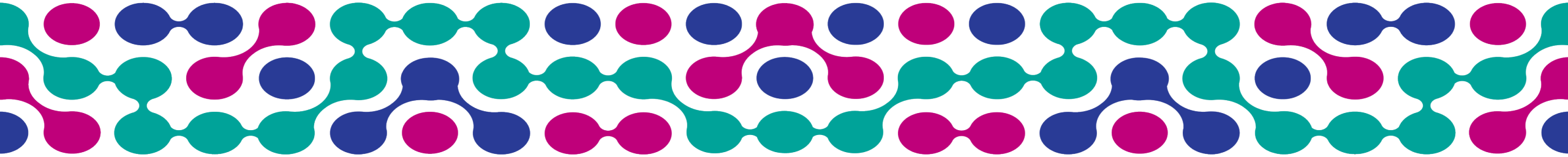
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Health and Wellbeing Board Update

Implementation Plan and Outcome Framework

January 2025



Background and context

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What is the Implementation Plan (Joint Forward Plan)?

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

Why do we have one?

- It is a statutory requirement under the Health and Care Act 2022
- The plan is also used to support meeting the requirements of the ICB Annual Assessment
- It must be published each year by 31st March

Our approach for 2025_26

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- Implement learning and feedback from our previous versions about what has worked well and what hasn't including:
  - Strengthen evidence on our NHS statutory duties
  - Clearer golden thread between our ICP strategy, implementation plan and our operating plan
  - Review of approach to the Place section of the Plan taking on board feedback from locality partners
  - Be clearer on NHS contribution to prevention and outcomes sections
  - Review of outcomes framework to make fit for purpose
- Refresh will be relatively light touch given national conversation ongoing re 10-year plan
- Plan to be split into tow documents
  - Front facing, easily digestible public document
  - Supporting companion document/appendix with detailed delivery plans
- Aim for full initial draft for HWB's to review in mid-Feb
  - Request for sign off to be delegated to board chair
  - Will require a statement from HWB to embed into the plan

Steering group members/representatives

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We have set up a steering group to support this work – the member organisations and roles are as follows:

- Health and Care Professional Director, ICB
- Head of Strategic Intelligence, ICB
- Head of Delivery, ICB
- People and Communities Engagement Specialist, ICB
- Delivery Officer, ICB
- Head of Locality, ICB
- PH consultant, Swindon Borough Council
- PH consultant, BaNES council
- PH consultant, Wiltshire council
- Associate Director of Strategy, GWH
- Associate Director of Strategy, SFT
- Head of Performance and Capacity, SFT
- Head of Workforce Planning and Intelligence, RUH
- Data analyst, BaNES council
- Director of Transformation, RUH
- VCSE Representatives

Objective and Proposed Key Priorities 25-26

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Objective 1 – Prevention and Early Intervention

1. Mobilise our Integrated Community Based Care service will be mobilised and enter the first year of operation, engaging with the public on the future of services
2. We will increase our focus on prevention, embedding our revised approach to hypertension and expanding our approaches to mental health

Objective 2 – Fairer Health Outcomes

1. We will further embed our approach to reducing inequalities by championing a focus on our CORE20Plus5
2. We will realise more consistent clinical and patient benefits of greater acute collaboration as identified in clinical case for change

Objective 3 – Excellent Health and Care Services

1. We will continue the recovery of services to improve quality and outcomes for our patients, and make sure services are sustainable for the future
2. The second year of our medium-term financial plan will be delivered to aid the continuation of our financial recovery
3. Use of Digital Tools and Technology will be increased to provide a system wide approach to patient care and services
4. Workforce retention and opportunities will be improved by working closer together with system partners and developing our BSW People Plan

What delivering our priorities will mean

Priority	Outcome
Mobilise our Integrated Community Based Care service and enter the first year of operation, engaging with the public on the future of services	Increased patient satisfaction and access to community-based care, with measurable improvements in health outcomes and reduced reliance on acute care services.
Begin to realise clinical and patient benefits of greater acute collaboration as identified in clinical case for change	Improved clinical outcomes and patient experiences through streamlined, collaborative care across provider pathways, reducing duplication and inefficiencies
Deliver the second year of our medium-term financial plan and continue financial recovery	Achieved financial sustainability, with clear evidence of cost savings and reinvestment in frontline services supporting long-term system resilience
Further embed our approach to reducing inequalities by championing a focus on our CORE20Plus5	Measurable reductions in health inequalities, demonstrated by improved health metrics within underserved and vulnerable populations
Increase our focus on prevention, embedding our revised approach to hypertension and expanding our approaches to mental health	A decrease in the prevalence and complications of hypertension through enhanced prevention strategies, leading to a reduction in avoidable hospital admissions.
Continue recovery of services to improve quality and outcomes for our patients, and make sure services are sustainable for the future	Shortened waiting times for elective care and increased early-stage cancer diagnosis rates, improving patient outcomes and system performance metrics. Shorter waits for urgent care treatment, reduced unnecessary stays in our hospital, more people kept well at home.
Increase use of Digital Tools and Technology to provide a system wide approach to patient care and services	Enhanced patient care through widespread adoption of digital tools, reducing administrative burden and improving clinical efficiency and accessibility.
Improve workforce retention and opportunities by working closer together with system partners and developing our BSW People Plan	A more engaged, resilient, and well-supported workforce, with lower turnover rates and a clear impact on service quality and staff satisfaction.

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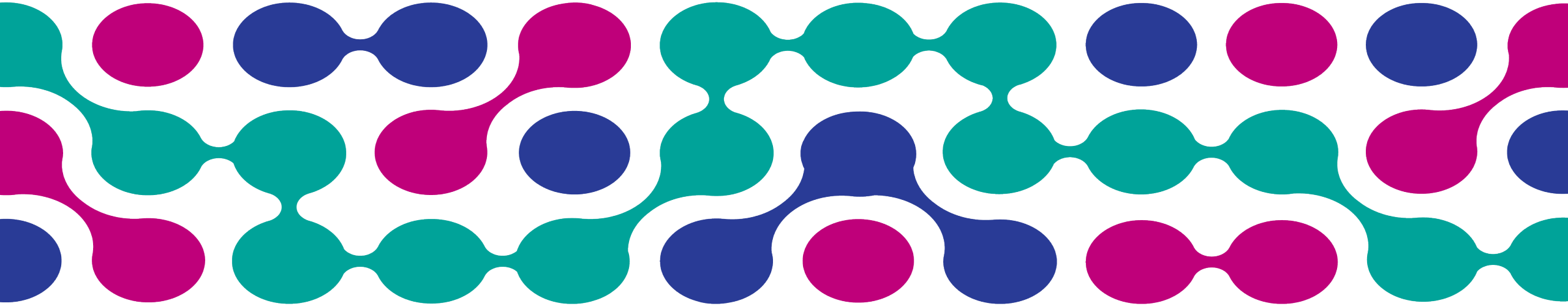
Locality Plans



Introduction to place

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The Role of Integrated Care Alliances in BSW

- Integrated Care Alliances (ICAs) play a central role in delivering the vision of the Bath and North East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS). As collaborative partnerships, ICAs bring together health, care, Local Authority, voluntary, and community sector organisations to improve outcomes, reduce inequalities, and promote the health and wellbeing of local populations.

- ICAs focus on the integration of services to ensure residents receive joined-up, high-quality care that meets their needs. By operating at a local level, ICAs are able to respond to the specific challenges and strengths of their communities while contributing to wider system goals.

Purpose of Integrated Care Alliances?

ICAs are responsible for planning, coordinating, and overseeing health and care services in their local areas. By working together, ICA partners ensure that services are:

Person-centred: Seamless and accessible, enabling residents to receive the right care, in the right place, at the right time.

Focused on prevention: Promoting early intervention to address issues before they escalate, improving long-term outcomes.

Aligned to tackle inequalities: Addressing health disparities and ensuring equitable access to care for all parts of the population.

Each ICA works in alignment with the Joint Strategic Needs Assessments (JSNAs), Health and Wellbeing Strategies, and the BSW Integrated Care Strategy. This ensures their priorities reflect both local population needs and system-wide ambitions.

Governance and Accountability

ICAs operate as key components of the BSW ICS, providing a forum for senior decision-makers from NHS, local authority, and community partners to collaborate effectively. Each ICA is established as a formal partnership with robust governance arrangements to oversee delegated functions and resources.

Decisions are made collectively, with members working towards shared goals that benefit local populations. Regular reporting ensures accountability to the Integrated Care Board (ICB) and relevant sub Committees, local Health and Wellbeing Boards, and partner organisations.

Introduction to Place, cont'd

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Core Responsibilities

- **Health and Care Strategy**: Develop local strategies to improve outcomes, informed by data and partner expertise.
- **Service Transformation**: Oversee integrated service delivery, quality, and resource use to meet local needs.
- **Tackling Inequalities**: Identify and address health disparities through targeted programmes.
- **Population Health Management**: Use data to design services that improve health and reduce inequalities.
- **Resource Alignment**: Oversee budgets, including the Better Care Fund, to support shared priorities.
- **Community Connections**: Link health and care services with voluntary and community partners for locally rooted support.

What This Means for Our Residents

ICAs ensure that health and care services are more integrated, making them easier to navigate and more effective in meeting the needs of local populations. Their focus on prevention, tackling inequalities, and using shared resources means better long-term outcomes and fairer access to services for everyone.

Looking to the Future

The recent Darzi Report emphasises the importance of place-based partnerships in integrated care systems. ICAs are key to this transformation, promoting innovation, prevention, and integrated approaches to meet local needs. By focusing on prevention and reducing inequalities, ICAs help create sustainable health and care systems with better outcomes for everyone.

Place Priorities

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Programme Priorities

The following pages highlight three key programme areas for each ICA in 2025/26, aligned with the goals of prevention, reducing inequalities, and excellent care. These priorities represent a focus within the broader scope of ICA activities, which encompass extensive efforts to improve outcomes, tackle local challenges, and deliver the Integrated Care Strategy. The ICAs are working through a series of steps to develop and refine the focus of these priority areas.

BaNES

- CYP emotional health and wellbeing
- Integrated Neighbourhood Teams
- Inequalities

Swindon

- CYP emotional health and wellbeing
- Adults with Serious Mental Illness
- CYP Dental Health

Wiltshire

- CYP emotional health and wellbeing
- Integrated Neighbourhood Teams
- CYP Dental Health

*BANES priorities due to be workshopped on 31st Jan

* These cover the top headlines, however further work taking place in all localities to refine and set SMART objectives

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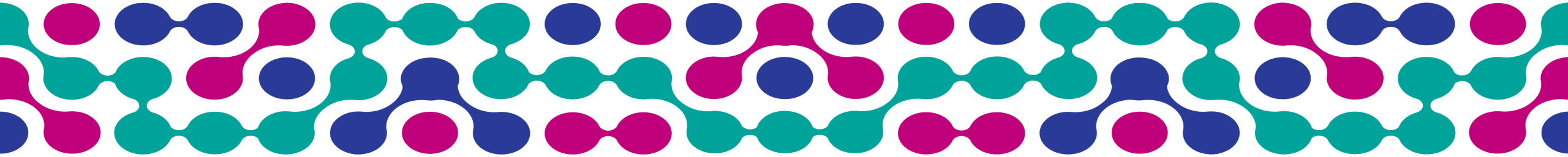
Outcomes Framework

Approach to Updating for 25/26



BSW System Outcomes Framework overview

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- Outcomes were developed as part of the 2023/24 Implementation Plan.
- There was significant consultation around these outcomes.
- However, many of the outcomes are not fit for purpose – there is no recent data available, they cannot be segmented by place or to explore inequalities (Core20, BAME) and they are not reported on regularly enough.
- In addition, they have not been embedded in our delivery infrastructure i.e. it is not clear which group is responsible for delivery on which metric.
- Major programmes like ICBC and the development of our Case for Change have now influenced our approach and plans..
- We now have an opportunity to update these outcomes as part of our Implementation Plan refresh.

- The following checklist was used to guide our selection of outcome metrics to ensure these issues were addressed:
  - ✓Can be split by Place
  - ✓Can be segmented by Deprivation, Ethnicity, Age and Sex
  - ✓Frequency of reporting (at least quarterly)
  - ✓Reporting lag (3 months max)
  - ✓Benchmarking available
- It was not possible to find a single indicator that met all these criteria. Therefore bundles (generally 2) of indicators have been identified that meet the criteria between them.
  1. Indicator that is produced nationally and therefore benchmarking data is available.
  2. A complementary local indicator that achieves the other criteria,

BSW ICB System Outcomes Framework (Draft)

Key outcomes	
1	**Life expectancy at birth**
	Years of life lost (use 100 as benchmark)
2	**Healthy life expectancy at 65**
	Average age when someone becomes mildly frail.
3	**Emergency bed days**

Contributory outcomes	
1	*Staff satisfaction*
2a	*% of employees who are residents in BSW.*
2b	*% employees paid real living wage or above*
2c	*% of apprenticeships as a proportion of all employees.*
2d	*% of apprenticeships who are residents of BSW.*
2e	*Purchasing for social benefit.*
2f	*Collaborating with communities – how well we have listened.*
3	*Carbon savings through transformational schemes.*

Alignment with value
Personal value
Technical value
Allocative (or Population) value
Societal value

Indicators available in national frameworks

Placeholder indicators to be developed

Contributory outcomes	
4a	**Under 75 mortality from CVD (including diabetes)**
	Years of life lost from CVD
4b	**Under 75 mortality from Cancer**
	Years of life lost from Cancer
4c	**Under 75 mortality from Liver Disease**
	Years of life lost from Liver Disease
4d	**Under 75 mortality from Respiratory Disease**
	Year of life lost from Respiratory Disease
4e	**Dementia diagnosis rate**
	Dementia prevalence recorded in GP records
4f	**Premature Mortality in adults SMI**
	Years of life lost with SMI
4g	**Admissions for self-harm (PHOF &** SUS)
4e	*Placeholder for MSK indicator*
5a	**% patients reporting, they have a care plan**
	% patients reporting care plan helpful (GPPS)
	No. Care Plans on ICR
5b	*No. completing CollaboRATE. % scoring 9+*
5c	*Place holder – social prescribing*
5d	*Place holder – Personal Health Budgets*
5e	*No. completing IntegRATE. % scoring 8+*
5f	*Place of death/ Place of Care* • Proxy - % deaths in hospital

Contributory outcomes	
6	% ICS resource invested in prevention (or % ICB budget invested in acute services)
7	**Personal Wellbeing ONS4 scores (Life Satisfaction, Worthwhile, Happiness, Anxiety)**
	No. people on QOF depression registers/ with anxiety code
	GP patient survey - report mental health condition
	Measure of Loneliness
	Measure of independence
	Child mental wellbeing (from school surveys?)
	Placeholder for something better
8	**School readiness: % children achieving a good level of development at the end of Yr R**
	Good level of development at 2 ½
9	**Smoking prevalence in adults/ age 15**
	Smoking prevalence recorded in GP records
10	**Alcohol admissions for alcohol specific conditions (PHOF &** SUS)
	Placeholder high alcohol consumption recorded in GP records
11	**Obesity prevalence in adult/ children**
	Obesity prevalence recorded in GP records
12	*Vaccination rates (Childhood and adults)*