Bath and North East Somerset,
Swindon and Wiltshire Together

Bath and North East Somerset, Swindon and Wiltshire

Integrated Care Strategy (Draft)

Note: This is a draft version and is being shared with local people, politicians, colleagues and partners so that the Strategy can be further developed and improved. At this stage the design of the document has not been reviewed by experts for presentational format or to refine the language to make it as accessible as possible. This process will be undertaken for the final version.

Integrated Care Partnership

January 2023

Ver2.1 (draft)

Bath and North East Somerset,
Swindon and Wiltshire Together

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Welcome to our Integrated Care Strategy

Welcome to the Bath and North East Somerset (B&NES), Swindon and Wiltshire (BSW) Draft Integrated Care Strategy.

This draft strategy sets out our ambition as partners in health, social care and the voluntary sector to support the people of BSW to live their best lives. The content of the strategy has been drawn from many conversations with partners and the public on many different topics and in many different forums across BSW.

The draft strategy provides an overview covering the whole BSW area and connects with local strategies that are being developed in each of our three areas of B&NES, Swindon and Wiltshire (referred to as 'Places'). It also connects with those developments that are being undertaken within individual services and organisations. In this context the draft strategy provides a summary of why we are working together and outlines some of the specific actions we are undertaking.

The intention is for the strategy to continue to evolve over the coming years as we hear and learn more from local people and our colleagues who deliver our services.

The strategy is therefore a first chapter in a much broader story of the work that we as partners within BSW are involved in. I hope you find it informative and useful in finding out more about our approach. We would welcome your thoughts on how it can be further improved.

Cllr Richard Clewer
Chair of the BSW Integrated Care Partnership

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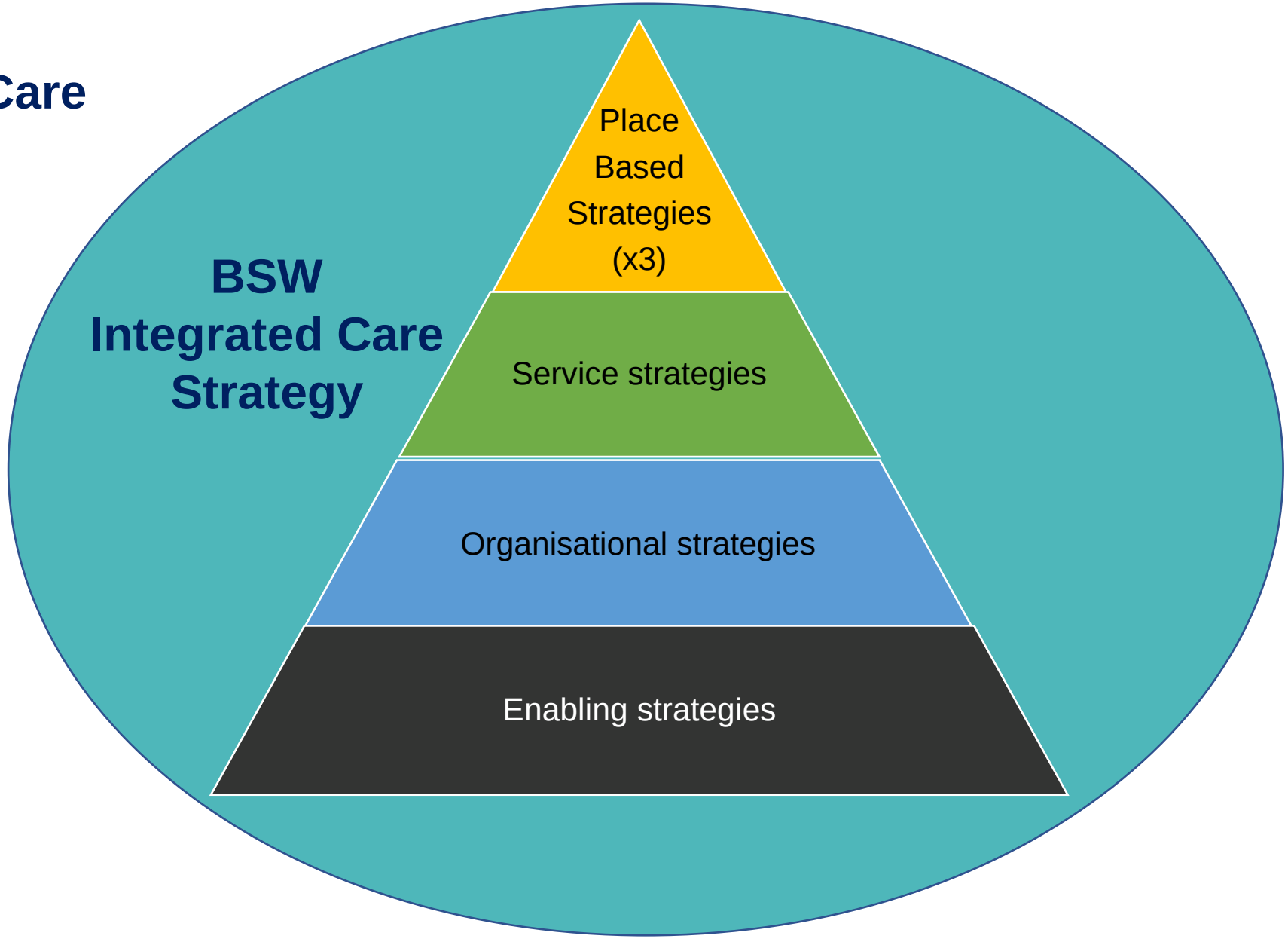
What is our Integrated Care Strategy

Our Integrated Care Strategy tells the story of how we are working together across BSW.

It brings together elements from individual strategies that exist across our health and care system under the guidance of our local Health and Wellbeing Boards.

It is not intended to duplicate or replace these other strategies, but to provide a summary of how these different elements are being coordinated to improve the health and wellbeing of the local population, to tackle the health inequalities that exist and to deliver better services.



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Common Themes Across our System (1)

Through our Integrated Care Strategy we will set out our common goals across partners. We recognise that this does not mean that our individual approaches will not be exactly the same because we need to ensure that our efforts are driven by the needs of our populations but this does not preclude us having the same overarching approach:

- Reducing inequalities across our population and targeting unwarranted variation in health and wellbeing outcomes for different communities;
- Working together to strengthen resources that can help prevent and reduce the impact of poor health across our population;
- Developing a more integrated approach to addressing the wider determinants of poor health and wellbeing; and
- Working with partners to continue the work of further developing community based resources.

Whilst our three Health & Wellbeing Strategies approach meeting the needs of communities at a Place level in slightly different ways there are strong themes of focussing on children and young people, older people and strengthening our work on prevention, early intervention and the things we can all do to keep in as good health as we can.

The previous work on the BSW Care Model is reflected in the Strategy as a way of demonstrating the line of continuity in our collective thinking in recent years. We have retained the principles and approach from the Care Model in our current work and have built on this work as we continue to strengthen our integrated approach to improving the health and wellbeing of our population across BSW.

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Common Themes Across our System (2)

The subsequent slides describe headlines from the Place based work that is being developed. We have not yet settled on shared wording for our goals and the approach mapped out above is still being worked through. We believe that the process of working through what we mean and what we want to achieve is more important that the words set out on these slides as they take us to a more integrated set of relationships that will continue to grow and evolve over the life of the strategy.

Therefore we anticipate that the wording and content will evolve and change in response to feedback on our draft documentation and in the next version of the strategy as a reflection of how the partnership is growing. In order to assure our communities and all partners that we have specific initiatives, activities and outputs that we are working to we are producing an Implementation Plan alongside the Strategy where key milestones and deliverables for 2023/24 and beyond taken from our Place and System based strategies will be set out.

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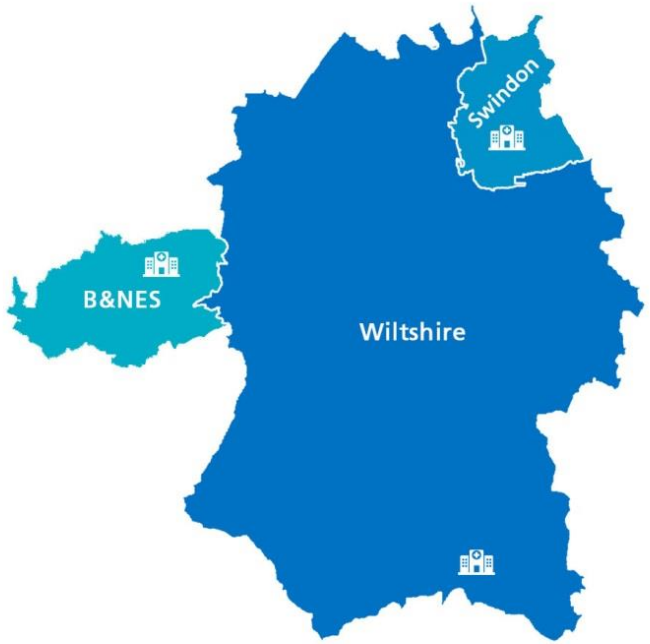
Health for the people of Bath and North East Somerset, Swindon and Wiltshire

Health for the people of Bath and North East Somerset, Swindon and Wiltshire

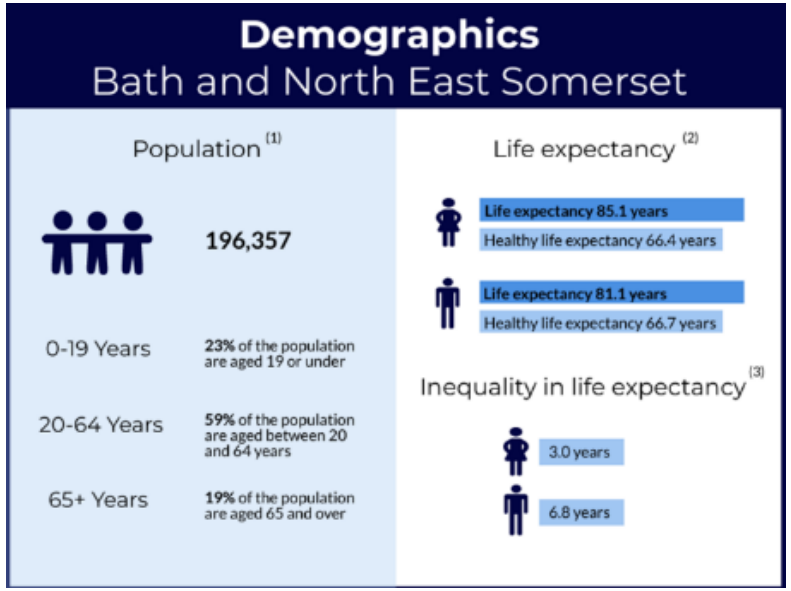


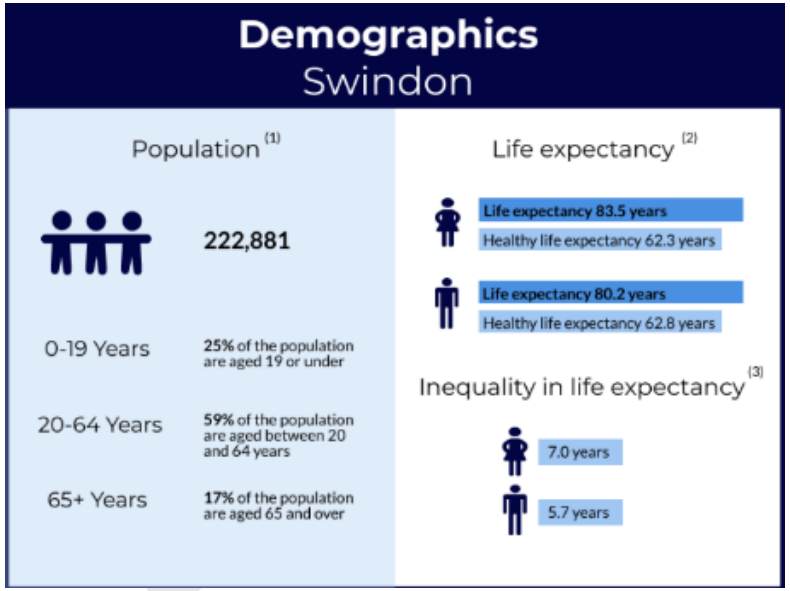
- BSW has a growing population, particularly in older age groups
- The area is more affluent than the England average, but there is a highly unequal distribution of wealth
- The cost of housing is many parts of BSW is unaffordable for the local population, with many employment options in the area offering low wages.

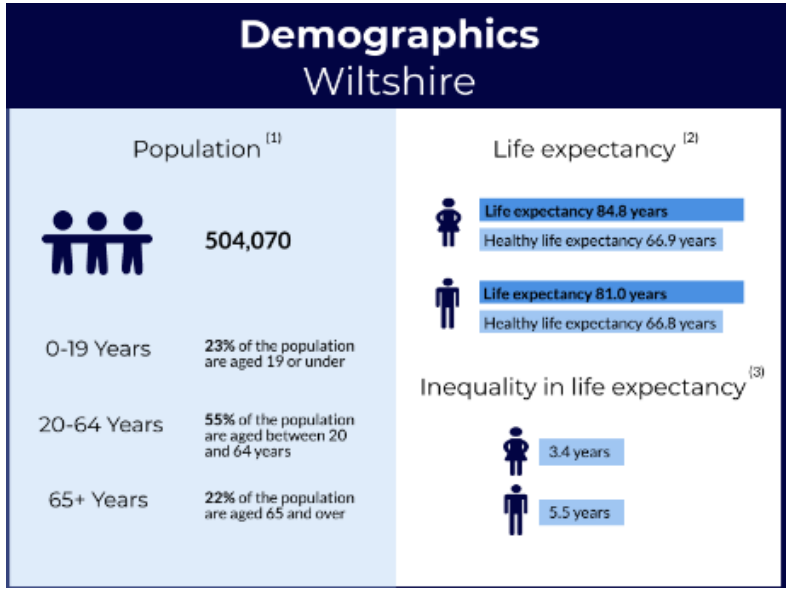
- As partners we directly employ 37,600 colleagues and benefit from the contribution of many more carers and volunteers. The majority of these individuals are also supported by the services we provide.
- In BSW there are 2,800 Voluntary, Community and Social Enterprises, three Local Authorities, 88 GP practices, 26 Primary Care Networks, three public health and three social care teams, two community services providers, three acute hospital trusts, two mental health trusts, an ambulance trust and an Integrated Care Board (ICB).
- Access to some highly specialised services requires travel outside of BSW.

Health for the people of Bath and North East Somerset, Swindon and Wiltshire

The health outcomes experienced by local people are not as good for those living in our most deprived communities compared to those living in more affluent areas. There are significant differences in healthy life expectancy across our populations and the prevalence of many health conditions is higher for those living in less advantaged communities. Tackling this inequality is a priority for all our partner organisations.







Average life expectancy in early 80s

- Women 83.5 – 85.1 years
- Men 80.2 – 81.1 years

Variation according to neighbourhood and sex

- Female in Bathavon South – 91 years
- Male in Trowbridge Central – 73 years

Access to a range of social care, NHS and partner services has been a challenge for many BSW residents since the Covid pandemic. Our strategy must prioritise improving the accessibility of services for all local people.

Health for the people of Bath and North East Somerset, Swindon and Wiltshire

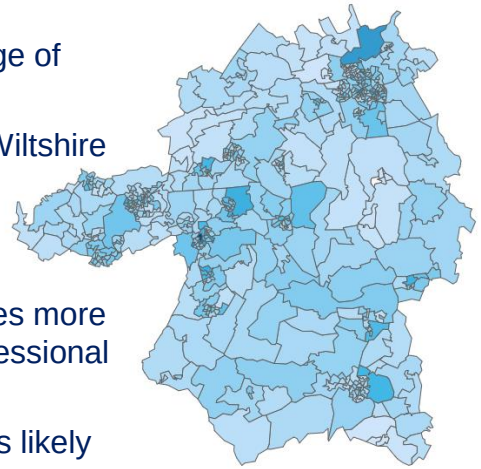
Mortality

The primary causes of premature mortality in BSW are **cancer, cardiovascular disease, and respiratory disease**

Lung cancer is the most common cause of cancer death in BSW, although lung cancer mortality rates are lower than the national average

Smoking prevalence across BSW – Indicative Heat Map

(as recorded on the GP Record for those practices and individuals that share data)



- Smoking prevalence is similar to national average of 13.9%
  - 13.0% BANES, 13.1% Swindon, 14.6% Wiltshire
  - 128,000 smokers
- Variation between social groups
  - Routine and manual workers are two times more likely to smoke than managerial and professional ones. l
  - Social housing residents are four times as likely to smoke as homeowners

Most child health indicators better than national average

Many children have difficult living circumstances

- 1 in 4 children do not achieve a good level of development at the end of Reception
- 1 in 10 children are living in poverty
- 1 in 200 children are in care

Child health challenges are changing

- Teenage pregnancy rates are decreasing
- Obesity and mental health problems are increasing

Obesity

- Adult prevalence of overweight or obesity similar to national average in Swindon and Wiltshire, below national average in BANES
  - BANES 55.4%, Swindon 66.1%, Wiltshire 63.9%
  - 578,000 people
- Swindon has highest prevalence of childhood overweight or obesity
  - Reception: BANES 7.4%, Swindon 11.2%, Wiltshire 7.9%
  - Year 6: BANES no data, Swindon 36.1%, Wiltshire 31.6%

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What difference are we trying to make?

What difference are we trying to make?

"Bottom up strategy – thinking about need of the individual before the restrictions of the system."

"I won't have to spend an inordinate amount of time and energy finding out what services are available to help me care for my disabled grandson. "

"Meeting the needs of the people on the street."

"All partners working together with the same goal, clear communications with clients"

"I wont have to beg for help"

Some messages from the population of BSW

What difference are we trying to make?

Reduce the inequalities that exists in health outcomes for the population of BSW

Improve access to services

Provide continuity of care for those living with complex health needs and long term conditions.

Create sustainable services and focus on the wellbeing of those who deliver services.

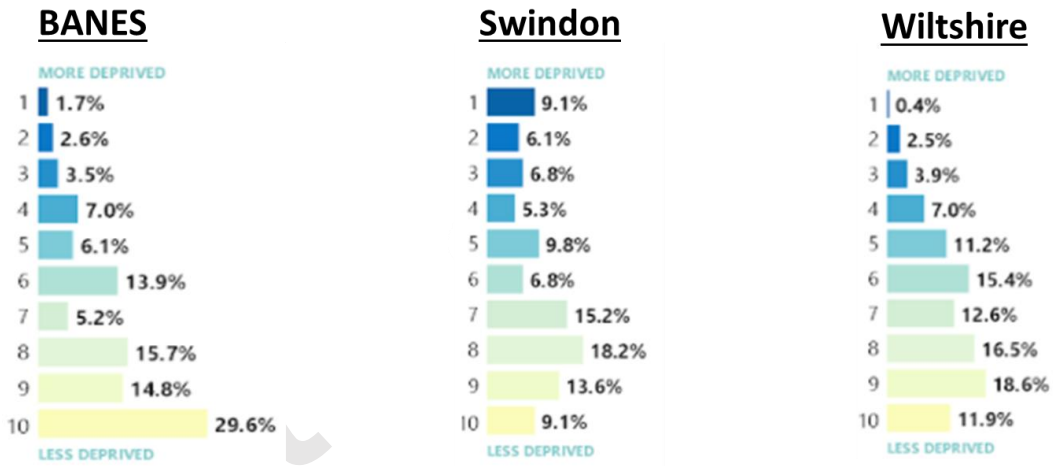
What difference are we trying to make?

Reducing Inequalities

Health inequalities describe differences in the opportunities that people have to lead healthy lives. These inequalities can include shorter life expectancy, living with poorer health and less access to care services.

These inequalities are commonly contributed to by a range of factors such as diet, exercise, smoking, employment, housing and access to transport.

These health inequalities are often experienced by those living in our most deprived communities and those living with certain health conditions such as learning disabilities and autism. Due to the scale of health inequalities across BSW, reducing them is a core priority within our strategy.



Our approach to reducing inequalities will include:

- accelerating programmes that focus on preventing ill health
- prioritising resources towards communities experiencing inequality
- developing care services fairly so that they are accessible to all
- working together to prevent digital exclusion
- ensuring we maintain and take action on accurate, complete and timely information relating to inequalities
- strengthening leadership and accountability for reducing inequalities.

What difference are we trying to make?

Draft – for discussion

Achieving the outcomes that matter.

In BSW we want to support everyone:

- to have the best possible start in life – **starting well**
- to live a healthy and fulfilling life – **living well**
- as they get older, to do so in as active, independent and healthy way as possible – **aging well**
- to have the best possible experience for them and their families when their life ends – to **die well.**

The draft BSW outcomes on the right link to our commitment as partners to focus greater attention on prevention of ill health, maintaining wellbeing and to tackle the health inequalities within our population.

As partners we want to develop these further through discussion and agree how we will measure our progress against them.

Start well 0-25 years

1. I am a healthy baby and child
2. I am ready for school
3. I am safe and live in a caring environment
4. I am active and healthy
5. I can cope with life, feel safe and know how to seek help
6. I have life and career aspirations

Live well 25-64 years

1. I can lead a healthy lifestyle in a good environment
2. I feel I have control over my daily life
3. I am happy and have a good quality of life

Age well +64 years

1. I lead an independent life
2. I am active and feel safe
3. I can access services if I need them

Die well

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help.

Whole life outcomes for the population of BSW

1. Raise the healthy life expectancy for our whole population
2. To reduce the gap in healthy life expectancy between different areas by a minimum of 50%
3. Reduce the prevalence and impact of poverty within BSW
4. Improve wellbeing and reduce the prevalence of mental health conditions within the population of BSW.
5. Reduce early deaths from preventable diseases

Note: The objectives developed around 'end of life are not currently described from the perspective of "I" is this something we wish to consider changing?

What difference are we trying to make?

Draft – for discussion

Following feedback from across B&NES, Swindon and Wiltshire we have developed a number of principles on which our approach to delivering our priorities will be based.

Principles for how we will deliver our priorities.

1. We will improve the health of our population through prevention of illness, early intervention and promoting wellbeing and independence through out life
2. We will take responsibility for addressing the wider determinants of health and will reduce health inequalities in our communities
3. We will work as one system without boundaries
4. We will focus as much on improving mental health and wellbeing as we do on physical health
5. We will make the best use of our combined available resources to deliver the best outcomes
6. We will use shared evidence, listening and learning, and co-design care around the individuals we serve
7. We will treat and support people at home or as close to home as possible
8. We will nurture a flexible and ambitious workforce
9. We will innovate and maximise the use of digital technology to improve care and access to care while supporting those with limited access to technology
10. We will make decisions as close as possible to the people they affect.
11. We will be a learning system in everything we do

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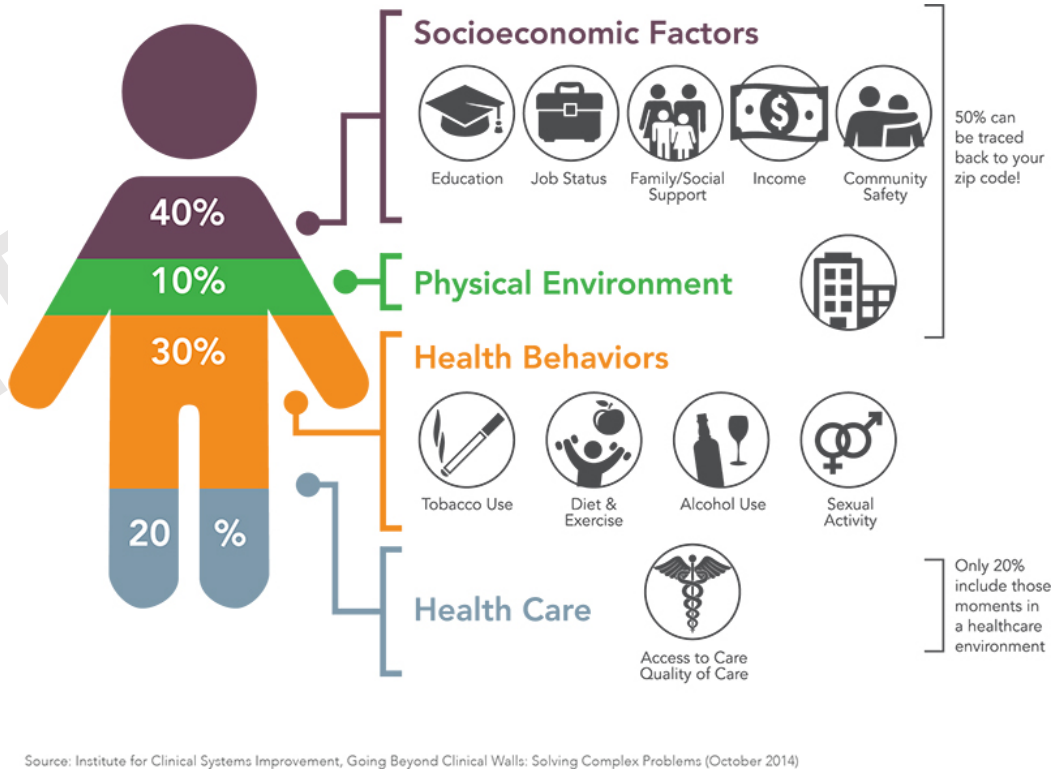
Making it happen.

Making it happen

What will make the difference?

To make a significant difference in the health and wellbeing of the people of BSW we must change those things that impact most on health outcomes. These include:

1. **The wider determinants of health** – the range of social factors such as income, employment and transport which are the most important driver for health.
2. **Health behaviours and lifestyles** – covering behaviours such as smoking, alcohol consumption, diet and exercise which are the second most important driver for health.
3. **The place and communities that we live in** – which influence our health behaviours, social relationships and networks.
4. **An integrated health and care system** – to coordinate and tailor services to individual needs rather than to suit organisations



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Making it happen

Our BSW Care Model has been designed to illustrate how we will work together to address these four elements that impact most on health

The BSW Care Model was developed through engagement with a wide range of partners. It was also informed by the development of health and care systems in the UK and internationally.

The BSW Care Model is for:

- **The whole population** - adults and children, vulnerable groups, families and carers.
- **The whole life course** – starting well, living well, ageing well, end of life care and dying well.
- **All aspects of health and care** – physical and mental health, social care, health and care services and all the wider determinants of health like education, employment and housing.

Making it happen

The Care Model consists of five core elements. Partners across BSW are working together to develop each of these.

The five elements of the Care Model are consistent with programmes of work being undertaken by partners across BSW. The model emphasises the need to develop care services around the needs of individuals, putting a stronger focus on prevention and wellbeing and working together to create an integrated health and care system.

1. Personalised care

   We want everyone who lives in BSW to experience a personalised approach, however they interact with health and care

2. Healthier communities

   We want every community in BSW to be a healthier community with reduced health inequality so that everyone has a better chance to live a healthy life

3. Joined-up local teams

   Multi-disciplinary teams, designed for and based in healthier communities, will be able to work together seamlessly to serve local people

4. Local specialist services

   We will make more specialist services available at home and closer to where people live

5. Specialist centres

   Our network of specialist centres will develop to focus more on the most specialist care and less on routine services which we can provide elsewhere

Making it happen

Note: Is this something that is common across BSW, or are there differences in approach that we need to explain?

Personalised Care
By focussing on personalised care we will support local people at three levels:

- **whole-population** - to support people 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 **people with long-term physical and mental health conditions** to build knowledge, skills and confidence and to live well with their health condition

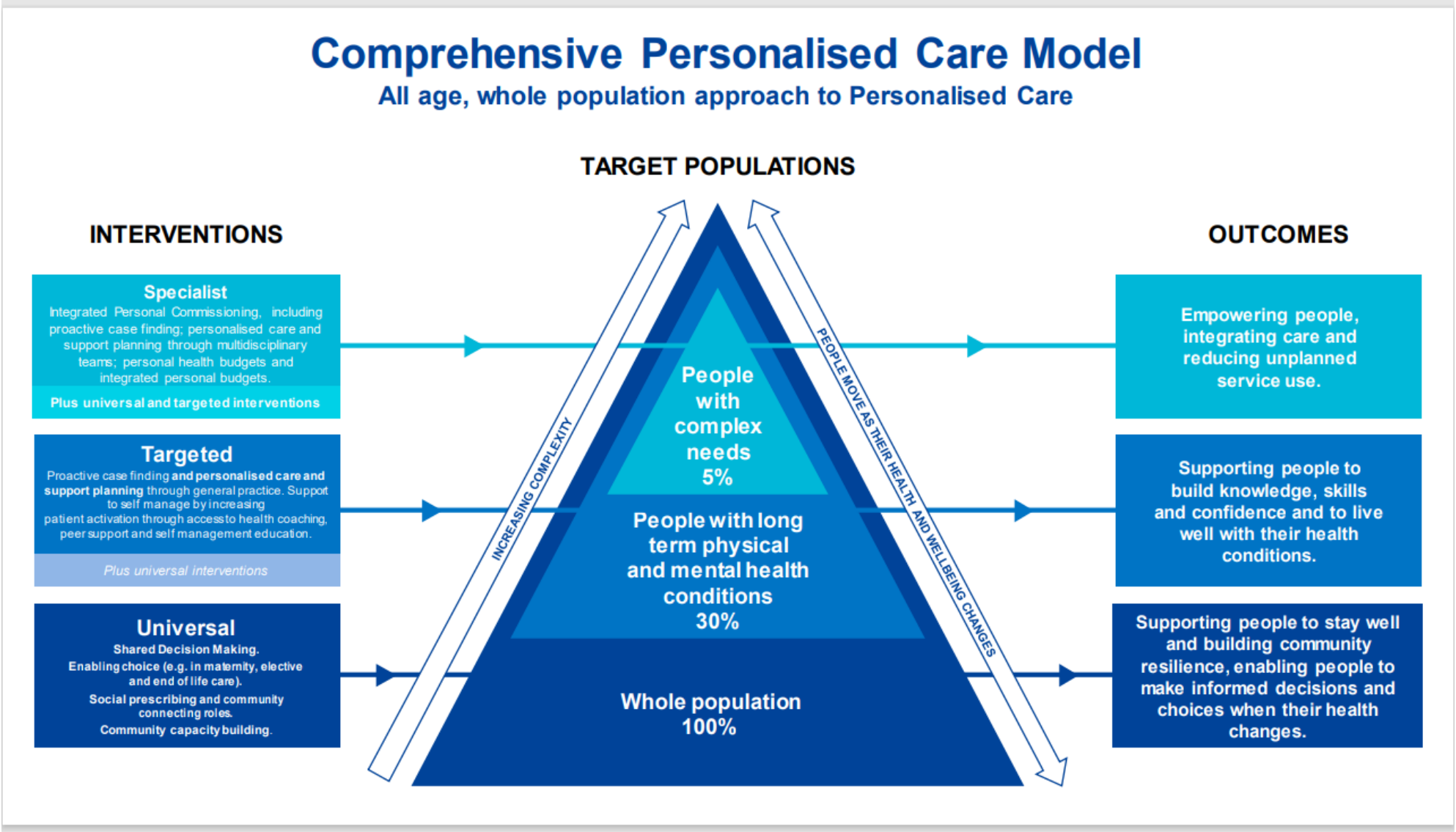
- Intensive and joined up approaches to empowering **people with more complex needs** to have greater choice and control over the care they receive.

The personalised care approach is intended to help individuals to take control and responsibility for managing their own health and wellbeing.

We will deliver a personalised care approach by implementing six, evidence-based approaches:

1. **Shared decision making** - Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.
2. **Personalised care and support planning** - a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.
3. **Enabling choice, including legal rights to choice**
4. **Social prescribing and community based support** – in which individuals are supported to access the widest range of support and services available in their community.
5. **Supported self management**
6. **Personal health budgets and integrated personal budgets**

Making it happen



Making it happen

Healthier communities

Supporting the development of healthier communities encompasses a range of interventions by partners.

- Good work
- Education and skills
- Our surroundings
- The food we eat
- Money and resources
- Transport
- Housing
- Families, friends and communities

"Voluntary Sector an equal partner/fully appreciated "

Improve skills, good work and employment

Increased employment prospects and skill development can have a direct impact on people's health and wellbeing. Workplaces therefore have a critical role in supporting the physical and mental health of their employees. In addition to supporting wider development within the local economy, as large employers, health and care organisations can play a direct role in contributing to the health and wellbeing of their employees and their families within BSW.

Housing

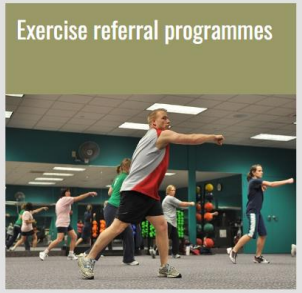
The state of housing has a significant impact on both mental and physical health and the inequalities that exist within BSW.

Improving the quality of housing across BSW is a priority for Local Authority and Housing Association partners and will have benefits in the health of local people.

Making it happen

Healthier communities

The Move More Programme in Swindon is supporting local people to become more active through a range of support and interventions.



Wellbeing and mental health

Our approach across B&NES, Swindon and Wiltshire is focussed on how individuals can manage their own health and wellbeing and draw upon the wide range of support available within their local community to help them do so.

Insert other examples of work being undertaken in particular communities across BSW (e.g. food, environment, transport, physical activity programmes etc) (Ideas/material from Directors of Public Health, Place Directors and Partners)

Emergent priorities in the B&NES Joint Health and Wellbeing Strategy

1. Ensure that children and young people are healthy and ready for learning and education
2. Improve skills, good work and employment
3. Strengthen compassionate and healthy communities
4. Creating health promoting places

Pharmacy Optometry and Dentistry

From April 2023 BSW Integrated Care Board will become responsible for the commissioning of pharmacy, optometry and dentistry within our area. This provides an excellent opportunity to work with these providers at a local level to support the health of the communities in which they operate.

Making it happen

Joined up local teams

Joined up local teams will have a critical role to play in providing both same day access for urgent care and continuity of care for individuals with long term conditions or complex care needs.

They will focus on three key ‘offers’ to the local population:

- improved access to care & advice
- proactive personalised care from a range of team members for individuals with long term or complex health needs.
- helping everyone to stay well for longer (prevention)

Joined up local teams will be designed to serve populations of around 30,000-50,000 people in natural neighbourhoods across BSW.

Forming these teams is an important element in developing sustainable health and care services.

They will enable partner organisations to work together to ensure that individuals are accessing care and support from the most appropriate sources, including voluntary and third sector organisations. This is important if health and care organisations are to address the current workforce challenges that exist today and individuals are to make the most of the wide range of resources that are available within their community.

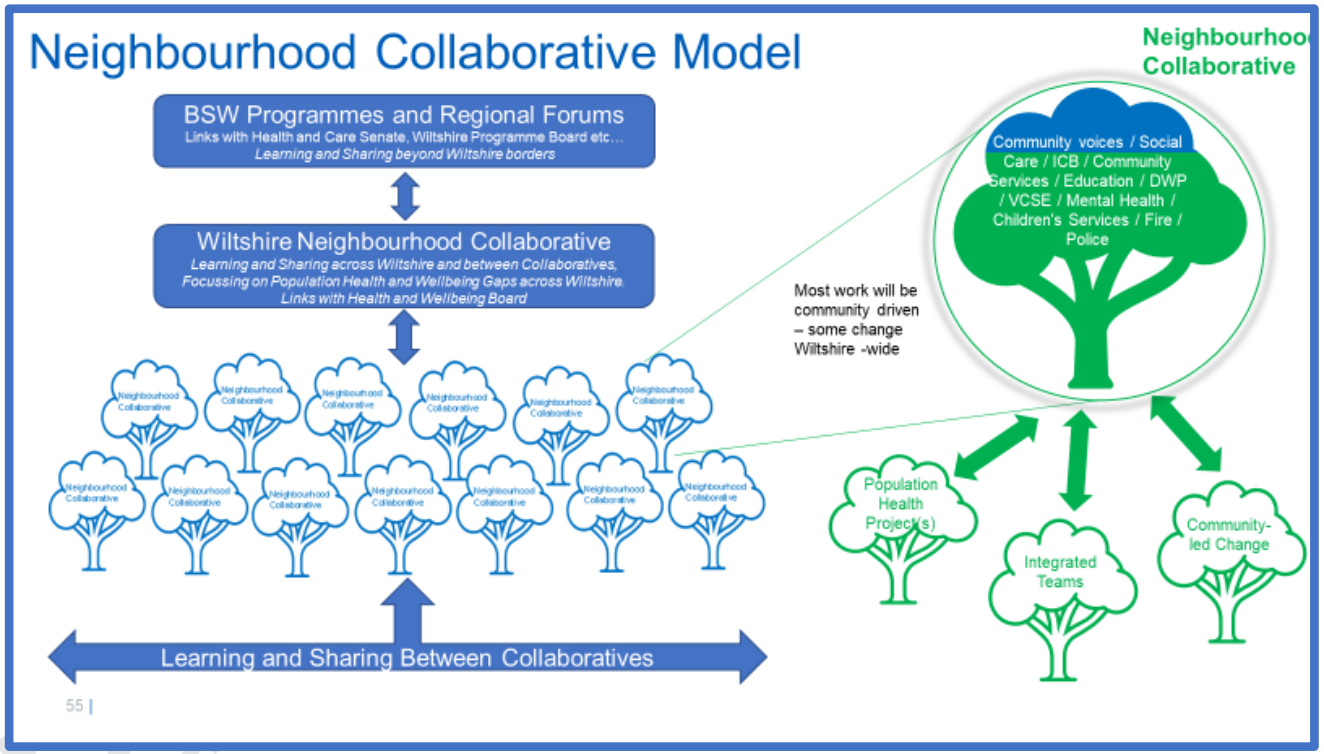
These teams will work across traditional professional and organisational boundaries. To support this way of working we will revise how our performance management, information sharing, clinical governance, information technology, finances and contracting processes operate. This will help these neighbourhood teams operate with flexibility and responsiveness in the way they support their local population.

Making it happen

Joined up local teams

Work is underway in Wiltshire to develop a series of thirteen Neighbourhood Collaboratives.

These collaboratives will bring together partners from a range of sectors to provide integrated support to the local populations across the County.



STARTING WELL

LIVING/AGEING WELL

DYING WELL

1 **UNIVERSAL AND EARLY HELP SUPPORT**
Providing children, young people and families support and care in the community including physical and emotional wellbeing.
- Delivering the Healthy Child Programme 0-19 (25).
- Health Visitors and School Nurses holistic health including escalation and support into specialised services and safeguarding.

2 **COMMUNITY HEALTH**
Providing children, young people and families care in the community for both physical and emotional wellbeing.

3 **TARGETED SUPPORT**
Providing children, young people and families with targeted specialist care for physical health.

4 **SPECIALIST SUPPORT – CHILDREN WITH COMPLEX NEEDS**
Providing children, young people and families with targeted and specialist care for complex needs and physical health.

5 **SUPPORTING SELF CARE & PREVENTION**
- Care co-ordinators / navigators, diabetes courses
- One to one support/care navigation
- Education/information giving
- Includes LD and Autism

6 **PROACTIVE CARE AND SUPPORT**
- Clinical support at home (short, medium & long term)
- Advice and treatment for health need
- Specialist support for people living with one or more long term condition and/or frailty
- Includes LD and Autism

7 **RESPONDING TO URGENT NEEDS**
- MIUs / Urgent care hubs, Urgent Community response
- Response to urgent need in your own home
- Response to urgent need in a healthcare setting

8 **REHABILITATION AND RECOVERY FROM ILL HEALTH AND/OR CRISIS**
- At home
- Not at home

9 **PALLIATIVE AND END OF LIFE CARE IN ALL SETTINGS**
- Provision of the health & care support. Early identification,
- Personalised & co-ordinated care with staff & carers.
- Fair access to care. Shared care records, Meeting complex needs.
- 24/7 access, including rapid response. Integrated services.

10 **BEREAVEMENT SUPPORT**
Meeting the needs of the dying person's loved ones before and after death to prepare them and support them adapting to their loss.

These services have critical interfaces with other services (e.g. voluntary sector, social care, public health, primary care, mental health and acute services). These interfaces will need to be considered as part of the co-design process.

LIFE STAGES / ICBC BUNDLES

Integrated Community Based Care Services

We are reviewing the way our current community based health and care services need to operate to ensure they align with these new local teams across BSW. This is a significant programme of work and will need to involve partners from across our health and care system.

Making it happen

Local specialist services

Advances in technology means more services can be provided in local settings. Increasing the range of specialist services available within people homes and the community is a priority and is important in ensuring services are easy to access for local people.

Work is already underway on a range of initiatives including:

- enhanced access to diagnostic facilities at locations across BSW
- access to specialist services to support prevention and management of long-term conditions
- the creation of virtual wards to enable local people to access a range of specialist services without the need to spend as much or any, time in a hospital bed.

Community diagnostic centres

The initial work in 2023 on community diagnostic facilities will focus on the deployment of mobile units.

From 2024 the focus will be on additional permanent facilities within BSW.

"Community Diagnostic facilities will deliver additional, digitally connected, diagnostic capacity in BSW, providing all patients with a coordinated set of diagnostic tests in the community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of a clinical pathways."

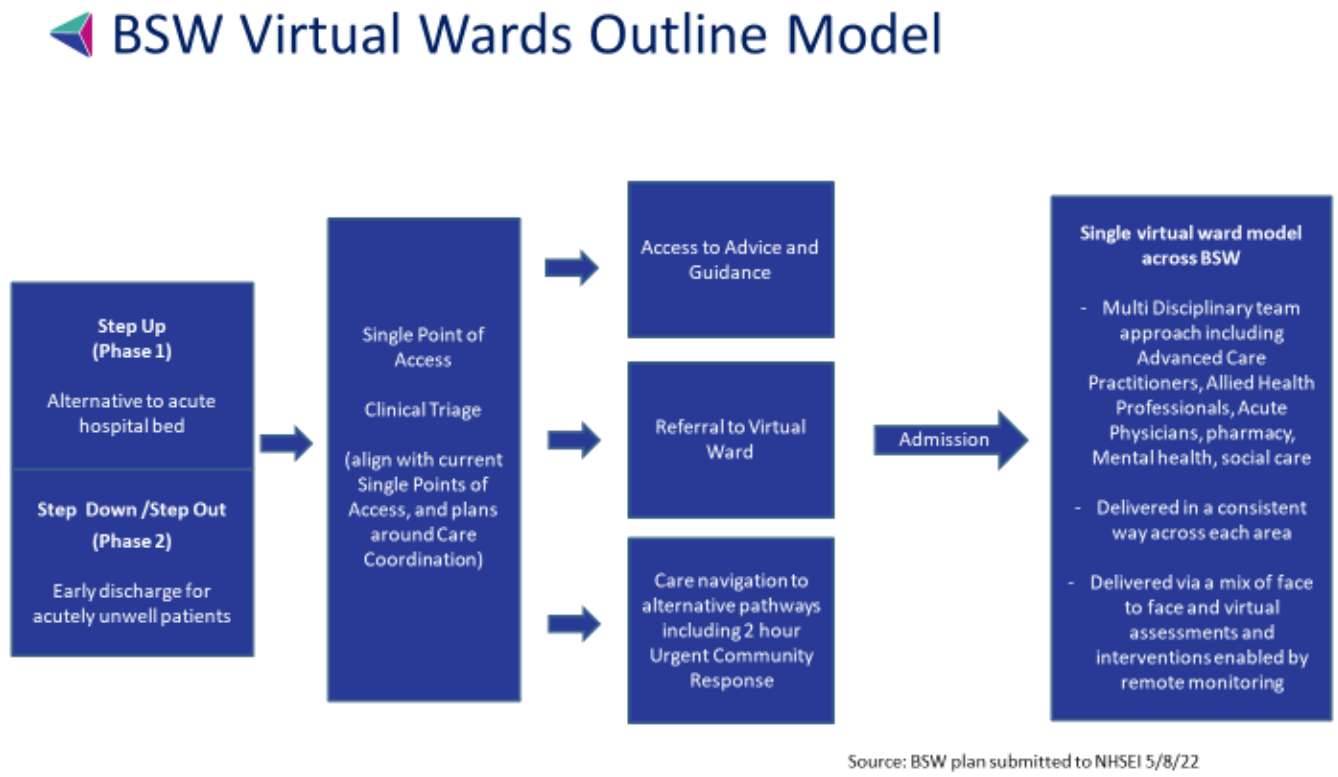
Vision Statement for Community Diagnostic facilities

Making it happen

Local specialist services

Virtual Wards provide a safe and efficient alternative to the use of an NHS hospital bed, by supporting individuals to receive their care, assessment, monitoring and treatment in their home or usual place of residence. Virtual Wards combine care delivered by a range of staff supported by technology including a shared care record and remote monitoring.

The virtual ward services in BSW will provide a range of interventions, tailored to meet the needs of the individual, to help prevent hospital admissions and to accelerate discharge from hospital.



Source: BSW plan submitted to NHSEI 5/8/22

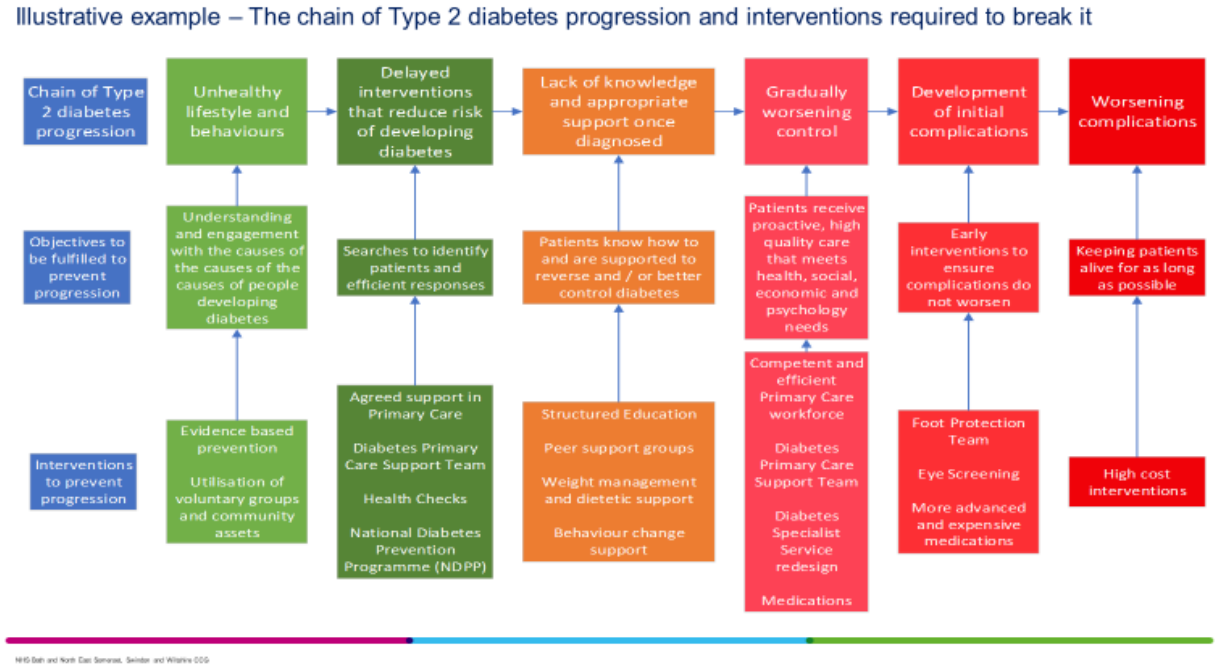
Making it happen

Local specialist services

Long Terms Conditions

With an ageing population the prevalence of conditions like mental illness, cardiovascular disease, respiratory disease and diabetes is increasing across BSW. Our work on managing these conditions is designed to focus on three areas:

- Prevention: encouraging behaviours that prevent the onset of conditions.
- Prevalence: early and proactive identification of people at risk to reduce the impact of conditions.
- Treatment: increasing the percentage of people, particularly those facing health inequalities, achieving NICE guidance treatment targets.



We are working with our specialists in these conditions to connect them with the emerging joined up local teams in each neighbourhood in order to provide coordinated lifestyle, psychological and medical advice and support.

Through our specialist services and our neighbourhood teams working together, our aim is to prevent, break or slow the chain of progression that results in poorer outcomes for our population and increased costs and pressure for the health and care system.

Making it happen

Specialist centres

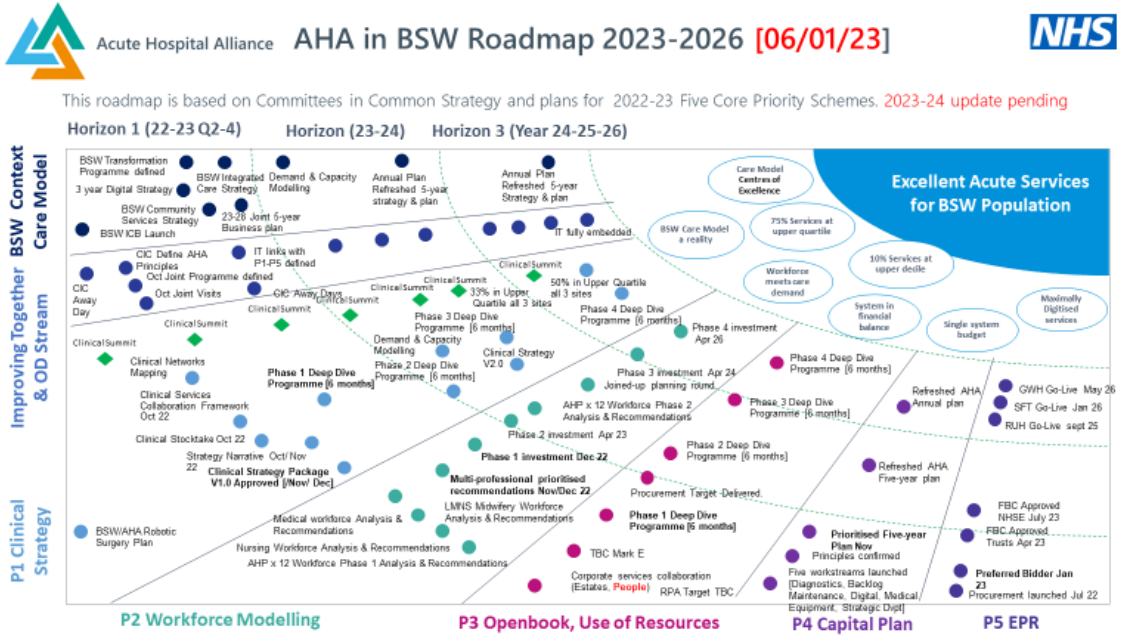
Our hospitals and other specialist facilities play a critical role in the provision of services to individuals with urgent, long-term and elective health care needs.

The challenges of the pandemic and the pressures during the winter of 2022/23 have highlighted the importance of the hospital sector capacity being available for individuals with acute conditions.

Through the work of our Acute Hospitals Alliance (AHA), which involves the organisations that run the Great Western Hospital in Swindon, the Royal United Hospital in Bath and Salisbury District Hospital colleagues are working together to improve the way services are delivered.

The AHA are developing a clinical strategy that will set out the role the hospitals will play in the delivery of urgent care services, the management of long-term conditions and how they can improve the quality and productivity of elective care services in areas like outpatients, diagnostics and surgery.

Note: Image being updated over the next few weeks.



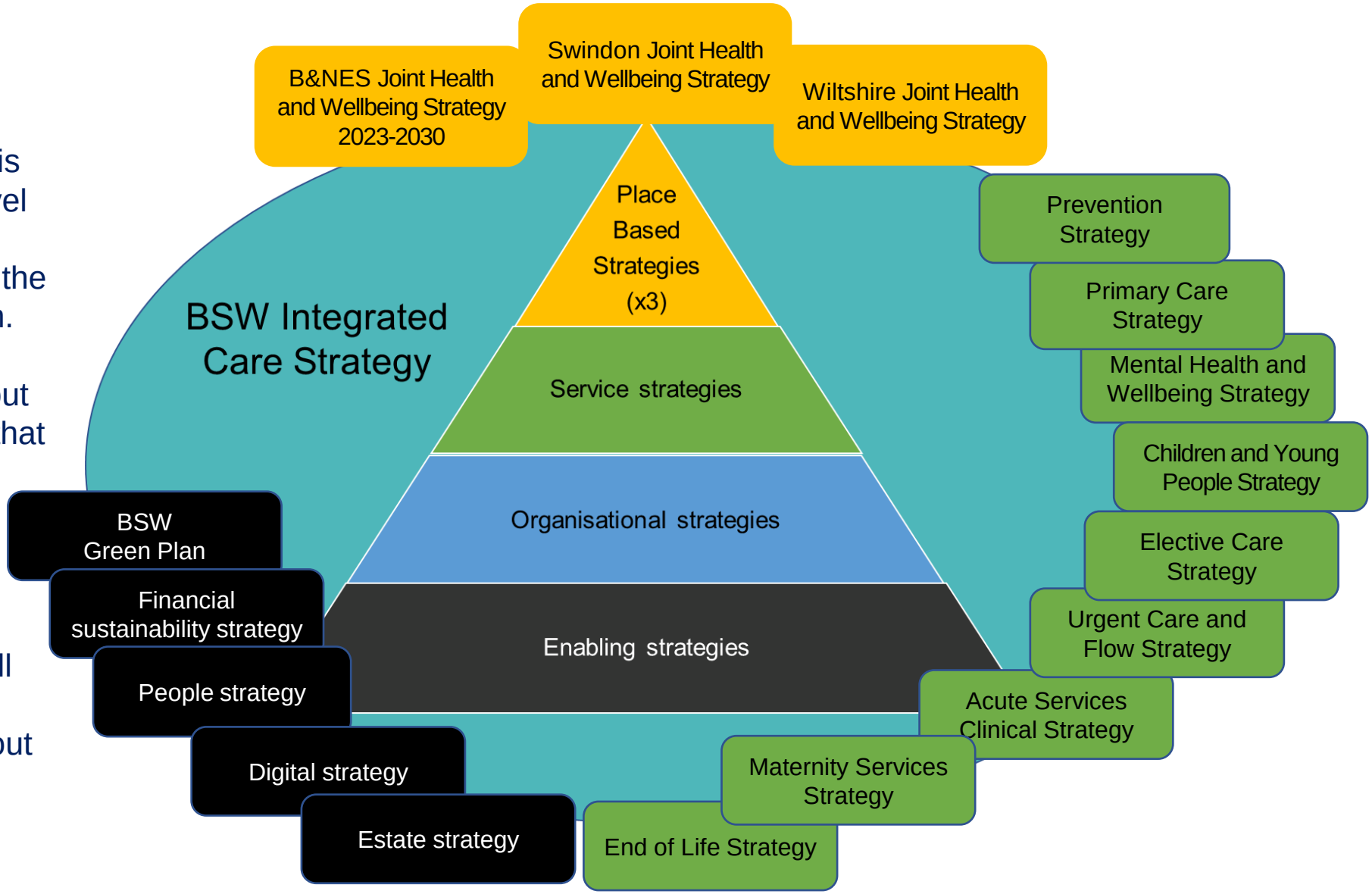
The partners in the Acute Hospital Alliance are also working together on the development of facilities in the Sulis Hospital in Peasdown St John. This modern facility could play a critical role in reducing the waiting times for surgical procedures for the population of BSW

Making it happen

This integrated care strategy is intended to provide a high-level overview of the strategic approach being taken across the whole health and care system.

Far greater detail will be set out in each of the sub strategies that are being developed across BSW.

The individual strategies will clearly demonstrate how the approach being developed will help to deliver the priorities, outcomes and principles set out in this strategy.



Making it happen

Transformation Programme

Delivering the changes described in this strategy will require coordinated programmes of work to be delivered at pace. To be successful these programmes will need to make a difference from the homes in which individuals live through, every setting where care is delivered up to and including our specialist hospitals.

The proposed programmes of work are illustrated below. These programmes will be overseen by the three Local Authorities and the Integrated Care Board and will report into these statutory organisations as appropriate.

A strategic programme management office will support the delivery of these programmes, ensuring they are properly initiated, resourced and managed. The strategic programme management office will also facilitate progress reporting to partner organisations across BSW.

- B&NES Place Based Transformation Programmes
- Swindon Place Based Transformation Programmes
- Wiltshire Place Based Transformation Programmes
- BSW Elective Care Programme
- BSW Mental Health Programme
- BSW Urgent Care and Flow Programme
- BSW Learning Disability and Autism Programme
- BSW Population Health and Care Programme
- BSW Integrated Community Based Care (Including Children and Young People) Programme

Making it happen

Delivering the Strategy (1)

Our strategy brings together the range of strategies in place and in development across our system. Each of these strategies, either at a Place or System level, set out a range of priorities and areas of change and improvement for our population.

We are clear that we need to demonstrate how we are progressing each of these strategies and the overarching Integrated Care Strategy.

Our approach to doing this is through our Integrated Care Strategy Implementation Plan. This is our local version of the Joint Forward Plan which all Integrated Care Boards across England are required to produce. Our Implementation Plan sets out the key elements of the plans to deliver our system strategy and the Place and population group strategies therein.

It should be noted that as part of our assurance that our strategies and plans are consistent and complementary, we are required to consult on the Implementation Plan with our local Health and Wellbeing Boards. This is an important component of the work to strengthen the integration of approach across all system partners.

Making it happen

Delivering the Strategy (2)

The Implementation Plan is also a Five-Year document that will be updated to reflect progress and future development of the Strategy. This annual refresh process will take place alongside the refresh of the Strategy and will enable partners to review progress and to take into account any changes in priority and population need.

The plan will reach across all partners rather than solely the NHS. The Implementation Plan should be considered alongside the Strategy. It is aimed at fulfilling the following:

- Setting out key milestones and deliverables from the constituent strategies that make up the body of what we want to deliver through our Integrated Care Strategy. This will not be an exhaustive list of all the milestones and deliverables in those strategies but, instead, the key ones that demonstrate our integrated partnership approach;
- The 2023/24 version of the Plan will focus on the coming year and will be updated annually;
- Setting out the key duties required of the NHS as part of the Joint Forward Plan; and
- Setting out the key transformation programmes and services that deliver the NHS elements of the Strategy.

Bath and North East Somerset,
Swindon and Wiltshire Together

Making it sustainable

by using our resources people, technology, buildings and money differently

Making it happen

There are a range of enabling activities that will underpin the development of sustainable health and care system.

Developing our workforce
37,600 people work in health and care in BSW. Work is underway to respond to the 10 improvement themes identified in the People Plan, with a strong focus on recruitment and retention of the workforce required.

Making the best use of technology and data
We will make the best use of technology and data to improve health and care for people in BSW. We know that some people cannot access technology and we will make sure our services are always accessible for everyone.

Investing in facilities of the future
We will invest millions of pounds to improve community facilities, open up new locations and ensure that our specialist centres are fit for the future.

Financial sustainability
BSW faces a significant financial challenge over the next decade. Partners will to work together to ensure we achieve the maximum value for every £ we spend.

Making it sustainable

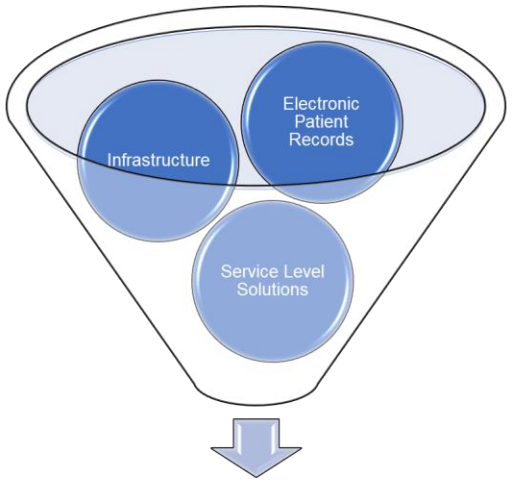
Place holder for our workforce response

Action Jas Sohal

Making it sustainable

Place holder for our digital response

Action Jane Moore



Use of information?

Making it sustainable

Place holder for our Estates response

Action: Simon Yeo

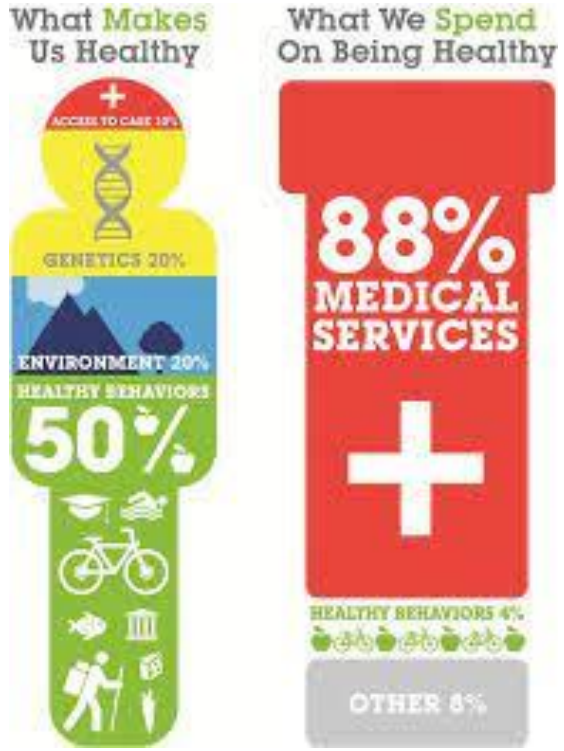
Making it sustainable

Place holder for our financial response

(covering NHS and Local Authority financial position required and setting out our approach.

Key messages – how we use our resources today
What do we want to be different in future?)

Action: Gary Henege



"A system that understands the whole cost of health care "

Making it sustainable

Place holder for summary of our Green Plan

Action: Simon Yeo/Geoff Underwood

Anchor System

Place holder for our narrative on our role as Anchor Institutions

Proposed Authors: Place Directors/Dir of Strategy and Transformation

- Anchor culture
- What do we mean by and want from an Anchor Culture within BSW?
- What are the Macro and Micro interventions that we want to make?

Bath and North East Somerset,
Swindon and Wiltshire Together

Please let us know what you think

We are asking our local colleagues working in B&NES, Swindon and Wiltshire to discuss this strategy and gather feedback as part of their ongoing engagement with local residents and health and care colleagues. The intention is to have an approved version of the Strategy by 31st March. After that the approach and the strategy will continue to evolve as we respond to the changing needs of the local population.

We would welcome any feedback you would like to provide on this draft strategy and how you feel it cimprove it.

Please send your thoughts to (we need a generic email address that can be used to capture this feedback)

Action – Jane Moore