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

Integrated Care Board

Calne Area Board 05th December 2023

Jo Cullen, Director of Primary Care

To Cover:

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

- Integrated Care System (ICS) overview
- Neighbourhood Collaborative
- Pharmacy, Optometry and Dental Services
- PCN
- Demographics
- Premises

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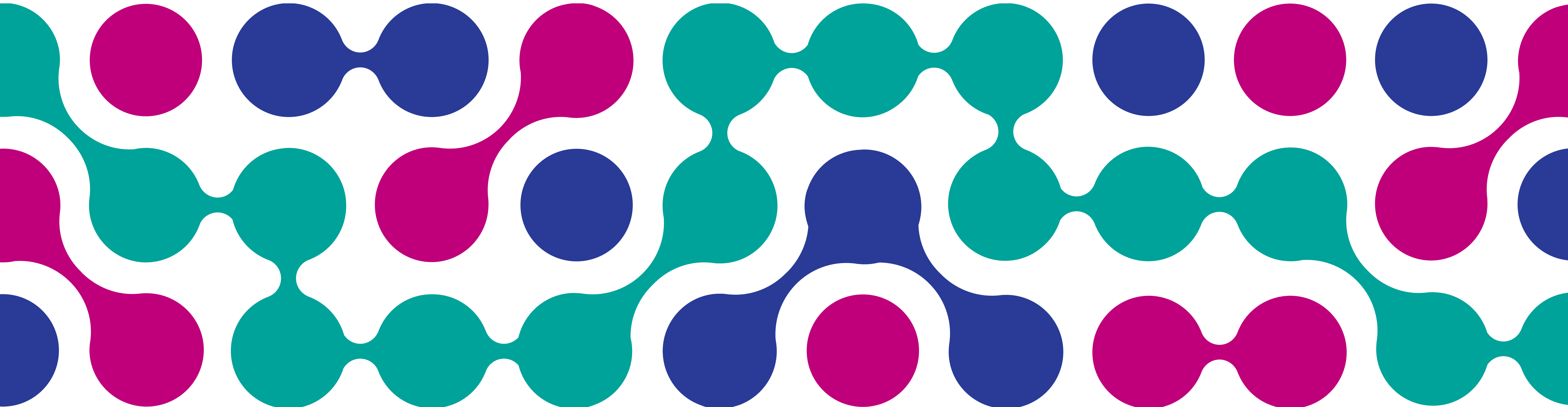
Integrated Care System (ICS) overview



How the BSW ICS is made up

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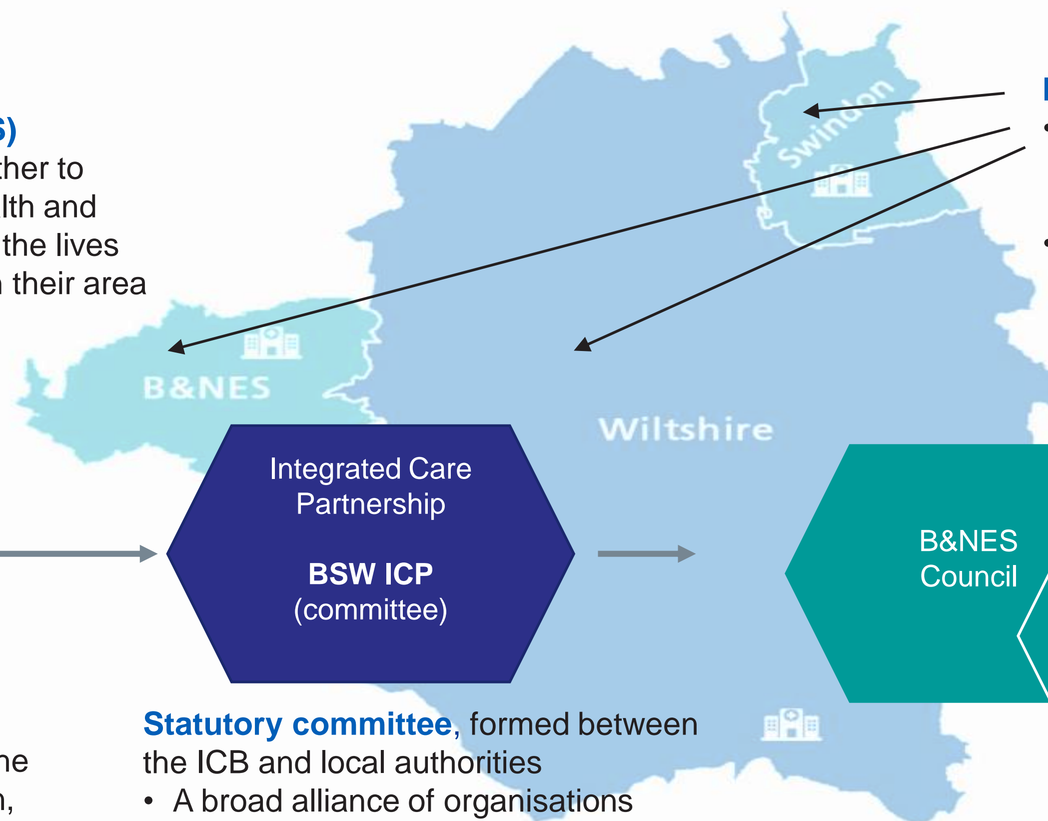

Integrated Care System (ICS)
Organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area

Integrated Care Alliances (ICA)
- Place-based partnerships of NHS, councils, community and voluntary organisations, local people, carers
- Lead the design and delivery of integrated services at place

Statutory NHS organisation
- Develops a plan for meeting the health needs of the population,
- Managing NHS budget
- arranges for the provision of health services in BSW

Statutory committee, formed between the ICB and local authorities
- A broad alliance of organisations concerned health and wellbeing of the population
- Author of the Integrated Care Strategy advocate for innovation, new approaches and improvement

Local Authorities
- Responsible for social care and public health functions and other services for local people and businesses

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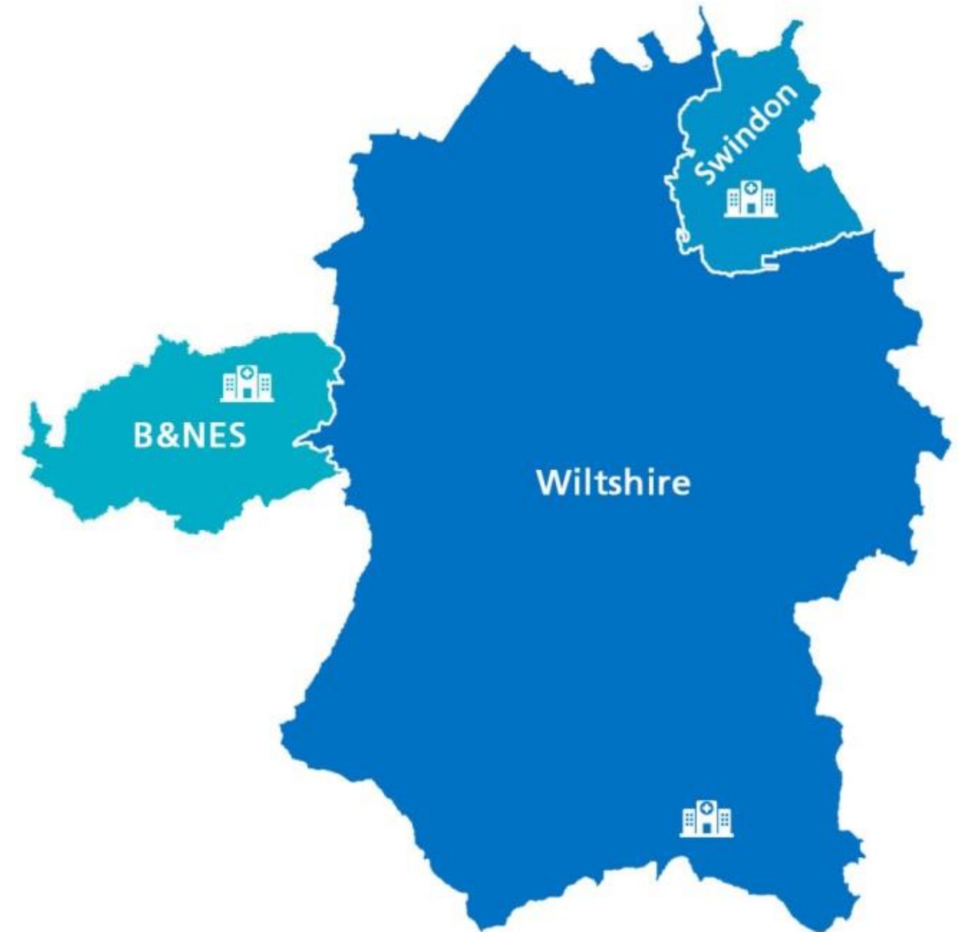
Who we are

- We serve a combined population of 940,000
- We directly employ 37,600 colleagues and benefit from the contribution of many more carers and volunteers
- We are made up of 87 GP practices, 27 Primary Care Networks, two community providers, three acute hospital trusts, two mental health trusts, an ambulance trust, an Integrated Care Board (ICB), three Local Authorities, 2,800 Voluntary, Community and Social Enterprises



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Our purpose

- The changes to the way we organise services are important steps in our journey to become a thriving integrated care system by 2023 and contribute to our core purpose

Our vision: Working together to empower people to lead their best life

- Provide better joined-up care
- Enhance productivity and value for money
- Help the NHS support broader social and economic development
- Reduce health inequalities

Areas of concern in BSW

180,000 people have some form of mental health condition

156,000 people have three or more long-term conditions

Nearly 6% of the population has diabetes

85,000 people aged 65+ receive ten or more regular prescriptions for medicines

100,000 adults are smokers

(Taken from BSW Partnership 'NHS Long Term Plan - internal intelligence briefing' 2021)

Our vision: Working together to empower people to lead their best life

Plus, a wide range of voluntary and community sector organisations that help provide invaluable support to our populations and our health and care services

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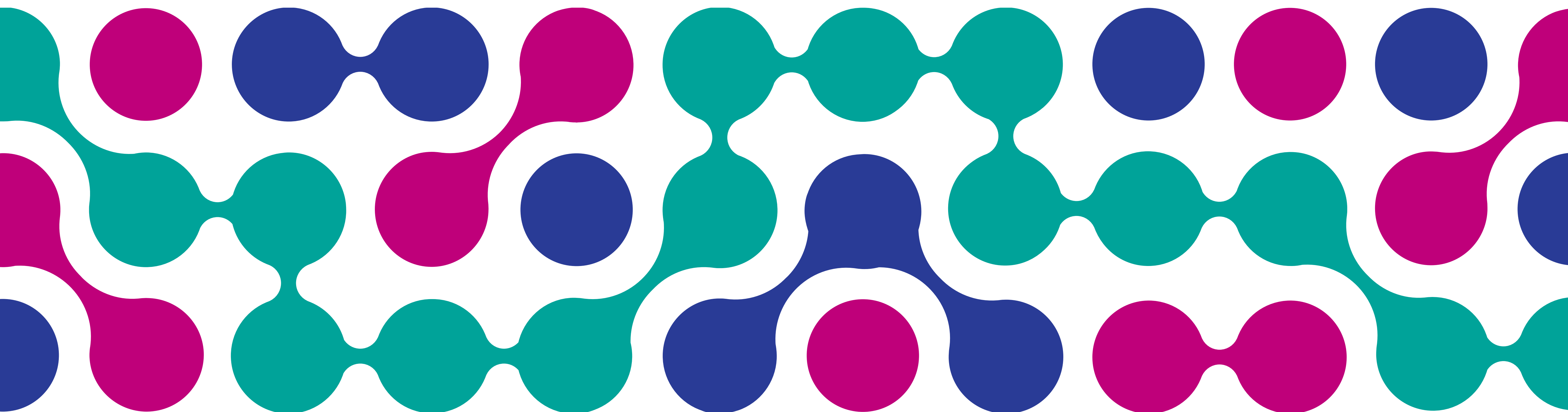
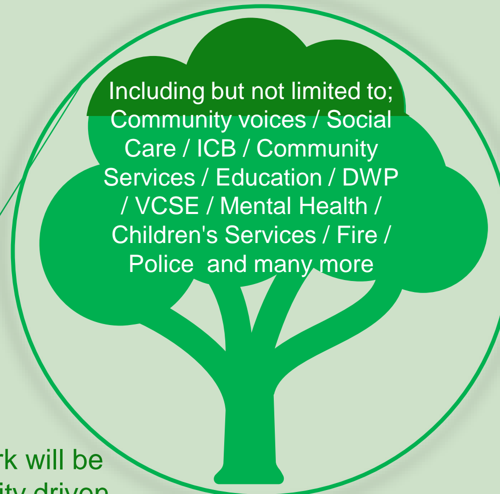
Neighbourhood Collaborative



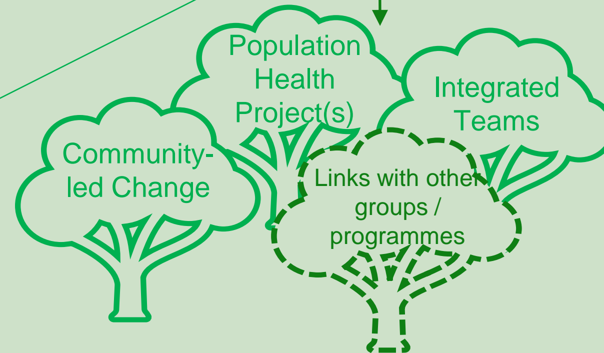
Neighbourhood Collaboratives

BSW Programmes and Regional Forums
Learning and Sharing beyond Wiltshire borders and across programmes.

Wiltshire Neighbourhood Collaborative
Learning and Sharing across Wiltshire and between Collaboratives, Focussing on Population Health and Wellbeing Gaps through prevention and strengths-based approach. Links with Health and Wellbeing Board



Most work will be community driven – some change Wiltshire -wide



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

ENABLERS

Readiness Review
Helps grow a baseline understanding of what's working well and what areas would benefit from more support.

Launch Programme
Brings everyone together – puts the foundations in place for sustainable, successful relationships and outcomes.

Toolkit
Already available. Plans to develop further and integrate with other programmes. Will include different ways to access knowledge and training including videos and bite size learning. Supports launch programme.

Co-Production Training
Offered via Academy and Wessex Community Action

SIX CORE PRINCIPLES SUPPORT THE COLLABORATIVES

1. Partnership working – building relationships, agreeing vision and structure.
2. Co-production – community engagement and participation in telling us what to improve and how to improve it.
3. Whole community approach to addressing equality gaps in health and wellbeing - taking a population health and continuous improvement approach with a focus on prevention
4. Integration to create the community led vision - using data, insight and intelligence in new ways to identify focus areas, working through prevention lens.
5. Enabling volunteers and staff to thrive – what are they telling us, what's their experience and how can we work together in more integrated ways?
6. Creating a movement for change – establishing your collaboration for a sustainable future.

Collaboratives

Neighbourhood	Highlights
Trowbridge site	(initial pilot) continues with its work in preventing increases in the housebound population. HI and NC project team met with Trowbridge on 2/08/23 to discuss current project work and again in October – plan in place to establish a broader collaborative group and commence launch programme.
Melksham and Bradford on Avon	Pathfinder site – quick testing and learning from the model and will be able to share the learning to inform the tools and the approach that will be used by other sites. Coproduction training has taken place with an additional date booked. Feedback from the training will be used to help identify our baseline awareness of Co-production within the locality which should help to identify areas of future need. Cohort identified: Previously unidentified people as first of a first serious fall – aiming to reduce prevalence of serious first falls and subsequent ambulance attendances / hospital admissions. • Mapped and collected existing falls prevention resources across MBoA – will share example • Engagement with the identified group of patients is nearing completion – utilising co-production • Delivery of the Development programme, (an adaptation of the Launch Programme), happened 27/11/23
Devizes community partners and PCN	After a period of engagement with partners in this neighbourhood and plans to focus on children and young people, the project team are stepping back. The PCN are taking forward their own programme of work. Partners outside of the PCN have expressed ambition to continue to work together which the project team are exploring.
Chippenham, Corsham & Box (CCB)	PCN have considered areas of interest and undertaken data analysis with the Health Inequalities team. The early stages of this collaborative are progressing well and there is a structure of meetings in place. The Readiness Review has been completed – launch programme due early 2024. Reducing Hypertension is initial area of focus.
Salisbury PCNs	Three of the four Salisbury PCNs (offer to join will be extended to the 4th PCN area) have proposed a Salisbury-wide approach to developing a Collaborative. This will be taken forward – next step is to undertake the Readiness Review.

Actions and Next Steps

RISKS

- New way of working – challenges accepted norms and requires commitment to continue progress.
- Extraordinary operational demands divert operational capacity away from NC development.
- Long term development and vision – requires belief and support for longer term benefits. Risks losing engagement.
- Perception that funding is required to move to this way of working – seen as ‘additional’. This is not the case; it’s about how we make use of expertise and resources together.
- Consistent messaging from leadership needed to reinforce change in cultural and behavioural values and enable Neighbourhood Collaborative to thrive.

NEXT STEPS

- ‘Firm up’ the initial plans for current collaboratives and confirm progress.
- Establish outline ambitions for moving across Wiltshire and a road map
- Complete development of Launch Programme and offer to additional neighbourhood areas.
- Demonstrate connection to other work steams – all interconnected
- Complete initial MBoA cohort and share learning.
- Develop plan for future Wiltshire meetings – including schedule of national speakers.
- Explore opportunities for learning and support with B&NES and Swindon – joining up our work where alignment is identified
- Continue to develop and refine comms and engagement plans.
- Develop and share plans for the £100k Health Inequalities funding that the programme has been awarded to develop engagement best practice collaborative model and support interventions around Core20Plus5 cohorts.

Wiltshire Alliance Priorities – key highlights

- Development of Neighbourhood Collaboratives across Wiltshire
  - aligned to PCN footprints with population-health and wellbeing, prevention focus.
- Alliance Delivery Sub Groups established
  - Living Well – long term conditions population health focus
  - Mental Health, LD and Autism; driving local improvement
  - Ageing Well and Urgent Care; including improving discharge services performance and other key work programmes.
  - Families and Childrens Transformation; implementing family help hubs and wider programme
- Community Services post 2025
- Carers – improving recognition and support
- Joining up service commissioning
- Targeting outreach activity
- All priorities are detailed in the Joint Local Health and Wellbeing Strategy Actions and BSW Implementation Plan.

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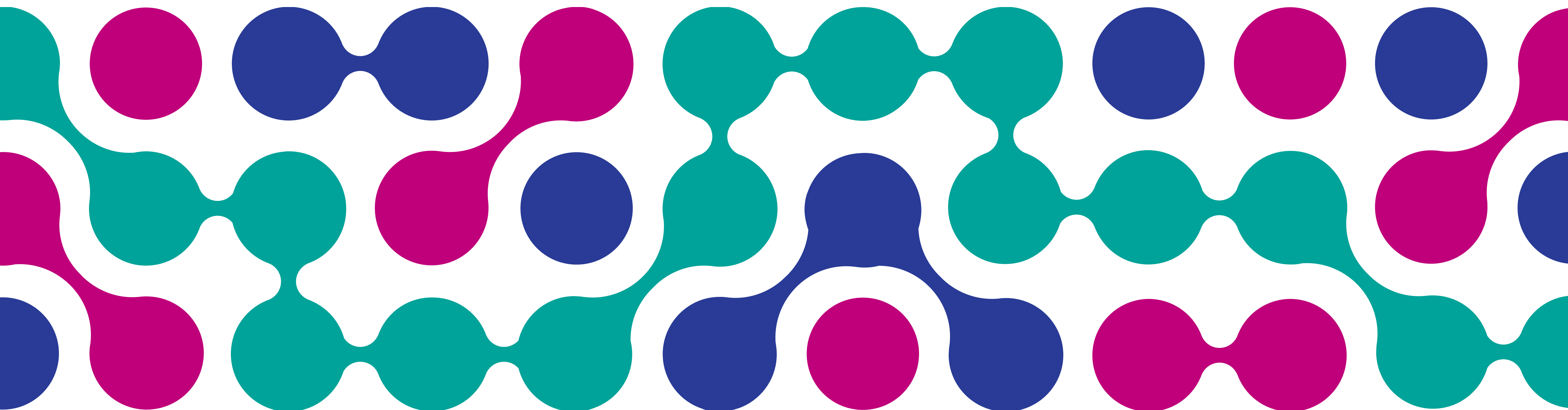
Pharmacy, Optometry and Dental Services



POD Delegation Opportunities for BSW

- The ability to be ***locally responsive*** to population health needs and commission services accordingly.
- A tailored approach working with partners to respond to ***health inequalities*** and ensure a focus on ***preventative care.***
- Transformation and pathway integration – greater ability to ***integrate these services into local transformation*** and system working both within the place and system agendas and to incorporate these services more fully into a ***local primary care strategy.***
- The ability to develop ***closer relationships*** which can then support ***increased partnership working*** at all levels further integrating care delivery in Primary Care Networks
- The opportunity to build a more ***integrated clinical and professional leadership model*** which reflects the wider primary care system.
- The ability to involve the wider primary care services in developing approaches to ***quality improvement*** and supporting ***wider primary care resilience***.

All contributing to:

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

Expanding Community Pharmacy Services

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Community Pharmacy has been seen as an **essential part of primary care** offering patients easy access to health services in the heart of their communities. As **over 80% of patients live within a 20-minute walk of their pharmacy** who give expert clinical advice.

Building on the success of the existing services outlined in the CPCF delivered by Community Pharmacy - this plan wants to **expand the range of services** offered making **better use of** the **clinical skills** in community pharmacy, making them the **first port of call** for patients for many **minor illnesses.**

IT System Connectivity - work with community pharmacy suppliers and general practice IT suppliers to develop and deliver interoperable digital solutions

What does this mean for Community Pharmacy?

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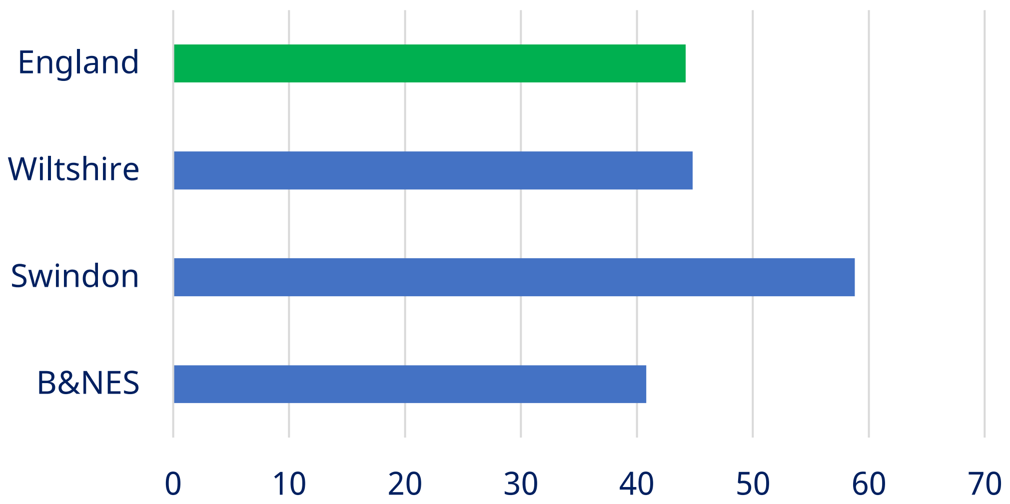
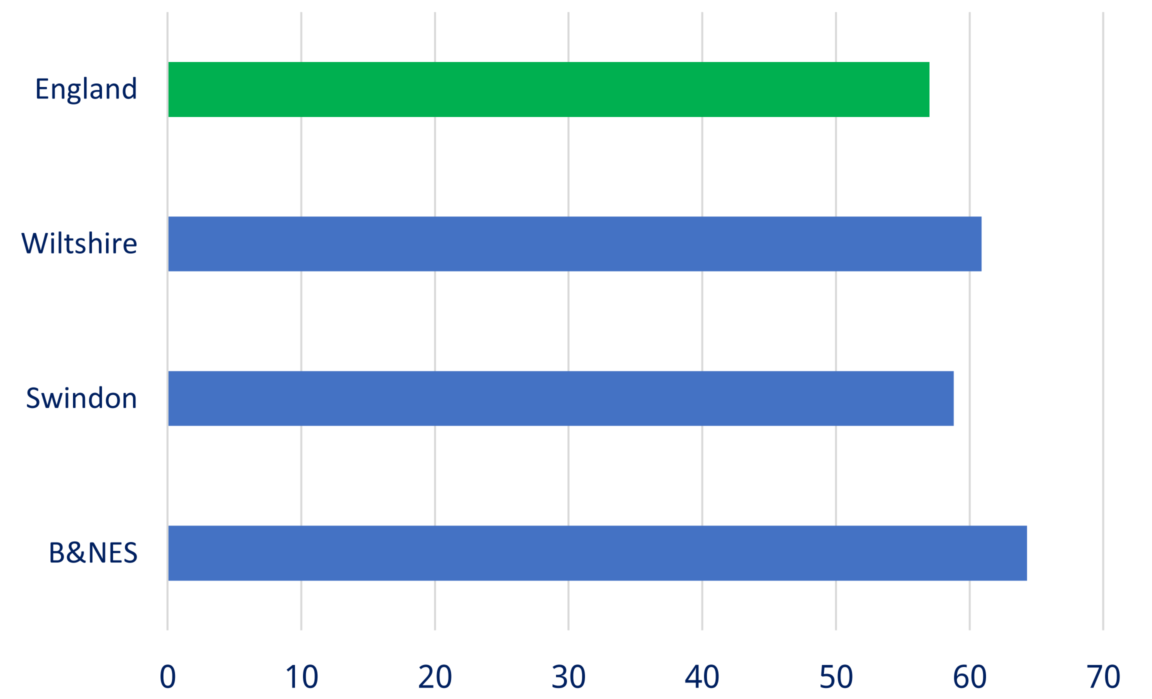
- **Common Conditions** - Pharmacists to **supply prescription only medicines** (POMs) including **antibiotics and antivirals** where clinically appropriate, treating **seven common health conditions** – without the need for the patient to visit the GP
    - Uncomplicated UTIs
    - Shingles
    - Impetigo
    - Infected Insect Bites
    - Sinusitis
    - Sore Throat
    - Acute Otitis Media
  - **Our already commissioned local service in BSW (a PGD Service) puts us in a great place for this!**
- **Hypertension Case Finding Service** - Further funding for Community Pharmacies to support the ongoing monitoring in partnership with GP Surgeries has been agreed
- **Oral Contraception Service** - Further funding for Community Pharmacies to support the ongoing monitoring in partnership with GP Surgeries has been agreed
- **Independent Prescribing Pathfinder**
  - Establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care.
  - To **identify the optimum processes including governance, reimbursement and IT requirements** required to enable independent prescribing in community pharmacy
  - BSW will have **5 sites**, and the model will be prescribing for minor illness (CPCS+)

Access to Dentists



Data from NHS Digital – percentage of children not accessing NHS dental services as of June 2022 (NHS Digital, 2022)

Data from NHS Digital – percentage of adults not accessing NHS dental services as of June 2022 (NHS Digital, 2022)



Adults 17-64 years

Population mid-2030

- 1.3 % predicted growth to 40.8M

Main disease

- National data shows marked inequalities in people's experience of oral cancer, tooth decay, gum disease and tooth loss.
- 27% had tooth decay and 53% had gum disease, 18% had pain (Adults in Practice survey 2018)
- Oral health inequalities (deprivation, ethnicity, health inclusion groups)
- Oral cancer mortality rate is 4.3 per 100,000. Rates range from 2.14 per 100,000 in South Hams, to 6.73 per 100,000 in Plymouth (England average 4.54 per 100,000)

Dental care

- Adult patients seen in previous 24 months is 35% in Southwest*

*NHS Dental Statistics: 2022-23

Oral healthcare requirements

- Community based empowerment and support for inclusion health groups
- Preventive care (DBOH) & risk based recall
- Easy access to dental care
- Easy access for special care dentistry groups
- Easy access for HI groups (more than one type of model is required, HI models cost more but reduce oral health inequalities)
- Specialised networks of care: consultant-led

65+ years: diverse population

Population mid-2030

- 20% predicted growth to 15 M
- And 137.5% increase 85+yrs

Disease and conditions

- Most have some natural teeth
- Caries risk increases ≥60 years
- Periodontitis increases with age
- Heavily restored dentitions including implants
- Tooth wear: natural and pathological
- Head and neck cancers

Dental service use

- 50.5% of 65+ used NHS dental care in last 24mths cf 27% privately
- 62% of 69-70yrs has used NHS
- Private care increases with age and
- 44% privately ≥85 years

Other challenges

- Long term conditions, co-morbidities, polypharmacy, etc
- Reduced manual dexterity
- Multiple hospital/medical appointments
- 1 in every 14 of the population ≥65 years will have dementia
- 5-6% in care homes (16% of adults 85 years and over)
- Dependence increases with vulnerability

65+ years: diverse population

- The Care Quality Commission's report: Smiling matters: Oral health in care homes - 2023
- CMO Report 2021: Rural and Coastal Inequalities:
  - Higher density of older persons in rural and coastal areas
- CMO Report 2023: Health & Ageing Society:
  - Maintaining care home residents' oral health is an essential foundation for good nutrition and therefore QoL
  - Services must be tailored and located to meet needs of older people
- Recommendations for an integrated Oral Health and Dental Care Pathway for Care Home Residents:
  - Produced by SW Dental Public Health team (2023)
  - Available from zoe.allen4@nhs.net

Oral healthcare requirements

- Self care/assisted care (Mouth Care Matters)
- Prevention in all policies
- Team approach using skill mix
- Competent skilled workforce to provide a wide range of dentistry including domiciliary, special care, restorative and dementia friendly
- Range of models of care for vulnerable adults
- Networks of care (including specialists in special care, gerodontology and domiciliary services)
- Oral health care for end of life

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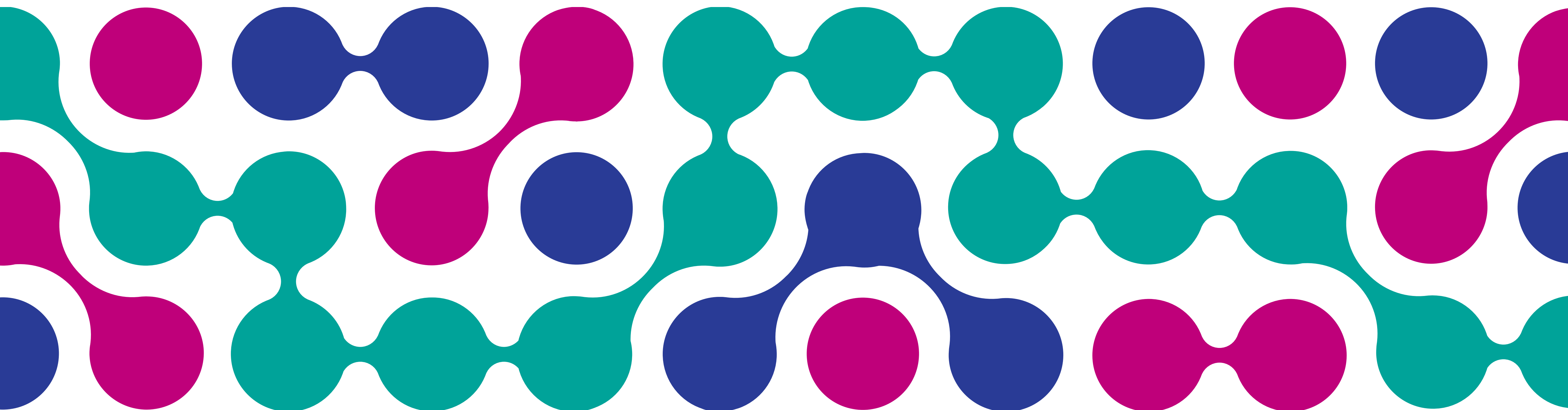
PCN Update



GP Access Recovery Plan

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Why we need the plan:

- General practice is under immense pressure, with demand outstripping capacity in many areas. This negatively impacts patient access and experience, which in turn can shift pressure to other parts of the system as patients seek alternative routes to access care.
- The ageing population is a key driver of the increase in pressure as the majority of over 70s live with one or more long term conditions.
- The pandemic also contributed to the changing nature of demand with the COVID–19 backlogs contributing to a 20-40% increase in patient contacts with practices.
- Though the general practice workforce has grown by 27%, the net number of GPs has lagged behind, and the impact of measures to increase the number of GPs have not yet been felt in practices.
- Existing GPs are under greater pressure, managing larger practices, supervising ARRS and trainee GPs, estimated to take up to 20% of GP time, in addition to core clinical responsibilities.
- As demand rises, patient satisfaction is falling across 99% of PCNs, with the greatest decreases being linked to difficulty booking an appointment.

To tackle the increasing demands on Primary Care the plan focuses on four pillars:

1. Empowering patients

2. Implementing Modern General Practice Access

3. Building Capacity

4. Cutting Bureaucracy

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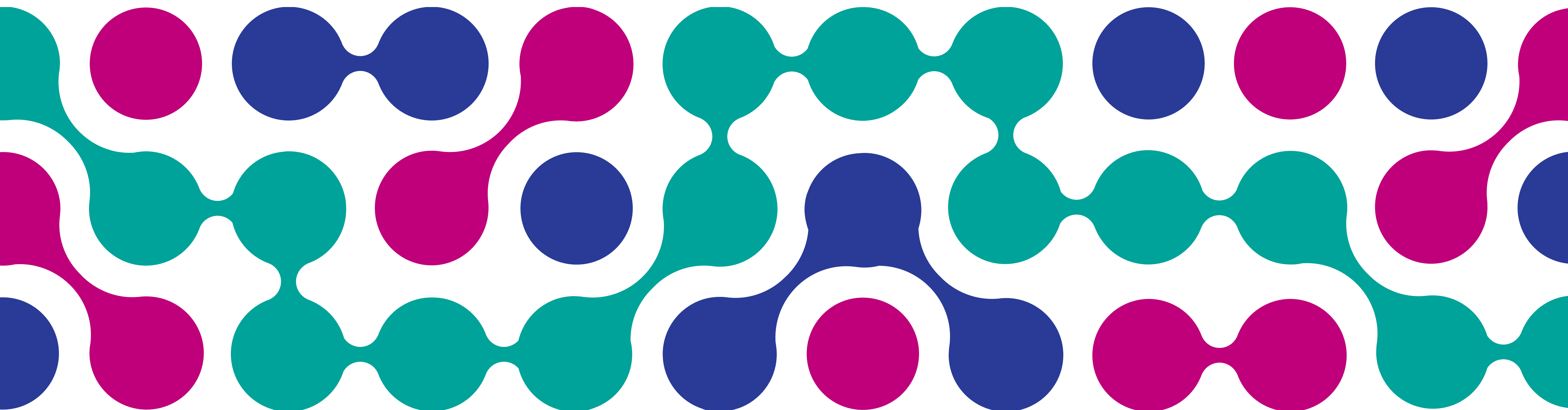
Premises

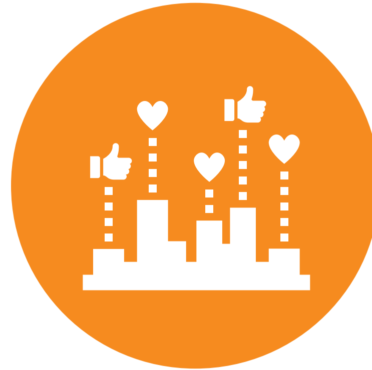


PCN Toolkit – What is it and why are we doing it ?

This is a national programme endorsed by Department of Health and Social Care, which was developed by NHS England into the development of a PCN toolkit, which would help support decisions on future investments into the Primary Care Estate that enables delivery of the left shift and wider prevention initiatives. It is not mandatory for PCN to participate, but NHS England will not support any business case or investments into primary care for those PCNs and practices within it who have not completed the toolkit.

A DHSC-endorsed and funded national programme to **ascertain** and **understand** the current **quality, condition, capacity** and **flexibility** within the **PC Estate** at a local, regional and national level;

Developed by CHP and NAPC to **inform** and **support** requests for **long-term, sustainable investment** into the PC Estate that enables the 'left shift' and prevention agendas;



To assist in the **prioritisation** of the basis of need that takes into account quality and capacity of current estate, **population health needs**, local **demographics** (including IMD data), **access times** and **rates**, and more;

To raise the profile of Primary Care at a national level to support the **delivery** of successive **national policy initiatives** (see the **Fuller Stocktake**, annex 1);

To **empower PCNs** with effective **estates management tools** and empirical **capacity data** which enable them to better understand **opportunities and barriers** to **workforce** and **population growth** forecasts.