Bath and North East Somerset,
Swindon and Wiltshire Together

Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW Together) v04

Implementation Plan Refresh 2024 – 2026

March 2024

Bath and North East Somerset,
Swindon and Wiltshire Together

BSW Implementation Plan Refresh 2024 – introduction for Health and Wellbeing Boards

You may remember from last year that the HWB was approached to provide an opinion on the BSW Implementation Plan, which is our version of the Joint Forward Plan that all Integrated Care Boards (ICBs) across England are required to produce for their respective systems.

The BSW Implementation Plan sets out how we and our partners work together at a system level and in our places to deliver our Integrated Care Strategy; the purpose of which is to enable our local populations, partners, and stakeholders to have a clear picture of the programmes and plans that will be delivered in support of our partnership strategy, describing how the ICB and partners will arrange and provide services to meet physical and mental health needs including the ICS four core purposes and ICB legal requirements. Last year BSW partners produced the BSW Implementation Plan setting out how we will implement the BSW Strategy over the period 2023 – 2028. The plan focussed on Year 1 (2023/24) and expected changes by 2028. Here is a link to the document: BSW Implementation Plan.

In line with the ICB's statutory requirements (Health and Care Act 2022) we are in the process of refreshing the plan. This includes reflecting on last year's plan, to identify if across BSW we have collectively achieved those things we said we would do. It is a requirement for a draft of the refresh to be shared with our local Health and Wellbeing Boards to seek their agreement that the plan reflects the respective joint local health and wellbeing strategies. The refresh does not replace the previous version published last year, but should be read alongside it.

We are still in the process of reviewing and improving the refresh. This includes reviewing the document to make sure it is as concise and focussed as possible, as we acknowledge that it is quite long. That being said, we are now at the point where we would like to seek the views of the HWB members. We are seeking views as to whether the totality of the plan (the original version and the refresh) is:

- Reflective of the joint local health and wellbeing strategies.
- Aligns with system partnership ambitions.
- Suggested amendments/changes you would propose and your rationale for this.

The ICB is required to publish the Implementation Plan to its website by no later than the end of March along with the opinion of the relevant HWBs. We would appreciate a response as soon as practicable and no later than 27th March ahead of our board meeting on 28th March.

As mentioned above we are undertaking further work on this refresh over the rest of the month and we will of course let you know if there are any significant changes.

Bath and North East Somerset,
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Contents

1. Introduction

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

This Plan sets out how we and our partners, working together at system level and in our places, Bath and Nort East Somerset, Swindon and Wiltshire (BSW), will deliver our Integrated Care Strategy over the period 2023-28. This is our version of the Joint Forward Plan that all Integrated Care Boards (ICBs) across England are required to produce for their respective systems.

We published our first Implementation plan in July 2023, and this update sits alongside that first plan. As only a short time has passed, rather than update the plan in its entirety we have focussed on:

- Reflecting on what we have delivered over the first 9 months of working together in this new way;
- Prioritising and re-focusing on key deliverables and outcomes that will help us achieve our ICP Strategy.
- Setting out what we want to achieve in the next two years;

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

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

The structure of the Plan places a particular focus on how we are delivering our BSW Priorities together through system activities and our Place Level Priorities which are described in more detail in our Place based local implementation plans.

Current Context

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

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

We have also:

- Published a new primary and community care delivery plan
- Reviewed our programme delivery arrangements (covered later in the document)
- Co-developed a new system-wide way of sharing information to help health and care professionals provide hospital patients, as well as their families and carers, with extra support before and during their onward care journey. https://bswtogether.org.uk/discharge/
- These resources will help people to understand the hospital discharge process and how to access onward care and support.
- Achieved funding for BSW Youth Worker Pilot, embedding a dedicated Youth Worker into each Acute hospital emergency department to support Children and Young People aged 11-25 with their mental wellbeing needs, and those struggling with the impact of long-term conditions including diabetes and epilepsy.

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

Whilst we are dealing with financial challenges, we are committed to ensuring that our transformation programmes continue and that we are investing in areas that will help our patients and residents to live healthier and longer lives. This means that we are aiming to prioritise our focus on evidence-based programmes that we believe will delivery meaningful contributions to the outcomes we set out in our first implementation plan.

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

2. Updating our plan – our priorities for the next two years

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

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

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

We have set out within later sections our plans to deliver these key priorities and how we will measure whether we have been successful.

3. Working Together to deliver our Plan

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

In parallel, we have also been working to set up a new financial recovery board.

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

We are establishing a new Delivery Oversight Group which is an Executive-led forum charged with the responsibility for mutually overseeing delivery of our agreed priorities. We will agree our priorities through our implementation plan, and these will form the mandate for each programme (now called 'Delivery Group') and our work programme for the year.

Delivery Groups will be asked to report regularly on achievements and use a standard approach to escalating concerns through to the Delivery Oversight Group.

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

Programmes will now be called delivery groups and will be established in a uniform way. Delivery groups are partner forums that come together to deliver our operating plan and implementation plan commitments.

The main delivery groups as currently identified are UEC, Elective, Mental Health, LD&A, CYP and Primary and Community Care. Enabling delivery groups are Digital, Estates, Finance, Green and Workforce. New groups can only be added in agreement with the ICB Executive.

The ICAs and the AHA also have responsibility for delivering elements of our implementation plan – we are working through how we will ask partners to share updates on progress.

4. Health and Wellbeing Board Opinions

[to add when received]

5. Some examples of our achievements in 2023/24

[these are being further developed and added to as we receive more case studies]

Developing an Integrated Neighbourhood Team model in Swindon

Over the last 12 months the Swindon Locality have been engaged on a number of Integrated Neighbourhood Team (INT) projects with a regular steering group working towards designing Integrated Neighbourhood Teams and developing pilot projects incorporating partners from across the Swindon Locality. Represented partners include Great Western Hospital, Swindon Borough Council, Avon and Wiltshire Mental Health Partnership, First City Nursing, Swindon Carers, Voluntary Action Swindon, Swindon Mind, local GP surgeries, and the ICB. Following the recommendations set out in the Fuller Stocktake report, published in May 2022, the steering group have worked proactively to develop a template for piloting smaller projects within targeted populations, bringing together front-line staff and community organisations that either support our local communities, or groups of people who have complex needs. The overall aim is to improve the experience of people and our communities and ultimately their health and wellbeing.

Through our pilot projects, we have started small and are working in targeted areas with targeted populations, to test out what is achievable. Our pilot projects have been developed from our learning from other areas where integrated neighbourhood working is further developed, and from learning from organisations across the country, for example our Team Around the Person Project which has been developed based on the success of a similar project in Sheffield. Partners have offered their resources and shared their assets to enable solutions to be developed to support in tackling health inequalities and promote health and wellbeing within their local community. We have ensured a focus on effective and robust evaluation on the impact of these projects, particularly on left shift and the potential to implement at scale. Within our steering group we have focused on developing a positive culture with strong collaboration amongst all partners which will support the ongoing success of the work on Integrated Neighbourhood Teams.

Leadership and Management

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

Successful mobilisation of a quality improvement community of practice with improvement leads from across BSW building new relationships and understanding. In partnership with NHS Aqua a system wide diagnostic was completed with the outcome of a baseline assessment of improvement with identified recommendations. Cohort of staff trained in Calderdale framework, a service transformation tool, with 10 facilitators taking forward service transformation projects. As part of the improvement work foundation training successfully designed and provided to system partners and leadership and support provided through the Acute Hospital Alliance and their aligned improvement methodology.

Oliver McGowan Training

As part of NHSE expectations mobilisation of a training model made available to system partners that to date has trained over 2000 members of staff for Tier 2 face to face session.

Bank and Agency

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

BSW Youth Worker Pilot

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

6. Our local implementation plans

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

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

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

Over the past nine months the following key deliverables have been achieved:

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

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

Swindon
• Completion of Building the Right Support peer review in 2023 with resulting action plan in place
• Health Inequalities Funding to support health inequalities projects across the locality, as part of year 1 funding, the projects delivering progress include ○ Changing Suits - project to raise awareness of mental health within the South Asian community (SAC), and to increase SAC engagement with local service providers. ○ Kennet Furniture Refurbishment - Local support organisation to alleviate furniture poverty (including beds) for the most vulnerable households in Swindon. ○ Citizens Advice Swindon cost of living support & Live Well - Citizens Advice Lead based in Sanford House alongside the Live Well team to identify and provide debt, benefits, energy, or housing advice. The aim will be to increase knowledge and shared expertise in identifying and providing solutions in relation to practical advice issues. ○ Patient Educators - 4 Primary Care Networks to deliver obesity & smoking cessation through providing education and support to new parents within the CORE20 PLUS.
• Delivery of an integrated health response and service to asylum seekers, Afghan and Ukrainian refugee families
• As part of the Integrated Neighbourhood Teams (INT) initiatives in Swindon, we have: ○ Held 3 workshops with stakeholders to develop INT approach in Swindon. This has now developed into a steering group which has met monthly since Jul-23 ○ First pilot Team Around the Person established with Kingswood Surgery and partners (Brunel 2 Primary Care Network) ○ Explored and developed ideas for additional INT approaches focussing on people living with obesity, children with complex health needs, and women's health hubs. These can be pursued in 2024/25.
• Reduction in people delayed waiting to leave hospital by 30%
• Increased capacity to 40 virtual ward beds

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

Wiltshire
Wiltshire has clustered the ICS Strategy Themes with the aims in the Joint Local Health and Wellbeing Strategy. Please refer to the JLHW strategy for more detail Wiltshire's Joint Local Health and Wellbeing Strategy 2023 to 2032 - Wiltshire Council. Key achievements in 2023/24 include:-
• Wiltshire has reviewed the findings of the latest pupil survey to inform work on reducing risk behaviours and health coaches are delivering targets work on health lifestyles and smoking cessation.
• With a target to reach 60% by 2032, the rate of children estimated to be physically active has risen to 48% (above England average) although Wiltshire is now behind the South West average of 49% - there are initiatives to improve this further. Activity levels in adults are above national and regional averages.
• Local work has been successful in improving screening and vaccination rates – there is an ongoing focus to improve rates within groups who experience inequitable outcomes. For example, flu vaccination rates are now at 85% for people aged over 65 years.
• The aim for children and young people with SEND to have improves outcomes and life experience is a clear priority for Wiltshire partners. The local area partnership is working in collaboration to implement an ambitious programme for children and young people with Special Needs and Disabilities in Wiltshire. We are particularly focused on addressing identified priority areas as well as exploring creative and innovative ways of ensuring children and young people with SEND can fully engage in all aspects of life and have the best chances during their adult lives.
• The Implementation Plan and JLHWS is clear on the importance of vaccination, screening and smoking cessation, particularly in communities where rates are below average – these are shared priorities. There are a range of measures in place -

Wiltshire for example performs at above national average rates for smoking cessation 4 weeks after seeking support.
• Improvement has been made in the target to reduce obesity in the adult population, currently at 27% against a target of 25% by 2032.
• The Health Intelligence Team has been established using Health Inequalities Funding – they work across the Wiltshire system, supporting services to understand and use a Population Health Management approach.
• In advance of a Peer Review of SEND services by the Local Government Associate, a self-evaluation was completed to identify strengths and areas of development. Wiltshire is working with Wiltshire Parents and Carer Council (WPCC) and children and young people to ensure their voices are embedded into local service improvements and engaging on ongoing developments to evolve the quality of provision and expand choice. Key developments have been the expansion of special school places and associated resource centres, the development of the Local Offer website, and the introduction of health advisors
• Wiltshire has recommissioned children's community health services, ensuring they are inclusive of a coordinated approach and core offer for emotional wellbeing in schools; and public health nursing services.
• Childrens Services were rated Outstanding in the last Ofsted/ CQC inspection in September 2023. 50235241 (ofsted.gov.uk)
• The Families and Childrens Transformation Programme (FACT) partnership launched its Family Help project to enhance local arrangements for the delivery of early intervention and prevention services for children, young people and families. **All Together - Wiltshire Together** 5 schools are signed up to the Restorative Approaches Pilot – an evaluation will offer key learning and insights to inform future adoption of the approach.
• The Wiltshire Health Inequalities Group focusses on work to reduce health and wellbeing inequalities and aligns to the CORE20Plus5 approach. The group has successfully identified priority investments for the health Inequalities Funding for 23/24 and is engaged in monitoring the delivery against those plans
• The Wiltshire Autism Partnership has been initiated with both professionals and service user forums held in January 2024.
• An improvement group has been established working in partnership with VCSE sector colleagues to increase the uptake of Annual Health Checks for people with Serious Mental Illness or Learning Disabilities – Wiltshire is currently under performing against national targets (48% against a combined target of 23%) despite comparing favourably at a regional level.
• The Wiltshire Dementia Strategy was approved by the Health and Wellbeing Board in September 2023 - an implementation plan will ensure the successful delivery and transformation of services through 2024 and beyond.
• Neighbourhood Collaboratives have launched the first sites in 2023 – there are 5 in different stages of progression – the ambition is to have commenced work in all areas by the end of 24/25.
• Following successful pilots, the Community Conversations programme which started in Bemerton Health (Salisbury) and Studley Grange (Trowbridge) is increasing its reach to identified areas across Wiltshire in 2024.

• Partners have developed new pathways and models to ensure that people who are able to go home after an inpatient hospital stay, are able to do so (taking a Home First approach) and are less likely to need extended inpatient care in the community setting.
• Wiltshire has introduced a new Carers Strategy to rightly focus on improving the way in which informal carers are supported across our services and improve their outcomes. A new contract for services is in the commissioning process to take forward the ambitions in the strategy.
• Wiltshire has developed and launch the Caring Steps Together resources which are available across BSW – we worked as partners with patients and their support networks, staff and others to develop new resources that support people through the process of being discharged from hospital and require either admission to a care home or support at home on a short- or longer-term basis
• The community Urgent Care Response service met and now exceeds its target of attending 70% of cases at home within 2 hours of the referral. This ensures avoidable admissions to hospital are prevented.
• The local authority implemented a Care Home Hub Model for people going into a care home bed on a temporary basis after an inpatient stay in hospital. This model has shorted the length of stay in the care homes, meaning people return to their own home much quicker than previously.

Key priorities for delivery in 24/25

BaNES
Workforce: • Continued joint working across all sectors to consider new models of working in an integrated way to respond to opportunities, local needs and challenges. This will be a key enabler to attract, retain, and provide development opportunities to create a multi skilled sustainable workforce. • Locality objectives achieved: further work required on new ways of working and organisational change / development to inform next year's deliverables

Health Inequalities, including:
• Implementation of Women's Health Hubs
• Implementation and monitoring of schemes supported via the Health Inequalities Fund, agreed through the ICA Board. These include:
  ○ Support for safe discharge of homeless people from the RUH;
  ○ Partnership with Bath Rugby for Children & Young People with additional needs;
  ○ Supporting individuals experiencing domestic violence.
• Learning from Paediatric PUSH clinics to confirm offer for Winter 2024 – 2025.

Foundations to Deliver, including: • Integrated Neighbourhoods: Q1: collaborative review of plans and agreement of next steps. • Review of Reablement provision by end of Q1 linking into demand and capacity planning.

- Redesigning Community Services: continue to deliver Home is Best Programme with a revised focus on attendance and admission avoidance, and Mental Health (including Dementia) and Homelessness Pathways. Home is Best revised priorities launching 1 April 2024.

- ICA Cross-cutting themes and deliverables: the ICA will continue to work in collaboration with System-wide programmes to deliver the agreed priorities. These include:
  - Learning Disabilities and Autism
  - Mental Health
  - Children & Young People
  - Urgent Care and Flow
  - Community Transformation, including ICBC.

Swindon

- Focus on reducing inequalities in '5' focus clinical areas requiring accelerated improvement, to include as part of the action plan:
  1. Maternity - ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.
  2. Severe mental illness (SMI) - ensure annual physical health checks for people with SMI to at least nationally set targets.
  3. Chronic respiratory disease - a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
  4. Early cancer diagnosis - 75% of cases diagnosed at stage 1 or 2 by 2028.
  5. Hypertension case-finding and optimal management and lipid optimal management - to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

- Consideration of how social determinants of health impact on those at risk of developing an ABI/TBI and those with an ABI/TBI. Risk factors such as frailty and alcohol misuse provide opportunities for targeted prevention actions

Integrated Neighbourhood Teams (INT)

- Q1 - Launch Team around the Person INT in Brunel 2 PCN
- Q2 - If PCN support is secured, launch Connecting Care for Children INT in Wyvern PCN
- Q2 - If funding is forthcoming launch Women's Health Hub INT in Brunel 2, Brunel 4 and Wyvern A PCNs
- Q1/Q2/Q3 - Test aspects of Obesity INT in Brunel 3 PCN

Carers

- Q1 - Tender for Carers Services contract is published after engagement with carers + Feedback from carers informs the Integrated Neighbourhood Team pilot + SBC/SCC work with Carers on co-designing training around access to Direct Payments/Personal Budgets
  - Q2 - Preferred provider for Carers Services contract is confirmed by end Sept 2024 + Carers have access to training on Direct Payments/Personal budgets + Plan

developed for ensuring all registered carers with SCC and/or GP surgeries have access to annual health check • Q3 - Current provider recommissioned and action plan for implementation of new contract delivery in place OR Robust plan in place for current provider to work with new provider for seamless transfer of carer services + Provider works with GP surgeries on ensuring all registered carers have access to an annual health check • Q4 - New carer services contract commences + Feedback from carers shows support they receive evidence they are better able to balance their caring role to protect their own health and wellbeing
System Flow • Q1 - Review the step down and D2A capacity, including processes and function of the beds • Q1 - Maximise Home First pathways and review processes • Q1 - Launch and embed SwICC admission criteria • Q1 - NHS@Home capacity increase in line with trajectories • Q2 - Implement new Trusted Assessor model, including bed management oversight • Q2 - Start winter planning • Q2 - Scope potential further elements of an ICA demand and capacity plan (primary care, voluntary sector for example) • Q3 - Complete and sign off Winter Plan • Q3 - Stand up winter respiratory clinics • Q4 - NHS @ home (virtual ward) beds 90 (80% bed occupancy) • Q4 - Implement lessons learnt review from Winter Plan and outcomes
Left Shift of Care • Q1 - Deliver workshop with ICA and DEG to look at examples of where resource has been successfully shifted left into prevention, identify the barriers that have prevented further left shift and how they can be overcome, agree opportunities for further left shift. • Q2 - Develop a plan for how left shift work can be taken forward within the existing financial envelopes, including in Integrated Community Based Care, mental health and talking therapies • SBC and ICB to continue to increase connectivity and joint working with voluntary sector partners
Mental Health • Q1 - Embed integrated access model in Swindon alongside third sector providers – redesign expected end April 24 • Implement a Talking therapies pathway • Embed integrated access model in Swindon alongside third sector providers • Improve Urgent care pathway and 111 press 2 • Increase dementia diagnosis rates • Carry out Impact evaluation and continue to monitor effectiveness of the Family Safeguarding Model • Develop an action plan based on the Mental Health Strategy & Suicide Prevention Strategy • Reduce out of area hospital inpatient admissions

○ Q1 - To continue to hold Tier 1 Multi agency meetings where specialist placement avoidance is explored (third sector are involved). ○ Q1 - To liaise with Crisis Houses to determine if those in current specialist MH placements can be supported in Crisis Houses. ○ Q1 - To continue to repatriate people within specialist inpatient placements to AWP inpatient wards. ○ Q2 - AWP Windswept Rehabilitation ward – MDT should be fully recruited and accepting referrals to support the repatriation from Specialist Mental Health inpatient units to Windswept Ward, Swindon. • Embed the iThrive model into the Swindon mental health pathway • Working in partnership with SBC and other Swindon partners to develop an enhanced offer for CLA, supporting earlier intervention and increased access to specialist trauma support, ensuring permanency of placement and a reduction in the number of CLA who are admitted to acute hospitals with significant emotional distress. • Explore options for long term placements within Swindon for patients with more complex needs (working age) • Develop and implement plan to upskill workforce in the changing mental health needs across Swindon
Learning Difficulties & Autism • Work with people to co-produce improvements for people with learning difficulties and autism • Improve prevention and maximising using technology • Improve response to learning disabilities and autism with Mental Health complaints • Fully embed the key worker service for people with learning difficulties by Q1: ○ Update to the local offer pages ○ Ensuring consent forms (to be added to DSR) contain information on the key worker scheme. ○ Development of service user friendly comms ○ Share relevant data regarding the scheme with strategic partners, i.e. social care. ○ Key worker colleagues being invited into DSR meetings • As part of the SBC Building the Right Support programme: ○ We will launch and promote Working Together Plan in Adult Services and with partners and key stakeholders ○ We will have completed a baseline survey to measure the knowledge and understanding of staff on working together principles ○ We will develop Working Together training ○ We will roll out new My Care, My Views forms
Children & Young People • Complete plan for investment into oral health • Develop community hubs (in conjunction with mental health) with co-located teams taking a holistic approach to children's services • Commission new provider for Children Community Services

Wiltshire

The Wiltshire ICA is committed to the delivery of the Joint Local Health and Wellbeing Strategy (https://www.wiltshire.gov.uk/article/8528/Wiltshire-s-Joint-Local-Health-and-Wellbeing-Strategy-2023-to-2032).

Additionally, the Alliance is currently re-focussing on a small set of shared priorities aimed at reducing population health inequalities, aligned to a prevention focus / left shift. The processes to achieve this is well advanced and will conclude in May 2024. The agreed priorities will be published after this date.

The following are significant areas of delivery in 24/25.

Healthcare Inequalities

The Wiltshire Health Inequalities Group is driving change and improvement in the agreed Strategic Priority areas of the Core 20 % most deprived population areas, and the agreed cohorts of people in Wiltshire, defined as: -

- Routine and Manual workers, Gypsy, Roma and Boater communities (Wilts)
- Or are included in any of the five agreed priority clinical areas:

Adults	**Children and Young People**
CVD	Asthma
Maternity	Diabetes
Respiratory	Epilepsy
Cancer	Oral Health
Mental Health	Mental Health

In Phase 3 - Prevention and social, economic, and environmental factors, Priority Areas are:

- Anchor institutions
- Publish three place-based Joint Strategic Needs Assessments for BANES, Swindon, and Wiltshire
- Establish local priorities that address public health and the social, economic, and environmental factors most affecting inequalities at place
- Plan and enable progress on prevention where outcomes will take longer to see

Committed areas of focus have been agreed as: -

- Whole system approach to Obesity
- Whole system approach to Smoking

Neighbourhood Collaboratives (Integrated Neighbourhood Teams)

In Wiltshire, Neighbourhood Collaboratives are where our collective energy, capability and capacity is breaking new ground in improving population health and wellbeing.

Aligned to the compelling vision in the Fuller Stocktake, Wiltshire is continuing its journey towards a shared vision of full integration across a wide network of partners around each neighbourhood area.

In 2024/25 priorities include: -

- Successful delivery of the Health Inequalities-funded project to develop an engagement best practice model and deliver a programme of intervention around

a cohort of people within the Core20Plus 5 groups. This will enable the work to move forward having 'pump primed' part of the development work.

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

System Flow Priorities Include

- Carer Breakdown
  Continue with additional capacity for domiciliary care to support carer breakdown, preventing avoidable admissions to hospital.
- Mental Health, Learning Difficulties and Autism
  Intensive Enablement Service – preventing admission by preventing escalations in need and supporting discharge
- Home First
  Continue with ongoing Home First Improvement Programme – including the Streaming Framework, implementing the Wiltshire Model – hybrid services, interdisciplinary working, new performance standards, Discharge to Assess improvement, Transitions and Discharge Optimisation, new Technology opportunities.
- Domiciliary Care Support
  Test and develop a hybrid model of working, which utilises domiciliary care to enable earlier discharges and maximise effective use of therapy capacity.
- Community Hospitals
  Redesign the Community Hospital Model in line with the case mix and future demand profile. A new pathway approach will ensure improved flow through the service. The work will include reviewing staff mix, patient cohorts and length of stay.
- Demand and Capacity
  Following the previous action, we will Scope potential opportunities for reduction in Pathway 2 capacity from 25/26 on the basis that Home is the best place for most people to be.

- Discharge Referral Attrition Rates
  remain above efficient levels, review to take place with aim to reduce 'waste' within current processes.
- Length of Stay
  Reduction in length of stay across all services and achievement against 'stretch targets' where appropriate.

Children

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

ICA Cross-cutting themes and deliverables: the ICA will continue to work in collaboration with System-wide programmes to deliver the agreed priorities. These include:

- Learning Disabilities and Autism (this includes a focus in Wiltshire on a new Autism strategy)
- Mental Health
- Children & Young People
- Urgent Care and Flow
- Community Transformation, including ICBC.

7. Our outcome measures update

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

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

The development of these measures will happen during Q1 of 24/25. We are working to develop Logic Models for our major programmes of work ensuring we have a good understanding of how and where our work will impact. Out of our Logic Models will fall outcome measures for our specific programmes. We'll quantify our levels of ambition over the coming years, stress-testing the impact of our change work against the do-nothing challenges our system faces. Importantly, with the addition of financial sustainability as our fourth objective, we will adapt our measures to ensure our change delivers the outcomes required for our population whilst ensuring our system is financially sustainable.

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

In this section:

- Introduction
- Physical wellbeing
- Mental Wellbeing
- Smoking Cessation
- Long term conditions: Cardiovascular disease (CVD) and Diabetes
- Cancer and Screening (cervical, breast and bowel)
- Long term conditions: Respiratory Long-term conditions: CVD event recovery

Introduction

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

In our strategy we have committed to:

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

Achievements in 23/24 include:

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

• Swindon launched their Tobacco Control Strategy at an event in September 2023 and appointed a public health practitioner to lead on implementation. • Wiltshire have redesigned their health coaching service (using new KPIs) to encourage a focus on Routine and Manual Workers (PLUS group)
• Work with the Southwest Illegal Tobacco Team on engagement campaigns and enforcement activity. • Trading Standards involved in test purchasing for underage sales resulting in seizures of illegal vaping products and other enforcement activity. • Educational activities with partner organisations.
• Stoptober and other campaign material have been distributed for partners with local success stories from clients of local services. • Local stop smoking services continue to be promoted through local partners and initiatives such as the Targeted Lung Health Checks. • Swindon launched their Tobacco Control Strategy at an event in September 2023.
• Started development of a dashboard to enable system wide visibility of key diabetes and cardiovascular disease targets.
• We started to improve coordination between specialist diabetes services. This is now built into the Integrated Community Based Care programme and Primary and Community Care Development Programme.
• Plans have been developed for how patients with modifiable risk factors of a new condition are identified and received support.
• We have implemented the Diabetes Pathway 2 Remission programme (Low Cal diet). Roll out commenced in quarter 3.
• We planned how to increase uptake of diabetes digital Structure Education and implementation will start in early 2024/25.
• We shared with all practices and PCNs the learning and outcomes from cancer projects that we funded in primary care in 22/23 aimed at increasing early presentation and screening uptake. Practices and PCNs were able to use this learning to consider rolling out in 2023/24.
• Planned the next stage of Targeted Lung Health Check development which will include roll out to Salisbury and Trowbridge.
• Successful rollout of FENO testing to support asthma diagnosis has been achieved over the last two years, with good outcomes. Over the 12 months, there were 1733 appropriate referrals for a FENO test in primary care. 1638 initial assessments were done and 387 follow up assessments. Of those patients diagnosed with a raised FENO, 312 patients were given an asthma care plan, 466 patients were given education on how to manage their condition, and 39 patients had their medication changed.
• Spirometry has restarted in some practices across BSW. However, this is still being funded inconsistently across primary care, creating variation in services. Work is currently going on to review the GP Local Enhanced Service (LES), and as part of also review spirometry funding.
• BSW Pulmonary Rehab services are progressing the priorities set out in the Five-Year BSW Pulmonary Rehabilitation Plan. 2023/24 is the second year of the plan and services are working in integrated ways to benefit people, increase personalisation of services and reduce health inequalities. The following positive outcomes have been achieved: • Increased capacity of programmes to provide patients with greater choice by offering virtual courses, in addition to face to face.

• Offering up spaces on running courses to new patients if patients DNA or drop out to maximise capacity. • Adapting models of delivery in response to waiting lists. • Offering appropriate IT on loan e.g. iPads to help reduce inequalities due to lack of access to equipment. • Integrating community respiratory teams with acute in-reach teams, to keep abreast of patients who are admitted with exacerbation of COPD and to enable a pathway for hospital discharges to attend pulmonary rehabilitation.
• We have redesigned community mental health services to: ➢ Improve access to MH support for people with Severe Mental Illness through new access models that provide immediate advice, support and signposting to community and secondary services as required at PCN level ➢ Develop secondary MH service provision to provide timely therapeutic interventions aligned to PCNs and ARRS investment
• We have introduced a new model for Children and Young People's Mental Health in Swindon that: ○ Integrates TAMHS (Targeted Mental Health Service), CAMHS and MH Support Teams across Swindon ○ Increases the digital offer of early help and support ○ Improves support to CYP presenting in crisis at A&E through the appointment of MH Champions and developed a BSW Hospital based Youth Worker pilot ○ Rolls out assessment and liaison for paediatric inpatients with eating disorders (ALPINE)

Priorities for 24/25 and 25/26

As set out in our introduction, over the next years using our population health data and through review of our key partnership documents in joint strategic needs assessments, we have identified two priorities on which to focus our prevention activities. These are: preventing cardiovascular disease and promoting mental wellbeing.

We will continue to progress our work on other prevention activity as set out in our strategy including promoting physical wellbeing, smoking cessation, cancer and screening, diabetes and other long-term conditions. The detail of this work is included within our respective organisational plans, and we will continue to monitor progress.

Cardiovascular disease

In 2024/25 we plan to:

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

In 2025/26 we plan to:

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

Mental Wellbeing

In 2024/25 we plan to:

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

In 2025/26 we plan to:

Build on the work of 2024/25

Smoking Cessation

In 2024/25 we plan to:

Develop and implement an E-Cigarette offer for stop smoking services
• Provide free vaper start kits in BANES and across BSW for pregnant women and their household members (funded through the Government Swap to Stop Scheme)

• Develop and implement an E-cigarette offer in Swindon including sourcing reputable nicotine vaping products, training for stop smoking practitioners, offering vaping as a stop smoking product, evaluation and ongoing workshops to prevent use of vapes in children and young people. • Wiltshire
Continue to reduce the availability and access to illegal tobacco and illegal nicotine vaping products in the community
• In BANES support enforcement action to reduce access to illegal tobacco. • In Swindon: work with comms teams to highlight any seizures, prosecutions, closure orders etc; undertake educational activities to promote responsibility in relation to tobacco. Ensure all retailers are fully compliant with any new/updated regulations relating to tobacco/nicotine products; and continue to improve quality and use of regional intelligence reporting via closer working with South West Trading Standards Regional Intelligence Team, HMRC and Police
Focus on health inequalities and target resources for those that need it most
• In BANES use additional section 31 public health grant funding to increase capacity to support smokers to quit, raise awareness of support options and services available and reaching out to target groups where smoking prevalence is high. • In Swindon: Explore perceptions of pregnant women who do not engage with stop smoking services, develop a lived experience group and develop Stop smoking pathways for priority cohorts e.g. people accessing substance misuse services and housing support. • In Wiltshire: deliver a Smoking Health Needs Assessment considering smoking prevalence, health outcomes related to smoking and services to assist individuals to become smokefree supported by the Wiltshire Tobacco Control Alliance.

In 2025/26 we plan to:

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

Cancer and Screening

In 2024/25 we plan to:

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

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

In 2025/26 we plan to:

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

Respiratory

In 2024/25 we plan to:

Achieve year 3 priorities as set out in the BSW Pulmonary Rehab 5-Year Plan

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

In 2025/26 we plan to6

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

9. Strategic Objective 2: Fairer Health and Wellbeing Outcomes

Introduction

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

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

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

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

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

In BSW we have chosen the following PLUS population groups

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

		• Children and Young People with Adverse Childhood Experiences (ACE; with a focus on delivering trauma informed services)

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

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

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

Core20Plus5 - Adults

Achievements in 2023/24:

• Quality improvement projects in progress to improve access and earlier booking for maternity care for Black and Asian women having identified later accessing of booking for maternity care.
• Investment into Inclusion midwives and provider BI to support improved data flows. All providers have maternity and neonatal inequalities quality improvement workstreams which align with LMNS Equity and Equality action plan. Work in progress to embed ethnicity and deprivation data into all audits in maternity and neonatal services.
• Thematic review of perinatal mortality undertaken to identify any impact of ethnicity and deprivation on outcomes will continue annually into 24/25
• Work in progress and hoping to be completed by April 2024 on access pathway for pregnant people in the boating community.
• Completion of cohort of 20 staff trained to be champions through Health Innovations WOE programme to support provider and LMNS QI projects to reduce inequitable outcomes for women and babies from ethnic minorities. Phase 3 cohort underway currently will continue into 24/25 for Black Mothers Matter training.
• Anti- racism training for all Maternity and Neonatal Staff across BSW (including those in non-clinical roles) - Training commissioned by ICB Local Maternity and Neonatal System and continued to be provided up to end of financial year. Awaiting final numbers trained
• We have increased the number of women receiving continuity of care focusing on women from ethnic minority groups and those from deprivation primarily due to established Continuity of carer models in Swindon- however this model of care has now paused in Swindon due to staff not wishing to work within this model of care currently. Continued focus on Continuity of care antenatally and postnatally within all services. Ongoing work to future models of care provision across maternity services

Annual health checks for those living with SMI

- We have undertaken a pilot in four GP surgeries whereby we provided some funding for Admin staff to contact patients on the LD register and explain the purpose of the Annual Health check, identify any barriers and support the individual to attend their appointment. A follow up call was made on the morning or afternoon before their appointment to ensure reasonable needs were being met.

Annual health checks for people with a Learning Disability

- The outcomes from the pilot were that this was a successful approach with the number of LD patients receiving their annual health check increasing and the likelihood of DNA's reducing.
- Due to funding constraints, we are unable to extend this project across all GPs and we have not been able to continue with First Options attending schools to give the children over 14 an annual health check.
- The LDAN Programme Board has agreed that the next stage communications and engagement campaign to raise awareness about the annual health check and the benefits.
- It is noted that we have seen a significant increase in those registering as LDA, together with the known issue that checks are often towards the end of Q3/4, this has meant that proportionally we are currently below our target trajectory. We hope that with the targeted support and campaign set out above we will meet out trajectory overall by year end.

- BSW was 2nd nationally for COVID vaccination uptake.
- Data led community engagement was delivered by Local Authority Teams to raise awareness, confidence, build trust and educate.
- Health and wellbeing engagement sessions with a focus on vaccine confidence were run with groups supporting Black and Ethnic Minority populations in Swindon.
- Vaccination clinics were offered at migrant hotels including Making Every Contact Count literature in appropriate languages.
- Targeted vaccination clinics were held in Core20 areas.
- Covid and flu vaccinations were co-administered where possible.
- Roving clinics were set up supporting vaccination for care home staff with low uptake.
- A proactive project was run in Brunel 2 PCN targeting COPD patients who were smokers and prescribed steroids who hadn't taken up their vaccination.
- Outreach clinics to SMI and maternity in-patient and immunosuppressed patients were organised.
- Specific clinics for people with learning difficulties were delivered offering people on the LD register and their carers vaccinations in a quiet space.
- Additional clinics were arranged at GP practices with the lowest uptake.
- All clinics have been used as an opportunity for wider health promotion using a Making Every Contact Count approach including cancer screening and hypertension case finding.

- In 2023, 57% of cancers in BSW were diagnosed at stage 1 or 2.
- We have continued to optimise cancer screening (bowel, breast, cervical) working with the NHS Cancer Screening Programme Boards, working with BSW public health teams on prevention work regarding alcohol, smoking and obesity, appointing Swindon Cancer Champions to encourage uptake of screening programmes in under-served populations, linked with partners to increase cancer screening uptake in people with serious mental illness or Learning Difficulties
- We have supported timely presentation by the public: using 'Be Clear on Cancer' campaign messaging via GP practices, providing cancer information on GP practice websites, sharing resources (posters, screen ads, leaflets etc) with GP practices, Swindon Cancer Champions

have raised awareness at local events, BANES have had a Bowel Cancer Awareness campaign at bus stops and on buses and BANES also appointed a Health Inequalities/ Population Health Management facilitator. • We have improved cancer guideline 'compliance' and improve pathways for referrals; by refining Urgent Suspected Cancer (USC) pathways, specifically LGI, gynae and skin, and using FIT for symptomatic patients. • We have improved pathway availability and shortened the time to testing and diagnosis; by implementing the Faster Diagnostic Standard (FDS) – 28 day 'rule in/out cancer diagnosis' rolled out, appointing Cancer navigators in Trusts, implementing Best Practice Timed Pathways and implementing Consultant Advice e.g. telederm A&G for skin cancer. • We have innovated introducing early diagnosis interventions: by rolling out Targeted Lung Health Check to Swindon, parts of Bath and implementing the Lynch surveillance programme to detect bowel cancer. • Given Swindon is our area of highest deprivation we have done some additional work here: to increase cancer screening uptake with particular focus on low uptake groups, focussing on deprived areas - Community Cafes & Food Share locations, engaging with vulnerable groups- LD & neurodivergent groups, substance misuse disorder, homelessness and asylum seekers, recruited over 50 Community Cancer Champions (CCCs) who have engaged with over 2500 people through 68 awareness talks and 42 events. • We have funded 21 PCN/Practice cancer projects across BSW with the aim of increasing cancer screening uptake in under-served groups, education and proactive outreach.
• 68% of patients aged 18 and over with GP recorded hypertension had their last blood pressure reading (measured in the preceding 12 months) as below the age appropriate treatment threshold as of September 2023. • 51% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more were on lipid lowering therapy as of September 2023. • Work has developed with community pharmacy to optimise testing and diagnosis of hypertension. • Circulated hypertension diagnosis flow chart all practices to encourage accurate diagnosis and appropriate management

In 2024/25 we plan to:

Consider future models of care provision across maternity services to ensure building blocks are in place to increase percentage of pregnant people on continuity of care (CoC) pathway in line with staffing trajectories
Annual health checks for 60% of those living with severe mental illness and learning disabilities
• Annual health checks for those living with SMI – building on the 23/24 work • Delivering annual health checks for people with learning disabilities and autism - Building on the work we have done so far. We will be looking to produce a communications and engagement campaign to raise awareness of the annual health check to ensure people with a learning disability are aware of their rights. The campaign will be split into two workstreams with a public and professional workstream, each with differing engagement requirements. In addition, we will be looking to improve the quality of the annual health checks by joining them up with statutory services and cancer screening
Increased uptake of COVID-19, flu and pneumonia vaccines in C20+ and people with COPD
• Funding has been secured to deliver 5 projects focussing on addressing inequalities in 2024/25.

• A focus on improving vaccination uptake in people with Learning Disabilities and Serious Mental Illness is planned: identify areas with lowest uptake, understanding key barriers, utilising training to address. • A community bid has been submitted to support vaccine confidence empowering communities to shape their own work and deliver sustainable responses. • Family clinics in communities with low uptake focusing on vaccination in the context of wider health and wellbeing. • Care Home engagement project evaluating outbreaks and staff vaccination uptake and aiming to improve vaccination confidence, dispel myth, maximise uptake and reduce outbreaks. • Community champion project using networks across BSW to deliver health improvement initiatives including a focus on vaccinations. • Continue Core20Plus5 driven vaccination clinics and community engagement.
75% of cancer cases diagnosed at stage 1 or 2 by 2028
• Continue to optimise cancer screening (bowel, breast, cervical) • Continue to support timely presentation by the public. • Continue to improve cancer guideline 'compliance' and improve pathways for referrals with a focus on Urgent Suspected Cancer Pathways for additional specialities, establishing 3 non-symptom specific pathways for each Trust, holding 2 cancer education webinar/events for primary care and ad hoc Trust focused cancer pathway webinars. • Continue to improve pathway availability and shortened the time to testing and diagnosis by continuing to implement Best Practice Timed Pathways, continuing to implement Consultant advice, refining the Straight to Test Pathway and implementing the Personalised Stratified Follow Up Pathways for red flag symptom management. • Continue to innovate introducing early diagnosis interventions by rolling out Targeted Lung Health Check to Trowbridge and Salisbury in 2024; and implementing the Multi Cancer Blood Test Implementation Pilot Programme – Jul 24 • Continue some specific work in Swindon to address inequalities with a range of events scheduled for 2024 inc. South Asian Cancer Roadshow - February 24
Increase hypertension case finding and optimal management and lipid optimal management
• Funding secured to address inequalities in attainment of lipid targets in those at risk of Cardiovascular Disease. Implementation of this project planned.

Core20plus5 – Children and Young People

In 2023/24

• CYP Clinical asthma lead in post and leading delivery on the National bundle of care for children and young people with asthma • Launching a BSW approach to accrediting Asthma Friendly Schools
• NICE guidance TA943 Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes was published December 2023 with CYP as a priority group. Implementation of this guidance is overseen by the BSW Diabetes Commissioning Group, with support from the BSW CYP Programme.
• Successful bid for ESN Pilot in April 2023. ESN will work across the community and be based at RUH Bath. ESN commenced role February 2024.

• The workplan for this role includes inequalities screening for all patients and prioritising the most deprived 20% and CYP with LDA.
• Oral health working group linked to the BSW CYP Programme Board and Elective Recovery Board alongside ongoing public health preventative work under the umbrella of the Population Health Board.
The Thrive and CYP Programme Boards along with the CYP MH Oversight group are bringing together key partners to review access and service delivery. Actions to support this in 2023/24 are described in our section on Child and Adolescent Mental Health – all actions taken contribute to improving mental health service access for Children and Young People.

In 2024/25 we plan to:

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

10. Strategic Objective 3: Excellent Health and Care Services

Introduction

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

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

Implementing our primary and community care delivery plan

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

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

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

Primary Care

Delivery Against 2023/24 Plan

Additional specialised roles have increased the appointment capacity within primary care.

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

Key deliverables for 2024/25

- Increase usage of patient facing digital tools focusing on adoption of NHS App uptake and usage, evidenced by national NHS App reporting.
- Once Cloud based telephony is in place across practices in Spring 2024 ensure benefit are realised by ensuring practice make the most out of new functionality available, ultimately reducing patient telephone wait times and increasing satisfaction.
- Ensure all practices are transition onto a compliant online consultation product via the new PCARP national framework making the most out of the national PCARP digital allocation.
- Complete move to sing EPR (TPP) for primary care.
- Review GP IT support arrangements across the ICB to create a single sustainable consistent service.
- Trial in one PCN of Brave AI tool using AI to target patients in most need of proactive interventions.
- Continuation of the delivery of the two-year National Primary Care Access Recovery Plan to enable access to Primary Care Services
- The PCNs will be continuing to enact their Capacity and Access Improvement Plans through their engagement and transformation to Modern General Practice. Plans include using practices' own General Practice Access Data to analyse and review capacity and demand; co-production of communications about Modern General Practice and the different roles within General Practice.
- The ICB will continue to develop self-referral pathways by patients to Musculoskeletal; Audiology; Weight Management Services; Community Podiatry; Wheelchair; Community Equipment and Falls services by working with service providers to enable further pathway implementation during 2024-25.

The ICS will also expand the original self-referral list and jointly develop additional self-referral pathways to other services, thereby creating further capacity within primary care. • The ICB will continue to develop the interface between Primary and Secondary Care which has the opportunity to streamline patient journeys and the administration between the sectors. The locally developed 'Excellence in Partnership Working' sets out the principles to facilitate better joint working will be implemented during 2024-25. • Its anticipated there will be a 1.5% increase in primary care appointments (driven by 0.52 % population growth factor) across BSW.
The ICB will work closely with PCNs on workforce plans and forecasting for 24/25. The 24/25 will be a 'stepping stone' year with future direction still to be shared by NHSE. Expenditure beyond the PCN allocation for 24/25 is at the PCN own risk. NHSE will not support the sharing of allocations in 24/25. It is expected that ARRS recruitment will flatline, and any future growth will be determined by the contract. PCNs will be encouraged to develop their ARRS teams and ensure full integration to the PCN Practices and support work capacity and staff wellbeing.
The ICB continues to work towards to recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels, focusing on key population groups, working with local authority public health and NHS partners to develop appropriate service specifications and target key geo-demographics. The ICB will continue to co-produce an oral health and prevention agenda working with Local Authorities, focusing on reducing dental decay in children and reducing child tooth extractions in acute settings. Finally, the ICB will review its current domiciliary, community and special care dental services provision, acknowledging increase in those aged 60 years and over in the next 15 years.
The work to recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels focuses on key population groups where evidence shows they may face additional access barriers and will address to provide fairer health and wellbeing outcomes. Our focus on prevention and early intervention will co-produce an agenda with public health Local Authorities, focusing on reducing dental decay in children and reducing child tooth extractions in acute settings. Finally, reviewing current domiciliary, community and special care dental services provision, aims to ensure continued excellent health and care services provision acknowledging the increase in those aged 60 years and over in the next 15 years who may access those services.
Continued focus on integrating community pharmacy clinical services which form part of the Community Pharmacy Contractual Framework, Pharmacy Integration Fund or GP Access Recovery Plan to support access, public health priorities and tackling health inequalities. Priorities are Pharmacy First, Independent Prescribing Pathfinder, Hypertension Case Finding, Contraception Service and Discharge Medicines Service.

Urgent and Emergency Care

Delivery Against 2023/24 Plan

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

Key deliverables for 2024-26

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

Virtual Wards

Delivery Against 2023/24 Plan

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

Key deliverables for 2024-26

Following evaluation of our current models including data and finance deep dives, clinician visits with each VW team and a number of Clinical Big Room sessions we have agreement to transition to a One-BSW Integrated Model with medical leadership collaboration (minimum of 6x PA sessions per week per virtual ward) to:

- align current unwarranted clinical variation to ensure consistency of access and offer
- provide more Tier 4 support to patients that would otherwise be in an acute trust bed
- build clinical confidence and increase referrals/utilisation rates
- develop new virtual ward pathways
- maximise our 24/25 envelope by re-setting trajectories for One-BSW model

Mental Health

Delivery Against 2023/24 Plan

Urgent Mental Health and Inpatient Services

Work to implement single-sex wards across BSW mental health services and focus on right sizing our bed base informed by population health needs. We will engage stakeholders and service users in this work.

- Pilot of single-sex wards was undertaken between Swindon and B&NES wards.
- Following completion of this pilot it was determined that restructuring of Beechlydene ward in Salisbury would be more effective. To be mobilised in 2024/25, supported by National Inpatient Quality Improvement Programme work.

A pan-system review of Section 136 pathways, action plan to be co-developed with partners from Q1 2023/24 and to be delivered by Q4 2023/24.

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

Further development and expansion of our NHS111 offer in order that we can deliver 'press 2 for Mental Health'.

- Implementation of a 'shadow' solution for NHS111-2 from December 2023 including extension of hours to 9am-midnight
- Full enhanced solution to be implemented from October 2024 pending recruitment to the final workforce model. A pan-system working group which meets weekly is overseeing this development.

Deployment of a mental health response vehicle to reduce conveyance to A&E and improve crisis response

- Unable to progress due to challenges with vehicle availability. We remain on plan to deploy a Mental Health Ambulance in 2025/26 as per the submitted capital plan in partnership with SWASFT.

Continued work to implement the 10 Discharge Priorities, in partnership with AWP and pan-system.

- Continued implementation of flow developments across mental health services, which has supported delivery of a significantly improved out of area placement position across BSW.
- From 2024/25 to be embedded in our inpatient quality improvement programme approach.

Development of a further Wellbeing House in Swindon and securing long term estate for the Place of Calm in BaNES (capital funding provided by NHSE) to support admission avoidance and improve step down provision.

- Plans are in place to secure purchase of a long-term solution for the B&NES Place of Calm (anticipated achievement date end March 2024). Work is underway to purchase a property in Swindon to provide crisis house capacity in that footprint – to be realised in Q2 2024/25.

Older Adult Services

Developing specialist Older People's Mental Health resource to work in primary care, using ARRS funding.
Developing a diagnosing advanced dementia mandate (DiaDEM) model to support improving diagnosis of dementia in care homes
Supporting primary care colleagues to record DDR in practices which is currently not consistent.

- 3 new practitioners have been recruited – initial focus will be on supporting diagnosis in care homes with the intention that these will then work alongside primary care colleagues to support diagnosis in primary care
- We remain below national trajectory of 66.7% dementia diagnosis rate but anticipate recovery to national position in 2024/25
- Older adult mental health practitioners are supporting our virtual wards programme, this has been implemented in year.

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

Perinatal mental health services

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

- Consistent delivery of the nationally mandated perinatal access rate and anticipate continuing to deliver against plan in 2024/25.
- Pathway work remains ongoing to support women with specific needs, and this will continue in 2024/25.

Talking Therapies (Improving Access to Psychological Therapies)

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

- All three B, S & W service operational models reaching comparative alignment in June 2023, and compliance with respective NICE guidance and the NHS E National Manual for Talking Therapies.
- Improving trajectory with some wavering associated with seasonal trends and other noted pressures.
- Service is on course to meet the locally set access rate by year end.

- Recovery has also improved throughout the year and is on course to be compliant with the national KPI standard by year end
- Referral to treatment remains compliant.
- Scoping digital offers will be encapsulated in the Full Service Review which will commence in 2024/25.

Physical Health Checks for people with Severe Mental Illness (SMI)
Work with primary care to review their individual registers of people with SMI.
Review recording to ensure that we are accurately capturing those people who have had both a full SMI check (all 6 elements) and those people who have declined parts of the check.

- SMI registers for all practices have been reviewed in year.
- Plan in development to implement a Locally Enhanced Service (LES) agreement with all GP practices, alongside primary care improvement work
- AWP has continued to provide annual health checks for those service users who are open on their caseload, ensuring that regular checks are completed.

Community Services Framework delivery

- Good progress has been made to deliver nationally mandated community mental health improvements, in line with the NHSE mandate
- Challenges have remained throughout the year in achieving our ambitions for a new model of access to mental health services. This has been as a result of:
  - Securing agreement to the new model and associated ways of working (incl. digital access) – now progressing but some delays have meant this will continue into 2024/25
  - Inability to recruit to ARRS roles which means we have yet to realise a fully 'transformed' model as per the CMHF mandate. Work is underway to review how we can provide support in primary care, whilst not being reliant on secondary mental health staff
- Good progress has been made in developing plans to implement a new approach to Care Planning (using Dialog framework) in collaboration with third sector providers, who are frequently the first point of contact and lead the early support conversation. The intention is to roll this revised approach across BSW in Q3 & Q4 2024/25.

Key deliverables for 2024-26

- Implement the National Quality Improvement Programme for Mental Health across all BSW wards (to run from April 2024 until March 2027) – programme milestones to be agreed
- Implementation of Phase 3 & 4 of Right Care Right Person in partnership with Police colleagues
- Implementation of the Fully Enhanced Model for NHS 111-2 by October 2024
- Go live of Swindon Crisis House and B&NES Place of Calm (capital funding ready to be deployed)
- Further deployment and development of Older Adult roles to support dementia diagnosis to achieve 66.7% rate by end 2024/25
- Delivery of Full Service Review (FSR) for Talking Therapies to achieve revised national standards (currently being finalised as part of operational planning guidance within NHSE) – FSR to be completed by end Q2 2024/25, with new model to be commissioned from April 2025

- Roll out of new Physical Health Checks LES – to be agreed with primary care by end Q2, with the intention to roll out thereafter
- Implementation of new access model by end Q3 2024/25 as per CMHF requirements, to deliver an improvement in the overall 2+ contact rate as per the national trajectory
- Roll out of new care planning approach from Q3 2024/25 to support CMHF delivery
- Procurement of Community Mental Health (non-NHS) contracts to be completed by October 2024, in readiness for contract go live from 1st April 2025.
- Implementation of BSW Mental Health Strategy following its approval via Board and sub-committees in May 2024.

Learning Disabilities & Autism

Delivery Against 2023/24 Plan

Reducing the number of people who are in inpatient care. BSW ICB are the lead commissioning organisation for the new LDA capital build for the North of the Southwest patch covering the BSW, BNSSG and Gloucester footprint. This work covers the whole end to end pathway for people with a further focus on improving and expanding community provision. The planned completion date for the facility, which will be provided by AWP, is August 2025.

We have commenced collaborative work on **transforming our community provision** that will sit alongside the inpatient clinical model and have convened workshops reviewing our community services to set out what we plan to achieve in the next year and what we plan to achieve as part of the community procurement (ICBC)

Delivering annual health checks for people with learning disabilities and autism. This builds on our improvement work during the last year, which provided additional resources for primary care and dedicated health checks in special schools. We have undertaken a pilot in four GP surgeries to support individuals to attend their appointment, which increased uptake and reduced DNA's. Our focus for the next year will include a dedicated communications and engagement plan learning from the pilot and collaborative working with our new health screening clinicians. We hope that with the targeted support and actions set out above we will meet out trajectory overall by year end.

The focus of the **Keyworker service** is to work with children and young people with a Learning disability and/or are autistic with escalating mental health needs. The Keyworker service will work with the children, young people and their families/carers to help them receive the support they need as part of our early intervention and prevention support offer. In BSW, we are piloting this service from within the ICB to test and adapt what is needed before implementing permanently. The team has a caseload of 22 children and young people (March 24) and further recruitment is currently underway.

The localities have undertaken a joined up approach to **implementing the required changes to Dynamic Support Registers and Care and Treatment Reviews (CTR) / Care, Education and Treatment Review (CeTR) processes**. This is a statutory function of ICBs, and is critical to

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

Key deliverables for 2024-26

In addition to those mentioned above, our other key deliverables are:

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

Delivery Against 2023/24 Plan

- **Additional and protected capacity** Modular theatre opened at Sulis in March. In the period March – Dec it has treated 546 patients, including 231 joint replacements.
- The eyecare diagnostic hub opened at the Central Health Clinic in Sept 2023. All diagnostic assessments are performed by technicians
- The majority of the work is for the glaucoma service
- A successful capital bid (£165k) is allowing an increase the equipment in the hub and an expansion of the type of work performed from April onwards
- Through the Acute Hospitals Alliance Clinical Strategy delivery project the following have been delivered:
    - Orthopaedics: Team in place and BSW Sulis model is in development
    - Dermatology: Team in place and 3-year Transformation Plan in place
    - Gastroenterology: Team in place

- **Long wait recovery** The system-wide demand and capacity model has been developed. It is being used to support business planning for next year, and to model capacity requirements for the Salisbury Day Surgery Unit business case.

- **Referrals** All trusts have the inpatient, outpatient and RTT modules of the national Care Coordination Solution (CCS) and we are talking to the national team about creating a system wide version. This is also supporting waiting list validation, with RUH (an earlier adopter of CCS) achieving 100% validation of their waiting list down to 12 weeks.
- Pathway redesign work is being taken forward in 4 areas: T&O; Gastro; Derm; and Urology.

- **Outpatients productivity** Across the 3 acute providers in BSW, outpatient first appointments have increased by 9% in the period April – December 2023/24 when compared with the same period in 2019/20
- Outpatient follow ups across the 3 acute providers have increased by just over 2% in the period April – December 2023/24 when compared with the same period in 2019/20. This reflects a number of issues: 1) on non-admitted pathways it often takes several follow up appointments to stop a clock; (2) there is a follow up backlog in addition to the waiting list; and (3) levels of PIFU across the 3 providers have remained in the 1%-3% range compared to a target of 5%

- **Surgical productivity** BADS day case rates for the system shows an upward trajectory reaching 80% in September 2023 from 73% in March 2023.
- Theatre utilisation has increased from mid-70% to high 70% between March and January.
- Day case arthroplasty rates have increased significantly with particular progress at Sulis, GWH and RUH.

- **Diagnostic productivity** The Hub at Sulis Hospital has delivered 7,927 diagnostic tests YTD in 2023/24
- During the year a new CT scanner became operational; a new MRI scanner exclusively for CDC patients became operational; and the expanded ultrasound and endoscopy offering came online.
- Imaging activity was initially focused MSK patients transferred from the RUH, but has expanded to include CT Head and CT Chest. CDC Cardiology diagnostic tests started in Jan 24.

• At the spokes at Salisbury and Swindon, activity has been delivered by mobile vans located on the acute sites, pending completion of the permanent solution. • There has been a combination of CT and MRI shared mobile capacity across both GWH and SFT from April 23. Endoscopy mobile activity has been delivered at GWH from August 23.
• Continued focus throughout the year on improving cancer performance resulting in trusts expecting to achieve (GWH and SFT) or get close to (RUH) the fair shares number of patients waiting over 62d at 31/3/24

Key deliverables for 2024-26

TBC by planning guidance but likely to be: • Increase activity to c.107- 100% in 2024/25. • No one waits longer than 65 weeks for elective care by September 2024 (?); and waits of longer than a year are eliminated by March 2026 (?). • 95% of patients needing a diagnostic test receive it within six weeks by March 2025. • By March 2025, 80% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
Key areas of focus: • Delivery of SEOC – new capacity at Sulis to open in autumn 2024 • Delivery of further CDC modalities – additional capacity at hub and spokes to open during the course of 2024 • Excellence in basics – continued implementation of standard work for operational teams • Elective referral and coordination centre – 'air traffic control' centre working across BSW to ensure patients get seen as quickly as possible • Pathway transformation – high intensity support areas: Derm; Gastro; Urology; T&O
Cancer: **Faster Diagnosis and Operational Performance** •Operational Performance •Faster Diagnosis – 24/25 changes and Priority Pathways; Skin, Gynaecology. Urology, Breast **Early Diagnosis and Innovation** •Targeted Lung Health Checks (TLHC) •Galleri Interim Implementation Pilot •Faecal Immunochemical Testing (FIT) •Liver surveillance and pilots •Pancreatic cancer **Local and cross-cutting Early Diagnosis delivery** •Screening •Timely Presentation •Primary Care Pathways •Early Diagnosis Initiatives (Innovation) •Health Inequalities **Treatment and care** •Treatment Variation •Living With and Beyond Cancer (LWBC) •Experience of Care

Maternity

Delivery Against 2023/24 Plan

Successful application to be part of national pilot of **Independent Maternity and Neonatal Senior Advocate**. ISA recruited and commenced in post Sept 2024. NHSE Greenlight to commence seeing families within Q1 24/25
Maternal Mental health service (OCEAN) implemented as fast follower for Long term Plan objectives. Successful implementation and evaluation demonstrating significant improvements in PTSD scores and trauma scores following treatment.
Standardised preceptorship package Joint work ongoing in 23/24. Scoping completed with continuing work to agree components of programme across BSW maternity providers. Improvements in retention demonstrated in reduction of turnover rates in BSW to support excellent health and care services but not yet completed.
International recruitment joint initiative across BSW maternity providers. Midwifery degree apprenticeship commenced in 1 provider with others considering. Acute Healthcare Alliance work to map workforce with LMNS input. Business cases for maternity and neonatal staffing to meet Birthrate Plus and British Association of Perinatal Medicine standards in progress
Promotion of Dad's Pad during 2023. Maternity services participated in BSW Safeguarding Under One's audit. Safer sleep policy and pathway work almost complete. Planned BSW system spotlight event for March 2024 to share best practice. 12 maternity and neonatal videos with subtitles for 10 languages co-produced with Maternity and Neonatal Voices Partnership.
Dashboard compilation in progress but not yet completed. Ongoing work dependent upon BI capacity. Maternity providers now progressing implementation phase of single maternity digital system with planned roll-out 24/25.
Continued work to support aim of improved access to provision of essential nutrition for babies- Milk project provision of additional breast-feeding support in area of deprivation supporting prevention of ill health and increasing support.
Maternity and Neonatal Voices partnership supported and embedded within maternity and neonatal services.
Scoping for maternity triage digital application and centralised triage in progress for single point of access. Senior Leadership perinatal culture participation in national leadership training and staff culture surveys conducted. Perinatal Quality Surveillance model in place. Maternity providers continued work to implement Saving Babies Lives Care Bundle and Clinical Negligence Scheme for Trusts to support safe outcomes for mothers and babies.
Mapping of antenatal parent preparation to identify possible potential BSW standardised provision.
Additional staff recruited into maternity services to support treating tobacco dependency and smoke free pregnancy aim to reduce smoking in pregnancy.
Perinatal pelvic health services implemented across BSW system.

Key deliverables for 2024-26

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

1. To complete actions ongoing from 23/24 objectives as described in 23/24 implementation plan in line with three year delivery plan.
2. To align commissioning of services to meet the ambitions outlined in the national 3 Year Delivery Plan for Maternity and Neonatal Services. This includes:
    - Commissioning services that enable safe, equitable and personalised maternity care for the population of BSW. and evaluate using national patient experience measure (PREM) by 2025.
    - Commissioning perinatal pelvic health services (already implemented as fast follower as per Long Term Plan for Health (by April 2024).
    - Supporting commissioning of community perinatal mental health services including maternal mental health services (already implemented as fast follower as per Long Term Plan for Health (by April 2024).
    - To commission, fund and agree staffing levels with trusts for those professions where a nationally standardised tool has not yet been developed (following available national guidance). We will work with trusts and higher education institutions to maximise student placement capacity to support pipeline of BSW Maternity and neonatal staffing.
    - Commission sustainable model for Maternity and Neonatal Voices provision to reflect the diversity of local population ensuring that MNVP leads are remunerated to implement the agreed workplan.
    - This may include delegated responsibility for commissioning of neonatal services from 2024/25.

3. Monitor the impact of work to improve culture within maternity and neonatal services and provide additional support when needed.

4. Use data to compare outcomes to similar systems and identify variations and opportunities for quality improvements. This includes completion of LMNS dashboard for quality and safety to bring together intelligence from providers.

5. Continue ongoing quality improvement actions in line with BSW LMNS Equity and Equality Action Plan including enhancing community links with service users from minority ethnicity communities and those living in areas of deprivation and young parents.

6. Embedded use of ICON across BSW Maternity and neonatal services in line with Safeguarding Under 1's quality improvement workstream. This contributes to reduction of sudden unexpected deaths in infancy in BSW.

7. To participate in evaluation of pilot of Independent Senior Advocate Role (national pilot site) in 2024/25.

8. Share learning and good practice across all trusts in BSW ICS to continue to improve effectiveness of services and improvements in outcomes of women and babies.

9. Oversee implementation of the PSIRF safety improvement plan, monitoring the effectiveness of incident response systems in place.

10. Oversee quality in line with perinatal quality surveillance model and NQB guidance.

11. Complete implementation of Saving Babies Lives Care Bundle and monitor outcomes with aim of reducing stillbirths and neonatal deaths in pregnancy.

12. Oversee and be assured of provider trusts declarations to NHS Resolution for Maternity Incentive Scheme. Compliance with this results in rebates in CNST payments contributing to financial plans.

13. Monitor and support trusts to implement national standards whilst commissioning care that has regard to NICE guidelines with updated service specifications to provide high quality care in line with national guidance.

14. Have a digital strategy for ICB which includes maternity and neonatal and support implementation of one system across BSW maternity providers.

15. Continue to support preventative programmes of work within maternity and neonatal services which contribute to increasing life expectancy, reducing ill health and reducing inequalities in care. This includes:
    - Treating tobacco dependency (smoke free pregnancy) – ensuring embedded and monitoring of outcomes throughout 24/26 to reduce smoking in pregnancy to below 5%.
    - Infant feeding – supporting safe infant feeding and promotion of breastfeeding in line with BSW Infant feeding strategy objectives. This reduces admissions to paediatric wards due to reduced rates of infections in babies and young children.
    - Pre-conception provision review to identify any opportunities for improvement in 24/25
    - ATAIN project reducing separation of mothers and babies improving attachment bonds between mothers and babies and reduced length of stay in hospital.
    - PERIprem project optimising outcomes for premature babies – improving outcomes for babies to optimise development and reduce risk of ongoing ill health that impact on health, education and care services long term.
    - Focus on preventing pre-term birth- majority of disability is associated with pre- term birth with significant impact on the family unit -emotionally, physically and financially therefore reducing pre – term birth has the potential to reduce both health and financial burden on the family and healthcare system.

11. Children & Young People

Delivery Against 2023/24 Plan

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

Key deliverables for 2024-26

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

Special Educational Needs and Disabilities - We will hear the voice of children and young people, their parents and carers. We will collaborate with social care, education and local authorities to make sure that children and young people with SEND are supported across BSW.
Early intervention will support better experience and outcomes for Children and Young People and their families, and support a reduction in acute presentations and poorer outcomes. A focus on long-term conditions will support planning and delivery of excellent health and care services for Children and Young People and their families.
Work with key Boards and Delivery Groups to ensure children and young people are planned for in our hospital (acute), primary and community provision
Address identified gaps in Paediatric Palliative Care with Hospices, VCSE organisations, clinical colleagues and including the voice of Parent Carer Forums, parents, carers, children and young people to map provision, identify gaps and the pathway for Children and Young People in BSW with life-limiting conditions and palliative care needs
Embed paediatric expertise within community/primary care to (i) drive earlier intervention (ii) support better self-care for Children and Young People and their families / carers (iii) support Children and Young People with long term conditions and complex needs (iv) move care out of hospital where appropriate. Establish a Connecting Care for Children approach that brings together a multi-disciplinary team across primary, secondary and community services, enabling Children and Young People to be treated and receive advice and guidance in their community. Implement an initial 'test and learn' site within one PCN, based on number of 0-15 years olds within Core20 population. Rollout across BSW over two years.
Deliver BSW CYP Strategy underpinned by the voice of children and young people with BSW CYP Programme Board's leadership and collaboration and an audit of current BSW ICB delivery Continue to use the CYPCore20PLUS5 framework to deliver a targeted approach and drive data-led improvement in population health and inequalities Improve links across BSW programmes to maintain focus on babies, children and young people 0 to 25 years and prioritise the CYPCore20PLUS groups **Youth Voice -** Develop a delivery plan for how Children and Young People voice will be meaningfully embedded in our work across BSW. **Data -** Develop a Children and Young People data dashboard and setup ongoing reporting through appropriate BSW Programme Boards and continued development of a case for change

Child and Adolescent Mental Health Services

Delivery Against 2023/24 Plan

• We increased our digital offer (via Oxford Health working with Healios) to provide earlier supported access to CAMHS – this has enabled us to achieve an improvement in access rates throughout the year. Reporting has remained a challenge for Oxford Health following the cyber-attack in 2022, which has meant visibility of performance has been more difficult. Oxford Health uploaded all historic activity information for 2022/23 into the Mental Health Services Dataset by October 2023 (as per NHS England requirements) and is now retrospectively updating activity information for 2023/24. We anticipate that full performance reporting will be back in place by 1st April 2024. • Our new Swindon offer went live (partially) in October 2023 – commissioned from ABL Health. This includes provision of the Mental Health Support Teams (MHSTs) in Swindon. ABL Health

will be providing a Single Point of Access to mental health services across Swindon from April 2024.

- Operating as Be U Swindon, ABL also now provide an online resource offer for parents, children and young people. This enables self-referral, as well as access to online support and advice.
- Oxford Health NHS FT have launched their procurement of a third sector partner in each locality – this is underway and to be finalised in the final quarter of 2023/24. It is anticipated that once live, this will again provide improved access to early help and support for children and young people.
- Mental Health Champions have been appointed within each of our 3 acute providers. These have been funded for a period of 2 years by NHS England. Job descriptions are being developed and finalised for these roles, with a strong focus on training and support for wider paediatric team colleagues.
- We have provided capital investment to support the development of the Children's Emergency Department in Swindon. Work is progressing to support the creation of an environment that is more suitable to assess children and young people with mental health needs. This will be operational from 2024/25 as the work on the front door at GWH is completed.
- ALPINE continues to be rolled out across our acute providers. Alongside this we continue to work within the Thames Valley Provider Collaborative for CAMHS to support the development and improvement of inpatient CAMHS provision across our BSW footprint. This includes the further development of Hospital@Home models.

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

Key deliverables for 2024-26

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

12. Financial Recovery

[section still in development]

We are making financial recovery one of our key objectives for the next two years. This will mean working together to develop a financial recovery plan that delivers the savings we need to make whilst ensuring we can provide high quality services to our population.

Delivery Against 2023/24 Plan

All NHS organisations that make up an ICS have a mutual obligation to work to deliver financial balance as a system. It is likely that the ICS will end 2023/24 with a financial deficit. The ICS has entered financial recovery during 2023/24 but it will be a multi-year recovery programme. We have taken collective action to control costs this year. Measures delivered include:

- Triple lock in place for any investment > £50k
- System vacancy control panels in place
- Voluntary introduction of NHSE forecast protocols in early 2023/24
- Recovery Board in place
- Workforce cost & WTE movement review (since 2019/20) undertaken
- Investment review (since 2019/20) completed
- Safer staffing review ongoing
- Full balance sheet reviews undertaken in Q3 2023/24.
- 23/24 Agency plan has over delivered with a plan to reduce by 35% by M12 and already delivering 59.5%

Key deliverables for 2024-26

Financial planning for 2024/25 indicates that the year will be even more challenging financially. The financial recovery programme initiated during 2023/24 will be a multi-year recovery programme with three key strands of work.

1. Savings Delivery. In 2024/25, organisations are targeting 5% efficiencies for 2024/25 which will be c.£100m. The programme will have continued focus on improved delivery of efficiencies.
2. Cost Controls. The programme will ensure continuation of the cost control measures put in place in 2023/24.
3. Delivering the benefits of our system transformation projects to include:
    - Impact of our UEC transformation projects at ICS level including virtual wards, care-co-ordination, transfer of care hubs in alignment with our BCF & work with system partners.
    - Impact of closer working and sharing of best practice in elective care
    - Further improvements in productivity up to upper quartile – specifically Gastro; Dermatology; Urology
    - Prevention – focus on hypertension for next two years

In addition, we have some large-scale work programmes underway that should bring benefit in subsequent years of the financial recovery through our integrated community transformation programme.

13. Enabling Workstreams

Workforce

Delivery Against 2023/24 Plan

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

Key deliverables for 2024-26

- Completion of a BSW People Plan.
- Roll out of Calderdale workforce transformation tool against 4- 5 agreed projects focused on creating new ways of working and improved productivity.
- Delegation of health care activities project to be completed for domiciliary care
- Supporting the necessary workforce transformation required for BSW community and primary care programme.
- Identifying and developing new shared training solutions for collective system partners for scaling of offer and effective use of resource including ongoing mobilisation of the Oliver McGowan training.
- Working with region and local partners to develop sustainable and affordable models for an increasingly grow our own training model and collaborative apprenticeship opportunities.
- Continuing to build strategic partnerships with education partners for employer led models of education that increasingly attract from local communities and train a workforce with future focused skills.
- Evaluation of health and care ambassadors and design of a school engagement map and identified points of contact to enhance communication and relationship building.
- Increase education and clinical placement capacity, with a focus on community and primary care

• Development of integrated career pathways and improved opportunities for moving easily across organisational boundaries. • Design of a BSW wide leadership and management framework based on supporting leaders to lead and manage their teams.
• All trainee pharmacy posts will be cross sector in 2026 and improve retention of workforce • Actively use the skills of community pharmacists to move services closer to home • Work towards pharmacy roles which respond to expertise shortages and support medical consultant shortage

Financial Sustainability and Shifting Funding to Prevention

Delivery Against 2023/24 Plan

- In 2023/24, we undertook extensive financial planning work to refresh the underlying financial deficit position which stood at £109m in May 2023. Building on this, the NHS system delivered a 3-year financial plan which balanced finance, quality and performance, returning to a sustainably balanced position by 2025/26.
- The 3-year plan is based around our system recovery programme which comprises six themes and is focused on working together to improve patient care through productivity, efficiency and innovation and is achievable and deliverable based on our benchmarking of productivity and efficiency opportunities.
- In 2023/24, we are forecasting to miss our plan by £9.9m plus the impact of industrial action, driven by the costs of agency staff, pay cost growth and drug price increases. We expect to deliver £95m of efficiency savings, 1.3% under the plan.
- The plan included creation of an investment fund for service improvement and innovation in line with our strategic plan to invest in prevention and early intervention. BSW has not yet baselined prevention programmes and spend across the ICS, the focus has been to ensure redistribution of funding into prevention and early intervention in 2023/24.
- BSW NHS finance teams have achieved systemwide HFMA Future Focussed Finance accreditation level 1, this nationally recognised standard supports strengthening of good processes, practices and controls.

Key deliverables for 2024-26

- Investment fund to increase measures delivering prevention and early intervention – May 2025
- Prevention Baseline – March 2025
- Investment Assessment Criteria aligned to the 3 outcomes – May 2025
- Deliver years 2&3 of 3-year Financial Recovery plan – March 2026
- Deliver existing financial plan including recurrent efficiency schemes – March 2025.
- Achieve HFMA Accreditation Level 2 – March 2026

Technology and Data

Delivery Against 2023/24 Plan

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

Key deliverables for 2024-26

- The EPR programme will move into implementation following the confirmation of support from NHSE national team.
- The ICR programme will increase the number of connected partners to the shared care record and increase the benefits derived from the record through increasing utilisation.
- Increase usage of patient facing digital tools focusing on adoption of NHS App uptake and usage, evidenced by national NHS App reporting.
- Once Cloud based telephony is in place across practices in Spring 2024 ensure benefit are realised by ensuring practice make the most out of new functionality available, ultimately reducing patient telephone wait times and increasing satisfaction
- Continue to ensure strong cyber security is in place with increased board awareness.

- Review GP IT support arrangements across the ICB to create a single sustainable consistent service
- The System Intelligence Programme is under review in early 2024 however the proposed focus during 24-25 is:
- Generating Insight - focus on generating more population-based insights to support BSW Priority Programmes. Better resourcing population health analytical work and advanced analytics to embed it within priority work. Ensuring analysts across all domains have the time and skills to produce more meaningful insight.
- Capability & Capacity - Embedding the National Competency Framework for Analysts across BSW organisational BI Teams in collective fashion.
- Data & Infrastructure - focus on the development of the BSW data infrastructure, making data more accessible across organisations using resourcing from the regional Secure Data Environment for Research.

Population Health Management

Delivery Against 2023/24 Plan

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

Key deliverables for 2024-26

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

Estates of the Future

Delivery Against 2023/24 Plan

- The ICB working with Primary Care across BSW has completed the Primary Care Network Toolkit (PCN Toolkit). This work is now collated to provide list of future estate investments needed over the next 10 years.
- As part of our system and collaborative working, the BSW Estate Board has agreed its plans for the future transformation of estates and the way in which estate functions are delivery in the future. This will focus on 4 key areas, where we can work at scale across the whole of our system with shared resources, how we delivery services jointly including cleaning, linen, and catering; and the general management and maintenance of the estate.
- We concluded our review of the existing community estate and how well it is being used, this resulted in a number of changes to we will be looking to implement as part of future service delivery to ensure we are maximising the use of our estate further and creating more opportunities do dispose of estate that is coming to its end of life and using what remains more effectively or developing new buildings where there is need. We recently opened the new Devizes Health Centre in February 2023, enabling us to dispose of the old Devizes Hospital site, which provides additional capital we can reinvest into new premises or to improve existing ones.
- We piloted a new activity data estates planning toolkit (ADEPT), this will help us understand the current and future estate requirements for services.
- The work to develop and approve our Infrastructure / Estate Strategy was paused in September 2023. This was to enable the important work we have been doing in the delivery of the PCN Toolkit and the development of ADEPT, can be completed, which will help shape what goes into our final Infrastructure / Estate Strategy, which we are looking to complete and publish in the next 12 months.

Key deliverables for 2024-26

- We are improving the way we use space by removing organisational barriers that used to allocate rooms to individual organisations or services to one based on sharing space and increasing utilisation across all settings to maximise the use of our investments.
- Our workforce will be able to work across different locations, consolidating back-office functions and changing the way that we work, reducing unwarranted variations in provision of estate services and automating manual processes.
- With the completion of the PCN Toolkit and ADEPT Toolkit, we will be able to complete the development of the BSW Infrastructure / Estates Strategy which will help inform futures investments and support better utilisation of the estate.

We will focus on four key areas of work over the next 12 months, which will support delivery of Excellent Health and Care services.

1. Integrated Estate Management & Assurance Function (Developing a single estate management function that manages the estate across for our hospitals and health centre premise)
2. Soft Facilities Management Delivery (Cleaning, Linen, Catering and Waste)
3. Hard Facilities Management Delivery (Maintenance, improvements, and plant)
4. Utilisation, Rationalisation and Disposals (How we use our buildings well and dispose of buildings no longer needed to support their sale).

Environmental Sustainability

Delivery Against 2023/24 Plan

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

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

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

Key deliverables for 2024/26

The Greener BSW PDG remains committed and continues to meet monthly to progress our commitments and overcome shared challenges. A selection of actions for delivery by our partners (within the scope of the Green Plan requirements) over the remainder of the Green Plan delivery period, in addition to those listed above, are outlined below:

- Reduction in carbon impact of care models
- Staff have access to sustainability training/sustainability information within their induction
- 100% paperless or, if essential, using 100% recycled paper content within all office-based functions
- Reduce the use of all single use plastic items within catering services
- 25% of outpatient appointments conducted as virtual appointments online, where clinically appropriate

We recognise that our BSW Green Plan (2022-25) needs to be refreshed at the end of 2025. We have therefore taken proactive steps to start planning what the next iteration of our Green Plan needs to include so we can re-evaluate the sustainability vision for our system and identify key areas of focus.

Although we will continue to work towards the achievement of a Net Zero NHS by reducing our emissions across our NHS fleet, estate, and supply chain; we acknowledge that we will also have an opportunity to review our existing commitments and potentially identify new areas for focus such as health inequalities and anchor institutions.