Bath and North East Somerset,
Swindon and Wiltshire Together

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

Primary and Community Care Delivery Plan

September 2023

V1

Bath and North East Somerset, Swindon and Wiltshire Together

Contents

Executive summary

Primary and community care services work to improve our populations' health, support them when they are unwell, and achieve fairer outcomes for children and adults across our system.

BSW Together has the opportunity to transform how we deliver primary and community care services across the integrated care system (ICS). We want those living and working within our communities, and those who use and deliver these services to feel a step change in how we come together and collaborate. This will create a truly integrated network where everyone's contribution is valued and recognised.

We need to address important drivers including an ageing population with increasingly complex needs, including frailty; growing demand and pressure across our services and on our workforce; the need for a person-centred approach to care; and the relationship between greater equality, better care, and a healthier economy.

This delivery plan builds on our existing strategies, including the BSW Together Integrated Care Strategy and Implementation Plan, and national policy and guidance. It consolidates existing documentation (over 20 documents) and reflects the engagement work completed to date with service users, providers (including market engagement events) and wider stakeholders to identify initiatives and solutions to deliver our ambition. This delivery plan also incorporates direct feedback from over 40 stakeholders including primary care GPs, integrated care board (ICB) members, the clinical oversight group, and the integrated community-based care (ICBC) programme.

Our delivery plan sets out six transformation priorities:

1. **Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams.** We will build on our existing primary care networks to create more integrated neighbourhoods serviced by providers who can share information, caseloads, and estates to provide more joined up care and the capacity to do so.

2. **Adopt a scaled population health management approach by building capacity and knowledge.** We will use data and insight to understand our populations better, identify health inequalities, target marginalised groups, and develop initiatives and services that improve access and result in fairer health and outcomes.

3. **Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets**. We can promote healthier communities and increase healthy life expectancies through better understanding and working with our local communities. We recognise that care and support is best delivered by those who understand the adults and children who live within them.

4. **Increase personalisation of care through engaging and empowering our people.** We need to shift towards greater prevention and early intervention. We can do so by tailoring our support to a persons' specific needs and using technology

advances to provide support in formats that fit with individuals' needs and preferences.

5. **Improve access to a wider range of services closer to home through greater connection and coordination.** We will deliver excellent health and care services closer to people's homes and overcome inequality of access by creating stronger physical and virtual connections between primary and community care and specialist services.

6. **Support access to the right care by providing co-ordinated urgent care within the community.** We want emergency care to be for those who need it most and know we can help people to address their urgent needs within the community. This can prevent avoidable admissions and result in better outcomes and experiences.

Within each priority, we have outlined its **context** and rationale, the **ambition** of what will look and feel different and identified **interventions and actions** that will support its delivery. These are intended to enable places, neighbourhoods, and providers to understand the direction of travel for primary and community care and support them to make decisions on how they are delivered within their local populations.

We also recognise the importance of the five **focus areas** which have been considered for each priority. The focus areas are health inequalities, children and young people, mental health, major conditions, and learning disabilities and autism.

This delivery plan will be supported by the six enablers identified in the BSW Together Integrated Care Strategy, as well as an additional enabler on commissioning and contracting:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as an anchor institution
- Commissioning and contracting

This document is intended to be a strategic articulation of the future of our primary and community care services across BSW as we work better, and closer, with our partners and providers including the NHS, local authorities, the private sector, and voluntary, community and social enterprise (VCSE) organisations.

The intention is for this delivery plan to evolve over time as we hear and learn more from those who deliver and those who receive our services. We know we have more work to do to build the detail to deliver on these priorities and recognise this document is the starting point for our journey to transform primary and community services across BSW.

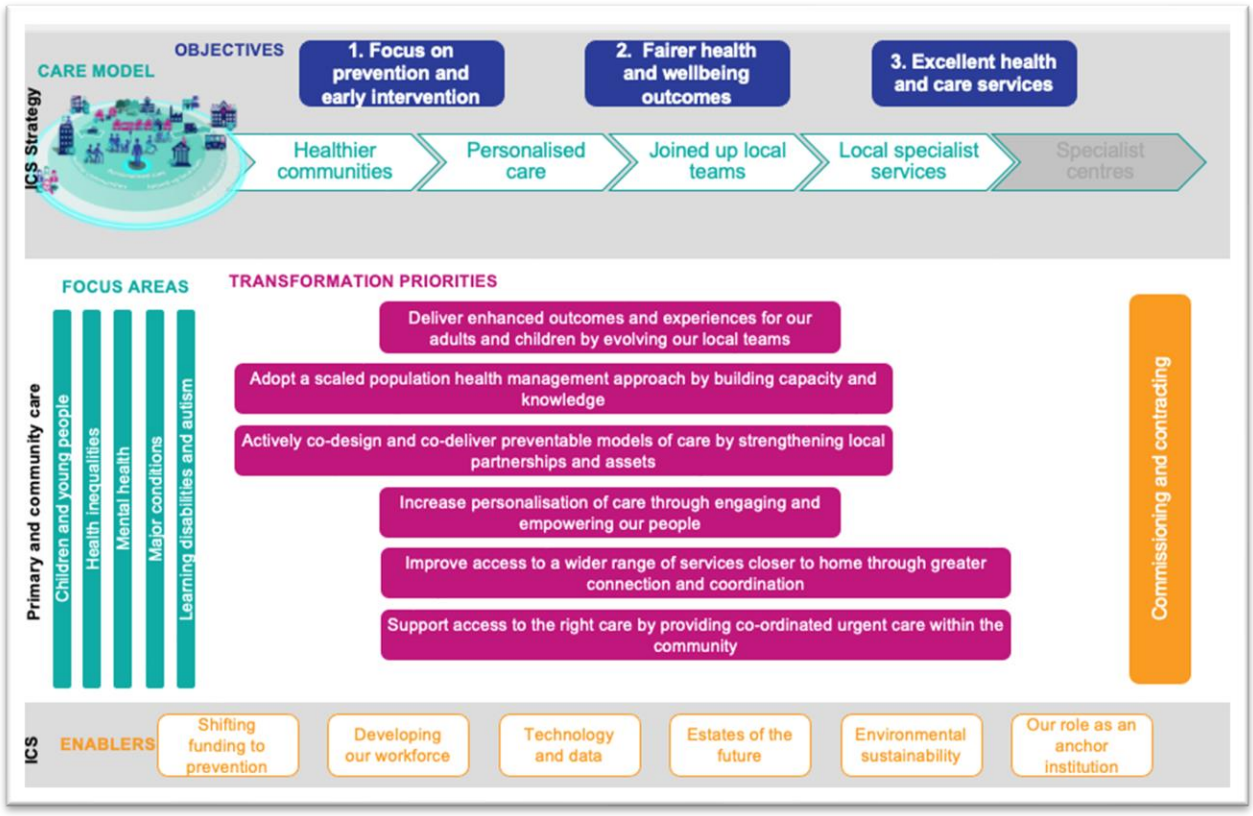

Figure 1: Summary of transformation priorities and alignment to BSW care model

Delivering our transformation priorities will mean:

- Our children, young people and their families and carers are recognised and valued, with a healthy environment to grow and learn in, and access to the support they need
- Individuals can equitably access care closer to home, within their communities and delivered by people who understand their specific needs
- Our older people, particularly those living with frailty, are supported to age well and stay independent at home for longer, where they are cared for at or near their home
- Our workforce is engaged and inspired, supported by technology, data and space that helps them to be happier at work
- Our providers and partners collaborate and innovate to drive fairer outcomes as well as delivering services. These providers are supported to be sustainable, providing the basis for transformation and shifting services into the community.

Introduction

The primary and community care delivery plan is a strategic document that supports the broader BSW Together Integrated Care Strategy and Implementation Plan and informs operational planning and financial recovery, so that we can better serve our BSW population of children and adults.

Scope

This delivery plan has been developed at the system level and encompasses primary and community care services. It focusses on the first four parts of the BSW care model (personalised care, healthier communities, joined up local teams, and local specialist services).

Central to delivering locally is our ability to enable joined-up local teams. However, we also need to consider how we best provide care and support to our communities and our peoples' individual needs, reduce health inequalities, and how we integrate with secondary care. As a result, not all care will be provided through joined-up teams, some will be delivered by other providers, across multiple neighbourhoods or at place to address the challenges we face.

Primary care, specifically general practice (GP), will remain the point of access for many patients and, working within PCNs/neighbourhoods are the foundations for transforming community-based care. We recognise the challenges faced by GPs both in terms of demand (increasing activity), and supply (workforce, estates). As such, focus will be given to creating a resilient structure.

This system level delivery plan outlines transformation priorities for primary and community care services. It is not prescriptive, as the way in which places, neighbourhoods and providers deliver these priorities may differ. We want to empower GPs, VCSEs, or individual providers to make their own decisions for their local populations.

This is intended to be a dynamic document that represents current priorities and activities and should not be seen as an exhaustive list of actions to be taken.

Key definitions[1]

- **Primary care services** ("primary care") should be considered in its broadest sense and encompasses GPs/ Primary Care Networks (PCNs), pharmacy, optometry and dental (POD) services.
- **Community based care services** ("community care") includes universal or core services (place based), extended services, and community-based specialist services (such as virtual wards and community diagnostic services).

We expect that a variety of partners and providers (including VCSEs, NHS, local authorities, and the private sector) will contribute to the delivery of these services, as we

[1] As defined in the Primary and Community Care exec summary presentation

acknowledge that many different organisations operate across our neighbourhoods and places.

Acute level care is out of scope of this delivery plan. We have however considered where primary and community care services intersect with acute services and pathways.

Investment assumptions

Defining the financial envelope required to deliver the priorities outlined within this delivery plan is out of scope. We have indicated a desire to shift activity and outcomes through the BSW Together Integrated Care Strategy. This infers an associated increase in investment in future years. The system is however required to ensure fiscal sustainability and final investment decisions will emerge through the development of the BSW ICB Medium Term Financial Plan. Consideration by the ICB and Local Authority partners of the strategic benefits as part of this work will identify the optimal and sustainable level of investment they wish to commit into primary and community care services.

Key drivers

This delivery plan is an opportunity to address drivers for change across the system; reframing and transforming how we deliver primary and community care. It will also guide the upcoming recommissioning exercise for community service providers. Below is a summary of drivers, with a more complete narrative provided in the appendix.

- **Tackling health inequalities -** there is a strong link between a higher prevalence of health conditions and living in less advantaged communities. Delivering interventions within the community and as close to peoples' homes improves access; promotes prevention; and results in better outcomes.
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- **Addressing an ageing population** – ageing well and keeping people healthier for longer within our communities can reduce pressure from increased complexity, multimorbidity, and frailty.

- **Increasing pressure on existing primary, community, and social care services** – many of our services are already stretched and we must transform how we deliver care and support to either reduce pressure or improve our ability to deal with it.

- **Addressing wider health and care pressure** – improving prevention and early intervention will not only help people to live healthier lives, but reduce avoidable demand on our wider health system, meaning resources can be utilised elsewhere.

- **Integrating to deliver a better experience and outcome for our adults and children** – we need to reduce the number of people falling through the gaps as they move between providers and improve our design of services by basing them on what our people need and want.

- **The economic value of health and care** – a healthier population is not only happier, but also more economically active. Investing in care, particularly prevention and early intervention, is key to our ability to maintain a healthy economy.

Delivery plan methodology

This delivery plan was developed through consolidation and alignment of existing documentation as well as engagement with stakeholders across the system.

This delivery plan builds on the Integrated Care Strategy and is aligned to the BSW care model. It should be read in conjunction with wider BSW transformation programmes and strategies outlined in the Implementation Plan. It consolidates and aligns to existing system and national strategies, policy, and guidance. Supporting narrative is provided in the appendix.

Stakeholder engagement for the overall ICBC programme took place through a series of market engagement events during summer 2022 which were held to gather views from local providers. The feedback from these events has shaped the transformation priorities in the delivery plan. Feedback was also gathered from primary care GPs, ICB members and the Clinical Oversight group.

To structure the plan, a framework was developed with five interlinked areas, visualized below. The plan flows from the six **transformation priorities** which are delivered through **interventions and actions** (pink). These are driven by **principles** (blue), supported by **enablers** (yellow), and feature cross cutting **focus areas** (green).

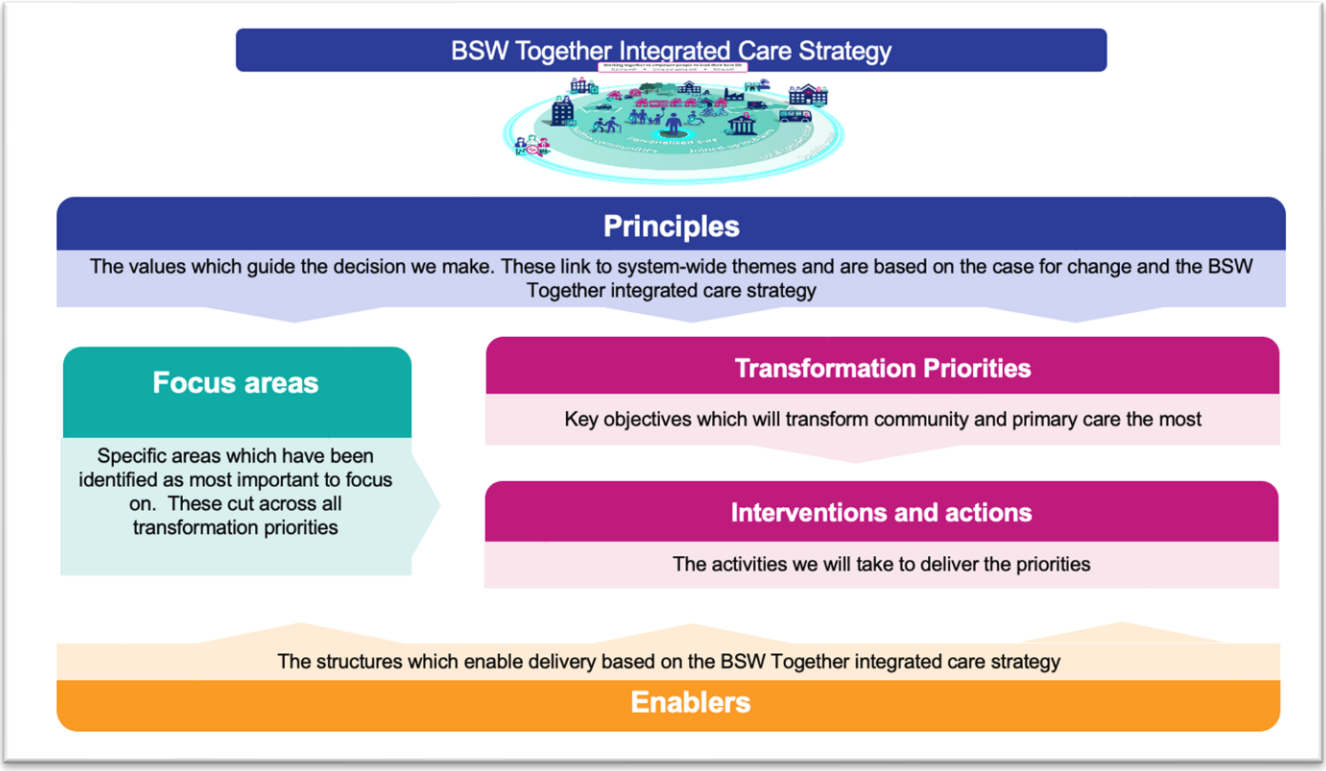

Figure 2: Structure of the delivery plan

Principles

These principles link to system-wide themes and have been developed based on existing principles across system strategy and programmes. They have guided, and underpin, all the focus areas, transformation priorities (including interventions and actions), and enablers.

Localisation - Focusing on the population's needs rather than sectors, organisations, or services. Highlighting the importance of community engagement and activation and emphasising the involvement of the third sector.

Equitable access - Reducing inequalities by utilising data and intelligence to inform planning and decision-making processes. Target interventions and enhancements based on identified areas for improvement.

Collaborating for outcomes - Changing our ways of working (both formal and informal) to create a culture of trust and innovation across providers. Empower local decision-making and delivery and strive for better outcomes.

Closer to home - Wherever possible, our people should be seen, supported, and treated within at-home or near-home settings and in their local communities so that we can keep people well and healthy at home.

Transformation Priorities

Based on the system strategy, national policy and guidance, case for change, and guided by the principles and focus areas, six transformation priorities have been identified for primary and community care:

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

These priorities support the delivery of, and are aligned to, the BSW care model and focus areas.

Focus areas

At the system, and national level, there are several focus areas that have been identified that should be considered across all transformation priorities:

- Health inequalities
- Children and young people (CYP)
- Mental health
- Major conditions
- Learning disability (LD) and autism spectrum disorder (ASD)

Where relevant, interventions or actions within this plan have been identified for a specific focus area. Those mentioned are not an exhaustive plan for each focus area. Further work is required to align this delivery plan to existing programmes or develop new strategies. Additional detail can be found in the appendix.

Enablers

Reflecting the enablers identified in the BSW Together Integrated Care Strategy, this delivery plan will be supported by the following enablers:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as an anchor institution

We have identified an additional enabler for the purposes of this delivery plan:

- Commissioning and contracting

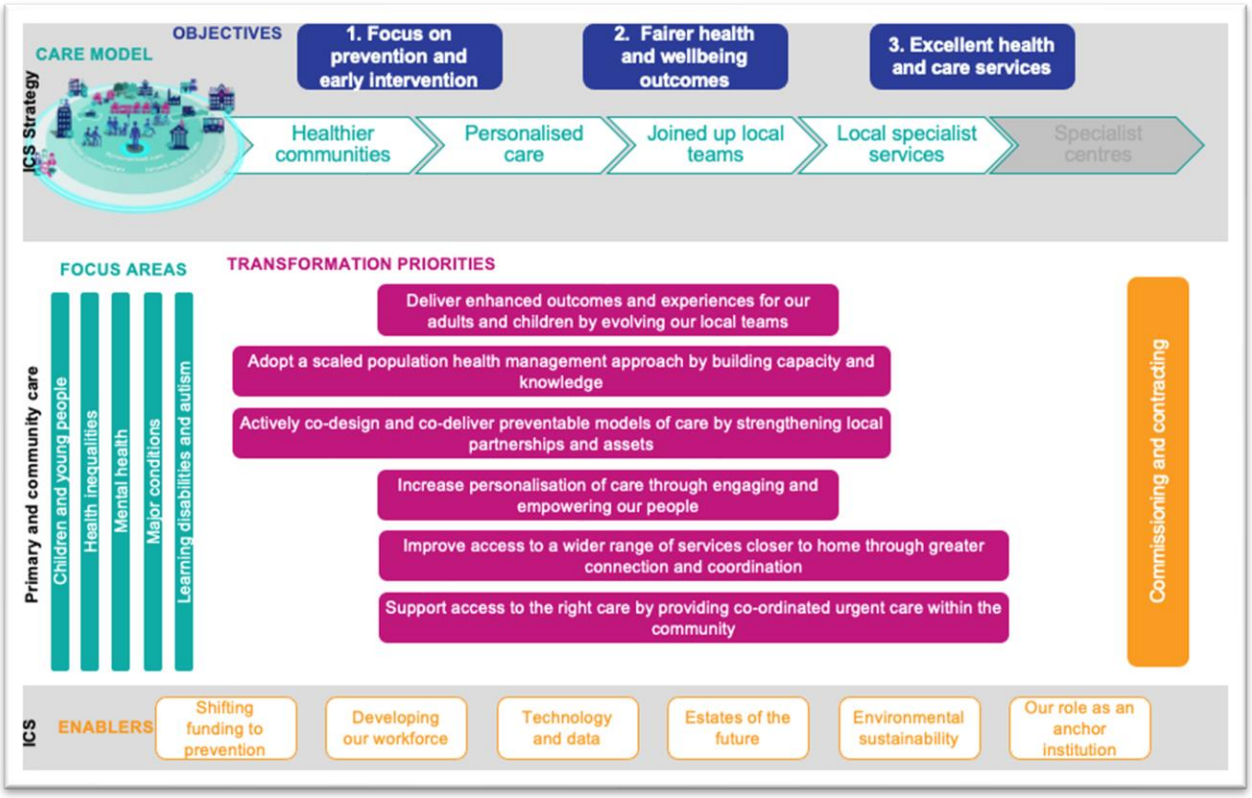

Figure 3: Summary of transformation priorities and alignment to BSW care model

Each transformation priority is described in four sections:

- **Context** – an overview of the priority and rationale
- **Our ambition** – what will be achieved by delivering the transformation priority and address the key drivers identified
- **How we will deliver** – detail on the interventions and activities that support delivery. Interventions and actions are not intended to be exhaustive and further work is required to build the detail required to implement.
- **Impact on focus areas** – commentary outlining how the transformation priority will affect each specific focus area

Priority 1: Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams

Context

Our care model states that joined-up local teams will enable us to deliver in a more coordinated way. We need to shift from operating as individual providers to operating together, using the strengths and expertise of different professionals.

Joined-up local teams[2] (sometimes referred to as integrated neighbourhood teams, INTs) enable providers to work together to personalise the care they deliver to a specific person. INTs were described in the Fuller Stocktake as having the potential to deliver more personalised care through support provided by a multidisciplinary team (MDT) of professionals. Designing our services around our neighbourhoods and connecting health and care professionals through these teams will provide coordinated lifestyle, psychological and medical advice, and support.

These teams bring together individuals from the health and social care sector, such as social care leads, nurse leads, health development coordinators, and GP leads, working alongside local partners such as local housing associations, policy, mental health services and voluntary organisations. Teams do not necessarily need to be physically located together, nor is a dedicated resource needed in every team and neighbourhood from every provider. We need to develop a model that provides greater connection between services so that we can pull in the right expertise when it is needed.

Joined-up local teams and their ways of working will provide benefits to all our adults and children within BSW but be particularly beneficial to those who need the most care or those with the multiple and complex needs including moderate frailty.

As outlined in the Fuller report, support for the new INTs will need to come from ‘larger providers such as GP federations, supra-PCNs, NHS trusts’ as they have the scale required to support this new way of working. This will include integrating enablers such as HR, quality improvement, organisational development, data and analytics, finance, etc.

Our ambition

- Organisations and providers work together to deliver co-ordinated care for those with complex and long-term conditions, delivering continuity of care throughout and leading to a better experience for service users
- Local teams deliver targeted initiatives that support prevention and early intervention and reduce inappropriate referrals and avoidable admissions, reducing pressure on the wider system
- Joined-up local teams and primary care deliver place-based integration of mental and physical health and ensure parity of esteem

[2] As defined in the BSW care model

- We take a trauma informed approach to assessment and care planning so that we can recognise that lived experiences can impact how we support and care for children and adults

How we will deliver

1.1 Create a system-wide blueprint for local teams and set up the structures needed to enable it

1.1.1 Define the 'core' capabilities which should be aligned to neighbourhoods and interactions between neighbourhood-place-system providers
1.1.2 Understand the feasibility (including value for money) of sharing estates and equipment and design a model that enables greater awareness of estate / equipment that is available across the system
1.1.3 Define a BSW approach/policy identifying and removing blockers for sharing risk and caseloads between providers
1.1.4 Define requirements to deliver interoperable systems and required supporting processes and workforce to deliver
1.1.5 Clarify data governance and process requirements to enable and increase the sharing of information and data (such as a shared care record) to deliver greater continuity of care
1.1.6 Review feasibility (including value for money) for establishing a centralised back-office and transformation function for joined-up neighbourhood teams. If feasible define how teams can access it.
1.1.7 Identify what is required (investment, resources, training, etc.) to deliver joined up local teams

1.2 Harness the role of wider primary care in local delivery

1.2.1 Work with providers to understand the variation in provision, and future required alignment and provision of pharmacy, optometry and dental (POD)
1.2.2 Identify opportunities to support GP practices by providing additional capacity through alternative delivery models
1.2.3 Use understanding of community assets (action 3.2.1) to identify opportunities and partnerships that can be used to deliver signposting and preventative measures (such as blood pressure monitors) within non-NHS services

1.3 Build the capacity and capability to deliver local teams within primary care

1.3.1 Support Places to undertake a maturity assessment against the local teams' blueprint (action 1.1) and identify required actions
1.3.2 Develop solutions to address existing challenges impacting general practice sustainability (such as physical estates, workforce recruitment, and finance)
1.3.3 Specific examples include identifying plans to address the need for local teams to have:
- Adequate physical space within general practice required for MDT meetings and delivery of onsite training
- Adequate workforce resource to deliver local teams
- Reasonable adjustments for those with learning disabilities, autism, and other complex needs

- Statutory duties for babies, children and young people, and parental/carer support requirements for CYP specific services

Impact on focus areas

- **Health inequalities** – by knowing communities and the people within them, our local teams can use their interactions to identify and tackle instances of inequality or wider determinants of ill health.
- **Children and young people** – local teams can support those who may be on multiple pathways and have co-dependencies, and during their transition from child to adult services. These local teams must deliver connected care aligned with Connecting Care for Children.[3]
- **Mental health** – local teams will adopt a team-based approach that will include expertise from a range of professions, support greater parity of esteem and recognise the interdependency between mental and physical health.
- **Major conditions** – local teams will be able to support those with long-term and complex conditions to stay at home and access care and support in the community, reducing growth in hospital demand and shift away from a hospital-centric model of care.
- **Learning disability and autism spectrum disorder** – local teams will help us to improve the autism assessment process and post diagnostic services and help to implement the Key Worker Programme.

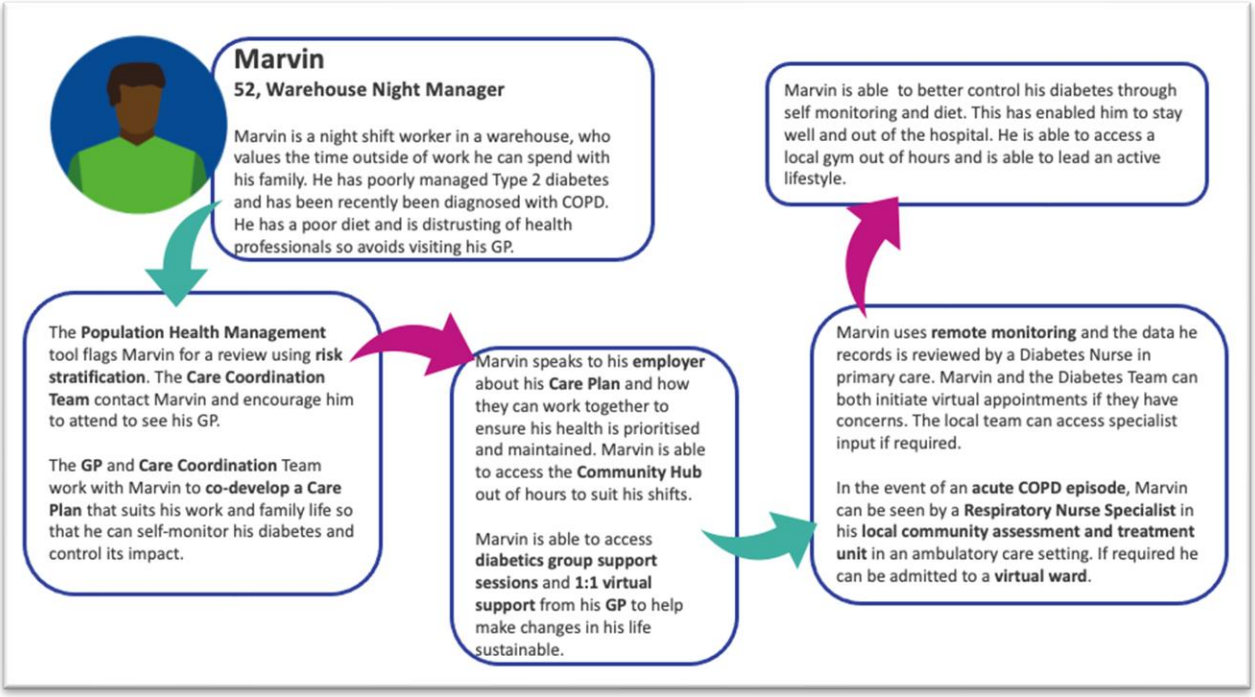

Figure 4: How care could be different – long term conditions[4]

[3] https://www.cc4c.imperial.nhs.uk/
[4] From BSW Together Integrated Care Strategy

Priority 2: Adopt a scaled population health management approach by building capacity and knowledge

Context

Population health management (PHM) is an approach used to understand a populations' current needs and predict what children and adults will need in the future. It uses historical and forecasted data to generate insight that enables providers to tailor better care for individuals, design and deliver in a more joined-up way, ensure that services are sustainable, and make better use of resources.[5]

Approaches typically focus on wider determinants of health to identify at-risk individuals and groups that can benefit from targeted, personalised, or preventative interventions. It can also be used to target and overcome barriers impacting marginalised groups or provide proactive support to older people living with frailty in the community. It is included in the NHS Long Term Plan; Fuller Stocktake; the Major Conditions Strategy; and BSW Together Integrated Care Strategy. We should consider Core20PLUS5 and CYP Core20PLUS5 approaches to reduce inequalities when designing these interventions.

Following participation in the NHSE funded programme, PHM has become an important driver in BSW's ICS journey and will be a key source of intelligence and insight driven solutions. BSW is currently piloting five projects across PCNs. A suite of tools is available to many organisations including data sets of identifiable cohorts, a health inequalities dashboard, and support for population health analysis.[6]

Primary and community care providers and partners must use PHM to support the delivery of longitudinal and preventative care.

Our ambition

- Services provided locally are based on the needs of local populations. While access is equitable there is some variation to reflect local need
- The ICB will develop and commission services according to local need of our children and adults so that we can prioritise resources and effort
- Organisations and providers will be able to work together to deliver across boundaries (organisational and geographical)
- Providers have access to data (both NHS and non-NHS) that enables them to use a PHM approach in their work

[5] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/
[6] BSW Together Integrated Care Strategy and Implementation plan

How we will deliver

2.1 Provide system-wide support to embed a consistent PHM approach

2.1.1 Complete review of current attitudes, cultures, and ways of working to PHM approaches

2.1.2 Define the minimum expectations in relation to PHM approaches (such as risk stratification, segmentation, impact modelling, alignment to Core20PLUS5 approaches) that should be adopted by local teams and set up methods to monitor and support its use

2.1.3 Establish formalised mechanisms to share good practice and learning across the system to spread innovation and success stories

2.1.4 Establish governance and plans related to data sharing and inclusion of non-NHS data such as that provided by adult social care, children's services, domiciliary care and VCSEs

2.1.5 Build dashboards to support providers to understand and identify differences in NHS health check invites and updates, delivery of vaccines, treatment targets, and care process attainment (including health inequality cohorts)

2.2 Use insight to identify care gaps and develop and prioritise targeted initiatives

2.2.1 Based on 2.1.2, use PHM to make evidence-based decisions on prioritisation, specific initiatives currently identified include:

- Increase capacity to provide annual health checks for those with long term conditions, learning disabilities and autism, serious mental health illness and CYP
- Increase focus on behavioural interventions including initiatives like tobacco control/ smoking cessation, weight management, alcohol use, oral health promotion, and high-risk condition monitoring
- Identify groups at risk of missing cancer screening and develop targeted initiatives to increase uptake
- Increase access to tailored Talking Therapies including digitalised programmes for those with long-term physical health conditions and child and adolescent mental health services (CAMHS)

2.3 Support local teams to scale the use of PHM in their work

2.3.1 Establish a programme to boost capability and resource capacity to apply PHM standards across the system, with specific focus on local neighbourhood teams. Specific examples include:

- Undertake a readiness review based on PHM standards of local teams' existing capability and access to data sets
- Review local teams' access to PHM toolkit and provide upskilling on how to use it
- Ensure local teams can operate within governance frameworks

Impact on focus areas

- **Health inequalities** – a PHM approach (such as expanding the use of the BSW Health Inequalities dashboard, and better use of deprivation and ethnicity data) increases our ability to identify where there are areas or cohorts of unwarranted variation such as in access or provision and develop initiatives to address them. Improved identification and targeting is central to reducing inequalities.
- **Children and young people** – we can use insight to better understand our CYP groups[7] and drive a reduction in inequalities. A data-led approach will mean developing targeted initiatives that are specific to their needs and those of their parents and carers.
- **Mental health** – we can use PHM to identify wider determinants of health which are increasing risk of mental illness, and tailor our mental health services for certain cohorts such as asylum seekers / refugees. Bringing data together will allow us to better target patients with both mental and physical health conditions, promoting earlier intervention.
- **Major conditions** - using PHM will enable us to develop more tailored prevention and early intervention initiatives through identifying and closing care gaps. As above, joint datasets will enable us to identify patients with both physical and mental health conditions, as well as those in receiving other services.
- **Learning disability and autism spectrum disorder** – we can use the insight from PHM to identify and deliver our LD, ASD, and neurodevelopment pathways including improving access and uptake of annual health checks.

[7] BSW Together Implementation Plan

Priority 3: Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets

Context

Care and support are best delivered by those who understand the children and adults who live within their communities. Similarly, organisations outside of the NHS can help people live healthier lives and help us deliver services in a more sustainable, accessible way.

While GP practices remain the foundations, neighbourhoods have multiple assets including physical space and estates, relationships and partnerships, and capabilities. Understanding these mean that we can support people in the most appropriate way and support the resilience of providers within and outside the NHS.

Part of integration is building on and strengthening closer working between health and care providers and wider organisations that operate within our communities. This includes local authorities, VCSEs, the wider public sector, and private organisations. They can be the bridge into local communities and help connect and deliver important services. The information flows both ways; they also provide a wealth of insight and expertise. They will be key to us improving our ability to deliver prevention and early intervention through closer links and better partnerships.

Better and stronger partnerships can help us to direct adults and children to self-care or self-initiated care. Promoting and signposting these services within primary and community care will help us shift towards greater prevention and early intervention.

Our ambition

- Community and local teams work with local organisations to support the design and delivery of health and care services for children and adults, working together to coordinate care and support
- We make best use of our assets including workforce, estates, and technology to reduce pressure across the system
- Citizens feel they have a voice in the services provided to them

How we will deliver

3.1 Address current barriers to working with local partners and providers

3.1.1 Explore and adapt our approach to commissioning and funding models (with consideration to long term investment in VCSEs and inclusion of training budget for the third sector)

3.1.2 Increase local partner representation within clinical and professional leadership forums and groups (including decision making) across BSW, at Place and Neighbourhood level

3.1.3 Increase training and development pathways available for the community workforce, leveraging opportunities such as the BSW Academy. Specific examples include:

- Community nurses
- Mental first aid
- Physiotherapy rehabilitation for care workers

3.2 Increase our awareness and use of community assets in the delivery of care

3.2.1 Support neighbourhoods to review and record community assets through the creation of frameworks, toolkits, and resources to assist completion

3.2.2 Identify and promote opportunities to promote the multi-use of space within neighbourhoods, utilising NHS estates and other assets

3.2.3 Use alternate workforce roles to complement existing services. Potential options include:

- Uplift in capability and capacity of wellbeing advocates, link workers, care navigators, or village agents
- Increased use of trusted assessor status to reduce delays such as in treatment assessment and discharge

3.2.4 Identify opportunities to increase use of community assets, specific examples include:

- Design a standardised social prescribing offering within local teams
- Continue to build a community mental health model that uses third sector mental health alliance partners to deliver a 'no wrong front door' approach
- Expand and develop our mental health support teams (MHSTs) in schools and work with education providers to support delivery of their local mental health plans
- Increase connections between local authorities, education providers, and health providers within the special education needs and disabilities (SEND) programme
- Deliver healthy weight programmes in partnership with, and based at, schools, gyms, and community centres

3.3 Build meaningful relationships to ensure our communities and local people are involved in the design and delivery of services (note this action also relates to priority 4)

3.3.1 Support partners and providers to identify and increase use of innovation and community engagement with the services they provide. Specific examples include:

- Increase resource capacity to undertake community engagement initiatives
- Identify and connect with local groups and agencies (such as education probation, charity organisations, and faith leaders) to understand lived experience and use this to drive design
- Identify and proactively engage with marginalised groups to identify and breakdown barriers to accessing healthcare
- Tailor approach to contacting at-risk people who are less likely to attend services due to barriers they may experience

3.3.2 Create formalised feedback loops (supported by resource and capacity) between providers, VCSEs, and individuals (such as child and adult participation groups and community conversations) to gather and respond to feedback

3.3.3 Demonstrate ongoing commitment to local area partnerships and alignment to initiatives. Specific examples include:

- Healthy high streets[8] and Liveable neighbourhoods[9]
- Local Area Inclusion Partnership (LAIP)
- Family hubs[10]

Impact on focus areas

- **Health inequalities** – research suggests that wider determinants of health are more important to healthcare in determining health outcomes[11]. Closer working of the NHS, local authorities and the VCSE sector can help to improve the lives of people in our communities such as to ensure warm houses and clean air.
- **Children and young people** – stronger relationships with our schools and local authorities will ensure we can give our children and young people a better start in life both in the prevention of preventable conditions and management of long-term conditions.
- **Mental health** – increasing our use of community-based wellbeing services means our third sector mental health alliance partners can 'walk alongside' and direct people to alternative offers in local communities, aligned to the community mental health framework.
- **Major conditions** – initiatives like social prescribing can help those living with long term physical and mental health conditions to build knowledge and skills so that they are confident to live well with their condition.
- **Learning disability and autism spectrum disorder** – if we can strengthen the support in the community, we can build on preventative support that avoids crises and helps to enable people to be active members of their communities, learn new skills and have new experiences.

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699295/26.01.18_Healthy_High_Streets_Full_Report_Final_version_3.pdf
[9] https://beta.bathnes.gov.uk/liveable-neighbourhoods
[10] https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme
[11] https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

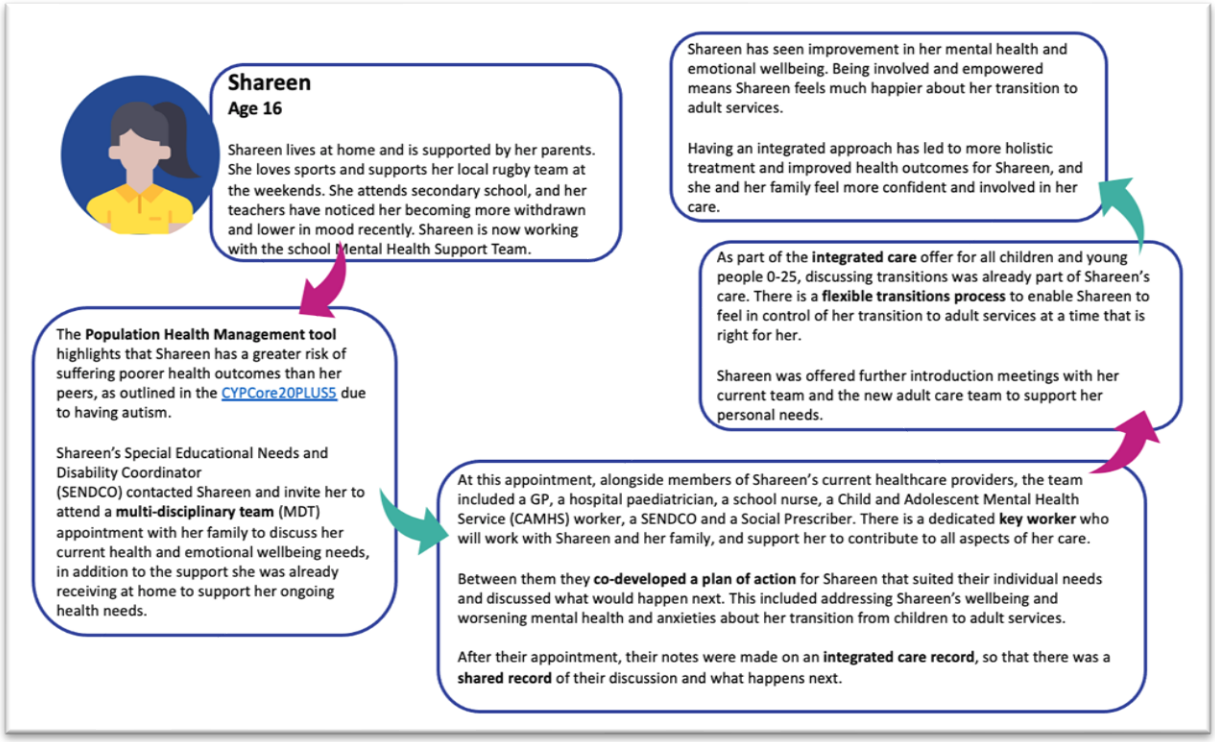

Figure 55: How care could be different – improving outcomes[12]

[12] Provided by the CYP Programme

Priority 4: Increase personalisation of care through engaging and empowering our people

Context

We know that engaged people are more likely to take an active role in their health and wellbeing. We need to support our people to shift mindsets away from doctor-led, on-demand care and encourage self-care and the use of alternate services and professionals. We need to put people at the heart of care: giving them choice and control, and better, fairer access.

Engaging children and adults in the design of services is the first step in supporting their empowerment. By giving a voice to residents and communities, they are actively involved in the design and ongoing improvement of services. This increases our chance of providing services they will be able to, and want to, access.

By providing adults and children with tools, services, and opportunities tailored to their needs, we can give them greater autonomy over their health and wellbeing. Digital and technological based services represent a major opportunity in this area. We expect developments like artificial intelligence (AI) to play an increasing role in future delivery.

Our ambition

- Our people are proactively offered initiatives that are tailored to their needs and circumstances so they can have better experiences and outcomes
- Individuals feel supported by a team that understands their specific needs, provides them choice, and involves them in decision-making
- Children and adults feel they have a voice in the services provided to them and know what services exist and how to access them, so that they access the right care and support

How we will deliver

4.1 Expand the use of personalised budgets across the system

4.1.1 Define a system-level standard set of practices for personalised care and support planning for children and adults

4.1.2 Implement standardised practices for personalised budgets so people have the maximum amount of control on the support they receive

4.2 Increase awareness of services to support better decision making

4.2.1 Undertake ongoing campaigns to increase awareness of alternatives to GPs amongst our communities so that more people access alternate services

4.2.2 Review use of patient-held records and identify initiatives to increase availability and support providers to use technology such as the NHSApp[13] to do so

[13] https://www.nhs.uk/nhs-app/about-the-nhs-app/

4.2.3 Identify and unlock barriers to support providers to access and offer clinical trials and research to their local populations

4.3 Roll out digital and remote initiatives that support at-home and near-home management

4.3.1 Increase the provision and use of NHS@Home[14] offerings including self-monitoring and at-home diagnostics
4.3.2 Build resource capacity and capability, and provide career development pathways across the system to deliver virtual wards (aligned to the BSW NHS@Home virtual wards programme)
4.3.3 Review and select digital tools and systems to enhance care coordination across providers
4.3.4 Support providers to expand the new digital NHS health check to boost capacity

NB: section 3.3 of this plan also describes our plans to involve communities and local people in the design and delivery of services.

Impact on focus areas

- **Health inequalities** – personalised care will empower our people to take more control of their health. Providing greater choice and awareness will help improve access for all patients, similarly, increasing capacity within primary and community care will enable providers to focus on addressing inequalities and supporting more complex patients.
- **Children and young people** – greater personalised care means that children and young people are actively involved as service users of health services in their own right.
- **Mental health** - we need to bring together treatment for physical and mental health and consider what holistic support an adult or child specifically needs and how best they can access it. Personalised budgets can improve delivery of care and support for those with mental health needs and their unpaid carers.
- **Major conditions** – greater use of technology and personalised care will enable us to consider treatment and support over the long term, particularly when recovery is not possible, managing periods of intensive support followed by periods where less support is needed.
- **Learning disability and autism spectrum disorder** – people with Down's syndrome are at significantly higher risk of experiencing other conditions[15] and we need to make sure we look at people as individuals with needs that may not fit neatly into condition specific pathways.

[14] Refers to NHS@Home definition https://www.england.nhs.uk/nhs-at-home/ which is different to BSW Together NHS@Home (virtual wards programme)
[15] Major conditions strategy

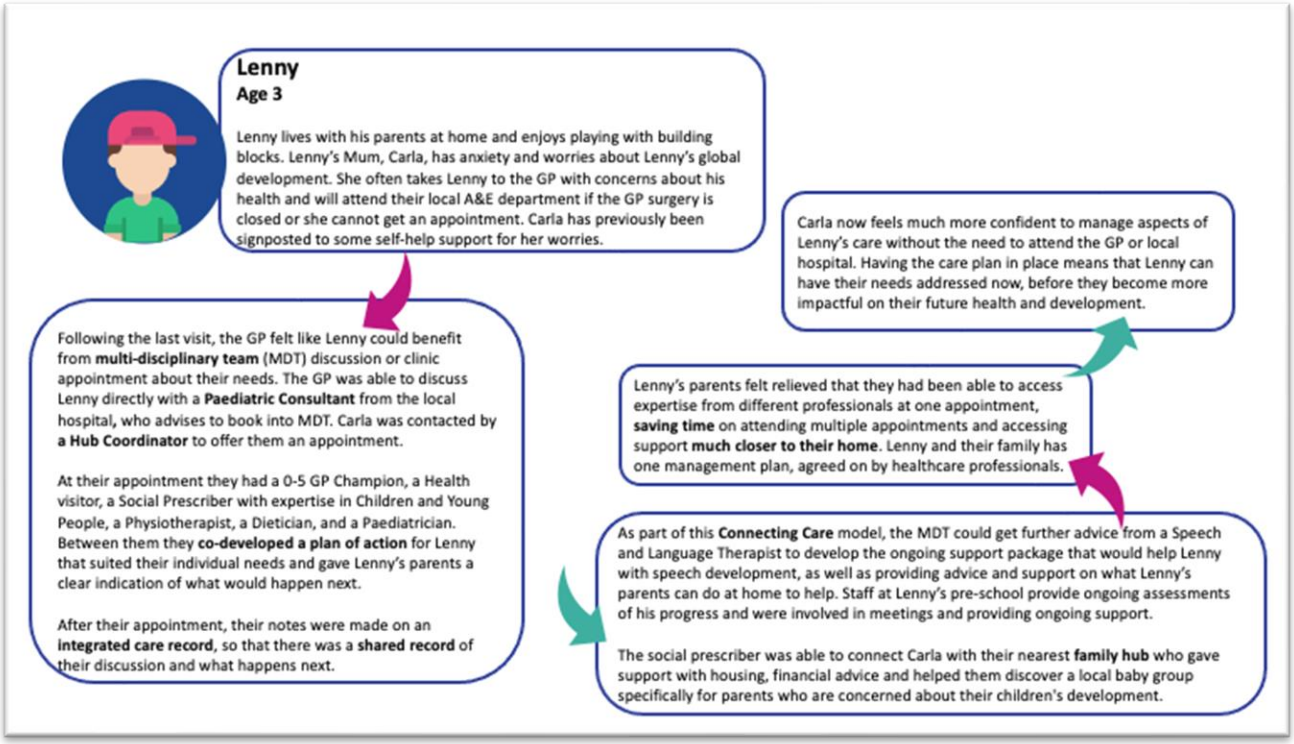

Figure 6: How care could be different – personalised care[16]

[16] Provided by CYP Programme

Priority 5: Improve access to a wider range of services closer to home through greater connection and coordination

Context

Aligned to the BSW Care model, we want to enable our services, particularly specialist services, to be provided and accessed more easily. Equitable access to healthcare and better outcomes can be achieved when we deliver care either at home or closer to where people live. This is particularly the case where there are issues of frailty, deprivation or where there are significant distances required to travel to acute sites from rural locations.

Some local specialist services[17] are already organised around neighbourhoods. We want to increase the range that are delivered closer to communities, provide a greater choice of how and where children and adults access services and deepen connections between services. This will require revising existing models of care, where patients are referred to external specialists, and instead focus on embedding specialists within local teams. This may involve providing advice and guidance to our clinicians, to use case finding for the early identification of individuals who require specialist support, and to prevent referrals for acute care that could have been managed, with appropriate resource and governance, more locally.

Traditional models of delivering care through doctors and nurses can be transformed using non-traditional roles and realising the potential of existing community services. Whilst this might not result in the physical relocation of services or people, we want to create better and stronger links between our services and use technology, data, and our facilities to enable this. This will result in improved experience for patients and resilience of providers working within our neighbourhoods, including general practice.

Our ambition

- Local specialist services are designed around treating co-morbidities with equitable delivery and access to children and adults living in the community
- Providers and organisations work together to support the early identification and treatment of conditions and those at risk of potential deterioration

How we will deliver

5.1 Define the local specialist care model to link services together

5.1.1 Aligned to the local team blueprint (1.1.1), develop a local specialist team system level blueprint that supports a 'core' offer through local specialist teams including where they are located, how they interact and how they can support continuity of care. Specific examples include:

- Explore and adopt alternative referral mechanisms such as self-referral, triage of need, or stepped care delivery (reducing the need for a GP to act as a gatekeeper)

[17] As defined in the BSW Care Model

- Explore integration with providers to improve timely conversion of urgent referrals (such as urgent mental health or urgent suspected cancer referral) including booking and validation activities
- Define a risk stratification, complexity-based model that maximises opportunities to provide care outside of an acute setting

5.1.2 Support local teams to define the required representation and alignment of generalist and specialist resources within their area based on the 5.1.1 blueprint

5.2 Provide more wrap around services within the community

5.2.1 Develop processes to increase coordination between local teams and social care in complex discharge and care planning. Specific examples include:

- Dementia, delirium, and diabetes pathways
- Discharge to assess
- Enhanced health in care homes

5.2.2 Drive increased use of pre-habilitation and re-habilitation to enable patients to manage conditions at home while they wait for elective procedures and recover more effectively following a procedure

5.2.3 Increase provision and acute outreach within the community. Specific examples include:

- Provide seven-day extended access to community diagnostic services (both fixed and mobile) to deliver lower complexity services such as cancer screening, phlebotomy, electrocardiograms, spirometry, childhood asthma, and endoscopies
- Provide pulmonary rehab in areas with health inequalities
- Increase use of geriatricians
- Uplift capacity of urgent community response services

5.3 Increase local teams' access and connections to specialist advice and guidance

5.3.1 Support local teams to utilise existing technologies such as Cinapsis to access advice, guidance, and referrals more effectively

5.3.2 Identify opportunities to improve efficiency in shared-care referral and handover processes for individuals moving into and out of secondary care

5.3.3 Create opportunities for providers to identify and engage with local specialists to build strong working relationships that reduce bounce backs and inappropriate referrals

5.3.4 Create opportunities to transfer skills from specialist colleagues to other members of local teams

Impact on focus areas

- **Health inequalities** – extending services to the most vulnerable groups and places with the highest need enables us to have the greatest impact. Driving secondary prevention (stopping, or delaying the progress of conditions) at the local level means we can shape services to meet the needs of different communities and address inequalities. By diversifying how we deliver services, we can reach more people and reduce their risk of developing more serious illness.
- **Children and young people** – we want to reduce out of area placements which can be disruptive and difficult for both CYP and their families and carers. We can

consider the specific needs of children with complex needs through neurodevelopmental pathways and ensure they receive packages of care that are home-based.

- **Mental health** – we can deliver more local mental health offers and improve access to mental health support for people with Severe Mental Illness by using new access models that provide immediate advice, support and signposting to community and secondary services.
- **Major conditions** – pursuing the full potential of pre-habilitation and rehabilitation, such as those waiting for surgery for or in advance of cancer treatment can improve outcomes and result in children and adults who feel more empowered in their care.
- **Learning disability and autism spectrum disorder** – we want to reduce the number of people cared for in an inpatient unit out of area and deliver a centralised, consistent approach to how we manage escalations and complex cases.

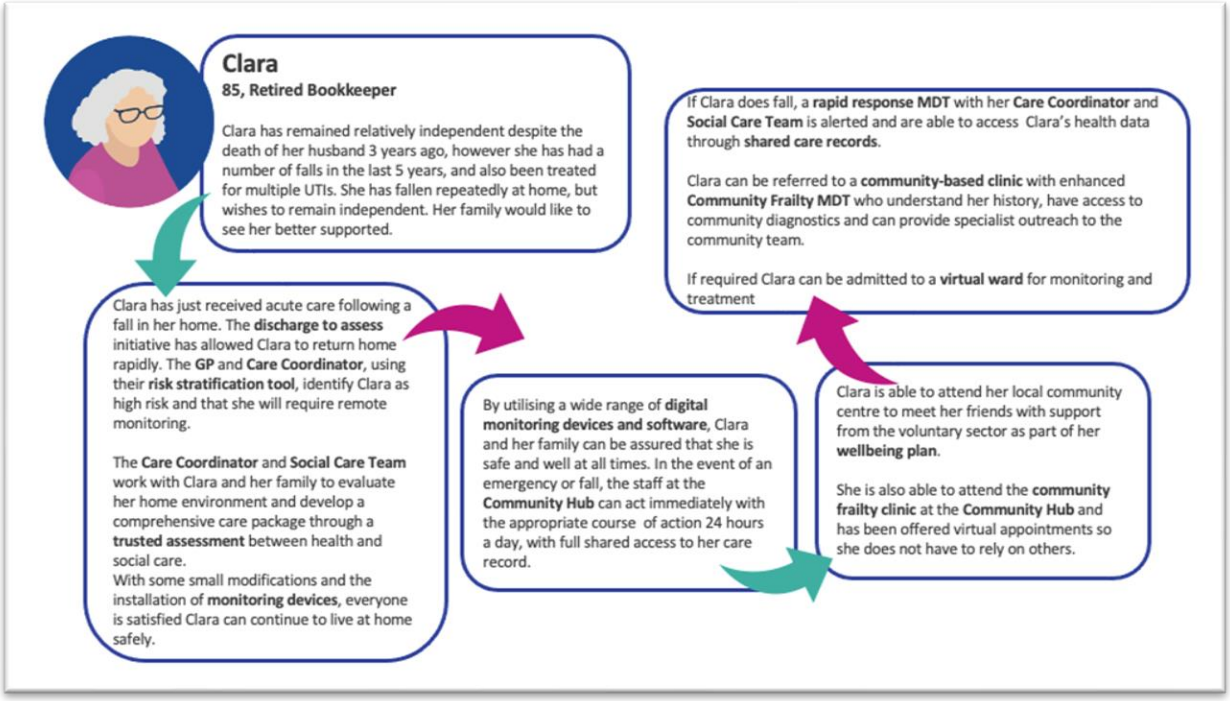

Figure 7: How care could be different – ageing well[18]

[18] BSW Together Integrated Care Strategy

Priority 6: Support access to the right care by providing co-ordinated urgent care within the community

Context

Many children and adults struggle to access same-day urgent care, and this increases the demand on both GP practices and emergency care. In turn, this impacts GPs' ability to provide continuity of care to those who need it most and reduces the capacity of emergency care services to deal with the most life-threatening cases.

Changing how we deliver urgent care – making it more accessible and bringing it closer to babies, children, young people, their parents and carers, and adults – will improve service user experience, staff experience and better management of system wide demand.

Urgent care is currently provided across many different, and often confusing services. They include GP in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community response services, home visiting, community pharmacy, 111 call handling and 111 clinical assessments[19]. We need to move away from these services operating in siloes to a connected system that works together to manage front door demand. We need to make it easier for people to know how they access the right care in the right place, which may be self-care, so they can achieve better outcomes and the system can cope with the demand.

Our ambition

- Increase capacity and capability within the community to enable individuals to resolve urgent but non-emergency needs without recourse to emergency services, reducing avoidable admission and pressure
- Primary and community providers provide consistent access and pathways to manage capacity and demand both in and out of hours, so that we can provide some services 24 hours a day / 7 days a week
- As a system, we offer care that is appropriate to need and makes best use of clinician and patient time
- We use a graduated response in our pathway design to support step-up and step-down services, supporting children and adults to be cared for closer to home

How we will deliver

6.1 Design a system wide single integrated urgent care pathway that can flex to local needs

6.1.1 Investigate opportunities to simplify and standardise services across the system
6.1.2 Explore opportunities to use co-location, local coordination services, or community hubs to deliver single front door access to urgent care

[19] Fuller Stocktake

6.1.3 Identify opportunities to increase access and reduce pressure through winter, while allowing teams to be redeployed as demand changes

6.2 Increase awareness and optimise use of same day urgent care services

6.2.1 Pilot and evaluate a community pharmacy prescribing service for minor ailments, urgent care, and urgent prescriptions

6.2.2 Initiate engagement and communications plan with local communities to improve awareness of urgent care services offered in their area

6.3 Improve the community-based mental health interfaces

6.3.1 Develop appropriate response provision within the community, with first contact provided by third sector partners

6.3.2 Support local teams to deliver mental health crisis response services out of hours and ensure there is provision in rural as well as town areas

6.3.3 Review the provision of mental health practitioners within existing services (such as within general practice)

6.3.4 Deliver the expansion of NHS111 to provide universal access to mental health support

Impact on focus areas

- **Health inequalities** – using co-located hubs and services like community pharmacies, especially those provided locally, can help us to improve access and prevent and reduce health inequalities. Examples include the hypertension care finding service.
- **Children and young people** – delivering urgent care and same day services that are appropriate for children, young people and their parents and carers (such as paediatric short-stay assessment units) can enable them to be cared for closer to home and avoid admission to hospital.
- **Mental health** – we must ensure that we can expand community-based crisis services that are open access, age appropriate and meet local population needs. For example using NHS111 to ensure 24/7 freephone access to mental health helplines
- **Major conditions** – patients with major conditions will have better access to a range of providers to help manage their condition. This will promote and support earlier intervention.
- **Learning disability and autism spectrum disorder** – targeted interventions and support for those at risk of requiring urgent care will improve experience and outcomes.

Enablers

The six enablers outlined in the BSW Together Integrated Care Strategy will underpin interventions and actions that are detailed in this Delivery Plan. Where specifically relevant, the enabling actions are outlined within the transformation priorities, interventions, and actions. Ownership and delivery of these is expected to be driven through existing transformation programmes and strategies.

A summary of the enablers is provided below.

7.1 Financial sustainability and shifting funding to prevention

A key enabler to the primary and community care delivery plan will be the left shift of funds, currently dedicated to treating ill-health, towards initiatives and structures which prevent it in the first place.

The first step will require the system to gain an accurate and consolidated picture of funding and resourcing across self-care, primary care, community care, and hospital care.

Shifting funding to prevention may look like:

- Savings made in core mental health provision are reinvested into targeted wellbeing initiatives, directing funding through our Third Sector Mental Health Alliance
- Focussing on children and young people as they are ‘tomorrow’s adults’
- Investment being reorganised and geared towards personalisation including the wider rollout of personal budgets for service users
- Changing the way we invest so there is more funding for targeted initiatives that address health inequalities
- Supporting our providers (including VCSE and community partners) through more sustainable models

7.2 Developing our workforce

The NHS workforce is under strain throughout the system. To enable this delivery plan, we need to develop both the capacity and the capability of our workforce. Key to unlocking both will be to partner with community partners and VCSEs. This must be aligned with broader programmes such as the BSW workforce programme.

Over 37,600 people work in health and care in BSW, with many more working across the VCSE sector as well, who in turn are also supported by valued volunteers. Work is underway to develop a BSW People Strategy, with a strong focus on recruitment and retention of the workforce. We must make primary and community care (including non-NHS providers such as adult social care and children’s services) an attractive place to work, address reputational challenges that we know exist and ensure our workforce diversity reflects the communities in which we operate. In particular, we need to build general practice capacity as this workforce is fundamental to our ability to deliver joined-up local teams.

One course of action could be to invest in staff training across providers through links with the BSW Academy so that we can better train, retain and reform. We must also understand how we can offer and support training of the third sector through opportunities like shared

budgets, and paid volunteering time. Reviewing our existing ways of working will enable us to ensure equity of time and funding for workforce development across all our providers and partners.

Additionally, a more flexible approach to resourcing will need to be adopted. Workforce planning will need to include Social Care partners, independent/ private providers, and VCSE provision. We must focus on leadership at all levels and across all providers to contribute to and drive our workforce planning. This will require building on our work on Health and Care Professional leadership to develop our system leaders. We should also consider how we can better share the workforce across providers and make the most of non-traditional roles and workforce models across the system.

A particular area of demand is domiciliary care. BSW workforce projections have identified a growing demand with raising rates of frailty and dementia against a backdrop of high staff turnover and decreasing numbers of people applying for care worker roles. In 2022/23, partnership work led by Local Authorities across BSW resulted in the development of a domiciliary care workforce modelling tool. This now needs to be implemented and integrated into wider community workforce planning.

7.3 Technology and data

The BSW Digital Strategy commits to (1) an electronic patient record (2) shared infrastructure across BSW and (3) a system wide approach to the use of technology. All three commitments will be required to enable a significant part of this primary and community care delivery plan.

We must also understand how our information governance frameworks can enable greater sharing of information and risk across partners, and make sure our workforce has the digital skills to deliver. Specifically, data and technology should support:

- Data unlocking areas within PHM including using predictive capabilities to promote prevention and reduce health inequalities
- Joined-up local teams to work together seamlessly through shared care records and increased sharing of information
- Virtual wards and supporting patients to receive treatment and care at or close to home
- Individuals who are empowered to access information and deliver self-directed care
- Improving service user experience through digital tools including self-monitoring and self-referrals where appropriate
- Increased access through tele-medicine and online appointments
- Successful implementation of Modern General Practice Access[20] in PCNs and practices
- Increasing use of AI to support delivery and clinical decision making

[20] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/

7.4 Estates of the future

The way we use estate needs to evolve and become more flexible to the changing needs of our populations. In addition our estates must be supported by integrated technology that enables us to deliver care at the right place based on those needs.

The ICS Estates Board is already working with NHSE to develop a national estates toolkit and the BSW Infrastructure Strategy[21]. One of its aims is to support clinical pathway redesign and the left-shift of care delivery in line with the BSW care model.

This new direction will support the primary and community care delivery plan. For example, estates should support:

- Modernisation of primary care infrastructure including GP surgeries that creates a positive working environment for staff and service users
- Virtual consultations to reduce the need to come into buildings and bring care closer to home
- Multi-use of existing wider public, community and third sector estates to be able to provide services closer to home
- Increased flexible and mixed use of NHS Estates including allowing community use
- Consolidation of back-office functions enabling the workforce to work across different locations, reducing unwarranted variation in care, and enabling joined-up working
- The removal of organisational barriers and an increase in utilisation across all settings to maximise the use of our investments

7.5 Environmental sustainability

The BSW Green Plan 2022-25 published in July 2022 sets out how we will begin to reduce the environmental and carbon impact of our health and care estate, services, and wider activities over the next three years. It sets out how we will work towards achieving net zero by 2040 for direct emissions and 2045 for the emissions we can influence.

We must consider how we enable people and organisations to make decisions which benefit the environment. Any design or delivery of primary and community services must consider the environmental impact and seek to reduce it wherever possible. Bringing care closer to home can reduce travel time for both service users and practitioners and making better use of our resources and estates can reduce waste and emissions.

7.6 Our role as anchor institutions

We must harness the potential of our anchor institutions (such as the ICS, acutes and local authorities) to play a greater role in promoting the social and economic interests of the local areas they are rooted in.

All primary and community care providers and partners should seek to support and benefit from BSW's role as an anchor institution. This includes creating jobs for local people, investing in local infrastructure, and supporting local businesses. Using local providers for

[21] BSW Together Implementation Plan

our primary and community care services will also support a greater contribution to the social and economic wellbeing of our communities.

7.7 Commissioning and contracting

The way in which our services are commissioned and contracted needs to change for us to deliver more joined up care. We have therefore included an additional enabler for the purposes of this delivery plan.

Our providers will only be able to deliver if they are sustainable, so we need to create a funding model that enables that.

Greater emphasis should be placed on collaboration and working across the system and therefore we must consider how services are funded and incentivised to enable this. At the same time contracts should be reviewed to remove unnecessary barriers as well as support new models of care.

We need to include all those who can support us to deliver better health and care, such as the voluntary sector, and move away from only looking at traditional providers.

Key areas that we need to consider include:

- Exploring alternate models of funding and commissioning such as outcome based and place-based contracts
- Reviewing the primary care and GP commissioning approach
- Develop the capability to measure ‘value for money’ and track progress towards a ‘left shift’
- Reduce contractual barriers between providers that is increasing competition and inhibiting collaboration
- Enabling innovation within our contracts by increasing flexibility of available funding

Appendix

Appendix 1.1: Key drivers

Tackling health inequalities

Although more affluent than the England average, BSW has a highly inequal distribution of wealth[22]. There is a strong link between a higher prevalence of health conditions and living in less advantaged communities. This is due to factors including ease of access to health and care services and wider determinants of health. Delivering health and care interventions within the community and as close to peoples' homes is key: it improves access; promotes prevention; and often results in better outcomes due to better treatment uptake.

Addressing an ageing population

The BSW population is projected to grow by 6% over the next 15 years with an additional 60,000 residents in 2038 falling in the over-60 category (representing a 35% increase in this age category).[23] An older demography is associated with increasing complexity, multi-morbidity, and frailty of our people. This increases pressure across health and care providers, local authorities, VCSE organisations, and the wider public sector. Primary and community care supports better management of age-related conditions locally, which can prevent deterioration and help people to live independently for longer.

Increasing pressure on existing primary, community, and social care services

Demand on health and care services is increasing year-on-year and is acutely felt on front-line staff and services. Within primary care, there is growing discontent from both children and adult service users and professionals, with patient satisfaction at an all-time low. Challenges with urgent care access is impacting GPs' ability to delivery continuity of care to those who need it most. Additionally, social care services are under pressure both locally and nationally. Growing demand, longer waiting times for both physical and mental health and complex health needs are adding pressure to services for children and young people and leading to preventable deterioration of conditions.

GPs practices are having to work harder and longer to meet contractual targets and they face inflexible funding streams. Estates and technology are extremely variable; old buildings with poor connectivity limit GPs' ability to increase capacity through a digital-first offering. Within community care, BSW needs to improve the sustainability of providers and overcome current commissioning challenges. Without sustainable provision, particularly in GPs, PCNs and VCSEs, BSW will struggle to deliver the core elements of this delivery plan.

Addressing wider health and care pressure

Increasing complexity and frailty for adults is anticipated to cost our acute, inpatient, outpatient, and accident and emergency services an additional £5M per year for the next 15

[22] BSW Together Integrated Care Strategy
[23] BSW Case for Change analysis

years (before inflation or new treatments). An already stretched urgent and emergency care is facing an additional 115 acute beds, 40 ambulance journeys, and 51 emergency department attendances a day in five years' time[24]. This significantly impacts the quality of care that individuals receive. For children, there has been an increase in attendances where they could have been seen in community settings and we must address the complex reasons for presenting in urgent care and out of hours settings.

Primary and community care can reduce front door emergency demand and provide alternate urgent care pathways within the community. Similarly, it can support flow through admission avoidance as well as discharge and at home-support to ensure better continuity of care.

Integrating to deliver a better experience and outcomes for our adults and children

A key tenet of ICSs is to integrate the delivery of health and care services across an area and between providers. Primary and community care is often the first, and last, interaction that individuals have with the health system. Children and adults move from GPs through to secondary and tertiary care, and then are discharged back into the care of primary, community, and social providers. Many people will recognise the pain of constantly repeating symptoms, diagnostic tests, and ineffective and confusing care and support as they are transferred between providers.

Truly integrated care must be based on local population needs and a person-centred approach. This means increasingly integrated ways of working between primary and community care workers and the wider system. This should be supported by technology and data, new commissioning arrangements and flexible estates so that can be coordinated to respond to the individual needs of children and adults.

The economic value of health and care

A healthy population is critical to a healthy economy. In BSW, around 30% of GPs are over 50, and the ratio of people who are over the retirement working age will drop from 1:3.1 to 1:2.3 in 15 years.[25] This ageing population is impacting the number of people in our communities who are economically active and contributing to our economy. Ill health is also a large contributor to economic cost, with lost output due to illness among working age people estimated to be 7% of gross domestic product (GDP).[26] There is some evidence of a relationship between health spending and economic growth, with spend on community and primary care having the largest effect.[27] Healthy babies, children and young people will be the healthy adults of our future and are the future working population. This supports a key enabler of the BSW Together Integrated Care Strategy – shifting funding to prevention (left shift).

[24] BSW Case for Change analysis
[25] BSW Case for change analysis
[26] Major Conditions Strategy
[27] https://www.nhsconfed.org/publications/creating-better-health-value-economic-impact-care-setting

Appendix 1.2: Delivery plan methodology

System and national documents reviewed

- BSW Together Integrated Care Strategy
- BSW Together Implementation Plan
- NHS Long term plan
- Fuller stocktake report
- Major conditions strategy
- Delivery plan for recovering access to primary care
- NHS long term workforce plan
- BSW Case for change
- Avoidable admissions + Frailty
- Benefits Master Version
- SO CSF PWF and Benefits
- ICBC Programme outputs
- ICBC service design
- ICBC service design CYP
- Children's services review
- Care model personas
- NHS long term workforce plan
- Major Conditions Strategy
- Creating better health value: understanding the economic impact of NHS spending by care setting
- Market engagement July
- Market Engagement August
- ICBC SOC extract
- Healthwatch report

Supporting narrative

BSW Together Integrated Care Strategy[28] and Implementation Plan[29]

The BSW Together Integrated Care Strategy 2023-2028 was published in March 2023. It sets out the ambition for the BSW ICS as well as partners in health, social care, and the voluntary sector, to enable local people to live happier and healthier for longer.

The strategy outlines three objectives

1. Focus on prevention and early intervention
2. Fairer health and wellbeing outcomes
3. Excellent health and care services

It is supported by an Implementation Plan published in July 2023. This brings together initiatives underway or planned across the ICS, including Place based plans, related to the strategic objectives and commitments outlined in the strategy. This delivery plan has identified and consolidated key priorities from the Implementation Plan.

NHS long term plan[30]

The 10-year plan published in 2019 sets out the NHS's plan to be fit-for-the-future and for delivering care for patients. Within the plan are commitments to increase investment for primary medical and community health services; increase rapid community response teams; bring people together to coordinate care better; and tackle health inequalities; and a focus on babies, children, young people, and their parents and carers. To enable this, there

[28] https://bswtogether.org.uk/wp-content/uploads/Integrated-Care-Strategy-v4.pdf
[29] https://bsw.icb.nhs.uk/document/bsw-implementation-plan/
[30]https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

must be a focus on attracting and retaining a flexible workforce, and making better use of data, digital and technology.

Fuller stocktake[31]

Published in May 2022, the Fuller report covers the current challenges and outlines a vision for better integration of primary care. Key elements include: the evolution of PCNs into integrated neighbourhood teams; using a population-based approach to build models of personalised care and targeted interventions; bringing together specialist and generalist workforces; and developing a single integrated urgent care pathway. Underpinning these is the ability to drive improvement through system leadership; optimising estates across networks; improving data and digital transformation; and ensuring ongoing primary care sustainability.

The vision outlines key areas for primary and community care: greater choice about how people access care which is available in the community when they need it; providing proactive personalised care through multidisciplinary teams; and helping people stay well for longer.

Major conditions strategy[32]

This strategy, released in August 2023, considers the whole care pathway from prevention to treatment for six major conditions: cancer, cardiovascular diseases including stroke and diabetes, chronic respiratory diseases, dementia, mental ill health, and musculoskeletal disorders. It articulates how these affect people throughout their lives, including children, young people and working age adults as well as older people.

25% of adults in the UK have at least two of these conditions and they drive over 60% of mortality and morbidity. The strategy takes a whole care and whole life approach to tackling these conditions by focussing on proactive prevention and early intervention; better management of multiple conditions; investing in Children's Health; and better connection, integration, and design of services. For those conditions that aren't preventable, we need to deliver specialist support and ongoing management that can be delivered easily in the community.

Delivery plan for recovering access to primary care[33]

Published in May 2023, the delivery plan aims to tackle the 8am rush and ensure individuals get the help they need from primary care. It focuses on four areas to reduce pressure and improve access: building capacity; reducing bureaucracy; empowering patients; and modernising GP access. Delivering this will require improving information,

[31] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf
[32] https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2
[33] https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf

functionality, and interoperability of technology; expanding community pharmacy; and increasing capacity through enabling workforce and estates initiatives.

NHS long term workforce plan[34]

Workforce remains a key challenge for the NHS and this plan, published in June 2023, aims to understand future requirements, and set direction for the workforce. It outlines three key areas of focus: train, retain and reform. Train recognises the need to grow the workforce through increased training for doctors and nurses and the expansion of other professions. Retain centres on improving culture, leadership, and wellbeing to improve retention. Reform aims to support the workforce to work and train differently, within multidisciplinary teams, and harnessing digital and technological innovations.

[34] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Appendix 1.3: Focus areas

A summary of the focus area and relevance to primary and community care is provided below.

Health inequalities

Although more affluent than the England average, BSW has a highly inequal distribution of wealth[35]. There is a strong link between a higher prevalence of health conditions, poorer life outcomes and living in less advantaged communities. For example, the most deprived 20% areas of Wiltshire have repeatedly poorer outcomes than the least deprived 20%, with similar patterns seen in other areas.[36] This can be due to factors including ease of access to health and care services and wider determinants of health. Delivering health and care interventions within the community and as close to peoples' homes is key: it improves access; promotes prevention; and often results in better outcomes due to better treatment uptake. We can also build on safeguarding work to have oversight of our most vulnerable communities aligned to our ambition to reduce inequalities.

Primary and community care providers can come together and use data, insight, and their local links to better understand where inequalities exist, and design tailored initiatives that tackle them. A greater focus on improving the life chances of children, especially those under five with a focus on early years will create fairer society and reduce health inequality.[37]

Children and young people (CYP)

Children and young people (0-25 years) represent 30%[38] of our population and are a key opportunity to break progression cycles and enable prevention in action for the improved health and wellbeing of our future population. However, many services are under extreme pressure due to growing demand post-Covid resulting in long waiting times and poorer health and learning outcomes.

As part of the CYP strategy development, BSW must scope, plan, and deliver a comprehensive suite of CYP primary and community services for babies, children and young people that meet local needs. We need to work more closely with local authorities and the education sector to make sure our children get the best possible start in life.

Mental health

Mental health conditions have been rising across BSW for adults and children. We need to focus on improving mental health across the system and ensure the principle of 'parity of esteem' is encompassed across our priorities. People with a mental illness are statistically

[35] BSW Together Integrated Care Strategy
[36] BSW Together Implementation Plan
[37] https://www.bmj.com/content/340/bmj.c818#:~:text=News-,Focus%20on%20early%20years%20will%20create%20fairer%20society,health%20inequality%2C%20Marmot%20review%20says&text=More%20public%20money%20should%20be,evidence%20based%20review%20has%20concluded
[38] BSW Integrated Care Strategy

more likely to also have a physical health condition[39] and we need to co-deliver services to provide a more holistic approach to comorbidity.

Many mental health services can, and should, be provided within the community. Aligned to the community mental health framework[40] and BSW mental health strategies[41], we need to expand services by working with local partners and providers who can help people with mental health conditions to easily access services when and where they need it, manage their conditions, or support individualised recovery, and enable them to contribute to and be participants in the community.

Major conditions

Nationally, people with two or more conditions account for around 50% of hospital admissions, outpatient visits and primary care consultations, over half of NHS costs and around three-quarters of the costs of primary care prescriptions. They also have an economic cost to the nation where long-term sickness is the most common reason for being economically inactive.[42] 16% of children up to 15 years old had one or more long standing condition, increasing to one in four for those aged 16 to 24[43]. These children will require support throughout their lives in the management of their long-term conditions.

Locally, major conditions are also a challenge with BSW currently spending over £120m on events and complications due to diabetes and cardiovascular disease.[44] We can address lifestyle drivers and behavioural risk factors, increase prevention, and maximise early intervention through targeted and considered involvement and integration of primary and community providers and partners.

Learning disability (LD) and autism spectrum disorder (ASD)

People with a learning disability have a 49% rate of avoidable death, compared to 22% in the general population.[45] One of BSW's transformation programmes centres around Learning disability and autism and is a key theme within local Implementation Plans for Bath and North East Somerset, Swindon, and Wiltshire. Across the system, we want to reduce the number of people who receive inpatient care; by expanding community provision and delivering initiatives locally that reduce admission. We need to identify and address care gaps such as missing recommended screening or access to early diagnosis and intervention services. We want to improve accessibility and ensure we can deliver care that recognises the specific needs of this cohort and the impact of comorbidity.

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[39] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing
[40] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf
[41] BSW Together implementation plan
[42] Major Conditions Strategy
[43] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018
[44] BSW Together Implementation Plan
[45] https://www.kcl.ac.uk/research/leder

Glossary

Term	Description
AI	Artificial intelligence
ASD	Autism spectrum disorder
BSW Together	Bath and North East Somerset, Swindon, and Wiltshire integrated care system
CAMHS	Child and adolescent mental health service
COPD	Chronic obstructive pulmonary disease
CYP	Children and young people
GP	General practice
HR	Human resources
ICB	Integrated care board
ICBC	Integrated community-based care
ICS	Integrated care system
INT	Integrated neighbourhood team
LD	Learning disability
MDT	Multidisciplinary team
MHST	Mental health support teams
PCN	Primary care network
PHM	Population health management
POD	Pharmacy, optometry, and dentistry
SEND	Special educational needs and disabilities
SENDCO	Special education needs and disability coordinator
UTI	Urinary tract infection
VCSE	Voluntary, community and social enterprise