Our plan for health and care
2020-2024

Bath & North East Somerset, Swindon and Wiltshire

Draft, February 2020

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Introduction

The way we deliver health and care across Bath and North East Somerset, Swindon and Wiltshire (BSW) is changing.

As demand for services grow, particularly from our older population, we need to find new ways of working so that we can continue to deliver the highest standard of health and care to everyone who needs it and still provide value for money.

One way we'll do this is to pool our NHS, local government and independent sector resources - including staff, skills, specialisms and finances - to form a new integrated care system (ICS) across primary, community ,secondary care and social care. We can also do this by working even more closely with public health, local authorities and voluntary groups to ensure a more seamless experience of care across a person's lifetime.

At the heart of the health and care system will be the development of Primary Care Networks (PCNs), designed to break down the historic barrier between care providers to focus on the specific needs of individual patients and their local community. PCNs will also help to manage demand, particularly on hospitals, by putting much more emphasis on prevention, ageing well and support for self-care.

To ensure the success of our ICS, we need to listen to local people on what they want from care services, foster leaders that can bring about integration, and harness better use of data and digital technology, particularly in areas where we are under-performing.

In Janaury 2019, the NHS published a Long Term Plan to set out its national vision for the future of health and care services over the next five years.

We intend to use three priority programmes to test out how we will Manage Change in BSW and our proposed new ways of working to transform services as we deliver our LongTerm Plan. These priorities are: ageing well, learning disabilities and autism and mental health.

The following pages summarise how we arrived at our plan, our priorities and objectives for an Integrated Care System (which reflect NHS England's Long Term Plan), and how we'll achieve these over the next five years.

To read our long term plan in full, go to www.bswstp.nhs.uk.

Our Mission Statement

People First: To deliver the best possible health and care for the people of BaNES, Swindon & Wiltshire

We will do this by:

- Working with partners to deliver seamless care both locally and at a system level
- Valuing our talented and capable staff by providing an amazing place to work
- Achieving value in everything we do.

About the area

Bath and North East Somerset, Swindon and Wiltshire (BSW) has a combined population of around 940,000 served by 94 GP practices, three acute hospital trusts, two independent health providers, a mental health provider, an ambulance trust and three clinical commissioning groups (CCGs) that will soon merge into one CCG. It is served by three Local Authorities.

While the area as a whole is less deprived than other parts of England, there are pockets of deprivation sitting alongside more wealthy communities where people do not live as long and are more likely to have health issues.

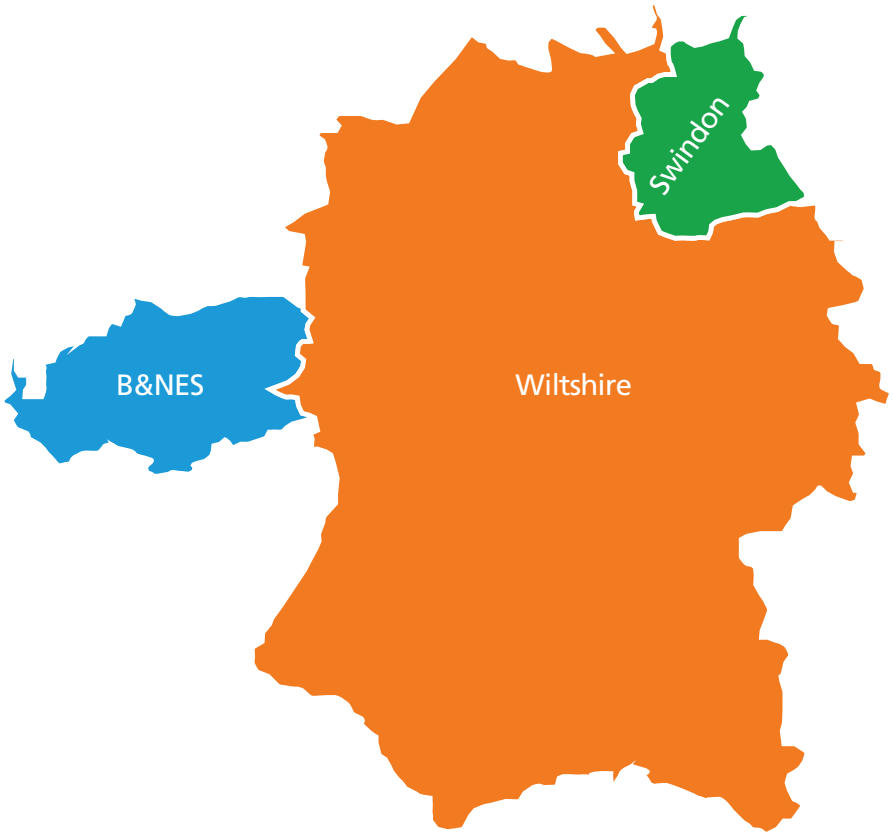
For example, in some areas of Wiltshire, the gap in life expectancy between the most and least deprived is 11.7 years. One of our goals, working across geographical boundaries and with better collaboration, is to reduce this variation in outcomes.

In the next five years, we expect our older population to grow considerably. Currently there are 80,000 people aged over 75 in the area, many with multiple long-term illnesses. By 2024 we expect this figure to exceed 100,000. We also expect significant population growth in Wiltshire because of an on-going programme to relocate army personnel into the authority and a number of large scale housing developments planned or underway.

Cancer, cardiovascular disease and respiratory disease are the main causes of death here, but we know that people in deprived areas will suffer more from these diseases. A focus for our integrated care system will be to help people to improve their outcomes, or prevent disease, by making healthier choices about smoking, over-eating and alcohol use. While the three geographical areas represent different challenges locally, as we integrate and work better across boundaries, we'll prioritise some key challenges across the area:

- Aging well
- Improving care for people with learning disabilities and autism
- Transforming mental health care.

These are outlined in more detail in this summary.



What you told us

We want local people to play a central role in planning and improving our services and we're already working hard to ensure that your views have an impact on how we deliver health and care.

For example, we went out to people from across the area in spring 2019 to ask three simple questions:

1. What's the one thing you wish you'd known sooner to help you be as healthy as possible?

2. What's the one thing that would help you to find and use health and care services more easily?

3. What is the one thing that would help to make a difference to your heath and care in the future?

We received over 1,400 online responses and met with over 1000 people. Some common themes emerged:

- You want better access to primary care services and continuing care
- The use of digital technology and e-health tools such as video consultations would help you to access more health services and information
- You'd like to better understand the impact of lifestyle choices, family history and behaviour on physical and mental health
- You'd like more control and to share decisions over your own health and care.

"Mental health services should be more accessible to younger people and doctors should provide more information for young vulnerable people affected by mental health issues."

"Being listened to and to have health professionals understand that I should have some influence over the type of treatment I receive. They are the experts, but I am the expert on myself and my symptoms so let's work together to solve problems."

Listening to your views

We spoke to hundreds of people to find out how they want to see health and care services develop in Bath and North East Somerset, Swindon and Wiltshire. You can read these throughout our plan in the special quote boxes throughout our plan.

Why we're changing

We need to change the way we work if we're to meet the needs of local people while at the same time making the best possible use of our available resources. We are not alone, with many other areas facing similar problems.

For example, we're not meeting waiting list standards in our emergency departments and people are also waiting too long for planned surgery. Patients are also travelling a long way to receive specialist and mental health care, which is not acceptable.

Some of our buildings and facilities are not fit for purpose, and in some areas we're struggling to recruit and retain specialist staff due to national shortages.

While we can boast some excellent services, we need to change now so that we can respond efficiently to a changing social landscape and growing demand.

We want to:

- Reduce inequalities in people's access to care and treatment
- Simplify an overly complex system to improve services and make efficiencies
- Improve people's pathway through care by putting them at the centre of everything we do
- Ensure we protect access to specialist treatment
- Supporting our communities and citizens to take better ownership of their own health and care.

We can achieve this by pooling our resources across the three areas of BSW - including staff, skills, specialisms and finances - to form a new integrated care system (ICS), working even more closely with public health, local authorities (including housing, education and leisure), voluntary and community groups across the whole area. Integrated Care System have been shown to deliver the best outcomes for patients and populations.

What we want to achieve

As an ICS, working collaboratively across Bath and North East Somerset, Swindon and Wiltshire, our plan for the next five years will prioritise projects and new ways of working that will have the most significant impact on the health and care of our local population. We'll do this by focusing on the following key areas:

Improving the health and wellbeing of our population
We'll help people to stay well, act early and find the right support to prevent ill health through all stages of life.

Developing healthy communities
With the development of Primary Care Networks, we'll break down the historic barriers between primary and community care to improve outcomes for patients.

Achieving sustainable secondary care services
Improved collaboration among acute hospital trusts , local authorities and independent health providers will help us to achieve a truly sustainable secondary care service into the future.

Transforming the way we deliver care across BSW
Both our maternity and mental health services are undergoing a transformation to improve services as a priority.

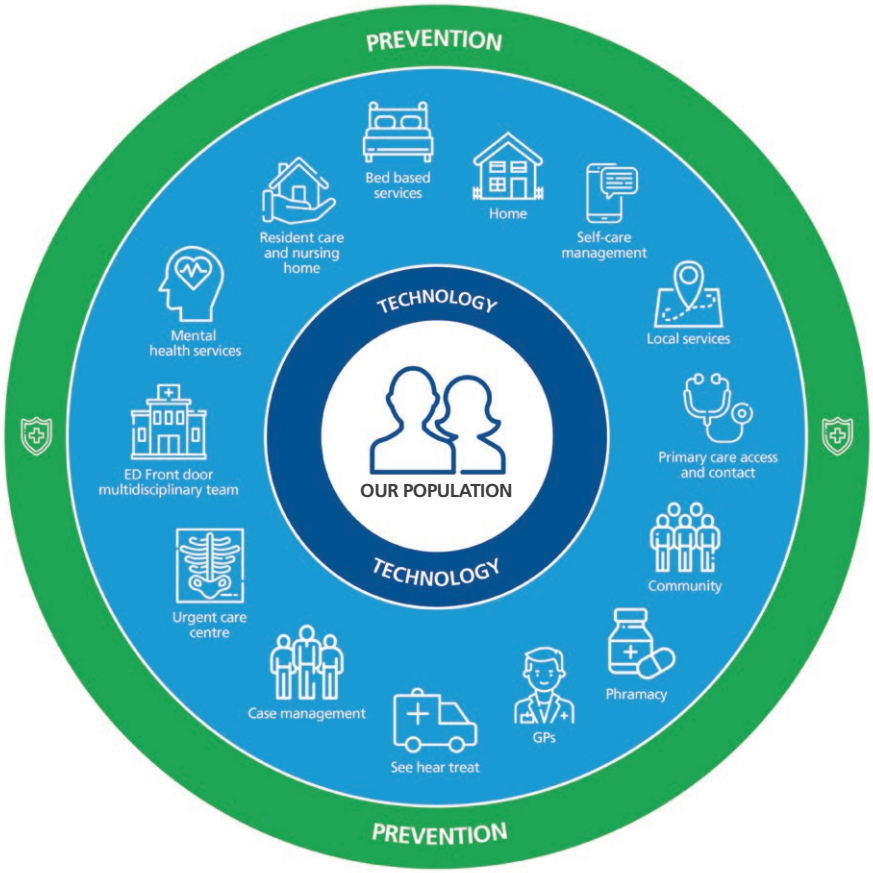
Helping people to age well
We'll help individuals to stay well at home, improve the responsiveness of community services and help older frail people to keep well and stay out of hospital

Helping people with learning disabilities and autism
We'll look to improve the quality of life for individuals with learning disabilities and autism by reducing preventable crises and improving access to health and care.

Helping people affected by mental health issues
We want everyone to be able to access the most appropriate support for mental health within their local communities, and have more timely access to specialist help if required. In particular we want to help people avoid crisis and ensure more people with serious mental illness (SMI) receive regular physical health checks.

You'll find a summary of how we'll achieve these aims in the following pages. Full details are outlined in our long term plan, available at www.bswstp.nhs.uk.

Proposed care model for BSW



With the shift to system-wide working, there will be changes to how health and care services are delivered.

Our integrated model of health and care is the first step in that process. The model is the basis for our integrated health and care strategy. Our local population is at the centre of our model, surrounded by our different services.

- Our model starts with the individual and looks to place prevention at the heart of everything we do. We will do this through encouraging healthy living, reducing levels of smoking and alcohol consumption and encouraging weight loss
- Self-care and self-management also form a central part of the story and are underpinned by self-care technology and domiciliary care
- Primary care also plays a role through the foundation of strong, inter-connected Primary Care Networks offering a wider range of roles including clinical pharmacists, social prescribers, paramedics and physiotherapists
- Local services play an important role, including specialist services, community groups, health and wellbeing ambassadors, palliative care, rapid assessment services and mental health services being available to people near to where they live
- Wider support will also be provided by social care and mental health teams focused on adults, children and young people, palliative care and community nurses
- Our advanced practitioners and multi-disciplinary teams provide support through case management, while our ambulance service is central
- Our urgent treatment centres (UTCs), walk-in centres and minor injury units will see those who need urgent medical attention for minor health issues, freeing up accident and emergency for the most serious cases
- In our emergency departments, mental health liaison services for adults, children and young people will help to make sure people get the right care at the right time
- Finally, bed-based services, mental health support and nursing homes will will provide help to those who have the greatest need for ongoing care and treatment.

Improving the health and wellbeing of our population

We want to help people to stay well, act early and find the right support to prevent ill health through all stages of life.

Prevention

One way that we can manage to reduce demand on hospitals and other services is to focus on helping people and communities to be healthy and live their best lives so all of our health and care services can provide help to those with the greatest need.

All health and care staff will play a key role in promoting prevention messages, which will include advice on protecting mental and sexual heath and on making better decisions around alcohol, diet and smoking. For example, we will:

- Work together as an Integrated Care System to educate and inform people across the whole area on living well
- Appoint community information champions to support individuals across the area to access information and support
- Start to promote the importance of bone health for pre-menopausal women to reduce the risk of osteoporosis in later life
- Target obesity to reduce cases of cardiovascular disease and diabetes.

"I wish I'd know sooner that caring for my own health every day may have helped me more."

Involving people in their own care

Our approach to all health and care will be based on shared decision-making, which means ensuring that you are supported and informed to make decisions that are right for you.

It's a collaborative process through which a clinician supports you to reach a decision about your treatment. The conversation brings together the clinician's expertise, such as treatment options, evidence, risks and benefits, and what you know best, such as your preferences, circumstances, values and beliefs.

We'll also encourage you to manage your own care as far as possible and empower you to do this with better information and support. For example, good management of diabetes at home will help to avoid emergencies.

Our commitment is to:

- Ensure patients have the information they need to make decisions about their care and are able to discuss it with everyone involved. This is particularly important for vulnerable and disadvantaged groups who may lack the skills and confidence to make such decisions.
- Improve access to health records and to inform patients of support groups in their community.

"The one thing that would make a difference to my health and care is for GPs and doctors to really listen to what I am saying and be more understanding."

Tackling health inequalities

We know people from our more vulnerable and deprived communities have generally worse health and shorter lives than those in better-off areas, and that levels of smoking, obesity, alcohol abuse and mental health issues are higher in these communities.

As an integrated care system we want to tackle this inequality by formally implementing 'health in all' policies across all health and care partners that specifically help people in disadvantaged or vulnerable communities to access support.

Among other initiatives, this will include:

- Helping people with severe mental health problems to access regular health checks
- Ensuring children with learning disabilities and autism have access to hearing, eyesight and dental services
- Extending our healthy schools programme
- Addressing the links between alcohol and mental health
- Promoting our smoke-free programmes in acute and community settings
- Ensuring all key organisations delivering health and care across the area use the behaviour change programmes such as 'Making Every Contact Count' and 'Connect 5'
- Establishing a rough sleeping pathway to address housing and finance issues
- Promoting healthy living messages in places of work.

"As a reformed smoker I wish I'd had more and better information about the effects of smoking."

Screening and immunisation

One way we can prevent ill health and disease is to ensure that local people take up opportunities for vaccinations and screening programmes. This includes the MMR vaccination, the seasonal flu vaccination and three cancer-screening programmes.

Over the next five years our ambition is to improve the number, quality and reach of immunisation and screening programmes, working collaboratively across health, care and education, particularly in disadvantaged communities. This includes:

- Implementing a new programme for bowel screening and the HPV vaccination for boys aged 12-13 from September 2019 to help protect them from HPV-related cancers
- Using Primary Care Networks to improve access and delivery of immunisation and screening programmes locally
- Ensuring that all screening programmes meet or exceed national performance standards
- Increasing uptake of screenings and vaccinations among people with learning disabilities and autism and in more disadvantaged communities
- Achieving more than 95% uptake across routine childhood immunisation programmes
- Improving MMR vaccination uptake with personalised approaches, catch up campaigns and prompt, targeted campaigns where measles occur
- Supporting the delivery of vaccinations during pregnancy and the shingles vaccination in older people.

We'll achieve this by developing a new screening network, local immunisation groups and by sharing a delivery plan across the area.

We'll also work closely with colleagues in public health, local authorities and independent health providers to ensure we have the resources in place that we need to meet increased demand, before launching an extensive engagement with local people to raise awareness.

Developing healthy communities

Primary Care Networks

With people living longer and requiring a wider range of health and care services over a longer period of time, we need to reduce the historic barrier between primary and community care that's preventing a truly seamless experience for patients across all of their care needs.

We currently have 94 GP practices across B&NES, Swindon and Wiltshire serving a population of 940,000 people. In order to improve integration of services, each practice are now part of wider Primary Care Networks (PCN) encompassing community and primary care providers, typically serving a local area of 30,000 to 50,000 people, each with its own clinical director.

How will PCNs work?

PCNs will be the heart of our BSW integrated health and care system (ICS).

The networks will build on the joined-up working that already exists in general practices, with primary, community and secondary care providers working even more closely together around an individual's care needs.

PCNs will typically include GPs, pharmacists, physiotherapists and paramedics and will work closely with other professionals such as District Nurses, dementia workers, mental health workers and voluntary sector organisations such as carers' centres. They will also include social prescribers who will help patients to improve their health and wellbeing by connecting them to community services.

Every PCN will have common characteristics such as longer opening hours (including weekends and evenings) but they will also tailor care specifically for the needs of their local population, drawing on local health data and better use of digital technology to address inequalities in access to care.

Networks will be small enough to provide personal care, but large enough to benefit from collaboration between providers and deliver economies of scale.

Culturally, there will be an emphasis placed on prevention, proactive personalised care and helping people to manage their own care where appropriate. The aim is to address health issues earlier on and reduce demand for hospital-based services, particularly urgent care.

Better use of digital technology will be central to improving integration, delivering preventative health information, providing seamless care between providers and offering more choice and convenience to patients.

For example we aim for 80 per cent of our population to be able to access video consultations by 2024 and single, shared care plans and records will be available in real time so that all information about the patient is available to help with decision making and planning.

"It would be a real help to be able to book more convenient appointments after work or early evening, and not have to wait weeks to get an appointment."

Why do we need PCNs?

The traditional model of care isn't working as well as it could be and is not sustainable in the face of growing demand, particularly from a growing older population.

- People are finding it harder to get GP appointments when they need them
- Practices are struggling to recruit and retain colleagues and a high number of GPs and nurses are soon to retire
- Newly qualified GPs do not find the current primary care model attractive to work in
- Practices are struggling to meet the demands of patients with multiple long-term conditions and complex needs
- We are faced with growing demand and increasing financial pressure. PCNs can deliver efficiencies at the same time as meeting the needs of patients.

A more integrated system helps take the pressure off GPs, and where emerging networks are in place, clear benefits are being recorded, particularly in the management of patients with long-term conditions.

Our vision for PCNs is outlined in more detail in appendix 4 of our Long Term Plan.

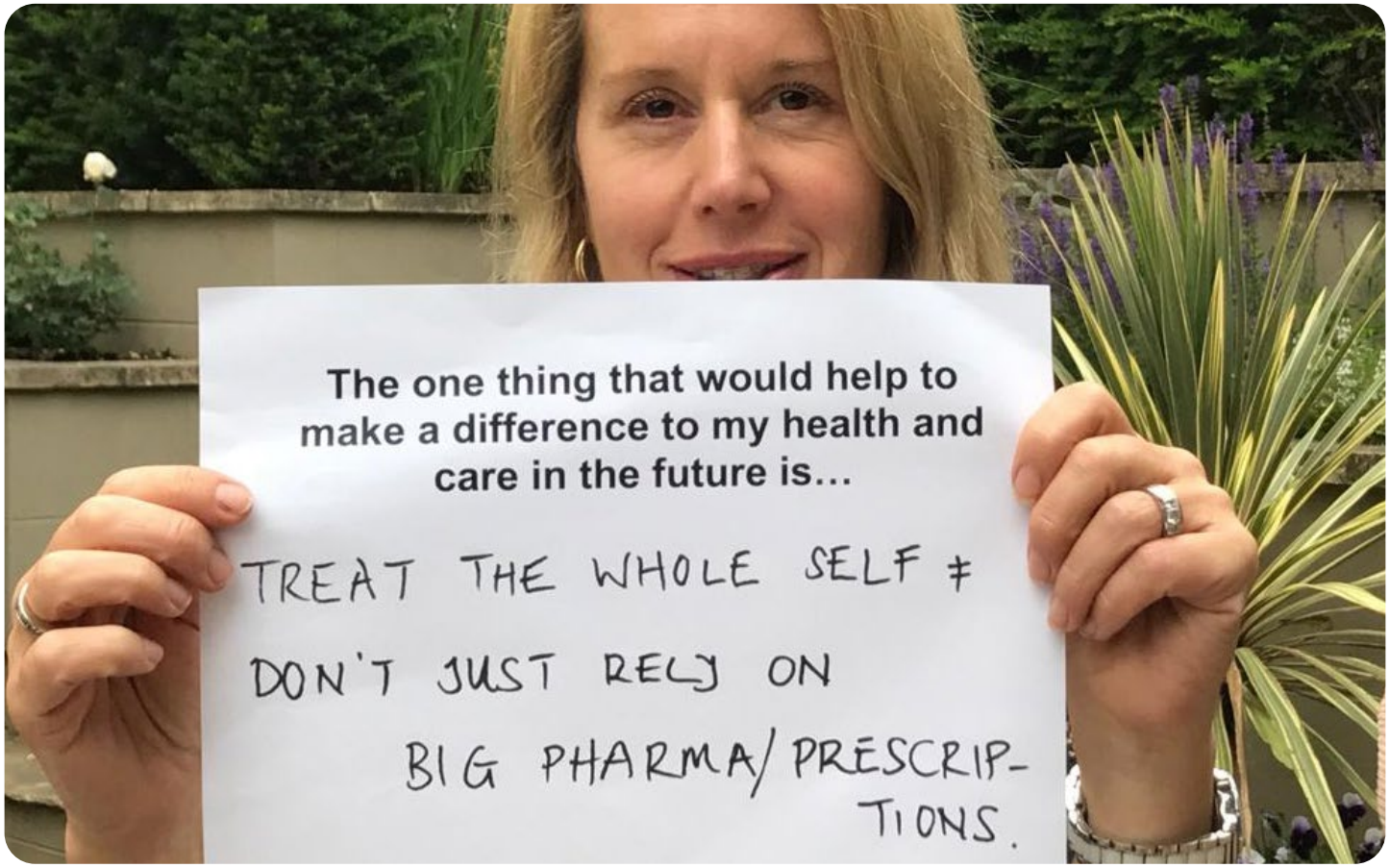
Support for networks

We're actively supporting the development of PCNs by funding training for all providers, with clear plans for integration, shared models of care, and better digital technology to support integration, planning and a more patient-centred service.

By providing data and analysis on local population health, PCNs can target resources effectively and design tailored strategies that will help to address inequalities. The outcomes can be measured and shared with other PCNs.

We'll be supporting practices to manage their workload, recruit and retain colleagues and to promote wellbeing at work. Improved IT infrastructure and mobile working will help people to work more flexibly and in new ways.

A central Primary Care Transformation Team will help to identify and share alternative ways of working and opportunities to improve joined-up working.



Helping people to age well

By 2024/25 our population aged over 75 will grow by 40 per cent. Given that older people are more likely to experience a range of complex conditions affecting their health and wellbeing, this will put a lot of pressure on our hospitals and other health and care services unless we do more to help people live well into old age.

What we plan to do

Our focus will be on helping individuals to stay well at home, improving the responsiveness of community services and encouraging the community to draw on its strengths and resources to help older frail people to keep well, stay out of hospital and socialise with others. We will:

- Provide PCNs with population and health data that enables them to target resources where they are most needed
- Implement a new care model for older people that embraces collaborative working and further use of digital technology
- Work with our local authority and voluntary group partners to encourage older people to pursue active, healthy lifestyles in their community and give up smoking
- Support the work of community groups such as dementia cafes
- Encourage volunteering among older people locally
- Improve identification of and support for carers
- Provide rapid response to incidents at home or in the community.

Shared decision-making

We know that people want more choice in the way that care is provided and to be involved in decisions about their care, so over the next few years we'll be piloting a programme for shared decision-making across the area. This will include:

- Improving patients' knowledge and expectations of shared-decision making
- Training clinicians and health professionals to facilitate shared-decision making and measure its effectiveness
- Improving people's knowledge about their own health and wellbeing, and how to talk about it
- Developing patient-decision aids to be used in consultations.

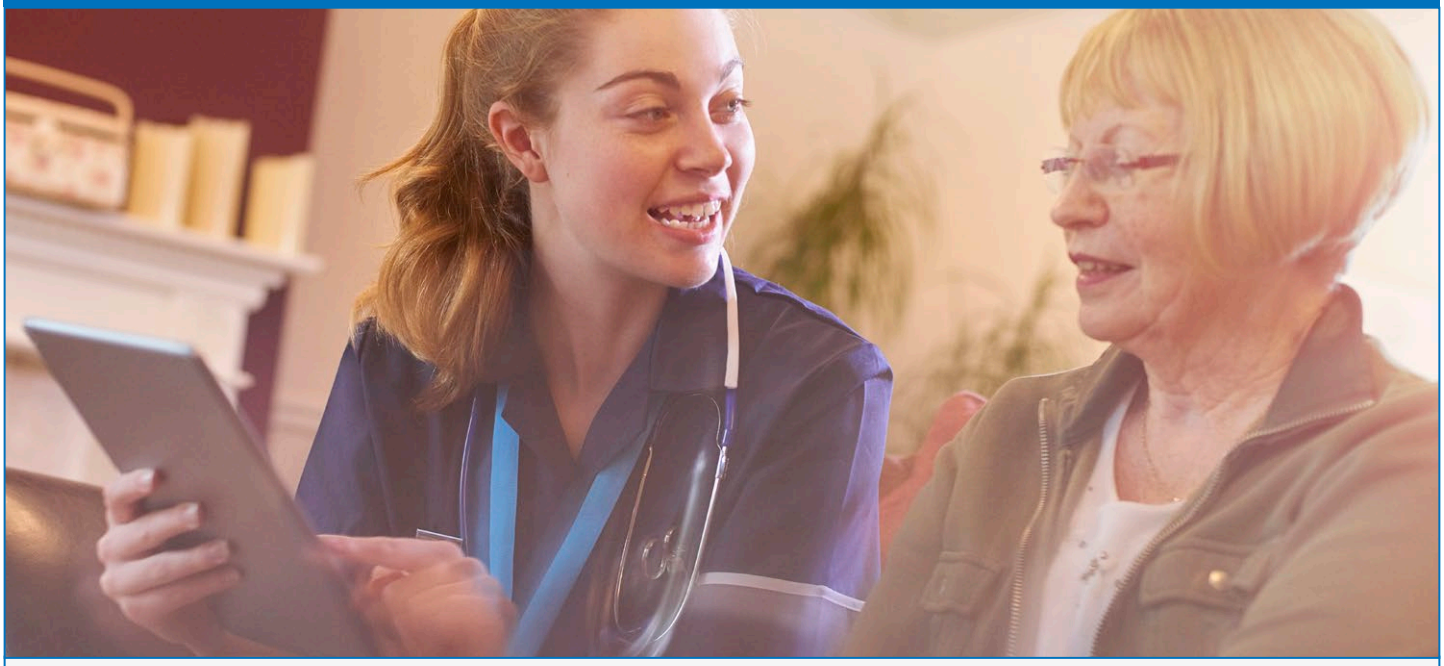
"The one thing that would make my health and care better in the future would be if health professionals listened to older people rather than just putting everything down to being old."

Improving the responsiveness of community services

As a priority, we aim to provide rapid response to a crisis at home within two hours as well as increasing capacity in community and social care to develop reablement services to support people to remain or return home rather than staying in a hospital. This includes:

- Treating and managing patients in their own homes or communities when possible
- Reacting quickly and within two hours to avoid unnecessary hospital admissions
- Assessing and treating individuals using shared-decision making and informing other professionals to avoid duplication
- Providing a response to a referral for reablement within two days including a multidisciplinary assessment
- Using an approved triage process to identify urgent health and care needs.

CASE STUDY
Home First



Home First was launched in 2017 and aims to help people leave hospital when they are well enough to do so, and gives them the extra support they need to stay well at home. The scheme was a regional winner in the NHS 70 Parliamentary Awards that recognises the massive contribution made by the individuals who work in and alongside the NHS.

How does Home First work?

When hospital care is no longer needed, most people prefer to be at home where usually recovery is faster. It also helps to free up beds for those who urgently need them.

Home First brings together a team of experts from the health and care community to assess and put in place the help required for a patient to safely return home from hospital and manage their day-to-day lives.

The first step is for a hospital nurse to discuss the option with a patient and together decide whether to make a referral to the Home First team. For example, they must be fit for discharge and have friends or family or another support network close by. If a referral is accepted, a patient will be given a date to leave hospital.

On return home, a member of the Home First team, such as an occupational therapist, will visit the patient to discuss and agree their needs before making the necessary arrangements. This support is reviewed regularly to help a patient stay at home for as long as possible.

Home First is available across the BSW area and is a partnership of organisations that includes the Royal United Hospital Bath NHS Foundation Trust, Wiltshire Council, Wiltshire Health & Care, Medvivo, Virgin Care, Age UK Bath, Somerset Partnership NHS Foundation Trust and Somerset County Council.

" Home First is a real team effort requiring health, social care and charity colleagues to work together. We're all working with the shared goal of getting more patients home, on their feet and regaining their independence."
Kerrie Hopson, Home First clinical lead for Royal United Hospital

Helping people with learning disabilities and autism

All too often we are supporting people with learning disabilities and autism in a crisis when their needs could have been met earlier. This can result in hospital stays and residential placements some distance from family and friends.

We want to improve the quality of life for individuals with learning disabilities and autism by reducing preventable crises and improving access to health and care as a priority. This will involve professionals and volunteers across health, social care and education working even more closely to improve learning difficulty (LD) services and outcomes. Our plan includes:

- Reviewing capacity within the system to respond to demand and support people with LD to live independently
- Developing an integrated health and care pathway which covers the lifespan of a person with LD (working with the Academic Health Science Network)
- Ensuring a better transition between children and adult services to avoid people getting 'lost in the system'
- Developing an integrated health and care pathway for people diagnosed with an autistic spectrum disorder and reducing waiting times for assessment
- Training health and care professionals to support people with LDs and encourage more people into LD nursing
- Increasing availability of social prescribing and community-led support
- Working with local authorities to provide adequate local housing
- Improving people's choice, control and independence.

"It would be great if there were more services for people affected by autism and their families to offer more help."

CASE STUDY
Sunflower lanyards

Great Western Hospital in Swindon was the first in the country to launch an innovative scheme to support young patients with hidden disabilities.

Where children had no visible symptoms of their condition, such as autism, bipolar disorder and epilepsy, they were offered a bespoke sunflower lanyard so that colleagues could be made aware of their disability.

"Loud noises, large crowds and unfamiliar surroundings can cause real distress and anxiety to a child with autism and, while we can't change the sometimes scary sights and sounds of a hospital, we can get behind this simple yet effective scheme. As soon as we saw the difference the lanyards were making to children at airports, we knew we wanted to replicate that success." **Gill May, Director of Nursing and Transformation at BaNES, Swindon and Wiltshire Clinical Commissioning Group**

All colleagues working with children know how to recognise and respect the lanyard, and change their behaviour accordingly. This could include using shorter simpler sentences, keeping body language calm, avoiding taking the child to crowded places, and repeating directions patiently. The scheme was developed in partnership with Swindon SEND Families Voice, a local forum for parents of children with disabilities, and has been warmly received by families, many of whom spend days, and sometimes weeks, preparing their little one for a trip to hospital. Once a child has been given a lanyard, it's their choice to wear one and is theirs to keep, meaning it can be brought along to all of their hospital visits.

Helping people affected by mental health issues

As a priority, we want everyone to be able to access the most appropriate support for mental health within their local communities, and more timely access to specialist help if required. In particular we want to help people avoid crisis and ensure more people with a serious mental illness (SMI) receive regular physical health checks.

Over the last year, we've worked closely with people who've experienced mental health issues, along with a range of clinicians, Avon and Wiltshire Mental Health, Oxford Health and commissioners, to produce a new mental health strategy that seeks to address current shortfalls.

For example, we know that people who require specialist inpatient care currently have to go out of the area for treatment, and that only 17 per cent of people with an SMI (compared to a target of 60 per cent) currently have health checks. Children and young people are asking for earlier help and support, and in some areas we have higher than average rates of admission for self-harm. We also have a shortage of skilled colleagues and will need to adopt new, innovative working models if we are to meet demand in future.

The 'Thrive' model vision

We're driving forward a model of care, jointly produced with people who've experienced mental health issues, which reduces the stigma of mental health. Our model puts people's needs first, and encourages all health and care providers to work more closely together to diagnose and promptly provide effective interventions to help avoid a crisis.

We will facilitate the development of ongoing, trusted relationships with skilled and compassionate colleagues in the community, and if crisis occurs, we'll provide better support closer to home.

How we'll achieve this

A 'Thrive' programme board is in place to oversee this transformation. Initiatives include:

- A single point of access for out of hours mental health via NHS111
- Working with PCNs, support the uptake of physical health checks among people with SMI,
- Roll out of 'crisis cafes' and community-based 'places of calm'
- Training for Primary Care Networks to encourage early interventions and better joined-up working to reduce the risk of crisis
- Better, more integrated support pathways for people with SMIs
- An Avon and Wiltshire Mental Health Partnership NHS Trust review of inpatient pathways, with a focus on length of stay and preventable admissions
- Improvements to perinatal and infant mental health services, with strong links to maternity services
- Development of an 0-25 year-old pathway, working closely with young people and families
- Support to improve dementia diagnosis
- A dedicated strategy to improve mental health care for people who are homeless
- A BSW-wide suicide strategy led by Swindon
- Delivering mental health diagnosis in schools from January 2020.

For further information, see appendix seven of our Long Term Plan.

"I think it should be far more easy to access mental health support, particularly for young people."

CASE STUDY
Trailblazing better mental health in schools

The process of growing up can lead to a number of issues that impact on mental health and wellbeing.

In 2017, one in nine young people aged 5 to 15 had a diagnosable mental health condition, and we know that teenagers with a mental health disorder are twice as likely to develop disorders in adulthood. But if intervention took place early on, in the right place, it could help stop these worries becoming much bigger problems.

A new government Trailblazer programme aims to do just that. The scheme started across a number of schools and colleges in Swindon as a pilot during 2019 and will now roll out to selected schools and colleges across BANES and Wiltshire during 2020.

The specialist Trailblazer team will offer onsite support for mild to moderate mental health issues, such as exam stress, low mood or friendship difficulties, with the aim of intervening early to avoid these problems getting worse.

The team will offer support to school staff and a link with local specialist services to help pupils access intensive support if required. The team will also host group sessions on self-harm and anxiety and parenting classes that aim to help with behaviour and communication difficulties.

Under the scheme, nearly £2 million will go towards putting Trailblazer mental health support teams into schools and colleges over the next three years.

"We know there is some excellent support already available. The Trailblazer programme will build on that and provide even more support earlier and where young people tell us that they want to receive it – in schools. It will help young people to improve their emotional health and wellbeing and get back on track."
Lucy Baker, Director of Service Delivery across B&NES, Swindon and Wiltshire

Achieving sustainable secondary care services

Operating a fully integrated service across three acute providers is a challenge given the geographic distance between our acute hospitals. However, improved collaboration is already helping us to achieve the economies of scale and improved services required for a truly sustainable secondary care service into the future.

Reducing variation across our hospitals

In 2018, the Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospital NHS Foundation Trust and Salisbury Foundation NHS Trust formed an alliance to help forge more collaborative working.

Their focus has been to bring about efficiencies by looking to be more efficient through shared approaches in all areas - including financial systems and forging strong clinical networks to improve variation in the quality and access to services across the area.

The Alliance already conducted a review of stroke, cardiology and gastroenterology services to address local issues. As part of this it has offered advice on how to improve access to cardiology and stroke services, improved care pathways and planned for an integrated stroke delivery network to pool resources and skills.

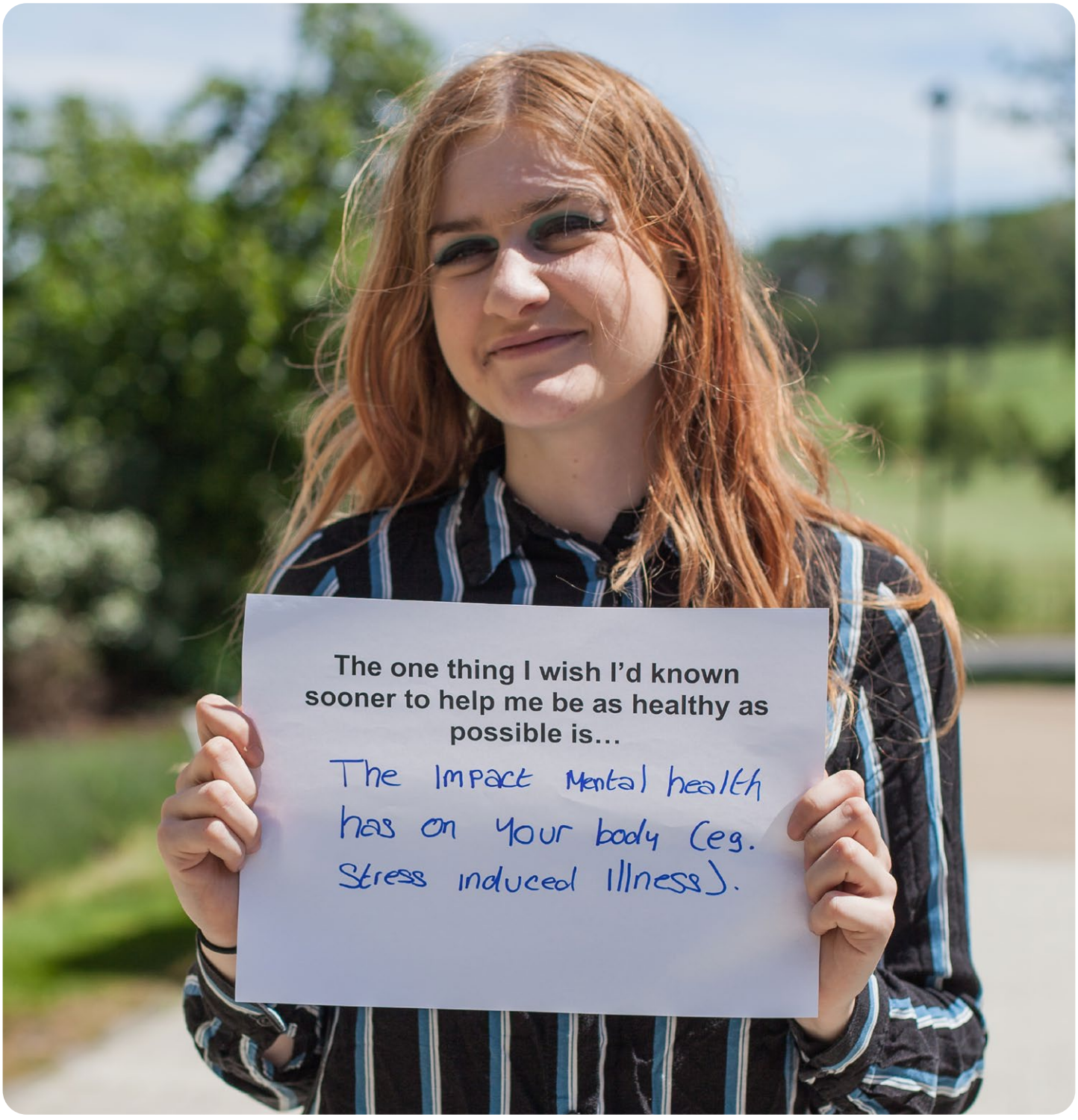
The alliance has identified opportunities to develop clinical speciality teams to work with primary care across the area to improve outpatient services and digital approaches to patient care. For example, exploring how secondary care could benefit from the adoption of a common electronic patient record, establishing decision-support systems for standardised clinical pathways, and adopting telemedicine tools.

The alliance will oversee around 31 Getting It Right First Time (GIRFT) review programmes that allow acute providers and commissioners to share learning locally and across the NHS.

"I believe hospitals should do more to share notes about patients. At the moment I have to keep all of my letters to take along to appointments and it would be easier if the different hospitals I visit knew more about my history."

Acute providers, commissioners and primary care colleagues have worked together on initiatives that include:

- Ensuring services meet the accreditation requirements of Joint Advisory Group of GI Endoscopy (JAG)
- Introducing a range of initiatives to increase consultant capacity
- Extending the use of Consultant Connect service which offers GPs telephone advice and guidance from specialists
- Adoption of a six to seven day working week
- Scoping additional clinic and endoscopy services
- Dedicated plans to improve partnerships and grow our own skilled workforce
- Common referral forms, protocols and a patient decision-making tools
- Increasing the use of patient initiated follow-up.



Transforming care across BSW

Our maternity and mental health services are currently being transformed. While our work to transform maternity services is well under way, work across mental health is just beginning.

Transforming maternity services

A programme to fully transform maternity services across B&NES, Swindon and Wiltshire aims to ensure a safe and positive birth and maternity experience for families across the area. The programme was created with public and professional contributions, and was subject to public consultation at the end of 2018. Among other changes, it proposed a major reconfiguration of services from 2020:

- Provision of 'alongside midwifery units' at the Royal United Hospital Bath (RUH) and Salisbury District Hospital. These are midwife-led units within a hospital providing obstetric care.
- Reducing free-standing midwifery units in the area from four to two and improving those birthing environments
- Improving the provision and promotion of home birth services
- Enhancing antenatal and postnatal care including community hubs across the area
- Replacing provision of nine community post-natal beds in the RUH with support in the home or close to home
- Changing staffing models to reflect new services.

The co-created plan for maternity transformation has also driven several improvements to maternity services that support the objectives of our long term plan, such as a more seamless care pathway for mums, and improved information to reduce risk. Many initiatives are already completed or under way and include:

- Launching a 'continuity of carer' pilot programme for mums with complex pregnancies and those choosing home births to test the benefits of having the same key person involved in care prior to and after birth
- Launching community hubs that integrate midwives and primary care and will later include health visiting, feeding support and mental health support
- Support for stopping smoking in pregnancy
- Regular robust reviews of and shared learning from incidents, stillbirths and neonatal deaths
- A focus on the most appropriate place of birth for pre-term babies for improved outcomes
- Introduction of mental health services for mums and infants, extending to include partners and more support for mums with mild to moderate symptoms
- Screening for diabetes in pregnancy
- Dedicated apps and online information for mums and dads.

"One thing that would make a difference to the health and care I receive now would be better maternity care and especially breastfeeding support."

Key workstreams

We will continue to deliver the following workstreams as part of our Five Year Plan to align our work with the ambitions of the national NHS Long Term Plan and to continue to meet the needs of local people.

Diabetes

Improving access to diabetes diagnosis and care remains a priority for BSW. For example, we know that around 5,700 people across the area live with undiagnosed diabetes, and that not enough patients diagnosed with diabetes are attending self-care education programmes or reaching treatment targets. This can lead to conditions deteriorating leading to complications such as limb amputations that then require more intensive support.

Following a review of all the individual programmes in place, we will develop a better, more integrated pathway for diabetes, focusing on places where diabetes is more prevalent. There will be a particular focus on improving the availability of education and support for patients to manage conditions at home, including the use of digital communications.

Cardiovascular disease

A recent Right Care review has highlighted ways to improve cardiovascular health are, and much of this is already underway. A cardiology clinical board will oversee the programmes in place, with representatives from the cardiovascular network, PCNs and public health. We expect to see the following outcomes:

- Improved detection rates for heart failure and hypertensive vascular disease
- Improved identification of people at risk of stroke and heart attack, and better management of conditions within primary and community care
- Improved heart failure pathways, including cardiac rehabilitation with increased uptake and completion of the rehabilitation service
- Improved stroke rehabilitation services and more people receiving this care within six weeks.

Respiratory disease

Tackling respiratory disease across the whole area will focus on ensuring early and accurate diagnosis, support for self-care, better uptake of flu vaccinations and stopping-smoking programmes, particularly in more disadvantaged communities and improving uptake and completion of pulmonary rehabilitation programmes.

The aim is to reduce hospital admissions from pneumonia and flu, and reduce the length of hospital stays for related problems.

Planned care

We want to create consistently good patient pathways for planned (elective) care across the area which maximise opportunities for preventative and community-based care.

Due to increasing demand for both emergency care and elective surgery, continual pressure is placed on the capacity of the service and the availability of beds for planned care, and this often results in long waiting lists. However, with successful delivery of initiatives to address demand and to improve outpatients and theatre capacity, we hope to steadily reduce waiting lists each year. A specific ambition is to reduce the number of patients waiting over 26 weeks.

We're currently conducting a review of our elective capacity (with a focus on protecting services during winter pressures) to see where more resources are required, and exploring more joined-up working with the private sector to help.

For patients that are waiting over 26 weeks (without a treatment date) we are looking at programmes where a trust/CCG might offer more choice to the patient if there's concern over a patient's wellbeing and the treatment could be performed quicker somewhere else.

Cancer

Working collaboratively to include the cancer alliances, our aim is to detect cancers earlier, ensure swift diagnosis and access to treatment, and improve our personalised support for people to live well with and beyond cancer.

We have put in place very specific targets, in line with the national Long Term Plan:

- We want 107 more people each year to survive their cancer for at least five years after diagnosis (5 more people per PCN)
- Of those diagnosed with cancer, we want 130 more people each year to be diagnosed at stage 1 or 2 (6 more people per PCN).

Subject to the necessary allocation of funding, we'll put in place the following initiatives to achieve our targets:

- Timed pathways to help speed up access to diagnosis, treatment and follow-up
- Rapid diagnosis service pilots for patients with vague symptoms
- Supporting the use of FIT by GPs for symptomatic patients
- Encouraging better attendance at cancer screenings
- Introducing personalised care and support programmes with pathways - particularly follow-up pathways - more closely matched to a patients needs in primary and secondary care.

To achieve this we are addressing some limitations in capacity, particularly in gastroenterology (see page 17), urology and dermatology.

Outpatient transformation

It is nationally accepted that the way we deliver outpatient services is out-dated, and unless we change our system, waiting times and lists will continue to grow. Over the next five years, we're therefore planning to transform outpatient services to improve our services and outcomes for patients. This includes:

- Improving referral pathways and standardising internal care pathways
- Finding a new model for outpatient clinics, with 30 per cent of activity delivered differently such as in the community or via virtual consultation (rather than in a hospital setting)
- Introducing more shared decision making and support to the patient to better manage their own care
- Providing appropriate recruitment, training and development for colleagues, and putting in place the required technology
- Better forecasting of demand using population health data to inform planning.

Children and young people

Improving services for children and young people (CYP) is a priority for our integrated care system and an area that will benefit from more seamless working between health, social care and education providers.

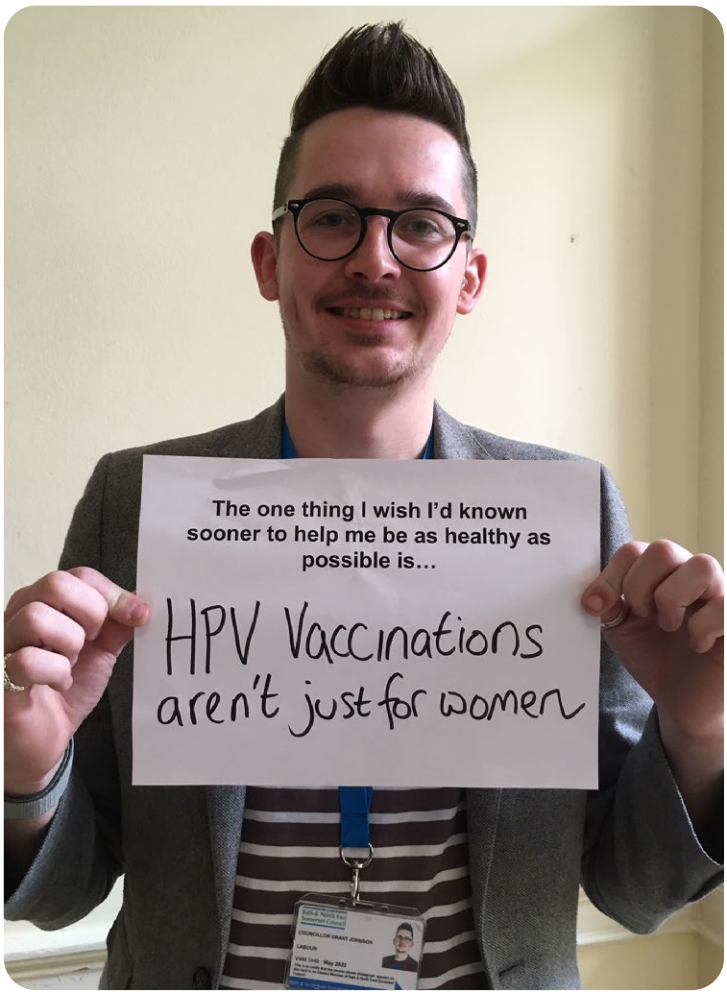
From reviewing our services and talking with children and their families, we are clear on what we need to achieve over the period of this plan.

An overarching aim is to ensure parents and communities are helped to create a nurturing, stable and engaging environment in a child's early years. More specifically, we need to tackle self-harm among young people, reduce the time it takes for young people to access specialist mental health services, improve our support for autistic spectrum disorders and encourage better use of personal care budgets.

Initiatives are planned and under way - including new, integrated health and care pathways, parenting pilots and community hubs - that will help to reduce preventable admissions to hospital, improve counselling services and provide a better experience for families with children with complex needs.

Making change happen

Our Five Year Plan is underpinned by a number of enabling workstreams which will help us achieve our aims.



The BSW Academy

A new BSW Academy is being developed that will support learning, development and leadership among all of our health and care providers through a number a colleges or schools.

Specifically, it will focus on enhancing collaborative work and leadership at system level, which cuts across all of our geographies and traditional organisational boundaries, to have the most impact on our local population and workforce.

A college of quality improvement (QI) – providing a central resource of specialist skills to support teams and leaders conducting change programmes, such as our ageing well and learning difficulty programmes, and by providing tools for shared-decision making and person-centred care as an example.

Leadership development – provides specific programmes to strengthen clinical leadership, organisational development and system-wide leadership. For example, a GP mastermind programme to promote leadership in GP practices.

Training hubs – supports education and training for primary and community care workers in a virtual network with educational programmes, training infrastructure, support for Primary Care Networks, and help with recruitment and retention.

Virtual academy of training and education at scale – scopes and identifies key areas of collaboration and partnership for education and training across the system.

Improving leadership culture – The Local Workforce Action Board is establishing a leadership and organisational development programme designed to help BSW become a fully integrated care system. Its ambition is to align governance, leadership behaviours, cultures, finance and design of services across the whole health and care system.

Developing our Integrated Care System

The Long Term plan sets out an expectation that Integrated Care Systems (ICSs) will be in place across the country by April 2021. The plan encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations .

In BSW developing as an ICS represents a deliberate decision of all organisations to pool resources and decision making to achieve common goals. Our role is to work with local people to identify priorities for health and care, develop a common set of standards and work to reduce unnecessary variations in performance. By working with our communities we can develop trust and understanding about what really matters.

Digital strategy

A bold digital strategy underpins this plan and there are a number of agreed aims to improve the digital capability across BSW and, in turn, improve the efficiency of services and the experience of patients, service users and staff. The strategy can be summarised under the following headings:

Digital First – Existing services will be improved through the use of digital technology to help local people play a bigger role in their own care

Integrated Care Records – We will meet the strong public demand for patient information to be available to those providing them with care through a system to consistently share records across BSW.

Shared Diagnostic information – We will work with the Cancer Alliance and Local Health and Care Record Exemplars to share and view diagnostic images within BSW and across the South West

Digital workforce – We will support our workforce by providing them with tools that maximises the impact they have in their role.

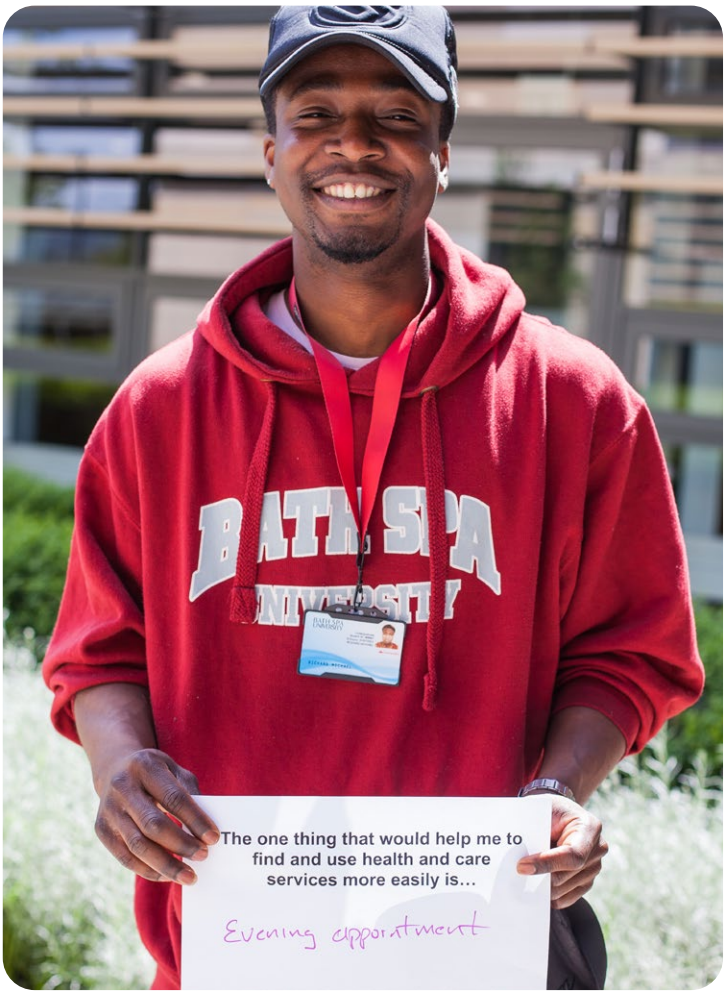
Our people

Planning how to make the best use of the workforce across BSW is a key part of the way we plan to develop towards an Integrated Care System. We plan to do this in the following ways and by identifying initiatives that can be delivered as an Integrated Care System rather than as individual organisations.

- Making the BSW health and care system the best place to work. We will look to address high colleague turnover levels and improve retention by promoting BSW as a good place to live and work and introducing new training infrastructures and well-being programmes.
- Releasing time for care. We will explore opportunities to release staff time and reduce and simplify some of the administrative processes our colleagues are involved with in order to free up front-line staff to spend more time focusing on care.
- Addressing urgent workforce strategies. We will address the national problems of an aging workforce, high turnover, shortages and reliance on agency staff through a series of initiatives including a well-established apprenticeship programme and internal recruitment programmes.

Finance

BSW funding covers three Clinical Commissioning Groups: Bath and North East Somerset (BaNES), Swindon and Wiltshire which will merge into one organisation on April 1st 2020, three hospitals in Bath, Swindon and Salisbury, one mental health provider (AWP) with community services provided by Wiltshire Health & Care, Virgin Care and Great Western Hospitals NHS Foundation Trust.



The BSW healthcare system spends around £1.4billion a year and over half of this amount is used towards the cost of providing care for patients in our three main hospitals.

As a health and care system, BSW is relatively underfunded. Like many health systems across the country we face financial pressures bought about by the challenge of maintaining our relatively old hospitals and GP practices, high levels of demand for emergency services, pressure on our primary care workforce and an ageing population with complex needs.

We know that the financial pressures faced in BSW over the next five years are likely to continue, so we are developing a strong plan to live within our budgets and make the best use of our resources.

Our financial plan involves implementing a number of significant transformational change programmes to help to make the system more financially sustainable in the future. There are three strands to this work:

- Priority Programmes – the Aging Well, Mental Health and Learning Disabilities programmes outlined earlier in this document
- Different Ways of Working – increasing clinical productivity, use of data to understand the needs of our population enabling us to redesign services to best effect and making better use of digital technology
- Unwarranted Variation – ensuring that we are delivering services that offer demonstrable value for money.

Our leadership team in BSW have considered the impact of implementing these schemes and are optimistic that our financial situation can be addressed. This will be enhanced by increasingly working together as an Integrated Care System to maximise the health and care benefits for all of our citizens across BaNES, Swindon and Wiltshire.

Next steps

This plan sets out our vision for how health and care services will be provided across BaNES, Swindon and Wiltshire over the next five years and how, through evolving into an integrated care system, we will ensure a joined up approach to how these services are delivered, developed and managed.

The views of local people have played an important part in how this plan has developed and will continue to be central to the way our services are delivered.

Over the next five years, we will continue to engage with the public about our services, especially should there be any major changes or reconfigurations.

We will also seek the views of the public and all of our stakeholders at regular engagement events throughout the BaNES, Swindon and Wiltshire areas. You can keep up to date on planned events by visiting our website at www.bswstp.nhs.uk

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