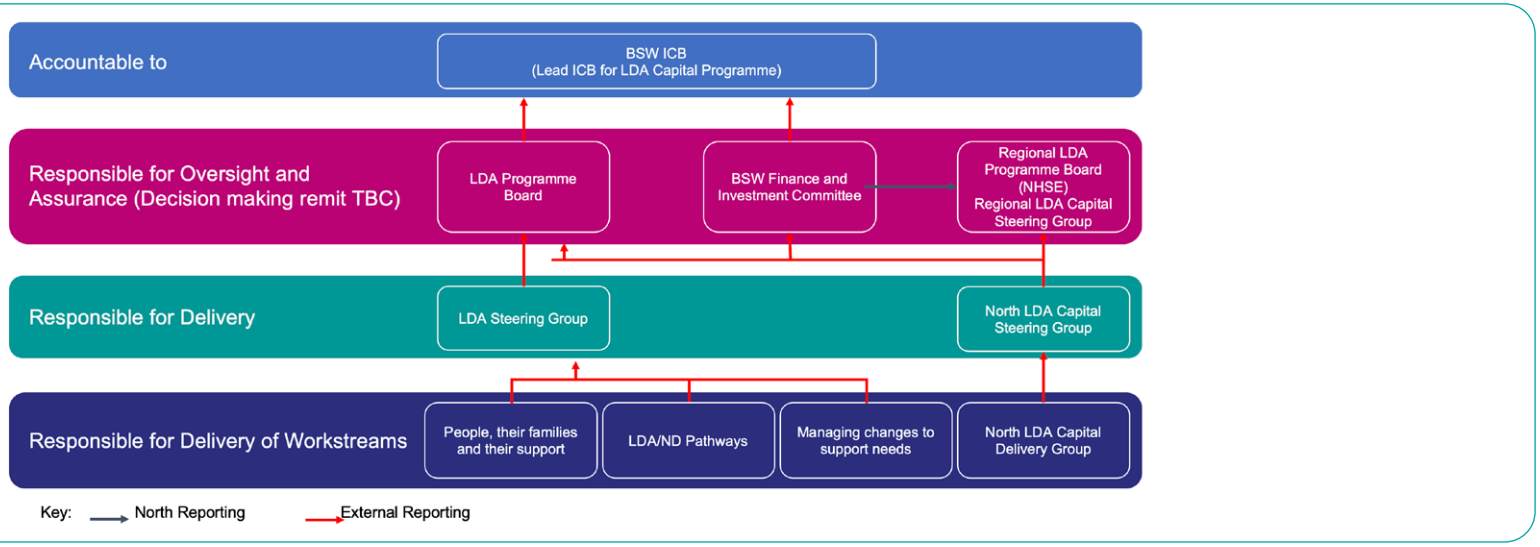
- Implementing the Key Worker Programme and improving care co-ordination as we collaboratively develop what future support for people looks like.
- Implementing together with system partners the required changes to Dynamic Support Registers and Care and Treatment Reviews (CTR) / Care, Education and Treatment Review (CeTR) processes.
- Ensuring robust oversight of patient pathways with an enhanced focus on prevention and early intervention. Delivery of a centralised, consistent approach to the management of escalations and complex cases.
- Improving access across the end-to-end pathway including reducing waiting times for ASD and ADHD assessments and increasing support for people post diagnosis.

How we are organised to deliver

Our refreshed BSW Governance structure illustrated in Figure 21.

Figure 21: Learning Disability and Autism governance structure



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What we will do in the next twelve months

- By October 2023: BSW Key Worker programme to go live providing community based support, early intervention and prevention for people with learning disabilities and autism. Recruitment is due to commence by June 2023 and a hub and spoke delivery model has been co-designed.
- From May 2023: The revised Acute Care Pathway, Prevention and Oversight pilar will be in place providing further consistency of approach across BSW. This includes oversight of our plans to reduce the number of children, young people and adults cared for in an inpatient setting.
- From July 2023: The business case for the proposed new LDA Capital building to serve the populations of BSW, BNSSG and Gloucester will be finalised. Work on engagement around the new facility and co-production commenced in 2022.

What will be different for our population in 5 years' time

People will experience more coordinated care, delivered together across partners closer to their home and local community.

Elective Care

Over the next 2 years our approach will be framed by the ambitions set out in the elective recovery plan, including:

- Increase activity to 106% in 2023/24, with the aim of delivering around 30% more activity by the end of 2024/25.
- No one waits longer than 65 weeks for elective care by March 2024; and waits of longer than a year are eliminated by March 2025.
- 95% of patients needing a diagnostic test receive it within six weeks by March 2025.
- By March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

Beyond the end of 2024/25, by year 5 our aim is to have returned performance back to the Referral To Treatment (RTT) 18-week standard. A summary of the elective plan is set out in the figure on the next page.

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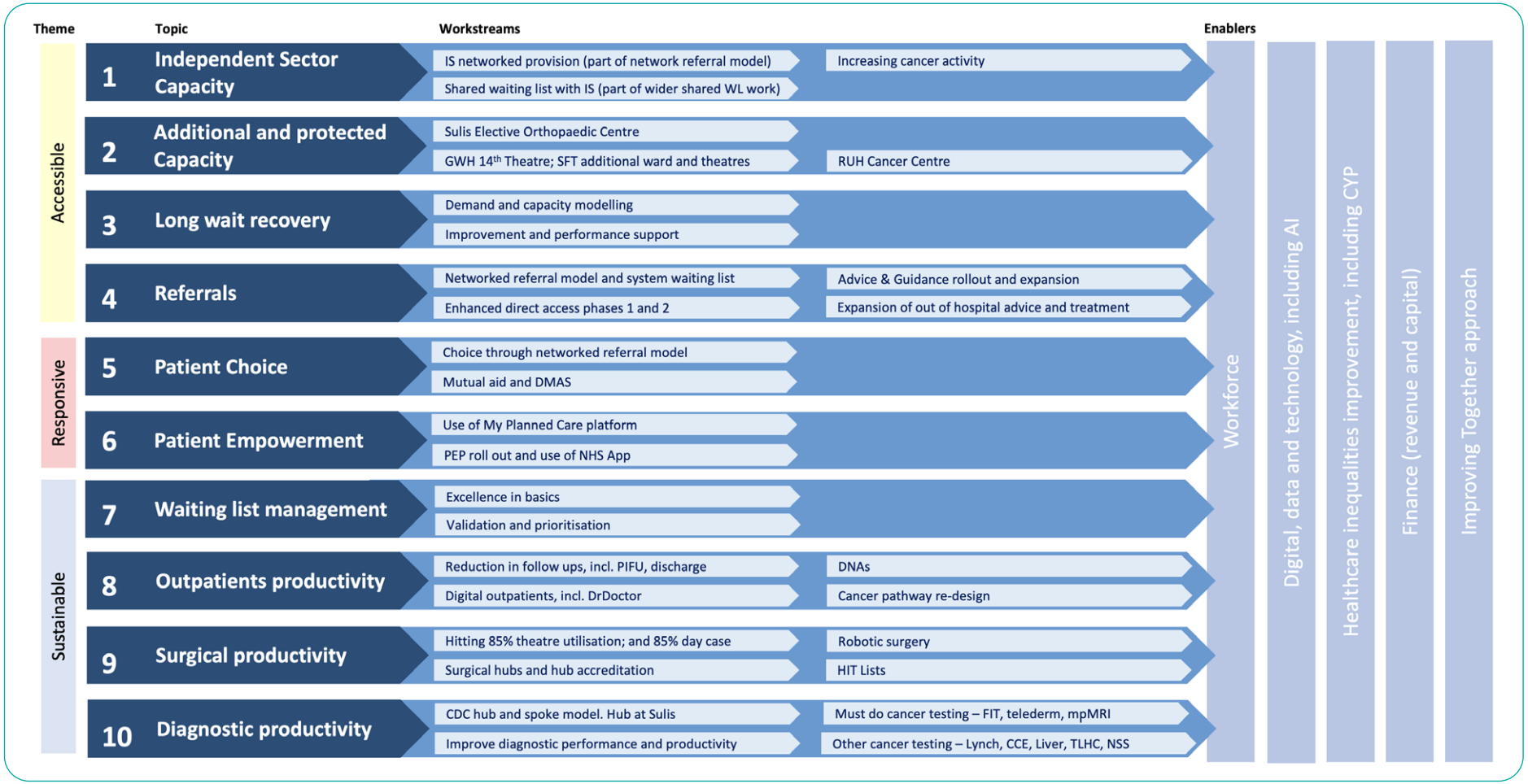
Figure 22: Elective Care plan summary



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What we will do in the next twelve months

Additional and protected capacity – open a modular 5th theatre at Sulis to go live in March 23, which will provide an increase in protected orthopaedic surgical capacity. Implementation of eye-hub model, starting at Salisbury Foundation Trust (SFT) and rolling out, utilising optometrists and ophthalmic technicians to undertake imaging and diagnostic tests.

Long wait recovery – develop a sector wide demand and capacity model to understand challenged specialties, and help patients choose where they can be seen quickest.

Referrals – develop a networked model of provision across our NHS and independent sector providers supported by a system-wide view of the waiting list to maximise utilisation of the system capacity for the population and reduce variation is access times.

Outpatients productivity – drive towards reducing outpatient follow ups to free up capacity to see new patients, including through the use of patient initiated follow up (PIFU)

Surgical productivity – work across providers to identify further opportunities to significantly increase day case activity and drive up theatre utilisation, including increasing day case arthroplasty. Diagnostic productivity – Establish a new hub and spoke CDC, with the hub at Sulis

Health inequalities – improving data to identify children, patients from more deprived areas, and taking targeted actions, such as reducing 'do not attends' (DNAs).

What will be different for our population in 5 years' time

- Quicker and more equal access to inpatient, outpatient and diagnostic services.
- Shorter length of stay in hospital for high volume, low complex procedures, with the majority of people discharged on the day.
- More access to out of hospital services, including on the high street.
- More ability to manage their conditions at home, or while they wait, including through the use of technology.

Elective Care performance and transformation is overseen by the system Elective Care Board. This Board currently has sub- groups for:

- Elective Recovery (including cancer – which also has its own system operational delivery groups).
- Outpatient Transformation.
- Diagnostics (including performance improvement in part 1 and transformation including CDC oversight in part 2).
- Health Inequalities (new subgroup).

The Elective Care Board will also work with the Acute Hospital Alliance, who are developing and implementing the joint clinical strategy to ensure it supports delivery of the elective plan.

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Cancer

Context

To deliver improvements in line with the national cancer strategy and national cancer planning guidance for 2023/24 using allocated cancer alliance funding in pursuit of and to contribute towards the two overarching national cancer ambitions (1) by 2028, the proportion of cancers diagnosed at stages 1 and 2 to be three-quarters of cancer patients; (2) from 2028, 55,000 more people each year survive their cancer for at least five years after diagnosis.

Our delivery plan

We are planning to achieve our commitments made in the BSW ICB planning submission thus with a focus for adults and children on – improved early diagnosis, improved screening uptake, faster diagnosis, improved operational performance, more effective and efficient pathways based on nationally published best practice timed pathways. We will also implement recent technical innovations as they are rolled out e.g., expansion of targeted lung health check programme.

How we are organised to deliver

Delivery through existing arrangements – commissioning lead, and GP clinical lead for cancer, at ICB level; acute trust cancer clinical leads and cancer managers; primary care lead for cancer at each GP Practice; linked to, and working with, SWAG and TVCA (Thames Valley Cancer Alliance) Cancer Alliances, and quarterly assurance via SWAG Cancer Alliance.

What we will do in the next twelve months

- Address known issues within challenged pathways e.g. improve performance and delivery of lower GI at RUH and skin at GWH; reduce urology and gynaecology waiting times at RUH and SFT.
- Implement same day/next day protocol for Computed Tomography (CT) for Gynaecology patients, and lower and upper GI patients at SFT.
- Implement additional best practice time pathways
- Complete the coverage of NSS pathways to achieve 100% by Apr 2024.
- Deliver against agreed primary care cancer projects focussed on early diagnosis, screening and post-treatment support.
- Support expansion of SWAG Targeted Lung Health Checks programme into Trowbridge and Salisbury.
- Agree programme of actions to address identified inequalities.
- Improve personalised care and support offer for all cancer patients.

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What will be different for our population in 5 years' time

- Keep the number of patients waiting over 62 days for start of treatment, to below the levels seen in Feb 2020 (adjusted for growth).
- Consistently achieve diagnosis of cancer/no cancer within 28 days of a 2ww referral.
- Continue to improve the proportion of those diagnosed with cancer, being diagnosed "early" (stage 1 / stage 2) towards the national aspiration of 75% by 2028.
- Expand TLHC provision to cover full population.
- Achieve an enduring funding solution for NSS pathways whether provided in primary or secondary care.
- Maintain a level of use of QFIT such that more than 80% of LGI 2ww referrals are accompanied by a QFIT score.
- Ensure sustainable teledermatology Advice & Guidance.
- Continue and strengthen the use of the current network of a lead GP for cancer in every GP Practice.
- Level up, to reduce (or remove) the disparity in access to cancer care currently experienced by those in under-represented groups across BSW, and in particular to raise screening uptake and early presentation rates in the Swindon area.
- Expand the use of voluntary community cancer champions, as already developed in the Swindon area, across the rest of BSW.
- Become a consistently top quartile performer on the full range of cancer performance measures; alongside seeing and treating a higher number of people with cancer compared to the pre-covid baseline.
- Provide a holistic and comprehensive support capability for all cancer patients.
- Promote the continued increased uptake of national cancer screening programmes such that BSW is a top quartile performer nationally.

Maternity

Context

Maternity services within BSW are provided by NHS Acute Trusts. Integrated care boards (ICBs) commission maternity services. The local maternity and neonatal system (BSW LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making ensuring that they are guiding and co-creating service provision within BSW maternity and neonatal services.

Maternity and Neonatal Delivery Plan

This was published by NHSE in March 2023 as a three- year, national delivery plan and sets out how the NHS will make care safer, personalised and more equitable for women, babies and families. This builds upon and includes the key recommendations from the Better Births 5 year forward plan (2016) to improve maternity services.

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It also incorporates recommendations from the recent Maternity Service reviews including Ockenden Initial report (2020) and Ockenden final reports (2022) and East Kent review (2022)

It also includes national key drivers from the Neonatal Critical Care Implementation Plan.

This plan has been used to identify the key maternity and neonatal deliverables for BSW maternity and neonatal system and provider, guiding key priorities and system based strategy including the BSW Strategy implementation plan.

The key aims of the maternity and neonatal delivery plan is to make care safer, more personalised, and more equitable. The plan outlines four key themes to guide how BSW system will achieve the key aims using a system approach (as listed below):

- Listening to and working with women and families, with compassion.
- Growing, retaining, and supporting our workforce.
- Developing and sustaining a culture of safety, learning, and support.
- Standards and structures that underpin safer, more personalised and more equitable care.

What we will do in the next 12 months

Listening to women and families with compassion, ensuring care is personalised and equitable.

- Accelerate preventative programmes, ensuring data is accurate, timely and complete to inform equity workstream.
- Create Gypsy, Roma, Traveller, Showman and Boating Communities Pathway, ensuring all communities can access maternity care in a way that reflects their needs.
- Pilot of new Independent Senior Advocate role.

- Reduce inequitable outcomes for black mothers and their babies by appointing and training 20 staff across BSW to become Black Maternity Matters Champions.
- Provide Anti Racism training to 600-700 staff across BSW to improve cultural awareness and eliminate bias.
- Ongoing collaboration with the Maternity & Neonatal Voices partnership to incorporate service user experience into pathways.
- Evaluate service user experience of Offering Compassionate Emotional Support for those Living Through Birth Trauma and Birth Loss (OCEAN) Services and maternal mental health pathway.

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Growing, retaining, and supporting our workforce

- Improve support offered to newly qualified staff and their supervisors in practice by critically analysing/reviewing all preceptorship packages with the South-West region and create a standardised template.
- Aim to mitigate the risk regarding recruitment and retention through the continuation of the workforce planning workstream to ensuring safe staffing across the system.

Developing and sustaining a culture of safety, learning, and support

- Aim to reduce risk and avoidable harm to babies under 1, including unborn babies through promotion of wider resources and campaigns.
- Collaborate working across the system to ensure data/ dashboard includes all high-level metrics for reporting.
- Provide safe assessment process via a centralised telephone assessment line.
- Complete a Perinatal Culture Survey and monitoring impact.
- Implement PSIRF Safety Improvement plans.
- Oversee quality in line with Perinatal Quality Surveillance Model (PQSM) and National Quality Board (NQB) guidance ensuring that maternity and neonatal are included in ICB quality objectives.

Standards and structures that underpin safer, more personalised, and more equitable care

- Aim to create a standardised antenatal education package across BSW.
- Create an Infant Feeding Pathway that is reflective of service user needs.
- Provide oversight to Breast Milk Donation working group for birthing people with HIV diagnosis.
- Ongoing transformation programmes linked with LTP.
- Progress the maternity and neonatal digital action plans to procure system-wide maternity digital system to incorporate personalised care and support plans.
- Implement provision of perinatal pelvic health services across three acute providers within BSW.
- Prioritise areas for standardisation and co-produce ICS policies such as those for implementation of Saving Babies Lives Care Bundle NHS Resolution Maternity Incentive Scheme (SBLCBv2) participation.
- Adopt national maternal early warning score (MEWS) and newborn early warning trigger and track (NEWTT-2) tools.

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Strategic Objective 3: Excellent Health and Care Services

What will be different for our population in 5 years' time

Listening to women and families with compassion, ensuring care is personalised and equitable

- Improved access to services for all, including marginalised groups.
- Enhanced positive outcomes for the population.
- Improved mental health for individuals, including postpartum.
- Improved learning processes for maternity services at local, system and national level.
- Reduction in inequitable outcomes for black mothers and their babies.

Growing, retaining, and supporting our workforce

- Improve retention and level of competency/education for newly qualified midwives.
- Improved outcomes for pregnant people and their babies.
- Developing and sustaining a culture of safety, learning, and support.
- Deceased cases of avoidable harm to infants under 1.
- Streamlined data collection, business intelligence and reporting to ensure resources can be targeted to areas that need the highest level of intervention.
- Robust triage process in place for birthing people to gain assessment; reducing avoidable negative outcomes.
- Positive safety culture to support effective escalation of clinical issues in a safe and just environment; supporting safe service user outcomes.
- Rapid identification of learning from incidents to support effective actions to reduce risk of harm to service users and improve outcomes.

Standards and Structures that underpin safer, more personalised, and more equitable care

- Improved knowledge regarding birthing, pregnancy and parenting; resulting in improved physical, social, emotional and psychological outcomes for birthing people, babies and children.
- Improved access to provision of essential nutrition for babies, impacting psychological, physical, emotional and cognitive functions, leading to improved progression/develop for babies and children.
- Reduction in adverse outcomes, such as still birth, neonatal deaths, brain injury.
- Improved holistic outcomes for birthing people, partners, babies and children.
- Improved information sharing across services.
- Reduced short term and long term impact of untreated perinatal pelvic health conditions associated with childbirth.

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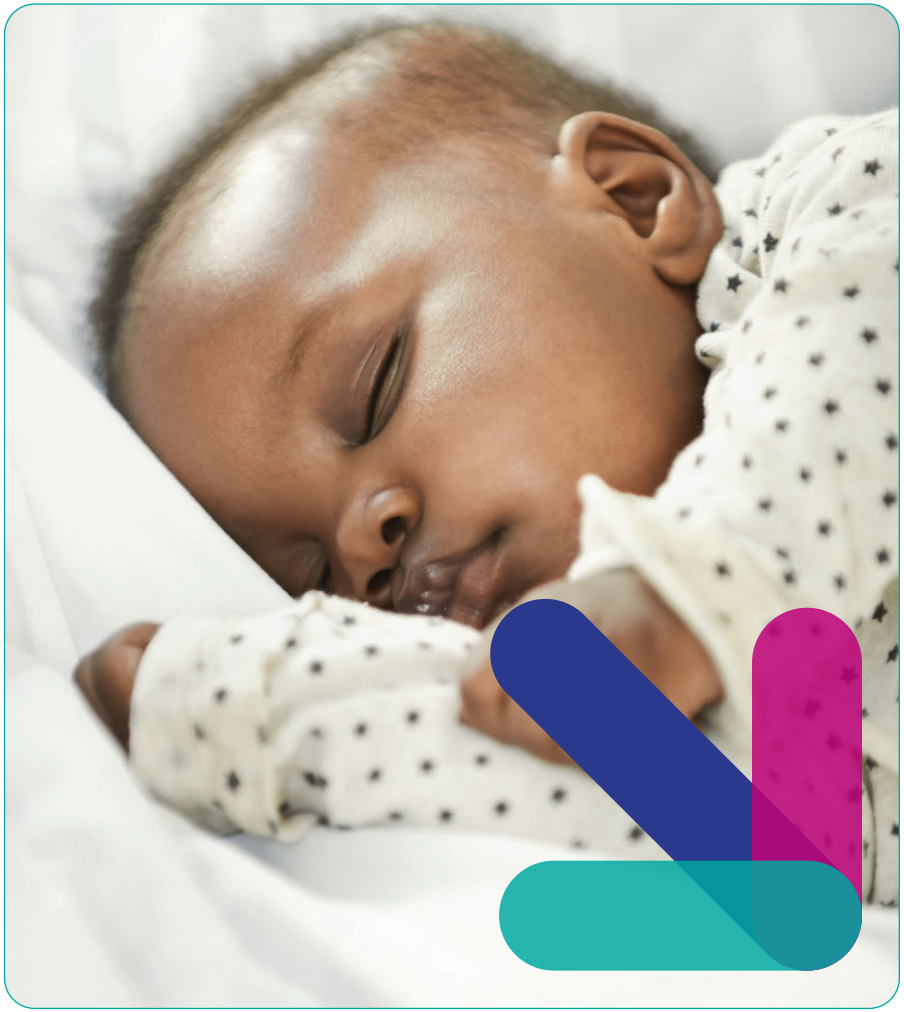
- Reduced need for surgical intervention.
- Improved outcomes by early identification and management of deteriorating person.

We will be working collaboratively with stakeholders including, acute trusts, LMNS, Public Health, National Maternity Voices Partnership (NMVP), Health Visitor Leads, all maternity and neonatal based services, third sector agencies, and regional networks.



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Children and Young People

An increased focus on children and young people

Context

Children and young people 0-25 represent a third of BSW and of our country. We want to increase our focus on children and young people, recognising this is prevention in action for the improved health and wellbeing of our future population. While most child health indicators are better than national average, many children have difficult living circumstances across the system.

We must put more focus on our children, young people and families, to better support them in all areas of their lives, including the environment they grow up, their education, and the support around them. This includes addressing fragmented provision and different models of care, issues related to short term funding and ongoing cost pressures for services. As well as these structural issues, Children and Young People's services also face imminent and growing current challenges, including:

- Increase in demand for children's community health services, for example with the Neurodisability Pathway requests for an Autism diagnosis.
- Increasing number of children and young people with an Education, Health and Care Plan (EHCP) combined with changes in the complexity of EHCPs (108% increase since 2015).
- Increase in the complexities of Children Looked After – including the number of Unaccompanied Asylum Seekers and Refugee children. Unaccompanied Asylum Seeker Children (UASC) in care requiring initial health assessments have seen a 47% increase in Wiltshire since 2019/20.
- Post covid impact and cost-of-living crisis.

There are widening inequalities across BSW, with disproportionate impact on children. Presenting our data as a system masks pockets of deep deprivation and inequality for children within each area, including two neighbourhoods within the most deprived 10% nationally. Swindon has a higher level of deprivation compared to Wiltshire and BaNES, being the 5th most deprived local authority (LA) in the SW. Many of our poorest children grow up in communities where their circumstances are in stark contrast to those around them. There is a complex interplay between children and young people with SEND, safeguarding, inequalities, physical and mental health.

Social and Emotional Mental Health as the primary SEND need has significantly increased. Worsening mental health and wellbeing with high and increasing levels of under 18 hospital admissions for mental health conditions, eating disorders, self-harm and alcohol and an increase in complexity and demand for children's social care, SEND and early help services.

Our ambition is to close and prevent the inequality gap in health and wellbeing outcomes for children and young people across BSW and for children and young people to live happy, healthy lives regardless of their circumstances. As we build back from the

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devastating impacts of the pandemic, the BSW approach provides the first stage framework to reduce inequalities across the life course, to nurture and value the health and wellbeing of babies, children and young people, their families, and communities.

Our BSW Vision is that all children and young people will start well with the support and care needed to enable them to have a sense of belonging, be safe from harm, to enjoy healthy lifestyles, do well in learning and have skills to choose and live their best life, to age and die well. We want the voices of children and young people to be heard and at the heart of everything we do, so we are asking one question... "What is it like being a child growing up in BSW and how do we make it better?"

Our delivery plan

We have exciting ambitions for placing babies, children, young people, and families at the heart of BSW. As part of this commitment to 'Starting Well' within the Integrated Care Strategy, our ambitions are that:

1. Children, young people and families have a healthy environment in which they can grow up in.

2. Mental health support is available for children and young people who need it.

3. The most vulnerable children and young people are well supported, including those in and leaving care, as well as those who need to be kept safe.

4. Children are ready to start education.

5. There are better links between health and care services and schools.

As Children and Young People are one third of the BSW population, the scope of work to achieve improved outcomes is broad. We continue to build on our strong integrated partnership to deliver co-created priorities. We will influence and hold ourselves and our partners to account, ensuring we focus on children and their needs within the BSW Care Model, providing increased equity of provision whilst reducing unwarranted variation, focusing on key BSW initiatives such as the community based integrated care transformation.

For Children and Young People, the proposed groups have been chosen because they have been identified as the areas where children and young people are at most risk of the poorest outcomes in BSW:

- Children with Special Educational Needs and Disability (SEND).
- Children with excessive weight and living with obesity.
- Children Looked After (CLA) and care experienced CYP.
- Early Years (with a focus on school readiness).
- Children and Young People with Adverse Childhood Experiences (ACE; with a focus on delivering trauma informed services).

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How we are organised to deliver

The BSW Children and Young People's Board is focused on improving our defined local priorities for children, young people and their families in BaNES, Swindon and Wiltshire with appropriate attention on the national and regional priorities, for the South West these are Bladder and Bowel Health and Paediatric Palliative Care.

The BSW CYP Board provides a strong foundation to drive our ambition to focus BSW ICB on the needs of children and tackle inequalities. It is a collaboration between Local Authority partners with Directors of Children's Services, Education and Public Health alongside BSW ICB and NHSE colleagues.

We will expand membership of the Board to reflect our partnerships with VCSE, paediatric and clinical colleagues, to develop further workstreams and system level engagement with children, parents and carers so we can find solutions at scale.

For example, collaborating to develop universal and early help services and family hubs to nurture and value the health and wellbeing of babies, children and young people, their families, and communities.

What we will do in the next twelve months

- We will use the framework of the BSW Inequalities Strategy and the CYPCore20PLUS5 to improve equity of access, experience and outcomes for Children and Young People across BSW.
- 2023/24 Q1 to embed the CYP Programme into the inequalities work and establish the governance arrangements with links to the BSW Inequalities Strategy Group and Population Health Board. Arrange appropriate clinical representation for CYP within the five clinical areas of the C20+5 for CYP.
- 2023/24 Q2 establish a working group with a focus on long-term conditions.
- Co-produce and develop a BSW Children and Young People's Strategy.
- Better hear and listen to the voice and lived experience of children and young people, their parents and carers.
- Develop workstreams to ensure sufficient focus on progress and improvement in key areas.
- Continue to support and focus BSW ICB on needs and priorities for babies, children and young people.
- Continue our journey of a holistic and trauma informed approach to children and young people with reduced silo working.
- Improve links between maternity and babies, children's and young people.

The focus on the next 12 months aligns with our priority workstreams (Figure 24), both locally and regionally. We will be working on the wider developments of the BSW Children's and Young People's Board with specific projects in 2023-24 funded by the NHSE Children and Young People Programme (CYPP), see Figure 25.

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Figure 23: BSW Children, Young people and Families approach

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What will be different for our population in 5 years' time

- BSW planning for children will be embedded and will include relevant CYP data and insights so we can better identify and deliver for the longer-term priorities and ambitions for BSW's population of children, young people and families.
- We will have better integrated health services, social care and health-related services to improve quality and reduce inequalities for Babies, Children and Young People.
- All those in the BSW will understand that children and young people are 30% of our population.

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BSW CYP Programme Priority Workstreams

Figure 24: CYP Programme Priority Workstreams

Starting Well

- New workstream to bring together planning for Early Years.
- Early Years Pilot to enable future development of services.
- Links to Maternity, Best Start, Starting Well and Healthy Child Programme, BSW Health and Wellbeing Boards.

Healthy Weight, Nutrition & Food Resilience

- Enabling joined up BSW approach to supporting healthy weight.
- Prevention and supporting children and families living with obesity and excessive weight.
- BSW expansion of specialist Children With Excessive Weight Clinics – linking SW regional CEW Hub.
- Link to adult healthy weight approach and diabetes prevention.
- Link to food poverty and cost of living crisis.
- Whole systems approach and place based working

CYP Long Term Conditions

- Asthma bundle delivery including asthma friendly schools, Diabetes, Epilepsy, Bowel and bladder.
- Epilepsy Specialist Nurse (ESN) PilotSupport and NHSE Youth Worker Pilot.
- Transitions.
- Link SEND, LDA and elective care waiting lists, Acute Hospital Alliance, Royal College of Paediatrics and Child Health (RCPCH) and BSW Paediatrician network.

Paediatric Palliative Care

- New Programme co-producing pathway and offer with Hospices, VCSE organisations, parents, carers, children and young people and clinical colleagues.
- National Programme matched funding.
- Working with End of Life Alliance Board.
- Transitions.
- Link Complex Needs, SEND, LD and A.

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BSW CYP Programme Priority Workstreams

Figure 24: CYP Programme Priority Workstreams (Continued)

BSW Complex Needs & SEND

- Working through existing programmes to coordinate approach for babies, children and young people and parents and carers across BSW.
- Collaborative BSW leadership, ensuring adherence to statutory duties, supporting and enabling place based work for new joint inspection framework and referencing each place based SEND strategy or SEF.
- Developing relationships with Complex Needs and SEND practitioners and leads across BSW as a platform for collaboration for example developing a BSW CYP Neurodisability pathway.

Reducing inequalities

- Working through existing programmes to coordinate approach for babies, children and young people and parents and carers across BSW.
- CYPCore20PLUS5.
- BSW CYP Dashboard.
- Link to SW Marmot Region.
- National NHSE Inequalities programme and Barnardo's Health Equity Foundation.

BSW Children Looked After and Care Experienced Young People

- Support BSW Children Looked After Strategy Group.
- Support how we work as an ICS to improve outcomes for CLA and care experienced young people.
- Focus BSW ICS on NHS Care Leavers Pledge, protected characteristic and role of corporate parent.
- Link to ADCS/ DfE Southwest Regional Offer graduating from care southwest project.

BSW CYP Mental Health

- Support and increase BSW focus on CYP mental health and emotional wellbeing.
  - Strengthen and build on partnerships:
  - THRIVE Board.
  - BSW CYP MH Oversight Group.
  - Acute Hospital Alliance, RCPCH and BSW Paediatrician network.
- Supporting links between MH and physical health including long term conditions.
- NHSE Youth Worker Pilot and Paediatric Mental Health Leads.

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Children and Young People

Children and Young People Programme Projects 2023-24

Figure 25: Children and Young People Programme Projects 2023-24

Early Years

- We will deliver a Connecting Care for Children approach that brings together a multi-disciplinary team across primary, secondary and community services, enabling CYP to be treated and receive advice and guidance in their community.
- We will adopt a phased rollout, launching initially at an already identified GP Practice in Swindon which has the (estimated) highest number of 0-15 aged Core20 patients. BaNES & Wiltshire will follow in quick succession.

Timeline

- 2023/24 Q1 – agree and develop co-created outcome metrics.
- 2023/24 Q2-3 – scope GPs/PCNs/develop model for 0-5 caseload, identify or recruit community connectors (care coordinators – paid/volunteers) the initial impacts in developing shared priorities and an integrated approach.
- 2023/24 Q4 – benefits from redesigned services and influencing redesign of community based integrated care. Contribute BSW findings to toolkit + business case structure.

Mental Health Champions

- We will support implementation of Mental Health Champion roles for CYP within emergency departments in each acute hospital in BSW.
- Key functions of the role have been co-developed with Royal College of Paediatric and Child Health (RCPCH) colleagues and include to:
- 1. Facilitate joint working across Mental & Physical Health.
- 2. Encourage uptake of training.
- 3. Build team confidence & morale.
- 4. Provide leadership and link into Trust, ICB and regional network governance structures.

Timeline

- 2023/24 Q1 – funding made available to ICBs to transfer to acutes. Regions and systems to support recruitment/ mobilisation of MH Champions.
- 2023/24 Q2 – reporting for MH Champion role.
- 2023/24 Q2-4 – support evaluation and development of framework for role progression. Share and spread learning.

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Children and Young People

Children and Young People Programme Projects 2023-24

Figure 25: Children and Young People Programme Projects 2023-24 (Continued)

Youth Workers

- We will recruit a network of Youth Worker support for CYP across our acute hospitals as part of an NHSE pilot.
- These roles will deliver a person centred and trauma informed intervention for CYP, aged 11-25, accessing our Children's Wards, Emergency Department and adult wards, focusing on mental health needs and children struggling with the impact of long term conditions including diabetes and epilepsy.

Timeline:

- 2023/24 Q1-2 – funding made available to ICBs. Allocation to VCSE based on procurement guidance. Link to MH Champions.
- 2023/24 Q2-4 – support evaluation and development of framework for role progression. Share and spread learning.

Epilepsy

- We will recruit an Epilepsy Specialist Nurse (ESN) for two years as part of an NHSE pilot to work across a system footprint in providing care for CYP with epilepsy.
- This will improve the quality of care for CYP with epilepsy by taking an integrated approach to the diagnosis, management and treatment of epilepsy.
- ESN(s) will be involved in care planning as well as supporting continuity of care for CYP with LDA as a result of joint-working with community paediatric and neurodevelopmental services.

Timeline:

- 2023/24 Q1 – agree and develop plan with RUH.
- 2023/24 Q2-3 – advertise and recruit to ESN post.
- 2023/24 Q4 – review progress and plan for 2024/25.
- 2025 – support evaluation (commissioned by NHSE) and share learnings across BSW and beyond Acute.

Children and Young People Programme Projects 2023-24

Figure 25: Children and Young People Programme Projects 2023-24 (Continued)

Paediatric Palliative Care

- We will develop a robust BSW Paediatric Palliative Care Workstream with partners including hospices.
- We will support transition pathways and services and align adult and paediatric palliative workstreams, to develop a BSW whole systems approach for Paediatric Palliative Care.

Timeline:

- 2023/24 Q1 – agree and develop plan with partners.
- 2023/24 Q2-3 – establish working group.
- 2023/24 Q4 – review progress and plan for 2024/25.
- 2025 – support evaluation (commissioned by NHSE) and share learnings across BSW and beyond.

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Workforce

A system wide workforce plan

Improved outcomes in population health and healthcare are one of the fundamental purposes of integrated care systems (ICSs). To achieve this, partners from across health, social care and the third sector must come together to plan and develop a workforce that integrates and connects across all parts of the system to deliver person-centred care to their local populations now and in the future.

To deliver on this aspiration, the ICB will firstly work with their NHS system partners to develop plans to meet the national objectives 23/24 set out by the NHS in the priorities and national planning guidance. Central to this process is the drafting of detailed 5-year workforce plan for all NHS provider Trusts, primary care providers and mental health provider organisations.

System plans are required to be triangulated across activity, workforce, and finance, and signed off by ICB, partner trust and foundation trust boards.

The second phase will ensure the workforce plan captures the wider ICS workforce and includes Social Care partners, independent/ private providers and third sector and charity provision, where appropriate. Using data and intelligence from Skills for Health, NHSE and other sources, we will develop the detailed ICS workforce plan, and this should inform the workforce interventions required to deliver on our ambitions as a system.

BSW Workforce Priorities 23/24

To identify and agree collective system wide workforce priorities for 23/24, the BSW People Directorate led by the Chief People Officer undertook a series of diagnostic sessions to collaboratively discuss and understand the workforce 'problem' trying to be solved. The output of these sessions has identified specific priorities to be taken forward as an ICS which will enhance workforce productivity, staff engagement and overall care delivery:

Older care workforce

Consensus to focus on a pathway multi-disciplinary and person-centred approach rather than traditional workforce models.
The ambition is to identify workforce and skills shortages and transformation opportunities as part of the pathway. The approach enables the full involvement of all partners and agencies involved in the care of the patient in our system inclusive of academic partners. The pathway approach will employ an integrated methodology to workforce planning looking at ways to develop, introduce and deploy new roles, skills and supply routes.

Domiciliary care

Domiciliary care continues to be a core area of challenge affecting both hospital discharge flow and, more importantly, being able to keep people well and at home. BSW workforce projections have identified a growing demand for domiciliary care with raising rates of frailty and dementia against a backdrop of high staff turnover and decreasing numbers of people applying for care worker roles. In 2022/23, partnership work led by Local Authorities across BSW have developed a domiciliary care workforce modelling tool and a

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detailed analysis of the workforce with several recommendations to be taken forward in 23/24.

Leadership and Management
Development of our system leaders and managers is essential for organisational success and the delivery of high quality, safe, effective and inclusive health and care services. The aim is to co-develop and implement a collaborative offer for partners building on efficiency and reducing variation across our partners and staff groups. It is expected that the initiative will also look for enhanced opportunities for leaders and mangers to increasingly work and move across organisational boundaries.

Early career attraction
Recognition that attracting a future workforce that engages and attracts young people is fundamental to the success of all partners. The aim is to work together for innovative, positive approaches for promoting and raising the overall profile of careers available across BSW and with a focus on attracting more young people. It will encompass how employment can address health inequalities so that employment offers and access to skills becomes increasingly inclusive. The scope will include working with schools, colleges and education providers and local community groups.

Retention
Retention relates to the extent to which an employer retains its employees and may be measured as the proportion of employees with a specified length of service (typically one year or more) expressed as a percentage of overall workforce numbers. Reducing turnover and improving retention is essential to stabilise the workforce, increase efficiency and reduce cost. The BSW turnover rate currently stands at 14.3% (month 12 22/23) which is a declining position so further work will be undertaken to look at the underlying causes of higher turnover themes and hotspots. Suggested areas to include:

- Collective marketing and attraction for health and care careers in BSW as a system.
- Health and wellbeing initiatives.
- Recognition of interdependencies across partners.
- Links between leadership/management and retention.
- Exploring available schemes able to further support retention such as deployment, NHS and Care ambassadors and housing solutions.

Bank and agency usage
BSW is committed to reducing agency spend in line with NHS target of 3.7% of total pay bill in 2023/24. As part of the wider recovery programme a number of initiatives will be supported to enable provider NHS organisations to meet the target and improve productivity and efficiency.

A more detailed diagnostic employing a quality improvement methodology will be employed to further refine the scope of the system wide workforce priorities. In addition to the priorities there are activities that we will continue to support and invest in whilst also enabling the success of the stated workforce priorities.

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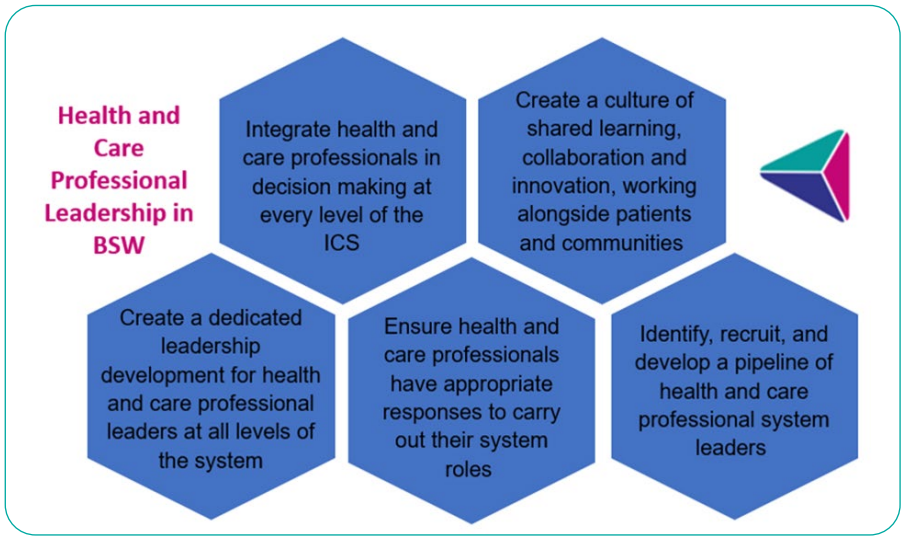
Maximising Apprenticeships
Overall recognition that apprenticeships offer opportunities for upskilling and developing new supply routes. However, the overall investment model for staff backfill often remains as a core barrier for releasing their full potential. Commissioning and collaborative working aim to explore possible efficiencies and consistency.

Health and Care Professional Leadership
It is health and care professional leaders, working in partnership with each other and with people in local communities, who make improvements happen. In BSW we have various examples of excellent practice demonstrating this, but not consistently. Nor do we involve health and care professional leaders in all our transformational work as much as we should.

The term Health and Care Professional Leadership is intended to be diverse and fully inclusive of the broad range of professionals who work together across BSW beyond the traditional boundaries of health and care, such as partners across the VSCE sector, education and housing. Even in our examples of excellent practice our involvement could be more diverse and inclusive.

Our vision for health and care professional leadership in BSW is to:

Figure 26: Our vision for health and care professional leadership in BSW



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Our first steps towards this vision have been to:

1. Establish a Health and Care Professional Leadership (HCPL) team. Led by the Chief Medical Officer, we have three Health and Care Professional Directors, working across the system together and dedicated into each Place. These complement the existing leadership in the Chief Medical Office introducing different professional backgrounds representing the diversity of health and care professionals.

2. Held a series of conversations with over 100 health and care professionals in the system to understand the current picture of health and care professional leadership (good practice and areas for improvement), to develop a shared vision for the future, and to gather ideas of the steps needed to achieve this vision.

3. Started to embed the HCPL team in key governance structures including Integrated Care Alliances, Transformation and Nursing/ Quality.

4. Started to engage in key transformation programmes and to lobby and build the expectation for greater involvement of a more diverse range of health and care professional leaders.

The output from the conversations is supporting the next steps towards this vision:

What will we do in the next twelve months

1. By September 2023 there will be a system map, a platform and directory of contacts from which to build the network of health and care professional leaders.

2. By October 2023 there will be a programme of regular, large scale engagement events for existing and future health and care professional leaders.

3. By March 2024, following extensive engagement, there will an ICP approved Statements of Intent and associated Action Plan to deliver aligning to the ICS Strategy, the vision and commitments for Health and Care Professional Leadership in BSW.

4. By March 2024 aligned to the Integrated Care Strategy, there will be the instigation of annual reportable outcomes of impact of HCPL against: Focus on prevention and early intervention, Fairer Health and wellbeing outcomes and Excellent Health and Care Services.

In addition, we will work closely with other ICB teams to support enablers that can accelerate progress including:

- Access and use of the integrated care record for direct patient care and population health management to enable transformation.
- Development of and uptake of leadership development opportunities developed by the Academy.
- Developing opportunities and encouraging uptake of involvement in transformation programmes.

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What will be different in 5 years' time

The People of BSW will receive high quality, effective health and integrated health and care provision, led by health and care professional leaders who are confident in working and leading differently in systems. Their Personalised care will be focused on prevention and early intervention, as health and care professional leaders lead services with a focus on population need and tackling health inequalities. The services will be accessible, timely and sustainable, enabled by the dedicated development and time for current and future health and care professional leaders to work effectively as system leaders.

Pharmacy Workforce

The landscape for Pharmacy is set to change dramatically over the next few years with a complete revision of the MPharm degree starting from September 2023. This will see increase student placement activity and all new pharmacists qualifying as prescribers from 2026. This requires significant investment in education and training but will lead to many opportunities to use the Pharmacy workforce to help deliver the BSW ICS Strategy by providing care closer to home and helping to address health inequalities.

What will we do in the next twelve months

- Work with local higher education institutions to increase our quality assured MPharm student placements across the system from 4 weeks to 20 weeks, so that students start to become a valuable part of our workforce whilst developing essential skills.
- Collaborate across the system to support the development of cross sector partnerships for training opportunities for both Pharmacy Technicians and Pharmacists.
- All of our 49 Trainee Pharmacist posts submitted in 2024 will be cross sector (an increase from 9 in 2022 and 24 in 2023).
- Secure system funding for our 'Teach and Treat' model to increase the number of post-registration pharmacists attaining the independent prescribing qualification in preparation to be in a position to provide support for all newly qualifying pharmacists registering as independent prescribers in 2026.
- Actively pilot & evaluate a community pharmacy prescribing service for minor aliments/urgent care to ensure active use of prescribing qualifications, move services closer to home and to ease pressure on urgent and GP services.
- Develop varied career and training pathways, as a system, for all of the Pharmacy team, both clinical and non-clinical.
- Develop reliable networks across the system to improve education and training.
- Raise the awareness of importance of Equality, Diversity and Inclusion in attracting and retaining our workforce and start taking steps to address identified risks.

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What will be different in 5 years' time

- A fulfilled and inclusive workforce with equal opportunities for all.
- 'Community pharmacy first' to alleviate pressure on GP appointments and access to urgent care. Patients will reliably be able to visit a community pharmacy as the first entrance into the NHS where they will be consulted by a prescribing pharmacist, Pharmacy Technicians will be able to offer a range of services (e.g. flu vaccines) and Pharmacy assistants will be able to provide the supply function.
- Barriers across current traditional sectors (Hospital, Community and GP) will be reduced, with Pharmacy teams in each sector able to access the same information and refer easily to one to avoid duplication and improve patient care and flow. For example – at discharge from hospital medication requests can be sent directly to community pharmacy for dispensing, queries with medication can be handled by any member of the pharmacy team, pharmacists can prescribe as readily in any setting.
- Close links with the University of Bath to enable us to participate in research and to be involved with developing the future workforce capabilities.
- Consultant pharmacists in post where there are medical expertise shortages, with an aspiration to deliver specialist services closer to home e.g. in cancer services.

International recruitment

A centralised international recruitment team has been established to support the ICS with a focus on recruiting to known hard to fill roles. The first programme has been sourcing mental health nurses from India with the delivery of an integration course delivered in-country. The first cohort has worked in with Avon and Wiltshire Mental Health Partnership in recruiting registered mental health nurses.

Housing Hub

Developing a system wide offer for affordable and accessible accommodation for BSW workforce. The model will offer an affordable and sustainable solution for relocation such as international recruitment.

BSW Academy

The ICS has a BSW Academy that brings together agreed workforce development and transformation priorities across all our health and care partners. The aim of the BSW Academy is to enable scalability of programmes, reduce duplication, unwarranted variation and enhance the synergies of sharing and learning from across our diverse partners. Creating a cross system learning ethos is core to the BSW Academy that encompasses quality improvement where we can evidence impact and value of our initiatives. Examples of work programmes include developing new supply routes, skills

pathways, system leadership and inclusion development whilst optimising training capacity and capability. The BSW Academy also enables an increasingly strategic approach to education partnerships with our providers such as colleges, universities, and skills funding opportunities such as the Local Skills Improvement Plans. Moving forward a stronger emphasis will be placed on a 'grow our own' model of development that works with local communities and builds accessible career pathways.Our People Strategy will focus on four ambitions:

1. Creating inclusive and compassionate work environments that enable people and organisations to work together.

2. Making BSW an inspiring and great place to work.

3. All staff feeling valued and having access to high quality development and careers.

4. Using resources wisely to reduce duplication, enhance efficiency and share learning.

Financial sustainability and Shifting funding to Prevention

BSW has a strategic intention to focusing funding and resources on prevention rather than treatment of healthcare conditions. There are significant pressures facing all health and care services at present. The organisations within BSW have had a substantial underlying financial deficit in recent years.

To address this, BSW System has committed to deliver a substantial system wide financial recovery programme with a structured approach to drive delivery. The financial recovery plan is part of a sustainable system wide transformation strategy, and this approach brings together productivity and efficiency improvements under one umbrella.

The system recovery plan sets out a focused two-year Transformation and Cost Improvement Programme with the target of bringing the BSW health system into financial balance by March 2025. This is not a traditional organisational strategy but a developing approach to working collaboratively together as a system to resolve significant issues to create a sustainable health system for the population of BSW.

We have developed a financial recovery action plan that includes a focus on restoring underlying productivity aligned to our system transformation programmes. Ten existing areas have been prioritised including UEC, Elective Care, Workforce, Medicines optimisation and community transformation. The scope, actions required, resources, timeline and delivery impacts of each programme with SROs will conclude in April 2023.

BSW System Recovery Board will ensure the programmes are delivering at pace and resolve any cross-system issues. The board will be chaired by a Chief Executive Officer (CEO) and to include CEO's, Chief Financial Officer's (CFO's), clinical and technical input. The board will initially meet fortnightly from April and will report into the system board. The purpose of the recovery board is to act

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as a dynamic working committee, ensuring financial recovery and overall sustainability within organisations and across the system, while it proactively drives delivery forward, unblocking issues and facilitating solutions.

In parallel, BSW will develop a longer-term financial strategy which will emphasise a population health management approach to take a longer-term view of new investments. This will underpin moves to prioritise future funding increases towards community and primary care and self-care and over time, achieving a shift in the overall balance of funding towards prevention.

What we will do in the next twelve months

- 3-year financial plan – August 2023.
- Refresh underlying financial deficit run-rate – July 2023.
- Benchmarking of productivity and efficiency opportunities – July 2023.
- 3-year Financial Recovery implementation plan – September 2023.
- Deliver existing financial plan including recurrent efficiency schemes – March 2024.
- Prevention baseline and commitment – March 2024.
- Systemwide HFMA accreditation level 1 – March 2024.

What will be different for our population in 5 years' time

1. We will be targeting a greater proportion of our funding towards prevention and intervention measures to improve the health of our population.

2. A long-term commitment to directing funding to address health inequalities.

3. We will be investing in services closer to our local communities.

4. We will deliver financially sustainable services alongside partner organisations.

5. We will have reduced waste and enhanced outcomes.

Technology and Data

Making the best use of Technology and Data

Digital solutions give us the potential to work differently, facilitating better, safer care and more efficient and effective use of resources. Through our BSW Digital Strategy we have identified three strategic priorities in digital and data:

1. Information Sharing.

2. Development of our digital workforce via a portfolio of projects.

3. Ensuring contemporary cyber security is in place.

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Our commitments include

- An Electronic Patient Record.
- Working toward a shared infrastructure across BSW.
- Digital design principles – an agreed system wide approach to the use of technology and digitally enabled transformation that is relevant for all professionals.

How we are organised to deliver

Digital strategy across BSW is set by the BSW Digital Board. This comprises digital leadership representatives across our acute, mental health, social care, urgent care, community, carer, hospice and primary care partner organisations.

Sub groups report to the Digital Board on clinical and professional leadership, cyber and a technical design authority, business intelligence, Shared Care Records, ICS use of N365 and the Digital Board reports to the Finance and Investment Committee.

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What we will do in the next twelve months

Table 13: Technology and Data twelve-month delivery plan

Project	Objective	Major Milestones	Measure
Delivery of Single Electronic Patient Records (EPR) (AHA)	Deliver a single, shared EPR across 3 acutes in line with NHSE EPR Convergence approach to level up digital maturity across acutes	Q1: FBC approved Q3: Contracts signed/NHSEI approval of FBC/ implementation resources in place	
Development of Shared Care Record	Enhance capability and usage of the BSW Shared Care Record (ICR) to release efficiencies, improve care and patient experience	Q2: Benefits review completed and usage to reach 40k records per month Q4: Extension of ICR across 3 Local Authorities	Patient record views and staff access levels Efficiency savings quantified Qualitative patient/user stories
Remote monitoring for Virtual Wards	Introduce a consistent digital solution to support virtual wards through remote monitoring technology	Q1: Sign off of specification Q3: Implementation of solution	Patients monitored
Robotic Process Automation (RPA)	Introduction of robotic process automation (RPA) across organisations building on successful service in place in GWH	Q1: Processes automated in 'new' organisations Q4: Business case for sustainable delivery model	Efficiency savings
Use of patient facing digital tools	Increase capability of patients to enable easy patient access to key information	Q1: Pilot use of maternity app about care choices during pregnancy Q4: Increase functionality of Dr Doctor in acutes to enable appointment management for patients	Number of users

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Table 13: Technology and Data twelve-month delivery plan

Project	Objective	Major Milestones	Measure
Building upon ICS wide cyber strategy	Creation of long-term ICS wide cyber lead and ICS cyber risk register	Q1: Banded Job description Q1: Finance agreed Q2: Post in place and chairing Cyber TDA Q3: ICS wide cyber risk register and key KPIs Q4: Development of ICS wide cyber projects and workplan in line with cyber strategy	ICS wide Cyber Risk register created Improvement in KPIs created Reduction in Microsoft Defender Endpoint (MDE) risk scores
TBC GP IT Delivery in BSW	Completing plans put in place pre- Covid to in-house into ICS from CSU GP IT delivery across BSW New service to be delivered by the ICB in conjunction with ICS partners building on exiting teams and strengths	Q1: Draft Operating model and costing. Q2: Approval Go ahead Q4+: Implementation (NB due to requiring network migration implementation would be at least a 12month program on a ramp up ramp down approach April 2025: Migration to new service fullycomplete	Saving from current 23/24 Commissioning Support Unit quote of £2.4M % of GP IT estate fully, public cloud hosted (no on site servers)
Business Intelligence – Data and Infrastructure Workstream	Develop an infrastructure which facilitates ICS business intelligence (BI). Includes development of a shared data platform at ICS level, linked to the regional secure data environment service (SDE)	Q1 + 2: - Initial phase of ICS Data Platform - Enhance our linked data set and roll-out major population health management (PHM) / health inequalities (HI) reports - Co-develop ICS plans for Power Business Intelligence and SharePoint collaboration Q3 + 4: - Further progress data platform, linked to SDE and federal data platform (FDP) - Deliver joint plan on Power BI and SharePoint	More data held centrally Wider access to ICS data and reporting Some functions centralised Reduced cyber risk

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Table 13: Technology and Data twelve-month delivery plan

Project	Objective	Major Milestones	Measure
Business Intelligence – Capability and Capacity Workstream	Assess the existing analytical skills across the entire ICS. Map against future requirements and develop a workforce plan to close gaps, partly through closer working	Q1 + 2: - Undertake local knowledge and intelligence service (LKIS) Skills Mapping across the ICS - Develop next steps following Mapping - Begin to map the skills of non-Analysts in using data and information - Establish more formal links to neighbouring systems Q3 + 4: - Begin delivery of workforce plan, focusing on shared, system-wide advanced analytical skills	Workforce plan developed Demonstrable closure in identified skills gaps in BSW More advanced analytical outputs
Business Intelligence – Insights Workstream	Improving the way data is utilised by the system to make more effective decisions. Making data and information easier to access and clearer for those using it	Q1 + 2: - Agree a formal approach to analytical collaboration between orgs at system and place - Review and agree a better approach to analytical requests Q3+Q4: - Embed changes to the way insight is generated across the system via agreed action plan developed in Q1/2	Usage of reports Staff confidence working with data Embedded decision-making framework

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What will be different for our population in 5 years' time

1. Patient experience will be enhanced by empowering patients with digital tools to manage their own health and wellbeing.
2. Operational efficiency will be increased by adopting digital solutions that streamline processes and reduce administrative burden.
3. The quality of care will be improved by using data and analytics to inform decision making and drive evidence-based practices.
4. A greater culture of digital innovation will be developing by encouraging staff to embrace technology and continuously look for ways to improve patient care.
5. We will be collaborating with healthcare providers and other stakeholders to develop a comprehensive digital ecosystem that supports the delivery of integrated care.

Population Health Management

In BSW Population Health Management (PHM) is an intelligence and insight solution that utilises local health, care and other wider data sources for analysis, segmentation, and risk stratification to inform and support decision making; to make the best use of collective resources; and to get the greatest impact in improving health for people and communities.

The ambition is to enable individuals, communities, professionals, teams, alliances/places, localities, and systems to maximise outcomes by working cooperatively on what matters to those individuals and communities. PHM challenges layered assumptions that have prevented a system measuring and working on what is valued, as opposed to what can be counted.

PHM promotes prevention and personalised care approaches as well as the use of incentives to target interventions to the areas of greatest need, to tackle health inequalities, and to move from reactive to proactive care.

The two key strategic areas of focus for PHM in BSW are:

1. To design and develop a coordinated approach across BSW to the implementation of initiatives which aim to support individuals to stay well and to prevent ill health.
2. To develop the culture, tools and processes needed to embed a 'population health management' approach across BSW.

Following the experience of the NHSE funded Optum Programme, PHM has become a key driver in the ICS journey as it has enabled the system to understand the population through their data and local intelligence and increased the opportunities for operational, strategic, and clinical decision makers to work together in an integrated way.

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There are currently 5 pilot projects using PHM principles involving a number of PCNs and Swindon locality.

A suite of tools is already available to many organisations across the ICS. Using the Graphnet ICR care-giving organisations can access patient-identifiable information on cohorts of interest to intervene.

The ICS has established a linked, longitudinal data set on the BSW population to support Population Health analysis. The ambition is to continue to enhance this, as well as the Graphnet ICR and other reporting which sits on top this linked data. Working together as a system, we aim to make this data and reporting accessible for wider use to support clinical, operational, and strategic decision makers understand population health as well as health inequalities with a view to assist them to drive action.

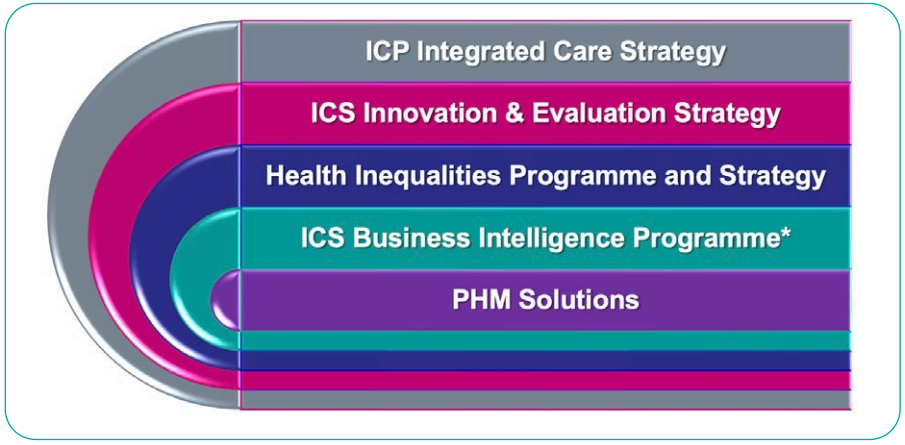
The application of PHM principles to Health Inequalities has resulted in the development of a new automated tool using power BI: the BSW Health Inequalities Dashboard. The tool, now available on a SharePoint platform and can be accessed by clicking on this link, draws from a pool of data from primary and secondary care sources and provides an overview of health inequalities across BSW system and the three Places. The tool is at the beginning of its development and the ambition is to increase the number of automated reports on population focusing on activities, deprivation, age, ethnicity and conditions.

Another key advantage of this tool is that it has been created and developed in house ensuring the highest degrees of control and flexibility. In line with the health inequalities mission to support clinical, strategic and operational decision makers accessing better data, this tool has been instrumental in providing insight and evidence base throughout the process of allocation and prioritisation of the Health Inequalities Funds.

The implementation of PHM is overseen by a number of system boards: the Digital Board oversees the technical side whilst the Population Health Board oversees the actual application and deployment of PHM tools.

PHM is already a key component of a number of programmes and strategies.

Figure 27: Population Health Management is a key component of a number of programmes and strategies



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The road map to embed this key enabler into every activity of the ICB will include the following actions:

Table 14: Actions and milestones to embed Population Health Management into every activity of the ICB

Actions	Milestone
Health Inequalities Dashboard – Demos including ICAs and Providers	April – June 2023
ICS Business Intelligence Programme implementation plan Delivery PHM key component in analytics Capacity and Capability skills and Generating Insight	June 2023 – April 2024
Review of the Optum pilots	September 2023
Further Refinement of the Health Inequalities Dashboard	June-October 2023
PHM solutions embedded into the Prevention Programmes	September-December 2023
PHM solution embedded into the Transformation Programmes	October 2023 – April 2024

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Estates of the future

Context

The Integrated Care System (ICS) aspire to have high quality estate across Bath and North East Somerset, Swindon, and Wiltshire (BSW) with seamless information technology (IT) connectivity across locations, designed for maximum efficiency. Our ICS infrastructure strategy will set out our approach to achieving this, by ensuring the key enablers such as digital, equipment and estates an integral consideration linked to service redesign.

Estate is one of the key enablers to deliver the truly transformational changes that BSW ICS wishes to achieve to deliver outstanding care and support healthy communities.

How we are organised to deliver

The way we use estate needs to change and become more flexible to the changing needs of services and service deliver, which will be supported by technology to enable us to deliver care at the right place for the needs of our population.

Our vision as an ICS Estates Board is ambitious and will require commitment from us all to work differently. It will also require significant resources, in terms of capital and revenue investment into the estate, informed by our ICS estate strategy.

The Estates Board, which meets monthly and considers capital investments in the system and recommends new building investment decisions into the BSW Director of Finance Group have already started to look at how we can work closer together to achieve this transformation and will be doing more work in the future to look at how we structure ourselves across organisations to better align the use of resources.

We are also working with NHSE to develop a national estates toolkit. The aim of the Toolkit programme is to produce a clinical and activity driven ICS Estates Planning Framework Toolkit that is evidence based and:

- Supports clinical pathway redesign and left-shift care delivery in line with the BSW Care Model.
- Helps to define the requirements for estate of the right size, in the right place, of the right type, which is of high quality and well utilised.

The work will support the ICS and other systems who use it to drive cost efficiencies which can be realised to support wider prevention and early intervention agendas to improve health outcomes.

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Our Delivery Plan

Our estate will be flexible and provide sufficient access and capacity in the right place, with the highest standards in sustainability, with a low carbon footprint.

Estate is our third largest cost after workforce and medication, so it must be financially sustainable and utilised well. We are improving the way we use space by removing organisational barriers that used to allocate rooms to individual organisations or services to one based on sharing space and increasing utilisation across all settings to maximise the use of our investments.

What we will do in the next twelve months

- Initiate PCN Toolkit Phase 3 - This involves modelling the BSW estate to inform future investment / dis-investment decisions - Apr 2023.
- Agree the BSW Estates Board work plan for 2023/24 - Apr 2023.
- Development of BSW Infrastructure Strategy - Jan to Jun 2023.
- Approval of BSW Infrastructure Strategy - July to Sep 2023.
- Conclude review of existing community estate utilisation - Sep 2023.
- Initiate planning for BSW Estates Strategy - Oct 2023.
- Collate outputs from PCN Toolkit Phase Three - Mar 2024.

Figure 28: The BSW Estate vision

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What will be different for our population in 5 years' time

- Our future estate will be shaped and informed by the changes to our care model, to deliver better patient, staff, and visitor experience and to significantly improve the way we deliver services in the future enabling us to dispose of ageing buildings no longer required and investing in new solutions. This includes, technology and buildings, utilising the existing wider public, community and third sector estate, where necessary to delivery this at system, place, and neighbourhood levels, which we continue to develop..
- Technologies will allow patients to access sophisticated diagnostics within community settings as part of an integrated service. Virtual spaces for virtual consultations with professionals reducing the need to come into buildings, physical spaces for face-to-face consultations in different locations where these are necessary, including the patients' own home, which will help to transform service delivery.
- Funding constraints inevitably create risks to achieving this vision, but it is important to have a clear aspiration for the future BSW estate.
- Our workforce will be able to work across different locations, consolidating back-office functions and changing the way that we work, reducing unwarranted variations in provision of estate services and automating manual processes.

Note that the above list reflects the current position at the time of publishing. It is likely that additional projects / schemes will be identified following the BSW Estates Board work plan review in April 2023.

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Environmental sustainability

BSW Green Plan 2022-25

The BSW Green Plan 2022-25 published in July 2022 sets out how we will begin to reduce the environmental and carbon impact of our health and care estate, services, and wider activities over the next 3 years, with a view to achieving net zero by 2040 for direct emissions and 2045 for the emissions we can influence. Aligned to the BSW ICS vision, the Plan supports our ICS strategic priorities by improving the health and wellbeing of our population so they can age well and reducing health inequalities caused through poor environments.

Our delivery plan

BSW has made a series of system wide commitments to improve our environmental sustainability over the coming years. These are aligned to the following focus areas:

- Sustainable care model.
- Workforce and leadership.
- Estates and facilities.
- Travel and transport.
- Supply chain and procurement.
- Medicines optimisation.
- Digital transformation.
- Adaptation.
- Food and nutrition.

Delivery of our commitments is supported through a work plan, which outlines key actions for the system to undertake.

How we are organised to deliver

The delivery of the BSW Green Plan 2022-25 is supported by a robust programme management approach.

A Greener BSW Executive Leadership Group exists to provide strategic leadership and direction, support delivery, and hold the Greener BSW Programme Delivery Group to account.

The Executive Leadership Group comprises of Senior Leaders from partner organisations, across the BSW system, to ensure appropriate board-level oversight and ownership. The group meets on a quarterly basis.

The Greener BSW Programme Delivery Group brings together a wide range of partners from across health and care to collaboratively drive change. The Programme Delivery Group meets monthly and focuses on the delivery of our Green Plan commitments, along with priority actions.

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What we will do in the next twelve months

A selection of actions for delivery by our partners (within the scope of the Green Plan requirements) to deliver tangible reductions in emissions are highlighted below:

Table 15: Examples of actions for delivery by BSW partners to result in emission reductions

Focus Area	What do we want to do?	How will we achieve this?
Workforce & Leadership	Inform, motivate, and empower staff to make sustainable choices at the workplace and home, and enable them to live a sustainable, healthy lifestyle.	ICB Board to undertake sustainability training. Staff are made aware of the relevant Green Plans (ICS/Trust) via training / inductions / comms.
Travel & Transport	Reduce the environmental impact of our travel by encouraging sustainable low-carbon and active travel.	NHS Trusts signed up to clean air hospital framework.
Medicines Optimisation	Reduce the environmental impact of our prescribing activities and the use of medicines by reducing use and switching to lower carbon alternatives.	All NHS Trusts to reduce use of desflurane in surgical procedures to <5%.

Note that additional actions for delivery over the coming years are outlined in the BSW Green Plan 2022-25 across all focus areas.

What will be different for our population in 5 years' time

- Climate change threatens the foundations of good health, with direct and immediate consequences for individuals, our infrastructure, and public services. Addressing climate change is important in helping us to meet our system-wide goals of developing healthier communities, improving health outcomes, and addressing the wider social determinants of health that can lead to health inequalities.
- Climate change requires collective action across the system. If we fail to take a coordinated approach, then we are failing to address the biggest health risk that we face as a society. In recognition of this, we will continue to work collaboratively with our health and care partners, local authorities, VCSE and the public to drive sustainable change and achieve a sustainable future for our population, and future generations to come.

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Our role as Anchor Institutions and supporting wider social and economic development

Context

The concept of anchor institutions has been understood within the NHS for a number of years, and pre-dates the COVID-19 pandemic, but the imperative to address health inequality triggered by the differential impacts of Covid has given this new impetus.

Anchor institutions are large, typically public sector organisations, rooted in place (hence the term 'anchor') and by the nature of their role and scale are uniquely placed to positively influence the social, economic and environmental conditions of local communities.

The long term sustainability of these organisations is inextricably linked to the health and wellbeing of their populations and so there is a 'virtuous circle' in the role of these organisations leveraging their ability to impact on the wider determinants of health locally.

Given the role of our ICP in improving the health and well-being of individuals, we want our constituent organisations and partnerships to play this crucial role in supporting wider social and economic development, acting as anchor institutions that contribute to the economic and social development of local communities.

As noted in the infographic below, we have the potential to stimulate economic growth by creating jobs, investing in local infrastructure, and supporting local businesses. Our organisations provide a range of services, such as health care, social care, and community support, which contribute to the social and economic well-being of our local communities.

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Figure 29: Six benefits where health Anchor Institutions can benefit their communities

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Our ICP also supports wider social and economic development by seeking to reduce health inequalities. Health inequalities are a significant issue in many communities, with people from disadvantaged backgrounds often experiencing poorer health outcomes.

We can help to address these issues by delivering integrated health and social care services that are tailored to the specific needs of our communities. This can include providing culturally sensitive services, addressing social determinants of health, and working with community groups to promote healthy lifestyles.

Our delivery plan

As noted in the infographic above, there are a range of measures organisations and collaborations can take to act as anchors. Our aim is to share best practice through the BSW Academy, ICAs and provider collaboration, to ensure that individually and collectively partners are using their inherent capacity to create improved conditions for healthy lives.

There is a clear link in between deprivation and life outcomes, in Swindon for example those that live in deprived wards have lower life expectancy for both men and women, 42% of children living in poverty located in the most deprived wards and poor educational attainment. The most deprived 20% of areas within Wiltshire have repeatedly poorer outcomes than the least deprived 20% and similar patterns are seen in Bath and North East Somerset. Smoking rates (Swindon already has a significantly higher rate than the national average) and substance misuse are higher in deprived areas as are higher levels of severe mental illness. Rates of hospital stays for instances of self-harm are significantly higher across all parts of BSW compared to the England average.

In Swindon, GWH have considered all the ways in which they can use their anchor status to improve health outcomes for their local population. Some examples of this are outlined in the infographic below against 5 key areas.

Given that the majority of their spend is on staff costs, it was determined that their role as an employer would be the most significant contribution they could make initially, and so they have focussed a programme of work around widening access to employment and development opportunities, and working with their partners at New College to target training and recruitment opportunities at those most in need of a foothold to a stable career.

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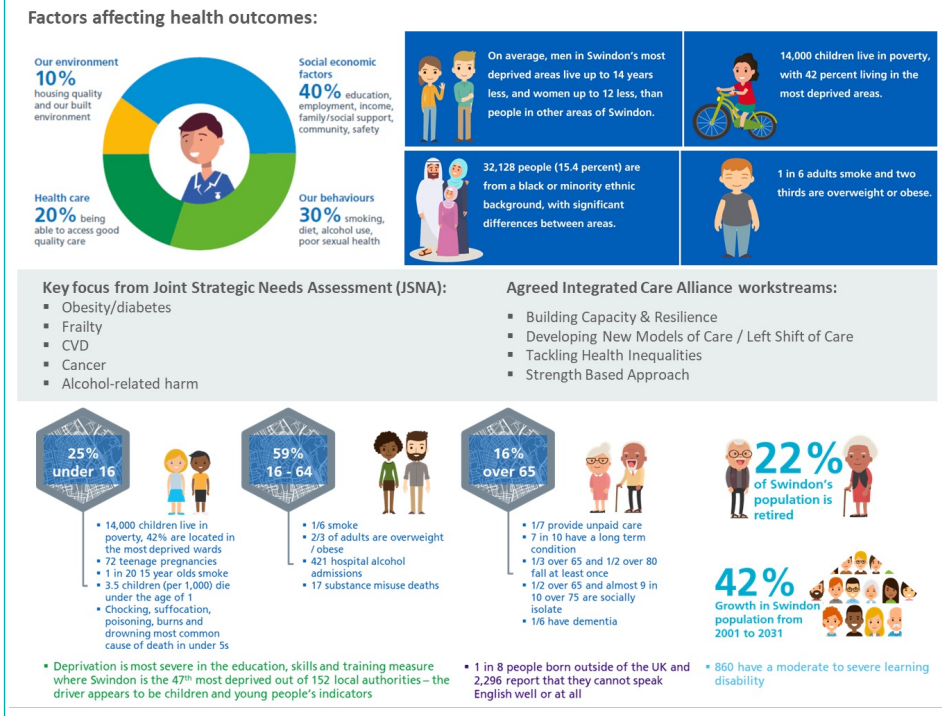
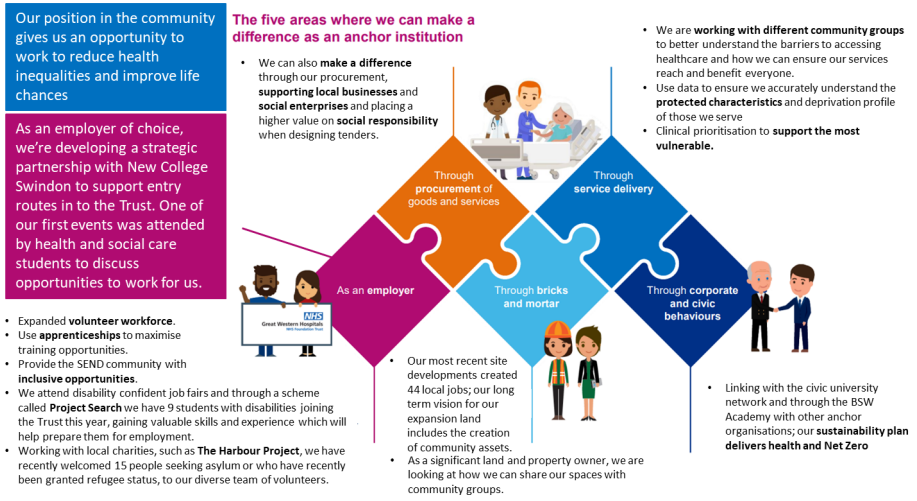
Case Study: Swindon – Great Western Hospitals NHS Foundation Trust (GWH NHS FT)

Figure 30: Case Study - Great Western Hospital as an Anchor Institution



As an integrated provider, we identified five key areas where they were able to make a positive difference. The diagram below outline some of the initiatives that have been taken forward over the last twelve months.



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How we are organised to deliver

Across our Acute Hospital Alliance, we are working together to not only bring benefits from each organisation but to also release the potential of a collaborative approach, as together we can have a bigger impact.

At Place level each Trust is also working closely with the local authority to ensure that we consider the wider determinants of health and work together on opportunities to reduce inequalities and improve the health and wellbeing of local communities.

What we will do in the next twelve months

For the established Anchor work around employment opportunities in Swindon, GWH will continue to engage with local organisations to:

- Increase awareness of an entry to supported roles.
- Make applying for roles more accessible.
- Target recruitment at local communities.
- Work with schools and colleges particularly with regard to our most diverse or deprived neighbourhoods.
- Promote the NHS' wider (non-pay) employment benefits.
- Run tailored interview skills sessions.
- Provide bespoke support to those with learning disabilities or those not in employment, education or training.

Through Phase 3 of the Health Inequalities Strategy to work collectively across BSW to establish anchor collaboratives or areas of focus for our other anchor institutions.

What will be different for our population in 5 years' time

- We know that where people live is a big contributor to their health – your health, life expectancy, and the opportunities you'll get are different depending on which part of Swindon you live in.
- While COVID-19 has really highlighted inequalities, it's also brought communities together and brought us closer to our community – not just through the lives we've touched, but through the closer working relationships we've forged with partner organisations in Swindon. We now have a golden opportunity to continue and build upon that spirit and make the most of community participation and engagement.
- We can't achieve our ambitions alone. We're stronger working with others, and together we can make a real difference to people's lives.
- We want to better the lives of people in our communities – working collaboratively to share what we have and provide opportunities for people to improve their health and life chances and benefit the whole of Swindon and surrounding areas.

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Monitoring performance and delivery

A key element in providing assurance on the delivery of the strategy is how we monitor and report on progress with the plan.

We are in the process of developing how reporting across system wide programmes, place-based activities and within partner organisations comes together to provide a clear and integrated picture of delivery against the plan.

Individual arrangements are already in place for some of our programmes through existing programme governance arrangements. For example, Delivery of Virtual Wards (NHS@Home) is overseen by a monthly steering group with place level oversight through local implementation groups that report to the steering group.

We are developing a framework for monitoring and assuring performance and delivery against the plan as a whole to enable us to provide our first update report by December 2023.

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Duty to obtain Appropriate Advice

Each ICB must obtain advice appropriate for enabling it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in the prevention, diagnosis or treatment of illness and the protection or improvement of public health.

BSW ICB will follow this approach in seeking advice, including from local authority partners and through formal governance arrangements and broader engagement:

1. Clearly identify the issue requiring advice with specific objectives outlined for the advice being sought.

2. Determine the most appropriate type of advice needed for the objectives and issue, whether in prevention, diagnosis or treatment of illness, or the protection or improvement of public health. That could be legal, financial, technical, strategic, clinical or other types as required.

3. Determine the potential sources of appropriate advice, drawing from experts either inside or outside the system.

4. Work to understand the most appropriate advice source from those selected based on expertise, experience, credibility, and alignment to the ICB vision.

5. Establish formal contact with sources of advice against a clear brief, explaining the issue. Following ICB procurement practices where applicable, asking for experience, expertise, qualifications, availability, any conflicts of interest, and rates where any of these are unknown.

6. Evaluate advice received, determining the relevance and applicability, together with the effectiveness in addressing the issue.

7. Consider seeking second opinion or further advice as appropriate.

Advice may be deemed ongoing or on-demand. On-going advice may be incorporated in permanent representation to governance mechanisms associated with ICB as required, for example with particular clinical advice.

BSW ICS is fortunate to feature clinical networks, alliances, public health, social care, clinical senates, academic institutions, as well as having access to regional networks including NHSE SW.

All ICBs have varying demographics, and it is therefore important for BSW ICB to be able to seek the most appropriate advice for its partners and population.

Duty to Promote Innovation

Each ICB must promote innovation in the provision of health services (including innovation in the arrangements made for their provision). The ICB in partnership with the BSW Academy, Academic Health Science Network (AHSN), and the Dragon's Heart Institute are co-producing an Innovation and Evaluation strategy to promote Innovation and Evaluation across BSW both at System and Place level. The strategy will promote and guarantee the highest degree of inclusivity and participation by creating a fertile, accessible, and supportive place for innovative, evidence-based, and impactful ideas from the ground-up to be implemented and scaled across time. Through the implementation of this strategy BSW will promote local innovation and build capacity for the adoption and spread of proven innovation. Using the following process:

Figure 31: Process for promoting the adoption and spread of innovation

The approach will be grounded on the following 5 principles or pillars:

- Culture: Creating a culture in which Innovation and Evaluation are embedded in clinical, operational and strategic decision-making processes.
- Connections and Community Engagement: Promote collaboration across the system to maximise the use of limited resource through innovation.
- Capacity and Capability: Empower, train, mentor and support workforce with shared knowledge, infrastructure, and
- opportunities to drive innovation.
- Patient Experience: Deliver innovative evidence-based care that reflects the needs of the population and tackles health inequalities.
- Continuous Improvement: Deploy evaluation as an approach to positively challenge the status quo and drive change through innovative solutions.

Duty in Respect of Research

Each ICB must facilitate or otherwise promote research on matters relevant to the health service, and the use in the health service of evidence obtained from research. For BSW ICB this is a unique opportunity to help support and facilitate research across the BSW ICS to the benefit of our population, to capture and share learning from successful research elsewhere, and to disseminate successful research within BSW into the wider NHS.

Research in this context includes all research benefitting health and care outcomes such as advancing health and care operations, management, and leadership, as well as clinical trials.

Some of the ways in which the ICB will support research include:

1. Fostering collaboration: Identifying all partners connected to BSW ICS which are either involved, aspire to be, or would benefit from connection with research including academic institutions. Bringing together health and care professionals, researchers, and patients to collaborate and understand contemporary issues, facilitating a more integrated approach to research.
2. Enabling funding: ICB can help to coordinate the enablement of funding to support research projects. This can help to incentivise researchers to conduct studies aligned to system priorities and can help coordinate necessary resources.
3. Providing and supporting with data collection: BSW ICB can provide support for data collection and analysis. This can help researchers to access the data they need to conduct their studies and can ensure that data is collected and analysed in a consistent and reliable way.
4. Encouraging and facilitating patient involvement: BSW ICB can work to involve patients in research projects, mindful of existing inequalities evident in the conduct and application of research.
5. Supporting research governance: BSW ICB can play a key role in ensuring research is conducted in an ethical and transparent manner. We can provide guidance on research governance.

Recent guidance from NHSE titled "Maximising the Benefits of Research" will inform the next steps for action. These will be achieved by establishing an ICB Research Lead within the Medical Directorate working with colleagues in the BSW Academy. One of the outputs from this would be a system led research strategy and a system-wide research network.

By fostering a collaborative approach to research, BSW can help to improve patient outcomes and better leverage research potential to deliver the ICS strategy. In 5 years' time the system should see a more effective, aligned (as section 3.2 of the guidance), systematic and comprehensive approach to research.

One of the aims of the ICS Research Strategy will be to enable a systematic monitoring of research progress with regular updates. As the strategy is developed and partners agree on monitoring mechanisms, these will be replayed into the Joint Forward Plan reviews.

Addressing the particular needs of victims of abuse (including Serious Violence Duty)

The ICB Safeguarding Team is located within the Nursing and Quality Directorate. The ultimate accountability for safeguarding for the ICB is with the ICB Accountable Officer. The Chief Nurse is identified as the Responsible Officer for Safeguarding, supported in this role by the ICB's Safeguarding Designated Professionals and the Associate Director for Strategic Safeguarding. Safeguarding reports to the Quality and Outcomes Committee which has Director level representation and the ICB Board.

There are three Safeguarding Partnerships across BSW ICB. All three bring together the work of the Safeguarding Adults Board, the Community Safety Partnership and partnership activity in relation to Safeguarding Children.

BSW ICB Chief Nurse and the ICB safeguarding team are representatives on all three safeguarding partnerships, including the Violence Reduction Unit (VRU) in BaNES locality, Swindon Community Safeguarding Partnership and Wiltshire Community Safeguarding Partnership. Community Safety Partnerships (CSPs) and VRUs have an explicit role in evidence based strategic action on serious violence and these partnership meetings will be the driver for delivering the serious violence duty (SVD) and safeguarding Statutory Duties.

Domestic abuse prevention is an important aspect of the SVD and each of the LAs across BSW ICS have domestic abuse partnerships which feed into the CSPs. There is expertise within the safeguarding team around domestic abuse with participation in the domestic abuse partnerships. BSW has in place information sharing across providers and primary care to the multi-agency risk assessment conference (MARAC)/ multi-agency public protection arrangements (MAPPA)/ PREVENT programme.

The team also works closely with NHS providers, Police and the LAs to support continuous education and updates in this evolving workstream. This includes Female Genital Mutilation, forced marriage and violence against women and girls, PREVENT and Multi Agency Public Protection arrangements.

Over the coming year specified authorities will need to have prepared their joint local strategy, which should contain activity to prevent and reduce serious violence based on the needs of their area to do this.

Recommendations for data sets include anonymised hospital and primary care data on serious violence injuries. Information is currently collected on a case by case basis from health services. It is likely the development of consistent gathering of data will be a large focus of the strategic delivery of SVD across agencies and practice. The new duty strengthens the requirement for cross agency data sharing to enable local and national timely prevention and response strategy developments to reduce serious violence. BSW ICB are well placed to enable the safeguarding team to carry out the development of the new duty during 2023 – 2024.

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Duty to enable Patient Choice

Each ICB must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

We will remain compliant with the legal regulations for choice whilst also developing the elective strategic ambition to network our provision for best deployment to reduce waiting times and reduce inequities in access and associated inequalities.

We will also develop our approach to reducing harm of urgent referrals that are not converted in a timely way by patients and explore integration opportunities with booking and validation activities in our providers.

The BSW Referral services currently comprise of two services: BSW Referral Service and SARUM Referral Service - a separately commissioned referral services for SARUM area (South Wiltshire) GP Practices. BSW referral services interface between GP practices and secondary care, to facilitate patients making informed choices about where to go for consultation and possible treatment. The main objective of the service is to provide a smooth journey from referrer to provider and ensure that patients are offered appropriate patient choice of healthcare provider ensuring that they are seen in the 'right clinic, first time'. This process therefore reduces the burden on both referrers and providers and supports the patient journey. Patient choice is also promoted and publicised on the ICB website.

Over the next year we are undertaking a number of actions to further develop patient choice. This includes investigating opportunities for integration of referral support services with other system "front end" administrative processes and reviewing the operation of the right to change provider after 18 weeks alongside the digital mutual aid system.

Responsible procurement and our supply chain

The BSW Acute Hospital Alliance Procurement Service created in April 2021 delivers procurement and supply chain services as a hosted model to the three local Acute trusts and Wiltshire Health and Care and is hosted by Salisbury NHS Foundation Trust. The team also work collaboratively with the ICB to provide a professional procurement and supply chain service across the region. Through establishing a single procurement service, opportunities to gain greater security of supply, process efficiencies and economies of scale have been created to improve the patient experience.

The procurement service is a key enabler of each of the strategic objectives through ensuring good governance, timely delivery and value for money in the consumables and equipment which it purchases for clinical care.

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The BSW ICS procurement strategy will be submitted to appropriate boards for approval Summer 2023, but short term objectives are as follows:

- Develop a business case for a central warehouse and distribution centre to reduce carbon footprint for supplies, with plan to be in place during 2024/5.
- Standardising and aggregating consumables held across the ICS for economies of scale and greater supply chain resilience and to reduce wastage for the benefit of patient care.
- Common platforms and ways of working across the ICS for greater efficiencies and resilience, using technology as appropriate.
- Implementation and development of the Procurement People Strategy.

The procurement of goods and have processes which can be designed to support local business opportunities, recirculate wealth and bring community benefits – while still getting buyers at the right price and quality, and often improved supplier responsiveness and relationships. This links to the work described in the Anchor Institutions section. The procurement team is working with government directives to allocate a minimum of 10% of the award criteria to social value, net zero and sustainability issues. Full details can be found in the ICS BSW Procurement Alliance Procurement Policy[1].

The BSW Procurement Alliance will make an impact in Local supply chains through:

- Monitoring spend with suppliers across the region.
- Helping Small and Medium Enterprises (SME) with cash flow by insisting that our suppliers pay subcontractors promptly, and by splitting big contracts into smaller lots to make it easier to bid for them.
- Communicating with potential local suppliers so they know what opportunities are coming up, how to bid, and what you expect of them (e.g. A minimum of 10% weighting within tenders will be given to environmental and sustainability issues. All suppliers awarded a contract value greater than £5m required to submit a carbon reduction plan).
- Identifying key areas of spend where there are no or few local supply options and see if new enterprises or groups of local firms working together can close them.
- Including wider criteria such as social/community, health and environmental impacts and benefits and include clear criteria and goals on these.
- Monitoring and enforcing the implementation of the actions that contractors said that they would deliver, and track and share any wider good practice by suppliers.

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Duty to have regard to wider effects of decisions

As ICS partners we are committed to using our scale and finances in a way which support the social and economic development of our three local authority areas. With an annual budget across the partnership of £2bn and an employed workforce of 35,500 our organisations can have significant influence beyond our core role as health and care providers. Through our work on the wider determinants of health we recognise that the delivery of health and care services represent only one element of how we can positively support the wellbeing of the local population.

Our commitment to delivering the triple aim of improving population health and achieving better quality of patient care whilst ensuring financially sustainable services is set out through our BSW Strategy and this BSW Implementation Plan demonstrating how all partners, including all local NHS organisations. These duties will be fulfilled through the lens of our three Strategic Objectives and success in doing so will be demonstrated through our monitoring against delivery of the actions included in the plan and the achievement of the system outcomes we have put in place.

An example of this approach is our work to deliver our Green Plan which is at the heart of our commitment to making BSW a prosperous and pleasant place to live. With initiatives targeting the employment opportunities that are available to local residents, the quality of the air that local people breath and our drive to embed local organisations in our supply chain, we are taking a holistic approach to developing our roles as anchor institutions. Initiatives such as apprenticeship schemes and joint recruitment activities between partner organisations reflect our focus on developing rewarding careers for local people. This will continue to develop during 2023/24.

Partners are also working together on how best to utilise the physical estate that we directly manage with the intention of making our investments drive the maximum value for the local area. Increasingly, we expect to operate out of shared premises and to locate these in places that offer both easy access for our population and support the regeneration of communities.

Our work on wider social and economic development is being coordinated by different teams across the ICS, but ultimately will be overseen by the ICP as part of its work to quantify and measure our impact on the health and wellbeing of the local population.

In five years' time, our partnership will be able to understand and monitor how we are using every £1 of the resources we have in BSW to achieve the maximum return on investment. This will be achieved by our organisation working ever more closely together and recognising that value is not driven by cost alone but must be judged on a wider set of social impacts.

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Record of engagement for the Implementation Plan Development work

Table 16: Record of engagement events held

Dates	Meeting
TBC	BaNES Citizens Panel
Via email	Swindon Health and Wellbeing Board
21/04/23	Wiltshire ICA Partnership Committee.
16/05/2023	Joint H&W, ICA, ADoG meeting
16/05/23	BaNES ICA Workshop on the Implementation Plan
17/05/23	Wiltshire ICA Partnership Committee
24/05/2023	BSW Population Health Board
24/05/2023	Population Health Board
25/05/2023	Wiltshire Health and Wellbeing Board
25/05/23	BSWICB Colleague Briefing
26/05/2023	BSW Directors of Finance Group
30/05/23	BSW Inequalities Strategy Group
31/05/23	BSW CYP Programme Board
02/06/2023	Swindon ICA Inequalities Meeting
05/06/2023	BSW Medicines Optimisation Board
05/06/2023	BSW Strategy Outcome Measure Sub-Group
13/06/2023	BaNES Third Sector Alliance (3SG)
14/06/2023	NHS LTP TTD Leads Working Group
20/06/23	BaNES Health and Well Being Board

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Acronyms

Table 17: Acronyms used within BSW Implementation Plan and definitions

Acronym	Definition
A&E	Accident and Emergency
ACE	Adverse Childhood Experiences
AHA	Acute Hospital Alliance
AHSN	Academic Health Science Networks
ALPINE	Assessment + Liaison for paediatric Inpatients with eating disorders
ARRS	Additional Roles Reimbursement Scheme
ASD	Autism Spectrum Disorder
ASH	Action on Smoking and Health
AWP	Avon and Wiltshire Mental Health Partnership
BAME	Black, Asian and Minority Ethnicity
BaNES	Bath and North East Somerset
BaNES	Bath and north East Somerset Council
BCF	Better Care Fund
BCSP	Bowel Cancer Screening Programme
BNSSG	Bristol, North Somerset, South Gloucestershire
BSW	Bath and North East Somerset, Swindon and Wiltshire
CDC	Community Diagnostic Centres
CEO	Chief Executive Officer
CeTR	Care, Education and Treatment Review
CEW	Children Living with Excess Weight
CFO	Chief Financial Officer
CLA	Children who are Looked After
CoC	Continuity of care

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Table 17: Acronyms used within BSW Implementation Plan and definitions (continued)

Acronym	Definition
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CPA	Care Programme Approach
CQUIN	Commissioning for Quality and Innovation
CSP	Community Safety Partnerships
CT	Computed Tomography
CTR	Care and Treatment Review
CVD	Cardiovascular Disease
CWH	Community Wellbeing Hub
CWOC	Connecting with our Communities
CYP	Children and Young People
CYPP	Children and Young People Programme
DEG	Delivery Executive Group
DiaDEM	Diagnosing Advanced Dementia Mandate
EHCP	Education, Health and Care Plan
EPR	Electronic Patient Records
ESN	Epilepsy Specialist Nurse
FDP	Federal Data Platform
FENO	Fractional Exhaled Nitric Oxide
GWH	Great Western Hospital (Swindon)
HCPL	Health and Care Professional Leadership
HI	Health Inequalities
IAPT	Improving Access to Psychological Therapies

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Table 17: Acronyms used within BSW Implementation Plan and definitions (continued)

Acronym	Definition
ICA	Integrated Care Alliance
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICR	Integrated Care Record
IMD	Index of Multiple Deprivation
INT	Integrated Neighbourhood Teams
IT	Information Technology
JLHSW	Joint Local Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LD	Learning Disability
LDA	Learning Disability and Autism
LES	Local Enhanced Services
LGBTQ+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning and others
LKIS	Local Knowledge and Intelligence Service
LMNS	Local Maternity and Neonatal System
LTP	Long Term Plan
MDE	Microsoft Defender for Endpoint
MDT	Multi-Disciplinary Team
MEWS	Maternal Early Warning Score
MH	Mental Health
MHST	Mental Health Support Team
MMHS	Maternal Mental Health Service

Section 13

Appendices

Table 17: Acronyms used within BSW Implementation Plan and definitions (continued)

Acronym	Definition
MPAC	Multi-Professional Approved Clinician
NCTR	No Criteria to Reside
NEWTT-2	Newborn Early Warning Trigger and Track
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NMVP	National Maternity Voices Partnership
NQB	National Quality Board
NSS	Non-Specific Symptoms
OCEAN	Offering Compassionate Emotional Support for those Living Through Birth Trauma and Birth Loss
ONS	Office for National Statistics
PC	Primary Care
PCN	Primary Care Network
PHE	Public Health England
PHM	Population Health Management
PHOF	Public Health Outcomes Framework
PIFU	Patient Initiated Follow-Up
PQSM	Perinatal Quality Surveillance Model
PSHE	Personal, Social, Health and Economic Education
PSIRF	Patient Safety Incident Response Framework
Q1/2/3/4	Refers to the quarter of the financial year
Rehab	Rehabilitation
RPA	Robotic Process Automation

Section 13

Appendices

Table 17: Acronyms used within BSW Implementation Plan and definitions (continued)

Acronym	Definition
RTT	Referral to Treatment
RUH	Royal United Hospitals (Bath)
SDE	Secure Data Environment Service
SDEC	Same Day Emergency Care
SEND	Special Educational Needs and Disability
SFT	Salisbury Foundation Trust
SME	Small and Medium Enterprises
SMI	Severe Mental Illness
SNAPS	School Nutrition and Activity Project Swindon
SOP	Standard Operating Procedure
SQG	System Quality Group
SRO	Senior Responsible Officer
STCA	Swindon Tobacco Control Alliance
SVD	Serious Violence Duty
SWAG	Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance
SWAST	South Western Ambulance Service NHS Foundation Trust
T&F	Task and Finish
TAMHS	Targeted Mental Health Service
TAN	Tobacco Action Network
TBC	To be confirmed
TLHC	Targeted Lung Health Check
TTD	Treating Tobacco Dependency

Section 13

Appendices

Table 17: Acronyms used within BSW Implementation Plan and definitions (continued)

Acronym	Definition
TVCA	Thames Valley Cancer Alliance
UASC	Unaccompanied Asylum Seeker Children
UCB	United Care Bath
UCFB	Urgent Care and Flow Board
UEC	Urgent and Emergency Care
VCSE	Voluntary, Community and Social Enterprise
VRU	Violence Reduction Unit
WHIG	Wiltshire Health Inequalities Group
WSA	Whole System Approach
WSATC	Wiltshire system approach to tobacco control

Bath and North East Somerset, Swindon and Wiltshire Together

July 2023

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Wiltshire Council

Health and Wellbeing Board

20 July 2023

Subject: Joint Capital Resource Use Plan for NHS BSW ICS

Executive Summary

There are new obligations under the Health and Care Act 2022 for Integrated Care Boards (ICBs) and partner NHS trusts and NHS foundation trusts to prepare joint capital resource use plans.

The Joint Capital Resource Use Plan for NHS Bath & NE Somerset, Swindon and Wiltshire Integrated Care System outlines the system allocation of capital and the key strategic priorities and schemes.

Proposal(s)

It is recommended that the Board:

i) Notes the Joint Capital Resource Use Plan at **Appendix 1**;

ii) considers how the capital plan interrelates with other relevant plans for system infrastructure and estates; and how it will support delivery of the Integrated Care Partnership strategy and the priorities of the Health and Wellbeing Board

Reason for Proposal

Joint Capital Resource Use Plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to Integrated Care Boards is being prioritised and spent to achieve the ICB's strategic aims. ICBs were established to empower local health and care leaders to join up planning and provision of services, both within the NHS and with local authorities.

Under s14Z56 of the Health and Care Act 2022 the ICB must provide a copy of the Joint Capital Resource Use Plan to the relevant Health and Wellbeing Boards.

Bina Kakad
Capital Resource Use Planner
NHS BSW ICB

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REGION	**South West**
ICB / SYSTEM	**NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)**

Introduction

Guidance:
Please provide some high level commentary about the joint capital plan which should be developed between the ICB and partner NHS Trust and foundation trusts – key strategic priorities, key schemes throughout the year, background to what happened last year, overview funding sources etc.

2023/24 Plan

The joint capital plan for BaNES, Swindon & Wiltshire (BSW) Integrated Care System (ICS) has been developed through collaborative working across the BSW Integrated Care Board (ICB) and partner Provider organisations. The plan covers the full financial year from 1 April 2023 to 31 March 2024. It is noted that whilst the ICB was only formally established from 1 July 2022, partners worked together under the pre-existing BSW Health and Care Partnership arrangements on the system capital plan.

Our ICS aim is to utilise our Capital allocation differently to maximise value and deliver cost effective sustainable solutions. As part of the ICS Capital Group, partner organisations in BSW have committed to deliver transformation as collaborative, system wide initiatives to maximise efficiency and effectiveness. The 23/24 provider "core" allocation values remain largely consistent with those reported in 22/23 as part of the roll out of the 3-year allocation programme.

The system operational capital resource is used for schemes within organisations which primarily support day-to-day operational investment in infrastructure, clinical equipment and information management and technology. The plans are developed by individual trusts based on their prioritised cycle of reinvestment/replacement of assets and assessment of backlog and safety works.

The system allocation is resourced through internally generated funding (cash and depreciation within organisations), and national programme schemes are resourced through the issue of public dividend capital (cash). There is no planned material disposal of assets within our plans at this stage.

Key Strategic Priorities and Schemes

The system aims to best deploy operational and national capital to support strategic priorities. It is however recognised that the level of capital resource available to BSW does not allow all strategic priorities to be delivered. As a system we will need to continue to work together to prioritise our available capital and ensure we maximise opportunities to align resources and investment across the system partners.

This plan builds on system successes in 2022/23, including how the funding will support delivery of operational and national capital to support strategic priorities and local system priorities (increasing capacity through elective recovery, new build, maintenance, digital and diagnostics).

Our NHS provider plans also include pre committed national programme funding streams subject to business case approval. These are linked to: -

• New Hospital Programme approved development of Cancer centre at Royal United Hospitals Bath
• National programme enabling schemes - Sulis Orthopaedic Centre, Salisbury NHS Trust additional Elective ward, redevelopment at Great Western Hospital to expand and reconfigure Urgent & emergency care.
• National programme funding of £40.5m secured to build two specialist therapeutic environments (One in the North and one in the South of the Region) to treat and care for people with Learning Disability or Autism that cannot be cared for in mental health units within reasonable adjustments. The business case is being developed to look at the overall pathway with the aims to treat people closer to home, reduce out of region admissions, improve treatment, care and experience whilst building expertise and capacity.
• Range of other national programmes, including Community Diagnostic Centre, Diagnostic equipment, schemes to support elective recovery, and digital schemes which support clinical care.

System Planning and National Funding - The system operational capital available is focused on delivering operational demands and is not sufficient to allow the progression of some of the key strategic developments that are considered priorities within BSW. We are reliant on securing funding through national funding sources and their related bidding processes which are generally over-committed and have challenging delivery timescales.

The ICB continues to work to support NHS provider trusts in BSW with their respective planning and profiling of nationally approved capital plans awaiting the next phase of national support or capital bids awaiting a national decision.

Pipeline Schemes BSW as a system has identified pipeline of priority schemes that we do not yet have identified funding for: -

- Additional bed capacity
- Day Surgery Unit
- Relocate Maternity
- Spinal unit Refurbishment
- Critical Infrastructure

Inflation - The current level of inflation is having a significant impact on the ability to manage project expenditure to original plans, particularly across multi-year projects.

Delivery - As a system we are continuing to manage the consequences of the worldwide economic conditions which has dramatically affected the procurement lead times of some items of equipment and makes capital planning less certain.

IFRS16 - The planning assumption made is that these will be funded in 2023/24, but this is not yet confirmed and is noted in the risks below. We are progressing on the basis that any additional capital cost impact related to the mandated implementation of IFRS16 are funded by NHS England, although this has not yet been formally confirmed.

Cash - As described above, operational capital is funded through a combination of depreciation and cash.

Funding Sources
The ICB has been notified by NHS England of its provider system operational capital resource which has been allocated to individual organisations based on the national methodology. The capital programme for 2023/24 will be funded from internally generated sources and approved national funding programmes but subject to the approval of business cases for the Sulis Orthopaedic Centre, Community Diagnostic centres, and frontline digitisation programmes.

Annex A demonstrates that the Integrated Care Board (ICB) total capital departmental expenditure limit (CDEL) allocation is £155m (including national funding, IFRS 16 & technical accounting adjustments). Provider Operational capital which is for improvements in estates backlog, digital and replacement diagnostic equipment amounts to £43m. Organisations have reviewed all leases to ensure the correct level of IFRS16 resource is in the plan.

Outturn 2022/23 - The BSW system worked together successfully to deliver an operational capital plan for 2022/23. The funding in 2022/23 was made up of Provider operational Capital, National Programme funding and funding for IFRS 16.

Assumed Sources of Funding for 2023/24

Guidance:
Please provide detailed of the overall funding envelopes to which the system will be working to.
Explain any assumptions (and related risks) associated with the assumed sources and quantum's of funding for the ICB and Partner Trusts
Draft table inserted which can be expanded upon.

The capital programme for 2023/24 will be funded from internally generated sources and approved national funding programmes for the Elective Hub, CDC, and frontline digitisation programmes.

Annex A (below) demonstrates that the ICB total operational Capital allocation is £155m (including national funding, IFRS 16 & technical accounting adjustments).

The total BSW capital plan for 2023/24 is £155m which is broken down as follows:

- Provider operational capital £43m - for improvements in Estate, maintenance, backlog, digital and replacement diagnostic equipment
- ICB operational capital £1.58m will be used on a combination of GPIT and primary care estate. These assets are held by NHS England, not the ICB.
- National Programme funded schemes £94m incl New Hospital programme
- IFRS 16 impact £13m - organisations have reviewed all leases to ensure an accurate level of IFRS16 resource is in the plan.
- Other Technical accounting £3m

Overview of Ongoing Scheme Progression

Guidance:
Please provide an overview of scheme progression. Probably should only be schemes above a certain level

There are several schemes that are ongoing across financial years, which are set out below, and all are funded from national funding routes.

Royal United Hospitals Bath Cancer centre – the RUH was successful in being included in an earlier wave of the New Hospital Programme redevelopment – New 7000 Sq Mtr Cancer Centre on RUH Coombe Park Hospital site that co-locates Cancer pathway into a single building (Diagnostics, Outpatients, Treatment, In-Patient, support services such as Macmillan Hub). Moves services into new accommodation from failing (high backlog) WW2 building stock.

Sulis Elective Orthopaedic Centre (SEOC) – Development of an elective orthopaedic surgical hub at Sulis Hospital as part of the BSW ICS and South West region's response to the national elective recovery programme. This will support additional surgical capacity for elective orthopaedics and addressing the backlog in patient waiting times.

GWH Integrated Front door - Way Forward Programme - Expand and reconfigure UEC front door, co-locate UEC services on ground floor, reduction in adult admissions as more treated on the day, 8 inpatient bed capacity growth on children's ward.
Community Diagnostic Centres (CDC) – provide earlier diagnostic tests closer to home for BSW population through easier, faster, and more direct access to the full range of diagnostic tests needed, a reduction in hospital visits and community diagnostic centres focus on tackling the backlog. BSW approach is it will be. Mobile unit providing a single endoscopy suite to fill in geographical gaps in provision.

Community Diagnostic Centres (CDC) – provide earlier diagnostic tests closer to home for BSW population through easier, faster, and more direct access to the full range of diagnostic tests needed, a reduction in hospital visits and community diagnostic centres focus on tackling the backlog. BSW approach is it will be delivered in a hub and spoke approach: A hub site to be located at Sulis Hospital with an additional endoscopy suite. Spoke site with two endoscopy suites at Savernake hospital addressing the localities and populations with the greatest need. A mobile unit providing a single endoscopy suite to fill in geographical gaps in provision.

Electronic Patient Record (EPR) – The frontline digitisation programme will commence in 2024/25 as part of the levelling up initiative across the NHS. Investment will ensure a baseline level of digital capability in all system organisations, ensuring health and care staff have access to health-related information when and where it is needed. Enabling BSW's new Model of Care by providing a single EPR across the three acute Trusts supporting new care designs such as virtual wards (cross-Trust clinical teams managing patients at home with real-time access to medications prescribing, test requesting and clinical data viewing) and enhanced clinics (an outpatient clinic could extend to 7-days a week). This will support improved clinical outcomes and efficiencies within and across the system (e.g., standardising order sets for hip replacements resulting in more equitable outcomes for patients whichever Trust they attend; enabling work to move across Trusts

LDA - (joint working BSW, BNSSG and Gloucester integrated Care systems) Building a facility to cover North side of the Southwest. Treating people closer to home whilst reducing our reliance on inpatient beds. To improve care and experiences for people within the Southwest region with a learning disability and those with autism (or both). Deliver innovative solutions and improvements to environment and service models that deliver a positive impact to service users.

Risks and Contingencies

Guidance:
Insert any notable risks and/or contingencies associated with the capital plan. Consider RAG rating risks also.

The system has reviewed risks relating to the capital programme and has summarised them as outlined below.

System Planning and National Funding - The system operational capital available is focused on delivering operational demands and is not sufficient to allow the progression of some of the key strategic developments that are considered priorities within BSW. We are reliant on securing funding through national funding sources and their related bidding processes which are generally over-committed and have challenging delivery timescales.

The ICB continues to work to support NHS provider trusts in BSW with their respective planning and profiling of nationally approved capital plans awaiting the next phase of national support or capital bids awaiting a national decision.

Pipeline Schemes - BSW as a system has identified pipeline of priority schemes that we do not yet have identified funding for:-

- Additional bed capacity
- Day Surgery Unit
- Relocate Maternity
- Spinal unit Refurbishment
- Critical Infrastructure

Inflation - The current level of inflation is having a significant impact on the ability to manage project expenditure to original plans, particularly across multi-year projects.

Delivery - As a system we are continuing to manage the consequences of the worldwide economic conditions which has dramatically affected the procurement lead times of some items of equipment and makes capital planning less certain.

IFRS16 - The planning assumption made is that these will be funded in 2023/24, but this is not yet confirmed and is noted in the risks below. We are progressing on the basis that any additional capital cost impact related to the mandated implementation of IFRS16 are funded by NHS England, although this has not yet been formally confirmed.

Cash - As described above, operational capital is funded through a combination of depreciation and cash.

Business Cases in 2023/24

Guidance:
Please insert detail of some of the key business cases in the ICB that are likely to be submitted in 2023/24.

As outlined in the overview - business cases in progress which we are working towards the Full Business Case (FBC) approval:-

- Sulis Orthopaedic Centre – business case in final stages
- Community Diagnostic Centre business cases is in final stage.
- Electronic Patient Records – FBC being prepared for submission in 2023.
- LDA hub – working with Devon ICS and SW collaborative on business case for submission.

The ICB will continue to submit plans to NHS England for approval of spend on primary care estate and GPIT.

Cross System Working

Guidance:
If applicable, can you detail how your system capital plan is coordinated with other systems or providers located in other systems.

Our aims and objectives as a Integrated Care system (ICS) are to work together across all partners to maximise available capital resources into BSW by having a coherent, strategic plan for capital investment.

BSW will develop a capital prioritisation and governance framework for all capital programmes to support system and local priorities.

BSW aims to work with partners to co-develop opportunities where greater coordination, alignment and/or integration of resources can lead to better outcomes or greater efficiency.

BSW is working with BNSSG, Gloucester & Devon ICS to develop the Learning Disability and Autism facility business case so that we can co create innovative solutions and service models that deliver a positive impact to service users.

Capital Planning & Prioritisation

Guidance:
Please detail how your system is prioritising available resources for investments which contribute to the wider local strategic priorities of the ICS, and maximise efficiencies within an affordable envelopes as well as how this aligns with and supports the ICS' wider infrastructure strategy - in particular, priorities and plans for future use and development of its estate and assets.

The system recognises the need to develop our Capital Strategy, aligning this to the BSW Integrated Care Strategy to develop a comprehensive Capital Infrastructure Plan which identifies the medium-term requirements for NHS Capital.

BSW has set up a Strategic Capital Planning group including wider members from partner NHS Trusts. As a collaborative we are working through developing a framework for Capital investment and priorities to support the integrated Care strategy for the system. Estates and digital are seen as key enablers to our Integrated Care Strategy.

Our aim is to develop a focused Capital strategy development framework including clear principles guiding how we will collectively respond to national requests for funding. BSW to develop a plan working towards net zero carbon sustainability standards across the ICS system.

As national programme funds become available, the ICB ensures full adherence to well established collaborative arrangements to identify and prioritise investment, the most current examples being the multi-year community diagnostic allocation, Great Western Hospital urgent and emergency reconfiguration and working collaboratively with Devon ICS on the LDA facility.

We will be embarking on a programme to develop an ICS Infrastructure Strategy which will shape our Capital investment plans and will ensure continued alignment of our strategic estates objectives to system clinical strategies and will consider further opportunities for achieving efficiencies and disposals.

We are continuing to work with system partners to review our public sector estate which can then be used effectively by other partners, to make the best use of public sector assets.

Annex A – NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) 2023/24 CAPITAL PLAN

BSW	CDEL	ICB	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	SALISBURY NHS FOUNDATION TRUST	Total Full Year Plan £'000	Narrative on the main categories of expenditure
Provider	Operational Capital	0	13,553	13,878	15,871	43,302	This includes additional schemes to compensate for slippage as per guidance
ICB	Operational Capital	1,585					ICB (GPIT & Minor Improvement Grant schemes)
	Total Op Cap	1,585	13,553	13,878	15,871	44,887	
Provider	Impact of IFRS 16			7,555	5000	12,555	IFRS 16 leases
ICB	Impact of IFRS 16	492				492	Office space leases
Provider	Upgrades & NHP Programmes		22,180	6,650		28,830	GWH Integrated Front Door and RUH Cancer centre
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, Elective recovery)		34,377	13,749	17,249	65,375	Community Diagnostic Centres,Frontline Digitisation and Elective Recovery schemes
Provider	Other (technical accounting)		2,269		509	2,778	Private Finance Initiative residual Lease
	Total system CDEL	2077	72,379	41,832	38,629	154,917	

Wiltshire Council

Health and Wellbeing Board

Subject: Update on the delegation of accountability for commissioning of further primary care services (pharmaceutical services, primary ophthalmic services, and dental services) from NHS England (NHSE) to Integrated Care Board (ICB) from April 2023.

Executive Summary

I. The White Paper "Integration and Innovation: working together to improve health and social care for all" in February 2021 set the direction for Integrated Care Systems to become responsible for a greater range of primary care services – namely to take on the responsibility for Pharmaceutical Services (including Dispensing Doctors and Dispensing Appliance Contractors), general Ophthalmic Services, and Dental (Primary, Secondary and Community); this was confirmed by the Health and Care Bill published in July 2021, which confers the duty on Integrated Care Boards to secure the provision of these services for their populations.

III. For BSW this covers:
147 Community Pharmacies (April 23)
86 total opticians including domiciliary (June 23)
117 Dental Contracts (June 23)

IV. The BSW ICB POD Delegated Allocation for 2023/24 is £88.619m. £51.304m of the Delegated POD allocation is ringfenced for Dental services and "NHS England reserves the right to direct any unused resources to be used on improving dental access or other NHS England priorities or, exceptionally, the unspent allocation is returned to NHS England".

V. In BSW, our ambition is to realise the benefits of further delegation on the way in which we can deliver care locally and to form stronger place-based partnerships. We have been working in partnership with NHS England during 2022 ahead of taking further responsibilities from 2023.

Proposal(s)

It is recommended that the Board:

i) Note the update.

Reason for Proposal

To update the Health and Wellbeing Board on the progress to date and the key priorities for each of the service areas.

Jo Cullen
Director of Primary Care
BSW ICB

Wiltshire Council

Health and Wellbeing Board

Subject: Update on the delegation of accountability for commissioning of further primary care services (pharmaceutical services, primary ophthalmic services, and dental services) from NHSE to ICB from April 2023.

Purpose of Report

1. To update the Health and Wellbeing Board on the delegation of accountability for commissioning of further primary care services (pharmaceutical services, primary ophthalmic services, and dental services) from NHSE to ICB from April 2023.

Relevance to the Health and Wellbeing Strategy

2. The opportunities provided by the delegation of these services to BSW are seen as:
    - The ability to be locally responsive to population health needs and commission services accordingly.
    - A tailored approach working with partners to respond to health inequalities and ensure a focus on preventative care.
    - Transformation and pathway integration – greater ability to integrate these services into local transformation and system working both within the place and system agendas and to incorporate these services more fully into a local primary care strategy.
    - The ability to develop closer relationships which can then support increased partnership working at all levels further integrating care delivery in Primary Care Networks
    - The opportunity to build a more integrated clinical and professional leadership model which reflects the wider primary care system.
    - The ability to involve the wider primary care services in developing approaches to quality improvement and supporting wider primary care resilience.

All contributing to:

- ✓ Joint Strategic Needs Assessment and Health & Wellbeing Strategies
- ✓ BSW Integrated Care Strategy's 3 prioritised strategic objectives:
    - Focus on prevention and early intervention.
    - Fairer health outcomes
    - Excellent health and care services
- ✓ Core20Plus5 for adults and children
- ✓ Fuller Stocktake – next steps for integrating primary care and development of integrated neighbourhood teams

Background

- Previously Clinical Commissioning Groups (CCG) held delegated responsibility from NHSE for commissioning primary medical services (GP Contracts), this commenced in 2017

- The ICB signed a Delegation Agreement on the 1st July 2022 to enable NHSE to delegate these functions to ICB under section 65Z5 of the NHS Act.

- The White Paper "Integration and Innovation: working together to improve health and social care for all" in February 2021 set the direction for ICBs to become responsible for a greater range of primary care services namely to take on the responsibility for Pharmaceutical Services (including Dispensing Doctors and Dispensing Appliance Contractors), general Ophthalmic Services, and Dental (Primary, Secondary and Community); this was confirmed by the Health and Care Bill published in July 2021, which confers the duty on ICB to secure the provision of these services for their populations.

- The ICB has been through a Pre-Delegation Assessment Framework (PDAF) which was approved by the NHS England Board in October 2022; and a Safe Delegation Checklist which provided a breakdown of key areas to be worked through by ICBs and NHSE to ensure readiness and assurance for delegation. Internal Audit has reviewed the processes and arrangements. Briefing papers have been taken to the ICB and its Committees for assurance and sign off during 2022/2023.

- Workstreams have been set up including quality, finance, contracts, governance and digital.

- Governance for delegation is underpinned via a Delegation Agreement, Memorandum of Understanding, Data Protection Information Agreements and Financial Standard Operating Procedures.

- For the South West, a Collaborative Commissioning Hub (CCH) has been established by NHSE to support continued delivery by current staff (POD commissioning, GP Transformation Team and Complaints), and will incorporate the functions involved in commissioning services for the seven South West ICBs.

- The programme has now moved into the Transition Phase with NHSE and South West ICBs; and a BSW Transition Steering Group have been established.

- From 1 July 2023, CCH will transfer to an ICB employer arrangement with Somerset ICB, until April 2024 with NHSE still responsible for activity.

- Process now to secure ICB to host full CCH on longer term basis from April 2024 (include all commissioning teams covering POD, specialised

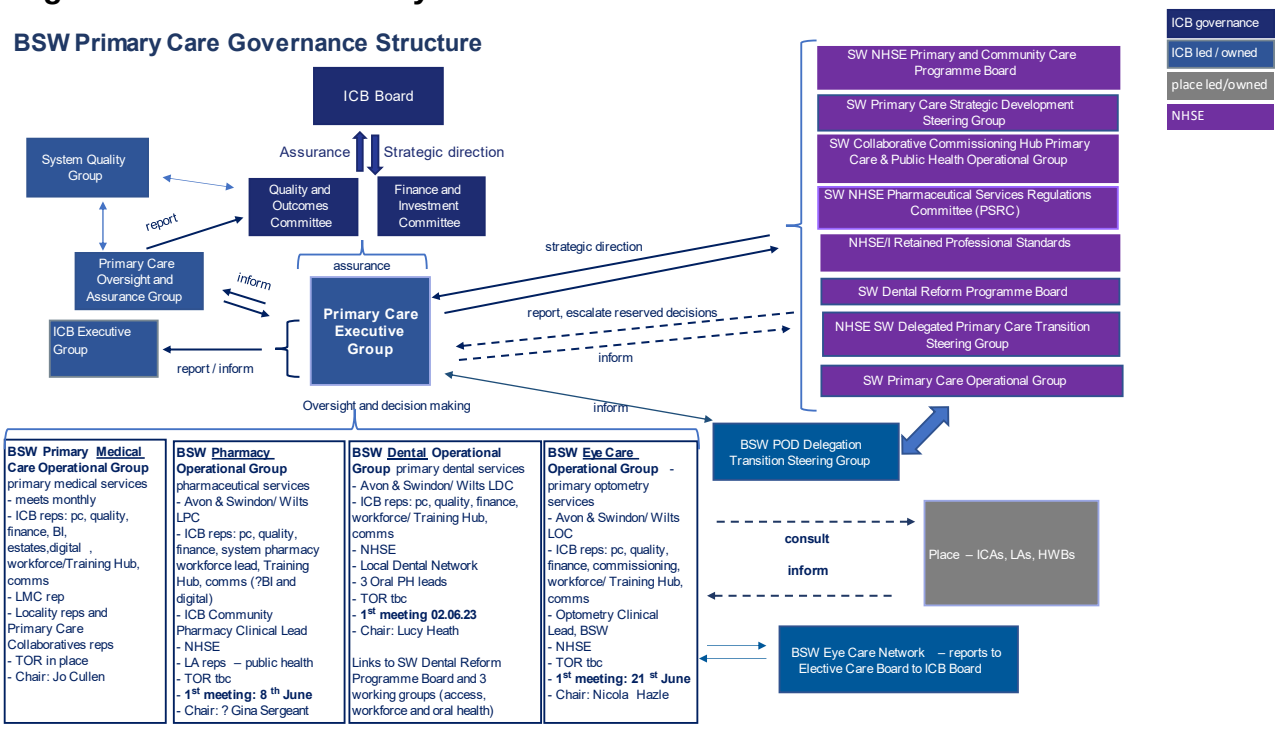
services, health and justice, and screening and immunisation, as well as commissioning quality and commissioning finance colleagues).

Main Considerations

4. **Progress to date:**

- Three Operational Groups have been established for pharmacy, dental and eye care services reporting to the BSW Primary Care Executive Group for oversight and decision making.
- The Eye care Operational Group will now link into the established BSW Eye Care Services Network meeting to support and understand the ongoing work that has been established in the group
- BSW representation at NHSE South West meetings and working groups has been established
- Governance structure across the BSW and NHSE system has been developed (diagram one)

Diagram One – BSW Primary Care Governance Structure



5. Current Priorities:

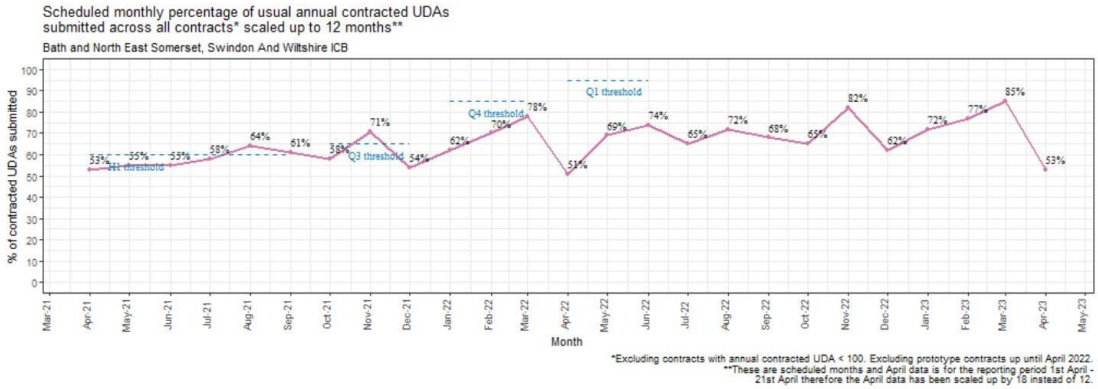
- **Current BSW priorities for Community Pharmacy are:**
  - To establish roles for Community Pharmacy PCN leads.
  - Increase use of the Community Pharmacy Consultation Service (taking referrals both from GPs and NHS 111) to support the system with minor illness and urgent care.
  - Increase use of the locally commissioned Patient Group Direction Service for minor illness (legal framework that allow a pharmacist to provide specified Prescription Only Medicines in certain circumstances) & review this service in the event of a national Common Conditions Service being commissioned.
  - Increase Discharge Medicines Service referrals from acute trusts to community pharmacy. For every 10 referrals, one readmission to hospital is prevented and there are significant patient safety benefits.
  - Implementation of new clinical services that support integration such as the hypertension case finding service and contraceptive service, which help tackle health inequalities.
  - BSW submitted expression of interest to be a Pathfinder Site for Independent Prescribing in Community Pharmacy.

- **Current BSW priorities for Eye Care Services include**:
  - BSW Eyecare Strategy has three strategic priorities:
    - Patient Communication/Information/Education
    - System Mapping
    - Optometry First (First Contact Practitioners (FCP) for community and secondary care settings)
  - Tackling health inequalities increasing access to ophthalmology services (deprived areas, homeless).

- **Current BSW priorities for Dental Services include**:
  - The National priorities for dental care are:
    - Increase access.
    - Reduce inequalities.
    - Improve oral health.
  - Core20Plus5 sets out oral health implications for all, and key clinical areas of health inequalities for children.
  - Oral Health in Care Homes (already a group led by NHSE Dental Public Health pulling together a framework to implement an oral health and dental care pathway for care home residents)
  - Children's Programme Board
  - Diabetes and CVD
  - Access to urgent dental care and stabilisation pilots (some specific local work underway in Wiltshire/Swindon for service users in refugee/asylum accommodation)
  - Making Every Contact Count (MECC)
  - Workforce – recruitment and retention

6. Overview of Performance:

Dental:
Scheduled data: The monthly percentage of usual annual contracted UDAs submitted and scaled up to 12 months for the South-West was 46%. The value for BSW was 52%.



- This graph shows the average monthly performance of the **106** GDS/PDS/PDS+ contracts scaled up by 12 months measured against the delivery thresholds (60% for Apr-Sep 21, 65% for Oct-Dec, 85% for Jan-Mar and 95% for Apr-Jun 22).

Pharmacy:
Advanced Community Pharmacy Consultation Service (CPCS) - in BSW, 142 out of 148 pharmacies (95.9%) participated in the Community Pharmacist Consultation Service; and the number of completed Minor Illness consultations April 2022 – March 2023 (referred to community pharmacies from GP Surgeries) completed 21,425 GPCPCS consultations in BSW. The ICB is working with Community Pharmacy Avon & Community Pharmacy Swindon & Wiltshire to continue to grow GP CPCS.

7. Next Steps
There is further work to develop and understand contractor performance and activity for the BSW system and its population.
Work continues with the POD commissioning hub team to ensure integration and inclusion into BSW system priorities and workstreams.

Report Author: Jo Cullen, Director of Primary Care BSW ICB

Wiltshire Council

Health and Wellbeing Board

20 July 2023

Subject: BSW Children and Young People's Programme

Executive Summary

I. Children and young people 0-25 represent a third of BaNES, Swindon and Wiltshire and of our country. We want to increase the BSW focus on children and young people, recognising this is prevention in action for the improved health and wellbeing of our future population.

II. Our BSW Vision as set out in the BSW Implementation Plan, Chapter 10, is that all children and young people will start well with the support and care needed to enable them to have a sense of belonging, be safe from harm, to enjoy healthy lifestyles, do well in learning and have skills to choose and live their best life, to age and die well.

III. The BSW Children and Young People's Board is focused on improving our defined local priorities for children, young people and their families in BaNES, Swindon and Wiltshire with appropriate attention on the national and regional priorities.

The BSW CYP Board provides a strong foundation to drive our ambition to focus BSW ICB on the needs of children and tackle inequalities. It is a collaboration between BaNES, Swindon and Wiltshire Local Authority partners with Directors of Children's Services, Education and Public Health alongside BSW ICB and NHSE colleagues.

Proposal(s)

It is recommended that the Board notes the role and function of the BSW CYP Programme Board as set out in Appendix 1.

Reason for Proposal

To update the Wiltshire Health and Wellbeing Board on the work of the BSW CYP Board

Sadie Hall
Associate Director BSW Children and Young People's Programme
BSW ICB

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Bath and North East Somerset,
Swindon and Wiltshire Partnership

Working together for your health and care

BSW Children and Young People Programme

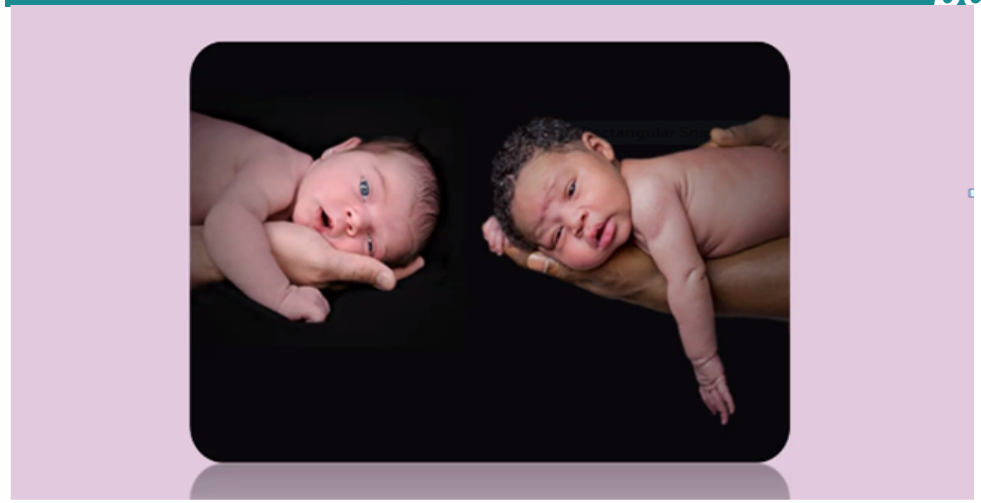
July 2023

Sadie Hall
Associate Director BSW Children and Young People's Progamme

The BSW Children and Young People's Programme Starting Well

Ambition: To nurture and value the health and wellbeing of all babies, children and young people, their families, and communities across BaNES, Swindon and Wiltshire to live happy, healthy lives, regardless of their circumstances, no matter where they were born, live and go to school, so we can close and prevent the inequality gap in their outcomes

Vision: All babies, children and young people will start well with the support and healthcare needed to enable them to have a sense of belonging, be safe from harm, to enjoy healthy lifestyles, do well in learning and have skills to choose and live their best life



Voice of the child and young person to be heard and at the heart of everything we do asking one question…

"What is it like being a child growing up in BSW and how do we make it better?"

BSW Children, Young People and Families Approach

What should we do?

Get it right for children Start Well
Holistic focus on CYP
Tackle **health inequalities**
Improve CYP population health & wellbeing
Prevention + early intervention

How should we work?

Children first
THINK Family
Co-production
Close to community
Multi-agency, Integrated working **Strengths Based**
Engagement
Trauma informed
Supported transitions
Maximum impact

Inputs Required

- Increased BSW **CYP capacity**
- BSW Children's **leadership, accountability**
- BSW CYP **Dashboard**
- **Partnership Governance** arrangements
- **Linking** with maternity, MH, LDA, SEND, Safeguarding
- **BSW Executive and Partner champion**

Activities

- Establish **holistic BSW Children and Young People Programme Board**
- Agree **structure and governance** working (system and place)
- **BSW local priorities** scoped and agreed
- **CYP in key BSW developments**
- Recognition that **CYP 0-25 are 30% of population**
- **BSW** at all key **SW + NHSE** meeting

Outcomes

- Children's **health and wellbeing is prioritised and improved**
- **Inequalities – data driven** and **needs led**
- BSW CYP **Strategic Plan + Integrated Outcomes Framework**
- BSW **supporting wider system**
- **NHSE Funding achieved and sustained**

How will we know if we have made a difference?

BSW working is **benefitting babies, children and families** in place and neighbourhood

Meaningful plan that provides **solutions at scale** – doing together that which **adds value** whilst **reducing unwarranted variation**

Children and Young People's Transformation Programme Workstreams

NHS England

Complications from Excess Weight (CEW) Clinics
By 2022/23 we will treat up to a further 1,000 children a year for severe complications related to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health.

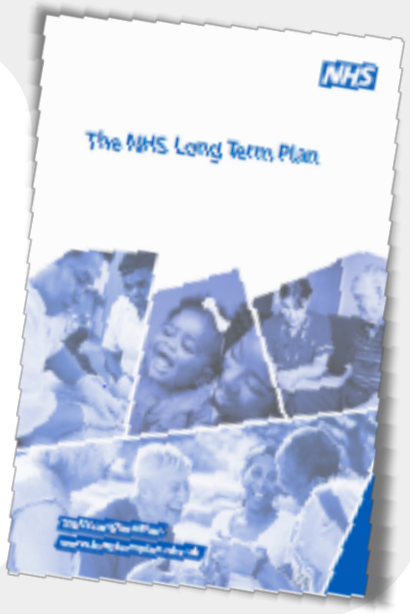
System-wide Paediatric Observations Tracking Programme (SPOT)
To create a platform that facilitates a standardised and interoperable method of tracking and detecting the deteriorating child. This system will adapt and expand the inpatient paediatric early warning score into ED, community, ambulance and primary care, creating aligned tools, training in communication and evaluation to deliver a cross-system approach to acute deterioration in paediatrics.

Urgent & Emergency Care
To reduce avoidable CYP A&E attendances, identify innovative, more integrated models of care and areas of positive practice, and test the feasibility of a national paediatric NHS111 Clinical Assessment Service (CAS) and evaluate its impact on patient pathways and wider local system.

Data & Digital
To ensure that high quality, timely data is available and used on a national and local level to provide a holistic overview of children and young people's health and care and to drive improvements in their outcomes and experience. To support digital solutions and appropriate local data sharing agreements as enablers of person-centred, multi-agency, integrated care.

NHS Long Term Plan – a strong start in life for children and young people

- Children and Young People (CYP) represent a third of our country. Their health and wellbeing will determine our future. Recent years have seen improvements in certain services which have been singled out for action, but there is a mixed picture overall.
- The NHS Long Term Plan (LTP) set out a vision for the future of the NHS including action to improve the health and wellbeing of children and young people.
- The Children and Young People Transformation Programme was established to oversee the delivery of LTP commitments in relation to children and young people.
- The COVID pandemic has also highlighted further areas of development which are also being taken forward by the CYP Transformation Programme.



Mental Health/Physical Health integration
We will work across NHSEI to ensure that the paediatric workforce is supported when caring for children and young people presenting to hospital with acute mental health needs such as eating disorders or crisis presentations; and understand where to get additional support.

Asthma
To prevent deaths, reduce the number admissions and improve the quality of life of CYP with asthma

Voice
To collaborate with and embed the voice of children, young people, and families across our programme of work.

Integration
Work with local health systems to co-develop what good looks like to integrate care both horizontally – across health care and education; and vertically – across secondary, primary and community care.

Keeping Children Well
We aim to work with leading health and care systems to understand how to improve outcomes for CYP by working across health, care and education where there is a shared ambition (i.e. vulnerability, speech language and communication needs)

Transition
By 2028, no child, young person or adolescent will be able to become lost in the gaps between children's and adults services, and that their experience of moving between services is well planned and prepared for and they feel supported and empowered to make decisions about their health and social care needs.

Long term conditions
To improve quality of care and outcomes for children with diabetes and epilepsy

New Statutory Role for Integrated Care Systems to Focus on Babies, Children and Young People – Published 9th May 2023

Executive Lead Roles within Integrated Care Boards

The commitment was given to Parliament, during consideration of the Health and Care Act 2022, that every integrated care board (ICB) would identify members of its board which would have explicit responsibility for the population groups and functions set out in this guidance[1]:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (all-age), including looked after children
- Learning disability and autism (all-age).
- Down syndrome (all-age).

Please note that when referring to 'children and young people' throughout this document, this covers ages 0 to 25 and refers to babies, children and young people.

Children and Young People

The ICB executive lead for Children and Young People will lead on supporting the chief executive and the board to ensure the ICB performs functions effectively and in the interests of children and young people, including but not limited to:

- championing and working in co-production with children, young people and families
- ensuring the ICB articulate in their joint forward plan, how they will meet the needs of children and young people, with a focus on improving their physical and mental health outcomes and reducing inequalities[2] which is a legal duty
- maintaining an overview of the quality of services for children and young people, and the impact these services have on outcomes for children and young people and their families/carers
- ensuring appropriate resources are allocated to children and young people for the provision of services, including the transition to adulthood and joint funding with key partners, e.g., social care, education, police, and Youth Offending Services
- leading the relationship with key partners across public health, social care, justice and education while working through the governance structures of the ICS (e.g., the ICP, place-based partnerships, provider collaboratives, and VCSE organisations) as regards children and young people. Key partners will include directors of children's services, lead members of children's services and directors of public health

National Context

The NHS Long Term Plan set out the vision for an NHS focused on improved outcomes for children and young people. Each ICB is receiving funding from the Children and Young People's Transformation Programme to deliver the commitments in the NHS Long Term Plan. The executive lead should have a line of sight of delivery of all children and young people commitments led by the ICB, such as mental health, safeguarding, learning disability and autism, health and justice, SEND, and improving outcomes for babies (for example, through implementing the recommendations of the neonatal critical care review or work of the Local Maternity and Neonatal System [LMNS]). They should also contribute to the leadership of wider system work to help keep children healthy and well, for example, through the Healthy Child Programme.

As outlined in the National Health Service Act 2006 (as amended by the Health and Care Act 2022), each ICB has a legal duty to involve the public in planning, proposals, and decisions regarding NHS services. Executive leads should ensure the ICB works in co-production with children and young people and their parents, carers, families and representatives to understand issues which affect children and young people. NHS England statutory guidance outlines ICBs' legal duties for public involvement in more detail, and provides general support on how to meet them.

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1. **ASTHMA**
Address over reliance on reliever medications and decrease the number of asthma attacks

2. **DIABETES**
Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

3. **EPILEPSY**
Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

4. **ORAL HEALTH**
Address the dental backlog by increasing the number of tooth extractions, in hospital, for children aged 10 years and under

5. **MENTAL HEALTH**
Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

CYP Programme Board – 2023 NHSE funding…

Early Years

- We will deliver a Connecting Care for Children approach that brings together a multi-disciplinary team across primary, secondary and community services, enabling CYP to be treated and receive advice and guidance in their community
- We will adopt a phased rollout, launching initially at an already identified GP Practice in Swindon which has the (estimated) highest number of 0-15 aged Core20 patients. BaNES & Wiltshire will follow in quick succession.
- **Timeline**
  - 2023/24 Q1-2 – agree and develop co-created outcome metrics
  - 2023/24 Q2-3-scope GPs/PCNs/ develop model for 0-5 caseload, identify or recruit community connectors (care coordinators – paid/volunteers) the initial impacts in developing shared priorities and an integrated approach
  - 2023/24 Q4– benefits from redesigned services and influencing redesign of community based integrated care. Contribute BSW findings to toolkit + business case structure.

Epilepsy

- We will recruit an Epilepsy Specialist Nurse (ESN) for two years as part of an NHSE pilot to work across a system footprint in providing care for CYP with epilepsy
- This will improve the quality of care for CYP with epilepsy by taking an integrated approach to the diagnosis, management and treatment of epilepsy
- ESN(s) will be involved in care planning as well as supporting continuity of care for CYP with LD&A as a result of joint-working with community paediatric and neurodevelopmental services
- **Timeline:**
  - 2023/24 Q1-2 – agree and develop plan with RUH
  - 2023/24 Q2-3- advertise and recruit to ESN post
  - 2023/24 Q4– review progress and plan for 2024/25
  - 2025 – support evaluation (commissioned by NHSE) and share learnings across BSW and beyond Acute

Mental Health Champions

- We will support implementation of Mental Health Champion roles for CYP within emergency departments in each acute hospital in BSW
- Key functions of the role have been co-developed with Royal College of Paediatric and Child Health (RCPCH) colleagues and include to:
  1. Facilitate joint working across Mental & Physical Health
  2. Encourage uptake of training
  3. Build team confidence & morale
  4. Provide leadership and link into Trust, ICB and regional network governance structures
- **Timeline**:
  - 2023/24 Q1-2 – Funding made available to ICBs to transfer to acutes. Regions and systems to support recruitment/mobilisation of MH Champions
  - 2023/24 Q2 – Reporting for MH Champion role
  - 2023/24 Q2-4- Support evaluation and development of framework for role progression. Share and spread learning.

Paediatric Palliative Care

- We will develop a robust BSW Paediatric Palliative Care Workstream with partners including hospices
- We will support transition pathways and services and align adult and paediatric palliative workstreams, to develop a BSW whole systems approach for Paediatric Palliative Care.
- Timeline:
  - 2023/24 Q1-2 – agree and develop plan with partners
  - 2023/24 Q2-3- establish working group
  - 2023/24 Q4– review progress and plan for 2024/25
  - 2025 – support evaluation (commissioned by NHSE) and share learnings across BSW and beyond

Youth Workers

- We will recruit a network of Youth Worker support for CYP across our acute hospitals as part of an NHSE pilot
- These roles will deliver a person centred and trauma informed intervention for CYP, aged 11-25, accessing our Children's Wards, Emergency Department and adult wards, focusing on mental health needs and children struggling with the impact of long term conditions including diabetes and epilepsy.
- **Timeline**:
  - 2023/24 Q1-2 – Funding made available to ICBs. Allocation to VCSE based on procurement guidance. Link to MH Champions
  - 2023/24 Q2-4 - Support evaluation and development of framework for role progression. Share and spread learning

CYP Programme Board – what we are doing now…

Starting Well

- New workstream to bring together planning for Early Years
- Early Years Pilot to enable future development of services
- Focus on inequalities and improving outcomes through CYPCORE20PLUS5.
- Link Maternity, Best Start, Starting Well and Healthy Child Programme
- BSW Health and Wellbeing Boards
- Oral Health

Healthy Weight, Nutrition & Food Resilience

- Enabling joined up BSW approach to supporting healthy weight.
- Prevention and supporting children and families living with obesity and excessive weight
- BSW expansion of specialist Children With Excessive Weight Clinics – linking SW regional CEW Hub
- Focus on inequalities and improving outcomes through CYPCORE20PLUS5.
- Link to adult healthy weight approach and diabetes prevention
- Link to food poverty and cost of living crisis
- Whole systems approach and place based working
- BSW Health and Wellbeing Boards

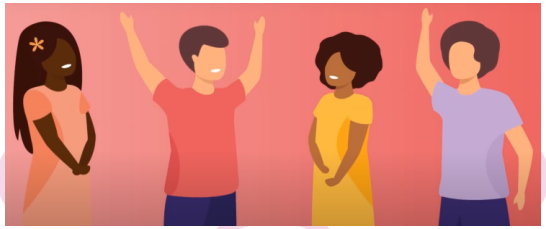
CYP Long Term Conditions

- BSW Asthma bundle delivery including asthma friendly schools, Diabetes, Epilepsy, Bowel and bladder
- Epilepsy Specialist Nurse (ESN) Pilot
- NHSE Youth Worker Pilot
- Transitions
- Link SEND, LD and A and elective care waiting lists
- BSW Health and Wellbeing Boards
- Acute Hospital Alliance, RCPCH and BSW Paediatrician network

Paediatric Palliative Care

- New Programme co-producing pathway and offer with Hospices, VCSE organisations, parents, carers, children and young people and clinical colleagues
- National Programme matched funding
- SW regional approach and link to Bristol SW pilot
- Working with End of Life Alliance Board
- Transitions
- Link Complex Needs, SEND, LD and A

New workstreams 2023-24



CYP Programme Board – what we are doing now…

BSW Complex Needs & SEND

- Working through existing programmes to coordinate approach for babies, children and young people and parents and carers across BSW:
  - Learning Disability and Autism (LD and A) Board.
  - BaNES, Swindon and Wiltshire Strategic SEND Boards
- Focus on inequalities and improving outcomes through identifying CYP as a BSW plus category in BSW CYPCORE20PLUS5
- Collaborative BSW leadership, ensuring adherence to statutory duties, supporting and enabling place based work for new joint inspection framework and referencing each SEND strategy or SEF.
- Developing relationships with Complex Needs & SEND practitioners and leads across BSW as a platform for collaboration for example developing a BSW CYP Neurodisability pathway

Addressing Inequalities

- Working through existing programmes to coordinate approach for babies, children and young people and parents and carers across BSW:
  - BSW Population Health Board
  - BSW Inequalities Strategy Group,
  - BSW Prevention
- BSWCYPCORE20PLUS5-reducing inequalities for CYP – Most deprived 20% of the population, local population priority groups and 5 clinical areas of health inequalities
- BSW Health and Wellbeing Boards
- BSW CYP Dashboard
- Link to SW Marmot Region
- National NHSE Inequalities programme and Barnardo's Health Equity Foundation

BSW Children Looked After and Care Experienced Young People

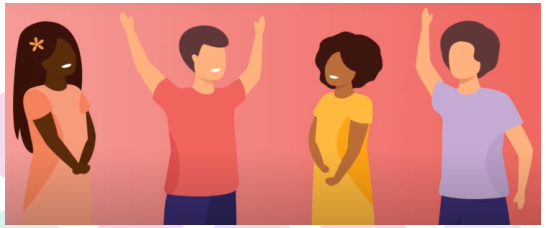
- Support BSW Children Looked After Strategy Group
- Support how we work as an ICS to improve outcomes for CLA and care experienced young people
- Focus BSW ICS on NHS Care Leavers Pledge, protected characteristic and role of corporate parent.
- Link to ADCS/ DfE Southwest Regional Offer Graduating from Care southwest project.
- Focus on inequalities and improving outcomes through identifying CYP as a BSW plus category in BSW CYPCORE20PLUS5

BSW CYP Mental Health

- Support and increase BSW focus on CYP mental health and emotional wellbeing
- Strengthen and build on partnerships, working through existing programmes to coordinate approach for babies, children and young people and parents and carers across BSW:
  - THRIVE Board
  - BSW CYP MH Oversight Group

Focus on inequalities and improving outcomes through BSW CYPCORE20PLUS5

- Acute Hospital Alliance, RCPCH and BSW Paediatrician network – - supporting links between MH and physical health including long term conditions
- NHSE Youth Worker Pilot and Paediatric Mental Health Leads



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Wiltshire Council

Health and Wellbeing Board

20th July 2023

Subject: BCF Planning

Executive Summary

I. The BCF planning documents (appendices A and B) were submitted to the national team on 28th June 2023.
2. Delegated authority for sign-off prior to submission was agreed at the HWB meeting on 25th May 2023.
3. This is a formal presentation of the documents to the Board.
4. A review of BCF schemes will take place and the Commissioning Manager would welcome feedback from the Board about'

- What information they would like to receive about the BCF (in excess of the statutory reporting), and
- Any thoughts they have on how we could best present the information to them. Some examples might include a focus on 'themes' such as hospital discharge or prevention schemes or more detailed information on the work programmes, such as demand and capacity or falls prevention.

Proposal(s)

It is recommended that the Board:

i) Notes the final BCF planning submissions.

Reason for Proposal

It is a condition of funding that the BCF plans are agreed and signed off by Wiltshire HWB.

Helen Mullinger
Better Care Fund Commissioning Manager
Wiltshire Council

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HM Government

NHS England

Wiltshire Council

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

Wiltshire Health and Wellbeing Board Better Care Fund Narrative Plan

Contents

1. Cover

This plan was overseen by the Wiltshire Alliance Partnership Committee, which includes representation from a wide range of bodies including Wiltshire Council, BSW ICB, acute hospital trusts, community health and care providers, Healthwatch and the VCS. A full list of membership (consultees) is available in Appendix A.

This plan builds on the priorities previously developed with and agreed by the Wiltshire Health and Wellbeing Board, outlines the challenges and progress made in 2022-23 and identifies the plan for 2023-24 and 2024-25.

BCF is a high-profile vehicle for change in Wiltshire and the extensive programme of service reviews, tenders and operational feedback, alongside system wide ICB led development programmes are regularly reported to a wide range of stakeholders. Stakeholder's views are gathered year-round through formal and informal means. Table 1 gives an example of this involvement.

Table 1: BCF Plan Consultees

Consultee	Detail
Wiltshire Alliance Partnership Committee	Replaced Locality Commissioning Groups in July 2022. Enables the involvement of a range of stakeholders (Appendix A) to shape priorities for BCF funding and oversees submissions to the Health and Wellbeing Board (HWB).
Health and Wellbeing Board	Reviews and approves BCF spending and plans, creates links with Joint Local Health and Wellbeing Strategy and Joint Strategic Needs Assessment which both inform Wiltshire BCF priorities.
Operational Services	Operational staff across health and social care are involved and consulted on BCF funded services performance and development. 2022-23 examples include therapy and social care involvement in the PW2 pilot (Appendix C), OT's and reablement staff in service improvement work on community equipment, Support workers in Mental health services and falls prevention etc
Healthwatch and Wiltshire Centre for Independent Living	Commissioned to mobilise engagement of Wiltshire residents. 22-23 – engaged users of discharge pathways for feedback, 23-24 – Use of TEC, discharge communications, understanding carers voices, co-production of ASC strategy etc
VCSE	Representatives attend the ICA and HWB, acting as a focal point for wider engagement across the voluntary sector. We also commission some BCF services through Voluntary sector organisations, such as the Home from Hospital service delivered through by Age UK who carry out service-user feedback as part of the contract monitoring.
Housing	Housing sits within the portfolio of the Director for Living and Ageing Well. The Director sits on the ICA and HWB and oversees the DFG expenditure. The Director works closely with the BCF commissioning team across the BCF workplan.

2. Governance

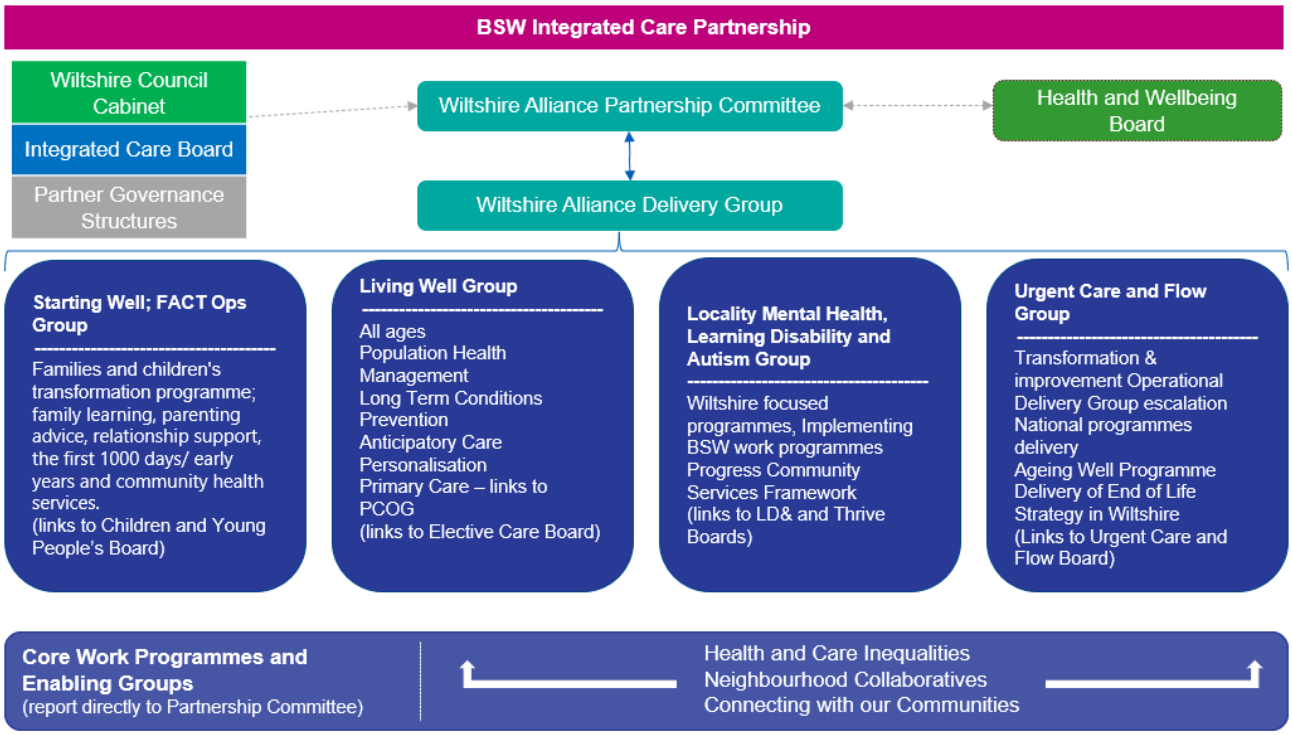
The strategic direction of travel is governed through several groups sitting under the BSW Integrated Care Partnership (see figure 1).

The findings of the Joint Strategic Needs Assessment (JSNA) 2022 directly informed the development of a co-authored Joint Local Health and Wellbeing Strategy (JLHWS). The JLHWS sets out 4 guiding priority themes for our work and these, together with the ICS Strategy and Wiltshire Council's social care strategies, priority objectives have set a clear pathway towards improving outcomes for and with our population, drawing on the combined resources and skills of Alliance partners.

At the highest level, the Joint Local Health and Wellbeing, Integrated Care System and Local Authority Strategies align with each other in scope and priorities, the clusters represent linked and related priority areas of work. Localisation and connecting with our communities are seen as integral to our way of working across all themes and objectives and aligns with the ICS Vision of "Listening and Working Effectively together to improve health and wellbeing and reduce inequalities". Public Health intelligence also influences BCF priorities.

Though each place is developing their own Better Care Fund Narrative Plan to address needs set out in their joint strategic needs assessment, Bath, Swindon and Wiltshire have formed a strong, collaborative partnership and work closely together, drawing on the arrangements that are possible within the BSW Integrated Care Board.

Figure 1: Alliance Partnership Committee and Delivery Sub-Group Structure



Clear metrics and targets are being set to monitor progress which provides oversight and assurance that we are delivering the benefits and managing spend as set out in the plan. Shared risks, information sharing protocols and robust governance arrangements are in place to support whole system ownership for the delivery of the BCF.

3. Executive summary

The ambition of this plan is to consolidate the strong relationships and governance formed during the last 2 years, and to use the BCF as an integration enabler to maximise the opportunities for people to remain independently well at home, and, in the event of hospital admission, return home for recuperation and rehabilitation as soon as possible.

There are some key changes in this year's plan, including the introduction of further schemes funded under the Adult Social Care Discharge Grant and a greater focus on understanding our demand and capacity requirements across our local services.

We have also reviewed progress since last year's BCF plan. Key challenges for us to note were our higher-than-expected avoidable admissions to hospital and higher than expected admissions to care homes. This tells us that we have more to do to deliver alternative pathways to hospital and to provide a credible alternative to residential and nursing care through our pathway 2 offer, keeping people at home for longer. Our plan explains more about how we will achieve this.

Table 2: Wiltshire Priorities

	National conditions	Wiltshire 23/24 Priorities
1	A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board	Consolidate the relationships and integrated working established during the pandemic and now secure recurrent service changes made at pace to deliver the joint strategic aims

	National conditions	Wiltshire 23/24 Priorities
2	NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution	Continue to develop integrated services and maintain investment in supporting adult social care. There has been significant investment in the Wiltshire Support at Home Service with in-house domiciliary care capacity to prevent hospital admission and aid hospital discharge in complex cases. This came from a recognition of our challenges in domiciliary care capacity and the market position.
3	Invest in NHS commissioned out-of-hospital services	Continue with added impetus to develop the anticipatory care and urgent response community-based services. Deliver improvement as required against the High Impact Change model for transfers of care. Falls prevention is an area for review and improvement Deliver joint plans and funding for End-of-Life care and prevention of hospital admissions Commission a new carer support service Develop and implement housing and technological strategies for independent living. Secure recurrent investment in community-based care services, recognising the significant investment already made.
4	Implementing the BCF policy objectives	Enable people to stay well, safe and independent at home for longer Provide the right care in the right place at the right time As part of this national condition, commissioners will agree how services delivered via BCF funding sources will support these objectives. This includes continued implementation of the High Impact Change Model for Transfers of Care, which is integral to meeting BCF requirements around supporting discharge. Wiltshire will agree and submit a plan showing expected demand for intermediate care services in the second half of the financial year and expected capacity across the ICA area to meet this. These capacity and demand plans will need to be submitted at the same time as main BCF plans. BSW is conducting demand and capacity work for community services, with support from WSP. Outcomes from this work will be closely reviewed as part of checking BCF investments are supporting the systems discharge pathways at the right level Planning will continue to understand and address Health inequalities as defined in the Equality Act and for the NHS Core20Pluss Development of Health Equity audits and use of HEAT to assess Better Care Plan Services Development of Wiltshire Alliance Neighbourhood collaboratives

A review of our original HICM self-assessment was carried out, focusing on those areas self-identified as 'to note' or 'opportunities'.

Table 3: Updates to 2022 HICM self-assessment

Change	Issues noted	Progress
1. Population health management approach to identifying those most at risk	Single shared truth, driven by 'live' data not yet possible across many services	HomeFirst dashboard now established and a good example of joint activity and performance data collection. JSNA good example of population, it's health and challenges to service delivery. **2023-24 Plan:** Developing a system-wide dashboard to inform service delivery across Wiltshire.

		Build on the BI 'Population Insight Tool' developed to inform the Falls work into other health areas for more targeted interventions.
	Little evidence of risk modelling at the system level	Still progress needed but signs of developing a shared risk approach shown in the PW2 re-model which used locality-based stratification tools. **2023-24 Plan:** PW1 modelling has been started with plans for PW3 in 2023-25.
2. Target and tailor interventions and support for those most at risk	System is reactive and focused on hospital discharge pathways rather than a more holistic and planned approach to meeting needs	Work in 2022-23 and into 2023-24 has focused on maintaining independence (PW2, community equipment, an independent living centre review. **2023-24 Plan:** There will continue to be a focus on embedding the Rapid Response, 24hr nursing and Intensive Enablement Services as well as implementing Virtual Wards.
	No clear baseline to assess against	HF and PW2 baselines identified and monitored against. Demand and capacity work prioritised and KPIs under development. **2023-24 Plan:** To use the developed system-wide dashboard to inform service delivery across Wiltshire.
	Lack of 24hr community nursing	This service is now operational. **2023-24 Plan**: Monitor service delivery to assess it's impact on hospital avoidance.
	Opportunity to explore use of technology in supporting public health	TEC commissioning team fully recruited to in 2022-23 and strategy under development which will shape work plan for 2023-25. **2023-24 Plan:** Influence Tec applications to support targeted intervention on identified groups
3. Practise effective multi-disciplinary working	MDTs often formed informally without structured TORs	Formal MDT's now fully embedded and 'business as usual' across the system. Daily MDTs for every pathway are now established. **2023-24 Plan:** Continue to monitor the effectiveness of the MDTs.
	Insufficient evidence on; family and carer involvement in assessments;	Dedicated resource has resulted in a revised Carers Strategy and improvement in the collection of data to ensure evidence-based decision-making. Hospital Carer teams provide dedicated support in acute settings, ensuring more carer involvement in discharge decisions. **2023-24 Plan:** Continue to monitor the effectiveness of the service.
	Training and skills mix	Skills for care training modules **2023-24 Plan:** Continue to monitor the number/type of training and its impact on services.
	Understanding impact of inequalities	JSNA, Public Health and the Core20PLUS5 provides a clear picture of health inequalities and impacts across Wiltshire. **2023-24 Plan:** Clearly link service developments to specifically support groups most affected.
4. Educate and empower people to manage their own health and wellbeing	Strategy to develop TEC not yet complete	TEC commissioning team fully recruited to in 2022-23 and strategy under development which will shape work plan for 2023-25. **2023-24 Plan:** Influence Tec applications to support targeted intervention on identified groups and how better use of TEC across services can support people's independence.
5. Provide a coordinated and rapid response to	There are some gaps in the current level of services including 24/7 support, community nursing cover and emergency weekend cover	**2023-24 Plan:** will continue to be a focus on embedding the Rapid Response, 24hr nursing and weekend emergency cover.

crises in the community	Recruitment and retention issues in ensuring appropriate levels of service	2022-23 say ongoing recruitment issues across services. The ASCDF investment showed significant benefits for both recruitment and retention figures (as high as 4 times higher than same time in previous year). **2023-24 Plan:** To review what we can apply from this learning in 2023-25 to continue the benefits to service provision. .
	Issues in allocating dom care packages to patients ready to be discharged from services. A reflection of a lack of available provision in the market.	A re-tender in 2022-23 has resulted in capacity now meeting demand. Overnight nursing, 24/7 Rapid response and county-wide weekend brokerage services are also embedded. **2023-24 Plan:** Embed the new Dom care flexible framework in Wiltshire and monitor impact on hospital discharges in particular.

4. National Condition 1: Overall BCF plan and approach to integration

Partners across the health and care system share a common aim to keep people independent and healthier for longer, keeping people in their own homes where possible. Where people do need additional help, we will ensure it is person centred, strength based and offers choice and control. Our BCF Plan submission priorities for 2023/2025 are an added layer of detail to our ICA Delivery Plan. Our core ICA principles for working together are:

Table 4: Wiltshire Alliance Collaboration Principles

The Wiltshire Alliance Principles	
1.	Work as one: partners collaborate sharing expertise, data and resources in the interest of our population.
2.	Be led by our communities: decisions are taken closer to, and informed by, local communities.
3.	Improve health and wellbeing: we take an all-age population health approach to improve physical and mental health outcomes and promote wellbeing.
4.	Reduce inequalities: we focus on prevention and enhancing access to services for population groups who are in poorer health or challenging social circumstances.
5.	Join up our services: we develop integrated and personalised service models around the needs of individuals.
6.	Enable our volunteers and staff to thrive; we support ongoing learning and development, and work collectively to ensure well-being is prioritised.

In Wiltshire, a jointly funded BCF commissioning team works together across services on demand and capacity modelling and actively seeking models of care than bring operational services together in a patient-focused way. The Neighbourhood Collaboratives (Appendix D) are an example of an approach to understanding where we are and where we want to go – and how we might get there.

The planning template details the specific schemes and actions the partnership has identified to deliver our priorities and provides confirmation of the agreed funding contributions. The schemes align with the BSW Operational Plan submission and the UEC Recovery Plan. Each of these plans has common themes around understanding demand and capacity, creating flow and keeping the person at the centre of decision-making. Often services such as Virtual Wards will meet objectives across several plans.

Table 5: Summary of BCF Schemes

Scheme	National Condition 2	National Condition 3
Assistive Technologies and Equipment – Telecare and community based equipment	☐	

Carers Services – Respite, and Carers advice and support	☒	
Community Based Schemes – Community Health Services Contract		☒
DFG related schemes – Adaptations (including statutory DFG grants)	☒	
High Impact Change Model for Managing Transfer of Care – Hospital based Social Work teams	☒	☒
Home Care or Domiciliary Care – Domiciliary care packages, and care packages to support HomeFirst discharges		☒
Integrated Care Planning and Navigation – Assessment teams/joint assessment	☒	
Bed Based Intermediate Care services – with reablement /therapy to support discharge	☒	☒
Home Based Intermediate Care services – with reablement to support discharge	☒	
Urgent Community Response	☒	
Residential Placements – Extra Care, Care Home, Nursing Home and Short term residential care (without reablement or rehabilitation)		☒
Trusted Assessor Service		
Rapid Response Service	☒	☒
Voluntary Sector Contracts	☒	☒
Prevention/early Intervention – Social Prescribing	☒	
Intensive Enablement Service (Mental Health/LD/Autism)	☒	☒
Care Act Implementation		☒
Overnight Nursing		☒
Mental Health Liaison		☒
End-of-life 72 hr pathway discharge service		☒
Community Services – Integrated neighbourhood services	☒	☒

Wiltshire Council and the ICB work closely together. A jointly funded BCF commissioning team oversees the Lead Commissioning, brokerage, and contract management of services on behalf of the ICB and work with the ICB throughout the commissioning process. Third sector commissioning within the Section 75 is also managed under a pooled budget by Wiltshire Council on behalf of both partners, with reporting and oversight provided by the Locality Commissioning Group. Wiltshire Council and the ICB will continue to explore options for further joint commissioning across the period of this plan.

The governance structure ensures support across the system for multi-disciplinary working which is core across services. One example of this is the HomeFirst review (appendix E), where the optimal model is being developed with a central notion of multi-skilled staff reducing handovers and making the service more efficient. It also ties in closely with wider system work on changes to the domiciliary care framework, which ensures capacity to support individuals both during and after receiving the service.

Interventions for health inequality populations are determined locally through a variety of means. One example is the Neighbourhood Collaboratives (appendix D) that is working with system partners and residents (already identified as a health inequalities group) to agree the type of support that is appropriate. Marginalised groups as identified by the Wiltshire Core20Plus 5, such as gypsy, Roma and boating communities will be engaged with in a similar manner, utilising experienced community engagers such as the Wiltshire Independent Living Centre.

Further analysis of individual scheme Equality Impact assessments give important insights which need incorporating into commissioning specifications and the development of new metrics. We intend to assess ourselves against the Health Equity Assessment Tool (HEAT) In 2023-24.

Table 6 sets out protected characteristics where there is inequity from our current service EIA and actions to address:

Table 6: Protected characteristics

Protected characteristic	Inequity	Addressing the inequity

Age	Barriers for access to services based on rural location and lack of transport. Also, digital inequity Barriers are fear of statutory assessment, lack of access to information about next steps in hospital discharge pathway, separation from family during rehabilitation	Improving transport is a priority are for Wiltshire. Action is being taken for individuals and also service providers which will make services more available to those living in remote locations – eg paying travel costs for domiciliary carers. The new PW2 model, by reducing length of stay and exploring communication with Healthwatch to assess needs. ICA communication work group
Ethnicity	Disproportionate levels of homelessness, less likely to ask for support as carers. Access to information	Refreshed Carer's strategy and recommissioning of services to include KPI's to address inequity. Neighbourhood collaborative to review issues and address priority local issues. Review all communication across all BCF pathways
Disability	From our Brokerage analysis, people with greater disability are more likely to have delays in leaving hospital and accessing care at home	Escalation processes and MDT approach to develop individual solutions
Religion or belief	People with faiths who require designated areas for worship are not accommodated in some parts of the discharge bedded pathway	PW2 recommissioning addresses this in the specification
Sexual orientation	LGBTQIA+ impacts are: • Limited transport to other areas of Wiltshire and England to attend events with likeminded individuals. • Stigma within health services • Lack of support in schools	Raise profile of issue within all services, address through specification, priority transport already identified for Wiltshire. Education and Training in H&SC workforce Training to GP surgeries and hospitals about the LGBTQIA+ community will ensure to abolish the stigmas and change the culture around languages and treatment to people in the LGBTQIA+ community. Counselling services in schools, colleges, and universities to include dedicated services for the LGBTQIA+ community Working with services in Wiltshire to hold more LGBTQIA+ events in local areas Working with carer contract holder to create dedicated carers cafes for carers in the LGBTQIA+ community Working with carer contract holder to dedicate educational sessions to parents of children in the LGBTQIA+ community
Carers	Key barrier to working age unpaid carers accessing suitable employment was insufficient social care services	Include workplace support services including support with recruitment. Targeted approach to minority groups and areas to offer respite and SC support

The plan has yet to be developed to describe how the BCF provides for inclusion health populations? As noted in the draft plan (page 17), HWB partners expect to develop the plan to gain visibility of those accessing BCF-funded services by deprivation quintile to understand equity of access, with ambitions to also demonstrate how services are

being targeted at the most deprived groups/areas across the county? In baselining equity of access, it would be helpful to include drilldowns by protected characteristics as defined in the Equality Act 2010.

Rather than simply looking for new schemes to initiate, this plan seeks to identify and challenge, from an evidence base, those local schemes and delivery outcomes that can be expanded or amended to deliver better outcomes and value for money, and to ensure that the wider footprint of the BSW Partnership is aligned to create appropriate economies of scale.

It is important that the BCF schemes follow the agreed Wiltshire Alliance Principles and maximise the opportunities that integrated working brings. Accordingly, three of our major delivery vehicles in 2023/24 have been jointly designed and commissioned and delivered through the Wiltshire Alliance partners (table 7).

Table 7: Wiltshire BCF Major Delivery Vehicles 2023-24

2 hr Crisis Response Service	Wiltshire Health and Care (WHC) community teams have integrated with Wiltshire Council and Medvivo to provide the core service model for 2 hr crisis response services. Enables a response to all two-hour community crises with a full multidisciplinary approach WHC community teams will also be an important service to provide ongoing planned health care after the crisis has been attended to Adult social care responding to carer breakdown are integral to supporting people to stay at home or in their usual place of residence and preventing hospital admission Medvivo are integral in the provision of a Single Point of Access and providing Urgent Care at Home services. Recognising a service gap - further investment in a Wiltshire adult community overnight nursing service supports the Rapid Response service to avoid admissions. Now an established 7-day a week service
PW2 'Hub' Model	Using evidence-based analysis of patient outcomes and an integrated approach to piloting and commissioning a service Wiltshire has a new 'hub' model for pathway 2 that provides targeted rehabilitation for patients discharged from hospital with the aim of retaining independence at home (see Appendix A. Case Study 1).
HomeFirst Services	Although operated by two different providers, Wiltshire Health and Care and Wiltshire Council, the service shares a joint pathway, joint MDTs and has a monthly shared dashboard to monitor overall performance and effectiveness. A service review is underway in 23/24 to reduce length of stay and improve access for PW1 (see appendix E. Case Study 3)

Reducing inequalities (see also health inequalities section): Wiltshire partners have established a Wiltshire Health Inequalities Group (WHIG) to coordinate Population Health Inequalities improvement across the NHS Core20PLUS5, BSW Reducing Inequalities Strategy and Salisbury Hospital 'Improving Together' work programme. Gypsie, Roma, Traveller and Manual Workers (specifically those in minority groups) have been identified as the Wiltshire Plus Groups.

The Alliance Living Well Delivery Subgroup has been established to support this work, as well as addressing priority improvements around Long-Term Conditions and Anticipatory Care. Partnership working with VCSE sector colleagues will be essential is promoting prevention and co-production and reducing our health inequalities. Neighbourhood collaboratives will also tackle inequalities (appendix D).

Hospital Discharge: Urgent Care and Flow Transformation. Aligned with our Better Care Fund Programme, a comprehensive programme of work across our Alliance is focussed on improving flow across services and reducing unnecessary hospital admissions and delayed discharges. Work programmes under this heading include reducing length of stay in community and care home settings, maximising capacity of the HomeFirst service, increasing the number of people returning to their own home following a hospital admission and improving hospital discharge communication to improve service users experience.

Avoidable Admissions: The Urgent Care and Flow Transformation work aims to deliver improvement in 2hr Rapid Response times and expand same-day emergency care to support a reduction in avoidable admissions. We also work

with primary care and communities to identify opportunities to support early preventative and intervention, for example leg lunch clubs, strength and balance classes based in community venues. We also work with acute trusts to increase assessment at the front door and turnaround through both health and social care interventions.

5. National Condition 2: Enabling people to stay well, safe and independent at home for longer.

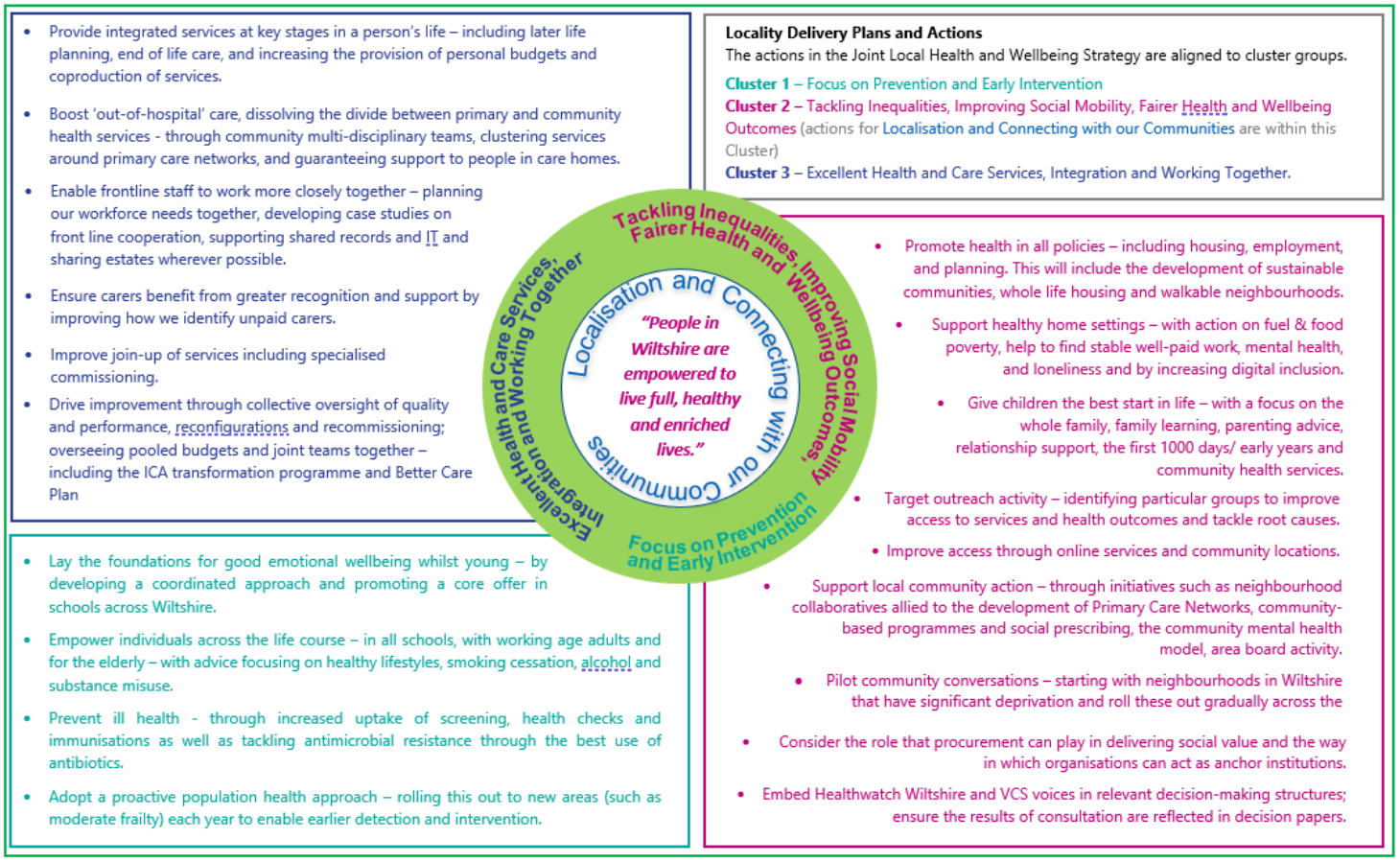
Delivering all the actions in the JLHW Strategy will require intense effort across many parts of the Wiltshire system and Wiltshire ICA has a key part to play. Embracing the opportunities that partnership working and our Alliance now bring, a structure of ICA Partnership Subgroups and additional delivery programme structures across the locality has been established to help drive the change that the JLHW and ICS Strategies have set out, as well as ensuring delivery against national and local aims, improvement work and standards.

The Subgroups will embed links to ICS Programme Boards, acting as a key link with the wider system across BSW. Once fully operational, each group will own delivery against key national and local indicators for health and wellbeing improvement for the Wiltshire population and will drive some of the actions in the JLHW Strategy. Membership of each group represents the broad Alliance partnership and engages the resources across our organisations. The groups are accountable to the Wiltshire ICA Partnership Committee, with close relationships to the Health and Welling Board which monitors achievement against the JLHW Strategy.

Figure 1 shows the Alliance delivery structure and relationships to other groups and programmes of work. This ensures maximised resources and limits duplication whilst affording a line of sight across the matrices in which we now function, both at neighbourhood, locality and broader system.

Further to this the Wiltshire ICA Delivery Plan Actions align across the common priorities.

Figure 2: Wiltshire ICA Delivery Plan



The Wiltshire JSNA 2022[1] highlights how by 20240 Wiltshire's 65+ population is estimated to increase by 43%, and the 85+ population by 87%. We must therefore ensure we commission schemes to mitigate the impact of this on health and social care services. The ICB have developed a suite of population health tools, making use of integrated care records, which will provide further assistance in analysing and improving population health and be preventative in our approach. We will feed into the community area JSNA which is being written this year to ensure key indicators, such as falls data, are included enabling us to make informed commissioning decisions and develop more targeted proactive interventions.

Multidisciplinary teams (MDTs) are core to the Alliance principles of working (see table 4); 'Work as one: partners collaborate sharing expertise, data and resources in the interest of our population'. Many services already use MDTs as standard practice, but it is also widely used across management within the system. Examples of this include the Homefirst review (appendix E) where a MDT of Alliance partners jointly developed the optimal HomeFirst model, aligning a true D2A model with interdisciplinary teams. This will result in a multi-skilled workforce and less handovers of care. It is also closely aligned with a recent re-launch of the domiciliary care framework. The Alliance approach and close working relationships resulted in key services being in place to support a homefirst goal. The Pathway two hub model beds are also an example of effective interdisciplinary team development and working (appendix C).

5.1 How work to support unpaid carers and deliver housing adaptions will support this objective.

Supporting parent carers through activities such as the 'healthy movers programme' (supporting young children with physical literacy) it trains parent carers to support their own children. It builds confidence, provides a forum to create support networks, helping their emotional wellbeing and resilience.

Training is provided to Carer Support Wiltshire on 'five to thrive' trauma training which equips them to support young carers with trauma. It allows them to support the young person going through trauma with a quick response time and allowing the young person the safe space to talk. Knowing that there is a professional who is trained in understanding what they are going through and can support them with techniques leaves the young person at a lower risk of self-harm or becoming diagnosed with anxiety or depression.

Carers themselves are also offered training opportunities, for example training in manual handling or understanding autism and how to safeguard yourself. Equipping carers with the right tools enables carers to help the diagnosed navigate through life easier. Advice is also provided for carers about safeguarding themselves, for example advising carers about services like legal power of attorney allows them to support the cared for legally.

Carer input to service development and feedback on existing services is gathered across numerous carer engagement events and these feed into several contracts/projects and strategies, for example the Dementia and Carer's Strategies. Developing services while taking into consideration the carer and cared for we can show commitment to both to support them in a happier, healthier life.

This work supports preventative care, ensuring the carer is supported and able to care while maintaining their own health and wellbeing.

Also see unpaid carers section of this plan.

5.2 Demand and capacity for intermediate care to support people in the community and hospital discharge.

Intermediate care services in Wiltshire

Service	Description

[1] Population and deprivation Wiltshire Intelligence

HomeFirst	Supporting people to return home following hospital discharge. The service provides assessment within a person's home to ensure they are supported to carry out daily activities required to be independent.
Wiltshire Support at Home	Providing domiciliary support in domestic settings; supporting people on discharge from hospital as well as long-term. Also supports HomeFirst and Reablement services with additional capacity when required.
Rapid Response	Support within two hours to help people to remain at home and avoid hospital admission.
Reablement	a short-term service within a person's home from specially trained social care staff, including occupational therapists and reablement workers, enabling people to regain independence. The service is available to adults who normally live independently at home, but who might have lost physical ability or confidence in carrying out their day-to-day living tasks.

Wiltshire's intermediate care services sit within a system with a shared vision to promote independence and shift care away from hospitals and other bedded care. We are aware that the HomeFirst service will need to plan for increasing demand over the coming years and a review is under way (appendix E) to understand the improvements that could be made to increase efficiency and capacity with this service. The recent launch of a newly commissioned dom care framework has resulted in an increase in available packages of care in the community. The resulting reduction (or in some cases removal) of waiting times has assisted both discharge and hospital avoidance intermediate care services. The ambition is to continue to look to ways to better integrate services, strengthen the existing multi-disciplinary team approach and continue work to develop performance dashboards that reflect services as single delivery mechanisms.

Wiltshire ICB has recently undertaken a detailed analysis of demand and capacity across its health and social care system. The aim of the modelling was:

- A clear Plan for the ICA which aligns to respective system and Wiltshire strategies, and which includes a phased implementation plan, and clear risk mitigating actions for the transition period to the future state.
- Sustained reduction in non-recurrent spend from 2023-24 on spot purchasing and high cost bedded care
- Investment in an ICA model that improves our ability to deliver and flex to sustain a default "Home First" offer.
- The Wiltshire ICA has the optimal number and types of Community and D2A capacity to meet the needs of the population, and deliver improved performance across sectors (financial and qualitative)

Since the modelling work started in January 2023 the following has been achieved:

- Assessed the proposals to reduce non-recurrent spend and risk assess the impact on Wiltshire flow
- Started to develop a mitigation plan for 2023-24, identifying key improvement areas
- Scoped the size of the backlogs on P1 and P2 and quantified.
- Modelled the Pathway 2 demand and capacity across each Trust geography and evidenced this can be accommodated in the proposed P2 bed model (appendix C)
- Demonstrated Capacity and Demand of -/+ 65yrs against John Bolton and National Guidance
- Provided progress update towards final phase of modelling (P1 and P3)

Our next steps will be to carry out a Home First Review (appendix E) and create an Urgent Care and Flow Group

The work has resulted in predicted demand being fully scoped and a full year 'plan on a page' has been developed (appendix B). The Wiltshire Ageing Well and Urgent Care Group are responsible for monitoring and delivery of actions.

5.3 Learning from 2022-23

Our work on the PW2 development included analysis of referrals and outcomes (appendix x) using the NHSE stratification model we found that our then Intensive Rehabilitation beds were not achieving the desired outcomes because people were not being properly aligned to the correct pathway. There were cohorts of patients that would have been better placed in end-of-life, long-term bedded accommodation or pathway 1. The analysis supported a wholescale review and re-modelling of pathway 2 (appendix C). Early feedback from the new hub model that started in April 2023 shows an overall reduction in length of stay and more appropriate alignment of customers.

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions:

We did not meet our plans for 2022-23 avoidable admissions – we were approximately 1000 higher than planned. We have several actions in place that we hope to have a positive impact on avoidable admissions. This includes:

- A significant programme of work to reduce falls. This includes the work done to identify those at risk of falls but who have not yet fallen, making used of health and population data from across system organisations.
- Rapid Response and Overnight Nursing services will continue to be rolled out across Wiltshire.
- In 2022-23 the Wiltshire system reporting 3,207 unplanned admissions against a target of 2,261. Rapid Response and Overnight Nursing services continue to be rolled out across Wiltshire and once at full complement we expect to see them having an impact on these figures. Further analysis of avoidable admissions per acute trust has found significant differences between Trusts. Of these, 42% are into RUH, 31% into SFT and 19% into GWH. In recognition of this we used the ASCDF to increase in-reach roles in EDs across acute trusts. We expect to see an impact on discharges in 2023-24. We will complete further analysis in quarter 2 of 2023-24 to better target discharge resources.

Discharge to usual place of residence:

The PW2 model (see Appendix C) is an example of providing focussed rehabilitation to patients on discharge with the sole aim of enabling them to return home (with or without packages of care). Patient criteria is strict to ensure those able to are offered a multi-agency support to get them home and as independent as possible, as quickly as possible post hospital discharge.

The HomeFirst service across Wiltshire also supports pathway 1 discharges for a finite period to assist people to remain independent in their homes.

The BCF funded Home from Hospital service supports people being discharged on pathway 0 that need some support and minimal intervention in the early days of discharge. This support can range from the provision of meals to HELP boxes that provide essentials such as food and toiletries for the initial days at home. This enables people to have the time they need to then coordinate shopping etc from their own homes, rather than while in hospital.

The BCF funded Intensive Enablement Service supports provides time-limited care, enabling support for people with mental health needs, learning disability and/or autism who are at risk of hospital admission and/or for people being discharged from acute psychiatric hospital and/or rehab. It provides outreach-based support in people's own homes (where appropriate). This new service is like the Council's existing Reablement team working with older adults focusing on maximising independence for people with complex needs.

Emergency hospital admissions following a fall for people over the age of 65:

Wiltshire has seen a reducing trend since 2021-22 with a maintained improvement of 2%. This is due to increasing our focus on helping people to stay in their own homes and improving therapy available on hospital discharge. The ICA are making use of the national funding to support a reduction in hospital admissions because of non-injurious falls. This includes amongst other things, working with community teams and care home providers to purchase and utilise new equipment. In addition, our Neighbourhood Collaboratives Programme (appendix D) is rolling out across Wiltshire. Recognising that we have responsive services in place and good outcomes in preventing second falls following an initial event, the Pathfinder site, working through a prevention lens, is focussed on identifying people at

risk of a first fall (i.e., they are not known to be at risk of a fall and are not receiving support or prevention advice) and working with them to reduce that risk. The developed population insight tool pulled together public health, primary care and other population data which was reviewed against an agreed set of filters. Through this new approach to data collection and analysis 154 people have been identified in the Pathfinder area who have been defined as being highly likely to fall within the next 12-24 months if we do not intervene – we are now at the stage of working with them to understand their needs and develop our plan. Lessons from this work will be shared across the system to support rapid adopt and spread of any successful activities.

The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population:

Some of the 2023-24 ICB element of the Winter discharge funds is committed to Wiltshire Support at Home; to increase capacity in the home care market and support more people returning home. The focus on our BCF funded HomeFirst service with a review (Appendix E) will further drive efficiencies and supporting discharge flows. The new PW2 'hub' model (Appendix C) brings therapy, social care and triage services together to provide targeted support to patients with rehabilitation that supports independence and a return home.

We have gaps in bed based and community care for specialist dementia services. We are working with providers and conducting analysis with public health specialists and ICB analysts to predict demand and capacity and have incorporated findings into our Market Sustainability planning.

Changes and new schemes in 2023-25: (Some suggestions to include)

- In-reach teams in the acute settings, supporting discharge flows
- PW2 model (Appendix C)
- Service improvement work on community equipment service (to support rehab and greater independence)
- 7-day brokerage function now established
- HomeFirst review (appendix E)

The BCF also funds carer support in Wiltshire to further support people to remain at home. Please see the Carers section for more information.

6. National condition 3: Provide the right care in the right place at the right time.

Aligned with our Better Care Fund Programme, a comprehensive programme of work across our Alliance is focussed on supporting people to remain in their own homes, improving flow across services and reducing unnecessary hospital admissions and delayed discharges. Over the next 12 months the HWBJS locality plan's 'Integration and working together subgroup' will deliver: -

- Reduced Length of Stay in Care Homes (to achieve 28 days by July 2023)
- Achievement of the 70% 2-hour Urgent Care Response target (by June 2023)
- Delivery against Virtual Ward development targets, (reaching 136 'beds' by December 2023 and 180 by March 2024)
- Reduced length of stay in community hospitals (to reach 35 days across all wards by July 2023)
- Reducing hospital trust lengths of stay.
- Maximising capacity of Home First services
- Complete Discharge Communications Project to improve patient, family and carer experience and reduce discharge delays (resources launching July 2023, full impact September 2023)
- Increasing the number of people returning to their own home after a hospital admission (% increase TBC once modelling completed).
- Implementing new End of Life care provision model, ensuring people are supported to die in the place of their choosing (launch new model October 2023).
- Increased 0-day lengths of stay

- Same Day Emergency Care expansion.

Our approach to improving outcomes for people being discharged from hospital is based on the national policy of Discharge to Assess, as outlined in the Hospital Discharge and Community Support Policy and Operating Model. All operational teams work to integrated discharge pathways, with oversight by the weekly Wiltshire Discharge Review group, reporting to the weekly Wiltshire Urgent Care & Flow Operational Group.

The principles for the service are:

- Unified vision that brings system partners together
- Simplify and standardise as far as possible.
- Use services for diversion and admission avoidance as well as discharge
- No discharge destination determined from the ward
- Coordinate the use of voluntary sector at all decision points
- Outcomes and whole person journey are a key indicator of success not just flow data
- Understanding our demand, capacity and outcomes
- The BCF Dashboard is an important performance management tool to measure our improvement - it is a reference for all decision-making points. In 2023-24 it will undergo review and it will incorporate contextual and key ICB required data so ensure it is it is 'fit for purpose' across the system.

Table 8: Hospital Discharge Schemes

BCF Hospital Discharge Schemes	How the scheme supports safe, timely and effective discharge
Hospital discharge service performance and commissioning	A dedicated commissioner within the BCF commissioning team oversees performance of the schemes against local and national targets and monitors capacity in all hospital discharge services, with direct commissioning of beds and domiciliary care, enabling early identification of issues and rapid flex of capacity
Home First Plus	The aim of the service is to provide short-term reablement for recover at home safely following discharge from hospital. Home First teams identify the support needed and using strength-based approaches encourage independence at home. This service is also used for admission avoidance
Social work teams	This dedicated hospital discharge team supports triage and social care support to people who require it on hospital discharge. The service case manages individuals until they get safely home, when there is hand over to community teams if required
VCS	Age UK Bath are commissioned to support hospital discharge and Pathway 1 discharges. A transformation project will look at how we can more effectively level community and VCSE resource
PW2 Beds	When people required bedded support for discharge if they are still unwell or unable to manage or be safe at home even with support packages of care
GP and AHP support to PW2 beds	Dedicated GP support based on an agreed specification. The additional support is required to support sub-acute hospital discharges and manage readmissions from PW2 beds, due to the increase in complexity following the implementation of criteria to reside standards. The team also includes Nurses, Occupational Therapists, Physiotherapists and Pharmacy review
Housing support	Hospital discharge teams work closely with Housing support including use of the Disabled Facilities Grant (DFG) to support people with housing issues at discharge. In 22/23 BCF commissioners are working with housing and other with key stakeholders to include equipment and Technology as an enabler of independence at home.
Intensive Enablement Service	The service provides time-limited care, enabling support for people with mental health needs, learning disability and/or autism who are at risk of hospital admission and/or for people being discharged from acute psychiatric hospital and/or rehab. It provides outreach-based support in people's own homes (where appropriate). This new service is like the Council's existing Reablement team working with older adults focusing on maximising independence for people with complex needs.

BCF Hospital Discharge Schemes	How the scheme supports safe, timely and effective discharge
Equipment and technology	OTs can access support for equipment and technology from an integrated service to enable discharge home, particularly focused on those people at risk of falls who live alone, and early dementia
Integrated Brokerage	The integration of the brokerage service has enabled the sourcing all care post assessment, including the hospital to home service, discharge to assess pathways, continuing healthcare and end of life provision. The approach also offers enhanced brokerage and care navigators to support self-funders to reduce delays. Multidisciplinary team (MDT) case management and frailty pilots are showing significant cost and quality benefits. Brokerage has also moved from being a 5 to 7-day service
Rehabilitation Support Workers	The rehab support workers enable the required capacity for reablement at home
DFLG	Three OTs and also Kingsbury Square emergency homelessness service have been funded to assist with hospital discharge and disabled placement
Trusted Assessor	When the discharge process was altered during the pandemic, it provided sound evidence of the positive impact the role can have on increasing the efficiency and timeliness of hospital discharges. While the pandemic occurred just as the TA was beginning to become established, the evidence shows 152 process days were saved during the early weeks of the pandemic when hospitals were urgently trying to discharge as many patients as was safely possible in preparation for the peak of the outbreak.
Patient Flow Hub (PFH) SPA	The Wiltshire Patient Flow Hub is the single point of access for all supported hospital discharge, currently pathways 1-3. The flow hub MDT team triage referrals and allocate to a discharge destination, home or bedded support. It operates 8-8, 7 days a week
End of life care - 72-hour pathway	This service supports the early discharge of patients requiring hospital discharge home with end-of-life care needs. it is a 7 day a week service. Fast track offer is under review with a proposed way forward for Wiltshire to be approved in 22/23 by BSW ICB.
Acute Trust Liaison	This is an in-reach service to support discharge issues such as access to voluntary sector support

6.1 How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

The Wiltshire locality was granted approval for proposed schemes to support hospital discharges during the winter period December 2022- March 2023. The total pooled budget was £4,265,220. The schemes implemented in the Wiltshire locality were developed in partnership with health colleagues and mobilised and demonstrated an increase in capacity to support discharges. The schemes were varied and took a multi-faceted approach to supporting discharges; including staff retention, the purchase of additional capacity in existing services, work to release existing roles to focus on discharge etc. The funds supported the following types of discharge support.

45% of the funding went to providers – either through the purchasing of additional bedded care or through direct support via a grant to support recruitment and retention.

50% funded additional key roles in hospital discharge services or funded agency staff to free capacity in existing roles.

Table 9: ASCDF Spend 2022-23 1

Type	Total	% of total
Recruitment and Retention	**£1,647,000**	**39**
Additional Capacity (bedded care)	**£1,412,000**	**33**
Market Support	**£500,000**	**12**
Other spend to increase staff capacity		
Care Act Ax backlog	**£375,000**	**9**

VCS offer - Meals	**£85,000**	**2**	

Table 10 highlights some of the learning from the 2022-23 ASCDF:

Table 10: Learning from ASCDF 2022-23 1

Learning from the 2022-23 ASCDF
The benefit of using voluntary sector to support discharge support services. We engaged voluntary services to deliver meals that also acted as welfare checks, to release Reablement staff to support additional hospital discharges. This was a cost-effective means of increasing capacity within an established service and was well-received by service-users.
Increasing in-reach team capacity in Emergency Departments at the acute Trusts serving Wiltshire residents: Salisbury, Bath and Swindon. These teams liaise with patients; supporting them and their families to be proactive and ensure timely discharge.
Staff recruitment and retention – The staff incentive and recruitment bonuses have had a significant impact on both the level of applications and the number of roles filled. January applications across all three services (Wiltshire Support at Home, Reablement and Outreach and Intensive Enablement Service was 2.5 times higher than the same period the previous year with February applications almost four times higher than the same period the previous year.

Team	**Jan-22**	**Jan-23[1]**	**Feb-22**	**Feb-23**
Wiltshire Support at Home	12	32	18	29
Reablement	31	36	8	32
Outreach & Intensive Enablement	6	49	2	45
Total:	**49**	**117**	**28**	**106**

[1] Jan 23 data is from 10th-31st January.

In 2023-24 we have identified the following schemes that will support capacity in hospital discharge pathways:

Table 11: ASCDF 2023-24 Schemes 1

	Scheme	**Detail**
1	Supporting community equipment	Provides additional funding to support the increase in demand for community equipment associated with increased number of patients being discharged to their homes.
2	Wiltshire Support at Home	Providing additional capacity in domiciliary care to provide the required increase in packages of care
3	Risk pool for PW3 beds and domiciliary care provision	To provide additional capacity across the care market to support winter pressures.
4	Micro-provider Support	Funds to support recruitment and retention within the smallest providers to support market capacity.
5	VCSE and Carers Support	Using the voluntary sector to support hospital discharge and provide additional capacity to support carers with discharge planning.

6.2 Using BCF funding to ensure that duties under the Care Act are being delivered.

Better Care Fund investment is being used in a variety of ways to ensure that Care Act related duties are being delivered:

Health and social care integration: The Better Care Fund will be used to support the integration of health and social care services to ensure that patients receive the care they need in a coordinated and timely manner through integrated commissioning of services, delivering the right care in the right place at the right time.

Care planning: We will use Better Care Fund money to support the development of care planning for individuals, ensuring that their care needs are identified and met at the earliest opportunity, with service user engagement where possible and that they receive the appropriate services and support.

Care coordination: The Better Care Fund will be used to support the coordination of care services for individuals, including the provision of care journey coordinators who will help individuals to access the services they need and through community wellbeing hub interventions who will connect service users and their relatives to a range of community services that can assist with a range of discharge and ongoing care support services.

Training and development: The Wiltshire system will use funding to support the ongoing training and development of health and social care staff, particularly via our ongoing BSW commitment to the Skills for Care Partnership. This partnership leads on several duties including bidding for Skills for Care funding and advising providers on the minimum standards of training which staff are required to have to do their job effectively under the Care Act whilst improving outcomes for people who use our services. The BSW Academy supports domiciliary care agency workers through the provision of co-production training, supporting the personalisation of care.

6.3 Supporting unpaid carers.

These services are jointly commissioned in Wiltshire. The BCF funds the 'Carers Support Wiltshire contract and Wiltshire Council provide a team of commissioners to support carers in the county. The carers strategy, 'Carer Friendly Wiltshire – all age carers strategy 2023-28' is currently in final draft stage. The work that carers do to support those they look after is invaluable to the health and social care system in Wiltshire. The strategy explains the vision of a career friendly Wiltshire, describes the outcomes carers have told us they would like to achieve, describes the new service offer that will help meet carer's needs, and identifies the tools to measure our progress against expected outcomes.

- 42,262 people in Wiltshire are caring for a family member, friend or neighbour.
- In 2021 8.6% of Wiltshire residents provided unpaid care and support.

Wiltshire has a draft development plan – a support offer for all carers. The following is an outline of key services provided by Carers Support Wiltshire.

- Improving carer awareness across health, social care, education, and the wider community, recognising that people do not always know what they need or what is available to support them and that carers may not identify with the term as carer. This includes offering carer awareness training across health and social care and other statutory partners, a General Practice Accreditation Scheme and a School Accreditation Scheme.
- Operating a Reduce, Prevent, Delay (RPD) model of service delivery, which includes information, advice, intelligent signposting, and onward referral.
- Facilitating carer involvement and ensuring that the voice of carers is heard when decisions are made about how their own needs and the needs of those they care for are met. The provider facilitates and supports both the Council and the ICB with engagement with carers. A Carers Forum is in place and regular engagement events are help. Carers are key to informing strategy development and involvement takes place in a variety of ways e.g., focus groups, carer cafes, surveys and engagement events.
- The provider has delegated responsibility for undertaking Care Act compliant carers' assessments for carers aged 18+. They operate a two-level function: primarily undertaking health and wellbeing assessments that result in a RPD support plan and a secondary function of 'Statutory Carer Assessments' that lead to the provision of commissioned services either through a Direct Payment or a brokered support service. These services include the commission of replacement care or respite services for the cared for.
- Undertaking health and wellbeing assessments of parent carers of disabled children and offering support through carer cafes, information, advice, and signposting.
- Undertaking young carer and parent carer transition assessments.
- Organising carer break activities that provide opportunity to meet others in a comparable situation and who share the same interests, which helps to build a network of peer support.
- Supporting access to and organising training for carers to support them to provide care and support safely (e.g., manual handling), maintain their own wellbeing and build resilience.
- Providing emotional wellbeing support.

- Supporting opportunities for carers to get into volunteering, which adds value to the service as well as an opportunity, particularly for those whose caring role has ended and who are seeking a return to employment.
- Supporting Carers to plan for emergencies. This includes administering and supporting registration to a carers' emergency card scheme.

Young carers are one of the hardest to reach and are vulnerable due to age but also without being correctly supported to achieve whilst caring could end up on relying social care support later in life. Carer Support Wiltshire has also recently brought the young carers service (5-18) back 'in-house', ensuring a whole life approach to carer support. They have also recently employed a family key worker to this end and link with commissioned support provisions in the council to reach more vulnerable groups of people. For example, Julian House is contracted to support people who do not have a fixed address (travelling families), the Early Help team are commissioned to support families of which their first language is not English, the corporate team support resettled families in Wiltshire and our LGBTQIA forum has several resources to support community engagement. With these tools we can support carers in different communities and engage with them when needed

6.4 Disabled Facilities Grant (DFG) and wider services

The Disabled Facilities Grant (DFG) is managed as a component of the BCF, ensuring a whole system approach to prevention and reablement. DFG supports people to live at or as close to home as possible and is a key enabler to increase the number of people living in their own homes, avoiding longer residential or other support costs. Allocation of funding from the DFG is based on need, which varies month to month depending on the case load and professional assessment of need. There is strong collaboration between Health, Public Health and the Council to meet the housing needs of older and disabled people.

We value working with Planning, Policy and Public Health teams, in addition to Housing and Health colleagues, to exploit the potential to secure new housing built in Wiltshire is fit for purpose for older and disabled people, through strategic working and medium to long term planning. We see the potential of innovative housing solutions, such as cohousing, to create intentional communities that incorporate health and wellbeing into the design, leading to less reliance on health and social care as the members of these communities can provide support to one another.

There are Occupational Therapists in the Private Sector Housing Team that provide advice for anyone who requires adaptations, to either consider if a property would be suitable for adaptation before they move or can be adapted for those who are already living in the properties. Consequently, the Occupational Therapists link in with Housing Allocations (from the Housing Register – Homes 4 Wiltshire), the Homelessness Team and Tenancy Services Term – demand for the housing OTs are very high.

The council has a statutory duty to provide means-tested Disabled Facilities Grants to adapt the homes of disabled occupiers to make them more suitable for their needs. Residents are assessed by an Occupational Therapist who makes recommendations. DFG Priority 1 adaptations are high priority major adaptations, and DFG 2 refer to other or standard adaptations. Wessex Loans are for essential repair and maintenance work to properties or to pay for adaptation where the cost is above the Disabled Facilities Grant, or the person doesn't qualify for a grant. Adaptations made to council owned properties are funded through the Housing Revenue Account. Housing colleagues within the council work closely with BCF commissioned hospital discharge services such as Reablement and Home from Hospital (voluntary sector) to enable timely adaptations that support efficient discharges.

Adaptations made to households in Wiltshire saw a decrease in 2020/21, where the impact of the pandemic had a negative impact on timescales and number of completions. Planned works had to be delayed due to restrictions and shielding requirements, and the need to introduce new health and safety measures.

There is also a Rough Sleeper Outreach Team within the Homelessness Team and health inequality is a big issue. Through grant funding there are various officers with specific support links to the Drug and Alcohol and Mental Health service provision as these are two significant areas of need when looking at rough sleepers' health issues. In

2022-23 three homeless hostels were refurbished. These were specifically used to facilitate and support homeless people on discharge from hospital. In 2023-24 a further two flats will be refurbished, doubling the capacity for homeless discharge support.

This year's plan aims to see closer working between housing, health and care commissioners to evaluate the impact of DFG schemes and to strengthen the links between DFG, Community Equipment services and Assistive Technology. A TEC commissioning team was recruited to in 2022-23 and is in the final stages of a strategy which will identify plans for 2023-24. It is the ambition that TEC solutions that support independence are trialled and applied across a range of services to support people to be independent at home.

6.5 Additional information (not assured)

Discretionary grants provide a top up to the Disabled Facilities Grant where the cost of essential works exceeds the maximum grant. If eligible. Wiltshire Council will fund a top up to the DFG to a maximum of £10,000. The type of work includes extensions and other significant adaptation work.

Due to inflation and other cost increases work it has become increasingly challenging to complete required works within the maximum DFG grant (£30,000). There has, therefore been a corresponding increase in the use of the discretionary grant in recent years (table 12).

Table 12: Discretionary Grants 1

Year	No. Cases	Cost
2020-21	2	£32,586
2-21-22 (covid)	0	£0
2022-23	4	£70,979
2023-24 (to date)	5 cases committed	£48,196

7. Equality and Health inequalities

2022-23 saw Wiltshire move toward a more strategic, population-based approach to determining our priorities. Local priorities for health inequalities have been set in two main ways. At a strategic level, the BSW Reducing Inequalities Strategy requires each BSW Place to set place-based priority groups. For Wiltshire, our Adult PLUS group (The PLUS is the CORE20PLUS5) is Gypsy Roma Traveller and Boater (GTRB), and routine and manual workers. For Children and Young People, the PLUS group is GRTB children. Phase three of the strategy requires a wider determinant priority for the county, which the Wiltshire Alliance Delivery Group agreed to be Transport and Connectivity. At an operational level, the Wiltshire Health Inequalities Group held a workshop in March 2023 setting themselves some draft 1- and 5-year priorities. These are being reviewed and will be used to inform spend of the Health Inequalities funding in 2023-24.

The projects funded through the health inequalities fund are chosen to align with the CORE20 – in that they must all focus on reducing the impact of inequalities for those people in the nationally most deprived 20% of areas. For Wiltshire we only have a small number of areas in this group, notably, Bemerton Health and Studley Green, where the council are doing targeted work through Community Conversations. The PLUS groups (as above) are priorities for all health inequality spend and the 5 clinical areas are overseen by the ICB clinical leads.

Neighbourhood collaboratives as a new approach to identifying and tackling inequalities (appendix D).

8. Approval and sign off

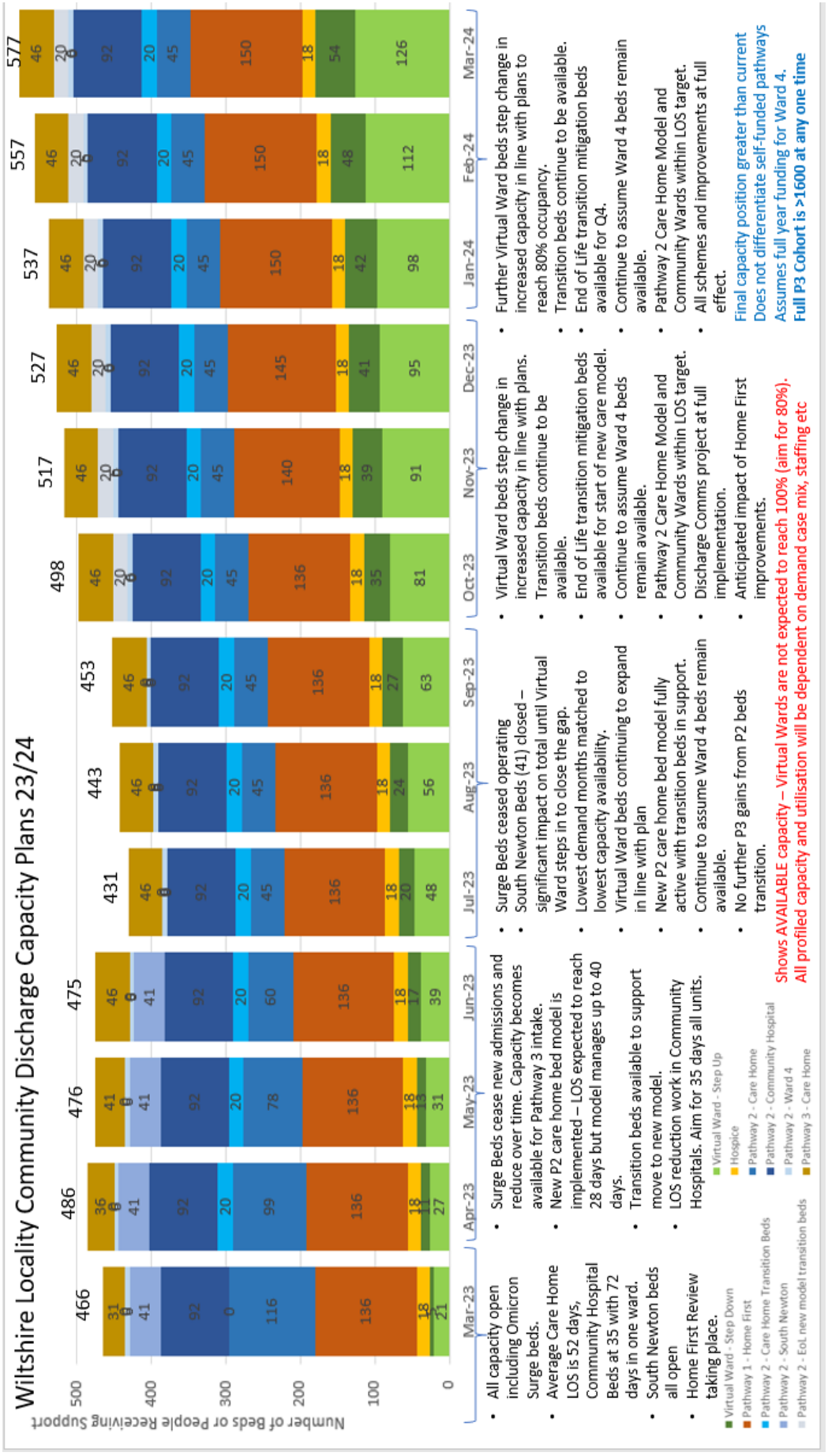
This plan has been created in partnership with all organisations detailed in section 1.0 and has been signed off by the Health and Wellbeing Board delegated authority, before formal sign off by the HWB on 20th July 2023.

Appendix A:

Representatives from the following groups have either been consulted or directly input to the content of the Wiltshire BCF Plans.

Representative	Group(s)
Wiltshire Locality BSW ICB Executive Director for Place - Wiltshire Associate Director Finance Director of Locality Commissioning Health Care Professional Director BSW ICB Medical Director	Integrated Partnership Committee, Alliance Delivery Group
Wiltshire Council Corporate Director for People Director of Ageing and Living Well Director of Procurement and Commissioning Head of Finance	Integrated Partnership Committee, Alliance Delivery Group
Acute Trusts (SFT/RUH/GWH) CEO, COOs	Integrated Partnership Committee, Alliance Delivery Group
Community Services Managing Directors – children's and Adults	Integrated Partnership Committee
VCSE Leadership Alliance (voluntary services) Nominated individual	Integrated Partnership Committee
Healthwatch Organisation Deputy Chair	Integrated Partnership Committee, Alliance Delivery Group
Social Care Providers	Integrated Partnership Committee, Alliance Delivery Group
Mental Health Providers Locality leads for adults and children's. AWP and Oxford Health	Integrated Partnership Committee, Alliance Delivery Group
Public Health Consultant	Integrated Partnership Committee, Alliance Delivery Group
Housing Head's of Service – Wiltshire Council	Represented through Ageing Well Director's attendance at System-wide meetings as well as project specific meetings.

Appendix B: Wiltshire Locality Community Discharge Capacity Plans 2023-24



Appendix C. Case Study 1: Pathway 2 'Hub' model of care

Our Pathway 2 hospital discharge pathway has recently been re-modelled to ensure the provision of effective multi-disciplinary therapy to assist a return home for patients discharged from hospital. A number of issues were identified with the bed based care in pathway 2.

- Inequitable access to therapy
- Excessive lengths of stay
- provision not meeting patient needs
- Poor outcomes for patients

Table A shows the analysis of patient outcomes.

PW2 discharge outcomes	Average % (Oct 20-Mar 22)	Notes
Hospital readmission	17%	This is likely due to a worsening of an existing condition – whatever the reason, PW2 bed are not appropriate for this level of need.
Nursing home	18%	These customers would have been better suited to PW3 rather than a therapy-based bed
Residential home	14%	
Home independently	10%	This is the aim for most people being admitted to a PW2 therapy-based model
Home with Package of Care	16%	
Home First	12%	For those discharged with Home First it is assumed this could have been an option in the first instance. The bed review showed a high proportion of PW2 customers who, on clinical reassessment, were deemed to have been appropriate for Home First rather than a bedded facility.
End-of-life	13%	On many levels, this is not satisfactory, and alternative bedded provision should be found.

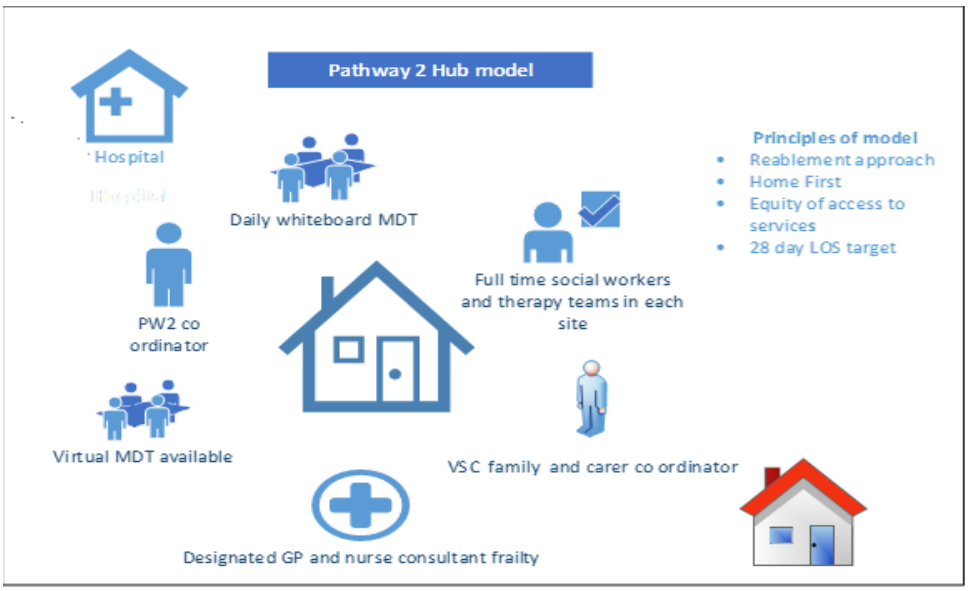
Further stratification was then conducted, using the NHSE Stratification model, along with

Due to this analysis of patient outcomes a stratification of the pathway was conducted collaboratively with colleagues from Wiltshire Health and Care, Adult Social Care, Integrated Care Board and the Better Care Fund as well as involvement from GP's, providers, and acute providers. This highlighted that if the correct patients are admitted into a therapy-based bed model, the Wiltshire system would require between 53 and 61 beds.

PW	**Definition**	**Current outcomes (Oct 21-Mar 22) as % of demand**	**Beds required**	**Beds required plus 15% capacity to aid system flow**
2a	Medically stable cognitively and physically able to participate in rehabilitation activities. Current dependency, rehabilitation or cognition mean not yet able to be managed in community	21%	22 PW2 Hub Model	25
2b	As per 2a plus: Higher rehab complexity (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation[5])	20%	21 PW2 Hub Model	24
2c	Clinical risk is too high to go home at this stage. relatively low rehab e.g., end of life care	16%	18 Nursing beds	21
2d	As per 2a plus; Both clinical risk and rehab requirements are high (but not reaching requirement for NHSE&I Level 1 and 2	10%	10 PW2 Hub Model (Complex)	12

	rehabilitation) delirium and complex MH with clinical complexity			
2e	Residing in P2 due to lack of P1 capacity	6%	6 HomeFirst Service	
2f	Residing in P2 due to other reasons (e.g., P3, Specialist capacity, other	11%	12 PW3	14
-	Hospital readmissions from PW2	20%	21 Community Hospital or clinical optimisation	24
Totals of PW2a, 2b and 2d suitable for PW2 'Hub' model			53	61

The review further identified areas where efficiencies could be made both to pathway 2 admissions and across other discharge pathways to enable a reduction in the overall number of pathway 2 beds. It was proposed that these beds could be delivered through a new 'hub' model.



The proposed organisational model is to establish specialist hubs – adaptable, equitable and able to deliver a short term, rapid, high-quality level of assessment and rehabilitation. A hub model provides economies of scale – enabling GPs, Social Care and therapy staff to concentrate support in one place.

Collaborative Approach

A pilot was conducted 1st September 2022 and 31st March 2023, to understand how best to identify suitable patients, test ways of collaborative working, how to affect a cultural shift in the provision of therapy to improve independence and a return to the individuals home and do all of this with a LOS at or around 28 days. The pilot tested:

1. GP Support	We will use existing support services to ensure medical support to the beds
2. Therapy Support	Qualified occupational therapists and physiotherapists will be available as part of the 'hub' team so access to this support is equitable across all the beds, including the more complex dementia and delirium cases.
3. Social Care support	Social workers will be part of the 'hub' teams and therefore able to be more reactive in terms of timely assessments etc.
4. Training to support a cultural shift toward reablement	Training for care home staff on the ethos and approach to reablement and increasing independence will be provided to support the service.

5. Revised eligibility criteria	To ensure only those with rehabilitation or reablement potential are admitted to the beds.
6. Reducing Length of Stay	Length of stay in Wiltshire across all D2A and IR pathways are on average more than twice the national standard of 28 days. In some instances, there are stays in D2A and IR of over 180 days. This has the biggest impact on current capacity. Delays in discharge from these beds will be addressed through the pathway 1 review. A hub model will also result in the right expertise, such as social care on site to enable timely assessment of individuals. Any reduction in length of stay, even on an incremental basis, to allow the system to calibrate and increase resources where needed, will be transformative.
7. Access to a consultant geriatrician and a virtual MDT	Support of a weekly virtual MDT and consultant geriatrician will support providers in making decisions on residents' care and ensure appropriate support of individuals.

To create the collaborative working environment social work staff, home staff and therapists shared office space to promote conversation regarding patients' needs as well as triaging referrals together and attending weekly MDT's.

The outcomes of the pilot;

• Reduced LOS • Staff reported greater job satisfaction with the model, citing a more holistic view of the patient.	• Improved outcomes (increase in the number of patients returning home) • Patient has regular input and oversight from a range of professionals. • A quicker turnover of patients.

As a result of the positive outcomes being shown it was collaboratively agreed to change the model to the one used during the pilot. It ended with a successful tender for the new service model which is currently in the first months of mobilisation.

Appendix D. Case Study 2: Collaborative Neighbourhoods

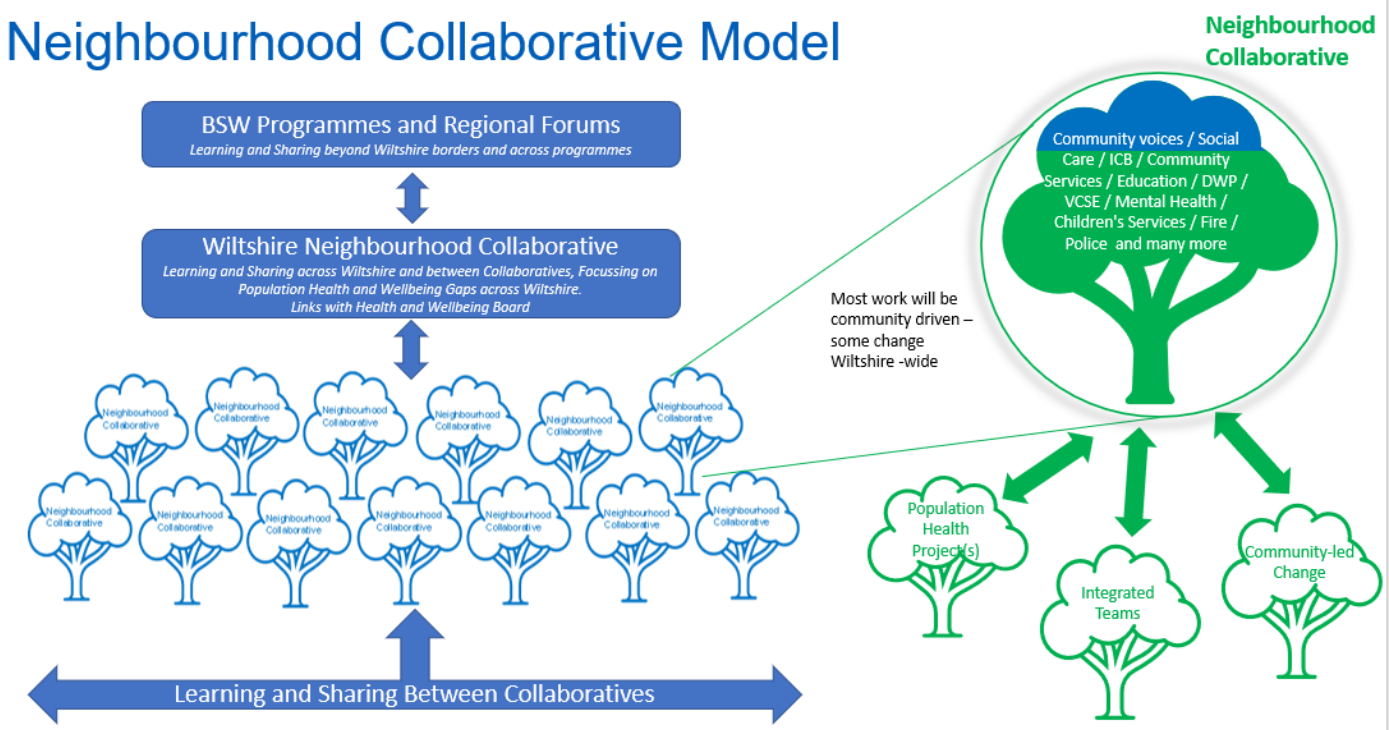
Integrated and explicit in the Joint Local Health and Wellbeing Strategy (2023) for Wiltshire, The Neighbourhood Collaborative programme has been co-designed by Integrated Care Alliance members to enable partnership working to flourish across services, organisations and community groups within areas loosely defined by each of the Primary Care Network footprints. Once established there will be 12 to 13 Collaboratives across Wiltshire.

Each Collaborative will connect partners from health and Social Care, Voluntary Community Social Enterprise, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire and many Community Groups who will offer their resources and share their expertise and assets to enable solutions to be developed that can tackle health inequalities and promote health and wellbeing within their local community. Community views and engagement will be the key to success.

Each Neighbourhood Collaborative will be grown from the ground up, which means they may be structured differently to each other, and partner staffing models may look different depending on what works for each area. They will establish their own needs and priorities.

The six Principle Areas are:-

- Partnership working
- Co-production
- Community-led approach for health & wellbeing
- Working as one using data analysis
- Enabling volunteers and staff to thrive
- Creating a movement for change



The Collaborative approach aligns with guidelines set out in the recent Fuller Primary Care Stocktake report (2022) and has been integrated into the Joint Local Health and Wellbeing strategy, and aligns with the BSW Care Model and ICS Strategy. The programme also supports other key areas of focus within Area Boards, Families and Childrens Transformation and Community Conversations and Mental Health, LD and Autism.

Over the next 12 months, the Collaborative programme aims to:-

Milestone	Progress and Next Steps

1	Complete Pathfinder site (Melksham and Bradford on Avon) development and initial project area, feeding learning into the full programme structure.	• February to April 2023 – Collaborative group in one neighbourhood on a 'fast track' launched to gather early learning to add to the initial pilot findings. • May 2023 - Engagement work with Collaborative cohort, focussing on prevention. • June – Define and agree Collaborative structure and leadership. Publish First report. • July 2023 – Co-production training delivered with MBoA teams. Start working directly with an identified group of patients • September -2023 – Progress update • December – Progress updates
2	Deliver Initial Readiness Review and Launch Programme. (June '23)	Onboarding Launch programme agreed and online portal established. Full programme pathway agreed (indicates place and pace of Collaboratives launching). Currently establishing sites in Devizes, and in discussion with two other areas for full set up.
3	Hold first Wiltshire Collaborative event. (August '23)	Design Wiltshire Collaborative model with the Steering Group. Hold first Wiltshire Collaborative group – aiming for August but dependant on site development – may move to Autumn. Release Programme Update report.
4	Establish Neighbourhood Collaborative in each area of Wiltshire (April '24)	By April 2024 all neighbourhood areas will be on their collaborative journey at different points of maturity and will have completed or commenced the Launch programme. Initial impact results will be available for multiple collaboratives areas.

Appendix E. Case Study 3: HomeFirst Service Review

Since 2018 Wiltshire has commissioned two providers –Wiltshire Health and Care (WHC) and Wiltshire Council Reablement (WC) to deliver Home First, working within an integrated delivery pathway. Other providers also contribute to delivery - Wiltshire Support at Home (WSAH) and independent providers in the domiciliary care sector.

Despite multiple developments and innovations, Wiltshire has struggled since the pandemic to maintain its ability to rapidly meet demand, both in terms of volume and complexity. The time is right to undertake a full review of the Wiltshire Home First Service. The review is working to deliver a report to the ICA Partnership Committee by the end of July 2023:

- Identify a proposed optimal Home First Pathway for all people discharged with support needs (excluding those at the end of their lives).
- Undertake a gap analysis against the proposed Home First Pathway, making recommendations for service change, including workforce needs.
- Provide an assessment of current performance against best practice indicators and requirements, identifying future performance measures and implementing a shared minimum data set.
- Identify current and future capacity and demand and an assessment of service capacity and funding to meet needs.
- Identify a current cost per case for all service lines, and a cost per case for the proposed optimal pathway.
- Establish if we have the correct assurance systems in place for PW1
- Proposed recommendations for consideration at the ICA Partnership Committee, identifying immediate opportunities for improvement and those requiring further consideration and approval.

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Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Wiltshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	134.5	130.3	135.9	562.0	Figures for 22-23 are incorrect but unable to change in template. Figures added consider last years actuals with a small improvement factored in. Rapid Response and Overnight Nursing services continue to be rolled out across Wiltshire. We are starting to look at avoidable admissions per acute trust and	We are developing a service development plan targetted at reducing avoidable admissions over the next two years
	Number of Admissions	839	813	848	-		
	Population	504,070	504,070	504,070	504,070		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	134.6	131.57	157.38	140.33		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,233.5	3,234.0	3,298.7	An uplift was applied based on population growth and a 5% reduction accounted for as a result of the Falls programme of work.	The ICA are making use of the national funding to support a reduction in hospital admissions because of non-injurious falls. This includes amongst other things, working with community teams and care home providers to purchase and utilise new equipment. In addition, our Neighbourhood Collaboratives Programme
	Count	2,600	3,820	3,896		
	Population	112,461	119,115	121,497		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
	Quarter (%)	91.5%	91.7%	91.4%	93.1%	The baseline was established based on population growth and improvements	Some of the 2023-24 ICB element of the Winter discharge funds is committed to
	Numerator	8,931	8,986	9,083	8,487		

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	9,765	9,797	9,936	9,113	made per quarter, based on the new servies in palce to support a return home.	Wiltshire Support at Home; to increase capacity in the home care market and support more people returning home. The review of our HomeFirst service will further drive efficiencies and supporting discharge flows. The new PW2 'hub' model brings therapy, social care and triage services together to provide targeted
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	91.7%	92.2%	92.1%	92.1%		
	Numerator	9,132	9,215	9,340	9,363		
	Denominator	9,959	9,992	10,136	10,164		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	366.1	382.8	334.8	316.6	Reducing trend since 2021-22. Will be looking to maintain at least a 2% improvement during the plan.	Maintain our focus on helping people to stay in their own homes and improving therapy available on hospital discharge.
	Numerator	404	438	383	370		
	Denominator	110,358	114,408	114,408	116,879		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	65.5%	65.5%	78.5%	75.2%	Issues concerning data collection have now been resolved and provide an accurate presentation of performance.	Continue to improve data collection. Review of reablement and HomeFirst pathways to evidence service improvement plan.
	Numerator	216	216	299	310		
	Denominator	330	330	381	412		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Wiltshire Council

Health and Wellbeing Board

20 July 2023

Subject: Healthwatch Wiltshire Annual Report 2022/23

Executive Summary

Healthwatch Wiltshire is the independent consumer champion for health and social care. We have a legal requirement to publish an annual report and this gives an opportunity to demonstrate to local people, stakeholders, and the Wiltshire Health and Wellbeing Board the progress which has been made in 2022/23 and to look forward at our plans for 2023/24.

The Healthwatch Wiltshire Annual report highlights the range of activities that were undertaken during 2022/23 including:

- Our work with Salisbury hospital on their complaints process.
- Hearing feedback form those that have been through the continuing healthcare application process.
- Our volunteer led project reviewing GP websites and phone messages
- Our priorities for the coming year .

Proposal(s)

It is recommended that the Board:

I. Notes the key messages from the report.
II. Notes the contribution made by Healthwatch volunteers.
III. Confirms its commitment to listening to the voice of local people to influence commissioning and service provision.

Reason for Proposal

Healthwatch Wiltshire has a statutory duty to promote the voice of local people with regard to health and social care services and has the opportunity to influence commissioners on the Health and Wellbeing Board. This opportunity is provided through Healthwatch Wiltshire's membership of the Board. As such it is important that the Board receive Healthwatch Wiltshire's Annual Report in order to make any comment, recognise the work undertaken to date, and confirm its commitment to listen to the voice of patients, unpaid carers and the wider community through Healthwatch Wiltshire.

Stacey Sims
Manager

Healthwatch Wiltshire

The full report can be viewed here:
https://www.healthwatchwiltshire.co.uk/sites/healthwatchwiltshire.co.uk/files/HWW_annual_report_2022_2023.pdf

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Together

we're making health and social care better

healthwatch Wiltshire

Annual Report 2022–23

Contents

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

Message from our Chair

We've had another busy year here at Healthwatch Wiltshire and remain hugely proud to be your champion for health and social care services in the county.

Thank you to everyone who has shared their views and experiences with us, not just in the past year, but in the past decade! 2023 marks our 10th anniversary and it's down to you that we've been able to help make so many positive changes to services in Wiltshire.

The impact of Covid-19 is still apparent in the delivery of health and social care services in the county but it's inspiring to see the efforts of our partners who are working hard to restore services.

We've been working with those partners in the NHS, Wiltshire Council, the voluntary sector and the private sector, to help achieve better co-operation across the new Integrated Care System, which launched last summer.

Our contribution to this very much depends on the information and stories you share with us about health and care services. And it's been wonderful to talk to people face to face once more to hear these experiences. Remember, we want to know what works best for you, as well as understand the things that haven't gone well.

Sharing your feedback really does make a difference – not only have we been able to make more than 30 recommendations to services this year, but we've already seen improvements being made to the complaints process at Salisbury District Hospital, and to the application process for Continuing Healthcare.

Finally, my thanks go to our staff and our volunteers for their passion and commitment, and for shining a light on what local people want and need from their care.

Alan Mitchell
Healthwatch Wiltshire Chair

"Remember, we want to know what works best for you, as well as understand the things that haven't gone well."

About us

Healthwatch Wiltshire is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

Our vision

A world where we can all get the health and care we need.

Our mission

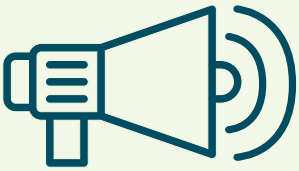
To make sure people's experiences help make health and care better.

Our values are:

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation – especially those who don't always have their voice heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

Year in review

Reaching out



637 people
shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

4,125 people
came to us for clear advice and information about topics such as mental health and the cost of living crisis.

Making a difference to care

We published
7 reports
about the changes people would like to see to health and social care services.

From these we made
31 recommendations
for improvement.

Health and care that works for you

We're lucky to have
21
outstanding volunteers who gave up **680 hours** to make care better for our community.

We received
£179,617
in funding from our local authority in 2022-23.

We currently employ
3 staff
who help us carry out our work.

10 years of improving care

This year marks a special milestone for Healthwatch Wiltshire. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes that have stepped up and inspired change. Here are a few of our highlights:

How have we made care better, together?

Helping young people talk about wellbeing

We picked up our first Healthwatch England award for our Young Listeners project, where young volunteers learned how to provide mental health support to their peers.

Improving dementia care and support

Our work helping to improve care and support for people living with dementia earned us a second Healthwatch England award.

Launching our mental health forum

Our free forum now has more than 100 members and provides a unique opportunity for people to speak directly to those who run mental health services in Wiltshire.

You Said, We Did

We've continually shown how your feedback has been used to make changes to services, including those at Great Western Hospital.

Being a trusted source of information

We gathered your feedback and kept you up to date with all the changes throughout the Covid-19 pandemic.

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community a priority. This allows us to understand the full picture, and feed this back to services and help them improve.

Making the application process for NHS Continuing Healthcare easier

The findings of our survey, which focused on how people apply for NHS Continuing Healthcare (CHC), has led to changes in the process and better support for applicants.

CHC is a package of care for adults with significant health needs. Applying for CHC, which is arranged and funded by the NHS, involves a person being assessed for their eligibility on factors such as their breathing, mobility, nutrition and psychological needs.

Our survey in early 2022 revealed people prepare carefully for a CHC assessment but don't always receive key information, and often find the process complicated and challenging. Our findings included:

- Key information for people applying for CHC is in an NHS leaflet that many people do not receive.
- The majority of applications are made by someone other than the person whose eligibility is being assessed.
- The application process is made easier for people if a social worker assists them, ideally in the initial stage of the application.
- A clear theme was the need for better liaison between CHC teams and care providers, particularly when a change of care setting is required, such as when a person is moving to a care home.
- People thought staff were professional, empathetic and supportive.

What difference will this make?

Our survey findings have led to improvements being made in the application process and better support for applicants.

The CHC team will start with developing an Application Process document, providing a timeline and stages of the process and a Frequently Asked Questions section to provide information on roles, responsibilities and CHC funding. This will involve listening to people who have been through the process to ensure to ensure the document is fit for purpose and answers the questions in terminology that is understood by applicants. More changes are outlined in our You Said, We Did.

"I have welcomed the opportunity to work with Healthwatch to gain valuable feedback from our population's experience of the CHC process. We will continue to seek feedback from everyone who has been through the application process to facilitate ongoing learning and improvements."

Kirstie Jackman, Head of Operations and Clinical Quality for CHC and Funded Nursing Care, BSW ICB

Providing best practice guides for GP practice websites and messages

A two-part volunteer-led project has culminated in best practice guides to help GP surgeries improve the way they communicate with patients.

Our research team of six volunteers assessed the websites and phone messages of all 49 GP practices in Wiltshire.

Identifying what 'good' looks like

The GP Websites Review looked at how useful, accessible, up-to-date and informative the GP websites were, with our volunteer researchers putting themselves in the position of someone needing to contact their surgery.

They found that the majority of the websites were easy to find, navigate, read, and understand, but there was significant variation in the quality and quantity of information.

Mystery shop focuses on message content

For the GP Phone Messages Review, our volunteers carried out a mystery shop, listening to automated messages and assessing their content, tone and length.

The mystery shop revealed a wide variation in the information provided in recorded phone messages, and the way the messages were delivered.

Our research team identified that good messages are easy to understand, are as short as possible and have a friendly, reassuring tone. Calls that cut off, long, rambling messages and a defensive tone are confusing, and may make the patient feel they are a nuisance.

What difference will this make?

Our volunteers made a series of recommendations for improving websites and phones messages which can be used as checklists for GP practices to follow. A template message was also created by one of our volunteers.

Both reports have been shared with Wessex Local Medical Committees Ltd (Wessex LMC), who represent GPs and practices across the region. They will be the topic of a Wessex LMC podcast, featuring Healthwatch Wiltshire, which is due to be broadcast in late spring 2023.

> "Constructive feedback with examples of what 'good' looks like are always welcome. Your list of recommendations will provide a useful crib sheet for practices to refer to when reviewing their websites... [and] a good aspirational template on which practices can base their phone messaging."
>
> **Andy Purbrick, Joint Chief Executive of Wessex LMC**

Sparking an overhaul of a hospital's complaints process

Feedback from patients who made a complaint about their care at Salisbury District Hospital is being used to overhaul its complaints handling process.

We ran a survey which heard the views of people who had been through the hospital's complaints handling process between April and June 2022.

Patients and their families told us of feeling lost in the system, that they weren't listened to and had little confidence that changes would be made following the issues they had raised.

Our report revealed that people found it difficult to find information on how to make a complaint and didn't fully understand the role of the Patient Advice and Liaison Service (PALS) at Salisbury District Hospital. We also found:

- People didn't feel they were kept properly informed of where they were in the complaints process.
- There was a lack of signposting to additional support, such as advocacy services.
- Staff sometimes seemed reluctant to take ownership of a complaint.
- People felt disempowered and that they could not challenge decisions made by the hospital Trust.
- People thought that points or questions they raised were not properly addressed.
- Apologies did not feel meaningful or sincere.

What difference will this make?

These experiences have led to a review of the way the hospital handles complaints by Salisbury NHS Foundation Trust, which manages it.

Our findings will form the basis of a new Complaints Handling Policy, which is due to be launched by the Trust in April 2023. Visit our website to read our report.

"We have welcomed the opportunity to work with Healthwatch Wiltshire.

"The Trust acknowledges and accepts the findings from this project and strongly supports the identified areas for improvement… with the findings shaping both our new Complaints Policy and improving the processes associated with this.

"Our aim is to provide an accessible, supportive and robust complaints process, that commits to putting the complainant at its heart."

Victoria Aldridge, Head of Patient Experience, Salisbury NHS Foundation Trust

Ways we have made a difference for the community

Throughout our work we gather information about health inequalities by speaking to people whose experiences aren't often heard.

Projects under way to hear from minority groups

In September 2022, we began a new project with Wiltshire Council's Ethnic Minority and Traveller Achievement Service (EMTAS), and children's charity Spurgeons, to hear the experiences of Fijian and Nepalese military families.

We held two workshop sessions, funded by the Armed Forces Covenant Fund Trust, with members of these communities, where we listened to their feedback on services and offered advice and guidance.

Key themes were the language barrier in making GP and healthcare appointments over the phone; being understood in an emergency; and a lack of understanding about the GP triage system. But all were registered with a GP, reported good experiences of hospital treatment and had no problems with getting the medication they needed. They were also satisfied with the dental treatment they had received.

This work continues in 2023, with a two-year project to signpost key medical services and deliver activities to support Ethnic Minority families' mental health and wellbeing. Funded by NHS Charities Together, it will involve engaging with Eastern European and Boater communities.

Staff training to focus on autism awareness

Our mental health forum provides a unique opportunity for people to talk directly to those who run mental health services in Wiltshire.

Our forum members thought emergency services staff, and staff working in mental health and council-run services, needed to improve their awareness of autism and receive more specific training to better support autistic people and their carers.

Feedback was taken to Avon and Wiltshire Mental Health Partnership NHS Trust's (AWP) Quality and Standards meeting, and training has now been provided for all AWP staff who support autistic people, including the Primary Care Liaison and Crisis and Intensive Support teams. We're doing more to hear the views of autistic people in 2023, in a joint project with Wiltshire Service Users' Network.

Hearing people's views on rehabilitation scheme

In October 2022, we visited Little Manor Care Centre in Salisbury, where a new hospital discharge project is being trialled, to interview patients, care staff and therapists about the scheme.

Questionnaires were also sent out to families and carers to invite them to give their views.

Feedback about the pilot project, known as Pathway 2, was overwhelmingly positive, except for comments on the lack of communication to patients around their discharge from hospital.

The multidisciplinary team approach, where staff are based on one site, was seen as beneficial to patients, speeding up the rehabilitation and recovery process so that most patients are ready to move on after 28 days.

The findings of our interim report were incorporated into Wiltshire Council's Better Care Fund paper for consideration of continued funding approval at the council's Cabinet meeting in December. Our full report came out in spring 2023, with our recommendations being used to develop the Pathway 2 model, which is now being provided at two care homes in the county.

A pathway is a plan for patient care that covers their treatment from beginning to end.

We call on local people to help us set priorities

In March 2022, we called on local people to tell us what they thought our priorities should be for 2023-24. We asked them to choose from six potential projects:

- The wellbeing of children and young people
- Mental health and autism
- Hospital discharge and care at home
- Accessing GP services
- How the cost of living is affecting our health
- Pharmacy services

We were delighted to receive 127 responses to our short survey, and a wealth of comments and insights. Our work for the year ahead will be driven by what people told us is important to them and we will ensure they play a key role in helping to shape services. See page 19 for our new priorities.

2022-23 outcomes

Priority area	Projects
Primary care - Accessing GP services and how they are recovering post-pandemic	• Back in 2021, we worked with other Healthwatch teams across the south of England to gather the views of patients and staff on access to GP services during the Covid-19 pandemic. Following the publication of our Wiltshire report in August 2022, an overarching report featuring the results of all the Healthwatch teams was published in October 2022. • Our GP website and phone message reviews, both carried out in 2022, are the subject of a podcast by Wessex LMC to be broadcast in late spring 2023.
Mental health - with a focus on learning disability and autism	• In 2022, the Care Quality Commission asked us to carry out joint project with Healthwatch BaNES and Healthwatch Swindon focusing on how people with mental ill health accessed services during the pandemic. The joint report, published in October, is on our website. • Our free online mental health forum continues to provide a safe space for people to share their views directly with those who run services. Members' views have been fed directly into our upcoming survey on mental health and autism, one of our priorities for 2023/4.
Children and young people - sexual health	This work has been postponed to 2023-24 and has now been broadened to focus on the wellbeing of children and young people and their ideas of how they can be better supported.
Hospital discharge - Exploring the links between discharge and social care	In October 2022, we gathered the views of patients, staff and families and carers on a pilot scheme for hospital discharge and accelerated rehabilitation, known as Pathway 2. The scheme was being trialled at a care home in Salisbury and has now been rolled out to more care settings.
Providing local and national information and guidance.	Our website is regularly updated with local and national information and seen as a trusted source for information. During 2022-23, our advice and information pages were visited 3,820 times.

Enter and View and PLACE visits

This year, we made the following Enter and View and Patient-Led Assessments of the Care Environment (PLACE) visits.

Healthwatch Wiltshire has a statutory right to carry out Enter and View visits in health and social care premises to observe the nature and quality of services, as set out in the Local Government and Public Involvement in Health Act 2007.

Enter and View visits could be to NHS organisations, GPs, dentists, opticians and community pharmacists. Visits are not inspections but aim to offer a layperson's perspective.

PLACE assessments look at the care environment of services such as hospitals and day care centres.

Visit our website for more information.

Location	Reason for visit	What happened next
Little Manor Care Centre, Salisbury - October 2022	To survey patients, staff and families about a pilot rehabilitation scheme called Pathway 2	Feedback was shared with Wiltshire Council and the pilot scheme is currently being trialled at other care homes.
PLACE assessment at Chippenham Hospital 7.11.22	Visit carried out on the invitation of Wiltshire Health and Care	Observations shared with Nick Davey, Estates Officer
PLACE assessment at Warminster Hospital 14.11.22	Visit carried out on the invitation of Wiltshire Health and Care	Observations shared with Nick Davey, Estates Officer
PLACE assessment at Savernake Hospital 25.11.22	Visit carried out on the invitation of Wiltshire Health and Care	Observations shared with Nick Davey, Estates Officer

"Following successful tenders, two care homes in Wiltshire are now providing the Pathway 2 hub model and we are continuing to develop the hub, reflecting on all points highlighted through the Healthwatch survey."

Helen Mullinger, Commissioning Manager — Better Care Fund, Wiltshire Council

Advice and information

If you feel lost and don't know where to turn, Healthwatch is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding an NHS dentist, how to make a complaint or choosing a good care home for a loved one – you can count on us.

This year we've helped people by:

- Providing up to date information people can trust
- Helping people access the services they need
- Supporting people to look after their health during the cost of living crisis

Signposting to complaints handling support

Susan* called us to explain that they are housebound and have a nurse attending to administer injections. For several months she had great difficulty obtaining her prescription of needles.

She reported that she keeps being passed from her GP surgery to the pharmacist and for the last couple of months has ended up calling 111. When she has tried to speak to the practice they appear not to listen and won't acknowledge the problems this is causing for her.

Our Hub team told her that her feedback would be recorded and signposted her to the Advocacy People for further support.

> "It makes such a difference, people listening."
>
> **Susan***

Finding support for an autistic person

Our Hub team received an email from an autistic person about their treatment and care in hospital and mental health services.

"I have very bad [Post Traumatic Stress Disorder] from misdiagnosis and mistreatment. I am autistic, I have a heart condition, I have had mini strokes. When overwhelmed I cannot speak properly and behaviour takes over as a means of communication... My treatment in the past has caused me to be traumatised. Better understanding of [Autism Spectrum Disorder] is needed, in hospitals and GP surgeries... I ask for more training, more educating in the signs to look for, for all the autistic people that find themselves being misunderstood and mistreated."

We suggested the person contacted the Wiltshire Autism Hub for help and to recount their experience as the Autism Hub also provides autism training. We also invited them to our Wiltshire Mental Health Open Forum and highlighted that we are planning to look at the experiences of people with autism accessing mental health services in an upcoming project.

Helping people to find local cost of living support

An A-Z of organisations offering help and support during the cost of living crisis has been one of the most visited page on the Healthwatch Wiltshire website.

The page provides contact details and links to local organisations who can help, such as food banks and warm spaces, as well as information on initiatives such as the National Databank, which provides free SIM cards to people in need.

The A-Z has so far been visited 300 times and will continue to be updated.

Volunteering

We're supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we're able to understand what is working and what needs improving.

This year our volunteers:

- Attended events to promote Healthwatch Wiltshire and what we have to offer
- Collected experiences and supported local people to share their views
- Passed on advice and information
- Carried out Enter and View and PLACE visits to local services to help them improve
- Designed and managed their own projects to review GP practices' websites and automated phone messages

Sarah

"I have a background in nursing and I was CEO of Dorothy House Hospice Care before I retired. I wanted to use some of my experience in a voluntary role, and becoming a Healthwatch volunteer has been one way of doing that. I've done a range of activities over the years including giving talks about Healthwatch, manning information stalls, and teaching other volunteers about Enter and View visits. Come and give it a go! We're a friendly group who support each other and you can volunteer in a flexible way to suit your commitments or responsibilities."

Mary

"After being a Gamesmaker at the London Olympics in 2012, I was inspired to continue volunteering. I used to teach Health and Social Care, so volunteering with Healthwatch seemed to be a perfect opportunity to make use of my interest and background. I've now been doing it for 10 years! I've made lots of friends and there are so many ways to be involved. Recent activities I've taken part in include a Patient Led Assessment of the Care Environment (PLACE) at Warminster Hospital, and representing us at the Children and Families Voluntary Sector Forum (CFVSF). I'm sure we could find the perfect role for you too!"

Andy

"I've worked in the NHS (General Practice) across the South Coast since 2009 and moved to Wiltshire in 2016 just before the birth of my son, Charlie. Our experiences as a family during this time — both good and bad — inspired me to take a more active role in helping support and shape services. I am a Local Leadership Board member, but I still work full time in the NHS and try to bring my professional perspective on the issues of the day. I enjoy working with other volunteers to see how the combination of our knowledge, experience and skills can benefit all Wiltshire residents."

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch today.

healthwatch.co.uk/volunteer
01225 434218
info@healthwatchwiltshire.co.uk

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Funding received from local authority	£179,617	Staff costs	£79,340
Additional income	£300	Operational costs	£36,864
		Support and administration	£30,600
Total income	**£179,917**	**Total expenditure**	**£146,804**

Additional funding:

- **£300** was received from the Armed Forces Covenant Trust to support a project with Wiltshire Council's Ethnic Minority and Traveller Achievement Service and children's charity Spurgeons.

Top priorities for 2023-24

- Mental health and autism
- The wellbeing of children and young people
- Hospital discharge to virtual wards
- Accessing GP services

Next steps

Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services.

We will also continue our work to tackling inequalities that exist and work to reduce the barriers you face when accessing care.

New projects for 2023-24 include working with Wiltshire Service Users Network (WSUN) to review how mental health services are accessed by autistic people, and to ask children and young people for their views on how support for their wellbeing could be improved. We will also be looking at virtual wards and care at home after people have been discharged from hospital. And we'll follow up on our recommendations from our previous reports to see what impact changes to services have had for local people.

Statutory statements

Healthwatch Wiltshire, The Independent Living Centre, St George's Place, Semington, Trowbridge BA14 6JQ.

Healthwatch Wiltshire uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

Help and Care hold the contract for Healthwatch Wiltshire. Help and Care, A49, Aerodrome Studios, Airfield Way, Christchurch, Dorset, BH23 3TS. Registered Company No. 3187574. Registered Charity No. 1055056.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

Our Healthwatch Board consists of 6 members who work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Throughout 2022/23 the Board met 7 times and discussions included our partnerships with stakeholders and our contributions to their strategies. Our wider group of volunteers were involved in a priority setting workshop to decide our projects for the forthcoming year.

We are committed to taking additional steps to ensure we obtain the views of people from diverse backgrounds who are often not heard from. This year we have done this by talking to Fijian and Nepalese military families, and interviewing patients about their rehabilitation in a care home setting.

Our work priorities are driven by what people have told us is important to them, through our surveys and feedback forms, information and signposting enquiries, web page views, and our mental health forum. Our survey to hear Wiltshire people's views on possible projects for next year earned 127 responses.

Methods and systems used to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of using services. During 2022/23 we have been available by phone, email, provided a webform on our website and through social media, as well as attending meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. It will be published on our website and shared with our mailing list of 800 subscribers and on social media.

Responses to recommendations

All providers responded to our requests for information and recommendations. There were no issues or recommendations escalated by us to Healthwatch England Committee, so no resulting reviews or investigations.

Taking people's experiences to decision makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us.

In our local authority area we take information to a number of committees and forums, including:

- Wiltshire Council's Health and Wellbeing Board and Health Select Committee
- BSW VCSE Alliance (Voluntary Community and Social Enterprise)
- Children and Families Voluntary Sector Forum
- Neighbourhood Collaboratives
- Health and Wellbeing Forums
- Patient experience groups (run by the hospital trusts)
- Wiltshire Integrated Care Alliance Partnership Meeting (NHS, council, VCSE, care homes)

This year we've also shared feedback to inform Wiltshire Council's new Dementia Strategy and provided evidence for the Integrated Care Board's work to improve communications for patients being discharged from hospital.

We also take insight and experiences to decision makers in Bath and North East Somerset, Swindon and Wiltshire Integrated Care System, in meetings that include the BSW System Quality Group (NHS providers and local authorities).

We also share our data with Healthwatch England to help address health and care issues at a national level.

Health and Wellbeing Board

Healthwatch Wiltshire is represented on Wiltshire Council's Health and Wellbeing Board by Alan Mitchell, Chair of Healthwatch Wiltshire, where we have voting rights. During 2022/23 our representative has effectively carried out this role by regularly attending meetings and workshops and reminding partner agencies about the importance of involving local people.

Integrated Care Board

Alan also represents Healthwatch Wiltshire on the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Alliance Partnership, and the Wiltshire Integrated Care Alliance (WICA) Partnership Committee. He has voting rights at both meetings.

We also have a place on the BSW Integrated Care Board (ICB) Public and Community Engagement Committee.

Photo: BSW ICB

Clockwise from top: At the official opening of Devizes Health Centre in February 2023; the Warm and Well event in Marlborough in January 2023; the Wiltshire Parent Carer Council event in November 2022 and Chippenham College Freshers' Fair in September 2022.

Healthwatch Wiltshire
The Independent Living Centre
St George's Road
Semington
Trowbridge
BA14 6JQ

healthwatchwiltshire.co.uk

t: 01225 434218

e: info@healthwatchwiltshire.co.uk

@HWWilts

HealthwatchWiltshire

healthwatchwiltshire