Bath and North East Somerset, Swindon and Wiltshire Together

BSW ICP Meeting in Public - Agenda

12th March 2024, 13:00-16:00, Kennet Meeting Room, County Hall, Bythesea Road, Trowbridge BA14 8JN

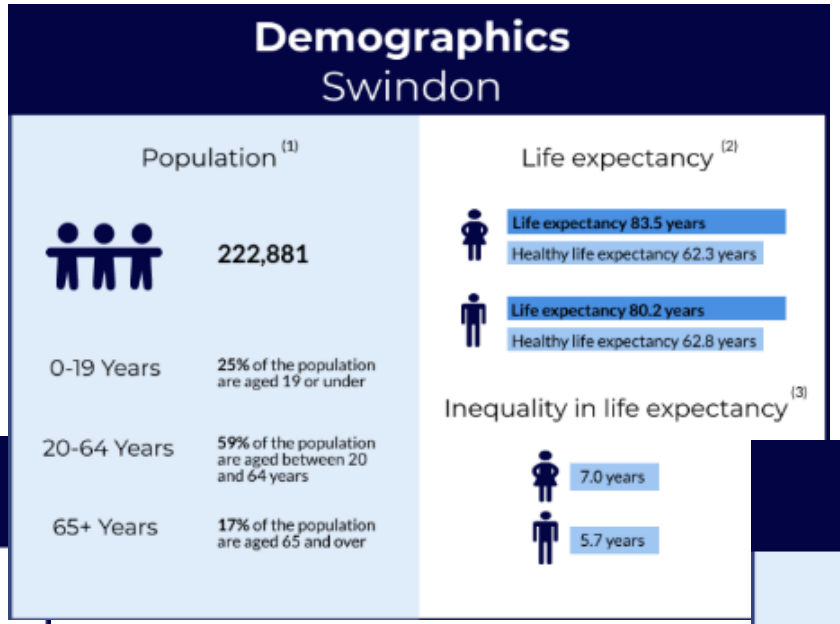
Timing	No	Item title	Lead	Action	Paper ref.
13:00	1	Networking with colleagues			
Opening Business					
14:00	2	Welcome and Apologies	Chair ICP	Note	Verbal
	3	Declarations of Interests	Chair ICP	Note	Verbal
	4	Minutes from last meeting 24th October 2024	Chair ICP	Approval	
	5	Public Questions	Chair ICP	Note	Verbal
Business Items					
14:15	6	**BSW Together strategy Prevention and Early Intervention led by BaNES** Introduction and overview of the session	Rebecca Reynolds	Discuss/ Note	Verbal/ Presentations
14:20	6b	Wider context of the three places and contributions from system partners to improving health	Abbey Mulla		
14:30	6c	'Prevention': what do we mean by the term in the context of improving health	Rebecca Reynolds		
14:45	6d	Delivery against BSW Integrated Care Strategy Outcome One (Prevention and Early Intervention) 23-24	Lucy Heath/ Amanda Webb		
14:55	6e	Moving forward: the Prevention Strategy group - a refreshed approach to providing strategic direction to prevention and early intervention	Rebecca Reynolds		
15:05	6f	Early proposed key deliverables for 24-26 against BSW Integrated Care Strategy Outcome One (Prevention and Early Intervention)	Lucy Heath/ Amanda Webb		
15:15	6g	The role of Population Health Management underpinning this work	Sam Wheeler/Kate Blackburn	Note/ Discuss	Verbal/ Presentations
15:35		The role of the ICP to help support and drive this work going forward	Rebecca Reynolds		
Closing Business					
15:45	7	Chairs summary and direction	Chair ICP	-	Verbal

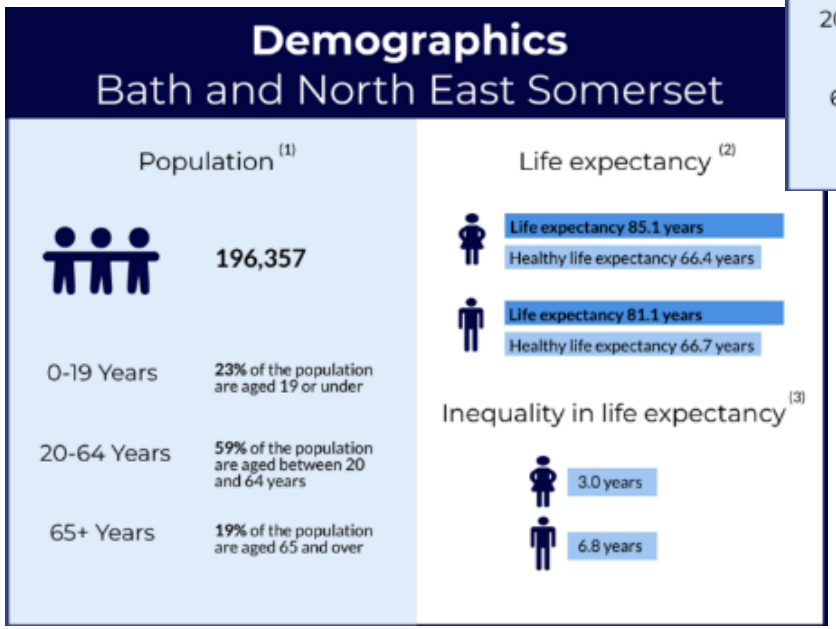
Bath and North East Somerset,
Swindon and Wiltshire Together

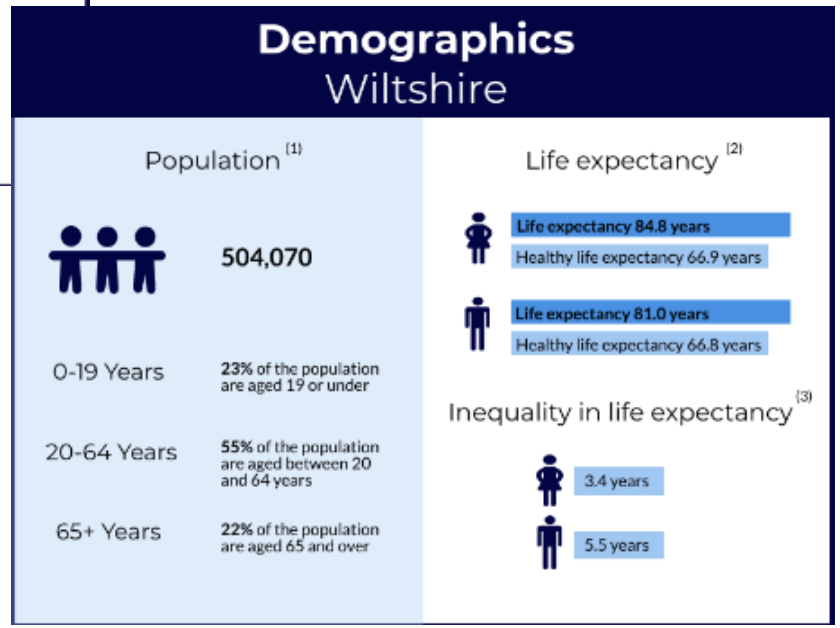
Wider context and contributions from system partners

Abbey Mulla, Head of Health
Inequalities and Prevention, BSW ICB

Place Demographics







Life expectancy

- Across the three areas varies from 73 years to 91 years

Diversity

- Approximately 87,000 people from ethnic minority communities live in BSW (ONS, 2021).
  - Swindon has significantly more residents from a black and ethnic minority group: 18.5% in Swindon, compared to 7.8% in BANES and 5.6% in Wiltshire (ONS, 2021).
  - In all three areas the largest ethnic group after ‘White British’ is ‘Asian/Asian British/Asian Welsh’ (ONS, 2021).

Deprivation

- BSW is one of the least deprived parts of the country (IMD) (2019) but:
  - 14 neighbourhoods within the most deprived 10% nationally (2 in BaNES, 1 in Wiltshire, and 11 in Swindon).

Rurality

- A high proportion of areas are considered rural across BSW, especially across Wiltshire and BaNES.
  - Rural areas face challenges around transport, broadband connectivity
  - Acute trusts tend to treat more older people than in urban areas.

Children's health

- Most child health indicators are better than national average, however:
  - 1 in 4 children do not achieve a good level of development at the end of Reception
  - 1 in 10 children are living in poverty
  - 1 in 200 children are in care
  - Obesity and mental health problems are increasing

BSW has a combined population of approximately 941,000 people

- Significant population growth in the older age groups is expected
- Currently over 80,000 people are aged over 75
- By 2025 this is expected to grow by over 40 per cent to over 100,000
- BSW population is likely to exceed one million, with one in five people - or more than 200,000 - aged over 65 years

Areas of concern in BSW

180,000 people have some form of mental health condition

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

Nearly 6% of the population has diabetes

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

100,000 adults are smokers

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

Role of Health and Wellbeing Boards

There are three Health and Wellbeing Boards for BSW. They are a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Minimum membership required includes:

- local elected representative
- local Healthwatch representative
- local director of adult social services
- local director of children's social services
- local director of public health
- ICB representative

Additionally, local boards include:

- Police and Crime Commissioner
- NHS Provider Organisations and Community Services
- Mental Health Providers
- Local Medical Committee
- Fire and Rescue Service
- VCSE Leadership Alliance
- Council Opposition Group representative
- Ambulance Service
- NHSE
- Universities
- 3SG
- Curo

Health and Wellbeing Strategies Priorities

BANES
- Ensure that children and young people are healthy and ready for learning and education.
- Improve skills, good work and employment.
- Strengthen compassionate and healthy communities.
- Create health promoting places.

Swindon
- Improve mental health and wellbeing.
- Eat well and move more.
- Stop smoking and reduce alcohol.

Wiltshire
- Prevention and early intervention.
- Improving social mobility and tackling inequalities.
- Integration and working together.

Role of Integrated Care Alliances

To ensure that our health and care services meet the needs of the many different communities living across BSW, we have three "localities", each represented by place-based partnership called Integrated Care Alliances (ICAs).

Each ICA is made up of local doctors, hospital chief executives, clinical commissioners, council officers and patient and voluntary and social enterprise sector groups and will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. Each will play their part in empowering people to live their best life.

The Integrated Care Alliances in BaNES, Swindon and Wiltshire have responsibility for oversight and assurance of the delivery of the relevant parts of the Integrated Care Strategy and the Local Health and Wellbeing Strategy

‘Prevention’

What do we mean by this term in the context of improving population health?

Becky Reynolds

BSW ICP meeting 12 March 2024

‘Prevention’ – what are we preventing?

‘Prevention’:

- **Hospital admission lens:** predicting and preventing avoidable admissions to hospital or long-term residential or nursing care
- **Social care lens:** providing a protective layer of support to individuals and families to prevent problems from arising
  - Early intervention: intervening early by offering programmes and services for individuals and families who show signs of needing support
- **Improving population health lens:** preventing disease or a health problem from occurring, or reducing the impact of it if it has

Prevention – improving population health

- **Primary prevention:** stopping disease or health problems before they develop in a person who is “well”
- **Secondary prevention:** detecting a disease or health problems early by identifying individuals for whom a disease process has already begun and intervening early to reduce illness and death associated with disease progression
- **Tertiary prevention:** managing established chronic disease or health problems to reduce their impact
- **Wider determinants of health:** improving health by strengthening the social, economic and environmental building blocks that affect health

Prevention is everyone's business – some examples….

	Wider determinants – factors which influence how people live and/or behave	Primary prevention – stopping disease/health problem before it develops	Secondary prevention - detecting disease/health problem and intervening early	Tertiary prevention - reducing impact of disease/health problem
Individuals and families	• Contribute to formal and informal activities that strengthen society	• **Make positive changes to improve own health** • Support friends and family to make positive changes to improve health	• **Take up invitations to attend screening appointments, and encourage family and friends to do the same**	• **Work with healthcare and community services to develop confidence in self-managing long term health conditions**
Community, primary and secondary healthcare providers	• **Engage with being an Anchor Institution** • Seek to engage and employ people from under-represented groups • Be a good employer • Promote active travel to workforce and community • Have a Smoke Free Site • Procure with social responsibility • Consider green space available onsite and how this could be developed/used • Advocate for the community to make the local area more amenable to a healthy life	• Support patients interacting with secondary care to take more control of their health • Make necessary referrals to services for lifestyle interventions eg exercise on referral • Provide smoking cessation services • Identify unimmunised and provide routine and catch-up immunisations	• Cardiovascular disease prevention including through NHS Health Checks • Effective and efficient cancer diagnostic pathways for early diagnosis • Identify patients who smoke or drink alcohol with impacts on disease pathway • **Refer frail patients or those at risk of falls to preventative services** • Support role of carers	• **Work with patients and community organisations to manage multi-morbidity and complex long-term conditions, eg, pain management in cancer care, ulcer care in diabetes, support for remaining independence in frailty** • Understand and meet workplace needs of employees managing long term health conditions • Provide quality end of life care

Acknowledgement to work of BSW Consultants in Public Health, CVD Programme Manager, and Public Health Registrars for much of these slides

	Wider determinants – factors which influence how people live and/or behave	Primary prevention – stopping disease/health problem before it develops	Secondary prevention - detecting disease/health problem and intervening early	Tertiary prevention - reducing impact of disease/health problem
Community pharmacy	• Seek to engage and employ people from under-represented groups • Be a good employer • Promote active travel to workforce and community • Have a Smoke Free Site • Advocate for the community to make the local area more amenable to a healthy life	• Provide information on healthy lifestyle, self-care and support services (eg, stopping smoking, maintaining a healthy weight, social prescribing) • **Deliver seasonal flu vaccination programme**	• **Deliver the NHS Community Pharmacy Blood Pressure Check Service**	• **Provide information and support on management of medicines for people managing long term health conditions**
Third Sector	• **Influencing, advocating and lobbying for local communities** • Seek to engage and employ people from under-represented groups • Be a good employer • Promote active travel to workforce and community	• Facilitate flu and covid-19 vaccination outreach with targeted communities • Embed prevention messages into communications, projects and service delivery • **Provide insight into under-served communities to inform Joint Strategic Needs Assessments, strategy development and commissioning**	• **Facilitate blood pressure testing particularly to higher risk and underserved groups** • Provide insight into under-served communities to support local commissioning and development of detection approaches which reduce inequalities	• Provide information materials and signpost sources of advice and support to those managing/monitoring long-term conditions

	Wider determinants – factors which influence how people live and/or behave	Primary prevention – stopping disease/health problem before it develops	Secondary prevention - detecting disease/health problem and intervening early	Tertiary prevention - reducing impact of disease/health problem
Local authorities	• **Use planning, regulation, overview and scrutiny and other levers to maximise opportunities to improve health through, eg, the Local Plan, transport plans, trading standards, economic strategy, environmental health, affordable housing, education, access to green spaces etc** • Leverage influence with other local organisations of all sectors • Work with local communities to understand need and co-create solutions • Procure with social responsibility	• Deliver comms activities that raise awareness of living healthily • Ensure provision of wellbeing services that support healthier lifestyles, eg, stop smoking, alcohol brief interventions, behaviour change programmes • Ensure that social care services integrate prevention and healthy lifestyle messages into all pathways • **Support behavioural change training for social care professionals to enable effective conversations about healthy lifestyle, as part of their wider work** • Provide community leisure centres	• Commission the NHS Health Check programme • Promote cancer screening to identified populations • Contribute to development and delivery of outreach screening programmes • Accommodate NHS referrals aimed at physical rehabilitation after illness at community leisure centres	• **Understand and meet the workplace needs of employees managing long term health conditions** • Enable flexible working arrangements

	Wider determinants – factors which influence how people live and/or behave	Primary prevention – stopping disease/health problem before it develops	Secondary prevention - detecting disease/health problem and intervening early	Tertiary prevention - reducing impact of disease/health problem
BSW Integrated Care Board	• Engage with being an Anchor Institution • **Seek to engage and employ people from under-represented groups** • Be a good employer • Promote active travel to workforce and community • Have a Smoke Free Site • Procure with social responsibility	• Use tools available such as strategy development, commissioning, training, programme transformation and monitoring to drive action on primary prevention • **Review levels of 'prevention' financing to drive improved levels of activity across the system** • Work to ensure the system has routine access to high quality primary prevention data • Bring together networks to work on joined up care pathways e.g. CVD prevention	• Use Population Health Management to understand the size and distribution of unwarranted variation in detection and management of disease and inform interventions to address this • Bring together networks to work on joined up prevention pathways e.g. CVD prevention • **Use tools available such as strategy development, commissioning, training, programme transformation and monitoring to drive action on secondary prevention** • Support primary care to deliver incentive schemes such as QOF, DES and IIF priorities related to prevention	• Use tools available such as strategy development, commissioning, training, programme transformation and monitoring to drive action on tertiary prevention • Understand and meet the workplace needs of employees managing long term health conditions • Enable flexible working arrangements

	Wider determinants – factors which influence how people live and/or behave	Primary prevention – stopping disease/health problem before it develops	Secondary prevention - detecting disease/health problem and intervening early	Tertiary prevention - reducing impact of disease/health problem
Other employers	• **Engage with being an Anchor Institution** • Seek to engage and employ people from under-represented groups. • Be a good employer • Promote active travel to workforce and community • Have a Smoke Free Site • Procure with social responsibility	• **Support healthy workforce practices and identify opportunities to support employee health and wellbeing, eg, supporting healthy eating, physical activity, stopping smoking, mental wellbeing, alcohol use, musculoskeletal health**	• **Support outreach NHS Health Checks delivered in the workplace** • Enable flexible working arrangements	• Understand and meet the workplace needs of employees managing long term health conditions • Enable flexible working arrangements

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Swindon and Wiltshire Together

Delivery against BSW Integrated Care Strategy Outcome One

Prevention and Early Intervention

2023-2024

5.4 OBJECTIVE 1

Focus on prevention and early intervention.

Area of focus

1. Focusing funding and resources on prevention rather than treatment
2. Intervening before ill-health occurs (primary prevention)
3. Identifying ill-health early (secondary prevention)
4. Slowing or stopping disease progression (tertiary prevention)
5. Wider determinants of health

5.4.1 Focusing funding and resources on prevention rather than treatment

Our commitment…

- Partners across the ICP will work together to identify an accurate picture of funding and resourcing across BSW when it comes to self-care, community care and hospital care.
- We will aim to increase the share of health and care funding going towards preventative measures (self-care and community care) over the next five years. Our ICP will monitor over time the degree to which this balance is shifting

Focusing funding and resources on prevention rather than treatment

What we said we would do…	What have we done…
We will come together as partners across the ICP to identify the proportion of funding spent on prevention. Initial measurements will be worked up through the Population Health Board and the Finance and Investment Committee which will report to the integrated care board and tested through engagement. We will use national definitions and metrics where practicable (e.g. UK Health Accounts).	• As part of the Integrated Community Based Care (ICBC) procurement there has been a robust analysis of resources streams around community care. • There has been focussed action to improve the uptake of Personal Health Budgets.
We will endeavour to create a repeatable definition and prepare comparable figures year on year. By March 2024, we expect to have a common, recognised spend baseline for prevention.	• This is a complex area and further works is planned through the Population Health Board.
We will take a similar approach to determine a spend baseline for babies, children and young people's services. This reflects our commitment to increase the spend on young people's services.	• Community services for babies, children and young people are an integral part of the ICBC procurement.
In developing medium term financial plans, we will increase weighting of new investment decisions in favour of the six prevention focus areas outlined in our strategy.	• There is ICB Board commitment to invest £5 million in preventative measures (subject to final budget sign off). This will be invested in the six prevention focus areas.
Successful implementation of financial sustainability plans will deliver improvements in the use of resources allowing reinvestment in prevention. All business cases will need to outline how they will address health inequalities across our population to proceed.	• The ICS Investment Committee has developed a prioritisation framework which includes increased weighting on preventing future illness or complications of current conditions and addressing health inequality or health equity.

5.4.2 Intervening before ill-health occurs (primary prevention)

Our commitment…

Physical wellbeing

1. We will increase the proportion of physically active adults 2.
2. We will reduce the proportion of adults considered overweight or obese .
3. We will increase the proportion of children and young people who are healthy weight

Mental wellbeing

1. We will improve Personal Wellbeing ONS4 scores (Life Satisfaction, Worthwhile, Happiness, Anxiety)
2. We will reduce the prevalence of mental health conditions

Smoking

1. We will further reduce the proportion of people in BSW who smoke
2. We will expand stop smoking services across partners, recognising the opportunities that points of interaction with services offer on prevention. A current example of this is the Treating Tobacco Dependency service.

Physical wellbeing

B&NES	Swindon	Wiltshire

Whole systems approach to obesity strategy developed
• supported by a Whole systems Working Group and Steering Group.
• System mapping and stakeholder consultation completed.
• Ongoing work with community partners to define system priorities and develop action plans.
• Final framework and action plan to be completed by May 24.
	Whole system approach to obesity strategy approved by Health and Wellbeing Board (HWB)
	• Delivery plans for each thematic area :
	  • food environment,
	  • physical activity environment
	  • identification and management
	  • positive community influences
	  • schools and services
	• Action plans approved by HWB.
	• School Nutrition and Activity Project in Swindon evaluated.
	• Contract for Tier 2 WM services extended until 2025
		Whole system approach to healthy weight scoped
		• Core working group set up
		• Mapping of local system progressed
		• Food insecurity work incorporated
		• Tier 2 WM services promoted including digital.

The ICS has partnered with LA colleagues to enable a joined up approach to supporting health weight. • Working group formed to tackle current challenges in weight management services and scope vision for future weight management pathway. • Specialist Children with Excessive Weight (CEW) clinics expanded.		

Mental Wellbeing

Community Mental Health Services	New model for CYP MH in Swindon	Improve talking therapies provision	Implement new GP LES
• Improved access to MH support for people with Severe Mental Illness through new access models that provide immediate advice, support and signposting to community and secondary services as required at PCN level. • Reviewed and developed secondary MH service provision to provide timely therapeutic interventions aligned to PCNs and ARRS investment. • Continued redesign of pathways for older adults, people with complex emotional needs (personality disorder). Young people aged 16-25, people who need community based rehab and people with eating disorders	• Commissioned new model that integrates TAMHS (Targeted Mental Health Service), CAMHS & MH Support Teams across Swindon. • Increased digital offer of early help and support. • Appointed single third sector lead for each Place to connect community based provision in partnership with Oxford Health as our secondary CAMHS provider. • Appointed MH Champions to improve support to CYP presenting in crisis at A&E. Developed BSW Hospital based Youth Worker pilot. • Redesigned urgent response for CYP including redesign of the Paediatric front door at GWH. • Roll out of assessment and liaison for paediatric inpatients with eating disorders (ALPINE)	• Embedded IAPT offer into the Community MH Framework so that we make best use of not only IAPT but also wider services that would help meet individual needs. • Implemented a consistent, BSW wide service model that is IAPT manual compliant. • Started first phase of recruitment to training post providing additional capacity in year and beyond. • Scoped digital offers and their use, with a plan to implement from 2024/25.	• SMI registers for all practices reviewed. • Local Enhanced Service (LES) developed for annual physical health checks for people with SMI. • Implementation delayed due to wider primary care improvement work. • Agreement to defer this until 2024/25. • AWP continued to provide annual health checks for those service users who are open on their caseload

Smoking

	B&NES	Swindon	Wiltshire
Focus on health inequalities and target resources for those that need it most.	Outreach events by B&NES wellness service	Tobacco Control Strategy launched at event in Sept. PH practitioner recruited to lead.	Health coaching service redesigned to encourage focus on routine and manual workers
Increase knowledge, awareness & skills in talking about e-cigarettes & vaping.	School surveys to understand attitudes (S & W) Resources produced and disseminated to all schools. (B,S&W) Supported by webinars, workshops and Healthy School Award. (B & W)		
Reduce availability and access to illegal tobacco & vaping products	Work with the Southwest Illegal Tobacco Team on engagement and enforcement. Trading Standards – underage test purchasing resulting in seizures of illegal vaping products. Educational activities with partner organisations.		
Raise profile of tobacco control and local services	Stoptober and other campaign material distributed to partners with local success stories. Promote local stop smoking services through partners and initiatives such as the Targeted Lung Health Checks.		
'Treat Tobacco Dependency' (TTD) across inpatients, maternity and MH services	Providers (AWP, SFT, GWH) appointed to roles to deliver the TTD objectives. ICB Health Inequalities team supporting RUH with challenges around recruitment. TTD Business Group formed with stakeholders from providers and Local Authorities to collaboratively deliver TTD services, track progress and report to NHSE quarterly.		

5.4.3 Identifying ill health early (Secondary Prevention)

Our commitment…

1. We will work to ensure the system has routine access to high quality secondary prevention data
2. We will bring together BSW partners to work on joined-up prevention pathways. On cardiovascular disease prevention, for example, we will support primary care partners to increase home blood pressure monitoring activity and work with community pharmacy to roll out a Hypertension Case Finding Service
3. We will improve uptake of cervical, breast and bowel cancer screening

Identifying ill health early (secondary prevention)

Data	CVD and Diabetes	Cancer Screening
• Development of dashboard to enable system wide visibility of key diabetes and cardiovascular disease targets started. • Data used to support uptake and target attainment discussions with primary care.	• Plans made to share care between general practice and community pharmacy focussing on patient with out of range blood pressure but no hypertension diagnosis. • Improved coordination between specialist diabetes services (built into ICBC and PCCD) • Plans developed to identify patients with modifiable risk factors of new condition identified and supported. • Implemented Diabetes Pathway 2 Remission programme (Low Cal diet) • Planned to increase uptake of diabetes digital structured education. Implementation to start early 24/25.	• Learning and outcomes from funded PCN projects aimed at increasing early presentation and screening uptake in 2022/23 shared with all practices and PCNs. Practices and PCNs were able to use this learning to consider rolling out in 2023/24. • Planned the next stage of Targeted Lung Health Check development which will include roll out to Salisbury and Trowbridge. • Decided not to expand or extend the PCN-based non-specific symptoms pilots. RUH non-specific symptom pathway commissioned instead due to open in 2024/25.

5.4.4 Slowing or stopping disease progression (Tertiary Prevention)

Our commitment…

1. With an ageing population the prevalence of conditions like mental illness, cardiovascular disease, respiratory disease and diabetes is increasing across BSW. We are working with our specialists in these conditions to connect them with the emerging joined up local teams in each neighbourhood in order to provide coordinated lifestyle, psychological and medical advice and support.
2. Through our specialist services such as hospitals working together with local authorities, VCSE organisations and neighbourhood teams, we will prevent, break or slow the chain of progression that results in poorer outcomes for our population and increased costs and pressure for the health and care system.

Slowing or stopping disease progression (tertiary prevention)

Respiratory	Cardiovascular Disease
• Successful rollout of FENO testing to support asthma diagnosis - 1733 referrals,1638 initial assessments and 387 follow up assessments. 312 patients given an asthma care plan, 466 patients provide with education and 39 medication changes. • Spirometry restarted in some practices across BSW. Funded across primary care inconsistent, creating variation in services. Work underway to review the GP Local Enhanced Service (LES) which includes spirometry. • Implementation of 2nd year of 5 year Pulmonary Rehabilitation plan progressed with increased capacity, choice of face to face or virtual, including loaning of digital equipment to reduce inequalities. Community respiratory teams and acute in-reach teams integrated.	• Work in 2023/24 has been limited because of lack of agreement around resources, governance, outcome ambitions and key deliverables. • This will progress in 2024/25. • Started work with WHC to support optimisation of the Heart Failure Service.

5.4.5 The wider determinants

Our commitment…

In BSW, we will work together to create health promoting places, including action to:

1. Increase green space, accessible for all to use, and promote greener transport
2. Improve air quality, including by incentivising greener forms of travel
3. Keep all of our residents in warm and decent homes, through investment in our social housing stock and both supportive and enforcement interventions in private sector homes
4. Prevent homelessness by engaging with vulnerable individuals at the earliest possible stage
5. Prioritise social housing to those in greatest need to support their health and social care needs

Wider determinants of health

<table>
<tr><th></th><th>B&NES</th><th>Swindon</th><th>Wiltshire</th></tr>
<tr><td rowspan="5">Utilise place-based strategies/plans that are being refreshed/ developed as an opportunity to shape, promote and deliver healthy and sustainable places and reduce inequalities</td><td colspan="3">Focus on Core20 (people living in the 20% most deprived areas nationally) population</td></tr>
<tr><td>Focus on ethnic minority communities, homeless, people living with SMI and children eligible for free school meals.</td><td>Focus on ethnic minority communities</td><td>Focus on routine and manual workers, Gypsy, Roma, Boater and Traveller communities</td></tr>
<tr><td colspan="3">Appointed health inequalities lead.
Developed health inequalities group.</td></tr>
<tr><td colspan="3">Funded 35 projects using the additional health inequalities funding. Many focussing on shaping, promoting and delivering healthy and sustainable places and reducing inequalities.</td></tr>
<tr><td>• Healthy Lifestyle programme.
• Inclusive after school club.
• Community connectors.
• Perinatal MH support.
• Homeless hospital discharge.
• Homeless palliative & EOL care.
• Increased LD nursing capacity.
• MH Motorbike community.
• MH support for CYP.
• Targeted family support.
• Music/ art therapy.
• Domestic Abuse work.</td><td>• Live Well team focus on BAME.
• Furniture for those on low income.
• Bilingual parent sessions.
• Early cancer diagnosis.
• Heart failure project.
• Harbour project for asylum seekers and refugees.
• AF clinics to improve access.
• Oral health promotion.
• Therapeutic mentoring.</td><td>• Outreach to Gypsy, Roma, Traveller and Boater communities.
• Finance support in ill health.
• Mindfulness Collaborative.
• Under 5s health club.
• Crisis avoidance project.
• Research into health of military.
• Neighbourhood collaboratives
• Health coach - workplace health.
• Counselling for R&M workers.
• Neurodevelopmental assessment.
• Fuel poverty and prevention.
• LD nurse in dental care.</td></tr>
</table>

Wider determinants of health

	B&NES	Swindon	Wiltshire
Commit to supporting delivery of strategies/ plans as anchor institutions and agree specific actions, outcomes and timescales to support delivery.	• Signature of a Civic Agreement. • Establishment of a Future Ambition Board for B&NES. • Shared support in development and delivery of the B&NES Economic Strategy which addresses many of the socioeconomic determinants of health. • Cocreated Health and Wellbeing strategy.	GWH have: • Provided volunteer opportunities for 15 refugees • 9 students with disabilities joined Trust for Project Search to prepare for employment • Apprenticeship opportunities promoted to 5 secondary school in deprived areas. • Designed work experience placements for YP with special educational needs and those not in education, employment or training. • Worked with NHS Cadets (scheme to provide 14-16 year olds from under-represented communities with opportunities) • Working with alternative education providers. • Enterprise advisers attached to each school the Trust works with.	To be confirmed

Areas for improvement

More focus on defining and understanding what we spend on prevention as a system.

Explore opportunities for further collaboration on primary prevention. Greater focus on mental wellbeing.

Improve governance and explore investment in secondary prevention.

Understand and enhance actions in other workstreams around tertiary prevention

Explore actions that other NHS organisations can take as Anchor Institutions and how we can learn across the system.

Strengthening remit of the B&NES, Swindon and Wiltshire (BSW) ‘Prevention’ Strategy Group

Becky Reynolds

BSW ICP meeting 12 March 2024

Background

BSW Population Health Board (PHB):

- Has oversight and accountability for delivery of the Health Inequalities and Prevention programmes
- Is accountable to the BSW Quality and Outcomes Committee

Two strategy groups report to the PHB:

- BSW Inequalities Strategy Group
- BSW Prevention Strategy Group *(working title)*

Inequalities Strategy Group and work programme - well established

Prevention Strategy Group and work programme - less well established. Ideal time now to strengthen remit:

- Objective 1 in BSW Integrated Care Strategy and implementation plan: 'Focus on prevention and early intervention'
- Creation of a small team in the ICB to take forward health inequalities and prevention work
- Increased leadership role of Directors of Public Health in B&NES Swindon and Wiltshire in Prevention, Health Inequalities and Population Health Management respectively, working closely with the ICB Chief Medical Officer
- Ongoing commissioning for Integrated Community-based Care

BSW Prevention Strategy Group proposal

The BSW Prevention Strategy Group:

- will have a ***main/initial focus on the health and care system:***
  - on responsibilities which sit at system
  - and on system prevention activity which can best add value to work done at Place
- will remain ***strategic and focused*** in its purpose
- will use ***population health analysis*** and ***evidence*** in relevant workstreams
- aims to eventually ***combine with the BSW Inequalities Strategy Group*** of the BSW PHB

Continued…

The BSW Prevention Strategy Group will need:

- to review scope in light of ongoing commissioning for Integrated Community-based Care
- to consider its relationship with:
  - BSW Primary and Community Services Delivery Group
  - BSW Children and Young People's Programme Board
- to align its work programme with that of BSW Health Inequalities Steering Group
- capacity from the population health analytics team to contribute to its workstreams
- to consider membership and draft Terms of Reference

Proposed purpose and work streams – work in progress

Draft purpose: To set strategic direction for implementation of Objective 1 in the BSW Integrated Care Strategy - 'Focus on Prevention and Early Intervention'

Proposed workstreams:

1. Lead on one agreed priority system prevention programme
2. Funding shift towards prevention
3. Organisational culture and workforce for health improvement
4. Influence the plans of identified BSW Delivery Groups to strengthen focus on prevention
5. *Oversee delivery of identified BSW-wide prevention programmes*
6. *Have oversight of delivery of Prevention and Early Intervention commitments in the BWS Together Integrated Care Strategy*

The above bullet points are detailed in the next six slides

1. Lead on one priority prevention programme across the system

- Drive forward one agreed priority prevention programme across system with commitment from system partners
- Work to be underpinned by population health analytics
- Hypertension suggested as a potential programme for consideration – further discussion needed
- Learning from this approach of focusing on one system-wide priority programme could be applied to a different system-wide priority in the future

2. Funding shift towards prevention

- Work on commitment in BSW Together Integrated Care Strategy to ‘make progress on shifting funding towards prevention’
- Potentially focus on one of the workstreams of this strategy group, possibly workstream 1

3. Organisational culture and workforce for health improvement

- Workstream held as marker to recognise the enormous importance of the culture of a workplace and its workforce in championing and embedding a preventative approach throughout an organisation
- Potential to pilot an initiative with one workforce?
- Need to engage with BSW Academy for further discussion

4. Influence the plans of identified BSW Delivery Groups to strengthen focus on prevention

- Workstream held as marker to identify programmes to work in partnership with that have greatest potential for population health improvement

5. Oversee delivery of identified BSW-wide prevention programmes

- Coordination at system would add value to delivery of related elements at place
- Initial suggestions for prevention programmes to be housed here include:
  - Treating Tobacco Dependency programme
  - Join up Tier 2 with Tiers 3 and 4 weight management pathway

6. Have oversight of delivery of Prevention and Early Intervention commitments in BSW Integrated Care Strategy

- Refresh of BSW Strategy's Implementation Plan currently underway, focussing on a fewer number of high priority deliverables
- Once completed, we will be agreeing a framework for monitoring delivery, including how we measure delivery of outcomes
- Propose that the prevention commitments are overseen as part of that delivery framework, through the BSW delivery oversight forum that is being set up

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Early proposed key deliverables for 2024-2026 against BSW Integrated Care Strategy

Outcome One Prevention and Early Intervention

5.4 OBJECTIVE 1

Focus on prevention and early intervention.

Area of focus

1. Focusing funding and resources on prevention rather than treatment
2. Intervening before ill-health occurs (primary prevention)
3. Identifying ill-health early (secondary prevention)
4. Slowing or stopping disease progression (tertiary prevention)
5. Wider determinants of health

5.4.1 Focusing funding and resources on prevention rather than treatment

Our commitment…

- Partners across the ICP will work together to identify an accurate picture of funding and resourcing across BSW when it comes to self-care, community care and hospital care.
- We will aim to increase the share of health and care funding going towards preventative measures (self-care and community care) over the next five years. Our ICP will monitor over time the degree to which this balance is shifting

Focusing funding and resources on prevention rather than treatment

In 2024-26
• Through the Population Health Board continue to focus on defining and understand what we spend on prevention as a system.
• Complete procurement of Integrated Community Based Care and ensure continued focus on prevention as part of this contract.
• Effectively using the increased investment in preventative measures.
• ICS Investment Committee will implement a revised prioritisation framework with and increased weighting on preventing future illness or complications of current conditions and addressing health inequality or health equity.

5.4.2 Intervening before ill-health occurs (primary prevention)

Our commitment…

Physical wellbeing

1. We will increase the proportion of physically active adults 2.
2. We will reduce the proportion of adults considered overweight or obese .
3. We will increase the proportion of children and young people who are healthy weight

Mental wellbeing

1. We will improve Personal Wellbeing ONS4 scores (Life Satisfaction, Worthwhile, Happiness, Anxiety)
2. We will reduce the prevalence of mental health conditions

Smoking

1. We will further reduce the proportion of people in BSW who smoke
2. We will expand stop smoking services across partners, recognising the opportunities that points of interaction with services offer on prevention. A current example of this is the Treating Tobacco Dependency service.

Physical wellbeing

In 2024-26

B&NES	Swindon	Wiltshire
• Implementation of whole systems health improvement framework action plan which includes recommissioning health improvement services as part of the BANES Community Transformation Programme.	• Increase the uptake of Healthy Start Vouchers, with focus on deprivation. Widen distribution network. • Promote uptake of ORCHA Digital App software to help service users improve their mental health and manage their weight. • Use street trading powers to restrict fast food vans near schools. • Establish a 'Green social prescribing' programme to encourage people to use green space.	• Continue delivery of the Whole Systems Approach (WSA) to Healthy Weight: • Phase 1 – Set up core working group.. • Phase 2 – Building the local • Phase 3 – Mapping the local systems Phase 4 – Action • Develop end to end weight management pathway across the life course
Increase the BSW provision for children with excessive weight by expansion of Complications from Excessive Weight Clinics (CEW) clinic at the RUH Bath. This delivers on the NHS Long Term Plan ambition to treat children for severe complications related to their obesity, including diabetes, and avoiding the need for more invasive treatment.		

Mental Wellbeing

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

Smoking

	B&NES	Swindon	Wiltshire
Develop and implement an E-Cigarette offer for stop smoking services	Develop and implement E-cigarette offer including free vaper start kits. Focus on supporting pregnant women and their household members (funded through the Government Swap to Stop Scheme).		
Focus on health inequalities and target resources for those that need it most.	• Use additional section 31 public health grant funding to increase capacity in stop smoking services • Target groups where smoking prevalence is high.	• Explore perceptions of pregnant women about stop smoking services, • Develop a lived experience group. • Develop Stop smoking pathways for priority cohorts (substance misuse and housing support).	Smoking Health Needs Assessment supported by the Wiltshire Tobacco Control Alliance.
Continue to reduce availability and access to illegal tobacco & vaping products	• Support enforcement action to reduce access to illegal tobacco. • Develop comms highlighting seizures, prosecutions, closure orders. • Educational activities to promote responsibility in relation to tobacco. • Closer working with SW Trading Standards Regional Intelligence Team, HMRC and Police		
'Treat Tobacco Dependency' (TTD) across inpatients, maternity and MH services	• Emphasis on targeted provision for the plus groups in the Core20Plus5 framework. • Use PHM analytical date to identify groups to be targeted and in which localities. • In partnership explore how VCSE sector can assist in extending the reach to these plus group. • Prevention group which will be refocused in 2024/25 will have a much sharper focus and TTD will be one of a small number of key prevention priorities.		

5.4.3 Identifying ill health early (Secondary Prevention)

Our commitment…

1. We will work to ensure the system has routine access to high quality secondary prevention data
2. We will bring together BSW partners to work on joined-up prevention pathways. On cardiovascular disease prevention, for example, we will support primary care partners to increase home blood pressure monitoring activity and work with community pharmacy to roll out a Hypertension Case Finding Service
3. We will improve uptake of cervical, breast and bowel cancer screening

Identifying ill health early (secondary prevention)

CVD and Diabetes	Cancer Screening
• Text messages to support people with cholesterol not treated to target to understand the risks of their condition and with behaviour risk reduction support and increased agency. • Optimise Practice use of Community Pharmacy hypertension offer • Standardised implementation of Hybrid Closed Loops (NICE TA943) • Reduced risk complication patients with T2DM < 40 years.	Implement all requirements in the national cancer programme's annual planning guidance for 24/25. Anticipated to include: • Implement faster diagnosis and operation performance with anticipated priority pathways: skin, gynaecology, urology and breast. • Expansion of early diagnosis programmes including targeted lung health checks, Galleri Interim Implementation Pilot, Faecal Immunochemical Testing (FIT), Liver surveillance and pilots and Pancreatic cancer. • Develop local and cross cutting early diagnosis delivery focusing on screening, timely presentation, primary care pathways, early diagnosis initiatives and health inequalities.

5.4.4 Slowing or stopping disease progression (Tertiary Prevention)

Our commitment…

1. With an ageing population the prevalence of conditions like mental illness, cardiovascular disease, respiratory disease and diabetes is increasing across BSW. We are working with our specialists in these conditions to connect them with the emerging joined up local teams in each neighbourhood in order to provide coordinated lifestyle, psychological and medical advice and support.
2. Through our specialist services such as hospitals working together with local authorities, VCSE organisations and neighbourhood teams, we will prevent, break or slow the chain of progression that results in poorer outcomes for our population and increased costs and pressure for the health and care system.

Slowing or stopping disease progression (tertiary prevention)

Respiratory	Cardiovascular Disease
Achieve year 3 priorities as set out in the BSW Pulmonary Rehab 5-Year Plan • Reduction in PR waiting times • Range of approaches to increase capacity and choice • More work done to improve uptake and completion rates. • Identifying population groups that have disproportionate participation • Adapting service delivery to improve uptake and completion of programmes for these groups; working with other teams and local partners to serve groups at risk of not being referred, likely to decline if referred or drop out before completing • Proactively working with other teams and organisations across the pathway to provide personalised services • Improving quality of PR through accreditation of services	• Agree the resources available for cardiovascular disease tertiary prevention. • Agree the governance for decision making around cardiovascular disease tertiary prevention. • Agree the outcome ambitions for cardiovascular disease tertiary prevention. • Agree key deliverables for 2024/25 and 2025/26

5.4.5 The wider determinants

Our commitment…

In BSW, we will work together to create health promoting places, including action to:

1. Increase green space, accessible for all to use, and promote greener transport
2. Improve air quality, including by incentivising greener forms of travel
3. Keep all of our residents in warm and decent homes, through investment in our social housing stock and both supportive and enforcement interventions in private sector homes
4. Prevent homelessness by engaging with vulnerable individuals at the earliest possible stage
5. Prioritise social housing to those in greatest need to support their health and social care needs

Wider determinants of health

	B&NES	Swindon	Wiltshire
Utilise place-based strategies/plans that are being refreshed/ developed as an opportunity to shape, promote and deliver healthy and sustainable places and reduce inequalities	• Continue to use health inequalities working groups in each place to explore how place based plans can be used to shape, promote and deliver healthy and sustainable places and reduce inequalities.		
Commit to supporting delivery of strategies/ plans as anchor institutions and agree specific actions, outcomes and timescales to support delivery.	• Explore actions that other NHS organisations can take as Anchor Institutions and how we can learn across the system.		

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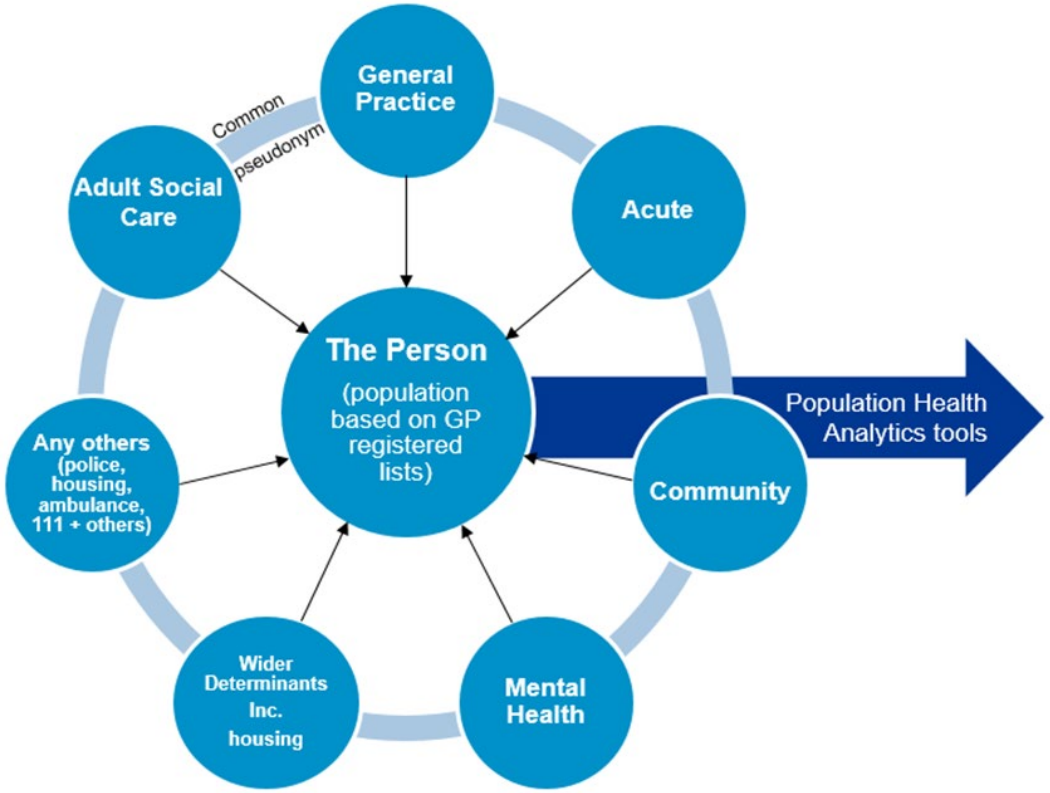
Population Health Management Data, and its Role in Prevention

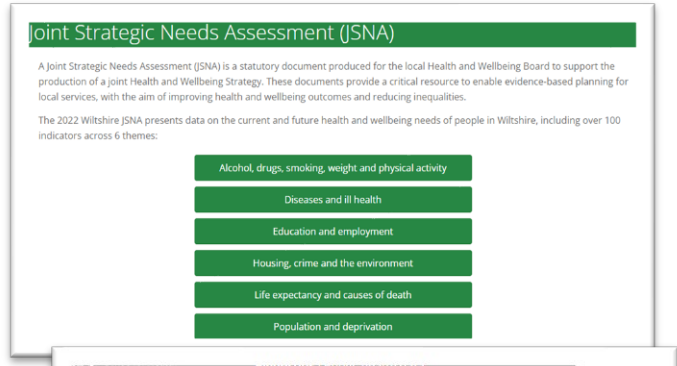
Sam Wheeler, Kate Blackburn

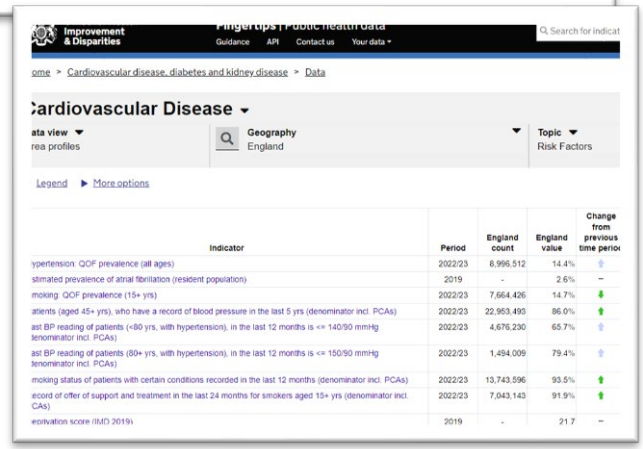
‘PHM’ Data



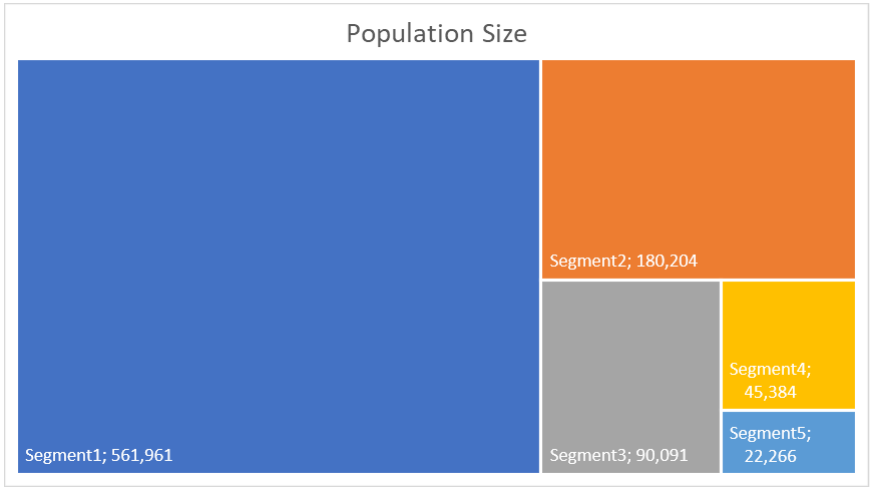
Graphnet Integrating Care

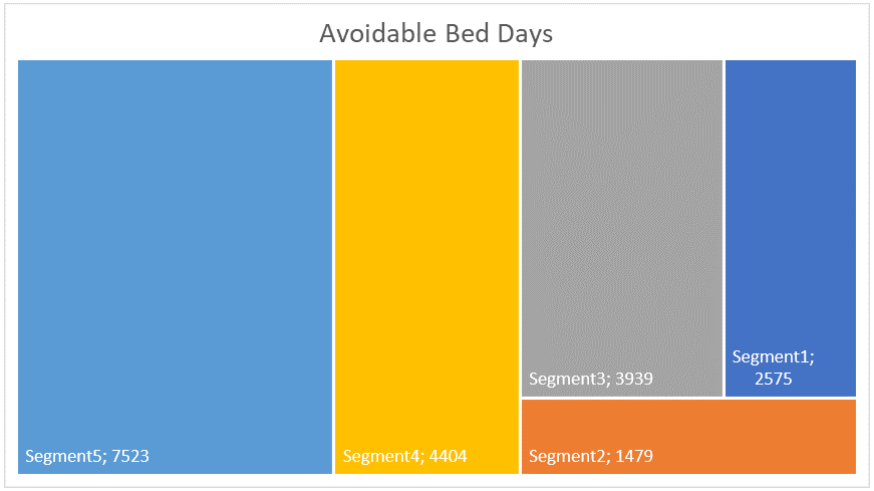
ICB Data Warehouse





‘PHM’ Data – A BSW Example





Proactive Rehab Service

Segment 4

Deprivation Quintile 1

3,172 people

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Live well

Personalised Care Plan

Rehab options below virtual or F2F, 1:1 or group

- Living well with your energy levels
- Get active and Strong
- Mood Management
- Eating well
- Vocational Rehab
- Co-produced care plan
- Breathing well
- Living well with brain fog
- Voice & swallow rehab
- Psychology informed treatment

A Focused Approach to using PHM Data

From….

To….

"Tell me how many diabetic people we have in BSW"

"Can you produce a map of BSW deprivation"

"Summarise the Elective Waiting List by Deprivation Decile"

Data
- Data quality / completeness
- Data Linkage

Intelligence
- Population definition / segmentation
- Impactability analysis

Change
- Targeted interventions
- Community Engagement
- Evaluation

How to perform the perfect stone skim (telegraph.co.uk)
drilling deep - Search Images (bing.com)

Two Priority Areas

Hypertension

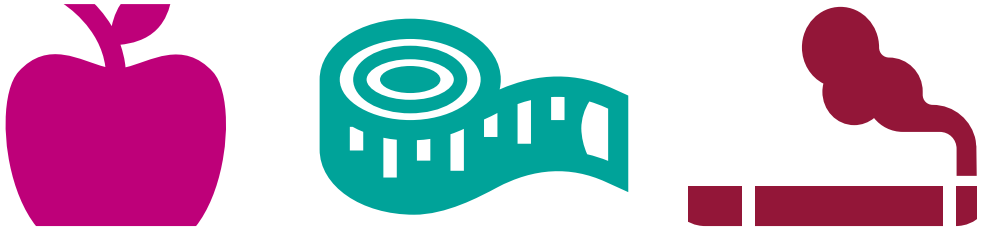
- Impacts 1 in 4 adults
- Case for Change and JSNA identified issue
- Risk factors amenable to PHM and Prevention
- Focus of many existing programmes
- Cuts across many BSW Boards

Mental Health

- Impacts 1 in 4 adults
- Case for Change and JSNA identified issue
- BSW drafting a strategy in 2024
- Cuts across many BSW Boards

Hypertension – Primary Prevention

Modifiable Risk Factors

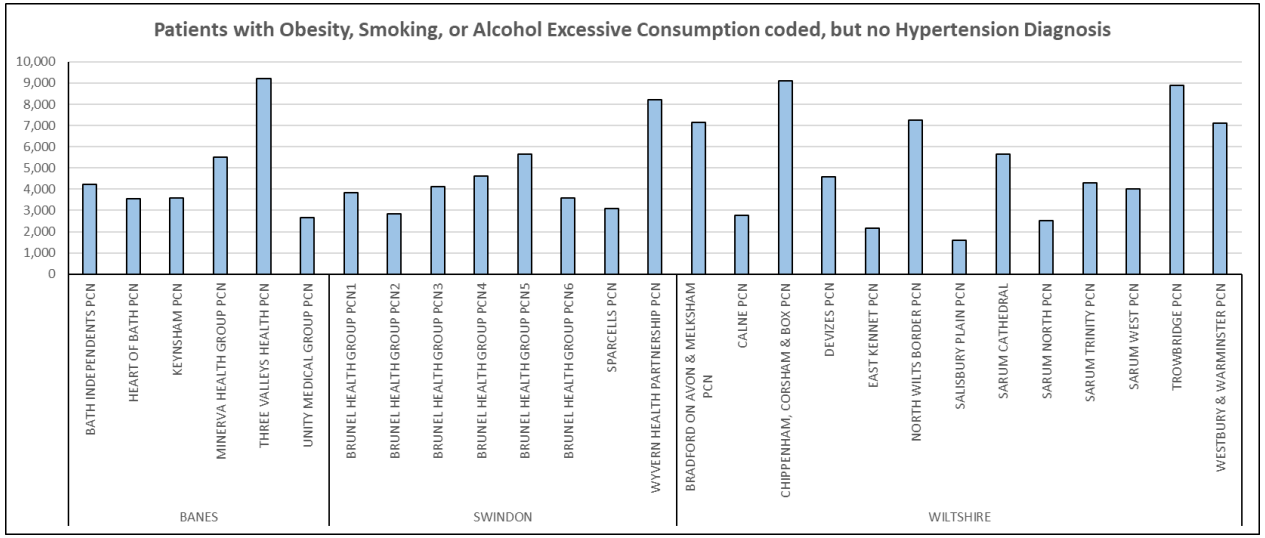


Diet Weight Smoking

Exercise Alcohol

Weight Smoking Alcohol

130,000 people in BSW where the data flags at least one of these risk factors, but no (diagnosed) hypertension is recorded



Hypertension – Secondary and Tertiary Prevention

Secondary Prevention

Expected prevalence in BSW = 200,000

Recorded with hypertension = 150,000

CVD Risk Patients without Health Check in last 12 months = 215,798

Tertiary Prevention

Ambulatory Care Sensitive Conditions are those…'where early intervention can prevent complications or hospitalisation'.

ACS Conditions which relate in some way to Cardiovascular Disease more broadly include Hypertension, but also Angina, Congestive Heart Failure and Diabetes.

In the last 12 months, ACS admissions for these conditions:

Admissions = **2,656**
Cost = **£7.8M**
For **2,325** people