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

Engagement Draft BSW Implementation Plan - V01

1. Introduction and purpose:

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

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

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

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

Our system is made up of three distinct local areas – or Places – and a wide range of organisations which may operate at one or more of Neighbourhood, Place or System level. The name we have given to our Integrated Care Partnership is BSW Together. The BSW Strategy, from which this Implementation Plan is derived, sets out what BSW Together aims to achieve for our population in the next five years and is informed by strategies and plans, including the three Health and Wellbeing Strategies, produced by partners singly and collectively. The aim is that when these strategies and plans are seen together, they provide a coherent whole of what we aim to do and achieve. Whilst this plan, and its subsequent refreshes, seeks to set out the key elements of how we will implement the strategy the detail of particular transformation programmes and Place based strategies and plans will set out the specifics and detail of what is needed in each area. We recognise that as part of our engagement and communication with partners and local people that we will need to set out the roadmap of how everything comes together as the aligned and constituent parts of BSW Together.

The structure of the document reflects our intention for the plan to be a working document setting out our plan for the year in an easily digestible form as well as providing a summary of how the ICB will meet each of its legislative duties. The structure gives a particular focus on how we are delivering our BSW priorities together through system activities, and also our Place level priorities through our Place based local implementation plans. Both of these activities are supported by our enabling plans and our engagement work with our local communities.

Assurance on delivery will be shared with our ICB Board on a quarterly basis and published in our public meeting papers.

Our strategy-on-a-page:

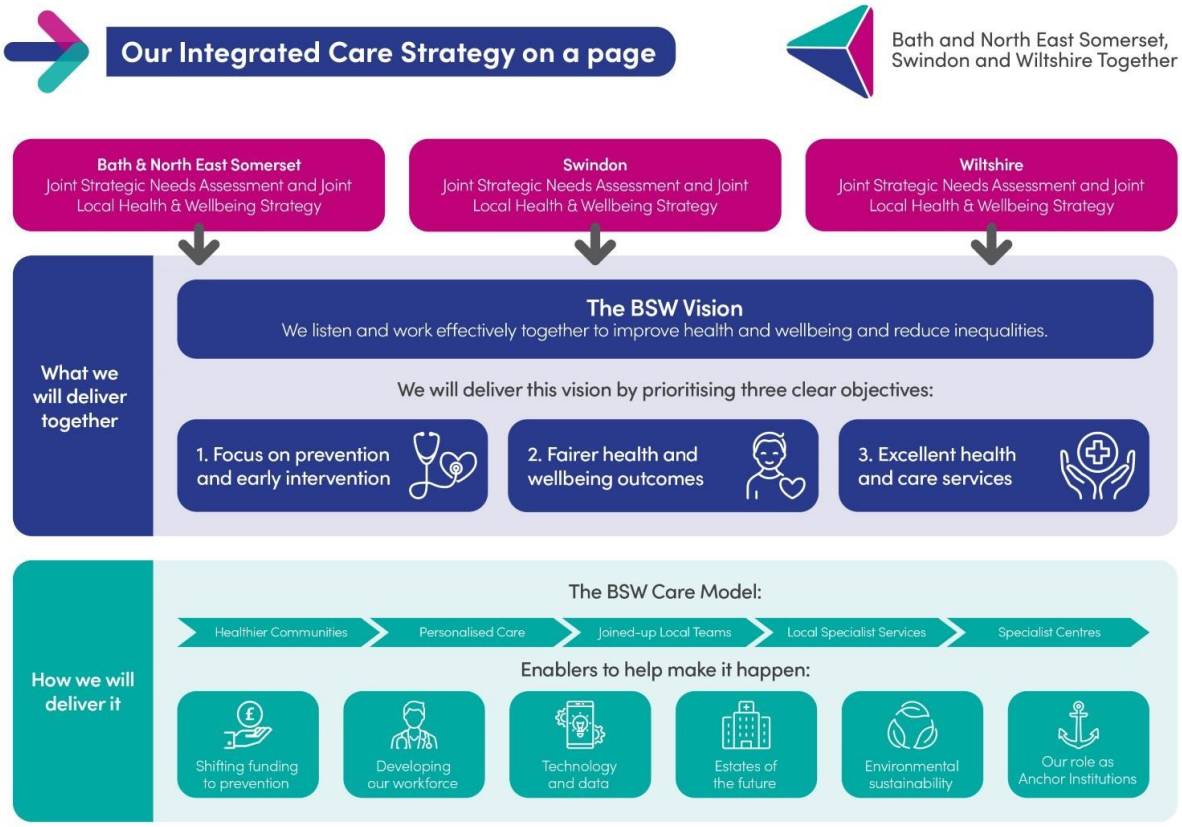

Figure 1: Our Integrated Care Strategy on a page

Our partnership vision and strategy

The Integrated Care Strategy, from which this Plan is informed, has built on the emerging priorities outlined in the following individual strategies:

Place Based Strategies

- BaNES Joint Local Health and Wellbeing Strategy
- Swindon Joint Local Health and Wellbeing Strategy
- Wiltshire Joint local Health and Wellbeing Strategy

Organisational Strategies

These include:

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

Thematic Strategies

These include:

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

Enabling Strategies

These include:

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

In our BSW strategy, we set out our vision that our partners across health and care are "Listening and working effectively to improve health and wellbeing and reduce inequalities". It sets out that partners across our Integrated Care Partnership are united in a belief that our future must be based on meaningful, ongoing engagement with local people.

Our strategy has three primary objectives:

Focus on prevention and early intervention

Areas of Focus

1. Focusing funding and resources on prevention rather than treatment
2. Intervening before ill-health occurs (primary prevention)
3. Identifying ill-health early (secondary prevention)
4. Slowing or stopping disease progression (tertiary prevention)
5. Wider determinants of health
6. Support babies, children, and young people to Start Well recognising an increased focus on children and young people, this is prevention in action for our future population.

Fairer health and wellbeing outcomes

Areas of Focus

1. Adopting CORE20PLUS5 and Children & Young People CORE20PLUS5
2. A system wide focus on reducing health inequalities

Excellent health and care services

Areas of Focus

1. Personalised care
2. Joined up local teams
3. Responsive local specialist services
4. High quality specialist centres
5. Mental health and parity of esteem

The strategy also describes our key enabling pieces of work that will help make this happen:

- Shifting funding to prevention
- Developing our workforce
- Technology and Data
- Estates of the Future
- Environmental sustainability
- Our role as Anchor institutions

This Implementation Plan describes how we are going to fulfil these objectives through our work at system, place and through our enabling programmes. It describes the key goals and milestones that will help us track progress and deliver these three objectives and the associated commitments set out in the strategy.

How this plan is structured

The BSW Strategy and this Implementation Plan bring together the key elements of what we aim to deliver and change through the three Strategic Objectives though the lens of the whole array of place based, organisational, thematic and enabling strategies we have agreed in the BaNES, Swindon and Wiltshire system. Whilst undoubtedly complex, we have structured the plan to present the work being driven forward at a place level in support of the respective Joint Local Health and Wellbeing Strategies and then moved on to examine thematic and organisational strategies in the context of the three Strategic Objectives. We have separated out the enabling workstreams which support work against some or all of the local plans and delivery of the three Strategic Objectives as it would probably be repetitive to list the enabling workstreams as part of each of the other delivery chapters.

2. Working together to deliver our strategy

Over the last seven years our ways of working together have been evolving as we have transitioned from our Sustainability and Transformation Partnership into an Integrated care System. Our Integrated Care System is made of a number of statutory organisations, and partnership collaboratives, system-wide programmes that together help us achieve the aims set out for ICSs in legislation.

DIAGRAM – to be added

During 2023/24 we will be reviewing the effectiveness of both our governance and programme management arrangements with the aim of identifying where refinements should be made in order to drive both our partnership and transformation work forwards. This process will draw on our experiences of the last twelve months and will help us to refine how we align the authority to lead with the responsibility and accountability for delivery across our system. This may result in delegation of resources and responsibilities to designated parts of our system (e.g., ICA, Provider Collaboratives).

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

There has been active participation in the ICP from a range of statutory and non-statutory organisations across BSW, however it is still a relatively small forum, and we need to further develop both the ICP's role within our integrated care system and the involvement opportunities that it can offer to stakeholders across BSW. The development of our ICP needs to take due account of, and bring additional value to the engagement and involvement activities that are already underway in each of our three Place's.

To achieve this the ICP will use its meetings throughout 2023/24 to bring together colleagues from our three places to focus on areas of common interest, and how we can evidence our progress towards a greater focus on prevention and early intervention. In doing this we will take opportunities for wider engagement activities with our local population and other stakeholders to co-develop both the outcomes we are working towards and the initiatives that will enable us to deliver them. The approach will be underpinned by the use of population health information.

List lead and email address for further information
Richard Smale, ICB Director of Strategy and Transformation – r.smale@nhs.net

BSW ICB
The Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) is a statutory body which brings together NHS organisations with local authorities and other partners to work to improve population health and establish shared strategic priorities.

The ICB oversees how money is spent and makes sure that health services work well and are of high quality. It brings together hospitals, primary care, local councils, hospices, voluntary community, and social enterprise (VCSE) organisations and Healthwatch partners in our local places: Bath and North East Somerset, Swindon and Wiltshire.

As an ICB, we have taken on the functions and broader strategic responsibility for overseeing healthcare strategies for the system from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group, which has now been dissolved

[Placeholder for inclusion of description of other statutory organisations]

Acute Hospital Alliance:

The BSW Acute Hospital Alliance (AHA) is a provider collaborative, made up of Salisbury NHS Foundation Trust, Royal United Hospital Bath NHS Foundation Trust, and Great Western Hospitals NHS Foundation Trust.

The AHA aims to maximise delivery of benefits to the people of BSW helping them to live happier and healthier for longer. The collaborating Trusts will enable the delivery of excellent health and care services working closely with the UEC and Elective Care programmes to deliver the BSW Care Model and ICP Strategy. As a provider collaborative, the AHA is committed to financial sustainability in BSW.

Our AHA Clinical Strategy sets the ambition to deliver the highest quality care for the population of BSW. We want to set a clear aim for services to achieve excellent (upper-quartile) performance against relevant measures, compared nationally. We will work together to deliver our elective strategy, maximising the benefit of elective cold site, Sulis, for the BSW system and SW partners.

A ***Corporate Services Excellence Programme*** is in development with scoping taking place on; digital, people, estates, financial services, communications and legal.

In February 2023, BSW AHA was selected to be part of the first cohort of the NHS England Provider Collaborative Innovation Scheme. Membership of this scheme will drive delivery with tailored support and the opportunity to network and share learning and innovation with peers.

A Clinical Strategy Programme Board, chaired by the SFT CMO, is in place overseeing emergent clinical priorities (linked to UEC and elective care strategy delivery) as well as the programme of specialty deep dives. An EPR Programme Board oversees delivery of the EPR programme and delivery of associated benefits. Our programme delivery is underpinned by our *continuous quality improvement approach*, Improving Together.

Leads for further information

- *AHA SRO –Stacey Hunter. stacey.hunter@nhs.net*
- *Programme Director – Ben Irvine. ben.irvine@nhs.net*

System-wide Programmes

[placeholder for description of system-wide programmes]

3. Ongoing engagement and involvement

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) has a duty to involve patients and the public. ICBs are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively) requiring the ICB to have regard to 'all likely effects' of their decisions in relation to three areas:

- Health and wellbeing for people, including its effects in relation to inequalities.
- Quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services.
- The sustainable use of NHS resources.

Our Integrated Care Strategy is the first chapter in an iterative process which will continue to develop with input from stakeholders across BSW.

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

Since developing a full first draft of the strategy in January 2023, we have engaged with members of the Voluntary, Community and Social Enterprise Sector Alliance groups across Bath and North East Somerset, Swindon and Wiltshire.

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

Ongoing engagement with our people and communities will be guided by our people and communities' engagement strategy and based around the 10 principles for engagement. Our Public and Community Engagement Committee provide assurance to the board that that the ICB discharges its statutory duties and functions re public involvement and engagement. The committee provides assurance that ICB and its system partners have effective public and community engagement processes, at system and place level.

We are engaging with partners and local Health and Wellbeing Boards on the draft Implementation Plan, and this will include receiving opinions from the three Health and Wellbeing Boards that the Plan is aligned with their respective Health and Wellbeing Strategies and their associated priorities. The strategy and implementation plan will be refreshed annually and this will provide a framework for ongoing engagement with partners and also our local communities. The detail of how we will undertake this work in a way that is closely linked with engagement on other strategies and developments is currently being worked through and will be further set out in the final version of the 2023/24 Implementation Plan.

4. Our population:

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

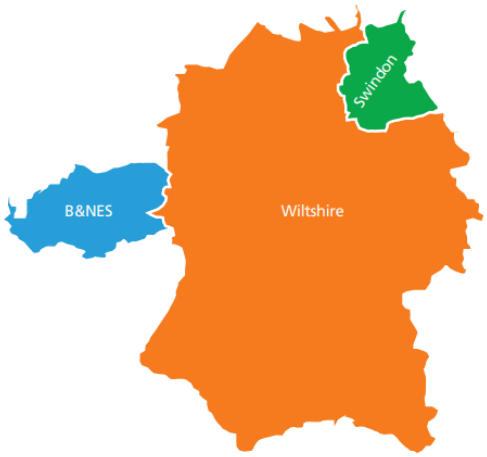

Figure 2 Map of Bath and North East Somerset, Swindon and Wiltshire taken from 'Our plan for health and care 2020-2024', BSW Partnership (2020)

Figure 3/Figure 4/Figure 5 (from *BSW system Intelligence Report*; BSW, 2021; updated 2023 with permission) highlights population sizes, breakdown by age group, life expectancy, healthy life expectancy, and inequality in life expectancy.

Inequality in life expectancy is represented by the slope index of inequality (SII), which is based on statistical analysis of how much life expectancy varies with area deprivation. The SII represents the range in years of life expectancy across the social gradient from most to least deprived.

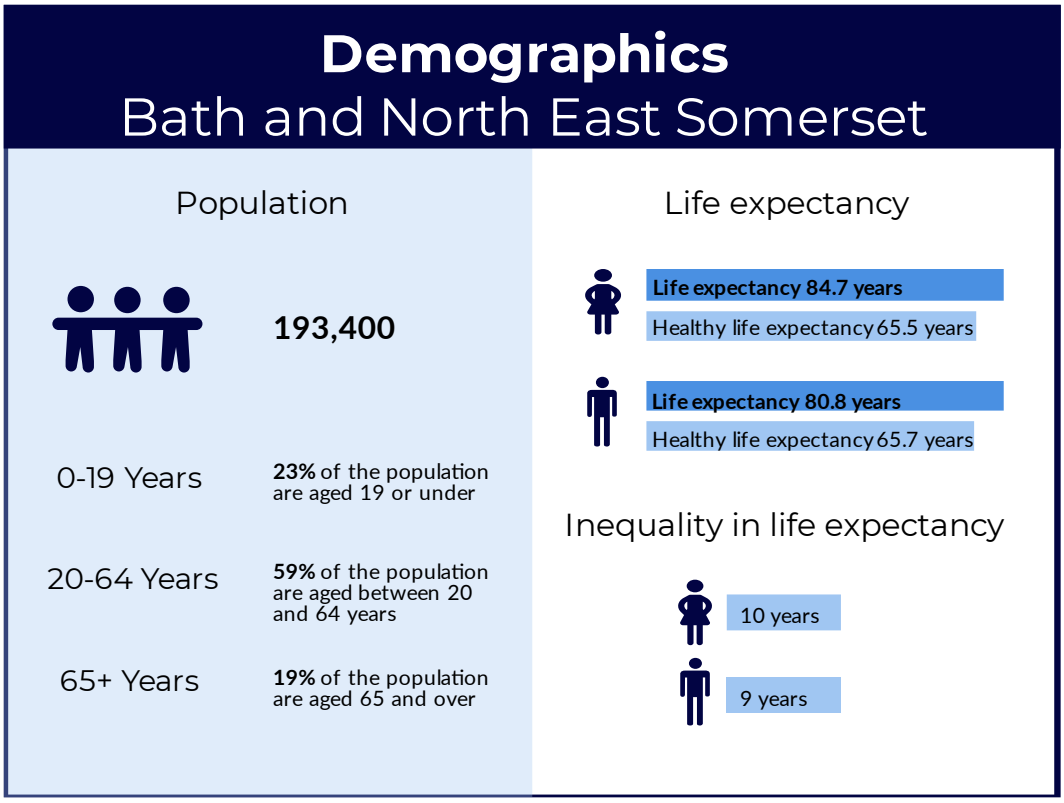

Figure 3: Demographics BANES (BSW Partnership, 2021). Figures updated with permission from Bath and North East Somerset Council Strategic Evidence Base (Bath and North East Somerset Council, 2022).

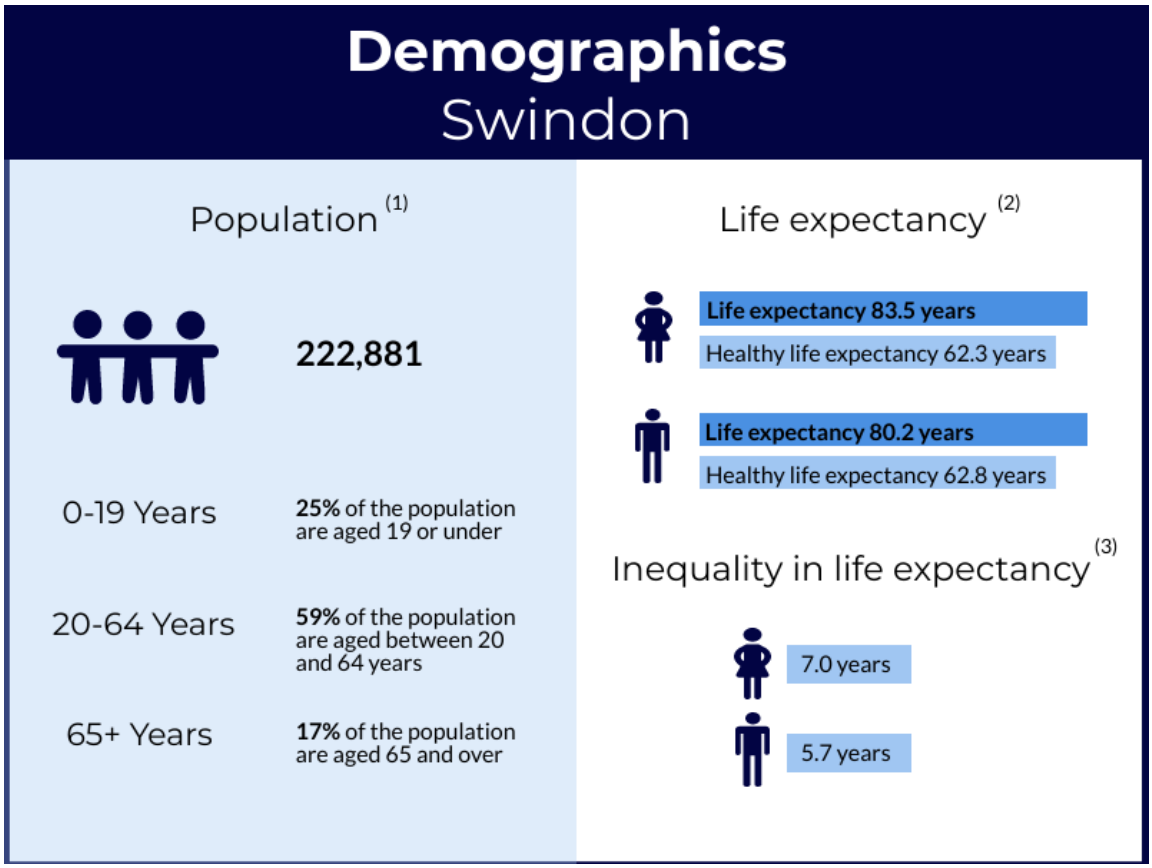

Figure 4: Demographics Swindon (BSW Partnership, 2021

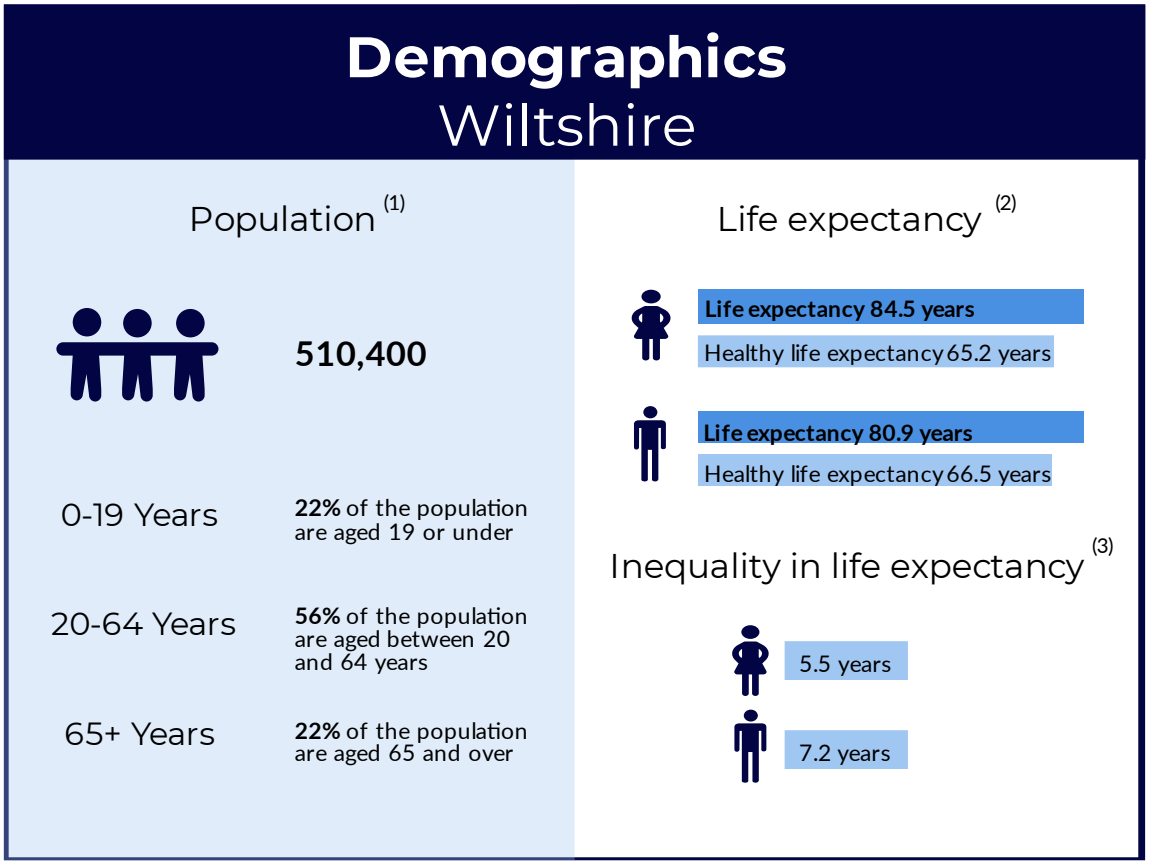

Figure 5: Demographics Wiltshire (BSW Partnership, 2021). Figures updated with permission from Wiltshire JSNA 2022 (Wiltshire Council, 2022).

In BANES and Wiltshire, and nationally, the social gradient in life expectancy is steeper for males. In Swindon, however, the social gradient in life expectancy is steeper for females.

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

Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men (Department of Health and Social Care, 2022). Women in inclusion health groups often experience severely poor health outcomes. For example, women sleeping rough, on average, die almost 40 years earlier than women in the general population (ONS, 2019), and Gypsy, Roma and Traveller women are 20 times more likely than the wider population to have experienced the death of a child (Women and Equalities Committee, 2019). The Women's Health Strategy for England acknowledges that It is vital that we address these stark disparities and improve health outcomes for women in these groups.

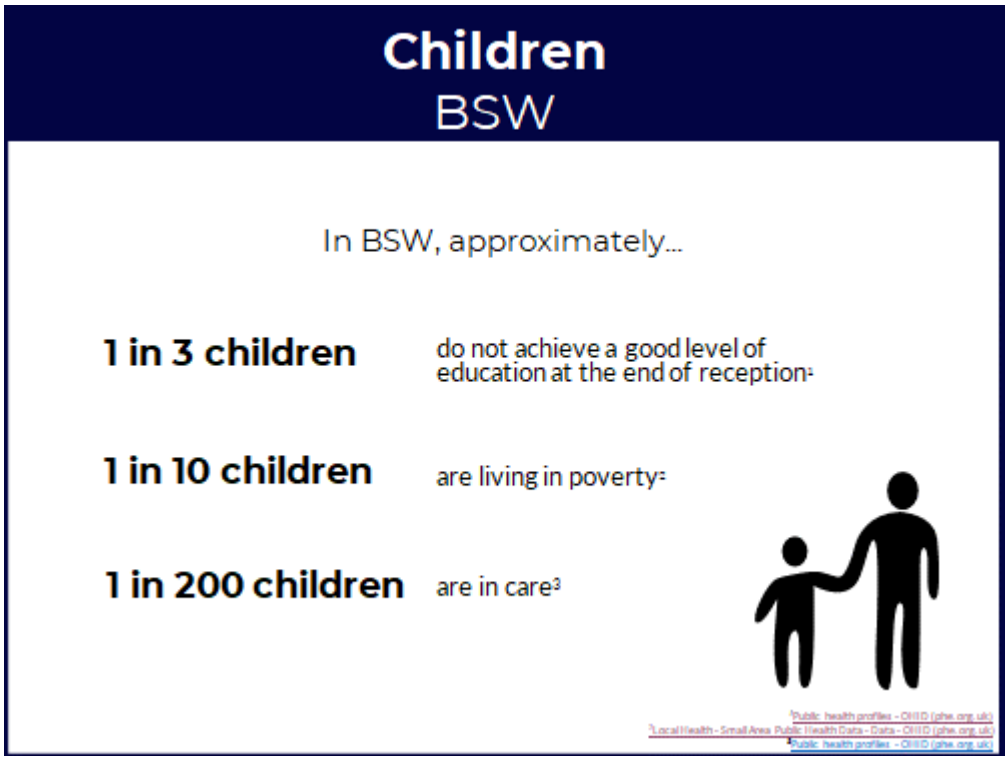

Figure 6: Children in BSW (BSW Partnership, 2021). Values updated in 2023 with permission: 1Public health profiles - OHID (phe.org.uk); 2Local Health - Small Area Public Health Data - Data - OHID (phe.org.uk); 3Public health profiles - OHID (phe.org.uk)

Figure 6 illustrates that, although many childhood indicators are better than the national average in BSW, there are still many children that have difficult living circumstances.

Table 2 (BSW Partnership, 2021) shows measures of child health and wellbeing (rates of child poverty, children in care, school readiness, teenage motherhood, and child mortality).

Deprivation

People living in deprived areas on average have poorer health and shorter lives. Research shows that socioeconomic inequalities result in increased morbidity and decreased life expectancy. The UCL Institute of Health Equity estimates 1.3 to 2.5 million potential years of life lost annually due to inequalities (Marmot, 2010). Males living in the most deprived tenth of areas can expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years (Public Health England, 2017).

What defines whether an area is a deprived area is based on a number of characteristics included in the Index of Multiple Deprivation (IMD) – Income Deprivation, Employment Deprivation; Education, Skills and Training Deprivation; Health Deprivation and Disability; Crime; Barriers to Housing and Services; Living Environment Deprivation.

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

Somerset. See appendix one for detailed breakdown of deprivation by neighbourhood across BSW.

Table 1: Office for Health Improvement & Disparities (2022). Deprivation score for BaNES, Swindon and Wiltshire is highlighted.

Deprivation score (IMD 2019) 2019

Score

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	21.7	-	-
South West region	–	-	18.2	-	-
Torbay	–	-	28.1	-	-
Plymouth	–	-	26.6	-	-
Bristol	–	-	26.4	-	-
Cornwall	–	-	23.1	-	-
Swindon	–	-	18.6	-	-
Somerset	–	-	18.6	-	-
Bournemouth, Christchurch and Poole	–	-	18.2	-	-
Devon	–	-	16.6	-	-
North Somerset	–	-	15.8	-	-
Dorset	–	-	15.7	-	-
Gloucestershire	–	-	14.9	-	-
Wiltshire	–	-	13.4	-	-
Isles of Scilly	–	-	12.0	-	-
Bath and North East Somerset	–	-	11.7	-	-
South Gloucestershire	–	-	11.7	-	-

As there is variation in deprivation across the South West region, there is also variation within the local authorities as exemplified here across the wards in Swindon.

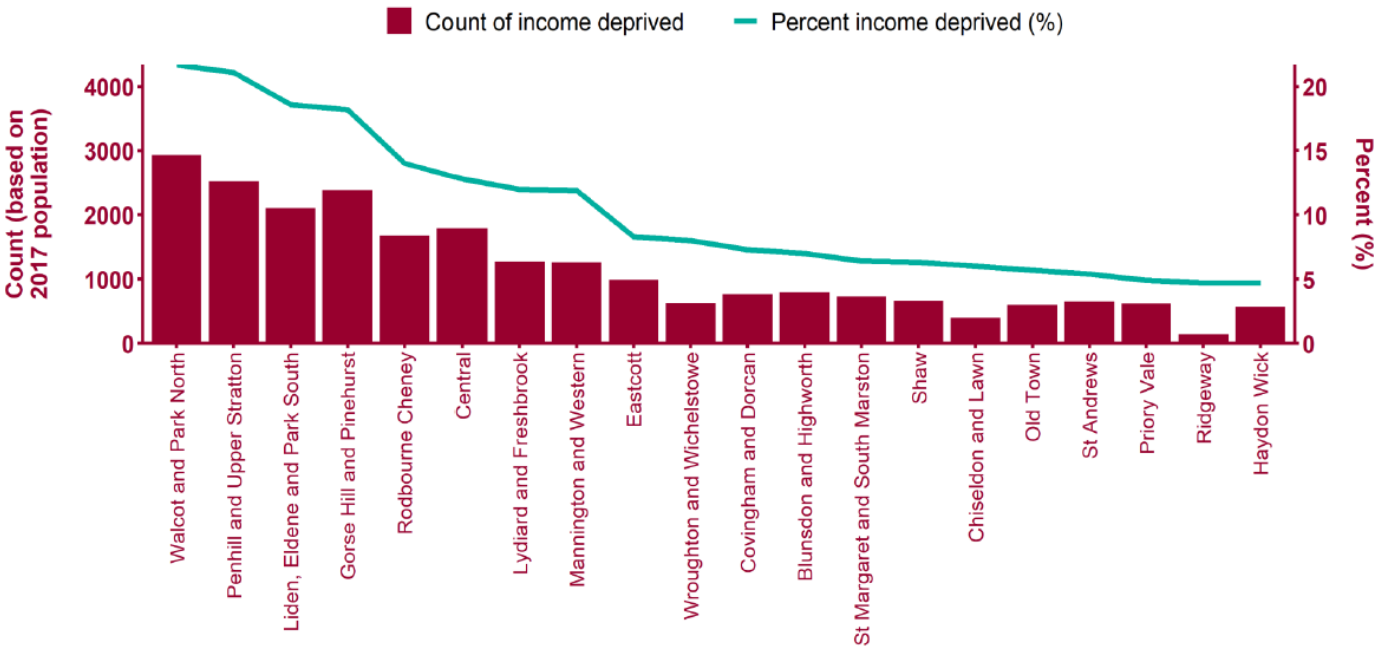

Figure 7: Income deprivation by ward in Swindon (IMD, 2019; taken from presentation by Maddern and Arulrajah, 2021)

During the pandemic there have been disproportionate deaths from COVID-19 between those living in the most deprived areas and those living in the least deprived areas. These mirror higher mortality due to other causes, in line with social gradient (Dodge and Owolabi, 2021).

Table 2: CYP Statistics in BSW (Data from Public Health Outcomes Framework Child and Maternal Health and Mortality Profiles) Adapted from: BSW Partnership 'NHS Long Term Plan - internal intelligence briefing' 2021

	BANES	Swindon	Wiltshire	National
Children in absolute low-income families (under 16s) (2019/20)	8.1%	11.4%	8.5%	15.6%
Children in relative low-income families (under 16s) (2019/20)	9.6%	13.8%	10.3%	19.1%
Children in care per 10,000 population (2020)	50	60	43	67
Children in need due to family stress or dysfunction or absent parenting per 10,000 children under 18 (2017)	69	88	47	94
School readiness: % of children achieving a good level of development at the end of Reception (2018/19)	74%	71%	72%	72%
Teenage mothers: Under 18s conception rate per 1,000 (2019)	13.1	17.7	9.0	16.7
Teenage mothers: % of deliveries where the mother is under 18 (2019/20)	0.6%	0.6%	0.5%	0.7%
Infant mortality per 1,000 live births (2017-2019)	2.0	3.3	3.1	3.9
Child mortality per 100,000 population (1 -17 years) (2017-19)	No data	9.5	11.1	10.8

In BSW, significantly less children live in poverty compared with the national average, which may reflect the relative affluence of the South West region. Still, around 1 in 10 children in BSW live in poverty. Of the three local authority areas of BSW, Swindon has the highest proportion of children living in poverty, although it is significantly less than the national average.

Ethnicity

Ethnicity also has a large and complex effect on health. In England, inequality is experienced when comparing ethnic minority groups and those from white ethnic groups, and between different ethnic minority groups (Robertson et al., 2021). The infographic (Figure 8) highlights just some of the stark health inequalities related to ethnicity in the UK.

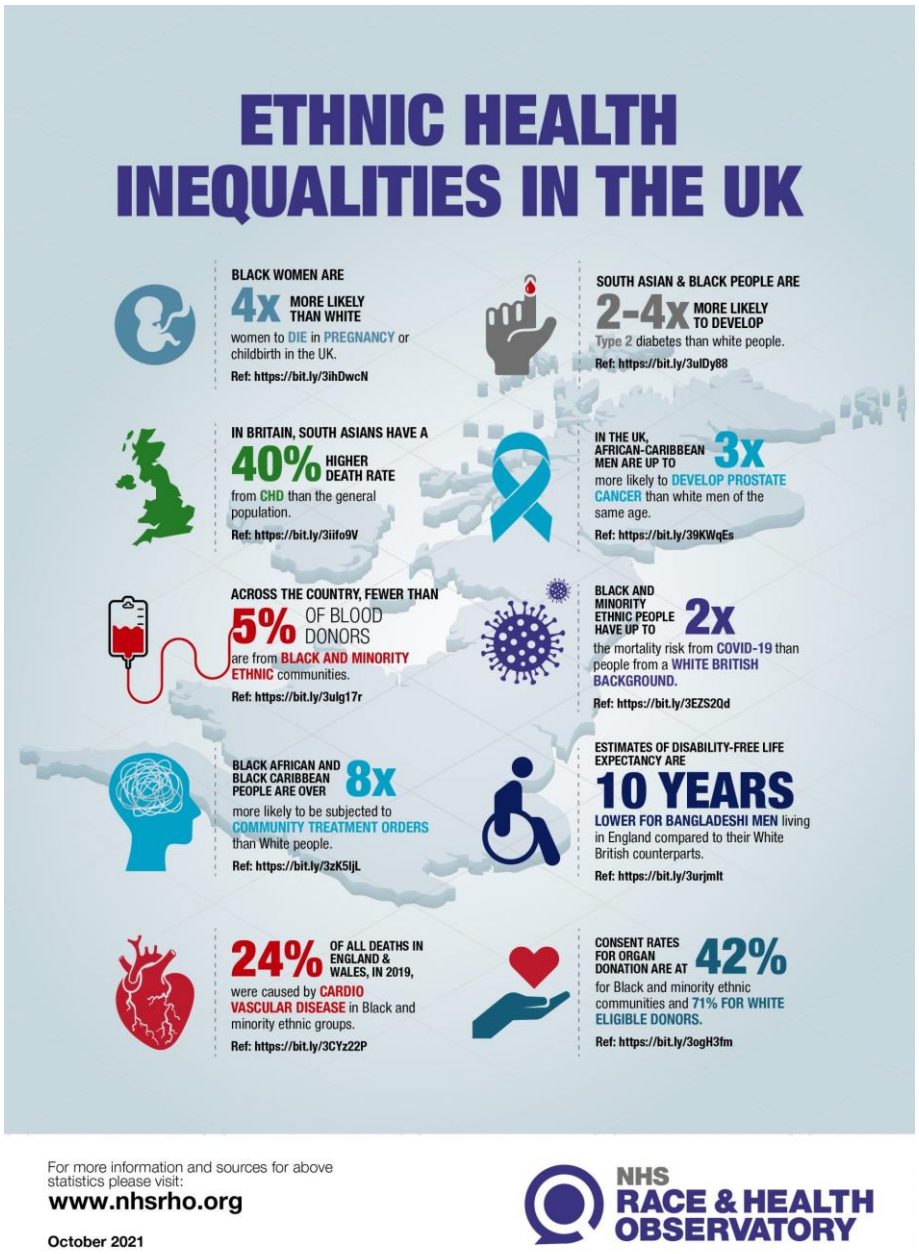

Figure 8: Taken from NHS - Race and Health Observatory (2021)

Nationally, the Covid-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population. Geography, deprivation, occupation, living arrangements and health conditions such as CVD and diabetes accounted for a large proportion, but not all, of the excess mortality risk of Covid-19 in ethnic minority groups (Raleigh and Holmes, 2021). It is important to understand the distribution of different ethnic groups across BSW as health outcomes, attitudes and beliefs, as well as health service accessibility and usage can vary.

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

5. Our local implementation plans:

Much of our work is driven at a Place, or local authority footprint, level and is informed by the needs of the local population. Our three local Joint Strategic Needs Assessments have been developed by the respective public health departments and underpin the priorities and strategic direction of each of the Joint Local Health and Wellbeing Strategies which, in turn, have informed the local implementation plans set out in this chapter.

This chapter sets out how partners across health and care are working together to provide accessible care nearer to where people live and also enable us to build an approach rooted in prevention and early intervention to support our population to remain healthier and happier and as long as possible. This focus sits at the heart of the BSW Strategy and is taken forward through the three Strategic Objectives on which the strategy is built.

BaNES:

Context

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

- Ensure that children and young people are healthy and ready for learning and education
- Improve skills, good work and employment
- Strengthen compassionate and healthy communities
- Create health promoting places

These priorities are directly informed by the intelligence collated in the BaNES Strategic Evidence Base (also known as the Joint Strategic Needs Assessment, or JSNA).

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

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

How we are organised to deliver

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

This includes:

1. an Integrated Care Alliance and Locality Commissioning group that feed directly into the ICB Board and other sub-committees as required and works closely with our Health and Wellbeing Board.

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

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

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

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

Our delivery plan

Our Integrated Care Alliance (ICA) priorities are collaboratively developed across all our partners and reviewed annually. Our current set of priorities, which respond to the Statutory functions of the BSW Integrated Care Board (ICB) and align with the aforementioned H&W priorities, have a two to three year timeframe to deliver given their scale. Our current priorities are set out in Figure 9 alongside cross cutting themes.

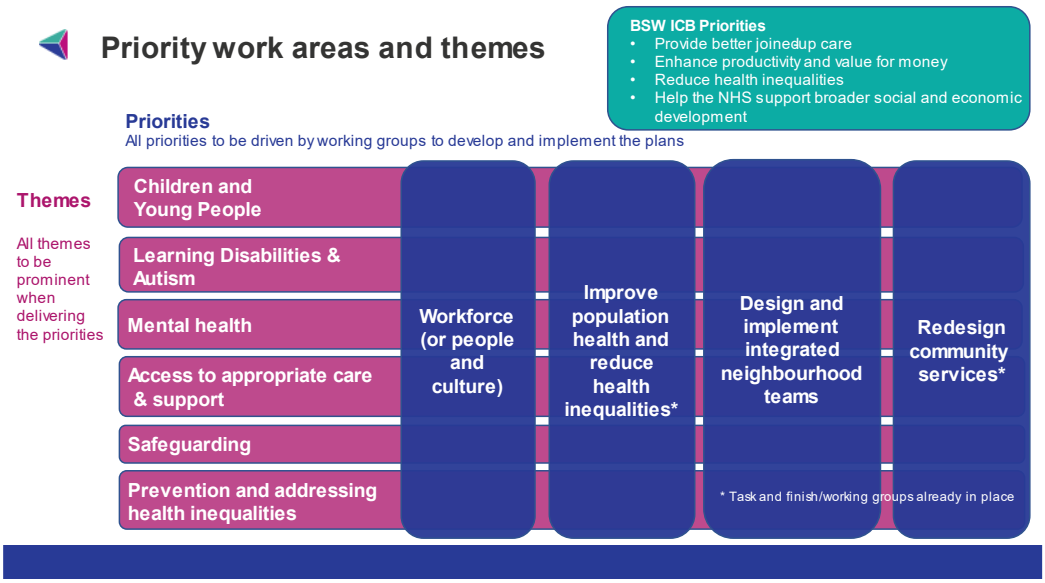

Figure 9: Bath and North East Somerset Integrated Care Alliance priority work areas and themes

1. Workforce culture and people

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

Workforce milestones include:

- **Between May and April and May 2023**: Update on outputs from the work commissioned from the BSW Academy.

Between May and September 2023: consider B&NES local response.**2. Improving health and reducing health inequalities**

From the Strategic Evidence Base an emerging area of health improvement need on which to give focused attention is improving cardiovascular disease outcomes. Over the coming months the scope of this work this will be agreed, identifying opportunities to make concerted efforts to drive improvements in areas such as tobacco control, the Health Check offer, whole system approach to weight management, alcohol use, and variation in high risk condition monitoring and intervention, taking a population health management approach. We will take an approach to this work that aligns with and maximises benefit to other work programmes that benefit the population.

What we will do in the next twelve months

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

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

Cardiovascular disease outcomes will be improved. (Detail for this section to be produced as part of creation of the implementation plan)

In relation to reducing health inequalities, we are establishing a Health Inequalities Network in BaNES with dedicated resource to strengthen capacity and understanding about inequalities. We are taking an evidence-based understanding of how inequalities impact on our population and will build on this with coordinated and planned action to prevent and tackle inequalities through activity at different levels including through wider determinants of health, health and wellbeing services, ill health prevention programmes, health care services, and social care programmes..

An example of this is the Community Wellbeing Hub (CWH). The CWH is made up of a partnership from the public, private and third sector organisations. It provides a "one-stop-shop" for wellbeing services for adults and their families. We have a hub and spoke model with a Central Wellbeing hub and a spoke in the Atrium of the RUH to assist with discharge planning. The 'Culture' and ways of working is different and critical to implementation. The approach is one of shared responsibility, and working practices and organisational boundaries removed, which enables the focus to be on the individual. The hub is an example pre-cursor of how we can utilise community assets to implement Integrated Neighbourhood Teams

What we will do in the next twelve months to tackle health inequalities:

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

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

People from groups experiencing greater inequalities Set out longer term goals and relevant delivery dates where possible

3.The design and implementation of Integrated Neighbourhood Teams.

Our delivery plan

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

How we are organised to deliver

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

What we will do in the next twelve months

- By July 2023: create an INT Maturity Matrix and associated outcome measures to enable teams to develop INT ways of working
- From May 2023: collaborate with Community Frailty 12-month pilot to trial INT approach to working with 2 PCNs in B&NES
- Between August and October 2023: Identify at least 4 other teams and services - working with different scales of geography, population need, range of providers - to test the Maturity Matrix and outcome measures
- By September 2023: Evolve the BaNES INT T&F Group into a Steering Group to oversee and assure the progress against agreed programme timescales

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

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

Monitoring delivery

- Number and range of INTs developed across BaNES
- Patient/carer experience of collaborative working by INT's
- Staff reported change in ways of working as INT's

4. Redesigning Community Services

We have a transformational opportunity to consider the needs of our population and to design and shape our services and provision so that it is outcome focussed and meets the needs of individuals within the community in line with the BSW Care Model. This will involve discussions to determine what we mean by left shift of resources and funding across our ICA and to understand where the opportunities are for place to drive delivery and where working at scale provides added value.

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

Access to Care and Support

Home is Best is an umbrella programme of work being undertaken across multiagency partners in BaNES to deliver the espoused improvement in access to care and support for our local population. This programme also feeds into and aligns with system wide work across the end-to-end health and social care pathway. The programme plan features as illustrated in Figure 10:

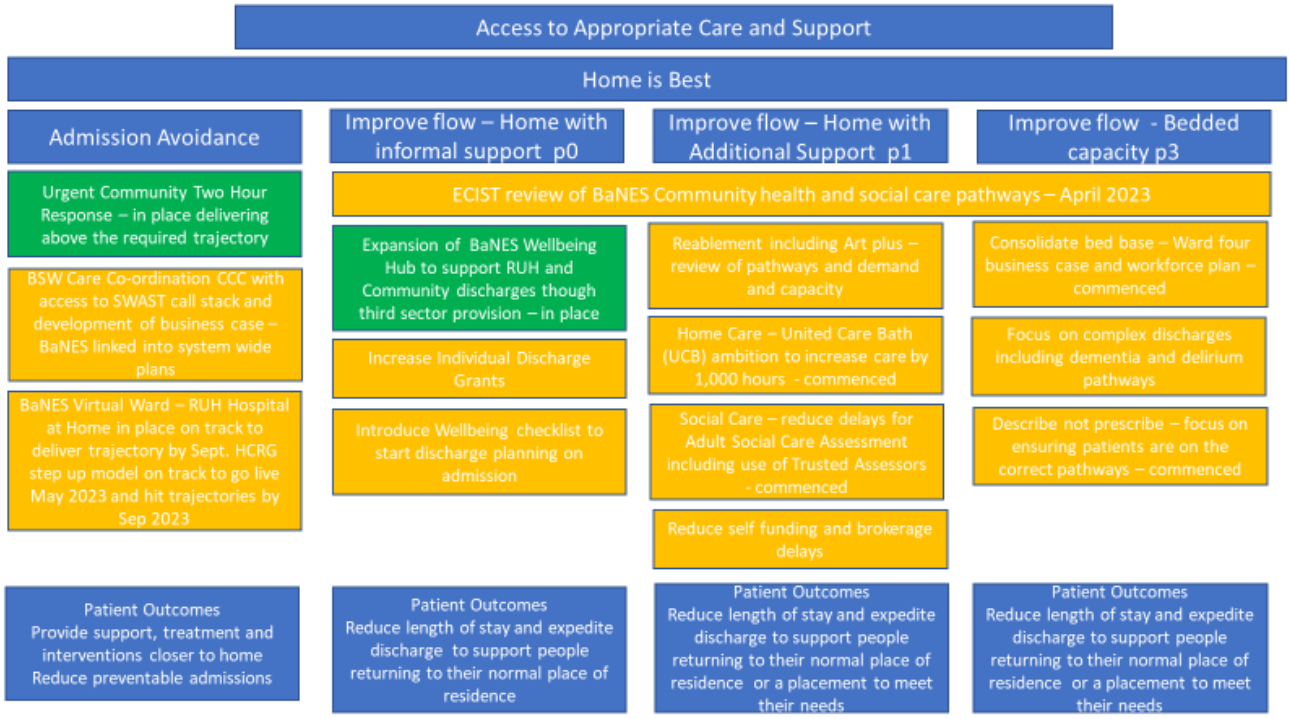

Figure 10: Home is Best programme plan

What we will do in the next twelve months

- **By end of May 2023**: Our BaNES step up Virtual Ward will be operational and supporting patients to stay safely in their community reducing preventable hospital admissions.
- **By September 2023**: Both our BaNES Step Up and Step Down Virtual Ward models will deliver the required capacity to meet the national trajectory.
- **By the end of April 2023**: We will have conducted, with the support of the national Emergency Care Intensive Support Team, a further review of community health and social care pathways. This will build on the strong foundation we have developed together to reduce the Non-Criteria to reside position in our acute hospital and support people to return home or their usual place of residence.
- **By the end of April 2024**: Our focus for the next 12 months will be the delivery of the Home is Best work streams as documented above with the initial priority of increasing community hospital flow. This will deliver improved patient flow across our system supporting patients to be in the best environment to lead happy and healthy lives.
- **By end of April 2023:** our community wellbeing hub will be piloting in both our acute and community hospitals.
- **By July 2023:** We will have increased care by an extra 600 hours through our United Care Bath (UCB) project.
- **By end of April 2024:** Care through the UCB project would be increased by 1,000 hours.
- **By May 2023**: We would have collaboratively developed the business case to secure funding for Ward Four – which provides additional community hospital beds. This will support our 'left-shift' agenda to reduce reliance on acute hospital beds.

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

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

Themes:

All of our ICA themes are a lens that we apply to everything that we do and also have been identified in our evidence base as key areas to improve outcomes for our local population.

Below we have set out more detail around two of our themes: Children and young people and Learning Disabilities and Autism.

Children and Young People

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

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

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

Reduce the existing educational attainment gap for disadvantaged children and young people including:

- Provide intensive support for children eligible for free school meals and with SEND to help them achieve better outcomes at school

Ensure services for children and young people who need support for emotional health and wellbeing are needs-led and tailored to respond and provide appropriate care and support (from early help to statutory support services).

Our work will align with the BSW Children and Young People's system agenda.

Learning Disabilities and Autism

We will continue to collaboratively develop our local priorities for people with Learning Disabilities (LD), Autism (ASD) and those needing support with their emotional wellbeing and mental health. These will align with system wide priorities including:

- Reducing the number of people cared for in an inpatient unit out of area
- Introducing the national Key Worker programme in B&NES for people with LD and ASD to support people in their local community
- Expanding the community emotional wellbeing and mental health support as part of the implementation of the community mental health framework
- Improving access to services including Autism diagnosis and support for children, young people and adults and Talking Therapies

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

Monitoring delivery

We will monitor delivery of our ICA plan through regular updates to our ICA and our Health and Wellbeing Board.

This will include monitoring specific metrics for the relevant priorities, for examples for Integrated Neighbourhood Teams we will monitor:

- Number and range of INTs developed across BaNES
- Patient/carer experience of collaborative working by INT's
- Staff reported change in ways of working as INT's

Swindon:

Context:

Swindon has a population of nearly 223,000 which is projected to increase by about 5% between 2020-2030. Our Swindon population has a significantly lower healthy life expectancy than Wiltshire or BaNES. In terms of deprivation, Swindon ranks as the 98th most deprived area out of 151 upper tier authorities in England but some of the smaller areas are in the 10% most deprived in the country. Tackling health inequalities and the impact of deprivation run through the heart of our ICA delivery plan which draws on the three clear priorities set out in the refreshed Health and Wellbeing Strategy for Swindon set out below. These priorities are:

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

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

Our Delivery Plan

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

The principles guiding our plan are as follows:

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

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

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

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

Figure 11: Swindon ICA - Our Vision and Delivery Objectives

How we are organised to deliver

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

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

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

A diagram illustrating our governance structure is set out Figure 12 below.

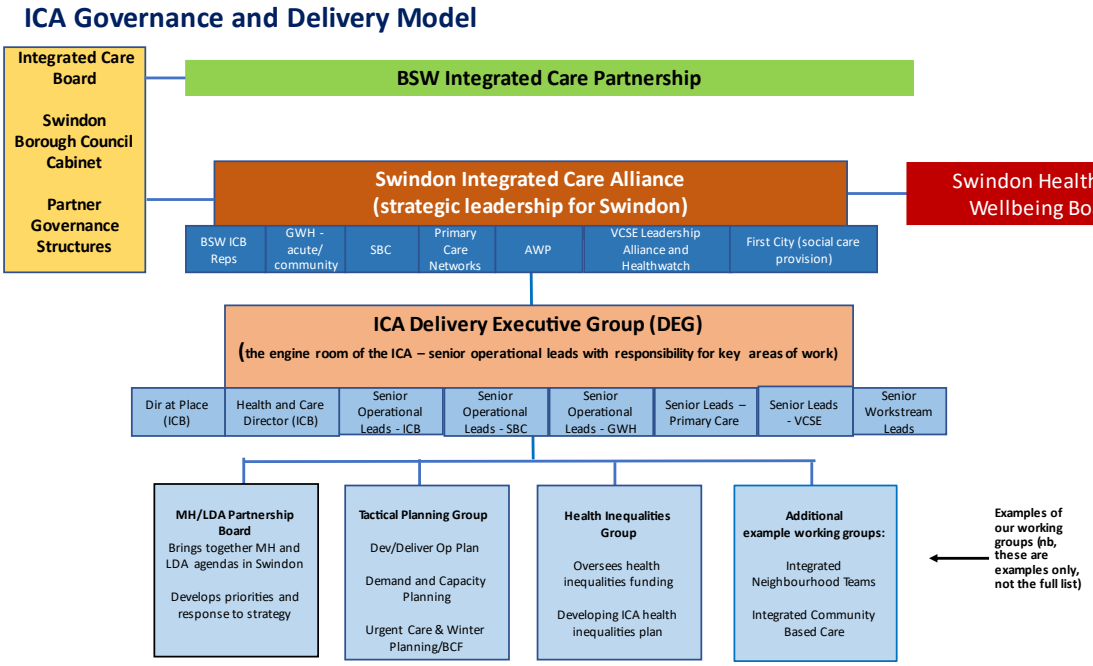

Figure 12: ICA Governance and Delivery Model

What we will do in the next 12 months

Set out below are the core segments in our ICA Plan and the actions taking place to achieve our objectives in the next 12 months. It is important to note that our plan is iterative; this is not the final version, and it will continue to evolve over the coming months and during its lifetime. We are currently designing the outcomes framework for our delivery plan with key metrics that will enable us to measure the impact of our actions. These metrics are blended with core national metrics including those set out in the Better Care Fund.

Table 3: Swindon ICA 5 Year Delivery Objectives and Milestones – Care and Quality

Swindon ICA 5 Year Delivery Objectives & Milestones

Care and Quality

Milestones 23/24	CYP We will improve outcomes for CYP with SEND. We will tackle CYP health inequalities and manage transition. We will listen and ensure a person centred approach. We will jointly commission services We will explore how to improve oral health for CYP.	LD & Autism We will improve access to education, and support transitions into adulthood and employment. We will improve support offers and crisis interventions. We will reduce out of area placements. We will improve autism assessment process and post diagnostic services.	Mental Health We will increase delivery of talking therapy services. We will increase SMI health checks. We will tailor MH services for asylum seekers/ refugees. We will strengthen the local discharge pathway. We will improve access to mental health services for CYP.
Q1	• Continue prep work for recommissioning of Children's Health Services • Embed programme of work for Delivering Better Value • Sign off of Joint Funding Guidance for CYP	• Carry out Building the Right Support Peer Review – Jun23	• Review SMI health check registers with primary care and the wider system • We will hold a mental strategy workshop to determine how best to deliver mental health services • Commission new model of CYP MH services for CAMHS/TAMHS & MH Support Teams
Q2	• Plan for recommissioning of supported living in support of transition planning • Develop plan for implementation of national strategy for autistic children, young people and adults: 2021 -2026		
Q3	• Complete SSP project on self -neglect and exploitation • Scope opportunities to improve oral health	• Complete review of dynamic support process • Launch BSW Autism Care Co -ordination pilot • Carry out a review on how to improve LD assessment process and post diagnostic services	• Family Safeguarding Model with MH becomes operational • Commission new Wellbeing House • Implement new primary care SMI health check model
Q4	• Review opportunities for jointly commissioned SEND roles • Complete review of market sufficiency	• Monitor the improvement of the uptake of annual health checks	• Implement revised BSW wide IAPT model
	Design and implement an integrated commissioning model and ways of working		

Table 4: Swindon ICA 5 Year Delivery Objectives and Milestones - Community Wellbeing

Swindon ICA 5 Year Delivery Objectives & Milestones

Community Wellbeing

Milestones 23/24	Integrated Neighbourhood Teams We will create an integrated neighbourhood team model. We will listen to what neighbourhoods need from local services whilst managing expectation. We will enable people to stay well, safe and independent for longer (BCF).	Carers We will tackle unequal health outcomes for carers. We will ensure carers receive assessments. We will support carers to better balance their caring role to protect their health and wellbeing.	Health Inequalities We will increase the number of years people spend in good health and reduce inequalities. We will improve mental health and well-being. We will support people to eat well and move more. We will support people to stop smoking and reduce alcohol intake.
Q1	• Identify pathfinder area(s) • Workshop with frontline workforce • (BCF milestone – TBC) • Confirm key milestones for integrated community based care programme and update plan	• Explore financial sustainability of Carers services • Plan for re-procurement of Carers Services is in place	• First meeting of reformed ICA Inequalities group
Q2	• Integrated Neighbourhood Team Task & Finish Group formed which reports to ICA • (BCF milestone – TBC)	• Engage carers in development of Integrated Neighbourhood Team model	• Publish the Health & Wellbeing Board Strategy and associated implementation plans
Q3	• Initial integrated neighbourhood team model developed • (BCF – TBC)	• Integrated Neighbourhood Team know the carers in the pathfinder geography	• Recurrent funding for inequalities work is identified and a recurrent process developed
Q4	• Implementation of integrated neighbourhood team started • (BCF – TBC) • Year 2 milestones for integrated community based care programme planned		• Inequalities projects are aligned with Integrated Neighbourhood Team model when appropriate

Table 5: Swindon ICA 5 Year Delivery Objectives and Milestones - Demand and Capacity

Swindon ICA 5 Year Delivery Objectives & Milestones

Demand and Capacity

Milestones 23/24	System Flow We will build capacity together to reduce length of stay in hospital for those that don't need to be there. (NCTR) We will work together to manage front door demand. We will provide people with the right care at the right time. (BCF)	Left Shift We will shift more investment into prevention. We will prevent crisis rather than support crisis. We will profile and signpost preventative health & care support.
Q1	• Home First and Discharge hub 5 days a week • Intermediate Care and Demand plan complete (BCF) • Trusted Assessor for Care Homes in place 7 days a week • Additional care managers in place to support discharges	• £100k 'Community Investment' in Falls Prevention • VCSE and Primary / secondary care engaged in system level shaping of Integrated Community Care Programme • Confirm key milestones for integrated community based care programme and update plan
Q2	• Home First and Discharge hub 7 days a week • Complete winter plan • Scope potential further elements of an ICA demand and capacity plan (primary care, voluntary sector for example) • Confirm and plan winter respiratory clinics	• New falls prevention capacity in place and being evaluated by PH and working with coordination centre • VCSE and Primary / secondary care engaged in place -based shaping of Integrated Community Care Programme • Identify left shift and what it means for Swindon – what does it look like? Our vision • Deliver key milestones for integrated community based care programme (TBC)
Q3	• NHS @ Home (virtual ward) beds 65 (80% bed occupancy) • Stand up winter respiratory clinics – funding TBC	• Deliver key milestones for integrated community based care programme (TBC) • Identify wider implications - what does left shift means for the system – what will be better?
Q4	• NHS @ home (virtual ward) beds 90 (80% bed occupancy)	• VCSE and Primary / secondary care built into tender process for Integrated Community Care Programme • Evaluation of impact of Left Shift investment in Falls Prevention • Identify actions to deliver left shift change • Deliver key milestones for integrated community based care programme (TBC)

NB: Care Co-ordination Centre and falls milestones will be added by 15/5/23

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

Together we have set out what will be different for our population by 2028 under the key segments of our plan and what we will do to achieve these changes. At the heart of our plan is our Team Swindon vision which clearly sets out how we will work together to tackle inequalities and empower all people in Swindon to live longer, healthier, fulfilling lives, supported by thriving and connected communities. Our next priority is to develop logic models for each of our priorities which will enable us to identify specific and measurable outcome measures of success for 5 years' time.

A spotlight on Integrated Neighbourhood Teams:

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

Integrated neighbourhood teams are a way of bringing together front line staff and community organisations that either support our local communities, or groups of people who have complex needs. In essence, it is a way of creating a "team of teams," that improves the experience of people and our communities and ultimately their health and wellbeing. Figure 13 below gives a simple description of what will be different.

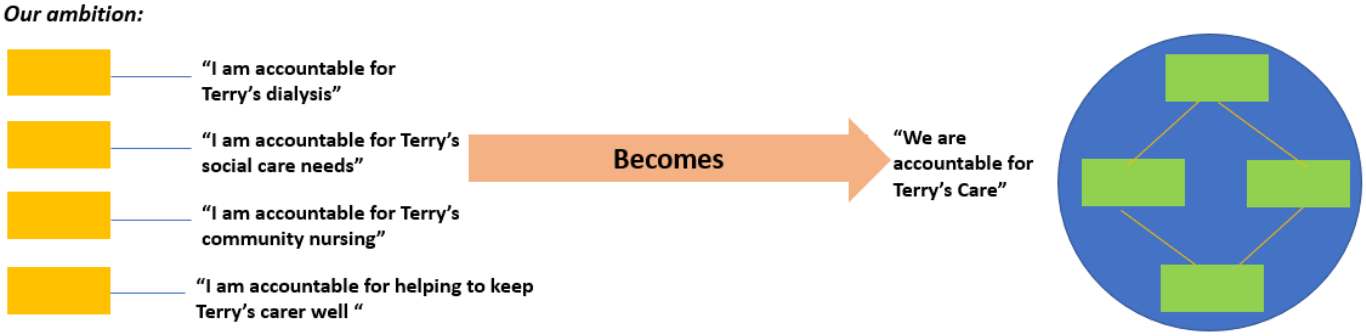

Figure 13: Our ambition for bringing together front-line staff and community organisations.

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

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

We will start small, working in target area(s), to test out what is achievable. We will evaluate for the impact on left shift and the potential to implement at scale.
We will focus on developing a positive culture with strong collaboration. This will start with our approach which will focus on coproduction with our frontline workers and the populations they are working with.

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

What will be different for our population in 5 years time

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

Contact Details for further information:

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Wiltshire:

The Wiltshire Context

Wiltshire is a vibrant community of over 500,000 people living across our area in large towns, small towns, villages, and large areas of rurality, including across Salisbury Plain. Wiltshire is home to significant populations of current or former armed forces service personal and their families. Our current population is 510,400, we are expecting our residents over 65 to increase by 43% by 2040 (representing about a third of our population) and our over 85 population will rise by 87%. Although Wiltshire is one of the 'least deprived' local authorities in England, approximately 14,000 people currently live in areas that are considered 'most deprived' when compared nationally - this is about 3% of our population.

Life expectancy compares favourably at a national level, however the 2022 Joint Strategic Needs Assessment (JSNA) has identified female healthy life expectancy as an area of decline and people living in deprivation as a significant life and healthy life expectancy inequality gap. Figure 15 provides some high level key points and areas of focus from the JSNA.

Life expectancy

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

Healthy Life expectancy

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

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

All-age all-cause mortality – 2021

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

Identifying inequalities in life expectancy in Wiltshire

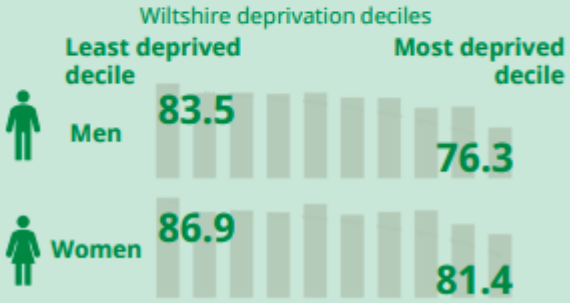
Healthy life expectancy – in years (England)

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

	Least deprived decile	**Most** deprived decile
Men	70.5 years	52.3 years
Women	70.7 years	51.9 years

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

Life Expectancy - in years



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

Diseases and ill health: Key focus areas

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

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

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

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

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

Disease prevention and health protection with a specific focus on

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

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

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

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

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

Supporting good mental health and emotional wellbeing.

The prevalence of common mental health disorders is rising in Wiltshire

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

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

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

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

Figure 14: Extract from Joint Strategic Needs Assessment for Wiltshire (2022)

Additional detail around all areas of focus can be found using this link https://www.wiltshireintelligence.org.uk/jsna/ which takes you to the Joint Strategic Needs Assessment in full.

Locality Strategy

Using the findings of the JSNA (2022) to directly inform development, colleagues across our Integrated Care Alliance in Wiltshire have co-authored a new Joint Local Health and Wellbeing Strategy (JLHWS) – this will be our locality plan for the next 5 years. The JLHWS sets out 4 guiding priority themes for our work and these, together with our Alliance Principles and Core Commitments and the ICS Strategy priority objectives have set a clear pathway towards improving outcomes for and with our population, drawing on the combined resources and skills of our Alliance partners.

Figure 16 demonstrates at the highest level how the JLHWS and the ICS Strategy align with each other in scope and ambition, the clusters represent linked and related priority areas of work. Localisation and connecting with our communities is seen as integral to our way of working across all themes and objectives and aligns with the ICS Vision of *"Listening and Working Effectively together to improve health and wellbeing and reduce inequalities"*

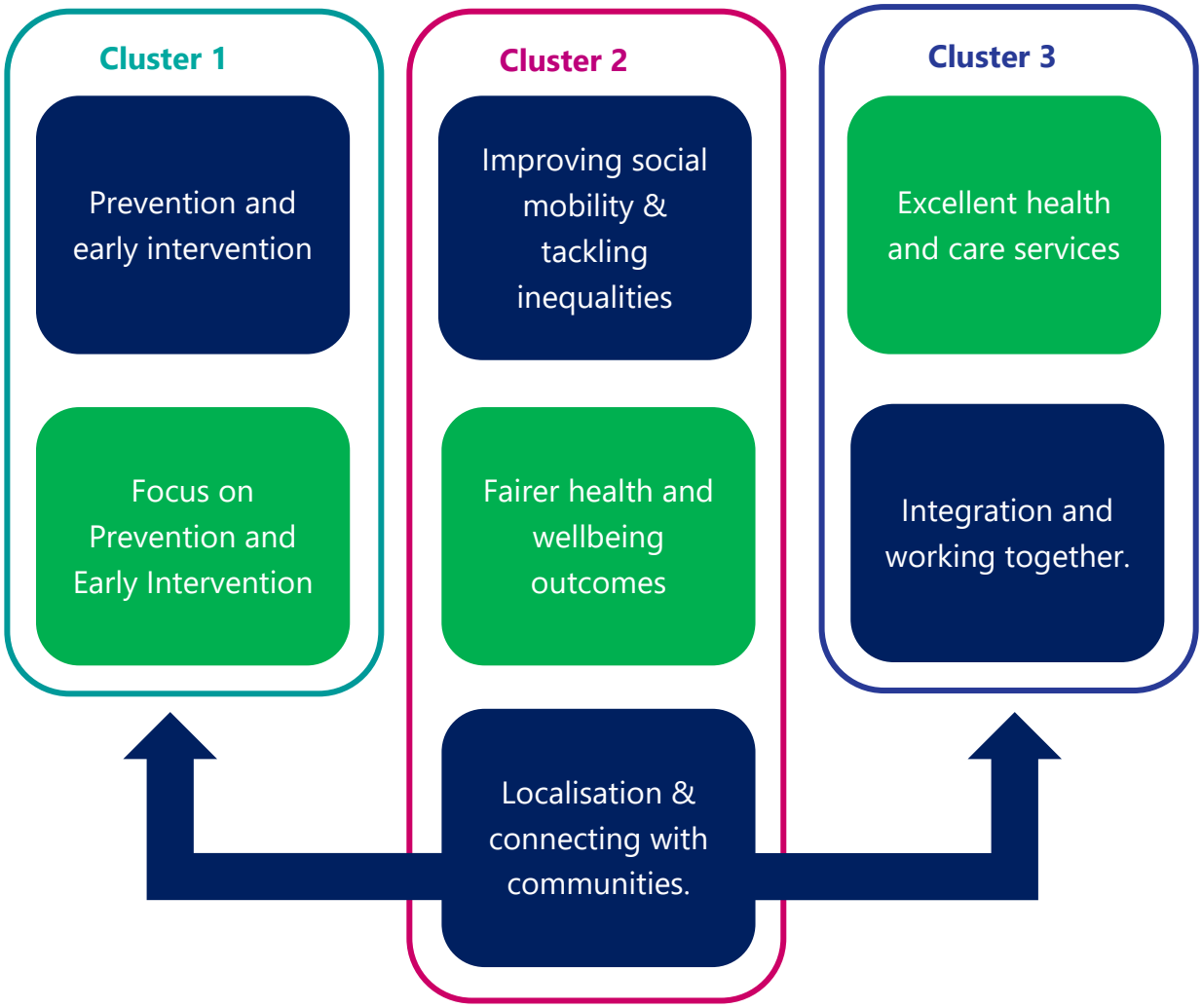


Figure 15: Joint Local Health and Wellbeing themes (blue) and ICS Strategy Objectives (green)

In developing our plans, Alliance Partners agreed 8 Core Commitments, which are aligned to the clusters, set out in Figure 16 The commitments guide the way in which we work together in our Alliance.

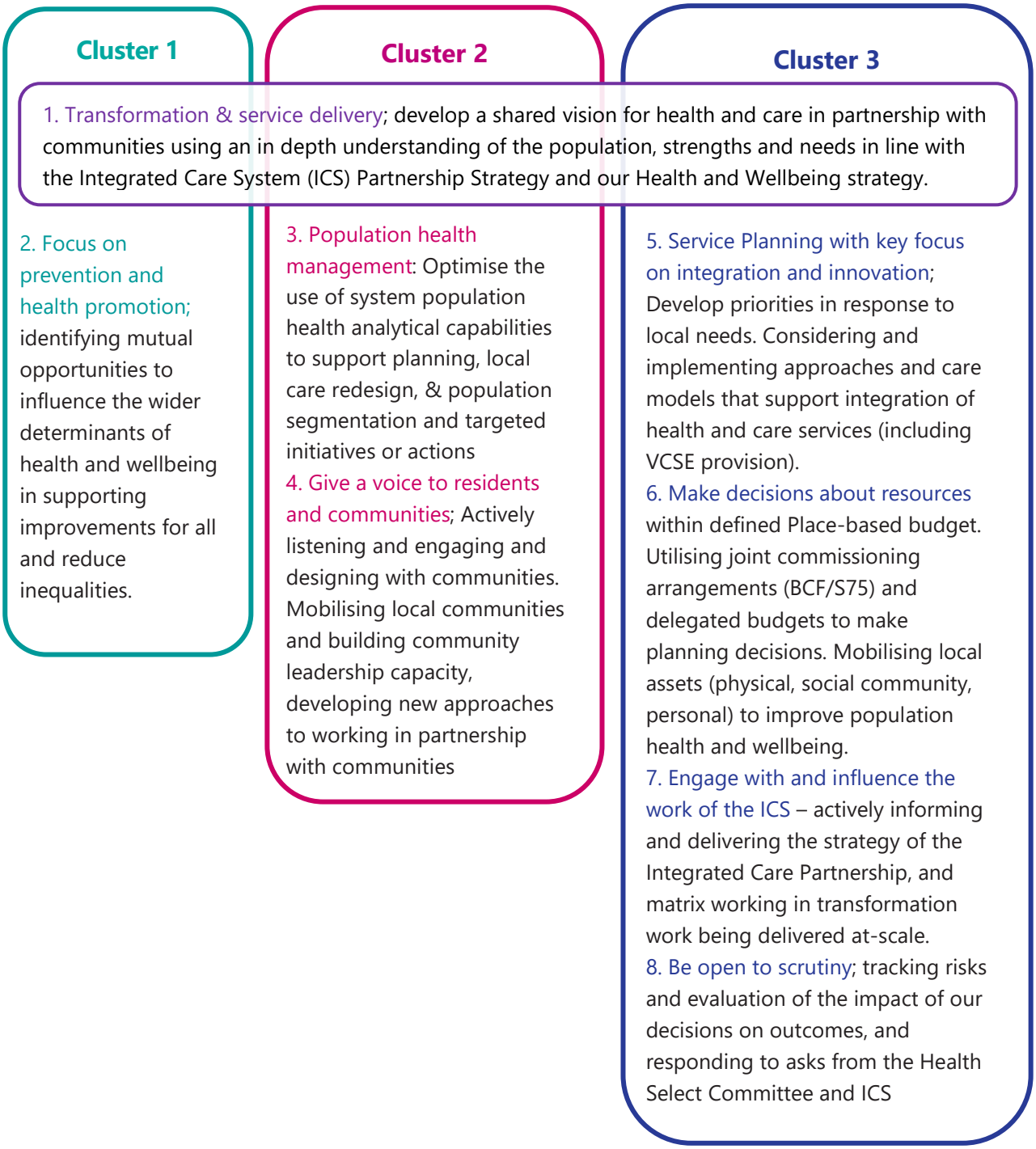


Figure 16: Wiltshire ICA Core Commitments as Partners

Locality Delivery ***Plans and Actions***

The Joint Local Health and Wellbeing Strategy is so newly developed and agreed, that more detailed planning around and milestones is still ongoing, with Wiltshire-level Key Performance Indicators and thresholds to be set and agreed.

Alliance Partners, working as part of the Health and Wellbeing Board, have however, agreed the actions as set out in Table 6 as the priority deliverables against the strategy. Some programmes and key actions are already well established.

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

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

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

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

How we are organised to deliver

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

The Subgroups will embed links to ICS Programme Boards, acting as a key link with the wider system across BSW. Once fully operational, each group will own delivery against key national and local indicators for health and wellbeing improvement for the Wiltshire population. Membership of each group represents the broad Alliance partnership and engages the resources across our organisations. The groups are accountable to the Wiltshire ICA Partnership Committee, with close relationships to the Health and Welling Board which monitors achievement against the JLHW Strategy.

Figure 17 sets out the structure and relationships to other groups and programmes of work. This ensures maximised resources and limits duplication whilst affording a line of sight across the matrices in which we now function, both at neighbourhood, locality, and broader system. Each action to achieve change will have a link to one of the cluster groups for support, although we recognise that some actions will require broad-based effort and may not be ‘owned’ by one of the delivery sub-groups. The Health and Wellbeing Board will monitor progress against all actions.

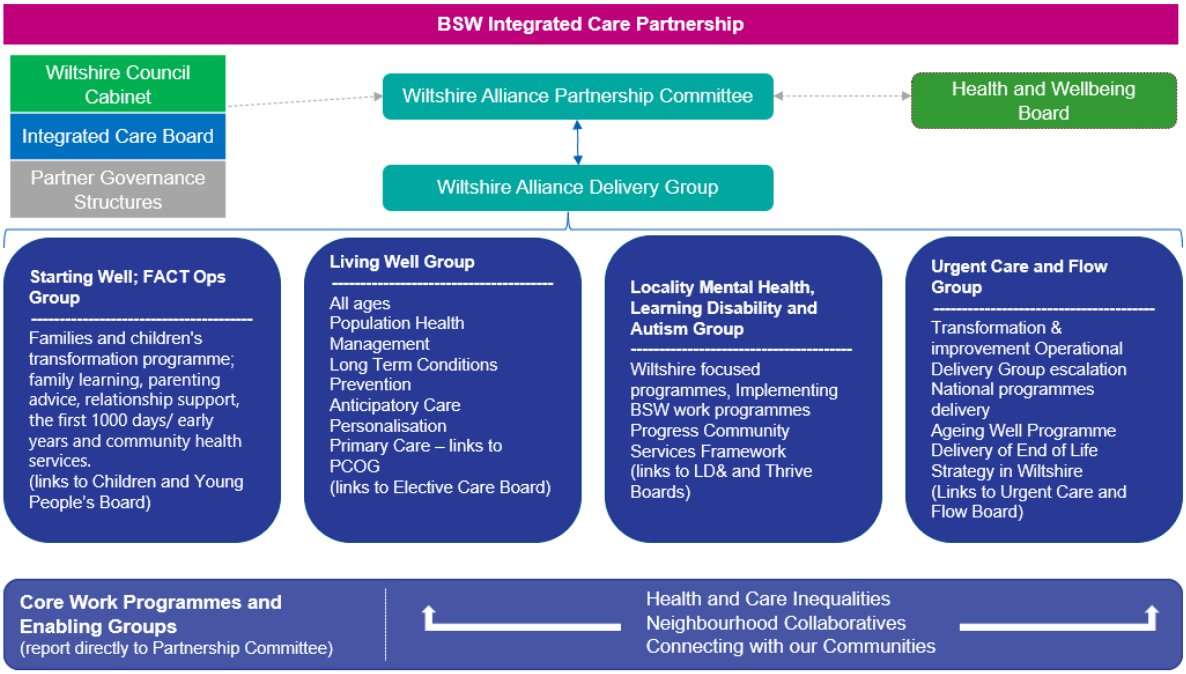


Figure 17: Map of Alliance Partnership Committee and Delivery Sub Group Structure

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

WILTSHIRE

Context

Having completed a new Joint Strategic Needs Assessment in 2022, the Wiltshire Joint Local Health and Wellbeing Strategy recognises the population health and wellbeing inequality gaps across our area and identifies actions to reduce those gaps and improve population outcomes.

In early 2022, Wiltshire ICA Partners recognised the right approach to improvement health outcomes in our communities, is to work directly with them to do so – bringing together partner colleagues, organisations, partners, and residents in a new way. The concept of Neighbourhood Collaboratives was born from this work and are within areas loosely defined by each of the Primary Care Network footprints. Once all are established there will be 12 to 13 Collaboratives across Wiltshire.

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

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

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

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

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

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

The six Principle Areas are:

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

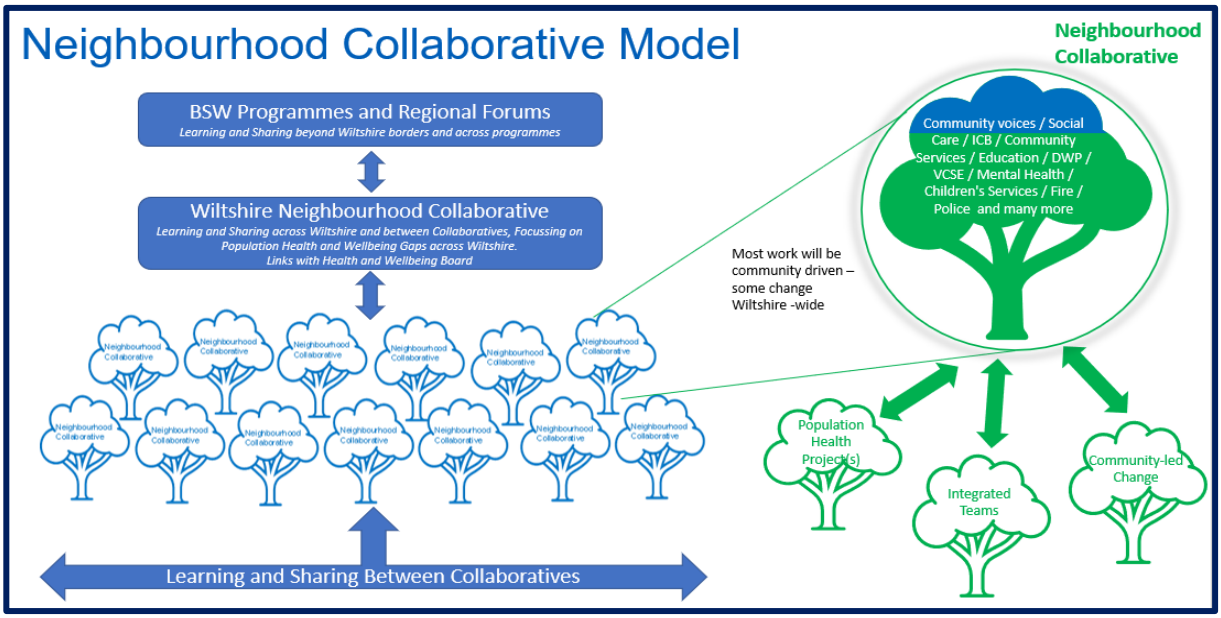


Figure 18: The Neighbourhood Collaborative Model

How we are organised to deliver

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

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

What we will do in the next twelve months

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

- Pathfinder Site (Melksham and Bradford on Avon):

- February to April 2023 – Collaborative group in one neighbourhood on a 'fast track' launched to gather early learning to add to the initial pilot findings.
- May 2023 - Engagement work with Collaborative cohort, focussing on prevention.
- July 2023 - Start working directly with an identified group of patients
- September -2023 – Progress update
- December – Progress updates

- May 2023 – Onboarding Launch programme agreed and online portal established. Full programme pathway agreed (indicates place and pace of Collaboratives launching)
- June 2023 – Devizes and Chippenham, Corsham, Box areas commence launch, first pathfinder report.
- July 2023 – First Wiltshire-wide Collaborative event; share learning; and Pathfinder report.
- By April 2024 all neighbourhood areas will be on their collaborative journey at different points of maturity and will have completed or commenced the Launch programme. Initial impact results will be available for multiple collaboratives areas.

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

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

Monitoring delivery

- Number and range of Collaboratives developed across Wiltshire
- Patient/carer and colleague experience of collaborative working
- Improvements in local health inequalities and outcomes.

Our delivery plan

The Alliance Partnership is focussed on achievement via it's Delivery Groups and key Transformation programmes. Table 7 sets out some key programmes of work and associated milestones and targets. Each Delivery Group will however, also be responsible for an agreed programme of work, which aims to reduce health inequalities and address the priorities identified in the JLHW and ICS Strategies

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

	Alliance Actions to Support JLHW Strategy
Cluster 1; Prevention and early intervention	**Wiltshire Health Inequalities Group and Living Well** Wiltshire partners have established a Wiltshire Health Inequalities Group (WHIG) to coordinate Population Health Inequalities improvement across the NHS Core20PLUS5, BSW Reducing Inequalities Strategy and Salisbury Hospital 'Improving Together' work programme. Gypsie, Roma, Traveller and Manual Workers (specifically those in minority groups) have been identified as the Wiltshire Plus Groups. The planning phase of this group is ongoing. • July 2023 – agree and launch work programme. The Alliance Living Well Delivery Subgroup has been established to support this work, as well as addressing priority improvements around Long Term Conditions and Anticipatory Care. Partnership working with VCSE sector colleagues will be essential is promoting prevention and co-production and reducing our health inequalities. **Adopting a proactive population health approach** Working through the Health and Wellbeing Board and the Living Well Delivery Group, over the next 12 months we will: • Develop a programme of work to delivery improvements in identified areas of unwarranted variation. This may correlate to areas set out below. • Population health management approach will be applied to areas such as moderate frailty, diabetes, deprivation, air quality, CVD, cancer, maternity and infant health, mental illness, end of life and chronic illness. **Childrens Community Health Services** In the next twelve months, we will recommission children's community health services, ensuring they are inclusive of a coordinated approach and core offer for emotional wellbeing in schools. **Empower individuals across the life course** Working through the Health and Wellbeing Board, over the next 12 months we will: • evaluate the findings of the Safe Outside the Home pilot in Wiltshire • consider the findings of the latest pupil survey and the implications for work to reduce risky behaviour in schools. • PSHE support materials will be rolled out as part of Healthy Schools and education on the risk of smoking and vaping. • We will review the impact of health coaches on delivering targeted work on healthy lifestyles and smoking cessation. • Implement a new whole life substance misuse service and evaluate its performance. **Prevent ill health - through increased uptake of screening, health checks and immunisations as well as tackling antimicrobial resistance** Working through the Health and Wellbeing Board, over the next 12 months we will: • Continue to support and work as partners to improve immunisation and screening uptake, in particular through local community engagement and addressing place level health inequalities.

	Alliance Actions to Support JLHW Strategy
	• Promote antimicrobial stewardship with the public and through professional networks **In five years time:** • Health and wellbeing outcomes for Gypsie, Roma, Traveller and Manual worker populations will have improved in line with targets (to be identified). • Health screening rates will be improved in line with targets (to be identified) • School age children will be able to develop improved emotional wellbeing • We will take very opportunity to support residents in reducing risky health behaviours and improve self-care. • There will be improved levels of wellbeing in schools in Wiltshire • There will be reduced levels of risky behaviour in schools • There will be reduced levels of obesity and substance misuse in adults • There will be herd immunity for a range of illnesses and early detection of illnesses • Public and professionals understand the need to optimise use of antibiotics • Health professionals will have a better understanding of predictors of disease and implement appropriate preventative and predictive capability
Cluster 2; Improving social mobility and tackling inequalities	**Neighbourhood Collaboratives** The Neighbourhood Collaborative programme has been co-designed by Integrated Care Alliance partners to enable partnership working to flourish across services, organisations and community groups within neighbourhood areas loosely defined along Primary Care Network footprints. Once established there will be 12 to 13 Collaboratives across Wiltshire, connect partners from health and Social Care, Voluntary Community Social Enterprise, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire and many Community Groups. The partners will offer resources and assets to tackle health inequalities, focus on prevention, improve outcomes, and promote health and wellbeing within their local community. Community views and engagement will be the key to success. This programme works closely with the **Community Conversations** work led by local authority partners which focusses on working with our most deprived areas of Wiltshire to support and drive improvements those communities want to see. Over the next 12 months the programme will: • April 2023 – Pathfinder site launched. • May 2023 – Onboarding Launch programme agreed and online portal established • June 2023 – Devizes and Chippenham, Corsham, Box areas commence launch, first pathfinder report. • July 2023 – First Wiltshire Collaborative event; share learning; and Pathfinder report. • By April 2024 all neighbourhood areas will be on their collaborative journey and will have completed or commenced the Launch programme. **Community Conversations** The community conversations programme has begun, with two pilot areas in North and South Wiltshire – starting with neighbourhoods in Wiltshire that have significant deprivation. We will roll these out gradually across the county. Over the next 12 months, we will: • Continue the community conversation pilots in Studley Green and Bemerton Heath and evaluate the early learning for other potential areas. • The community conversation approach will have been rolled out to several other areas of deprivation in towns such as Chippenham, Melksham and Calne. **Families and Childrens Transformation Programme** Wiltshire's multi-agency Family Help arrangements enable children, young people and families to access the right help at the right time through a co-ordinated approach to prevention and early intervention. To enable the delivery of our Family Help Strategy for 2022-2027, the partners have committed to a programme of development and implementation activity. The focus is on the development of Local Hubs and Clusters. Across Wiltshire, the project will deliver:

- A clear unifying brand for Family Help
- Online database of services, community resources & activities
- Co-ordinated whole system workforce development offer
- Consistency of core approaches across the Early Help workforce

Over the next 12 months the project will deliver:
January '23 – April '23:

- Family and stakeholder engagement
- Launch and embed a pilot area (Warminster and Westbury) including Family Help Practitioners operating.
- Launch Online platform and branding
- Workforce Development Offer phase 1 launched

May '23 – September '23:

- Family and stakeholder consultation
- Initial interim report

September '24:

- Final report

Connecting with our Communities (CWOC)
This programme is an 'enabler' of our work together. Once fully established, the CWOC group will have a 'helicopter view' of Alliance work and will provide a mechanism to support and guide meaningful community engagement throughout development, initiation and delivery of our transformation and service improvement work. It brings together organisations and people to share views, inform the development of our work and align our efforts around engagement and feedback with and from our residents. The group is responsible for ensuring best practice against the BSW People and Communities Strategy and is developing a work programme, which will launch in July 2023, having completed the work on a gap analysis and identified priority work areas. Our Voluntary Community Social Enterprise and HealthWatch colleagues are welcome partners in this space and have joined us as full members of the ICA Partnership Committee and Health and Wellbeing Board.

Promote health in all policies – including housing, employment, and planning.
Working through the Health and Wellbeing Board, over the next 12 months we will:

- Publish a new Local Plan and Local Transport Plan outlining measures for the development of sustainable communities, whole life housing and walkable neighbourhoods.
- Develop health and care campuses that transform healthcare, employment and economic opportunities (e.g. HEAT project in Salisbury)

Support healthy home settings
Working through the Health and Wellbeing Board, over the next 12 months we will:

- Expand provision of the warm and safe service
- Employment support team will help those with mental health or learning disabilities gain employment
- Area Board health and wellbeing champions and grants will undertake a range of activity to tackle loneliness, alongside measures in the adult social care prevention strategy

Target outreach activity – we will improve access to services for people who can or do not access them easily in the current way, improving health outcomes and tackle root causes.
Working through the Health and Wellbeing Board, over the next 12 months we will:

- Outreach to homeless, Gypsy, Roma, Traveller and boater communities and asylum seekers on screening and immunisations.
- Finalise WHIG work programme in July (See Cluster 1 actions)
- Promote take up of health improvement coaches and active health programmes.

	Alliance Actions to Support JLHW Strategy
	In five years time: • Across Wiltshire, our children and families will be supported within their local area to access timely prevention-focussed help and support. • More children will achieve a good level of development before starting school. • There will be 13 fully operating, self-sustaining neighbourhood collaboratives, which are able to evidence their impact on improving local health and wellbeing outcomes and reducing inequalities. • Residents will be able to share their views and thoughts on our work and understand how their opinions can directly shape our work and priorities. • People will find services easier to access with increased co-location and online booking facilities. • Reduced digital exclusion and maximised opportunities technology can bring to improve equitable access to services. • It will be easier to move around local communities in a sustainable manner and vulnerable groups will be supported to access public transport as a wider determinant of health (identified as a priority area of improvement through the Health Inequalities Strategy work). • There will be fewer experiencing fuel poverty and the impact of fuel and fuel poverty will be reduced.
Cluster 3; Integration and working together	**Urgent Care and Flow Transformation.** A comprehensive programme of work across our Alliance is focussed on improving flow across services and reducing unnecessary hospital admissions and delayed discharges. Over the next 12 month this programme will deliver: • Reduced Length of Stay in Care Homes (to achieve 28 days by July 2023) • Achievement of the 70% 2-hour Urgent Care Response target (by June 2023) • Delivery against Virtual Ward development targets, (reaching 136 'beds' by December 2023 and 180 by March 2024) • Reduced length of stay in community hospitals (to reach 35 days across all wards by July 2023) • Reducing hospital trust lengths of stay. • Maximising capacity of Home First services • Complete Discharge Communications Project to improve patient, family and carer experience and reduce discharge delays (resources launching July 2023, full impact September 2023) • Increasing the number of people returning to their own home after a hospital admission (% increase TBC once modelling completed). • Implementing new End of Life care provision model, ensuring people are supported to die in the place of their choosing (launch new model October 2023). • Increased 0-day lengths of stay (target TBC) • Same Day Emergency Care expansion. **Community Services Transformation** Re-thinking the design and delivery of Community services across BSW is a key priority. Wiltshire Alliance is actively engaged in this process and will continue to shape and inform the work as it develops, ensuring we deliver the best possible future model of support for our residents. This programme relates to all of our Delivery Subgroups, a 'task force' group will be established from across the groups to ensure appropriate and agile collaboration, feeding work across our Alliance as needed, but acting as a single point of engagement and coordination. **Provide integrated services at key stages in a person's life** This work includes later life planning, end of life care, and increasing the provision of personal budgets and coproduction of services. Over the next 12 months we will: • Evaluate additional areas suitable for personal budgets • Roll out later life plans to everyone over 85 and earlier cohorts as appropriate

- Implement the new End of Life care provision model, ensuring people are supported to die in the place of their choosing (launch new model October 2023).

Boost 'out-of-hospital' care, dissolving the divide between primary and community health services

We will achieve this through community multi-disciplinary teams, clustering services around primary care networks, and guaranteeing support to people in care homes. Over the next 12 months we will:

- Review primary care commissioning arrangements and alignment with public health, pharmacy, optometry and dental services alongside local community and social care provision
- Prepare for delegation of specialised services and identify opportunities to improve integration with local services
- Identify opportunities to commission provision for military communities alongside that for spouses and families and local communities

Mental Health, Learning Disabilities and Autism

Linking closely with system-wide groups, this group leads the delivery and improvement work around these areas in Wiltshire. This Delivery group has been established for some time, with the focus on embedding the Community Services Framework and has included implementing the SMI, LD and Autism Register and increasing the number of Annual Health checks. An alliance of third sector partners has developed an access model, reducing waiting times and travel distances for people to seek support. This group is currently refreshing it's work programme in line with the ICS and JLHW Strategies, taking account of key national targets and requirements. It will be responsible for prioritising and delivering:

- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
- Recover the dementia diagnosis rate to 66.7%
- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
- by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.

Enable frontline staff to work more closely together

This will include planning our workforce needs together, developing case studies on front line cooperation, supporting shared records and IT and sharing estates wherever possible. Over the next 12 months we will:

- Develop Wiltshire workforce plans as part of BSW strategy
- Enable NHS access to the social care record system as appropriate and increased shared records.
- Develop Wiltshire estate plans as part of BSW strategy

Support for Unpaid Carers

We will ensure carers benefit from greater recognition and support by improving how we identify unpaid carers. Over the next 12 months we will:

- Rollout training for GPs and other health professionals on recognising and referring for support unpaid carers, this will support our ongoing work in other areas to identify carers and offer support.

In five years time:

	Alliance Actions to Support JLHW Strategy
	• Those of our residents requiring support to be discharged from hospital will experience timely, integrated care and enables as many people as possible to return to their own homes. • Access to NHS dentistry will be improved • Primary care will be commissioned alongside other services locally • Our colleagues will feel supported in their roles, and able to work with people across organisations, taking advantage of improved training, technology and integrated systems, able to focus on prevention and early intervention. • There will be clear career pathways in place for both health and social care and professional recognition across both • Data is collected once and shared with those who need it • Residents who experience mental health problems will be able to seek and receive timely support, locally to them – preventing deterioration. • People on the learning disability or autism will be better supported to access health care and support. • Performance is measured in a transparent and understandable way • Unpaid carers know how to access support. • There is seamless provision in areas such as CAMHS • The military covenant statutory responsibilities are fully delivered

Monitoring delivery

Our Alliance will continue to deliver against our priorities, whilst evolving and refining our programme, targets, and pathway to the future. We have built a robust and trusting partnership which will grow and strengthen over time. Our Health and Wellbeing Board and Alliance Partnership Committee will continue to monitor and manage progress against our commitments and to chart the course ahead, guided by our communities and our colleagues.

As a key action in the JLHW Strategy, we have committed to driving improvement through collective oversight of quality and performance, reconfigurations and recommissioning; overseeing pooled budgets and joint teams together – including the ICA transformation programme and Better Care Plan. To support this, and the commitments set out in this plan, we are developing a dashboard of metrics and progress reporting for regular review by the Wiltshire Integrated Care Alliance and in turn the Wiltshire Health and Wellbeing Board.

Contact: Emma Higgins, emma.higgins1@nhs.net

6. Our outcomes measures:

What we will measure:

We want to ensure that we have clear and effective ways to measure our progress against the commitments set out in the BSW Integrated Care Strategy over the next five years. The sections below include the outcome measures we will use across a range of priority areas. However, this section summarises our headline commitments and how we will measure them.

Strategic Objective 1: Focus on prevention and early intervention

Table 8: Prevention and early intervention Our commitments and outcome measures

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
Partners across the ICP will work together to identify an accurate picture of funding and resourcing across BSW when it comes to self-care, community care and hospital care.	BSW ICB is developing a new approach to financial reporting which will help to provide a clear picture of current spending on treatment vs prevention. The ICB will engage with the three local authorities on this to ensure alignment.	TBC	No	TBC
We will aim to increase the share of health and care funding going towards preventative measures (self-care and community care) over the next five years. Our ICP will monitor over time the degree to which this balance is shifting.				
We will increase the proportion of physically active adults	Percentage of physically active adults	OHID, Public Health	Yes BaNES: 77.3% Swin: 67.5%	

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
		Outcomes Framework	Wilt: 71.9% [Eng: 67.3%]	
We will improve Personal Wellbeing ONS4 scores (Life Satisfaction, Worthwhile, Happiness, Anxiety)	Annual personal well-being estimates	Office for National Statistics	Yes	
We will reduce the proportion of adults considered overweight or obese	Percentage of adults classified as overweight or obese	OHID, Public Health Outcomes Framework	Yes BaNES: 62.7% Swin: 69.1% Wilt: 67.2% [Eng: 63.8%]	
We will increase the proportion of children and young people who are healthy weight	Reception: Prevalence of healthy weight Year 6: Prevalence of healthy weight	OHID, Public Health Outcomes Framework	Yes *Reception:* BaNES: 80.7% Swin: 74.5% Wilt: 77.5% [Eng: 76.5%] *Year 6:* BaNES: 70.6% Swin: 61.7% Wilt: 65.6% [Eng: 60.8%]	

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
We will reduce the prevalence of mental health conditions				
We will improve uptake of cervical, breast and bowel cancer screening	Cervical screening coverage: aged 25 to 49 years old Cervical screening coverage: aged 50 to 64 years old Breast screening coverage: aged 50 to 70 years old Bowel cancer screening coverage: aged 60 to 74 years old	OHID, Public Health Outcomes Framework	Yes *Cervical (25 to 49)* BSW ICB: 72.8% [Eng: 68.6%] *Cervical (50 to 64):* BSW ICB: 76.6% [Eng: 75.0%] *Breast:* BSW ICB: 63.3% [Eng: 62.3%] *Bowel:* BSW ICB: 74.2% [Eng: 70.3%]	
Increase green space, accessible for all to use, and promote greener transport	Utilisation of outdoor space for exercise/ health reasons *This dataset appears to have ended in 2015-16*	PHOF/ Natural England	BaNES: Swin: Wilt [Eng:]	

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
Improve air quality	Fraction of mortality attributable to particulate air pollution (new method)	PHOF/ DEFRA	BaNES: 5.2% Swin: 5.9% Wilt: 5.3% [Eng: 5.5%]	
Keep all of our residents in warm and decent homes, through investment in our social housing stock and both supportive and enforcement interventions in private sector homes	Availability and uptake of warm housing interventions		BaNES: Swin: Wilt [Eng:]	
Prevent homelessness by engaging with vulnerable individuals at the earliest possible stage	Households owed a duty under Homelessness Reduction Act	PHOF/ MHCLG	*Per 1,000* BaNES: 4.4 Swin: 13.3 Wilt: 6.9 [Eng: 11.7]	
Prioritise social housing to those in greatest need to support their health and social care needs	Adults in contact with secondary mental health services who live in stable and appropriate accommodation.	PHOF	BaNES: 19% Swin: 45% Wilt: 32% [Eng: 26%]	
	Adults with a learning disability who live in stable and appropriate accommodation		*WP – Struggling to locate data by local authority*	

Strategic Objective 2: Fairer health and wellbeing outcomes

Table 9: Fairer health and wellbeing outcomes commitments and outcome measurements

Headline commitment	Overall goal	Specific objectives	Outcome measurements	Baseline data?	Milestones
Healthcare inequalities and CORE20PLUS5	Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and clear plans on how close the inequality gaps to offer exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes	Increased access across the system to data segmented by ethnicity and deprivation (as standard)	Performance reports will be broken down by patient ethnicity and IMD quintile, focusing on: - Under-utilisation of services (e.g., proportions of cancelled appointments) - Waiting lists - Immunisation and screening - Late cancer presentations		
		Identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile	Data on access and %broken down by patient age, ethnicity, disability status, condition, IMD quintile		
		Improved data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning	% completeness of data on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning		
		Increased understanding of equity of access, experience and outcomes for priority groups as shown through patient engagement	Development of a strategic approach to community engagement embedded through the System, focusing on equity of access, experience and outcomes for C20+ groups		

Headline commitment	Overall goal	Specific objectives	Outcome measurements	Baseline data?	Milestones
	Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas (adults)	Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups	Increase in percentage of pregnant people on CoC pathway in line with staffing trajectories		
		Enhance provision to better address physical health risks and needs for people with SMI	Annual health checks for 60% of those living with severe mental illness and learning disabilities		
		Driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations	Increased uptake of COVID, flu and pneumonia vaccines in C20+ and people with COPD		
		Increased proportion of cancers diagnosed at stage 1 or 2	75% of cancer cases diagnosed at stage 1 or 2 by 2028		
		Hypertension case-finding and optimal management and lipid optimal management to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024		
			Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%		
	Achieving the Core20PLUS5 targets to reduce the inequality gaps	Address over reliance on reliever medications	Reduce the percentage of children and young people with a reliever: preventor ratio greater than 1:6		

Headline commitment	Overall goal	Specific objectives	Outcome measurements	Baseline data?	Milestones
	identified in the five clinical areas (CYP)	Decrease the number of asthma attacks	Reduce the number of asthma attacks as indicated by unplanned hospital admissions, presentations in ED, prescriptions of oral steroids		
		Reducing health inequalities and variation in outcomes for children and young adults with diabetes, including more equitable access to treatment technology	Increased access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.		
		Address variation in access to Epilepsy Specialist Nurses (ESNs) within ICSs/Trusts, with a specific focus on access for patients from the most deprived quintile and those with LD&A	Increase access to ESNs for CYP within the most deprived 20%, and CYP with LD&A, within the first year of care		
		Address the backlog for tooth extractions in hospital for under 10s	Tooth extractions in hospital due to decay for children aged 10 years and younger		
		Improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender and deprivation	Children and young people (ages 0-17) mental health services access (number with 1+ contact)		

Headline commitment	Overall goal	Specific objectives	Outcome measurements	Baseline data?	Milestones
Tackling inequality by addressing social, economic, and environmental factors	Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy	Reduce smoking in adults across BSW	Smoking prevalence in BSW		
		Reduce smoking in adults in routine and manual occupations	Smoking prevalence of adults in routine and manual occupations		
		Reduce smoking in pregnancy	Prevalence of people smoking in pregnancy/smoking at time of delivery		
		Increase proportion of acute or maternity inpatient settings offering smoking cessation services	Proportion of smokers received smoking cessation support within hospital		
			Proportion of pregnant smokers offered support in maternity settings		
	Halt and reverse of obesity prevalence in children and adults across BSW		Number of referrals to NHS digital weight management services per 100k head of population		
			Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled		
			Engagement in Digital Weight Management Programme (PH tbc)		
	Establishing and harnessing the potential of local anchor Institutions in our three acute hospitals and mental health trust to		All three acute hospitals in BSW achieve chartered anchor institution status by 2025		
			Increased number of local hires		
			Increased number of apprenticeships		

Headline commitment	Overall goal	Specific objectives	Outcome measurements	Baseline data?	Milestones
	deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact		Increased recruitment representative of local demographic data		
			Increased local vs. central spend where possible		
			Increased community use of NHS estates		
			Increased support for NHS staff to access affordable housing		
			Increase in accessible community green space		
			Decreased carbon output through improved energy efficiency, increased sustainable travel options		
			Reduced waste and water consumption		
			Develop and support anchor collaboratives/networks (e.g. AWP, Local authorities, campuses, leisure centres)		

Add in school readiness and JSNA from BaNES, Swindon and Wiltshire

Strategic Objective 3: Excellent health and care services

Table 10: Excellent health and care services commitments and outcome measurements

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
Shared decision making to ensure that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach decisions about treatment	Number of people completing Collaborate and proportion scoring 9+. (NB. This will require a process to collect and collate CollaboRATE)	http://www.glynelwyn.com/collaborate-measure.html		
Personalised care and support planning to ensure facilitated conversations take place in	% people reporting they have agreed a plan with a healthcare professional from their GP practice to manage their condition. % people reporting they found this plan very or fairly helpful in managing their condition.	GPPS		

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
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				
Social prescribing and community based support to ensure individuals are supported to access the widest range of support and services available in their community	Number of referrals to Social Prescribing	ICB		

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
Supported self management to ensure people are helped to manage their ongoing physical and mental health conditions themselves	% people reporting they are very or fairly confident that they can manage any issue arising from their condition.	GPPS		
Joined up local teams: We will accelerate placed based integration of mental and physical health, through integrated neighbourhood teams and primary care.	Number of people and number of partners (including MH providers) access the ICR Number of shared care plans recorded on the ICR and the frequency in which these are accessed by multiple front line workers (including MH workers). Number of people completing IntegRATE (http://www.glynelwyn.com/integrate.html) and proportion scoring 8+ (NB. This will require a process to collect and collate IntegRATE)."			
Local specialist services: We will work with	Number of out of area placements	ICB		

Our commitments	Outcome measurement	Source	Baseline data?	Milestones
our specialist mental health providers to ensure local specialist provision is accessible, responsive, financially sustainable and reduces the need for out of area care.				

7. Strategic Objective 1: Focus on Prevention and Early Intervention

Introduction

Our ambition is to move the dial of how we work towards a greater focus on prevention, and this needs to be wider than individual, subject specific, prevention programmes. The development of a wider, joined up approach to prevention across our system is an opportunity to maximise the weight behind taking prevention programmes seriously across whole pathways, from primary to tertiary. Key things to be considered are:

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

Our approach to all health and care will be based on shared decision-making, which means ensuring that our population is supported and informed to make decisions that are right for them. It's a collaborative process through which a clinician supports individuals to reach a decision about their treatment. The conversation brings together the clinician's expertise, such as treatment options, evidence, risks and benefits, and what the individual knows best, such as their preferences, circumstances, values and beliefs. We will also encourage people to manage their own care as far as possible and empower them to do this with better information and support. For example, good management of diabetes at home will help to avoid emergencies.

With this end in mind, we have set out a number of areas of focus within our ICP strategy under this objective. This section sets out these areas of focus, and how we are going to deliver our joint commitments made within the strategy.

Areas of Focus

1. Focusing funding and resources on prevention rather than treatment
2. Intervening before ill-health occurs (primary prevention)
3. Identifying ill-health early (secondary prevention)
4. Slowing or stopping disease progression (tertiary prevention)
5. Wider determinants of health
6. Support babies, children and young people to Start Well recognising an increased focus on children and young people, this is prevention in action for our future population.

Focusing funding and resources on prevention rather than treatment

We have made the following commitments in our strategy:

- Partners across the ICP will work together to identify an accurate picture of funding and resourcing across BSW across self-care, community care and hospital care; and
- We will aim to increase the share of health and care funding going towards preventative measures over the next five years.
- *We will aim to increase the share of health and care funding for babies, children and young people as we know that the needs of children are multifaceted and need a higher profile.*

[need a section on this – how we are going to build the accurate picture of funding, how we are going to seek to increase the share of health and care funding over the next five years]

Intervening before ill-health occurs (primary prevention)

We have made the following commitments in our strategy:

Physical wellbeing:

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

Mental wellbeing:

- We will reduce the prevalence of mental health conditions.

Physical wellbeing -Tackling obesity in adults and increasing the proportion of children and young people who are healthy weight:

Context

Currently much of our work on obesity is driven at a Place level and this is reflected in our current approach to this area of prevention work.

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

In 2019, Bath and North East Somerset Council (B&NES) initiated a whole system leadership approach to obesity. Extensive engagement and system mapping was completed with partners and stakeholders during the first phase of this project. In 2020, the COVID-19 pandemic interrupted the implementation of the approach however this work is now moving forward, and we now propose to develop an integrated health improvement strategy for physical activity, healthy weight, mental wellbeing, alcohol, tobacco and food in B&NES.

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

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

Our delivery plan

In Swindon there are a range of programmes for adults and children to help reduce obesity, including implementing the 'Whole Systems Approach to Obesity[1]' using PHE guidance, provision of programmes in early years and schools' settings, and a range of weight management offers. Using a whole systems approach, we have mapped the key drivers of obesity in Swindon including addressing food poverty, physical inactivity, and the built environment and eating as a coping mechanism. Woking in partnership with a range of stakeholders, we are developing actions plans to tackle each of these key drivers.

In B&NES, we are currently developing the integrated health improvement strategy, aiming for completion in November 2023.

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

How we are organised to deliver

The Public Health Directorate at Swindon Borough Council leads on implementing the whole systems approach to obesity. A systems network with a range of partnerships and organisations has been developed to support the implementation of the whole systems approach and to take forward actions to tackle each of the identified drivers of obesity. Our commissioned weight management services are also delivered in partnership with colleagues from the Council's Livewell Team and partners including schools, and Swindon Town FC Community Foundation. Our programmes include Slimming World, Football Fans in Training and our pilot whole school programme 'School Nutrition and Activity Project in Swindon' (SNAPS).

In B&NES, this is to be determined.

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

The BSW C&YP Programme Team is now fully staffed with capacity to move forwards on this priority.

What we will do in the next twelve months

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

- Publication of our Whole Systems Approach to Obesity strategy (June 2023)

[11] https://www.gov.uk/government/publications/whole-systems-approach-to-obesity

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

In B&NES, our key deliverables over the next 12 months are:

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

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

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

For the C&YP Programme team:

- Launch a C&YP Obesity pilot study – Timeframe tbc
- Identify where barriers and difficulties for C&YP lie and address those barriers
- Learn from previous local weight management initiatives, scrutinise their outcomes and use our findings to shape future commissioned support, which is fun, engaging, motivational and effective
- Establish a commissioning model

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

As stated at the start of this section, this work is being driven at the Place level meaning that work still needs to be undertaken around what this will mean at a system level in 5 years' time.

In Swindon, the vision for the Whole Systems Approach to Obesity is that "*Together we will create an inclusive environment that supports everyone in Swindon to be a healthy weight."* We want everything in our environment to help people increase their levels of physical activity, eat nutritious food and maintain a healthy weight. In five years', time we want the environment in which our residents live to support them to achieve a healthy weight and for healthy weight will be a consideration in a range of policies and strategies.

In B&NES, this is to be determined in conjunction with our system partners.

In Wiltshire, this will be a continuation of the phases mentioned above:

- Phase 4 – Action Plan
- Phase 5 – Managing the system network
- Phase 6 – Reflect and refresh

For the C&YP Programme team, this will be determined and linked to the localities 5-year plans.

Monitoring delivery

In addition, a set of metrics has been identified by BSW Inequalities Strategy around halting and reversing Obesity prevalence in children. These outcomes include:

Table 11: Halting and reversing obesity prevalence metrics

Vision	KPI/Metric
Halt and reverse of obesity prevalence in children and adults across BSW	Number of referrals to NHS digital weight management services per 100k head of population
	Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled
	Engagement in Digital Weight Management Programme (PH tbc)

As part of our developing system working, we will agree how we bring together the outputs of Place led activities to provide a clearer System picture of progress in this area.

In Swindon, our performance targets are to:

- Increase the proportion of children and young people who are healthy weight at year 6 and at reception in line with the national average by 2027/28.
- Reduce the proportion of adults considered overweight or obese in line with the national average by 2027/28, particularly reducing inequalities
- Increase the proportion of physically active adults and children and young people to be above the regional average by 2027/28

For each of the above, there will be a particular focus on reducing inequalities in obesity and activity levels within our population.

In B&NES, this is to be determined in conjunction with our system partners.

In Wiltshire, progress will be monitored against prevalence data and indicators in the local obesity profiles as part of the national Public Health Outcomes Framework. The overarching ambition will be to reduce obesity prevalence in children and adults over the next 5 years.

List lead and email address for further information:
Lead on collating: Janani Arulrajah JArulrajah@swindon.gov.uk / Brian Leitch ***brian.leitch1@nhs.net***
Swindon: R.Clark@Swindon.gov.uk

B&NES: Annette Luker Annette_Luker@BATHNES.GOV.UK / Hannah Thornton Hannah_Thornton@BATHNES.GOV.UK
Wiltshire: Katie.davies@wiltshire.gov.uk

Smoking cessation

As a cross cutting activity, smoking cessation activity takes place at both system and place level, detail of each element is below:

Context

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

Smoking is an ongoing concern across BSW with current smoking prevalence at 9.7% in BANES, 12.5% in Swindon and 11.7% in Wiltshire (PHOF), compared to an England average of 13.9%.

Costs of smoking across BSW can be illustrated through the ready reckoner: ASH ICB Ready Reckoner - ASH

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

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

Our delivery plan

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

The NHS Long Term Plan requires that everyone admitted to hospital will be offered NHS funded tobacco treatment services, including maternity and mental health inpatients. Funding has been provided by NHSE to ICBs for onward allocation to NHS Trusts for delivery.

Key components of the inpatient delivery model (including mental health) are:

- The patient's smoking status is recorded during the admission process.
- Initial stop smoking medication is prescribed to all admitted smokers to help with nicotine withdrawal, with delivery of very brief advice (VBA) on tobacco dependence and stopping smoking.

- On an opt out basis, a 1:1 meeting with a tobacco dependence adviser is provided within 24 hours of admission to agree a personalised plan to support either a quit attempt or temporary abstinence.
- Provision of a minimum of two weeks of NRT/other pharmacotherapy provided upon discharge alongside a referral to a service which will continue to supply the 12-week course e.g., a community local stop smoking service and provide ongoing support

Key components of the maternity delivery model are:

- Smoking status is recorded for pregnant people admitted to hospital at time of delivery and pregnant people at booking and at 36 weeks
- A 1:1 meeting with a Tobacco Dependence Adviser (TDA) is arranged at the first antenatal booking appointment,
- Weekly face to face appointments with the Tobacco Dependence Adviser take place for at least four weeks.
- NRT should be supplied for up to 12 weeks beyond the quit date.
- A further six face to face appointments should take place throughout pregnancy to support the woman to remain smokefree.

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

How we are organised to deliver

Local Authority Public Health leads support the delivery of the TTD programme through chairing of the monthly BSW NHS Long Term Plan for Treating Tobacco Dependency network meetings. The group is accountable to the ICS Population Health Board and provides updates on delivery and implementation at least annually. Executive level support and named senior clinicians from acute trusts are identified in project plans.

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

What we will do in the next twelve months

- BSW Tackling Tobacco Dependency Business Case is reviewed and agreed across the system for 23/24 delivery.
- Trust project plans are in place and resources identified for delivery (to include named leads, finance, etc)
- Recruitment and confirmation of system leadership for Treating Tobacco Dependency, with programme management support to work with Trusts to ensure delivery plans continue to be monitored and reporting back to NHS England as appropriate.
- Delivery of the Treating Tobacco Dependency programme is fully embedded in the system and place inequalities workstreams to ensure integration of work across organisation and adequate finance resource is in place to achieve delivery of the programme.

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

The BSW business case for Treating Tobacco Dependency contains the implementation plan for the programme, with further detail on what NHS Trusts will deliver found here: *NHS England » Guide for NHS trust tobacco dependence teams and NHS trust pharmacy teams*

Monitoring delivery

Delivery will be monitored via the TTD Project Pack, overseen by the ICB programme lead. Monthly reporting to NHS England, reporting trajectories, milestones, risks & issues and actions are completed via Trust leads. NHS England are developing a TTD dashboard to share metrics of programme delivery which will include the following;

List lead and email address for further information
Gemma.brinn@wiltshire.gov.uk
Massimo.morelli@nhs.net

Smoking cessation – B&NES, Swindon and Wiltshire

Context:

In Bath and North East Somerset the strategic vision is to achieve a smokefree generation which will build healthier, more equal communities by reducing smoking prevalence, exposure to second-hand smoke and illicit tobacco. A Tobacco Control Needs Assessment for B&NES was completed in early 2019 and informed the priorities outlined in our Smoke Free B&NES Tobacco Control Strategy 2019 – 2024 [2]

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

In Wiltshire there is a gap in life expectancy for men of 5.5 years mapped between the most and least deprived areas, and 3.4 years for women. Tobacco is still the largest preventable cause of these differences[3]. Smoking has been identified as a cross cutting theme in the work to deliver the BSW Reducing Inequalities Strategy, and a core focus of the Wiltshire Health Inequalities Group. Wiltshire Council's Business Plan includes an aim to reducing smoking prevalence to 5% or less in line with the government's 2030 smokefree ambition.

Our delivery plan

In B&NES the Tobacco Control Strategy plan sets out an ambition to reduce health inequalities by achieving a smoke free generation - 5% smoking prevalence by 2030, in line with national ambitions and local needs. The strategy seeks to build on the progress resulting from the previous 2014-2018 strategy by defining how the local authority and its partners will seek to act in an evidence based and needs based way in order make meaningful impact on:

- Prevention of uptake of tobacco use and relapse into tobacco use

- Protection from the harm of smoking in existing smokers and from second-hand smoke
- Increasing quit attempts and evidence-based support to quit

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

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

The vision for a smokefree Wiltshire is where everyone lives a long and healthy life protected from the harms caused by tobacco. We aim to reduce smoking prevalence to 5% or less by delivering wide ranging and accessible support to encourage more of Wiltshire's population to avoid taking up or to stop smoking.

Delivery will occur across 4 priority areas:

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

How we are organised to deliver

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

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

It has been agreed for a Wiltshire Tobacco Control Alliance to be established to oversee delivery of the tobacco control activity, reporting to the Wiltshire Health Inequalities Group.

The Alliance will adopt a whole systems approach to tobacco control, involving a range of partners and will be guided through the delivery of an agreed action plan.

What we will do in the next twelve months

Delivery across BSW over the next 12 months will focus on:

- Focus on health inequalities and target resources for those that need it most (linked to local health inequalities activity)
- Increasing knowledge, awareness and skills in talking about e-cigarettes and vaping, particularly amongst those working directly with children and young people e.g. schools
- Reduce the availability and access to illegal tobacco and illegal nicotine vaping products in the community
- Raise the profile of tobacco control and local services through marketing and communications programmes e.g. Stoptober
- Working with BSW partners to support implementation of the NHS LTP on Treating Tobacco Dependency including provision of support across inpatient, maternity and mental health services in B&NES.

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

- Reduction in the inequality gap in smoking prevalence between those in routine and manual occupations and those with a Serious Mental Illness and the general population
- Reduce the prevalence of smoking in the adult population towards the national ambition of 5% by 2030
- Reduce the prevalence of women who smoke at the time of delivery towards the national ambition of below 5%
- Reduce the prevalence of smoking in CYP

Specific place-based targets will be contained in local tobacco control strategies and action plans.

Monitoring delivery

Progress will be monitored against prevalence data and indicators in the local tobacco control profiles as part of the national Public Health Outcomes Framework.
In addition, a set of metrics has been identified by BSW Inequalities Strategy around reducing smoking prevalence. These outcomes include:

Table 12: reducing smoking prevalence metrics

Vision	KPI/Metric
Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy	Smoking prevalence in BSW
	Smoking prevalence of adults in routine and manual occupations
	Prevalence of people smoking in pregnancy/smoking at time of delivery
	Proportion of smokers received smoking cessation support within hospital

	Proportion of pregnant smokers offered support in maternity settings

List lead and email address for further information:
BANES: cathy_mcmahon@bathnes.gov.uk / ruth_sampson@bathnes.gov.uk
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Wiltshire: gemma.brinn@wiltshire.gov.uk / gemma.dummett@wiltshire.gov.uk / helen.aston@wiltshire.gov.uk

Mental wellbeing - Prevention

Context

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

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

Although a large proportion of our population live in relatively less deprived areas, there are pockets of challenge across our communities that we will need to address if we are to support improvements in mental wellbeing and a reduction in common mental illness. The map below shows that overall Swindon has a far higher rate of deprivation than Wiltshire or B&NES. This is evident in lower income levels, greater levels of unemployment, poorer education attainment and challenges with housing. From a health outcomes perspective, people in Swindon have a lower life expectancy than people in B&NES or Wiltshire:

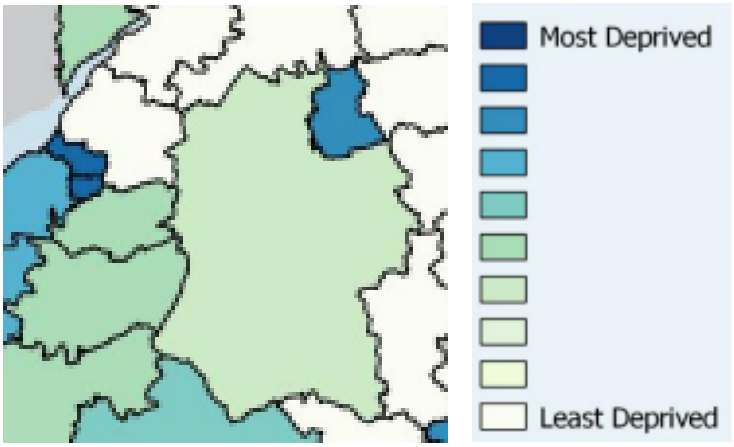
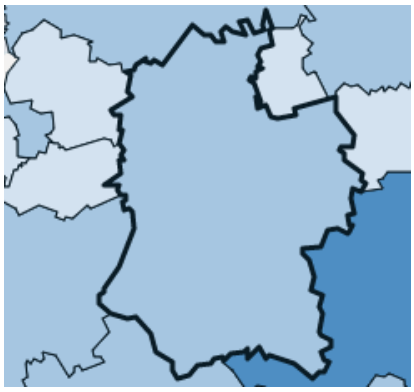


Figure 19: A map of BSW coloured by deprivation scale. Source: The English Indices of Deprivation 2019 (publishing.service.gov.uk)

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



Local Authority	Number of CLA (2020)
B&NES	181
Swindon	301
Wiltshire	458

Figure 20: Number of Children Looked After in B&NES, Swindon and Wiltshire (2020). Source – Joint Strategic Needs Assessments for B&NES, Swindon and Wiltshire

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

People with mental health needs care be broadly segmented into the following groups:

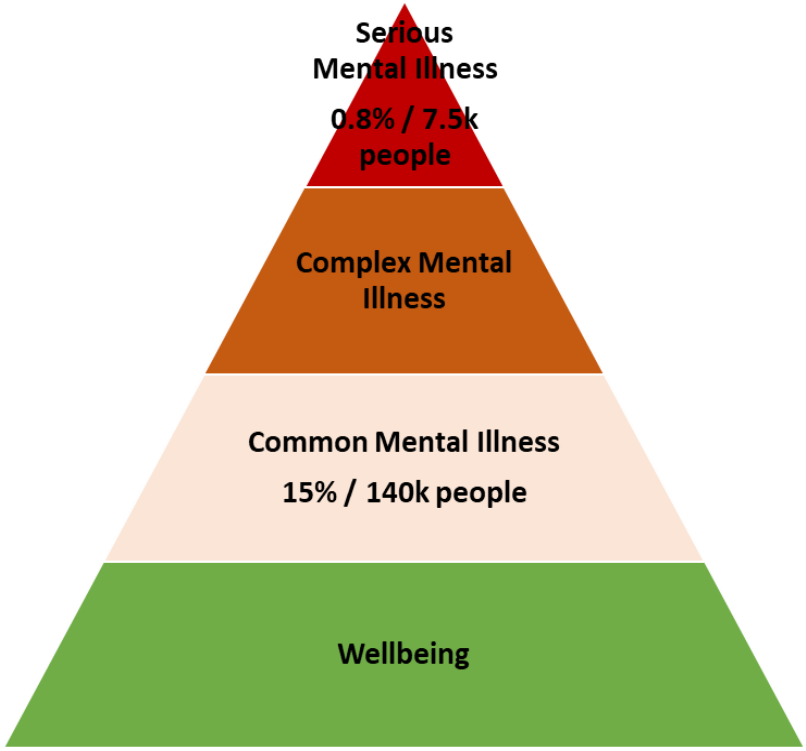


Figure 21: Broad groupings of people with mental health needs

Whilst the number of people with Serious Mental Illness is relatively consistent across B&NES, Swindon and Wiltshire, the number of people with Common Mental Illness is

increasing in every geography[2]. This is across both adult and children's services, and if we are to arrest this growth in future years, we need to have a more systematic and consistent approach to wellbeing that focuses on providing opportunities for people to access community based offers that support them to stay well in the community.

The following groups are more likely to experience poor mental health:
- People from Black, Asian and Minority Ethnic (BAME) groups
- People with physical disabilities
- People with Learning Disabilities
- People with alcohol/drug dependence
- People in prison
- People who identify as LGBTQ+
- People who are carers
- People with sensory impairments
- People who are homeless
- People who are refugees or seeking asylum

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

Our older adult population is increasing, and similarly we need to respond to this with the right support to both people and their carers in order to reduce demand on both mental health and physical health services – across primary, secondary and tertiary care services. The development of our Integrated Care Board affords us the opportunity to work together to address these health inequalities, with a collective and concerted effort to improve prevention and reduce mental ill health.

Our delivery plan

Our delivery plan to improve mental health and wellbeing is focused on increasing investment in early intervention and prevention initiatives, reducing demand for secondary mental health services and achieving a 'left shift' in provision. This will involve working through our Integrated Care Alliances (ICAs) to coordinate and develop thriving local communities, equipped to support people's mental health and wellbeing. Over the coming 5 years we will:
- Reinvest savings made in core mental health provision in targeted wellbeing initiatives, directing funding through our Third Sector Mental Health Alliance
- Increase the number of people across our communities trained in mental health first aid
- Expand and develop our Mental Health Support Teams (MHSTs) in schools and work with education providers to support delivery of their local mental health plans
- Continue to increase the number of people with serious mental illness accessing annual physical health checks in primary care
- Develop targeted support offers for people who are refugees or asylum seekers across our communities

[2]

- Make best use of social prescribing and navigation support available in primary care and reduce the medicalisation of low

How we are organised to deliver

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

What we will do in the next twelve months

Over the next twelve months we will:

- Improve access to community based mental health services with a no wrong front door approach delivered by our third sector alliance partners, across BSW. Their service will 'walk alongside' and direct people to alternative offers in local communities. Achieve LTP target for Community Mental Health service provision (by Q4)
- Implement a new model for Children and Young People's mental health in Swindon, with this then operating as a blueprint from which we will develop similar services across our ICB footprint (Q3)
- Improve our Talking Therapies provision, recruiting new staff to implement phase 1 of our plan to deliver national LTP metrics (by Q4)
- Reduce long lengths of stay in out of area placements, investing savings in new models of community rehabilitation and wider mental health transformation (by Q4)
- Implement a new GP LES for Physical Health Checks for people with SMI in order that they can be managed successfully in primary care (Q2)

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

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

Monitoring delivery

- 21,095 people accessing Talking Therapies by 2025/26
- 14,115 people accessing a fully transformed community based services
- A year-on-year increase in people accessing mental health first aid training
- 26 ARRS workers operating in primary care – supporting early access to mental health services combined with navigation and social prescribing support

Identifying ill-health early (secondary prevention)

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

Long term conditions: Cardiovascular disease (CVD) and Diabetes

Context

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

Our delivery plan

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

- Increased use of data to highlight and work as a system to understand and engage with differences in NHS Health Check uptake, and treatment targets and care processes attainment, including by different cohorts
- Focused as much on behavioural interventions as medical treatments, with all care providers implementing Making Every Contact Count
- Care aligns with the BSW Care Model and through Integrated Neighbourhood Teams, moving to a population health approach to diabetes and CVD

How we are organised to deliver

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

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

What we will do in the next twelve months

- Agreed governance and priorities for Long Term Conditions across BSW by end of Q2
- Dashboard to enable system wide visibility of NHS Health Check uptake and CVD and diabetes care processes and treatment targets attainment by health inequalities cohorts by end of Q1, with further development into Q2
- Utilisation of data to support uptake and attainment discussions to commence in Q2
- Plan for how Practices could be supported to deliver step change in CVD and diabetes care developed, by end of Q3
- Pilot of Pharmacist Facilitator role to support PCN Pharmacist role development, to commence from Q3
- Options and plans for integrating Primary Care services with Community Pharmacy are developed
- Increased coordination between specialist diabetes services, planned from Q1 and implementation commence from Q3
- Plans developed for how patients with modifiable risk factors or new condition identified and receive support through NHS Health Checks
- Implementation of Diabetes Pathway 2 Remission (Low Calorie Diet Programme), to commence roll out from Q3

- Increasing utilisation of diabetes digital Structured Education options for appropriate patients, to commence roll out from Q2

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

- Treatment will commence with a good understanding and level of engagement with each patient's individual behavioural risk factors and how medical treatments most effectively plays a part in their care
- Specialist services are risk stratified, complexity based and aligned with the BSW Care Model
- We will use the Population Health Management approach to diabetes and CVD care alongside Integrated Neighbourhood Teams to identify patients with unresolved risk factors and agree solutions
- Ensure all clinicians involved in care of patients have the information required for effective shared care with decisions being jointly agreed by clinicians and patients
- Structured Education services at scale and scope to meet demand for patients to attend within one year of diagnosis and for people who have had diagnosis for longer to attend as required for risk reduction
- Remote delivery of care, using technology to assess when someone needs support

Monitoring delivery

The focus on monitoring will be on the following metrics:

23/24 Planning Guidance:

- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

Diabetes key metrics

- % patients achieving the 8 Care Processes
- % patients achieving the three treatment targets (HbA1C, Blood Pressure and Cholesterol)
- % patients attending Structured Education within one year of diagnosis

Health checks

- % eligible people attending a health check within last five years

List lead and email address for further information
Brian Leitch, CVD and Diabetes Programme Lead, brian.leitch1@nhs.net
PH Leads?

Cancer and Screening (cervical, breast and bowel):

Context

Provision in the BSW area is as follows:

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

Our delivery plan

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

How we are organised to deliver

See Context section above.

What we will do in the next twelve months

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

- Early presentation and uptake of cancer screening – we will share with all practices and PCNs the learning and outcomes from projects that we have funded in primary care in 22/23 aimed at increasing early presentation and screening uptake.
- Targeted Lung Health Check – Swindon and parts of Bath are already covered by TLHC projects (the initial focus in BSW has been on those areas with the greatest need, identified based on a combination of factors including - highest rates of ever-smokers, greatest volume and extent of deprivation, highest rates of lung cancer). In 2023/24 we will submit bids to support expansion to cover the remaining parts of BSW population footprint in line with national TLHC opportunities
- Bowel Cancer Screening Programme – to ensure sufficient capacity of trained staff to deliver the BCSP at all three trusts, as well as access to screening colonoscopies; BSW ICB will continue to engage in this process alongside our providers, and link with our CDC programme regarding provision of sufficient colonoscopy capacity. As part of the extension to BCSP, the SFT service is currently looking to appoint a nurse endoscopist with BCSP accreditation. Discussions are underway as part of the CDC work, to have a mobile endoscopy unit at GWH; in turn this increased capacity will create additional colonoscopy capacity for the expansion of BCSP.
- Non-specific symptoms - currently c65% of BSW population is covered. We intend to expand NSS pathway provision to cover the remaining 35% of BSW population – subject to agreement by BSW ICB to fund provision

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

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

Monitoring delivery

Via cancer screening programme quarterly assurance review meetings chaired by NHSE regional commissioning leads

List lead and email address for further information

Andy Jennings andyjennings@nhs.net

Long term conditions: Respiratory

Context

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

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

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

Our delivery plan

- Progress Year 2 priorities as set out in the BSW Pulmonary Rehab Plan
- Improve diagnosis process and monitor impact on diagnosis rates and prescribing patterns and expenditure
- Expand pulmonary rehab into areas where not provided and increase provision in areas of health inequalities (see BSW 5-Year Plan
- Develop plans and understand assigned resources to enables reviews of inhaler prescribing, scope personalisation and behaviour risk factor reduction projects and scope community acquired pneumonia, if CQUIN

How we are organised to deliver

- Early Diagnosis through Primary Care and Community Diagnostic Hubs
- Rehab through Community Service providers
- No single group with an Exec SRO coordinates respiratory priorities across localities and system

What we will do in the next twelve months

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

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

- Patients presenting with respiratory issues are diagnosed correctly and treated appropriately
- Pulmonary rehab available in format most appropriate to patient needs and preference within 90 days of referral
- All Pulmonary rehab services accredited and compliant with National Asthma and COPD Audit Programme
- Use of FeNO testing for monitoring and dose adjustment
- Treated combines behaviour risk factor reduction with medical interventions
- Rates of community acquired pneumonia have reduced
- Clear governance of respiratory within the ICS

Monitoring delivery

Set out the key metrics for this area including targets

- All data broken down by health inequalities cohorts
- Pulmonary rehab uptake and completion rates
- A&E presentation for people with COPD
- Medication optimisation from FENO and spirometry testing

List lead and email address for further information

Lucie Owens, Respiratory Lead, lucieowens@nhs.net

1. Slowing down or stopping disease progression (tertiary prevention)

We have made the following commitments in our strategy:

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

Long term conditions: CVD event recovery

Context

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

Our delivery plan

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

How we are organised to deliver

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

What we will do in the next twelve months

- Provider led Stroke and Neuro Group will map the prevalence and outcomes data against current provision, with a view to agreeing priorities and optimum model, to commence from Q2
- Scope creating a neuropsychology service for individuals on the stroke pathway, living in the community and in stroke rehabilitation beds across BSW, by end of Q3
- Newly implemented Wiltshire Heart Failure service to be developed to agreed scale and scope, by end of Q4
- Lessons learned from Wiltshire Heart Failure service developed into plans for Swindon and BaNES services, including integrating heart failure rehab with pulmonary rehab
- Review scale, scope and service models of rehab services to emphasise individualised patient care and patient choice in physical and educational components of rehab, including groups, home based where appropriate and digital offers, with robust data collection
- Plan how to embed rehab into the wider MDT to include nurses, physicians, dietitians, pharmacist, OT, psychology practitioner to meet the full spectrum of patients physical and psycho-social needs.

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

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

Monitoring delivery

Set out the key metrics for this area including targets

- Metric of service accessibility
- Readmission rates for cardiology

List lead and email address for further information

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Wider determinants of health

We have made the following commitments in our strategy:

- We will increase green space, accessible for all to use, and promote greener transport;
- We will improve air quality, including by incentivising greener forms of travel;
- We will keep all of our residents in warm and decent homes, through investment in our social housing stock and both supportive and enforcement interventions in private sector homes;
- We will prevent homelessness by engaging with vulnerable individuals at the earliest possible stage; and
- We will prioritise social housing to those in greatest need to support their health and social care needs.

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

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

The quality of the built and natural environment such as air quality, the quality of green spaces and housing quality, transport, education also affect health. While the proportion of homes meeting the Decent Homes Standard has increased, homelessness has continued to rise, and housing has continued to become less affordable.

Variation in the experience of wider determinants (i.e., social inequalities) is considered the fundamental cause (the ‘causes of the causes’) of health outcomes, and as such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist. Addressing the wider determinants of health has a key role to play in reducing health inequalities, of the Office for Health Improvement and Disparities (OHID).

With the South West Region commitment to becoming the first Marmot region in England, BSW as a system has the moral imperative to deliver Prevention and Early Interventions through addressing the social determinants of health across the three Places.

Table 13: Metrics to assess the change across all domains of anchor influence including employment, procurement, and environmental impact

Vision	KPI/Metric
Establishing and harnessing the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact	All three acute hospitals in BSW achieve chartered anchor institution status by 2025
	Increased number of local hires
	Increased number of apprenticeships
	Increased recruitment representative of local demographic data
	Increased local vs. central spend where possible
	Increased community use of NHS estates
	Increased support for NHS staff to access affordable housing
	Increase in accessible community green space
	Decreased carbon output through improved energy efficiency, increased sustainable travel options
	Reduced waste and water consumption
	Develop and support anchor collaboratives/networks (e.g., AWP, Local authorities, campuses, leisure centres)

Children and Young People Focus on Prevention and Early Intervention:

Context

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

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

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

- Increase in demand for children's community health services, which impacts waiting times. In Wiltshire for example, there is a waiting time of over 18 months for an autism diagnosis
- Increasing number of children and young people with an Education, Health and Care Plan (EHCP) combined with changes in the complexity of EHCPs (108% increase since 2015).
- Increase in the complexities of Children Looked After – including the number of Unaccompanied Asylum Seekers and Refugee children. Unaccompanied Asylum Seeker Children (UASC) in care requiring initial health assessments have seen a 47% increase in Wiltshire since 2019/20.
- Post covid impact and cost-of-living crisis

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

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

Our ambition is to close and prevent the inequality gap in health and wellbeing outcomes for children and young people across BSW and for children and young people to live happy, healthy lives regardless of their circumstances. As we build back from the devastating impacts of the pandemic, the BSW approach provides the first stage framework to reduce inequalities across the life course, to nurture and value the health and wellbeing of babies, children and young people, their families, and communities.

Our BSW Vision is that all children and young people will start well with the support and care needed to enable them to have a sense of belonging, be safe from harm, to enjoy healthy lifestyles, do well in learning and have skills to choose and live their best life, to age and die well.

We want the voices of children and young people to be heard and at the heart of everything we do, so we are asking one question… "What is it like being a child growing up in BSW and how do we make it better?"

Our delivery plan

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

1. Children, young people and families have a healthy environment in which they can grow up in
2. Mental health support is available for children and young people who need it
3. The most vulnerable children and young people are well supported, including those in and leaving care, as well as those who need to be kept safe
4. Children are ready to start education
5. There are better links between health and care services and schools

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

We have agreed 5 BSW key priorities for children and young people:

1. Special Educational Needs and Disability (SEND)
2. CYP Community Mental Health and emotional wellbeing
3. CYP with complex Mental Health needs including those with autism and learning disabilities
4. Inequalities
5. Investing in prevention and early intervention including Early Help - with Children Looked After and Care Experienced Young People threading through each priority

With delivery across these priorities, we aim to achieve:

- Improved outcomes and experiences for children with reductions in inequalities, linked to BSW CYPCORE20PLUS5.
- Improved effective, integrated services and use of resources across the Local Authorities, VCSE, health and care system.
- Enhanced alignment across BSW, between provider organisations and greater clarity of statutory roles and responsibilities.
- Shift to prevention and early intervention, to support reduction and need for intensive and specialist interventions and services

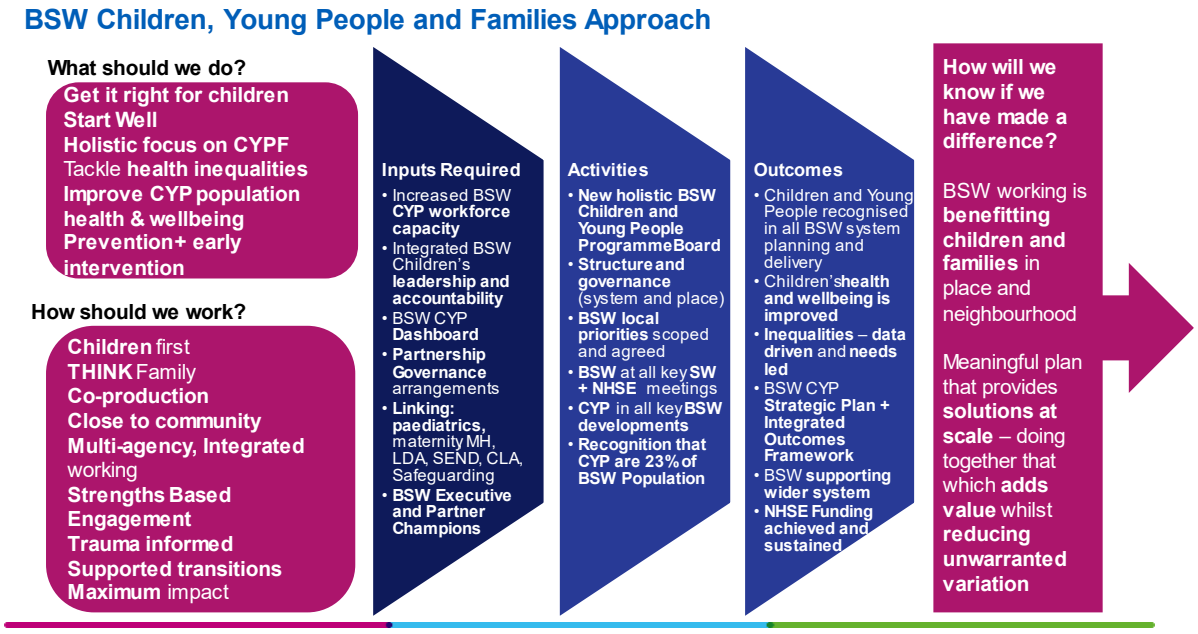


Figure 22: BSW Children, Young people and Families approach

How we are organised to deliver

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

The BSW CYPP Board provides a strong foundation to drive our ambition to focus BSW ICB on the needs of children and tackle inequalities. It is a collaboration between Local Authority partners with all Directors of Children's Services and Public Health alongside BSW ICB and NHSE colleagues. This partnership brings momentum and focus to scope and understand the priorities and needs of the children and young people within our communities, recognising and respecting locality and neighbourhood level developments.

The next stage plan is to expand membership of the Board to reflect our partnerships with VCSE, paediatric and clinical colleagues, to develop further workstreams and system level engagement with children, Parents and Carers so we can collaborate to find solutions at

scale – doing together at BSW system level that which adds value and eliminates unwarranted variation. For example:

- children in the development of Neighbourhood Teams as part of our BSW Integrated Community-based Care delivery
- Collaborating to invest in universal and early help services preparing for family hubs to nurture and value the health and wellbeing of babies, children and young people, their families, and communities

What we will do in the next twelve months

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

Early Years

Through the proposed model for a BSW Intervention Based Approach for Supporting Early Years we seek to provide a pragmatic, achievable and replicable BSW model to enhance and support existing Early Years provision. We want to spend each £ once and combine the learning from Sure Start, Children's Centres, Family Hubs, Connecting Care and Child Health Hubs to build a strong BSW integrated partnership Early Years model to deliver co-created priorities and outcomes for children and their carers/parents/families from early conception to 5 years old.

We plan to take this to neighbourhood level within each locality (using the 20% most deprived to select location). Based on the demographics of Swindon, BaNES and Wiltshire this would mean that we will select 2 x Swindon, 1 x BaNES and 2x Wiltshire of the 20% most deprived (5 overall- subject to scoping and affordability) and seek to add value to developed posts or 'new role' community connector to support the uptake and delivery of Early Years interventions in 5 neighbourhoods across BSW.

We aim to build on existing services and seek to recruit posts that can attach to GP/ PCN's emerging Integrated Neighbourhood Teams linking to developing Family Hubs/Children Centres/BSW integrated service delivery for Early Years.

Timeline:

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

Paediatric Palliative Care

We are developing a BSW Paediatric Palliative Care Workstream with partners including hospices. By linking this to the BSW End of Life Board and the BSW CYP Programme

Board we plan to support transition pathways and services and align adult and paediatric palliative workstreams, to develop a BSW whole systems approach for Paediatric Palliative Care. We want to consider the best delivery model and pathway to deliver BSW wide service improvement, eliminating unwarranted variation across BSW.

The BSW Paediatric Palliative Care workstream has been linked to BSW SEND and Continuing Health Care and complex care processes and decision making for children. So, we can support children and young people eligible for end of life care and ensure families understand they can apply. We have developed and established a team of assessors, operational manager, and administrative staff to support this cohort of children.

In 2022/23 we coproduced systems, processes and information with families, and multi-agency colleagues to support identifying the needs and putting appropriate support packages in place.

Timeline:

- **Short-term (2023/24 Q1)** – agree and develop plan with partners
- **Short-term (2023/24 Q2-3)**- **establish working group**
- **Medium-longer term (2023/24 Q4)**– review progress and plan for 24/25
- **Longer-term (2025→)** – support evaluation (commissioned by NHSE) and share learnings across BSW and beyond

Epilepsy

Epilepsy is one of the five key clinical priorities within the CYP CORE20PLUS5 framework. Within this, increasing access to Epilepsy Specialist Nurses (ESNs) for CYP from the most deprived quintile, and those with learning disabilities and/or autism, is a key improvement priority and metric.

We will recruit a paediatric specialist nurse for two years as part of an NHSE pilot to work across a system footprint in providing care for CYP with epilepsy. This includes supporting continuity of care across secondary, tertiary, community and mental health services where applicable.

Our proposed model aligns with NHS England's ambition is to improve the quality of care for CYP with epilepsy by taking an integrated approach to the diagnosis, management and treatment of epilepsy. Alongside the evidence-based impact that ESNs will provide, we seek to ensure our ESN(s) will be involved in care planning as well as supporting continuity of care for CYP with LD&A as a result of joint-working with community paediatric and neurodevelopmental services.

This service will help us ensure CYP involvement in service delivery and pathway improvement and through the ESN roles at RUH we will hear the voice of the child to support a better understanding as we rollout and scale up this pilot in the future. Through this model we will also benefit from improving child, young person and parent choice and

access to ESN and epilepsy service and be able to offer a greater consistency of service provision across BSW.

The BSW Inequalities Strategy Group are keen to link in with this project and explore the opportunities for learning, particularly around the Core20PLUS5, with epilepsy being an area of clinical focus that spans the Inequalities Programme and the CYP Transformation Board.

Timeline:

- **Short-term (2023/24 Q1)** – agree and develop plan with RUH
- **Short-term (2023/24 Q2-3)**- advertise and recruit to ESN post
- **Medium-longer term (2023/24 Q4)**– review progress and plan for 24/25

Longer-term (2025→) – support evaluation (commissioned by NHSE) and share learnings across BSW and beyond **Acute**

Mental Health Champions

From 2023/24, each of our three acute trusts will receive funding to support development of Mental Health Leadership/Championship roles within emergency departments. This funding is calculated to meet the requirements for 1 medical consultant PA a week (i.e. £19k) and is secured for 23/24 and 24/25 (after which point it is anticipated that the funding would be held within individual health budgets).

The deterioration in Children & Young People's mental health is a trend that has been ongoing over the last 10-20 years, but we have seen a compression and an acute exacerbation of this trend in the years during and following the COVID-19 pandemic. The causes for this are multifactorial, but the extraordinary pressure on acute paediatric wards, social care and mental health services is undeniable. Data from Mental Health of Children and Young People in England 2022 highlights that:

1. 1 in 6 children have a diagnosable mental illness (anxiety, depression, disordered eating), rising to 1 in 4 17-19yr olds.
2. 50% of adult mental illness is embedded by the age of 14 years
3. Suicide continues to be one of the top 3 leading causes of death for 5-19 year old.

This role is intended to be interpreted and implemented in a way that suits individual department and system needs, meaning that there is no strict "job description", however the anticipation is that this leadership role would be at a Strategic & Systems level to coordinate improvements in the way in which Acute Trusts interact and support children's mental health.

NHSE have developed a Framework for practice which lays out a roadmap for how departments can begin to tackle the problem: NHS England » Supporting children and young people (CYP) with mental health needs in acute paediatric settings: A framework for systems.

Key functions of the role have been co-developed with RCPCH colleagues and include to:

1. Facilitate joint working across Mental & Physical Health
2. Encourage uptake of training
3. Build team confidence & morale
4. Provide leadership and link into Trust, ICB and regional network governance structures

Timeline:

- **Short-term (2023/24 Q1)** – Funding made available to ICBs to transfer to acutes. Regions and systems to support recruitment/mobilisation of MH Champions
- **Short-term (2023/24 Q2)** – Reporting for MH Champion role
- **Short-term (2023/24 Q2-4)**- Support evaluation and development of framework for role progression. Share and spread learning.

Youth Workers

This project will be developed to deliver proactive Youth Worker support to Children and Young People through VCSE partners across our acute hospitals. We will build on the developments within our acutes and paediatric departments. We will partner with VCSE colleagues to host the roles within their organisation, based at our hospitals to deliver a person centred and trauma informed intervention for children and young people, aged 11-25, accessing our Children's Wards, Emergency Department and adult wards, focusing on mental health needs and children struggling with the impact of long term conditions including diabetes and epilepsy.

Cohort of patients that would directly benefit from a Youth Worker service are:

1. Young people admitted to ED, Children's and Adult wards with mental health needs
2. CYP who may be experiencing health inequalities
3. Focus on transition through 18-25 (in RUH linking directly with adult MIND service)

Youth Workers would provide a range of sessions based on busiest times, to offer children and young people a plan of support and safety plan and this will include a forward plan and signposting transitions to community based services.

Timeline:

- Short-term (2023/24 Q1-2) – Funding made available to ICBs. Allocation to VCSE based on procurement guidance. Link to MH Champions

- Short-term (2023/24 Q2-4)- Support evaluation and development of framework for role progression. Share and spread learning.

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

Following initial BSW CYP Programme Board activity the work is expected to be delivered in two key stages: ***Tactical stage*** – Agree improvement milestones/outcomes for 2023 and identify what we need to have in place to support delivery of these. Review,

prioritisation, establishment of new and refinement of existing programmes of work, ensure they are the right things and are set up to succeed

Strategic stage – key questions we want answered – HOW DO WE……? Ensure the ICB recognise that as 30% of the BSW ICB population that Children, Young People and their Families receive sufficient ICB focus through BSW ICB Strategy and BSW Care Model Understand how we work together effectively as a system to reduce unwarranted variation, so we define future services operating at the optimum scale for effectiveness. Review required workforce and collaborate with partners to support its creation and availability. Define role of technology. Deliver affordable and sustainable services. Better integrate community services to ensure ease of access, clear provision that is understood and used by children and their families, that avoid duplication and spend each £1 once

When will we start seeing the benefits?

- **Short-term** (2022/23 Q3-4) – the initial impacts in developing shared priorities and an integrated approach, workforce and financial recovery during 22/23.
- **Medium-longer term** (from April 23) – benefits from CYP embedded within ICB strategy, transformation and planning, integrated and redesigned services and simplified workstreams

Monitoring delivery

We will develop a BSW Children and Young People's Strategy and develop and co-produce key metrics and outcomes including targets

List lead and email address for further information

Lead: Sadie Hall, Sadie.hall3@nhs.net

8. Strategic Objective 2: Fairer Health and Wellbeing Outcomes

- 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;
- An increased focus on children and young people;
- We will work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and set out clear plans on how to close the inequality gaps; and
- We will demonstrate action on inequalities that spans from system to place through joined up strategy and planning.

Fairer Health and Wellbeing Outcomes – An Overview

Tackling health inequalities to guarantee fairer health and wellbeing outcomes across all sectors of our communities is a matter of fairness and social justice. The lower a person’s social position, the worse this person’s health will be (this is called the social gradient of health).

Action should focus on reducing the gradient in health to ensure fairness in health outcomes and wellbeing. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

BSW ICB has a legislative requirement to:

a) Reduce inequalities between person with respect to their ability to access health services and
b) Reduce inequalities between patients in respect to the outcomes achieved for them by the provision of health services.

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

Delivering our commitments

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

The BSW Inequality Strategy 2021-2024, first published in 2021, aims to provide a framework for system activity to reduce health inequalities. The strategy has been developed from key guidance and policy relating to reducing healthcare inequalities, as well as recognising the need for close partnership working with colleagues at a place level to address social, economic and environment determinants of health (also known as 'wider determinants'). This strategy aims to address inequalities across the life course, to include pregnancy, children and young people, adults and into old age.

The BSW Inequalities Strategy builds a foundation for a shared understanding of health inequalities as a system, bringing together existing strategy and local data and intelligence and focusing this on the CORE20PLUS5 population.

This approach focusses on the 'core' 20% of most deprived areas 'PLUS' communities at higher risk of inequality (e.g., those with black, Asian and minority ethnic backgrounds) focussing initially in five clinical areas. For adults these are:

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

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

In December 2022, the NHS also published the Core20PLUS5 approach for Children and Young People (CYP) which focuses the following five clinical areas:

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

Alongside the 20 per cent most deprived population and the clinical priority areas, the BSW PLUS (inclusion) populations are defined at a place level for Bath and North East Somerset, Swindon, and Wiltshire separately. This decision was taken to capture the

unique populations of each locality and ensure health inequalities are not exacerbated by reflecting an average of a much larger group. Each PLUS group was chosen based on the local Joint Strategic Needs Assessments (JSNA) for each area. The PLUS populations for BSW are outlined as follows:

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

Continuously improving BSW data on inequalities both at System and Place level is a key priority. This includes routine use of postcode of residence and indicators of place, and improved ethnicity recording. The aim is to enable the use of good quality data, disaggregated by deprivation and ethnicity, to provide the best evidence-base for decisions to be made. This includes:

- Reporting designed and published that operationally supports improvements in ethnicity coding completeness.
- Process, technicalities and governance arrangements being investigated to flow ethnicity data back from Primary Care and other organisations to the three BSW Acute Providers. This process will support further improvements in coding completeness across the BSW System.
- Development of System-level Core20PLUS5 dashboards, alongside a suite of other data tools that identify the inequality groups within populations and enable providers and programmes to understand and take action to reduce inequality gaps within their remit.

The Programme at System will focus on embedding inequalities and prevention across the BSW programmes. In addition, they will work specifically with CYP and MH programmes in developing their focus on Health Inequalities and Prevention.

The areas of focus on data improvement this year will include Mental Health, Elective Care, Cancer, and Urgent & Emergency Care. Funds for better data will be non-recurrent with the ambition to transition into Business as Usual (BAU) by 2025-26.

The Strategy is available in appendix and provides a defined set of targets to deliver across three phases:

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

Each Phase will include an implementation plan and a set of metrics which is also available in Appendix 2 of the Strategy.

*Table 14: **TABLE TITLE TO BE ADDED***

Phase	Vision	KPI/Metric
1. Making inequalities everybody's business	All staff, partners, and communities to understand inequality and how we seek to address this in BSW	Training Needs Analysis to be completed by **June 2022**
		20 sessions delivered by **April 2024**
		Inequalities online 'hub' online by **November 2022** and disseminated. Traffic to site to show increasing access from baseline to **April 2024**.
		Resource library to be available and distributed by **December 2022**
		BSW Inequalities Communication Plan completed by **December 2022**
		Full membership of the BSW Inequalities group established by **April 2022**
		All thematic and organisation leads to deliver action plans as outlined by the BSW Inequalities Strategy by **April 2023**
2. Healthcare inequalities and CORE20+5	Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and clear plans on how close the inequality gaps to offer exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes	Performance reports will be broken down by patient ethnicity and IMD quintile, focusing on: - Under-utilisation of services (e.g. proportions of cancelled appointments) - Waiting lists - Immunisation and screening - Late cancer presentations
		Data on access and %broken down by patient age, ethnicity, disability status, condition, IMD quintile
		% completeness of data on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning
		Development of a strategic approach to community engagement embedded through the System, focusing on equity of access, experience and outcomes for C20+ groups
	Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas (adults)	Increase in percentage of pregnant people on CoC pathway in line with staffing trajectories
		Annual health checks for 60% of those living with severe mental illness and learning disabilities
		Increased uptake of COVID, flu and pneumonia vaccines in C20+ and people with COPD
		75% of cancer cases diagnosed at stage 1 or 2 by 2028
		Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas (CYP)	Reduce the percentage of children and young people with a reliever: preventor ratio greater than 1:6
		Reduce the number of asthma attacks as indicated by unplanned hospital admissions, presentations in ED, prescriptions of oral steroids
		Increased access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those

Phase	Vision	KPI/Metric
		with Type 2 diabetes receiving recommended NICE care processes.
		Increase access to ESNs for CYP within the most deprived 20%, and CYP with LD&A, within the first year of care
		Tooth extractions in hospital due to decay for children aged 10 years and younger
		Children and young people (ages 0-17) mental health services access (number with 1+ contact)
3. Tackling inequality by addressing social, economic, and environmental factors	Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy	Smoking prevalence in BSW
		Smoking prevalence of adults in routine and manual occupations
		Prevalence of people smoking in pregnancy/smoking at time of delivery
		Proportion of smokers received smoking cessation support within hospital
		Proportion of pregnant smokers offered support in maternity settings
	Halt and reverse of obesity prevalence in children and adults across BSW	Number of referrals to NHS digital weight management services per 100k head of population
		Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled
		Engagement in Digital Weight Management Programme (PH tbc)
	Establishing and harnessing the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact	All three acute hospitals in BSW achieve chartered anchor institution status by 2025
		Increased number of local hires
		Increased number of apprenticeships
		Increased recruitment representative of local demographic data
		Increased local vs. central spend where possible
		Increased community use of NHS estates
		Increased support for NHS staff to access affordable housing
		Increase in accessible community green space
		Decreased carbon output through improved energy efficiency, increased sustainable travel options
		Reduced waste and water consumption
		Develop and support anchor collaboratives/networks (e.g. AWP, Local authorities, campuses, leisure centres)

Phase 1 of the strategy is currently underway and focuses on Making Inequalities Everybody's Business. This phase targeted ICS leaders to ensure Health Inequalities drivers and priorities were understood and addressed. This area of work is ongoing and there will be further development around developing training modules on health inequalities in partnership with the BSW Academy and the Health Inequalities National Academy. This work will be a key component of the Health Inequality programme.

How we are organised to deliver

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

The Governance and oversight of Health Inequalities is provided by the Population Health Board. The Board oversees the delivery of the BSW Inequality Strategy as well as the Health Inequality Programme.

An integrated System Inequalities group is held six-weekly to gain a comprehensive insight into the local population's diverse health needs and assets. The group provides the opportunity to coordinate activity and offer wider collaboration to reduce inequalities through working in partnership. This includes representation from public health, local authority partners, clinical leads, acute hospitals, providers and commissioners.

Roadmap

Table 15: TITLE TO BE ADDED

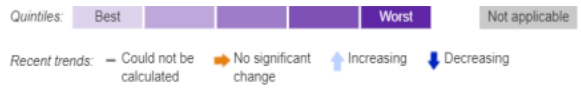
Actions	Milestone
BSW Inequality Strategy and Allocation ratified by Population Health Board and ICB Board.	May 2023
Funds Devolved to Place and System and System resource recruited	May-July 2023
Development of a comprehensive Health Inequalities and Prevention Programme	January – June 2023
Programme Implementation	August 2023 – March 2024

An increased focus on children and young people;

Context

In BaNES and Wiltshire 0-19 years olds form 23% of their population, in Swindon, 25%. Presenting our data as a system masks pockets of deep deprivation and inequality for children within each area, including two neighbourhoods within the most deprived 10% nationally. Swindon has a higher level of deprivation compared to Wiltshire and Banes, being the 5th most deprived LA in the SW.

Table 16: Office for Health Improvement & Disparities (2022). Deprivation score for BaNES, Swindon and Wiltshire is highlighted.



Deprivation score (IMD 2019) 2019

Score

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	21.7	-	-
South West region	–	-	18.2	-	-
Torbay	–	-	28.1	-	-
Plymouth	–	-	26.6	-	-
Bristol	–	-	26.4	-	-
Cornwall	–	-	23.1	-	-
Swindon	–	-	18.6	-	-
Somerset	–	-	18.6	-	-
Bournemouth, Christchurch and Poole	–	-	18.2	-	-
Devon	–	-	16.6	-	-
North Somerset	–	-	15.8	-	-
Dorset	–	-	15.7	-	-
Gloucestershire	–	-	14.9	-	-
Wiltshire	–	-	13.4	-	-
Isles of Scilly	–	-	12.0	-	-
Bath and North East Somerset	–	-	11.7	-	-
South Gloucestershire	–	-	11.7	-	-

We have complex geography and demographics with wide variation; diverse urban populations in Bath, Salisbury and Swindon; alongside 55% of the BSW population living in large and rural Wiltshire; a large military presence with 17,700 army personnel and their families; ethnic minorities population of 10.2% Swindon, 5.4% BaNES and 3.4% Wiltshire, significant boater and traveller populations.

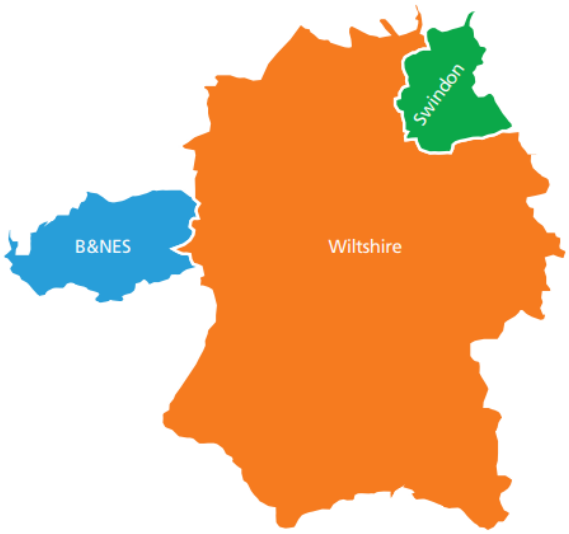


Figure 23: Map of BaNES, Swindon and Wiltshire

Many of our poorest children grow up in communities where their circumstances are in stark contrast to those around them. Social and Emotional Mental Health as the primary SEND need has significantly increased. Worsening mental health and wellbeing with high and increasing levels of under 18 hospital admissions for mental health conditions, eating disorders, self-harm and alcohol and an increase in complexity and demand for children's social care, SEN and early help services.

BaNES identifies those with inequality indices experience poorer social and health outcomes for physical and mental health, aspiration, and school engagement. The attainment gap for children eligible for free school meals in early years, is one of the highest gaps in the country.

This picture is reflected in Wiltshire, where CYP at risk of poorer outcomes are those with SEND and receiving FSM.

Obesity is a key issue for CYP within BSW, Swindon JSNA shows one in three children aged 10-11 and one in four children aged 4 or 5 in Swindon are overweight or obese, excess weight in Year 6 children (36.1%) continues at higher levels than South West (31.8%) in 2019/20. High prevalence of overweight in children is noticeable amongst the most deprived areas for both Reception and Year 6 children.

Place based examples of excellence

- Swindon's Whole Systems Approach tackling obesity in children and young people, trialling a whole schools healthy weight programme (SNAPS) targeted at schools in the highest areas of deprivation, and running a child and family weight management programme.
- BaNES approach to improving education outcomes for disadvantaged pupils through their programmes Poverty Proofing Our School, Primary Empowerment - addressing MH needs of primary children living in areas of deprivation, and Early Years Language for Life

- Wiltshire's Five to Thrive: Attachment, Trauma and Resilience Initiative, training the CYP workforce to be attachment aware and trauma informed, with over 600 Champions and 900 additional staff 'light touch' trained, to be part of the Family Help Strategy, created by Family and Children's Transformation (FACT) partnership driving forward work for Early Help.

Our delivery plan

We have strength in our integrated ICB leadership, combined with the power of bringing together the key partners and leaders for children across BSW. The BSW CYPP Board coordinates work for children and young people on behalf of the Integrated Care Board and Partnership.

Our VCSE Alliance at system level is made up of the three CVS's, the Rural Community Council and Healthwatch. Each locality has a Leadership Alliance offering a gateway into the sector and the communities its supports and reaches, with networks for Children and Families.

We are investing in meaningful engagement with children, young people, and families, working with place based and LA colleagues to ensure their voices are listened to in decision making.

We have LAs that are demonstrating sound performance and are therefore well placed to focus on this project, with all three BSW Children's Services rated good by Ofsted.
Our footprint provides a unique challenge and opportunity for rich learning. The BSW combination of rural Wiltshire with large geographical area, perceived rural idyll that can mask deprivation, urban Swindon with associated high levels of deprivation and BaNES, with Bath as an affluent city, and children living with significant deprivation.

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

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

Our approach is to focus on:

- Outcomes for children, recognising adverse childhood experiences mean investing in children is WHOLE POPULATION prevention and early intervention
- BSW Children Looked After, who are at particular risk of poor outcomes, improving the MH of CLA and the BSW Care Leavers Pledge
- Delivering changes for children set out in the BSW Care Model, through BSW Integrated Community-based Care, links to early help and family hub arrangements,

the shift to prevention and early intervention whilst meeting current service demand pressures and creating a sustainable workforce and financial position

- Bringing together key leaders to consider how we address the mental health crisis we see in our children across BSW.

What we will do in the next twelve months

- We will use the framework of the BSW Inequalities Strategy and the Core20+5 to improve equity of access, experience and outcomes for Children and Young People across BSW.
- The focus of the next twelve months will be:
- **2023/24 Q1** to embed the CYP Programme into the inequalities work and establish the governance arrangements with links to the BSW Inequalities Strategy Group and Population Health Board. Arrange appropriate clinical representation for CYP within the five clinical areas of the C20+5 for CYP.
- **2023/24 Q2** establish a working group with a focus on long-term conditions
- <include or reference the relevant aspects of final draft content for SO3 12m deliverables>

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

BSW is a place where children and young people will experience great divides in family income, health, wellbeing, and attainment outcomes. The BSW Inequalities strategy recognises that whilst inequality affects people of all ages it is children and young people more often affected by, and subject to, inequality than adults whilst least able to defend themselves against it.

We have acknowledged that inequalities experienced in childhood can have a long-term effect across the life-course. We know that Covid-19 has deepened the impact on children, their parents/carers and the professionals who support them, now compounded by the cost-of-living crisis.

Monitoring delivery

- Set out the key metrics for this area including targets

We will work on the national ambitions for healthcare inequalities as part of the Core20+5 which are:

Table 17: National ambitions for healthcare inequalities (Core20+5) and measures

Outcome	Measure
Address over reliance on reliever medications	Reduce the percentage of children and young people with a reliever: preventor ratio greater than 1:6
Decrease the number of asthma attacks	Reduce the number of asthma attacks as indicated by unplanned hospital admissions, presentations in ED, prescriptions of oral steroids

Reducing health inequalities and variation in outcomes for children and young adults with diabetes, including more equitable access to treatment technology	Increased access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.
Address variation in access to Epilepsy Specialist Nurses (ESNs) within ICSs/Trusts, with a specific focus on access for patients from the most deprived quintile and those with LD&A	Increase access to ESNs for CYP within the most deprived 20%, and CYP with LD&A within the first year of care
Address the backlog for tooth extractions in hospital for under 10s	Tooth extractions in hospital due to decay for children aged 10 years and younger
Improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender and deprivation	Children and young people (ages 0-17) mental health services access (number with 1+ contact)

List lead and email address for further information

Lead: Sadie Hall, Sadie.hall3@nhs.net

9. Strategic Objective 3: Excellent Health and Care Services

Excellent Health and Care Services – An Overview
This chapter discusses the work we are undertaking in health and care services across the BSW system to meet our commitments for the delivery of excellent health and care for our population. It should be noted that the focus is on transformation and developmental work in those delivery areas specifically highlighted in the strategy and set out below. Therefore, this section is not a comprehensive directory of all services provided but in no way means that areas not included are not as important. It is more the case that the areas covered are priorities for 2023/24 and therefore will change and develop through the life of the strategy. The chapter is structured in line with the commitment areas set out below.

It should also be noted that service areas that are primarily Place based are discussed in the local implementation plans chapter rather than in this chapter which is more focussed on system wide delivery areas.

Our Commitments

Personalised Care

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

Joined up local teams / Neighbourhood teams

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

Responsive local specialist services

- We will provide virtual ward services in BSW that will provide a range of interventions tailored to the needs of the children and adults to help prevent hospital admissions and to accelerate discharge from hospital; and
- BSW is committed to expanding community diagnostic facilities that will deliver additional, digitally connected, diagnostic capacity.

High quality specialist centres

- The Acute Hospitals Alliance (AHA) is developing a clinical strategy that will set out the role hospitals will play in the delivery of urgent care services, management of

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

Mental health and parity of esteem

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

Safeguarding

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

As part of the ICB duty to safeguard, a key area of focus is the protection of the victims of abuse and to prevent and reduce serious violence within our local communities. This is in line with the Serious Violence Duty which launched in December 2022. Funded by the Home Office, the Duty brings key partners across health, police and the local authorities together to form specialist teams, which will design and implement strategies to protect our local communities across the life course.

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

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

To assess readiness to tackle and prevent serious violence a training skills analysis will be completed to determine any training needs for healthcare professionals. BSW ICB are proactive in ensuring healthcare staff are confident and competent in knowing how to safely identify, refer and respond to victims of serious violence.

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

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

Objectives

- Implement training to all necessary staff to meet the health requirements of the Serious Violence Duty 2022
- Embed learning and improvements to practice following children Safeguarding Practice Reviews, Safeguarding Adult Review and Domestic Homicide Reviews
- Working in collaboration with partner agencies to establish pathway for victims of serious violence
- Ensure Safeguarding and vulnerability are linked to the broader ICB health inequalities and commissioning agendas with focus on placements for our vulnerable population within and out of area

Personalised Care:

Context

BSW integrated care system is committed to further implementing the comprehensive model of personalised care to establish:

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

Personalised care is core to the delivery of our system strategy. Where individuals feel well informed about their care and are able to work in partnership with health and care professionals to manage their health and wellbeing, they are more likely to achieve better outcomes and have a better experience of care because their hopes, fears and expectations are being listened to. Health and care professionals are also likely to have a better understanding of individuals' strengths and needs and thus be best place to provide the best and most appropriate care. It is therefore our ambition to ensure this approach is applied to everything we do in the future.

Our delivery plan

As set out in BSW ICB commitments, we will utilise the model and supporting tools to deliver this plan by focusing on the six, evidence-based components each of which is defined by a standard set of practices:

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

How we are organised to deliver

We are developing as integrated health and care neighbourhood teams within PCNs and at place to implement and monitor the comprehensive model of personalised care. Working closely with BSW Primary Care and Community Care Training Hub, Quality and Continuing Care Teams.

What we will continue to build on in the next twelve months

- We will develop further opportunities for self-management and self care which will be promoted wherever possible in an appropriate way based on the individual's activation level
- We have building blocks in place including 100+ Personalised Care ARRS roles recruited by our PCNs, together with a developing in-house training programme with 25+ people trained in part one of our in house Health Coaching Training Programme.

Plan to focus resources to further develop and fund the Personalised Care Health Coaching Programme and Personalised Care Ambassador

- Within identified PCNs we will aim for people with 2+ long term conditions and low activation to have a personalised care worker (that is a core part of an integrated neighbourhood team) as their first and consistent point of contact
- Integrated neighbourhood teams will include Social Prescribing Link Workers that can encourage access to community-based support. We will further develop social prescribing along the Compassionate Frome model.
- Anyone offered an elective intervention will have had a shared decision-making conversation prior to this decision.
- We will provide additional training to meet mandated requirements of all Personalised Care ARRS roles.
- Develop a network of workforce using a personalised care approach, starting with known ARRS roles and then expand. Extend training to this wider group in 2024 and beyond.
- Through other transformation programmes increase the scale of workforce using a personalised care approach. Focus on integrated community-based transformation programme.
- Promote Personal Health Budgets

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

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

Monitoring delivery

As a system we aim to continuously improve approaches to implementing the comprehensive models of personalised care:

- Utilise personalised care tools, national and local quality and safety metrics and quality improvement methodology to monitor impact on health and care outcomes and experience
- There have been examples of good practice shared within individual PCNs via people's feedback and stories of their improved experience. With appropriate consent, we will continue to promote the sharing of people's experience and stories to encourage similar projects across PCNs
- We will ensure qualitative outcomes and experience will inform transformation programmes and quality improvement initiatives.
- We will continue to evaluate the process and impact of PCN innovations developed around their Personalised Care ARRS roles at neighbourhood and place, and strengthen feedback mechanisms at system level

Joined up local teams / Neighbourhood teams

Across BSW we are developing Integrated Neighbourhood Teams in response to a belief, both locally and nationally, that the work of different teams working in the community feels fragmented for the patients and clients they are supporting. Historically this has been for a number of reasons including the teams coming from a range of health and care organisations, and sometimes the same organisation, where arrangements for the pooling information on the support they are providing have not always been clear or simple to navigate. The results of this have meant individuals have had to "tell their story" multiple times to different teams or professionals, having to travel to a wide range of different services or being visited by a range of different teams or professionals that can feel disjointed or duplicative.

In response we are setting in place local multidisciplinary teams bringing together different types of clinicians and professionals from a range of teams and organisations in order to provide more joined up care and support which would be ideally in people's homes or otherwise as close to them as possible.

The detail of what is being developed in each part of BSW is described in the earlier Local Implementation Plans chapter.

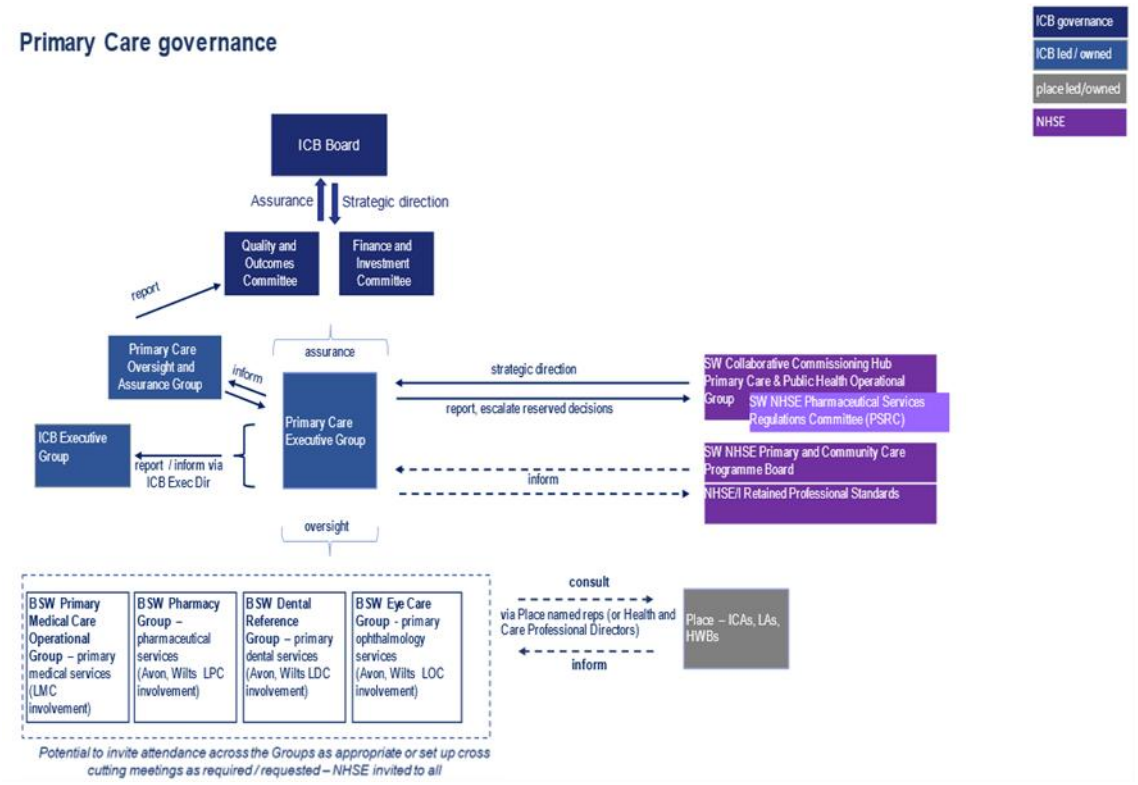
Primary Care:

Context

Nationally and locally, it is recognised and appreciated the incredibly hard work of general practice during this period of sustained significant pressure. The past few years have demonstrated the dedication of practice and Primary Care Network (PCN) teams in innovating and responding to the needs of their populations. In March 2023, BSW General Practice delivered 497,783 appointments, an increase of 7.4% on March 2022, 67% were face to face appointments, a testament to the incredible work of GP teams.

The key focus for 2023/24 is on improving patient experience and satisfaction of access. 2023/24 is the last year of the 5-year framework *Investment and Evolution and* in 23/24 NHSE will engage widely re *Fuller Stocktake* with next steps towards integrating primary care; and consult on *QOF* and its future form. The *Delivery Plan for Recovering Access to Primary Care (*published 09.05.23) sets out how practices and PCNs can be supported to improve access, recognising changes will require time and support – including freeing up workforce through changes to QOF (practices) and IIF (PCNs).

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



How are we organised to deliver

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

Across BSW we have:

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

What will we do in the next twelve months

Key targets for primary care include:

- Making it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or the next day according to clinical need.
- Implementing the GP Access Recovery Plan to improve patient experience, ease of access and demand management and accuracy of recoding appointments
- Continue on the trajectory to deliver more appointments in general practice by the end of March 2024 (national)
- Supporting PCN with workforce planning and recruitment to continue to recruit Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- Implement the GP Contractual Changes for 23/24

- Working closely with NHSE and Public Health to deliver the SW Dental Development Sustainability Plan to recover dental activity to pre pandemic levels and deliver the key priorities from the local oral health needs assessments.

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

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

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

We will have developed closer working relationships with our local Independent Contractors across primary care which will have supported increased partnership working at all levels further integrating care delivery in Primary Care Networks; and built a more integrated clinical and professional leadership model which reflects the wider primary care system.

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

Monitoring Delivery

The primary care deliverables contribute to the successful delivery of:

- ✓ Joint Strategic Needs Assessment and Health & Wellbeing Strategies
- ✓ BSW Integrated Care Strategy's 3 prioritised strategic objectives:
    - Focus on prevention and early intervention
    - Fairer health outcomes
    - Excellent health and care services
- ✓ Core20Plus5 for adults and children
- ✓ Fuller Stocktake – next steps for integrating primary care and development of integrated neighbourhood teams

The ICB is taking on responsibility for the commissioning of primary care and, as part of setting in place these arrangements, we are developing the necessary monitoring arrangements to be assured of the effectiveness of our efforts.

Urgent and Emergency Care:

Context

Despite system responses and efforts over the last few years post the pandemic, across England hospitals are fuller and occupied by patients who are clinically ready to leave, patients are spending longer time in A&E and patients waiting longer for an ambulance response and pressure is taking a toll on staff health and wellbeing. This is no different in BSW, as we had:

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

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

Our delivery plan

The Delivery plan for recovering urgent and emergency care services: NHS England » Delivery plan for recovering urgent and emergency care services outlines the expectation that everyone should get the very best urgent and emergency care, and systems are expected to raise the standards of quality and safety for the most vulnerable patients and their families, including older people living with frailty, children and young people, people with disabilities and people with mental health needs.

The plan sets out the two main ambitions set out in the delivery plan for recovering urgent and emergency care services.

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

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

How we are organised to deliver

How we are planning on delivering them e.g., how are we organising ourselves, who is involved

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

1. Increasing urgent and emergency care capacity
2. Increasing workforce size and flexibility

3. Improving discharge
4. Expanding care outside of hospital
5. Making it easier to access the right care

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

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

BSW's Urgent Care and Flow board and UEC tactical group representatives from each of BSW's localities, including primary care, mental health, social care. UCFB will provide monthly oversight and assurance of our delivery against the recovery plan and report back to the Integrated Care Board and Integrated Partnership group BSW's weekly UEC tactical with system partners will monitor progress against schemes to achieve our anticipated non criteria to position to deliver required bed occupancy and handover performance to achieve Cat 2 performance aided by our BI colleagues. On a daily basis, the BSW daily touchpoint calls will have operational oversight of the system performance including handover delays and system flow.
The plan should also be viewed in conjunction with the Elective Care Recovery Programme and the GP Access Recovery plan.

What we will do in the next twelve months

- Care Coordination will be fully embedded in the system as single point of access for 999 and Care Home providers by Winter 2024
- Same day emergency care (SDEC) capacity and provision will be increased in each of the 3 acute hospitals.

- RUH are planning on expanding their assessment space from the bed base to 20% to support SDEC requirements including introducing new pathways, processes, and ways of working by July 2023.
- From April 2023 SFT are planning to extend their SDEC will be 0800-1830 Monday to Friday. Some weekend activity will also be planned based on medical workforce cover(locum).
- During 2023/24 GWH will continue with their estates programme of work to develop an integrated front door, increasing UEC capacity from June 2024.

- Providers will be required to implement electronic bed management systems by the Summer 2023 and utilise A&E admission forecasting tool. SFT will be refreshing E-Whiteboard in April 23 and will be developing a training programme for staff.
- Discharge to assess programme will continue to build on best practice interventions and Home First initiatives to improve discharge across the system to support the delivery of flow and reduce non criteria to reside. This will include implementation and utilisation of A&E admission forecasting tool.

- Discharge Hubs will be rolled out in each of the 3 acute trusts 7 days week by September 2023
- Phase 2 of our Domiciliary care work programme in 2023/24 will continue to develop the BSW strategic workforce plan for domiciliary care.
- Installation of a new, permanent X-Ray machine at Paulton in April 2023 which will reduce pressure on acute provision and support an improvement in 4-hour performance.
- Minor Injury Unit Transformation work programmes will continue and look at plans developing to co-locate Trowbridge MIU clinicians with local GP practice to improve minor illness offer.
- Work will continue to support the Home First approach across BSW, learning from the successful model implemented in Swindon during 22/23. This model for Swindon should be 7 days a week from June 2023
- Care Coordination will be fully embedded in the system as single point of access for 999 and Care Home providers by Winter 2024
- SWAST have 6 key priority workstreams to improve Category 2 response times, which include Category 2 segmentation, improved call answering, improving front line resource (Core and Private), Ambulance vehicle preparation hubs and reducing sickness over 2023/24.
- A strategic workforce plan with key priorities will be in place.

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

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

Monitoring delivery

As a system we are expecting to be assessed nationally on the following key metrics

- ED Performance (Type 1) – Target 76%
- Percentage of patients waiting over 12 hours – Target is to get to 0 %
- Percentage of patients with 14+ LOS – Target is to be confirmed.
- Category 2 response times – Target 30mins
- General and Acute Bed occupancy – Target 92%

Locally we will measure all the above metrics on a weekly basis plus additional metrics that support the delivery of key schemes such as virtual ward, 2hr urgent care response, average handover delays.

List lead and email address for further information

- *Heather Cooper, Director for Urgent Care and Flow. Email: Heather.Cooper8@nhs.net*
- *Emma Smith, Head of Urgent Care. Email: esmith17@nhs.net*
- *Jo Williamson, Head of System Flow. Email: Jo.Williamson1@nhs.net*

Virtual Wards:

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

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

Our delivery plan

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

The baseline position as at Q4 2022/23 is 87 virtual ward beds. Table 18 below sets out our profiled growth in capacity by Place for the coming year.

Table 18: Virtual Wards profiled growth in capacity by Place

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

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

Benefits for People using virtual wards and their carers

Through the development of our integrated care record, our aim is to use patient level data to analyse and monitor outcomes, which will allow us to use this intelligence to address variation and adapt the operating model to better meet the needs of local communities. The expected benefits of Virtual wards are:

- To support increased patient choice and personalised care, allowing patients to be treated in a more comfortable home environment.
- To reduce conveyances, emergency department (ED) presentations and hospital admissions through the provision of timely multidisciplinary care.
- That people are less likely to decompensate while acutely unwell, meaning they do not need as much increase in care provision when they recover
- That virtual wards improve staff experience and can allow for better and more flexible use of the existing workforce.
- That they are an opportunity for people to become more confident in use of digital technology to manage their condition, and reduce digital inequalities through support given

- That they release acute hospital beds for elective/non elective procedures to support wider recovery ambitions

How we are organised to deliver

Subject matter experts from across BSW make up our key delivery groups. Clinicians and operational professionals from across all partners across health and care, including the voluntary sector, have been working together to co-produce a Standard Operating Procedure (SOP) for virtual ward delivery. Alongside a BSW SOP for our NHS@Home Virtual Wards, each ICA (Integrated Care Alliance) in BSW has developed their own implementation plans to reflect local population needs.

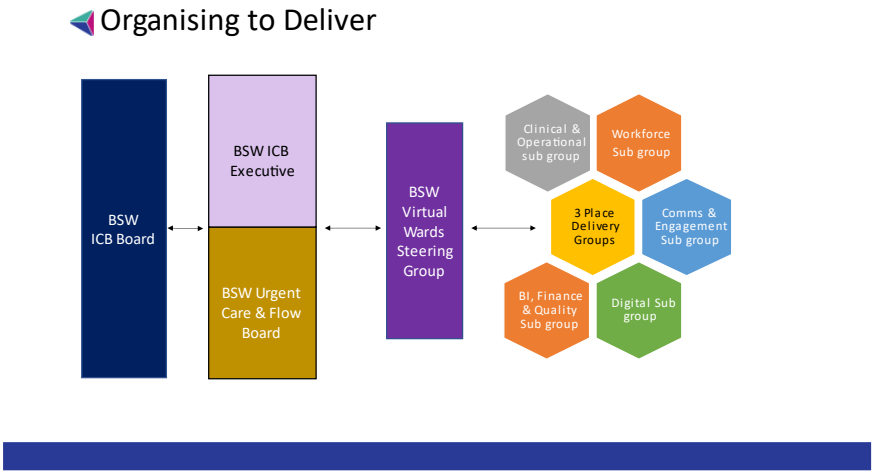


Figure 24: Organisation diagram for Virtual Ward delivery

What we will do in the next twelve months

Throughout England, ICBs have committed to achieving 40-50 virtual ward beds per 100,000 population by March 2024 in the two-year nationally funded Virtual Ward programme. This equates to 2,228 beds in the South West and 360 beds across BSW. As detailed above we have a clear trajectory for expansion over the next 12 months.

Monitoring delivery

The delivery of NHS@Home (Virtual Wards) is overseen by a Steering group which meets monthly, and which is supported by a series of sub groups. Individual Place oversight takes place through local implementation groups which report into the Steering Group. Weekly highlight reports and deep dives are produced as part of our Urgent and Emergency Care Board governance arrangements.

Formal reporting on performance, quality and finance against the annual Operating Plan and System Outcomes Frameworks is into the BSW Executive groups, and the ICB Board and its sub committees.

List lead and email address for further information
Fiona Slevin-Brown (Senior Responsible Officer – BSW NHS@Home Virtual Wards Programme) f.slevin-brown@nhs.net

Jill Couvreur (Programme Manager – BSW NHS@Home Virtual Wards Programme)
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Community Diagnostic facilities:

Context

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

- A hub site to be located at Sulis Hospital, an established planned care site
- Spoke sites situated in Swindon (2 sites), Salisbury, and West Wiltshire (Corsham) addressing the localities and populations with the greatest need.

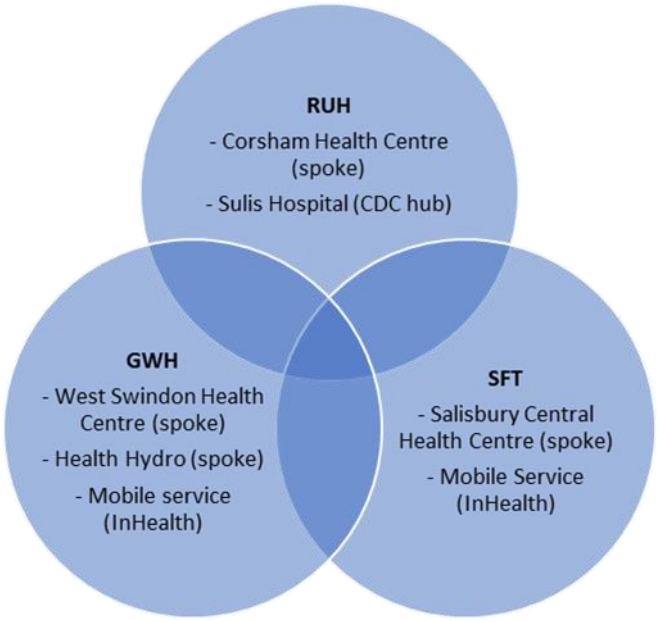

Figure 25: Community Diagnostic facilities at Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust

The investments will:

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

Our delivery plan

- A key feature of the development of diagnostic services is the implementation of our Community Diagnostic Centre model, which includes a fixed hub site at Sulis Hospital alongside additional services (including mobile facilities) for imaging, endoscopy and physiological measurement in Swindon and Salisbury.

- This additional capacity and standardised approach to pathways will reduce waiting time reduce backlogs and support delivery of elective pathway waiting time reductions in Year 1 and 2 and support the national ambitions for earlier diagnosis in cancer over the five-year period.

How we are organised to deliver

The Diagnostic Steering Group and Elective Care Board have considered options for the governance of CDC delivery. In order to make the most effective use of existing 'load bearing' system architecture, and to support the movement of resources from acute provision to community settings, a delivery model through the Acute Hospital Alliance (AHA) has been agreed in principle with the ICB, as part of the business case submission to NHSE SW.

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

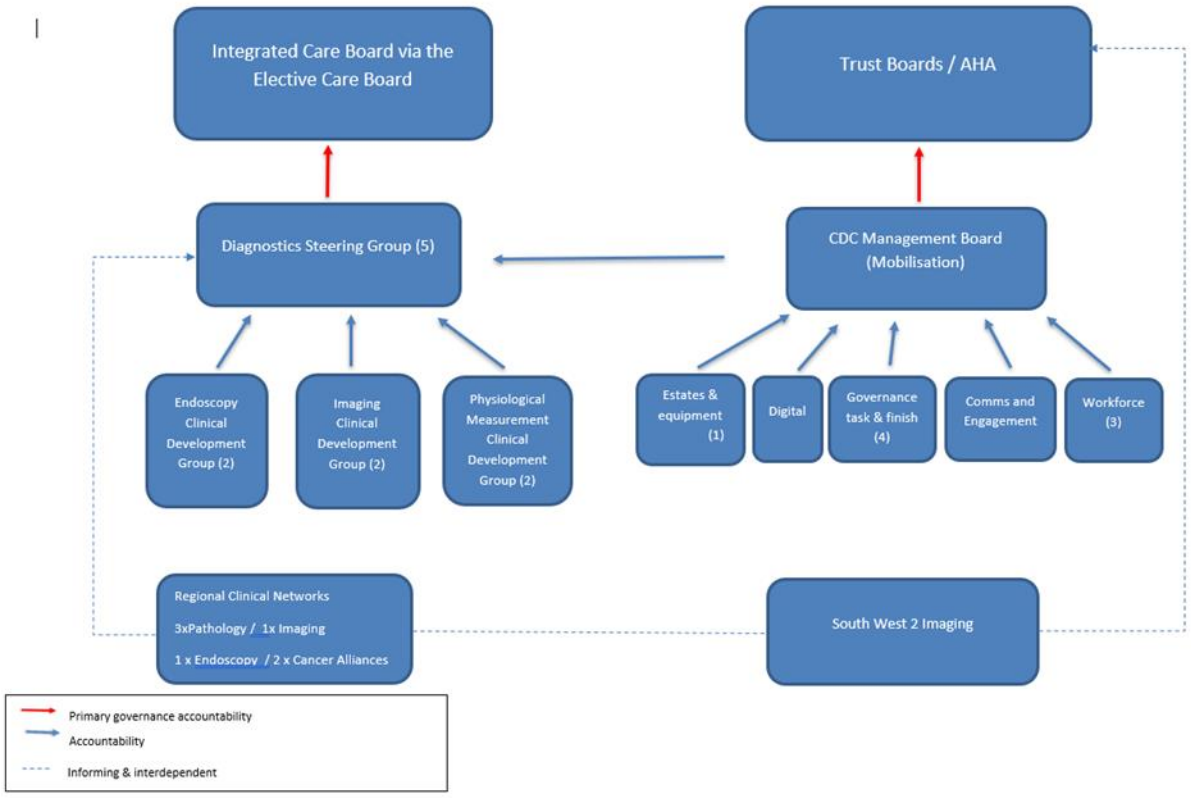

Figure 26: Governance structure for the Community Diagnostic facilities programme utilising a delivery model through the Acute Hospital Alliance

Each provider has their own clinical governance arrangements which flow to their respective boards and through the ICB quality mechanisms. CDC activity will be governed in the same way, noting that as consistent system-wide pathways are developed, these will need to be agreed across all providers.

The CDC clinical director (once appointed) will have responsibility for oversight and management of standardising clinical pathway arrangements. This should support and

accelerate the desired consistency of offer for services across BSW, whilst retaining appropriate local variation should population need require it.

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

Medium term plans to improve on this infrastructure position is the introduction of a Shared EPR across the Acute trusts and consideration of a single interface for requesting and results for CDCs (and wider community services).

CDC activity will be reported separately, with spoke activity 'nesting' under the CDC hub code, but separately identifiable by each trust (location dependent).

The current proposal is for a single patient tracking list (PTL) to be developed using Power BI to ensure there is a single version of the truth for diagnostic waiting times across the ICS, including CDCs.

What we will do in the next twelve months

The following aspects of the CDC programme will go live in 23/24 contributing to diagnostic recovery, reducing the backlog and supporting elective delivery of the waiting time ambitions: -

- Sulis hub – MRI (fixed) April 23; CT (Fixed) April 23, Endoscopy Sept 23
- Salisbury spoke – MRI April 23
- Corsham spoke – CT April 23
- West Swindon spoke – MRI April 23
- Hydro Health spoke – MRI April 23

This will deliver 10,268 additional CT scans, 6,882 additional scopes and 11,478 additional MRI scans in 23/24. (Activity to be rechecked with business case updates currently taking place)

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

This investment will facilitate additional activity over and above the diagnostic capacity currently being delivered at acute hospital sites. The proposed model is designed to enhance the current offering of diagnostic testing services from existing, mostly fixed, sites. The implementation of the hub and spoke model will enhance diagnostic endoscopy services bringing them closer to people's home in the local area and with the core objectives being:

- Meet demand and capacity requirements of the local population – demand and capacity planning forecasts large gaps over the next three years if no actions are taken
Improve access with focus on areas of higher deprivation
- Address and reduce identified health inequalities
- Transform and streamline pathways, enabling more personalised care and improved patient experience delivered from digitally connected, multi-diagnostic facilities

The intent is to generate communities of practice with a networked range of diagnostic services which are efficient and equitable in their delivery.

The enhanced facilities will provide a multi-functional approach to design, achieving a purpose-built, generic, flexible infrastructure for diagnostic endoscopic examinations, which will support one stop diagnostic pathways and reduce waiting lists.

Monitoring delivery

- Activity v plan for initially mobiles and then spoke sites
- Additional activity versus 19/20
- DM01 performance
- Reduction of waits over 13 weeks
- Uptake of diagnostics from deprived wards

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TBC, CDC Programme Director

Mental Health:

Context

Improving the overall mental health and wellbeing of our population is a core component of our plan. Our three strategic priorities are reflected in our transformation ambitions, with our intention to complete a radical change to mental health delivery over the next 5 years. This will move us away from a provider based model of provision to an integrated service model that is pathway based and which makes best use of our collective strengths. Although people in BSW have relatively good mental health, pockets of deprivation (as outlined in our prevention chapter) drive poorer outcomes for people living in our most challenged communities. In mental health services, we remain challenged in our delivery of core mental health standards for people across our communities. Key issues are:

- Continued challenges in delivering improvements in Access and Recovery rates in our Talking Therapies services. Although progress has been made to integrate services and secure additional training we still fall short of the Long Term Plan ambition for our population. This is of particular concern given that the number of people with Common Mental Illness is increasing across B&NES, Swindon and Wiltshire.
- Challenges associated with ensuring early access to children and young people's mental health services, with a lack of consolidated early support provided by third sector partners across B&NES, Swindon and Wiltshire
- Continued high cost long term placements for people with severe mental illness, resulting in people having to travel out of area for extended periods of time affecting patient experience and outcomes, as well as causing financial pressure
- Although out of area placements have reduced significantly during 2022/23, sustaining this is contingent on having adequate flow through our mental health estate. Challenges in securing housing and ongoing care packages mean that a high proportion of our beds (c30%) are occupied by people who do not need to reside in an acute mental health environment.
- Pace of community services transformation, meaning that we are still working to an historic model of community provision that is not fully aligned to Primary Care Networks or which makes best use of the community assets and capability available.
- Delivering an integrated and effective model of provision for older adults care that supports earlier diagnosis of dementia, enables people to live for as long as possible in their communities and provides intervention and support to people in care homes/settings rather than in an inpatient mental health unit.
- Establishing a local crisis response that is enabled by better working with South Western Ambulance Service NHS FT, taking the staff to the person and de-escalating at scene to avoid attendance in A&E departments with consequent impact on front door acute flow.

Our delivery plan

We will transform our services to achieve integrated and effective mental health and wellbeing services across BSW. Children and adults will be supported to live well in their community, with additional support offered to them at the point of need from expert third sector partners. Where people require secondary mental health services, this will be as

part of a wider pathway with individuals offered timely therapeutic interventions enabling them to transfer back to community based provision as rapidly as is clinically appropriate.

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

How we are organised to deliver

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

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

In partnership with our Integrated Care Alliances, we will design our new model of provision informed by local population health needs. Our ICAs will take responsibility for working with community partners (in conjunction with Third Sector Alliance colleagues) and primary care to increase local community-based provision.

What we will do in the next twelve months

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

Children and Young People's Mental Health Transformation

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

- Increasing our digital offer to provide early help and support for children and young people
- Commissioning a new model of service provision that integrates TAMHS, CAMHS and Mental Health Support Teams across Swindon – this will be the blueprint for our future BSW wide CAMHS model
- Developing a third sector alliance for Children and Young People's mental health, appointing a single third sector lead for each Place who will be the connector for all

community based provision who will work in partnership with Oxford Health NHS Foundation Trust as our secondary CAMHS provider

- Working with partners in acute hospitals to appoint Mental Health Champions (in line with NHSE mandate) to improve mental health support provided to children and young people who present in crisis at A&E. Develop a BSW Hospital based Youth Worker offer pilot using the funding achieved from NHSE to support young people, including with their Mental Health.
- Redesign our model of urgent response for children and young people, including supporting the redesign of the Paediatric front door at Great Western Hospitals NHS FT
- Continuing to support the roll out of ALPINE across Paediatric Departments to support targeted intervention for children with Eating Disorders who have physical and mental health needs, enabling a rapid 'reset' for them and their families and from that sustained recovery

Community Mental Health Services Transformation

Implementation of the new model of community mental health services, focusing on three elements:

1. Improving access to mental health support for people with Severe Mental Illness through new access models that provide immediate advice, support and signposting to community and secondary services as required at PCN level. This will build on the pilot work undertaken in B&NES, Swindon and Wiltshire during 2022/23 in order that we have a pan-system access model that delivers a new model of transformed care.
2. Reviewing and developing our secondary mental health service provision so that we provide timely therapeutic interventions as and when they are needed through redesigning our secondary mental health workforce and aligning this successfully with Primary Care Networks and ARRS investment
3. Continued redesign of pathways of care for older adults, people with complex emotional needs (personality disorders), young people aged 16-25, people who need community based rehabilitation and people with eating disorders. This will include developing specialist older adult focused ARRS staff, further expansion of our training offer to all partners to support people with complex emotional needs so that we have a fully trauma-informed provision, focusing on the key drivers of high cost out of area placements and co-designing and implementing a new model of community rehabilitation and making best use of third sector agencies to support people with Eating Disorders.

To support this work, we will continue to:

1. Work with AWP to support transfer from CPA to an alternative model of care planning in line with the national Community Mental Health Framework mandate.
2. Embed new roles aligned with our workforce plan with a particular focus on developing and increasing the number of ARRS workers, making best use of Multi-Professional Approved Clinician (MPAC) roles and developing our healthcare support worker offer across all providers.

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

We expect that with the implementation of our ambitions we will increase the numbers of people being treated within transformed services. Consequently, we anticipate a higher proportion of contacts within third sector provided services. Pilot work carried out in 2022/23 has informed our access approach and will further inform our modelling and data projections during 2023/24.

Eliminating out of area placements

In partnership with AWP, we have significantly reduced our out of area placement position. This has been as a result of targeted work supported by system partners through the AWP led Right Care Programme. During 2023/24 we will work to implement single-sex wards across BSW mental health services, which will form part of our wider estates strategy for mental health capacity focusing on right sizing our bed base informed by population health needs. We will engage stakeholders and service users in this work and will align this with our ambition to reduce admissions and support more people in the community.

During 2023/24, we will focus on:

- A pan-system review of Section 136 pathways, action plan to be co-developed with partners from Quarter 1 2023/24 and to be delivered by Q4 2023/24
- Further development and expansion of our NHS111 offer in order that we can deliver 'press 2 for Mental Health'
- Deployment of a mental health response vehicle to reduce conveyance to A&E and improve crisis response. Data from early adopters (BNSSG) shows that the impact of this is significant, in terms of both the overall ambulance pathway but also reducing the number of MH patients that present to A&E departments.
- Continued work to implement the 10 Discharge Priorities, in partnership with AWP and pan-system
- Development of a further Wellbeing House in Swindon and securing long term estate for the Place of Calm in B&NES (capital funding provided by NHSE) to support admission avoidance and improve step down provision.
- Review and development of our Wellbeing House specifications to provide a consistent offer across BSW, including supporting people who may be 'No Fixed Abode' (NFA)

Dementia

We will continue to work with partners across our system to develop and deliver our Ageing Well programme in line with our BSW system strategy. In mental health services, a core component of this is the effective and timely diagnosis of dementia, with targeted support provided by secondary mental health services delivered in partnership with primary care and third sector organisations.

In 2023/24, we will focus on:

- Aligned with population health needs, developing specialist Older People's Mental Health resource to work in primary care, using ARRS funding. We anticipate that this will support improving the diagnosis of dementia and associated recording.
- Supporting primary care colleagues to record DDR in practices which is currently not consistent.
- Developing a DiaDEM model to support improving diagnosis of dementia in care homes

As we develop our Virtual Wards programme, we will continue to work with partners to ensure that mental health expertise is available to support those people with co-morbid physical and mental health diagnoses and who require additional support in the community.

Perinatal

Our current performance is above the planned trajectory for access to perinatal mental health services. Consequently, we are not anticipating investing significant additional resource in 2023/24. We will continue to develop the service further including:

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

IAPT

We will continue to work with NHS England partners to support the rebranding of IAPT services to 'Talking Therapies'. Engagement work has already started with partners across our system.

We recognise that our existing IAPT services are not current configured or resourced to meet the needs of our population. As a result, during 2022/23 we developed and commenced a programme of transformation that will move from our existing model to a new, IAPT compliant offer that is consistent across our three localities. The scale of transformation required is extensive and will take time to implement. Consequently, we have developed a workforce plan that delivers a stepped change in access and recovery from 2023/24 – 2025/26.

As part of our development work, we will also consider how we can make better use of technology to improve access using recognised digital platforms.

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

More broadly, as we develop our access offers in response to the Community Mental Health Framework, we will examine how we can successfully embed our IAPT offer into this so that we make best use of not only IAPT but also wider services that would help

meet individual needs.

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

Over the last 2 years, we have invested in additional service provision to support physical health checks for people with SMI. We have confirmed that we will not be continuing this funding in 2023/24, and will instead have a primary care based model for those people on GP registers who are not open to AWP services, and for AWP to provide physical health checks for those people on their caseload. We anticipate that this will provide a more integrated service and will align with our community services framework ambitions. In addition to this service change we will:

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

Long term, we will maintain our approach to providing health checks for people with SMI. We know that mental illness represents a key inequality in outcomes, with people with SMI typically dying 10-20 years earlier than those who do not. Our approach will ensure that we offer parity of esteem in primary care provision for people with SMI, and that we not only identify health needs but also act promptly on outcomes of health checks so that we provide wider physical health support to people with SMI.

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

As outlined, our intention is that we will move away from provider based models of provision to fully integrated, pathway-based contracts.

In five years time, we expect that:

- All direction, intervention and community based support will be personalised to an individual's needs
- We will have a vibrant and effective model of preventative care, with social prescribers working with third sector partners embedded in PCNs to direct people to earlier help and support available in their communities
- People will be able to access Talking Therapies via a range of modalities (digital, face to face, group work) in line with national standards and our recovery rate will exceed 50%
- Children and Young People will be treated in community hubs that will bring together primary care, third sector, Local Authority and secondary mental health services. These services will wrap around the young person and their family, working with them and education partners to provide earlier help and advice and risk support when required in line with the Anna Freud iThrive model
- There will be a single front door for adult mental health services, with first contact provided by third sector partners who will support people to reach the right professional

for their needs at the right time. Specialist provision will be drawn in as and when required.

- We will make best use of NHS111 and other emergency response, and where people (of any age) present in crisis their needs will be met by the most appropriate staff
- Services will use interoperable records that allow multi-disciplinary input to records and enable supported transfers between services
- Care planning will be strengths and goals based, personalised to the individual

Monitoring delivery

Key metrics are outlined below:

- Achieving a CYP access rate (first contact) of 14,110 by 2024/25
- 21,095 people accessing IAPT services across BSW, with an overall recovery rate of >50% by 2025/26
- 5% year on year increase in the number of older adults supported by community mental health services (ongoing)
- Out of area placements sustained at zero by end 2024/25
- Achieving a Dementia Diagnosis Rate of 66.7% by end 23/24
- Sustaining improvements in perinatal mental health service provision

In addition, we will establish further developmental metrics using Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) that will evidence sustained improvement and transformation.

List lead and email address for further information

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Learning Disability and Autism

Our delivery plan

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

- Reducing the number of people who are in inpatient care. BSW ICB are the lead organisation for the new LDA capital build for the North of the South West patch covering the BSW, BNSSG and Gloucester footprint. This work covers the whole end to end pathway for people with a further focus on improving and expanding community provision.
- Delivering annual health checks for people with learning disabilities and autism. This builds on our improvement work during the last year, which provided additional resources for primary care and dedicated health checks in special schools.
- Implementing the Key Worker Programme and improving care co-ordination as we collaboratively develop what future support for people looks like
- Implementing together with system partners the required changes to Dynamic Support Registers and CTR/CeTR processes
- Ensuring robust oversight of patient pathways with an enhanced focus on prevention and early intervention. Delivery of a centralised, consistent approach to the management of escalations and complex cases
- Improving access across the end to end pathway including reducing waiting times for ASD and ADHD assessments and increasing support for people post diagnosis

How we are organised to deliver

Our refreshed BSW Governance structure illustrated in Figure 27 below:

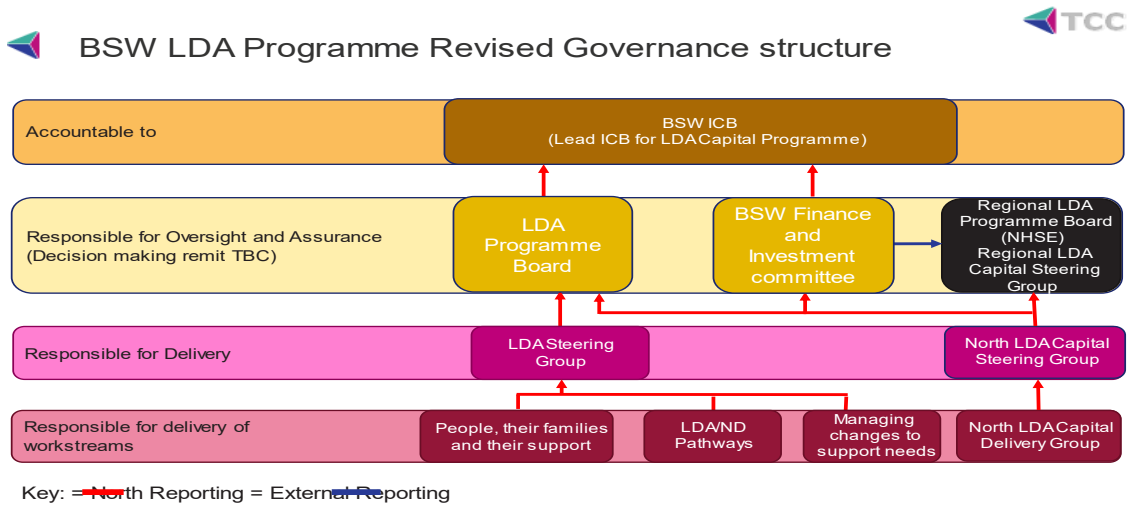

Figure 27: Learning Disability and Autism governance structure

What we will do in the next twelve months

- **By October 2023**: BSW Key Worker programme to go live providing community based support, early intervention and prevention for people with learning disabilities and autism. Recruitment is due to commence by June 2023 and a hub and spoke delivery model has been co-designed.

- **From May 2023**: The revised Acute Care Pathway, Prevention and Oversight pilar will be in place providing further consistency of approach across BSW. This includes oversight of our plans to reduce the number of children, young people and adults cared for in an inpatient setting.
- **From July 2023:** The business case for the proposed new LDA Capital building to serve the populations of BSW, BNSSG and Gloucester will be finalised. Work on engagement around the new facility and co-production commenced in 2022.

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

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

Reducing inequalities requires targeted action for groups that experience poorer than average health access, experience and/or outcomes. For CYP, our priority groups are:

We will take a trauma-informed approach to the work we do across all aspects of the CYP Programme.

How we are organised to deliver

The BSW Children and Young People's Programme (BSW CYPP) Board is focused on improving our defined local priorities for children, young people and their families in BaNES, Swindon and Wiltshire

What we will do in the next twelve months

- Co-produce and develop BSW CYP Strategy
- Better hear and listen to the voice and lived experience of children and young people, their parents and carers
- Develop workstreams to ensure sufficient focus on progress and improvement in key areas
- Continue to support and focus BSW ICB on needs and priories for babies, children and young people
- Continue our journey of a holistic approach to children and young people with reduced silo working
- Improve links between maternity and babies, children's and young people

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

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

List lead and email address for further information

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Elective Care:

Our aim is to provide elective services that are accessible, responsive and sustainable for the population of BSW Population. Over the next 2 years our approach will be framed by the ambitions set out in the elective recovery plan, including:

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

Beyond the end of 20224/25, by year 5 our aim is to have returned performance back to the Referral To Treatment (RTT) 18 week standard.

A summary of the elective plan is set out in Figure 28 below.

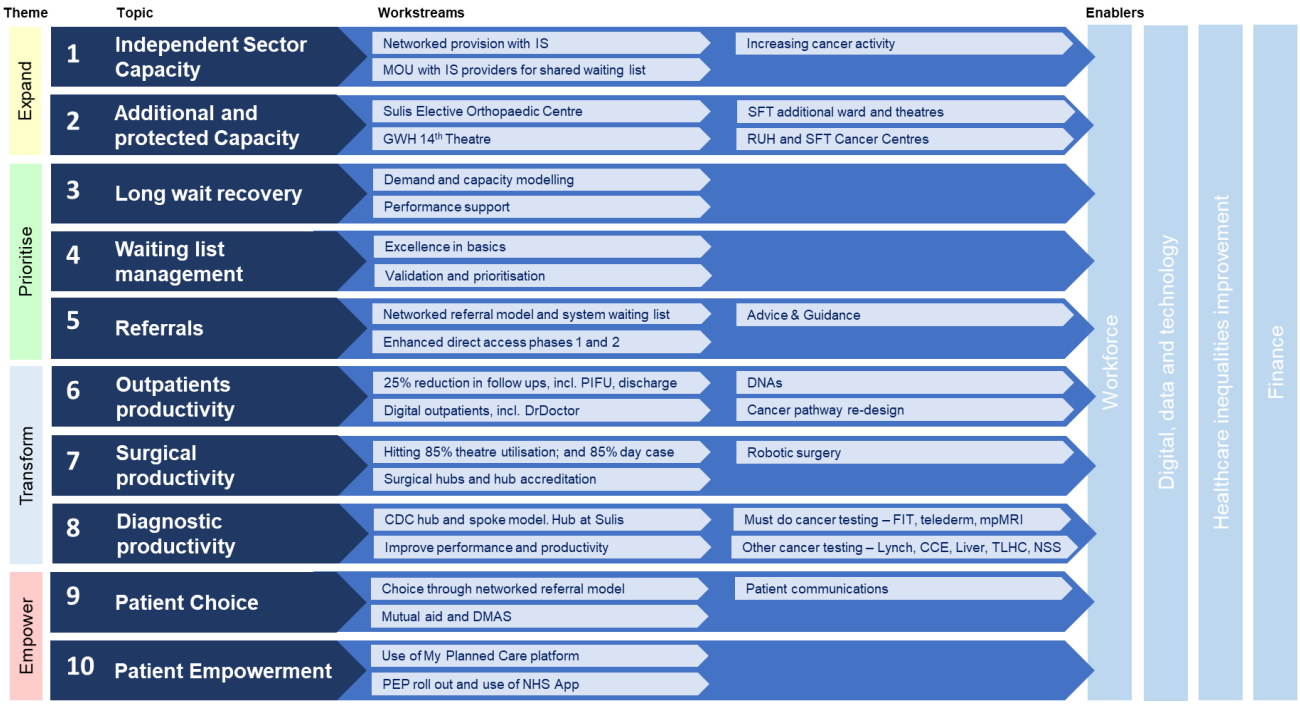

Figure 28: Elective Care plan summary

What we will do in the next twelve months

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

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

Referrals – developed a networked model of provision across our NHS and independent sector providers supported by a system waiting list to maximise utilisation of the system capacity for the population and reduce variation is access times.
Outpatients productivity – strong drive towards delivering the 25% outpatient follow up reduction to free up capacity to see new patients, including through the use of patient initiated follow up (PIFU)
Surgical productivity – significant increase in day case activity, including day case arthroplasty.
Diagnostic productivity – Establish a new hub and spoke CDC, with the hub at Sulis
Health inequalities – improving data to identify patients from more deprived areas and taking targeted actions to ensure we recover inclusively.

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

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

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

- Elective Recovery (including cancer – which also has its own system operational delivery groups)
- Outpatient Transformation
- Community Diagnostic Centres (it has been agreed to change this to a 2-part, performance and CDC oversight committee)
- Health Inequalities (new subgroup)

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

Cancer:

Context

To deliver improvements in line with the national cancer strategy and national cancer planning guidance for 2023/24

Our delivery plan

Achieve in line with commitments made in the BSW ICB planning submission (cancer section)

How we are organised to deliver

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

What we will do in the next twelve months

Deliverables are in line with details already provided in the BSW ICB planning submission

The key milestones for 23/24 are:

Table 19: Key milestones for cancer care delivery in 2023/24

2023/24	Milestones
Q1	RUH – additional urology consultants, additional MRI capacity, resulting in reduced waits. Reduced CT waits for CRC due to additional mobile CT capacity. SFT - Same day / next day CT Protocol finalised for Gynaecology patients. Same day / next day CT for LGI / UGI patients after abnormal scope. Reduced gynae waits due to pathway improvements. Reduced CRC treatment waits due to additional consultant surgeon starts. RUH, SFT – receive additional SWAG CA funding for 23/24 for additional posts/equipment – RUH: gynae, CRC, breast, radiology. SFT: CRC. GWH – once sighted on TVCA funding arrangements for 23/24 consider viability and propose bids for funding to support cancer agenda All trusts - submit bids through SWAG/TVCA funding processes ICB – initiate primary care cancer projects process Primary care – develop and submit bids for primary care cancer projects All – data analysis to identify inequalities in access to and provision of cancer care
Q2	SFT - Reduced urology waits due to bladder and prostate pathway changes. PET CT on site and in use, reduced waits. All trusts – receive funding, initiate recruitment Primary care – deliver against agreed primary care cancer projects ICB, RUH, SFT – support expansion of SWAG Targeted Lung Health Checks programme into Trowbridge and Salisbury All – agree programme of actions to address identified inequalities

Q3	RUH – reduced gynae waits due to pathway improvements. Reduced CTC waits due to additional capacity. Reduced CRC treatment waits due to additional consultant surgeon starts. All – newly recruited roles are in place and delivering Primary are – progress report on delivery of agreed primary care cancer projects All – begin to implement actions to address identified inequalities
Q4	Primary care – complete projects and submit end of project reports ICB – collate responses, circulate outcomes and learning for wider benefit across primary care All – continue to implement actions to address identified inequalities

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

Faster diagnosis; earlier diagnosis; improved treatment; improved support during and after treatment for cancer; improved survival rates (1 and 5 year); reduced inequality between different patient cohorts

The long-term vision is to achieve the following within the next 5 years:

1. Keep the number of patients waiting over 62 days for start of treatment, to below the levels seen in Feb 2020 (adjusted for growth).
2. Consistently achieve diagnosis of cancer/no cancer within 28 days of a 2ww referral being received in secondary care.
3. Continue to improve the proportion of those diagnosed with cancer, being diagnosed "early" (stage 1 / stage 2) towards the national aspiration of 75% by 2028 – for the contributing factors that are within our control/influence.
4. Expand TLHC provision to cover full population, in line with national cancer strategy direction of travel.
5. Achieve an enduring funding solution for NSS pathways whether provided in primary or secondary care, such that 100% of BSW population is able to be referred to these pathways.
6. Maintain a level of use of QFIT such that more than 80% of LGI 2ww referrals are accompanied by a QFIT score.
7. Ensure sustainable teledermatology Advice & Guidance such that there is parity of provision pan-BSW; ideally with a single pan-BSW solution.
8. Continue and strengthen the use of the current network of a lead GP for cancer in every GP Practice.
9. Level up, to reduce (or remove) the disparity in access to cancer care currently experienced by those in under-represented groups across BSW, and in particular to raise screening uptake and early presentation rates in the Swindon area to that of the rest of BSW.
10. Expand the use of voluntary community cancer champions, as already developed in the Swindon area, across the rest of BSW.
11. Become a consistently top quartile performer on the full range of cancer performance measures; alongside seeing and treating a higher number of people with cancer compared to the pre-covid baseline.

12. Introduce new treatments as they become available and gain a reputation for high quality provision of cancer care.
13. Provide a holistic and comprehensive support capability for all cancer patients, incorporating primary care (CCRs and wider support and signposting), secondary care (PC&S support including H&WB events, HNS, treatment summaries; psychological support; links to primary care) and voluntary and community sector (signposting, community support groups, access to advice, psychological support) -potentially implement the Scottish model of “Improving the Cancer Journey” (currently being investigated for consideration of implementing in Swindon area).
14. Promote the continued increased uptake of national cancer screening programmes such that BSW is a top quartile performer nationally.

Monitoring delivery

- Achievement of deliverables within respective quarters in line with the details submitted in the BSW ICB planning submission.

List lead and email address for further information
Andy J

Maternity:

Context

Maternity Single Delivery Plan

Maternity deliverables are governed ultimately by the Maternity Single Delivery Plan, this is a national, three-year delivery plan, published by NHSE which aims to guide and govern system-based strategy such as the BSW Implementation Plan. The report was published initially on 30th March 2023 and brings together previous maternity and neonatal national key drivers including Better Births, Ockenden reports, East Kent Report and Neonatal Critical Care Implementation plan. Although the initial report outlines key areas of importance, local maternity and neonatal systems are awaiting further detail regarding planning and implementation of the deliverables nationally and locally. The delineated aim of the maternity single delivery plan is to make care safer, more personalised, and more equitable. The plan uses four key themes to outline how we will achieve this within a system approach, listed below.

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support

Standards and structures that underpin safer, more personalised, and more equitable care. ***The LMNS BSW ICB are due to meet for a planning session on 4th May 2023***

BSW Integrated Care Strategy

The integrated care strategy will incorporate the deliverables that are identified within the maternity single delivery plan, pre-existing deliverables that are outlined in section 2.

East Kent Report

The deliverables/metrics outlined in section 2 have been informed by The East Kent report. This has recently been published by NHSE and outlines areas for improvement regarding maternity care, specifically in the East Kent area, however, applies to local maternity and neonatal system practice.

Existing key metrics/deliverables

There are several key metrics that are monitored to ensure safe practice within maternity and neonatal care, these are mentioned below. These metrics may not need to be included in the BSW implementation plan/strategy, however, will guide local maternity and neonatal systems. Some metrics, await further planning and discussion regarding specifics.

Our Commitments

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

2. Have clear **governance** and **accountability** arrangements for collective monitoring of quality and safeguarding
3. **A shared commitment** to delivering **seamless pathways** of care where the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation
4. Develop a **Just Culture** which is open, transparent, and supports continuous improvement
5. Work with local **communities** to shape the design and delivery of services

Our Approach

Delivery of quality care in the system is underpinned by:

- Quality assurance framework aligned to an agreed governance structure at place and system level, including Swindon, Wiltshire and BaNES localities, ICB Quality Assurance and Outcomes Committee, BSW System Quality Group, ICB Board and Integrated Partnership Board
- Key quality and safeguarding metrics that focuses on safety, effectiveness and experience, triangulated with performance data/ intelligence and professional insight. These metrics are understood at both integrated place and system level via quality and performance reporting within agreed quality governance structures and safeguarding partnerships
- A focus on population health and system quality priorities across pathways/ settings with particular emphasis on reducing inequalities in access, experience, and outcomes. This is aligned to priorities set out within the BSW implementation plan including elective care; urgent care, mental health, learning disability and autism and children and young people
- Role of the BSW System Quality Group in the identification of risks and issues to patient safety and quality and strength of the mitigation at both an organisational and system level, recognising and supporting the capability to deliver safe and effective services
- BSW Patient Safety Specialist Community of Practice and implementation of national Patient Safety Incident Response Framework (*PSIRF) in 2023
- Development of BSW EQIA panel to strengthen equality and quality impact assessment monitoring at system / strategic level
- Identification of collaborative and inclusive patient safety leadership, with a shared vision and values, driven by continual promotion of learning and aligned to a just and inclusive culture.
- Consistent and up to date guidelines and evidence that enables continuous improvements in quality based on best evidence
- Actively promoting co-production with people using services (experts by experience, for example, BSW Carer's Forum), the public and staff

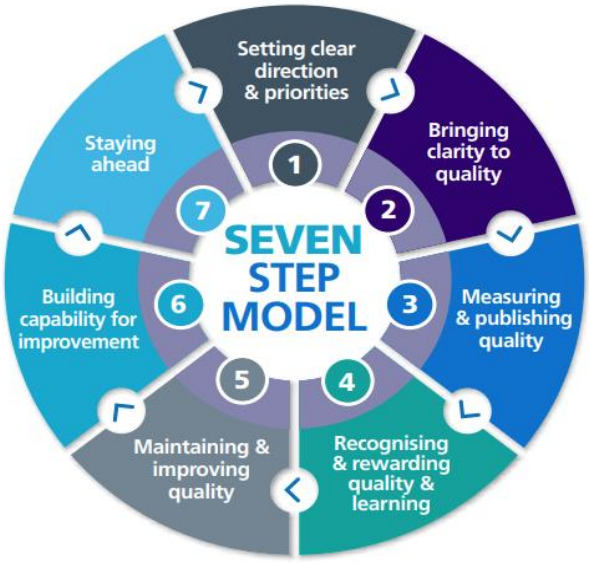

Figure 29: FIGURE LEGEND TO BE ADDED

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

Through the introduction of the NHS Patient Safety Strategy (2019) and the aim of continuously improving patient safety, the new Patient Safety Incident Response Framework (PSIRF) will be implemented across all providers from September 2023, this will replace the Serious Incident Response Framework and prioritises compassionate engagement with those affected, advocates a coordinated data driven approach, and embeds a wider system of improvement. Through the Patient Safety Specialists Community of Practice, BSW will support all providers to adopt the new approach, and continue to learn, develop, and improve patient safety across the whole system. BSW will also ensure providers collaborate to deliver the nationally recognised patient safety improvement programmes; maternity and neonatal safety improvement programme, medicines safety programme and mental health safety programme, as well as supporting safety improvement in priority areas such as safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.

How we are organised to deliver

What we will do in the next 12 months

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

- Accelerate preventative programmes, ensuring data is accurate, timely and complete to inform equity workstream
- Create Gypsy, Roma, Traveller, Showman and Boating Communities Pathway, ensuring all communities can access maternity care in a way that reflects their needs
- Pilot of new role: Independent Senior Advocate to facilitate critical review/analysis of the role at a national level to ascertain if the role will be permanently integrated at a system level
- Reduce inequitable outcomes for black mothers and their babies by appointing and training 20 staff across BSW to become Black Maternity Matters Champions

- Provide Anti Racism training to 600-700 staff across BSW to improve cultural awareness and eliminate bias; leading to improved outcomes for pregnant people and their babies
- Ongoing collaboration with the Maternity & Neonatal Voices partnership to incorporate service user experience into pathways
- Evaluate service user experience of OCEAN Services and maternal mental health pathway

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

Developing and sustaining a culture of safety, learning, and support
- Aim to reduce risk and avoidable harm to babies under 1, including unborn babies through promotion of wider resources and campaigns
- Collaborate working across the system to ensure data/dashboard includes all high-level metrics for reporting, ensuring this is accurate and timely to inform programme management / system quality surveillance groups
- Provide safe assessment process via a centralised telephone assessment line
- Develop and sustain a positive safety culture by completing a Perinatal Culture Survey and monitoring impact
- Implement PSIRF Safety Improvement plans
- Oversee quality in line with PQSM and NQB guidance ensuring that maternity and neonatal are included in ICB quality objectives

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

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

Listening to women and families with compassion, ensuring care is personalised and equitable
- Improved access to services for all, including marginalised groups

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

Growing, retaining, and supporting our workforce
- Improve retention and level of competency/education for NQM r
- Improved outcomes for pregnant people and their babies

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

Standards and Structures that underpin safer, more personalised, and more equitable care
- Improved knowledge regarding birthing, pregnancy and parenting; resulting in improved physical, social, emotional and psychological outcomes for birthing people, babies and children
- Improved access to provision of essential nutrition for babies, impacting psychological, physical, emotional and cognitive functions, leading to improved progression/develop for babies and children
- Reduction in adverse outcomes, such as still birth, neonatal deaths, brain injury.
- Improved holistic outcomes for birthing people, partners, babies and children
- Improved information sharing across services
- Reduced short term and long term impact of untreated perinatal pelvic health conditions associated with childbirth
- Reduced need for surgical intervention
- Improved outcomes by early identification and management of the deteriorating person

We will be working collaboratively with various stakeholders including, the three acute Trusts in BSW, LMNS, Public Health, MNVP, HV Leads, all maternity based services, third sector agencies, providers across BSW and regional networks.

This works aligns with existing initiatives including, Maternity Single Delivery Plan, Integrated Care Strategy, Core 20+5, East Kent Report, Ockenden, Maternity Transformation Programme, SBLCBv2, Better Births and the NHSE Long Term Plan.

Monitoring delivery

Please see above for key metrics

List lead and email address for further information
Sandra.richards@nhs.net kerrie.wood4@nhs.net

Duty to Improve Quality of Services:
Quality is a shared goal that requires system commitment and action.
System Quality will be based on these principles:
•**Collaboration, trust and transparency**
•**Transformation**
•**Equity and equality**
In practice this means that the system will deliver care that is **safe**, **effective**, **well led**, **sustainably resourced** and **equitable**. The care **experience** of the population will be positive through **responsive**, **caring** and **personalised** delivery.

Figure 30: FIGURE LEGEND TO BE ADDED

10. Enabling workstreams:

Delivering Against our Strategies:

Health and Care Professional Leadership

It is health and care professional leaders, working in partnership with each other and with people in local communities, who make improvements happen. In BSW we have various examples of excellent practice demonstrating this, but not consistently. Nor do we involve health and care professional leaders in all our transformational work as much as we should.

The term Health and Care Professional Leadership is intended to be diverse and fully inclusive of the broad range of professionals who work together across BSW beyond the traditional boundaries of health and care, such as partners across the VSCE sector, education and housing. Even in our examples of excellent practice our involvement could be more diverse and inclusive.

Our vision for health and care professional leadership in BSW is to:

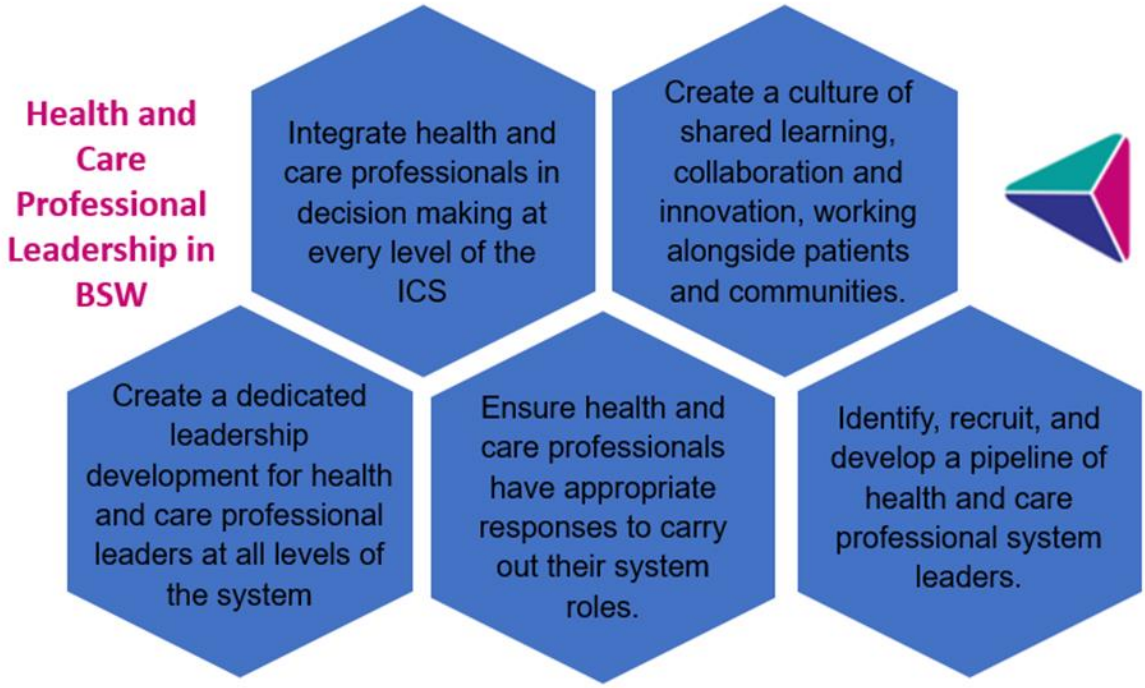

Figure 31: Our vision for health and care professional leadership in BSW

Our first steps towards this vision have been to:

1. Establish a HCPL team. Led by the Chief Medical Officer, we have three Health and Care Professional Directors, working across the system together and dedicated into each Place. These complement the existing leadership in the Chief Medical Office introducing different professional backgrounds representing the diversity of health and care professionals.

2. Held a series of conversations with over 100 health and care professionals in the system to understand the current picture of health and care professional leadership (good practice and areas for improvement), to develop a shared vision for the future, and to gather ideas of the steps needed to achieve this vision.
3. Started to embed the HCPL team in key governance structures including Integrated Care Alliances, Transformation and Nursing/Quality.
4. Started to engage in key transformation programmes and to lobby and build the expectation for greater involvement of a more diverse range of health and care professional leaders.

The output from the conversations is supporting the next steps towards this vision:

1. By September 2023 there will be a system map, a platform and directory of contacts from which to build the network of health and care professional leaders.
2. By October 2023 there will be a programme of regular, large scale engagement events for existing and future health and care professional leaders.
3. By March 2024, following extensive engagement, there will an ICP approved Statements of Intent and associated Action Plan to deliver aligning to the ICS Strategy, the vision and commitments for Health and Care Professional Leadership in BSW.
4. By March 2024 aligned to the Integrated Care Strategy there will be the instigation of annual reportable outcomes of impact of HCPL against: Focus on prevention and early intervention, Fairer Health and wellbeing outcomes and Excellent Health and Care Services.

In addition, we will work closely with other ICB teams to support enablers that can accelerate progress including:

- Access and use of the integrated care record for direct patient care and population health management to enable transformation.
- Development of and uptake of leadership development opportunities developed by the Academy.
- Developing opportunities and encouraging uptake of involvement in transformation programmes.

Looking forward, in 5 years' time, the People of BSW will receive high quality, effective health and integrated health and care provision, led by health and care professional leaders who are confident in working and leading differently in systems. Their Personalised care will be focused on prevention and early intervention, as health and care professional leaders lead services with a focus on population need and tackling health inequalities. The services will be accessible, timely and sustainable, enabled by the dedicated development and time for current and future health and care professional leaders to work effectively as system leaders.

Lead and email address for further information

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Lucy Heath - Health & Care Professional Director (Swindon) lucy.heath10@nhs.net

Gina Sargeant - Health & Care Professional Director (Wiltshire) gina.sargeant@nhs.net

Financial sustainability and Shifting funding to Prevention:
BSW has a strategic intention to focusing funding and resources on prevention rather than treatment of healthcare conditions. There are significant pressures facing all health and care services at present. As a health system the organisations within BSW has had a substantial underlying financial deficit and exited the 2022/23 financial year with the position further deteriorated.

To address this, BSW System has committed to deliver a substantial system wide financial recovery programme with a structured approach to drive delivery. The financial recovery plan is part of a sustainable system wide transformation strategy and this approach brings together productivity and efficiency improvements under one umbrella.

The system recovery plan sets out a focused two-year Transformation and Cost Improvement Programme with the target of bringing the BSW health system into financial balance by March 2025. This is not a traditional organisational strategy but a developing approach to working collaboratively together as a system to resolve significant issues to create a sustainable health system for the population of BSW.

We have developed a financial recovery action plan that includes a focus on restoring underlying productivity aligned to our system transformation programmes. Ten existing areas have been prioritised including UEC, Elective Care, Workforce, Medicines optimisation and community transformation. The scope, actions required, resources, timeline and delivery impacts of each programme with SROs will conclude in April 2023.

BSW System Recovery Board will ensure the programmes are delivering at pace and resolve any cross-system issues. The board will be chaired by a CEO and to include CEOs, CFOs, clinical and technical input. The board will initially meet fortnightly from April and will report into the system board. The purpose of the recovery board is to act as a dynamic working committee, ensuring financial recovery and overall sustainability within organisations and across the system, while it proactively drives delivery forward, unblocking issues and facilitating solutions.

In parallel, BSW will develop a longer-term financial strategy which will emphasise a population health management approach to take a longer-term view of new investments. This will underpin moves to prioritise future funding increases towards community and primary care and self-care and over time, achieving a shift in the overall balance of funding towards prevention.

Workforce:

A system wide workforce plan

Improved outcomes in population health and healthcare are one of the fundamental purposes of integrated care systems (ICSs). To achieve this, partners from across health, social care and the third sector must come together to plan and develop a workforce that integrates and connects across all parts of the system to deliver personal, person-centred care to their local populations now and in the future.

To deliver on this aspiration, the ICB will firstly work with their NHS system partners to develop plans to meet the national objectives 23/24 set out by the NHS in the priorities and national planning guidance. Central to this process is the drafting of detailed 5-year workforce plan for all NHS provider Trusts, primary care providers and mental health provider organisations.
System plans are required to be triangulated across activity, workforce, and finance, and signed off by ICB, partner trust and foundation trust boards.

The second phase will ensure the workforce plan captures the wider ICS workforce and includes Social Care partners, independent/private providers and third sector and charity provision, where appropriate. Using data and intelligence from Skills for Health, NHSE and other sources, we will develop the detailed ICS workforce plan, and this should inform the workforce interventions required to deliver on our ambitions as a system.

BSW Workforce Priorities 23/24

To identify and agree collective system wide workforce priorities for 23/24, the BSW People Directorate led by the Chief People Officer undertook a series of diagnostic sessions to collaboratively discuss and understand the workforce 'problem' trying to be solved. The output of these sessions has identified specific priorities to be taken forward as an ICS:

1. **Older care workforce** – consensus to focus on a pathway to enable a multi-disciplinary and person-centred approach rather than traditional workforce models. The ambition is to identify workforce and skills shortages and opportunities as part of the patient pathway. The approach enables the full involvement of all partners and agencies involved in the care of the patient in our system inclusive of academic partners. A more detailed diagnostic exercise, employing a quality improvement methodology will be undertaken to further refine the scope, actions and measures of success. The pathway approach will employ an integrated approach to workforce planning looking at ways to develop, introduce and deploy new roles, skills and supply routes. Learning from the pathway workforce approach will be undertaken able to be applied to future workforce planning activities.

2. **Domiciliary care** – Domiciliary care continues to be a core area of challenge affecting both hospital discharge flow and, more importantly, being able to keep people well and at home. BSW workforce projections have identified a growing demand for domiciliary care with raising rates of frailty and dementia against a backdrop of high staff turnover and decreasing numbers of people applying for care worker roles. In 2022/23, partnership work led by Local Authorities across BSW

have developed a domiciliary care workforce modelling tool and a detailed analysis of the workforce with a number of recommendations to be taken forward in 23/24.

3. **Leadership and Management** – Development of our system leaders and managers is essential for organisational success and the delivery of high quality, safe and effective health and care services. The aim is to co-develop and implement a collaborative offer for all partners building on efficiency and reducing variation across our partners and staff groups. It is expected that the initiative will also look for enhanced opportunities for leaders and mangers to increasingly work and move across organisational boundaries.

4. Early career attraction – Recognition that attracting a future workforce that engages and attracts young people is fundamental to the success of all partners. Aim to work together for innovative, positive approaches for promoting and raising the overall profile of careers available across BSW and with a focus on attracting more young people. It will take into account how employment can also help address health inequalities so that employment offers and access to skills becomes increasingly inclusive. The scope will include working with schools, colleges and education providers and local community groups.

5. **Retention** – Retention relates to the extent to which an employer retains its employees and may be measured as the proportion of employees with a specified length of service (typically one year or more) expressed as a percentage of overall workforce numbers. Reducing turnover and improving retention is essential to stabilise the workforce, increase efficiency and reduce cost. The BSW turnover rate currently stands at 14.3% (month 12 22/23) which is a declining position so further work will be undertaken to look at the underlying causes of higher turnover themes and hotspots. Suggested areas to include:

I. Collective marketing and attraction for health and care careers in BSW as a system
II. Health and wellbeing initiatives
III. Recognition of interdependencies across partners
IV. Links between leadership/management and retention
V. Exploring available schemes able to further support retention such as deployment, NHS and Care ambassadors and housing solutions

6. Bank and agency usage

Ensuring BSW work collectively to reduce agency spending across the NHS to 3.7% of the total pay bill in 2023/24 which is consistent with the system agency expenditure limits for 2023/24.

7. Maximising Apprenticeships

Overall recognition that apprenticeships offer opportunities for up skilling and developing new supply routes. However, the overall investment model for staff backfill often remains as a core barrier for taking forward. Commissioning and collaborative working aim to explore possible efficiencies and consistency.

The identified system workforce priorities will be further refined to identified programmes of work working closely with the BSW System Recovery programme for workforce. Timelines will be agreed for when they will take place recognising that work will need to be prioritised according to importance, impact and resources available to enact them. Progress will be reported through the BSW Strategic Workforce Group which reports into the BSW People Committee.

International recruitment

The ICB has established a centralised international recruitment team held at ICB level that will specialise in hard to recruit roles. It will work closely with all providers to support programmes that will benefit from a system level response. The first programme has been looking at sourcing mental health nurses from India and the delivery of an integration course delivered in-country. We have just recruited the first 52 nurses for AWP.

BSW Academy

The ICS has a BSW Academy that brings together agreed workforce development and transformation priorities across all our health and care partners. The BSW Academy is formed around the core pillars of leadership, inclusion, education, innovation and improvement that form a collective programme of work. As part of the governance organisational teams such as education and training leads are brought together to share, discuss, and work on agreed collaborative projects coalesced around the integrated workforce plan. Examples of these workstreams are expansion of clinical placements for increasing supply routes, apprenticeship programmes / levy sharing, preceptorship, work experience, pass porting of training, new development/skills pathways, coordination of CPD programmes and leadership/inclusion training interventions.

Working in an integrated manner has enabled education to be increasingly to the benefit of all partners aiming for consistency and scalability in a ‘do once and do well’ philosophy. For example, an increasing focus on social care offering both new and integrated training models aimed to enhance supply and retention of a known workforce priority in BSW. Education and training will be applied as part of our transformation priorities both enhancing supply routes but also offering new skills and models of education necessary for staff engagement and proposed new models of care. Examples of this application can be evidenced through career /competency pathways for new ways of delivering care such as virtual wards and addressing health inequalities.

The BSW Academy also enables an increasingly strategic approach to education partnerships with our providers such as colleges, universities, and skills funding opportunities such as the Local Skills Improvement Plans. Moving forward a stronger emphasis will be placed on a ‘grow our own’ model of training that works with local communities and builds accessible career pathways.

Our People Strategy will focus on four ambitions:

1. Creating inclusive and compassionate work environments that enable people and organisations to work together
2. Making BSW an inspiring and great place to work
3. All staff feeling valued and having access to high quality development and careers

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

Technology and Data:

Making the best use of Technology and Data

Digital solutions give us the potential to work differently, facilitating better, safer care and more efficient and effective use of resources.

Through our BSW Digital Strategy we have identified three strategic priorities in digital and data:

1. Information Sharing
2. Development of our digital workforce via a portfolio of projects
3. Ensuring contemporary cyber security is in place

Our commitments include:

- An Electronic Patient Record
- Working toward a shared infrastructure across BSW
- Digital design principles – an agreed system wide approach to the use of technology and digitally enabled transformation that is relevant for all professionals

How we are organised to deliver

Digital strategy across BSW is set by the BSW Digital Board. This comprises digital leadership representatives across our acute, mental health, social care, urgent care, community, carer, hospice and primary care partner organisations. Sub groups report to the Digital Board on clinical and professional leadership, cyber and a technical design authority, business intelligence, Shared Care Records, ICS use of N365 and the Digital Board reports to the Finance and Investment Committee.

What we will do in the next twelve months

Table 20: Technology and Data twelve-month delivery plan

Project	Objective	Major Milestones	Measure
Delivery of Single EPR (AHA)	Deliver a single, shared EPR across 3 acutes in line with NHSE EPR Convergence approach to level up digital maturity across acutes	Q1: FBC approved Q3: Contracts signed/NHSEI approval of FBC/implementation resources in place	
Development of Shared Care Record	Enhance capability and usage of the BSW Shared Care Record (ICR) to release efficiencies, improve care and patient experience	Q2: Benefits review completed and usage to reach 40k records per month Q4: extension of ICR across 3 Local	Patient record views and staff access levels Efficiency savings quantified Qualitative

Project	Objective	Major Milestones	Measure
		Authorities	patient/user stories
Remote monitoring for Virtual Wards	Introduce a consistent digital solution to support virtual wards through remote monitoring technology	Q1 Sign off of specification Q3 Implementation of solution	Patients monitored
Robotic Process Automation	Introduction of RPA across organisations building on successful service in place in GWH	Q1 Processes automated in 'new' organisations Q4 Business case for sustainable delivery model	Efficiency savings
Use of patient facing digital tools	Increase capability of patients to enable easy patient access to key information	Q1 Pilot use of maternity app about care choices during pregnancy Q4 Increase functionality of Dr Doctor in acutes to enable appointment management for patients	Number of users
Building upon ICS wide cyber strategy	Creation of long-term ICS wide cyber lead and ICS cyber risk register	Q1 Banded JD Q1 Finance agreed. Q2 Post in place and chairing Cyber TDA. Q3 ICS wide cyber risk register and key KPIs Q4 Development of ICS wide cyber projects and	ICS wide Cyber Risk register created. Improvement in KPIs created. Reduction in Microsoft MDE risk scores

Project	Objective	Major Milestones	Measure
		workplan in line with cyber strategy.	
TBC GP IT Delivery in BSW	Completing plans put in place pre-Covid to In house into ICS from CSU GP IT delivery across BSW. New service to be delivered by the ICB in conjunction with ICS partners building on exiting teams and strengths	Q1. Draft Operating model and costing. Q2. Approval Go ahead Q4+ implementation (NB due to requiring network migration implementation would be at least q 12month program on a ramp up ramp down approach April 2025 – Migration to new service full complete	Saving from current 23/24 CSU quote of £2.4M. % of GP IT estate fully public cloud hosted (no on site servers)
Business Intelligence – Data and Infrastructure Workstream	Develop an infrastructure which facilitates ICS business intelligence. Includes development of a shared data platform at ICS level, linked to the regional SDE.	Q1 + 2 - Initial phase of ICS Data Platform - Enhance our linked data set and roll-out major PHM / HI reports - Co-develop ICS plans for Power BI and SharePoint collaboration Q3 + 4 - Further progress data platform, linked to SDE and FDP - Deliver joint plan on Power BI and SharePoint	More data held centrally sets Wider access to ICS data and reporting Some functions centralised Reduced cyber risk
Business Intelligence – Capability and Capacity Workstream	Assess the existing analytical skills across the entire ICS. Map against future requirements and develop a workforce plan to close gaps, partly	Q1 + 2 - undertake LKIS Skills Mapping across the ICS - Develop next steps following Mapping - Begin to map the	Workforce plan developed Demonstrable closure in identified skills gaps in BSW More advanced

Project	Objective	Major Milestones	Measure
	through closer working	skills of non-Analysts in using data and information - Establish more formal links to neighbouring systems Q3 + 4 - Begin deliver of workforce plan, focusing on shared, system-wide advanced analytical skills	analytical outputs
Business Intelligence – Insights Workstream	Improving the way data is utilised by the system to make more effective decisions. Making data and information easier to access and clearer for those using it.	Q1 + 2 - agree a formal approach to analytical collaboration between orgs at system and place - review and agree a better approach to analytical requests Q3+Q4 - Embed changes to the way insight is generated across the system via agreed action plan developed in Q1/2	Usage of reports Staff confidence working with data Embedded decision-making framework

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

1. Patient experience will be enhanced by empowering patients with digital tools to manage their own health and well-being.
2. Operational efficiency will be increased by adopting digital solutions that streamline processes and reduce administrative burden.
3. The quality of care will be improved by using data and analytics to inform decision making and drive evidence-based practices.
4. A greater culture of digital innovation will be developing by encouraging staff to embrace technology and continuously look for ways to improve patient care.
5. We will be collaborating with healthcare providers and other stakeholders to develop a comprehensive digital ecosystem that supports the delivery of integrated care.

Monitoring delivery

Our digital governance framework will ensure that the ICB remains accountable and transparent in its use of digital technology.

We will regularly review and evaluate the effectiveness of the digital strategy and make necessary changes to ensure that it remains relevant and effective. The Digital Maturity Assessment offers the opportunity to baselines, benchmark and assess improvements over time as to the progress of our digital aims with regard to national and local priorities. Our Business Intelligence plans are assessed against the Intelligence Functions self-assessment tool, which regular review of deliver through our system BI Oversight Group and the Digital Board.

List lead and email address for further information
Jason Young Assistant Director of Digital Transformation, jasonyoung@nhs.net

Population Health Management

In BSW Population Health Management (PHM) is an intelligence and insight solution that utilises local health, care and other wider data sources for analysis, segmentation, and risk stratification to inform and support decision making; to make the best use of collective resources; and to get the greatest impact in improving health for people and communities.

The ambition is to enable individuals, communities, professionals, teams, alliances/places, localities, and systems to maximise outcomes by working cooperatively on what matters to those individuals and communities. PHM challenges layered assumptions that have prevented a system measuring and working on what is valued, as opposed to what can be counted.

PHM promotes prevention and personalised care approaches as well as the use of incentives to target interventions to the areas of greatest need, to tackle health inequalities, and to move from reactive to proactive care.

Following the experience of the NHSE funded Optum Programme, PHM has become a key driver in the ICS journey as it has enabled the system to understand the population through their data and local intelligence and increased the opportunities for operational, strategic, and clinical decision makers to work together in an integrated way.

There are currently 5 pilot projects using PHM principles involving a number of PCNs and Swindon locality.

A suite of tools is already available to many organisations across the ICS. Using the Graphnet ICR care-giving organisations can access patient-identifiable information on cohorts of interest to intervene.

The ambition for the ICB is to create in house a linked data set and PHM tools available for use by the wider system to help clinical, operational, and strategic decision makers understand population health as well as health inequalities with a view to assist them to drive action.

The application of PHM principles to Health Inequalities has resulted in the development of a new automated tool using power BI: the BSW Health Inequalities Dashboard. The tool, now available on a SharePoint platform and can be accessed by clicking on this link, draws from a pool of data from primary and secondary care sources and provides an overview of health inequalities across BSW system and the three Places.

The tool is at the beginning of its development and the ambition is to increase the number of automated reports on population focusing on activities, deprivation, age, ethnicity and conditions.

Another key advantage of this tool is that it has been created and developed in house ensuring the highest degrees of control and flexibility. In line with the health inequalities mission to support clinical, strategic and operational decision makers accessing better data, this tool has been instrumental in providing insight and evidence base throughout the process of allocation and prioritisation of the Health Inequalities Funds.

The implementation of PHM is overseen by a number of system boards: the Digital Board oversees the technical side whilst the Population Health Board oversees the actual application and deployment of PHM tools.

PHM is already a key component of a number of programmes and strategies.

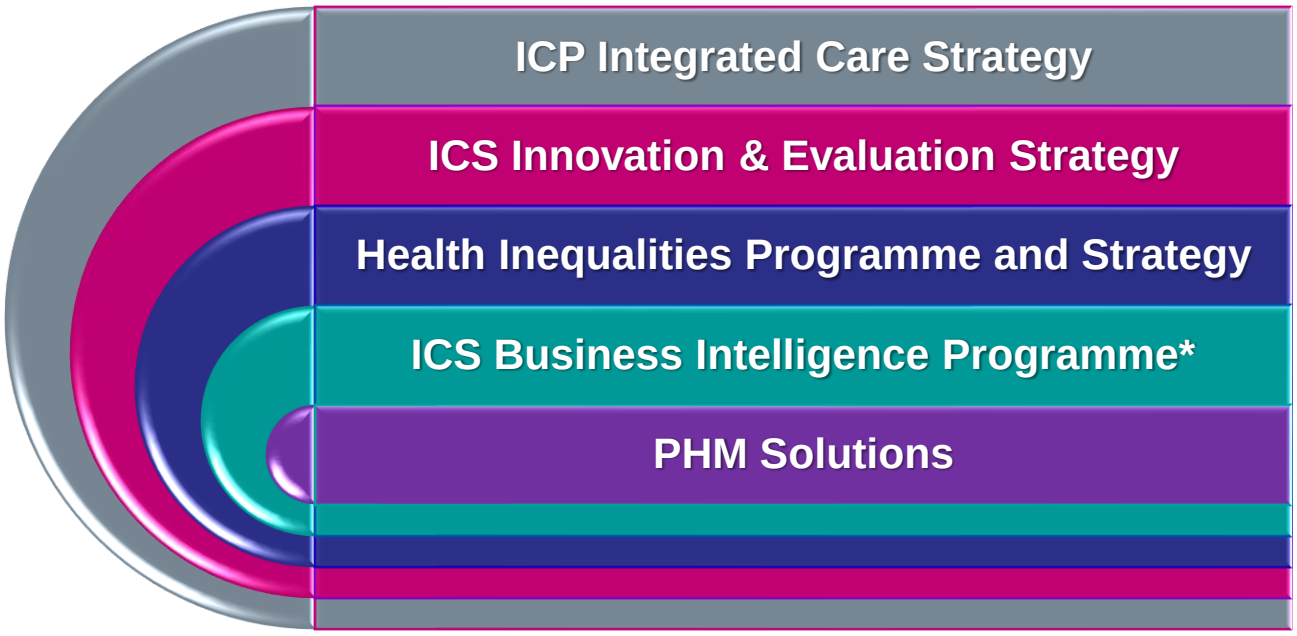


Figure 32: Population Health Management is a key component of a number of programmes and strategies

The road map to embed this key enabler into every activity of the ICB will include the following actions:

Table 21: Actions and milestones to embed Population Health Management into every activity of the ICB

Actions	Milestone
Health Inequalities Dashboard – Demos including ICAs and Providers	April – June 2023
ICS Business Intelligence Programme implementation plan Delivery PHM key component in analytics Capacity and Capability skills and Generating Insight	June 2023 – April 2024
Review of the Optum pilots	June 2023
Development of the Innovation Strategy	June-August 2023
Further Refinement of the Health Inequalities Dashboard	June-October 2023

PHM solutions embedded into the Prevention Programme	September-December 2023
PHM solution embedded into the Transformation Programmes	October 2023 – April 2024

Estates of the Future:

Context

The Integrated Care System (ICS) aspire to have high quality estate across Bath and North East Somerset, Swindon, and Wiltshire (BSW) with seamless IT connectivity across locations, designed for maximum efficiency. Our ICS infrastructure strategy will set out our approach to achieving this, by ensuring the key enablers such as digital, equipment and estates an integral consideration linked to service redesign.

Estate is one of the key enablers to deliver the truly transformational changes that BSW ICS wishes to achieve to deliver outstanding care and support healthy communities.

How we are organised to deliver

The way we use estate needs to change and become more flexible to the changing needs of services and service deliver, which will be supported by technology to enable us to deliver care at the right place for the needs of our population.

Our vision as an ICS Estates Board is ambitious and will require commitment from us all to work differently. It will also require significant resources, in terms of capital and revenue investment into the estate, informed by our ICS estate strategy.

The Estates Board, which meets monthly and considers capital investments in the system and recommends new building investment decisions into the BSW Director of Finance Group have already started to look at how we can work closer together to achieve this transformation and will be doing more work in the future to look at how we structure ourselves across organisations to better align the use of resources.

Figure 33: BSW Estates' vision

We are also working with NHSE to develop a national estates toolkit. The aim of the Toolkit programme is to produce a clinical and activity driven ICS Estates Planning Framework Toolkit that is evidence based and:

- Supports clinical pathway redesign and left-shift care delivery in line with the System's Out of Hospital Strategy and
- Helps to define the requirements for estate of the right size, in the right place, of the right type, which is of high quality and well utilised.

The work will support the ICS and other systems who use it to drive cost efficiencies which can be realised to support wider prevention and early intervention agendas to improve health outcomes.

Our Delivery Plan

Our estate will be flexible and provide sufficient access and capacity in the right place, with the highest standards in sustainability, with a low carbon footprint.

Estate is our third largest cost after workforce and medication, so it must be financially sustainable and utilised well. We are improving the way we use space by removing organisational barriers that used to allocate rooms to individual organisations or services to one based on sharing space and increasing utilisation across all settings to maximise the use of our investments.

What we will do in the next twelve months

Table 22: BSW Estates' actions and milestones for 2023/24

Actions	Milestone
Initiate PCN Toolkit Phase Three This involves modelling the BSW estate to inform future investment / dis-investment decisions	April 2023
Agree the BSW Estates Board work plan for 2023/24	April 2023
Development of BSW Infrastructure Strategy	January – June 2023
Approval of BSW Infrastructure Strategy	July - September 2023
Conclude review of existing community estate utilisation	September 2023
Initiate planning for BSW Estates Strategy	October 2023
Collate outputs from PCN Toolkit Phase Three	March 2024

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

- Our future estate will be shaped and informed by the changes to our care model, to deliver better patient, staff and visitor experience and to significantly improve the way

we deliver services in the future enabling us to dispose of ageing buildings no longer required and investing in new solutions, such as technology and buildings, utilising the existing wider public, community and third sector estate, where necessary to delivery this at system, place and neighbourhood levels, which we continue to develop.

- Technologies will allow patients to access sophisticated diagnostics within community settings as part of an integrated service. Virtual spaces for virtual consultations with professionals reducing the need to come into buildings, physical spaces for face-to-face consultations in different locations where these are necessary, including the patients' own home, which will help to transform service delivery.
- Funding constraints inevitably create risks to achieving this vision, but it is important to have a clear aspiration for the future BSW estate.
- Our workforce will be able to work across different locations, consolidating back-office functions and changing the way that we work, reducing unwarranted variations in provision of estate services and automating manual processes.

Note that the above list reflects the current position at the time of publishing. It is likely that additional projects / schemes will be identified following the BSW Estates Board work plan review in April 2023.

Environmental Sustainability:

BSW Green Plan [2022-25]

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

Our delivery plan

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

- Sustainable care model
- Workforce and leadership
- Estates and facilities
- Travel and transport
- Supply chain and procurement
- Medicines 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.

How we are organised to deliver

The delivery of the BSW Green Plan [2022-25] is supported by a robust programme management approach.

A Greener BSW Executive Leadership Group exists to provide strategic leadership and direction, support delivery, and hold the Greener BSW Programme Delivery Group to account. The Executive Leadership Group comprises of Senior Leaders from partner organisations, across the BSW system, to ensure appropriate board-level oversight and ownership. The group meets on a quarterly basis.

The Greener BSW Programme Delivery Group brings together a wide range of partners from across health and care to collaboratively drive change. The Programme Delivery Group meets monthly and focuses on the delivery of our Green Plan commitments, along with priority actions.

What we will do in the next twelve months

A selection of actions for delivery by our partners (within the scope of the Green Plan requirements) to deliver tangible reductions in emissions are highlighted below:

Table 23: Examples of actions for delivery by BSW partners to result in emission reductions

Focus Area	What do we want to do?	How will we achieve this?
Workforce & Leadership	Inform, motivate, and empower staff to make sustainable choices at the workplace and home, and enable them to live a sustainable, healthy lifestyle.	- ICB Board to undertake sustainability training. - Staff are made aware of the relevant Green Plans (ICS/Trust) via training / inductions / comms.
Travel & Transport	Reduce the environmental impact of our travel by encouraging sustainable low-carbon and active travel.	- NHS Trusts signed up to clean air hospital framework.
Medicines Management	Reduce the environmental impact of our prescribing activities and the use of medicines by reducing use and switching to lower carbon alternatives.	- All NHS Trusts to reduce use of desflurane in surgical procedures to <5%.

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

What will be different for our population?

- Climate change threatens the foundations of good health, with direct and immediate consequences for individuals, our infrastructure, and public services. Addressing climate change is important in helping us to meet our system-wide goals of developing healthier communities, improving health outcomes, and addressing the wider social determinants of health that can lead to health inequalities.
- Climate change requires collective action across the system. If we fail to take a coordinated approach, then we are failing to address the biggest health risk that we face as a society. In recognition of this, we will continue to work collaboratively with our health and care partners, local authorities, VCSE and the public to drive sustainable change and achieve a sustainable future for our population, and future generations to come.

Our role as Anchor Institutions & supporting wider social and economic development:

Context

The concept of anchor institutions has been understood within the NHS for a number of years, and pre-dates the Covid-19 pandemic, but the imperative to address health inequality triggered by the differential impacts of Covid has given this new impetus.

Anchor institutions are large, typically public sector organisations, rooted in place (hence the term 'anchor') and by the nature of their role and scale are uniquely placed to positively influence the social, economic and environmental conditions of local communities. The long term sustainability of these organisations is inextricably linked to the health and wellbeing of their populations and so there is a 'virtuous circle' in the role of these organisations leveraging their ability to impact on the wider determinants of health locally.

Given the role of our Integrated Care Partnership (ICP) in improving the health and well-being of individuals, we want our constituent organisations and partnerships to play this crucial role in supporting wider social and economic development, acting as anchor institutions that contribute to the economic and social development of local communities.

As noted in the infographic below, we have the potential to stimulate economic growth by creating jobs, investing in local infrastructure, and supporting local businesses. Our organisations provide a range of services, such as health care, social care, and community support, which contribute to the social and economic well-being of our local communities.

Figure 34: Six benefits where health Anchor Institutions can benefit their communities

Our ICP also supports wider social and economic development by seeking to reduce health inequalities. Health inequalities are a significant issue in many communities, with

people from disadvantaged backgrounds often experiencing poorer health outcomes. We can help to address these issues by delivering integrated health and social care services that are tailored to the specific needs of our communities. This can include providing culturally sensitive services, addressing social determinants of health, and working with community groups to promote healthy lifestyles.

Our delivery plan

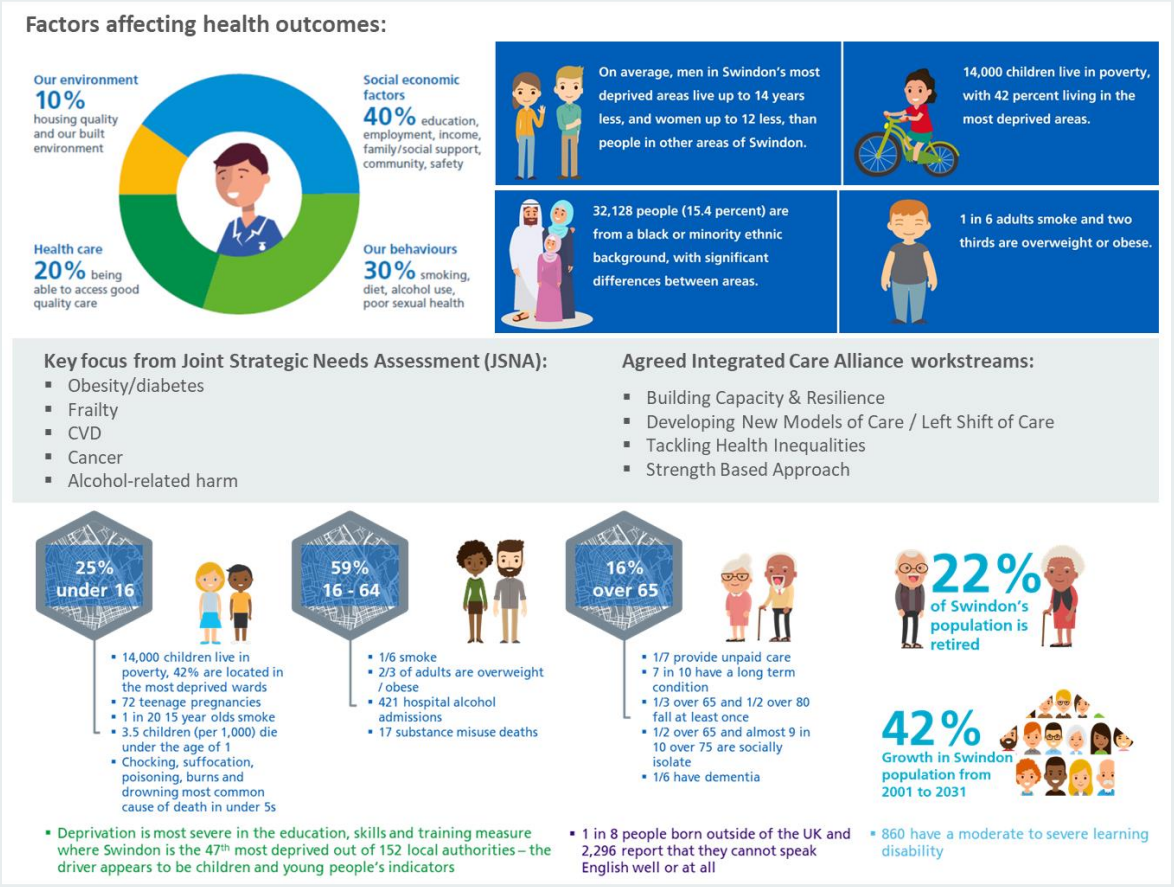
As noted in the infographic above, there are a range of measures organisations and collaborations can take to act as anchors. Our aim is to share best practice through the BSW Academy, ICAs and provider collaboration, to ensure that individually and collectively our partners are using their inherent capacity to create improved conditions for healthy lives.

There is a clear link in between deprivation and life outcomes, in Swindon for example those that live in deprived wards have lower life expectancy for both men and women, 42% of children living in poverty located in the most deprived wards and poor educational attainment. The most deprived 20% of areas within Wiltshire have repeatedly poorer outcomes than the least deprived 20% and similar patterns are seen in Bath and North East Somerset. Smoking rates (Swindon already has a significantly higher rate than the national average) and substance misuse are higher in deprived areas as are higher levels of severe mental illness. Rates of hospital stays for instances of self-harm are significantly higher across all parts of BSW compared to the England average.

In Swindon, GWH have considered all the ways in which they can use their anchor status to improve health outcomes for their local population. Some examples of this are outlined in the infographic below against 5 key areas. Given that the majority of their spend is on staff costs, it was determined that their role as an employer would be the most significant contribution they could make initially, and so they have focussed a programme of work around widening access to employment and development opportunities, and working with their partners at New College to target training and recruitment opportunities at those most in need of a foothold to a stable career.

Case Study: Swindon – Great Western Hospitals NHS Foundation Trust (GWH NHS FT)

A snapshot of Swindon in 2019 is outlined in the diagram below.



As an integrated provider, we identified five key areas where they were able to make a positive difference. The diagram below outline some of the initiatives that have been taken forward over the last twelve months.

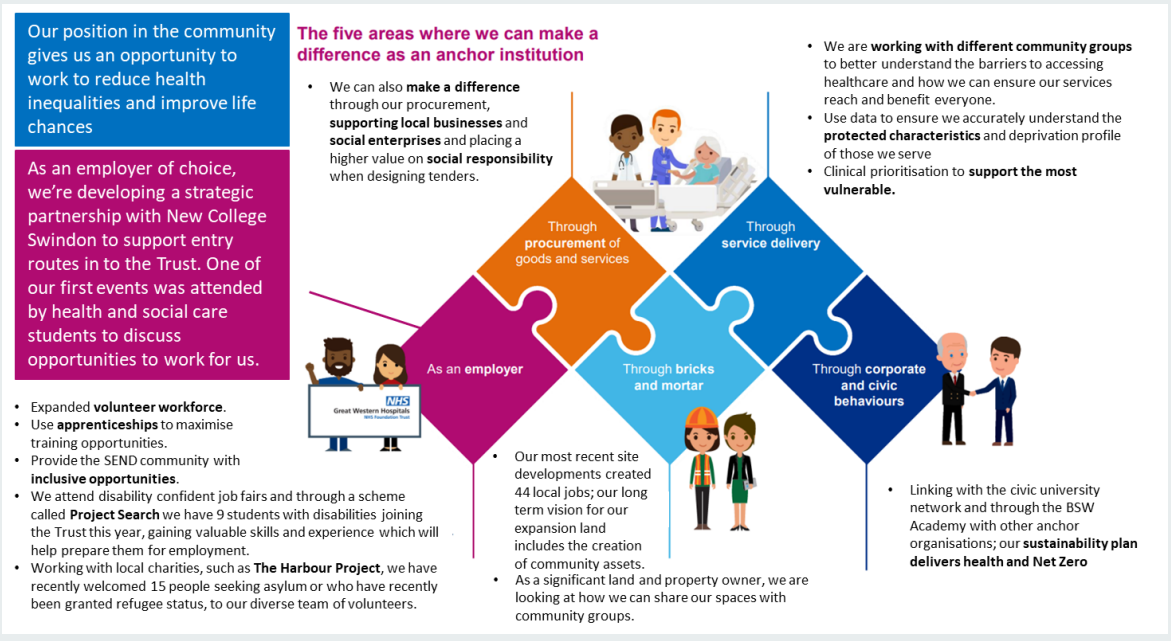


Figure 35: Case Study - Great Western Hospital as an Anchor Institution

How we are organised to deliver

Across our Acute Hospital Alliance, we are working together to not only bring benefits from each organisation but to also release the potential of a collaborative approach, as together we can have a bigger impact.

At Place level each Trust is also working closely with the local authority to ensure that we consider the wider determinants of health and work together on opportunities to reduce inequalities and improve the health and wellbeing of local communities.

What we will do in the next twelve months

See appendix 1 and 2 – needs expansion / examples outside of Swindon.

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

- We know that **where people live is a big contributor to their health** – your health, life expectancy, and the opportunities you'll get are different depending on which part of Swindon you live in.
- While Covid-19 has really highlighted inequalities, it's also brought communities together and **brought us closer** to our community – not just through the lives we've touched, but through the closer working relationships we've forged with partner organisation in Swindon. We now have a golden opportunity to continue and build upon that spirit and make the most of community participation and engagement.
- **We can't achieve our ambitions alone. We're stronger working with others, and together we can make a real difference to people's lives.**
- **We want to better the lives of people in our communities – working collaboratively to share what we have and provide opportunities for people to improve their health and life chances and benefit the whole of Swindon and surrounding areas.**

Monitoring delivery

- Reduce inequalities in life expectancy
- Reduce hospital admissions, particularly from worst performing wards

List lead and email address for further information

Claire Thompson, Chief Officer of Improvement & Partnerships
claire.thompson10@nhs.net

Duty to have regard to wider effects of decisions:

Context

As ICS partners we are committed to using our scale and finances in a way which support the social and economic development of our three local authority areas. With an annual budget across the partnership of £2bn and an employed workforce of 35,500 our organisations can have significant influence beyond our core role as health and care

providers. Through our work on the wider determinants of health we recognise that the delivery of health and care services represent only one element of how we can positively support the wellbeing of the local population.

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

Our delivery plan

Initiatives such as apprenticeship schemes and joint recruitment activities between partner organisations reflect our focus on developing rewarding careers for local people. This will continue to develop during 2023/24.

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

How we are organised to deliver

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

What we will do in the next twelve months

Specific dates for initiatives around workforce, the Green Plan and our estates plans are set out in the relevant sections of this plan.

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

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

Monitoring delivery

Monitoring social impact is not straight forward and we need to learn from others both within and outside of our ICS on how this can best be achieved. Over the next 12 months we will work with partners to identify a range of metrics to help us better understand the social return on investments that we are achieving.

Appendix

1 Recruitment Initiatives led by Great Western Hospitals NHS Foundation Trust

Table 24: Recruitment Initiatives led by Great Western Hospitals NHS Foundation Trust

Area	What we are doing	Future opportunities
Engaging with local organisations	- Partnership working with our local Job Centre including delivering training to their careers coaches on NHS roles available - Actively supporting local community initiatives - Kickstart (6 roles) & Prince's Trust (18 candidates employed through this route)	- Link in with other local authorities
Ensuring applying for role in the NHS more accessible	- Use of language in adverts including a section referring to 'applicants welcomed from underrepresented groups' - Advertise in accessible formats and wide range of outlets (disability confident) - Recruitment process removes specific information from applications to avoid bias - Flexible working more widely spread, specific goals to open up more jobs to be quality part time and flexible working.	- Explore values-based job descriptions - Obtaining feedback through our EDI Network from our wider communities on advertisement/ language
Targeted local recruitment campaigns	- Encourage applications from our most deprived communities through our advertising - Attending local events such as PRIDE, Swindon Careers Fair, Local Armed Forces events - Different approaches to marketing (utilisation of leaflets to underrepresented areas in March - HCA). - Working with local colleges and universities to promote career pathways. - Advertising through our social media such as Facebook, Twitter etc.	- Linking in with specific feeder organisations for health, social and admin care careers.

Run tailored interview skills sessions for the local community	- Utilising our microsite to inform candidates on how to apply - Providing advice to candidates on interview best practice / completing applications via telephone.	- Hosting webinars on how to complete an application & interview best practice.
Non pay benefits available	- Promotion of NHS benefits e.g. blue card, discounts, annual leave etc. - Salary sacrifice schemes. - Pension.	- Exploring benefits that would support the local community.

2 Early Years Careers Support in Swindon

Table 25: Early Years Careers Support in Swindon

SEND STUDENT SUPPORT:		
Crowdy's Hill School	KS4 / KS5 Career Assemblies	To promote entry level job roles / myth busting gender stereotyping / emphasising all the job roles are equally as important / hidden heroes of NHS – Sept 22 / Careers Fair attendance
Horizon's College	KS5	Careers Fair / Mock interviews planned for July 23.
New College Swindon	KS5	SEND/NCS - Project Search starting in the Trust from Sep 2023: 9 young people with learning difficulties and disabilities have been offered an internship. This will be in conjunction with New College who will provide a tutor and SBC who will provide a job coach to support the students. In addition, SERCO will support with placement opportunity promoting a partnership employer. Project SEARCH is a program that provides training and education for people with disabilities to gain and maintain competitive employment and involves an 11-month unpaid internship, where participants rotate through different jobs and receive support and guidance.
YOUNG CARERS /CHILDREN IN CARE:		
Swindon Borough Council	YEET	The apprenticeship team are now working collaboratively with SBC to recognise pathways into employment with 2 of the largest employers of Health/Social care. In addition, we are reviewing National Initiatives (Princes Trust, introduction for Healthcare T Levels) and sharing project plans to encourage and support our local community and influence apprenticeship opportunity.
Swindon Carers		Introduction email sent to see how we can support – ongoing Apr 23

Send family voices		Introduction email sent to see how we can support – ongoing Apr 23
NEET:		
Kickstart	16 – 24 yr. olds	The Kickstart Scheme is a new programme launched by the government to deliver funding for employers offering new job roles for 16-24 years olds who are currently in receipt of Universal Credit. The programme is aimed at preventing young people who are currently unemployed facing long term unemployment.
Princes Trust	11 – 30 Yr. olds	To help vulnerable young people get their lives on track. It supports the unemployed and those struggling at school and at risk of exclusion. - We participated in the “Get into” programme in October 2022 and were able to identify apprenticeship vacancies within the Trust at the end of the programme. Of the 4 applicants that applied for the role, 2 of which were shortlisted for interview, but unfortunately were not successful for appointment.
NHS Cadets	14 – 18 yr. olds	It is aimed at young people aged 14 to 18 who are from communities currently under-represented within the NHS and St John Ambulance -This means that this project aims to reach a diverse range of young people who have barriers to entering health volunteering and/or a health care career.
T-levels	16-17 yr. olds	To support industry placements for T-Level students from our local colleges (New College Swindon and Cirencester College). To support their progression to health care careers. Students will complete their clinical placements; complete care certificates and any ESR training modules required.
Stem ambassadors		Life-changing impact for young people, delivered by STEM professionals in classrooms and communities. STEM subjects are brought to life by over 37,000 volunteers, available across the UK, all free of charge. Inspiring communicators and relatable role models - Aspirations raised, careers illuminated and learning supported.
NEET / SEND support:		
EOTAS (Educated Other Than At School)	14 – 18 yr. olds	Careers fair – Riverside / Oakfield / St. Luke’s / Horizons College / Crowdy’s School / St Joseph’s Careers Talks – To all EOTAS schools Nov 22.
SEND WEX	14 – 18 yr. olds	A virtual WEX programme for SEND / NEET students within our local community.

Building Bridges	14 – 18 yr. olds	Catch – up meeting arranged to discuss how we can support each other going forward.
School and College SEND / NEET support	14 – 16 Yr. olds	Connections made with our feeder schools to offer small group presentations / apprenticeship talks – questionnaire sent to schools.
Green Labyrinth	16 – 19 yr. olds	Work closely with SBC to support particular learners / traineeships. GWH volunteer team to also support.
Primary School support:		
Meet a doctor day	KS1	Dates booked in for the summer term / working with our CTF's to create half day workshops for our feeder primary schools.
Secondary School support 2022 / 2023:		
Mock Interviews	Year 10	Support with Year 10 mock interviews
Careers Fairs	KS3 / KS4	With Covid restrictions easing we are pleased to have attended 10 physical careers fairs this year along with the support of our CTF's. This is a great opportunity for us to showcase job roles not only to students but to their parents / carers
Careers Presentations	KS3 / KS4	Virtual presentations to either whole Key stages / year groups or tutor groups – adapted to each audience to highlight all careers and the entry routes.
Virtual Work Experience	KS4	A virtual work experience programme for students within our catchment area
6th Form / College support 2022/2023 academic year:		
Mock Interviews	Year 12	We have interviewed Health and Social Care students from our local feeder colleges
Careers Fairs	KS5	Showcasing job roles not only to students but to their parents / carers
Careers Presentations	KS5	Focusing on different job roles and entry requirements
T-Level Students	KS5	27 T-level student placements secured at GWH from our feeder colleges
Virtual Work Experience	KS5	A virtual work experience programme for students within our catchment area

11.Monitoring performance and delivery

A key element in providing assurance on the delivery of the strategy is how we monitor and report on progress with the plan. This is still being worked through and arrangements will be set out in the final version of the plan.

12. Appendices

Duty to obtain Appropriate Advice:

The ICB duty 14Z38, to obtain appropriate advice states:

Each integrated care board must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in—

(a)the prevention, diagnosis or treatment of illness
(b)the protection or improvement of public health.

This plan outlines the ICB's strategy for seeking any expert advice it requires, including from local authority partners and through formal governance arrangements and broader engagement.

BSW ICB will follow this approach in seeking advice:

1. Clearly identify the issue requiring advice with specific objectives outlined for the advice being sought.
2. Determine the type of advice needed most appropriate for the objectives and issue, whether in prevention, diagnosis or treatment of illness, or the protection or improvement of public health. That could be legal, financial, technical, strategic, clinical or other types as required.
3. Determine the potential sources of appropriate advice, drawing from experts either inside or outside the system.
4. Work to understand the most appropriate advice source from those selected based on expertise, experience, credibility, and alignment to the ICB vision.
5. Establish formal contact with sources of advice against a clear brief, explaining the issue. Following ICB procurement practices where applicable, asking for experience, expertise, qualifications, availability, any conflicts of interest, and rates where any of these are unknown.
6. Evaluate advice received, determining the relevance and applicability, together with the effectiveness in addressing the issue.
7. Consider seeking second opinion or further advice as appropriate.

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

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

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

Duty to Promote Innovation:

Innovation and Evaluation Strategy
A solution focused approach to continuous improvement

The ICB in partnership with the BSW Academy, AHSN, and the Dragon's Heart Institute are co-producing a robust strategy to promote Innovation and Evaluation across BSW both at System and Place level.

The strategy is underpinned by the following legislative requirement:

- Each ICB must **promote innovation in the provision of health services** (including innovation in the arrangements made for their provision).

- The plan should set out how the ICB and work with academic health science networks and other local partners to support the identification and adoption of new products and pathways that align with population health needs and address health inequalities.

The strategy will promote and guarantee the highest degree of inclusivity and participation by creating a fertile, accessible, and supportive place for innovative, evidence-based, and impactful ideas from the ground-up to be implemented and scaled across time. Through the implementation of this strategy BSW will promote local innovation and build capacity for the **adoption and spread** of proven innovation. Using the following process:

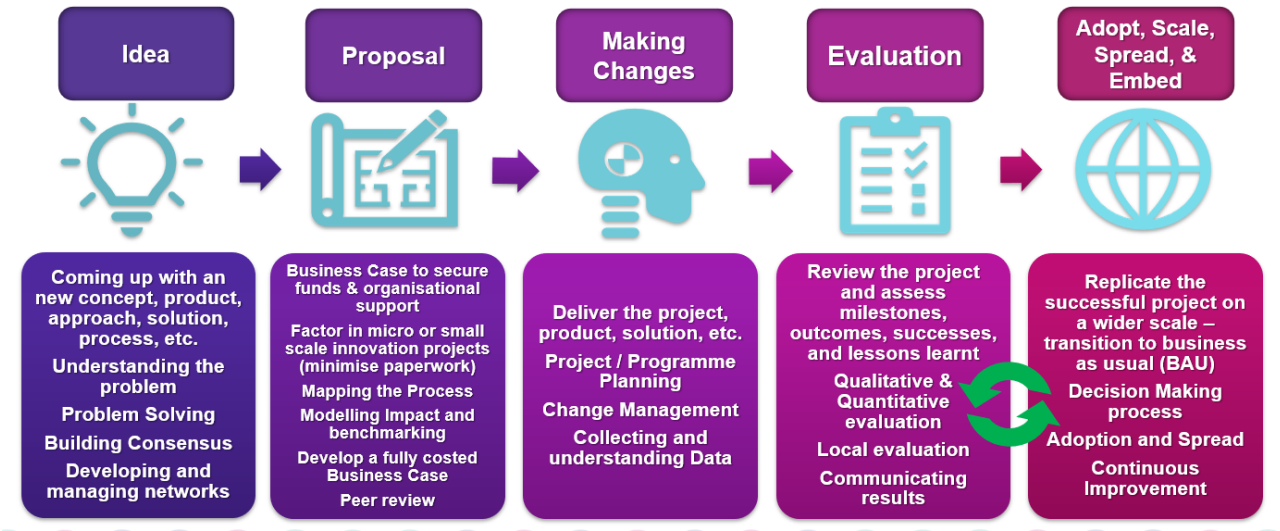


Figure 36: Process for promoting the adoption and spread of innovation

The approach will be grounded on the following 5 principles or pillars:

- Culture: Creating a culture in which Innovation and Evaluation are embedded in clinical, operational, strategic decision-making processes.
- Connections & Community Engagement: Promote Collaboration across the system to maximise the use of limited resource through innovation.

- Capacity & Capability: Empower, Train, mentor, support workforce with shared knowledge, infrastructure, and opportunities to drive Innovation.
- Patient Experience: Deliver innovative evidence-based care that reflects the needs of the population and tackles health inequalities.
- Continuous Improvement: Deploy evaluation as an approach to positively challenge the status quo and drive change through innovative solutions.

The key enablers for the successful delivery of this strategy have been identified in Figure 37 below:

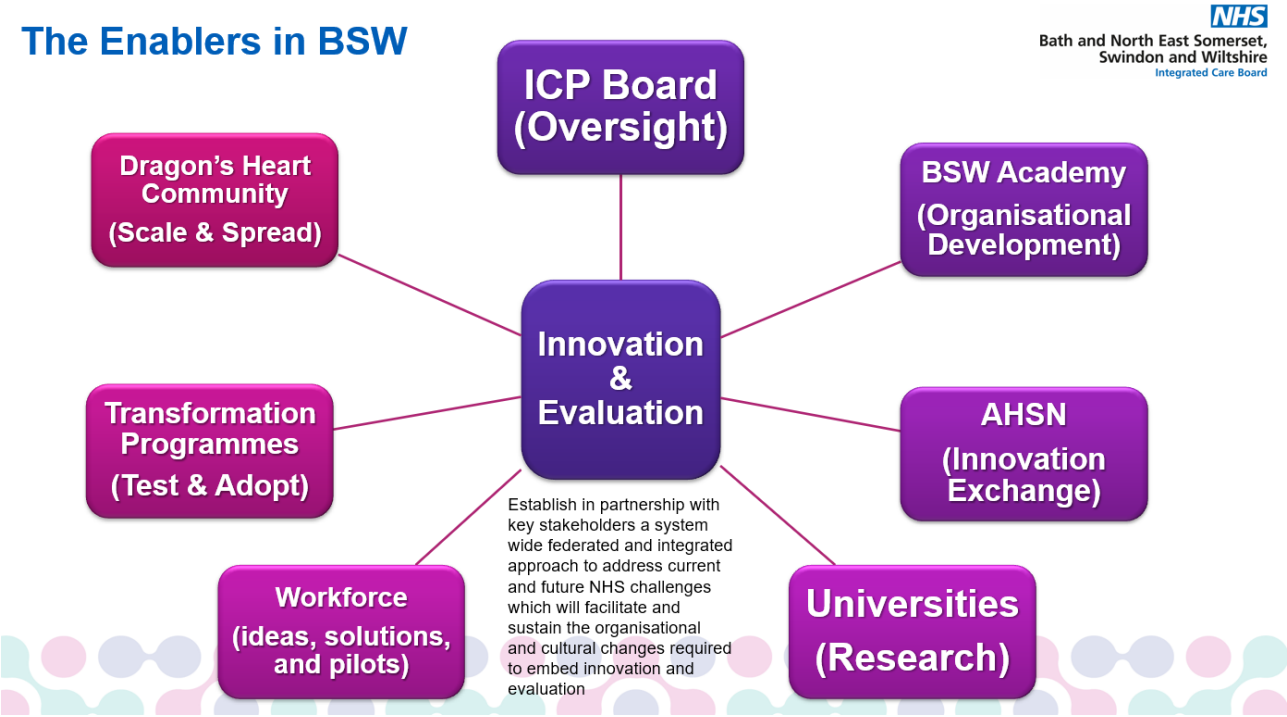


Figure 37: Seven key enablers for delivery of the Innovation and Evaluation strategy

Roadmap

Table 26: Innovation and Evaluation strategy roadmap

Actions	Milestone
Strategy blueprint presented to ICB Executives	March 2023
Preparation of a programme of work	May 2023
Creation of a Multi-Disciplinary Innovation Group with task to develop the strategy and the evaluation framework	May-June 2023
Strategy and Evaluation Framework Ratified by the ICB Board	August-September 2023
Establishment of a centre of excellence for innovation	TBC working BSW Academy and AHSN

Duty in Respect of Research:

This ICB duty 14Z40, Duty in Respect of Research, states:

Each integrated care board must, in the exercise of its functions, facilitate or otherwise promote:

(a) research on matters relevant to the health service, and

(b) the use in the health service of evidence obtained from research

This is a significant step change from the research promotion function required of a former CCG, as ICBs are now required to facilitate. This is an important chance to embed research into the heart of the NHS. For BSW ICB this is a unique opportunity to help support and facilitate research across the BSW ICS to the benefit of our population, capture and share learning from successful research elsewhere, and to disseminate successful research within BSW into the wider NHS.

The economic benefits suggest research is a sound investment, with research supported by the NIHR CRN generating an estimated £2.7bn PA of gross added value, and 47,500 FTE jobs in the UK (NIHR, 2019). For each patient recruited onto a commercial trial supported by NIHR CRN, on average NHS providers in England received an estimated £9,200 from life sciences companies, saving an estimated £5,800 per patient. The approximate cost saving to the NHS is around £30m per year.

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

Our Delivery Plan

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

1. Fostering collaboration: Identifying all partners connected to BSW ICS which are either involved, aspire to be, or would benefit from connection with research. Bringing together health and care professionals, researchers, and patients to collaborate and understand contemporary issues, facilitating a more integrated approach to research. This includes collaboration with academic institutions to support research.
2. Enabling funding: ICB can help to coordinate the enablement of funding to support research projects. This can help to incentivise researchers to conduct studies aligned to system priorities and can help coordinate necessary resources to carry out effective research.
3. Providing and supporting with data collection: BSW ICB can provide support for data collection and analysis. This can help researchers to access the data they need to conduct their studies and can ensure that data is collected and analysed in

a consistent and reliable way. This could include anonymised patient records to identify trends and patterns.

4. Encouraging and facilitating patient involvement: BSW ICB can work to involve patients in research projects, mindful of existing inequalities evident in the conduct and application of research. This can help to ensure that research is focused on areas that are important to patients and can help to ensure that research is conducted in a way that is respectful and ethical, as well as addressing research needs of BSW's diverse communities.
5. Supporting research governance: BSW ICB can play a key role in ensuring research is conducted in an ethical and transparent manner. We can provide guidance on research governance, including obtaining ethical approvals and managing data.

How we are organised to deliver

Recent guidance from NHSE entitled "Maximising the Benefits of Research" will inform the next steps for action. These will be achieved by establishing an ICB Research Lead within the Medical Directorate working with colleagues in the BSW Academy. The Lead will work to support development of the five areas above within BSW ICS to help cocreate the BSW System Research Strategy based on the NHSE guidance, also helping to systematically use evidence from research when ICB is exercising its functions. The Research Lead will also work to understand research workforce challenges and ensure this supports organisational workforce planning. The Research lead will continue to strengthen and develop ICB's collaborative relationship with its local NIHR networks. The System Research Strategy will span across boundaries horizontally and vertically in BSW to support a comprehensive multidisciplinary approach to research.

What we will do in the next twelve months

1. Appoint an ICB Research Lead – by August 2023
2. Facilitate the co-creation of the ICS Research Strategy – by October 2023
3. Facilitate dissemination of the ICS Research Strategy – by November 2023
4. Support the early adoption of the strategy and initial actions resulting from the cocreated approach – from November 2023 to March 2024
5. Establish reporting and monitoring progress of the above – by August 2023

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

BSW ICB can support ICS research by working with system partners, researchers, academic institutions, industry partners, and patients to facilitate access to resources, expertise, and data.

One of the outputs from this would be a system led research strategy and a system-wide research network. By fostering a collaborative approach to research, BSW can help to improve patient outcomes and better leverage research potential to deliver the ICS strategy. In 5 years' time the system should see a more effective, aligned (as section 3.2 of the guidance), systematic and comprehensive approach to research.

Monitoring Delivery

One of the aims of the ICS Research Strategy will be to enable a systematic monitoring of research progress with regular updates. As the strategy is developed and partners agree monitoring mechanisms these will be replayed into the Joint Forward Plan reviews.

Lead and email address for further information

Dr James Whitehead – james.whitehead10@nhs.net

Addressing the particular needs of victims of abuse (including Serious Violence Duty)

The ICB Safeguarding Team is located within the Nursing and Quality Directorate. The ultimate accountability for safeguarding for the ICB is with the ICB Accountable Officer. The Chief Nurse is identified as the Responsible Officer for Safeguarding, supported in this role by the ICB's Safeguarding Designated Professionals and the Associate Director for Strategic Safeguarding. Safeguarding reports to the Quality and Outcomes Committee which has Director level representation and the ICB Board.

There are three Safeguarding Partnerships across BSW ICB. All three bring together the work of the Safeguarding Adults Board, the Community Safety Partnership and partnership activity in relation to Safeguarding Children.

BSW ICB Chief Nurse and the ICB safeguarding team are representatives on all three safeguarding partnerships, including the Violence Reduction Unit (VRU) in BaNES locality and Swindon and Wiltshire Community Safeguarding Partnership. Community Safety Partnerships (CSPs) and VRUs have an explicit role in evidence based strategic action on serious violence and these partnership meetings will be the driver for delivering the serious violence duty (SVD) and safeguarding Statutory Duties.

Domestic Abuse prevention is an important aspect of the SVD and each of the LAs across BSW ICS have domestic abuse partnerships which feed into the CSPs. There is expertise within the safeguarding team around domestic abuse with participation in the domestic abuse partnerships. BSW has in place information sharing across providers and primary care to MARAC/MAPPA/PREVENT.

The team also works closely with NHS providers, Police and the LAs to support continuous education and updates in this evolving workstream. This includes Female Genital Mutilation, forced marriage and violence against women
and girls, PREVENT and Multi Agency Public Protection arrangements.

Over the coming year specified authorities will need to have prepared their joint local strategy, which should contain activity to prevent and reduce serious violence based on the needs of their area to do this.

Recommendations for data sets include anonymised hospital and primary care data on serious violence injuries. Information is currently collected on an individual and case by case basis from health services. It is likely the development of consistent gathering of data will be a large focus of the strategic delivery of SVD across all agencies and practice. The new duty strengthens the requirement for cross agency data sharing to enable localised and national timely prevention and response strategy developments to reduce serious violence.

BSW ICB are well placed to enable the safeguarding team to carry out the development of the new duty during 2023 – 2024. However, the duty implementation will no doubt mean an increase in specific workstreams. These will include information sharing and data collection and extensive education programmes for our health and partner agencies. As

understanding of the duty becomes clearer further analysis of compliance will be undertaken.

Duty to enable Patient Choice:

Context

The ICB duty 14Z37, in regard to patient choice states:

Each integrated care board must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

Patient choice is currently underpinned by two separate sets of regulations. These are :

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the Standing Rules")

National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 ("the PPCCRs").

Part 8 of the NHS Standing Rules places obligations on commissioners in relation to patient choice, including enabling the legal rights to choice of provider and team. The rights apply when:

1. the patient has an elective referral for a first outpatient appointment (new episode of care)
2. the patient is referred by a GP, optometrist or dentist into secondary care
3. the referral is clinically appropriate as determined by the referrer
4. the service and team are led by a consultant or a mental healthcare professional
5. the provider has a commissioning contract with any ICB or NHS England for the required service.

This plan outlines the ICBs compliance with patient choice.

Our delivery plan

Our plan is to remain compliant with the legal regulations for choice whilst also developing the elective strategic ambition to network our provision for best deployment to reduce waiting times and reduce inequities in access and associated inequalities.

We will also develop our approach to reducing harm of urgent referrals that are not converted in a timely way by patients and explore integration opportunities with booking and validation activities in our providers.

How we are organised to deliver

The BSW Referral services currently comprise of two services: BSW Referral Service and SARUM Referral Service - a separately commissioned referral services for SARUM area (South Wiltshire) GP Practices.

Teams comprise administrative and clinical team members with the core functions based on supporting GPs to make referrals to secondary care to the appropriate services with the

necessary information regarding the referral, and guiding patient choice of appropriate local providers.

BSW referral services interface between GP practices and secondary care, to facilitate patients making informed choices about where to go for consultation and possible treatment. The main objective of the service is to provide a smooth journey from referrer to provider and ensure that patients are offered appropriate patient choice of healthcare provider ensuring that they are seen in the 'right clinic, first time'.

This process therefore reduces the burden on both referrers and providers and supports the patient journey.

Interface between referrer and onward referral

- EFR

In addition to the above, the Referral Service enables and supports the technical connection between the EFR team and providers, meaning that a request for funding can be converted to a referral without being returned to the referrer for onward referral.

- Community Providers

The same process is followed to enable a connection between a number of triage services such as MSK, Dermatology and Urology and providers. This connection enables a referrer to submit a referral once only.

- Ophthalmology

BSW Referral Service also provide the interface between Community Optometrists and providers for elective referrals. This connection means that an Optometrist can refer a patient via email and the Referral Service will convert the referral to e-Referral, including provision of clinical triage by Optometrists within the service.

Other benefits

- Patients

- Referrals are received by the referral service or provider through direct referral instantly removing a possible delay created by a patient not activating their referral and ensuring that referrals get to the right place first time
- Patients are provided with choice even when RAS services are in operation locally.
- Point of information and queries for public, providers and referring organisations.
- Provision of single patient queries service, avoiding need for multiple patient phone calls.

- General Practice/ referrers

- Single process via use of RAS's
- Provision of GP Query line
- Point of information and support regarding technical aspects of the referral service, via both monthly drop in sessions and ad hoc support as required

- Referral Process
- Emphasis on adding value and reducing workload for the system as a whole
- Processing of referrals using the most efficient method possible, such as use of clinical triage only where it adds identified value
- Supports cross system communication and working
- Maximising use of clinician resource within the service
- Follow up of referrals not booked, to reduce the risk of a patient not actioning a referral
- Specialist technical knowledge of referral process systems, including service creation and smartcard role assignment

Patient choice is promoted and publicised on the ICB website.

What we will do in the next twelve months

1. Review pilot to directly book where a choice has not been acted upon and a referral has not been converted to ensure that urgent referrals are converted, reducing risk of harm to patients – July 23
2. Investigate opportunities for integration of referral support services with other system "front end" administrative processes – Oct 23
3. Review the Sarum service and potential in-housing to ensure common service offering to the whole system.
4. Review the operation of right to change provider after 18 weeks alongside the digital mutual aid system – Jul 23

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

It is anticipated that NHSE will integrate eRS into the NHS app over the course of the next two years which will add further direct control of choice to patients.

Monitoring delivery

- Number of referrals processed daily and weekly (no target)
- Number of choice offers not converted, weekly (no target)

List lead and email address for further information

Mark Harris
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Procurement/Supply Chain:

Context:

The BSW Acute Hospital Alliance Procurement Service created in April 2021 delivers procurement and supply chain services as a hosted model to the three Acute trusts in the region as well as Wiltshire Health and Care and is hosted from Salisbury NHS Foundation Trust on behalf of the region. The team also work collaboratively with the ICB to provide a professional procurement and supply chain service across the region. Through establishing a single procurement service, opportunities to gain greater security of supply, process efficiencies and economies of scale have been created to improve the patient experience.

Our Delivery Plan

The procurement service is a key enabler of each of the strategic objectives through ensuring good governance, timely delivery and value for money in the consumables and equipment which it purchases for clinical care. Full details can be found in the procurement annual Planning Template 23-25.

Financial Stability

Through the aggregation of demand across the ICS and consolidation of expenditure, working with NHS Supply Chain and Partners, the Sourcing Team will be able to achieve economies of scale and maximise efficiencies. The Supply Chain Team will build on this consolidation work to create further operational efficiencies and to reduce wastage.

Environmental Sustainability and an Anchor Institution

The procurement of goods and have processes which can be designed to support local business opportunities, recirculate wealth and bring community benefits – while still getting buyers the right price and quality, and often improved supplier responsiveness and relationships. The procurement team is working with government directives to allocate a minimum of 10% of the award criteria to social value, net zero and sustainability issues. Full details can be found in the ICS BSW Procurement Alliance Procurement Policy[1].

BSW Procurement Alliance will make an impact in Local supply chains through:

- Monitoring spend with suppliers across the region
- Helping SMES with cash flow by insisting that our suppliers pay subcontractors promptly, and by splitting big contracts into smaller lots to make it easier to bid for them
- Communicating with potential local suppliers so they know what opportunities are coming up, how to bid, and what you expect of them (for example: A minimum of 10% weighting within tenders will be given to environmental and sustainability issues and all suppliers awarded with a contract value greater than £5m will be required to submit a carbon reduction plan)
- Identifying key areas of spend where there are no or few local supply options and see if new enterprises or groups of local firms working together can close them.
- Including wider criteria such as social/community, health and environmental impacts and benefits and include clear criteria and goals on these
- Monitoring and enforcing the implementation of the actions that contractors said that they would deliver, and track and share any wider good practice by suppliers.

Forward Look

The BSW ICS procurement strategy found ***include hyperlink*** in May following approval…….but short term objectives are as follows:

- Develop a business case for a central warehouse and distribution centre to reduce carbon footprint for supplies, with plan to be in place during 2024/5
- Standardising and aggregating of consumables held across the ICS for economies of scale and greater supply chain resilience and to reduce wastage for the benefit of patient care
- Common platforms and ways of working across the ICS for greater efficiencies and resilience, using technology as appropriate
- Implementation and development of the Procurement People Strategy

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[1] ICS BSW Procurement Policy will be found on each Acute Trust's Website