Wiltshire Council

AGENDA

Meeting: **Health and Wellbeing Board**

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

Date: **Thursday 26 September 2024**

Time: **10.00 am**

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

Press enquiries to Communications on direct line (01225) 713114/713115.

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Voting Membership:

Cllr Richard Clewer (Chairman)	Leader of the Council and Cabinet Member for Climate Change, MCI, Economic Development, Heritage, Arts, Tourism and Health & Wellbeing
Cllr Laura Mayes	Deputy Leader and Cabinet Member for Children's Services, Education and Skills
Philip Wilkinson/Rob Llewellyn	Office of Police and Crime Commissioner
Dr Nick Ware	Wiltshire Locality Healthcare Professional, NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)
TBC	Clinical Representative NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)
Kevin Peltonen-Messenger	Healthwatch Wiltshire

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Public Participation

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

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

The full constitution can be found at this link.

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AGENDA

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

The Chair will welcome everyone to the meeting and give any announcements.

2 **Apologies for Absence**

To receive any apologies for absence.

3 **Minutes** *(Pages 7 - 12)*

To approve the minutes of the meeting held on 11 July 2024.

4 **Declarations of Interest**

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

5 **Public Participation**

The Council welcomes contributions from members of the public.

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

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

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **Thursday 19 September** in order to be guaranteed of a written response**.** In order to receive a verbal response questions must be submitted no later than 5pm on **Monday 23 September**. Please contact the officer named on the front of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

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

6 **Better Care Plan - standing update** *(Pages 13 - 20)*

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

7 **BSW Implementation Plan** *(Pages 21 - 134)*

To receive a presentation and report from Caroline Holmes highlighting revisions in the BSW's Implementation Plan.

8 **SEND AP and Inclusion Strategy** *(Pages 135 - 154)*

To note the new SEND Alternative Provision (AP) and Inclusion Strategy.

9 **Gypsy-Roma-Traveller-Boater Strategy** *(Pages 155 - 160)*

To note the findings of the review of the Gypsy, Roma, Traveller & Boater Strategy (2020-2025).

Supplement to follow

10 **Healthwatch Wiltshire Annual Report** *(Pages 161 - 162)*

To receive and note Healthwatch Wiltshire's Annual Report for 2023/2024.

11 **Wiltshire Community Safety Partnership Update**

To receive a verbal update from Ian Saunders, Assistant Chief Constable, on the Wiltshire Community Safety Partnership.

12 **Date of Next Meeting**

The date of the next meeting will be the 28 November 2024.

13 **Urgent Items**

To discuss any items the chair agrees to as a matter of urgency.

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Wiltshire Council

Health and Wellbeing Board

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 11 JULY 2024 AT KENNET ROOM - COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:
Cllr Richard Clewer (Chair), Dr Nick Ware, Fiona Slevin-Brown, Shirley-Ann, Edd Rendell, Cllr Ian Blair-Pilling, Cllr Jane Davies, Terence Herbert,

Also Present:
Terence Herbert, Lucy Townsend, Kate Blackburn, Fiona Slevin-Brown, Clare O'Farrell, Jo Cullen, Helen Mullinger, Emma Legg and Marc House

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

The Chairman welcomed everyone to the meeting and asked those present to introduce themselves.

The Chair also announced that following discussion at the previous meeting, the stated support of the Health and Wellbeing Board and the issuing of a supplementary statement to the PNA, that the ICB had granted the application for an additional pharmacy in the west of Warminster.

Reports had been circulated via email to members before the meeting.

27 **Apologies for Absence**

Apologies were received from:

Cllr Laura Mayes
Cllr Gordon King

28 **Minutes**

The minutes of the previous meeting on 23 May 2024 were presented for consideration.

Resolved

The Wiltshire Health and Wellbeing Board approved and signed the minutes of the previous meeting held on 23 May 2024 as a true and accurate record.

29 **Declarations of Interest**

There were no declarations of interest.

30 **Public Participation**

There was no public participation.

31 **Primary Care (GP Services)**

Jo Cullen briefly introduced the report, which updated the board on the delegated primary care medical services across Wiltshire, recovery plans and the impact of ARAP (Afghan MOD) resettlement and potential impact of collective action by the BMA.

It was clarified that although equal access was incredibly important, gaps were largely due to significant resource issues, and this was a nationwide concern. It was accepted that such a concern could not be solved by this Board, but efforts should be made to ensure access was available to as many as possible and specifically by targeting those areas and demographics that have the largest access issues. It was noted that estates remain a significant area of focus (particularly the funding for areas such as Calne, Sherston and Hindon) and a more detailed update on funding for this (including through the planning system) could be provided at a future meeting.

It was clarified that shifting to prevention focused strategies rather than "day-by-day firefighting" was an essential target. The Board commented that it was important that care and prevention not be pitted against each other.

Resolved

To note the update

To receive further updates highlighting successes with prevention

32 **Pharmacy Update**

David Bowater introduced the report and the Board noted that Carolyn Beale from Community Pharmacy Swindon and Wiltshire (the Local Pharmaceutical Committee) was in attendance for this item. It was noted that consultation would be an important part of the process and views would be sought from both the public and providers.

Victoria Stanley and Uzo Ibechukwu (chief pharmacist) provided an update on the ICB's community pharmacy initiatives, including Pharmacy First and independent prescribing which was being piloted in two locations in Wiltshire. This initiative had hit the ground running. The aim now was described as replicating that success in other areas. The potential for closer collaboration with care homes on dispensing and the opportunity to consider dosette boxes was also raised.

It was raised that a lot of pharmacies are contained within larger shops whose staff don't necessarily understand the value of Pharmacy First. It was clarified

that communication was really important for this and would be improved so that staff and the public can be more aware of what pharmacies can and cannot provide.

Resolved

That the Board:

i) Approves the formation of a steering group for development of the PNA for Wiltshire as set out in paragraph 10.

ii) Notes the outline timescale for development of the PNA (appendix 1)

iii) Confirms the governance for responding to consultations on market entry and market consolidations and the issuing of supplementary statements set out in paragraph 15.

iv) Note the update on wider community pharmacy initiatives to be provided by NHS Bath & NE Somerset Swindon and Wiltshire Integrated Care Board (NHS BSW ICB)

33 **Military Covenant and the NHS**

The Board received a report from Emma Higgins highlighting progress regarding the ICB's work and self-assessment on embedding the statutory Armed Forces Covenant Duty.

The Board debated the significant problems military personnel face accessing secondary care, including travelling issues where a lot of soldiers don't have cars and can end up catching two buses to reach care facilities from some garrisons.

Further issues surrounding military personnel registering onto systems was raised as they and their families can move around frequently.

Mandy Stokes of the Veterans Healthcare Alliance also provided an update on the national work to ensure veterans are not overlooked in healthcare. The accreditation of GP surgeries as veterans-friendly was also discussed as well as the specific research undertaken by Healthwatch Wiltshire

ICB executives clarified that the Self-Assessment was essentially formalising what was already suspected to be true.

Resolved

To note the update

34 **Urgent Care**

Helen Mullinger introduced the report to the Board, and it was noted that some services would be moving in house from Medvivo at the end of July 2024, 9 months earlier than that original date in May 2025.

Resolved

That the Board:

i) **Notes the recent decision of Cabinet to approve the delivery of the Urgent Care at Home and Telecare Response Service to Wiltshire Council in-house services from the 1 August 2024 at an annual cost of £1.665m, to be funded from the Better Care Fund.**

ii) **Delegate to Emma Legg, Director Adult Social Care in consultation with Cllr Jane Davies, Cabinet Member for Adult Social Care, SEND and Inclusion to finalise operational matters to ensure a safe transfer of the services. This will include the TUPE transfer of eligible staff and the purchase of the necessary resources such as uniforms, laptops, phones, equipment for service deliver and the use of fleet vehicles.**

35 **Better Care Plan - standing update**

Helen Mullinger introduced the report highlighting developments relating to the implementation of the Better Care Plan, with a PowerPoint presentation including budget statistics, demand and capacity numbers and future contracts due to be re-commissioned in the next 12 months.

Councillors acknowledged the national reporting requirements but also requested that more contextual narrative be set around performance measures for the Board to fully understand progress wherever possible.

Resolved

i) To approve the 2024-25 BCF Planning Refresh.

36 **Date of Next Meeting**

The next meeting will take place on 26 September 2024.

37 **Urgent Items**

There were no urgent items.

(Duration of meeting: 10.00am – 12.10pm)

The Officer who has produced these minutes is Max Hirst of Democratic Services, e-mail Max.Hirst@wiltshire.gov.uk

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Wiltshire Council

Health and Wellbeing Board

26th September 2024

Subject: Better Care Fund Quarterly Reporting

Executive Summary

The BCF Q1 quarterly reporting document was submitted to the national team on 29th August 2024. Sign-off prior to submission was agreed by the HWB Chair on 29 August 2024. This is a formal presentation of the documents to the Board. The Q1 reporting focussed on expenditure and outputs of schemes associated with the Discharge Fund only.

Verbal updates will also be provided on community health services procurement, s75 agreements and the latest performance against the Joint Local Health and Wellbeing Strategy.

Proposal(s)

It is recommended that the Board:

i) Notes the quarterly report submitted to the national team on 29th August 2024 (Appendix A).

ii) Notes a verbal update on the investment agreed at cabinet in community health services and the related ICB procurement (see links under background papers)

iii) Notes a verbal update on the refresh of a s75 agreement between BSW ICB and Wiltshire Council

iv) Notes the latest performance in delivery against indicators in the Joint Local Health and Wellbeing Strategy (appendix B)

Reason for Proposal

It is a condition of funding that the BCF reporting submissions are agreed and signed off by Wiltshire HWB.

Helen Mullinger
Better Care Fund Commissioning Manager
Wiltshire Council

Alison Elliott
Director of Commissioning
Wiltshire Council

Caroline Holmes
Place Director
NHS Bath and NE Somerset, Swindon, Wiltshire Integrated Care Board

Wiltshire Council

Health and Wellbeing Board

26th September 2024

Subject: Better Care Fund Quarterly Reporting

Purpose of Report

1. To formally present the BCF nationally required Q1 quarterly reporting submission.

Relevance to the Health and Wellbeing Strategy

2. The Better Care Fund supports the integration of health and social care services across Wiltshire, 'ensuring health and social care is personalised, joined up and delivered at the right time and place'.

3. Regular reports are required by the national team to monitor Wiltshire's performance against the approved plans.

Background

4. It is a condition of funding that BCF plans and monitoring reports are agreed and signed off by Wiltshire HWB.

5. The Health and Wellbeing Board signed off the BCF Planning Refresh for 2024-25 on 11th July 2024.

6. The Q1 reporting focussed on expenditure and outputs of schemes associated with the Discharge Fund only.

Main Considerations

7. The core aim of the Discharge Fund is to reduce delays to discharge. However, national guidance is clear that where funding schemes to reduce admissions to hospital will contribute to reducing delays to discharge, they can be funded from the discharge fund.

8. Wiltshire schemes reflect a balance of schemes that increase capacity in discharge schemes alongside additional support for community rapid response services that support the prevention of admissions.

9. Wiltshire is on target to meet planned outputs. Spend is also on track for the quarter one reporting period. (See Appendix A).

Next Steps

8. That the submission is formally approved by the Board.

9. Q2 reporting is required for submission on 31st October 2024.

Helen Mullinger
Commissioning Manager, Better Care Fund
Wiltshire Council

Report Authors:
Helen Mullinger, Commissioning Manager, Better Care Fund.

Background papers

- **ICB Community Health Service Procurement V2 (1) , item 10.PDF 266 KB**
- **ICB Report - Updated Exec Summary Sheet , item 10.PDF 135 KB**

Appendix A: BCF quarterly report: Submitted 29th August 2024 (separate document)

Appendix B: Joint Local Health and Wellbeing Strategy Delivery – latest performance against indicators

Appendix B:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)
10	Integrated Equipment - CCG (excluding continence)- Discharge funded	Home first /discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services	ICB Discharge Funding	£800,343	£200,086	6,187	640
44	TF Dom Care - in house - a - Discharge Fund - ICB	Dom Care - Rapid response	Home-based intermediate care services	Reablement at home (accepting step up and step	ICB Discharge Funding	£829,378	£207,345	380	62
46	Dom Care - Rapid response a Discharge Fund ICB	Dom Care - Rapid response (WS@H)	Home Care or Domiciliary Care	Domiciliary care to support hospital	ICB Discharge Funding	£1,100,279	£275,070	199	32
48	Wiltshire Council Discharge Fund	Discharge Fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Local Authority Discharge Funding	£2,393,210	£598,303	-	60
70	Brokerage Support	Programme Office, internal staff	Workforce recruitment and retention	Improve retention of existing	ICB Discharge Funding	£190,000	£47,500	-	3
71	WC In Reach (Discharge Hubs)	Staffing support to coordinate hospital discharges	Integrated Care Planning and Navigation	Care navigation and planning	ICB Discharge Funding	£339,000	£84,750	-	6.2
72	Urgent Community Response (Flow staffing supports rapid response)	Rapid response service	Urgent Community Response	0	ICB Discharge Funding	£320,000	£80,000	-	7
73	WC Reablement Staffing	HomeFirst/Reablement	Home-based intermediate care services	Rehabilitation at home (to prevent	ICB Discharge Funding	£228,000	£57,000	825	37

Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
Integrated Equipment - CCG (excluding continence)- Discharge funded	Home first / discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services	ICB Discharge Funding	£800,343	£200,086	6,187	640		No	The output figure is based on total funding across schemes 9,10,17,18. This schems acciounts for 12% of the total funding. Therefore the activity reflects the same percentage (based on uniques service users).
TF Dom Care - in house - a - Discharg	Dom Care - Rapid response	Home-based intermediate care services	Reablement at home (accepting step up	ICB Discharge Funding	£829,378	£207,345	380	62	Packages	No	

e Fund - ICB			and step down users)								
Dom Care - Rapid response a Discharg e Fund ICB	Dom Care - Rapid response (WS@H)	Home Care or Domiciliary Care	Domiciliar y care to support hospital discharge (Discharg e to Assess pathway 1)	ICB Dischar ge Funding	£1,1 00,2 79	£275,070	199	32	Hours of care (Unless short-term in which case it is packag es)	No	Outputs are Packages of Care (POC)
Wiltshire Council Discharg e Fund	Discharge Fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Local Authorit y Dischar ge Funding	£2,3 93,2 10	£598,303	-	60		No	Winter Discharge Fund contribute 60% of budget towards total spend on PW3.
Brokerag e Support	Programme Office, internal staff	Workforce recruitment and retention	Improve retention of existing workforc e	ICB Dischar ge Funding	£190 ,000	£47,500	-	3	WTE's gained	No	Funding being used to support 3 WTE on an ongoing basis.
WC In Reach (Dischar ge Hubs)	Staffing support to coordinate hospital discharges	Integrated Care Planning and Navigation	Care navigatio n and planning	ICB Dischar ge Funding	£339 ,000	£84,750	-	6.2		No	Funding being used to support 6.2 FTE on an ongoing basis.

Urgent Community Response (Flow staffing supports rapid response)	Rapid response service	Urgent Community Response	0	ICB Discharge Funding	£320,000	£80,000	-	7		No	Funding used to support 7 FTE on an ongoing basis.
WC Reablement Staffing	HomeFirst/Reablement	Home-based intermediate care services	Rehabilitation at home (to prevent admission to hospital or residential care)	ICB Discharge Funding	£228,000	£57,000	825	37	Packages	No	This scheme links with schemes 19 and 52 with the outputs recorded for the total, pooled funding. Scheme 73 funding accounts for 18% of the total budget, and so 18% of the Output per year - 149. This equates to 37 Packages of Care for Q1.

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WJLHWS commitments by Integrated Care Strategy theme	What we will do in the next twelve months	What will be different for our population in 5 years time?	Metric (specific measure)	Target (including timescale)	Frequency of Reporting	Next Due	Latest Date	Latest Value
Boost 'out-of-hospital' care, dissolving the divide between primary and community health services - through community multi-disciplinary teams, clustering services around primary care networks, and guaranteeing support to people in care homes			% receiving 2-hour Urgent Care Response seen within 2 hours (ICB)	70% (by June 2023)		3 x year	Sep-24	Yes. Average is 71 % with only one month (May) dipping to 69%.
			Virtual Ward 'beds'	136 'beds' by December 2023 180 by March 2024		3 x year	Sep-24	Target has changed as agreed with NHS England to 64 beds. 56 are consistently open with a utilisation rate of av. 42 which is a strong performance.
			length of stay in community hospitals	35 days across all wards by July 2023		3 x year	Sep-24	Yes. 33.72 for WH&C community wards is now 33.72 for the latest 4 months (April to July).
			number of people returning to their own home after a hospital admission	Increasing number of people returning home (Home First approach).		3 x year	Sep-24	Yes. 65% of people discharged from acute hospital with support return to their own home. This compares to c45% 18 months ago. 97% of all cases

WJLHWS commitments by Integrated Care Strategy theme	What we will do in the next twelve months	What will be different for our population in 5 years time?	Metric (specific measure)	Target (including timescale)	Frequency of Reporting	Next Due	Latest Date	Latest Value
								return to their usual place of residence.
			hospital trust lengths of stay.	To be confirmed following completion of current demand and capacity refresh		3 x year	Sep-24	Wiltshire LoS is on average a day longer than B&NES and Swindon. RUH and GWH is 7 days, SFT is 8 days. Significant improvement delivered in waiting times for discharge to Home First at 5.8 days from 8 days a year ago. Target is 2 days however this is being revised in line with rising complexity for some cases.

WJLHWS commitments by Integrated Care Strategy theme	What we will do in the next twelve months	What will be different for our population in 5 years time?	Metric (specific measure)	Target (including timescale)	Frequency of Reporting	Next Due	Latest Date	Latest Value
Enable frontline staff to work more closely together – planning our workforce needs together, developing case studies on front line cooperation, supporting shared records and IT and sharing estates wherever possible	Develop Wiltshire estate plans as part of BSW infrastructure strategy	colleagues will feel supported in their roles, and able to work with people across organisations, taking advantage of improved training, technology and integrated systems, able to focus on prevention and early intervention	Roll out of BSW population health insights tools to be accessible to all providers including primary care.	100% coverage		Annual	Sep-24	The ICB has the in-house Population Insights Tool, which is available to colleagues from across the system, on request. 86 ICB colleagues, 62 from Primary Care, 43 from various NHS providers, 54 from the Local Authorities, and 5 from Third Sector organisations now have access.

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

BSW Implementation Plan

Leanne Field – Head of Delivery

The plan – what, why and how?

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

What is the Implementation Plan (Joint Forward Plan)?

- The blueprint as to how we aim to achieve what's set out in the ICP Strategy

- The purpose of the plan is:
  - To set out how the ICB will meet its population's health needs;
  - To describe how the ICB and partners will arrange and provide services to meet physical and mental health needs including the ICS core purposes and ICB legal requirement

- Our original plan was developed and signed off in 2023 (covered 9 months) and we have undertaken a high-level refresh covering the two years 2024/25 and 2025/26

Why do we have one?

- ICBs and their partner trusts are required to publish a Joint Forward Plan before the start of each financial year, setting out how they intend to exercise their functions (Health and Care Act, 2022)

- The plan is also used to support meeting the requirements of the ICB Annual Assessment

The plan – what, why and how?

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

How is the plan developed?

- The plan has been developed with regard to the Integrated Care Strategy, our Operating Plan and other system partnership key plans particularly the Joint Local Health and Wellbeing Strategies
- Working with the 11 Delivery Groups Leads (Programme Boards) to develop
- Review and comment by Health and Wellbeing Boards
- High level review by NHSE

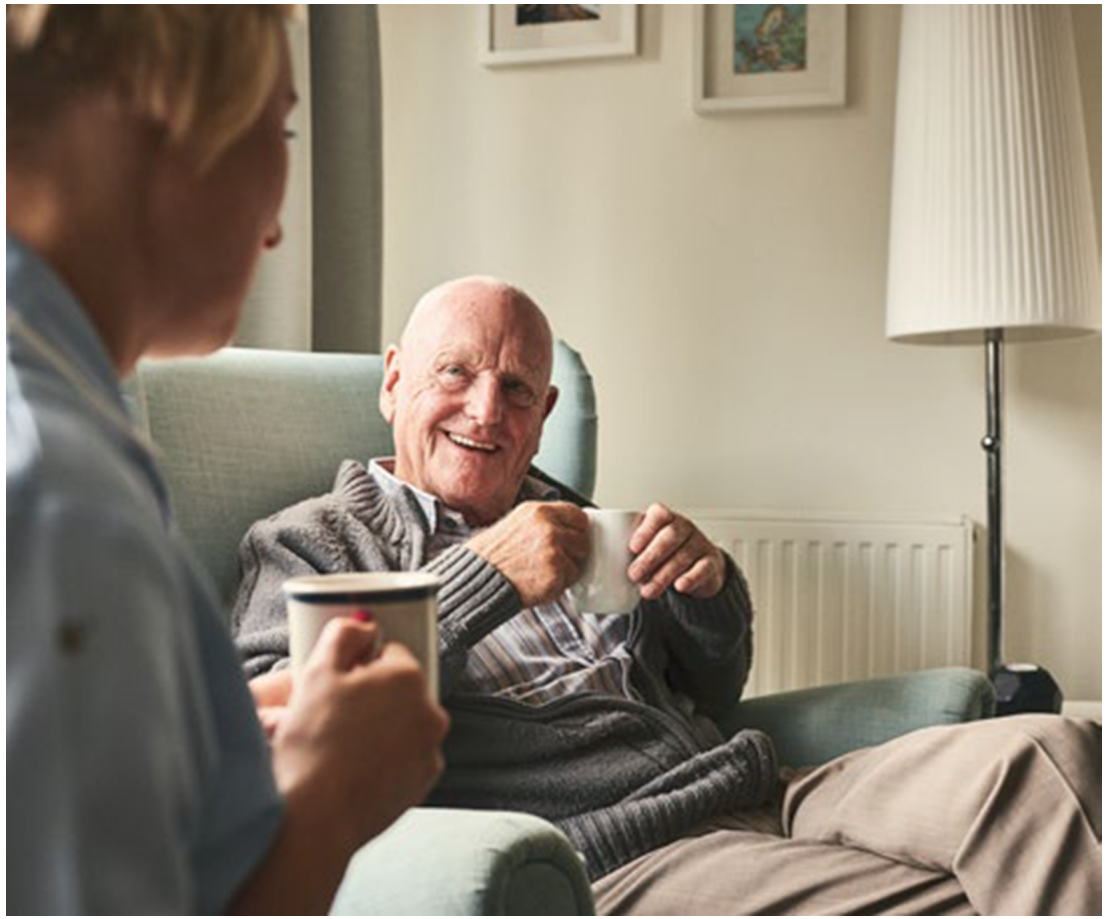
Implementation Plan Principles:

1. Fully aligned with the wider system partnership ambitions
2. Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments
3. Delivery focused, including specific objectives, trajectories and milestones as appropriate

Our 2023_2024 success across BSW

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

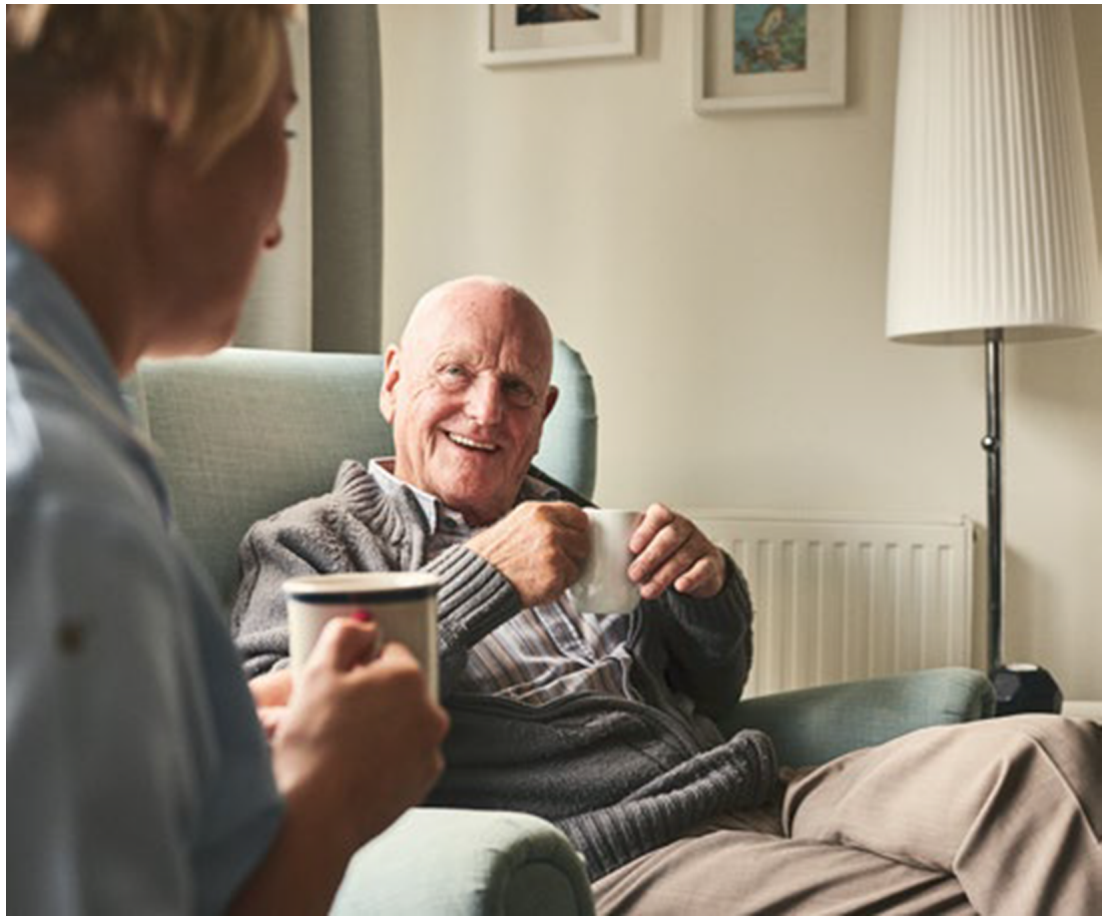
- Development of Integrated Neighbourhood Team in Swindon
- Youth worker pilot
- Unborn and under 1 system improvements
- Bank and agency
- Oliver McGowan training



Wiltshire specific 2023_2024 success

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

- Obesity
- Improvements in services for CYP
- Public Health
- Data and Intelligence



Priorities for 2024_25

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

ICP objectives	Implementation Plan update priorities
Focus on prevention and early intervention	Cardiovascular disease prevention Early intervention in mental health
Fairer health and wellbeing outcomes	Adopting CORE20PLUS5 Children and Young People
Excellent health and care services	Delivering our primary and community care transformation programme including the recommissioning of community services ready for 25/26 Improving access to, and the quality of, local services
Financial recovery and sustainability	

Wiltshire priorities for 2024_25

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

Area	Priority
Healthcare Inequalities	The Wiltshire Health Inequalities Group is driving change and improvement in the agreed Strategic Priority areas of the Core 20 % most deprived population areas, and the agreed cohorts of people in Wiltshire, as defined in the BSW Health Inequalities Strategy
Neighbourhood Collaboratives (Integrated Neighbourhood Teams)	• Successful delivery of the Health Inequalities-funded project to develop an engagement best practice model and deliver a programme of intervention around a cohort of people within the Core20Plus 5 groups. • Integrate the Collaboratives Group with the Connecting with our Communities Group. • Move the current resources and launch programme to a shared delivery model – bringing in partners to support the work across a wider footprint will enable the best use of resources. • Successfully deliver the Chippenham, Corsham and Box Launch programme
System flow	**Carer Breakdown** • Continue with additional capacity for domiciliary care to support carer breakdown, preventing avoidable admissions to hospital. • Intensive Enablement Service – preventing admission by preventing escalations in need and supporting discharge. **Home First** • Continue with ongoing Home First Improvement Programme – including the Streaming Framework, implementing the Wiltshire Model – hybrid services, interdisciplinary working, new performance standards, Discharge to Assess improvement, Transitions and Discharge Optimisation, new Technology opportunities. **Domiciliary Care Support** • Test and develop a hybrid model of working, which utilises domiciliary care to enable earlier discharges and maximise effective use of therapy capacity. **Community Hospitals** • Redesign the Community Hospital Model in line with the case mix and future demand profile.

Wiltshire Health and Wellbeing Board

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

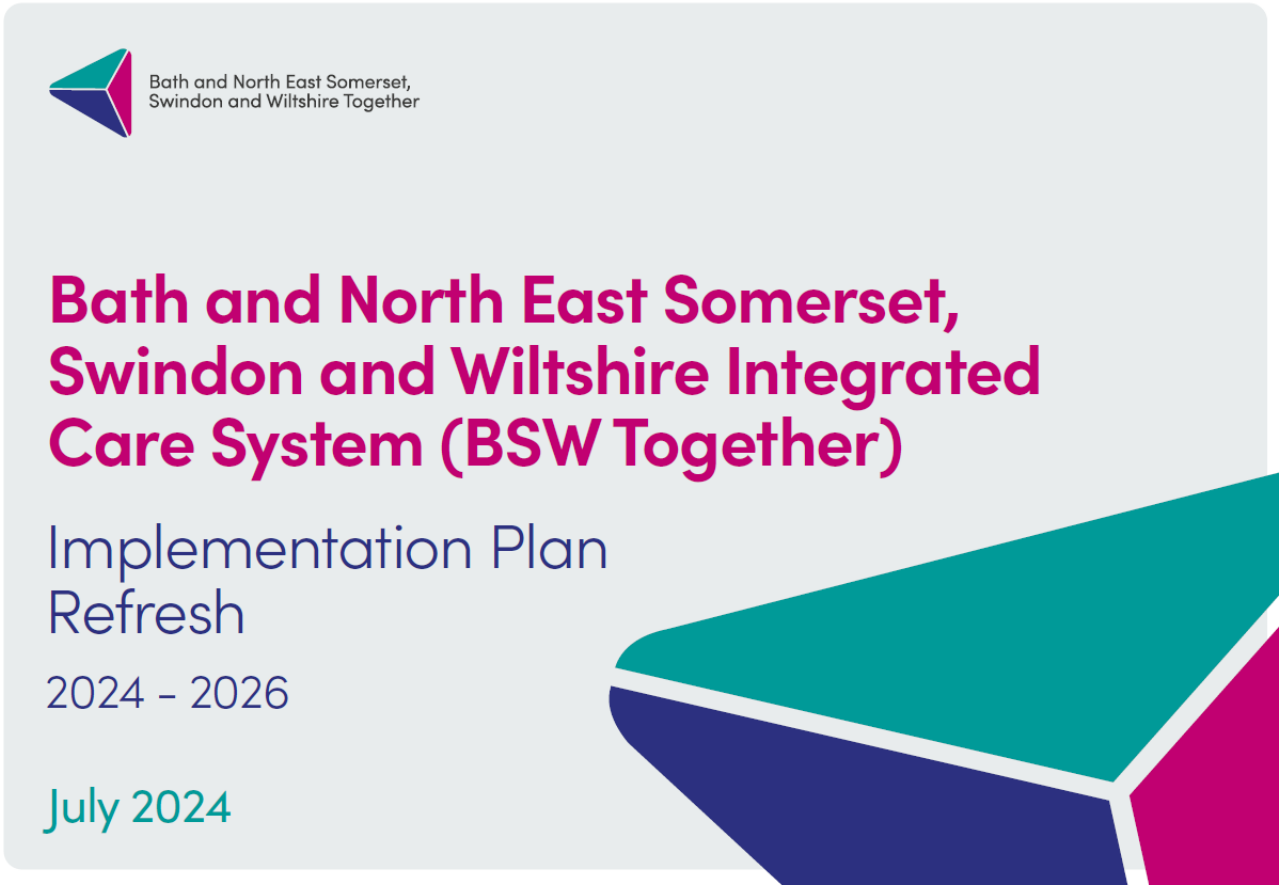
"Wiltshire In the opinion of the Wiltshire Health and Wellbeing Board, the BSW Implementation Plan for the Integrated Care Strategy takes account of the Wiltshire Joint Local Health and Wellbeing Strategy. We welcome the work undertaken by the Wiltshire Integrated Care Alliance to set out priorities for delivery for the year ahead and look forward to working with the Integrated Care Board to develop detailed resource allocations for delivery and to finalise metrics to oversee quality and performance."

What's next?

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

- Review and update of the refresh
- Working with Delivery Group Leads
- Strengthen our statutory duties
- Engagement with key partners and our communities

[BSW Implementation Plan - Bath and North East Somerset, Swindon and Wiltshire ICB]



Questions?

Bath and North East Somerset,
Swindon and Wiltshire Together

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

Implementation Plan Refresh

2024 - 2026

July 2024

Contents

Section 1

Introduction and purpose

This plan sets out how we and our partners, working together at system level and in our places, Bath and North East Somerset, Swindon and Wiltshire (BSW), will deliver our Integrated Care Strategy over the period 2023-28.

This is our version of the Joint Forward Plan that all Integrated Care Boards (ICBs) across England are required to produce for their respective systems.

We published our first Implementation Plan in July 2023, and this update sits alongside that first plan. As we are only a year on from publication, rather than update the plan in its entirety we have focussed on:

- reflecting on what we have delivered over the first nine months of working together in this new way;
- prioritising and re-focusing on key deliverables and outcomes that will help us achieve our Integrated Care Partnership (ICP) Strategy; and,
- setting out what we want to achieve in the next two years.

This Year 2 Implementation Plan Update does not provide the contextual detail that is set out in the 23/24 Plan but is a companion document focussed on describing delivery in 2023/24 and our plans for the coming year 2024/25. Readers are asked to also refer to the 2023/24 document which can be found on the ICB website.

Our system is made up of three distinct local areas – or places – and a wide range of organisations which may operate at one or more of neighbourhood, place or system level. The name we have given our Integrated Care System is BSW Together. The BSW Strategy, from which this Implementation Plan is derived, sets out what BSW Together aims to achieve for our population over the 2023-28 period and is informed by strategies and plans, including the three Health and Wellbeing Strategies, produced by partners.

The structure of the Plan places a particular focus on how we are delivering our BSW priorities together through system activities and our place level priorities which are described in more detail in our place based local Implementation Plans.

Section 1

Introduction and purpose

Current context

During the last financial year, the partners across the ICP have been working together to progress our transformation work, and deal with challenges, both individually and collectively. Alongside increasing demand and operational pressures, we are facing increasing financial challenges that must be addressed for us to achieve financial sustainability.

We have made progress in several areas together during 2023/24, and there have been significant changes to the way that we operate and our collective responsibilities. In particular, the ICB has taken on delegated responsibility for Pharmacy, Dental and Optometry Services from 1 April 2023. This enables us to take a more integrated and joined-up approach to planning and designing care around our population's health needs.

We have also:

- Published a new primary and community care delivery plan, developed following engagement with our primary care providers and partners.
- Reviewed our programme delivery arrangements (covered later in the document).
- Developed and implemented a system-wide campaign, informed by feedback from patients and staff, to help health and care professionals provide hospital patients, as well as their families and carers, with extra support before and during their onward care journey. https://bswtogether.org.uk/discharge/
- Achieved funding for BSW Youth Worker Pilot, embedding a dedicated Youth Worker into each acute hospital emergency department to support Children and Young People aged 11-25 with their mental wellbeing needs, and those struggling with the impact of long-term conditions including diabetes and epilepsy.

As part of our work on updating our Implementation Plan, we have specifically looked to ensure that our programmes of work will support delivery of our strategic priorities, as well as help return us to financial balance. These programmes will shape our focus on reducing inequalities and increasing our preventative activities, in turn enabling us to achieve financial sustainability. This is part of our 'left shift' priority.

While we are dealing with financial challenges, we are committed to ensuring that our transformation programmes continue and that we are investing in areas that will help our the people and communities of BSW to live healthier, happier and longer lives. This means that we are prioritising our focus on evidence-based programmes, grounded in meaningful engagement and involvement with local people and communities, that will deliver meaningful contributions to the outcomes we set out in our first Implementation Plan.

As part of putting this into practice, the next section sets out how we are using the ICP strategic priorities to develop a focussed number of priorities for delivery over the next two years.

Section 1

Introduction and purpose

Updating our plan – our priorities for the next two years

Since publishing our Implementation Plan in July 2023, we have been responding to an increasingly challenging operational and financial landscape, alongside a rising demand for health and care services within our population. We need to deliver key priorities if we are to make the changes we need to make in the face of these challenges. We are using this opportunity of refreshing our plan to set out a smaller number of priorities that we will help us deliver our overarching ICP objectives.

ICP objectives	Implementation Plan update priorities
Focus on prevention and early intervention	Cardiovascular disease prevention Early intervention in mental health
Fairer health and wellbeing outcomes	Adopting CORE20PLUS5 Children and Young People
Excellent health and care services	Delivering our primary and community care transformation programme including the recommissioning of community services ready for 25/26 Improving access to, and the quality of, local services
Financial recovery and sustainability	

We are committed to ensuring a return to financial sustainability within our healthcare system and have added this a new objective and priority for us for the next two years.

We have set out within later sections our plans to deliver these key priorities and our measures for success.

Section 2

Working together to deliver our Plan

During the summer of 2023, the ICB initiated a set of discussions around reforming the way that we oversee delivery of our collective priorities through our programmes. We engaged with CEOs and key stakeholders (including our Health and Wellbeing Boards) to discuss and agree a set of proposals.

In parallel, we have been working to set up a new financial recovery board. As part of agreeing how we work together to deliver changes, we have developed the following set of principles:

- We want to continue working in a way that respects our agreed commitments to mutual accountability and collective oversight.
- We need to establish mechanisms that operate effectively across system partners, and are based on a high trust, high transparency approach.
- We need clear delivery governance and decision-making routes that are easy to understand and collectively owned, are effective at ensuring that we have the right groups set up to carry out delivery, and that delivery is on track.
- By delivery, we mean putting in place the actions to deliver our agreed strategy, Implementation Plan and operating plan.
- We need to recognise the interdependencies and the differences between oversight of 'business as usual' activities and transformation work ensuring the mechanisms we put in place are capable of overseeing both.
- We need to be clear that the ICB risk management framework applies to delivery groups.
- There is a desire to have a consistent programme and project methodology using initiation, gateways, milestones, evaluation, closedown etc.
- We want to be clear on what decision-making powers / authorisations sit at different forums.
- We aim to weave engagement and involvement work through all of our priority work projects and programmes, reflecting our Section 14 duties as an ICB, but also because we want relationships to grow, flourish and strengthen our wider health and care system.
- System partners will, as business as usual, ensure that their own organisations are delivering against their plans. However, there is benefit in partners carrying out oversight together, in the understanding that under current legislation, performance / delivery oversight cannot be delegated from / by sovereign organisations.
- To ensure efficient and effective ways of working, we will not set up new forums if another group could be re-purposed or modified to undertake the function required.

Section 2

Working together to deliver our Plan

We are establishing a new Planning and Delivery Executive which is an Executive-led forum charged with the responsibility for mutually overseeing delivery of our agreed priorities.

We will agree our priorities through our Implementation Plan, and these will form the mandate for each programme (now called 'Delivery Group') and our work programme for the year.

Delivery groups are partner forums that come together to deliver both our Operating Plan and Implementation Plan commitments, and will be expected to report regularly on achievements, using a standard approach to escalating concerns through to the Planning and Delivery Executive.

The main delivery groups as currently identified are:

- Urgent and Emergency Care
- Elective
- Mental Health
- Learning Disability and Autism
- Children and Young People
- Primary and Community Care

Enabling delivery groups are:

- Digital
- Estates
- Finance
- Green
- Workforce

New groups can only be added in agreement with the ICB Executive, and consideration will be given in 2024/25 to the inclusion of an engagement and involvement delivery group.

The Planning and Delivery Executive will sit alongside the Financial Recovery Board, which will focus on whether we are seeing the expected financial benefits of the delivery of our collective priorities – both in terms of organisational performance and delivery of system-wide financial recovery initiatives.

The ICAs and the Acute Hospital Alliance (AHA) also have responsibility for delivering elements of our Implementation Plan – we are working through how we will ask partners to share updates on progress.

Section 3

Some examples of our achievements in 2023/24

Developing an Integrated Neighbourhood Team model in Swindon

Integrated Neighbourhood Teams are one of eight priority areas in our Swindon Integrated Care Alliance Delivery Plan. We have three commitments:

- We will create an integrated neighbourhood team model.
- We will listen to what neighbourhoods need from local services whilst managing expectation.
- We will enable people to stay well, safe and independent for longer.

We have established a steering group with representation from Voluntary, Community, and Social Enterprise (VCSE) sectors, LiveWell, and other local community organisations. This group has been instrumental in shaping the direction and implementation of our pilot projects. Different forms of engagement and feedback sessions have been held to ensure that the voices of local residents, particularly those from targeted populations, are heard and integrated into our planning and execution processes.

Through our pilot projects, we have started small and are working in targeted areas with targeted populations to test out what is achievable. Our pilot projects have been developed from our learning from other areas where integrated neighbourhood working is further developed, and from learning from organisations across the country.

Our first pilot project 'Team Around Me' has involved extensive stakeholder engagement from the outset, including with the organisation that initially ran a very similar project in a different region and inspired our pilot. We have specifically engaged with patients and carers to gather their insights and feedback. This has included one-on-one interviews where patients and carers have shared their experiences, needs, and suggestions for improvement. We have also worked closely to gain feedback from the clinical staff involved in the pilot to ensure a comprehensive understanding of their perspective and possible challenges. These interactions have been crucial in tailoring our approaches to better meet the needs of those we serve. We have also set up feedback mechanisms to continually gather input from patients, carers, and staff throughout the duration of the project.

Our second pilot project 'Connecting Care for Children' is also based on a successful model running in London. We have coproduced our approach with a small working group including acute paediatrician and managers, primary care clinicians and managers, health visitor services, social care and community navigators.

Partners have offered their resources and shared their assets to enable solutions to be developed to support in tackling health inequalities and promote health and wellbeing within their local community. We have ensured a focus on effective and robust evaluation on the impact of these projects, particularly on left shift and the potential to implement at scale. Within our steering group we have focused on developing a positive culture with strong collaboration amongst all partners which will support the ongoing success of the work on Integrated Neighbourhood Teams.

Section 3

Some examples of our achievements in 2023/24

Leadership and Management

We have worked on a new system leadership and inclusion development offer designed with partners from health, care and the VSCE. This is based on increasing opportunities for collaboration and system thinking with the aim to build a longer-term leadership alumni network. The inclusion programme focused on middle managers being equipped with practical action orientated tools for transforming the inclusion agenda. Two cohorts completed a co-production module successfully delivered in partnership with Wiltshre VSCE with marketing across all health and care partners. Collectively the leadership and management work has been focused on embedding compassionate and inclusive workplaces.

We have achieved the successful mobilisation of a quality improvement community of practice with improvement leads from across BSW building new relationships and understanding. In partnership with NHS AQUA (who work as a improvement partner for NHS organisations) a system wide diagnostic was completed with the outcome of a baseline assessment of improvement with identified recommendations. A cohort of staff were trained in Calderdale framework, a service transformation tool, with 10 facilitators taking forward service transformation projects. As part of the improvement work foundation training successfully designed and provided to system partners and leadership and support provided through the Acute Hospital Alliance and their aligned improvement methodology.

Oliver McGowan Training

We have mobilised a training model that has been made available to system partners that to date has trained over 2000 members of staff in face to face sessions.

Bank and Agency

BSW is the lead ICB for the SW regional response to agency spend, this will see us move to a Nursing Price Cap compliant Card (excluding certain specialities) by the 1st June 2024 as a region. We are also leading the implementation of a SW regional Medical rate card which we hope will be on similar timelines. This will offer significant savings to BSW and the wider region. Work will then continue to remove Off-Framework by July 2024 and review other staff groups including STT and Admin and Clerical. As of February 2024, we are on target to achieve our agency ceiling, although industrial action could impact this position.

BSW Youth Worker Pilot

We have achieved funding for a Children and Young People (CYP) Youth Worker Pilot, embedding a dedicated Youth Worker into each Acute hospital emergency department. Through working agreements with VCSE partners, a network of Youth Workers will be based in each of our Acutes hospitals in Bath, Swindon and Wiltshire. The youth worker roles will deliver a person centred, trauma informed intervention for CYP aged 11-25 accessing our Children's Wards, Emergency Departments and adult wards, focusing on mental wellbeing needs and children struggling with the impact of long-term conditions including diabetes and epilepsy.
The pilot aims to reduce A&E attendances, hospital admissions and provide accessible, quality youth work which has positive impacts on CYP wellbeing.

Section 3

Some examples of our achievements in 2023/24

Unborn and Under 1 system improvements

Research nationally has established the increased risk to under 1s from abuse and neglect. Local case reviews across BaNES, Swindon and Wiltshire have also identified this risk, with both Wiltshire and Swindon publishing thematic reviews relating to serious injuries in this cohort of children. Across the individual safeguarding partnerships work has previously taken place to respond to the learning from these reviews, however the response has lacked oversight and coordination in order for it to be most effective and impact on practice.

A steering group has been chaired by BSW ICB and members have included representatives from BSW ICB, the three safeguarding partnerships, children's social care, community and acute health services and the police.

Outputs of the group have focused on improvements of response to the under 1's and have included the development of a BSW bruising in non-mobile babies' policy; development of BSW Pre-birth protocol; development of BSW Faltering growth Policy; development of a Safer Sleep policy and a focus on professional curiosity and working with fathers. ICON interventions, Preventing Abusive Head Trauma in Infants has also been adopted across BSW.

Engagement and Involvement

Our engagement activities have been recognised by NHS England as part of the ICB Annual Engagement Assessment 2022/23 and assures that BSW ICB has made good progress towards fulfilling its legal duties on public involvement.

During 2023/24, BSW ICB has:

- Continued to facilitate two public engagement forums within BSW, meeting regularly to update on BSW ICB developments and opportunities for involvement.
- Worked closely with the BSW Voluntary, Community and Social Enterprise Alliance to deepen our reach into communities within BSW and provide opportunities to have their say.
- Developed and delivered targeted campaigns based on data and insights to:

  1. Reach 17-30 year olds across BSW with the aim of encouraging them to have their MMR vaccination as a preventative measure.

  2. Support health and care staff, patients, their carers and families to better understand the process for being discharged from hospital and the benefits of this happening as soon as the patient is well enough to go to their onward place of care. Staff and patients were involved in focus groups to help develop the communications materials. Both campaigns will be evaluated and reviewed for learning points to inform future activities.

- Commissioned a third-party survey and interviewed a number of staff in relation to the new BSW Integrated Care Record, intended to provide a joined-up service for patients, a quicker treatment time and means that they need only tell their story once.

Section 3

Some examples of our achievements in 2023/24

- Undertook targeted engagement with general practice on the development of the Primary and Community Care Delivery Plan.

Our ambitions for our statutory duty to involve people and communities (as set out in section 14Z45 in the NHS Act 2006, as amended by the Health Care Act 2022) are significant. Our organisational change programme will ensure that the ICB will have a dedicated engagement and involvement resource within the communications and engagement team, offering practical advice and guidance to colleagues across the organisation to help embed engagement and involvement as key enablers.

Some of the tangible ways in which we intend to strengthen and embed engagement and involvement throughout our work include:

- Updating and refreshing our people and communities engagement strategy.
- Closer collaborative working with our system partners and the wider SW regional communications and engagement communities to deliver evidence-based campaigns e.g. hypertension, that address specific health inequalities.
- Focus on the CORE20PLUS5 groups when considering outreach and engagement, looking at appropriate and credible methodologies to gain feedback and insights from these groups to inform our work.
- Review and refresh stakeholder mapping, ensuring that we have the knowledge base on which to begin more proactive outreach and to enable us to build better, stronger relationships.
- Continue to build on the patient and public forum models that we have established, working to increase the diversity of group members and attendees via active recruitment to seldom heard groups.
- Work with system and regional colleagues to invest in an effective engagement platform to draw insights from our citizens and communities in the broadest sense.
- Support and champion guidance and best practice principles to inform transformational programmes and workstreams, nurturing co-design and co-production, and facilitating engagement and involvement so that people can see their views and opinions reflected in the services and innovations we deliver.
- Proactively use the insights we gather to 'hold a mirror' up to our organisation, helping BSW ICB become a 'listening' organisation that understands the views, opinions and ideas of the people and communities it serves.
- Ensure that the governance structure of our ICB and wider system, embeds engagement and involvement best practice at every level so that accountability for our duties is at the heart of our work.

Section 4

Health and Wellbeing Board Opinions

Each of our Health and Wellbeing Boards (Bath and North East Somerset, Swindon and Wiltshire) have considered the plan and how well it takes account of local needs.

The three boards have provided the following opinions:

Bath and North East Somerset
The BaNES Health & Wellbeing Board welcomed the opportunity to work with ICB colleagues on responding to the Implementation Plan.

We have been working together closely on the ICB Implementation Plan and can confirm that it is reflective of and informed by the activity at local level and our H&W Being priorities.

In BaNES our Health & Wellbeing action plan and Implementation Plan map across to one another with key objectives, and we have a model of distributed leadership across our organisations who lead on relevant priorities. We have provided specific comments around the prevention agenda which have been taken into account and can confirm the place priorities also reflect our ICA joint working.

Swindon
We note that the BSW Strategy, from which this plan is derived, is focussed on the delivery of three Strategic Objectives which have been agreed across partners and were arrived at through a process of consideration of the priorities in the three local health and wellbeing strategies, including that of Swindon, as part of a wider stakeholder engagement process. Themes from priorities in the Swindon Health and Wellbeing Strategy flow through the plan. The plan also includes a chapter pulling out key 2024/25 deliverables from the local Implementation Plans for each of the three-place based Integrated Care Alliances.

In its feedback so far, the Swindon Health & Wellbeing Board has encouraged further links with the BSW Mental Health Strategy, Swindon Public Health Mental Health strategy, oral health and access to dentistry in future refreshes of the Implementation Plan.

We welcome the opportunity to align the priorities of the Integrated Care Alliance and the Swindon Health and Wellbeing Board.

Wiltshire
In the opinion of the Wiltshire Health and Wellbeing Board, the BSW Implementation Plan for the Integrated Care Strategy takes account of the Wiltshire Joint Local Health and Wellbeing Strategy. We welcome the work undertaken by the Wiltshire Integrated Care Alliance to set out priorities for delivery for the year ahead and look forward to working with the Integrated Care Board to develop detailed resource allocations for delivery and to finalise metrics to oversee quality and performance.

Section 5

Our local Implementation Plans

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

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

The Integrated Care Alliances in BaNES, Swindon and Wiltshire have responsibility for oversight and assurance of the delivery of the relevant parts of the Integrated Care Strategy and the Local Health and Wellbeing Strategy. They have undertaken this work during 2023/24 and will continue to do so.

Section 5

Our local Implementation Plans

During 2023/24 the following key deliverables have been achieved:

BaNES

Delivery of Home is Best programme, including:

- Launch of NHS@Home step-up model (delivered by HCRG Care Group) with a target occupancy of 65 by April 2024. Full utilisation of RUH NHS@Home step-down model continues (35 beds).
- Launch of Community Wellbeing Hub discharge service within the acute, resulting in significant month-on-month increases in referrals to the CWH (1,400 referrals received and 639 people supported during Q3 2023 – 2024, compared to 403 referrals received and 262 people supported in the same Quarter 2022 – 2023). During Q3 2023 – 2024, 26 complex cases were reported via Riviam and discussed at the CWH MDT.
- Significantly improved access to Dom Care packages of care and hours as a result of work to diversify the market. This includes an additional 1,600 hours as part of the United Care BaNES project.
- Frailty Pilot, delivering an anticipatory service to provide proactive assessment and advice for people with early frailty, supported 24 people Jun – Dec 2023 via MDT approach.
- Planned opening and closure of Homeward Unit at St Martin's Hospital to support Winter pressures and delivery of financial efficiencies.
- New ways of working embedded in response to ECSIT review including detailed evaluation of Reablement provision and embedding use of MADE framework across community, D2A, and Mental Health bedded capacity.
- Delivery of reduction in Care Home bedded capacity (achieved target of 30).
- Reduced and maintained Non-Criteria to Reside position within the acute below target of 20.

Section 5

Our local Implementation Plans

BaNES
Integrated Neighbourhood Team model developed via a series of co-designed workshops working with CSU and all partners across the ICA: • Four key pillars of work and partner leads identified to take this forward; • Prototype tested via the Frailty pilot; • Project currently on hold pending the progression of the ICBC programme of procurement as Integrated Neighbourhood Teams is a key requirement in the commissioning intentions: locality work will be resumed aligned to the System leadership on ICBC.
Joint working between BSW Academy and Local Authority to lead on the Domiciliary Care workforce across BSW: lessons learned embedded in practice, and support given to the System-led work on International recruitment and pastoral care.
Establishment of Health Inequalities Network with dedicated resource to strengthen capacity and understanding about inequalities. This has included targeted offers and adjustments for known areas of deprivation, including Paediatric PUSH clinics (which have seen in excess of 950 children to date) and Homeless & Rough Sleeper clinics. The latter delivered COVID-19 and 'flu vaccinations and offered eight MECC contacts.
Community Investment Fund in place, supporting universal and targeted schemes to support local people by addressing know inequalities including warm housing and help with cost-of-living.

Section 5

Our local Implementation Plans

Swindon
Completion of Building the Right Support peer review in 2023 with resulting action plan in place
Health Inequalities Funding to support health inequalities projects across the locality, as part of year 1 funding, the projects delivering progress include: • Changing Suits - project to raise awareness of mental health within the South Asian community (SAC), and to increase SAC engagement with local service providers. • Kennet Furniture Refurbishment - Local support organisation to alleviate furniture poverty (including beds) for the most vulnerable house-holds in Swindon. • Citizens Advice Swindon cost of living support & Live Well - Citizens Advice Lead based in Sanford House alongside the Live Well team to identify and provide debt, benefits, energy, or housing advice. The aim will be to increase knowledge and shared expertise in identifying and providing solutions in relation to practical advice issues. • Patient Educators - 4 Primary Care Networks to deliver obesity & smoking cessation through providing education and support to new parents within the CORE20 PLUS.
Delivery of an integrated health response and service to asylum seekers, Afghan and Ukrainian refugee families
As part of the Integrated Neighbourhood Teams (INT) initiatives in Swindon, we have: • Held 3 workshops with stakeholders to develop INT approach in Swindon. This has now developed into a steering group which has met monthly since Jul-23 • First pilot Team Around the Person established with Kingswood Surgery and partners (Brunel 2 Primary Care Network) • Explored and developed ideas for additional INT approaches focussing on people living with obesity, children with complex health needs, and women's health hubs. These can be pursued in 2024/25.
Reduction in people delayed waiting to leave hospital by 30%

Section 5

Our local Implementation Plans

Swindon
Increased capacity to 40 virtual ward beds.
Implementation of new Home First pathway from hospital now supporting over 120 people per month to go straight home from hospital – MDT working with lead home care provider and partners.
Launch of Motor Neurone Disease (MND) service in Swindon.
As part of Left Shift of Care VCSE organisations in Swindon have influenced inclusion and been involved in the design of new Integrated Community Based Care programme.
Involvement of Swindon Mental Health Carers Group in the BSW Mental Health Strategy development.
Making Carers Count project led by Swindon Carers Centre to increase engagement with carers.
Implementation of Access (community services framework) and development of integrated pathways for mental health with partners.
Having a clear mandate for change from LGA Peer Review and My Swindon report.
Setting up the Building the Right Support Programme Steering Group and having a collaborative thorough approach to scoping.
Co-producing working together plan setting out principles of what good co-production looks like.
Supported Living Framework for young people transitioning to adult services agreed with plan to implement from May 2024.

Section 5

Our local Implementation Plans

Wiltshire
Wiltshire has clustered the ICS Strategy Themes with the aims in the Joint Local Health and Wellbeing Strategy. Please refer to the JLHW strategy for more detail Wiltshire's Joint Local Health and Wellbeing Strategy 2023 to 2032 - Wiltshire Council. Key achievements in 2023/24 include:-
With a target to reach 60% by 2032, the rate of children estimated to be physically active has risen to 48% (above England average) although Wiltshire is now behind the South West average of 49% - there are initiatives to improve this further. Activity levels in adults are above national and regional averages.
Local work has been successful in improving screening and vaccination rates – there is an ongoing focus to improve rates within groups who experience inequitable outcomes. For example, flu vaccination rates are now at 85% for people aged over 65 years.
Improvement has been made in the target to reduce obesity in the adult population, currently at 27% against a target of 25% by 2032.
The Health Intelligence Team has been established using Health Inequalities Funding – they work across the Wiltshire system, supporting services to understand and use a Population Health Management approach.
Key developments for children with SEND needs have been the expansion of special school places and associated resource centres, the development of the Local Offer website, and the introduction of health advisors and increasing voice activity for children and young people and parents and carers.
Wiltshire has recommissioned public health nursing services, ensuring they are inclusive of a coordinated approach and core offer for emotional wellbeing in schools.
Childrens Services were rated Outstanding by Ofsted in September 2023. 50235241 (ofsted.gov.uk)
The Families and Childrens Transformation Programme (FACT) partnership launched its Family Help project to enhance local arrangements for the delivery of early intervention and prevention services for children, young people and families. All Together - Wiltshire Together 5 schools are signed up to the Restorative Approaches Pilot – an evaluation will offer key learning and insights to inform future adoption of the approach.
The Wiltshire Health Inequalities Group focusses on work to reduce health and wellbeing inequalities and aligns to the CORE20Plus5 approach. The group has successfully identified priority investments for the health Inequalities Funding for 23/24 and is engaged in monitoring the delivery against those plans.
The Wiltshire Autism Partnership has been initiated with both professionals and service user forums held in January 2024.

Section 5

Our local Implementation Plans

Wiltshire
An improvement group has been established working in partnership with VCSE sector colleagues to increase the uptake of Annual Health Checks for people with Serious Mental Illness or Learning Disabilities – Wiltshire is currently under performing against national targets (48% against a combined target of 23%) despite comparing favourably at a regional level.
The Wiltshire Dementia Strategy was approved by the Health and Wellbeing Board in September 2023 - an Implementation Plan will ensure the successful delivery and transformation of services through 2024 and beyond.
Neighbourhood Collaboratives have launched the first sites in 2023 – there are 5 in different stages of progression – the ambition is to have commenced work in all areas by the end of 24/25.
Following successful pilots, the Community Conversations programme which started in Bemerton Health (Salisbury) and Studley Grange (Trowbridge) the reach has been extended to Chippenham and Melksham.
Partners have developed new pathways and models to ensure that people who are able to go home after an inpatient hospital stay, are able to do so (taking a Home First approach) and are less likely to need extended inpatient care in the community setting.
Wiltshire has introduced a new Carers Strategy to rightly focus on improving the way in which informal carers are supported across our services and improve their outcomes. A new contract has been awarded to take forward the ambitions in the strategy.
Wiltshire has developed and launched the Caring Steps Together resources which are available across BSW – we worked as partners with patients and their support networks, staff and others to develop new resources that support people through the process of being discharged from hospital and require either admission to a care home or support at home on a short- or longer-term basis
The community Urgent Care Response service met and now exceeds its target of attending 70% of cases at home within 2 hours of the referral. This ensures avoidable admissions to hospital are prevented.
The local authority implemented a Care Home Hub Model for people going into a care home bed on a temporary basis after an inpatient stay in hospital. This model has shorted the length of stay in the care homes, meaning people return to their own home much quicker than previously.

Section 5

Our local Implementation Plans

Key priorties for delivery in 2024/25

BaNES
Workforce: Continued joint working across all sectors to consider new models of working in an integrated way to respond to opportunities, local needs and challenges. This will be a key enabler to attract, retain, and provide development opportunities to create a multi skilled sustainable workforce. Locality objectives achieved: further work required on new ways of working and organisational change / development to inform next year's deliverables
Health Inequalities, including: • Implementation of Women's Health Hubs • Implementation and monitoring of schemes supported via the Health Inequalities Fund, agreed through the ICA Board. These include: • Support for safe discharge of homeless people from the RUH; • Partnership with Bath Rugby for Children & Young People with additional needs; • Supporting individuals experiencing domestic violence. • Learning from Paediatric PUSH clinics to confirm offer for Winter 2024 – 2025.
Foundations to Deliver, including: • Integrated Neighbourhoods: Q1: collaborative review of plans and agreement of next steps. • Review of Reablement provision by end of Q1 linking into demand and capacity planning.
Redesigning Community Services: continue to deliver Home is Best Programme with a revised focus on attendance and admission avoidance, and Mental Health (including Dementia) and Homelessness Pathways. Home is Best revised priorities launching 1 April 2024.
ICA Cross-cutting themes and deliverables: the ICA will continue to work in collaboration with System-wide programmes to deliver the agreed priorities.

Section 5

Our local Implementation Plans

Swindon
Focus on reducing inequalities in '5' focus clinical areas requiring accelerated improvement, to include as part of the action plan: • Maternity – ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely. • Severe mental illness (SMI) – ensure annual physical health checks for people with SMI to at least nationally set targets. • Chronic respiratory disease – a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations. • Early cancer diagnosis – 75% of cases diagnosed at stage 1 or 2 by 2028. • Hypertension case-finding and optimal management and lipid optimal management – to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.
Consideration of how social determinants of health impact on those at risk of developing an ABI/TBI and those with an ABI/TBI. Risk factors such as frailty and alcohol misuse provide opportunities for targeted prevention actions
Integrated Neighbourhood Teams (INT) • Q1 – Launch Team around the Person Integrated Neighbourhood Teams in Brunel 2 PCN • Q2 – If PCN support is secured, launch Connecting Care for Children INT in Wyvern PCN • Q2 – If funding is forthcoming launch Women's Health Hub INT in Brunel 2, Brunel 4 and Wyvern A PCNs • Q1/Q2/Q3 – Test aspects of Obesity INT in Brunel 3 PCN

Section 5

Our local Implementation Plans

Swindon

Carers

- Q1 - Tender for Carers Services contract is published after engagement with carers + Feedback from carers informs the Integrated Neighbourhood Team pilot.
- Q2 - Preferred provider for Carers Services contract is confirmed by end Sept 2024 + Plan developed for ensuring all registered carers with SCC and/or GP surgeries have access to annual health check.
- Q3 - Current provider recommissioned and action plan for implementation of new contract delivery in place OR Robust plan in place for current provider to work with new provider for seamless transfer of carer services + Provider works with GP surgeries on ensuring all registered carers have access to an annual health check.
- Q4 - New carer services contract commences + Feedback from carers shows support they receive evidence they are better able to balance their caring role to protect their own health and wellbeing.

System Flow

- Q1 - Review the step down and D2A capacity, including processes and function of the beds.
- Q1 - Maximise Home First pathways and review processes.
- Q1 - Launch and embed SwICC admission criteria.
- Q1 - NHS@Home capacity increase in line with trajectories.
- Q2 - Implement new Trusted Assessor model, including bed management oversight.
- Q2 - Start winter planning.
- Q2 - Scope potential further elements of an ICA demand and capacity plan (primary care, voluntary sector for example).
- Q3 - Complete and sign off Winter Plan.
- Q3 - Stand up winter respiratory clinics.
- Q4 - NHS @ home (virtual ward) beds 90 (80% bed occupancy).
- Q4 - Implement lessons learnt review from Winter Plan and outcomes.

Section 5

Our local Implementation Plans

Swindon

Left Shift of Care

- Q1 - Deliver workshop with ICA and DEG to look at examples of where resource has been successfully shifted left into prevention, identify the barriers that have prevented further left shift and how they can be overcome, agree opportunities for further left shift.
- Q2 - Develop a plan for how left shift work can be taken forward within the existing financial envelopes, including in Integrated Community Based Care, mental health and talking therapies.
- SBC and ICB to continue to increase connectivity and joint working with voluntary sector partners.
- Explore developing pharmacy led lipid (cholesterol) clinics with enhanced consultant advice and guidance in general practice to address lipid out-patient clinic waiting lists and increasing ongoing capacity. Negotiate payment mechanism to shift resource from out-patient to primary care.
- Deploy new ICB prevention funding to reduce heart attacks and strokes and associated morbidity and mortality through a co-produced approach to risk reduction, casefinding and optimising management of hypertension all underpinned with addressing inequalities.
- Explore joined up system communications to encourage self-help with an initial focus on hypertension and CVD risk reduction.
- Develop prevention approach to mental ill-health in collaboration with system partners.

Section 5

Our local Implementation Plans

Swindon

Mental Health

- Plans underway to link ICA Delivery Plan Mental Health actions to Swindon Public Health Mental Health strategy (detail in next version).
- Q1 - Embed integrated access model in Swindon alongside third sector providers – redesign expected end April 24.
- Implement a Talking therapies pathway.
- Embed integrated access model in Swindon alongside third sector providers.
- Improve Urgent care pathway and 111 press 2.
- Increase dementia diagnosis rates.
- Carry out Impact evaluation and continue to monitor effectiveness of the Family Safeguarding Model.
- Develop an action plan based on the Mental Health Strategy & Suicide Prevention Strategy.
- Reduce out of area hospital inpatient admissions.
- Q1 - To continue to hold Tier 1 Multi agency meetings where specialist placement avoidance is explored (third sector are involved).
- Q1 - To liaise with Crisis Houses to determine if those in current specialist MH placements can be supported in Crisis Houses.
- Q1 - To continue to repatriate people within specialist inpatient placements to AWP inpatient wards.
- Q2 - AWP Windswept Rehabilitation ward – MDT should be fully recruited and accepting referrals to support the repatriation from Specialist Mental Health inpatient units to Windswept Ward, Swindon.
- Embed the iThrive model into the Swindon mental health pathway.
- Working in partnership with SBC and other Swindon partners to develop an enhanced offer for CLA, supporting earlier intervention and increased access to specialist trauma support, ensuring permanency of placement and a reduction in the number of CLA who are admitted to acute hospitals with significant emotional distress.
- Explore options for long term placements within Swindon for patients with more complex needs (working age).
- Develop and implement plan to upskill workforce in the changing mental health needs across Swindon.

Section 5

Our local Implementation Plans

Swindon

Learning Difficulties & Autism

- Work with people to co-produce improvements for people with learning difficulties and autism.
- Improve prevention and maximising using technology.
- Improve response to learning disabilities and autism with Mental Health complaints.
- Fully embed the key worker service for people with learning difficulties by Q1:
- Update to the local offer pages.
- Ensuring consent forms (to be added to DSR) contain information on the key worker scheme.
- Development of service user friendly comms..
- Share relevant data regarding the scheme with strategic partners, i.e. social care.
- Key worker colleagues being invited into DSR meetings
- As part of the SBC Building the Right Support programme:
- We will launch and promote Working Together Plan in Adult Services and with partners and key stakeholders.
- We will have completed a baseline survey to measure the knowledge and understanding of staff on working together principles.
- We will develop Working Together training.
- We will roll out new My Care, My Views forms.

Children & Young People

- Oral Health
- Q1 - Supervised toothbrushing programme.
- Q2/Q2/Q3/Q4 - Fluoride varnish treatment and advice in primary schools.
- Q1/Q2/Q3/Q4 - Continue to rollout dental plan for BSW.
- Develop community hubs (in conjunction with mental health) with co-located teams taking a holistic approach to children's services.
- Commission new provider for Children Community Services.

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Our local Implementation Plans

Wiltshire
The Wiltshire ICA is committed to the delivery of the Joint Local Health and Wellbeing Strategy (https://www.wiltshire.gov.uk/article/8528/Wiltshire-s-Joint-Local-Health-and-Wellbeing-Strategy-2023-to-2032). Additionally, the Alliance is currently re-focussing on a small set of shared priorities aimed at reducing population health inequalities, aligned to a prevention focus / left shift. The processes to achieve this is well advanced and will conclude in May 2024. The agreed priorities will be published after this date. The following are significant areas of delivery in 24/25.
Healthcare Inequalities The Wiltshire Health Inequalities Group is driving change and improvement in the agreed Strategic Priority areas of the Core 20 % most deprived population areas, and the agreed cohorts of people in Wiltshire, as defined in the BSW Health Inequalities Strategy (https://bsw.icb.nhs.uk/wp-content/uploads/sites/6/2023/07/Appendix-1-BSW-Inequalities-Strategy-21-24.pdf). Wiltshire's Health Inequalities Group is focussed on driving improvement against the strategy and delivering in line with agreed partner actions. The Health Inequalities Funded programmes will further ensure reductions in Health Inequalities in the Core20Plus5 populations.

Section 5

Our local Implementation Plans

Wiltshire

Neighbourhood Collaboratives (Integrated Neighbourhood Teams)

In 2024/25 priorities include: -

- Successful delivery of the Health Inequalities-funded project to develop an engagement best practice model and deliver a programme of intervention around a cohort of people within the Core20Plus 5 groups. This will enable the work to move forward having 'pump primed' part of the development work.
- Integrate the Collaboratives Group with the Connecting with our Communities Group.
- Move the current resources and launch programme to a shared delivery model – bringing in partners to support the work across a wider footprint will enable the best use of resources.
- Continue to share insights and learning from the Pathfinder (repeat initial co-production cycle following learning from round 1 and expand the cohort).
- Successfully deliver the Chippenham, Corsham and Box Launch programme.
- Commence Salisbury Collaborative (Farmers as initial focus).
- Engage all neighbourhood areas in the Collaboratives – recognising the different pace that each area will progress at.
- Fully develop the schedule of conferences for the year – this is the partnership vehicle for the Wiltshire-wide steering group.
- Explore opportunities for learning and support with B&NES and Swindon – joining up our work where alignment is identified and develop the Integrated Neighbourhood Teams blueprint for BSW.
- Continue to build the partnership model, developing new ways to share information and facilitate partnership.

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Our local Implementation Plans

Wiltshire

System Flow Priorities Include

Carer Breakdown

- Continue with additional capacity for domiciliary care to support carer breakdown, preventing avoidable admissions to hospital.
- Mental Health, Learning Difficulties and Autism.
- Intensive Enablement Service – preventing admission by preventing escalations in need and supporting discharge.

Home First

- Continue with ongoing Home First Improvement Programme – including the Streaming Framework, implementing the Wiltshire Model – hybrid services, interdisciplinary working, new performance standards, Discharge to Assess improvement, Transitions and Discharge Optimisation, new Technology opportunities.

Domiciliary Care Support

- Test and develop a hybrid model of working, which utilises domiciliary care to enable earlier discharges and maximise effective use of therapy capacity.

Community Hospitals

- Redesign the Community Hospital Model in line with the case mix and future demand profile. A new pathway approach will ensure improved flow through the service. The work will include reviewing staff mix, patient cohorts and length of stay.

Demand and Capacity

- Following the previous action, we will Scope potential opportunities for reduction in Pathway 2 capacity from 25/26 on the basis that Home is the best place for most people to be.

Discharge Referral Attrition

- Rates remain above efficient levels, review to take place with aim to reduce 'waste' within current processes.

Length of Stay

- Reduction in length of stay across all services and achievement against 'stretch targets' where appropriate.

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Our local Implementation Plans

Wiltshire

Children

- A new SEND and Alternative Provision Strategy for Wilshire is currently being co-produced and will be in place by September 2024. Engagement with young people and parent /carers through the Parent Carer Council is currently under way.
- Family Hubs, as part of the Early Help Offer, are launching in April 2024.
- Implementation of the Neurodiversity pathway to support the provision of holistic support to CYP and timely assessment as appropriate.
- Recommissioning of CYP community services to embed the delivery of ICB vision for CYP and the associated outcomes.
- Recommissioning of joint and/or aligned services, such as SALT in schools and Portage service, to facilitate early intervention and prevention.
- The implementation of the revised Public Health Nursing Services which includes Health Visiting and School Nursing
- A review of community CAMHS services – which is jointly commissioned by the Council and the ICB – to ensure the provision of a broad range of options and interventions to support the emotional health and wellbeing of children and young people.
- The delivery of the Safety Valve Programme.

Section 6

Our outcome measures update

Our 2023 Implementation Plan set out three broad, strategic outcomes around life expectancy which signal BSW's ambition to keep our populations healthy for longer, across all parts of our geography. These are supplemented by several 'contributing' outcomes. We committed to short-term actions to understand our baseline position and set trajectories.

The evolution of our plans, including our focus on a smaller number of priorities, means that many of these outcome measures are either too broad to detect shorter-term change, or need re-focusing on emerging priorities. The development of the BSW Case for Change, and programmes like the Integrated Community-Based Care Programme, now provide a clearer picture of the change we're targeting and give us the opportunity to develop a more meaningful set of outcome measures to help us track the impact of our strategy and work across BSW.

The development of these measures will happen during Q1 and Q2 of 24/25. We are working to develop Logic Models for our major programmes of work ensuring we have a good understanding of how and where our work will impact. Out of our Logic Models will fall outcome measures for our specific programmes.

We'll quantify our levels of ambition over the coming years, stress-testing the impact of our change work against the do-nothing challenges our system faces. Importantly, with the addition of financial sustainability as our fourth objective, we will adapt our measures to ensure our change delivers the outcomes required for our population whilst ensuring our system is financially sustainable.

In line with our Section 14 Duties relating to engaging and involving people and communities, we will also measure our success through the quality of the engagement and interactions that we have with the diverse groups and communities which make up our BSW system. Engagement and involvement success will be measured through qualitative and quantitative means, and through direct feedback from audiences and stakeholders. We aim to encourage and nurture long-term relationships and our refreshed people and communities engagement strategy will describe in more detail how we aim to achieve this.

Section 7

Strategic Objective One: Focus on Prevention and Early Intervention

Introduction

Our ambition is not only to treat people, but also to prevent them from getting ill in the first place. We aim to support people to live longer, healthier lives through helping them to make healthier lifestyle choices and treating avoidable illness early on.

In our strategy we have committed to:

- Focusing funding and resources on prevention rather than treatment
- Intervening before ill-health occurs (primary prevention)
- Identifying ill-health early (secondary prevention)
- Slowing or stopping disease progression (tertiary prevention)
- Wider Determinants of Health

Achievements in 23/24 include:

We have worked in partnership to enable a joined up BSW approach to supporting healthy weight. We will continue to support a Whole System Approach to healthy weight and continue supporting children and families living with obesity and excessive weight through the expansion of specialist Children with Excessive Weight (CEW) Clinics.
A working group has been established to tackle the current challenges in weight management services and to scope a vision for the future weight management pathway across BSW. This is considering challenges for children and young people and adults.
We have progressed the planned expansion of provision for CEW clinics in BSW to deliver on the NHS Long Term Plan ambition to treat children for severe complications related to their obesity, avoiding the need for more invasive treatment. All three BSW acute hospitals have been engaged and a joint decision made to pool funding at one site (RUH, Bath).
We have been learning from previous local weight management initiatives. For example, in Wiltshire, a co-produced approach to delivering children's weight management is being piloted in Bemerton Heath which focus on fun and enjoyment for families. Wiltshire Council has secured funding of £100k to commission insight work into obesity/healthy lifestyles and successful initiative options. Learning from this work will be shared across the system.

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Strategic Objective One: Focus on Prevention and Early Intervention

The BANES wellness service has participated in outreach events and activities supporting local vaccination clinics, employers and organisations working with vulnerable groups to offer NHS Health Checks and specialist stop smoking services. Swindon launched their Tobacco Control Strategy at an event in September 2023 and appointed a public health practitioner to lead on implementation. Wiltshire have redesigned their health coaching service (using new KPIs) to encourage a focus on Routine and Manual Workers (PLUS group).
Work with the Southwest Illegal Tobacco Team on engagement campaigns and enforcement activity. Trading Standards involved in test purchasing for underage sales resulting in seizures of illegal vaping products and other enforcement activity. Educational activities with partner organisations.
Stoptober and other campaign materials have been distributed for partners with local success stories from clients of local services. Local stop smoking services continue to be promoted through local partners and initiatives such as the Targeted Lung Health Checks. Swindon launched their Tobacco Control Strategy at an event in September 2023.
Started development of a dashboard to enable system wide visibility of key diabetes and cardiovascular disease targets.
We started to improve coordination between specialist diabetes services. This is now built into the Integrated Community Based Care programme and Primary and Community Care Development Programme.
Plans have been developed for how patients with modifiable risk factors of a new condition are identified and received support.
We have implemented the Diabetes Pathway 2 Remission programme (Low Cal diet). Roll out commenced in quarter 3.
We planned how to increase uptake of diabetes digital Structure Education and implementation will start in early 2024/25.
We shared with all practices and PCNs the learning and outcomes from cancer projects that we funded in primary care in 22/23 aimed at increasing early presentation and screening uptake. Practices and PCNs were able to use this learning to consider rolling out in 2023/24.
Planned the next stage of Targeted Lung Health Check development which will include roll out to Salisbury and Trowbridge.

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Strategic Objective One: Focus on Prevention and Early Intervention

Successful rollout of FENO testing to support asthma diagnosis has been achieved over the last two years, with good outcomes. Over the 12 months, there were 1733 appropriate referrals for a FENO test in primary care. 1638 initial assessments were done and 387 follow up assessments. Of those patients diagnosed with a raised FENO, 312 patients were given an asthma care plan, 466 patients were given education on how to manage their condition, and 39 patients had their medication changed.
Spirometry has restarted in some practices across BSW. However, this is still being funded inconsistently across primary care, creating variation in services. Work is currently going on to review the GP Local Enhanced Service (LES), and as also part of the spirometry funding review.
BSW Pulmonary Rehab services are progressing the priorities set out in the Five-Year BSW Pulmonary Rehabilitation Plan. 2023/24 is the second year of the plan and services are working in integrated ways to benefit people, increase personalisation of services and reduce health inequalities. The following positive outcomes have been achieved: Increased capacity of programmes to provide patients with greater choice by offering virtual courses, in addition to face to face. Offering up spaces on running courses to new patients if patients DNA or drop out to maximise capacity. Adapting models of delivery in response to waiting lists. Offering appropriate IT on loan e.g. iPads to help reduce inequalities due to lack of access to equipment. Integrating community respiratory teams with acute in-reach teams, to keep abreast of patients who are admitted with exacerbation of COPD and to enable a pathway for hospital discharges to attend pulmonary rehabilitation.
We have redesigned community mental health services to: • Improve access to MH support for people with Severe Mental Illness through new access models that provide immediate advice, support and signposting to community and secondary services as required at PCN level. • Develop secondary MH service provision to provide timely therapeutic interventions aligned to PCNs and ARRS investment.
We have introduced a new model for Children and Young People's Mental Health in Swindon that: • Integrates TAMHS (Targeted Mental Health Service), CAMHS and MH Support Teams across Swindon • Increases the digital offer of early help and support. • Improves support to CYP presenting in crisis at A&E through the appointment of MH Champions and developed a BSW Hospital based Youth Worker pilot. • Rolled out assessment and liaison for paediatric inpatients with eating disorders (ALPINE).

Section 7

Strategic Objective One: Focus on Prevention and Early Intervention

Priorities for 24/25 and 25/26

As set out in our introduction, over the next years using our population health data and through review of our key partnership documents in joint strategic needs assessments, we have identified two priorities on which to focus our prevention activities. These are: preventing cardiovascular disease and promoting mental wellbeing.
We will continue to progress our work on other prevention activity as set out in our strategy including promoting physical wellbeing, smoking cessation, cancer and screening, diabetes and other long-term conditions. The detail of this work is included within our respective organisational plans, and we will continue to monitor progress.

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Strategic Objective One: Focus on Prevention and Early Intervention

Cardiovascular disease

In 2024/25 we plan to:

Use text messages to support people with cholesterol not treated to target to understand the risks of their condition and with behaviour risk reduction support and increased agency. Research suggests that knowledge of a condition and increased sense of empowerment affects engagement and outcomes. Funded by NHSE.

In 2025/26 we plan to:

Optimise Practice use of Community Pharmacy hypertension offer - Development and provision of guidance to support Practices to identify patients in cohort, explain why important to improve attainment, suggest what Practices should do with the cohort, including how to best work with Community Pharmacy, and suggest what other support can be obtained to improve attainment. Supports with Practices improving testing, diagnosis and treatment of CVD.
Pilot local commissioning of community pharmacy independent prescribers to extend the scope of the Hypertension Case Finding Service; informing and preparing for September 2026 when all newly qualified pharmacists will be independent prescribers on the day of registration.
Standardised implementation of Hybrid Closed Loops (NICE TA943) - Hybrid Closed Loops automatically supply patients with Type 1 diabetes with the correct amount of insulin, improving care outcomes and psychological health. Introducing HCL has been included in NICE TA943, for implementation for selected cohorts from April 2024. Provision is required as part of the NHS constitution.
Reduced risk complication patients with T2DM < 40 years - Patients under the age of 40 who are diagnosed with Type 2 diabetes are at greater risk of complications and premature mortality. They are also less able to work. This deliverable, funded by NHSE, support behavioural and clinical risk reduction. Funding for 2023/24 has been divided between a Primary Care LCS to support reviews and funding which will be spent on education and/or psychological support. Additional funding for 2024/25 is expected, but with resources as yet unconfirmed.

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Strategic Objective One: Focus on Prevention and Early Intervention

Mental Wellbeing

In 2024/25 we plan to:

- Implement a new access model by end Q3 2024/25 as per Community Mental Health Framework requirements, to deliver an improvement in the overall 2+ contact rate as per the national trajectory.
- Roll out a new care planning approach from Q3 2024/25 to support CMHF delivery.
- Undertake a Procurement of Community Mental Health (non NHS) contracts to be completed by October 2024, in readiness for contract go live from 1st April 2025.
- Deliver a Full Service Review (FSR) for Talking Therapies to achieve revised national standards (currently being finalised as part of operational planning guidance within NHSE) – FSR to be completed by end Q2 2024/25, with new model to be commissioned from April 2025.
- Roll out new Physical Health Checks LES – to be agreed with primary care by end Q2, with the intention to roll out thereafter.
- Mobilise our Wave 12 MHSTs in Wiltshire from January 2025, with the intention that these will be fully operational by October 2025 (as per training programme timelines).

In 2025/26 we plan to:

Build on the work of 2024/25

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Strategic Objective One: Focus on Prevention and Early Intervention

Smoking Cessation

In 2024/25 we plan to:

Develop and implement an E-Cigarette offer for stop smoking services.
Provide free vaper start kits in BANES and across BSW for pregnant women and their household members (funded through the Government Swap to Stop Scheme).
Develop and implement an E-cigarette offer in Swindon including sourcing reputable nicotine vaping products, training for stop smoking practitioners, offering vaping as a stop smoking product, evaluation and ongoing workshops to prevent use of vapes in children and young people.
Continue to reduce the availability and access to illegal tobacco and illegal nicotine vaping products in the community.
In BANES support enforcement action to reduce access to illegal tobacco.
In Swindon: work with comms teams to highlight any seizures, prosecutions, closure orders etc; undertake educational activities to promote responsibility in relation to tobacco. Ensure all retailers are fully compliant with any new/updated regulations relating to tobacco/nicotine products; and continue to improve quality and use of regional intelligence reporting via closer working with South West Trading Standards Regional Intelligence Team, HMRC and Police.

Focus on health inequalities and target resources for those that need it most.
In BANES use additional section 31 public health grant funding to increase capacity to support smokers to quit, raise awareness of support options and services available and reaching out to target groups where smoking prevalence is high. In Swindon: Explore perceptions of pregnant women who do not engage with stop smoking services, develop a lived experience group and develop Stop smoking pathways for priority cohorts e.g. people accessing substance misuse services and housing support. In Wiltshire: deliver a Smoking Health Needs Assessment considering smoking prevalence, health outcomes related to smoking and services to assist individuals to become smokefree supported by the Wiltshire Tobacco Control Alliance.

Section 7

Strategic Objective One: Focus on Prevention and Early Intervention

In 2025/26 we plan to:

Continue to focus on health inequalities and target resources for those that need it most.
In Swindon we plan to work with local teams to implement the new SW guidance for smokefree homes (Public Health - SLI project) and to achieve more smokefree sites, prioritising those in areas of deprivation.
Continue to reduce the availability and access to illegal tobacco and illegal nicotine vaping products in the community.
We will build on our work in 2024/25.
Raise the profile of tobacco control and local services through marketing and communications programmes.
Will work with Wiltshire Communications and Marketing team and the Tobacco Control Alliance to plan an annual campaign calendar which promotes smokefree messages in national campaigns such as No Smoking Day and Stoptober as well as designing resources for local promotion. Will work with partners on how best to collaboratively promote the campaign materials and messages.
Continue to deliver the Treating Tobacco Dependence Programme.
Roll out of the programme will continue in 2025/26.

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Strategic Objective One: Focus on Prevention and Early Intervention

Cancer and Screening

In 2024/25 we plan to:

Implement all requirements in the national cancer programme's annual planning guidance for 24/25. Anticipated to include:

- Implement faster diagnosis and operation performance with anticipated priority pathways: skin, gynaecology, urology and breast.
- Expansion of early diagnosis programmes including: targeted lung health checks, Galleri Interim Implementation Pilot, Faecal Immunochemical Testing (FIT), Liver surveillance and pilots and Pancreatic cancer.
- Develop local and cross cutting early diagnosis delivery focusing on screening, timely presentation, primary care pathways, early diagnosis initiatives and health inequalities.

In 2025/26 we plan to:

Implement all requirements in the national cancer programme's annual planning guidance for 25/26.

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Strategic Objective One: Focus on Prevention and Early Intervention

Respiratory

In 2024/25 we plan to:

- Achieve year 3 priorities as set out in the BSW Pulmonary Rehab 5-Year Plan.
- Reduce PR waiting times.
- Introduce a range of approaches to increase capacity and choice.
- Improve uptake and completion rates.
- Adapt service delivery to improve uptake and completion of programmes for these groups; working with other teams and local partners to serve groups at risk of not being referred, likely to decline if referred or drop out before completing.
- Proactively work with other teams and organisations across the pathway to provide personalised services.
- Improve quality of PR through accreditation of services.

In 2025/26 we plan to:

Achieve year 4 priorities as set out in the BSW Pulmonary Rehab 5-Year Plan.

Section 8

Strategic Objective Two: Fairer Health and Wellbeing Outcomes

Introduction

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

The ICB has a legal duty under the Health and Care Act (2022) to reduce inequalities between persons with respect to their ability to access health services; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

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.

Core20 refers to 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 refers ICS chosen population groups experiencing poorer that average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored health care approach.

In BSW we have chosen the following PLUS population groups

	PLUS groups (adults)	PLUS groups (children)
BANES	Ethnic Minority communities Homeless People living with Severe Mental Illness	Children eligible from free school meals
Swindon	Ethnic Minority communities	Children from ethnic minority backgrounds
Wiltshire	Routine and manual workers Gypsy, Roma and Traveller communities Rural communities	Children from Gypsy, Roma, Boater and Traveller communities
System wide		Children with Special Educational Needs and Disability (SEND). Children with excessive weight and living with obesity. Children Looked After (CLA) and care experienced CYP. Early Years (with a focus on school readiness). Children and Young People with Adverse Childhood Experiences (ACE; with a focus on delivering trauma informed services)

Section 8

Strategic Objective Two: Fairer Health and Wellbeing Outcomes

The 5 refers to five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; with national and regional teams coordinating activity across local systems to achieve national aims.

There are 5 clinical areas for adults and 5 clinical areas for children and young people.

5 clinical areas (adults)	5 clinical areas (children)
Maternity	Asthma
Severe Mental Illness	Diabetes
Chronic Respiratory Disease	Epilepsy
Early Cancer Diagnosis	Oral Health
Hypertension case finding and optimal management and lipid optimal management	Mental Health

Section 8

Strategic Objective Two: Fairer Health and Wellbeing Outcomes

Core20Plus5 - Adults

Achievements in 2023/24:

Quality improvement projects in progress to improve access and earlier booking for maternity care for Black and Asian women having identified later accessing of booking for maternity care.
Investment into Inclusion midwives and provider BI to support improved data flows. All providers have maternity and neonatal inequalities quality improvement workstreams which align with LMNS Equity and Equality action plan. Work in progress to embed ethnicity and deprivation data into all audits in maternity and neonatal services.
Thematic review of perinatal mortality undertaken to identify any impact of ethnicity and deprivation on outcomes will continue annually into 24/25.
Work in progress and hoping to be completed by April 2024 on access pathway for pregnant people in the boating community.
Completion of cohort of 20 staff trained to be champions through Health Innovations WOE programme to support provider and LMNS QI projects to reduce inequitable outcomes for women and babies from ethnic minorities. Phase 3 cohort underway currently will continue into 24/25 for Black Mothers Matter training.
Anti- racism training for all Maternity and Neonatal Staff across BSW (including those in non-clinical roles) - Training commissioned by ICB Local Maternity and Neonatal System and continued to be provided up to end of financial year.
We have increased the number of women receiving continuity of care focusing on women from ethnic minority groups and those from deprivation primarily due to established. Continuity of carer models in Swindon- however this model of care has now paused in Swindon due to staff not wishing to work within this model of care currently. Continued focus on Continuity of care antenatally and postnatally within all services. Ongoing work to future models of care provision across maternity services.
Annual health checks for those living with Severe Mental Illness We have undertaken a pilot in four GP surgeries whereby we provided some funding for Admin staff to contact patients on the LD register and explain the purpose of the Annual Health check, identify any barriers and support the individual to attend their appointment. A follow up call was made on the morning or afternoon before their appointment to ensure reasonable needs were being met.

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Strategic Objective Two: Fairer Health and Wellbeing Outcomes

Annual health checks for people with a Learning Disability

The outcomes from the pilot were that this was a successful approach with the number of LD patients receiving their annual health check increasing and the likelihood of DNA's reducing.

Due to funding constraints, we are unable to extend this project across all GPs and we have not been able to continue with First Options attending schools to give the children over 14 an annual health check.

The LDAN Programme Board has agreed that the next stage communications and engagement campaign to raise awareness about the annual health check and the benefits.

It is noted that we have seen a significant increase in those registering as LDA, together with the known issue that checks are often towards the end of Q3/4, this has meant that proportionally we are currently below our target trajectory. We hope that with the targeted support and campaign set out above we will meet out trajectory overall by year end.

BSW was 2nd nationally for COVID vaccination uptake.

Data led community engagement was delivered by Local Authority Teams to raise awareness, confidence, build trust and educate.

Health and wellbeing engagement sessions with a focus on vaccine confidence were run with groups supporting Black and Ethnic Minority populations in Swindon.

Vaccination clinics were offered at migrant hotels including Making Every Contact Count literature in appropriate languages.

Targeted vaccination clinics were held in Core20 areas.

Covid and flu vaccinations were co-administered where possible.

Roving clinics were set up supporting vaccination for care home staff with low uptake.

A proactive project was run in Brunel 2 PCN targeting COPD patients who were smokers and prescribed steroids who hadn't taken up their vaccination.

Outreach clinics to SMI and maternity in-patient and immunosuppressed patients were organised.

Specific clinics for people with learning difficulties were delivered offering people on the LD register and their carers vaccinations in a quiet space.

Additional clinics were arranged at GP practices with the lowest uptake.

All clinics have been used as an opportunity for wider health promotion using a Making Every Contact Count approach including cancer screening and hypertension case finding.

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Strategic Objective Two: Fairer Health and Wellbeing Outcomes

In 2023, 57% of cancers in BSW were diagnosed at stage 1 or 2.
We have continued to optimise cancer screening (bowel, breast, cervical) working with the NHS Cancer Screening Programme Boards, working with BSW public health teams on prevention work regarding alcohol, smoking and obesity, appointing Swindon Cancer Champions to encourage uptake of screening programmes in under-served populations, linked with partners to increase cancer screening uptake in people with serious mental illness or Learning Difficulties.
We have supported timely presentation by the public: using 'Be Clear on Cancer' campaign messaging via GP practices, providing cancer information on GP practice websites, sharing resources (posters, screen ads, leaflets etc) with GP practices, Swindon Cancer Champions have raised awareness at local events, BANES have had a Bowel Cancer Awareness campaign at bus stops and on buses and BANES also appointed a Health Inequalities/ Population Health Management facilitator.
We have improved cancer guideline 'compliance' and improve pathways for referrals; by refining Urgent Suspected Cancer (USC) pathways, specifically LGI, gynae and skin, and using FIT for symptomatic patients.
We have improved pathway availability and shortened the time to testing and diagnosis; by implementing the Faster Diagnostic Standard (FDS) – 28 day 'rule in/out cancer diagnosis' rolled out, appointing Cancer navigators in Trusts, implementing Best Practice Timed Pathways and implementing Consultant Advice e.g. telederm A&G for skin cancer.
We have innovated introducing early diagnosis interventions: by rolling out Targeted Lung Health Check to Swindon, parts of Bath and implementing the Lynch surveillance programme to detect bowel cancer.
Given Swindon is our area of highest deprivation we have done some additional work here: to increase cancer screening uptake with particular focus on low uptake groups, focussing on deprived areas - Community Cafes & Food Share locations, engaging with vulnerable groups- LD & neurodivergent groups, substance misuse disorder, homelessness and asylum seekers, recruited over 50 Community Cancer Champions (CCCs) who have engaged with over 2500 people through 68 awareness talks and 42 events.
We have funded 21 PCN/Practice cancer projects across BSW with the aim of increasing cancer screening uptake in under-served groups, education and proactive outreach.

68% of patients aged 18 and over with GP recorded hypertension had their last blood pressure reading (measured in the preceding 12 months) as below the age appropriate treatment threshold as of September 2023.
51% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more were on lipid lowering therapy as of September 2023.
Work has developed with community pharmacy to optimise testing and diagnosis of hypertension.
Circulated hypertension diagnosis flow chart all practices to encourage accurate diagnosis and appropriate management

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Strategic Objective Two: Fairer Health and Wellbeing Outcomes

In 2024/25 we plan to:

Consider future models of care provision across maternity services to ensure building blocks are in place to increase percentage of pregnant people on continuity of care (CoC) pathway in line with staffing trajectories.
Undertaken annual health checks for at least 60% of those living with severe mental illness and learning disabilities.
Increased uptake of COVID-19, flu and pneumonia vaccines in C20+ and people with COPD.
Funding has been secured to deliver 5 projects focussing on addressing inequalities in 2024/25. A focus on improving vaccination uptake in people with Learning Disabilities and Serious Mental Illness is planned: identify areas with lowest uptake, understanding key barriers, utilising training to address. A community bid has been submitted to support vaccine confidence empowering communities to shape their own work and deliver sustainable responses. Family clinics in communities with low uptake focusing on vaccination in the context of wider health and wellbeing. Care Home engagement project evaluating outbreaks and staff vaccination uptake and aiming to improve vaccination confidence, dispel myth, maximise uptake and reduce outbreaks. Community champion project using networks across BSW to deliver health improvement initiatives including a focus on vaccinations. Continue Core20Plus5 driven vaccination clinics and community engagement.
Ensure that 75% of cancer cases diagnosed at stage 1 or 2 by 2028.

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Strategic Objective Two: Fairer Health and Wellbeing Outcomes

Continue to optimise cancer screening (bowel, breast, cervical). Continue to support timely presentation by the public. Continue to improve cancer guideline 'compliance' and improve pathways for referrals with a focus on Urgent Suspected Cancer Pathways for additional specialities, establishing 3 non-symptom specific pathways for each Trust, holding 2 cancer education webinar/events for primary care and ad hoc Trust focused cancer pathway webinars. Continue to improve pathway availability and shortened the time to testing and diagnosis by continuing to implement Best Practice Timed Pathways, continuing to implement Consultant advice, refining the Straight to Test Pathway and implementing the Personalised Stratified Follow Up Pathways for red flag symptom management. Continue to innovate introducing early diagnosis interventions by rolling out Targeted Lung Health Check to Trowbridge and Salisbury in 2024; and implementing the Multi Cancer Blood Test Implementation Pilot Programme – Jul 24. Continue some specific work in Swindon to address inequalities with a range of events scheduled for 2024 inc. South Asian Cancer Roadshow - February 24.
Increase hypertension case finding and optimal management and lipid optimal management.
Funding secured to address inequalities in attainment of lipid targets in those at risk of Cardiovascular Disease. Implementation of this project planned.

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Strategic Objective Two: Fairer Health and Wellbeing Outcomes

Core20Plus5 - Children and Young People

Achievements in 2023/24:

CYP Clinical asthma lead in post and leading delivery on the National bundle of care for children and young people with asthma Launching a BSW approach to accrediting Asthma Friendly Schools.
NICE guidance TA943 Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes was published December 2023 with CYP as a priority group. Implementation of this guidance is overseen by the BSW Diabetes Commissioning Group, with support from the BSW CYP Programme.
Successful bid for Epilepsy Special Nurses Pilot in April 2023. ESN will work across the community and be based at RUH Bath. ESN commenced role February 2024. The workplan for this role includes inequalities screening for all patients and prioritising the most deprived 20% and CYP with LDA.
Oral health working group linked to the BSW CYP Programme Board and Elective Recovery Board alongside ongoing public health preventative work under the umbrella of the Population Health Board.
The Thrive and CYP Programme Boards along with the CYP MH Oversight group are bringing together key partners to review access and service delivery. Actions to support this in 2023/24 are described in our section on Child and Adolescent Mental Health – all actions taken contribute to improving mental health service access for Children and Young People.

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Strategic Objective Two: Fairer Health and Wellbeing Outcomes

In 2024/25 we plan to:

Embed the recognition that inequalities impact the access, experience and outcomes for babies, children and young people, and their parents and carers and ensuring delivery accounts for this. Continue to use the CYPCore20PLUS5 framework to deliver a targeted approach and drive data-led improvement in population health and inequalities. Drive improvements in Young People's experience of transition to adult services across BSW.
CYP Clinical asthma lead will continue delivery on the National bundle of care for children and young people with asthma.
NICE guidance TA943 Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes was published December 2023 with CYP as a priority group. Implementation of this guidance will continue to be overseen by the BSW Diabetes Commissioning Group, with support from the BSW CYP Programme.
Increase access to Epilepsy Special Nurses (ESNs) for CYP within the most deprived 20%, and CYP with LDA, within the first year of care Continue to oversee the ESN Pilot that commenced March 2024. ESN will work across the community and be based at RUH Bath. The workplan for this role includes inequalities screening for all patients and prioritising the most deprived 20% and CYP with LDA.
Address Tooth extractions in hospital due to decay for children aged 10 years and younger by continuing to develop Oral health working group linked to the BSW CYP Programme Board and Elective Recovery Board alongside ongoing public health preventative work under the umbrella of the Population Health Board.
Children and young people (ages 0-17) mental health services access (number with 1+ contact) - Actions planned to support this in 2024/25 are described in our section on Child and Adolescent Mental Health – all actions taken contribute to improving mental health service access for Children and Young People.

Section 9

Strategic Objective 3: Excellent Health and Care Services

Introduction

Improving our local services, be they primary care, community care or secondary care is vitally important work that we do. We have achieved a great deal in this last year but there is more to do, and we are working closely together in order to do so.

Over the next two years we are focusing on a smaller number of key actions that we believe will support our population with getting timely access to high quality care, whilst continuing our longer-term quality improvement work.

Implementing our primary and community care delivery plan
The Primary and Community Care Delivery Plan was developed during 2023 and sets out six priorities to improve the delivery of services and the experience of local people and communities. Its roots are set out within the BSW health and care model, the ICP strategy and national strategies such as the Fuller Report and the NHS Long Term Plan. The delivery plan also sets the blueprint for the recommissioning of community health services under the Integrated Community Based Care Programme which will go live in April 2025. The six priorities in the primary and community care delivery plan are as follows:

- Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams
- Adopt a scaled population health management approach by building capacity and knowledge
- Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets
- Increase personalisation of care through engaging and empowering our people
- Improve access to a wider range of services closer to home through greater connection and coordination
- Support access to the right care by providing co-ordinated urgent care within the community.

The plan is supported by a number of enablers including technology and data, estates, environmental sustainability, anchor institutions, commissioning, workforce and shifting funding to prevention.

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Strategic Objective 3: Excellent Health and Care Services

Primary Care

Delivery Against 2023/24 Plan

Additional specialised roles have increased the appointment capacity within primary care. A large number of personalised care roles have been recruited across BSW and place focus on prevention and health inequalities, this includes working with neighbourhood teams to improve the reach to all communities and cohorts of patients. PCNs have successfully recruited over 500 WTE ARRS staff to date supporting health and care service provision. The Training Hub has worked with neighbouring ICBs to run Personalised Care training across BSW.
Review primary care commissioning arrangements and alignment with public health, pharmacy, optometry and dental services alongside local community and social care provision. From April 2023, the ICB has taken delegated responsibility to secure the provision of Pharmaceutical Services (including Dispensing Doctors and Dispensing Appliance Contractors); General Ophthalmic Services; and Dental Services (Primary, Secondary and Community) for our population. Our local governance structures are still being established but will cover all primary care contractor groups. Working closely with NHSE and Public Health to deliver the SW Dental Development Sustainability Plan to recover dental activity to pre pandemic levels and deliver the key priorities from the local oral health needs assessments.
Community Pharmacy - 27,109 consultations delivered. (GP – 18,383, NHS111 Minor illness – 3009, NHS111 Urgent Supply of Repeat Meds 5717).
85% of BSW pharmacies signed up to deliver hypertension case finding.
Provision of oral contraception – initiation or repeat supplies. Launched nationally 1st December 2023. Pharmacies currently setting up to deliver. Significant enthusiasm from pharmacy to deliver.
BSW have been accepted for 5 pilot sites to test an independent prescribing minor illness model within the national Pathfinder Programme.
Teach & Treat' model to increase the number of community pharmacists trained as Independent Prescribers. Medvivo have delivered three cohorts of students, with 25 students supported to qualify so far.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024/25

- Increase usage of patient facing digital tools focusing on adoption of NHS App uptake and usage, evidenced by national NHS App reporting.
- Once Cloud based telephony is in place across practices in Spring 2024 ensure benefit are realised by ensuring practice make the most out of new functionality available, ultimately reducing patient telephone wait times and increasing satisfaction.
- Ensure all practices are transition onto a compliant online consultation product via the new PCARP national framework making the most out of the national PCARP digital allocation.
- Complete move single electronic patient record for primary care (TPP) for primary care.
- Review GP IT support arrangements across the ICB to create a single sustainable consistent service.
- Trial in one PCN of Brave AI tool using AI to target patients in most need of proactive interventions.
- Continuation of the delivery of the two-year National Primary Care Access Recovery Plan to enable access to Primary Care Services
- The PCNs will be continuing to enact their Capacity and Access Improvement Plans through their engagement and transformation to Modern General Practice. Plans include using practices' own General Practice Access Data to analyse and review capacity and demand; co-production of communications about Modern General Practice and the different roles within General Practice.
- The ICB will continue to develop self-referral pathways by patients to Musculoskeletal; Audiology; Weight Management Services; Community Podiatry; Wheelchair; Community Equipment and Falls services by working with service providers to enable further pathway implementation during 2024-25. The ICS will also expand the original self-referral list and jointly develop additional self-referral pathways to other services, thereby creating further capacity within primary care.
- The ICB will continue to develop the interface between Primary and Secondary Care which has the opportunity to streamline patient journeys and the administration between the sectors. The locally developed 'Excellence in Partnership Working' sets out the principles to facilitate better joint working will be implemented during 2024-25.
- Its anticipated there will be a 1.5% increase in primary care appointments (driven by 0.52 % population growth factor) across BSW.

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The ICB will work closely with PCNs on workforce plans and forecasting for 24/25. The 24/25 will be a 'stepping stone' year with future direction still to be shared by NHSE. Expenditure beyond the PCN allocation for 24/25 is at the PCN own risk. NHSE will not support the sharing of allocations in 24/25. It is expected that ARRS recruitment will flatline, and any future growth will be determined by the contract. PCNs will be encouraged to develop their ARRS teams and ensure full integration to the PCN Practices and support work capacity and staff wellbeing.
The ICB continues to work towards to recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels, focusing on key population groups, working with local authority public health and NHS partners to develop appropriate service specifications and target key geo-demographics. The ICB will continue to co-produce an oral health and prevention agenda working with Local Authorities, focusing on reducing dental decay in children and reducing child tooth extractions in acute settings. Finally, the ICB will review its current domiciliary, community and special care dental services provision, acknowledging increase in those aged 60 years and over in the next 15 years.
The work to recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels focuses on key population groups where evidence shows they may face additional access barriers and will address to provide fairer health and wellbeing outcomes. Our focus on prevention and early intervention will co-produce an agenda with public health Local Authorities, focusing on reducing dental decay in children and reducing child tooth extractions in acute settings. Finally, reviewing current domiciliary, community and special care dental services provision, aims to ensure continued excellent health and care services provision acknowledging the increase in those aged 60 years and over in the next 15 years who may access those services.

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Continued focus on integrating community pharmacy clinical services which form part of the Community Pharmacy Contractual Framework, Pharmacy Integration Fund or GP Access Recovery Plan to support access, public health priorities and tackling health inequalities.

Priorities are Pharmacy First, Independent Prescribing Pathfinder, Hypertension Case Finding, Contraception Service and Discharge Medicines Service.

Working with general practice to increase referrals into the national commissioned community pharmacy services to optimise utilisation and enhance equitable access for patients across BSW – with an emphasis on Pharmacy First.

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Strategic Objective 3: Excellent Health and Care Services

Urgent and Emergency Care

Delivery Against 2023/24 Plan

Care Co-ordination –established with a specialist paramedic embedded within the care coordination team. Installation of a new, permanent X-Ray machine at Paulton in April 2023 which will reduce pressure on acute provision and support an improvement in 4-hour performance. **Community Pharmacy Consultation Service** - We have increased the number of referrals to CPCS from NHS 111 and we have the highest rate in the South West (from an average of 44% to 60%).
SDEC – Medical and Surgical SDEC offer 12/7 day per across each of our 3 acute trusts. **Electronic bed management system** – SFT rolled out the electronic whiteboard.
Discharge Hubs (now referred to as Transfer of Care Hubs) - have been in place at the 3 Acute trusts 7 days per week from Summer 2023. **Phase 2 Domiciliary programme** – phase 2 objectives identified and pilot in Swindon using Calderdale framework for service. transformation. Work programme is now being led by the BSW workforce group. **Home First approach adopted** – implemented across each of the 3 localities to increase P1 discharges and reduce non-criteria to reside position. Overall NCTR target however is 5% above 13% target.
Cat 2 segmentation – phased rollout in Spring 23 and validation volumes increasing with SWAST delivering highest rate compared to other ambulance trusts. **999 Call answering** – significant improvement and remains consistently above national target. **Frontline resource (Core and Private)** – improvements in operational resourcing because of targeted overtime incentives alongside third-party resources supporting whilst trust completes resourcing uplifts as part of recruitment plans and people plan 4 introduced in Jan 24. **Ambulance Vehicle Preparation (AVP) hubs** – work has started on this 2-year rollout programme and will continue into 2024/25 which will be rolled out in BSW. **Sickness reduction** – Overall incidents in frontline staff improved compared to 22/23 but overall trust sickness level remains above planned target.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024-26

Care Co – delivery and expansion to achieve is full objectives becoming a single point of access. **Redirection** – support the development of NHSE policy and identify opportunities locally to redirect people away from ED / UTCs / MIUs to the right care and right place for their health need and implement consistent BSW approach for redirection. **111-2 mental health** - Mental health support will also be universally accessible through 111 by selecting option 2.
Demand Intermediate care BSW programme group will be established to ensure that we achieve the recommendations from the Intermediate Care Framework that will deliver the following requirement. Improve demand and capacity planning. Improve workforce utilisation through new community rehabilitation and reablement model. Implement effective transfer of care hubs. Improve data quality.
Integration GWH Integrated Front door completed by Winter 2024. Acute trust improvements (including any actions identified from maturity index assessments and peer to peer reviews). Out of Hospital /Community Based capacity / provision to support. UCR and Falls will be fully optimised to support attendance and admission avoidance to ED. ECDS V4 will be adopted and implemented by August 2024.

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Strategic Objective 3: Excellent Health and Care Services

Virtual Wards

Delivery Against 2023/24 Plan

- Over 200% increase in available virtual ward beds across BSW from 60 in January 2023 to 191 in February 2024, delivering early intervention to avoid admission to hospital and offering safer health and wellbeing outcomes and patient choice through acute care services at people's usual place of residence.
- Received incredible feedback from users with national data showing 99% of patients on current virtual wards recommending the service.
- Procured Doccla remote monitoring and now rolling out implementation to our VWs.
- Collaboration from clinicians across all BSW partners to evaluate our current models and co-produce a new One-BSW Model for virtual wards in 24/25.
- Updated BSW virtual wards SOP.
- Public facing comms normalising the idea of Virtual Wards in local newspapers, partner and ICB newsletters, social media channels, websites and local radio.
- Patient information shared through waiting room displays and leaflets.
- Staff-facing comms shared through acute, community partner, SWAST intranets, newsletters and staff briefings.
- GP and community pharmacy facing comms shared in newsletters and through direct emails.
- Bi-weekly monitoring reports through BI leads.
- Financial transformation approach to modelling to support best use of investment in virtual wards and UEC.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024-26

- Following evaluation of our current models including data and finance deep dives, clinician visits with each VW team and a number of Clinical Big Room sessions we have agreement to transition to a One-BSW Integrated Model with medical leadership collaboration (minimum of 6x PA sessions per week per virtual ward) to:
- Align current unwarranted clinical variation to ensure consistency of access and offer.
- Provide more Tier 4 support to patients that would otherwise be in an acute trust bed.
- Build clinical confidence and increase referrals/utilisation rates.
- Develop new virtual ward pathways.
- Maximise our 24/25 envelope by re-setting trajectories for One-BSW model.

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Strategic Objective 3: Excellent Health and Care Services

Mental Health

Delivery Against 2023/24 Plan

Urgent Mental Health and Inpatient Services
Work to implement single-sex wards across BSW mental health services and focus on right sizing our bed base informed by population health needs. We will engage stakeholders and service users in this work.
Pilot of single-sex wards was undertaken between Swindon and B&NES wards.
Following completion of this pilot it was determined that restructuring of Beechlydene ward in Salisbury would be more effective. To be mobilised in 2024/25, supported by National Inpatient Quality Improvement Programme work.

A pan-system review of Section 136 pathways, action plan to be co-developed with partners from Q1 2023/24 and to be delivered by Q4 2023/24.
Launch of the national Right Care Right Person initiative has superseded this, a four phased approach to implementation now in progress including:
Removing police involvement from responding to welfare checks (Q3&4 2023/24) –
Removing Police involvement from responding to missing persons and walk-outs (Q1 2024/25.)
Further work is required with ambulance partners to ensure that we have an integrated and agreed approach to conveyance pan-system and across providers (Q2 & 3 2024/25).
Improving the Section 136 pathway (in line with RCRP priorities) and reducing inappropriate involvement of police in responding to people with mental health needs where there is no criminality or risk to life/serious harm (Q3 & 4 2024/25).

Further development and expansion of our NHS111 offer in order that we can deliver 'press 2 for Mental Health'.
Implementation of a 'shadow' solution for NHS111-2 from December 2023 including extension of hours to 9am-midnight.
Full enhanced solution to be implemented from October 2024 pending recruitment to the final workforce model. A pan-system working group which meets weekly is overseeing this development.

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Strategic Objective 3: Excellent Health and Care Services

Deployment of a mental health response vehicle to reduce conveyance to A&E and improve crisis response
Unable to progress due to challenges with vehicle availability. We remain on plan to deploy a Mental Health Ambulance in 2025/26 as per the submitted capital plan in partnership with SWAST.

Continued work to implement the 10 Discharge Priorities, in partnership with AWP and pan-system.
Continued implementation of flow developments across mental health services, which has supported delivery of a significantly improved out of area placement position across BSW.
From 2024/25 to be embedded in our inpatient quality improvement programme approach.

Development of a further Wellbeing House in Swindon and securing long term estate for the Place of Calm in BaNES (capital funding provided by NHSE) to support admission avoidance and improve step down provision.
Plans are in place to secure purchase of a long-term solution for the B&NES Place of Calm (anticipated achievement date end March 2024). Work is underway to purchase a property in Swindon to provide crisis house capacity in that footprint – to be realised in Q2 2024/25.

Older Adult Services
Developing specialist Older People's Mental Health resource to work in primary care, using ARRS funding.
Developing a diagnosing advanced dementia mandate (DiaDEM) model to support improving diagnosis of dementia in care homes
Supporting primary care colleagues to record DDR in practices which is currently not consistent.
3 new practitioners have been recruited – initial focus will be on supporting diagnosis in care homes with the intention that these will then work alongside primary care colleagues to support diagnosis in primary care.
We remain below national trajectory of 66.7% dementia diagnosis rate but anticipate recovery to national position in 2024/25
Older adult mental health practitioners are supporting our virtual wards programme, this has been implemented in year.

In our Virtual Wards programme, we will ensure that mental health expertise is available to support those who require additional support in the community.

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Strategic Objective 3: Excellent Health and Care Services

Perinatal mental health services

Establishing closer links with improving access to psychological therapies (IAPT) services in order that women identified through Maternal Mental Health Service provision (MMHS) are directed to this where clinically appropriate.

Considering how best to support the needs of women with personality disorders during the perinatal period, aligned with our community services pathway development work.

Consistent delivery of the nationally mandated perinatal access rate and anticipate continuing to deliver against plan in 2024/25.

Pathway work remains ongoing to support women with specific needs, and this will continue in 2024/25.

Talking Therapies (Improving Access to Psychological Therapies)

Implementing a consistent, BSW wide service model that is IAPT manual compliant.

Starting our first phase of recruitment to training posts, providing additional capacity in year and beyond to meet nationally agreed trajectories (Q2 2023/24).

Scoping digital offers and their use, with a plan to implement from 2024/25

All three B, S & W service operational models reaching comparative alignment in June 2023, and compliance with respective NICE guidance and the NHS E National Manual for Talking Therapies.

Improving trajectory with some wavering associated with seasonal trends and other noted pressures.

Service is on course to meet the locally set access rate by year end.

Recovery has also improved throughout the year and is on course to be compliant with the national KPI standard by year end

Referral to treatment remains compliant.

Scoping digital offers will be encapsulated in the Full Service Review which will commence in 2024/25.

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Strategic Objective 3: Excellent Health and Care Services

Physical Health Checks for people with Severe Mental Illness (SMI)

Work with primary care to review their individual registers of people with SMI.

Review recording to ensure that we are accurately capturing those people who have had both a full SMI check (all 6 elements) and those people who have declined parts of the check.

SMI registers for all practices have been reviewed in year.

Plan in development to implement a Locally Enhanced Service (LES) agreement with all GP practices, alongside primary care improvement work.

AWP has continued to provide annual health checks for those service users who are open on their caseload, ensuring that regular checks are completed.

Community Services Framework delivery

Good progress has been made to deliver nationally mandated community mental health improvements, in line with the NHSE mandate

Challenges have remained throughout the year in achieving our ambitions for a new model of access to mental health services. This has been as a result of:

Securing agreement to the new model and associated ways of working (incl. digital access) – now progressing but some delays have meant this will continue into 2024/25

Inability to recruit to ARRS roles which means we have yet to realise a fully 'transformed' model as per the CMHF mandate. Work is underway to review how we can provide support in primary care, whilst not being reliant on secondary mental health staff

Good progress has been made in developing plans to implement a new approach to Care Planning (using Dialog framework) in collaboration with third sector providers, who are frequently the first point of contact and lead the early support conversation. The intention is to roll this revised approach across BSW in Q3 & Q4 2024/25.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024-26

- Implement the National Quality Improvement Programme for Mental Health across all BSW wards (to run from April 2024 until March 2027) – programme milestones to be agreed.
- Implementation of Phase 3 & 4 of Right Care Right Person in partnership with Police colleagues.
- Implementation of the Fully Enhanced Model for NHS 111-2 by October 2024.
- Go live of Swindon Crisis House and B&NES Place of Calm (capital funding ready to be deployed).
- Further deployment and development of Older Adult roles to support dementia diagnosis to achieve 66.7% rate by end 2024/25.
- Delivery of Full Service Review (FSR) for Talking Therapies to achieve revised national standards (currently being finalised as part of operational planning guidance within NHSE) – FSR to be completed by end Q2 2024/25, with new model to be commissioned from April 2025.
- Roll out of new Physical Health Checks LES – to be agreed with primary care by end Q2, with the intention to roll out thereafter.
- Implementation of new access model by end Q3 2024/25 as per CMHF requirements, to deliver an improvement in the overall 2+ contact rate as per the national trajectory.
- Roll out of new care planning approach from Q3 2024/25 to support CMHF delivery.
- Procurement of Community Mental Health (non-NHS) contracts to be completed by October 2024, in readiness for contract go live from 1st April 2025.
- Implementation of BSW Mental Health Strategy following its approval via Board and sub-committees in May 2024.

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Strategic Objective 3: Excellent Health and Care Services

Learning Disabilities & Autism

Delivery Against 2023/24 Plan

Reducing the number of people who are in inpatient care. BSW ICB are the lead commissioning organisation for the new LDA capital build for the North of the Southwest patch covering the BSW, BNSSG and Gloucester footprint. This work covers the whole end to end pathway for people with a further focus on improving and expanding community provision. The planned completion date for the facility, which will be provided by AWP, is August 2025. We have commenced collaborative work on **transforming our community provision** that will sit alongside the inpatient clinical model and have convened workshops reviewing our community services to set out what we plan to achieve in the next year and what we plan to achieve as part of the community procurement (ICBC).
Delivering annual health checks for people with learning disabilities and autism. This builds on our improvement work during the last year, which provided additional resources for primary care and dedicated health checks in special schools. We have undertaken a pilot in four GP surgeries to support individuals to attend their appointment, which increased uptake and reduced DNA's. Our focus for the next year will include a dedicated communications and engagement plan learning from the pilot and collaborative working with our new health screening clinicians. We hope that with the targeted support and actions set out above we will meet our trajectory overall by year end.
The focus of the **Keyworker service** is to work with children and young people with a Learning disability and/or are autistic with escalating mental health needs. The Keyworker service will work with the children, young people and their families/carers to help them receive the support they need as part of our early intervention and prevention support offer. In BSW, we are piloting this service from within the ICB to test and adapt what is needed before implementing permanently. The team has a caseload of 22 children and young people (March 24) and further recruitment is currently underway.

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Strategic Objective 3: Excellent Health and Care Services

The localities have undertaken a joined up approach to **implementing the required changes to Dynamic Support Registers and Care and Treatment Reviews (CTR) / Care, Education and Treatment Review (CeTR) processes.** This is a statutory function of ICBs, and is critical to understanding our population health needs, early intervention and delivering excellent health services. We have updated our website and included self-referral forms.
Reducing inpatient admissions. Numbers across BSW are above the agreed trajectory and mitigations are in place as described below to bring inpatient levels in line with plan. Overall, there are 38 inpatients in Q2 against the plan of 32. Q3 data to follow at end of Feb. Oversight of actions is being undertaken through a weekly BSW LDAN MDT practice forum, with BSW leads to discuss each patient and discharge plans and support being provided to the localities to expedite actions. This group reports to the LDAN programme board. Monthly MADE events continue across all three localities. Oversight and actions for NHSE commissioned inpatients remains with NHSE. BSW ICB, through the practice forum, are increasing level of oversight of these individuals to ensure we are clear on actions and discharge plans. Concerns around process and progress in some cases has been formally escalated to NHSE.
Demand for **ADHD and Autism assessments** continues to grow and we do not have the capacity in the system to meet the demand. We are working with system partners on a solution that will deliver high quality and cost-effective provision. The group will test and trial the model and oversee its implementation. The end goal of the working group will be to have in place ASD and ADHD services for children, young people and adults that meet their needs and provides the right support at the right time, moving away from a diagnostic led model.

Key deliverables for 2024-26
In addition to those mentioned above, our other key deliverables are:

Partnership in Neurodiversity in Schools (PINS) - The project aims to facilitate the provision of support packages for 40 schools in BSW to assist the schools in creating environments to better meet the needs of neurodiverse children.
Improving access across the end-to-end pathway including reducing waiting times for ADHD assessments and increasing support for people post diagnosis.

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Strategic Objective 3: Excellent Health and Care Services

Elective Care & Cancer

Delivery Against 2023/24 Plan

Additional and protected capacity Modular theatre opened at Sulis in March. In the period March – Dec it has treated 546 patients, including 231 joint replacements. The eyecare diagnostic hub opened at the Central Health Clinic in Sept 2023. All diagnostic assessments are performed by technicians The majority of the work is for the glaucoma service. A successful capital bid (£165k) is allowing an increase the equipment in the hub and an expansion of the type of work performed from April onwards. Through the Acute Hospitals Alliance Clinical Strategy delivery project the following have been delivered: Orthopaedics: Team in place and BSW Sulis model is in development. Dermatology: Team in place and 3-year Transformation Plan in place. Gastroenterology: Team in place.
Long wait recovery The system-wide demand and capacity model has been developed. It is being used to support business planning for next year, and to model capacity requirements for the Salisbury Day Surgery Unit business case.
Referrals All trusts have the inpatient, outpatient and RTT modules of the national Care Coordination Solution (CCS) and we are talking to the national team about creating a system wide version. This is also supporting waiting list validation, with RUH (an earlier adopter of CCS) achieving 100% validation of their waiting list down to 12 weeks. Pathway redesign work is being taken forward in 4 areas: T&O; Gastro; Derm; and Urology.
Outpatients productivity Across the 3 acute providers in BSW, outpatient first appointments have increased by 9% in the period April – December 2023/24 when compared with the same period in 2019/20. Outpatient follow ups across the 3 acute providers have increased by just over 2% in the period April – December 2023/24 when compared with the same period in 2019/20. This reflects a number of issues: 1) on non-admitted pathways it often takes several follow up appointments to stop a clock; (2) there is a follow up backlog in addition to the waiting list; and (3) levels of PIFU across the 3 providers have remained in the 1%-3% range compared to a target of 5%.

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Strategic Objective 3: Excellent Health and Care Services

Surgical productivity BADS day case rates for the system shows an upward trajectory reaching 80% in September 2023 from 73% in March 2023. Theatre utilisation has increased from mid-70% to high 70% between March and January. Day case arthroplasty rates have increased significantly with particular progress at Sulis, GWH and RUH.
Diagnostic productivity The Hub at Sulis Hospital has delivered 7,927 diagnostic tests YTD in 2023/24 During the year a new CT scanner became operational; a new MRI scanner exclusively for CDC patients became operational; and the expanded ultrasound and endoscopy offering came online. Imaging activity was initially focused MSK patients transferred from the RUH, but has expanded to include CT Head and CT Chest. CDC Cardiology diagnostic tests started in Jan 24. At the spokes at Salisbury and Swindon, activity has been delivered by mobile vans located on the acute sites, pending completion of the permanent solution. There has been a combination of CT and MRI shared mobile capacity across both GWH and SFT from April 23. Endoscopy mobile activity has been delivered at GWH from August 23.
Continued focus throughout the year on improving cancer performance resulting in trusts expecting to achieve (GWH and SFT) or get close to (RUH) the fair shares number of patients waiting over 62d at 31/3/24.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024-26

Increase activity to c.124% in 2024/25 (including the use of the independent sector)
No one waits longer than 65 weeks for elective care by September 2024; and waits of longer than a year are eliminated by March 2026.
Significant improvement in waiting times for a diagnostic test.
By March 2025, 80% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

Key areas of focus:
Opening of Sulis Elective Orthopaedic Centre in autumn.
Opening of further Community Diagnostic Centre Capacity during the course of 2024.
Excellence in basics – continued implementation of standard work for operational teams.
Working across BSW to ensure patients get seen as quickly as possible.
Pathway transformation – high intensity support areas: Derm; Gastro; Urology; T&O.

Cancer:

Faster Diagnosis and Operational Performance

- Improved operational Performance
- Faster Diagnosis – Priority Pathways; Skin, Gynaecology. Urology, Breast

Early Diagnosis and Innovation

- Targeted Lung Health Checks (TLHC)
- Galleri Interim Implementation Pilot
- Faecal Immunochemical Testing (FIT)
- Liver surveillance and pilots
- Pancreatic cancer

Local and cross-cutting Early Diagnosis delivery

- Screening
- Timely Presentation
- Primary Care Pathways
- Early Diagnosis Initiatives (Innovation)
- Health Inequalities

Treatment and care

- Treatment Variation
- Living With and Beyond Cancer (LWBC)
- Experience of Care

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Strategic Objective 3: Excellent Health and Care Services

Maternity

Delivery Against 2023/24 Plan

Successful implementation of NHS Long term plan for health objectives including:

- Maternal mental health services (OCEAN) demonstrating significant improvements in maternal mental health measures of trauma and PTSD scores post treatment.
- Perinatal pelvic health services across BSW system supporting prevention of pelvic health issues, early identification and timely interventions to improve the pathway for service users with identified perinatal pelvic health issues.
- Additional staff recruited into maternity services to support treating tobacco dependency and smoke free pregnancy aim to reduce smoking in pregnancy. This supports potential reduction of stillbirths and neonatal deaths.

Continued focus on improving safety and quality of maternity and neonatal services in line with national report recommendations and best practice including:

- Maternity services continued work to implement NHS England Saving Babies Lives Care Bundle and Clinical Negligence Scheme for Trusts to support safe outcomes for mothers and babies.
- Participation in national pilot of Independent Maternity and Neonatal Senior Advocate role commenced in post Sept 2024 with NHS England agreement to commence supporting families who have experienced an adverse event in Q1 24/25
- Focus on workforce for safe staffing in maternity and neonatal services including international recruitment, midwifery apprenticeship programme, system mapping of maternity workforce with the BSW Acute Healthcare Alliance, preceptorship and increased investment into maternity and neonatal staffing to meet national standards for staffing Improvements in retention of staff and reduction of turnover rates.
- Perinatal Quality Surveillance model in place to identify any early signs of concern.
- Maternity providers progressing to implementation phase of planned rollout of single maternity digital system across BSW in 24/25.

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Strategic Objective 3: Excellent Health and Care Services

We have continued to improve maternity and neonatal services by listening to pregnant people/partners and Families. We have done this by ensuring that BSW Maternity and Neonatal Voices partnership are supported and embedded within maternity and neonatal services representing the service user's voices at all levels of the system and care providers to co-produce service improvements. These improvements have included:

- Production of 12 maternity and neonatal videos with subtitles in 10 languages.
- Promotion of Dad's Pad resource for parents.
- Participation in system wide work on safer sleep policy and pathway.
- Continued work to support aim of improved access to provision of essential nutrition for babies with pilots of additional breast-feeding support in areas of deprivation.
- Mapping of antenatal parent preparation to identify possible BSW standardised provision.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024-26

The BSW Local Maternity and Neonatal system (LMNS) remains committed to achieving the recommendations of the national Maternity and Delivery Plan which sets out the three-year plan to make care safer, more personalised and more equitable for women, babies and families by 2026. This plan includes recommendations from the service reviews Ockenden final report (2022) and East Kent Review (2022) and learning from the Countess of Chester legal case. The key deliverables are outlined in the appendix below and will continue in 25/26 dependent upon progress and finance available in 24/25. The key deliverables include:

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

1. To align commissioning of services to meet the ambitions outlined in the national 3 Year Delivery Plan for Maternity and Neonatal Services.
2. Have a digital strategy for ICB which includes maternity and neonatal and support implementation of one system across BSW maternity providers.
3. To support maternity services to identify appropriate estate requirements for continued care provision within local community areas
4. Oversee quality in line with perinatal quality surveillance model and NQB guidance, using data to compare outcomes to similar systems and identify variations and opportunities for quality improvements. This includes completion of LMNS dashboard for quality and safety to bring together intelligence from providers.
5. Continue ongoing quality improvement actions in line with BSW LMNS Equity and Equality Action Plan including enhancing community links with service users from minority ethnicity communities and those living in areas of deprivation and young parents.
6. Continue to support preventative programmes of work within maternity and neonatal services which contribute to increasing life expectancy, reducing ill health and reducing inequalities in care.

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Strategic Objective 3: Excellent Health and Care Services

Children & Young People

Delivery Against 2023/24 Plan

We have used CYPCore20PLUS5 as the framework for all the work we do as a Programme. This includes a consistent focus on our Core20PLUS populations and demonstrating progress across all five clinical areas: CYP MH, Asthma, Epilepsy, Oral Health and Diabetes. We have ensured the governance is in place to continue delivery into the future through System partnership.
Long term conditions have been identified as a key element of the BSW Primary and Community Care Delivery Plan. CYP will be represented within a series of sub-groups have been proposed to support delivery of this plan. This will enable us to achieve excellent health and care services and focus on fairer health and wellbeing outcomes, particularly for those CYP within CYPCore20PLUS5 groups.
We have worked to ensure Children and Young People are embedded across ICB programmes including community services. A dedicated BSW Children and Young People's Strategy will be developed in 2024-5.
We have mapped existing engagement and youth voice work being carried out across the System. We have started a programme of work to proactively seek the voice and lived experience of children and young people, their parents, carers and families.
The designate role of Executive Lead for Children and Young People is our Chief Medical Officer, and through this role supports the chief executive and the board to ensure the ICB performs in the interests of children and young people. Children and Young People are now represented on key Programme Boards including Population Health. Influenced key ICB and ICS strategies and ensure focus on babies, children and young people.
A holistic and trauma informed approach underpins all the work for Children and Young People, including the BSW CYP Programme Board.

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Strategic Objective 3: Excellent Health and Care Services

Key deliverables for 2024-26

- Increased Children and Young People representation, BI reporting, and focus in BSW Board and work programmes (Population Health, Urgent Care, Elective Recovery, THRIVE) and across newly established long-term conditions working groups as part of the Primary and Community delivery group.
- Within the governance for Boards across BSW, embed the focus on CYP as 30% of our population.
- Rollout of Paediatric Early Warning System (PEWS).
- **Asthma** - Continue delivery of the National bundle of care for children and young people with asthma.
- **Diabetes** - Focus on prevention of obesity and support expansion of provision for CEW clinics in BSW. Rollout the NICE guidance: Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes (TA943; published Dec 2023), with Children and Young People as a priority group.
- **Epilepsy** - Continue to support delivery of the Epilepsy Specialist Nurse (ESN) pilot and the National bundle of care for children and young people with epilepsy.
- **Mental Health** - We will continue to support and increase BSW focus on CYP mental health and emotional wellbeing, alongside supporting links between mental and physical health including long term conditions. Continue rollout of NHSE Youth Worker Pilot and Paediatric Mental Health Champions. Strengthen and build on partnerships.
- **Special Educational Needs and Disabilities** - We will hear the voice of children and young people, their parents and carers. We will collaborate with social care, education and local authorities to make sure that children and young people with SEND are supported across BSW.

- Early intervention will support better experience and outcomes for Children and Young People and their families, and support a reduction in acute presentations and poorer outcomes.
- A focus on long-term conditions will support planning and delivery of excellent health and care services for Children and Young People and their families.

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Strategic Objective 3: Excellent Health and Care Services

• Work with key Boards and Delivery Groups to ensure children and young people are planned for in our hospital (acute), primary and community provision.
• Address identified gaps in Paediatric Palliative Care with Hospices, VCSE organisations, clinical colleagues and including the voice of Parent Carer Forums, parents, carers, children and young people to map provision, identify gaps and the pathway for Children and Young People in BSW with life-limiting conditions and palliative care needs.
• Embed paediatric expertise within community/primary care to (i) drive earlier intervention (ii) support better self-care for Children and Young People and their families / carers (iii) support Children and Young People with long term conditions and complex needs (iv) move care out of hospital where appropriate. • Establish a Connecting Care for Children approach that brings together a multi-disciplinary team across primary, secondary and community services, enabling Children and Young People to be treated and receive advice and guidance in their community. • Implement an initial 'test and learn' site within one PCN, based on number of 0-15 years olds within Core20 population. Rollout across BSW over two years.
• Deliver BSW CYP Strategy underpinned by the voice of children and young people with BSW CYP Programme Board's leadership and collaboration and an audit of current BSW ICB delivery. • Continue to use the CYPCore20PLUS5 framework to deliver a targeted approach and drive data-led improvement in population health and inequalities. • Improve links across BSW programmes to maintain focus on babies, children and young people 0 to 25 years and prioritise the CYP-Core20PLUS groups. • **Youth Voice** - Develop a delivery plan for how Children and Young People voice will be meaningfully embedded in our work across BSW. • **Data** - Develop a Children and Young People data dashboard and setup ongoing reporting through appropriate BSW Programme Boards and continued development of a case for change.

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Strategic Objective 3: Excellent Health and Care Services

Child and Adolescent Mental Health Services

Delivery Against 2023/24 Plan

- We increased our digital offer (via Oxford Health working with Healios) to provide earlier supported access to CAMHS – this has enabled us to achieve an improvement in access rates throughout the year. Reporting has remained a challenge for Oxford Health following the cyber-attack in 2022, which has meant visibility of performance has been more difficult. Oxford Health uploaded all historic activity information for 2022/23 into the Mental Health Services Dataset by October 2023 (as per NHS England requirements) and is now retrospectively updating activity information for 2023/24. We anticipate that full performance reporting will be back in place by 1st April 2024.
- Our new Swindon offer went live (partially) in October 2023 – commissioned from ABL Health. This includes provision of the Mental Health Support Teams (MHSTs) in Swindon. ABL Health will be providing a Single Point of Access to mental health services across Swindon from April 2024.
- Operating as Be U Swindon, ABL also now provide an online resource offer for parents, children and young people. This enables self-referral, as well as access to online support and advice.
- Oxford Health NHS FT have launched their procurement of a third sector partner in each locality – this is underway and to be finalised in the final quarter of 2023/24. It is anticipated that once live, this will again provide improved access to early help and support for children and young people.
- Mental Health Champions have been appointed within each of our 3 acute providers. These have been funded for a period of 2 years by NHS England. Job descriptions are being developed and finalised for these roles, with a strong focus on training and support for wider paediatric team colleagues.
- We have provided capital investment to support the development of the Children's Emergency Department in Swindon. Work is progressing to support the creation of an environment that is more suitable to assess children and young people with mental health needs. This will be operational from 2024/25 as the work on the front door at GWH is completed.
- ALPINE continues to be rolled out across our acute providers. Alongside this we continue to work within the Thames Valley Provider Collaborative for CAMHS to support the development and improvement of inpatient CAMHS provision across our BSW footprint. This includes the further development of Hospital@Home models.

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Strategic Objective 3: Excellent Health and Care Services

In addition to our planned deliverables, we also:

- Appointed a new Children Looked After (CLA) lead within CAMHS (commenced in post February 2024). This role will support better oversight of the pathway of care for CLA – making adaptations to this as required.
- Undertaken a whole system workshop in November 2023 to review our current offer for CLA, and co-developed an action plan for improvement with our Local Authority partners.
- Developed and submitted our BSW proposal for 2 new Mental Health Support Teams (MHSTs) in Wiltshire as part of Wave 12 of the MHST programme – these teams are anticipated to be mobilised from January 2025.

Key deliverables for 2024-26

- New trauma support team to be mobilised (subject to financial investment) that will provide treatment to a small number of highly distressed children and young people, as well as advice and guidance to core CAMHS and wider partners on brief interventions, training and development of staff in supporting trauma informed practice across the whole system.
- Support Local Authority partners to define a new offer in home provision, with associated support from CAMHS colleagues
- Implementation of two new MHSTs to support improved access to mental health support in school settings in Wiltshire.
- New SPA in Swindon to provide earlier, coordinated access and to support ongoing improvement in access rates as per national requirements.

Section 10

Financial Recovery

Delivery Against 2023/24 Plan

- All NHS organisations that make up an ICS have a mutual obligation to work to deliver financial balance as a system. It is likely that the ICS will end 2023/24 with a financial deficit. The ICS has entered financial recovery during 2023/24 but it will be a multi-year recovery programme. We have taken collective action to control costs this year. Measures delivered include:
- Triple lock in place for any investment > £50k.
- System vacancy control panels in place.
- Voluntary introduction of NHSE forecast protocols in early 2023/24.
- Recovery Board in place.
- Workforce cost & WTE movement review (since 2019/20) undertaken.
- Investment review (since 2019/20) completed.
- Safer staffing review ongoing.
- Full balance sheet reviews undertaken in Q3 2023/24.
- 23/24 Agency plan has over delivered with a plan to reduce by 35% by M12 and already delivering 59.5%

Key deliverables for 2024-26

- Financial planning for 2024/25 indicates that the year will be even more challenging financially. The financial recovery programme initiated during 2023/24 will be a multi-year recovery programme with three key strands of work.
- **Savings Delivery.** In 2024/25, organisations are targeting 7% efficiencies for 2024/25 which will be c.£141.3m. The programme will have continued focus on improved delivery of efficiencies.
- **Cost Controls.** The programme will ensure continuation of the cost control measures put in place in 2023/24.
- **Delivering the benefits of our system transformation projects** to include:
- Impact of our UEC transformation projects at ICS level including virtual wards, care-co-ordination, transfer of care hubs in alignment with our BCF & work with system partners.
- Impact of closer working and sharing of best practice in elective care.
- Further improvements in productivity up to upper quartile – specifically Gastro; Dermatology; Urology.
- In addition, we have some large-scale work programmes underway that should bring benefit in subsequent years of the financial recovery through our integrated community transformation programme.

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Enabling Workstreams

Workforce

Delivery Against 2023/24 Plan

Completed system leadership and inclusion development offer.
Successful mobilisation of a quality improvement community of practice.
Development and implementation of a BSW multi-disciplinary preceptorship framework.
Expansion of clinical placement capacity.
Oliver McGowan Training for people with learning disabilities and autism for over 2000 members of staff.
BSW lead ICB for the SW regional agency collaborative. Implementation of regional Nursing Price Cap compliant rate card (excluding certain specialities) by the 1st June 2024. Implementation of a regional Medical rate card with a plan for delivery by October '24.
110 RMNs for Avon and Wiltshire Partnership and Kent and Medway. Further roll out across the country including the Midlands and Wales with an infrastructure to train 120 nurses every 12 weeks.
Mobilisation of Legacy Mentors and our Career Navigator.
Health Care Professional Leadership – development of Futures site and ongoing programme of events for existing and future healthcare leaders.

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Enabling Workstreams

Key deliverables for 2024-26

Completion of a BSW People Plan. Roll out of Calderdale workforce transformation tool against 4- 5 agreed projects focused on creating new ways of working and improved productivity. Delegation of health care activities project to be completed for domiciliary care. Supporting the necessary workforce transformation required for BSW community and primary care programme. Identifying and developing new shared training solutions for collective system partners for scaling of offer and effective use of resource including ongoing mobilisation of the Oliver McGowan training. Working with region and local partners to develop sustainable and affordable models for an increasingly grow our own training model and collaborative apprenticeship opportunities. Continuing to build strategic partnerships with education partners for employer led models of education that increasingly attract from local communities and train a workforce with future focused skills. Evaluation of health and care ambassadors and design of a school engagement map and identified points of contact to enhance communication and relationship building. Increase education and clinical placement capacity, with a focus on community and primary care. Development of integrated career pathways and improved opportunities for moving easily across organisational boundaries. Design of a BSW wide leadership and management framework based on supporting leaders to lead and manage their teams.
All trainee pharmacy posts will be cross sector in 2026 and improve retention of workforce. Actively use the skills of community pharmacists to move services closer to home. Work towards pharmacy roles which respond to expertise shortages and support medical consultant shortage.

Section 11

Enabling Workstreams

Financial Sustainability and Shifting Funding to Prevention

Delivery Against 2023/24 Plan

In 2023/24, we undertook extensive financial planning work to refresh the underlying financial deficit position which stood at £109m in May 2023.

In 2023/24, we are forecasting to miss our plan by £9.9m plus the impact of industrial action, driven by the costs of agency staff, pay cost growth and drug price increases. We expect to deliver £95m of efficiency savings, 1.3% under the plan.

The plan included creation of an investment fund for service improvement and innovation in line with our strategic plan to invest in prevention and early intervention. BSW has not yet baselined prevention programmes and spend across the ICS, the focus has been to ensure redistribution of funding into prevention and early intervention in 2023/24.

BSW NHS finance teams have achieved systemwide HFMA Future Focussed Finance accreditation level 1, this nationally recognised standard supports strengthening of good processes, practices and controls.

Delivery Against 2023/24 Plan

Investment fund to increase measures delivering prevention and early intervention – May 2025.

Prevention Baseline – March 2025.

Investment Assessment Criteria aligned to the 3 outcomes – May 2025.

Deliver years 2&3 of 3-year Financial Recovery plan – March 2026.

Deliver existing financial plan including recurrent efficiency schemes – March 2025.

Achieve HFMA Accreditation Level 2 – March 2026.

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Enabling Workstreams

Technology and Data

Delivery Against 2023/24 Plan

FBC approval for the Single Electronic Patient Record (EPR) with NHSE significantly later than planned due to the significant investment required.
The Shared Care Record has Over-achieved on usage target by 22%. Independent review identified ICR generated £3.8m of benefits in 23/24. Wiltshire LA connected to ICR in Summer 23. Swindon LA targeting Summer 24.
Remote monitoring for Virtual Wards solution was implemented on schedule with patients being supported across all 4 BSW virtual wards.
New robotic process automations are live in primary care releasing time efficiencies into the service. A new hub and spoke service model is being designed to be implemented in 24/25.
Maternity pilot completed. Appointment management in place at GWH, reminders in place at SFT & RUH.
All practices apart from one now on TPP final practice migration booked for Summer 24.
23 practices supported and funded to move to modern cloud system in Phase 1 with 8 ready for Phase 2. Installations take place early 2024 into spring 24.
55% of 13+ now registered on NHS App (above Southwest average of 53%).
Cyber strategy and risk register now in place.
Intelligence Forums established in support of priority BSW Boards. Several key projects developed including demand and capacity modelling.
Skills Mapping Assessment undertaken with SW LKIS, and Health Inequalities training developed. Many key roles remain unfunded.
ICB has moved data warehouse to the Cloud, and along with RUH have developed SharePoint sire making reporting accessible. Shared Data Platform remains unfunded, and Power BI developments stalled because of resourcing.

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Enabling Workstreams

Key deliverables for 2024-26

The EPR programme will move into implementation following the confirmation of support from NHSE national team.

The ICR programme will increase the number of connected partners to the shared care record and increase the benefits derived from the record through increasing utilisation.

Increase usage of patient facing digital tools focusing on adoption of NHS App uptake and usage, evidenced by national NHS App reporting.

Once Cloud based telephony is in place across practices in Spring 2024 ensure benefit are realised by ensuring practice make the most out of new functionality available, ultimately reducing patient telephone wait times and increasing satisfaction.

Continue to ensure strong cyber security is in place with increased board awareness.

Review GP IT support arrangements across the ICB to create a single sustainable consistent service.

Review community pharmacy IT barriers that impact patient care, considering future support and enablers that may be needed.

The System Intelligence Programme is under review in early 2024 however the proposed focus during 24-25 is:

Generating Insight - focus on generating more population-based insights to support BSW Priority Programmes. Better resourcing population health analytical work and advanced analytics to embed it within priority work. Ensuring analysts across all domains have the time and skills to produce more meaningful insight.

Capability & Capacity - Embedding the National Competency Framework for Analysts across BSW organisational BI Teams in collective fashion.

Data & Infrastructure - focus on the development of the BSW data infrastructure, making data more accessible across organisations using resourcing from the regional Secure Data Environment for Research.

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Enabling Workstreams

Population Health Management

Delivery Against 2023/24 Plan

Health Inequalities Dashboard completed and demonstrated to partners during April. Remains available on ICB's reporting portal.
Some Population Health-based insight has been generated through the PHM Intelligence Forum working in support of the PHM Board. Development of the BSW Case for Change is a leading example. A training programme for analysts across NHS organisations in Health Inequalities Analytics is another key deliverable from the Intelligence.
There remain key risks to the continued delivery of intelligence in support of PHM in BSW, highlighted to PHM Board in December '23. Risks relating to the wider Intelligence Programme have been raised through the Digital Board during 23-24 and form part of a review of the Programme during Q4 23-24.
This has not been fully embedded during 23-24 and will be embedded further during 24-25 working with the newly appointed Prevention Team.
The BSW ICB Team have established a strong linked data set with GP data from most BSW practices, as well as the Graphnet ICR. BSW has a suite of reports allowing population-based insights to be generated, and data stores which allow for ad hoc and project work in support of priority programmes. These tools and analytics have been embedded in a few projects and programmes however not widescale nor in a systematic fashion.

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Enabling Workstreams

Key deliverables for 2024-26

Agree with PHM Board priority developments to PHM Infrastructure for 24-25. Likely to include: - widening the scope of the BSW linked data set to include remaining 8 GP practices and Social Care data and give fuller population coverage. - documenting and improving the quality of priority data sets (primary and community care data) so decision making is based on a knowledge of data completeness. - collecting and linking data on the wider determinants of health to support better decision making. - embedding PHM data into the BSW decision-making process.
Agree with PHM Board priority developments to PHM Intelligence. Likely to include: - Agreement on key standard BSW population-based analysis routinely available, including segmentation methods and a small number of core dashboards (including mandated Health Inequalities reporting). Support their effective use into practical BSW work. - Agreement on priority projects or programmes which will be the focus on more-detailed PHM intelligence work, to be delivered via an agreed workplan and overseen by the PHM Board. - Agreement on standardised approach to embedding population health intelligence into BSW priority programmes, including using data to support community engagement. - Agreement of standard approach to evaluation of BSW interventions in a population-based fashion, including to support business cases and key BSW decisions.
Work with BSW Programmes to understand the priority Population Health Management interventions to be delivered during 24/25. Through Population Health Board, provide oversight and strategic direction to these programmes to support their delivery. To focus on how Prevention and Health Inequalities are integrated into the work of these programmes.

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Enabling Workstreams

Estates of the Future

Delivery Against 2023/24 Plan

The ICB working with Primary Care across BSW has completed the Primary Care Network Toolkit (PCN Toolkit). This work is now collated to provide list of future estate investments needed over the next 10 years.

As part of our system and collaborative working, the BSW Estate Board has agreed its plans for the future transformation of estates and the way in which estate functions are delivered in the future. This will focus on 4 key areas, where we can work at scale across the whole of our system with shared resources, how we delivered services jointly including cleaning, linen, and catering; and the general management and maintenance of the estate.

We concluded our review of the existing community estate and how well it is being used, this resulted in a number of changes we will be looking to implement as part of future service delivery to ensure we are maximising the use of our estate further and creating more opportunities do dispose of estate that is coming to its end of life and using what remains more effectively or developing new buildings where there is need. We recently opened the new Devizes Health Centre in February 2023, enabling us to dispose of the old Devizes Hospital site, which provides additional capital we can reinvest into new premises or to improve existing ones.

We piloted a new activity data estates planning toolkit (ADEPT), this will help us understand the current and future estate requirements for services.

The work to develop and approve our Infrastructure / Estate Strategy was paused in September 2023. This was to enable the important work we have been doing in the delivery of the PCN Toolkit and the development of ADEPT, can be completed, which will help shape what goes into our final Infrastructure / Estate Strategy, which we are looking to complete and publish in the next 12 months.

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Enabling Workstreams

Key deliverables for 2024-26

We are improving the way we use space by removing organisational barriers that used to allocate rooms to individual organisations or services to one based on sharing space and increasing utilisation across all settings to maximise the use of our investments. Our workforce will be able to work across different locations, consolidating back-office functions and changing the way that we work, reducing unwarranted variations in provision of estate services and automating manual processes. With the completion of the PCN Toolkit and ADEPT Toolkit, we will be able to complete the development of the BSW Infrastructure / Estates Strategy which will help inform futures investments and support better utilisation of the estate.
We will focus on four key areas of work over the next 12 months, which will support delivery of Excellent Health and Care services. Integrated Estate Management & Assurance Function (Developing a single estate management function that manages the estate across our hospitals and health centre premise). Soft Facilities Management Delivery (Cleaning, Linen, Catering and Waste). Hard Facilities Management Delivery (Maintenance, improvements, and plant). Utilisation, Rationalisation and Disposals (How we use our buildings well and dispose of buildings no longer needed to support their sale).

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Enabling Workstreams

Environmental Sustainability

Delivery Against 2023/24 Plan

Since the publication of our BSW Green Plan (2022-25) in July 2022, health, and care partners across the BSW system have continued to work collaboratively to support delivery of our green commitments and the achievement of the long-term vision of delivering a Net Zero NHS. Aligned to the BSW ICS vision, the Plan supports our ICS strategic priorities by improving the health and wellbeing outcomes of our population so they can age well and reducing health inequalities caused through poor environments.

Since the publication of the plan, the Greener BSW Programme Delivery group (PDG) has achieved the following commitments:

- Board-level lead identified at ICS and organisational level.
- Staff have access to a sustainability/green peer network.
- Staff are made aware of the relevant Green Plans (ICS/Trust) via training/comms/induction.
- Switch to 100% renewable electricity suppliers.
- NHS Trusts to reduce use of desflurane in surgical procedures to <5%.
- NHS Trusts signed up to clean air hospital framework by March 2023.

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Enabling Workstreams

Key deliverables for 2024-26

The Greener BSW PDG remains committed and continues to meet monthly to progress our commitments and overcome shared challenges. A selection of actions for delivery by our partners (within the scope of the Green Plan requirements) over the remainder of the Green Plan delivery period, in addition to those listed above, are outlined below: Reduction in carbon impact of care models. Staff have access to sustainability training/sustainability information within their induction. 100% paperless or, if essential, using 100% recycled paper content within all office-based functions. Reduce the use of all single use plastic items within catering services. 25% of outpatient appointments conducted as virtual appointments online, where clinically appropriate.
We recognise that our BSW Green Plan (2022-25) needs to be refreshed at the end of 2025. We have therefore taken proactive steps to start planning what the next iteration of our Green Plan needs to include so we can re-evaluate the sustainability vision for our system and identify key areas of focus. Although we will continue to work towards the achievement of a Net Zero NHS by reducing our emissions across our NHS fleet, estate, and supply chain; we acknowledge that we will also have an opportunity to review our existing commitments and potentially identify new areas for focus such as health inequalities and anchor institutions.

Section 11

Enabling Workstreams

Engagement and involvement

Delivery Against 2023/24 Plan

Our engagement activities have been recognised by NHS England as part of the ICB Annual Engagement Assessment 2022/23 and assures that BSW ICB has made good progress towards fulfilling its legal duties on public involvement. We recognise that we have much more to do within this area and are looking forward to working with system and regional partners to further embed and improve the way we engage and involve people and communities within our work.

During 2023/24, BSW ICB has:

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

We have achieved this is the following ways:

- Continued to facilitate two public engagement forums within BSW, meeting regularly to update on BSW ICB developments and opportunities for involvement.
- Worked closely with the BSW Voluntary, Community and Social Enterprise Alliance to deepen our reach into communities within BSW and provide opportunities to have their say.
- Development and delivery of targeted campaigns based on data and insights to:
  1. Reach 17-30 year olds across BSW with the aim of encouraging them to have their MMR vaccination as a preventative measure.
  2. Support health and care staff, patients, their carers and families to better understand the process for being discharged from hospital and the benefits of this happening as soon as the patient is well enough to go to their onward place of care. Staff and patients were involved in focus groups to help develop the communications materials. Both campaigns will be evaluated and reviewed for learning points to inform future activities.

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Enabling Workstreams

- Commissioned a third-party to survey and interview a number of staff in relation to the new BSW Integrated Care Record, intended to provide a joined-up service for patients, a quicker treatment time and means that they need only tell their story once.
- Undertook targeted engagement with general practice on the development of the Primary and Community Care Delivery Plan.

Key deliverables for 2024-26

- Update and refresh our people and communities engagement strategy so that it is aligned with the Implementation Plan.
- Closer collaborative working with our system partners and the wider SW regional communications and engagement communities to deliver evidence-based campaigns i.e. hypertension, that address specific health inequalities.
- Focus on the CORE20PLUS5 groups when considering outreach and engagement, looking at appropriate and credible methodologies to gain feedback and insights from these groups to inform our work.
- Review and refresh stakeholder mapping, ensuring that we have the knowledge base on which to begin more proactive outreach and to enable us to build better, stronger relationships.
- Continue to build on the patient and public forum models that we have established, working to increase the diversity of group members and attendees via active recruitment to seldom heard groups.
- Work with system and regional colleagues to invest in an effective engagement platform to draw insights from our citizens and communities in the broadest sense.
- Support and champion guidance and best practice principles to inform transformational programmes and workstreams, nurturing co-design and co-production, and facilitating engagement and involvement so that people can see their views and opinions reflected in the services and innovations we deliver.
- Proactively use the insights we gather to 'hold a mirror' up to our organisation, helping BSW ICB become a 'listening' organisation that understands the views, opinions and ideas of the people and communities it serves.
- Ensure that the governance structure of our ICB and wider system, embeds engagement and involvement best practice at every level so that accountability for our duties is at the heart of our work.

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Appendix 1 – Joint Forward Plan Legislative Requirements

As part of the Health and Care Act 2022, the ICB is required to describe within our Implementation Plan (our version of the Joint Forward Plan) how the legislative duties of the ICB set out in the Act are met.

Our response and work covering some of these duties are set out within the appropriate sections within the main body of the plan. These are set out in the table below.

Duties covered in the main body of the plan

Duty	Reference
Addressing the Particular Needs of Children and Young People	See the Children and Young People section of the Plan Refresh and the 23/24 Plan.
Implement any Joint Local Health and Wellbeing Strategies	See Health and Wellbeing Boards' Opinions in the Plan Refresh and the 23/24 Plan.
Financial Duties	See the Financial Recovery and Financial Sustainability and Shifting Funding to Prevention sections of the Plan Refresh and the 23/24 Plan.
Describe health services the ICB proposes to arrange to meet needs	See Strategic Objective 3 (Excellent Health and Care Services), as well as covered where appropriate in other sections including our local implementations and in relation to prevention and outcomes.
Duty to Promote Education and Training	See Strategic Objective 1 (Focus on Prevention and Early Intervention) as well as covered where appropriate in other sections including enabling workstreams and our local implementations

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Other duties are covered specifically in the section below with additional detail given in some sections of the main body of the plan (and referenced accordingly below).

It is also worth noting that the Implementation Plan has been produced with reference to the ICB Annual Assessment requirements and provides evidence against the 5 Key Lines of Enquiry (and, by extension, the statutory duties) for ICBs considered in the Annual Assessment.

1. Duty to Improve Quality of Services

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

System Quality is based on these principles:

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

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

In 2023/24 the ICS has developed an effective System Quality Group (SQG) that meets bi-monthly, chaired by BSW ICB Chief Nursing Officer.

The National Quality Board (NQB, 2021) risk response and escalation sets out the three levels of quality assurance and escalation process. This has been set out in the BSW SQG TOR to support system understanding and reporting processes. The approach is providing the required level of support needed at system level to understand level of risk, mitigations needed and priorities for improvement, for those organisations or pathways with risks identified.
A credible and focused draft strategy and quality assurance framework aimed at enhancing our understanding of quality and safety across the ICS is being socialised. The assurance framework sets out a defined governance, risk and response process, and is aligned to the national quality standards and regional NHSE quality forums.

To support this assurance framework, an agreed set of BSW Quality Assurance (QA) metrics has been developed with support from the BI Team, and now informs the BSW integrated performance and quality dashboard.

BSW Patient Safety Specialists Community of Practice has worked collaboratively to support the implementation of the new Patient Safety Incident Response Framework (PSIRF) and all providers will have implemented PSIRF by April 2024. BSW ICB has successfully collaborated in policy and plan development with commissioned providers and has effectively signed off provider policies and plans, as well has developing and verifying the ICB Patient Safety Response policy.

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In 2024 – 26, the BSW system will be recognised as a thriving and empowering patient safety learning system. All system partners will commit to working collectively to ensure the appropriate oversight is in place to maximise the opportunities of sharing insight, participating in collaborative Improvement, and learning, to continuously improve patient safety for everybody living in BANES, Swindon, and Wiltshire. A collective approach will be achieved through already existing improvement networks and Community of Practices, for example, Patient Safety Specialists, LeDeR and BSW Local Maternity and Neonatal System, and if required, through the development of new improvement networks to align to shared improvement priorities. West of England Health Innovation will be an important partner to help BSW system adopt and optimise continuous improvement and learning.

The integral relationship with BSW System Quality Group (SQG) will also offer further opportunity to share learning and ensure further opportunities for:

- Positive assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having the desired effect.
- Confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation are being addressed.
- System efficiency for thematic learning and improvement

See also the 23/24 Plan.

2. Duty to Reduce Inequalities

Strategic Objective 2 covers our work to achieve fairer health and wellbeing outcomes in detail.

The Health and Social Care Act 2022 described the duties as to reducing inequalities. Each integrated care board must, in the exercise of its functions, have regard to the need to a) reduce inequalities between persons with respect to their ability to access health services, and b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services, including the effectiveness of the services, the safety of the services and the quality of the experience undergone by patients.

During 2023/24, BSW has achieved this in five ways:

- Strengthening the governance around reducing health inequalities
- Improving data to understand health inequalities including considering NHS England's statement on information on health inequalities
- Our Population Health Board has led deep dives into the key delivery and transformation areas
- Adopting Core20plus5, the national NHS England approach to inform action to address healthcare inequalities at system level, for both adults and children.
- Using the additional health inequalities funding to work at place to address specific identified health inequalities

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The Population Health Board's purpose is to provide strategic oversight and accountability for the implementation and delivery of the Core20PLUS5 and Core20Plus5CYP Health Inequalities programme, and for BSW's Health Inequalities and Prevention Programme. The Population Health Board advises the ICB on how the prevention and health inequalities agendas can be integrated with the ICB's and BSW's strategies and plans.

The Population Health Board has established three sub-groups to support this purpose:

- Population Health Management Intelligence Forum, with system leadership from Director of Public Health for Wiltshire
- Health Inequalities Strategy Group, with system leadership from Director of Public Health for Swindon
- Prevention Strategy Group, with system leadership from Director of Public Health for Bath and North East Somerset

3. Duty to Promote Involvement of Each Patient

The ICB focuses on Personalised Care and making this business as usual, building relationships between people, professionals and the wider community to allow people more choice and control over the way their care is planned and delivered.

We will continue to plan utilising the comprehensive model of personalised care support improved health outcomes:

Patient choice, ensuring the Accessible Information Standard is met so that everybody has access to information they can understand and is able to communicate the things that are important to them.

We will look at evidence to demonstrate active choice conversations are regularly being held e.g. Ask me 3, BRAN- Benefits, Risks, Alternatives, Do Nothing It's ok to ask, What Matters To You which encourages people to ask key questions, so they are better supported to make a decision about care, support or treatment options

Shared decision making: Plan for decision making initiatives embedded in pathways with a shared understanding of what good looks like. 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 person to reach a joint decision about their treatment and agrees outcomes wanted.

Personalised care and support planning: Looking at opportunities to develop further, measuring impact and outcomes for shared learning. People are central in developing and agreeing their personalised care and support plan, including deciding who is involved in the process. There will be a focus on proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing.

Social prescribing and community based support (links to 3rd sector): Social prescribing is a key component of Universal Personalised Care. It is an approach that connects people to activities, groups, and services in their community to meet the practical, social, and emotional needs that affect their health and wellbeing. We plan to improve selfcare through people with:

- one or more long term conditions
- who need support with low level mental health issues.
- who are lonely or isolated.
- who have complex social needs which affect their wellbeing

There will be access to social prescribing link workers to co-produce a personalised care and support plan to support people to take control of their health and well-being.

Supported self management: Supported self-management means increasing the knowledge, skills, and confidence a person has in managing their own health and care by putting in place interventions. We will focus on how we can build on the use of evidence based interventions such as peer support, self management education and health coaching that can slow disease progression, reduce early mortality and reduce costs.

PHBs: The use of Personal Health Budgets will be explored further to allow for greater flexibility in meeting personal health needs. There will be a particular focus for those who have the following care needs:

- adults and children who receive NHS continuing healthcare funding.
- care funded jointly by NHS and social care.
- a learning disability
- those with mental health needs
- end-of-life care services.
- wheelchair services

Also please refer to the engagement and involvement sections of the plan.

4. Duty to Enable Patient Choice

Each ICB must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them. We will remain compliant with the legal regulations for choice whilst also developing the elective strategic ambition to network our provision for best deployment to reduce waiting times and reduce inequities in access and associated inequalities.

The BSW Referral services currently comprise of two services: BSW Referral Service and SARUM Referral Service - a separately commissioned referral services for SARUM area (South Wiltshire) GP Practices. BSW referral services interface between GP practices and secondary care, to facilitate patients making informed choices about where to go for consultation and possible treatment. The

main objective of the service is to provide a smooth journey from referrer to provider and ensure that patients are offered appropriate patient choice of healthcare provider ensuring that they are seen in the 'right clinic, first time'. This process therefore reduces the burden on both referrers and providers and supports the patient journey. Patient choice is also promoted and publicised on the ICB website.

Over the next year we will continue to develop our elective co-ordination activities to both ensure capacity across the system is used to provide in-system mutual aid, and to ensure patients have the best information available to inform choice decisions.

In 2023/24, we have implemented processes to reduce harm of urgent referrals that are not converted in a timely way by patients by directly booking them, whilst offering choice should that booking not meet patient requirements.

We have implemented our Right To Choose provider accreditation process and accredited two providers with two further providers in process of being accredited.

We have ensured all of our providers have mobilised the Digital Mutual Aid process, and co-ordinated a system response to the Patient Initiated Mutual Aid programme (Phase 1).

5. Duty to Obtain Appropriate Advice

Each ICB must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in the prevention, diagnosis or treatment of illness and the protection or improvement of public health.

BSW ICB will follow this approach in seeking advice, including from local authority partners and through formal governance arrangements and broader engagement:

1. Clearly identify the issue requiring advice with specific objectives outlined for the advice being sought.
2. Determine the type of advice needed most appropriate for the objectives and issue, whether in prevention, diagnosis or treatment of illness, or the protection or improvement of public health. That could be legal, financial, technical, strategic, clinical or other types as required.
3. Determine the potential sources of appropriate advice, drawing from experts either inside or outside the system.
4. Work to understand the most appropriate advice source from those selected based on expertise, experience, credibility, and alignment to the ICB vision.

5. Establish formal contact with sources of advice against a clear brief, explaining the issue. Following ICB procurement practices where applicable, asking for experience, expertise, qualifications, availability, any conflicts of interest, and rates where any of these are unknown.
6. Evaluate advice received, determining the relevance and applicability, together with the effectiveness in addressing the issue.
7. Consider seeking second opinion or further advice as appropriate.

Advice may be deemed ongoing or on-demand. On-going advice may be incorporated in permanent representation to governance mechanisms associated with ICB as required, for example with particular clinical advice.

BSW ICS is fortunate to feature clinical networks, alliances, public health, social care, clinical senates, academic institutions, as well as having access to regional networks including NHSE SW.

All ICBs have varying demographics, and it is therefore important for BSW ICB to be able to seek the most appropriate advice for its partners and population.

6. Duty to Promote Innovation

The ICB will promote innovation in the provision of health services (including in the arrangements made for our provision). This will promote local innovation, build capability for the adoption and spread of proven innovation and work with academic health science networks and other local partners to support the identification and adoption of new products and pathways that align with our population health needs and address health inequalities.

To achieve this in 2024/25, the ICB will:

1. Map innovation stakeholders
2. Produce draft Innovation and Evaluation Strategy based on the process for promoting adoption and spread of innovation and the 5 principles outlines in the 2023/24 implementation plan.
3. **Step 1 of process: IDEAS**
    a. Start to proactively collate innovation ideas and actively receive innovation ideas.
    b. For each innovation idea prioritised:
        i. Understand current activity (if any)
        ii. Take a step back and understand the problem the innovation aims to address.
        iii. Describe this problem in BSW. Share with Investment Committee to decide if a priority problem.

4. **Step 2 of process: PROPOSAL**
    c. If decided problem is a priority problem, identify other potential solutions to address the problem.
    d. Present Business Case to Investment Committee with options (including innovation) to address problem.
5. **Step 3 of process: MAKING CHANGES**
    e. For Business Cases supported at investment committee transition to implementation.
    f. Identify innovations that have already been approved and are at the Making Changes step of the process
6. **Step 4 of process: EVALUATION**
    g. Plan evaluation before as part of the proposal.
    h. Define what success will look like, the evidence needed to be confident in this success, timelines and prior decisions based on evaluation.
7. **Step 5 of process: ADOPT, SCALE, SPREAD & EMBED**
    i. If evaluation demonstrates success, present Business Case to Investment Committee for next phase of development.

In addition, the ICB are developing a Research & Innovation strategy for which the ICB will engage on and refine during 2024/25.

7. Duty to Facilitate and Promote Research and Use its Evidence

Each ICB must facilitate or otherwise promote research on matters relevant to the health service, and the use in the health service of evidence obtained from research. For BSW ICB this is a unique opportunity to help support and facilitate research across the BSW ICS to the benefit of our population, capture and share learning from successful research elsewhere, and to disseminate successful research within BSW into the wider NHS.

Research in this context includes all research benefitting health and care outcomes such as advancing health and care operations, management, and leadership, as well as clinical trials.

Some of the ways in which the ICB will support research include:

Fostering collaboration: Identifying all partners connected to BSW ICS which are either involved, aspire to be, or would benefit from connection with research including academic institutions. Bringing together health and care professionals, researchers, and patients to collaborate and understand contemporary issues, facilitating a more integrated approach to research.

Enabling funding: ICB can help to coordinate the enablement of funding to support research projects. This can help to incentivise researchers to conduct studies aligned to system priorities and can help coordinate necessary resources.

Providing and supporting with data collection: BSW ICB can provide support for data collection and analysis. This can help researchers to access the data they need to conduct their studies and can ensure that data is collected and analysed in a consistent and reliable way.

Encouraging and facilitating patient involvement: BSW ICB can work to involve patients in research projects, mindful of existing inequalities evident in the conduct and application of research.

Supporting research governance: BSW ICB can play a key role in ensuring research is conducted in an ethical and transparent manner. We can provide guidance on research governance.

Recent guidance from NHSE entitled "Maximising the Benefits of Research" will inform the next steps for action. These will be achieved by establishing an ICB Research Lead within the Medical Directorate working with colleagues in the BSW Academy. One of the outputs from this would be a system led research strategy and a system-wide research network.

By fostering a collaborative approach to research, BSW can help to improve patient outcomes and better leverage research potential to deliver the ICS strategy. In 5 years' time the system should see a more effective, aligned (as section 3.2 of the guidance), systematic and comprehensive approach to research.
One of the aims of the ICS Research Strategy will be to enable a systematic monitoring of research progress with regular updates. As the strategy is developed and partners agree monitoring mechanisms these will be replayed into the Joint Forward Plan reviews.

8. Duty to Promote Integration

The duty to promote integration requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved. This duty is considered in the work that we do through our Local Implementation Plans and within or individual Strategic Objectives.

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9. Duty to have Regard to the Wider Effect of Decisions

As ICS partners we are committed to using our scale and finances in a way which support the social and economic development of our three local authority areas.

With an annual budget across the partnership of £2bn and an employed workforce of 35,500 our organisations can have significant influence beyond our core role as health and care providers. Through our work on the wider determinants of health we recognise that the delivery of health and care services represent only one element of how we can positively support the wellbeing of the local population.

Our commitment to delivering the triple aim of improving population health and achieving better quality of patient care whilst ensuring financially sustainable services is set out through our BSW Strategy and this BSW Implementation Plan demonstrating how all partners, including all local NHS organisations, these duties will be fulfilled through the lens of our three Strategic Objectives and success in doing so will be demonstrated through our monitoring against delivery of the actions included in the plan and the achievement of the system outcomes we have put in place.

An example of this approach is our work to deliver our Green Plan which is at the heart of our commitment to making BSW a prosperous and pleasant place to live. With initiatives targeting the employment opportunities that are available to local residents, the quality of the air that local people breath and our drive to embed local organisations in our supply chain, we are taking a holistic approach to developing our roles as anchor institutions.

Initiatives such as apprenticeship schemes and joint recruitment activities between partner organisations reflect our focus on developing rewarding careers for local people. This will continue to develop during 2024/25.

Partners are also working together on how best to utilise the physical estate that we directly manage with the intention of making our investments drive the maximum value for the local area. Increasingly, we expect to operate out of shared premises and to locate these in places that offer both easy access for our population and support the regeneration of communities.

Our work on wider social and economic development is being coordinated by different teams across the ICS, but ultimately will be overseen by the ICP as part of its work to quantify and measure our impact on the health and wellbeing of the local population.

In five years-time our partnership will be able to understand and monitor how we are using every £1 of the resources we have in BSW to achieve the maximum return on investment. This will be achieved by our organisation working ever more closely together and recognising that value is not driven by cost alone but must be judged on a wider set of social impacts.

Also see the Working Together section of the Plan Refresh.

10. Duty as to Regard to Climate Change

Climate change threatens the foundations of good health, with direct and immediate consequences for individuals, our infrastructure, and public services.

Addressing climate change is important in helping us to meet our system-wide goals of developing healthier communities, improving health outcomes, and addressing the wider social determinants of health that can lead to health inequalities.

Climate change requires collective action across the system. If we fail to take a coordinated approach, then we are failing to address the biggest health risk that we face as a society. In recognition of this, we will continue to work collaboratively with our health and care partners, local authorities, VCSE and the public to drive sustainable change and achieve a sustainable future for our population, and future generations to come.

The BSW Green Plan 2022-25 published in July 2022 sets out how we will begin to reduce the environmental and carbon impact of our health and care estate, services, and wider activities over the next 3 years, with a view to achieving net zero by 2040 for direct emissions and 2045 for the emissions we can influence. Aligned to the BSW ICS vision, the Plan supports our ICS strategic priorities by improving the health and wellbeing of our population so they can age well and reducing health inequalities caused through poor environments.

11. ICB involve the Public in Decisions about Services

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

Maximising the opportunities to undertake engagement and involvement with our partners and communities jointly with partner organisations.

A devolved approach where all colleagues recognise their individual role in engaging and involving stakeholders and our local populations.

Adoption and implementation of the 10 elements of statutory guidance on involvement.

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

We plan to develop a BSW engagement portal and citizens panel, to make use of different approaches to achieving more effective interaction between services and communities. We will also create an engagement advisory panel, acting as a cohort of experts by experience, to inform our thinking and planning, and ensure

that senior leaders are directly, regularly, and fully in touch with our population . The work to bring these initiatives together will be captured in the ICB People and Communities Involvement Strategy.

12. Addressing the Particular Needs of Victims of Abuse

The BSW ICB Chief Nurse and the ICB safeguarding team are representatives on all three safeguarding partnerships, including the Violence Reduction Unit (VRU) in BaNES locality, Swindon Community Safeguarding Partnership and Wiltshire Community Safeguarding Partnership.

Community Safety Partnerships (CSPs) and VRUs have an explicit role in evidence based strategic action on serious violence and these partnership meetings will be the driver for delivering the serious violence duty (SVD) and safeguarding Statutory Duties. The ICB, as a Specified Authority, will work with Relevant and Specified Authorities to collaborate on a multi-agency approach to prevent and reduce serious violence

We will expand the intelligence we collect to inform the refreshed version of the serious violence duty Strategic Needs Assessment for 2024-25 ensuring the ICS and its partners hear and understand the lived experience of victims of abuse, including staff.
We will continue to ensure services are appropriately commissioned and developed to specifically address the needs of victims of abuse within existing funding allocation and ensure services are appropriately commissioned and developed which focus on early intervention and prevention.
In meeting our Serious Violence Duty as a specified authority, we have worked with our partners to publish a joint strategic needs assessment and strategy to tackle serious violence across BSW

Domestic Abuse

The ICB will further improve the effectiveness of the multi-agency approach to support victims, working with partners to tackle perpetrators and prevent domestic abuse in accordance with the requirements of the Domestic Abuse Act 2021.
The arrangements and resources into Multi-Agency Risk Assessment Conference (MARAC) differ across the ICB locality areas due to differences in demand, different police forces and arrangements for collation of information to represent primary care. We will continue to review the impact of this over the coming year and further develop this service to ensure system wide improvements.

Sexual Violence

The ICB will consolidate the commissioning of the non-recent service abuse service which will include holistic assessment and care for children referred whenever there is an allegation of non-recent sexual abuse.

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Access to sexual assault referral centres (SARC's) has been further developed with the commissioning of the Swindon and Wiltshire Sexual Violence Therapeutic Service and we will seek work with partners to further develop services across BSW.

In 2023/24 we have continued to lead on developing practice, policy and procedure which safeguards unborns and under 1's across all our system with partners with a focus on prevention and early intervention. This work is a direct result in the learning from our statutory reviews with a strong focus on prevention and intervening early.

We have worked with our partners using our population data to develop a serious violence strategy to consider the needs of, developing multi-agency interventions to support victims of abuse to deliver excellent health services and focus on early intervention.

We continue to be ambitious with our deliverables, we acknowledge this year that we have not delivered all targets but we have put in strong foundations to deliver these over the next two years.

Into 2024-26 BSW will work with providers to develop a package of training which recognises the needs of victims and survivors

Bath and North East Somerset, Swindon and Wiltshire Together

July 2024

Wiltshire Council

Health and Wellbeing Board

26 September 2024

Subject: Development of the SEND and Alternative Provision Strategy 2024-29

Executive Summary

Wiltshire's Joint Health and Wellbeing Strategy (2023-32) sets out the vision that 'People in Wiltshire are empowered to live full, healthy and enriched lives.' Our ambition to achieve this vision rests on ensuring that children and young people get a good start in life, build resilience and get the very best from their education. Offering support to all children, young people and their families, as well as focusing on those who need the help the most, reduces inequalities and improves outcomes.

Following the successful implementation of the 2020-2024 SEND and Inclusion Strategy, the Local Area has embarked on a rigorous period of co-production with parents and carers, children and young people to understand what was required from the next iteration. As a result of this work, the new strategy "Meeting Needs Together - Ambitious for All" has been written. The Strategy has six key priorities which will be underpinned by a clear implementation plan and oversight via the Local Area SEND and AP Board.

Proposal(s)

It is recommended that the Board:

I. Notes that the new SEND and AP Strategy will become the public document that will form the basis of our partnership approach to working with families and children with additional needs for the next five years.

II. Notes the extensive local area co-production activity used to produce the strategy

III. Approves the oversight of performance against the priorities of the new strategy be carried out by the SEND and AP Partnership Board with annual reports submitted to Children's Select Committee

Reason for Proposal

I. The SEND Code of Practice states that local authorities must place children, young people and families at the centre of their planning, and work with them to develop co-ordinated approaches to securing better outcomes.

II. To address this, following the end of the current strategy a new co-produced local area strategy has been produced to support children and young people, families and carers which will be in place from 2024-2029

III. The local area SEND and AP Partnership Board

Kai Muxlow
Head of Families and Children Commissioning

Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

26 September 2024

Subject: Development of the SEND and Alternative Provision Strategy 2024-29

Purpose of Report

1. To provide information on the development of the new co-produced local area SEND and AP Strategy which will form the basis for our approach to working with families and children with additional needs.
2. To provide detail on the coproduction process and the agreed priorities and timelines for the implementation of the strategy.
3. The report should be read in conjunction with the new SEND and AP Strategy 2024-2029, 'Meeting Needs Together - Ambitious for All'.

Relevance to the Health and Wellbeing Strategy

4. Wiltshire's Joint Health and Wellbeing Strategy (2023-32) sets out the vision that 'People in Wiltshire are empowered to live full, healthy and enriched lives.' The new SEND and AP Strategy references this vision from the very start of the document in order to focus our intentions and the relevance to the overarching Joint Health and Wellbeing Strategy.

5. Our ambition to achieve this vision rests on ensuring that children and young people get a good start in life, build resilience and get the very best from their education. Offering support to all children, young people and their families, as well as focusing on those who need the help the most, reduces inequalities and improves outcomes.

Background

6. The SEND Code of Practice states that local authorities must place children, young people and families at the centre of their planning, and work with them to develop co-ordinated approaches to securing better outcomes.

7. Following the end of the 2020-2024 SEND and Inclusion Strategy the local area has been working to develop a new strategy to ensure that we are meeting the needs of our communities.

8. The new strategy is a fully co-produced local area approach to supporting families and children with additional needs. Face to face events, online discussions and surveys were carried out with a wide range of stakeholders including parents and carers, children and young people, health professionals, and schools to ensure that the strategy addressed the needs of our local communities.

9. This strategy has been produced in partnership and the consultation process has taken a year to complete. The work represents a marked shift in our local area, as it has been built upon the current lived experience and expertise of our children, young people and their parents/carers as the driving force for change.

10. The strategy sets out an ambitious goal for making sure that SEND becomes 'everybody's business' through pro-active inclusion from the outset. The strategy was produced together with key partners and draws upon feedback from children, young people and their parents/carers, professionals and front-line workers, education settings and the voluntary sector.

11. The strategy sets out a comprehensive response to the views, comments and issues raised by stakeholders right through the consultation process. This strategy represents a core document with high levels of engagement which sits amongst a range of strategic responses to the scope of the issues that the local area partnership wants to develop and address. There are separate plans either in place or in development which create the detail behind each of the priorities identified in the strategy.

12. The new strategy, entitled 'Meeting Needs Together - Ambitious for All' sets out our joint vision and the priorities we will focus on as a partnership over the next five years. Our aim is to be ambitious for all our children and young people and to work together to deliver cohesive, holistic support, having the child or young person's aspirations and needs at the centre of our work. We believe that meeting the needs of every child and young person with SEND or in AP in Wiltshire, is the responsibility of everyone.

13. Over the last year we have worked together in consultation with our parent-carers at face-to-face events across the county and through a range of online discussion groups. We have listened and gained the voice of children and young people with lived experience of SEND, including those who may be educated other than at school or from other harder to reach groups. We have worked with our schools and settings via partnership forums and networks, via surveys and polls. Our workforce from across all services and teams have actively engaged in meetings and surveys as part of this consultation work and have given their views and experiences as practitioners and officers.

14. As a result, the vision created with stakeholders through consultation is:

    'To create a future where every young person in Wiltshire has the tools and support needed to thrive and achieve their dreams. We want to support children and young people to be aspirational and hopeful, to increase their confidence, to have the resources to live the futures they want to live and to foster a culture of empowerment and inclusion.'

15. In adhering to true coproduction principles, we ensured that the voice of the local area has fully informed the priorities identified and shaped our collective vision. We have pledged to embed coproduction principles in everything we do and as a result of conversations and a joint working group with families, have written a 'Working Together Agreement', which

is our commitment to deliver this. This agreement can be seen towards the beginning of the strategy document.

Main Considerations

16. This vision will be delivered through six priority areas:

    Priority 1: Children and young people and their families will be at the centre of planning, their views and aspirations heard and acted upon, as true partners.

    Priority 2: Getting the right support at the right time, identifying and acting on our children's needs at the earliest opportunity and through promotion of inclusive approaches and practice across the local area.

    Priority 3: Provide opportunities for timely planning, reflective of the views of the child or young person and parent carers' current needs, that have clear outcomes.

    Priority 4: Ensure good quality communication and information, for families to have a positive experience when navigating services, with information that is easy to access and use.

    Priority 5: Professionals and officers across the SEND system will have the skills, knowledge and training to enable effective collaboration across services, joint assessments and sharing of good practice.

    Priority 6: Children and young people will be prepared for adulthood and experience timely transitions, leading to increased skills, greater independence, and a greater range of opportunities in life.

17. The stakeholders agreed that we would work to these priorities through a joint implementation plan that will set our actions and outcomes framework, to monitor the effective delivery of strategy.
18. It is proposed that SEND and AP Partnership Board will provide the monthly oversight and challenge of reportable data used to measure outcomes in delivering against the priorities

Next Steps

19. Following Cabinet approval on 17th September 2024 and Health and Wellbeing Board on 26th September 2024, the implementation plan will be finalised and overseen by the SEND and AP Partnership Board with the development of a bespoke dashboard to highlight performance against agreed measures.

20. We have also committed to publishing regular reports on the Wiltshire SEND Local Offer website. We will ask ourselves the question 'what difference has this made?' at each point of delivery and will work with children and young people with lived experience of SEND and AP so they can tell us how we are doing.

Kai Muxlow

Head of Families and Children Commissioning

Report Authors:
[Name, title, organisation]

Meeting needs together, ambitious for all

Our plan for children and young people with SEND or in Alternative Provision in Wiltshire 2024 – 2029

DRAFT

Bath and North East Somerset, Swindon and Wiltshire Together

Wiltshire Parent Carer Council

Wiltshire Council

Meeting Needs Together, Ambitious for All – Our Plan for Children and Young People with SEND or in Alternative Provision in Wiltshire

Welcome to the Wiltshire SEND and Alternative Provision Strategy 2024-29

Wiltshire's Joint Health and Wellbeing Strategy (2023-32) sets out the vision that 'People in Wiltshire are empowered to live full, healthy and enriched lives.'

Our ambition to achieve this vision rests on ensuring that children and young people get a good start in life, build resilience and get the very best from their education. Offering support to all children, young people and their families, as well as focusing on those who need the help the most, reduces inequalities and improves outcomes.

We are committed to improving our services for children and young people with Special Educational Needs and/or Disabilities (SEND) and their families. We believe that SEND is everybody's business and are focused on providing excellent educational opportunities including alternative provision (AP) for those who need it. We are determined to do everything we can to provide better experiences and outcomes for all our children and young people with SEND in educational settings as well as for those that attend Alternative Provision.

A key to achieving this is placing children, young people and their families at the centre of our work, by ensuring joint working is at the heart of our services. Partners across the local area of Wiltshire are committed to working together with the Wiltshire Parent Carer Council as well as children, young people, parent carers and partner organisations. We know that this approach will mean improved support for children and young people with SEND, so that they have full, healthy and enriched lives.

'Meeting Needs Together, Ambitious for All' sets out our vision, the priorities we will focus on as a partnership and how we will do this work over the next five years. Our aim is to work together to deliver cohesive, holistic support to our children and families and to have the child or young person's aspirations and needs at the centre of our work.

We are developing our plan to reflect the priorities in this strategy. As we implement and measure our progress against each of the priorities, we will provide regular reports to the SEND and AP Partnership Board on the delivery of this strategy. We will regularly publish the outcomes of our actions on the SEND Local Offer website, and through an annual report, so that children and young people with SEND, their families and the wider public are fully informed on our progress.

Councillor Laura Mayes – Lead Member for
Children and Young People and Deputy Leader,
Wiltshire Council

Councillor Jane Davies – Cabinet Member for SEND,
Wiltshire Council

Lucy Townsend – Corporate Director of People Services,
Wiltshire Council

Strategic Director, Wiltshire Parent Carer Council

Gill May – Director of Nursing & Quality, B&NES, Swindon & Wiltshire Integrated Care Board

Kathryn Davis

Director of Education and Skills,

Wiltshire Council

How we produced our strategy, its scope and purpose

We worked jointly on this strategy with the Wiltshire Parent Carer Council (WPCC), our children and young people with lived experience of SEND and AP, our Young Pioneers group, our early years settings, schools and colleges, practitioners, the voluntary and community sector and the Bath and North East Somerset, Swindon and Wiltshire NHS Integrated Care Board.

Over the past year, we have worked together with our families at face-to-face events, through online discussion groups, surveys to our schools and settings, and with children and young people through polls and group discussions. In doing so, we have ensured that the voice of our local area has fully informed the priorities identified and shaped our collective vision.

We are dedicated to working together for better outcomes, through embedding the priorities in this strategy into a delivery plan. We understand that for us to deliver cohesive, holistic support to our children and families we must work together to keep aspirations and needs at the centre of what we do.

A child and young person guide can be found in easy read on the Wiltshire Local Offer webpages.

Our Working Together Agreement

The 'Meeting Needs Together, Ambitious for All' Strategy has been developed by working together with parents, carers, children, young people, services and teams within Wiltshire Council, health partners, schools and settings. The title of our strategy was chosen by parent carers and young people, to reflect the commitment to working together. The priorities and actions within the strategy have been formed as a direct result of the work we have carried out together in partnership.

We have written a 'Working Together Agreement', coproduced with families in Wiltshire to reflect the commitment to joint working at the heart of everything we do.

We talked together about what true partnership working looked like and this is our commitment:

Working in partnership

We will all:

- Agree what each partner will contribute
- Listen and accept that people have different views and perspectives
- Ensure that everyone's contribution is heard and valued equally
- Ensure partners are involved and agree outcomes together
- Do what we say we will do and be accountable

Communicating well

We will all:

- Be honest, transparent and clear
- Show active listening
- Let everyone have a voice that is heard
- Be open and respectful
- Share information promptly and clearly and keep everyone informed when things change

Feeling valued and included

We will all:

- Celebrate strengths, successes, differences
- Have a whole-system holistic understanding
- Recognise and care about lived experiences
- Empower everyone to express their voice so that children, young people and their families feel 'heard'
- Include families in decision making, in the shaping of services and in all planning

Feeling welcomed and cared for

We will all:

- Invest time and sufficient resources
- Be open and welcoming to all
- Treat parents as true partners
- Show empathy, understanding and emotional intelligence
- Give continuous feedback – 'you said, we did'

Our shared vision

Our shared vision and priorities have been built with young people, parent carers and professionals from across the local area.

'To create a future where every young person in Wiltshire has the tools and support needed to thrive and achieve their dreams. We want to support children and young people to be aspirational and hopeful, to increase their confidence, to have the resources to live the futures they want to live and to foster a culture of empowerment and inclusion.'

Meeting the needs of every child and young person with SEND in Wiltshire is the responsibility of everyone.

- We aim to change culture by embedding our shared vision and values into the practice of everyone who works with children, young people and families, ensuring good communication and a system that makes sense.
- We aim to identify and respond to needs at the earliest opportunity, in ways that value lived experience and expertise, offering personalised care and support.
- We will strive to deliver our services and support in the right place at the right time, ensuring good provision is provided locally and there is an inclusive approach across Wiltshire SEND system, making the best use of resources and ensuring best value for money.
- We will implement this integrated strategy, delivering quality and timely support for those who need it.

Our vision will be delivered through six priority areas:

Priority 1: Children and young people and their families will be at the centre of planning, their views and aspirations heard and acted upon, as true partners.

Priority 2: Getting the right support at the right time, identifying and acting on our children's needs at the earliest opportunity and through promotion of inclusive approaches and practice across the local area.

Priority 3: Provide opportunities for timely planning, reflective of the views of the child or young people and parent carers' current needs, that have clear outcomes.

Priority 4: Ensure good quality communication and information, for families to have a positive experience when navigating services, with information that is easy to access and use.

Priority 5: Professionals and officers across the SEND system will have the skills, knowledge and training to enable effective collaboration across services, joint assessments and sharing of good practice.

Priority 6: Children and young people will be prepared for adulthood and experience timely transitions, leading to increased skills, greater independence and a greater range of opportunities in life.

Priority 1:
Children and young people and their families will be at the centre of planning, views and aspirations heard and acted upon, as true partners.

What have children and young people and their families told us about this priority area?
"Help me plan for my future…I want to decide how to share my skills, needs and interests"
Young Pioneers feedback 2023

"Make decisions with us, not to us"
Parent Partnership event 2024

Why is it a priority?
We must value the lived experience and expertise of children, young people, and their families when we plan together and make decisions about individual needs and support.

We want all children in Wiltshire to be aspirational and hopeful and we know we need to build a culture of empowerment.

We want all children and young people with SEND (Special Educational Needs and/or Disabilities) to feel valued and welcome and in their communities. We know that by giving families a greater voice and by listening and acting upon those views, we can build trust so that parents have more confidence in the services and support they receive.

What children and young people and their families will see as a result:

- They will feel heard within the local area and be able to access help, where required, to express views, wishes and choices.
- Planning and reviews will be person-centred, with the voice of the child, young person and family integral to all planning.
- They will talk confidently about the future and the chosen pathway to adulthood, from school or alternative provision and feel like true partners in the decisions made.
- Opportunities to design new services will be available for all.

Priority 2:
Getting the right support at the right time, identifying and acting on our children's needs at the earliest opportunity and through promotion of inclusive approaches and practice across the local area.

What have children and young people and their families told us about this priority area?
"I want to have my options listened to and I want to get support when I need it"
Young person's questionnaire 2024

"The key to all this is prevention… to identify issues and solutions early"
Parent Partnership Event 2024

Why is it a priority?
We know that if we work together with families to identify needs, difficulties and challenges early, we can be proactive in putting timely and appropriate action in place to improve a child's life chances.

By continuing to develop a co-ordinated approach to prevention and early intervention, we know we can enable children, young people with SEND and their families to access the right help and support in the right place at the right time.

What will children and young people and their families see as a result?

- An integrated system of early support and intervention with holistic support available across education, health and social care.
- High quality SEN Support will be available in all education settings for those with needs that do not require an Education, Health and Care Plan (EHCP).
- More families and children with SEND will be able to find and engage with services, advice and guidance through our SEND Local Offer website.
- Families will see their community is growing a better network of coordinated local help, that enables them to feel strong, safe, happy and healthy.
- Fewer children and young people with mental health or emotional wellbeing concerns will be escalated to specialist services, as support will be accessed at the point of need.

Priority 3:
Provide opportunities for timely planning, reflective of the views of the child or young person and parent-carers' current needs, that have clear outcomes.

What have children and young people and their families told us about this priority area?
"Know my interests…. let me share my goals for the future"
Young Pioneers Group 2023

"Forward planning for the family – describe what other key things will happen and when, during the year."
Parent/Carer Discussion Group 2024

Why is it a priority?
We recognise that holistic and timely planning across education, health and care leads to stronger individual outcomes.

We know that when we work together, we are more joined up, efficient and timely in our work, and produce a better experience for our children and young people and their families.

The local area must continue to develop provision in response to emerging demand.

What children and young people and their families will see as a result:

- Children and young people and their families will tell us that their experience is improving and that our plans to support them are timely, person centred, meet their needs, and are jointly produced with them.
- Review meetings that are timely, ensure the child or young person is central to the process, with parent/carers confident in what is planned for their child.
- The local area partnership will use robust evidence to inform the commissioning of provision and services for our children with SEND, including the use of Alternative Provision.

Priority 4:
Ensuring excellent quality communication and information, for families to have a positive experience when navigating services, with information that is easy to access and use.

What have children and young people and their families told us about this priority area?
'Know how to communicate with me'
Young Pioneers Group 2024

"Take time to talk to us"
Parent Carer Discussion Groups 2024

Why is it a priority?
Families have told us how important it is to have good and easy access to information including for families of children who have an emerging need or are new to our processes.

They have told us that they would like to be able to contact the right person or service quickly, at the point of needing advice.

We must also demonstrate that when we receive feedback, we communicate back how we have listened and improved services as a result.

We want to be better at communicating with children and young people with SEND using their preferred way and by giving them a range of ways to express their needs.

What children and young people and their families will see as a result:

- They will tell us that we have a clear system of consistent and easy to access support services across education, health and care.
- Families will tell us that we are more transparent and open in our approach and that they feel respected and valued as partners.
- We will receive positive feedback from families regarding our advice and guidance in terms of accessibility and quality of information.
- Children, young people and their families will see evidence of planning and provision that reflects their views.
- Parents will feel more confident and less dependent on professionals and services.

Priority 5:
Professionals and officers across the SEND system will have the skills, knowledge, and training to enable effective collaboration across services, joint assessments and sharing of good practice.

What have children and young people and their families told us about this priority area?
"I wish all the adults who work with me understood my needs"
Young Person's Questionnaire comments 2024

"We need for families and professionals to jointly access and share information"
Feedback from parents at SEND Engagement Event 2023

Why is it a priority?
We want everyone working with and for children and young people to be knowledgeable about SEND and Alternative Provision and to have the appropriate knowledge, training and skills to be confident in their role.

We need more opportunities for professionals and families to work and learn together, to share skills, knowledge and experience.

We want parent/carers to feel more confident in the support offered in the mainstream school or setting.

We recognise that parent/carers should be seen and treated as 'experts by experience.'

What children and young people and their families will see as a result:

- Improved parental confidence in the inclusive practices within our Wiltshire schools and educational settings.
- A reduction in number of suspensions and permanent exclusions for children and young people with SEND enabling children and young people to be included in their settings.
- Alternative provision used in a planned way to support children and young people to be successful.
- A confident, skilled and knowledgeable workforce.
- Practitioners reflective in understanding the strengths we already have in our partnership, to nseek out best practice elsewhere and evidence regarding what works, bringing these elements together to create the best possible arrangements for our local context.

Priority 6:
Children and young people will be prepared for adulthood and experience timely transitions, leading to increased skills, greater independence, and a greater range of opportunities in life.

What have children and young people and their families told us about this priority area?
"People need to understand my needs and help me plan for my future"
Young People consultation groups 2024

"There should be clear pathways for young people when preparing for adulthood"
Parent carer discussion groups 2024

Why is it a priority?
For all young people with SEND, preparation for adulthood should be well planned. We want to ensure that every young person has the support and encouragement they need to get ready for the challenges, so that they can experience increased independence in preparation for adult life. This will need to be at a pace that is right for them and their family.

We want to ensure that there is breadth in our SEND and Alternative Provision Post-16 offer so that young people can work towards their personal goals and aspirations. As they grow up, we want them to feel accepted and valued in their local communities.

We aim for all our children and young people to achieve optimal health in adulthood, including their mental health, and we recognise that collaboration as partners is essential to achieving this goal.

What will children and young people and their families see as a result?

- Young people and their families will see a greater choice of local options, including alternative provision, communicated in a clear and accessible way.
- More young people will meet their outcomes and achieve their aspirations and goals.
- A joined-up approach to employability so that young people can see clear pathways into jobs and careers that are in demand in the local economy.
- More young people will have the confidence and independence to successfully transition to the next stage of their journey to adulthood.

How we will deliver our strategy, priorities and outcomes and monitor our progress

Professionals in Wiltshire with representative groups and local voluntary organisations understand that we must work together in partnership across education, health and social care, to deliver our strategy.

The priorities identified in our strategy will be included in the Wiltshire SEND Needs Assessment.

We will produce a joint delivery plan that will set out our actions and an outcomes framework to monitor the effective delivery of our action plan.

Our joint strategy will also steer our SEND Transformation Programme and associated budget recovery plan. The plan links to the strategic priorities and supports improvements in quality.

Our SEND and AP action plan will be overseen by the SEND and AP Partnership Board with regular reporting on progress against each priority. This group meets on a monthly basis and is attended by professionals across education, health, social care and commissioned services, alongside parent carer representation and youth voice. The Local Area Partnership has set up a new integrated dashboard that will tell us if we are achieving our vision linked to each of the priority areas.

We will also publish regular reports on the Wiltshire SEND Local Offer website at www.localoffer.wiltshire.gov.uk/. We will continue to consult with children and young people with lived experience of SEND and AP so that they can tell us how we are doing.

Wiltshire Council
Health and Wellbeing Board

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26 September 2024

Subject: Gypsy, Roma, Traveller & Boater Strategy - Review and Update

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Executive Summary

1. The first Wiltshire Gypsy, Roma, Traveller, and Boater (GRTB) strategy was published in 2010 and was refreshed in 2016. An increasing awareness of the specific needs of the boater population led to the first Health Needs Assessment (HNA) for GRTB communities in 2019[1]. The current Wiltshire GRTB strategy was published in 2020 is currently set to run until 2025.

2. It is important to note that the Covid-19 pandemic and subsequent fuel, financial and housing crises have disproportionately affected these already underserved populations. The housing crisis has had an impact, and whilst many people choose a transient lifestyle, increasing numbers are resorting to living on boats and in vehicles (either at the roadside or in discrete locations across the county) for economic reasons. Consequently, the number of families living on authorised and unauthorised traveller sites across the county has increased. Many are not from traveller heritage but are unable to access other housing.

3. This review was conducted to update understanding of nomadic communities, to assess progress against the existing strategy's ambitions, and to provide basis upon which to update the strategy for the next five years.

Proposals

That the Health & Wellbeing Board:

a) To note the findings of the review of the Gypsy, Roma, Traveller & Boater Strategy (2020-2025);

b) To note progress against the current strategy, and areas for development;

c) To encourage partners to work with Wiltshire Council: to raise awareness of the community's needs, and to further develop the aims and objectives for a new Strategy; and

d) To request an update report from officers on the development of the Strategy.

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[1] Agenda and minutes - Democratic Services - Wiltshire Council (Min 32 refers)

Reason for Proposal

To reduce health inequalities faced by communities, and to improve a range of outcomes that support good health & wellbeing.

Will Oulton
Corporate Support Manager & Chair of the Traveller Reference Group
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

26 September 2024

Subject: Gypsy, Roma, Traveller & Boater Strategy - Review and Update

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Purpose of Report

1. To present the findings of the review of the Gypsy, Roma, Traveller & Boater Strategy (2020-2025), including an updated assessment of health needs.

Relevance to the Health and Wellbeing Strategy

2. The review, development and implementation of a Gypsy, Roma, Traveller & Boater (GRTB) Strategy, by using evidence to target action where it will make the most difference, contributes to the Board's four thematic objectives, namely:

   - To improving social mobility and tackle inequalities.
   - To focus on prevention and early intervention.
   - To localise and connect with communities.
   - To promote integration and working together.

3. People from nomadic communities and heritage experience some of the starkest health inequalities of any population group. This is recognised with the Health and Wellbeing Strategy and the GRTB Strategy respectively. Amongst the relevant links are actions to: 'target outreach activity – identifying particular groups to improve access to services and health outcomes and tackle root causes'[2].

4. Additionally, as identified in the BSW Integrated Care Strategy for 2023-28[3], the recommendations from Core20Plus5 highlight the need to reduce inequalities in the most deprived 20% of the population, with a focus on those with poorer-than-average health access, experience, or outcomes (which in Wiltshire specifically includes the GRTB community).

5. One of the key aims of any successful strategy is to encourage a greater understanding of the different communities and their needs to improve service delivery. Further, supporting local communities to be able to come together to support themselves. With the expansion of the Community Conversation model, and other engagement plans such as the Neighbourhood Collaboratives[4] model, there is an opportunity to build capacity in communities.

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[2] WJLHWS_2023.pdf (wiltshire.gov.uk)
[3] Integrated-Care-Strategy-Summary-v3.pdf (bswtogether.org.uk)
[4] Neighbourhood Collaboratives Presentation

6. Whilst there are examples of good working relationships between partners, e.g. through the Traveller Reference Group (TRG), opportunities for coordination of action should not be overlooked.

Background

7. Under the auspices of the Traveller Reference Group (TRG), partners have come together, led by Public Health, to review the GRTB Strategy. The TRG meets quarterly and provides a forum to develop a new strategy, with the agreement of the Health & Wellbeing Board, and to create actions plans to deliver upon the aims of the strategy.

8. Part of the wider context, and linked to the wider determinants of health, is the need for appropriate housing. The Councils is currently consulting on the Gypsies and Travellers Development Plan Document[5], which identified sites that can be brought forward to meet the housing needs will be provided for over the plan period, from 2024-2038.

Main Considerations

9. The review of the GRTB Strategy identifies some areas of progress and best practice, whilst highlighting the areas where challenges remain.

10. Chief amongst those challenges, is the need to identify local sources of data to understand how well our services are meeting the needs of the community. This is true of other cohorts in our systems but the challenges in the area are more present.

11. Working with mobile and transient communities presents specific challenges around information sharing. Those still practicing a nomadic lifestyle, especially those living roadside or on boats are forced to move frequently, and maybe reluctant to share information with authorities. For those living roadside and subject to Enforcement action by the Local Authority or the Police, this may mean moving up to fifty times a year. For boaters without a mooring, the conditions of a continuous cruising licence mean they must change locations at least every 14 days.

12. Therefore, improving systems to record appropriate information about the people we work with will be an aim of the emerging new Strategy alongside a commitment to share information.

13. However, a change to systems will not be sufficient on its own, and further action to increase staff awareness of the community and its needs will be required. The aim should be to foster the practice of intellectual curiosity where culturally aware staff are primed to ask people about their backgrounds so that they can be supported in the right way. This, in turn, will give us the data to understand how effective those interventions have been.

[5] Wiltshire's Gypsies and Travellers Development Plan Document consultation begins next week - Wiltshire Council

Next Steps

7. With the support of the Health & Wellbeing Board, officers in Wiltshire Council will continue to engage with colleagues, partners, and the community to develop a new strategy, and to identify actions to deliver it.

Will Oulton
Corporate Support Manager & Chair of the Traveller Reference Group
Wiltshire Council

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Wiltshire Council

Health and Wellbeing Board

26 September 2024

Subject: Healthwatch Annual Report

Executive Summary

Healthwatch Wiltshire is the local independent consumer champion for health and social care. We listen to people's experiences of using health and care services and share these with decision makers and commissioners to influence change. The annual report gives an overview of our recent work including: Improving mental health services for autistic people; improving hospital complaint processes; and working with Eastern European and Boating communities. Headline figures include:

- 4,397 people accessed information advice and guidance
- 3 reports
- 14 recommendations
- 15 volunteers

Proposal(s)

It is recommended that the Board:

i) Note the key messages from the annual report

ii) Confirm its commitment to understanding the voice of local people and ensuring this voice is a key component of future commissioning.

Reason for Proposal

Healthwatch Wiltshire has a statutory duty to promote the voice of local people with regard to health and social care services and has the opportunity to influence commissioners on the Health and Wellbeing Board. This opportunity is provided through Healthwatch Wiltshire's membership of the Board. As such it is important that the Board receive Healthwatch Wiltshire's Annual Report in order to make any comment, recognise the work undertaken to date, and confirm its commitment to listen to the voice of patients, unpaid carers and the wider community through Healthwatch Wiltshire.

Kevin Peltonen-Messenger
CEO
TCF