Bath and North East Somerset, Swindon and Wiltshire Together

Note: Document to be designed before publication

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

Integrated Care Strategy 2023-2028

Integrated Care Partnership

March 2023

Ver 3.0 (Final)

Bath and North East Somerset,
Swindon and Wiltshire Together

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1. Welcome to our Integrated Care Strategy

Welcome to the BSW Together Integrated Care Strategy.

This strategy sets out our ambition as partners in health, social care, voluntary and other sectors to support the people of BSW to live happier and healthier for longer. 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 strategy provides a direction of travel covering the whole BSW area and connects with local strategies that are being developed in each of our three areas of **BaNES**, **Swindon** and **Wiltshire** (referred to as 'Places'). It also builds on the good work already being undertaken within individual services and organisations. In this context, the strategy provides a summary of why we are working together and outlines some of the specific actions we are already 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. Crucially, this strategy is not just about serving our residents, it is about working with them as active partners.

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

2. What is an Integrated Care Strategy?

Telling our story

BSW Together is required by law to produce an Integrated Care Strategy. This sets the direction of the system for the next five years, outlining how the NHS, local authorities, the private sector, voluntary, community and social enterprise (VCSE) organisations and other partners can improve integrated working to help people in BSW to live healthier for longer.

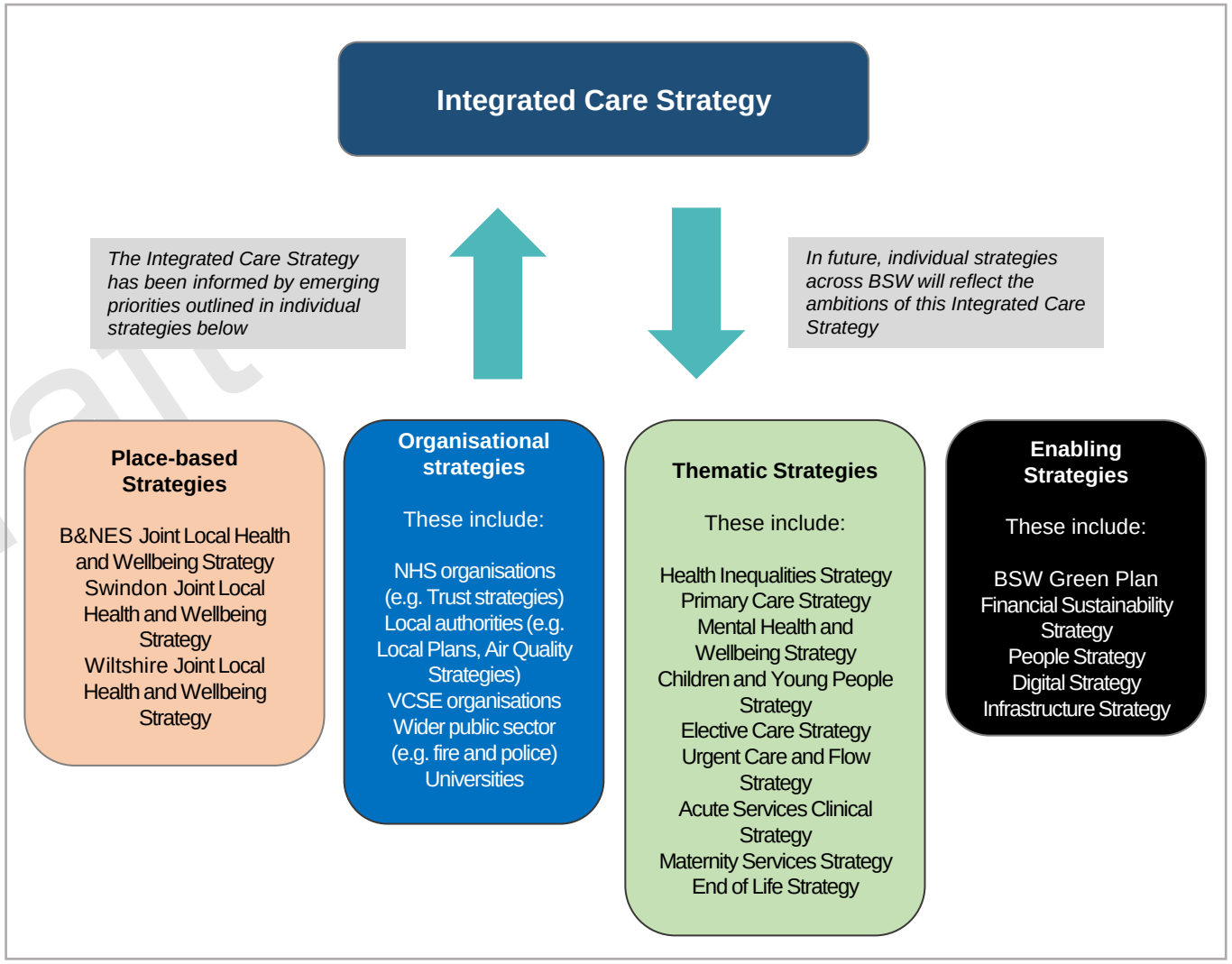
Importantly, therefore, this is a strategy for us all, not just the NHS. **We cannot help BSW residents to improve their health and wellbeing by working in silos – we can only do so by working together**.

This strategy sets out a vision and strategic objectives we will work in partnership to achieve. It is not 'set in stone' and we intend for the strategy to evolve over the coming years. Crucially, this document sets out **what** we hope to achieve and **why**, but an **Implementation Plan** (also known as a Joint Forward Plan) will be published later this year detailing **how** partners will deliver it, including key milestones and deliverables.

This document brings together elements from individual strategies that exist across our health and care system, including those 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 align.

It is also informed by the four purposes of integrated care systems, which are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.



2. What is an Integrated Care Strategy?

Who has produced our strategy?

This strategy has been produced by BSW Together's Integrated Care Partnership. The Integrated Care Partnership first met in October 2022 and our intention is for this forum to bring together the multiple different partners working not just across health and local government but also a range of other stakeholders whose work affects the health and wellbeing of our residents. This includes those listed on the previous page.

The Integrated Care Partnership's purpose is to consider long-term health and wellbeing challenges in BSW that are complex to solve and require joined-up approaches between partners. It will propose objectives to include when we update this Integrated Care Strategy in future and importantly it will also monitor the delivery of the Strategy over time, ensuring that we are all doing our bit to deliver it.

We want to use the ambition outlined in this strategy to keep us focussed over the coming years on the things we can only achieve by working together.

The Integrated Care Partnership holds all its meetings in public. If you would like to attend any of these meetings, ask any questions or find out more about the partnership then you can do so through our website at www.bswtogether.org.uk

Design principles for our strategy

The Integrated Care Partnership has set out to produce a strategy that is:

1)	**Bold**	The strategy represents an opportunity to set out an ambitious future for health and care across BSW, with significant benefits to be reaped through partnership working and prevention
2)	**Accessible**	Any resident across BSW should be able to read the strategy and understand it. We have therefore opted for a visual and digestible format, written as far as possible in plain English.
3)	**Commitment-oriented**	This strategy aims to unite partners across BSW behind behaviours and actions that will help us to achieve our system's vision.
4)	**Broad**	This strategy is not about taking action on everything at once, but rather to set key strategic objectives and a direction of travel.
5)	**Measurable**	Where possible, we have tried to ensure that the goals and commitments set out in this document are measurable so that BSW residents can assess us on our progress over time.
6)	**Locally-driven**	This strategy is not overly prescriptive on what should occur locally across our three places, which will also set their own priorities.

3. 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:

Listening and working 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 & Data
- Estates of the Future
- Environmental Sustainability
- Our Role as Anchor Institutions

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4. Our starting point: The current picture across BSW

This section outlines what BSW currently looks like in terms of demographics, health, wellbeing and socioeconomic profile.

In this section:

4.1 Challenges across BSW

Many of the challenges identified in individual Joint Strategic Needs Assessments are shared across the whole system. These include the following:

Inequality

BSW is more affluent than the England average, but there is a highly unequal distribution of wealth across the system. Deprivation levels are highest in Swindon and there are significant differences in life expectancy depending on where you live in BSW. For example:

- A female in Bathavon South – 91 years
- A male in Trowbridge Central – 73 years

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.

An ageing population

The age profile of the BSW population is changing and this is going to place further pressure on health and care services. In Wiltshire alone, the 65+ population currently represents just over a fifth of the population but by 2040 this age group will make up nearly a third of the total population. This will also have the long-term effect of reducing the proportion of our population who are working.

The cost of living

In 2022, annual inflation hit a 40 year high, with consumer price inflation at over 11%. This has placed a significant amount more pressure on our communities and individuals through the increased cost of living. Higher bills for heating and food, for example, is likely to have had a detrimental impact on health and healthy behaviours across BSW, in turn leading to increased health inequalities.

Access to services

Access to a range of social care, NHS and partner services has been a challenge for many BSW residents since the Covid pandemic. A recent report produced by Healthwatch and the CQC, for example, found that many people living with mental ill health in BSW are unable to access mental health services. Waiting lists are very long and people have reported feeling they are 'getting lost' in the system.

Our strategy must prioritise improving the accessibility of services for all local people.

Rurality

BSW, especially across Wiltshire and BaNES, has a high proportion of areas that are considered rural. There are several challenges that rural areas face, including around transport and broadband connectivity. In terms of health services, trusts operating in rural areas tend to treat more older people than in urban areas. This is partly caused by the migration of young people away from rural areas. Frailty and complex comorbidities amongst elderly populations present major challenges to the delivery of care in rural settings – particularly in isolated, small communities.

Children's health

While most child health indicators are better than national average, many children have difficult living circumstances across the system:

- 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
- Obesity and mental health problems are increasing

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.

Housing

The cost of housing in parts of BSW is unaffordable for the local population, with many employment options in the area offering low wages. In the South West, housing prices rose sharply during the pandemic and the most deprived parts of the population have been hit hardest by the rising cost of living. In Wiltshire, for instance, median house prices increased by 48% from 2011 to 2021, while gross annual residence-based earnings increased by only 14%. This problem is also shared in BaNES and Swindon.

There is a severe shortage of social housing across BSW. Over 6,000 households are in housing need and waiting for accommodation in Swindon alone. Quality of housing also remains a problem across both private and social housing. We know that cold, damp homes can have a significantly detrimental impact on occupants' physical and mental health and wellbeing.

4.2 Our assets

There is much to be proud of across BSW. Achieving our vision and addressing the challenges we face will not be easy, however we have excellent assets to draw on. These include:

Supportive communities

Thousands of people provide unpaid care to support loved ones and/or give up their time through a volunteer role. The Voluntary, Community and Social Enterprise (VCSE) sector makes a huge contribution to the health and wellbeing of BSW residents.

A history of partnership working

We have been working together since we formed a sustainability and transformation partnership in 2016. This means that we have a long history of integrated working.

Collectively, we work towards a vision which guides our collaboration and inspires the action needed to make change happen.

Above average health profile

Despite the challenges set out on the previous page, BSW benefits from having a positive health profile. On most health indicators, ranging from life expectancy to infant mortality, our three places perform better than average for England. That said, Swindon in particular has high levels of health inequalities and public health indicators reflect poorer performance here than England in some domains.

High quality services

In BSW there are 2,800 Voluntary, Community and Social Enterprises, three Local Authorities (including their public health and social care teams), 88 GP practices, 26 Primary Care Networks, two community services providers, three acute hospital trusts, two mental health trusts, an ambulance trust and an Integrated Care Board (ICB) overseeing NHS services, as well as hundreds of partners across the private sector who help deliver excellent care.

A diverse and committed workforce

In BSW, we directly employ 37,600 colleagues in health and care services alone, with many more thousands across the wider public, VCSE and private sectors.

We have an outstanding health and care workforce, delivering high quality services. The majority of these individuals are also supported by the services we provide.

Education and research

BSW is home to the University of Bath and Bath Spa University. This gives us an excellent research base within the system. Independent analysis has shown that the operational activities of the University of Bath alone generated £340 million gross value added (GVA) for the economy of Bath and North East Somerset. There are also colleges across each of the three places that help to ensure a skilled and dynamic workforce.

Our NHS providers also play a vital role in research and we are well prepared to take an increasingly systematic approach to research across BSW.

Industry and employment

There is a thriving private sector across BSW, generating growth and jobs across the system. In recent years the Swindon and Wiltshire LEP alone estimates that some 30,000 businesses thrive in the area contributing £21bn GVA annually to the UK economy. In BaNES, the main commercial and recreational centre, is Bath. This is a World Heritage City and is an international tourist destination that provides a spectacular setting for world-class arts, culture, and leisure facilities.

4.3 A system of three places

BSW's three places each have their own population health profiles and challenges. Each place is developing their own **Joint Local Health and Wellbeing Strategy** for addressing the needs set out in their **Joint Strategic Needs Assessment**. This strategy is directly informed by the public engagement and ambitions set out in these documents.

We want to empower each of the below three places to make their own decisions about services for their local populations. This strategy sets out priorities for all BSW partners, yet how each place delivers on these priorities may differ and is largely outside the scope of this strategy.

	Bath & North East Somerset	Swindon	Wiltshire
	Population 193,400 **Life expectancy** Male: 80.3 years [England 79.0 years] Female: 84.8 years [England 82.9 years] **Healthy life expectancy** Male: 66 years Female: 66 years *Source: Strategic Evidence Base for Bath & North East Somerset*	**Population** 222,881 **Life expectancy** Male: 79.1 [England 79.0 years] Female: 83.1 [England 82.9 years] **Healthy life expectancy** Male: 61.4 years Female: 62.2 years *Source: Joint Strategic Needs Assessment (2022)*	**Population** 510,400 **Life expectancy** Male: 80.9 years [England 79.0 years] Female: 84.5 years [England 82.9 years] **Healthy life expectancy** Male: 66 years Female: 65.2 years *Source: Joint Strategic Needs Assessment (2022)*
Other selected challenges *(from Joint Strategic Needs Assessment)*	**Effects of increased cost of living.** Estimates suggest 4,000 people (of whom 1,500 are children) will have fallen into absolute poverty in 2022/23. **Mental health & special educational needs and disability (SEND).** BaNES has a significantly higher rate of hospital admissions (19.4 per 100,000 population) due to eating disorders than the national average (12.1). The number of Special School places available in B&NES has not matched increasing demand. **Readiness for education.** There is a 28% attainment gap between children eligible for Free School Meals (FSM) and those not known to be eligible for FSM at Early Years Foundation Stage.	**Deprivation.** Swindon is ranked as the 98th most deprived area out of 151 Upper Tier Local Authorities (UTLAs) in England but some smaller areas are in the 10% most deprived in the country. **Mental health**. Admissions to hospital for self-harm across all ages is significantly higher than the average for the south west and England as a whole. The picture is particularly troubling in relation to children. **Healthy life expectancy**. Males in Swindon will spend 80% of their lives in good health, but for females it is only 74%.	**Mental health.** In 2020/21, 44,000 people (18 and over) had a diagnosis of depression, equivalent to 11% of the population. Rates of hospital admissions for self-harm are at their highest level for five years. **Age-related conditions.** By 2030, it is estimated that almost 11,500 people aged 65 and above will be living with dementia. **Education:** In Wiltshire, regarding attainment, those eligible for free school meals achieve much lower than other areas across a range of tests.
Joint Local Health & Wellbeing Strategy Objectives	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	1. Improve mental health and wellbeing 2. Eat well and move more 3. Stop Smoking and Reduce Alcohol	1. Improve social mobility and tackling inequalities 2. Prevention and early intervention 3. Localisation and connecting with communities 4. Integration and working together

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5. What do we want to achieve?

This section outlines our vision in more detail. It also explains what delivering our strategic objectives will mean for residents. While we outline in broad terms our approach to achieving each objective, the role of partners in reaching our goals will be set out in more detail in the BSW Implementation Plan.

In this section:

5.1 What we have heard

How have we engaged with organisations and residents

Phase One: Resident and community information gathering on health, care and wellbeing. Each of our three places (BaNES, Swindon and Wiltshire) has engaged directly with the public to inform the development of their joint health and wellbeing strategies. Residents and people working in BaNES, for example, were able to complete an online survey during a public consultation period to provide views on what mattered to them. Insights from this, as well as the public engagement processes adopted by Swindon and Wiltshire have been used throughout this strategy.

We have also benefited from the input and research of organisations working directly with residents. Again, for example, Healthwatch recently conducted research with the CQC into access to mental health services in BSW and this helped to establish why and how we must aim to improve access through this strategy. In Swindon, input from partners through the Swindon Carers Rights Day and VCSE Conference in late 2022 have been invaluable.

Phase Two: Stakeholder engagement. In December 2022, BSW held an Integrated Care Strategy event, which was attended by over 60 stakeholders across the health, care, wider public sector and voluntary sectors. Such organisations included NHS organisations, local authorities, VCSE organisations and Healthwatch, representing citizens and communities.

Between January and March, we also held dedicated engagement events with the VCSE Alliances of Bath & North East Somerset, Swindon and Wiltshire, as well as with other partners such as those in local government and primary care.

Phase Three: Publication and beyond. This strategy was published on xx further to the input, review and approval of the members of the Integrated Care Partnership during February and March 2023.

Importantly, we want to engage further with organisations and residents. The publication of this strategy does not represent the end of its development. The strategy will evolve over the coming years as the health and care landscape changes. We are able to update the strategy each year and the final page of this document provides details of how you can get in touch with us to tell us your thoughts.

Some messages from the population of BSW

We need ongoing engagement with residents

"[It should be] a bottom up strategy – thinking about need of the individual before the restrictions of the system."

We must focus on prevention

"[Success will mean] Treating cause before symptom."

We must be more responsive to our residents' needs

"[The strategy] should meet the needs of the people on the street."

We need to make it easier to understand services

"[Success will mean] 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."

We must ensure closer working between organisations whose work affects health and wellbeing

"[Success will mean] All partners working together with the same goal, clear communications with clients."

We need to deliver support by need, not by demand

"[Success will mean] I wont have to beg for help."

5.2 Explaining our vision

The BSW Vision

Listening and working effectively together to improve health and wellbeing and reduce inequalities

Listening together

Partners across our Integrated Care Partnership are united in a belief that **our future must be based on meaningful, ongoing engagement with local people**. We want to ensure that residents are given opportunities to shape the plans, decisions, and public services that affect their lives, and believe that this can lead to positive outcomes for the communities we serve. Importantly, **residents are partners in our system – we plan with them, not do to them**.

We are clear, therefore, that **this strategy represents the start, not the end, of a journey with our residents**. It will continue to evolve over the coming years and at the end of this document we invite views on whether the vision and objectives outlined in this document are the right ones for you.

Working together

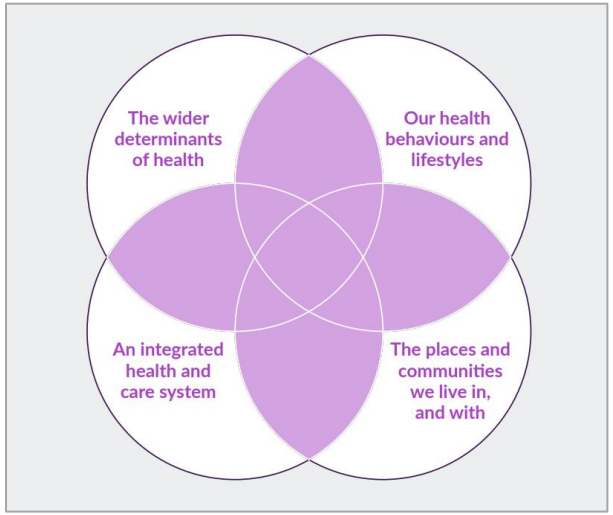
Our vision is for health and care organisations to work more effectively in partnership. This will be crucial to creating communities and environments that help people to live healthier for longer.

However, we know that people are living longer with multiple, complex, long-term conditions, requiring long-term support from several different services. We have heard our residents have often received fragmented care for such conditions and that are not effectively co-ordinated around their needs. We will therefore deliver **joined-up support** across our health and care services that better meets the needs of the population.

Improving health and wellbeing

To make a significant difference in the health and wellbeing of the people of BSW, partners are agreed that we must focus on those things that impact most on health outcomes. These include the following four 'pillars of population' health, as identified by The King's Fund:

1. **The wider determinants of health** – the range of social factors such as income, education and employment which collectively 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.
3. **The healthcare we receive** – including whether we are able to access services and receive high-quality care.
4. **Our environment** – the extent to which the environment we live in helps to support better health and wellbeing, for example through good air quality and green spaces, or hinder it



Reducing inequalities

This strategy highlights that there are **unfair and avoidable differences in health and wellbeing across our population**, and between different groups within society. Often these differences stem from the 'wider determinants of health' highlighted above. Residents who live in more deprived areas, for example, have worse health and wellbeing outcomes and, as highlighted on page 8, there are big differences in life expectancy across BSW matching levels of deprivation. However, other factors influence health and wellbeing too – we highlight that those in rural areas, for example, often have worse access in terms of distance to health, public health and care services.

We therefore intend to **put reducing inequalities at the heart of everything we do.** The Integrated Care Partnership will bring together partners with the common ambition of ensuring that everyone, regardless of who they are and where they live in BSW, is able to live a long, healthy and happy life.

5.3 What achieving our vision will look like

The BSW Vision
Working and listening effectively together to improve health and wellbeing and reduce inequalities.

Stage of life	What our residents can expect
Healthy pregnancy, birth and neonatal care	• Mothers have a healthy pregnancy and good birth experience • Babies are born in good health • Parents approach parenting with confidence
Start well 0-25 years	• Children, young people and families have a healthy environment in which they can grow up in • Mental health support is available for children and young people who need it • 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 • Children are ready to start education • There are better links between health and care services and schools
Live well 25-64 years	• Individuals are supported to look after their own health and wellbeing • All residents benefit from living and working in places that promote health and wellbeing • Those with physical disabilities, learning disabilities and mental health conditions are in good health. Their care and support includes access to opportunities such as accommodation, housing and employment.
Age well +64 years	• Older people feel that they are happy, healthy, independent and in control of their own care • The health and wellbeing of carers is prioritised and supported • When needed, health and care services are delivered at home, or as close to home as possible
Die well	• Individuals are consulted on where they would like their life to end and how they would like to be cared for in the final months of their life • Individuals feel that their wishes are respected by staff and those around them • Comprehensive support services are provided for individuals and their loved ones through palliative care, including bereavement support for families

5.4 OBJECTIVE 1:
Focus on prevention and early intervention

Why is this our objective?

Our first objective reflects our shared commitment to ensuring people are able to stay healthier for longer. It unites all partners across BSW and is a key part of our rationale for wanting to work together.

It is our first objective because **the most effective way to improve healthy life expectancy is to create the right conditions, communities and environments for people to remain healthy, regardless of where they live in BSW**. This will help to ensure individuals are able to live independently and are less reliant on health and care services. **Our Integrated Care Partnership will hold the partners within the system to account on whether we are putting prevention of ill-health at the heart of everything we do**.

Health and social care represents an important driver to improve health and wellbeing, but this strategy seeks to encompass the broader role of prevention and the wider determinants of health. To support progress on this, BSW will also include action that takes a broader view of prevention.

Areas of focus

- **Focusing funding and resources on prevention rather than treatment:** Working together as a system, we want to try and invest more funding and resources on services and infrastructure that will help people from becoming unwell.
- **Primary prevention:** This means taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.
- **Secondary prevention**: This means systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
- **Tertiary prevention**: This means softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.
- **Wider determinants of health**: These are the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces.

Definitions of prevention, adapted from: Prevention | Local Government Association

5.4.1 Focusing funding and resources on prevention rather than treatment

OBJECTIVE 1:
Focus on prevention and early intervention

The opportunity:

To improve the health and wellbeing of our residents, especially those living with disadvantages, we must seize the opportunity to focus our funding on activities that help to prevent people falling into ill health and wellbeing to begin with.

There is a saying that 'an ounce of prevention is worth a pound of cure' and we will put this at the heart of our efforts over the coming years.

Making progress on achieving a shift in funding towards prevention and away from treatment is one of our key long term priorities in BSW.

Over time, this will mean less spent on the treatment of illness in acute settings such as hospitals and through care services.

We will need to work together as a system to achieve this and our ICP will hold partners to account on our progress towards this goal over the coming years.

Our approach:

Our system ambition is to achieve what is called 'The Triple Aim'. This comprises:

1. Better health and wellbeing
2. Better quality of care
3. Financially sustainable and efficient services

Our approach will build on a commitment that has been set out nationally (in the 2019 national NHS Long Term Plan) to increase investment in primary medical and community health services as a share of the total revenue spend.

We are aware of the significant pressures facing all health and care services at present. Importantly, achieving a funding shift towards prevention will not involve taking money away from any health and care services. Rather, it will involve **prioritising 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.

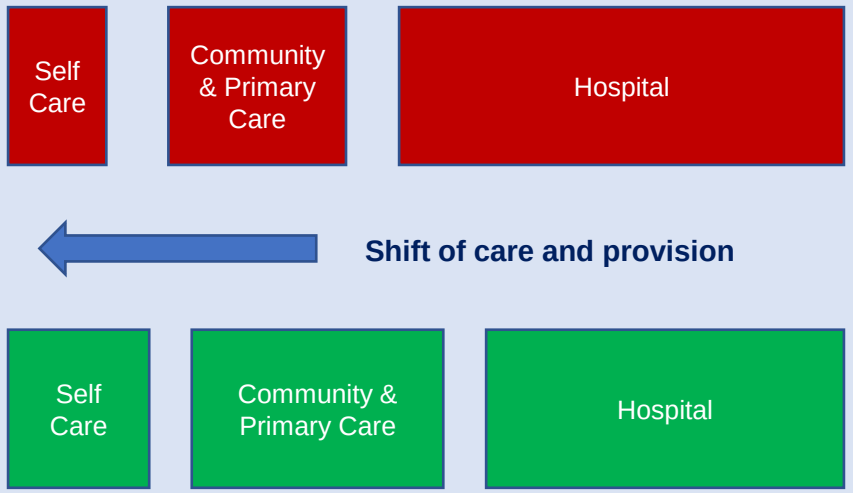
'Community care' includes services delivered across BSW by the voluntary sector.

Our commitments include:

- ✓ Partners across the ICP will work together to identify an accurate picture of funding and resourcing across BSW when it comes to self-care, community care and hospital care
- ✓ We will aim to increase the share of health and care funding going towards preventative measures (self-care and community care) over the next five years. Our ICP will monitor over time the degree to which this balance is shifting

A crude visualisation of this is provided below.

Where we are



5.4.2 Primary prevention

OBJECTIVE 1:
Focus on prevention and early intervention

The opportunity:

Many (but not all) health conditions, both physical and mental, are preventable. Health and wellbeing can be both positively and adversely affected by whether an individual engages in health promoting activity. Exercise, for example, is key to maintaining good cardiovascular health. However, some individuals have far greater opportunity than others to do more activity that improves their health and wellbeing. **We therefore want to work together to create health promoting places**, ensuring that all residents regardless of background have the right conditions and incentives to stay healthier for longer.

Through a focus on primary prevention we aim to help individuals to prevent disease, injury or ill-health before it occurs. This is done by preventing exposures to hazards that cause disease or injury, helping people to avoid unhealthy or unsafe behaviours that can lead to disease or injury, and increasing resistance to disease or injury.

Physical and mental wellbeing

Our approach:

Our approach across BaNES, Swindon and Wiltshire is focused 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.

This includes a focus on reducing obesity by creating opportunities for BSW residents to maintain their health through higher levels of physical activity.

Our commitments include:

- ✓ We will increase the proportion of physically active adults
- ✓ We will improve Personal Wellbeing ONS4 scores (Life Satisfaction, Worthwhile, Happiness, Anxiety)
- ✓ We will reduce the proportion of adults considered overweight or obese
- ✓ We will increase proportion of children who are healthy weight at reception age
- ✓ We will reduce the prevalence of mental health conditions

Building on what we are already doing

In **BaNES,** an Active Travel Social Prescribing Hub will actively encourage improved levels of physical activity. This will support improved physical and mental health and reduce the prevalence of future conditions. This is supported by developing the transport environment to support efficient and safe travel by cycling or walking.

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

In **Wiltshire**, ‘This Girl Can’ classes recently launched across Wiltshire council leisure centres. During the classes women are introduced to a variety of different group exercise styles, each with different moves and skills to try. These include dance fitness, box fitness, yoga-inspired stretch and interval training.

5.4.2 Primary prevention (continued)

Smoking

The opportunity:

Smoking rates vary slightly between BaNES, Swindon and Wiltshire and there are significant variations within each of these areas. However, the overall BSW smoking rate is similar to the national average.

Smoking is the single largest avoidable cause of death and social inequalities in terms of life expectancy in the UK. Lung cancer is the most common cause of cancer death in BSW, although lung cancer mortality rates are lower than the national average. We have an opportunity to improve health and wellbeing by ensuring that, as far as possible, **the future for BSW is smoke-free**.

Our approach:

Smoking is an ongoing concern in BSW, with each of our three places running their own programmes to stop smoking. One area of focus is people admitted to our hospitals, which provides an opportunity to simultaneously address health inequalities, reduce hospital re-admissions, help local people stay well and save money across our health and care services.

Our plans to treat tobacco dependency have been developed by a BSW Partnership working group which contains representatives from all local NHS Trusts, community providers and Public Health teams.

Our commitments include:

- ✓ We will further reduce the proportion of people in BSW who smoke
- ✓ To so we will expand stop smoking services across partners, recognising the opportunities that points of interaction with services offer on prevention. A current example of this is the Treating Tobacco Dependency service.

5.4.3 Secondary prevention

The opportunity:

While we will focus on primary prevention to keep people healthier and happier, we also have an opportunity to ensure we detect ill-health as soon as possible. A focus on secondary prevention will be key for detecting and treating disease prior to the appearance of any symptoms.

Our approach:

We are already working to ensure that signs of ill-health are detected as soon as possible. We undertake cancer screening and identify patients who smoke or drink alcohol with impacts on their condition. We try to detect as early as possible people with hypertension, signs of diabetes, atrial fibrillation and other conditions. We are, for example, sending text messages to certain patients who have not had a blood pressure check in over 18 months inviting them to do so using a machine located in the community.

Diagnosing ill-health as early as possible is best for patients and best for BSW's financial sustainability. By increasing the proportion of individuals with hypertension treated to 80%, over a three year period in BSW it is estimated we could prevent 89 heart attacks and 139 strokes and save around £2.5 million.

Our commitments include:

- ✓ We will work to ensure the system has routine access to high quality secondary prevention data
- ✓ We will bring together BSW partners to work on joined-up prevention pathways. On cardiovascular disease prevention, for example, we will support primary care partners to increase home blood pressure monitoring activity and work with community pharmacy to roll out a Hypertension Case Finding Service
- ✓ We will improve uptake of cervical, breast and bowel cancer screening

5.4.4 Tertiary prevention

OBJECTIVE 1:
Focus on prevention and early intervention

The opportunity:

Over time, and with an ageing population, some of our residents will develop long-term conditions. We have an opportunity to work with them more effectively to ensure that they stay as healthy as possible and do not develop further complications.

Our approach:

We will provide comprehensive support to our residents who have an ongoing illness or injury that has lasting effects to help prevent their situation worsening. On the right you can see the kind of approach we will take to ensure that Type 2 diabetes progression is slowed and managed effectively.

Our commitment:

Care for long term conditions

With an ageing population the prevalence of conditions like mental illness, cardiovascular disease, respiratory disease and diabetes is increasing across BSW.

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, local authorities, VCSE organisations and neighbourhood teams working together, we will 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.

Case study: Secondary & Tertiary Prevention in Diabetes

Marvin
52, Warehouse Night Manager

Marvin is a night shift worker in a warehouse, who values the time outside of work he can spend with his family. He has poorly managed Type 2 diabetes and has been recently been diagnosed with COPD. He has a poor diet and is distrusting of health professionals so avoids visiting his GP.

Our **Population Health Management** tool flags Marvin for a review by identifying he is at risk of worsening health. The **Care Coordination Team** contact Marvin and encourage him to attend to see his GP.

The **GP** and **Care Coordination** Team work with Marvin to **co-develop a Care Plan** that suits his work and family life so that he can self-monitor his diabetes and control its impact.

Marvin speaks to his **employer** about his **Care Plan** and how they can work together to ensure his health is prioritised and maintained. Marvin is able to access the **Community Hub** out of hours to suit his shifts.

Marvin is able to access **diabetics group support sessions** and **1:1 virtual support** from his **GP** to help make changes in his life sustainable.

Marvin uses **remote monitoring** and the data he records is reviewed by a Diabetes Nurse in primary care. Marvin and the Diabetes Team can both initiate virtual appointments if they have concerns. The local team can access specialist input if required.

In the event of an **acute COPD episode**, Marvin can be seen by a **Respiratory Nurse Specialist** in his **local community assessment and treatment unit** without having to go to hospital. If required, he can be admitted to a **virtual ward**.

Marvin is able to better control his diabetes through **self monitoring** and **diet**. This has enabled him to stay well and out of the hospital. In BSW he lives in a **health promoting environment** where is able to access a local gym out of hours and is able to lead an **active lifestyle**.

5.4.5 The wider determinants

The opportunity:

There is now a wealth of research that demonstrates **the intrinsic link between the community and environment we live in and our health and wellbeing**.

How our communities shape our health and wellbeing in BSW has been revealed through our local authorities' Joint Strategic Needs Assessments. For example, 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.

Through our integrated care system, we have the opportunity to take co-ordinated action across NHS organisations, local authorities, the emergency services, VCSE organisations, education providers, the private sector and others to address the wider determinants of health for people across BSW. **Again, this is part of our shared commitment to creating health promoting places.**

Each local authority in BSW is taking action to improve air quality. In Wiltshire, for example, their strategy is clear that improving local air quality requires changes to be made by everyone. Working collaboratively with communities, local authorities are seeking to maintain good air quality and work to deliver improvements in areas where air quality fails national objectives in order to protect public health and the environment.

Our approach:

Supporting the development of healthier communities encompasses a range of interventions by partners. These include (but are not limited to):

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. Our ICP will work to ensure that good employment across sectors remains a key priority across partners.

Housing

We will bring together partners to plan how we can ensure both that housing helps to improve, not worsen, people's health and wellbeing and that it is available to all.

Transport

We will work to promote cleaner forms of transport across BSW to improve air quality, support access to education and employment, and promote exercise.

Ensuring safe communities

We will work in partnership with the police and with communities to help prevent and reduce violence and offer holistic support to those affected by violence, with a focus on trauma, resilience, early intervention and education.

Our commitments include:

In BSW, we will work together to create health promoting places, including action to:

- ✓ Increase green space, accessible for all to use, and promote greener transport
- ✓ Improve air quality, including by incentivising greener forms of travel
- ✓ 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
- ✓ Prevent homelessness by engaging with vulnerable individuals at the earliest possible stage
- ✓ Prioritise social housing to those in greatest need to support their health and social care needs

Good work

Our surroundings

Money and resources

Housing

Education and skills

The food we eat

Transport

Families, friends and communities

5.5 OBJECTIVE 2:
Fairer health and wellbeing outcomes

Why is this our objective?

Health inequalities develop due to variations in the conditions in which we are born, grow, live, work and age; this means that not everyone has the same opportunities to be healthy. **As part of our commitment to deliver fairer health outcomes we will reduce health inequalities across BSW**. Health Inequalities are defined as the systematic differences in health between groups of people. Differences in life expectancy, and health life expectancy, are one of the key measures of health inequality.

It is time we took action to address such inequalities in BSW. There is evidence that for too long, the provision of health and care services has followed the 'inverse care law'. This describes how – perversely – people who most need health and care are the least likely to receive it.

A new approach to provision of services is needed to ensure that the services offered across BSW are delivered proportionately on the basis of need, with a scale and intensity that is proportionate to the level of disadvantage.

Areas of focus

- Adopting CORE20PLUS5
- A system-wide focus on reducing health inequalities

5.5.1 Adopting CORE20PLUS5

Our approach:

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.

Core20
The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS
Local population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. In BSW, the 'PLUS' population is defined at place using public health data to determine which population groups were experiencing the worst health outcomes in addition to the 'Core20'. For BSW these are:

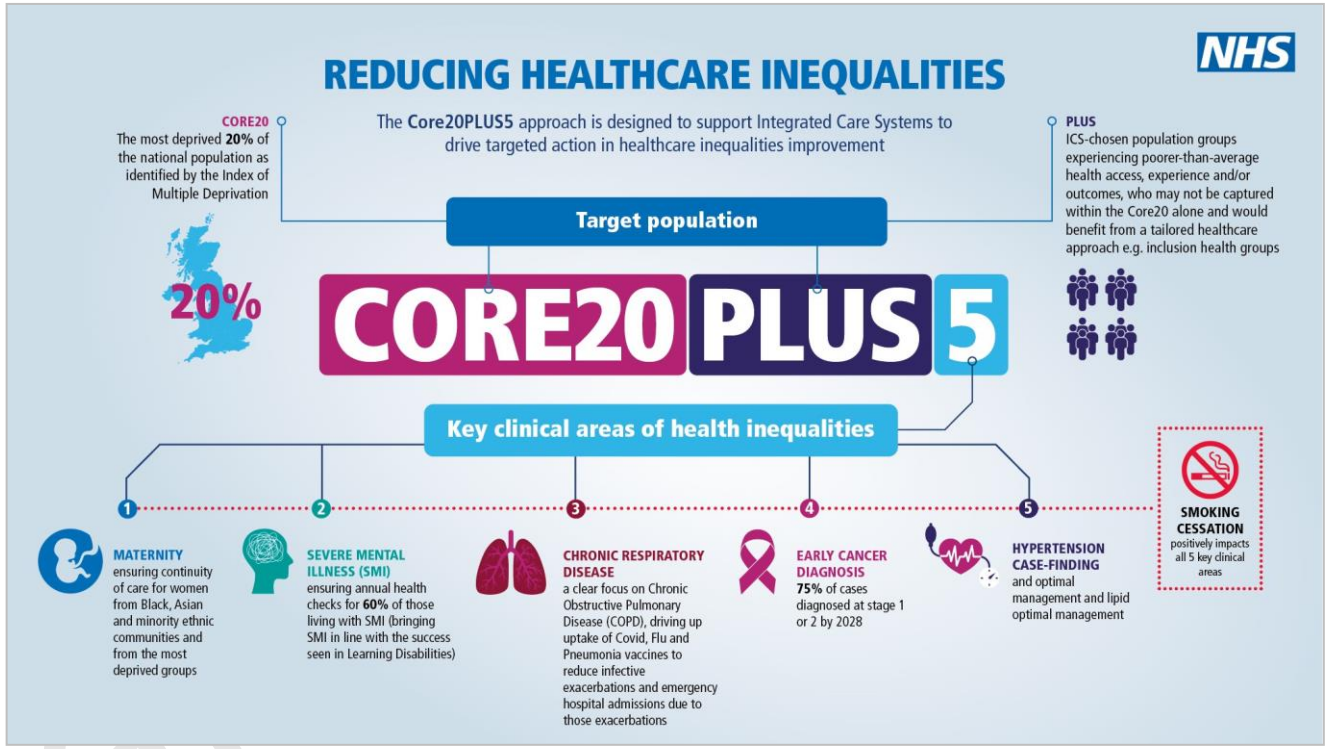
- **BaNES:** Socially excluded groups, migrants, vulnerable children, rural communities
- **Swindon**: People from ethnic minority backgrounds
- **Wiltshire**: Routine and manual workers (specifically those in minority groups) and Gypsy, Roma and boater communities

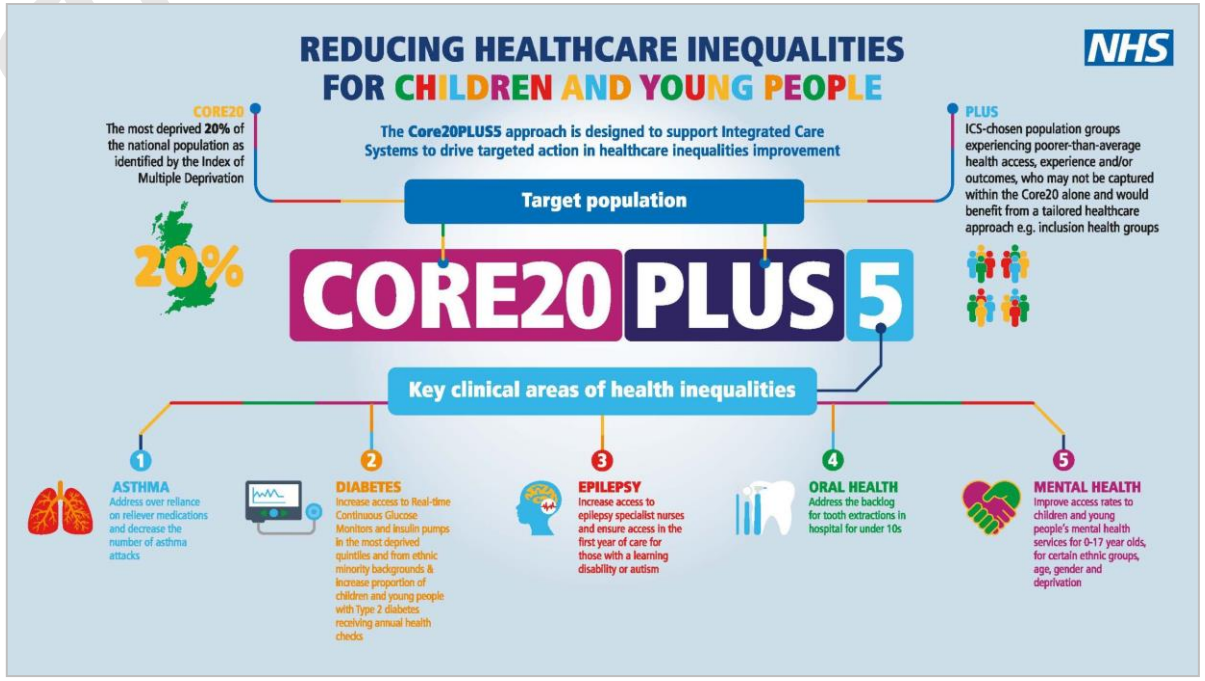
'5'
The final part sets out five clinical areas of focus:

Adults
1. Maternity
2. Severe mental illness (SMI)
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case-finding and optimal management and lipid optimal management

Children and Young People
1. Asthma
2. Diabetes
3. Epilepsy
4. Oral health
5. Mental health

Our commitment is to implement a CORE20PLUS5 approach across BSW, as outlined in our **Inequalities Strategy**





5.5.2 A system-wide focus on reducing health inequalities

OBJECTIVE 2:
Fairer health and wellbeing outcomes

The opportunity:

As highlighted, health inequalities across the BSW population arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health, and wellbeing. Health inequalities have been documented between population groups across at least four dimensions, as illustrated on the right, with evidence that the Covid-19 pandemic has exacerbated existing health inequalities.

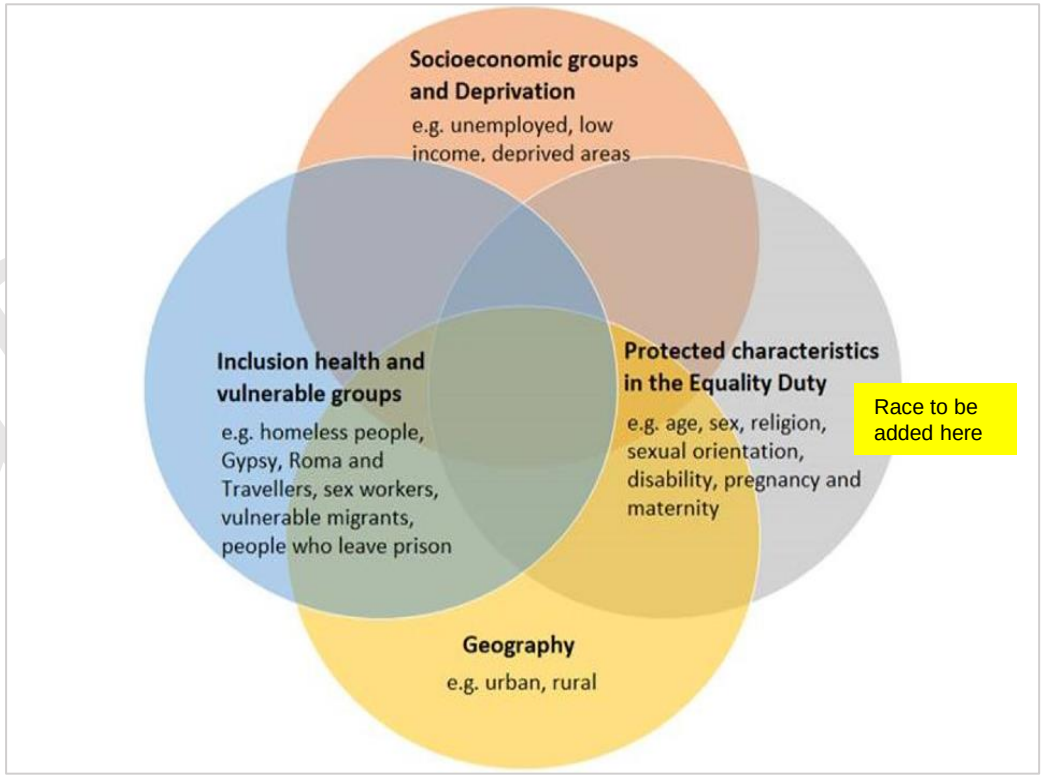
We have the opportunity to put addressing these inequalities at the heart of the way we work.

Our approach:

We plan to work in partnership to tackle inequalities across the life course to ensure that every resident can live longer, healthier, happier lives. Our dedicated Learning Disability & Autism programme is focused on ensuring that those with a learning disability, autism or both can live in the community with the right support. Our **Inequalities Strategy** also sets out how we will prioritise tackling inequalities, including the commitments set out below.

Our commitments include:

- ✓ 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.
- ✓ 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 close the inequality gaps
- ✓ Demonstrate action on inequalities that spans from system to place through joined up strategy and planning



Taken from: Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

5.6 OBJECTIVE 3:
Excellent health and care services

Why is this our objective?

By focusing on prevention (Objective 1), our goal is to help stop as many people as possible from needing to access health and care services. However, we also want to ensure that **when people do require such services they receive excellent care**.

BSW Integrated Care Partnership is proud of the high-quality health and care services we have across our system. We have a record of excellence; aiming to deliver timely, safe and effective interventions for our residents. We have also had positive rates of patient and service user satisfaction. In primary care, for example, a 2022 survey found that 85 per cent of BSW patients said their overall experience was good, which was above the national average of 82 per cent.

However, there is much more we can do as a system to improve the health and care services that serve our population. Working as a system presents us with a unique opportunity to wrap services around the individual and deliver care as close to their home as possible. Over the coming years we will strive to deliver the 'Triple Aim' in how we provide services: better health and wellbeing, better quality of care, and financially sustainable and efficient services.

Areas of focus

- Personalised care
- Joined-up local teams
- Responsive local specialist services
- High quality specialist centres
- Mental health and parity of esteem

This objective builds on the BSW Care Model. The components of this model feature across different strategic objectives and are key to delivering the vision and goals of our Integrated Care Strategy.

Public engagement
The BSW Care Model was developed through engagement with a wide range of partners. During the engagement period 1,441 people were engaged with at 65 events. In addition, 918 people completed a survey. 40 people were spoken to directly about their experiences of health inequalities. These included refugees and asylum seekers, people with learning disabilities and autism, members of the LGBTQ+ community, people with chronic long term conditions, an unpaid carer and people recovering from alcohol and substance misuse. It was also informed by the development of health and care systems in the UK and internationally.

5.6.1 Personalised care

OBJECTIVE 3:
Excellent health and care services

The opportunity:

Health and social care services deliver better outcomes for individuals when they feel that they feel they have the ability, tools and confidence to manage their own health and wellbeing. Personalised care is based on 'what matters' to people and their individual strengths and needs. In BSW, we have put it at the heart of our Care Model and we will apply it to everything that we do in the future.

Our approach:

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

Our commitments include:

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

1. **Shared decision making** to ensure 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 decisions about treatment.

2. **Personalised care and support planning** to ensure facilitated conversations take place 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.

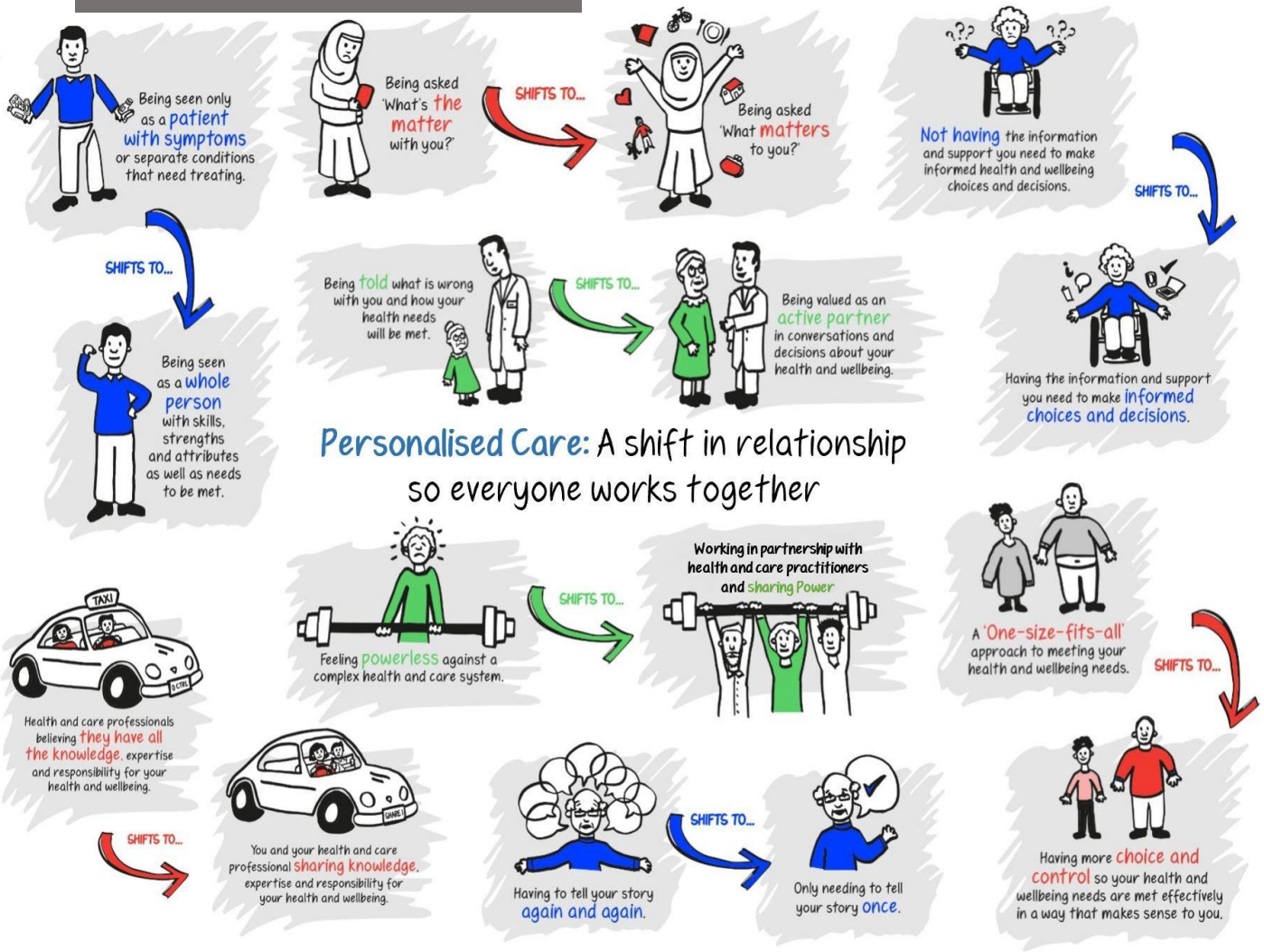
3. **Enabling choice, including legal rights to choice**

4. **Social prescribing and community based support** to ensure individuals are supported to access the widest range of support and services available in their community.

5. **Supported self management** to ensure people are helped to manage their ongoing physical and mental health conditions themselves.

6. **Personal health budgets and integrated personal budgets** to give flexibility on how people's assessed health and wellbeing needs are met.

What will this feel like for residents?



Source: NHS South West

5.6.2 Joined up local teams

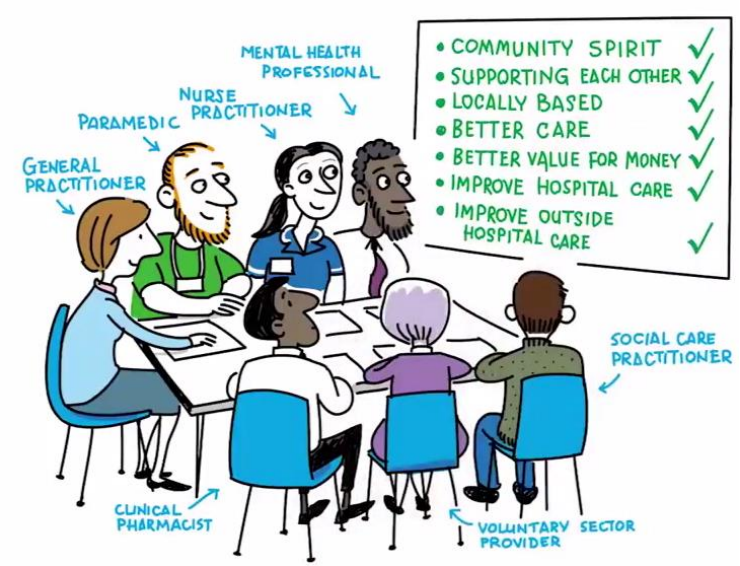
OBJECTIVE 3:
Excellent health and care services

The opportunity:

Health and care services for people in BSW, and across England, have often felt fragmented for those using them. This has meant, for example, lots of travelling for individuals for different aspects of their care and having to 'tell their story' multiple times.

We therefore want to implement local multidisciplinary teams (MDTs) that bring together different types of clinicians and professionals. These help to provide more joined up care and support, ideally in people's homes but if not then as close to them as possible.

There is evidence that suggests **MDTs can result in improved outcomes for people and their families**, and higher quality, personalised care. MDT working can lead to improved job satisfaction for professionals and practitioners as a result of greater autonomy, skill enhancement and knowledge sharing



Our approach:

Building on the excellent primary and social care services we have across BSW, 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.

Our commitments include:

Across BSW, **we will develop integrated, multidisciplinary teams** that deliver health and care services around the needs of individuals. These will include integrated teams at 'neighbourhood' level, which will bring health and wellbeing services closer to those who struggle to access services due to disability and poor access to transport.

We will also review community services and put integrated teams at the heart of the way these services are provided in future. This will be a significant programme of work and will involve partners from across our health and care system.

5.6.3 Responsive local specialist services

OBJECTIVE 3:
Excellent health and care services

The opportunity:

As highlighted, it can sometimes be hard for people across BSW to access services – particularly those who live in rural areas or who have limited mobility.

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

Our approach

We will aim to deliver services as effectively close to people's homes as possible, ensuring they are responsive to individuals' needs.

Work is already underway on a range of initiatives including:

i. Virtual wards to reduce the need to spend as much or any, time in a hospital bed.
ii. Enhanced access to community diagnostic facilities

Our commitments include:

i. Virtual wards

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.

We already have virtual ward beds in operation in the system and have plans to increase virtual ward capacity across BaNES, Swindon and Wiltshire over the coming year.

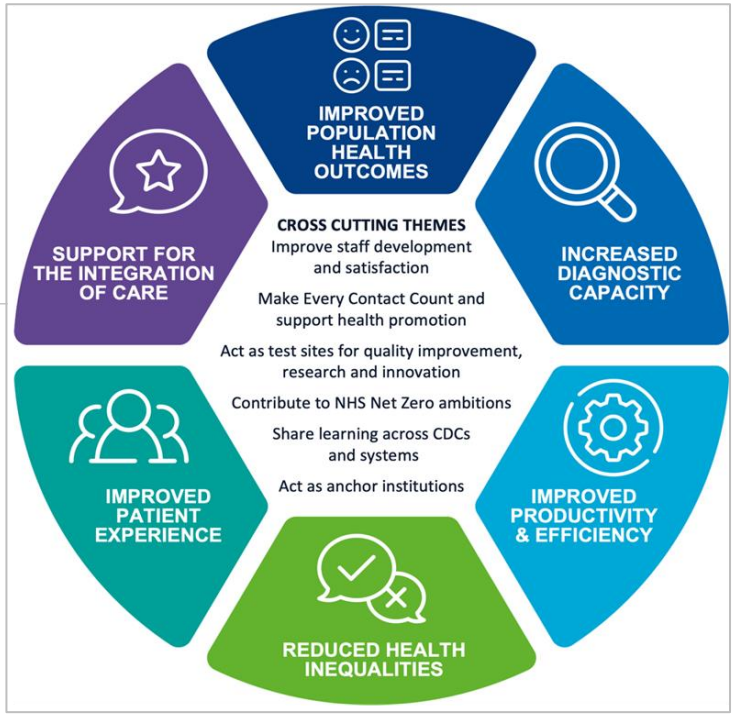
So far, the average length of stay has been 5-9 days and the majority of patients have been discharged to their usual place of residence.

Our commitments (cont.)

ii. Community diagnostic facilities

BSW is committed to expanding community diagnostic facilities. These 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.

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.



5.6.4 High quality specialist centres

The opportunity:

The challenges of the pandemic and the pressures during the winter of 2022/23 have highlighted the importance of hospital sector capacity being available for individuals with acute conditions. **We have the opportunity to ensure that residents across BSW benefit from the best acute care**.

Our approach:

Provider collaboration

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.

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.

Our commitments include:

- ✓ The AHA is developing a clinical strategy that will set out the role the hospitals will play in the delivery of urgent care services, management of long-term conditions and how they can improve quality and productivity
- ✓ 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 will play a critical role in reducing the waiting times for surgical procedures for the population of BSW

Quality and improvement

In BSW **we want to establish and nurture a culture of openness, learning and continuous improvement**. We will deliver care that is **safe**, **effective**, **well led**, **sustainably resourced** and **equitable**.

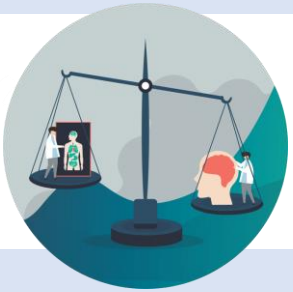
Our commitments include:

- ✓ We will work with local communities, people using services (who are experts by experience) and staff to shape the design and delivery of services.
- ✓ Set clear quality standards and expected outcomes when commissioning health and care services for the population we serve

5.6.5 Mental health and parity of esteem

The opportunity:

We know that mental health conditions have been rising across BSW, with mental health worsening due to factors such as the Covid-19 pandemic and cost of living crisis. We also know that many individuals have struggled to access the support they need when they need it. **We will therefore put improving mental health and the principle of 'parity of esteem' at the heart of our efforts to improve health and care services** over the coming years (see below).



Our approach:

We will deliver services against a key principle of parity of esteem. This means we will give as great a focus to mental wellbeing, mental health, and learning disabilities and autism as we do to physical health.

Our ambitions to improve mental health services across BSW will be set out in a dedicated **Mental Health Strategy** shortly. In producing this strategy, working with partners and residents across BSW, we will:

- Take a strength based approach and building on what is already working well
- Build on partnership working at system and place.
- Be informed by those who use our services and the families and carers that support them daily.
- Be outward looking and learn from other systems within our region and beyond.
- Align with the BSW Care Model (see below)

Our commitments include:

- ✓ **Personalised care:** We will use local intelligence to develop nuanced personalised models of care that reduce unwarranted variation whilst paying attention to localised differences in our populations.
- ✓ **Joined up local teams:** We will accelerate placed 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 local HWB strategies.
- ✓ **Local specialist services:** We will work with our specialist mental health providers to right size and shape local specialist provision that is accessible, responsive, financially sustainable & reduces the need for out of area care.
- ✓ **Addressing inequalities.** We will use data to inform our approach to targeted interventions in addressing inequalities

6. What enablers will help us to achieve our vision?

There are a range of enabling activities that will underpin our progress against our Vision and Strategic Objectives. Further detail on each will be set out in our **Implementation Plan**.

6.1 Developing our workforce
37,600 people work in health and care in BSW. Work is underway to develop a **BSW People Strategy**, with a strong focus on recruitment and retention of the workforce.

What we will do
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.

Our **People Strategy** will focus on four ambitions, which will be set out in further detail over the coming months:

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

The strategy will complement place-based workforce strategies within BaNES, Swindon and Wiltshire.

6.2 Estates of the future
We have an opportunity to create high quality estates with seamless IT connectivity across locations. We will designed our facilities to ensure they are sustainable, of high quality, technologically enabled and in the right place.

What we will do
The forthcoming BSW Together **Infrastructure Strategy** will focus on the following four priorities:

1. Access: Ensuring our estate is well-located, with good transport links and closer to communities with reduced access.
2. Performance: Ensuring our estate is operationally available when required, digitally-enabled to support system working, well-utilised and incorporates smart building management systems
3. Efficiency: Ensuring the estate reduces our impact on the environment and represents excellent value for money
4. Quality and Standards: Reducing unwarranted variations, with new buildings following modern methods of construction and future-proofed in design to provide flexibility

The strategy will complement local authorities' Local Plans and place-based infrastructure strategies within BaNES, Swindon and Wiltshire.

6.3 Environmental sustainability
We will ensure that we play our part in addressing the climate emergency and make our services as sustainable as possible.

What we will do
We have come together to agree 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. Headline commitments in our **Green Plan** include:

- 60% of BSW Together members will achieve net zero for the emissions we directly control by 2030
- 100% of BSW Together members will achieve net zero for the emissions we directly control by 2040
- 100% of BSW Together members will achieve net zero for the emissions we can influence by 2045

We will continue working to ensure alignment between this plan and environmental sustainability plans across BaNES, Swindon and Wiltshire.

6. What enablers will help us to achieve our vision?

6.4 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.

What we will do

Digital solutions give us the potential to work differently, facilitating better, safer care and more efficient and effective use of resources. No more so has this been demonstrated than through the BSW's response to COVID19.

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

Our commitments include:

An Electronic Patient Record (EPR). This is a critical building block to digital maturity for an organisation and provides massive opportunities for digital transformation in efficiency and improvements to care**.** The Acute Hospital Alliance is leading work to align patient records. Work to progress a **shared care record**, incorporating a broader range of health and care data, is also underway.

Infrastructure. We will develop shared infrastructure across BSW in terms of efficiencies and enable flexibility in ways colleagues work across our organisations.

Digital design principles. As part of the development of the BSW Care Model the BSW Digital Board agreed a set of design principles. These principles set out an agreed system-wide approach to the use of technology and digitally enabled transformation that are relevant for all professionals.

6.5 Our role as Anchor Institutions
We will harness the potential of BSW health and care organisations to play a greater role in promoting the social and economic interests of the local areas they are rooted in.

What we will do

Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local economic development, through procurement and spending power, workforce and training, and buildings and land.

We will harness the power of our existing institutions across BSW to deliver their potential as anchor institutions. This will help us support broader social and economic development. It will also allow us to deliver on the ambitions set out in this strategy, for example our focus on preventing people from falling into ill physical and mental health (as set out in Objective 1) through improving their socio-economic conditions and environment.

This will involve partners working as individual organisations. The main 'anchors' in a given place include the NHS, local authorities, universities, colleges, VCSE organisations and increasingly businesses. But sitting at the heart of our vision for delivering social and economic development is a long-term journey from focusing on anchor institutions to creating anchor systems. This will involve a more aligned focus on what we want to change, developed in partnership with the range of other NHS and non-NHS anchors across the system all pulling in the same strategic direction for the economy.

Some organisations in BSW have already begun thinking about how they can play a bigger role as an anchor institution. Great Western Hospital, for instance, has identified five areas where it can make a difference as an anchor institution, helping to create jobs, forge closer links with other civic organisations and improve its carbon footprint.

7. What happens next?

7.1 Delivering through our Implementation Plan

We are clear that we need to continue working with partners and communities across BSW to demonstrate how we are progressing the ambitions of this strategy and those which feed into it.

Our approach to doing this will partly be set out through our Integrated Care Strategy **Implementation Plan**. This is our local version of a 'Joint Forward Plan', which all Integrated Care Boards across England are required to produce. It will outline specifically how NHS bodies plan to deliver the ambitions of the Integrated Care Strategy, though we hope it will be supported by the wider system, including local authorities and voluntary, community and social enterprise partners.

The Plan will set out key milestones and deliverables residents can expect over the coming years as we set out to deliver the ambition and objectives of this strategy.

Like this strategy, the Implementation Plan is 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.

Importantly. we will consult on the Implementation Plan with partners, including our local Health and Wellbeing Boards.

BSW's first Implementation Plan will be published by **31 June 2023.**

7.2 Have your say

We invite residents and partners across B&NES, Swindon and Wiltshire to discuss this strategy and we intend to gather feedback as part of our ongoing engagement with the public and system stakeholders over the coming months. Details of this engagement exercise will be developed shortly after the publication of this document.

Our vision, approach and strategic objectives will continue to evolve as we engage further with BSW residents and respond to the changing needs of the local population.

This document is therefore simply a first iteration. **Have we got it right?**

We welcome your comments, whether before or after publication. If you would like to offer your thoughts on what you welcome in this strategy, or how it could be improved, then please do get in touch.

Please send your thoughts to bswicb.bswstrategy@nhs.net