Wiltshire Council

AGENDA SUPPLEMENT (1)

Meeting: **Health Select Committee**

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

Date: **Tuesday 28 February 2023**

Time: **10.30 am**

The Agenda for the above meeting was published on 20 February 2023. Additional documents are now available and are attached to this Agenda Supplement.

Please direct any enquiries on this Agenda to Cameron Osborn of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line or email Cameron.Osborn@wiltshire.gov.uk

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

This Agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

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7 **Draft Joint Local Health and Wellbeing Strategy 2023-2032** *(Pages 3 - 18)*

Two documents circulated.

8 **Integrated Care Strategy for B&NES, Swindon and Wiltshire** *(Pages 19 - 88)*

Strategy and presentation slides.

9 **Hearing and Vision Service Update** *(Pages 89 - 98)*

Presentation slides.

11 **Inquiry Session into Challenges being experienced with patient flow through hospitals** *(Pages 99 - 104)*

Two documents circulated.

DATE OF PUBLICATION: 24 February 2023

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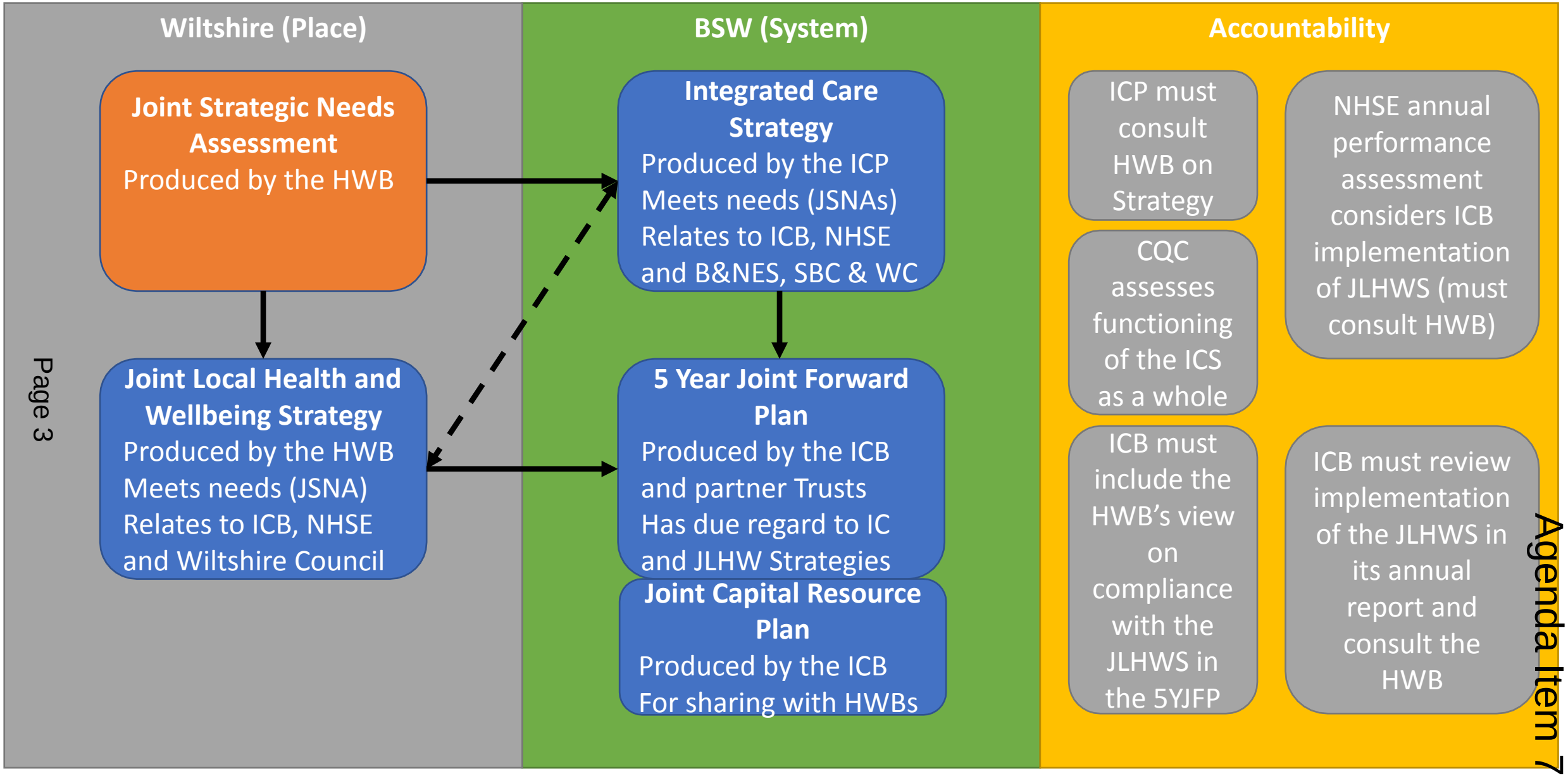
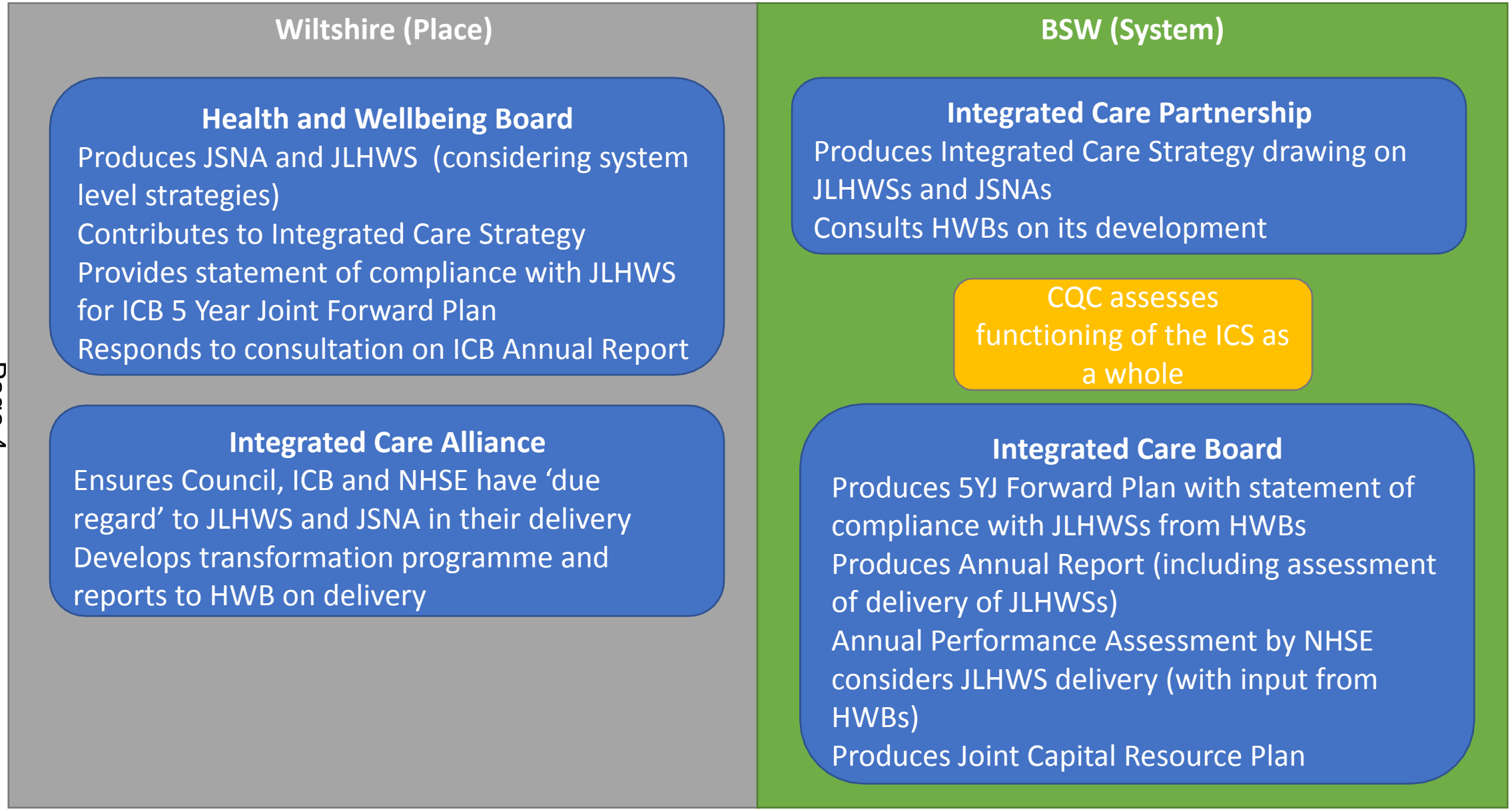
Responsibilities by Boards in Wiltshire and BSW



Boards by responsibilities in Wiltshire and BSW



Wiltshire input to JLHWS and Integrated Care Strategies

Group	Focus	Meeting Date
Health and Wellbeing Board	JSNA consideration Workshop on ICS and JLHWS development	1 December
World Café consultation	Integrated Care Strategy development	16 December 2022
Health Select Committee	IC strategy	18 January 2023
Health and Wellbeing Board	IC and JLHW strategies	26 January
Wiltshire Integrated Care Alliance	IC and JLHW strategies	31 January
Consultation through various partnerships e.g. FACT, SVPP including CSP, Healthwatch Wiltshire, VCSE, PCN clinical directors	IC and JLHW strategies	February/ early March
Health Select Committee	IC and JLHW strategies	28 February
Health and Wellbeing Board	Consideration of consultation feedback Agreement of IC and JLHW strategies and Forward Plan	30 March

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Wiltshire Joint Local Health and Wellbeing Strategy

2023-2032

Foreword

The health and wellbeing of the people of Wiltshire is the highest priority for the Wiltshire Health and Wellbeing Board. We are determined to ensure that "*people in Wiltshire are empowered to live full, healthy and enriched lives."*

This strategy has been developed based upon the evidence of need and has enabled the board to focus on four thematic areas where it can have its most impact, ensuring everyone has access to the opportunities and services that we would expect for our own friends and families. We know that our population is ageing (there is a forecast increase of 87% in our 85 and over population by 2040). We also know that where someone is born and raised in Wiltshire can have a significant influence on how healthy they are and how long they will live and that, sadly, the pandemic has further exacerbated these health inequalities. We want to ensure everyone can thrive in Wiltshire. Achieving this will mean a clear focus on reducing inequalities but also connecting with communities to encourage local action and better tailoring the delivery of our services to reflect the needs of local areas.

As organisations responsible for designing, commissioning and delivering a huge range of health and social care services for Wiltshire residents, we are keen to make services the best they can be and excellent value. Integrated working is an essential part of this. We also recognise the need to shift the focus from acute to primary and community care and, in turn, to preventative activity and population health. A population health approach will allow the risks and rewards of investment in services to be shared locally and the potential to try new approaches such as clustering more care services around GPs or commissioning on the basis of whole population health outcomes rather than systems which reward increased contact. It will also mean we fully recognise the difference good jobs, housing, natural environments, education and community can make to health and wellbeing.

We must target our collective resources where the evidence tells us action will make the greatest improvements to people's health and wellbeing. Therefore, our four guiding themes for this strategy build on those of our previous strategy (and those reflected in Wiltshire Council's Business Plan) as a clear long term commitment to this way of working. They are:

1. Improving social mobility and tackling inequalities
2. Prevention and early intervention
3. Localisation and connecting with communities
4. Integration and working together

As a board we will continue to work closely together to deliver the vision of this strategy so that our ambition is realised.

Cllr Richard Clewer

Chair, Wiltshire Health and Wellbeing Board

Organisational logos

Bath and North East Somerset, Swindon and Wiltshire Integrated Care System, Wiltshire Council, Healthwatch Wiltshire, NHS England, Wiltshire Police and Crime Commissioner, Wiltshire Police, Wiltshire Local Medical Committee, SW Ambulance Service Trust, Avon and Wiltshire Mental Health Partnership, Oxford Health Trust, Wiltshire Health and Care, HCRG, Royal United Hospital, Salisbury Foundation Trust, Great Western Hospital, DWFRS, VCS voice

Introduction

The Wiltshire Health and Wellbeing Board (HWB) was introduced by the Health and Social Care Act 2012. It is a partnership that brings together the leaders of the health and social care system. The board is required by legislation to deliver specific responsibilities:

- Produce a Joint Strategic Needs Assessment (JSNA) and Pharmaceutical Needs Assessment
- Develop a Joint Local Health and Wellbeing Strategy
- Encourage and enable integrated working between health and social care

The JSNA uses current data and evidence about health and wellbeing in Wiltshire, to highlight the health needs of the whole community. It demonstrates how needs may vary for different age groups, as well as identifying health differences for disadvantaged or vulnerable groups. The JSNA looks at a wide range of factors that help shape and influence the health and wellbeing of individuals, families and local communities such as education, employment, housing, transport and the environment.

www.wiltshireintelligence.org.uk

Within this document health is understood to be a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.

This Health and Wellbeing Strategy is a shared strategy, which aims to improve the health and wellbeing of the local population. It uses the analysis and data from the JSNA, to help identify and agree the key ambitions for our population which as a Health and Wellbeing Board we will work together to deliver.

It does not list everything that all organisations will be doing to improve health and wellbeing. Instead it focuses on where Wiltshire's Health and Wellbeing Board can add value and sets out our vision for integrated working for the future.

The purpose of the strategy is to enable:

- All health and wellbeing partners to be clear about our agreed priorities
- All members of the HWB to embed the priorities within their own organisations and ensure they are reflected in a joined-up way in their commissioning and delivery plans (this is a statutory duty for the council and the NHS)
- The board to hold organisations to account for their actions towards achieving the objectives and priorities in the strategy

Wiltshire's strategy has been developed in tandem with the new Integrated Care Strategy (the 'system level' strategy) for Bath and North East Somerset, Swindon and Wiltshire (BSW) and the first five-year Joint Forward Plan for the Integrated Care Board which will deliver it. The two strategies are complementary and differentiate the activity that will be taking place at 'system' (ie BSW) and 'place' (ie Wiltshire) levels. To ensure alignment Wiltshire's Health and Wellbeing Board is consulted on the system level strategies and related delivery plans and has the opportunity to include a statement on compliance with the JSNA and JLHWS within the forward plan, as well as to be consulted on the annual report for BSW.

Wiltshire's Health and Wellbeing Board will consider regular progress reports on the delivery of this strategy, which will inform the work programme of the Wiltshire Integrated Care Alliance and the individual work of members of the board. The progress reports will also inform the timescale for any refresh of this strategy before 2032.

Overview of Wiltshire population

Wiltshire's Joint Strategic Needs Assessment provides an in-depth analysis of the needs of the population of Wiltshire. Below is an overview of population and deprivation:

Wiltshire's current population:
- 510,400
- 51% female and 49% male

By 2040 in Wiltshire:
- Under 65+ population expected to have **decreased** by 3%
- 65+ population expected to have **increased** by 43%
- 85+ population expected to have **increased** by 87% (from 15,200 to 28,438)

Areas of deprivation:
There are 8 of the 285 small areas of geography (LSOAS) in Wiltshire that are within the 20% nationally most deprived. They are classified as "urban city and town", and found in **Trowbridge, Chippenham, Melksham and Salisbury.** Households in Wiltshire in the most deprived areas experience higher levels of fuel poverty (17% of households compared with 7% in the least deprived areas).

Health inequalities are understood to be avoidable, unfair and systemic differences in health between different groups of people. There are many groups experiencing health inequalities including those from ethnic minority communities, those experiencing homelessness, those with a learning disability and those living in rural areas. It is useful to keep this in mind when reading through the JSNA.

The health of those in Wiltshire is generally very good compared to the national average. On the whole people in Wiltshire have a higher life expectancy and healthy life expectancy than the England average. Fewer people are living in areas of deprivation, smaller proportions are living unhealthy lifestyles, more people have been vaccinated and crime and unemployment rates are very low. However, evidence from the Joint Strategic Needs Assessment has highlighted that the most deprived 20% of areas within Wiltshire have repeatedly poorer outcomes than the least deprived 20%.

Our communities living in those least deprived areas of the county, will enjoy a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. Inequalities within Wiltshire, and the need to maintain a focus on major health issues, for example reducing deaths from cancer and cardiovascular disease, mean that local services should always be accessible to all. Inequalities do exist in Wiltshire and, with an ageing population structure, health needs are due to change further over future years. This, combined with the reduction in the working age population, means that the current approaches to health and care will not be sustainable in the future and could have an impact on all aspects of our lives if good health is not prioritised. Therefore, we must narrow the gap in health and wellbeing outcomes. We have to make sure everyone has the opportunity to have an excellent education, to learn skills and get a good job, to live in a nice environment and live healthier lifestyles into old age.

Vision

"People in Wiltshire are empowered to live full, healthy and enriched lives"

Key Themes of Wiltshire's Health and Wellbeing Strategy

1. **Improving social mobility and tackling inequalities**

In everything we do, we consider the impact of the action on social mobility and ask how we can help to tackle the disparities in opportunities, experience, access and health outcomes that exist within Wiltshire. We focus on the factors that have the greatest influence on people's health, such as ensuring good and secure homes and jobs.

2. **Prevention and early intervention**

We take a long-term view, focusing on what is right for Wiltshire and invest in prevention and early intervention to tackle problems before they get worse. We encourage personal responsibility and have a whole life approach to planning and providing services for our residents alongside this, aimed at improving outcomes in population health and care.

3. **Localisation and connecting with communities**

We ensure our dialogue with communities is open, transparent and inclusive, in the right place and at the right time so that the distinctive needs of local communities are met. We enable stronger and resilient communities and support broader social and economic development

4. **Working together and integration**

We design and deliver our activities in partnership with service users, local communities and public sector partners. We collectively consider how to integrate our work, get maximum value for public sector spend and plan our use of the public sector estate together.

Theme 1: Improving social mobility and tackling inequalities

In everything we do, we consider the impact of the action on social mobility and ask how we can help to tackle the disparities in opportunities, experience, access and health outcomes that exist within Wiltshire. We focus on the factors that have the greatest influence on people's health, such as ensuring good and secure homes and jobs.

Case for change

Whilst a significant proportion of our population are healthy; good health isn't just about the treatment of illness. It is the food we eat, the relationships we maintain, the environments in which we live and work and the opportunities we have to thrive. Supporting people to remain healthy, independent and well is a crucial feature of this strategy. To make the biggest changes in people's health and wellbeing, we need to focus on the social and environmental factors impacting on people's lives. Addressing these wider determinants of health - such as housing, unemployment, homelessness, education, social isolation, transport and community safety - is critical for improving social mobility and tackling inequalities.

Achieving change

We will:

- Promote health in all policies – including housing, employment and planning. This will include the development of sustainable communities, whole life housing and walkable neighbourhoods. The review of Wiltshire's Local Plan and Local Transport Plan is an important opportunity to deliver this.
- Support healthy home settings – with action on fuel poverty, helping people to find work, mental health and loneliness and by increasing digital inclusion
- Give children the best start in life – with a focus on the whole family, family learning, parenting advice, relationship support, the first 1000 days/ early years and community health services
- Target outreach activity – identifying particular groups to improve health outcomes and access to services (identifying and then focusing on several of these each year) - work to tackle root causes, plan delivery and carry out evaluation.
- Improve access through online services, community locations and mobile services as well as community diagnostic hubs.

1. The Home Setting

The 'home' plays a key role in enabling people to achieve good health and wellbeing.

- Improved physical health, as well as better mental health and well being
- Better social interactions and inclusions
- Better access to services and opportunities

2. Early Identification and Prevention

Focus on children, working across **'whole' family interventions**

Lifecourse

Diverting people from statutory or formal services **through local, flexible, community solutions**

- Reducing long-term health effects from exposures of direct/in-direct harms on young people
- Increasing resilience of our whole population
- Reducing social isolation and loneliness
- Improved health and wellbeing

3. Tackling Root Causes

Tackling root-causes and addressing causal factors; not just focusing on the symptoms

Symptoms
The result or outcome of the problem

The Problem

Causes
"The Roots" – system below the surface bringing about the problem *(not always obvious)*

- Reduce risk of frequent and multiple contacts to services/agencies
- Reduced victimisation
- Improved health and wellbeing realised earlier

Theme 2: Prevention and early intervention

We take a long-term view, focusing on what is right for Wiltshire and invest in prevention and early intervention to tackle problems before they get worse. We encourage personal responsibility and have a whole life approach to planning and providing services for our residents alongside this, aimed at improving outcomes in population health and care.

Case for change

Evidence suggests 60% of what we do to prevent poor health and improve wellbeing relates to social determinants of health i.e. the conditions in which people are born, grow, live, work and age. Unhealthy behaviours for example smoking, alcohol misuse, poor diet and lack of physical activity, are significant contributors to a large proportion of ill health and long-term health conditions such as cancers, cardiovascular disease, diabetes and dementia. We need a system that is fit for purpose, can manage the challenges of increasing demand, focuses on prevention, supports those with long-term conditions and their carers and helps our populations to improve their health outcomes.

Achieving change

We will:

- Lay the foundations for good emotional wellbeing whilst young – by developing a coordinated approach and promoting a core offer in schools across Wiltshire relevant to the challenges young people face (including new challenges such as social media)
- Encourage personal responsibility across the life course – in all schools, with working age adults and for the elderly – focusing on healthy lifestyles, smoking cessation, alcohol and substance misuse
- Prevent ill health - through increased uptake of screening, health checks and immunisations as well as ensuring the best use of antibiotics.
- Enable a healthy workforce through targeted preventative activity
- Adopt a proactive population health management approach – rolling this out to new areas (such as management of moderate frailty) each year to enable earlier detection and intervention

Theme 3: Localisation and connecting with communities

We ensure our dialogue with communities is open, transparent and inclusive, in the right place and at the right time so that the distinctive needs of local communities are met. We enable stronger and resilient communities and support broader social and economic development

Case for change

Population growth and management of long term conditions means our health and care system is under increasing pressure, particularly as it recovers from the pandemic. When people have the skills, knowledge and confidence to manage their own health and care, not only do they achieve better health outcomes, there is also the benefit of reduced healthcare costs and increased satisfaction with services. However, when individuals in a community feel isolated, this impacts their ability to remain resilient, which is a strong predictor for poor outcomes. Enabling communities to be stronger and more resilient allows local solutions for local problems, by working together with partner agencies and the voluntary sector to meet their health and wellbeing needs.

Achieving change

We will:

- Support local community action – through initiatives such as neighbourhood collaboratives allied to the development of Primary Care Networks, the community mental health model, area board activity using community area JSNAs to inform local action planning and the allocation and bidding for wellbeing grants
- Pilot community conversations – starting with neighbourhoods in Wiltshire that have significant deprivation and roll these out gradually across the county.
- Consider the way in which we buy goods and services can deliver improved local job opportunities (acting as ‘anchor’ institutions) and other wider benefits (social value)
- Embed Healthwatch Wiltshire and voluntary and community sector voices in relevant decision-making structures and ensure the public voice is heard with consultation results and co-production reflected in decision papers and relevant attendance at the Health and Wellbeing Board.

Theme 4: Working together and integration

We design and deliver our activities in partnership with service users, local communities and public sector partners. We collectively consider how to integrate our work, get maximum value for public sector spend and plan our use of the public sector estate together.

Case for change

Our current health and care system is under pressure and can be confusing for staff, patients, families and carers. As our populations get older and more people develop long-term health conditions, our system is becoming less able to cope with the changing needs and expectations of the people it serves. This is leading to higher demand for social care, carers and community health services and these pressures will continue to increase with a reduction in the working age population. The way we pay for health and care services can encourage high end care in expensive settings, often reinforcing isolated working practices. We currently spend too much on services responding at the point of crisis and not enough on early intervention and preventative support that aims to keep people well for longer. Initial signs are that covid has reinforced the investment in acute services and although there has been some staffing growth there are also challenges with increasing activity and productivity across the system to address the elective care backlog.

Achieving change

We will:

- Provide integrated, personalised services at key stages in a person's life – this will include starting to complete later life planning with people in their early 60s (or before that in more deprived areas) so that we are preparing for when they are older, end of life care, and increasing the provision of personal budgets
- Boost 'out-of-hospital' care, encouraging a 'hospital without walls' model with improved digital and local access to consultants, and dissolving the divide between primary and community health services - through coordination of community multi-disciplinary teams, clustering services around primary care networks, and guaranteeing support to people in care homes
- Enable frontline staff to work more closely together – planning our workforce needs together, developing case studies on front line cooperation, supporting shared records and IT and sharing estates wherever possible
- Ensure carers benefit from greater recognition and support by improving how we identify unpaid carers

- Improve join-up of services through community healthcare, primary, secondary and tertiary healthcare (including specialist services, for the armed forces and their families, pharmaceutical services and healthcare in the justice sector)
- Drive improvement by delivering our vision through collective oversight of quality and performance, reconfiguration of clinical pathways, recommissioning of services and overseeing pooled budgets and joint teams together (through the Wiltshire Integrated Care Alliance). The ICA will bring together officers from the relevant organisations and report regularly to the Health and Wellbeing Board on progress against this plan and its own transformation programme as well as the Better Care Plan.

Summary

Theme	Improving social mobility and tackling inequalities	Prevention and early intervention	Localisation and connecting with communities	Integration and working together
Actions to achieve change	Promote health in all policies – including housing, employment and planning. This will include the development of sustainable communities, whole life housing and walkable neighbourhoods. Support healthy home settings – with action on fuel poverty, worklessness, mental health and loneliness and by increasing digital inclusion Give children the best start in life – with a focus on the whole family, family learning, parenting advice, relationship support, the first 1000 days/ early years and community health services Target outreach activity – identifying particular groups to improve access to services and health outcomes and tackle root causes Improve access through online services and community locations	Lay the foundations for good emotional wellbeing whilst young – by developing a coordinated approach and promoting a core offer in schools across Wiltshire Encourage personal responsibility across the life course – in all schools, with working age adults and for the elderly – focusing on healthy lifestyles, smoking cessation, alcohol and substance misuse Prevent ill health - through increased uptake of screening, health checks and immunisations as well as tackling antimicrobial resistance through the best use of antibiotics Adopt a proactive population health approach – rolling this out to new areas (such as moderate frailty) each year to enable earlier detection and intervention	Support local community action – through initiatives such as neighbourhood collaboratives allied to the development of Primary Care Networks, the community mental health model, area board activity using community area JSNAs to inform local action planning and the allocation and bidding for wellbeing grants Pilot community conversations – starting with neighbourhoods in Wiltshire that have significant deprivation and roll these out gradually across the county. Consider the role that procurement can play in delivering social value and the way in which organisations can act as anchor institutions Embed Healthwatch Wiltshire and VCS voices in relevant decision-making structures; ensure the results of consultation are reflected in decision papers	Provide integrated services at key stages in a person's life – including later life planning, end of life care, and increasing the provision of personal budgets Boost 'out-of-hospital' care, dissolving the divide between primary and community health services - through community multi-disciplinary teams, clustering services around primary care networks, and guaranteeing support to people in care homes Enable frontline staff to work more closely together – planning our workforce needs together, developing case studies on front line cooperation, supporting shared records and IT and sharing estates wherever possible Ensure carers benefit from greater recognition and support by improving how we identify unpaid carers Improve join-up of services including specialised commissioning Drive improvement through collective oversight of quality and performance, reconfigurations and recommissioning; overseeing pooled budgets and joint teams together – including the ICA transformation programme and Better Care Plan

Strategy Licensing Policy

Youth Justice Plan

FACT Partnership Strategy

Looked After Children

Strategy SEND Support

Strategy Transitions Plan

Early Help

Mental Health and Wellbeing

Children and Young People's Plan

Positive leisure time activities

Local Skills

Children's services

Voluntary and community sector

Voluntary and Community Sector

Digital Strategy

Local Plan and Local Transport Plan (LTP)

UK Shared Prosperity Fund Investment Plan and economic development activity

Wiltshire Climate Change Strategy and Delivery Plan. NHS Sustainability Strategy

Wiltshire Playing Pitch Strategy
Park and Open Spaces

Blue and Green Infrastructure

Air Quality

Health and care

Finance and corporate services

BSW Care Model

Suicide prevention

End of Life Care

Mental Health and Wellbeing Autism Strategy Annual Public Health Report

Wiltshire Community Safety Partnership Strategy Domestic Abuse and Sexual Violence Strategy Housing Strategy

Homelessness Strategy

Obesity Strategy

Dementia Strategy

Carers' Strategy

Leisure and Physical Activities, Libraries and Culture

Joint NHS and Council:

Integrated Care Strategy and Delivery Plan

Better Care Fund Plan

Adult and community services

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Bath and North East Somerset,
Swindon and Wiltshire Together

BSW Integrated Care Strategy

Bath and North East Somerset,
Swindon and Wiltshire Together

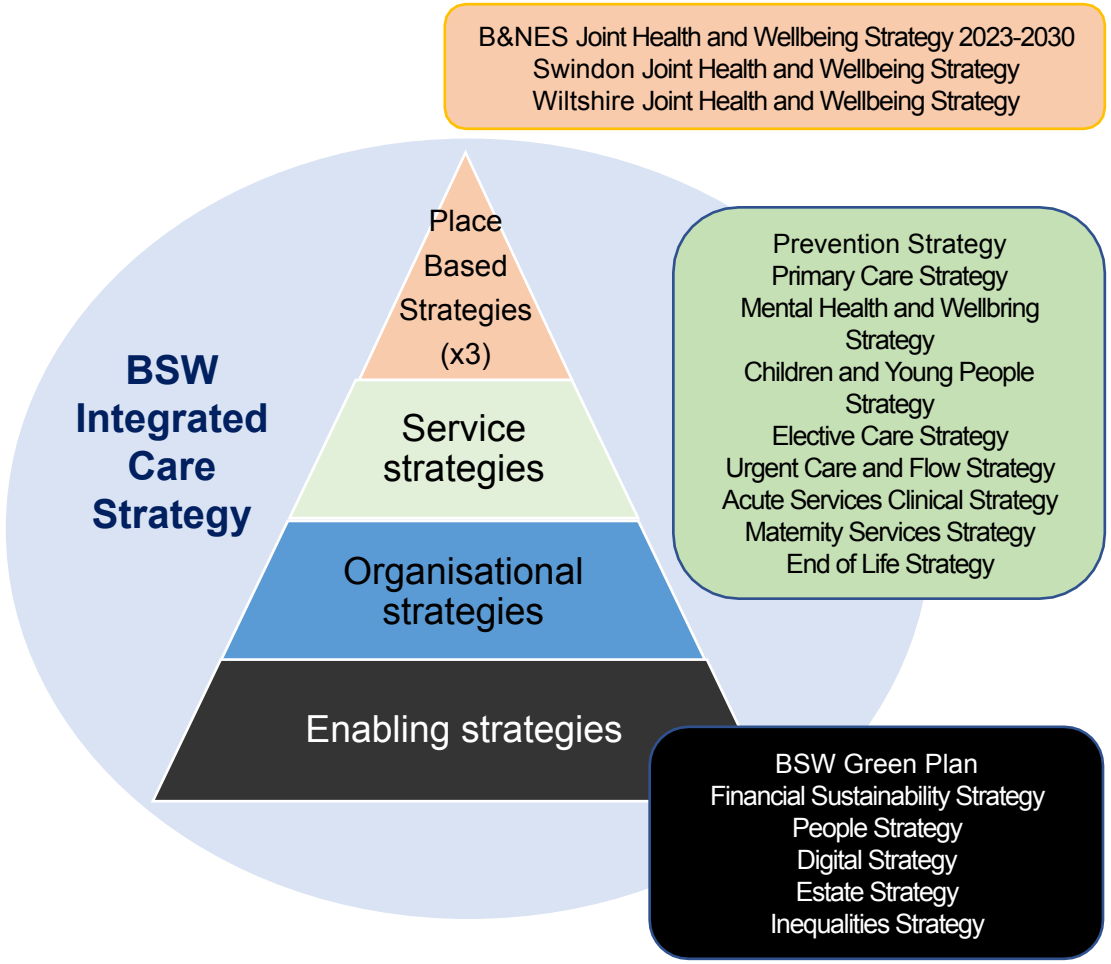
Update

- Reminder – context
- Strategy vision
- Strategy structure and strategic objectives
- Understand views across partners on ‘left shift’ of funding to support prevention
- Provide clarity on next steps (timeline for reviewing the document)

Context: A complex landscape of strategies

Emerging strategies in BSW

- Each strategy is of value and important to achieving system ambitions (limit to level of detail an Integrated Care Strategy could/should set out)
- However, understandable confusion (both among providers and when explaining to our residents)
- Key that the purpose of each strategy, as well as interactions between strategies, is as clear as possible. Aim not to duplicate
- Integrated care strategy – no legal enforcement. Depends on partner support and buy-in

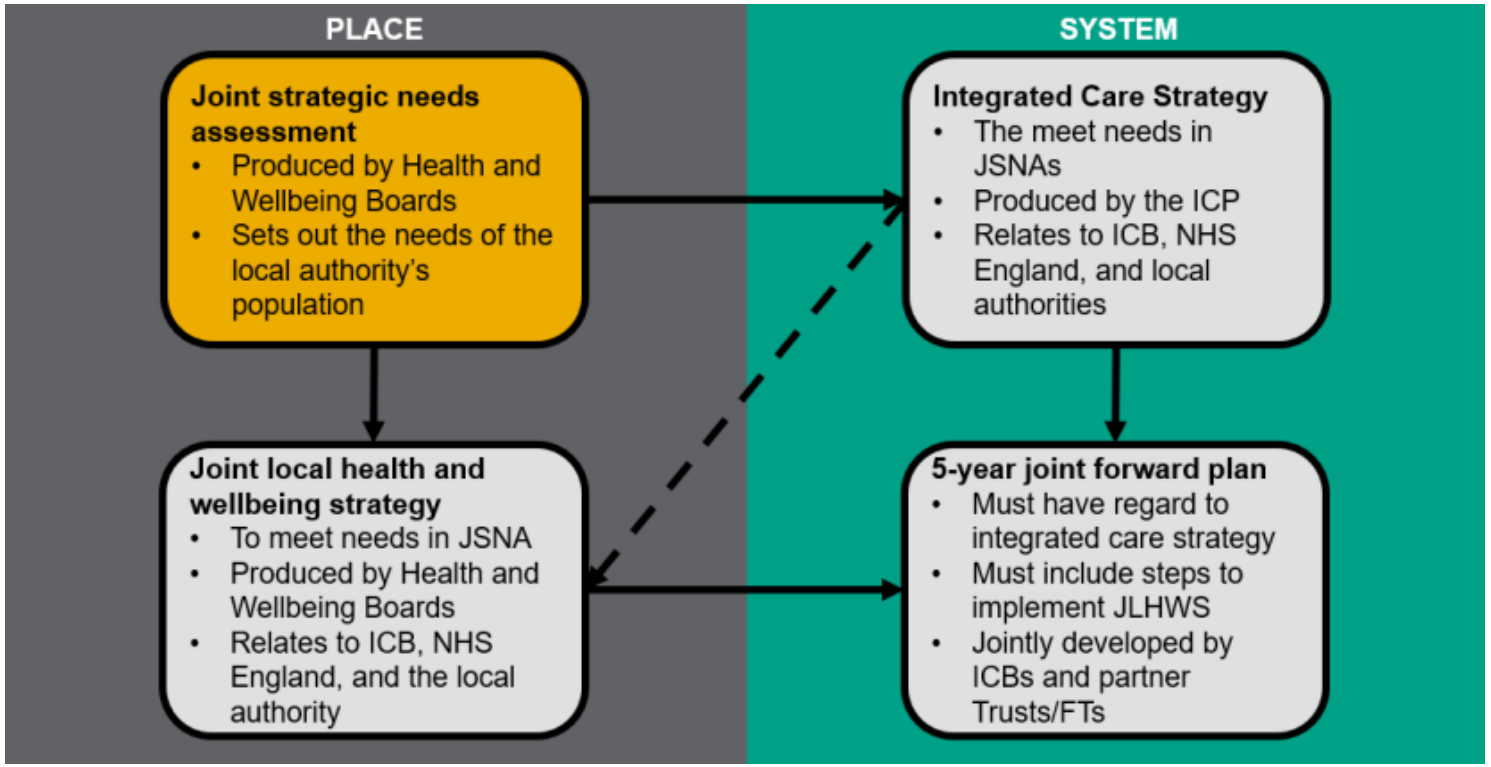


Context: A complex landscape of strategies

The relationship with strategies at place

- We are bound by intricacies of the new legislative framework

- Our aim to meet the needs identified in JSNAs but also align as far as possible with Health & Wellbeing Strategy ambitions



Department & Health of Care, based on Health & Social Care Act 2022

Purpose of integrated care strategies

Integrated care strategies were designed to support integration meet local healthcare, social care and public health needs. Guidance builds upon this so that the ICP, and the ICS more broadly:

addresses local needs in a way that works for local circumstances

engages a broad range of people, communities and organisations in the production of the strategy

addresses the big, complex problems that require a system response, and multiple partners

Create space to address population health and wellbeing and support socio-economic development

Our approach

Design principles

We aim to produce a strategy according to the following design principles. We have sought to produce a document that is:

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

Where we are

Imperfect conditions – multiple challenges including:

Challenge	Mitigation strategy
The strategy should be driven by community and resident engagement	• Using place-level engagement to inform the strategy, as well as feedback from December engagement event • Engagement events planned with VCSE Alliances (including Local Healthwatch) • The IC Strategy as the beginning, not end, of our engagement
The strategy should feel co-owned and developed with partners across the system	• Taking versions to partners on an iterative basis – current version still to evolve significantly • Development session to be planned with three DPHs • Engagement events to be planned with stakeholder groups including primary care and social care providers
Short window for development	• Using and signposting to material already approved/resulted from engagement within the system (e.g. BSW Care Model)

Bath and North East Somerset,
Swindon and Wiltshire Together

Defining priorities & making it measurable

A discussion on vision and structure

Developing a vision

Demographics
Bath and North East Somerset

Population [1]

196,357

0-19 Years	**23%** of the population are aged 19 or under
20-64 Years	**59%** of the population are aged between 20 and 64 years
65+ Years	**19%** of the population are aged 65 and over

Life expectancy [2]

- Life expectancy 85.1 years
- Healthy life expectancy 66.4 years
- Life expectancy 81.1 years
- Healthy life expectancy 66.7 years

Inequality in life expectancy [3]

- 3.0 years
- 6.8 years

Demographics
Swindon

Population [1]

222,881

0-19 Years	**25%** of the population are aged 19 or under
20-64 Years	**59%** of the population are aged between 20 and 64 years
65+ Years	**17%** of the population are aged 65 and over

Life expectancy [2]

- Life expectancy 83.5 years
- Healthy life expectancy 62.3 years
- Life expectancy 80.2 years
- Healthy life expectancy 62.8 years

Inequality in life expectancy [3]

- 7.0 years
- 5.7 years

Demographics
Wiltshire

Population [1]

504,070

0-19 Years	**23%** of the population are aged 19 or under
20-64 Years	**55%** of the population are aged between 20 and 64 years
65+ Years	**22%** of the population are aged 65 and over

Life expectancy [2]

- Life expectancy 84.8 years
- Healthy life expectancy 66.9 years
- Life expectancy 81.0 years
- Healthy life expectancy 66.8 years

Inequality in life expectancy [3]

- 3.4 years
- 5.5 years

Public engagement

Health & Wellbeing Strategy Objectives

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

1. Improve mental health and wellbeing
2. Eat well and move more
3. Stop Smoking and Reduce Alcohol

1. Improve social mobility and tackling inequalities
2. Prevention and early intervention
3. Localisation and connecting with communities
4. Integration and working together

The BSW Vision & Strategic Objectives

Defining priorities: First approach

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

Swindon
Joint Strategic Needs Assessment and Health & Wellbeing Strategy

Wiltshire
Joint Strategic Needs Assessment and Health & Wellbeing Strategy

What we will deliver

The BSW Vision:

Working effectively together to improve health and wellbeing and reduce inequalities across our population through a focus on prevention.

Start well 0-25 years	Live well 25-64 years	Age well +64 years	Die well	Whole life outcomes for the population of BSW
Headline Goals: 1. Xx 2. Xx 3. Xx	**Headline Goals:** 1. Xx 2. Xx 3. Xx	**Headline Goals:** 1. Xx 2. Xx 3. Xx	**Headline Goals:** 1. Xx 2. Xx 3. Xx	**Headline Goals:** 1. Xx 2. Xx 3. Xx

How we will deliver it

The BSW Care Model

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

Making it sustainable: Enablers

- Developing Our Workforce
- Technology & Data
- Estates of the Future
- Environmental Sustainability
- Financial Sustainability
- Our Role as Anchor Institutions

Our **strategy** on a page

Case Study

Our **ambition** is:

Humber and North Yorkshire Health and Care Partnership

for everyone in our population to live longer, healthier lives

by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.

To reach that ambition our **vision** is to ensure that all our people:

Start Well — We want every child to have the best start in life and enable everyone to be safe, grow and learn.

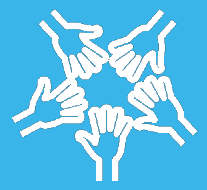
Live Well — We want to ensure the next generation are healthier than the last and have the opportunity to thrive.

Age Well — We want to ensure people live healthy and independent lives as long as possible by understanding what matters most to them.

Die Well — We want to create an environment in which people can have positive conversations about death and dying.

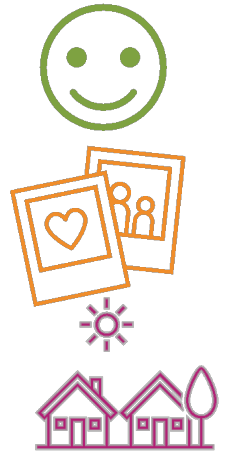
To deliver the ambition and vision, our **intentions** are to:

Create conditions



to

- **Think person**
- **Think family**
- **Think community**



Defining priorities: Proposed new approach

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

Swindon
Joint Strategic Needs Assessment and Health & Wellbeing Strategy

Wiltshire
Joint Strategic Needs Assessment and Health & Wellbeing Strategy

The BSW Vision:

Working and listening effectively together to improve health and wellbeing.

Shortened vision

Three strategic objectives spanning the life cycles

What we will deliver

STRATEGIC OBJECTIVE 1:
Focus on prevention and early intervention

STRATEGIC OBJECTIVE 2:
Fairer health outcomes

STRATEGIC OBJECTIVE 3:
Excellent health and care services

How we will deliver it

The BSW Care Model

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

Making it sustainable: Enablers

- Developing Our Workforce
- Technology & Data
- Estates of the Future
- Environmental Sustainability
- Financial Sustainability £
- Our Role as Anchor Institutions

Defining priorities: Alternative approach

North East North Cumbria Health & Care Partnership

Case Study

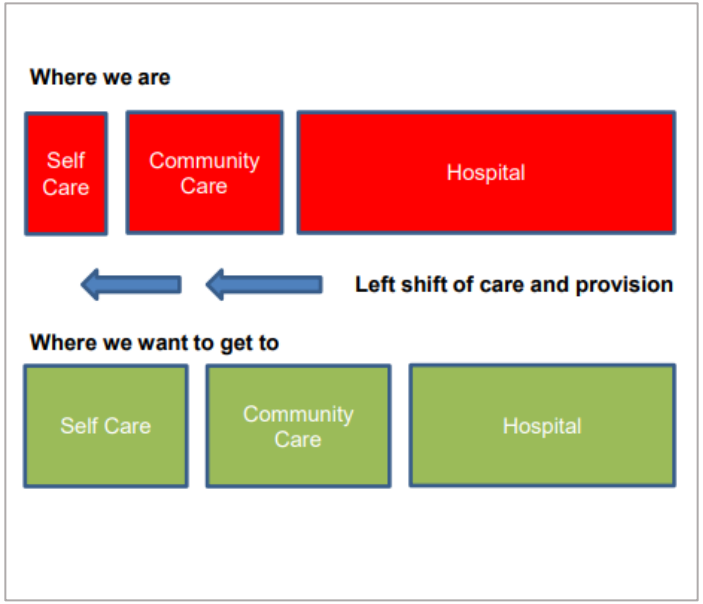
Discussion: Refocusing funding and resources to deliver prevention

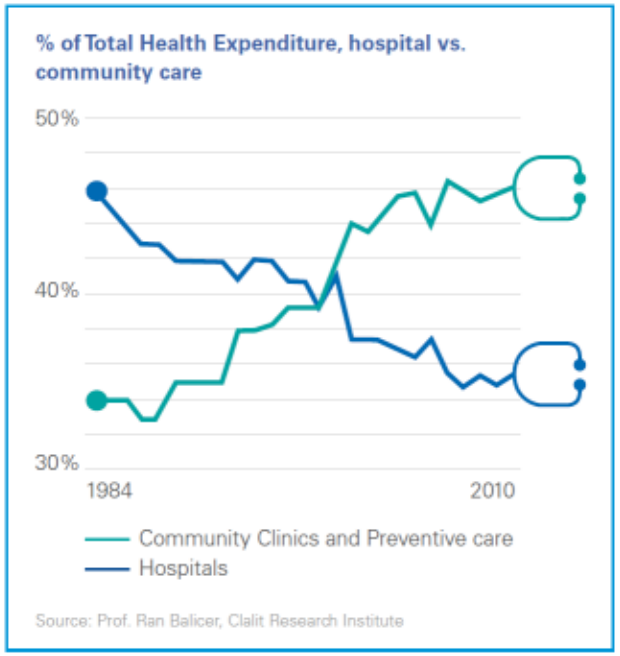
Overview

- Achieving the ‘left shift’ – moving clinically appropriate care and treatment for patients from hospitals into the community
- Objectives – better health and wellbeing, better quality of care as well as financially sustainable and efficient services (the ‘Triple Aim’)
- Approach would follow the 2019 national NHS Long Term Plan to ambition to increase investment in primary medical and community health services as a share of the total revenue spend.

Questions for discussion:

- ➢ Is there support for us including this ambition in the IC Strategy?
- ➢ Where are the barriers to, and opportunities for, achieving this over the coming years in BSW?





Bath and North East Somerset,
Swindon and Wiltshire Together

Next steps

Integrated Care Strategy (by 31st March 2023)

- Revised draft to be shared with ICP members on 21 February, for feedback and discussion at ICP meeting on 28 February
- Final version for ICP approval by mid-March
- Engagement sessions being planned with VCSE Alliances (inc Local Healthwatch), DPHs and primary care leaders

Associated documents

Integrated Care Implementation Plan (by 30th June 2023)

- Developed by the Integrated Care Board (ICB)

Operating Plan 23/24 (by 31st March 2023)

- Setting out our system plan key metrics for submission to NHSE

Individual NHS organisations will also be producing their annual Operational Plans and the ICB will submit a summary of these.

Discussion and Feedback

The draft strategy is still a work in progress and further updates will be generated over the coming weeks. We will share a working draft for views.

Potential areas for discussion:

1. What vision should run through the strategy? Should this formally become the new BSW Vision (replacing ‘Working together to empower people to lead their best life’)?

2. Do you believe a thematic approach is needed and are the proposed themes the right one?

3. Is there support for us including the ambition for refocusing funding and resources to deliver prevention in the IC Strategy?

ENDS

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Bath and North East Somerset, Swindon and Wiltshire Together

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

Bath and North East Somerset, Swindon and Wiltshire

Integrated Care Strategy (Draft)

Integrated Care Partnership

February 2023

Ver 2.3 (draft)

Bath and North East Somerset,
Swindon and Wiltshire Together

To be completed once content agreed

Bath and North East Somerset,
Swindon and Wiltshire Together

1. Welcome to our Integrated Care Strategy

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

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

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

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

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

Cllr Richard Clewer
Chair of the BSW Integrated Care Partnership

2. What is an Integrated Care Strategy?

Overview

BSW Together, through its Integrated Care Partnership (ICP), is required by law to produce an Integrated Care Strategy. This sets the direction of the system across the area of the integrated care partnership for the next five years, outlining how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life.

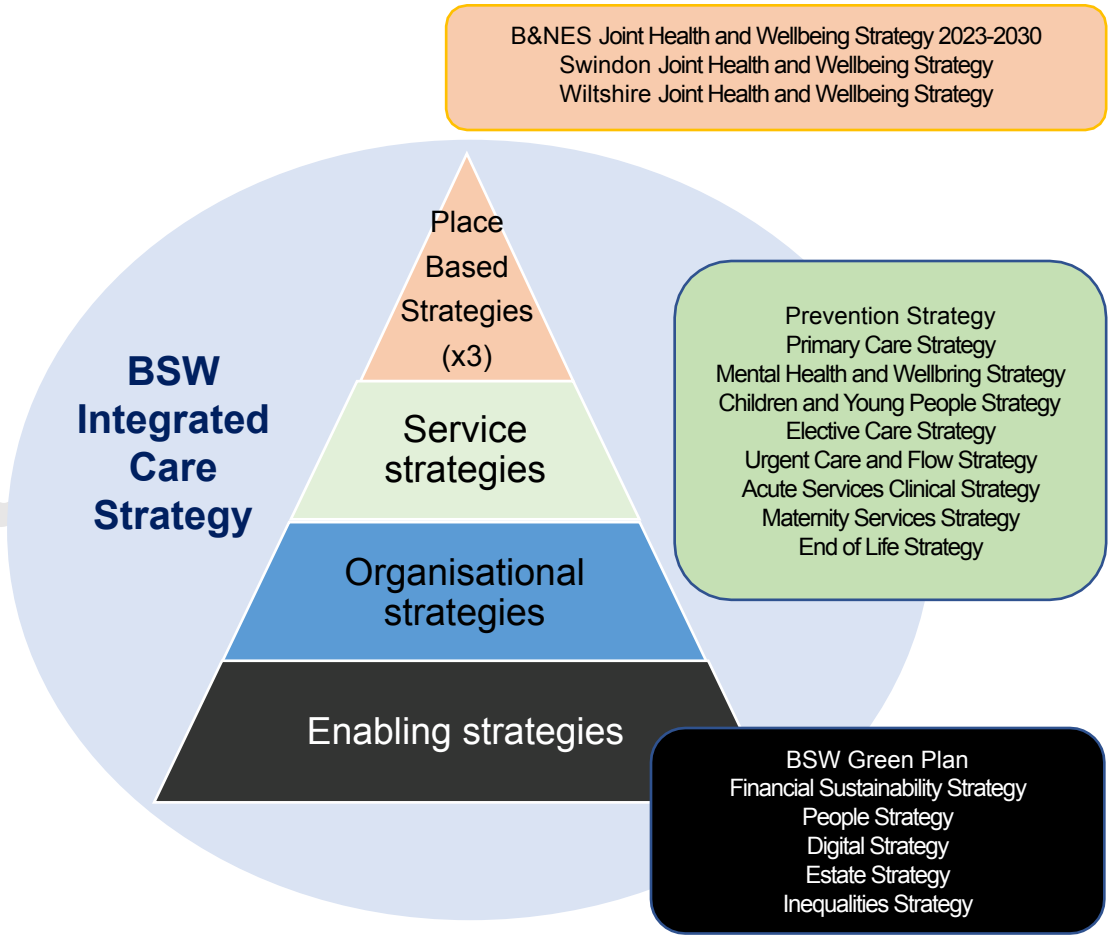
Importantly, therefore, **this is not just an NHS strategy**. Our Integrated Care Strategy tells the story of how all system partners – across the public, private and voluntary sectors – are working, and plan to work, together across BSW to improve health, care and wellbeing for our residents.

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

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

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

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



2. What is an Integrated Care Strategy?

Design principles

We have set out to produce a strategy that is:

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

2. What is an Integrated Care Strategy?

Achieving a shared vision

Through this strategy we will set out common goals for all partners. While organisational autonomy is respected, and individual approaches between partners will differ, we are committed to the same ambitions. This strategy therefore seeks to update and replace the BSW Vision as we look ahead to a future of partners working differently through the integrated care system.

The BSW Vision:

Working and listening effectively together to improve health and wellbeing.

This strategy sets out what achieving this vision will look like for BSW residents over the next five years. It is not 'set in stone' and we intend for the strategy to evolve over the coming years. Crucially, the Integrated Strategy Vision above will only come to fruition if all partners within the system work together to achieve it. This strategy sets out **what** we hope to achieve and **why**, but an **Implementation Plan** (also known as a Joint Forward Plan) will be published later this year detailing **how** partners will deliver it, including key milestones and deliverables.

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

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

3. Our Integrated Care Strategy on a page

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

Swindon
Joint Strategic Needs Assessment and Health & Wellbeing Strategy

Wiltshire
Joint Strategic Needs Assessment and Health & Wellbeing Strategy

What we will deliver

The BSW Vision:

Working and listening together to improve health and wellbeing.

Delivered through prioritisation of three clear objectives:

STRATEGIC OBJECTIVE 1:
Focus on prevention and early intervention

STRATEGIC OBJECTIVE 2:
Fairer health outcomes

STRATEGIC OBJECTIVE 3:
Excellent health and care services

How we will deliver it

The BSW Care Model

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

Making it sustainable: Enablers

- Developing Our Workforce
- Technology & Data
- Estates of the Future
- Environmental Sustainability
- Financial Sustainability
- Our Role as Anchor Institutions

4. Our starting point: The current picture across BSW

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

In this section:

4.1 A system of three places

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

This strategy is commited to the principle of **subsidiarity**, whereby decisions affecting citizens should be taken as close to the citizen as possible. In relation to BSW, this means that we want to empower each of the below three places to make their own decisions about services for their local populations.

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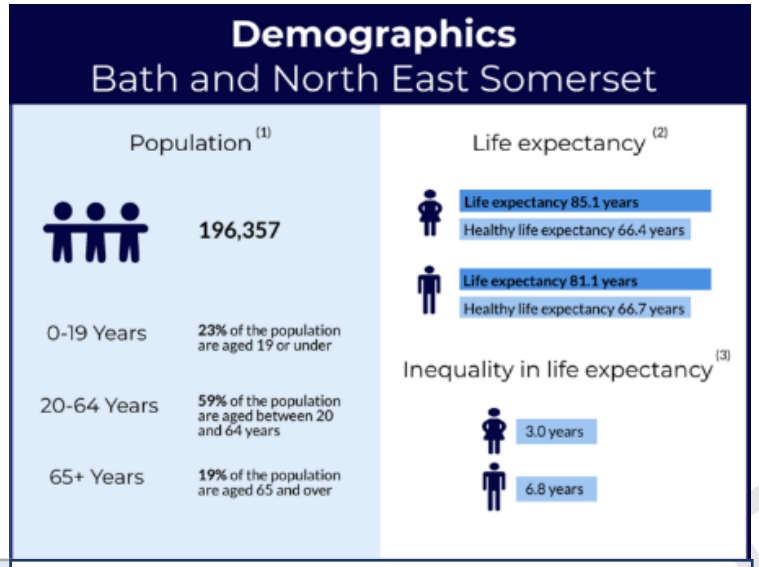
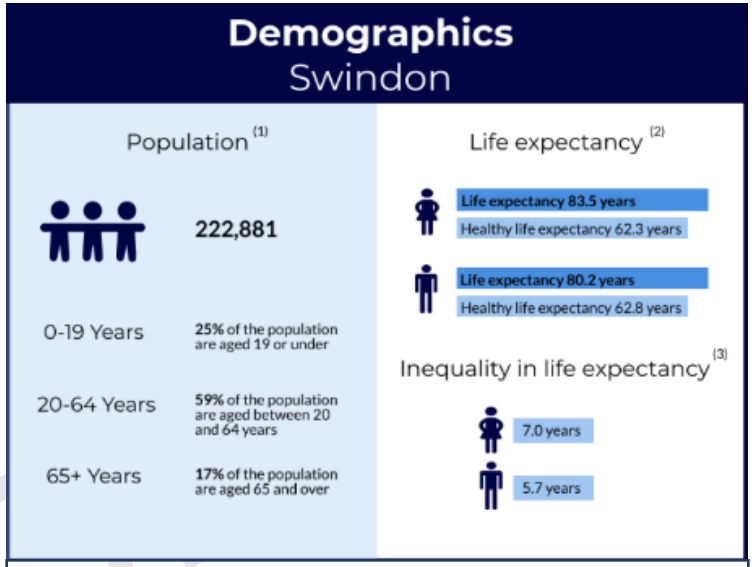
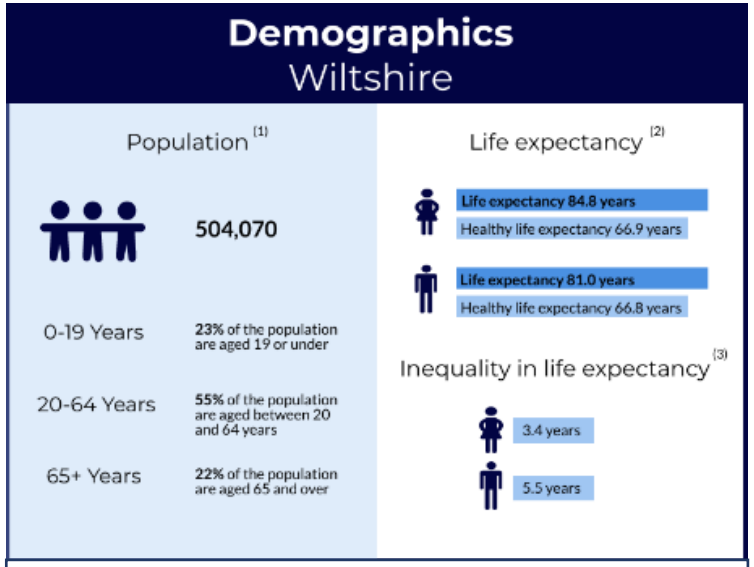






Selected challenges (from Joint Strategic Needs Assessment)	**Cost of living.** Estimates suggest 4,000 people (of whom 1,500 are children) have fallen into absolute poverty in 2022/23. **Mental health.** Reported levels of high anxiety have risen and are higher than the national average. Rates of hospitalisation are also up and comparatively high, particularly for young women and girls. **Special educational needs and disability (SEND).** The number of Special School places available in B&NEShas not matched increasing demand.	**Deprivation.** Swindon is ranked as the 98th most deprived area out of 151 Upper Tier Local Authorities (UTLAs) in England but some smaller areas are in the 10% most deprived in the country. **Mental health**. Admissions to hospital for self-harm across all ages is significantly higher than the average for the south west and England as a whole. The picture is particularly troubling in relation to children. **Healthy life expectancy**. Males in Swindon will spend 80% of their lives in good health, but for females it is only 74%.	**Mental health.** In 2020/21, 44,000 people (18 and over) had a diagnosis of depression, equivalent to 11% of the population. Rates of hospital admissions for self-harm are at their highest level for five years. **Age-related conditions.** By 2030, it is estimated that almost 11,500 people aged 65 and above will be living with dementia. **Environment.** In Wiltshire the percentage of emissions through transport is higher than the average for the South West and England.
Health & Wellbeing Strategy Objectives	1. ~~Ensure that children and young people are healthy and ready~~ for learning and education 2. Improve skills, good work and employment 3. Strengthen compassionate and healthy communities 4. Creating health promoting places	1. Improve mental health and wellbeing 2. Eat well and move more 3. Stop Smoking and Reduce Alcohol	1. Improve social mobility and tackling inequalities 2. Prevention and early intervention 3. Localisation and connecting with communities 4. Integration and working together

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

Early Years

- Most child health indicators are better than national average
- Many children have difficult living circumstances
  - 1 in 4 children do not achieve a good level of development at the end of Reception
  - 1 in 10 children are living in poverty
  - 1 in 200 children are in care
- Child health challenges are changing
  - Teenage pregnancy rates are decreasing
  - Obesity and mental health problems are increasing

Obesity

- Adult prevalence of overweight or obesity is similar to the national average in Swindon and Wiltshire. It is below the national average in BANES
  - BANES 55.4%, Swindon 66.1%, Wiltshire 63.9%
  - 578,000 people classified as obese across the system
- Swindon has the highest prevalence of children who are classified as overweight or obese
  - Reception: BANES 7.4%, Swindon 11.2%, Wiltshire 7.9%
  - Year 6: BANES no data, Swindon 36.1%, Wiltshire 31.6%

Smoking

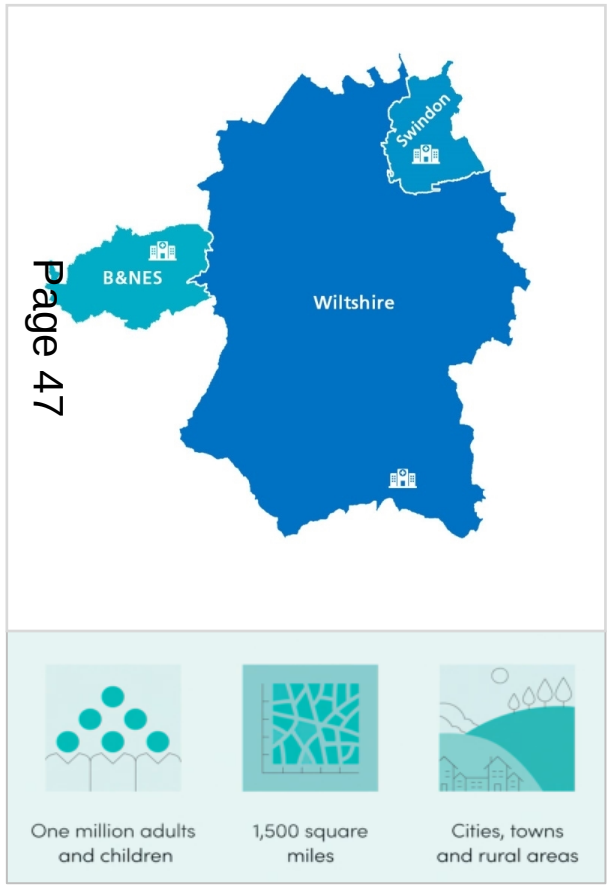
- Smoking prevalence is similar to national average of 13.9%
  - 13.0% BANES, 13.1% Swindon, 14.6% Wiltshire
  - There are an estimated 128,000 smokers across the system
- Routine and manual workers are two times more likely to smoke than managerial and professional ones.
- Social housing residents are four times as likely to smoke as homeowners

Mortality

- The primary causes of premature mortality in BSW are **cancer, cardiovascular disease, and respiratory disease**
- Lung cancer is the most common cause of cancer death in BSW, although lung cancer mortality rates are lower than the national average.

4.3 Challenges across BSW

Many of the challenges identified in individual JSNAs are shared across the whole system. These include the following:



Access to services

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

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

Inequality

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

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

The prevalence of many health conditions is higher for those living in less advantaged communities. Tackling this inequality is a priority for all our partner organisations.

An ageing population

The age profile of the BSW population is changing and this is going to place further pressure on health and care services. In Wiltshire alone, the 65+ population currentyl represents just over a fifth of the population but by 2040 this age group will make up nearly a third of the total population.

The cost of living

In 2022, annual inflation hit a 40 year high, with consumer price inflation at over 9%. This has had placed a significant amount more pressure on our communities and individuals through the increased cost of living. Higher bills for heating and food, for example, is likely to have had a detrimental impact on health and healthy behaviours across BSW.

Rurality

BSW has a high proportion of areas that are considered rural. Trusts operating in rural areas tend to treat older people than in urban areas. This is partly caused by the migration of young people away from rural areas. Frailty and complex comorbidities amongst elderly populations present major challenges to the delivery of care in rural settings – particularly in isolated, small communities.

Public health initiatives can also often fail to reach certain sections of the population in rural areas given their remoteness and sparsity. According to Public Health England, only 55% of rural households are based within 8km of a hospital compared to 97% of urban households

Children's health

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

- 1 in 4 children do not achieve a good level of development at the end of Reception
- 1 in 10 children are living in poverty
- 1 in 200 children are in care
- Obesity and mental health problems are increasing

Housing

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

4.4 Our assets

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

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

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

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

Above average health profile
Despite the challenges set out on the previous page, BSW benefits from having a positive health profile. On most public health indicators, ranging from life expectancy to infant mortality, our three places perform better than average for England.

High quality services
In BSW there are 2,800 Voluntary, Community and Social Enterprises, three Local Authorities, 88 GP practices, 26 Primary Care Networks, three public health and three social care teams, two community services providers, three acute hospital trusts, two mental health trusts, an ambulance trust and an Integrated Care Board (ICB).

A diverse and committed workforce
As partners we directly employ 37,600 colleagues. We have an outstanding health and care workforce, delivering high quality services across the ICP in all sectors.

The majority of these individuals are also supported by the services we provide.

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

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

5. What do we want to achieve?

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

In this section:

5.1 What we have heard

How have we engaged with organisations and residents

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

We have also benefited from the input and research of organisations working directly with residents. Again, for example, Healthwatch recently conducted research with the CQC into access to mental health services in BSW and this helped to establish why and how we must aim to improve access through this strategy.

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

January/February activity ongoing and to be completed later

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

Importantly, we want to do more. The publication of this strategy does not represent the end of its development. The strategy will evolve over the coming years as the health and care landscape changes. The final page of this document provides details of how you can get in touch with us to tell us your thoughts.

Some messages from the population of BSW

5.2 Explaining our vision

The Integrated Care Partnership has sought to develop a strategy that builds upon the public engagement undertaken, and priorities set, by the three places within BSW. There is strong consensus on what each place aims to achieve for its residents. This strategy sets out what any BSW resident can expect from their health and care services over the coming five years, setting out the priorities shared by each. How each place delivers on these priorities, however, may differ and is largely outside the scope of this strategy.

Public engagement

	Bath & North East Somerset	Swindon	Wiltshire
Health & Wellbeing Strategy Objectives	1. Ensure that children and young people are healthy and ready for learning and education 2. Improve skills, good work and employment 3. Strengthen compassionate and healthy communities 4. Creating health promoting places	1. Improve mental health and wellbeing 2. Eat well and move more 3. Stop Smoking and Reduce Alcohol	1. Improve social mobility and tackling inequalities 2. Prevention and early intervention 3. Localisation and connecting with communities 4. Integration and working together

The BSW Vision

Working and listening effectively together to improve health and wellbeing.

Delivered through prioritisation of three clear objectives:

STRATEGIC OBJECTIVE 1:
Focus on prevention and early intervention

STRATEGIC OBJECTIVE 2:
Fairer health outcomes

STRATEGIC OBJECTIVE 3:
Excellent health and care services

5.2 Explaining our vision

The BSW Vision

Working and listening together to improve health and wellbeing.

Working together

Our vision is for health and care organisations to work more effectively in partnership. We know that people are living longer with multiple, complex, long-term conditions, requiring long-term support from several different services. However, we have heard our residents have often received fragmented care from services that are not effectively co-ordinated around their needs.

We will therefore deliver joined-up support across our health and care services that better meets the needs of the population.

Listening together

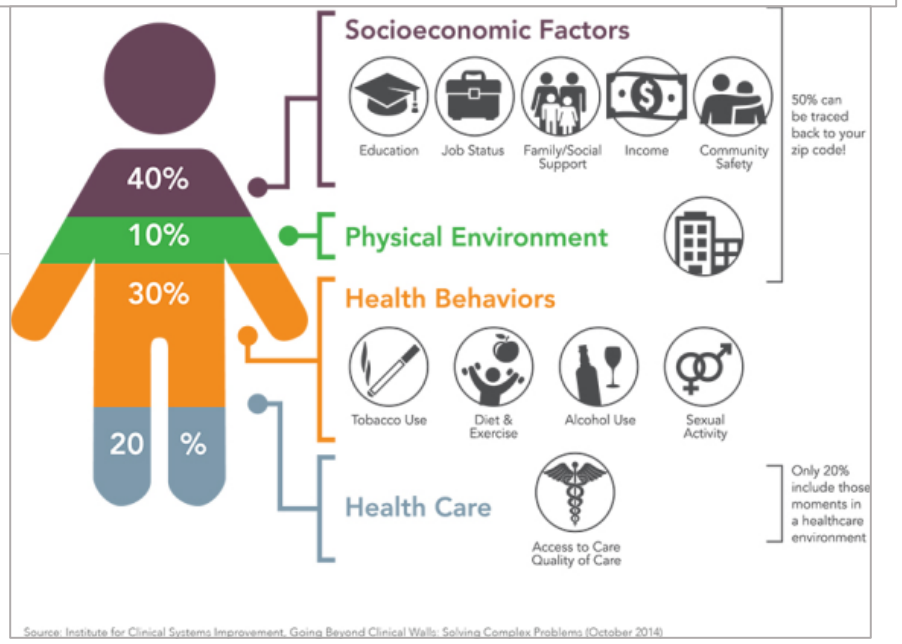
Partners across our Integrated Care Partnership are united in a belief that our future must be based on meaningful, ongoing engagement with local people. We want to ensure that residents are given opportunities to shape the plans, decisions, and public services that affect their lives, and believe that this can lead to positive outcomes for the communities we serve.

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

Improving health and wellbeing

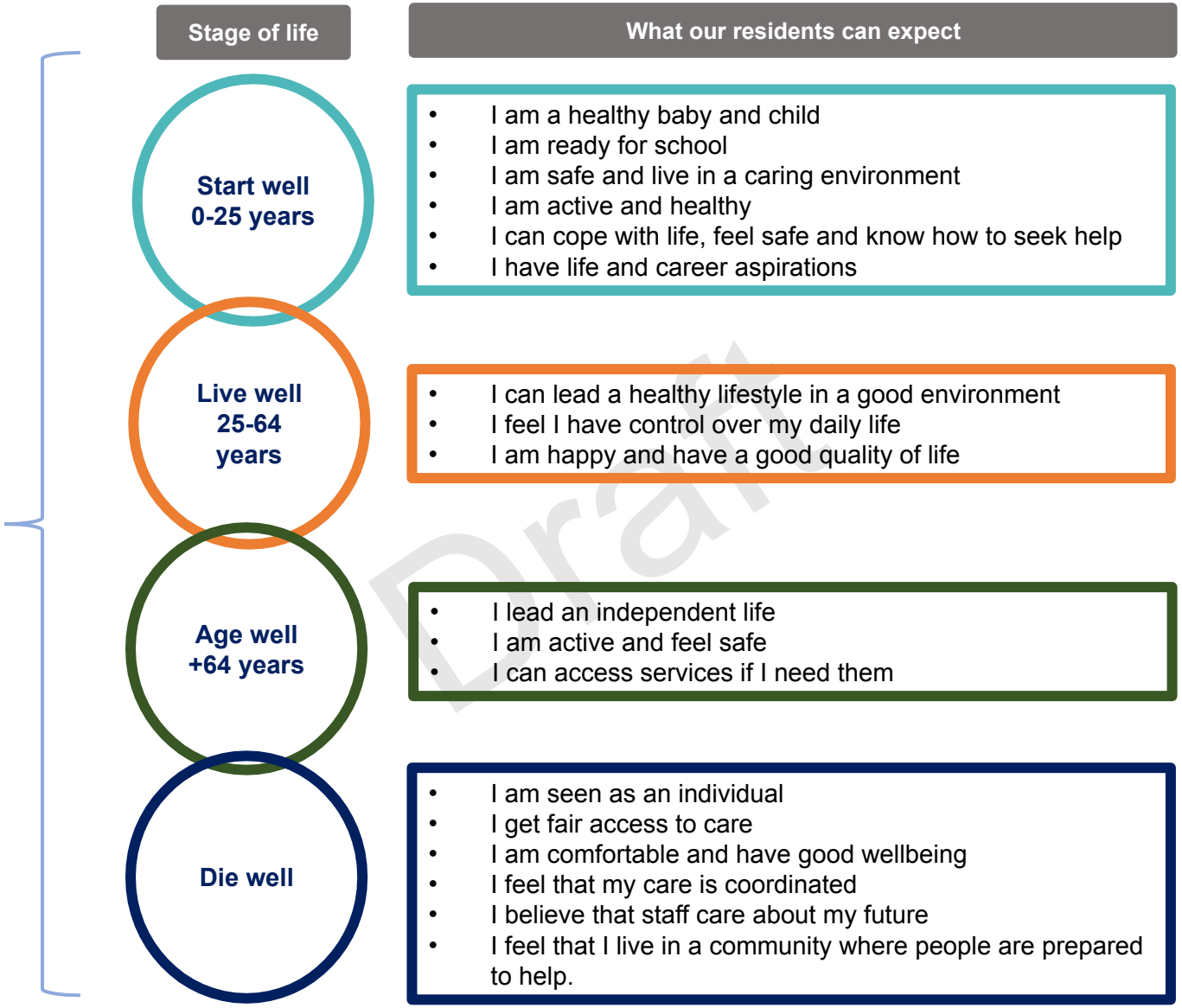
To make a significant difference in the health and wellbeing of the people of BSW, partners are agreed that we must focus on those things that impact most on health outcomes. These include the following four 'pillars of population' health, as identified by The King's Fund:

1. **The wider determinants of health** – the range of social factors such as income, education and employment which are the most important driver for health.
2. **Health behaviours and lifestyles** – covering behaviours such as smoking, alcohol consumption, diet and exercise which are the second most important driver for health.
3. **The healthcare we receive** – including whether we are able to access services and receive high-quality care
4. **Our environment** – the extent to which the environment we live in helps to support better health and wellbeing, for example through good air quality and green spaces, or hinder it



5.3 What achieving our vision will look like

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



5.4 Building on the BSW Care Model

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

The BSW Care Model is for:

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

Public engagement

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

5.4 Building on the BSW Care Model

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

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

1. **Personalised care**

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

2. **Healthier communities**

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

3. **Joined-up local teams**

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

4. **Local specialist services**

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

5. **Specialist centres**

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

5.5 STRATEGIC OBJECTIVE 1: Focus on prevention and early intervention

Why is this our objective?

The ageing population and growing number of people with long-term conditions is placing enormous strain on health and social care services. At the same time, organisations across health and care are facing constrained budgets, exacerbated by inflation. A key way to manage these dual pressures over the coming years is going to be keeping people healthier for longer and preventing them from becoming unwell.

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

Areas of focus

Primary prevention: Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.

Secondary prevention: Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.

Tertiary prevention: Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.

Wider determinants of health: These are the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces

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

5.5.1 Primary prevention

STRATEGIC OBJECTIVE 1:
Focus on prevention and early intervention

The challenge

Many (but not all) health conditions, both physical and mental, are preventable. We know that health and wellbeing can be adversely affected by an individual's lifestyle. The risk of cardiovascular disease, for example, can be reduced through healthy eating, while the risk of lung disease can be minimised through not smoking. Primary prevention also includes improving resistance to disease through immunisation, such as childhood vaccines. Our challenge is to ensure we are creating the right conditions and incentives for all BSW residents to stay healthy.

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

Wellbeing and mental health

Our approach

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

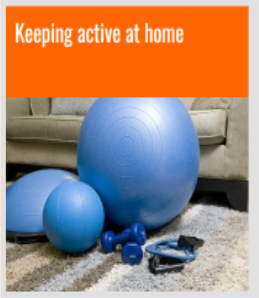
This includes creating opportunities for BSW residents to maintain their health through higher levels of physical activity.

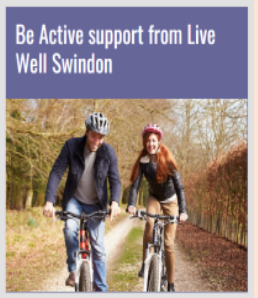
Our commitments

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

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

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





5.5.1 Primary prevention (continued)

Smoking

The challenge

Smoking is the single largest avoidable cause of death and social inequalities in terms of life expectancy in the UK. The impact of tobacco dependency on the health service is significant. According to Public Health England figures from 2017, the estimated annual cost to the NHS of treating smoking-related illness is £2.6bn. In primary care, smokers have a third more contacts with doctors and nurses than non-smokers.

Our approach

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

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

Our commitments

- ✓ We will further reduce the proportion of people in BSW who smoke
- ✓ All three acute providers will implement the Treating Tobacco Dependency Service

5.5.2 Secondary prevention

The challenge

While we will focus on primary prevention to keep people healthier and happier, we must also ensure that we are able to detect injury and disease as soon as possible. A focus on secondary prevention is needed to detect and treat disease prior to the appearance of any symptoms.

Our approach

[Awaiting input on screening, pre-emptive checks on hypertension etc.]

Our commitments

- ✓ Xxx

5.5.3 Tertiary prevention

STRATEGIC OBJECTIVE 1:
Focus on prevention and early intervention

The challenge

Over time, and with an ageing population, our residents will develop long-term conditions. Our challenge is to work with them to ensure that they stay as healthy as possible and do not develop further complications.

Our approach

We will support as best as possible our residents who have an ongoing illness or injury that has lasting effects. Below you can see the approach we are taking to ensure that Type 2 diabetes progression is slowed.

Our commitment

Care for long term conditions

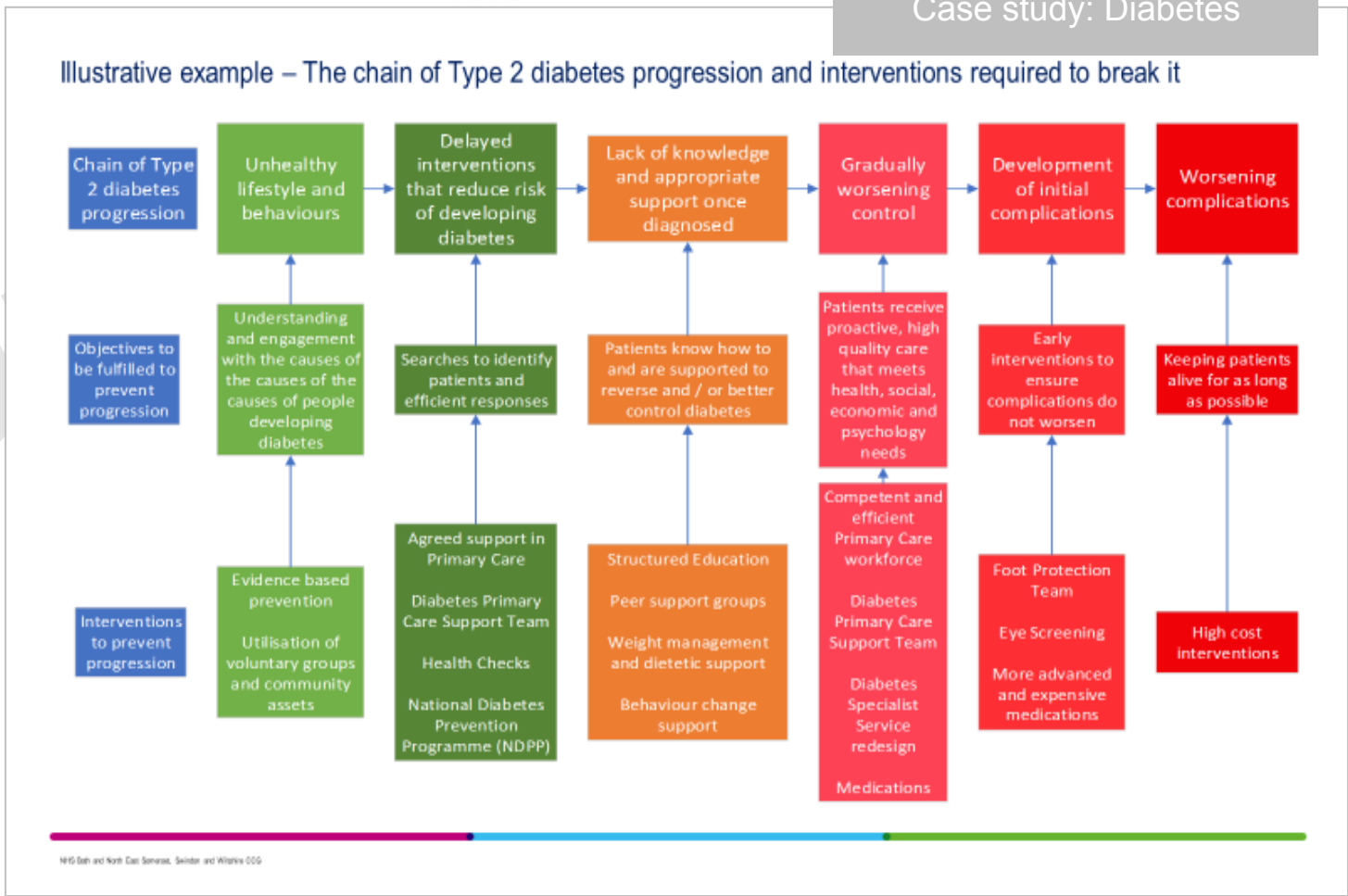
With an ageing population the prevalence of conditions like mental illness, cardiovascular disease, respiratory disease and diabetes is increasing across BSW. Our work on managing these conditions is designed to focus on three areas:

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

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

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

Case study: Diabetes



5.5.4 The wider determinants

There is a close link between poor housing and health and wellbeing

The challenge

There is now a wealth of research that demonstrates the intrinsic link between the community and environment we live in and our health behaviours, social relationships and networks.

How our communities shape our health in BSW has been revealed through our local authorities' joint strategic needs assessments (JSNAs). For example, the state of housing has a significant impact on both mental and physical health and the inequalities that exist within BSW. Improving the quality of housing across BSW is a priority for Local Authority and Housing Association partners and will have benefits in the health of local people.

Co-ordinated action is needed across NHS organisations, local authorities, the VCSE sector and others to address the wider determinants of health for people across BSW.

In **Wiltshire**, action is being taken to improve air quality for residents. Improving local air quality requires changes to be made by everyone. Working collaboratively with communities, Wiltshire Council is seeking to maintain the good air quality in the county and work to deliver improvements in areas where air quality fails national objectives in order to protect public health and the environment.

Our approach

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

Improve skills, good work and employment

Increased employment prospects and skill development can have a direct impact on people's health and wellbeing. Workplaces therefore have a critical role in supporting the physical and mental health of their employees. We set out how health and care organisations will best support staff in pages xx.

Housing

Input needed here

What else here?

Our commitments

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

- ✓ Increase green space, accessible for all to use
- ✓ Improve clean air, including by incentivising greener forms of travel
- ✓ Insulate the social housing stock, decreasing heating costs and improving number of housing associations.

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

5.6 STRATEGIC OBJECTIVE 2: Fairer health outcomes

Why is this our objective?

Health inequalities develop due to variations in the conditions in which we are born, grow, live, work and age; this means that not everyone has the same opportunities to be healthy. We are committed to delivering fairer health outcomes by reducing health inequalities and ensuring fairer health outcomes across BSW. Health Inequalities are defined as the systematic differences in health between groups of people. Differences in life expectancy, and health life expectancy, are one of the key measures of health inequality.

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

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

Areas of focus

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

[Feedback invited on whether Learning Disabilities & Autism could sit in this section?]

5.6.1 Adopting CORE20PLUS5

Our approach

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

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

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

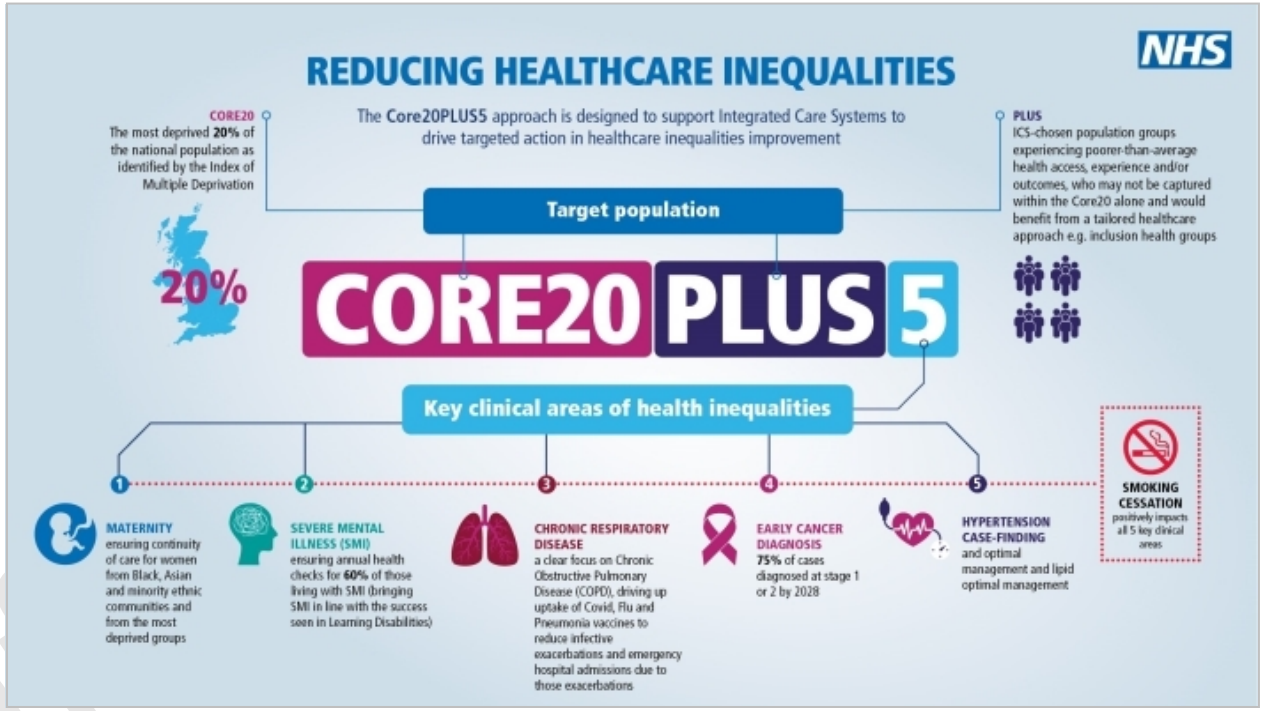
- **BaNES:** Socially excluded groups, migrants, vulnerable children, rural communities
- **Swindon**: People from ethnic minority backgrounds
- **Wiltshire**: Routine and manual workers (specifically those in minority groups) and Gypsy, Roma and boater communities

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

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

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

Our commitment is to implement a CORE20PLUS5 approach across BSW



5.6.2 A system-wide focus on reducing health inequalities

The challenge

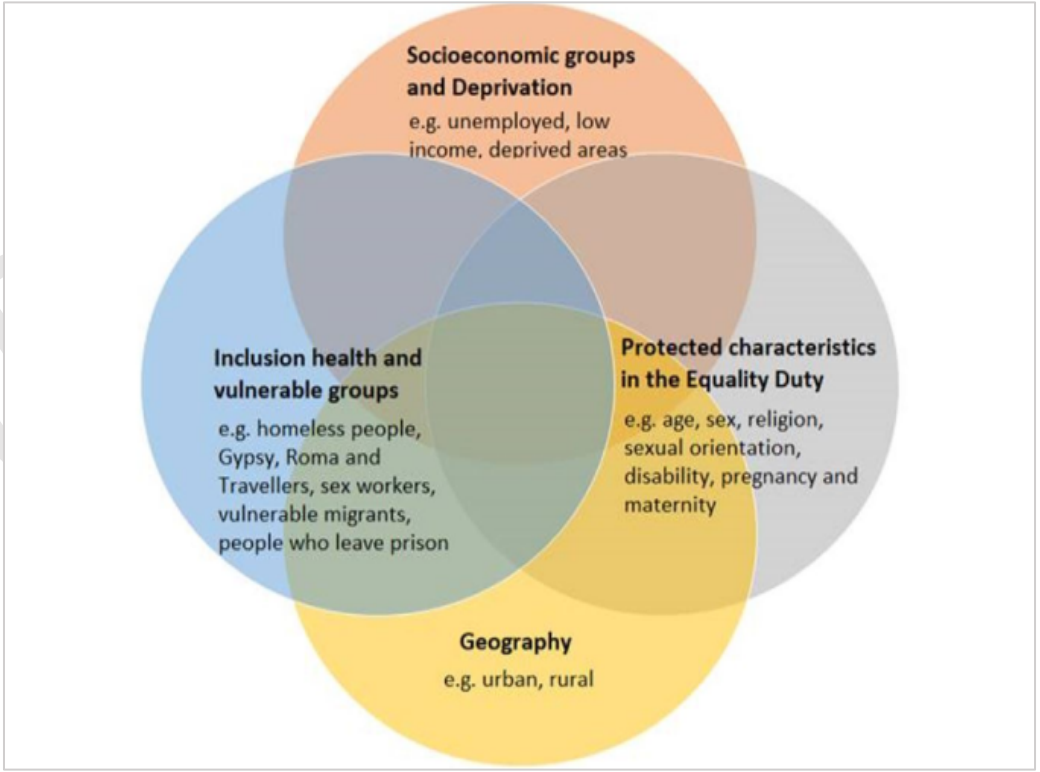
Inequalities across the BSW population arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health, and wellbeing. Health inequalities have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

Our approach

We plan to work in partnership to tackle inequalities across the life course to ensure that every resident can live longer, healthier, happier lives. Our Inequalities Strategy sets out how we will do this, including the commitments set out below.

Our commitments

- ✓ We will embed inequality as "everybody's business" across the system
- ✓ We will develop an inequalities 'hub' within BSW Academy to host learning and development resources.
- ✓ Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and set out clear plans on how close the inequality gaps
- ✓ Demonstrate action on inequalities that spans from system to place through joined up strategy and planning



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

5.7 STRATEGIC OBJECTIVE 3: Excellent health and care services

Why is this our objective?

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

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

Areas of focus

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

5.7.1 Personalised care

STRATEGIC OBJECTIVE 3:
Excellent health and care services

The challenge

Health and social care services deliver better outcomes for individuals when they feel that they feel they have the ability, tools and confidence to manage their own health and wellbeing.

Research from The Health Foundation, monitoring 9,000 people with long-term conditions, revealed that people who feel confident to manage their health have 18% fewer GP contacts and 38% fewer emergency admissions than people with less confidence.

Personalised care is based on 'what matters' to people and their individual strengths and needs. In BSW, we have put it at the heart of our Care Model and we will apply it to everything that we do in the future.

Our approach

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

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

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

5.7.1 Personalised care

STRATEGIC OBJECTIVE 3:
Excellent health and care services

Our commitments

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

1. **Shared decision making** to ensure that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

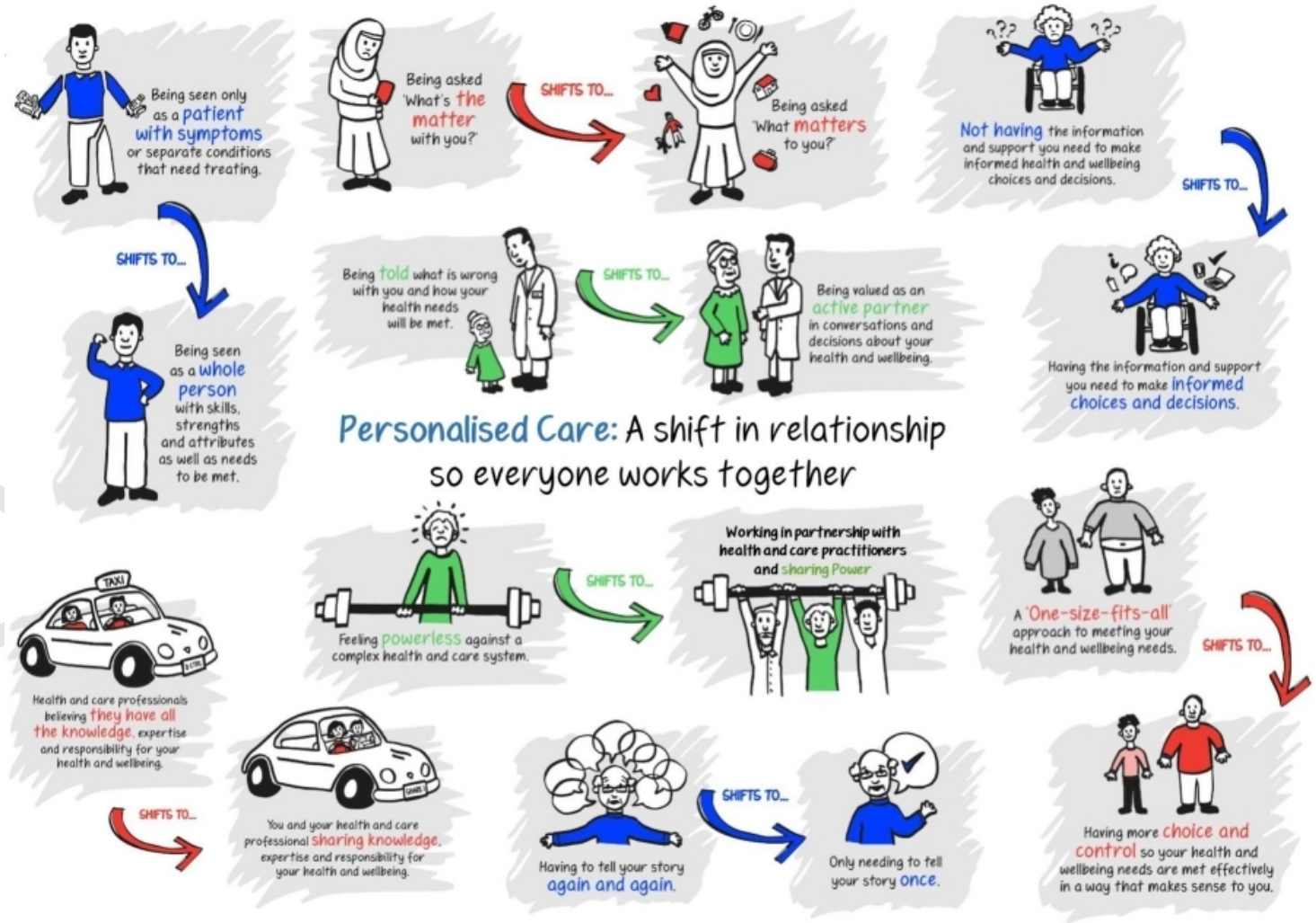
2. **Personalised care and support planning** to ensure facilitated conversations take place in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation.

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

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

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

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



5.7.2 Joined up local teams

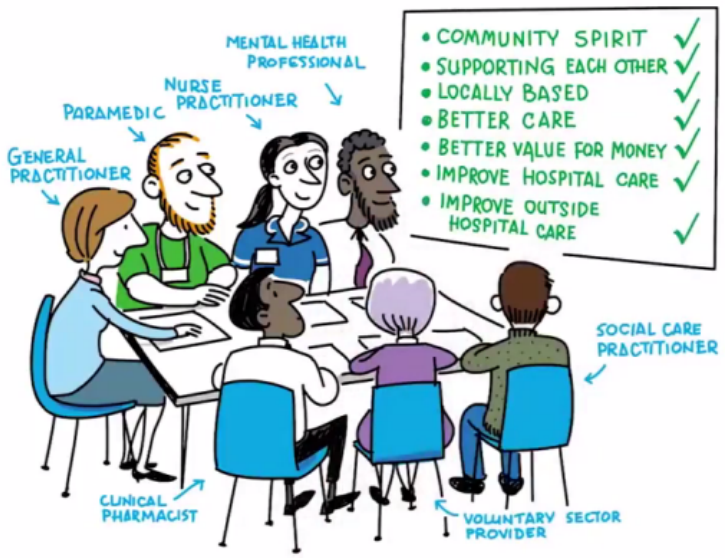
STRATEGIC OBJECTIVE 3:
Excellent health and care services

The challenge

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

We therefore want to implement local multidisciplinary teams (MDTs) that provide more joined up care and support, ideally in people's homes but if not then as close to them as possible.

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



Our approach

Building on the excellent primary and social care services we have across BSW, joined up local teams will have a critical role to play in providing both same day access for urgent care and continuity of care for individuals with long term conditions or complex care needs.

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

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

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

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

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

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

5.7.2 Joined up local teams

STRATEGIC OBJECTIVE 3:
Excellent health and care services

Our commitments

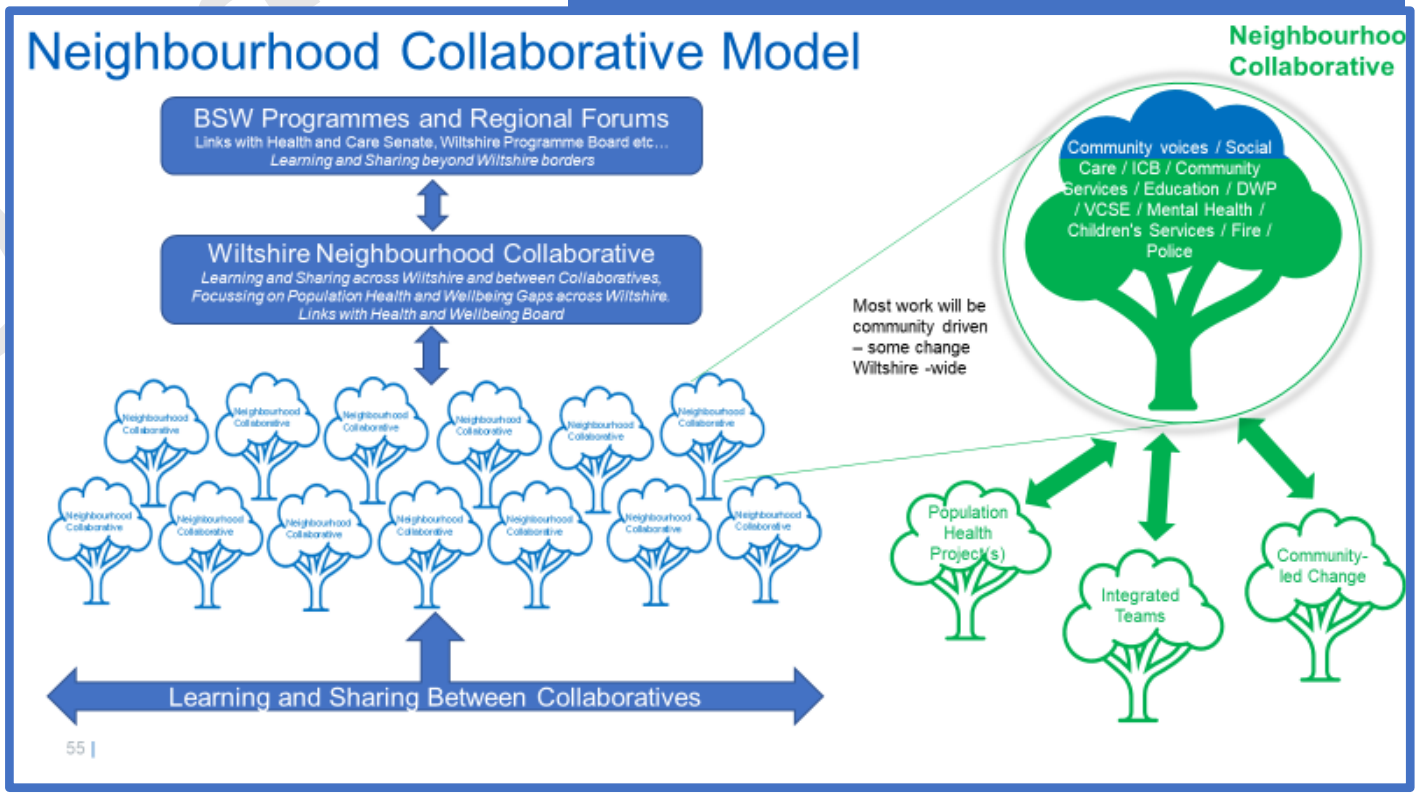
Across BSW, we will develop integrated, multidisciplinary teams that deliver health and care services around the needs of individuals.

These will include integrated teams at 'neighbourhood' level, which will will bring health and wellbeing services closer to those who struggle to access services due to disability and poor access to transport.

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

Case Study: Neighbourhood Collaboratives in Wiltshire

Work is underway in Wiltshire to develop a series of thirteen Neighbourhood Collaboratives. These collaboratives will bring together partners from a range of sectors to provide integrated support to the local populations across the County.



5.7.3 Responsive local specialist services

STRATEGIC OBJECTIVE 3:
Excellent health and care services

The challenge

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

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

Our approach

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

Work is already underway on a range of initiatives including:

i. Enhanced access to community diagnostic facilities
ii. The creation of virtual wards to enable access a range of specialist services without the need to spend as much or any, time in a hospital bed.

We address provide a summary of these initiatives over the next few pages.

Our commitments

i. Community diagnostic facilities

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

The initial work in 2023 on community diagnostic facilities will focus on the deployment of mobile units. From 2024 the focus will be on additional permanent facilities within BSW.

5.7.3 Responsive local specialist services

STRATEGIC OBJECTIVE 3:
Excellent health and care services

Our commitments

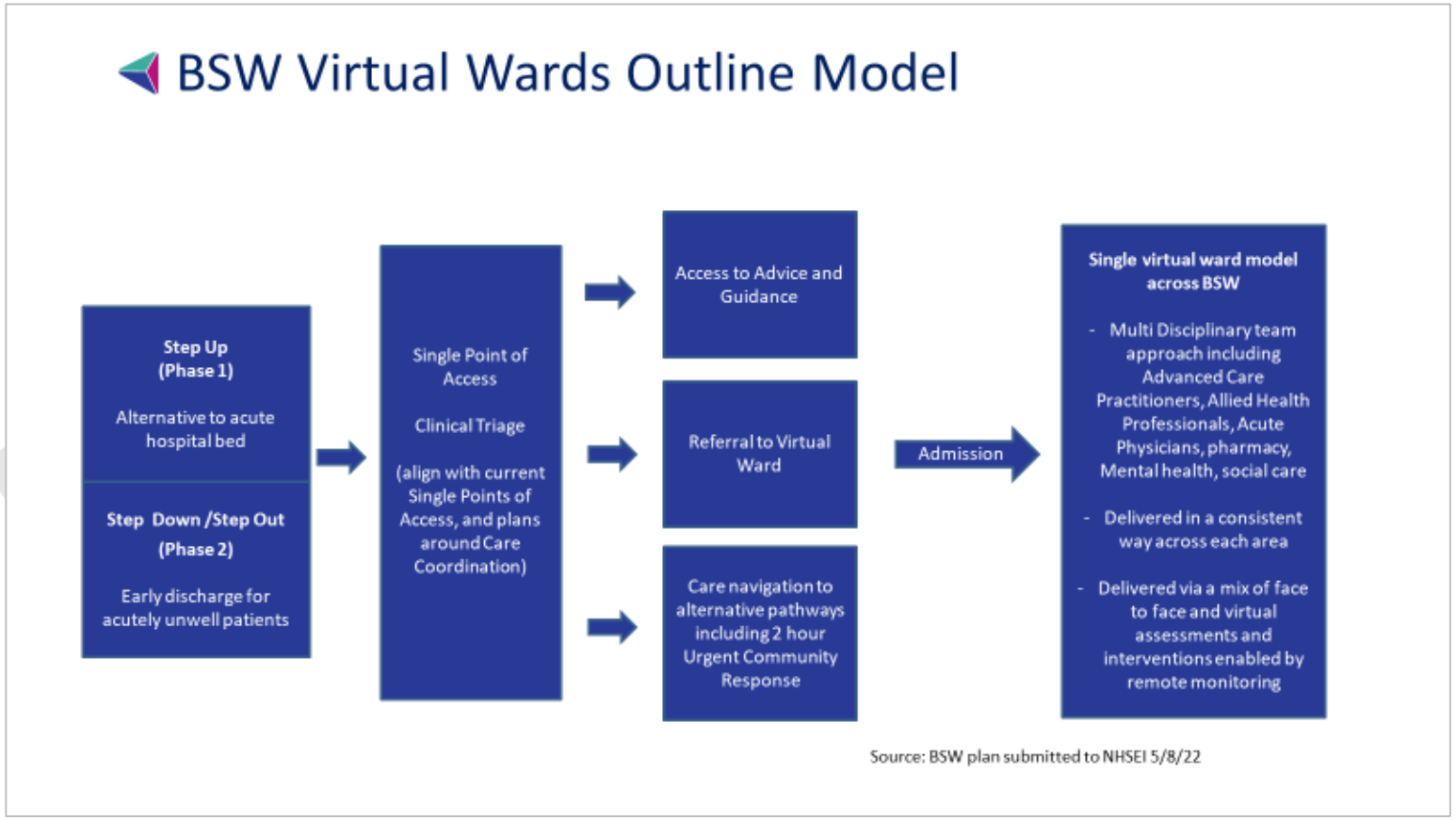
ii. Virtual wards

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

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

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

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



5.7.4 High quality specialist centres

STRATEGIC OBJECTIVE 3:
Excellent health and care services

Input required

The challenge

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

Our approach

Provider collaboration

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

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

Our commitments

- ✓ The AHA is developing a clinical strategy that will set out the role the hospitals will play in the delivery of urgent care services, the management of long-term conditions and how they can improve the quality and productivity of elective care services in areas like outpatients, diagnostics and surgery.
- ✓ The partners in the Acute Hospital Alliance are also working together on the development of facilities in the Sulis Hospital in Peasdown St John. This modern facility will play a critical role in reducing the waiting times for surgical procedures for the population of BSW
- ✓ Development and delivery of a Single Capital Priorities Plan
- ✓ Ensuring safe staffing levels across the AHA and delivering best in class patient outcomes.

What else can we say here on future commitments on provider collaboration?

Quality and improvement

It will be essential that partners across the system have a shared to commitment to ensuring robust oversight of the quality of care provided. In BSW we want to establish and nurture a culture of openness, learning and continuous improvement. Through quality assurance and improvement, we will deliver improvements in the quality of care, focussing on the areas our patients, service users, staff and regulators highlight as of concern.

Our commitments

- ✓ We will aim to maintain excellent standards of services and ensure that providers who are regulated by the CQC achieve a 'Good' or 'Outstanding' rating.

TBC Sub-headings needed on urgent and emergency care and elective backlog

5.7.5 Mental health and parity of esteem

STRATEGIC OBJECTIVE 3:
Excellent health and care services

The challenge

We know that mental health conditions have been rising across BSW. A summary of what this has looked like in each of BSW's three places was set out on page 9, with mental health worsening in each due to factors such as the Covid-19 pandemic and cost of living crisis. We also know that many individuals have struggled to access the support they need when they need it. We will therefore put improving mental health and the principle of 'parity of esteem' at the heart of our efforts to improve health and care services over the coming years (see below).

Our approach

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

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

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

Our commitments

- ✓ We will reduce the prevalence of mental health conditions
- ✓ We will ensure accessible, direct and flexible mental health and wellbeing support with a focus on de-escalation, prevention, intervention, post-intervention and complementary support based on the person's individual needs.
- ✓ We will improve access to Child and Adolescent Mental Health Services (CAMHS)
- ✓ We will increase the dementia diagnosis rate

6. What enablers will make progress sustainable?

This section sets out some of the system-level enablers that will help us to achieve the BSW Vision. It outlines how we will use our resources differently to improve integration, efficiency and sustainability.

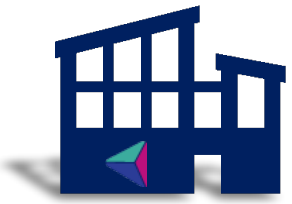
In this section:

6.1 Overview of enablers

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

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

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



Estates of the future
We will create high quality estate with seamless IT connectivity across locations, designed for maximum efficiency ensuring it is sustainable, of the right quality, capacity and in the right place, technological enabled.

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

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

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

6.2 Developing our workforce

INFO FOR THESE SLIDES TAKEN FROM STRATEGIC WORKFORCE PRIORITIES [JANUARY 2023] SLIDES FROM SARAH GREEN

The challenge

We have a highly skilled, dedicated and committed workforce across our ICP area. However, gaps in the health and social care workforce will be one of the key barriers to improving services in BSW over the coming years.

This a problem shared across the country, with over 130,000 vacancies in the NHS (representing 10%) of the workforce at the time of writing.

In social care, there are over 160,000 vacancies at the time of writing. The number of vacant posts increased nationally by 52% between 2020–21 and 2021–22 alone. This partly explains why it has been so difficult to discharge patients from hospital who have a social care need.

Organisations across BSW are experiencing severe challenge in the recruitment and retention of staff.

Do we have any system specific stats?

Our approach

Our priority is to improve both recruitment and retention of staff across BSW by creating a culture in which our workforce enjoy satisfying careers, feel valued and are able to make their best contribution.

We will do this by focusing on the following four ambitions, which will be set out in further detail in a **People Strategy** over the coming months.

Creating inclusive and compassionate work environments that enable people and organisations to work together

Making BSW an inspiring and great place to work

All staff feeling valued and having access to high quality development and careers

Using resources wisely to reduce duplication ,enhance efficiency and share learning

The next page sets out the commitments that BSW will commit to in order to deliver these ambitions.

6.2 Developing our workforce

INFO FOR THESE SLIDES TAKEN FROM STRATEGIC WORKFORCE PRIORITIES [JANUARY 2023] SLIDES FROM SARAH GREEN

Our commitments

BSW partners will…

Creating inclusive and compassionate work environments that enable people and organisations to work together	All staff feeling valued and having access to high quality development and careers	Making BSW an inspiring and great place to work	Using our resources wisely to reduce duplication ,enhance efficiency and share learning
Consistently implement the EDI actions for over hauling recruitment	Enable the same opportunities being available for bank staff	Increase the numbers of support workers	Address agency spend and increase numbers of bank staff
Coordinate a BSW model for succession planning and talent management	Develop BSW career pathways inclusive of both health and care	Create a BSW employer value proposition	Create development programmes through collective use of resource
Implement a BSW inclusive and compassionate leadership framework and development with a focus on both senior and middle managers	Increase awareness and access to staff health and wellbeing offers	Embed a collaborate international recruitment and integration model with a focus on hard to recruit roles	Share learning from patient safety initiatives
Equip all staff with quality improvement skills and tools	Provide career advice for early and late careers	Develop a mental health attraction strategy for reducing the vacancy gap	Horizon scan for innovative health and care workforce solutions
Develop education and training programmes focused on championing and improving equality, diversity and inclusion in the workforce with a focus on disabilities, race and ethnicity and LGBTQ	Develop a BSW offer for supporting and retaining support workers	Promote flexible working	Create a process for consistent evaluation to measure success and inform future use of resource
Improve relationships for working across organisations that brings benefit to staff	Implement skills, development and new roles that support new ways of working and providing care	Increase the focus on primary, social care and VSCE	Promote the conditions for improving efficiency
Adopt a cultural barometer with clear accountability	Focus on improving career progression for staff from under represented groups	Work with local schools and colleges for attracting and enabling new talent from our communities	
	Build high quality partnerships with colleges and universities	Review a BSW EAP offer	
	Improve access and uptake of apprenticeships with a focus on social care and known workforce gaps	Provide advice and support for staff who are carers	
		Develop a BSW housing solution	
		Promote the benefits of retire and return	
		Approve a new model of education that grows our own BSW workforce	

6.3 Digital and data

The challenge

To meet the current and future needs of our population, we need to make significant changes in the way we deliver services. Technology is an important enabler to make these changes. Digital solutions give us the potential to work differently, facilitating better, safer care and experience and more efficient and effective use of resources – both financial and time. No more so has this been demonstrated than through the BSW's response to COVID19.

Our approach

The BSW Digital Strategy describes our priorities and a summary of the associated work plan.

The Strategy will support our vision to empower people to lead their best life and the BSW Care Model. The digital solutions we have selected are anticipated to deliver care more effectively and efficiently, therefore contributing to the financial stability of services and the quality of care.

The organisations in BSW have committed through the Digital Board to deliver digital transformation as collaborative, system wide initiatives wherever feasible to maximise efficiency and effectiveness.

Our commitments

A key design principle of the BSW Digital Strategy is to avoid system proliferation and to aim for a simplification of the digital estate. To that end collaboration, shared working, joint roles and procurements will increasingly become the norm in order to maximise efficiencies of scale and to harmonise use of technology and systems by colleagues and the public we serve.

We have identified three strategic priorities in digital and data:

1. Information Sharing
2. development of our Digital Workforce via a portfolio of projects
3. Ensuring contemporary cyber security is in place

To achieve these three priorities, we will implement:

- ✓ **An Electronic Patient Record (EPR).** This is a critical building block to digital maturity for an organisation and provides massive opportunities for digital transformation in efficiency and improvements to care**.** The Acute Hospital Alliance is leading work to align patient records.

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

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

- ✓ **BSW shared services.** BSW partners will collaborate on procurements of new or replacement services where a single system wide product is appropriate.

6.4 Developing our Estate

The challenge

BSW has a mix of modern and old estate of varying ages and condition across the public sector where services are delivered.

Our challenge is to create a high quality estate (with seamless IT connectivity across locations) designed for maximum efficiency. Estate across the ICS must become flexible and provide sufficient access and capacity in the right place and at the right time.

As highlighted earlier in the strategy, the estate will need to be technologically enabled to support virtual consultations with consultants, GPs, and patients and support the delivery of some outpatient services in the community traditionally provided on a hospital site, which allow patients to access sophisticated diagnostics within community closer to their home.

Our approach

Our priority working with system partners in both health and the local authority to improve the estate, ensuring it is sustainable, of the right quality, capacity and in the right place, technological enabled to facilitate new and emerging models of care in the ICS.

Our estate will also meet the highest standards in sustainability with staff able to work across different locations, consolidating back-office functions and automating manual processes which will support changes in our future workforce.

We will do this by focusing on the following the key estate principles set out in the Estates Strategy on access, efficiency, performance, quality and standards.

Access – Ensuring our estate is in the right location and with good transport infrastructure and closer to communities to reduce inequity of access.

Performance – Operationally available when required, digitally enabled to support system working, well utilised and incorporate smart building management systems

Efficiency – The estate is fit for purpose, flexible, reduces our impact on the environment, and represent excellent value for money by using resources well

Quality and Standards – Reducing unwarranted variations, new buildings following modern methods of construction, future proofed in design to provide flexibility

The next page sets out the commitments that BSW will commit to in order to deliver these ambitions.

6.4 Developing our Estate

Our commitments

BSW partners will…

Access – Ensuring our estate is in the right location, designed well and with good transport infrastructure closer to communities to reduce inequity of access.	**Efficiency** –The estate is fit for purpose, flexible, reduces our impact on the environment, and represent excellent value for money by using resources well	**Performance** – Operationally available when required, digitally enabled to support system working, well utilised and incorporate smart building management systems	**Quality and Standards** – Reducing unwarranted variations new buildings following modern methods of construction, future proofed in design to provide flexibility
Have buildings that supports different types of service delivery both face to face and digitally enabled.	Ensure spaces are fit for purpose, flexible and support delivery of a range of health and care services now and in the future	Ensure all buildings where needed operational can open 7 days a week between the hours of 7am – 10pm as a minimum to maximise flexibility	Develop common standards and processes across the estate to reduce unwarranted variations in estate management and delivery of support services e.g. cleaning and catering.
Work together to delivery estate solutions the maximises the opportunities for greater integration of services.	Develop zoning of buildings to enable sections to be opened up and closed off at different times to support better use of the estate during different hours of operation or different use requirements.	Ensure the buildings incorporate digital technology to support integration and adapt easily as new innovations become available.	Support local public health preventing initiations to consider opportunities to incorporate community gardens to support local communities
Work together to ensure our building are well linked to new and existing communities to ensure suitable walking and cycling routes as well as public transport links to our premises.	Our buildings will be sustainable and support delivery of net zero carbon.	Look to develop arrangements to maximise the use by all partners so we have the right mix of dedicated and bookable space.	Develop new facilities in the community to support training and flexible meeting rooms that can support group activity and shared learning
Have an estate that can be used by local communities and voluntary sector to support the health and care needs of the local population including prevention initiatives.	Ensure the estate provides value for money by maximising the use of the existing public sector estate where possible, including clinical, care and administrative areas.	Implement a booking system to support maximum use of the estate to improve the efficiency and provide accurate data for future decisions.	Have an estate that is flexible, sustainable and easily adapted to changes in the future delivery of health and care.
Work closely across our area to support delivery of services at the right place.	Data driven and evidence based to help drive investments and cut costs in the estate	Ensure all new buildings or those that are significantly refurbished incorporate clever technology including building management systems to improve efficiency and reduce costs.	Ensure that new building designs for health care settings meets the latest standards and deliver modern methods of construction

6.5 Financial sustainability £

The challenge

Nationally and within BSW, local authorities are facing financial pressures in Adult and Children's Social Care, Public Health and the broader services that impact health and wellbeing outcomes.

At the same time NHS and VCSE services also face activity, workforce and financial challenges. It is evident that as a system we need absolute focus on system transformation and efficiency.

We will need to work together on system level responses where possible.

Our approach

Our system ambition is to achieve Best Value for Money, making effective use of resources together to ensure a financially sustainable health and care.

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

There is a broad consensus that to achieve high-quality, sustainable health and care services that can meet the changing needs of the population, there will need to be a radical shift in the focus of care from hospital to preventative community health services. We are clear that achieving this shift in BSW over the coming years will help us both to deliver better outcomes for patients and long-term financial savings.

Our commitments

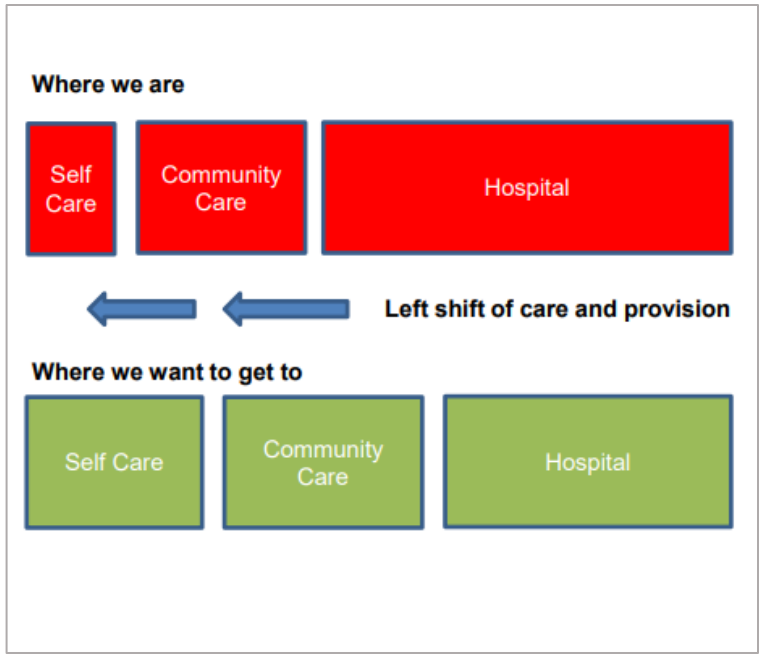
Xxx

Input needed.

Currently missing capital and local government perspective.

Key messages – how we use funding today and what do we want to be different in future? A focus on how we can shift resources into prevention

To be consulted: Gary Henege & Local Authority Partners



6.6 Environmental sustainability

The challenge

Climate change threatens the foundations of good health, with direct and immediate consequences for individuals, our infrastructure and public services. We are already facing significant increases in the intensity of heatwaves, more frequent storms and flooding and increased spread of infectious diseases such as tick-borne encephalitis and vibriosis.

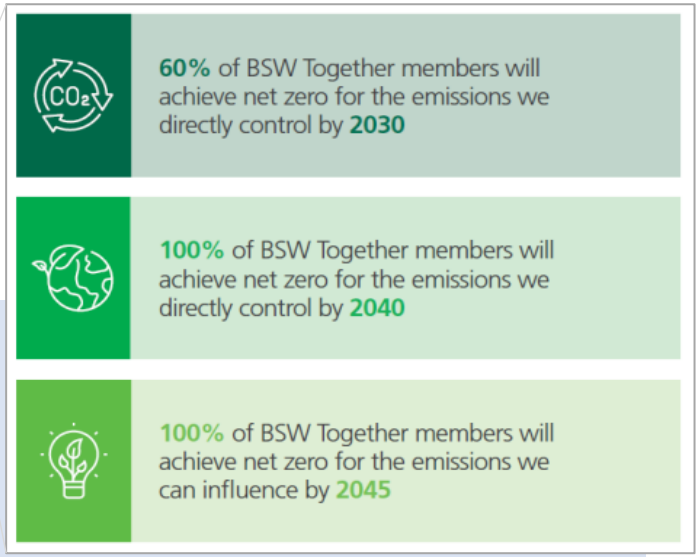
Collective action is required across the system. If we fail to take coordinated action on climate change, then we are failing to address the biggest health risk that we face as a society.

Our approach

BSW is committed to playing its part in tackling climate change. As an integrated care system we have come together to develop and agree an ambitious and cocreated system-wide vision and set of commitments to begin our journey towards delivering net zero health and care services in BSW. This is outlined in our Green Plan [2022-25].

The plan 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.

Key commitments, BSW Green Plan [2022-25]



Our commitments

BSW has made a series of system wide commitments to improve our environmental sustainability over the coming years. These are aligned to the following focus areas:

- Sustainable care model
- Workforce and leadership
- Estates and facilities
- Travel and transport
- Supply chain and procurement
- Medicines management
- Digital transformation
- Adaptation
- Food and nutrition

Delivery of our commitments is supported through a work plan, which outlines key actions for the system to undertake. A selection of actions for delivery in the near future by our partners (within the scope of the Green Plan requirements) are detailed below:

✓ Board-level lead identified at organisational and ICS level
✓ Integrated Care Board to undertake sustainability training
✓ Partners switch to 100% renewable suppliers
✓ NHS Trusts signed up to clean air hospital framework
✓ All BSW partners will include 10% social value weighting in all procurement tenders
✓ All NHS Trusts to reduce use of desflurane in surgical procedures to <5%
✓ Climate change included as key strategic risk on corporate risk registers and business continuity plans

Note that additional actions for delivery over the coming years are outlined in the BSW Green Plan [2022-25].

6.7 Our role as Anchor Institutions

The challenge

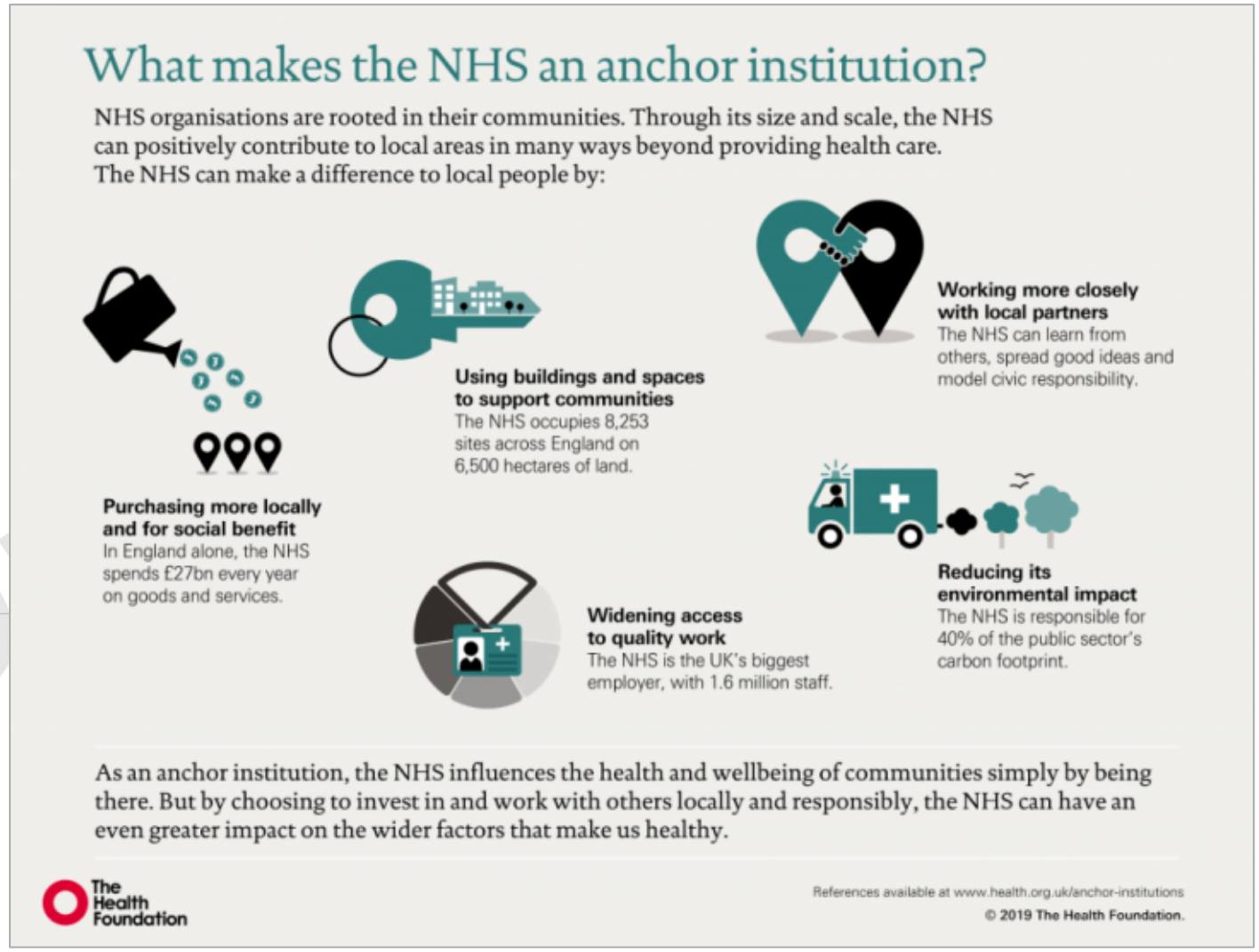
We have seen widening inequalities and increasing pressures on public services in recent years, both of which have been exacerbated by the COVID-19 pandemic. However, there is growing evidence about how anchor institutions can help to advance the welfare of the populations they serve.

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

Our approach

One of the purposes of ICSs is to support broader social and economic development, and we intend to take seriously this purpose over the coming years.

While our work on making health and care organisations anchor institutions is in its early stages, we will look to use the approaches outlined in the diagram on the right to ensure that we are harnessing the power



6.7 Our role as Anchor Institutions

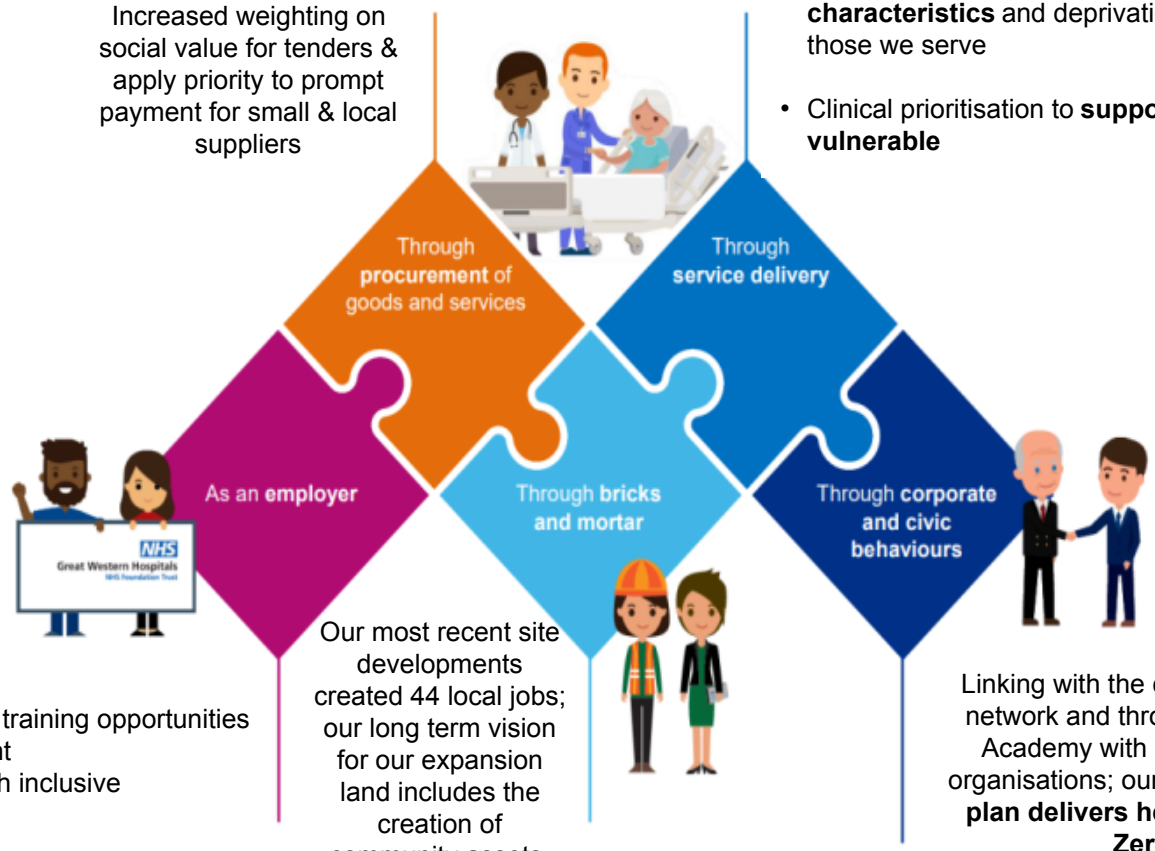
Our commitment

We will form anchor institutions across BSW as a lever to support change in the wider determinants of health.

The case study on the right shows what being an anchor institution means to Great Western Hospital, and how this will help to create jobs, forge closer links with other civic organisations and improve its carbon footprint.

Case study: Great Western Hospital

The five areas where we can make a difference as an anchor institution



- Use data to ensure we accurately understand the **protected characteristics** and deprivation profile of those we serve
- Clinical prioritisation to **support the most vulnerable**

- Expand volunteer workforce
- Use apprenticeships to maximise training opportunities
- Support refugees into employment
- Provide the SEND community with inclusive opportunities

Our most recent site developments created 44 local jobs; our long term vision for our expansion land includes the creation of community assets.

Linking with the civic university network and through the BSW Academy with other anchor organisations; our **sustainability plan delivers health and Net Zero**

7. What happens next?

This section summarises what will happen following the publication of this strategy and how we plan to continue to engage with BSW residents on our strategic vision, with consensus across system partners that this document represents the start and not the end of our engagement journey with the communities we serve.

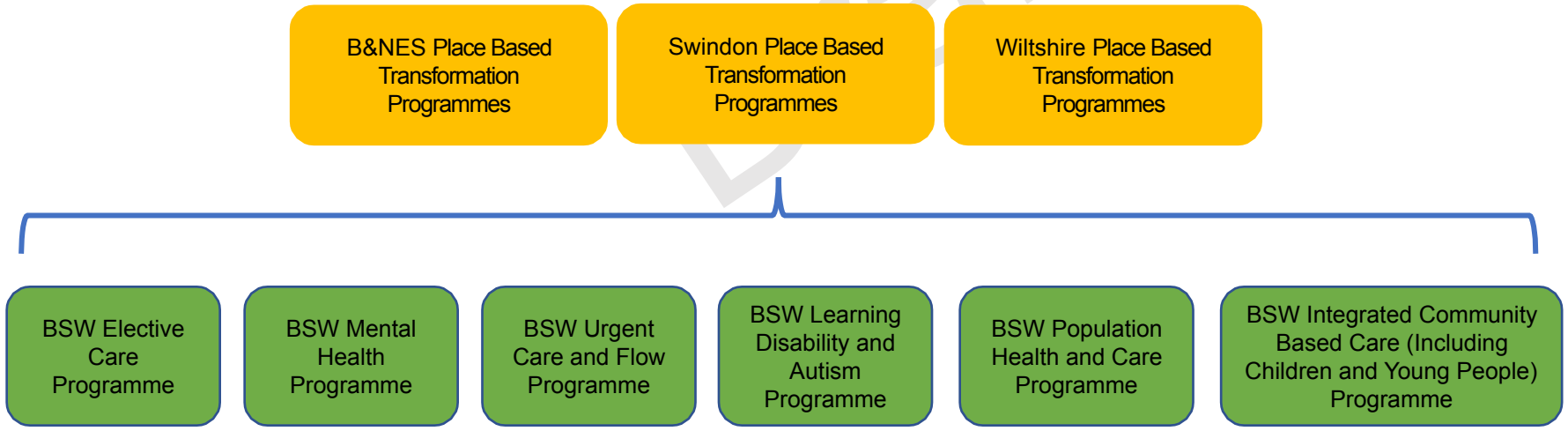
In this section:

7.1 Transformation Programmes

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

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

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



7.2 Delivering through our Implementation Plan

Overview

Our strategy brings together the ambitions of the three places and strategy documents for specific areas of health and care our system. Each of these strategies, either at a Place or System level, set out a range of priorities and areas of change and improvement for our population.

We are clear that we need to continue working with partners and communities across BSW to demonstrate how we are progressing the ambitions of strategies at both Place and System levels.

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

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

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

The plan will reach across all partners rather than solely the NHS. The Implementation Plan should be considered alongside the Strategy.

The Plan will set out key milestones and deliverables from the constituent strategies that make up the body of what we want to deliver through our Integrated Care Strategy. This will not be an exhaustive list of all the milestones and deliverables in those strategies but, instead, the key ones that demonstrate our integrated partnership approach.

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

Bath and North East Somerset,
Swindon and Wiltshire Together

7.3 Have your say

We invite residents and partners across B&NES, Swindon and Wiltshire to discuss this strategy and we intend to gather feedback as part of our ongoing engagement with stakeholders over the coming years. The publication date for this document is xx. However, our approach and strategic objectives will continue to evolve as we engage further with BSW residents and respond to the changing needs of the local population.

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

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

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Hearing and Vision Team - Focus on Support for People with Visual Impairments

Emma Townsend
Head of Living Well
28th Feb 2023

Wiltshire Council

Prevalence of Visual Impairment in Wiltshire

Prevalence data from IPC, Oxford Brookes University					
	2020	2025	2030	2035	2040
People aged 18-64 predicted to have a serious VI	189	190	189	187	186
People aged 65-74 predicted to have a moderate or severe VI	3,259	3,321	3,802	4,155	4,077
People aged 75 and over predicted to have a moderate or severe VI	6,423	7,787	8,593	9,498	10,751
Age related macular degeneration is the most common cause of registerable sight loss in older people.					
Wiltshire Council Sight Registers Data					
Severely Sight Impairment	2939				
Sight Impairment	2960				
Child – Visual Impairment	94				

The Hearing and Vision Team

The Hearing and Vision Team is a small county-wide specialist team of staff who work across a range of sensory loss areas:

- Team Manager
- Administrator
- Deaf community (dedicated social worker for Deaf people)
- People with Hearing Impairment
- **People with Visual Impairments**
- People with Dual Sensory Loss

Dual Sensory Work

Dual Sensory Specialists have specialist communication skills

Most deafblind people in Wiltshire have acquired their dual sensory loss as a result of the ageing process.

The dual sensory assessment may identify the need for specialist one-to-one support such as a **Communicator Guide or Intervenor**.

The Care Act has a specific section in relation to local authorities' duties towards people who are deafblind:

- We must ensure that an expert is involved in the assessment of adults who are deafblind, and the Care Act describes the level of training that the specialist assessor must have.

- The Care Act provides detail on how the assessment should be undertaken; what it needs to consider in relation to a person's specific sensory needs when they have a dual diagnosis; and who to involve (interpreter etc).

- Any care and support put in place to meet eligible assessed needs has to be appropriate and able to meet those needs.

Hard of Hearing/Support for Deaf community

We are currently reviewing this aspect of our work

- **Rehabilitation Officers with Hearing Impaired People (ROHIs) who:**

  - Give information, advice and support with hearing loss; assessment and provision of specialist equipment, for example to help with hearing around the home like smoke alarms, doorbell, telephone or television, or adaption of current equipment/environment to suit.

- **Specialist Social Worker with Deaf People who can support:**

  - People who are Deaf and whose first language is British Sign Language (BSL)

  - Assessment of care and support needs and mental capacity assessments, and acting as Investigating Officer in safeguarding enquiries

  - Provide a range of drop-in sessions with our specialist social worker for Deaf people across the county each month and are accessible via WhatsApp for referrals and enquiries

Visual Impairment Registrations

- The Care Act gives us a specific responsibility to hold registers for people who are Sight Impaired (SI) and Severely Sight Impaired (SSI)
- Once the team has received the required documentation (copy of their certificate of visual impairment as Severely Sight or Sight Impaired), we are required by the Care Act to make contact within 14 days to discuss registration and to offer an assessment by ROVI
- Only an assessment by an Ophthalmologist can determine if person meets the criteria for SI or SSI registration. The team has a good working relationship with the Ophthalmology departments within our hospitals.
- The team also hold the children's CVIs.

What is a ROVI (Rehabilitation Officer for Visually Impaired)

A ROVI is a specialist professional, qualified to assess and train people to gain the skills they need after losing sight/being diagnosed with sight loss, examples:

- safely preparing and cooking food
- navigating environments (inside and outside the home)

This service is specifically described in the Care Act 2014 as a means of local authorities meeting their preventative and enabling duties. The Care Act describes that, as aspects of independence training with sight impaired people require careful risk management, it should only be undertaken by professionals with relevant experience and training. It also describes it as being distinct from reablement, for example, it should be provided to the person for a period appropriate to meet their needs, rather than limited to 4-6 weeks.

The Rehabilitation Workers Professional Network (RWPN) established a register of qualified practitioners in 2019 - this register has now been accredited by the Professional Standards Agency – they estimate only about 500 ROVIs across the country

Also renaming the role to Vision Rehabilitation Workers

Current demand and performance

- We have a small team of 3.65 staff, 2 of which have taken maternity leave over the past 2 years
- Waiting list grew over COVID as many people requested to delay their assessment and/or rehabilitation (had family support, not going out, felt vulnerable etc)
- September saw the team being back to full complement of staff, starting to show an impact on the waiting list

Impact and Outcomes

1. A is registered as Severely Sight Impaired with light perception only. Her relationship has broken down and she is needing to learn to live and parent independently. ROVI has extensively supported her to:

- Access voice over on her mobile phone to enable her to communicate independently
- Direct Payment for a Personal Assistant to support her with reading, shopping and activities outside of the home.
- Supported to develop independence in daily living tasks her such as using washing machine & dryer
- Further work on independent mobility planned for the future once she has gained more confidence getting out and about with her PA.

2. B is a transition case; she has complex needs as well as registered Sight impaired. ROVI has supported her with:

- Extensive daily living skills in the home for example, to regularly prepare & cook her own meals
- Ongoing mobility training, she is now using her long cane when out in the community which is aiding her confidence and independence.
- ROVI support has played an important part in her moving over into Adult Services.
- All the skills LW is learning will help aid her move into independent living in the future.

Areas of development

- Action plan developed to address individuals waiting including development of Lead role and implementation of practice standards for allocation and consideration of Apprenticeship route to fill vacancy
- Working with the Fire Service - Safe and Well visits
- Developing closer working relationships with Wiltshire Sight – ensure there's no duplication and we are working effectively together
- Developing closer working relationship with Children's services re transition
- Monitoring performance through monthly Performance Outcomes Group
- Review of the services we provide to people who are Deaf and hard of hearing

Wiltshire Council

Health Select Committee

28 February 2023

Health Select Committee inquiry session: System-wide review of factors contributing to current pressures in urgent care

Purpose

1. To present a draft programme (Appendix 1) for committee discussion on an inquiry session to review the factors contributing to the extreme pressures currently being experienced and reported in urgent care. The session will also consider the systemic challenges impacting on patient flow through acute hospitals used by Wiltshire residents.

2. Further work will be done on the proposal in consultation with officers and ICB.

Background

3. In July 2022, the Committee resolved to have an inquiry session looking at this topic and in November 2022 asked for a report to come to the Committee in January 2023 setting out a more detailed proposal. This proposal was approved and the Committee requested that the arrangements should be developed further in consultation with the Chair and Vice-Chair of the Committee and reported back to the Committee in February.

Terms of Reference for the inquiry

4. The Committee will seek to understand the following:
   a) What factors are contributing to the increased demand for urgent care delivered through Acute Hospitals?
   b) What preventative strategies and services could reduce hospital acute care demand and are these in place in Wiltshire?
   c) What is the role of primary care and is there sufficient capacity in terms of GPs in the community?
   d) The most serious emergencies require rapid access to highly specialised skills and equipment. Many less serious cases can be treated safely in community settings, meaning patients do not need to go to hospital. Do we have the resources or a plan to deliver urgent care in community settings at home, and in care homes?
   e) What are patients' priorities when accessing urgent care, and are these understood in the design of urgent care in Wiltshire?

f) What principles should underpin the design of urgent and emergency care, as well as the key components?
g) The NHS management approach to the challenges appears largely reactive, with 90% of any management time addressing current urgent situations. Does the lack of focus on admission avoidance and prevention impact the system's ability to change?
h) Is there an unintended consequence of the No Criteria to reside (NCTR) policy in hospitals and does this drive early discharge and people leaving with complex needs? The NCTR policy was introduced in August 2020 as part of the 'Hospital Discharge Service Policy and Operating Model' to 'ensure that all individuals are discharged from hospital in a safe, appropriate and timely way' NHS England.
i) Do we have sufficient care home and domiciliary care capacity? If not, why and what are we doing about it?
j) To understand the data around ambulance transits in Wiltshire and explore whether ambulance transits could be reduced?

Stakeholder invitees

- Healthwatch Wiltshire
- Director Ageing and Living Well, Wiltshire Council
- Corporate Director People, Wiltshire Council
- Cabinet Member Social Care, SEND and Inclusion, Wiltshire Council
- Head of resources commissioning/ Director of Commissioning and Procurement, Wiltshire Council
- Chief Executive Wiltshire Health and Care
- Chief Executive Wiltshire Care Partnership
- Carers Support Wiltshire
- Age UK Banes and Wiltshire
- Bath and North East Somerset, Swindon and Wiltshire (BSW Integrated Care Board (ICB) Place Director for Wiltshire
- ICB Director of Commissioning for Wiltshire
- Director of Urgent Care BSW
- Chief Executive leads of urgent care each acute trust Salisbury Foundation Trust, Royal United Hospital and Great Western Hospital
- Dorothy House
- Director of Public Health Wiltshire
- GP representative Dr Nick Ware
- Primary Care representative, BSW ICB
- South West Ambulance Service (SWAST) representative
- CEO Medvivo (providing GP out of hours services in Wiltshire)
- Director of urgent care BSW
- Avon and Wiltshire Mental Health Partnership (AWP) representative

Evidence and Timescale

5. The evidence for the inquiry could include:

   a) Data and analysis on demand, activity, variation on standard service and outcomes from urgent care pathways from health and social care.

   b) Anonymised stories of 4 people who have experienced the urgent care system in Wiltshire, what led to the need, what happened, and what was the outcome for them and their family. Stories would be selected by a small panel of people to include service users to demonstrate the majority range of issues, rather than those issues which are an exception. Patient stories to include themes
      - Carer breakdown
      - End of life urgent care
      - Falls
      - Dementia and complex mental health.

   c) Wiltshire benchmark performance on urgent care against similar Counties and nationally.

Proposal

6. Health Select Committee to hold an inquiry session as set out in the programme in Appendix 1.

Report authors:

Julie Bielby, Senior Scrutiny Officer, Wiltshire Council, julie.bielby@wiltshire.gov.uk

Report date:

22 February 2023

Appendices

Appendix 1- Inquiry session programme on demands on hospitals and urgent care

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Appendix 1 - Patient Flow Inquiry Session – Draft Programme

Time	Agenda item	Who
10.00	Welcome and introduction to the Session Run through the agenda and explain how the session will run.	Chair
10.10	Setting the Scene – Presenting the key points of the factsheet[1] **Challenges being experienced with patient flow through hospitals.** • Flow performance for each of the 3 hospitals serving Wiltshire and overall for Wiltshire against national average and similar areas -benchmarking • Delays for each type of hospital discharge per Trust • Brokerage performance • Diagram of community support services for urgent care • Number and type of admissions form care homes • Analysis of admissions which could have been avoided - 1. admissions of under 2 days duration 2. non injurious falls 3. social care / carer breakdown 4. conditions which could be treated in community	Lucy Townsend (WC) Fiona Slevin-Brown (BSW ICB)
10:30	Session 1 **What factors are contributing to the increased demand for urgent care delivered through acute hospitals?** **Using case studies[2] as prompts for discussion.** • Attendees split into groups (attendees given table number before session or at beginning of session) • Group discussion led by facilitator • Make note of key points for feedback • Facilitator responsible for submitting notes at end of session • Group agrees who will feedback	All
10:50	Feedback from Session 1	Designated person from each table
11:20	BREAK	
11:40	**Session 2** **For those individuals who needed to be admitted into hospital for emergency care, what processes and services would**	All

	enable them to return home and as soon as possible and are those in place in Wiltshire? • Group discussion led by facilitator • Make note of key points • Facilitator responsible for collating feedback at end of session • Agree who will feedback	
12:10	**Feedback from Session 2**	Designated Person
12:40	**What will happen with the information?** A Second session to review follow up/action plan may be needed. HSC to take forward priority actions	Chair
13:00	**Thank everyone for participation** **Session ends**	Chair

[1]The factsheet would be circulated to attendees before the Inquiry Session

[2]Wiltshire Stories and case studies -urgent and emergency care

To aid discussion for participants who are unfamiliar with the health and social care, examples will be provided to illustrate circumstances that

- lead to people needing emergency care. As well as,
- support packages that have worked to prevent the need for urgent care.

The stories illustrate scenarios which have taken place in Wiltshire over the last 12 months. The names will have been altered but depict real life situations on the following themes:

- Falls and dementia
- End of life care
- Carer breakdown
- Complex mental health