Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS 75

Bristol, North Somerset and South Gloucestershire Integrated Care System

Joint Forward Plan

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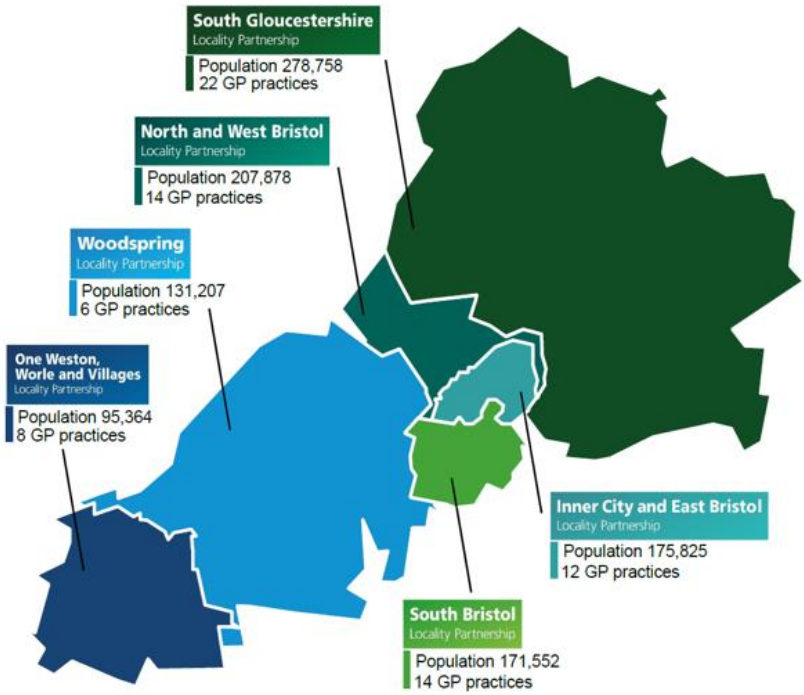
1. Background

1.1 Who are we?

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) became a statutory partnership in July 2022, working together to deliver high-quality health and care services tailored to the needs of the population. It is comprised of the three local authorities, NHS trusts, the new Integrated Care Board (ICB)[1], voluntary, community and social enterprise organisations, general practice providers, and other partners. Within our ICS, Integrated Locality Partnerships have also been established, operating at a 'place' level and responding to the specific needs of local populations.

Figure 1: Bristol, North Somerset and South Gloucestershire Integrated Care System



Population of 1 million served by:

- 6 integrated locality partnerships
- 3 local authorities and Health and Wellbeing Boards
- 56 children's centres
- 278 care homes
- 1 GP Federation & 1 GP Collaborative with circa 80 general practices and 20 primary care networks
- 1 of each Medical, Dental, Optometry and Pharmacy Committees
- 1 Primary Care 24/7 and 111 service
- 169 pharmacies
- 114 dental practices
- 79 opticians
- 1 community care provider
- 1 Healthwatch
- 1 mental health trust
- 1 ambulance service trust
- 1 Academic Health Science Centre
- 2 acute hospital providers
- Hundreds of voluntary, community and social enterprise organisations
- 1 Integrated Care Board planning NHS services

[1] Local authorities are responsible for planning and funding most social care services. The System's 'Integrated Care Board' is a statutory organisation responsible for planning and funding most NHS services.

1.2 Our purpose and vision

Our mission is "Healthier together by working together."

"People enjoying healthy and productive lives, supported by a fully integrated health and care system - providing personalised support close to home for everyone who needs it."

ICS aims

Our Strategy and Joint Forward Plan have been developed to align with, and support, the four aims of integrated care systems:

- **Improve outcomes** in population health and health care
- **Tackle inequalities** in outcomes, experience and access
- **Enhance productivity** and value for money
- Help the NHS support **broader social and economic development.**

All the work towards the Strategy has been orientated to these aims.

1.3 Our Strategy in development

Alongside this Joint Forward Plan, the Integrated Care Partnership (ICP) is launching the first Integrated Care System (ICS) Health and Care Strategy for Bristol, North Somerset and South Gloucestershire (BNSSG).

This Strategy is jointly owned by Local Authority, NHS and voluntary and community sector enterprise (VCSE) partners. By the same token, it will be delivered jointly by these three sets of partners who collectively make up our ICS.

The Strategy development is led by the principles and approach set out in the BNSSG Strategic Framework that was published in December 2022.

The purpose of the Strategy is to frame the challenges we need to address to meet our vision over the next two to five years, serving the four ICS aims and the shared outcomes set out in the BNSSG Outcome Framework. To do this, we will need to make choices, prioritising key measurable objectives where there is evidence that addressing these will make an impact on population inequalities and health outcomes, and support us to achieve the four aims of our ICS.

The Strategy has been developed from several important sources. It includes public views, including those who have used our health and social care services, information showing our communities' local health and social care needs, and the insights of practitioners working in our organisations. Following publication, each individual ICP partner organisation will need to approve through their own internal governance processes any specific commitments and actions as a result of the document.

1.3.1 Our drivers for change

BNSSG is home to a diverse population with varying health needs. In total, the area has a population of around 1.1 million people, with Bristol being the largest city in the region. The age distribution of the population is fairly typical for a UK region, with a slightly higher proportion of residents aged 20-34 years and a lower proportion of residents aged 65 and over, compared to the national average.

The population of BNSSG is expected to grow by around 8% over the next decade, but the number of people aged 65 and over is projected to increase by almost 20%. This will present significant challenges to health and social care services in the area, which will need to adapt to meet the changing needs of the population.

Our Joint Strategic Needs Assessment, also known as 'Our Future Health', highlights some of the key conditions and health issues that we need to ensure our plan addresses. These have been placed alongside the insights from our public engagement exercises to provide a clear picture of the case for change.

This has been summarised as **five opportunities** that are driving our strategy:

Opportunity one: Health inequalities

The social, economic and environmental conditions in which people live have an impact on health. They include income, education, access to green space, healthy food, people's work and their homes. Differences in these conditions are a significant cause of health inequalities. Health inequalities are the unjust and avoidable differences in people's health across and between specific population groups.

Poorer access to support, experience and outcomes often means that people don't have the opportunity to lead the lives they want to lead in the way that they want to lead them.
We are committed to correcting this.

Through our decision making process we need to change how these are currently done so that they are more inclusive. The initial national response to Covid-19 arguably didn't include enough different perspectives, which led to poor communication with and support for communities experiencing health inequalities. Our system will learn from those lessons.

Opportunity two: Strengthening building blocks

The foundations of good health and wellbeing are built on: family and community relationships; a safe environment with quality housing, places to exercise and clean air to breathe; good education; meaningful work; and freedom from discrimination.

BNSSG residents have told us that positive social connections are the most significant contributors to health and wellbeing. Yet in our Citizens' Panel survey of a representative sample of BNSSG residents, 29% of people reported feeling lonely in March 2023.

Education is key, but measures of school readiness at age five show a 20-25% gap between the most and least deprived areas of BNSSG. More people in BNSSG aged 16-17 are not in education, employment or training compared with the national average. These wider determinants of health must be addressed if we are to have a lasting impact on health and wellbeing.

Opportunity three: Prevention and early intervention

We all know that prevention is better than cure. Focusing on prevention will mean less reliance on our overstretched urgent and emergency services, as more people remain well for longer and know how to manage their health in a planned and informed way.

We know that heart disease is the single biggest condition where lives can be saved. Therefore, we will focus our joint efforts on heart disease. This condition alone is the top cause of years of lost life in BNSSG. Within our Citizens' Panel self-reported health status, cardiovascular disease is a main contributing factor to disability and poor health. For example, in Bristol, the rate of early

deaths from cardiovascular disease is around 2.6 times higher among people living in the city's most deprived areas, compared to the most affluent areas.

Opportunity four: Healthy behaviours

Key to our prevention strategy is working alongside communities to address risk factors, such as smoking and obesity, that have an outsize impact on the health of our population.

This will be done in a way that recognises our health-related behaviours and habits are not about individual lifestyle choices. Healthy behaviours are underpinned by solid building blocks for good health, like family relationships, our communities and environments, good employment and freedom from poverty and discrimination. Fragile building blocks and chronic stress mean unhealthy habits and behaviours are much more likely.

Addressing these risk factors through proactive interventions is crucial to improving the health outcomes of the population.

Opportunity 5: Long-term conditions

Tackling the conditions that impact the health of our population gives an opportunity to improve the outcomes and experience of our population. Better management of people's needs such as those with long-term conditions will also support our efforts to increase healthy life expectancy, ease pressures on the health and care system and reduce the number of people out of work due to ill health.

There is growing recognition of the impact of painful conditions and mental distress. Painful conditions and mental distress is in the top five most impactful conditions in BNSSG across the life course. Cancer and mental health needs also severely affect people's wellbeing. We must work with communities and the voluntary, community and social enterprise (VCSE) sector to develop new ways to help people prevent causes, early intervention and treatments, including psycho-social interventions to improve people's quality of life.

The health needs of our population are complex and multi-faceted, requiring a co-ordinated and collaborative approach from healthcare providers, policy makers and local communities. This Joint Forward Plan, alongside conjoining developments within our workforce, focus in digital, innovation, financial and service sustainability are the first steps in making that happen.

1.3.2 Our strategic approach

A strategy that simply articulates the problem, without clear commitments to change, is just a piece of paper. Our strategy contains a set of 10 commitments that we make to our population. These 10 approaches set out how we will tackle the health and care issues in BNSSG and, importantly, how we will go about delivering the outcomes in this Joint Forward Plan.

The 10 commitments offer guidance for decision makers in our system as they prioritise resources to align to this new strategy. We have aligned these commitments to the four aims of the ICS so it is clear how they contribute to our core business as a health and care system.

To deliver our Integrate Care System strategy, we will:

IMPROVE POPULATION HEALTH AND HEALTHCARE

1. **Align everything we do to the outcomes we want.**
   If we are going to make a difference in the health of people in BNSSG, we need to align everything we do with the outcomes we want to achieve. This will help us be confident that we are doing what we set out to achieve.
2. **Demonstrate our system-wide commitment to prevention.**
   Prevention has been highlighted as necessary for many years, but we will demonstrate commitment by actively funding prevention and creating prevention champions in every organisation. This will cover primary, secondary, tertiary and even primordial prevention.
3. **Focus on the first 1,000 days to give our children the best start.**
   The first 1,000 days after birth are vital in setting people on the right path for life. Our system will support the Health and Wellbeing Board's ambitions for these early years.

TACKLE UNEQUAL OUTCOMES AND ACCESS

4. **Change how we work to actively reduce health inequalities.**
   As organisational policies are reviewed, partners will identify opportunities to change working practices to remove barriers. We will also proactively review how the system inadvertently increases health inequality so that those things can be changed. This will also include further work on our system commitment to be trauma-informed.
5. **Prioritise the health impacts of poverty and disadvantage.**
   We also need to improve things for people already experiencing the ill effects of poverty and other structural disadvantages. We will use the CORE20plus5 framework as a starting point to develop supportive strategies around healthy habits.

ENHANCE PRODUCTIVITY AND VALUE FOR MONEY

6. **Build a workforce who are supported, skilled and healthy.**
   We cannot achieve anything without our staff. We will work with staff to develop an inclusive, best-in-class retention strategy for all our people. We will also ensure that our staff are healthy, and able to work flexibly across the system, including closer alignment with care homes.
7. **Focus on the whole person – not just the disease.**
   Alongside a focus on proactive care, we will also review how we can support people to solve multiple issues at once. For example, this approach to ‘clustered’ problems might be achieved through integrated care teams, like those piloted in Weston-Super-Mare, and social prescribing.
8. **Work together as equal partners to tackle our biggest problems.**
   If we get things right the first time, that is a much better way to do things. We will work with lived experience voices and communities to co-create solutions. We will also ensure that the voluntary sector and primary care teams? are valued for their experience and local insight.

9. **Support the economy with our purchasing and employment practices.**
   The partners in BNSSG have a responsibility to use their buying power to support local businesses to put money directly back into the local economy. We will also review how we can use our recruitment to support areas of deprivation, including targeted recruitment and apprenticeship schemes.

10. **Develop a better, healthier environment for people to live in.**
    We must acknowledge the impact on the health of where people live. We will ensure a 'wellbeing first' approach to all policies on housing, transport, green space etc. We also support commitments around NetZero to reflect the need to take climate change seriously, including its effect on health.

1.3.3. Defining our priorities

The strategic framework makes it clear that we need to collectively agree key priorities to focus on. The challenge we face is not that we lack a list of problems to fix, but that we have too many. Our challenge is to work together to collectively identify a handful of key strategic priorities that we would like to focus on first, understanding that any course of action comes with an opportunity cost of not being able to do something else.

This needs to happen at a system level and at a locality level so we can be confident that we are collectively responding to the needs of our population in totality and at a place-based level.

1.3.3.1 System prioritisation

Our system prioritisation process will be led by the Health and Care Improvement Groups (HCIGs). The HCIGs are best placed to determine what should be done first at a system level, and to include lived experience voices in that discussion The prioritisation will "respond to" the 10 commitments above to define what projects and programmes will be funded. This will ensure we are making progress towards our goals in a way that is aligned to the strategy, and is evidence led.

This process will be underpinned by evidence and population health data, including the BNSSG Population Segmentation model and will culminate in a set of strategic objectives aligned to the life-course model, system outcomes and four ICS aims that have system partner support.

We have begun a process of system strategy prioritisation, which reduced a longlist of healthcare opportunities and challenges down to a concise group of priorities and pivotal objectives. This shortlist will form the basis of the prioritisation that the HCIGs will undertake.

1.3.3.2 Locality partnership prioritisation

Our six locality partnerships, established in 2018, have been developing their local place-based identities and partnership approach to transforming and delivering services tailored around the needs of local communities.

Each locality partnership identified a core of two to three problem statements which were developed into SMART objectives for addressing these. The priorities are selected at local level and will have a cumulative effect at a system level, by targeting upstream in line with the BNSSG Outcome Framework.

The locality partnerships' priorities have been informed by local population need, alongside acting as the delivery vehicle for system programmes. Whilst there is some local variation, there is much in common across the partnerships, including a focus on children and adults' mental health and those with frailty and complex needs.

This is aligned to the system strategy through an underpinning focus on prevention and earlier intervention, through supporting and empowering people and communities, and through strengthening links between teams operating in different areas.

Intuitively, we understand this focus will support achievement of the four ICS aims. The key next step for locality partnerships is to develop robust operating models to implement their local plans, owned equally by all partners. See section 3.5.2 below, the detailed deliverables for each locality.

1.4 Our governance and approach – driving how we work and deliver together

Our health and care organisations have worked together for more than five years. Now, we are building on our Healthier Together Partnership and working even more collaboratively to plan ways to achieve joint goals.

The Integrated Care Board, NHS providers and other strategic partners such as the local authorities will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing.

The Integrated Care Partnership (ICP) brings together a broad range of partners to set the integrated care strategy to meet the population's health, care and wellbeing needs. It is a committee jointly established by the founding members – the BNSSG local authorities and the Integrated Care Board. In BNSSG, the ICP is chaired on rotation by our three local Health and Wellbeing Board Chairs, providing a direct strategic link between the provision of health and care services and the wider determinants of health.

1.4.1 Voluntary community and social enterprise (VCSE)

We must reimagine how we work with the voluntary sector (VCSE) to create a new working relationship where the NHS, local authorities and the voluntary community and social enterprise are equal partners within our system.

Voluntary organisations report an overreliance on short-term, piecemeal funding that limits the impact they can have in the longer-term. Our approach should seek to build capacity and resilience in the sector, moving it towards a more self-sufficient model.

In the medium to longer-term, we want to support the development and sustainability of this sector as a delivery partner of health and care services. Focusing on delivery through a strengths-based, community asset approach will maximise the impact on delivering against our collective system outcomes and local populations.

Through our locality partnerships, voluntary sector organisations may be best placed to connect with communities at a hyper-local level, delivering proactive interventions tailored towards people's needs.

Figure 2: Summary of our approach to achieve the four Integrated Care System aims

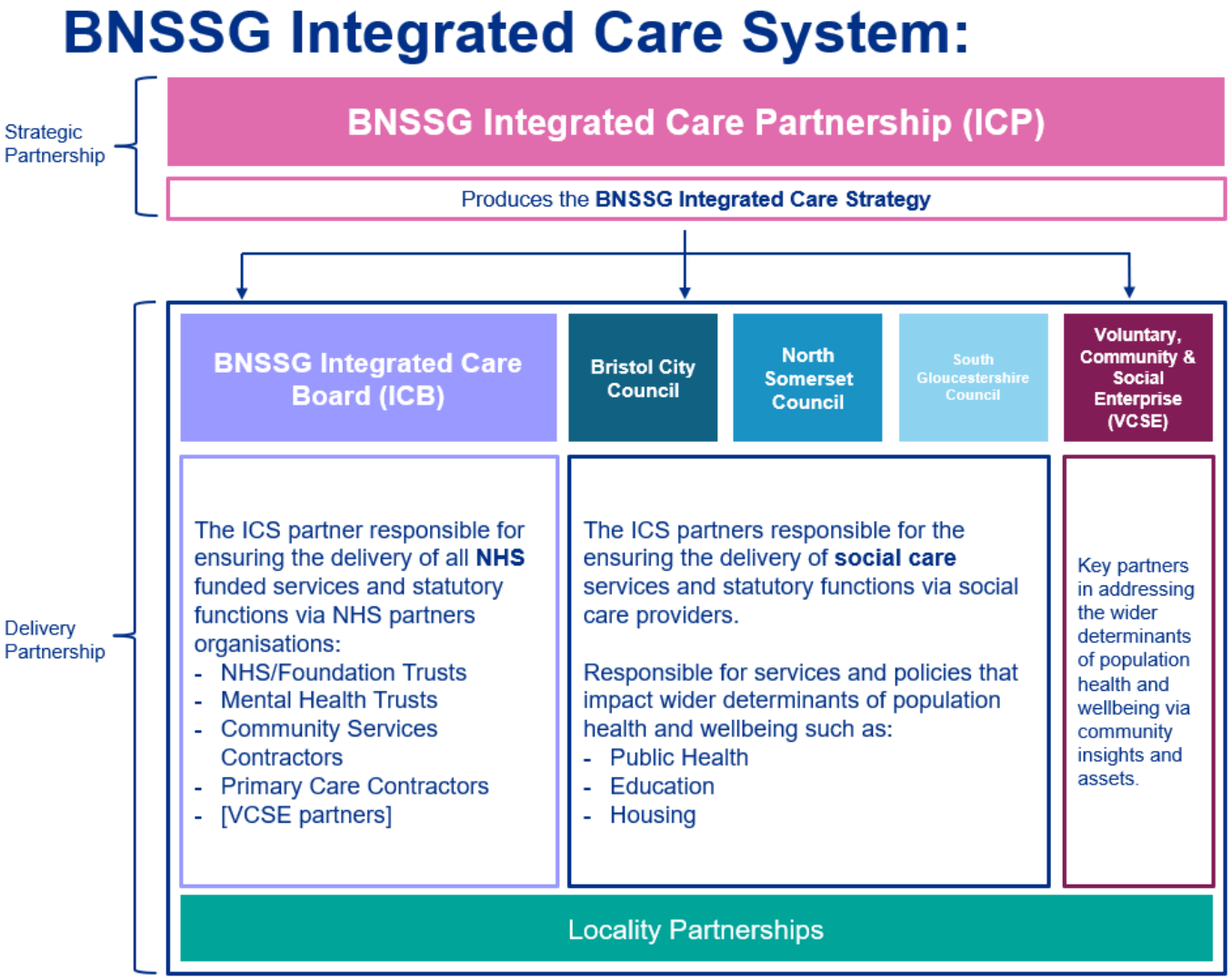


Figure 3: BNSSG Integrated Care System Partnership

1.4.2 Decision Making Framework

We have developed the BNSSG Decision Making Framework to ensure that the Integrated Care Board is able to discharge its functions in a timely, responsive and proportionate manner. This framework has been designed to align with the ICB's Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFIs), distributing decisions in accordance with appropriate delegated authorities. **During the development of the Decision Making Framework, BNSSG partners considered the triple aim[2] and created a process that could be embedded system-wide.**

The Decision Making Framework introduces new system groups with specified delegated authority:

[2] An ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.

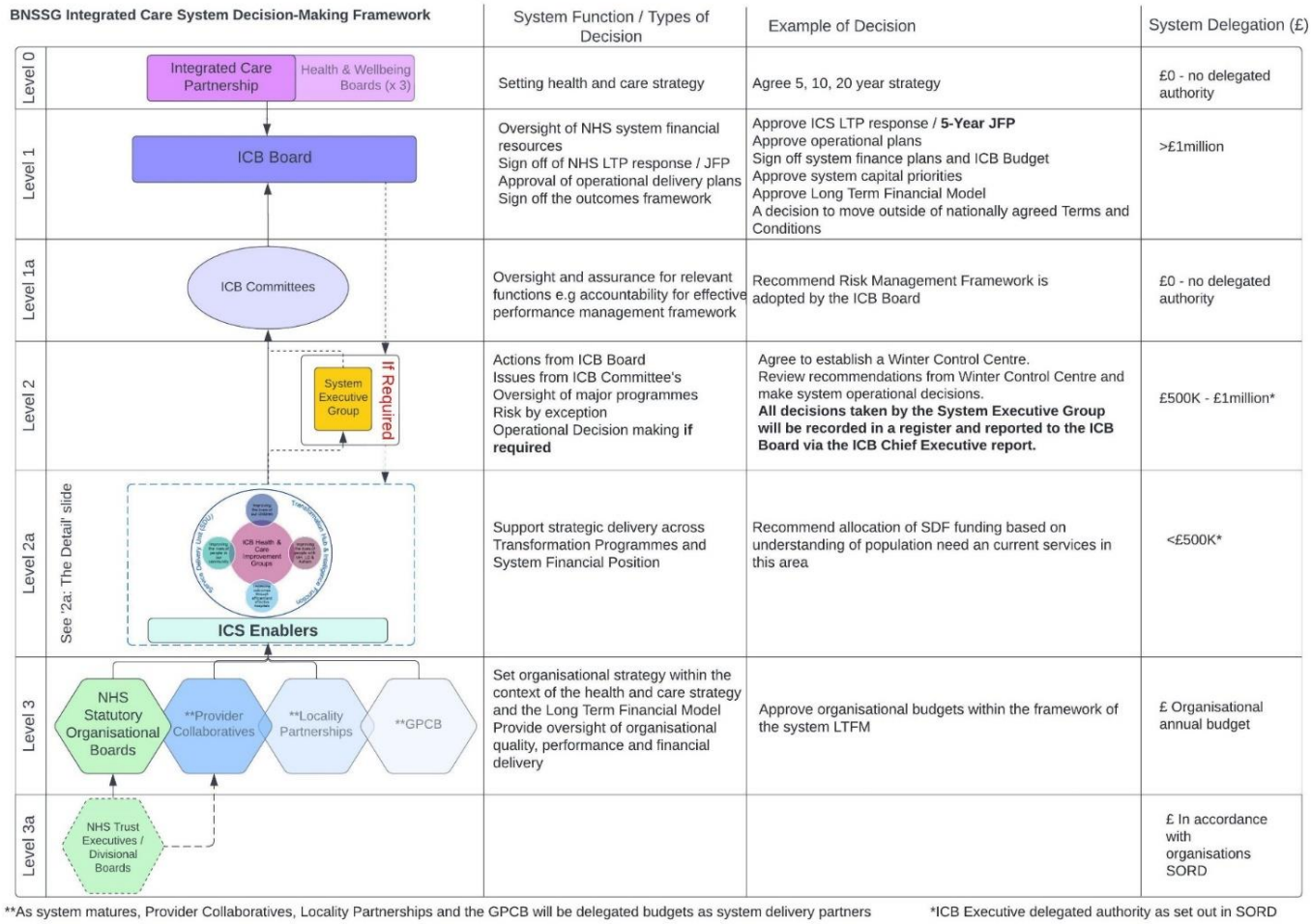


Figure 4: BNSSG ICB Decision Making

The **Health and Care Improvement Groups** (level 2a in the diagram above) will be directly responsible for achieving the ICS's **system deliverables:** the BNSSG Integrated Care Strategy (including the ICS Green Plan) and subsequent system outcomes and Joint Forward Plan, national priorities as directed by NHS England and the BNSSG ICB in-year and medium term financial operating plan. These groups will be supported by a set of system-enabling functions, including a System Strategy and Knowledge Network, which will ensure our ICS partners and ICB enabler functions are working together effectively and collaboratively. They will operate under standardised terms of reference, with system delivery as their primary purpose.

The ICB Health and Care Improvement Groups will be the gatekeepers of the **ICB Transformation Hub**; driving innovation and continuous improvement. They report directly to the ICB Board.

Local authorities and the Integrated Care Board are also responsible for delivering the Strategy via the Joint Forward Plan.

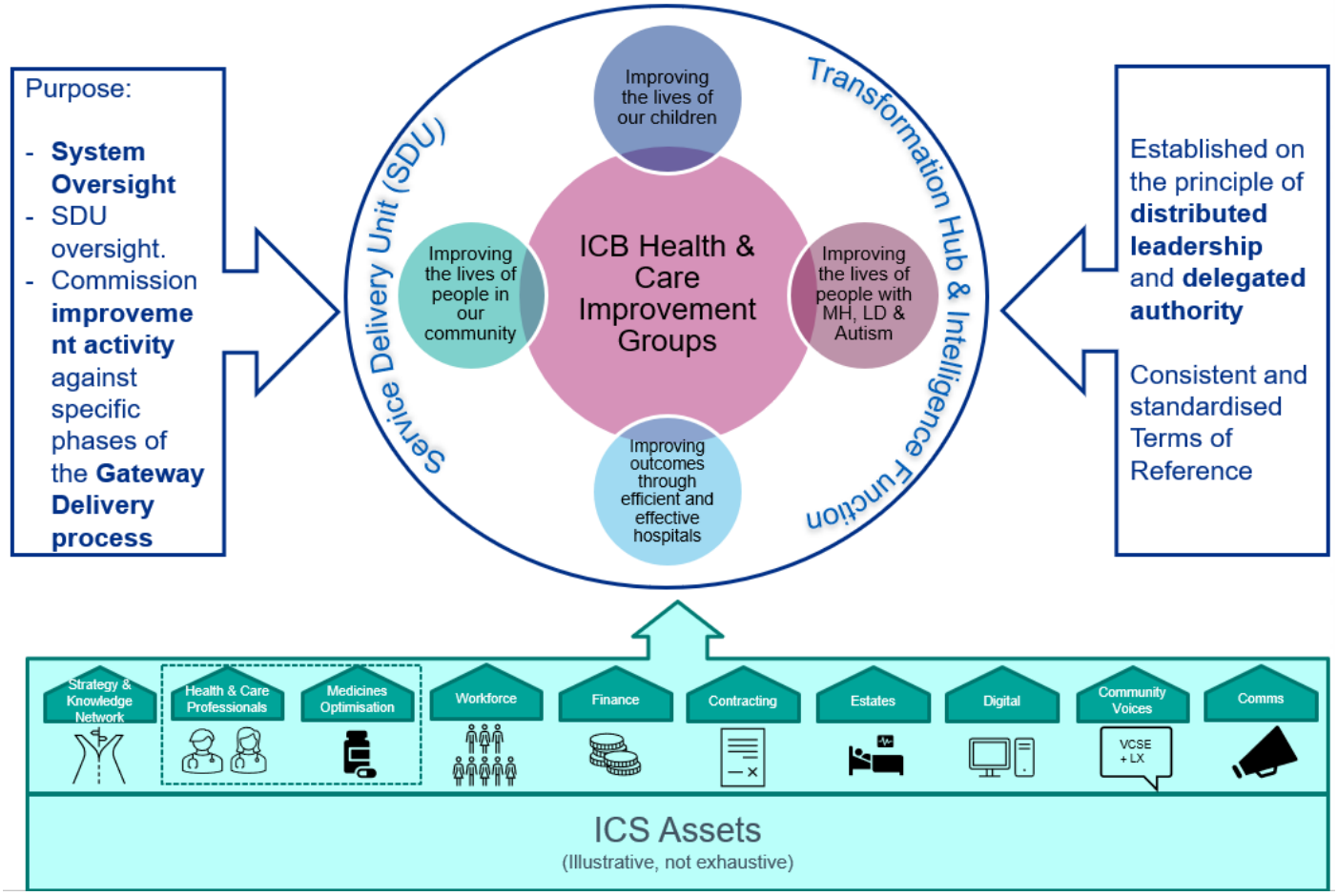


Figure 5: Integrated Care Board improvement groups that will deliver the Strategy

The **ICB Service Delivery Units (SDUs)** will be the substantive system architecture where ICS partners and ICS assets (enablers) collaborate to achieve the system deliverables. SDUs will report directly to a sponsoring (and where applicable, contributing) Health and Care Improvement Group(s). When SDUs are not achieving the system deliverables, the ICB Health and Care Improvement Groups will stand up **working groups** with the specific purpose of getting the SDU back on track.

The **System Executive Group** (level 2) will comprise of the ICS's delivery partners (NHS, including One Care, and local authorities) Chief Executives, chaired by the ICB Chief Executive. It will meet monthly between ICB Board meetings. It will drive activity requested by the ICB Board, take system decisions when required (explored further below) and be a forum for deeper discussions on system challenges or opportunities.

All groups will be expected to contribute to the strategic aims of the ICB including the reduction of inequalities and the ICS Green Plan.

The establishment of the locality partnerships and these other bodies and functions, give us the structure required to be outcome focused. They also allow us to operate as a strategic and delivery partnership; founded on the principles of distributed leadership as well as rigorous and robust system oversight, assurance and scrutiny; functioning through decisions that are timely, responsive and proportionate.

1.4.3 Gateway model for transformation

The methodology for delivering our transformational projects is through a series of structured gateways where each stage of a project is reviewed and evaluated.

Our gateway process adds rigour to system transformation by providing a standardised infrastructure for system-wide projects. The nature of our key projects is informed by the needs of the system's Health and Care Improvement Groups. The method contains seven go/no-go decision points (gateways) for each project, which at each point requires a series of review papers and information. The process follows a project from idea to testing and operational handover, finishing with a 'lessons learned' report. The methodology is supported by the Gateway Review Panel, which provides oversight and quality assurance, supporting the emerging Health and Care Improvement Groups in their role as the gatekeepers of system transformation.

This model requires comprehensive and diligent engagement of our enablers (assets) and partners at each gate ensuring clear governance and transparency in decision making. Transformational Improvements managed within gates 0-2 will be supported by the Transformation Hub, and continuous improvements within gates 3-5 will be managed by the Service Delivery Unit.

Our enablers (or assets) will facilitate and enable Health and Care Improvement Groups to achieve their agreed objectives. They are not limited to the Integrated Care Board teams but may be co-ordinated by them on behalf of all our partners. See enablers section 4 below for further information on how these assets will support delivery of the Joint Forward Plan, noting it is not an exhaustive description as they will continue to develop as our Integrated Care System matures.

1.4.4 System partnership agreements

The strategic framework envisages that we will develop more effective ways of working to further our four ICS aims by delivering strategic change in a small number of priority areas.

System Partnership Agreements help translate strategic intentions into action. We are developing this as a mechanism for codifying tangible action or policy changes across ICP partner organisations to improve system outcomes.

The System Partnership Agreements will be signed statements of joint intent by ICS partners, based on approved strategic priority objectives.

1.4.5 Quality assurance, improvement, learning and escalation processes

The System Quality Group forms part of our infrastructure to support reporting and oversight of quality. The National Quality Board guidance on quality risk response and escalation in Integrated Care Systems provides the expected approach for managing system level concerns and risks and the expected role of the system, in collaboration with NHS England and wider partners.

Risks should be managed as close to the point of care as possible. Where successful mitigation is not possible then escalation and management at the next level occurs, as linked to the designated risk framework and overseen by the system. However, as the Guidance on System Quality Groups made clear, there will be situations in which NHSE and other regulators have the right to intervene, particularly if there are complex, significant and/or recurrent risks.

Our System Quality Group provides an important strategic forum at which partners from across health, social care and the wider system share and triangulate intelligence, insight and learning on

all quality matters to manage risk. The Chair for this group is the Integrated Care Board Chief Nursing Officer.

There is a strong focus on quality being a shared commitment, which is achieved by developing local outcomes-driven performance and quality metrics with an approach to improve intelligence-sharing and data-driven decision-making.

Identified quality concerns and risks that provide opportunities for improvement and learning are escalated and discussed as part of the System Quality Group agenda. System partners collaborate to develop responses, and actions enable improvement, mitigate risks and demonstrate evidence that these plans have the desired effect.

Within the quality risk response and escalation framework for our system, there are three levels of escalation for responding to a quality risk/concern, which depend on the severity and scale of the impact of the risk/concern being raised.

Overview of main levels of quality assurance and improvement

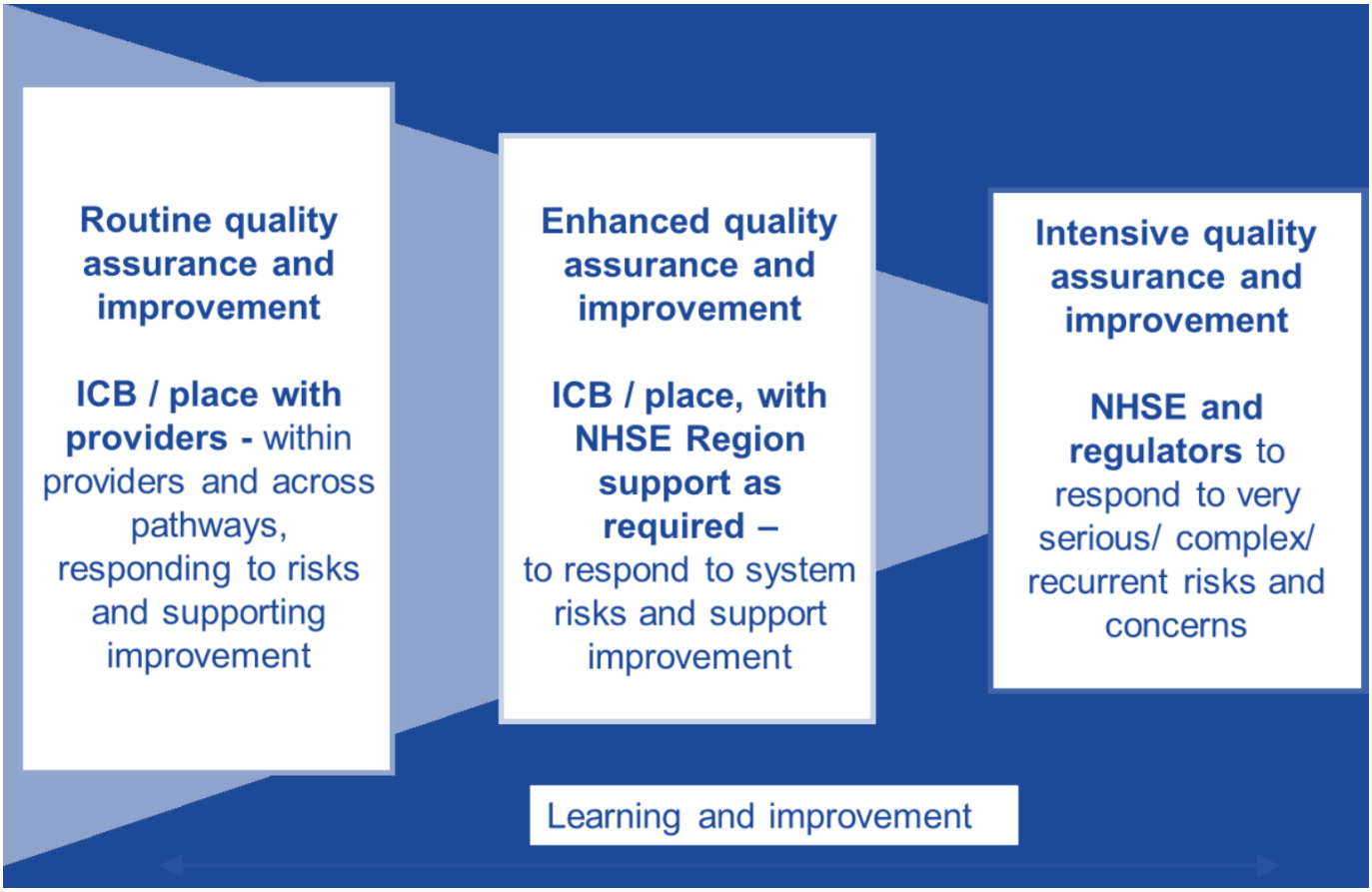


Figure 6: Overview of levels of quality assurance and improvement

1. **Routine quality assurance and improvement**

This level of assurance and improvement is “business as usual” activity where there are no risks or minor risks that are being effectively managed. Any areas of concern are escalated to the regional quality meeting as required.

2. **Enhanced quality assurance and improvement.**

This level of surveillance is undertaken when there are quality risks that are complex, significant and/or recurrent and require action/improvement plans and support to the system

partner(s). It is generally accepted that for health services to move into this level of assurance that it is authorised and overseen by the Integrated Care Board and is reported upwards to the regional quality group.

The process involves key stakeholders attending a rapid quality review meeting to establish and consider the intelligence and insight, which facilitates a collaborative decision that enhanced surveillance is required. These meetings can be called at short notice by the Board or wider partners (e.g., local authorities, NHSE, Care Quality Commission (CQC)) and may inform regulatory action.

Upon agreement that the organisation should enter 'enhanced surveillance', regular Quality Improvement Groups (which include multi-stakeholder members from CQC, NHSE, General Medical Council, etc) are established to set up, plan, co-ordinate and facilitate the effective and sustained delivery of action/improvement plans to mitigate and address quality concerns and risks.

It is usual for the organisation to remain in enhanced surveillance until the improvements undertaken to mitigate the risks are partially embedded and the risk(s) is/are reduced to an acceptable level.

3. Intensive quality assurance and improvement

This level of surveillance is generally a last resort when there are very complex, significant or recurrent risks that require mandated intensive support led by NHS England (NHSE) and the regulators. The move into this level of assurance is authorised by NHSE. This level of surveillance is escalated up to the most senior level via NHSE.

The System Quality group reports to the Integrated Care Board via the Outcomes, Quality and Performance Committee. The terms of reference for the System Quality Group can be found here. Papers of the ICB Board (open meetings) are available to the public via the ICB website.

2. Joint Forward Plan

2.1 What is the Joint Forward Plan?

This Joint Forward Plan sets out how the Integrated Care Board (ICB) intends to deliver on the national vision to ensure delivery of high-quality healthcare for all, through equitable access, excellent experience and optimal outcomes. It contains a set of quality objectives that reflect system intelligence. It includes clearly aligned metrics (on processes and outcomes) to evidence successful and sustained delivery. It demonstrates how quality priorities have gone beyond performance metrics looking at outcomes and? preventing ill-health using the Core20PLUS5 approach to ensure inequalities are considered. The plans align with the National Quality Board principles.

This Joint Forward Plan is structured around the responsibilities of the Health and Care Improvement Groups and describes how we plan to achieve and deliver the priorities set out in our strategy over the next five years. It addresses objectives set out in the government mandate with regards to ambitions described in the NHS Long Term Plan and NHS planning guidance.

See pictures below describing a summary of the changes planned for our system for the next five years, split by the relevant Health and Care Improvement Group.

2.2 How have we built this plan?

The approaches laid out in the strategic framework are guiding this work and so we will continue to build mutually-beneficial partnerships with the voluntary, community and social enterprise sector. As we move towards considering specific interventions or changes, we will continue to co-design with input from our clinicians/practitioners and service users/carers.

We started to develop our Joint Forward Plan building on the work of the Health and Wellbeing Boards, the locality partnerships? and the 2023/2024 Operational Plan. Our draft plan was published in March 2023, and following the relevant engagement and consultation described in the next section, we have updated the draft plan, making this final version published in June 2023. It is important to reiterate that this plan is the first iteration of an annual process to ensure we always have a five-year rolling plan aligned to the operational planning process.

During the development of this Joint Forward Plan, all partners and programmes of work including the system enablers have considered the triple aim, describing relevant steps to:

- Deliver improvements in population health and wellbeing ambitions.
- Describe quality of services that reflect system intelligence, aiming at reducing inequalities.
- Describe how the system will improve efficiency and sustainability of services.

We recognise that some deliverables within this Joint Forward Plan reflect the actions for the next one or two years for some programmes, but we expect this to mature and develop further as the system matures, our partnership develops, and the priorities are agreed. Leadership from the relevant Health and Care Improvement Groups will continue to review and ensure that their work aligns with the nascent strategy reflecting our vision and the totality of the work on-going across our? community, primary care and other partners.

See appendix 10 for a visual overview of our plans, split by Health and Care Improvement Group.

2.3 Engagement

2.3.1 Partner engagement

We have delivered a number of engagement sessions with different system groups and organisation trust boards and partners, seeking feedback and further input and contribution ahead of this publication. The Local Health and Wellbeing Boards and Integrated Care Partnership Board have been consulted on the draft Joint Forward Plan, with specific development sessions held for Bristol and South Gloucestershire during the month of May, including the voluntary sector partners and Healthwatch, supported by the strategy team. Further engagement sessions were held at Sirona care & health's Board, acute trusts (via planning colleagues), primary care (via Integrated Care Board colleagues) mental health, learning disability and autism, Children and Community Health and Care Improvement Groups, Health and Care Professional Leadership Group, System Medicines Optimisation Board and Integrated Care Board staff during the month of May 2023.

There has been a significant amount of engagement, feedback and collaboration across the system, reflecting that this is a system-level plan. Further work is required in future iterations to ensure the plans are fully integrated, delivering the strategy as the core ambition for the system.

2.3.2 Public engagement

In the summer of 2022, we asked local people what helps them to be happy, healthy and well. We had more than 3,000 responses, with over 21,000 different comments from those who completed an online survey or attended one of more than 50 community events. We worked with our local hospitals, community health, primary care, mental health, local council, charities, community groups, the voluntary sector, and businesses to help gather these responses.

Many different people from our communities in Bristol, North Somerset and South Gloucestershire are represented in the findings and this includes different age groups, health needs, abilities and people from a variety of backgrounds.

The findings have been an integral part of shaping our Integrated Care System (ICS) strategic framework and the subsequent strategy, this Joint Forward Plan and Operational Plans, and we are continuing to involve stakeholders as this work develops.

Central to this, will be strategy for 'Working with People and Communities' which is still in development and will be published in the summer. This strategy sets out how we will keep people and communities at the heart of our work through effective use of insights, through the inclusion of lived experience, through co-production and through user experience.

This Joint Forward Plan will not need consultation since it builds from existing Joint Strategic Needs Assessments, Joint Local Health and Wellbeing Strategies and NHS delivery plans. We are not proposing a significant reconfiguration or a major service change. This may be the case in a few years, when the ICS has developed further as an Integrated System, and whenever that happens, the Integrated Care Board will ensure that public and patient consultation and engagement is completed.

2.3.3 Healthwatch

Healthwatch provides data at a system and area level across Bristol, North Somerset and South Gloucestershire, which enables services and commissioners to hear about people's experiences of health services. Healthwatch actively seeks out people who are most likely to experience inequity in experience or outcomes and their feedback is part of the Local Voices reports and form

the basis of our service-user investigations. The drive towards a stronger prevention and early intervention agenda, and the recognition of the impact of barriers to access, experience and outcomes will benefit from insights that help to tailor services.

An example of outcomes from Healthwatch's insight work from 2021 led to the co-production of a 'Get Ready' Health Check checklist. This was steered by service users with a learning disability in an easy read format. This was uploaded to TeamNet and Remedy and GPs send it out before an annual health check is done. The average completion of annual health checks in 2021 was 70%. In 2023 it has become the highest in the southwest at 83%. 98% of those people now have a health action plan compared to 53% previously. Our work with partners continues to have an impact on the health and care of disadvantaged communities.

2.4 How will we know if we are succeeding?

Since 2021, Bristol, North Somerset and South Gloucestershire Integrated Care System has used a system outcomes framework (see table below) to measure our progress. Each outcome has linked indicators designed to monitor our progress and link it back to our strategic objectives. The outcomes framework is in the process of being reviewed to ensure it aligns with the new strategic context of our system so that it can monitor the impact of our ICS strategy.

The detailed plans below include a list of all the relevant programme metrics that align and/or support this outcomes framework. For each metric, there should be a link to one or more specific outcome framework. We expect that with the annual cycle review, each programme will develop and implement further measures that contribute to our system outcomes.

System Outcomes Framework

Domain	Code	Outcome
The healthy life expectancy of POPULATION	POP1	We will increase population healthy life expectancy across BNSSG and narrow the gap between different population groups
The health and wellbeing of our POPULATION	POP2	We will reduce early deaths from preventable causes in the communities which currently have the poorest outcomes
	POP3	We will lower the burden of infectious disease in all population groups
	POP4	We will reduce the proportion of people in BNSSG who smoke
	POP5	We will improve everyone's mental wellbeing
	POP6	We will give the next generation the best opportunity to be healthy and well
The health of our SERVICES	SER7	We will increase the proportion of people who report that they are able to find information about health and care services easily
	SER8	We will increase the proportion of people who report that they are able to access the services they need, when they need them
	SER9	We will increase the proportion of people who report that their health and care is delivered through joined up services
The health and wellbeing of our STAFF	STA10	We will increase the proportion of our health and care staff who report being able to deliver high value care
	STA11	We will reduce sickness absence rates across all our *Healthier Together* partner organisations
	STA12	We will improve self-reported health and wellbeing amongst our staff
	STA13	We will improve Equality and Diversity workforce measures in all *Healthier Together* Partner organisations
The health and wellbeing of our COMMUNITIES	COM14	We will reduce the number and proportion of people living in fuel poverty
	COM15	We will reduce the number of people living in poor housing conditions
	COM16	People will grow up and live in homes and communities where they are safe from harm
	COM17	We will reduce levels and impact of child poverty
	COM18	We will increase the number of people who describe their community as a healthy and positive place to live
The health and wellbeing of our ENVIRONMENT	ENV19	Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution
	ENV20	Specifically target carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030
	ENV21	Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

3. Our Plan

3.1 Inequalities

Background

The social, economic and environmental conditions in which people live have an impact on health. They include income, education, access to green space and healthy food, the work people do and the homes they live in. Differences in these conditions are a major cause of health inequalities. Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups.

Equity means we recognise that each person has different circumstances and gives the exact resources and opportunities needed to reach an equal outcome. "Equality is giving everyone the same pair of shoes. Equity is giving everyone a pair of shoes that fits."

Our approach to reducing inequalities in access to, experience of and outcomes from services and other types of support includes:

1. Addressing the structural nature of inequalities - thinking about how decisions are made and who is involved in making those decisions
2. Providing resources according to need – improving the way we spend money so that we provide funding in a way that supports people who experience health inequalities get what they need so they can achieve what matters to them
3. Exploring how we will achieve health equity in all policies and then implementing that approach
4. Further actions developed and implemented over the course of the five years of this Joint Forward Plan.

In addition, NHS England has asked systems to take a "Core20Plus5" approach to their work. The "Core20Plus" elements encourage systems to consider and address the needs of people living in the 20% most deprived areas nationally "Plus" another group of the population that is experiencing health inequalities. This "Plus" group will differ according to the type of condition / care / support and to each 'place'. This approach can be taken to all improvement work done jointly as a system and by individual providers and commissioners. The "five" aspect is five interventions across varying conditions that we have to focus on because there is evidence of inequality at a national level (for people living in the 20% most deprived areas nationally and a "Plus" group to be determined by systems) in those particular areas. For adults, the five interventions cover aspects of maternity care, support for people with a severe mental illness, respiratory care, cancer and cardiovascular disease prevention. For children, the five interventions cover aspects of care for asthma, diabetes, epilepsy, oral health and mental health. See below detailed plans for achieving this under the children and the community sections.

Further plans to reduce health inequalities can be found within the relevant programmes under the relevant health and care improvement groups described below.

The Integrated Care Board has agreed to fund a reserve of £3.2m for health inequalities. A plan will be developed and brought back to the Board for approval by the Chief Medical Officer who has executive responsibility for health inequalities.

Governance

At a system level, responsibility for taking the approach will lie with the appropriate Health and Care Improvement Group and/or another relevant group. At a 'place' level, locality partnerships will continue to take this approach. In addition, the appropriate Health and Care Improvement Group will be responsible for each of the specific interventions (five for adults and five for children).
We will establish an Inequalities Oversight Group to review and support the work of the Health and Care Improvement Groups in this area. Discussions within this group will be taken into the Health and Care Professional Executive. The Chief Nursing Officer and Chief Medical Officer will give the feedback to the relevant Health and Care Improvement Group. The Integrated Care Board Outcomes, Performance and Quality Sub-Committee will ask for assurance on progress and delivery.

3.1.1 Reducing homelessness

Homeless populations are known to experience multiple health disadvantages, poorer health outcomes and barriers to receiving healthcare. An initial gap analysis of medical provision to the homeless population of Bristol, North Somerset and South Gloucestershire has identified inequity in the accessibility and delivery of services required to meet the clinical needs of homeless people.

This further highlights the health inequalities experienced by homeless people, as evidenced through the Joint Needs Assessment. The re-commissioning of the Alternative Provider of Medical Services (APMS) contract for provision of primary medical services to the homeless population offers an opportunity to work collaboratively with system partners to co-commission medical and local authority services at a system level, supporting the provision of equitable, joined up, cohesive service provision to the homeless population of our system.

We will collaboratively commission services for the homeless population, facilitating:

- Equal service offer for the homeless population across our system
- Improved health outcomes
- Improved life expectancy
- Improved access to tailored services
- Streamlined, easily accessible pathways i.e., accommodation
- Reduced hospital length of stay
- Supported transition to receiving healthcare through mainstream services
- Reduction of return rates to homelessness.

3.2 Meeting the net zero target

Green Plan

Background

Climate change is one of 'the greatest threats to global health' (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. As an Integrated Care System, we have developed a green plan which sets outs our commitments to deliver three key outcomes for our population:

Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution. This will create a cleaner, safer, more ecologically sound environment locally and globally, including restoring biodiversity as much as possible

Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

The determinants and impacts of health and climate change are interconnected, and climate change impacts exacerbate health inequalities. People living in most deprived areas are often most detrimentally impacted by climate change and air pollution. Through focusing on these three outcomes, we intend to reduce health inequalities.

There are health co-benefits from mitigating climate change. We will design our services and estates in ways that support achieving cleaner air, healthier diets and increasing physical activity.

An initial version of the plan was approved in March 2022. Since then, we have engaged widely with stakeholders to develop a revised version. It is anticipated that a final public version will be approved by the Integrated Care System Executive Group and published in early 2023.

Embedding sustainability into decision making and how we operate as a system is core to meeting the aims and objectives of our ICS, delivering a sustainable health and care system and the long-term health of our population. In developing our Integrated Care System, we aim to deliver a truly sustainable health and care system that will bring multiple mutually reinforcing benefits:

Figure 7: BNSSG Sustainable system

Governance

Achievement of our ICS Green Plan will require a governance structure and supporting delivery infrastructure. Whilst much of the work of delivering change will be devolved to our core operations and strategic change programmes, the wide-ranging and large-scale nature of the ambition requires a formal governance structure.

Within Bristol, North Somerset and South Gloucestershire (BNSSG), we have established an executive-led **ICS Green Plan Steering Group** that reports directly into our ICS Executive Board. The steering group is responsible for:

1. **Holding our shared ambition** – building on the success of our organisational level work, we will hold a singular clear ambition as an ICS that all partners align to.

2. **Establish the enabling conditions for change** – putting the green agenda at the heart of our ICS – how we business plan, allocation of resources, development of frameworks and governance.

3. **Coordinating collaborative projects across partner organisations**, including advising the Executive Board on priorities and trade-offs. At an ICS level we will put our collective resources and energy behind a small number of impactful changes.

4. **Provide assurance of delivery of actions** devolved to other steering groups and organisations. Recognising that the green agenda is everyone's business we will build on the success of organisational plans, putting in place monitoring and support frameworks to maximise the impact across the system, target highest impact interventions, hold collective risks, and hold groups to account for delivery of key actions.

A Green Plan Implementation Group has been established to monitor progress of workstreams that have been established initially as a joint group working across the acute trusts but now with representation from other organisations including AWP and Sirona, reporting directly into the Green Plan Steering Group.

The Sustainability and Health Group also report directly into the Green Plan Steering Group. They enable wider representation from across the system including primary care, local authorities, SWAST and Sirona to provide input and coordination for cross cutting areas such as climate change adaptation.

Within these groups, other system-wide subgroups have been established to support delivery of the green plan, including:

- Net Zero Carbon
- Sustainable Procurement
- Travel, Transport and Air Quality
- Biodiversity
- Healthier With Nature
- Sustainable Waste
- Communications and Engagement
- Medicines Optimisation

Metrics and Trajectories

To assure ourselves and our citizens that we are on track to deliver our headline ambitions we will establish a number of key metrics. For some aspects of our sustainability ambitions there are not currently suitable measures. For these we will work to develop measures and use proxy measures in the meantime, the following will be monitored as our ambition:

Metrics	Link to Outcomes Framework
Procurement	
Carbon footprint of supply chain will be reduced by 50% before 2028	ENV19, ENV20, ENV21
Carbon footprint of supply chain will be net zero by 2030	ENV19, ENV20, ENV21
Estates	
All capital projects will be achieving NHS net zero building standard	ENV19, ENV20, ENV21
Our estate will be net zero by 2030	ENV19, ENV20, ENV21
Travel, Transport and Air Quality	
All our fleet vehicles will have ultra low emissions	ENV19, ENV20, ENV21
50% of journeys to sites will be by sustainable and active means	ENV19, ENV20, ENV21
Air quality will meet WHO standards (One City Plan target)	ENV19, ENV20, ENV21
100% of fleet vehicles are zero emissions	ENV19, ENV20, ENV21
Waste	
60% of all waste is reused or recycled by 2025	ENV19, ENV20, ENV21
80% of all waste is reused or recycled by 2026	ENV19, ENV20, ENV21
100% of all waste is reused or recycled by 2030	ENV19, ENV20, ENV21

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Programme																				
To establish a system-wide dashboard																				
Develop costed delivery plan to measure ourselves against																				
Ensure that we measure outcomes (i.e., what will be different for our population), rather than processes																				
Review our dashboard at least annually at organisational and system board level																				
Procurement																				
Establish a sustainable procurement training programme																				
Assess carbon impact of supply chain and progress reported																				
Embed sustainability and ethical commitments in business planning and procurement processes																				
Ensure all new contracts with suppliers have plan to take their operations to net zero by 2030																				
Estates																				
Complete and cost estates decarbonisation plan																				
Identify onsite renewable energy opportunities																				
Install electric vehicles charging infrastructure																				
Waste																				
Ensure all contracts have sustainable waste management in place																				
Implement NHSE clinical waste strategy ratios																				

Our detailed Green and Sustainability Plan can be found here.

3.3 Health and Wellbeing Board Strategies

3.3.1 Bristol Health and Wellbeing Strategy

The Bristol Health and Wellbeing Board's vision is for citizens to thrive in a city that supports their mental and physical health and wellbeing, with children growing up free of 'Adverse Childhood Experiences', and the gaps in health outcomes between the most economically-deprived areas and the most affluent areas of Bristol significantly reduced.

Although the Health and Wellbeing Board Strategy was created in 2020 setting out a strategic direction to 2025, it has been updated annually. Prioritisation has taken place in reference to the latest Joint Strategic Needs Assessment and is aligned with the Bristol City Council 'One City Plan'[3] health and wellbeing ambitions.

The Strategy is split into the following categories:

- ✓ **Healthy childhoods** – Improving health and care services for children and young people through the ongoing delivery of the Belonging Strategy and the cost-of-living response.
- ✓ **Healthy bodies** – To deliver the Drug and Alcohol Strategy, target smoking cessation support and the Food Equality Strategy.
- ✓ **Healthy minds** – Identify unpaid carers, assess, support and value their caring role, Thrive Bristol, the Healthier Together Community Mental Health Framework, Green Social Prescribing and the Suicide Prevention Strategy.
- ✓ **Healthy places** – Deliver the Fuel poverty action plan and contribute to the One City Climate Strategy.
- ✓ **Healthy systems** – Improve inclusive recruitment and deliver the cost-of-living response.

The Board also continues to work on public health challenges including obesity, mental health, and drug and alcohol misuse. To tackle the wider determinants of health, we are also contributing to work around housing, the economy, and environmental sustainability which are inextricably linked to improving health and reducing inequalities. Following the publication of a Women's Health Strategy for England, we will explore inequalities in health experienced by women in Bristol.

Governance and engagement

The Health and Wellbeing Board is a statutory body with strategic oversight of the health and care system in Bristol. It is also part of the One City partnership, overseeing the health and wellbeing theme of the One City Plan.

Three of the six Locality Partnerships are in Bristol, and they have been represented on the Bristol Health and Wellbeing Board since summer 2021, working together to increase a person-centred, place-based support in our communities.

Formal board meetings are held in public and Board members represent Bristol City Council, the NHS, Sirona care & health, Voscur, Carers Support Centre, Healthwatch, and race equality networks. Board reports are required to include evidence of community engagement and co-

[3] The One City approach is a partnership with public, private and third sector organisation in Bristol sharing an aim to make Bristol a fair, healthy and sustainable city.

production and reports from non-public sector organisations are encouraged where relevant to a priority as described above.

The board held a stakeholder event in February 2021, attended by more than 130 people from many sectors and areas of the city. It also contributes to biannual City Gatherings which bring together 200 representatives of organisations from across Bristol.

Metrics and Trajectories

As a whole system we will:

✓ **Healthy childhoods**
- Increase the percentage of children achieving a good level of development by the end of reception
- Reduce the percentage of children living in low-income families
- Reduce the number of first-time entrants to the youth justice system per year
- Reduce the prevalence of children and young people experiencing mental health problems

✓ **Healthy bodies**
- Reduce the prevalence of child and adult obesity
- Reduce the inequality in rates of obesity between most and least deprived areas of Bristol
- Reduce the percentage of households with a smoker
- Reduce the percentage of women smoking during pregnancy
- Reduce the percentage of manual workers who smoke
- Reduce the number of dependent drinkers
- Reduce the number of opiate and crack users
- Reduce the number of drug related deaths per year
- Reduce the number of alcohol related hospital admissions
- UNAIDS 95:95:95 HIV targets
- Increase the number of food businesses that offer takeaway that are selling healthier alternatives in line with the Bristol Eating Better Awards

✓ **Healthy minds**
- Decrease the percentage of residents reporting below national average mental wellbeing
- Decrease the difference in levels of poor mental wellbeing between the most and least deprived areas of the city
- Improve the Quality-of-Life survey wellbeing indicators
- Reduce the number of people admitted to hospital for deliberate self-harm
- Reduce the number of deaths due to suicide per year

✓ **Healthy places**
- Increase the percentage of vaccine and screening uptake and reduce inequalities in uptake
- Reduce the number of violent and domestic abuse crimes
- Increase the percentage of public sector fleet using non-fossil fuel
- Reduce the percentage of fuel poor households

✓ **Healthy systems**
- Increase the percentage of working age adults in employment
- Increase the number of health and care organisations and their suppliers paying the real living wage

Further metrics can be found in the Joint Strategic Needs Assessment.

Key Whole System Deliverables and Milestones from the One City Plan

Whole System Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Health and Wellbeing																				
Implement a cross-sectoral approach to domestic and sexual violence, female genital mutilation and forced marriage																				
Support the development of the Integrated Care System with voluntary sector as an equal partner																				
Increase inclusive recruitment in the health and care sector																				
Improve rates of physical activity																				
Implement Mental Health at Work Commitment																				
Deliver a resilience-building approach to improving children and young people's mental health																				
Deliver improved education and employment support for children and young people with special educational needs and disability																				
Achieve lower prevalence of smoking																				
Achieve the Fast Track Cities 95/95/95 targets on HIV																				
Deliver reduction in inequalities in vaccination and screening rates																				
Reduce fuel poverty, with improved energy efficiency of homes																				
Delivery of Drugs and Alcohol Strategy and action plan																				
More health and care organisations, and their suppliers, are Real Living Wage accredited and have more inclusive training and recruitment																				
Enable technology access to support those requiring social care																				

See the full detailed Bristol Health and Wellbeing Strategy here.

3.3.2 South Gloucestershire Health and Wellbeing Board Strategy

The South Gloucestershire Joint Health and Wellbeing Strategy vision is that all people in South Gloucestershire have the best start in life, live healthy and happy lives and age well in supportive, sustainable communities. Service partners will work with residents and service users to provide accessible and compassionate services. People will feel encouraged, enabled and inspired to take responsibility for their own health and wellbeing.

At its core is a commitment to work with partners at a local community, South Gloucestershire 'place' and wider health and care system level to recognise and reduce inequalities in South Gloucestershire. In addition, there is a focus on four strategic objectives:

Figure 8: South Gloucestershire Health and Wellbeing Board Strategic Objectives

The strategy was updated in December 2021 and whilst it was written with the four years in mind (2021 to 2025), the Health and Wellbeing Board will work with the South Gloucestershire Locality Partnership to re-evaluate its relevance during 2023-24 to ensure it reflects national and local developments in the health and care landscape.

Governance

The Joint Health and Wellbeing Strategy is owned by the Health and Wellbeing Board. The Health and Wellbeing Board provides a forum where political, clinical, professional and community leaders from across the health and care system in South Gloucestershire, come together to improve the health and wellbeing of the local population (including children and young people and vulnerable adults) and reduce health inequalities, ensuring a strong focus on establishing a sense of 'place'. Although a statutory committee of the Council, the Board functions as a partnership board and its work informs and is part of the South Gloucestershire Local Strategic Partnership's work and the Sustainable Community Strategy.

The Health and Wellbeing Board works collaboratively with the South Gloucestershire Locality Partnership, holds joint development sessions and agrees joint areas of focus and priorities.
The Health and Wellbeing Board promotes greater integration and partnership between the NHS (South Gloucestershire Locality Partnership, the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB) and Integrated Care Partnership (ICP)), local authority and wider partner organisations, paying regard to and challenging partners to work collaboratively and agree joint areas of focus.

Functions of the Health and Wellbeing Board include:

- Assessing the health and wellbeing needs of the South Gloucestershire population and publishing a Joint Strategic Needs Assessment (JSNA) (South Gloucestershire Our Population Dashboard).
- Publishing a South Gloucestershire Joint Health and Wellbeing Strategy, which sets out the priorities for improving the health and wellbeing of the local population and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the JSNA.
- Ensuring the Joint Health and Wellbeing Strategy directly informs the development of joint commissioning arrangements (see section 75 of the National Health Service Act 2006) in South Gloucestershire and the co-ordination of NHS and local authority commissioning, including Better Care Fund (BCF) plans, providing the governance for the BCF pooled fund in South Gloucestershire.
- Assessing needs for pharmaceutical services in South Gloucestershire and publishing and keeping up to date a Pharmaceutical Needs Assessment (PNA).
- Supporting the development and implementation of the BNSSG Integrated Care Strategy, which will set the direction for the system as a whole and tackle those challenges that are best dealt with at a system level.
- Supporting the development and implementation of this five-year BNSSG Joint Forward Plan; providing comments and confirming that it takes proper account of the South Gloucestershire Joint Health and Wellbeing Strategy.
- Being a forum for discussions about strategic and operational coordination in the delivery of services already commissioned.

Monitoring arrangements

Population outcomes and inequalities in outcomes are monitored through the JSNA, which includes a South Gloucestershire Our Population Dashboard. The dashboard provides a current and comprehensive overview of the health and wellbeing of the South Gloucestershire population, framed in the context of health inequalities and local strategies, and is regularly updated and reviewed. In addition, the Board undertakes a deep dive into one of the Joint Health & Wellbeing Strategy's strategic objectives at each quarterly meeting.

The current timetable is as follows:

	July 2023	***October 2023***	***January 2024***	***April 2024***	***June 2024***
JHWS Strategic Objective Deep Dive	Maximise the potential of our built and natural environment to enable healthy lifestyles and prevent disease	Overarching theme of reducing inequalities and taking a place and community-based approach	Improve educational attainment of children and young people, and promote their wellbeing and aspirations	Promote and enable positive mental health and wellbeing for all	Promote and enable good nutrition, physical activity and a healthy weight for all

Further details on the South Gloucestershire Health and Wellbeing Board Strategy, deliverables and metrics can be found here: South Gloucestershire Council (ourareaourfuture.org.uk).

3.3.3 North Somerset Health and Wellbeing Board Strategy

The North Somerset Health and Wellbeing Board's vision is for people to be enabled to optimise their health and wellbeing and to lead long, happy and productive lives in thriving communities, building on their strengths in a way that reduces inequalities in health. The vision will be achieved by:

- ✓ Preventing health problems before they arise
- ✓ Intervening early in relation to existing health and wellbeing problems
- ✓ Supporting communities to be connected, healthy and resilient.

Achieving this vision will improve health and wellbeing from the early years through to older age, providing opportunities to increase the number of people being supported and empowered to be healthy and well. This vision will also enhance the extent to which our local communities identify, own and implement tailored solutions to thrive, and, through targeted action, narrow gaps in health and wellbeing outcomes between groups.

The North Somerset Health and Wellbeing Board Strategy focuses on activities that will have the greatest impact on health and wellbeing. Underpinning this work are the following principles for how we will achieve our vision:

1. Strong and effective partnerships
2. Tackling health inequalities
3. A place-based approach
4. Life course approach
5. Informed by data, insight and ongoing learning
6. Enabling and empowering communities.

The approach taken by North Somerset Health and Wellbeing Board includes three main approaches that will optimise health and wellbeing across priority themes:

- ✓ Prevention – The actions focus on preventing people becoming unwell or having poor health and wellbeing. Upstream working and laying the foundations for better health are key to helping people stay healthy, happy and independent for as long as possible.

- ✓ Early intervention – The actions will support people to manage their health and wellbeing as effectively as possible, by implementing activities that support people to identify health problems or difficulties as early as possible, making sure that the right support is in place. The earlier action is taken to prevent or resolve a problem, the better the outcome.

- ✓ Thriving communities – The actions will support strategic plans and the extensive work already in place across North Somerset Council, BNSSG Integrated Care Board and with our partners in the wider health, care and voluntary sector system to support communities to thrive. This includes a focus on the wider determinants of health, such as employment, transport and housing, alongside ways to enhance access to green spaces and to address climate change.

Below is a picture describing North Somerset Health and Wellbeing Board's approach and priority areas to be addressed through the action plan:

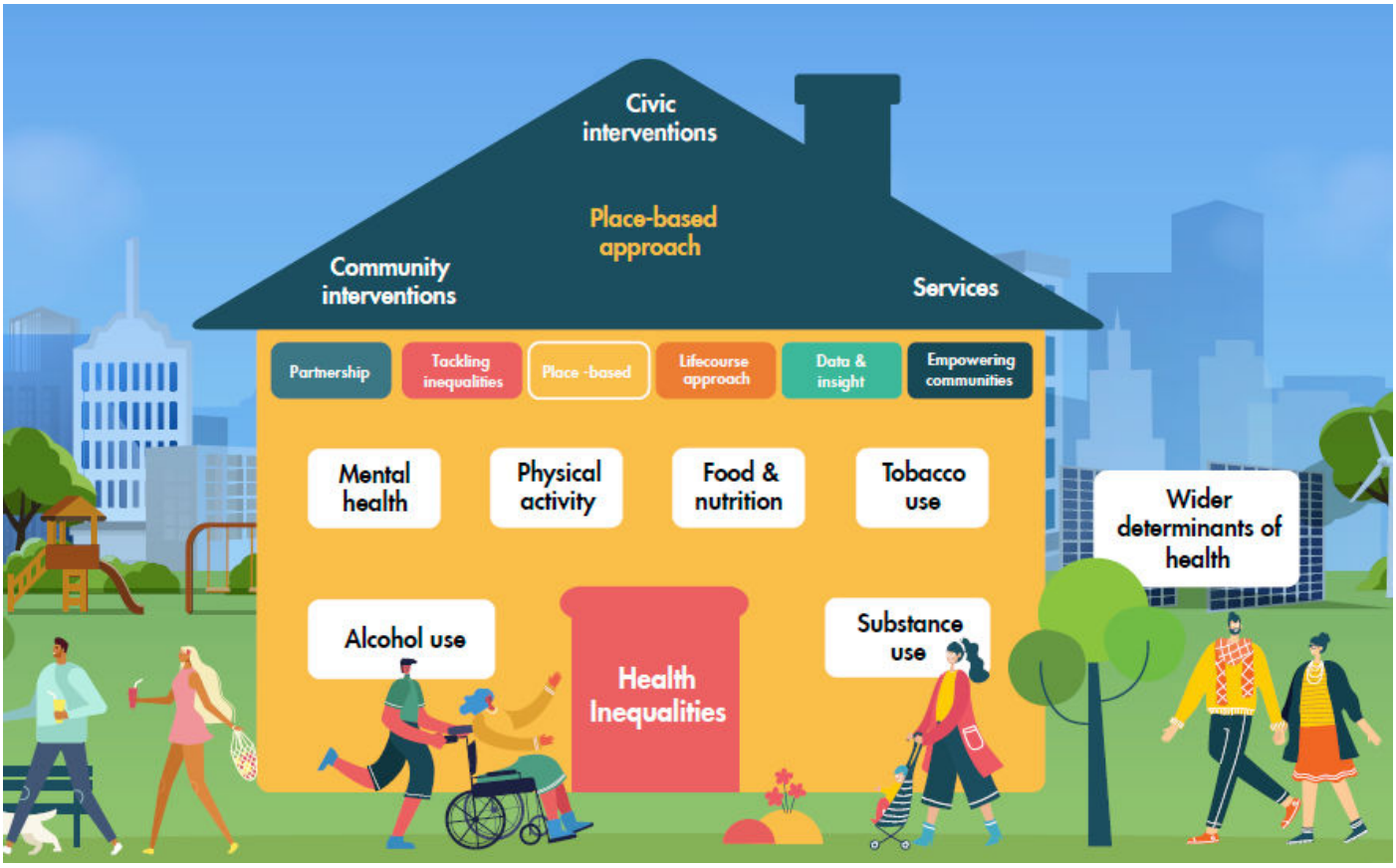


Figure 9: North Somerset Health and Wellbeing Board's approach and priority areas

Governance and engagement

The North Somerset Health and Wellbeing Board brings together key leaders from across the health and care system, to support improved partnership and integration and to plan how to improve health and wellbeing in the local population.

The Board is chaired by the Deputy Leader and Executive Member for Adult Services, Health and Housing of North Somerset Council and includes elected representatives, Bristol, North Somerset and South Gloucestershire Integrated Care Board, Healthwatch, and local leaders from adult social care, children's services, integrated locality groups and the voluntary, community and social enterprise sector (note: this information is correct in March 2023. The membership will be reviewed following elections in May 2023).

The North Somerset Health and Wellbeing Board Strategy and Action Plan have been developed based on the analysis of health and wellbeing needs and a wide range of engagement with different stakeholders to identify where we can make a difference to deliver short, medium and long-term benefits for local residents.

More than 150 people completed the online survey and workshops were held with members of the public, individuals working in health, wellbeing and associated public and third sector organisations, and town and parish councils. There was also engagement with representatives from more than 30 organisations through networks and forums and consultations with young people to hear their views. Overall, around 250 people were heard, and the outcome of this range of consultation and engagement activities conducted during spring 2021, ensures that the Strategy reflects the values, beliefs and priorities of people in North Somerset.

The Board's Strategy was developed in 2021 and covers three years. Recognising the complexity of the issues the strategy is trying to address and the speed at which circumstances can change, the action plan is subject to an annual review process. This process includes the relationships with the locality partnerships within North Somerset, reflecting the place-based approach:

Figure 10: North Somerset Health and Wellbeing Board's place-based approach

Further information on the governance of the North Somerset Health and Wellbeing Board can be found on North Somerset Council's website.

Further details of North Somerset Health and Wellbeing Board deliverables, metrics and action plan can be found on North Somerset Council's website and within appendix two.

3.4 Improving the lives of our children

Children and young people

Background

The children and young people's Joint Forward Plan is informed by qualitative insights from the public, our staff and partners through the Have Your Say engagement exercise as well as additional engagement with young people in the development of the Children and Young People's Outcomes Framework. Quantitative data has been sourced from the Strategic Needs Assessment about our population's health and care needs as well as more detailed Joint Strategic Needs Assessment data.

An overwhelming theme from all sources is the need to focus on the needs of children, young people and families to promote future health and wellbeing in a seamless way across services and to reduce the need for a diagnosis before they can access the help and support required. This will mean all organisations will be working in an integrated way to ensure that the total resources available across our health, social care, education, voluntary and other related sectors are targeted in the right way to ensure the best outcomes for children and young people. The children and young people Core20Plus5 will further support targeted action to address health inequalities goals for improvement in our system.

Population health need

Our Future Health presents an overview of key health and wellbeing issues for children and young people in our system. Poverty, affecting 25,000 children in Bristol, North Somerset and South Gloucestershire, is a major driver of future inequality in health. These children are more likely to experience health problems from birth and to accumulate physical and mental ill health throughout life. Higher levels of education are associated with better health. Measures of school readiness at age five show a 20-25% gap between the most and least deprived areas in the percentage of children ready for school. Some children from Black and Minority ethnic groups and those with special educational needs and disabilities are more likely to be lower educational achievers. Fixed period exclusions are increasing. Keeping children in education is important for achievement but also to protect mental health, confidence and self-esteem.

Prevention and treatment of childhood obesity has become a major public health challenge. There are around 2,260 children in our system either overweight or obese. Obesity rates are higher in some of our minority ethnic groups and in children living in the poorest areas. The consequences are a greater chance of being obese as an adult, with an increased risk of developing health conditions such as diabetes, cancer and heart disease.

Nationally, tooth decay is the leading cause of hospital admissions among 5 to9 year olds. The rate of admission to hospital for extraction of decayed teeth is higher in Bristol than the national average, and significantly higher in the most deprived wards.

Hospital admissions for mental health conditions and for self-harm in children and young people are significantly higher than the England average in each of the local authority areas, with around 1,320 self-harm admissions a year across the system. There are high rates of hospital admissions linked to alcohol and drug misuse – these are higher than the England average in all three local authority areas. Over a year, there were 245 admissions related to alcohol and 455 for drug use in young people. Drug misuse in young people increases risk of poor mental health and is linked to adverse experiences and behaviours including truancy, school exclusion, homelessness, time in care and offending.

In South Gloucestershire, over half of young people reported they are worried about their appearance, about being discriminated against and their mental health. In Bristol, children with low wellbeing scores were highest in young carers, children with free school meal status, children with disability, long-term illness, special educational needs and disabilities (SEND) or learning disabilities and those living in single parent families. Eating disorders rank in the top five most impactful conditions among 17- to 25-year-olds in our system. Nationally, it is estimated that the prevalence of eating disorders is around 8% of the overall population. The numbers of children and young people in treatment for eating disorders in our system has increased from 107 in 2017-18 to 367 in 2021-22. Compared with White British children, Black children are ten times more likely to be referred to children's mental health services via social services, rather than through their GP. Psychosis is in the top five most impactful conditions affecting young Black people in inner-city Bristol.

We recognise that experiences of trauma and adversity can have a wide-reaching impact on the social, physical and psychological wellbeing of children and young people. The prevalence and impact of trauma and adversity can be affected by wider cultural, social, political and contextual factors including health inequalities. These experiences may affect how children interpret their surroundings and how they engage with services. Within our system, we are committed to becoming trauma informed, building knowledge of trauma and adversity into our services and systems, to promote recovery and prevent further harm.

Service provision

Our health system is facing a range of operational challenges, including unprecedented levels of demand at the children's emergency department at the Bristol Royal Hospital for Children, which poses a significant safety risk with significant growth in minor presentations and physical space constraints. There is an increase in complex mental health admissions to the hospital, including eating disorders.

Within planned care, there are long waiting times for children and young people, and theatre and outpatient capacity constraints in key areas such as cardiology, respiratory, neurology and trauma and orthopaedics. There has been a 350% rise in referrals for autism and attention deficit hyperactivity disorder (ADHD) diagnosis with children waiting more than two years for an initial assessment.

There are workforce constraints and interdependencies between elective recovery, urgent care, mental health, community child health and estates/access to system capital investment which highlight the importance of progressing our service integration ambition.

In addition to providing acute hospital services for the local population of 225,000 children and young people, the Bristol Royal Hospital for Children (BRHC) is also a tertiary and major trauma centre for paediatric care, serving the South West population of 1,250,800 under 19-year-olds. It provides a full range of specialised services for children and its specialised teams work closely in partnership with district general hospitals across the region to provide shared care for a range of patients with long-term conditions and critical urgent health needs. It also provides supra-regional critical care and transportation, renal transplantation and congenital heart disease care for paediatric patients in South Wales and several highly specialised services that provide care nationally for children. Over 70% of the children's activity at the BRHC is for specialised services.

The BRHC works in partnership with the national Children's Hospital Alliance to develop best practice, innovation and policy for children's services. The BRHC is active in paediatric research and at the cutting-edge of children's health nationally. In 2023, a dedicated children's research facility will open on site. The division of Women's and Children's Services at University Hospitals Bristol and Weston NHS Foundation Trusts hosts a range of operational delivery networks, including neonatal, paediatric critical care, surgery in children, children and teenage young adult

cancer, congenital heart disease (all ages), and works collaboratively with the major trauma, palliative care, neurosciences and spinal networks hosted elsewhere.

Service improvement

The first 1,001 days of a child's life, from pregnancy to age two, is a critical period in a child's development, laying the foundations of the brain's architecture and the building blocks for lifelong physical, emotional and mental health and wellbeing. During this period, babies learn and develop communication and physical skills, are highly susceptible to their environment, and are strongly influenced by attachment with their caregivers. Traumatic events for a child in this period (or adverse childhood experiences), such as abuse, neglect or parental mental ill-health or conflict, can have long-term effects.[4] Early identification and intervention for children with disability or additional needs in this period can also improve long-term outcomes. We will continue to provide a range of preventive, early help, support and treatment services across our system to provide the best start in life for children in this period of life, ensuring that we provide seamless and integrated support through our services, hubs and centres where families can access services, and support and care that responds to children's and families' needs, in line with national action areas. Our work will also link into the system's ambition to become trauma-informed and will ensure that parents and carers' mental health needs are met to maximise bonding and secure attachment between parents or caregivers and children.

A major contribution to achieving the best start in life priority is the modernisation of the Healthy Child Programme (HCP) which is a universal programme available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. Universal and targeted public health services provided by health visiting and school nursing teams are crucial to improving the health and wellbeing of all children and young people. The modernised HCP recognises the importance of early childhood in creating the foundations for improving outcomes and reducing inequalities through universal provision and personalised response and has a renewed focus on prevention and early intervention to support better long-term health outcomes.

Sirona's Public Health Nursing services are currently delivering a large-scale transformation that aims to develop evidenced based pathways that are focused on the high impact areas identified in the Healthy Child Programme. These are the areas of public health where research shows health visitors and school nurses can make the biggest difference to child outcomes. The service is embedding the thrive principles that provide a framework for the transformation of public health nursing for children and young people aged 0 to19 and has a focus on partnership working to achieve shared goals.

We know that successful transition from children to adult services can be challenging for young people and their families and that we need to take steps to ensure that positive outcomes and experience of transition is consistently achieved for all. We aim to put young people at the centre of well planned, integrated and supported transition to support continued treatment or self-management of their health and wellbeing. One area of particular focus is mental health, where we want to improve care for young adults aged 18 to25 with mental health problems by achieving a safe transition, maintaining engagement, improving outcomes and supporting young people to be fully involved in their own care. We want to work in collaboration with young people, carers, providers, local authorities and the voluntary sector to ensure that the care of a young person before, during and after transition meets best practice and the ambitions of the NHS Long Term Plan.

The Integrated Care Board will lead a whole system transformation within community children's services in which neurodiversity is recognised and understood and the needs of children across our system are met without requiring a medical diagnosis. This transformation programme will

[4] HM government (2021). The Best Start for Life. A vision for the 1,001 critical days.

include developing capacity and capability in all sectors (teachers, health visitors, GPs, social workers etc.) to document children's strengths and needs in a neuro-profile and sign-post families to ordinarily available support and advice. The transformation plan will move the risk of the current referral load into a more sustainable system-led model where health collaborates with education and social care to deliver clinical support to the children with most need and those who are vulnerable in line with our iThrive approach of 'getting more help'.

To improve patient and family experience by providing care at home (rather than in hospital) where clinically safe and appropriate to do so, teams at the Bristol Royal Hospital for Children are working towards the development of paediatric virtual wards, in conjunction with the Integrated Care Board and NHS England. Virtual wards allow people to get the care they need at home, and also free up acute beds, improving physical beds capacity and availability for people whose care must be provided in a hospital setting. Virtual wards use technology and/or medical devices to support remote care and may involve remote care from hospital-based clinicians and/or face-to-face support from community-based clinicians. The Bristol Royal Hospital for Children is working with partners across the national Children's Hospital Alliance to develop plans for paediatric virtual wards, sharing expertise and best practice nationally.

We are developing and embedding engagement and co-production across our strategic work and key programmes. We have lived experience colleagues acting as co-chairs on significant work streams, or as members of programme boards and Barnardo's Helping Young People Engage (HYPE) service are employing young people, as lived experience champions, to support the Integrated Care System with greater insight into the experiences, views and needs of young people and to inspire change. As part of the newly established transformation approach and hub, led by the Integrated Care Board, we are committed to co-production at the beginning of any potential transformation or service change. Our commitment to co-production is to be inclusive and consistent, identifying and including everyone affected by the change from children, young people and parent/carers to system partners such as education and social care. We want to develop and embed a consistent approach to co-production across the system and strengthen how we work with our Parent Carer Forums.

We are working closely with NHS England to deliver the children and young people's programme, mental health and learning disabilities and autism through both system and assurance leads and being active participants in clinical and commissioning networks. This has allowed us to benchmark as well as understand regional innovations and best practice and improve local performance as a result. In addition to piloting an end of life care at home service in 2023/24, we are also working with Integrate Care Board colleagues from across the South West to map paediatric palliative care provision against the NHS England ambitions for palliative and end of life care.

Aims and objectives

We will improve the quality of services and reduce inequalities in access and outcomes by ensuring that health and care services are delivered in an integrated way.

We will enhance the productivity and value for money of children's services in our area by utilising the collective assets of the children's system to address population health need and maximise available capacity and capability of the workforce.

We will identify and set steps for delivery of the longer-term priorities for children, young people and their families using quantitative data and qualitative insights.

We aim to address the challenges faced by children's acute and community services to meet national requirements and our local deliverables described below.

We will take a structured approach to understanding and addressing the inequalities that exist for children and young people in their outcomes, experience and access to health and care services, including improving access to mental health services for minority ethnic children and young people, as supported nationally by the Royal College of Psychiatrists Advancing Mental Health Equality Collaborative.

Connection with the operational plan and Integrated Care System strategy

The Children and Young People's Joint Forward Plan connects our immediate, operational response to the challenges faced in our system with our longer-term strategic aims. For example, in 2023/24 we have committed to deliver additional capacity to address the backlog in demand for an autism assessment. Whilst this capacity will address the current backlog in the short-term, we recognise the need to understand and implement a longer term and more sustainable change to meet rising demand on autism services. A strategic, whole system collaboration is required to fully understand the challenges and solutions to ensure the needs of children, young people and their families are consistently met.

Further iterations of the Children and Young People's Joint Forward Plan will reflect the development of priorities with system partners to deliver the key areas of focus for children and families. For children's mental health, we will align to the development of the all-age mental health strategy described in section 3.4 'Improving the Lives of People with Mental Health, Learning Disabilities and Autism' and include detailed delivery plans for children and young people.

Further plans to improve the lives of our children can be found in the Health and Wellbeing Board Strategies, and Locality Partnership and Safeguarding Plans also included in this document (see section on how we will improve the lives of people in our communities and the Health and Care Professional Leadership enabler).

Health inequalities

The ambition to understand and address the health inequalities that exist in our system is central to our operational planning process and the development of the Joint Forward Plan. In 2023/24 we will focus on developing our understanding of the inequalities that exist within our population and the actions required to address them.

Our six locality partnerships are embedding a population health management approach, helping them to identify specific groups of the population that are experiencing poorer than average health access, experience and/or outcomes. Supported by engagement and co-production, locality partnerships are determining more effective approaches to engage and support these population groups to improve their outcomes and reduce inequalities.

Running concurrently with our discovery phase, we have a range of plans that drive targeted action in health care inequalities improvement aligned to the children and young people's core20plus5 framework, including:

- ✓ **Plans to continue to narrow health inequalities in access, outcomes, and experience:**
  - Increase Children and Adolescent Mental Health Service access rates
  - Deliver enhanced general paediatrics advice and guidance service and develop paediatric hubs in each of the six localities, including shared care community clinics
  - Delivery of universal services targeted at families with greatest need
  - Continue to deliver schemes to improve flow and elective activity in the acute sector
  - Increase the access to autism/ ADHD assessment for the most vulnerable groups ahead of our wider transformation programme to improve access for all.

- ✓ **Plans to focus on population groups that experience poorer than average health access, experience and/or outcomes:**
  - The Vanguard is a project set up to implement a framework for integrated care, to facilitate integrated trauma-informed systems that enable children and young people with complex needs to thrive. It is focusing on children and young people at risk of exclusion from school and risk of criminal and sexual exploitation and contact with the justice system, inclusion groups of children and young people with social emotional mental health issues, with drugs and alcohol issues, in the care of their local authority and/or living in poverty. There will be significant overlap with other groups of children and young people including those with special educational needs and learning disability, autism or both. Our ambition is to become a trauma-informed system to better support staff, children and families affected by adverse childhood experiences.
  - Continue to implement schemes to reduce waiting times for autism assessments
  - Transform current system to meet the needs of neurodiverse children and young people
  - Continuation of the Autism Intensive Service
  - Expansion of the key worker service.

- ✓ **Plans to focus on clinical areas of health inequalities:**
  - Continue to improve the care offered to children and young people with asthma, focusing on the ethos of preventative care
  - Increase Children and Adolescent Mental Health Service access rates
  - Implement mental health support teams in schools
  - Pilot transition services for young people with mental health problems
  - Continue to deliver schemes to improve flow and additional elective activity (includes dental surgery).

Governance

Health and care partners will be responsible for agreeing and delivering the Joint Forward Plan via the relevant health and care improvement group to improve the lives of our children, as part of the new delivery framework for Bristol, North Somerset and South Gloucestershire integrated care system.

All partners will actively work together ensuring services are delivered in an integrated way, crossing the boundaries of our health and social care services. This will ensure that all challenges we face as a system are proactively identified, prioritised and resolved and that services are delivered collaboratively across health, social care, education and the voluntary and community sector.

The children's health and care improvement group will work closely with other system groups recognising that children live in families and communities and the close links required with the Local Maternity and Neonatal System (LMNS) to ensure the effective delivery of services and improvements to meet the needs of women and babies in our system.

Metrics and outcomes

Our outcomes framework was informed by the insights of young people in our system and includes a range of impactful outcomes for children, young people and their families. A sub-set of outcomes of most significance for children and young people are included below:

Domain		Outcomes
The health and wellbeing of our POPULATION	**POP1**	We will increase population healthy life expectancy across BNSSG and narrow the gap between different population groups
The health and wellbeing of our RESIDENTS	**RES2**	We will reduce early deaths from preventable causes in the communities which currently have the poorest outcomes
	RES3	We will lower the burden of infectious disease in all population groups
	RES4	We will reduce the proportion of people in BNSSG who smoke
	RES5	We will improve everyone's mental wellbeing
	RES6	We will give the next generation the best opportunity to be healthy and well
The health and wellbeing of our COMMUNITIES	**COM14**	We will reduce the number and proportion of people living in fuel poverty
	COM15	We will reduce the number of people living in poor housing conditions
	COM16	People will grow up and live in homes and communities where they are safe from harm
	COM17	We will reduce levels and impact of child poverty
	COM18	We will increase the number of people describing their community as a healthy and positive place to live

The table below demonstrates the link between our plans, metrics and intended impact on outcomes:

Metrics	Link to Outcomes Framework
Children's statutory provision and legal responsibilities	
Children in Care - Improvement in timeliness of Initial Health Assessments (90% to be undertaken within 20 working days) and Review Health Assessments (90% to be undertaken every 6 months for under 5s and every year for over 5s) for all children placed into care across our system as per statutory timeframe by the first quarter of 2024/25. - Monitor recruitment/staffing WTE/Headcount to statutory recommendations for children in care	POP1, RES2, RES6, COM16
Multi-Agency Safeguarding Hubs (MASH) - Monitor the percentage of information requests responded to in required timescales by Local Authority area, including when health has no information to share (target to be agreed) - Monitor the percentage of information requests for MASH that led to strategy meetings/ discussion/S47 enquires, by Local Authority area (if available) - Twice yearly audit (supported by the Integrated Care Board Safeguarding team) reviewing the type of information requests and timescales to respond to such requests	RES6, COM16
Special Educational Needs and Disability (SEND) and Education, health and care plans (EHCPs) - 100% of requests for assessment are returned to Local Authority within 6 weeks. - Health contribute to 100% of Education, health and care plan annual reviews where health has active involvement and where known to service	RES6

- Monitor the number of co-produced and jointly commissioned services by the Integrated Care Board and local area partners - measured via Special Educational Needs and Disability (SEND) inspections; - A member of the ICB Board has specific responsibility for SEND	
Children and young people's mental health	
Improve children and young people's access to the Child and Adolescent Mental Health services with 1089 additional contacts per year by end Q4 2023/24.	POP1, RES5, RES6
Monitor urgent (1 week) and routine (28 days) access to community eating disorder services	
Number of young people attending emergency departments in crisis	
By June 2025 we will have ten Mental Health Support Teams, with each team able to support a population of 8000 children and young people.	
Children's learning disabilities and autism	
Increase the number of autism spectrum disorder assessments to be completed by end Q4 2023/24	RES6
Monitor the number of children on autism waiting List	
Monitor population health data for those children seen	
Children's elective care	
Eliminate waits over 65 weeks for planned care by March 2024	RES6
Ensure response to primary care requests for advice and guidance into secondary care within two working days for 80% in quarter 1 of 2023/24	RES6, SER9
Number of hubs set up and number of joint forums held by March 2024	
Children's urgent and emergency care	
Improve Emergency waiting times within 4 hours to 76% by March 2024	RES6
Monitor the number of attendances in children's emergency department	
Monitor the number of children and young people seen in outpatients (minor illness and injury stream)	
Monitor the number of failed minor illness/injury cases that could not be seen in outpatients department	
Children's community services	
Children's end of life care at home: 90% of families offered a choice of place of death at end of life by March 2024. Number of hospital or hospice bed days avoided through pilot service	SER9
Impact of implementation of the framework of integrated care on outcomes for children and young people with complex needs. Evaluation will be led by University of the West of England with interim report in quarter 3 of 2023/24, which will include: improved children and young people wellbeing, Reduction in high-risk behaviours, reduced mental health concern, Organisations are more trauma-informed, Improved purpose/occupation, Improved stability of home	RES5, RES6, SER9, COM16
Digitalisation of children's community services paper records: Convert ~152,000 paper records to digital. Removal of all paper records from 26 estates by quarter 3 of 2024/25	SER9
Addressing health inequalities	
Asthma prevention, treatment and management Improvement in percentage of children and young people with a reliever: preventor ratio greater than 1:6 (baseline to be measured) by end of 2023/24.	RES2, RES6
Evidence of increased awareness of the wide-reaching impact of trauma and adversity on the health and wellbeing of children and young people, their families and communities within our system's workforce, services and systems.	RES5, COM16, COM17, COM18

Key Deliverables and Milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Statutory Provision																				
Strengthen performance monitoring of statutory and legal requirements and associated improvement plans to support meeting statutory and legal requirements for children and young people																				
Improve consistency of adoption processes across our system																				
Implement learning from OFSTED / CQC SEND inspections, local area plans	SG		NS		B															
Deliver 'health' contributions to Multi Agency Safeguarding Hub arrangements																				
Improve timeliness of initial and review health assessments for all children placed into care as per statutory time frames																				
Re-procure special educational needs and disabilities (SEND) & You service																				
Children and young people's mental health																				
Increase Children and Adolescent Mental Health Service (CAMHS) access rates																				
Review CAMHS provision and options to meet the needs of children in care		Resource implications to be fully understood																		
Review options to increase access to health services for children in care and oversight of those in out of area placements		Resource implications to be fully understood																		
Continue eating disorders service development to achieve national waiting time standards																				
Continue naso-gastric feeding pilot for eating disorders			NHSE funding required from September 2023																	
Monitor the impact of current service developments by the number of young people attending emergency departments in crisis																				
Continue roll out of mental health support teams in schools					Potential to continue in 25/26 if 100% coverage required															
Scope and review transition services for young people with mental health problems																				
Pilot transition services for young people with mental health problems																				

Children and young people learning disability and autism (see related statutory provision and legal responsibilities above)																					
Undertake system transformation to ensure the needs of neurodiverse children and young people and their families are consistently met																					
Continue Autism Intensive Service and evaluate to inform longer term commissioning																					
Expansion of key worker service and evaluate to inform longer term commissioning																					
Review options to address the inequity of Positive Behaviour Service provision across BNSSG			Options and resource implications to be fully understood																		
Increase capacity for Autism assessment via waiting list initiative																					
Children and families' community services																					
Deliver Start for Life programme via family hubs in Bristol	Nationally funded until 2025																				
Deliver public health nursing transformation																					
Understand the delivery capacity within the community paediatrics service and review/re-design the health offer to support the neurodivergence transformation plan																					
Review of transition for young people with life limiting illnesses from the lifetime service to adult services																					
Review options to improve outcomes and value for money through joint commissioning for all age complex funded care																					
Pilot children's end of life care at home service																					
Implement Framework for Integrated Care to improve outcomes for children and young people with complex needs																					
Digitisation of paper records by removing legacy/existing paper records in estates and storage facilities																					
Children's elective care																					
Deliver enhanced general paediatrics advice and guidance service, including shared care clinics in all six localities																					
Continue to deliver to improve flow and additional elective activity																					
Continue to seek further mutual aid and private sector capacity for elective care																					
Complete pathway changes for Peninsula patients (Trauma and Orthopaedics, Ears, Nose and Throat, Urology)																					

Improve paediatric theatre productivity																				
Children's urgent and emergency care (see related mental health priority area above)																				
Continue children's emergency department minors' stream																				
Continue paediatric support for system clinical assessment service and development of paediatric assessment and coordination for urgent and emergency care																				
Health inequalities																				
Develop system-wide children and young people inequalities group to oversee discovery phase and agree actions to address inequalities																				
Develop and embed a consistent approach to co-production across the system																				
Improve awareness of the wide-reaching impact of trauma and adversity on the health and wellbeing of children and young people, their families and communities and begin to build knowledge into services and systems																				
Promote equity through co-production and engagement with young people																				
Address asthma training needs in primary care																				
NHS England children and young people's programme																				
Continue to pilot south west hub and spoke model for children and young people with excess weight																				
Aspirations for system prioritisation																				
Children and young people mental health: Deliver a range of preventative, early intervention and treatment programmes and services that address infant, children and young people's mental health needs, ensuring that optimisation of delivery is a system priority																				
Family services: Development and integration of universal, preventative and early help place-based services, targeting greatest need and addressing inequalities through system and Locality Partnership action																				
Complex care needs: Provide wraparound support for children and young people with complex needs with Tier 3+ model																				
Healthy weight: Contribution to whole system, all age approaches to healthy weight.																				

3.5 Improving the lives of people in our communities

Our overarching ambition is to implement an ethos of “home first” to keep people living well and supported in the community. We will do this through:

- ✓ A model of integrated care within localities that adopts a strengths-based approach to support people to stay well, makes best use of resources and reduces demand for emergency hospital services and long-term care;
- ✓ Greater emphasis on supporting people to age well, through proactive prevention, including support for carers and care homes, with a targeted approach to support areas where health outcomes are poor;
- ✓ Continued emphasis on managing increased complexity in community settings through Discharge to Assess and NHS@Home;
- ✓ Joint plans across primary and community care services to ensure integrated and multi-disciplinary team working at GP and neighbourhood level;
- ✓ Ensuring the threads of the Comprehensive Model of Universal Personalised Care are embedded across all aspects of delivery.

3.5.1 Community Services

Background

Community Services within our system is delivered by Sirona care & health. Our community services face many of the same challenges faced by primary care, including workload, workforce and estate, as well as managing the impact of the Covid-19 pandemic. Sirona care & health has recently completed a ‘reset’ programme of work to address these challenges. This also included a review of its clinical model, undertaken in collaboration with the General Practice Collaborative Board and with system partners, to:

- Identify new opportunities including those resulting from the Covid-19 pandemic
- Address demand in the system including waiting lists
- Respond to feedback from general practice, recognising the benefits of co-designing solutions.

This review has helped shape the aims and objectives for community services for 2023/24 which supports an intermediate care model built on personalised care, the principle of 'home first', equity of outcomes and local flexibility.

Aims and objectives

Urgent Community Response

Primary and community services are crucial in providing alternatives to hospital admission. We will continue to develop our urgent community response, ensuring that we offer a robust 2-hour response in line with national priorities and targets. We will also expand our capacity to deliver same day multi-disciplinary support to people who are at risk of hospital admission, enabling them to stay safe in their own homes by providing a short period of holistic support, utilising technology enabled care currently available through NHS@Home. This will be supported by a review of our current Single Point of Access to identify opportunities to improve urgent response, enabled by digital development. We will also support the further development of the Frailty Assessment and Coordination of Urgent and Emergency Care which brings together assessment services from across the system to provide alternatives to hospital admission. See detailed deliverables under the relevant sections below (primary care, localities and urgent care).

Care Home Support

We will work with General Practice and our system partners to provide support to people living in care homes by reviewing how we can best support them, including how community services can support the delivery of the Enhanced Health in Care Homes Framework. See further details under the localities section below.

Addressing Health Inequalities

There are many examples of how we have used the learning from the Covid-19 Vaccination Programme to work with local communities. We will build on this learning and the work being done in locality partnerships to develop a ‘’maximising access’ service. This service will be focussed on areas of deprivation within our system to provide place-based holistic wellbeing and prevention services, including support to address the wider determinants of health such as income, housing and employment. The service will be developed with our system partners, including locality partnerships, the voluntary, community, faith and social enterprise sector and local communities themselves to ensure we add value and maximising the impact of the skills and knowledge available. The key to this service will be building the trust of NHS services within local communities. We will do this by actively listening and understanding their needs so that we can improve access and health outcomes. See further details under the localities, prevention and health inequalities sections below.

Shifting Services ‘Upstream’

The increasing demand on NHS services further emphasises the need to help people keep well or manage their conditions effectively. We will implement a range of initiatives to support this including:

- Launching our maximising access service
- Developing place-based ‘health hubs’ which will offer access to holistic support to people with one or more long-term condition
- Working collaboratively with general practice to identify and support those most at risk of deterioration or hospital admission and providing holistic support, ensuring we are utilising best practice multi-disciplinary team meetings
- Implementing our approach to personalised care to transform how we deliver services; supporting shared decision making, supported self-management, social prescribing, wellbeing and personalised care budgets.

See further details under the primary care, localities, personalised care sections below.

Supporting People Leaving Hospital

We will continue to develop our Discharge to Assess services to support people after a period of time in hospital, so they get the right support to stay well and prevent readmission. This will include enabling more people to go home rather than into bedded units, by improving clinical decision making and utilising the voluntary, community, faith and social enterprise sector. We will make use of technology enabled care, such as NHS@Home, to help more people get safely discharged back to their own home. See further details under the home first section below.

Community Neighbourhood Teams

The Fuller Review set out an ambition for general practice to create a ‘team of teams’ with a sense of shared ownership for improving the health and wellbeing of the population. Our existing integrated network teams are organised around primary care networks to provide a range of

services to local populations. However, this has led to competing demands on the teams and has negatively impacted the important relationship between community services and general practices. We will review our integrated network teams, transforming them into community neighbourhood teams, so that they deliver services at local level, and are better able to manage demand and with a clear remit to build relationships at GP practice level. See further details under the primary care section below.

Enablers

There are some aspects of our services which can be better delivered by the voluntary, community, faith and social enterprise sector. To support our objectives, we will develop a robust framework which will set out how we will work with the sector in different aspects of our services, including ensuring robust and sustainable funding. See further details under section 1.7.1 above.

We will continue to develop collaborative opportunities with our system partners to explore opportunities to further improve services in the community for our population, embedding the principles of intermediate care. We will do this through our new community collaborative steering group, which is part of the community service provider and the GP collaborative board's governance structure (this is being reviewed to include the locality partnerships via the Integrated Care Board's relevant director).

3.5.2 Place-based Locality Partnerships

Background

Our ability to stay healthy and well depends on a range of things, including social connections, employment, housing, and education. To make a difference in people's lives, health and care services need to reflect the importance of these wider factors and the role they play in our health and wellbeing, as well as the role of the voluntary sector and the contribution they make. To do that, six locality partnerships have been established: Bristol Inner Centre and East, Bristol South, Bristol North and West, South Gloucestershire, Weston, Worle and Villages and Woodspring.

The national and local focus on population health management (PHM) since 2020 means we have a better understanding of the needs of our population. Importantly, that data enables a more informed, place-based, preventative approach to improving the lives of people in our communities.

This approach is essential because it will allow us, as a system, to deliver better outcomes by improving health and wellbeing delivered through targeted work in areas of higher need or risk, consequently reducing the demand on the services we all rely on when we are unwell.

The work of locality partnerships defines our system's broader approach to addressing the needs of Core20PLUS by being locally informed and locally led. Our approach is place-based.

- Core 20 = the most deprived 20% of the national population
- PLUS = underserved groups including ethnic minorities, those with learning disabilities, those who are autistic and those who have severe mental illness (SMI).

Local data has shown us where inequalities exist. Locality partnerships have used this data to assess where rates of unplanned care use are highest and have seen the correlation between those rates and areas of high deprivation. They have reached out to often marginalised groups and communities to improve health and wellbeing by listening and involving people in communities to develop solutions which will break the cycle of health inequality and poor outcomes.

This includes work in three of the five clinical areas of focus which require accelerated improvement – severe mental illness (SMI), chronic respiratory disease, hypertension case-finding, optimal management and lipid optimal management.

Aims and objectives

The locality partnerships will support delivery against those four aims we have as an Integrated Care System (ICS):

ICS aim	Role of the locality partnerships
Improve outcomes in population health and healthcare	By scrutinising population health management, CORE20PLUS and the joint strategic needs assessment data, partnerships understand the needs of their local population and where established approaches to improving outcomes are falling. Our approach builds upon work done during the Covid-19 pandemic to identify where vaccine take up rates were low and to work with local communities to address vaccine hesitancy to the benefit of broader health outcomes. This approach is currently helping us to address issues which prevent successful application of established treatment pathways. For example, wait lists across planned surgical pathways are impacted by increasing acuity – patients with multiple long-term conditions or who are at higher risk under anaesthetic.

	Localities have assessed evidence to identify where levels of excess weight in childhood and the rate of people with specific long-term conditions are highest. In response, the partnerships work with local providers and the voluntary sector to offer the opportunity to reduce the drivers of ill health which leave patients more at risk of disease and reduce the effectiveness of treatment pathways. The system as a whole works to provide a universal offer of high-quality healthcare. The role of the partnership supports the sustainability of that offer by using local intelligence to undertake geographically focussed work to reduce demand. Across Bristol, premature mortality caused by cardiovascular disease from 2018-2020 varied from 142.8 per 100,000 people in St George West to 20.7 in Clifton Down. We also know that at age 10/11 some 39% of children in St George West had excess weight (2017/2018 – 2019/2020) compared to 20% in Clifton Down. A local approach is vital to allow us to respond to that evidence and to better address the drivers of inequality across the life course. In South Gloucestershire we know that painful conditions are one of the most impactful causes of ill health and affect people substantially throughout their life course. This local intelligence is a key factor in enabling us to drive changes that are meaningful to our population.
Tackle inequalities in outcomes, experience and access	At system level, the work done by health and wellbeing boards, population health management and business intelligence illustrates significant inequalities in outcomes, experience and access. The partnerships lead the system's work to tackle inequality by being the delivery arm of both health and wellbeing boards and broader population health management work. The operational response to inequality sits with locality partnerships. Partnerships review the data we have with local communities and seek to better understand it in the context of lived experience. That experience informs the work of the partnerships which brings together capacity across statutory services and the voluntary sector to better meet needs and utilise assets in the community. In Woodspring, a high intensity use (HIU) service has been implemented with the Red Cross. The service provides a de-medicalised, de-criminalised and human approach to better meet the needs of people who attend the emergency department or their GP regularly. Two full-time staff support up to 90 people across the year by addressing the underlying reasons for accessing services. Evidence demonstrates the approach can transform the lives of the people supported and the services help us reduce inequality in outcomes as well as demand on services. In South Bristol the development of community connectors build on the need for support for growing numbers of individuals who have become increasingly visible because of the pandemic. The reliance and expectation that everyone can access everything they need online, or via an app, is unrealistic, and particularly affects older, less able and financially vulnerable people of South Bristol. Community connectors provide an actual person for individuals to talk to in their community to help them access local resources to improve wellbeing and to prevent their health

	deteriorating to the point of needing the support of health and social care agencies. Bristol North & West is working with the Health and Justice Partnership to build connections to improve mental health provision for offenders leaving prison 'through the gate'. That includes registration at GP practices and linking a person with the Integrated and Personalised Care Team (IPCT) before leaving prison. The aim is to foster closer collaboration between criminal justice system partners and mental health provision via the IPCT targeting support such as peer support groups and counselling. Inner City & East Bristol (ICE) has developed a community link workers service to provide additional mental health and wellbeing support for people from ICE's most marginalised populations. It is initially focussed on the Somali, African-Caribbean and South Asian communities as well as carers. These communities experience the poorest access to mainstream services and have the least satisfactory experiences of engaging with the system, resulting in negative outcomes. In South Gloucestershire, the development of village agents has enabled trusted community members to provide a connection between local people in more rural and isolated areas and the many existing voluntary and statutory organisations offering services and support. Working within their own communities, village agents are able to work with vulnerable individuals and provide support and signposting, helping them to access information, advice and services, and to actively engage cohorts at risk of loneliness and isolation with their local communities. South Gloucestershire is also supporting a project to tackle violence against woman and girls, delivered through its Safer and Stronger Communities Strategic Partnership, noting this can encompass a wide range of experiences including serious violence, stalking, harassment and public distress or verbal abuse.
Enhance productivity and value for money	Partnerships are focused on working with local communities to tackle inequality, the results of which are both poor outcomes for underserved communities and high use of services which are often unable to meet needs. The development of integrated mental health teams in all six localities provides the clearest example of how capacity could be better utilised to meet needs and enhance productivity. Whilst previously we have worked across health and social care to meet the needs of people with serious mental health teams, we have focussed too much on what our own organisation is responsible for I and not enough on what the individual needs. For those individuals with severe mental illness, our response will be to develop a 'My Team Around Me' approach to multi-disciplinary team (MDT) working. This approach recognises that every individual is different and that we need to remove the organisational boundaries and artificial barriers between different health conditions and physical/mental health and truly put the person in the middle. We will work with people to understand their needs and what matters to them and bring in support from different organisations and agencies as and when needed.

	The way we are working now will reduce the number of inappropriate referrals to services and increase the number of people who would benefit from wider support from local organisations. Vitally patients who have unmet needs despite regularly accessing services will benefit from MDT work which will seek to address their needs. Bristol North & West Locality Partnership is working with communities to explore whether co-designed community interventions can reduce the use of unplanned care before people get sick or frail. Through the Place Development Programme, North and West selected a cohort of 1,943 people with the majority living in areas of high deprivation, aged 50-70 with 2 or fewer long-term health conditions and some low-level mental health conditions (anxiety/depression). Average spend in unplanned care for this cohort is £5,500 per annum compared to £600 for the wider population. North and West are working with local voluntary and community sector organisations and a research and innovation organisation called Neighbourly Lab to reach the identified cohort.
Help the NHS support broader social and economic development	Our place-based partnerships have a key role in strengthening relationships with local government and communities, joining up health and social care to tackle the wider social and economic determinants of health. That approach is able to identify and address the wider barriers to self-care which lead to deteriorating health and inability to access or retain employment. In South Gloucestershire, the Prevention Fund is a joint initiative between health and the local authority. Under this there are a suite of projects targeting the wider determinants of health, aimed to provide immediate and longer-term impacts for local people and the way we work together as a local system, with an emphasis on reducing inequalities in health and wellbeing. South Gloucestershire is also exploring the Better Care Fund as a mechanism to support further joint working and a shift towards more proactive care. The University of the West of England (UWE) plays an integral role in the evaluation of all Prevention Fund projects. The use of the RE-AIM framework is aiding project development to include external validity that can improve sustainable adoption and implementation of effective, evidence-based interventions. Through the work of the partnership manager, employed by Southern Brooks Community Partnerships, engagement has taken place with over 22 community/voluntary groups to work alongside them to tackle challenges in organisational growth and effectiveness. Relationships have been built with the West of England Combined Authority Growth Hub to tailor their support programmes for the voluntary sector, as well as Quartet and Voscur to access voluntary sector support and grant programmes for different voluntary groups. A South Gloucestershire voluntary sector network event to share ideas and build collaborations has been established.

Metrics and trajectories

Below are the trajectories for the locality partnerships based on the relevant priority and needs of each area:

Priority	Trajectories	Outcomes framework code
Starting well Supporting children and young people who live with anxiety or depression or with risk factors for poor mental wellbeing	Bristol North & West - Reduction in self-harm admissions for North and West populations. Woodspring – Reduce the levels of anxiety in children and young people. South Gloucestershire – Children and young people Mental Health Training offer launched March 23. Bristol Inner City and East - Reduce the barriers to accessing mental health services in secondary school age for certain ethnic groups, age, gender, and deprivation.	POP2, POP5 POP5 POP5 POP5
Starting well Enabling healthy weight	Bristol South - To reduce the number of children who are overweight at ages 4-5 years old in Hartcliffe, Withywood and Filwood from 360 to under 250 by 2028. Bristol North & West - To reduce the rate of children who have excess at age 10-11 (Year 6) in outer areas of North & West Bristol, particularly Avonmouth & Lawrence Weston, Henbury & Brentry, Southmead and Lockleaze. Bristol Inner City and East - Slow the rate of increases in weight between reception and year 6 children (as recorded by the National Child Measurement Programme, 2019) in Eastville, Lawrence Hill, St. George Central and St George West. Weston - Reduce the number of children in reception and year 6 being an unhealthy weight by creating a longer-term platform of healthy eating. South Gloucestershire – Reduction in children being an unhealthy weight in reception and in year 6.	POP1, POP2, POP6 POP1, POP2, POP6 POP1, POP2, POP6 POP1, POP2, POP6 POP1, POP2, POP6
Starting Well Reduce health and wellbeing inequalities for children and young people	South Gloucestershire – to support the work of the Prevention Fund around the Think Family Database, Family Link Workers and Health Promotion in Education settings.	POP1, POP2, POP6
Starting Well Promote good mental health, wellbeing, and resilience for children and young people	South Gloucestershire – Support the seven proposals to be delivered under the South Gloucestershire Children and Young People Mental Health programme, including perinatal and early years, promoting mental health and emotional wellbeing, transition to adulthood, eating disorders and eating distress, understanding, preventing and responding to self-harm, special educational needs and disabilities, and mental health complex needs. South Gloucestershire - Reduce emotional-based school absence and exclusion. South Gloucestershire – Reduce hospital admissions due to substance misuse (15-24 years) from 20/21 levels. South Gloucestershire - Reduce hospital admissions as a result of self-harm (10-24 years) from 20/21 levels.	POP1, POP2, POP5, POP6 POP5 POP5

Living well People who might feel excluded from communities and/or are experiencing particularly poorer health outcomes	Bristol South - Increase the number of newly diagnosed patients who take part in education programmes to support better management of type 2 diabetes (in 2019 only 22.3% of newly diagnosed patients attended education programmes). Weston - Reduction in hypertension / high cholesterol results that contribute to shorter life expectancy and additional health problems. South Gloucestershire - Reduce the need for more costly specialist services, NHS admissions, referrals to social care and reduce demand on the crime, justice and welfare systems. North & West Bristol - Improve the health and wellbeing of people with chronic obstructive pulmonary disorder / diabetes, and their families. Bristol Inner City and East - Reduce the disparity and inequality in hypertension case finding and management in target areas of Inner City and East Bristol. South Gloucestershire - Focus on care leavers and young homeless people as part of the transition to adulthood workstream of children and young people's mental health programme. South Gloucestershire - Enable increased access for those experiencing poor mental health outcomes via the newly established South Gloucestershire Citizen's Advice Bureau. The service provides early intervention and support where socio-economic issues and financial hardship are impacting on their mental health.	POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2
Living well Reducing the harm from tobacco, alcohol and drugs	Bristol South - To reduce the admission episodes in South Bristol for alcohol-specific conditions to under 1,000 in 2027/28 (it was 1,364 in 2020/21 compared to 1,098 in Bristol). North & West Bristol - Reduce the impact alcohol and substance misuse has on mental and physical health. South Gloucestershire - Reduce the admission episodes in South Gloucestershire for alcohol-specific conditions (1,562 per 100,000 in 2020/21 compared to 1,442 in the South West).	POP1, POP5, POP1, POP5, POP1, POP5,
Living well Reduce the impact of chronic pain on mental health outcomes	South Gloucestershire – Reduce the impact of chronic pain and the impact it has on mental health outcomes. Test provision of holistic non-medical support to those experiencing chronic pain taking prescribed medication with depression and obesity.	POP1, POP5
Living well Support our vulnerable residents through early identification and intervention, to increase the number of individuals and families able to support themselves and live independently	South Gloucestershire – To support the delivery of three projects under the Prevention Fund, including cost of living, transforming our approach to complex needs, and Prevention of Violence Against Women and Girls (VAWG) inc. Drive programme.	POP1, POP2, POP5, COM14, COM16, COM17

Living well Supporting people with heart conditions, diabetes or stroke to keep healthy	South Gloucestershire – Increase the number of people aged 40-74 years being offered NHS health checks (only 29% of the eligible population received an NHS health check between 2017/18 and 2021//22).	POP2, SER8
Living well We will improve everyone's mental wellbeing	South Gloucestershire – Reduce the impact of chronic pain and the impact it has on mental health outcomes. North & West Bristol - Ensure those with dementia have access to psycho-social care, support and information when needed, so that people can live well with dementia.	POP1, POP5 POP1, POP5
Ageing well People at high risk of having a fall	Bristol South - Reduction in falls attending emergency departments in the over 65s by 770 - 50% over five years. Bristol North & West - Reduction in the number of conveyances to hospital by ambulance. Bristol North and West – Reduction in high levels of unplanned care use in people aged 50-70 who are not yet sick, frail or elderly. South Gloucestershire - 10% reduction in the number of falls requiring hospital admission within South Gloucestershire over the next two years, to bring the number of falls below the South West average (target -1918). Weston - Reduction in ambulance conveyance. Woodspring – Increase older people's confidence to go out post pandemic reducing the risk of falls and social isolation. Bristol Inner City & East - Reduce preventable falls through strategic coordination and integration of efforts across organizations.	POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2 POP1, POP2
Ageing well Help enable people to stay healthy and independent for longer	South Gloucestershire – To support the delivery of three projects under the Prevention Fund, including community clinics, village agent plus, and improving homes and wellbeing. South Gloucestershire – Social isolation; increase the percentage of adult social care users who have as much social contact as they would like (42% - 2021/22). South Gloucestershire – Establish Community Clinics with a focus on chronic disease management. Community Clinics will provide health education, information and peer support via partnership working between the Primary Care Networks and the voluntary sector. South Gloucestershire – Establish village agents in our rural communities to connect people, provide support and address loneliness and isolation.	POP1, POP2, COM15
Dying well Ensuring that people are given the support to make an informed choice about the most appropriate place for their death	Woodspring – A reduction in people dying in hospital rather than their preferred setting. Trajectory and target to be determined as part of locality-led implementation planning. All localities – continue to encourage the use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plus form for all end-of-life care planning, sharing of information across agencies, and to ensure the patient has a sense of control over their preferred place of death.	SER9 SER9

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All localities																				
Complete roll-out across all six locality partnerships of integrated models of care bringing together primary care, secondary care and the voluntary sector to better meet the needs of those with severe mental illness																				
Pilot place-based and person-centred care through new integrated mental health teams																				
Pilot different Test and Learn Approaches and collectively develop a consistent model of community mental health care across the system, which will be tailored to each area																				
Develop pro-active care models with system partners																				
Implement local interventions linked to pro-active care to tackle local needs, including enhanced health in care homes																				
Bristol Inner City & East																				
Reduce inequalities in mental health experience and outcomes amongst marginalised communities (initially Somali, African, Caribbean and South Asian) through Community Link Workers Service																				
Reduce the high prevalence of severe frailty in over 75s in Asian, mixed and Black communities in comparison to White communities																				
Roll out small grants scheme to enable community innovation and support healthy eating/active lives																				
Reduce preventable falls through strategic coordination and integration of efforts across organisations																				
Reverse the pattern of "early ageing" by focusing on prevention and better management of contributors to cardiovascular disease particularly diabetes, hypertension, inactivity, and unhealthy weight																				
Reduce the disparity and inequality in hypertension case finding and management in target areas of Inner City and East Bristol																				
Bristol South																				
Work with schools, children's centres and families specifically in Hartcliffe and Withywood, Filwood and Bishopsworth to improve access to interventions that support healthy weight in childhood																				
Implementation of small grants interventions (via Wesport) to enable community innovation and support healthy eating/active lives																				

Co-produce an approach to reduce alcohol harms within our communities and align with the launch of the integrated mental health team																					
Build on the existing range of interventions to better meet the needs of those at risk by working with voluntary sector partners and drawing on expertise in frailty and the causes of falls																					
Test, learn and evaluate the community innovation lead role within the community engagement work stream																					
Develop plans to increase take up of lipid lowering therapies in South Bristol																					
Support the roll-out of integrated community clinics to help people in South Bristol to age well																					
Identify an approach to reducing the impact of chronic obstructive pulmonary disorder on health and wellbeing in South Bristol, using data and input of those with lived experience																					
Bristol North and West																					
Identify and target specific areas with the relevant self-harm reduction interventions to support children and young people who live with anxiety or depression or with risk factors for poor mental health																					
Work with Sirona care & health, general practice, voluntary sector organisations and the community to improve access to pulmonary rehab provision to those communities most at risk of chronic obstructive pulmonary disorder including Avonmouth, Lawrence Weston and Shirehampton																					
Work with Northern Arc Primary Care Network and Southmead Development Trust to identify people with diabetes who would benefit from individualised 1:1 support, workshops and behaviour change support via education, motivational interviewing and peer discussions aiming to increase fitness levels and overcome barriers to engagement																					
Link drug and alcohol services with the integrated and personalised care team																					
Work with communities in outer areas of North & West Bristol to co-design preventative interventions that aim to reduce the use of unplanned care in people aged 50-70 who are not yet sick, frail or elderly																					
Link the Dementia Wellbeing service, secondary care older person's mental health and talking therapies with the integrated and personalised care team																					

Ensure the workforce receive training and are equipped to deliver care to those with dementia with kindness and empathy																					
Work with partners across Bristol, including Public Health, Education, Community Development, children and young people social prescribers and voluntary sector organisations and the community to address the causes of unhealthy weight - embedding interventions in school and community settings in outer areas of North & West Bristol, particularly Avonmouth, Lawrence Weston, Henbury & Brentry, Southmead and Lockleaze																					
Be an active partner of the Bristol-wide falls collaborative																					
South Gloucestershire																					
Support the three proposals around the Think Family Database, Family Link Workers and Health Promotion in Education settings, under the Start Well element of the Prevention Fund																					
Support the seven proposals to be delivered under the children and young people mental health programme, identified by their own needs assessment																					
Support delivery of three projects under the Live Well element of the Prevention Fund – cost of living, transforming our approach to complex needs and Prevention of Violence Against Women and Girls (VAWG) inc. the Drive programme																					
Rollout of an integrated mental health team hub, building on our integrated and personalised care team approach, supporting individuals who fall between the 'gap' of primary care and specialist services and their practitioners. Building on a ‘my team around me’ approach																					
Rollout complex debt and welfare advice for patients experiencing mental health illness and distress compounded by socio-economic worries. The service will offer direct referral to the specialist worker, who will be closely linked with the integrated and personalised care teams and the social prescribers																					
Test provision of holistic non-medical support to those experiencing chronic pain taking prescribed medication with depression and obesity																					
Explore the Better Care Fund (BCF) as a mechanism to support further joint working and a shift towards more personalised and proactive care																					
Support integration of services and the Dementia Wellbeing service as part of the ‘ageing well’ motion passed within the local authority																					

Support the delivery of three projects under the age well element of the Prevention Fund – community clinics, village agents plus and improving homes and wellbeing																					
Work towards creating an age friendly community in South Gloucestershire, enabling older people to live healthy, active and independent lives for as long as possible.																					
Rollout of action plan to improve support offer for carers																					
Develop and implement a model of complex care teams (building on the work of the North Bristol Care Home Interface Project) to proactively support frail and complex individuals, working upstream to avoid hospital admissions and to support people in their usual place of residence																					
Supporting care homes by developing a core training offer and support take-up and rolling out best practice collaborative working across GP practices and primary care networks																					
Supporting development and rollout of Adult Social Care Discharge Fund schemes, linking with and enhancing existing services and support																					
Support falls prevention workstreams																					
Implement learning from primary care network frailty model across South Gloucestershire primary care networks, to ensure frail and complex cohorts are supported																					
Support delivery of Community in Action projects under the Prevention Fund, including asset-based community development, community in action enablement funding and information, advice and guidance																					
Weston, Worle and Villages																					
Deliver a falls and frailty fast response service pathway to assess and keep people in their own homes																					
Ensure families and health professionals understand, know and respect an individual's wishes regarding places of death																					
Woodspring																					
Tackle increased levels of anxiety in children and young people and provide them and their families and schools with tools and techniques to support their mental health.																					
Support people aged between 50-74 living in Woodspring who suffer from painful conditions.																					

3.5.3 Prevention and inequalities

Background

The NHS Long Term Plan aims to support people to live longer through healthier lifestyle choices and treating avoidable illness early on and to reduce inequalities. It sets out plans for new evidence-based NHS prevention programmes that focus on reducing smoking, obesity and alcohol intake.

Our Future Health tells us that some illnesses are preventable in Bristol, North Somerset and South Gloucestershire. The leading causes of premature morbidity and early death in our population are ischaemic heart disease (IHD), stroke, cancer (especially lung cancer) and chronic obstructive pulmonary disease (COPD). These are largely due to the wider conditions of poverty, education, housing and discrimination, with unequal opportunities and access to healthy behaviours such as positive mental health, not smoking, a good diet and activity. Inequality can also be observed in patterns of high blood pressure and diabetes.

Aims and objectives

Our strategy sets out our commitment to work together as a system to ensure that prevention and reducing health inequalities are everyone's business and embedded in all system plans and deliver key cross-cutting prevention programmes to reduce smoking, obesity and alcohol intake.

Our aim is to create healthier populations and fairer systems. We will take action to:

- Improve outcomes in population health by working together across our health, social care and community infrastructure.
- Work together across local authority, health, voluntary and community services to develop a shared understanding of the variation that is unjust and amenable to action.
- Agree and prioritise that action and to hold the delivery mechanisms to account for sustained and effective change.

We will do this by:

Prevention Framework

Implementation of a system-wide Prevention Framework to embed prevention across our system including through the system's new health and care improvement groups and locality partnerships. Wwe will aim to develop a social movement led by prevention champions, understanding and addressing what causes inequalities and preventable poor health.

Core20PLUS5

Doing the basics well means a relentless focus on improvement in Core20Plus5 outcomes for children and adults and a commitment to adopt the systems high impact approaches that impact on modifiable risk factors for respiratory disease, Type 2 diabetes and cardiovascular disease, (NHS England » NHS Prevention Programme) and continued focus on infection prevention and preparedness for outbreaks of infectious diseases.

Smoking

- Development and delivery of a tobacco control strategy to deliver our vision for a "Smokefree BNSSG".

- Delivery of NHS long-term funded Tobacco Control programme so that tobacco treatment services are offered to:
    - Anyone admitted overnight to hospital who smokes
    - Pregnant women and members of their household
    - Long-term users of specialist mental health services.

Alcohol

- Development and delivery of a whole-system approach to alcohol which builds on the work of local authority drug and alcohol teams and the services they commission to improve awareness and the support offered within the health and care system.

Healthy weight

- Development and delivery of a whole-system approach to healthy weight that builds on approaches already in place in some areas of our system including the NHS Healthy Weight Declaration and the Local Authority Declaration on Healthy Weight.
- Mapping of weight management pathways across the system to better understand access to services for children, families and people at high risk of type 2 diabetes, with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+, and to ensure access is targeted to address inequalities and maximise outcomes.

Shifting investments

- Funding for anticipatory care of £5.8m is expected to increase to £11.6m in 2024/25. A plan will be developed by the Health and Care Improvement Group for improving the lives of people in our communities led by the Director of Integrated and Primary Care and brought to the Board for approval.

Governance

A focus on prevention and reducing health inequalities will help our system to deliver on key system, organisational and national policy drivers including:

- The four Integrated Care System aims of:
    1. Improve outcomes in population health and healthcare – *where a preventative and early intervention can significantly help to achieve this change*
    2. Tackle inequalities in outcomes, experience and access – *to address the unfair and systematic differences we know exist in our communities*
    3. Enhance productivity and value for money – *where prevention and early intervention can help to ease the pressure of complex needs and reduce the volume of demand for care*
    4. Help the NHS support broader social and economic development – *by supporting action in areas like access to employment and tackling the climate emergency.*

- The ambitions set out in the three local authority corporate plans for improving place;
- The system's three health and wellbeing strategies;
- The strategies and plans for the system's six locality partnerships;
- The goals set out in the NHS Core20PLUS5 plan.

A population health and inequalities leadership group provides oversight and leadership for prevention and inequality. The membership includes:

- Three Directors of Public Health
- System Consultant in Public Health
- Integrated Care Board Director of Strategy, Partnerships and Population
- Integrated Care Board Chief Medical Officer (also the lead for reducing inequalities).

We will establish a prevention oversight group to review and support the work of the health and care improvement groups in this area. Discussions within this group will be taken into the Health and Care Professional Executive. The Chief Nursing Officer and Chief Medical Officer will give the feedback to the relevant health and care improvement group. The Integrated Care Board Outcomes, Performance and Quality sub-committee will ask for assurance on progress and delivery. The group will be responsible for the delivery of the NHS Long Term Plan commitments on tackling tobacco dependency, alcohol and healthy weight.

Metrics and trajectories

We will track progress towards the delivery of prevention priorities by monitoring key metrics. Key prevention metrics related to our priority areas for prevention are outlined below:

Metrics	Link to Outcomes Framework
Smoking status in pregnant women at the time of delivery	POP4
Smoking prevalence in adults (18+)	POP4
Smoking prevalence in adults with a long-term mental health condition (18+)	POP4
Smokers setting a quit date and are successful in quitting at 4 weeks	POP4
Prevalence of overweight and obesity in children in reception and year 6	POP6
Prevalence of overweight and obesity in adults	POP6
Admission episodes for alcohol-specific conditions (under 18)	POP6
Admission episodes for alcohol-related conditions (18+)	POP6
Alcohol-related mortality	POP6
The number of people in treatment for alcohol-related conditions and successful treatment completions	POP6

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Implement the prevention framework																				
Promotion and oversight of Core20Plus5 outcomes for children and adults																				
Development and delivery of a whole-system tobacco control strategy																				
Delivery of NHS long-term funded tobacco control programmes																				
Development and delivery of a whole-system approach to alcohol																				
Development and delivery of a whole-system approach to healthy weight																				

3.5.4 Home first

Background

People who are medically fit for discharge remain in hospital until the appropriate pathway has capacity or are switched to another pathway. This could result in people coming to harm. It results in long ambulance waits, less quality of care in crowded services, limiting people's ability to stay independent. Hospital bed capacity is reduced, patients can't be admitted, having a knock-on impact for ambulance waits.

We have used population health management (PHM) and other insight to identify a small group of multi-morbid patients (segment 5 of our core segmentation model) who use the most bed days. Patients in this cohort are more likely to be admitted for ambulatory sensitive conditions, and when they are admitted they have long lengths of stay. Increasing length of stay in this cohort correlates with increases in the number of patients stuck in hospital with no criteria to reside.

We found that 62% of people discharged to pathway 2 (P2) could have gone home, 32% of people receiving homecare after discharge to assess had more care than they needed (c25% over provision). Over half of all residential and nursing home placements could have been avoided because the individual was well enough to be at home. 84% of patients could have left hospital sooner, reducing average length of stay from 29.1 days to 13.2 days.

We have not yet made new models of care widely available to enable people (patients and staff) to have confidence that a persons' needs can be safely met at home before they get worse. We lack shared decision making and anticipatory planning for the cohort of people most likely to be admitted to hospital for ambulatory sensitive conditions and have long lengths of stay. Disconnected service provision means there is poor understanding of real capacity and demand for same day support in the community. Around half of the people who are medically fit for discharge from hospital care can't be discharged because there isn't capacity in community care. The other half is caused by poor decision making, leading to delayed discharge planning, process delay, and pathway switching.

Home first is a collection of work across the system that is focused on supporting people at home, supporting the personalised care agenda. It represents several pathways, namely: preventative and anticipatory care; enhanced, wrap around support to care homes; response to a crisis; urgent community response; acute care at home; discharge from hospital.

The home first portfolio consists of different programmes including discharge to assess[5], virtual wards, ageing well and stroke. Other community transformation programmes are supporting this portfolio such as the community provider initiatives and system clinical assessment service (CAS) (see urgent care section, 3.7.4, for details on this). All of these programmes have a significant interdependency between each other and may also depend on other programmes such as primary care, health and wellbeing Boards, urgent and emergency care, planned care and mental health.

Better Care Fund

The Better Care Fund (BCF) continues to focus on reducing avoidable admissions and delays to discharge, as part of a shared longer-term strategic aim to make the community the default setting of care.

[5] Discharge to assess is a model which supports people to maximise their independence and go home from hospital as soon as clinically possible. People's future care and support needs are assessed at home or in another community setting rather than in a hospital bed.

The Integrated Care Board and Local Authorities' budgets for discharge to assess pathways are included in Better Care Fund (BCF) plans, ensuring collaborative commissioning that embeds integrated, person centred health and social care. In addition to discharge, the Bristol, North Somerset and South Gloucestershire better care funds include a focus on support for mental health. Community mental health has been identified as the first focus area for our locality partnerships, see further details under the Localities Plan (section 3.5.2) above.

Joint commissioning and planning also takes place through other system bodies including a Learning Difficulties and Autism Board, (examples include work on a shared approach to Positive Behaviour Support, see further details under section 3.6.2 below).

Aims and objectives

Discharge to assess

The aim of this programme is to reduce the amount of time people spend in hospital and support more people to go home first on pathway 0 (P0) or pathway 1 (P1) and regain their independence, rather than going into pathways 2 and 3 (P2/3) beds. To support timely discharge and reduce the number of people going on discharge to assess pathways or being stuck in these pathways.

We aim to improve support for people and their families/carers to remain independent and avoid hospital admissions; to free up acute hospital capacity and improve ambulance response times for other people who need urgent and emergency care. However, to deliver this we need to transform the culture, behaviour and delivery model across the system, not just increase community capacity.

Virtual Wards – NHS@Home

Also known locally as NHS@Home, this programme has been established across our system and provides capacity of 100-120 virtual ward beds. We aim to stand up generic and frailty step-up care urgently for winter 2023. We will continue to grow and develop our service offer, building to 450 virtual ward beds ensuring capacity is utilised for alternatives to admission as well as an enabler for earlier discharge – this capacity is equivalent to 200 to 280 acute beds.

We aim to simplify our service offer and establish one central referral management hub covering all pathways with one phone number, email address and electronic referral route for the entire system.

We will support work to develop a coordination centre which will manage referrals and 'gate-keep' provision. This will ensure capacity is utilised as an alternative to admission and establish a new operating model with a senior operational lead and clinical director enabling a sustainable, collaborative and fully integrated system service.

Ageing well

The aim is to allow integrated models of preventative care to embed and deliver returns on investment in terms of improved population health outcomes, and in turn, ambulance, emergency department admission and bed day savings. There are a number of other pilots that potentially contribute to avoidable admissions as part of the ageing well programme, these take an anticipatory care approach and work continues how to quantify the outcomes and capture avoidable admissions. See further details under the Locality Plans' section (3.5.2).

Governance and integration

The governance for the home first portfolio is complex and is driven by the partnership working in the community. It consists of system level support and oversight to ensure we are supporting people at home and in their communities with the interface of large NHS providers.

It will ultimately report to the Community Health and Care Improvement Group, with direct links and leadership provided collaboratively by the locality partnerships, primary care general practice, integrated care board, community provider clinical specialists, population health, digital enablers, communication and engagement, workforce development and commissioning arrangements.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Discharge to Assess	
The ambition is to: - Increase discharge to assess home first pathway 0 capacity to support more patients to be supported at home without the use of pathway 1 capacity. 40% of non-ideal pathway 1 activity to shift to pathway 0 by 2024/25. - 40% of non-ideal pathway 2 and pathway 3 current activity to shift to pathway 1. - 25% reduction in pathway 0 to pathway 3 length of stay prior to discharge from hospital to reduce waiting lists and delays going into and exiting hospital discharge pathways. - Reduce the number of people receiving a tier 3 (long-term care service) and increase the percentage of these people being supported in their own home or tenancy. - Maintain community bedded capacity at 250 beds per annum.	
Acute bed and bed days per month	SER8, SER9, STA10
Long-term care home (permanent placement of a person in a care home) - avoidable placement and avoidable placements starts per year	SER8, SER9, STA10
Long-term home care (permanent package of care provided by the council to support someone to live in their own home) – additional and avoidable weekly care hours	SER8, SER9, STA10
Net increase in weekly care hours	SER8, SER9, STA10
Pathway 2 and Pathway 3 - avoidable capacity and avoidable P2/P3 starts per year	SER8, SER9, STA10
Pathway 1 – additional and avoidable P1 starts per year	SER8, SER9, STA10
Net increase in pathway 1 starts per year	SER8, SER9, STA10
Increase in pathway 1 caseload	SER8, SER9, STA10
Virtual Wards – The target is to have 40-50 Virtual Ward beds per 100,000 population and include acute respiratory infection (ARI) and frailty provision. We will monitor and report on:	
Bed days saved	SER8, SER9, STA10
Acute beds avoided	SER8, SER9, STA10

Virtual Wards bed provision	SER8, SER9, STA10
Value created (based on £331 / bed days)	STA10
Ageing Well	
A&E attendances of segmentations 4 and 5 cohort	SER8, SER9, STA10
Average length of stay of segmentations 4 and 5 cohort	SER8, SER9, STA10
Emergency admissions of segmentations 4 and 5 cohort	SER8, SER9, STA10
Bed days saved, recognising this is also monitored under other programmes as above	SER8, SER9, STA10

See further information under the localities sections above and acute urgent care below.

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Home first																				
Test the concept of home first pathway and agree priorities for delivery																				
Understand the interdependencies across the system and the flow between parts of the system																				
Engage the front line and use best practice for change and for clinical management																				
Establish targeted multi-disciplinary team support, care planning and tech enabled care to anticipate & manage proactively																				
Building on system clinical assessment service and other infrastructure (GP professional line, Sirona single point of access and ambulance clinical hub) to create a coordination centre to shift culture to only consider admission to hospital if an intervention is required that can only be provided in a hospital setting.																				
Deploy home first services for crisis and non-crisis																				
Consider other models of outreach care for people to access specialist support in the community setting, supporting higher acuity care at home																				
Discharge to Assess																				
Implement and evaluate communications campaign to support home first behaviours																				
Design, develop and implement transfer of care hubs at Southmead Hospital, Bristol Royal Infirmary and Weston General Hospital																				
Design, develop and implement pathway 1 community integration in each local authority area																				
Support intermediate care value for money assessment across health and care to achieve a shared financial strategy for home based intermediate care																				

Review strategic workforce and professional clinical leadership																			
Implement additional community capacity (voluntary sector, night sitting, reablement, domiciliary care)																			
Set up short-term community escalation capacity (bridging)																			
Standardise pathway 3 processes and increase assessment/therapy capacity																			
Design, scope and implement improved patient and system level data sharing																			
Virtual Wards																			
Stand up generic and frailty step up care																			
Continue to grow and develop service offer																			
Establish one central referral management hub covering all pathways with one phone number, email address and electronic referral route for the entire system																			
Establish a new operating model																			
Establish the governance framework																			
Develop digital requirements into as few systems as possible. Work with digital partners to resolve digital challenges.																			
Establish a fully integrated system-wide workforce																			
Ageing Well																			
Create a full ageing well response, enhanced health in care homes (EHCH) and anticipatory care components																			
Develop a dashboard to track progress of all ageing well pilots, setting out anticipated impact against the ageing well outcome measures																			
Complete evaluation of the pilot schemes to assess the benefits																			
Stroke																			
Full South Bristol Community Hospital Stroke Sub Acute Rehab Unit (SSARU) go live																			
Hyper Acute Stroke Unit (HASU) and Weston SSARU go live																			

3.5.5 Primary care

Background

Primary care is the front door to the NHS and one of the most dynamic and innovative parts of the health service. Evidence shows that investing in primary care produces better health outcomes for patients.

In Bristol, North Somerset and South Gloucestershire Integrated Care System, primary care includes just under 80 GP practices, 20 Primary Care Networks (PCNs), a 24/7 GP out of hours service and delegated responsibility for 165 pharmacies, 101 opticians and 114 dental practices. We are working towards developing a strategy to support primary care to survive and thrive as a key partner in our system over the next five years. It will guide our decision-making and our planning, enabling us to work towards a shared vision for the future.

Primary care faces significant challenges including but not limited to patient access and experience, workload and demand, workforce and estates. There is a growing level of same-day demand, with higher acuity, which has impacted continuity of care. The backlog from the Covid-19 pandemic has resulted in huge challenges across our health and care system, which has had a significant impact on primary care. While demand and complexity grow, our traditional clinical workforce is shrinking.

Aims and objectives

We have a bold ambition for a primary care of the future, which builds on the ambition of the Fuller stocktake: Next steps for integrating primary care. Our desire is that primary care will be:

- Streamlined and enabling equitable access to care and advice
- Meeting the needs of our patients and improving patient experience
- Providing proactive, personalised care with support from a multi-disciplinary team of professionals to people with complex needs
- Helping people to stay well for longer as part of an ambitious and joined-up approach to prevention and addressing health inequalities
- A place where primary care clinicians are proud to work and can deliver the care they aspired to provide when training
- Supported with an at-scale infrastructure and delivery model that enables patients to be seen close to home and where non-patient facing support services can benefit from economies of scale
- Professional, respected, understood and supported
- Resourced fully and appropriately
- A home for the principles of continuity of care and personal relationships with measurable patient benefits and improved outcomes
- Autonomous and independent, enabling us to be the building block of community-based health and care
- In strong and flourishing relationships with other providers with effective integrated network teams in place.

Improving capacity and access – delivering the recovery plan

The key areas of focus for improvement are:

- Empowering patients
- Improving access, quality and resilience
- Building capacity
- Improving the primary/secondary and primary/community services interfaces

Most urgent care takes place in a community setting. If we can increase the capacity and effectiveness of services in the community, we can reduce demand in other parts of the system. We will continue to work with our system partners through our urgent care network, community reset and primary/secondary care interface work on a system-wide approach to managing integrated care that meets the needs of our patients and ensures a sustainable model for primary care. This will include ensuring our approach to winter planning is timely and effective, building on lessons learned from previous years, our integrated urgent care service and system clinical assessment service (CAS).

We will embed a proactive care approach to support admissions avoidance. Coordinated anticipatory care will support admission avoidance across our system, including associated targets in secondary care. Recently discharged patients are at their most vulnerable and are at high risk of readmission; a timed review from their trusted general practice team can reduce some of the anxiety and stress patients can feel following an admission.

Community pharmacy

We aim to transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the community pharmacist consultation service, while ensuring that the patient is seen in the right place according to their clinical needs. This includes an ambition to expand direct access and self-referral where GP involvement is not clinically necessary. We also aim to transfer all patients requiring further supplies of their oral contraceptive, along with moving over 50% of patients' annual blood pressure checks, to community pharmacy via the two nationally commissioned services.

Optometry

In addition, our optometry practices are conveniently located across our area. This enables the system to utilise both the clinical skills and specialist equipment that they possess to alleviate unnecessary pressures from overburdened secondary care services as well as GP practices who are often the first port of call for these patients. The ambition is to enable direct referrals from primary care optometry sites using a uniform IT system. This would support the services development and reduce unnecessary administrative burdens that currently exist for GP surgeries. We will explore further opportunities to reduce the need for GP appointments and referrals to secondary care including:

- Community urgent eye care service
- Primary are optometry-based referral refinement services
- An integrated service for children and young people and learning disabilities

The hope is to save 8,250 GP appointments.

Dental

Our dental services are not immune to the significant challenges to access, resilience and workforce. We will continue to strengthen internal relationships between primary care partners and take a collaborative approach to:

- Build a supportive community of practice
- Develop a dental strategy which supports the South West Dental Reform Programme
- Address access issues through initiatives such as additional access sessions and dental helplines – improving the current 60% units of dental activity (UDA) achievement against contract
- Identify and develop service models for vulnerable groups e.g. migrant health, care homes
- Maintain and improve urgent care access and unmet need - explore aligning work with community and urgent care dental services

- Increase work on oral health improvement, especially for children
- Develop a standard specification for high street dental
- Look at expanding the current GP resilience and workforce retention offers e.g. mentoring, lessons learned from the Access Resilience and Quality Programme (ARQ).

Spreading good practice and supporting continuous quality improvement

The Access Resilience and Quality Programme provides support to practices with short-term and long-term significant pressures along with responding to shared challenges.

The support provided by Access Resilience and Quality Programme includes:

- Supporting the spread and adoption of best practice. For example, access and workforce
- Supporting practices and primary care networks with continuous improvement
- CQC readiness support
- Escalation – short-term support for practices and general practice system representation
- Medium and long-term support for individual practices and primary care networks
- Responding to national requirements for example general practice appointment data (GPAD).

We aim to continue to grow our Access Resilience and Quality Programme. Ensure easier access to practices by patients and carers both for urgent appointments and routine appointments (same day and within two weeks, as appropriate). Ensure people can more easily contact their GP practice (by phone, NHS App or online). We will build on the learning for wider primary care services.

As an intrinsic part of this we will continuously improve patient safety by building two foundations: a patient safety culture and a patient safety system, enabling quality improvement.

Workforce

We will develop and implement a primary care workforce strategy for both clinical and non-clinical staff. This will support and enable recruitment, training, development, wellbeing and retention across the system.

We want to deliver on the Fuller stocktake report recommendation that systems should:

- Embed primary care workforce as an integral part of system thinking, planning and delivery
- Improve workforce data
- Support innovative employment models and adoption of NHS terms and conditions
- Support the development of training and supervision, recruitment and retention and increased participation of the workforce.

Primary Care Training Hub

Our training hub will continue to facilitate access to high quality training and education for the primary care workforce of today and tomorrow. Including:

- Delivery of the five-year strategy
- Building on the proven success & skills to enable ongoing development of a multi skilled primary care workforce (in line with priorities such as educational programmes for clinical & non-clinical workforce; supporting equality, diversity, and inclusion; and expanding and managing innovative and high-quality learning environments).
- Supporting induction to primary care
- Supporting early and late career stage, including widening newly qualified GP fellowships for nurses.
- Maximising recruitment and retention into Additional Roles Reimbursement Scheme roles

- Supporting recruitment and retention for wider primary care roles including pharmacists, allied health professionals and non-clinical staff.

Estates

Lack of appropriate space in general practice is often a major limitation to the number of appointments and services that can be offered to patients. As of January 2023, approximately 75% of all practices in our system are below NHSE's recommended space requirements for practices of their total list size. These capacity issues will worsen over the upcoming years due to increased pressure from population growth.

Whilst local and national policy outlines the ambition to shift care into the community, the appropriate infrastructure is required to enable this to happen. Primary care networks are being funded to recruit to new roles through the Additional Roles Reimbursement Scheme, however many practice staff in our system have communicated that they do not have the space to accommodate these new members of staff.

In addition to space and capacity, quality is another significant factor to consider within estates. Approximately 37% of all GP buildings in our system were constructed over 50 years ago, many of which are converted residential houses and therefore not configured to deliver primary care services. Poor quality estate has also been observed as a major barrier for the recruitment and retainment of general practice workforce.

Our system is not alone in experiencing this challenge – the Fuller stocktake report recommends that systems develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces. Our aim is to enable provision of additional estate capacity required by general practice by April 2028.

Digital

We will continue to increase our digital maturity in primary care:

- Telephony – all our practices are on cloud-based telephony. The next step is to ensure the correct functionality is available and enabled to support access e.g. call-back and queuing
- Develop and use digital tools and services to ensure care pathways work across organisational boundaries to support collaborative and multidisciplinary caseload management and care planning, such as shared care records and plans, virtual wards, advice and guidance
- Improve implementation and utilisation of shared digital interfaces and tools between primary care and care homes that enable better communication and improve sharing of health and care information
- Primary care electronic patient record (EPR) re-procurement with enhancements that enable greater cross-ICS collaboration. This will support faster data sharing between the system's electronic patient records, leading to improved patient care and outcomes.
- Support technology enabled care (TEC) for monitoring of long-term conditions for those who are able, including use of home monitoring for early detection of deterioration, allowing early intervention to try and prevent severe illness/admission e.g., severe chronic obstructive pulmonary disease and heart failure.
- Support a programme of work to give greater access to patient records to all sectors of primary care.

Governance

General practice in our system has come together to form the General Practice Collaborative Board (GPCB), a representative decision-making body for general practice to enable general practice to work and deliver as an equal partner in the integrated care system. The GPCB brings together representatives from all the primary care networks, localities, Avon Local Medical Committee (LMC), One Care and BrisDoc to represent 24/7 general practice.

System-wide engagement will be facilitated through GPCB and the newly established Primary Care Board (PCB), which includes representation from pharmacy, optical and dental services. A strategy is in development with publication expected in Q3 2023.

Primary care is part of the newly established 'Improving the lives of people in our community Health and Care Improvement Group'. The initial focus will be on co-ordination of integrated working, specifically for the following programmes of work: Ageing well, Sirona reset, rapid response, virtual wards and care home work.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Activity	
Number of GP appointments: continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024.	SER8
Percentage of same day appointments: achieve and maintain national average: 48.1%.	SER8
Percentage of appointments within two weeks: achieve and maintain national average: 85.7%.	SER8
Percentage of face-to-face appointments: achieve and maintain national average: 68.3%.	SER8
Number of community pharmacist consultation service referrals: Aim for over 5000 per month (90% of surgeries actively engaging with GP community pharmacist consultation service).	SER8, SER9
Number of units of dental activity (UDAs): trajectory to be determined as delegation work progresses building on current position of 60% of contracted UDAs	SER8
Number of community pharmacists supported to become Independent Prescribers	STA10
Workforce	
Total number of GPs.	SER8, STA10
Total number of nurses.	SER8, STA10
Number of direct patient care roles within the Additional Roles Reimbursement Scheme: Continue to recruit 26,000 Additional Roles Reimbursement Scheme roles by the end of March 2024.	SER8, SER9, STA10
Number of direct patient care roles (non-Additional Roles Reimbursement Scheme).	SER8, STA10
Total number of admin/non-clinical roles.	SER7, SER8
Prevention and Reducing Health Inequalities (in partnership with emerging system programmes)	
Number of individuals who have stopped smoking	POP2, POP4, POP6

Number of referrals to the NHS Digital Weight Management Programme	POP2, POP6
Number of NHS Health Checks completed	POP2
Number of blood pressure checks carried out in community pharmacy	POP2
Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.	POP1, POP2, SER7, SER8, SER9
Increase percentage of patients aged between 25-84 years with cardiovascular disease risk score >20% on lipid lowering therapies to 60%.	POP1, POP2, SER7, SER8, SER9
Decrease 10% escalation of patients back to the surgery to less than 5% with the aim to reduce further.	SER8, SER9

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Year 1: Deliver the recovering access to primary care plan.																				
Year 1 to 3: Deliver the system training hub strategy.																				
Year 1: Primary care assurance framework for all delegated services																				
Year 2 Priority: Enable all primary care networks to evolve into integrated neighbourhood teams.																				
Year 2: Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams.																				
Year 1: Establish a 24/7 primary care board and develop the primary care strategy.																				
Create a clear development plan to support the sustainability of primary care and translate the framework provided by next steps for integrated primary care into reality, across all neighbourhoods.																				
Year 2: Embed primary care workforce as an integral part of system thinking, planning and delivery/ create a single workforce strategy for the primary care workforce (clinical & non-clinical).																				
Year 3: Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care.																				
Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, considering demographic and cultural factors.																				
Year 1: Continue to improve digital maturity and re-procure a digital platform for GPs.																				
Support rollout of the Community Pharmacy																				
Year 1: Development and implementation of Pharmacy First																				
Year 1: Support the community pharmacy contraception supply service going live during the first half of 2023																				
Year 1: Expand the contraception supply service to include oral contraception initiation																				

Year 1: Add ear infections to the suite of patient group directions with a pilot picking up key areas of deprivation to increase access.																				
Community Optometry																				
Year 1: Embed system-wide post-operative cataract service																				
Year 1: Implement direct referral pathways from community optometrists to ophthalmology services for all eye consultations																				
Year 2: Implement referral refinement schemes including glaucoma referral refinement; cataract pre-operative assessment & macula pathways																				
Year 3: Implement community urgent eye care service																				
Community Dental																				
Year 1: Development of dental strategy which supports Southwest Dental Reform Programme																				
Year 1 and 2: Address access issues through initiatives such as additional access sessions and dental helplines – improving the current 60% units of dental activity achievement against contract																				
Year 1 and 2: Identify and develop service models for vulnerable groups e.g. migrant health, care homes																				
Year 1 and 2: Increase work on oral health improvement, especially for children																				
Year 2: Maintain and improve urgent care access and unmet need - explore aligning work with community and urgent care dental services																				
National requirements																				
Put in place self-referral routes to falls response services, musculo-skeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and equipment services.																				
Other																				
Explore facilitating referral routes for non-GP providers (e.g., dieticians, social prescribers, occupational therapists) working in primary care who cannot refer but need the GP to do so e.g. continence services, equipment services																				

3.5.6 Personalised Care

Background

Personalised care means that people have choice and control over the way their care is planned and delivered. The universal personalised care model is a whole-system approach for all ages and comprises seven evidence-based components: shared decision-making; NHS@Home; optimal medical pathways; personalised care support plans; social prescribing community-based activity; supported self-management; Personal/integrated budgets.

It is based on “what matters” to a person and their individual strengths and needs, rather than “what’s the matter with someone”. By putting ‘personalisation into practice’ this can be an enabler for delivering system priorities while delivering best value, best outcomes and targeting people to enable health equality. A culture of co-production is essential, working with people holistically and placing care at the heart of our communities so that we can support people to live purposeful and fulfilled lives.

Aims and objectives

The aim is to deliver services in our system in line with the principles and processes set out in the Universal Personalised Care national frameworks (2019). In addition, the Fuller stocktake (2022) recommends providing proactive, personalised care from multi-disciplinary teams of professionals.

A structured approach needs to be taken in our system as there are many examples of good practice within localities but not yet in a coordinated system ‘programme’. There needs to be commonality in language used as many components of good practice are already in place. With Sirona care & health taking a lead role within the system, the objectives are to:

- Develop baseline personalised care activity and data collection methodology and apply consistently.
- Ensure close relationships with providers – one personalised care & support plan is in place and shared.
- Embed shared decision-making with appropriate training support to the workforce.
- Increase social prescribing and community-based support working with the VCFSE, health coaching training.
- Continue to focus on home first.
- Partner with population health management, data and lived experience of health inequalities to target individuals who benefit most, first, maximising access.
- Target people with unmet need, high frequency/intensity users, utilise health and care improvement groups.
- Create communities of practice – delivery at place.
- Enable digital technology to strengthen interoperability of shared care records.
- Expand use of personal health budgets (our system currently had 2380 in 2022/23, 6% of South West region).

Governance

Sirona care & health is the system lead for personalised care and the chief therapy and allied healthcare professional officer is the executive lead. Overall, the ICB lead is the Director of Integrated and Primary Care.

A steering committee will be set up with membership from all providers, directors of adult social services, voluntary sector representation, and people representing communities, which will report into the system wide Health and Care Integrated Group for Improving Lives in the Community, co-chaired by Sirona and One Care Chief Executives and supported by the ICB Director of Integrated

and Primary Care. The steering committee will also network closely with the South West Integrated Personalised Care Team.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Increase number of people receiving personal health budgets to 3000 by end of Q4 2023/24 (25% increase)	POP1, POP2, POP5 SER7, SER8, SER9, STA10
Target of 30 for number of 'train the trainers' by end 2023/24	SER7, SER8, SER9, STA10

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Establish a personalised care steering committee to oversee delivery of universal personalised care																				
Deliver a consistent training programme for health coaching using a train the trainer approach to maximise local training resources																				
Deliver a consistent approach for development of personal care and support plans to be used across all partners – in paper and digital format (e.g., Black Pear)																				
Develop a trajectory to ensure that people will have more control over their own health and more personalised care via a personal health budget																				

3.5.7 Continuing Health Care – funded care

Background to NHS funded care

The Integrated Care Board is responsible for system leadership of the NHS funded care elements of children and young people's continuing care, continuing healthcare, and funded nursing care.

Children and young people's continuing care may be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. These needs may be so complex, that they cannot be met by the services which are routinely available from GP practices, hospitals or in the community or commissioned by the Integrated Care Board or NHS England. A package of additional health support via children and young people's continuing care may be needed.

NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need.' Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness. Eligibility for NHS continuing healthcare is not determined by the setting in which the package of support can be offered or by the type of service delivery.

NHS-funded nursing care is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 funded nursing care has been based on a single band rate. In all cases individuals should be considered for eligibility for CHC before a decision is reached about the need for funded nursing care.

Aims and objectives

The aim is to continue to deliver services for our population in line with the principles and processes set out in the two key national frameworks:

- National Framework for Children and Young People's Continuing Care (January 2016)
- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (July 2022) – updated in 2022 to reflect the Health and Care Act 2022 and is underpinned by the National Health Service Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012, issued under the National Health Service Act 2006.

Governance

The senior responsible officer for the funded care programme is the Integrated Care Board chief nursing officer who works closely with partners from all local authorities and other service providers.

Metrics and trajectories

In order to consistently deliver against key national adult continuing healthcare KPI standards, the following metrics will be monitored in order to achieve the target:

Metrics	Link to Outcomes Framework
Package of care assessments to be completed within 28 days of referral: >80%	SER7, SER8, SER9, STA10
Number of referrals breaching 12 weeks wait;	SER7, SER8, SER9, STA10
Number of fast-track end of life care in place within two working days of referral	SER7, SER8, SER9, STA10
The aim is for all adults in receipt of continuing healthcare at home to have their care via a form of personal health budget, aligning to the personalised care section above	POP1, POP3, SER7, SER8, SER9, STA10
The number of unplanned admissions will also be monitored so we can assess whether we are reducing it within the relevant cohort of patients.	POP1, SER7, SER8, SER9, STA10

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Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Explore the viability of a seven-day working fast-track service																				
Move to a place-based model – for case management for adults in receipt of continuing health care, and children and young people in receipt of children's continuing care																				
Develop a trajectory to ensure that people will have more control over their own health and more personalised care via a personal health budget (PHB)																				
Re-assess adult CHC and children's and young people's continuing healthcare against the national maturity framework to ensure that care needs are sufficiently met																				
Scope out gaps or misalignment in services that result in unmet need for individuals transitioning from children to adult services																				
Scope out optimisation of technology enhanced care (TEC) to promote independence, support improved case management, reduce reliance on traditional care, and support admission avoidance.																				
Develop improved ways of commissioning care services and delivering efficiencies to support individuals with the most complex needs, in partnership with BNSSG local authorities																				
Identify the most appropriate model for brokerage within BNSSG																				
Establish the most appropriate model for brokerage within BNSSG																				

3.5.8 Cardiovascular Disease (CVD)

Background

Cardiovascular disease (CVD) is one of the key priorities in the NHS Long Term Plan. In our system, according to the results of the Citizens' Panel around self-reported health status, cardiovascular disease is one of the main contributing factors to disability and poor health.

For men in our system, circulatory disease is the biggest contributor to the gap in life expectancy between the most and least deprived. For women it is the second biggest contributor. In addition, certain ethnic minorities have a higher prevalence of certain specific CVD conditions than the white British population.

Cardiovascular and respiratory diseases are significant drivers of acute hospital activity, and these are strongly influenced by deprivation.

Given the clear opportunity for improvement that CVD offers, it has been identified as a priority area for the ICS and this Programme Board has been established to drive our work forward. CVD is one of the conditions most strongly associated with socioeconomic deprivation. If you live in England's most deprived areas, you are almost four times as likely to die prematurely than those in the least deprived. CVD is also more common where a person is male, older, has a severe mental illness, or ethnicity is South Asian or African Caribbean.

In Bristol, the rate of early deaths from CVD is over 2.6 times higher among people living in the most deprived areas of the city compared to the most affluent areas.

The data shows us that CVD related deaths are higher in inner city and North and West Bristol. Life expectancy between the most and least deprived areas of Healthier Together varies by 7.5 years for males, and 6.7 years for females. The impact of deprivation on life expectancy for males has been stable across the system over the last decade and may now be worsening for females. A focus on cardiovascular disease, respiratory disease and cancer within the most deprived areas has the potential to add four years of life to these populations.

The CVD programme has three focus areas: Prevention, Heart Failure and Cardiac Rehabilitation.

Each focus area will include health inequalities, personalised care and how we can involve technology [6]. See the scope for each area below:

1. **Prevention –** This area is managed and monitored by primary care partners and it focusses on atrial fibrillation; blood pressure (hypertension) and cholesterol (including familial hypercalcemia) and lipid prevent and management. It encompasses mandated priorities for the national CVD prevention programme:

   - Hypertension- Core20Plus5 - BP@ home blood pressure monitors; Core20Plus5-Hypertension case finding; community pharmacy engagement re Hypertension Case Finding; Primary Care Network use of University College London Partners Proactive frameworks; NHS Health Checks
   - Atrial Fibrillation - Funded AliveCor Devices sent to primary care to be used for diagnosis of AF and other arrhythmia
   - Cholesterol - detection and management
   - Making every contact count
   - CVD Risk Factors - obesity, smoking, alcohol.

[6] a separate technology cell will be formed as the task and finish groups identify the needs for technology

There is also work ongoing to scope out the opportunities for the programme to collaborate and align with the Diabetes Programme and other long-term conditions prevention work, possibly forming a Primary Prevention and Management working group.

2. **Heart Failure** – It is the strategic intention of the BNSSG ICS Transformation Team to outline the areas of action needed across the Heart Failure service pathway to develop and support sustainable change to enhance patient experience, clinical workforce delivery and develop a system for excellent clinical care for a sustainable future. By taking a whole pathway approach, better cardiac health and healthcare outcomes for the population of BNSSG.

3. **Cardiac Rehabilitation** – This area will develop a collaborative cardiac rehab service across BNSSG and will link in with pulmonary rehab services.

Aims and objectives

We aim to improve the cardiovascular health of the population thus reducing mortality as a consequence.

We aim to achieve top quartile performance for cardiovascular indicators against comparator areas by maximising primary and secondary prevention.

We aim for our population to have equal access to acute cardiac services and be guaranteed the same service offer regardless of where they come from or where they receive their care.

We also aim for the specialist cardiac services in Bristol to be recognised nationally.

In addition to these priority areas, the programme is supporting our urgent and emergency care colleagues to develop proposals for the management of low-risk chest pain.

Other aims and objectives for the cardiovascular programme include:

- ✓ To develop a joined-up and collaborative system across all pathways and care deliveries
- ✓ To develop consistent and accessible care across the system
- ✓ To Improve patient education in better heart health to prevent the development of cardiovascular diseases
- ✓ To prevent the development of ABC conditions and to diagnose earlier, ultimately to then see a reduction in emergency department admissions and a reduction in avoidable acute admissions, as the risks of cardiac events including strokes will be reduced.
- ✓ To put the patient experience and journey at the centre of what we do
- ✓ To reduce health inequalities
- ✓ To provide equitable access to care
- ✓ Improving patient outcomes.

Governance

The Senior Responsible Officer for this programme is the Director of Integration and Primary Care at the Integrated Care Board and the Clinical Chair is the University Hospitals Bristol and Weston Foundation Trust Medical Director.

The programme board has representation from the Senior Responsible officer; Clinical Chair, General Practice, Integrated Care Board, each of the acute trusts (either clinical or managerial), the community provider, programme management team and Public Health.

Metrics and trajectories

We will track progress of the programme using a dashboard, tracking against the RightCare Cardiovascular Pack using key risk factor matrix. The following are the agreed trajectories for the cardiovascular disease programme:

Metrics	Link to Outcomes Framework
Increased number of people will be optimally managed for hypertension, blood pressure and cholesterol, as defined by both the person and their healthcare professional	SER7, SER8, STA10
Reduce the number of patients needing to be referred to out of area for highly specialist services, such as heart transplant	SER8, SER9
Improved the rate of genetic identification of high-risk individuals, for example, familial hypercholesterolemia (FH) reaching the LTP target of 25%	POP1, POP5
Reduce Inequalities in health outcomes for people with cardiovascular disease.	POP1, POP2

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall cardiovascular disease																				
Identify those at risk of cardiovascular disease to help prevent more people developing it and dying prematurely, ensuring that the population will have equal access to acute cardiac services and be guaranteed the same service offer regardless of where they come from or where they receive their care																				
Implement a targeted approach that addresses the poorest outcomes first in order to reduce inequalities in health outcomes for people with cardiovascular disease or at risk of it	To be confirmed																			
Stop low value activity to ensure that we are delivering the best possible outcomes and use the resources available in the most effective manner.																				
Prevention and case finding																				
Utilise the CVDPrevent national primary care audit to drive improvement in prevention and treatment of high-risk cardiovascular conditions	To be confirmed																			
Develop resources focussed on ABC Prevention to educate and assist primary care with prevention and case finding																				
Educate, develop, and provide training and webinars to raise awareness and share information for Primary Care via our Training hub, Primary care Network forum, clinical leads meetings and Primary care Network engagement and the Local Medical Committees to encourage collaborative working across the system.																				
Blood Pressure / Hypertension																				
Engage and support primary care with prevention, case finding, and risk stratification tools																				
Support pharmacies with implementation and delivery of Pharmacy Hypertension Case finding Network Contract Directed Enhanced Service (DES).																				
Develop and deliver training and support to Primary care encouraging collaborative working and utilising networks																				
Heart Failure																				
Redesign Heart Failure service phase 1 (referral and triage)																				
Redesign Heart Failure service phase 2																				
Implementation of system wide pathway																				
Roll out virtual ward pathways at North Bristol Trust																				
Roll out virtual ward pathways at University Hospital Bristol and Weston																				
Implementation of system wide digitalised (Doccla) pathway																				
Cardiac Rehabilitation																				
Design community cardiac rehab service																				
Implement Community Cardiac rehab services.																				

3.5.9 Respiratory Programme

Background

Our Respiratory Programme has been running in its current iteration for about two years. Our system has a history of comparatively high admissions for chronic respiratory conditions and steady growth in those admissions year on year until recently. The programme has delivered a focussed number of evidence based digital and rehabilitative interventions in primary care and the community to improve care and has supported linked initiatives with respiratory pathways, including the acute respiratory infection (ARI) hub development and the virtual wards. This development of system relationships and an integrated approach to care development and improvement has successfully and substantially reduced hospital admissions for the key respiratory conditions in our population. This includes for Chronic Obstructive Pulmonary Disease, asthma, pneumonia, and other respiratory infections.

To adapt to system pressures the programme has moved from a traditional programme framework to become an agile and relationship-based network to enable pace and collaborative thinking time about the targeted development of care. The basis of decision making and the prioritisation for the roll out of interventions has been underpinned by the research evidence base, sharing good practice with other systems and the regional network, our population health heat maps for conditions, and combining those with fuel poverty data in our system. We are also trialling a University College London (UCL) data tool which helps services to identify unseen individuals who would benefit from pulmonary rehabilitation. Sirona is piloting this, work with one of our hotspots in the North and West locality for chronic obstructive pulmonary disease admissions where we have low numbers currently engaged in services.

Work has and will continue to be locally focused with localities and Primary Care Networks to really understand and deliver for their populations.

Aims and objectives

For respiratory patients, we aim to deliver a better quality of life, improved management and prevention of exacerbations outside of hospital, and sooner access to diagnostics and the right treatment for its population.

As a system we should sustain our reduction in admissions for respiratory care and give people options for self-care be they digital or otherwise to support them to self-manage complex conditions.

We will learn and plan to develop effective strategies and services to manage the impact of flu and covid on the system. We will maintain effective working across organisations.

Governance

The Senior Responsible Officer for this programme is the Director of Integration and Primary Care at the Integrated Care Board. The programme is a network of clinical experts and managers committed to improvement and change.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Maintain current reductions in admissions for key conditions	SER8
Reduce the amount of flu and avoid related admissions in winter 23/24	POP3
Double the number of pulmonary rehab completions by 31 March 2026 (quarterly reporting to NHSE)	STA10, SER8
Increase the number of spirometry training completions.	STA10

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Continue the targeted expansion and development of pulmonary rehabilitation services in what is year 3 of a 5 year project																				
Continue the high uptake of those on the My COPD self-care app and plan for sustainability post December 2023																				
Take advantage the available additional spirometry training, and utilise Primary Care Network based champions to support practices and access																				
Deliver access across each Primary Care Network to Feno testing, building on the success of the Academic Health Science Network pilot																				
Use the learning from the Acute Respiratory Infection hubs and virtual wards to prevent covid/flu and respiratory infections admissions in 2023/24, in particular, to inform future Winter planning																				
Raise the profile of pneumococcal vaccinations in primary care as we have much more stock than previous years																				
Introduce Point of Care testing into the pathways, initially in the Acute Respiratory Infection hubs and virtual ward to further broaden respiratory diagnostics tools in the community and better inform care decisions																				
Evaluate MyCOPD																				
Agree new funding for MyCOPD.																				

3.5.10 Diabetes

Background

In 2022/23, there are approximately 54,000 people in Bristol, North Somerset and South Gloucestershire (BNSSG) with a diabetes diagnosis, amounting to around 5% of the population; 49,000 people have type 2 diabetes and 5,000 people have type 1 diabetes. Growth levels in BNSSG are in line with national trends. Furthermore, there are an estimated 34,000 people in BNSSG who have elevated blood glucose levels and would benefit from prevention interventions and support. For young people with type 1 diabetes, there is locally a particular challenge with the transition into adult services.

Spend on diabetes medication in BNSSG has significantly increased, up 8% since 21/22 taking the estimated spend to £34 million in 22/23. There is also a significant impact on other resources: an estimated 20% of all district nursing time is currently spent on third party insulin delivery, which is expected to increase as the population continues to age. There are also concerns in BNSSG about the care provided to people with diabetes while in hospital: length of stay for individuals with diabetes undergoing surgery is three days longer than that for patients without diabetes due to delays in healing, exacerbated by poor glucose control during that period.

Since 2017/18, NHS England has provided ring-fenced diabetes transformation funding to local diabetes programmes with the aim of reducing variation in access to services and improve outcomes for people living with diabetes. The national programme focuses on four evidence-based intervention areas:

1. Ensuring patients have access to specialist multidisciplinary footcare teams with an aim of reducing amputations.
2. Ensuring patients have access to diabetes inpatient specialist nursing teams in hospitals to improve the quality of their care.
3. Reducing variation in the achievement of the three NICE recommended treatment targets (HbA1c (blood sugar), cholesterol and blood pressure) for adults and one treatment target (HbA1c) for children.
4. Expanding provision of structured education (including digital options) to better support patient self-management.

The GP Collaborative Board agreed in December 2022 to lead work on improving primary care performance with a focus on:

- The identification, monitoring and management of all types of diabetes, improving the uptake of the eight care processes (HbA1c, blood pressure, cholesterol, foot check, urinary albumin and creatinine, weight check and smoking status) in annual diabetic reviews and achievement of the associated national treatment targets (HbA1c, blood pressure and cholesterol).

- Increasing primary care referrals to the NHS Diabetes Prevention Programme (NDPP) and the Low Calorie Diet programme.

A team based in One Care to work with practices is currently supported by non-recurrent funding made available by NHS England to support diabetes-related recovery following the pandemic.

Aims and objectives

Our diabetes programme was established to deliver locally the national diabetes programme aims and objectives for preventing type 2 diabetes and reducing variation in the quality of care for those people living with a diagnosis of type 1 or type 2 diabetes.

The programme's vision for diabetes services in our system is to deliver these national commitments, taking account of our local population's needs and within the wider context of our system plans for making the community the default setting of care with services delivered locally by integrated teams focused on the needs of the individual:

An integrated and seamless service, where clinicians work easily across organisational boundaries towards a common purpose of most effective patient centred care. This service will aim to reduce inequalities and will be delivered primarily in the community setting.

Our diabetes programme objectives are as follows:

- Improve patients' outcomes and experience of health care services for diabetes by the development and implementation of a new integrated model of care, drawing on national and international best practice.

- Reduce amputations (minor and major) by improving footcare services across the system, in line with the recommendations of the independent peer review of footcare services and pathways (February 2023). Gaps and inconsistencies in provision will be addressed, and progress made on health inequalities for people with diabetes.

- Improve the proactive monitoring and management of people with diabetes in primary care, developing the skills of clinicians providing this care, so that we recover our previous position as the regional leader in primary care support for patients via the annual delivery of all the NICE care processes and the achievement of the outcomes described in the national treatment targets.

- Expand the early identification of people at risk of developing type 2 diabetes, supporting individuals to take up and complete the opportunities available to reduce this (including structured education and the national programmes for diabetes prevention and digital weight management), and potentially reverse early diagnoses.

- Make progress on addressing health inequalities experienced by people with diabetes or at risk of developing type 2 diabetes, working with local voluntary and community groups to build trust and encourage marginalised communities to take up the health care support available via primary care.

- Maintain and develop acute-based specialist services, ensuring that these are available in our hospitals at least six days a week, together with a focus on hospital-wide education for supporting patients with diabetes while in hospital for other reasons, improving outcomes, reducing complications and readmissions.

- Continuously improve the provision, and support for, the safe use of high quality and cost-effective medicines and technology, improving patients' quality of life and outcomes while reducing admissions associated with medication and minimising the impact on community nursing teams.

Governance

The Senior Responsible Officer for this programme is the Director of Integration and Primary Care at the Integrated Care Board. Detailed governance arrangements are to be confirmed following the Integrated Care Board restructure and implementation of the decision-making framework.

A diabetes dashboard is available providing detailed information on a range of key measures and national targets, including at Primary Care Network level where appropriate. The dashboard is reviewed regularly at programme level with representatives of wider partners in our system.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Number of patients newly diagnosed with diabetes referred to education programme within nine months	SER8
Achievement of 3 Treatment Targets for patients with diabetes (national)	SER8
Referral trajectory to National Diabetes Prevention Programme (national)	SER8, SER9
Referral trajectory to Low Calorie Diet Programme (national)	SER8, SER9
Number of minor and major amputations	SER8, STA10
Emergency department attendances for diabetes-related primary diagnosis	SER8
Non-elective admissions for hyper/hypo	SER8
Admissions for appliance prescribing.	SER8

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Development and implementation of new model of integrated care					tbc															
Complete footcare review recommendations																				
Evaluate pilots and make a decision on future approach to health inequalities voluntary sector grant scheme																				
Deliver best value medicines and devices, to support patient outcomes																				
Development of pathway for hypoglycaemia related events with ambulance services.																				

3.5.11 End of Life

Background

The End of Life Care Programme has been pursuing a wide reaching improvement programme for end of life care services. This is underpinned by an evidence base of insights and engagement work and draws on data analysis informed by the system-wide data set and population health management. Stakeholder engagement has been carried across the heath and care system to co-produce a vision for end of life care in Bristol, North Somerset and South Gloucestershire (BNSSG) and develop a comprehensive plan. The plan outlines how our system will work towards meeting the six ambitions for palliative care as set out by the National Council for Palliative Care in 2021, and identifies the work needed to ensure the Integrated Care Board is able to meet its statutory obligations set out in the End of Life amendment in the Health and Social Care bill 2022.

The development of our Strategic Framework identified 'dying well' as an essential component of the life-course framework which this programme will support.

The end of life programme has undertaken desktop research and collated insights on palliative and end of life care from partners' engagement work. Further engagement activity is being planned using existing forums, such as the Citizens' Panel and Sirona care & health's People's Council, where we will further explore what matters to people.

- The Health Equity Assessment co-produced in February 2022 provides an overview of the health inequalities in end of life in our system. It draws together data sources and provides information on protected characteristics and different dimensions, for example, socio-inequalities status. This helped us consider a wide range of issues from digital literacy to how poor housing or heat poverty can limit the option to die at home. We thought about lifestyle choices creating stigma and how we can make services more representative by engaging with the right people in our communities.
- There is a live document on NHS Futures – an 'insights' shared resource.
- Previous engagement via the Citizens' Panel – which is demographically representative of our population – shows that most people feel comfortable talking about how they would like things to be when they near the end of life.
- A recent evaluation at North Bristol Trust demonstrates that more needs to be done to provide culturally appropriate services at the end of life.

There has been successful partnership building and relationship development between providers and the Integrated Care Board, which will continue to need support and development.

Aims and objectives

The programme membership has agreed three areas of collective focus:

- Supporting the whole person and those close to them, contributing to the personalised care agenda
- Understanding, sharing and following people's wishes and preferences
- Access to high-quality timely care at home.

These areas of focus were used together with the outputs from data analysis, insights work, mapping of services and an analysis of the national ambitions framework against our health and social care system to create a programme of improvement work. This can be summarised as follows:

Workforce and training

- Understand training and support needs for different health and care professionals
- Identify links and interdependencies with other workforce training, mapping against existing competency framework for delivery of end of life and palliative care
- Develop a proposal for delivery of training to meet competency standards, and to include training and support for professionals to have conversations about dying.

Communications, insights and engagement

- Develop an online resource centre for patients, carers and professionals
- Work with localities to understand how we can work with and support different communities
- Seek insights on existing and planned services using existing forums.

Digital

- Roll out of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT Plus) shared care plan
- Evaluate ReSPECT Plus
- Develop an end of life dashboard.

Business Intelligence Research and Evidence

- Review and recommend a tool and/or screening process to support the identification of people who may be at the end of life
- Review outcome measures frameworks, with a focus on persona reported measures, and propose measures for use across the system.

Services, pathways and improvements

- Review and update Anticipatory Drugs Prescribing and Drugs charts
- Refresh the review of services and provision against the six ambitions
- Review of patient pathways
- Review of 24/7 provision
- Piloting Compassionate Communities.

Governance

The official Governance of the End of Life and Care Programme is to be agreed following the Integrated Care Board restructure and implementation of the decision making framework.

Metrics and trajectories

Metrics	Link to Outcomes Framework
The following metrics will be monitored to support progress of the ReSPECT Plus evaluation:	
Number of people with a respect plus plan	SER7, SER8
Number of with preferred place of care and death recorded	SER9, STA10
Number of people achieving preferred place of death	SER7, SER8, SER9, STA10

Other metrics include:	
Number of unplanned admissions for people in last 12 and three months of life	SER8, SER9, STA10
Agreed Patient Reported Outcome Measure (PROM) measures	SER7, SER8, SER9
Number of people identified as at risk of death prior to dying.	STA10

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Implementation of ReSPECT Plus																				
Evaluation of ReSPECT Plus																				
Roll out of ReSPECT Plus to social care																				
Patient held ReSPECT Plus																				
Training and workforce education plan development																				
Workforce education plan implementation (ongoing)																				
Development of online resource centre																				
Online resource centre live																				
Pilot of Compassionate Communities																				
Evaluation of Compassionate Communities																				
Roll out of Compassionate Communities																				
Delivery of training, including communication skills, for end of life conversations (ongoing)																				
Identification of Cambridge multi-morbidity score pilot (CMS) at North Bristol Trust																				
Evaluation of CMS at North Bristol Trust																				
Roll out of CMS and other agreed tools across settings to support identification																				
Review of End of Life contracts																				
Implementation of agreed Patient Recorded Outcome Measures (PROMS)																				
Development of dashboard																				
Review PROMs and dashboard data and plan for service developments																				
Implementation of service developments																				

3.6 Improving the Lives of People with Mental Health, Learning Disabilities and Autism

3.6.1 Mental Health

Background

An all-age mental health strategy has been developed with system partners and underpins all aspects of mental health and wellbeing within our system. Our mental health strategy has been informed by local needs analysis including, 'Our Future Health' - the needs assessment accompanying the system's overarching strategy.

Co-production is at the core of our work in mental health, and we have lived experience colleagues acting as co-chairs and leads for significant workstreams on key programmes such as the Community Mental Health Framework. We work closely with NHS England assurance leads and are active participants in clinical and commissioning networks. This has allowed us to benchmark and understand regional innovations and best practice and improve local performance.

Aims and objectives

Our strategy has six ambitions:

- People of all ages will experience support and care as a whole person, considering their strengths and assets alongside needs, and understanding the wider determinants of health.
- We will invest in the mental health and wellbeing of people of all ages and their families and carers so they can access the right support early and in a timely way.
- People of all ages will be able access high quality treatment if they need it so they can stay well in their local communities or closer to home.
- Through working together, we will have an economically and environmentally sustainable mental health system where maximum benefit is delivered to the community.
- We will improve equity of access, experience and outcome throughout the life course and strive to become a system where no one is disadvantaged, reducing health inequalities as a result.
- We will ensure we have a happy, diverse, inclusive and stable workforce within our system.

Governance

The Mental Health, Learning Disabilities and Autism Healthcare Improvement Group will oversee the delivery of the vision, ambitions and priorities set out within our strategy. The Healthcare Improvement Group will include representatives from partners across our system. There will also be a Children's Healthcare Improvement Group, which will provide additional scrutiny on the delivery of work to improve mental health access and outcomes for children and young people.

We have agreed funding priorities as a system for the 2023/2024 financial year as part of submission of the NHSE Operating Plan, and this forms the first year of our Joint Forward Plan.

Going forward, we will work with the oversight of the Mental Health, Learning Disabilities and Autism Healthcare Improvement Group (with additional input from the Children and Young People's Healthcare Improvement Group), to agree as a system how we will deliver the ambitions in our strategy beyond 2023/24 for the whole Joint Forward Plan period. We will also develop qualitative and quantitative metrics to enable us to measure progress towards delivery of our ambitions.

Metrics and trajectories

Metrics	Link to Outcomes Framework
In line with the NHS Long Term Plan, we aim to:	
Reduce the number of inappropriate out of area placement (OAP) bed days for adults that are either 'internal' or 'external' to the sending provider by a quarter. The national target is zero.	SER8, STA10
Increase the number of people who first receive Improving Access to Psychological Therapies (IAPT) recognised advice and signposting, or start a course of IAPT psychological therapy within the reporting period. The target set nationally for 2023/2024 is 25,420.	POP5
Increase the estimated diagnosis rate for people with dementia. The target set nationally for 2023/2024 is 66.7%. This includes the number of people aged 65 or over diagnosed with dementia, which has a target by March 2024 of 7,927.	POP1
Increase the number of women accessing specialist community perinatal mental health services. The target set nationally for 2023/2024 is 1,164.	POP1, POP5, SER7, SER8, STA10
Increase the number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses. The target set nationally for 2023/2024 is 1,594.	POP5, SER8, SER9, STA10
Interdependency with children's services:	
Increase the access to children and young people's mental health services. National target for 23/24 is 13,287.	POP5, SER7, SER8
In addition to the above, we will be using our local population health data set, alongside the development of our strategy to consider what other priority areas we may want to address and measure the impact of at a local level. These are:	
Monitor the number of people with severe mental illness receiving a full annual physical health check and follow up interventions. The target for 23/24 is 6,024.	POP1, SER8
Number of people accessing individual placement and support services. Target for 23/24 is 893.	POP5, SER8
Number of people with first episode of psychosis treatment within 2 weeks of referral. Target for 23/24 is 60%.	POP5, SER8
Physical health checks for people with serious mental illness	
Increase the number of people with severe mental illness receiving a full annual physical health check and follow up interventions.	POP1, POP2, POP6
Individual Placement and Support (IPS) Service fidelity to model	
Increase the number of people accessing IPS.	POP5

Metrics	Link to Outcomes Framework
Community mental health services	
Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illness.	SER7, SER8, SER9
Increase the number of people who first receive NHS Talking Therapies (formerly IAPT) recognised advice and signposting or start a course of talking therapy within the reporting period.	POP5
Early intervention in psychosis services achieving Level 3 NICE concordance	STA10
Increase the number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses.	POP5, POP6
Increase the number of women accessing specialist community perinatal mental health services.	POP6
Increase the estimated diagnosis rate for people with dementia.	POP5
Inpatient mental health services	
Reduce the number of inappropriate out of area placement bed days for adults that are either 'internal' or 'external' to the sending provider by a quarter.	STA10
Mental health liaison services within general hospitals meeting the "core 24" service standard.	SER9
Children & young people's mental health services	
Increase the access to children and young people's mental health services.	POP5, POP6, SER8
Coverage of 24/7 crisis provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions.	POP5, POP6, STA10

As a system we will be working over the coming months to formulate specific delivery plans to add to our annual operating plan to deliver the strategic ambitions outlined above. These will form our full joint forward plan. To date, our confirmed plans are detailed below.

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Physical health checks for people with severe mental illness																				
Establish Avon Wiltshire Partnership Locality Partnership based teams																				
Integrate primary care/acute /voluntary sector & public health																				
Individual Placement and Support (IPS) Service fidelity to model																				
Individual placement & support workers in Bristol recovery teams																				
IAPT (NHS Talking Therapies) increased access																				
Step 3 waiting list action plan for 2023/24 as agreed with the Integrated Care Board																				
Recovery improvement action plan begun																				
Additional training courses agreed																				
Level 2 & 3 caseloads increased																				
Community Mental Health Framework (CMHF) Additional Roles Reimbursement Scheme (ARRS) roles																				
Complete clinical review of impact after first year of these posts																				
Integrated mental health (MH) teams																				
Deliver locality-based integrated MH teams across the system																				
Local development of integrated mental health teams, linking in with wider system programmes such as Integrated Access Hub/111																				
CMHF personality disorder																				
Appoint Voluntary Sector Community Enterprise partner																				
Recruit to service model & develop interventions																				
Roll out the personality disorder service																				
Develop a ‘managed clinical network’ service and increase psychological therapies																				
Identify and evaluate unmet needs from years 1 & 2 and assess whether tier 4 provision is required																				

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CMHF eating disorders																				
Implement the voluntary sector led eating disorder support (SWEDA) services across BNSSG																				
Start primary care physical health interface work																				
Community rehabilitation																				
Develop new model																				
Implement new service																				
Establish new community rehabilitation service																				
Perinatal access																				
Recruit additional support for achievement of the Long Term Plan flexible targets																				
Redesign our voluntary sector offer for perinatal services so that it focuses on health inequalities within perinatal, partner support and step down from the specialist team.																				

3.6.2 Learning Disability and Autism

We want everyone with a learning disability and/or autism to live longer, healthier and happier lives; to be supported to have choice, control and independence; and to always be treated with dignity and respect.

Our Learning Disabilities and Autism Programme and Delivery Plan is based on national policy mandates such as those set out in the NHS Long Term Plan, The NHSE LeDeR[7] Policy 2021 and local government requirements and ambitions. It is important that these improvements are embedded via a rights-based approach, focusing on citizenship and belonging. This ambition has been developed into a system-wide plan with four distinct but connected programmes as set out below.

1. Supporting people to move into their communities and thrive

Specific workstreams within the programme aim to:

- Reduce reliance on inpatient care, while improving the quality of inpatient care
- Ensure comprehensive understanding of the different needs of people with learning disabilities and/or autism, and inequalities we need to address.
- Ensure that our provider market has the capacity and resilience to provide highly individualised quality care (in line with Long Term Plan commitments and the Building the Right Support national service model - in collaboration with NHS Led Provider Collaborative).
- Support people to stay living locally when behaviour becomes exceptionally challenging; to return from out of area placements; contribute to placement development (i.e., employment, community inclusion) and quality improvement.

The Autism Intensive Service workstream aims to support:

- Reduction of breakdowns in school placements for the young people within the service during the period of intensive behavioural support. Successful transition to home or education settings.
- Reduced frequency and/or intensity of behaviour that challenges.
- Increased self-awareness and ability to respond more positively to emotions.
- Increased engagement with positive activities.
- Improved wellbeing; increased control and calm in the family home.
- Improved management of demands on the family and strengthened family support network.

The crisis support workstream aims to:

- Ensure the needs of people with learning disability and autism are well met.
- Support the mental health needs of children, young people and adults with autism, but no learning disability, and ensure they are identified and appropriately supported.
- Align with Dynamic Support Register, ‘Blue Light’ meetings, and reasonable adjustments.

2. Best start in life for children and young people (included in children's delivery)

The autism support pathway (4-11 years: needs-led approach) aims to support:

- Children having their needs met in school settings (decrease in requests for Education, Health and Care needs assessments).

[7] LeDeR is a service improvement programme for people with a learning disability and autistic people. A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. We look for areas that need improvement and areas of good practice.

- Increased parent and workforce skills (training volume).
- Decreased numbers on assessment/profiling waiting lists.
- Decreased length of time between identification and intervention.

Neon Daisy (Autis-M) online resource hub for young autistic girls workstream aims to:

- Support primary school aged girls who have a diagnosis or are on the waiting list so they can start fulfilling their potential at a young age.
- Reframe the narrative about autism so it becomes one of positivity and inspiration making sure it takes account of the unique needs of girls.
- Cost effective, early intervention to provide girls the tools they need before they reach crisis point and have to reach out to specialist mental health services.

The Autism Support Pathway – shifting focus from diagnosis to a needs-led approach aims to enable parents and carers of children on the autism pathways to gain the appropriate needs-led support at the right time and in the right place, shifting the focus away from diagnosis and the wait for diagnosis to meeting identified needs. This will be underpinned by a full and in-depth discovery process to understand and draw together best practice.

3. Improving healthcare

The aim is to strengthen our Annual Health Checks / plans to provide effective interventions and improved physical health to ensure that people aged over 14 on GP learning disability registers receive an annual health check and health action plan.

We will ensure that learning from LeDeR reviews is quickly and effectively used to improve care and support, to tackle the health inequalities experienced by people with learning disabilities and/or autism.

We will develop and implement comprehensive programme of physical health support for people with learning disabilities and autism, involving partners across the system (as part of health inequality improvement plans).

4. Voice and influence

We will support people with learning disabilities and autism to be listened to and understood, and have their needs met; support people to play a full role in coproducing the services and care they receive.

We will ensure insights form a key part of our autism improvement programme (identifying key areas for development).

We aim to remove barriers and increase employment opportunities for people with a learning disability across Bristol, North Somerset and South Gloucestershire.

We will ensure seamless delivery of health and social care services improving the quality of care and support.

See detailed deliverables below. The next phase of planning for learning disabilities and autism will commence in summer 2023 to expand plans beyond 2024 deliverables.

These will include the following priority areas:

- Designing improved community-based pathways of the support, including expanding the offer for people with forensic needs.
- Building on the in-reach and outreach models of care, creating greater seamless experiences for people where episodes of inpatient care are needed.
- Connecting the emerging model of assessment and treatment alongside neighbouring ICS partners.

Governance

This programme reports to the Learning Disabilities and Autism Board and the Mental Health and Learning Disabilities & Autism Health and Care Improvement Group. The deliverables detailed below reflect full integration and collaboration from all system partners to achieve the four key delivery programmes.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Increase the percentage of people aged over 14 on GP learning disability registers receiving an annual health check and health action plan to 75% by March 2024	POP5, SER7, SER8
Reduce the number (to 18) of adults with a learning disability and/or who are autistic cared for an inpatient unit (to no more than 30 per million) by March 2024	SER8
Reduce the number (to 2) of under 18s with a learning disability and/or who are autistic cared for in an inpatient unit (to no more than 12–15 per million) by March 2024	SER8
Reduce admissions, length of stay and readmission to Tier 4 Children and Adolescent Mental Health Service, Adult Mental Health Specialist and specialist inpatient services	POP5, SER9, STA10
All individuals with Length Of Stay 2 years+ will have a reviewed life plan and discharge plan and an allocated clinical reviewer working in tandem with provider collaborative for those in secure accommodation, in line with national expectations.	SER9, STA10,
All children and young people inpatients / identified as at risk of admission will have a named key worker.	POP5, STA10
90% of children, young people and adult admissions will have pre or post admission Care and Education Treatment Review within timescales.	POP5
Increase the number of people with learning disabilities and autism in paid employment by 1% above national averages.	POP5, STA13, COM18
Meet and consistently maintain the local delivery expectations of the NHS England LeDeR Policy 2021.	POP1, POP5, SER8,

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Programme 1 – Supporting people to move into their communities and thrive																				
Implement the revised system-wide Dynamic Support Register and Care (education) to enable early identification of children, young people and adults with learning disability and/or autism who may be at risk of admission to specialist inpatient care																				
Develop an ongoing quality assurance process to ensure effective application and evaluation of the Care (Education)Treatment Review process																				
Develop a new model of individualised, high quality community services underpinned by a baseline assessment of existing service provision and capacity in our system																				
Undertake Population Health Management (PHM) review of learning disabilities and autism, including community mapping to identify gaps in provision (for example, forensic outreach service)																				
Develop local authority and system level data																				
Establish new, proactive market development programme. Including community support options (both as preventative post assessment support, transitions and connected to the complex learning disability and autism pathway)																				
Develop a system-wide housing plan																				
Pilot a place-based approach in South Bristol to deliver learning disabilities and/or autism care close to home and share learning to other localities																				
Deliver all-age Adult Positive Behaviour Support (PBS) pilot: work with 40 service users to deliver programme/support for future model of delivery																				
Expand pilot of the Autism Intensive Service in North Somerset and across the system																				
Revise mental health crisis pathway/provision to support the needs of people with learning disability and autism																				
Implement 7-day service (delivered by a specialist team of Learning Disability Liaison Nurses) to work across health and social care to facilitate access to, and improve the experiences of, people with a learning disability and/or autism when using inpatient and outpatient acute hospital services.																				

Programme 2 - Best start in life for children and young people																				
Complete Early Adopter Keyworker Project for children and young people																				
Develop a needs-led pre-diagnostic service for children and young people aged 4-11 years using a health, education and parent/carer workforce																				
Provide psycho-educational training (to parent/carers and teachers) and therapeutic support to children aged 4-11 years with less complex presentation awaiting a diagnosis or autism assessment																				
Deliver workforce training to education to staff, psycho-educational training to parents (led by parent/carer forum) and therapeutic support																				
Provide family learning courses for parents/carers, including shorter post-diagnosis courses, to support parents/carers to better understand and cope with the behaviour of their child; to improve communication with their child; and to facilitate an improved quality of family life																				
Develop funding for an online resource hub targeted at teenage girls with autism heading towards and into transition, and their families and teachers																				
Provide free, accessible, light-touch tools: strength-based videos from other local girls of a similar age, and older girls/women; tips/advice on a range of subjects, for exmple self-advocacy, dealing with sensory overload, social skills; resource directory linking to other support (support workshops with a peer group; interest-based friendship matching)																				
Deliver workshops to respond to the challenge of the long waiting times for autism support																				
Programme 3 - Improving healthcare																				
Provide support to healthcare professionals, including quarterly webinars; easy read Annual Health Checks template on GP IT systems; training for staff; regular prompts and support calls																				
Roll out learning disability champions programme to all GP practices, supported by Community Learning Disability Team. Targeted support to practices with high numbers of learning disability patients and low annual health check compliance																				

Develop health check audit tools auditing 5 checks per practice to ensure they are comprehensive; actions identified and followed up; and Health Action Plans developed																				
Link health checks to quality improvement projects such as STOMP – see medicines optimisation plans																				
Assess opportunities to increase the numbers of people being referred to cancer screening services through effective annual health checks																				
Complete evaluation to assess the effectiveness of Annual Health Checks & Health Action Plans																				
Revise approach in line with new NHSE guidance to ensure that people with autism are included in LeDeR reviews																				
Commission LeDeR reviewer capacity across the system. Teams will be multi-disciplinary, led by a senior reviewer responsible for the team/more complex reviews																				
Agree LeDeR review recommendations via local governance panel. Recommendations will be limited in number and inform the health inequality improvement plan																				
Develop and Implement Physical Health Plan (LDA) including priority pathways (for example epilepsy, constipation, catheter care and cancer screening, through quality schedules); training programme for health and care professionals; improved data collection and information sharing across system; full implementation of Learning Disability Standard; identifying how this aligns with wider programmes such as Positive Behavioural Support and Population Health Management																				
Evaluate targeted interventions to improve access to physical health (for example prioritisation of learning disability patients on outpatient waiting lists)																				
Include Learning Disability and Autism Quality Schedules in all contracts																				
Provide dedicated screening clinics for women with learning disabilities at North Bristol Trust Breast Screening Centre																				
Work with speech and language therapists to raise awareness in primary care and with care homes to reduce the risks of people aspirating																				
Develop specialist epilepsy pathway in primary care; developing a specialist equipment resource list and guidance for carers/residential staff to reduce risks																				

Create task and finish group (public health, dieticians; social prescribing) to work with housing providers and Square Food Foundation to develop cookery schools for staff and people with learning disabilities																				
Deliver national pilot to implement reasonable adjustments digital flag on NHS Spine to feed into patient records/reach across primary, secondary and community care																				
Complete the Learning Disability and Autism Needs Analysis (using Population Health Management, including value framework / modelling) to tackle health inequalities																				
Implement NHSE's Advancing Equalities Strategy (extending to learning disability and autism)																				
Programme 4 - Voice and influence																				
Develop a robust and inclusive model of coproduction across the system (coordinated across health and care partners)																				
Test new models of support which seek to be culturally responsive																				
Establish a core group of Experts by Experience to test end-to-end autism pathway journey through services. It will include a range of approaches to gain insights, including 'secret shopper' audit of emergency departments; STOMP case reviews, engaging with parents/carers																				
Test and learn how we can increase the demand for employment for our care act eligible citizens. Identify 3 Care Act eligible population groups to support into employment (test and learn). Understand what the barriers and opportunities are in to paid employment. Use the learning from the test and learn exercise) to inform a universal approach to paid employment for care act citizens																				
Develop a business case to demonstrate how supporting citizens into employment can reduce the demand and spend within adult social care																				
Explore how more creative offers of community asset-based employment can be benefit local citizens																				
Implement recommendations of Bubb review																				
Agree integrated working relationships for community team for people with learning disabilities within our system (may be local variance)																				

3.7 Improving our Acute Healthcare Services

3.7.1 Acute Provider Collaborative (APC) partnership

Background

The Acute Provider Collaborative Board was established in May 2021 as a Trust Board Committee in Common across University Hospitals Bristol and Weston and North Bristol Trust.

Aims and objectives

The overall aim of the acute provider collaborative is to deliver benefits at scale and provide mutual aid, on behalf of the ICB, through contributing to the ICB improvement aims of:

- Reduce unwarranted variation and tackle unequal access, experience and health outcomes
- Improve resilience by mutual aid
- Ensure specialisation and consolidation occur where this will provide better outcomes, productivity and value for money
- Support broader social and economic development.

The acute provider collaborative's purpose is to ensure that by using University Hospitals Bristol and Weston and North Bristol Trust's collective experiences, expertise and resources, they will work together to ensure that the best care is provided for patients, and the best support and development for staff, and that they are active partners to the wider community.

The acute provider collaborative board has signed up to a number of "we pledge" statements to:

- ✓ **build** productive relationships amongst clinical and support teams across both acute trusts and work through difficult situations together.
- ✓ **agree** joint priorities and plan for the future together.
- ✓ **demonstrate** improved access, experience, and outcomes for patients and that are addressing inequalities.
- ✓ **develop** people with wider system resilience in mind.
- ✓ **share** corporate services that are effective and deliver efficiency and productivity gains.
- ✓ **share** data and integrate digital technologies.
- ✓ **support** the wider community through Anchor Institution responsibility.

Specialist regional services

The acute provider collaborative joint clinical strategy supports both organisations continuing to deliver excellent regional specialist services for our Bristol, North Somerset and South Gloucestershire (BNSSG) population and a population at a regional level and beyond. This is a clear provider intention within our integrated care system.

Our tertiary services are predominantly configured to be provided by a single organisation. These services consistently benchmark very well against peers, and several have the potential to be world leading services. Our tertiary services are central to the emerging regional strategy, focusing on tertiary capacity across two regional centres, Bristol and Plymouth, to serve the South West.

Our shared strategic intention is to retain the existing range of tertiary services and to focus on continuing to develop their reputations and influence across our regions. Our priorities for these services are to:

- Enhance their contribution through increased academic output.

- Understand and address inequalities of access to tertiary care across our region.
- Be at the forefront of advances in clinical practice to deliver efficient, high quality and effective care for patients.

There are a number of clear ways in which University Hospitals Bristol and Weston and North Bristol Trust are better together in relation to our specialist and regional services. These are:

- Act as 'one Bristol voice' to improve the profile of specialist services on the national and international stage and to effectively influence the formulation and implementation of specialist service strategies in areas of expertise.
- Collaborate on development of specialist services where opportunities arise (including on response to tenders etc).
- Ensure pathways for patients are optimised for referrals into and out of specialist services across both organisations. Often access is required to key services in the other trusts to progress a specialist pathway, for example neurosciences access to ears, nose and throat services.
- Maximise opportunities to work together to promote excellence in innovation, research and teaching associated with our joint specialised services portfolio.

North Bristol Trust Specialist Services

- ✓ Adult major trauma, neurology
- ✓ Thrombectomy, neurosurgery, burns,
- ✓ Plastics, urology, renal, breast surgery
- ✓ Vascular surgery, elective orthopaedics
- ✓ Immunology and allergy.

University Hospitals Bristol and Weston Specialist Services

- ✓ Paediatric services, including paediatric major trauma centre, cancer services, cardiothoracic
- ✓ Head and neck (including the Bristol Eye Hospital and the Bristol Dental Hospital)
- ✓ Oesophageal and hepato-pancreatico-biliary cancer surgery.

Governance

The acute provider collaborative board is jointly chaired by University Hospitals Bristol and Weston and North Bristol Trust's chairs and the membership includes both chief executive officers, executive and non-executive directors from both organisations and has three established workstreams - clinical services, corporate services and digital. The Patient First programme also reports to the acute provider collaborative board to ensure alignment.

Each workstream has joint executive senior responsible officers, one from each trust and its own programme board or steering group as appropriate, that report to the acute provider collaborative board.

A monthly highlight report is provided to the Integrated Care Board Executive Team.

Metrics and trajectories

These will be developed on a project-by-project basis and will demonstrate a contribution to one or all of the four overarching ICB improvement aims as outlined above.

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Clinical services																				
Agree Joint Clinical Strategy																				
Carry out wider communication and engagement																				
Optimise existing services – Phase 1 project (4 priorities: cardiology, maternity, acute medicines, gastro-intestinal services)																				
Optimise existing services – Phase 2 project (8 priorities)																				
Complete feasibility study recommendations to deliver further service opportunities																				
Undertake options appraisal to deliver further service opportunities																				
Implement preferred options to deliver further service opportunities																				
Undertake scoping exercise for quality & safety opportunities																				
Agree areas of focus for quality & safety opportunities																				
Corporate services																				
Approve and develop framework for shared services model																				
Agree priorities for implementation on shared services model																				
Implement the shared services model plan																				
Carry out visioning & engagement sessions for 'finance transactional' workstream																				
Carry out visioning & engagement sessions for 'HR transactional' workstream																				
Complete recruitment function element of the HR transactional workstream																				
Complete temporary bank element of the HR transactional workstream																				
Review benchmarking information & NHSE toolkit to support other corporate services priorities																				
Agree priority area for other corporate services priorities																				
Implement next set of priorities for other corporate services																				
Digital																				
Commencement of the Joint Chief Digital Information Officer																				
Establish Digital Convergence Board																				
Agree high level roadmap																				
Implement roadmap phases tbc																				
Complete phase 1 of roadmap implementation																				
Complete phase 2 of roadmap implementation																				
Complete phase 3 of roadmap implementation																				
Acute Provider Collaborative development																				
Agree and implement communications and engagement plan																				
Develop the Acute Services Health & Care Improvement Group																				

3.7.2 Healthy Weston (supporting the home first portfolio)

Background

The Healthy Weston 2 programme has an ambitious vision for Weston General Hospital to be a strong and dynamic hospital at the heart of the community, delivering truly integrated, safe and high-quality services that meets the needs of the population, now and in the future.

University Hospitals Bristol and Weston and other providers have already begun to deliver this ambition through the changes implemented at Weston General Hospital as part of Healthy Weston 1 and the creation of University Hospitals Bristol and Weston NHS Foundation Trust. These have made services safer and more sustainable, particularly for urgent and emergency care, critical care, emergency surgery and acute children's services. In addition, much closer working between local GP practices and hospital services has put more focus on providing joined-up care and integrated pathways.

Aims and objectives

Healthy Weston 2 builds on this progress aiming to secure a dynamic future for health services in Weston-Super-Mare, from community frailty to quality hospital care that meets the needs of local people.

On top of routine, ongoing service development at the hospital, Healthy Weston 2 will:

- ✓ help more people go home quickly after going to hospital in an emergency, with dedicated units for assessing and treating people rapidly;
- ✓ become a centre of excellence for more specialised older people's care as well as continued delivery of a wide range of services for people of all ages; and
- ✓ become a centre of surgical excellence, providing thousands more planned operations for adults of all ages.

The hospital will continue to provide accident and emergency (A&E) services from 8am until 10pm, exactly the same as for the last six years, and other services such as maternity care, children's services, cancer care, intensive care and emergency surgery will continue to be provided, and improved, for people of all ages.

Healthy Weston 2 Phase 1 - Helping more people to go home quickly after going to hospital in an emergency

From 2023/24 there is a particular focus on helping people appropriately get home faster after accidents and emergencies supported where needed by closer working between hospital and community-based teams. Plans include:

- ✓ Enhancement of the 24hr observation unit for adults providing rapid assessment, treatment and discharge
- ✓ Extending Same Day Emergency Care provision across seven days, providing the right care, in the right place at the right time
- ✓ Significantly increasing the number of frail patients supported by the already award-winning Geriatric Emergency Medicine Service, by extending service provision across seven days, better meeting the needs of the ageing population and integrating with a GEMs@Home "virtual ward" pathway

- ✓ Creating a new 14 bedded Older People's Assessment Unit providing specialist rapid assessment and treatment for older frail patients.

This step change in provision will help to avoid unnecessary admissions, reduce length of stay, improve patient outcomes and improve the quality and responsiveness of care.

Healthy Weston 2 Phase 2 – Centre of Excellence for the Care of Older people and changes to inpatient care pathways

Beyond 2023, the hospital will also offer more specialist care for older, frail people who are less likely to bounce back after being unwell. Specialised clinics and wards will mean older people who are frail will get even better care from hospital frailty experts, working closely with local GPs and community services.

For the majority of people of all ages who arrive at Weston General Hospital in an emergency, all their care will be provided at the hospital. A small number who require ongoing, specialist medical inpatient treatment for conditions such as heart, lung or stomach problems, will be transferred to a neighbouring hospital with the right specialist staff and equipment which will lead to shorter hospital stays as well as improved outcomes for these patients.

Healthy Weston 2 Phase 3 – Surgical Centre of Excellence

Enhancements to planned ('elective') operations are a key part of the plans. The changes to medical pathways into and out of the hospital create the opportunity for a centre for surgical excellence, meaning that more adults of any age can have less complex planned operations at the hospital, closer to home.

Metrics and trajectories

Metrics	Link to Outcomes Framework
10% reduction in length of stay	POP1, SER8, SER9, STA10, STA12
10% improvement in 'time to be seen, treated and discharged' targets	POP1, SER8, SER9, STA10, STA12
20% ED attendance through same day emergency care by 2024	POP1, SER8, SER9, STA10, STA12
Improved workforce outcomes [decrease vacancy rate and reduce reliance on agency staff]	STA10, STA11, STA12, STA13
Improved patient outcomes and experience.	POP1, POP2, POP5, SER8, SER9, STA10, STA12

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Recruit to Healthy Weston 2 Phase 1 workforce: Acute Monitoring Unit, Same Day Emergency Care, Geriatric Emergency Medicine Service & Older Person's Assessment Unit. T*he majority of the recruitment will take place in 23/24.*																				
Phased implementation of front door enhancements – Acute Monitoring Unit, Same Day Emergency Care, Geriatric Emergency Medicine Service, Older People's Assessment Unit																				
Develop and approve Healthy Weston 2 Phase 2 and 3 Full Business Cases																				

3.7.3 Local Maternity and Neonatology System (LMNS)

Aims and objectives

The aim of the Local Maternity and Neonatology System is to improve Maternity and Neonatology Services in partnership with providers, commissioners, local authorities and Bristol, North Somerset and South Gloucestershire (BNSSG) Maternity Voices Partnership. We aim to improve care for women, babies and their families, contributing to the personalised care agenda.

We will continue to build on learning and work to date from health needs analysis and community asset mapping for maternity and expand to include neonatology in 2023/2024. Ongoing work with BNSSG Maternity Voices Partnership will allow us to co-produce with women from a wider range of backgrounds. We will also apply the learning from other projects we have funded such as Green Prescribing Mother Nature and Black Mothers Matter.

We will understand and target services and support to women and families more likely to have poorer backgrounds, such as those from minority ethnic backgrounds and those living in more deprived communities.

We will embed learning from services where we have been early implementers such as smoking cessation and pelvic health.

We will continue to improve and report safety and quality outcomes, as well as experiences of women and their families as well as staff.

We will continue to identify potential areas of work and where possible fund capacity and resources from our Local Maternity and Neonatal Services money.

We will increase co-production from a wider range of women and their families to develop more responsive services and lead to a more positive experience for those accessing services.

We will continue to work with public health to modify health behaviours such as smoking, obesity and vaccination to support the prevention agenda.

We will continue to co-produce and engage with vulnerable groups as part of our equity and equality workstream in order to reduce health inequalities. Our regular monthly reporting will continue to identify women from minority ethnic backgrounds and also those from deprived communities in line with the CORE20PLUS5 approach.

We will continue using a Population Health Management (PHM) approach across the programme to identify and understand which women have poorer outcomes or experiences. We will also continue to improve our co-production and targeted interventions for our most vulnerable groups.

Governance

The Local Maternity and Neonatology System is led by health and care leads from the key services across NHS and Local Authority partners. Transformation money has also been used to fund secondments for health and care leads to deliver quality improvement projects within services working with women and their families. The recruitment of a maternity and neonatology patient safety lead means services are increasingly linking with system structures such as the System Quality Group.

Metrics and trajectories

The progress towards our aims and objectives is reported via the maternity dashboard at the Local Maternity and Neonatal System Delivery Board and Clinical Leads meetings.

Progress towards reducing health inequality will be monitored via the maternity and neonatology equity and equality working group which is a subgroup of the Local Maternity and Neonatal System Delivery Board.

Metrics	**Link to Outcomes Framework**
The number of women recorded as having informed consent information in their notes	SER 7/9, STA10
The number of women risks assessed at every contact	POP2
The number of new bookings given a personalised care and support plan	POP2
The fill rates at correct level for Midwifery and Obstetrician posts	STA10
Monitoring national requirements	
Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	POP2, POP6
Increase fill rates against funded establishment for maternity staff;	STA10
Increase the number of women receiving a personalised care plan and being supported to make informed choices	SER7, POP2
Reduce inequalities in access and outcomes for the groups that experience the greatest inequalities (Black, Asian and Mixed ethnic groups and those living in the most deprived areas).	POP1

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Co-produce and engage with women and their families and staff on all aspects of maternity and neonatology services																				
Increase breadth and depth of Maternity and Neonatal Voice Partnership membership and reach																				
Ensure that those most at risk of experiencing health inequalities are heard in all areas of our work																				
Review and continue to implement equity and equality action plan via task and finish group																				
Ensure a personalised Care and Support Plan is given to all new bookings and is reviewed throughout their time in the service																				
Improve recruitment and retention and scope new roles via safer staffing workstream																				
Increase fill rates in midwifery and obstetrics																				
Deliver anti-racist training to all staff groups																				
Explore clinical career progression for midwives e.g. Consultant Midwives & Advanced Clinical Practitioner roles to aid retention																				
Continue to deliver the actions from the final Ockenden report and recommendations of Kirkup report																				
Complete implementation of informed consent and risk assessment at every contact																				
Report progress and compliance at system-wide Reports Response Group																				
Fully implement Saving Babies Lives Care Bundle and monitor via Safety and Quality Group																				
Integrate Patient Safety Incident Response Framework in maternity and neonatology surveillance and oversight																				
Standardise Perinatal Quality Surveillance Model reporting and integrate with wider Local Maternity Neonatal System workstreams																				
Implement the electronic notes system (Badgernet Electronic Maternity Notes)																				
Deliver robust maternity and neonatology monthly data report which accurately reflects activity																				
Establish a rolling programme to standardise clinical guidelines across the system																				

3.7.4 Urgent and Emergency Care (UEC)

Background

The performance of Urgent and Emergency Care services in our system, as across the rest of the UK, was significantly impacted by the Covid-19 pandemic, and continues to be impacted to a degree by an effective backlog of demand for community rehabilitation and support with onward care needs. This impacts the flow of some patients through bed-based hospital pathways, in turn affecting waiting times in Emergency Departments and ambulance services during periods of high pressure. Urgent and Emergency Care services are therefore in a period of recovery, with the ambition of returning to pre-pandemic levels of performance by the end of 2023/24.

These ambitions are set out in NHS England's Delivery plan for recovering urgent and emergency care services and 2023/24 operational plan, which includes the primary aims of:

- Improving Accident & Emergency (A&E) waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024/25
- Improve category two ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
- Reduce Adult General and Acute (G&A) bed occupancy to 92% or below
- Consistently meet or exceed the 70% - two hour urgent community response standard.

Delivering these aims will deliver a material improvement in the quality of care provided across the Urgent and Emergency Care pathway, as individuals are seen more quickly and extensive waits – such as 12 hour 'trolley' waits in hospital – are eliminated. This has a positive effect on patient experience, safety and the effectiveness of emergency clinical interventions.

Delivering Urgent and Emergency Care priorities

In order to deliver these aims, we have invested significantly in expanding community urgent and emergency care services, and same-day emergency care (SDEC) services in hospitals. This focus aims to address urgent and emergency needs in the community at the earliest point, and to provide a response in the lowest-acuity setting possible, ideally in an individual's home. The focus on community-based care aims to reduce overall rates of admission, and, for the most frail patients, significantly reduce risks of 'deconditioning' associated with hospitalisation. It also improves the experience of care for many who would rather avoid a journey to an emergency department (ED).

These priorities complement the extensive plans in place to expand the provision and effectiveness of community rehabilitation pathways (i.e. Discharge to Assess), supported by adult social care services, as well as a significant increase in the capacity of NHS@Home services introduced in 2022.

We will deliver:

- An increase in same-day urgent community response (UCR) services, which provide a home-based response to individuals with certain needs that could otherwise lead to hospitalisation, such as blocked catheters, delivery of medicines via syringe drivers, or falls resulting in a minor injury. We are working to better integrate these teams with 999 and 111 services, so that, regardless of how someone 'enters' the urgent and emergency care pathway, their outcomes are consistent and the most appropriate for their need.

- Further growth within the System Clinical Assessment Service (SCAS) to become a seven-day service – this clinical service places groups of clinicians at the heart of responding to higher-acuity calls received via 111. An extensive evaluation in 2022 showed significant reductions in onward demand for 111 cases: both for ambulance dispatches, and 'send to ED' outcomes, versus the traditional 111 model. We are also connecting this service to 999 and ambulance crews, to support clinical decision-making in the community, and connecting up urgent community response teams to reduce avoidable conveyances to hospital. This approach is further supported by the introduction of a new Community Emergency Medicine Service, which marries a senior ED clinician with a paramedic, vehicle and nursing/ urgent community response support to respond to the highest acuity cases coming via 999 that are deemed to be avoidable in terms of conveyance to ED. The pilot showed that around 80% of cases avoided ED, 60% avoiding a conveyance altogether.
- Continued expansion in same-day emergency care units at all of our acute hospitals, covering medicine, surgery and frailty-based specialities. Same-day emergency care is a well-developed model of care, similar to day-case surgery, that front loads senior clinical review and diagnostics with the aim of treating an individual's needs that day, avoiding the multiple overnight stays of a traditional inpatient model. These pathways will be made increasingly accessible to community, 999 and 111 services, avoid unnecessary spells in ED.

Importantly, this focus on an upstream and community-based urgent and emergency care pathway, particularly the use of remote assessment, has the potential to realise better value from our investments in urgent and emergency care services. For example, the move to upstream remote triage and assessment typified by the System Clinical Assessment Service, supported by the 'team of teams' approach, has been shown to increase productivity, both through more rapid collective decision making, and more efficient telephony and IT-based workflow versus a traditional face to face setting. This productive gain has the potential to mitigate a degree of the workforce pressures experienced in the urgent care system, whilst increasing the value of investment made in these types of remote services.

Reducing Health Inequalities

To realise the potential of this model to reduce health inequalities, we continue to promote use of 111 among key population groups that are higher users of emergency departments where an alternative was available. This is based on a review of the usage of urgent care services in our system in 2022 and includes methods such as geo-targeted communications promoting services to people living in certain localities, accessible multilingual communication materials in a range of community languages, and ensuring that community-based face to face alternatives are available where remote assessment isn't appropriate.

Beyond 2023/24, we will learn from the delivery of these services, and aim to further expand and connect the urgent and emergency care pathway to consistently deliver highly response services in the most appropriate setting. This vision for a fully-integrated approach to higher-acuity urgent and emergent needs is captured below, with the Assessment and Coordination of Emergency services (ACE) hub:

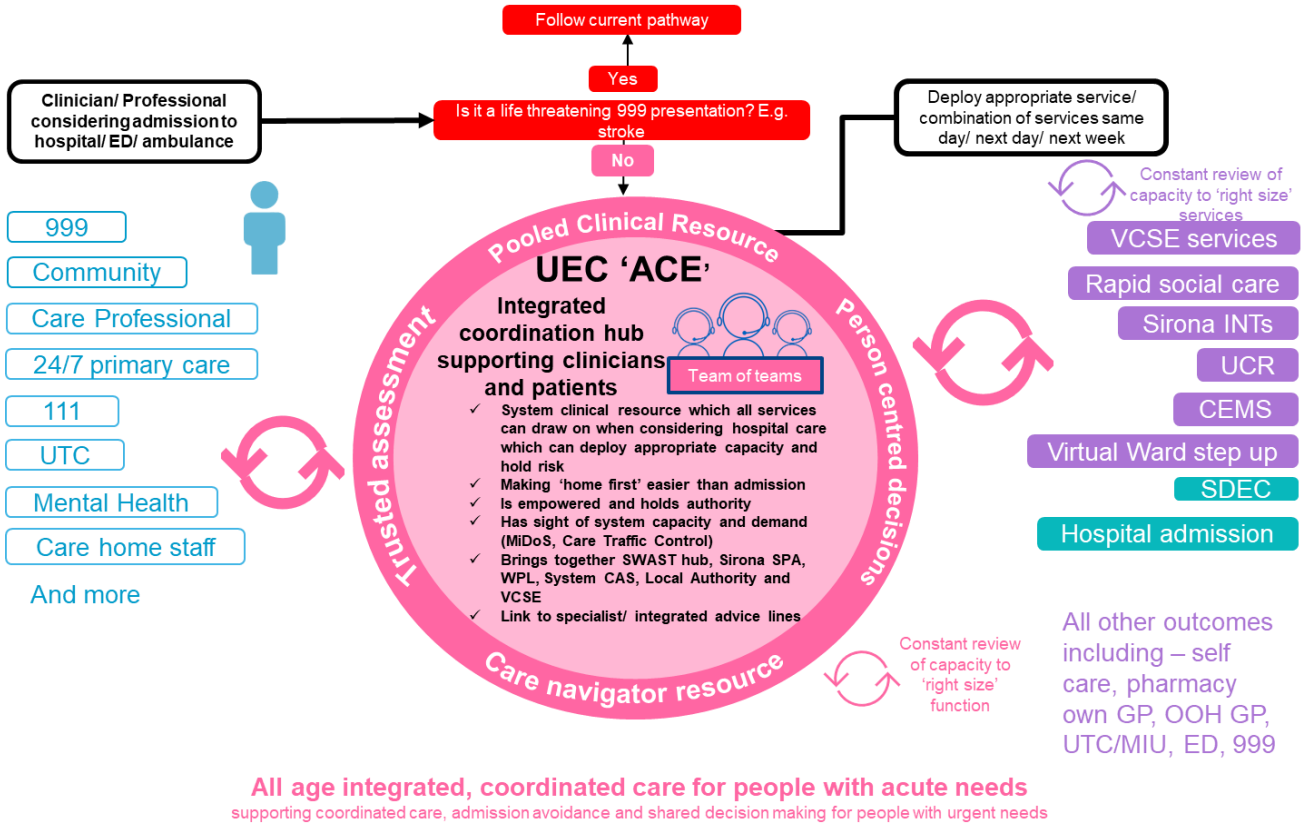


Figure 11: vision for a fully-integrated approach to higher-acuity urgent and emergent needs is captured below, with the Assessment and Coordination of Emergency services (ACE) hub

Governance

Delivery of the Urgent and Emergency Care priorities will be overseen the Urgent and Emergency Care Steering Group, which brings together senior operational clinical, and functional leads (such as finance and workforce) into a single forum spanning the whole urgent and emergency care pathway. This Steering Group will report to both the hospital and community-focused Health and Care Improvement Groups, given the breadth of the pathway, and be supported by a dedicated Service Delivery Unit in the Integrated Care Board. Matrix working with the children's and mental health service leads will ensure opportunities are not missed for quality improvements spanning the urgent and emergency care elements of those services, e.g. the role of pediatricians in the system Clinical Assessment Service. This approach is summarised below:

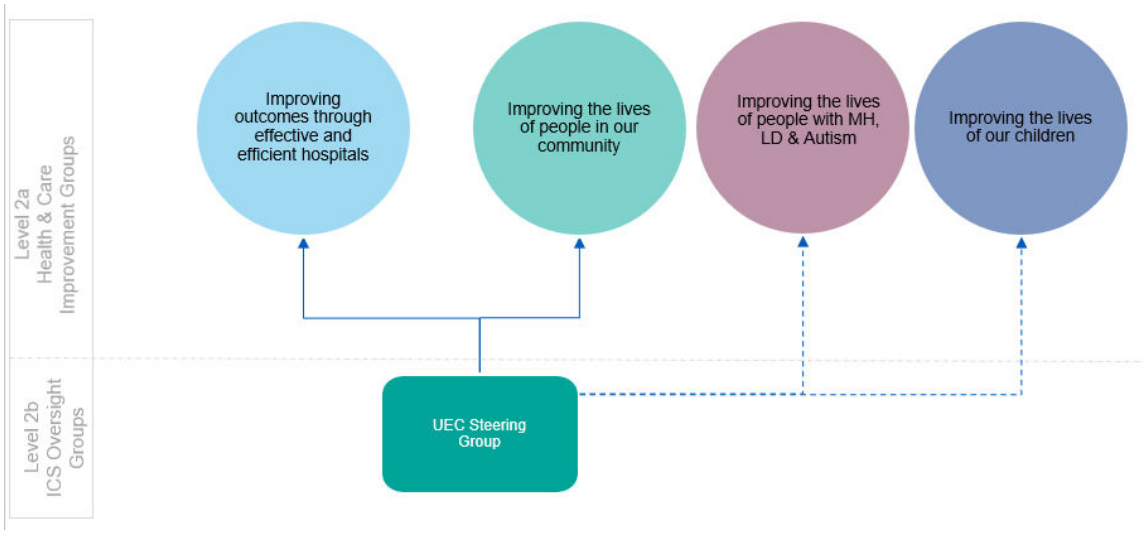


Figure 12: Urgent and Emergency Care Governance

Metrics and trajectories

Metrics	Link to Outcomes Framework
National trajectories for urgent and emergency care include:	
Reduce adult general and acute (G&A) bed occupancy to 92% or below	POP2, SER8, SER9, STA10, STA12
Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	POP2, SER8, SER9, STA10, STA12
Accident and Emergency (A&E) 4 hour – 76% by March 2024	POP2, SER8, SER9, STA10, STA12
Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	POP2, SER8, SER9, STA10, STA12
The impact of System Clinical Assessment Service (CAS) will be monitored using the following metrics:	
The number of patients assessed by the CAS	POP2, SER8, SER9, STA10, STA12
The number of people directed to an emergency department or 999, by 111	POP2, SER8, SER9, STA10, STA12
Category 3&4 ambulance waiting times	POP2, SER8, SER9, STA10, STA12
The number of ambulance see & treat and see & convey outcomes for Category 3&4 cases	POP2, SER8, SER9, STA10, STA12
The impact of Same Day Emergency Care (SDEC) expansion will be monitored using the following metrics:	
The number of new non-elective presentations seen and treated in SDEC	POP2, SER8, SER9, STA10, STA12
The number of new non-elective presentations of patients who convert to an admission of at least one night	POP2, SER8, SER9, STA10, STA12
The number of unplanned re-presentations of patients who had been managed by the SDEC unit within the previous seven days	POP2, SER8, SER9, STA10, STA12
The increase in same-day urgent community response (UCR) services will be monitored using the following metrics:	
The number of patients referred to and seen by the same day Urgent Community Response service	POP2, SER8, SER9, STA10, STA12
The number of urgent GP referrals to Emergency Department	POP2, SER8, SER9, STA10, STA12
The number of ambulance see & treat and see & convey outcomes.	POP2, SER8, SER9, STA10, STA12

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Urgent and Emergency Care Recovery Plan																				
Implement Same Day Emergency Care across every hospital with a major emergency department.																				
Standardise the first 72hrs in hospitals to expedite assessment, scans and treatment initiation.																				
Continue System Control Centre including working with councils on care capacity utilisation.																				
Direct referrals to specialties: frailty (CQUIN), respiratory, stroke.																				
Implement acute electronic bed management systems.																				
Launch new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111.																				
Roll out adult and paediatric Acute Respiratory Infection (ARI) hubs.																				
Implement a range of open-access age-appropriate services which meet local population needs.																				
Continue to roll out High Intensity User Services																				
Expand 111 online and connection to other services																				
Commission the clinical assessment of a greater proportion of NHS 111 Category 3 or 4 ambulance dispositions																				
Implement urgent mental health support through NHS 111																				
System transformation schemes impacting plan																				
Expand Same Day Emergency Care plus counting and coding (i.e. type 5 guidance)																				
Deliver Community Emergency Medicine Service																				
Continuation of System Clinical Assessment Service resourcing at circa 50% fill rate																				
Deliver Same day community response – Urgent Care Response right-sizing																				
Urgent Community Response																				
Address the gap in monthly data submission to the community service data set by involving staff																				
Develop a robust urgent community response 24- and 48-hour dashboard for our geography so that we can understand																				

our demand and capacity at a glance and flex our workforce to where it's needed most and respond to any problems that occur quickly																				
Introduce electronic prescribing to the urgent community response pathway to support efficient use of staff time and enable our teams to have more time to care																				
Align reporting with the nine clinical conditions/needs to have richer quality data to support the increase in referrals from all key routes																				
Increase our accessibility to care homes and domiciliary care providers by partnering with them to increase awareness of the South West Ambulance Trust falls traffic light system																				
Undertake two pilots in South Bristol working with a small number of care homes with a high percentage of fallers and with a pendant care provider in North Somerset																				
Develop links between urgent community response and the virtual wards so that we can ensure the safe flow of patients to maintain optimum capacity on the urgent community response pathway.																				
Continue to wrap around our Discharge to Assess pathway 1 to prevent readmissions to hospital.																				
Continue to work together to develop the proof of concept of the Assessment and Coordination of Emergency and Urgent Care																				
System CAS																				
Continue the remote clinical assessment of Emergency Department and 999 dispositions and validation of NHS111 pathways																				
Continue to join up mental and physical health provision via the Integrated model to support mental health needs in both 999 and Integrated Urgent Care Clinical Assessment Service queues, incorporating remote assessment, face to face response and onward referral when required.																				
8 to 8 service go live			Oct																	

3.7.5 Elective / Planned Care

Background

Elective care, including outpatients, cancer and diagnostics services were significantly impacted by the pandemic, causing backlogs of long waiting patients across most service areas.

The elective programme in 23/24 and 24/25 maintains focus on recovery from the pandemic and plans reflect national priorities (which are described in the metrics section below) in addition to a locally driven focus on productivity and efficiency, improving ways of working, progression of major strategic initiatives that will support sustainable recovery, and utilisation of digital enablers that optimise functions across our system, improve communication and support patients while they wait.

Within children's elective care services, there are long waiting times and theatre and outpatient capacity constraints in key areas such as cardiology, respiratory, neurology and trauma and orthopaedics. Plans to reduce waiting times for children and young people can be found in section 3.2 'Improving the lives of our children'.

Aims and objectives

The aim of the elective care recovery programme is to provide sustainable delivery, with immediate priorities to reduce the length of time people are waiting for appointments, tests and treatment; to reduce the volume of patients in the longer waiting cohorts; address demand and capacity gaps across elective, cancer, outpatient and diagnostic services; support patients while they wait; provide good patient experience; and to respond to national mandate.

This aim is addressed by:

- Increasing capacity to enable us to 'do more' – through for example, workforce recruitment and training; increasing delivery opportunities through waiting list initiatives; utilising capacity available through our local independent sector providers; developing estate; testing new ways of working; providing care through community settings; and working collaboratively across the system to improve and develop pathways that meet the needs of our population, providing best outcomes and experiences.
- Improving productivity to enable us to 'achieve more' – through for example 'getting it right first time' (GIRFT) metrics including a focus on theatre utilisation, day case rates, scheduling and booking efficiencies; increasing throughput on lists; approaching bed utilisation flexibly; working with system partners to support flow and optimise benefits from urgent and emergency care and integrated care schemes.
- Developing sustainable delivery platforms that enable us to transform the way we provide care and services – through developing and improving system-wide clinical pathways and models of care. The system is progressing two major strategic initiatives to support recovery and sustain delivery at levels that can meet future demand – firstly, Community Diagnostic Centre, with ambitions of delivery in the last quarter of 2023/24; and secondly the System Elective Centre with ambitions of delivery in the last quarter of 2024/25, subject to approval of the full business case.
- Optimising demand management and ensuring patients are directed to the right place at the right time for the care and treatment they need.
- Supporting patients to wait well, through perioperative initiatives, citizen facing digital enablers and waiting well apps.

- Driving a system focus and commitment to health inequalities through a number of projects and initiatives across elective and cancer services. The System Elective Recovery Working Group will develop understanding and associated measures that will help us capture and monitor reduction in health inequality.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Referral to treatment (RTT)	
To eliminate waits of over 65 weeks by the end of March 2024 (except where patients choose to wait longer).	POP1, POP6, SER7, SER9
To eliminate waits of over 52 weeks by the end of March 2025, (except where patients choose to wait longer).	POP1, POP6, SER7, SER9
Diagnostics	
85% of patients needing a diagnostic test receive it within six weeks by the end of March 2024 (Regionally set ambition)	POP1, POP2, POP6, SER7, SER9
No patients wait greater than 13 weeks for a diagnostic test, by the end of March 2024 (Regionally set ambition)	POP1, POP2, POP6 SER7, SER9
95% of patients needing a diagnostic test receive it within six weeks by March 2025	POP1, POP2, POP6, SER7, SER9
Cancer	
Reduction of 62+day cancer backlog to nationally set targets by the end of March 24	POP1, POP2, POP6, SER7, SER9
75% of patients urgently referred by their GP for suspected cancer (FDS) are diagnosed or have cancer ruled out within 28 days by the end of March 2024	POP1, POP2, POP6, SER7, SER9
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	POP1, POP2, POP6 SER7, SER9
Activity	
System- specific Elective Recovery Fund Value Weighted Activity target for 2023/24 - average of 103%, reaching 107% by the end of March 2024	POP1 SER8 SER9
Increase Day Case rates from 75% to 80-85%	POP1 SER8 SER9

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Elective																				
Continue reduction in waiters progressing towards constitution standard																				
Developing/improving pathways and models of care – for e.g., in 23/24 testing new 23 hour hip/knee pathway (from May), robotic gynae day case (from Sept), improving skin pathway (phased from July), out of hospital ophthalmology care – inc. post op cataract follow up by community optometrists (April). This deliverable will continue through to 2028, but specific focus will adapt to meet needs and priorities																				
BNSSG Elective Centre development																				
BNSSG Elective Centre delivery *(Pending full business case approval)*																				
Deliver Health Inequalities projects for 2023/24 (e.g., developing data and intelligence; DNA project in Cardiology services; Improvement in ethnicity and language recording; Community engagement events). This deliverable will continue through to 2028, but specific projects/schemes will adapt to meet needs and priorities																				
Support patients to wait well through improved communication across various media, citizen facing digital enablers, digital resources and apps. Launch of digital patient portal to streamline and improve booking process for outpatients, reduce DNAs; Developing perioperative initiatives (funding dependent). This deliverable will continue through to 2028, but specific projects/ schemes will adapt to meet needs and priorities																				
Deliverables around Children and Young People Elective Recovery are detailed in section 3.2																				
Diagnostics																				
Develop Community Diagnostics Centres fixed site (case / works)																				
Deliver Community Diagnostics Centre mobile unit (1 x endoscopy unit, 2 x imaging units)																				
Deliver (fixed site) of Community Diagnostics Centres to broaden the offer of elective diagnostics outside of acute facilities *(contracting negotiation underway at time of creating this document)*																				

Complete estates work at University Hospital Bristol and Weston Foundation Trust to regain Joint Advisory Group accreditation																				
Cancer																				
Develop Service to support earlier diagnosis and improve patient outcome and experiences - e.g., in 23/24 Targeted Lung Health Check scheme (starting in Northern Arc Primary Care Network in July) continuing delivery of non-symptom specific cancer pathway. This deliverable will continue through to 2028, but specific projects/schemes will adapt to meet needs and priorities																				
Redesign and implement pathways (for e.g., Gynae hysteroscopy, Prostate, UGI and HPB); Skin pathway improvement inc. focus on improving demand management through images with 2 week wait referrals. This implementation deliverable will continue through to 2028																				
Deliver personalised care projects (inc. for e.g. My Medical Record; Prehab; Cancer Enhanced Supported Care project delivery). This deliverable will continue through to 2028, but specific projects/schemes will adapt to meet needs and priorities																				
Deliver Health Inequality projects for 23/24 (including support inpatients with a serious mental illness to access cancer screening; work with patients with Learning disability around symptom awareness and access to screening; Community Outreach; work with voluntary sector and primary care networks to provide health promotion days; deliver comms campaigns on inequalities; localised focus on inequalities in breast, bowel and cervical screening). This deliverable will continue through to 2028, but specific projects/schemes will adapt to meet needs and priorities																				
Deliver program of education for primary care including education events for clinical and non-clinical roles																				
Continue ongoing dermoscopy education																				
Increased uptake of cancer screening programs (system partners collaboration)																				
Develop local resources and support national campaigns (collaboration between Communications Team and system partners).																				

4. Our Enablers – also referred to as 'enabling assets'

4.1 Workforce

We have a well-established People Programme, which has been in place for five years, bringing together providers to work in collaboration to deliver an integrated approach to workforce planning, recruitment, retention and development. This includes a Learning and Leadership Academy, which will enable the system to deliver in the long and short-term to support recovery, reform and resilience of services.

Details of the People Programme priorities and deliverables are provided on the Healthier Together website and within the appendices, including 1,3 and 5 year plan, and the mapping of current work to the 10 Functions of an Integrated Care System. The People Programme also provides support for the service transformation programmes across Bristol, North Somerset and South Gloucestershire.

The 22/23 workforce plan was heavily impacted by nursing supply, pipelines unable to keep up with turnover, cost of living and high absence rates. It is also recognised that there has been a reduction in workforce productivity compared to the pre-covid. A consequence of these impacts is that we were unable to achieve the levels of workforce outlined in the 22/23 plan. Recruitment initiatives put in place to grow the workforce have only mitigated turnover; there was limited growth in the nursing workforce during 22/23.

The People Programme sits within the People Directorate of the Integrated Care Board, headed by a Chief People Officer and is manged through a distributed leadership model which utilises the expertise of partner senior HR and Organisational Development professionals as SROs. The People Programme is overseen by the People Committee of the Integrated Care Board and is delivered through a People Programme Board.

The aim of the first year (23/24) multiyear workforce plan will be to:

"Create a sustainable nursing, midwifery, AHP and support workforce, working productively. This will be achieved by making BNSSG the best place to work and the employers of choice for nursing".

The key objectives will be:

1. **Pipeline:** The aim here is twofold a) to improve the pipeline into nursing, midwifery, Allied Healthcare Professional and support roles through expansion of educational places and clinical placements, including apprenticeships and b) to coordinate recruitment and return campaigns, including where beneficial international pipelines.

2. **Productivity**: This will focus on the development of shared system banks and agency switch incentives.

3. **Retention**: Most beneficial will be the development of system wide career paths and development opportunities and facilitated job moves across system partners.

Underpinning these objectives will be cultural competency and anti-racism actions. Investment in our workforce is fundamental to the 23/24 plan. Particularly in areas such as improved staff experience via focus on all elements of the NHS People Promise, flexible working practices, flexible deployment and regional multi professional education and investment plans.

The key milestones and detailed deliverables are outlined in appendix 3.

Metrics and trajectories

The People Programme Board and People Committee will receive regular updates on the progress of the work programmes and performance against agreed metrics. These will include the following:

- Performance against workforce plan intentions
- Reduction in turnover, year on year
- Benchmarking against other systems
- Reduction in agency costs, revised each year in the operating plan
- Increase in apprenticeships commencing
- Unspent levy in levy payers
- Levy transfers to smaller providers
- Statutory and mandatory passporting as a measure of productivity
- Increase in clinical placements
- Diversification of nursing pipeline to include routes such as apprenticeships
- Sickness absence as a measure of staff health and wellbeing
- Measures of equality, diversity and inclusion as reported in Workforce Race Equality Standard and Workforce Disability Equality Standard and staff attitude surveys
- Staff attitude survey outcomes review at system level.

4.2 Digital

The Digital Strategy is a key enabler for our Integrated Care System.

Digital teams across our system have come together to develop a system-wide Digital Strategy for 2023-2025. The strategy does not intend to intend to replace individual digital strategies of system partners. Rather, it intends to elevate, clarify, and codify what we are doing across the region, so that we can achieve together what cannot be achieved alone.

Our digital vision is to be an exemplar of a digitally advanced Integrated Care System. Working collaboratively and optimising design, data and modern technology to make ground-breaking improvements for the health and wellbeing of our population.

A key component of this vision is ensuring digital inclusion by understanding our population's digital inclusion needs, supporting digital access to services and ensuring digital services are person-centred in their design. See details in appendix 4.

The Digital Strategy responds to the recently published Strategic Framework. It also responds to:

- Key stipulations of the **NHS Long Term Plan**, that emphasises the need for local NHS organisations to increasingly focus on communicate health and care, population health and local partnerships with local authority-funded services, through Integrated Care Systems
- **Priorities and operational planning guidance (2021 – 2024)**, that mandates the development of underpinning digital and data capabilities to support population-based and personalised care approaches to monitor and improve health outcomes and address health inequalities
- The **What Good Looks Like** (WGLL) framework for Integrated Care Systems, with its seven success measures that include:
    - **Being Well led**: including setting out a clear strategy for digital collaboration and more joined up working across local digital partners
    - **Ensuring smart foundations**: including developing digital Infrastructure with increased standardisation and shared resources for efficiency and resilience
    - **Safe practice**: with improved information sharing to manage risk and improve outcomes for citizens; and enhanced cyber standards and compliance key pillars of safer health and care
    - **Supporting people**: to better support the frontline care with more frictionless working and released time to care
    - **Empowering citizens**: by giving citizens the tools needed to be active participants in their own care
    - **Improving care**: the Integrated Care strategy addresses this area which will look at improving the end-to-end journey for citizens, seeking to remove organisational boundaries where possible
    - **Healthy populations**: this area is more specifically addressed by the Shared Data Planning Platform (SDPP) project, however the proposed improvements across the system from the digital themes in this Strategic Outline Case would also contribute to this.
- The **Fuller Report** "Next steps for integrating primary care", specifically the role of digital such as: shared data, shared digital capabilities, a shared citizen record, and interoperability
- The **Data Saves Lives** data strategy, requiring reductions in data collection burden, sharing data for wider purposes, and improving access to information, and

- The **Integrated Care System Design framework**, requiring the development of cross-system intelligence functions supporting operational and strategic conversations, and enabling better clinical decision making; as part of moving up the Integrated Care System maturity index.

Following publishment of our digital strategy, our partners agreed a Strategic Outline Case for change, which highlights the digital investment and milestones required to implement the strategy. A digital delivery plan is currently being developed to highlight the key resources, milestones and timescales required to deliver our digital priorities.

The Digital Strategy sets out six core strategic digital objectives:

Theme	Theme objectives	Theme definition
***Digital Infrastructure Alliance**	• Create a system-wide collaborative infrastructure • Joining up key systems that drive cost saving • Remove duplication and create shared services	**#Build, simplify, run & maintain shared digital infrastructure and expertise** • How we set the right foundations for reliable modern, secure, sustainable and resilient digital, data and infrastructure operating environments • How we simplify, consolidate and share our infrastructure; invest in modern infrastructure & retire unsupported systems • How we own, configure and manage systems and underpinning architecture • What technological solution best meets the digital needs of our citizens, workforce and services.
***Digital for Integrated Care**	• Develop a fully integrated system-wide community first digital capability • Specifically design it to support our ambition for integrated community first care, as the default setting for care	**#Join things up** • How we 'join up' processes, systems, apps, tools & information, informed by New Models of Care (NMOC) such as more integrated care, care closer to home & remote care • How we digitally enable the move from organisational model, to care that is place-based and person centred and works across organisational boundaries • As a key enabler to transform care pathways and transfers of care, support 'joined-up working' and care delivery across the whole health and social care landscape.
***Digital Workforce**	• Enable more seamless working • Release time to care • Enable joint resource decisions and optimise our use of human resources to meet the demand for care	**#Learn, adopt and use digital tools and services** • How we digitise our frontline staff - equipping them with the know-how, skills and confidence • How we ensure our staff are digitally literate & competent to deliver • How we digitally enable staff to work optimally / do their job well, supporting the frontline to make best use of tech/digital, how they access and use systems/tools, how they share information, how do they stay (digitally) safe and how they share their innovative ideas • How we augment our workforce and promote self-care.
***Citizen First Digital**	• Create a system-wide citizen facing digital channel that draws together the various	**#Digitally interact with us** • How citizens digitally interact with health and care, and the tools they need to do so

Theme	Theme objectives	Theme definition
	digital aspects of being a partner in care • Focus on the user experience and consider drivers for behaviour change	• How we adopt a set of digital tools and services that enable citizens to access and actively participate in their care, own and encourage personalised care • How we encourage more personalised care, with citizens contributing to their healthcare information, and taking an active role in their health and wellbeing.
Digital Command Centre	• To develop a system-wide digital command centre • To exploit the new Shared Data and Planning Platform [SDPP] as the underpinning technology that powers the Digital Command Centre	• This theme is the subject of its own programme, and is outside the scope of the Strategic Outline Case.
Digital Innovation Hub	• To work in partnership with Academic Health Science Network, Bristol health partners and local universities to create a digital accelerator and innovation hub to test new technology and models of care	• This theme is the subject of its own programme, and is outside the scope of the Strategic Outline Case.

To deliver our priorities, and in response to the challenges and opportunities we face, we have structured our activity into four delivery themes. These are:

1. Digitally integrated community health and care
2. Supporting our workforce
3. Using data better
4. Connecting the person

For each theme we have detailed outline the outcomes each theme will provide and identify some of the key projects happening across our system that will deliver them.

The strategy sets out the outcomes and key projects to be delivered under each theme. Following approval of the Strategic Outline Case for Digital, we will set out key milestones, metrics and trajectories.

Figure 13: Digital vision

Governance

The Integrated Care Board Director of Transformation and Chief Digital Information Officer is the Executive Lead for Digital in our system. We have developed a revised governance structure in collaboration with partners, shown below:

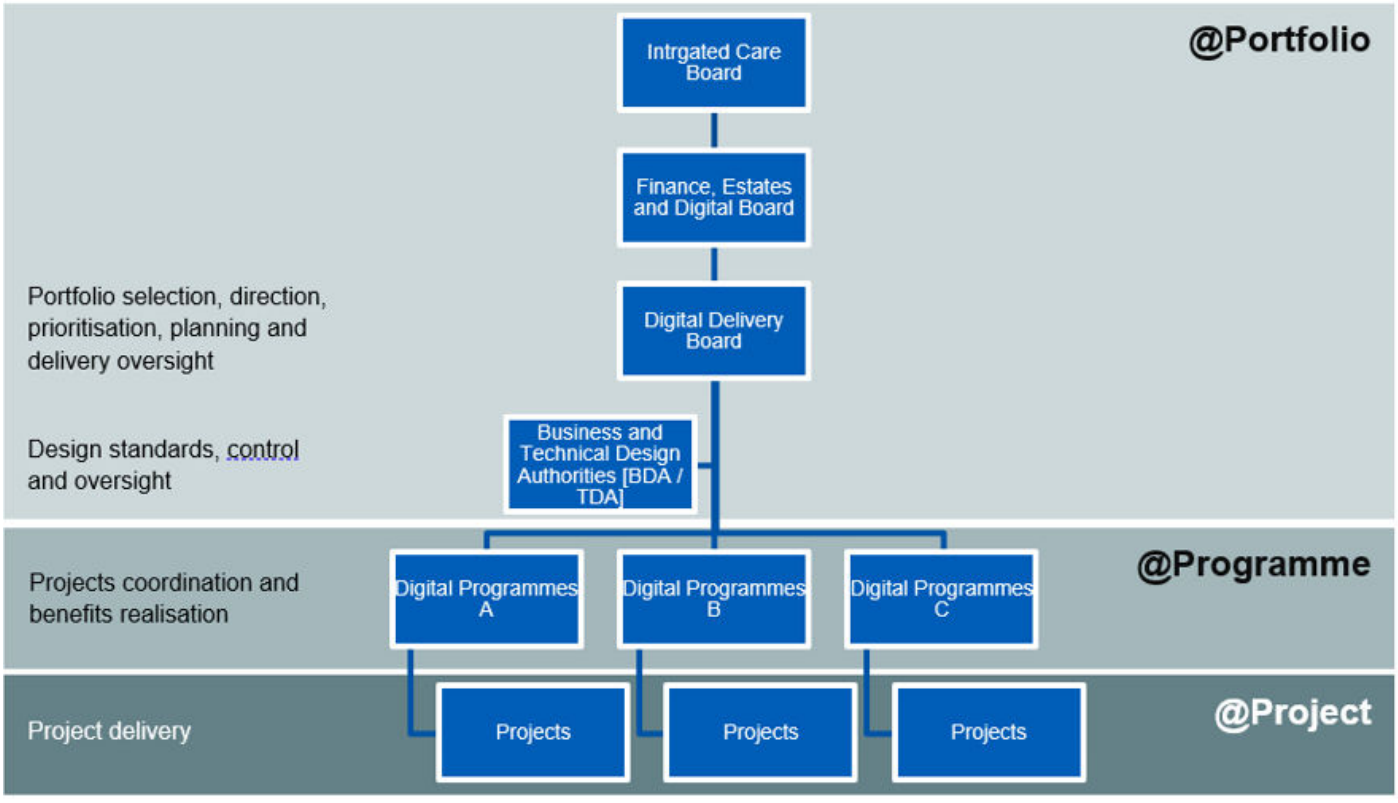


Figure 14: Digital Governance

4.3 Population Health Management and Intelligence

The Population Health Management capability is based on three things: the system wide dataset – a linked record level data set of health and care records, the core population health management team hosted at the Integrated Care Board – many of whom are on temporary contracts, and the network of contributors from Public Health, General Practice, academia and others.

Over the past few years, we have developed the capability to:

- Segment the population: an example of this is the Core Segmentation Model, based on the Cambridge Multimorbidity Index. This approach underpinned the 2022 Needs Assessment including the most comprehensive holistic analysis of deprivation and ethnicity-based health inequalities to date.
- Identifying the 'ageing well' cohort of older medically complex people, who were then identified by GP surgeries for anticipatory care.
- Revealing inequalities in bowel cancer screening uptake among black ethnic, and our most deprived communities.
- Demonstrating that bed-day use is dominated by a small older frail cohort of people, leading to an urgent and emergency care coordination pilot for frail people.
- Evaluating a new proactive care model for people with cardiovascular disease.
- Contributing to the design and evaluation of the COVID-19 maximising vaccine uptake programme.

In summary the data resource and expertise within our system for population health management is advanced, but currently overstretched and at risk due to multiple short-term contracts. Investment in the SDPP will be welcome but will not be fully exploited without retaining and growing the team. If sustained and developed, PHM is in a position to contribute significantly to tackling our most pressing challenges.

4.4 Research and Innovation

Leadership and governance

Our Research and Innovation Steering Group is provided by Bristol Health Partners, Academic Health Science Centre (AHSC) which includes organisations[8] and three public contributors.

The Steering Group formally aligns and integrates academic expertise in population and applied health research with the system's priorities. This is achieved through integration of research within the system decision making groups, including the Health & Care Improvement Groups, Health & Care Professional Executive Group, General Practice Collaborative Board and Locality Partnership Groups. Our approach was referenced as a case study of the value of research partnerships and integration with Integrated Care Systems in Maximising the benefits of research: Guidance for integrated care systems.

We have a dedicated Research Team, as do our partner Trust organisations, who ensure processes for the set up and delivery of research comply with the Health and Care Act and Health Research Authority. Indeed, we are a leading NHS area for research development and recruitment of participants to National Institute for Health and Care Research portfolio studies. We regularly work with Health Research Authority, Department of Health and Social Care, NHS England and the Clinical Research Network to co-develop efficient processes for research outside of NHS Trusts. Our Academic Health Science Network (AHSN) partners are fully integrated into our work and are developing an Innovation Hub which will connect with local academic partners and innovators to support the development of innovations to create new ways of delivering improved and more efficient patient care, that can be adopted at scale across the system, see below for detailed information on this.

Enabling cross-provider research which meets local needs by working with local communities

We will continue to build on and further expand our multidisciplinary, collaborative research, whereby research is designed and delivered by people in our communities along with people working in the health and care system and academics from our University Partners. This approach, embodied by the Bristol Health Partners delivery vehicle of our 20+ Health Integration Teams, is delivered across all our research development activities.

These teams and our wider research endeavours operate on the basis of drawing in multiple perspectives and talents from public contributors, health and care professional staff, voluntary sector partners and different research disciplines. We have a particular emphasis on developing research which is more diverse, inclusive, and better able to respond to the needs and aspirations of our under-served urban, rural and coastal communities. Our work with local communities is supported by People in Health West of England and our Diverse Research Engagement Network.

Using evidence for planning, commissioning and improving care

The Research and Innovation Steering Group will enhance System work, through robust development and evaluation of innovative practice, but also through securing increased external resources into our system. Our Partnership is very successful at securing funding from the National Institute for Health and Care Research (for example, we host a Biomedical Research Centre, all 3 National Institute for Health and Care Research schools and Clinical Research

[8] Avon and Wiltshire Mental Health Partnership NHS Trust, BrisDoc, Bristol City Council, Bristol, North Somerset and South Gloucestershire Integrated Care Board, NHS Blood and Transplant, NIHR Applied Research Collaboration West, NIHR Clinical Research Network West of England, North Bristol NHS Trust, North Somerset Council, One Care, People in Health West of England, Sirona care & health, South Gloucestershire Council, University Hospitals Bristol and Weston NHS Foundation Trust, University of Bristol, University of the West of England (UWE Bristol), West of England Academic Health Science Network

Facility and have current grants totalling c. £135M). These funds enable our system to generate evidence to inform our work, deliver greater innovation and robustly evaluate effectiveness.

Developing a research strategy
The Integrated Care Board, in collaboration with Research and Innovation Steering Group, is developing a research strategy for early 2024. We have already mapped our research activity, expertise, interests and infrastructure.

We are using information about local priorities through *Our Future Health* and engagement with under-served communities as part of our Diverse Research Engagement Network. This drives our areas of focus and will be aligned to the needs and intended outcomes of our Health and Care Improvement Groups.

Our research strategy will continue to support the research infrastructure required to develop and deliver nationally leading applied health research.

We will look to maximise the benefit to our local population from our strength as a national leader in research.

Our priority areas are:

Tackling inequality - Our commitment to work with people and communities is paramount. We are using our Programme of research and innovation both as a mechanism for improving the system's engagement with communities, as well as co-developing individual research projects and innovative products and services that explore solutions to inequity:

- Research and innovation priorities being generated by under-served communities.
- Language translation as standard, for all materials and findings.
- Supporting and maintaining long-term engagement between the ICS and our communities through combining research and service into a single, rich and empowering relationship for Voluntary sectors and Community Groups.
- Encouraging skills transfer and access to courses and/or work experiences for communities as a benefit from participation in research.
- Ensuring engagement insights are shared between research and system activities.
- Employing Community Research Ambassadors via People in Health West of England, at University of the West of England and Caafi Health, our lead voluntary sector enterprise for research.
- Using research collaborations as a model to challenge traditional power-dynamics.
- Co-creating research with communities, employing Community Researchers to deliver research, analyse data and to disseminate findings.
- Collecting data at scale on all protected characteristics from those participating in research studies across Bristol, North Somerset and South Gloucestershire.

Secure Data Environments for research - Working with the Population Health Management programme, we will align resources to support the system development of a Shared Data and Planning Platform (SDPP) and Greater Western Secure Data Environment across the South-West. Research partnerships will continue to contribute to the development of the digital infrastructure, as well as the processing of data and exploring novel opportunities for data led health service improvements.

Impact acceleration - To deliver on our duty to facilitate or otherwise promote the use in the health service of evidence obtained from research, we have launched the Impact Accelerator Unit (IAU). The IAU is a Partnership with the University of the West of England and University of

Bristol, and working with the West of England AHSN and Applied Research Collaborative West and is the first Unit we know of that is based within the health system it is designed to influence.

The Impact Accelerator Unit will ensure evidence generated locally is embedded into practice as swiftly as possible, so that our population benefits from our local innovations. Research and Innovation will also support other System enablers.

Workforce - Our universities train the pipeline of our workforce. The work of the Research and Innovation Steering Group supports training, and research has been shown to aid staff job satisfaction and retention. We will make it easier for all staff to be involved in research through structural support for research in health and care providers, as well as Integrated Care Board and Local Authorities. We will place particular emphasis on supporting Nurses, Midwives and Allied Health Professionals to develop research and innovation careers, aligned to national strategies from Health Education England and the Chief Nursing Officer for England. Our Research and Innovation Steering Group will also connect research about retention, staff wellbeing and new workforce models into the decision making of our system. An example is our joint post of a primary care Advanced Nurse Practitioner between the Training Hub, University of the West of England and the Integrated Care Board (with support from the Clinical Research Network) who will write a strategy for primary care nurses to be involved in design and delivery of research.

Digital - Innovation development, and translation of technology from ideas into products, which are tested and meet international standards.

Population Health Management - Using and creating evidence to maximise the value of our budget for our population. Research collaborations are seeking innovative ways to understand our population, modelling alternative interventions and working with colleagues across the system to develop and evaluate innovative practice.

Medicines Optimisation - Continuing collaborations between Medicines Optimisation and the University of Bristol. Optimising treatments and reducing waste.

Working with the West of England Academic Health Science Network (AHSN)

Working with the West of England AHSN and other partners, we will speed up the pipeline for the discovery, development and deployment of innovations so that proven and affordable solutions get to patients faster. We will prioritise research and innovation projects that address the health needs of our population.

As West of England AHSN member organisation, we are already an active contributor to the local innovation ecosystem, and benefit considerably from the at-scale support for the discovery, development and deployment of innovation provided by the AHSN and through this the wider opportunities available from the national AHSN Network and the Accelerated Access Collaborative.

The announcement of a further five-year license for AHSNs from 2023 sets the scene for a long-term partnership which will realise further benefits for our local population.

By working with the AHSN, our system has a rich history of research and innovation, with a track record for harnessing these through successful collaboration to improve health and health services for our population, and for exporting these innovations across the region and nationally. Patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery. Research and innovation are also important for the local economy, bringing investment and jobs.

As a central element of the approach for our system, the AHSN local innovation pipeline focuses on discovery and development of new products, services and pathways with evidence of effectiveness, which are capable of being adopted by local systems. This is realised through a process of needs identification, innovator support, and real-world validation. Each of these elements is informed by ongoing engagement and partnership with local heath and care professionals from the three local integrated care systems in the West of England, which also provides our system with access to cross-system learning.

In addition, as all 15 AHSNs nationally share data from their own local innovation pipelines this ensures visibility of promising innovations from across the country. The pipeline also incorporates research outputs that are ready for development and benefits from established partnerships with the Universities, with National Institute for Health and Care Research Applied Research Collaborative (ARC) West and with National Institute for Health and Care Research West of England Clinical Research Network, as well with Academic Health Science Centre.

Supporting the innovation pipeline, the AHSN team now includes an in-house insights and evaluation team, with expertise across a range of research, evaluation and analytical approaches. In addition, the AHSN team are able to support system partners to scope and commission independent evaluations and works with partner organisations, such as the National Institute for Health and Care Research, Applied Research Collaborative West to ensure a complementary approach.

The Integrated Care Board and all local system partners also benefit from the AHSN Academy which delivers a range of education resources to build knowledge, skills and confidence for improvement and innovation across our workforce.

This includes two Massive Open Online Courses offering an introduction to tools and techniques used by innovators and improvers, and bespoke training for new innovators through the Health Innovation Programme which boasts a growing community of successful alumni.
The AHSN Academy is complemented by the West of England online Evidence Repository. Established in partnership with our system, neighbouring systems and local hospital libraries. Now in its third year, the repository supports rapid evidence sharing of grey literature to facilitate rapid sharing of ideas and innovations.

We are already benefiting directly from the AHSN's diverse work programme which combines locally and nationally commissioned innovation projects and services as presented in the diagram below.

Figure 15: Academic Health Science network programmes supporting our research and innovation

In addition to the projects commissioned nationally by the Accelerated Access Collaborative and The Office for Life Sciences, current locally commissioned innovation projects being supported in West of England including specifically in our system are:

- Black Maternity Matters - a ground-breaking collaboration, supporting midwives to reduce the inequitable maternity outcomes faced by Black mothers and their babies.

- Non-Invasive Ventilation - aims to reduce mortality rates to 10% or lower for patients who require acute non-invasive ventilation for Type II respiratory failure through the implementation of an evidenced-based care bundle in all six acute hospitals across the West of England, including Bristol, North Somerset and South Gloucestershire.

- PreciSSIon - Building on an award-winning collaborative originating in our system, which halved surgical site infections after elective colorectal surgery, this successor project working with six acute hospitals and maternity units aims to reduce surgical site infections following caesarean births through an evidence-based care bundle supported by a bespoke digital patient outcome reporting tool.

- Domiciliary Care Workforce Challenge – with pilot sites in Bristol and Cornwall this programme is evaluating the use of an AI-based logistics solution which aims to increase the available capacity of the workforce and improve the working lives of care workers.

- Innovation for Healthcare Inequalities Programme - with a local focus on lipid optimisation for patients with raised cholesterol in deprived areas and one of the two projects located in our system, this nationally funded programme aims to increase awareness and adoption of evidence-based innovations that can reduce healthcare inequalities, thereby improving access, experience and outcomes for Core20PLUS5 populations.

In addition to the support provided by the AHSN through their nationally funded capacity and capability, we have prioritised additional local investment with the AHSN to support the development of a local innovation hub in 2023/24. Following scoping and initial mobilisation of project resources in Q1, the objectives of this 12-month programme are:

- Innovation Mindsets - using bespoke education and support to develop capability and capacity for innovation across our system including practical models and methods for adoption and spread.

- Accelerating uptake – working with a selected Health Care Improvement Group to accelerate adoption of innovation in response to local priorities using either proven solutions or a via a call to industry to identify promising new solutions.

- Building for the future – engaging with all the partner organisations across system to establish a sustainable model for the innovation hub to drive acceleration of innovation uptake.

4.5 Estates

Our Estates Steering Group refreshed their key strategic principles in 2023:

1. **Make best use of our existing assets**
   In order to make best use of limited resources, it is necessary to maintain a system-wide view of available estate in our system with a clear understanding of how assets are being used. We will proactively look to identify ways to drive utilisation of existing estate, in addition to identifying opportunities for the disposal of estate if beneficial to do so.

2. **Prioritise our investment options**
   We should use our evidence-base to identify priorities for investment.

3. **To secure funding**
   Capital funding is required to deliver the key objectives number of options are available including NHS capital funding, Local Authority funding, Section 106 legal agreements, Community Infrastructure Levy contributions, private finance, and disposal capital receipts. We should work proactively with system partners to identify potential sources and opportunities to secure shared funding.

It is understood that all Integrated Care Systems will be expected to produce joint system-level infrastructure strategies by early 2024, though NHSE has yet to issue guidance confirming requirements and deadlines. This strategy will build on the work that has been undertaken by the Estates Steering Group to develop a process for the prioritisation of system capital over the next 10 years. This will set the investment priorities, which will be aligned with system strategic priorities.

System Capital Prioritisation

In 2020/21, the NHS capital regime changed into a new model in which all Integrated Care Systems now have greater responsibility in deciding how system-level operational capital is spent. The previous regime meant that acute providers generated capital from a mix of cash from depreciation and surpluses which created cash for reinvestment in capital, which has now been amended to enable the Integrated Care Board to allocate funds to all NHS providers including primary and community care. This has provided the opportunity for system partners to take a more balanced and targeted approach to capital investment to support delivery of our shared strategic and operational objectives.
The Estates Steering Group have been undertaking work throughout 2022/23 to develop a method for how this system capital can be allocated. Firstly, a set of principles were produced to determine which capital schemes are system-level investment decisions and which can be agreed locally at organisational-level.

Organisation Level Decisions:

- Maintenance – critical risk items (organisations to agree risk tolerance for consistency)
- General Equipment replacement (excluding major diagnostic kit)
- Minor redevelopments – threshold for minor developments are schemes under £1m

System Level Decisions:

- New office / admin space
- Major redevelopments
- Major digital systems
- Additional operating theatres
- Outpatient / clinic / consulting space & waiting rooms.
- Additional beds (beyond ward reconfiguration that might give marginal gain)
- Diagnostics – location and major kit replacement
- Acquisitions and disposals of buildings
- Lease break clauses and renewals
- New leases

Using these principles, the process and milestones devised were as follows:

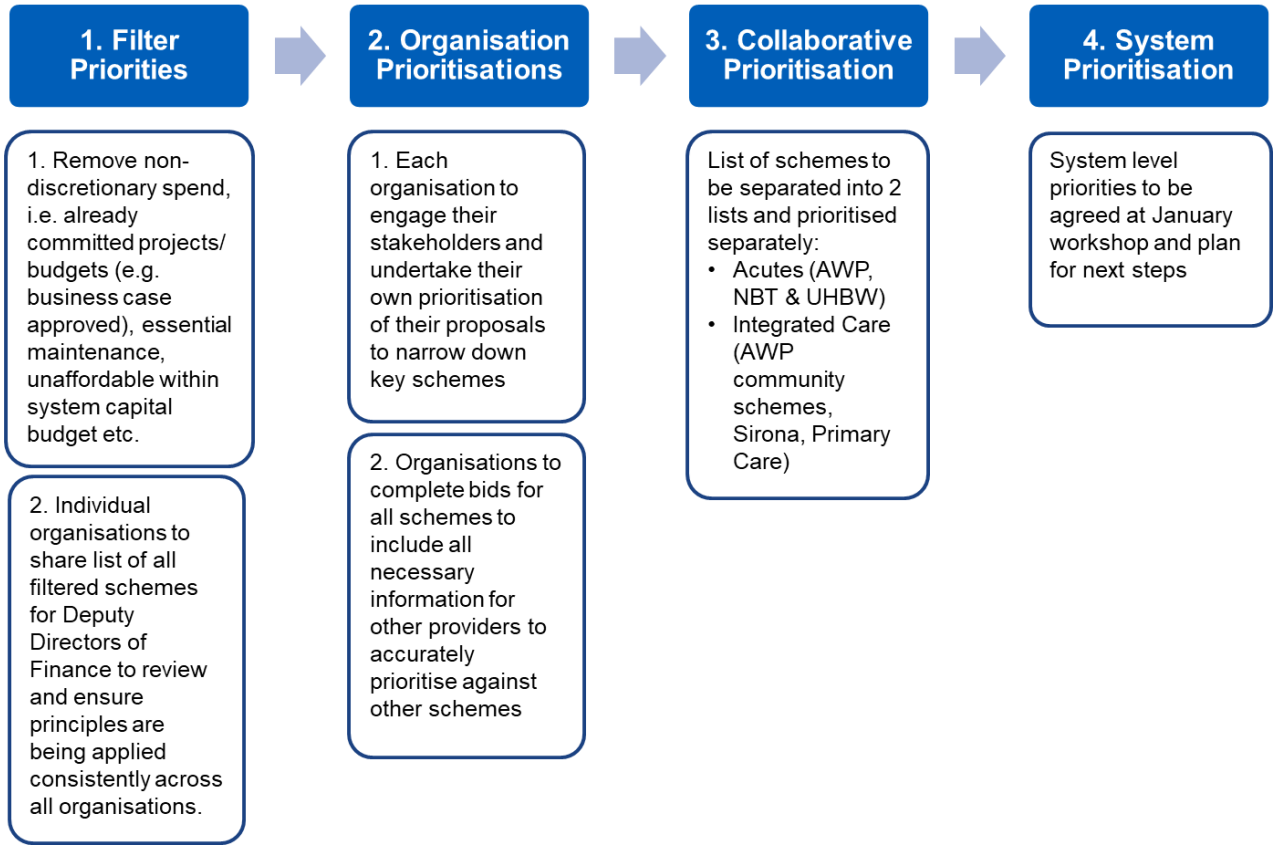


Figure 16: Estates Process for System prioritisation

The initial plan had been for each organisation to filter their current plans to take out those items that fitted within the organisation-level decisions. This would then leave a level of resource and a number of schemes to be prioritised at system level using the prioritisation matrix approved previously by the Directors of Finance. A total of 45 bids were submitted for system capital funding by the participating organisations (UHBW, NBT, AWP, Sirona, GPCB, ICB). Once all bids had been submitted, they were collated and shared with the organisations participating in the scoring process for them to undertake their scoring and prioritisation of each.

The intention was that this would culminate in a moderation session where a final agreed set of priorities would be agreed. In practice, this final moderation session did not take place as it was clear there were significant capital demands across the system which massively exceeded the limited capital available to the system. It also became clear that it would be preferable to complete

that stage of the process once the Joint Acute Clinical Strategy becomes available and so the agreement of a 2-year holding position was reached.

It was decided that an initial 2-year plan for 23/24 and 24/45 would be focused on:

- Delivery of “pre-commitment” projects i.e. projects that are already in the construction stage, or have funding allocated to them via a system approved business case.
- Acute Trust major diagnostic equipment replacement, and critical backlog maintenance to ensure that we don’t deteriorate the existing estate and that we maintain equipment at a reasonable standard
- Priorities for Integrated Care - those bids agreed by the Integrated Care collaborative estates group to be of highest priority in step 3 (Collaborative Prioritisation) in the overall prioritisation process. For PCN focused investments, this was backed up with the data led objective prioritisation tool that was developed from the strategic Health Asset Planning and Evaluation (SHAPE) matrix.

Once the Joint Acute Clinical Strategy is completed, the ICB Estates Steering Group will be coming together in summer 2023 to develop a longer range 10 Year Capital Plan. In addition to the investments the plan confirms as being prioritised for access to system capital, a secondary pipeline of business cases for prioritised strategic projects should be developed and readied in the event of national bidding opportunities arising. This 10-year plan will be the bedrock of the joint ICS Infrastructure Strategy.

The Estates Steering Group will lead an annual process of reviewing and checking that agreed priorities within the 10-year capital plan are still relevant and appropriately prioritised. The group will also be responsible for managing the reprioritisation of projects within the plan for system capital as well as the pipeline of projects for potential bidding opportunities.

4.6 Finance

Bristol, North Somerset and South Gloucestershire System Directors of Finances (DOFs) collaborate to maintain a rolling five-year Medium Term Financial Plan. The plan aims to maximise use of resources for our population and NHS providers; and deliver the duty to achieve breakeven in each financial year, with a minimum contingency of 0.5% of system revenue allocation. The plan is reviewed each financial year, refreshed to take account of the latest underlying system cost base, and notified NHS funding allocations.

The inputs to the model take account of Government and Office of Budgetary Responsibility (OBR) economic indicators and forecasts; notified NHS funding allocations; local strategy; approved business cases at Strategic Outline Case (SOC), Outline Business Case (OBC) or Full Business Case (FBC) level; system sponsored transformation programmes; local and national guidelines such as NHS England Operational Planning Guidance and Long Term Plan; national contracts and frameworks, such as Agenda for Change pay policy and GP contracts; plans from other major commissioners such as NHSE England Specialised Commissioning, Health Education England; and best practise and benchmarking data, such as NICE guidelines, CQC and other regulator recommendations, NHS Getting It Right First Time (GIRFT) programmes and benchmarking from a variety of sources.

The NHS Medium Term Financial Plan is assured by Integrated Care Board Finance, Estates and Digital Committee and recommended for approval by ICB Board. Local Authority Medium Term Financial Plan is assured through local authority governance, and ultimately relevant Mayor, Cabinet and Full Council approval. The plan is also reported to Integrated Care Partnership. System DoFs have agreed to a distributed leadership model to align themselves to key system enablers such as Health & Care Improvement Groups, and Enablers such as Digital Delivery Board, Estates Steering Group and Workforce Steering Group; to ensure professional financial advice and feedback between financial strategy and other strategies. System DoFs meet weekly and are supported by a weekly Deputy Directors of Finance's (DoFs) Group. ICB and LA DoFs meet fortnightly.

At present there are separate models for System revenue (Revenue Departmental Expenditure Limit (RDEL) basis) [incorporating costs analysed between NHS programme spend categories, inter-system and intra-system funding flows to NHS providers, primary care providers and Sirona, funding flows between NHS and LAs, and provider costs analysed between pay, non-pay, and financing costs]; System capital (Capital Departmental Expenditure Limit (CDEL) basis) [incorporating major medical equipment, digital, operational estates and strategy investments including those funding by NHS Programmes]; and 3 local authorities Medium Term Financial Plans. System DoFs have an ambition to create a fully integrated financial strategy, plan and model incorporating I&E, balance sheet, and cash flow; as well as integrating this with associated workforce, activity, capacity, performance, estate and digital plans. All aligned with ICS Strategy and JFP.

The purpose of the plan is to provide parameters and judge affordability of key investments and decisions required over multiple years and beyond the period of certain funding sources e.g., multi-year commissioning contracts, capita investment and borrowing decisions and multi-year contracts for supply of goods and services, and recruitment of staff. The Medium Term Financial Plan forms the baseline for the annual operating plan and budget. Whilst maintain delivery of statutory financial duties and further financial parameters defined by Government or NHS England regulation (e.g. Mental Health Investment Standard, Running Cost allowance).

The plan will identify evidence-based opportunities for savings and efficiencies, including the cashable benefits of transformation and against a reasonable do nothing growth scenario taking account cost inflation, business as usual efficiency plans, demographic demand growth and long-term non-demographic demand growth.

The plan can allow for recurrent deficits as long as non-recurrent funding sources are identified and the plan is balanced within five years. A key assumptions, risks and mitigations log is also maintained and incorporated into both ICB and system partners risk registers.

Once the overall plan is balanced but there remains surplus/deficits within individual organisational plans then System DoFs will propose solutions to Healthier Together Executives enable all organisations to achieve a balanced financial plan.

4.7 Procurement

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB) has a policy for healthcare and a strategy for procurement of goods and services. The ICB, through the objectives set out within the policy, ensures that in relation to the procurement of healthcare services it acts with a view to:

- Securing the needs of the people who use the services
- Improving the quality of the services
- Improving efficiency of the services
- Ensuring that services provided are accessible.

In relation to the procurement of all goods and services the ICB complies with the law, regulations and published guidance and its own standing orders / standing financial instructions.

Since 2009 the ICB commissions NHS South, Central and West as an expert provider of procurement professional services, within the health and social care sectors.

Regulatory environment

In partnership with the SCW team it is recognised that from a procurement perspective the working environment is facing its greatest challenge with the organisational system change to Integrated Care Boards (ICBs), phased delegation of direct commissioning and elements of specialised commissioning, and the emerging role of provider collaboratives and neighbourhoods. This shift is coupled with the proposed repeal of the competition requirements in the Health and Social Care Act, withdrawal of healthcare services from the Public Contracts Regulations 2015 and the introduction of a Provider Selection Regime (PSR).

Provider Selection Regime - PSR

Under the new PSR, we recognise that there will be various ways to secure healthcare services contracts as the regime is intended to provide ICBs greater freedom and flexibility to deliver integrated services, locally. We understand that once the regime is legislated we will still be required to act with probity, transparency and accountability and the responsibility to demonstrate the robustness through scrutiny of decision making alongside understanding the opportunities within the new regulations to identify the most appropriate route to secure the best providers for services – this will include a streamlined provider and service assessments alongside more traditional competitive processes – see figure 15 below.

BNSSG ICB Goods and Services procurement

Our system has access to Bristol and Weston Purchasing Consortium (BWPC) for the procurement of goods and services.

BWPC provides a comprehensive range of purchasing services to support local Trusts and Healthcare Providers. BWPC services include all aspects of clinical and non-clinical purchasing, supply chain management and capital equipping (CES) and our system tools include e-tendering, reporting, spend analysis and order management.

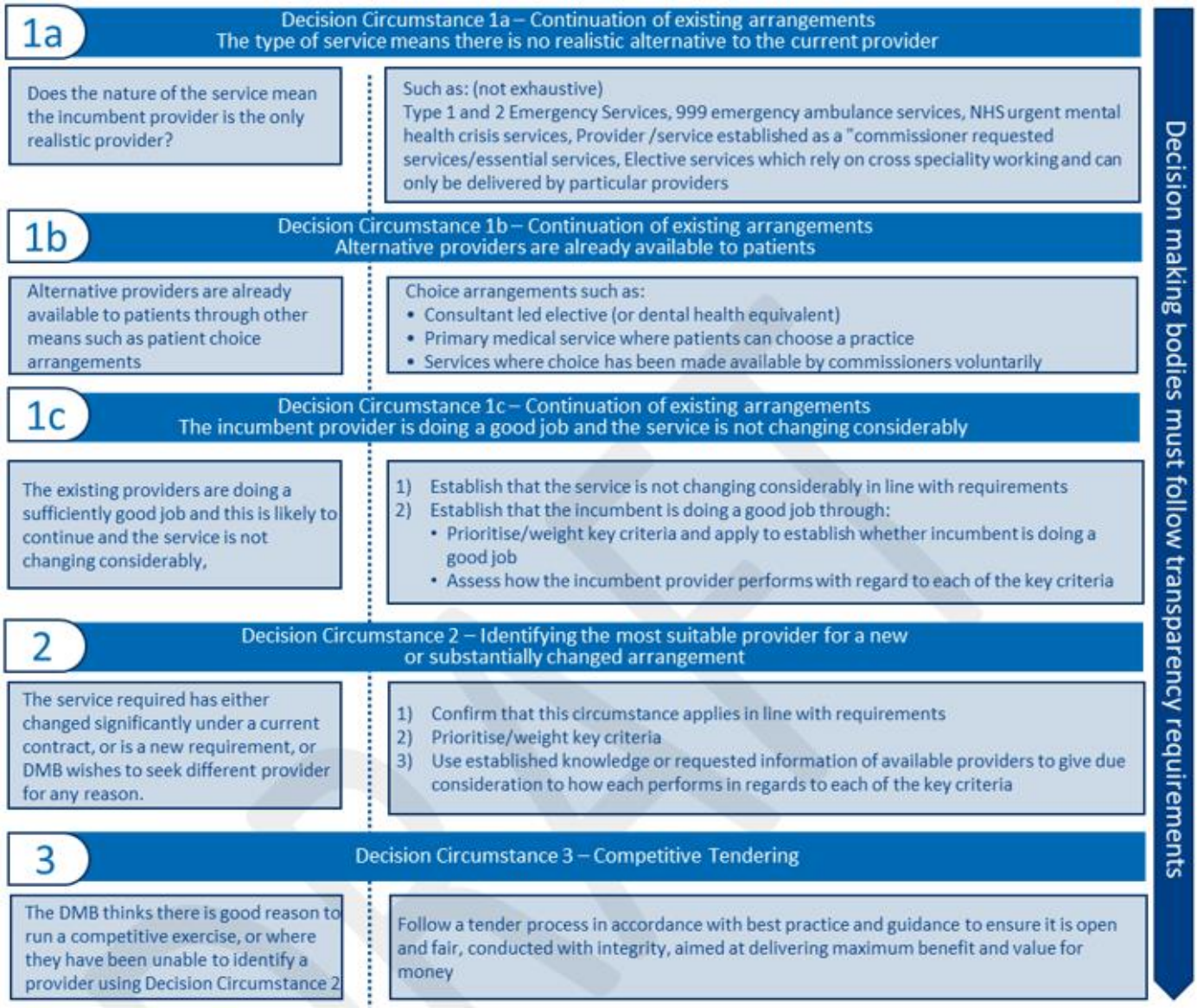


Figure 17: How Decision Making Bodies (DMBs) choose which Decision Circumstance to use under the Provider Selection Regime

Close working relationships with partners and also collaboration with other organisations brings economies of scale, sharing of data and best practice so that our system maximises savings and efficiencies.

BWPC work closely with each client to support compliance with all purchase-to-pay procedures and delivering improved efficiencies in all areas including automation, consolidation of invoices, strictly controlled access to purchasing systems etc.

BWPC and our partners drive to ensure we get value from our spend as is critical to the ongoing commercial sustainability of the wider ICS. It is recognised that the demands of the modern health service require that “value” means much more than just buying more for less. The systems approach within BWPC procurement can simplistically be defined as:

- Providing support to help the ICS be more commercially successful
- Providing support to help the ICS to be more socially responsible.

This will be delivered by focusing our efforts around four key themes:

Key Theme	Areas of focus
One Supply chain for the ICS	• Making the ICS footprint the foundation for procurement delivery • Increasing commercial compliance across the ICS • Increasing transparency through technology and Data • Managing spend across the whole value chain.
Getting value from all of our spend	• Portfolio management of our supply chain • Actively managing the Categories that we control • Effective management of our supply chain • Helping to deliver the financial recovery plan.
Being and employer of choice	• How we work together • Developing the skills of the team • Attracting talent.
Being an anchor in the community	• Driving the supply chain to net zero • Using our spend as a positive influence in our community • Promoting a fair, diverse, and inclusive supply chain.

BNSSG Contracting and promotion of patient choice

The NHS Choice Framework sets out when patients have the legal right to choose any provider or team that holds an NHS commissioning contract for the service they require, for their first outpatient appointment. This commitment applies to physical and mental health services – all age, where patients can choose from any service led by a consultant or mental health care professional. The NHS Choice Framework also sets out when there are exceptions to the legal right relating to first outpatient appointments. The legal rights to choice of provider and team apply when:

- The patient requires an elective referral for a first outpatient appointment
- The patient is referred by a GP, dentist or optometrist
- The referral is clinically appropriate (clinical appropriateness is assessed by the referrer)
- The service and team being referred to are led by a consultant (physical and mental health) or a mental healthcare professional (mental health)
- The provider has a commissioning contract with any ICB or NHS England for the required service
- No other exceptions to the legal right apply.

We follow Section 25 of the NHS Standard Contract 2022/23 Technical Guidance which describes the non-contract activity (NCA) approach “the term used to refer to NHS-funded services delivered to a patient by a provider which does not, at the point at which those services are delivered, have a written contract in place with that patient’s responsible commissioner, but which does have a written contract for the delivery of that service in place with at least one other NHS commissioner” and how this applies to patient choice referrals. Section 25 of the technical guidance makes clear that no prior commissioner approval is required for activity where the patient exercises their legal right to choice and also outlines the process in respect of payment for NCA.

We also understand that in addition to the legal right at the point of referral, patients who wait over 18 weeks to start treatment for a non-urgent condition can request that their commissioner refers them, to a different service who can see them sooner. This nationally determined choice applies to consultant-led services and is described in further detail in Section 4 of the NHS Choice Framework, including when requests may not be considered by commissioners. For services that are consultant-led (and when other exceptions noted do not apply), commissioners must take all reasonable steps to find an alternative health care provider who can see the patient sooner. In these circumstances if there is more than one available provider who can see a patient earlier then choice of provider must be offered. This is a duty on commissioners as set out in Regulation 48 of the Standing Rules.

We will actively promote patient choice by ensuring:

- GPs offer patients choice of providers at the point of a clinically appropriate referral
- Clarity that self-referrers can go back to their GP and restart their pathway with a GP referral and if a patient is referred and finds themselves on a pathway longer than 18 weeks, they can go back to the GP and request a referral to another provider cancelling the original referral
- Clarity that if a patient will not be seen within the 18-week target they have a right to contact the ICB and request to be seen by an alternative provider who can see them sooner, if available. As part of the ICBs legal responsibility, BNSSG will make reasonable attempts to find alternative providers
- If a referral is deemed 'clinically appropriate' (which is decided by the GP), it is understood that the patient can choose to be seen by another alternative provider if the alternative provider has a NHS Standard Contract with another ICB and are able to see them
- Primary Care Remedy is developed to ensure all services are in scope including children's services
- The processes of Providers are reviewed to ensure they are making patients aware of Patient Choice/ Right to choose at the appropriate places in the referral process.
- The performance of each contract is reviewed against the Patient Choice / Right to Choose criteria as set out above.

4.8 Health and Care Professional Leadership

Within Bristol, North Somerset and South Gloucestershire (BNSSG), we have cross-organisational, system-wide working in health and care leadership (HCL) and this leadership is integral to the function and delivery of our ICB. Our ambition is to cultivate leadership across our system and develop a culture that actively encourages health and care professional leaders to thrive and lead patient and population focused change, as part of delivering a high-quality, high-performing, outcomes-driven integrated care system for the people of BNSSG.

We began developing the HCL framework in summer 2021 and it has been a collaborative and iterative process co-produced with a wide range of system colleagues. The health and care leadership programme team have run a number of workshops, attended system meetings and engaged with a wide range of stakeholders to understand their priorities and perspectives. The learning and feedback will now be developed into a programme plan which will start to be implemented in 23/24.

The purpose and ambition of our health and care leadership framework is to cultivate leadership across the system and develop a culture that actively encourages health and care leaders to thrive and lead patient and population focused change, as part of delivering a high-quality, high-performing, outcomes-driven ICS for the people of BNSSG.

The agreed principles are set out below:

How we work together across our ICS	1. We **engage, listen to, and consider the impact and experience of the people we serve and those who work in our services**; we communicate with the public with credibility and authenticity 2. We actively shift the thinking upstream to focus on **prevention, earlier intervention, and the reduction of health i**nequalities 3. We **prioritise investments based on value**, ensuring equitable and efficient stewardship of system resources, and we take shared ownership in driving this 4. We act on insights from **pooled information and intelligence** 5. We are committed to working together as an **equal partnership**
Our culture and role as health and care leaders in the ICS	6. Across the system, we **do the right thing for the patients we serve**, even when it is challenging for us or our individual organisations 7. We **continuously improve** – we will try things together, learn, evaluate, and make changes to improve; we are actively promoting evidence-informed innovation and learning across the system 8. We work in partnership with system executives and managers to drive clear and **transparent decision-making** 9. We actively shape the agenda of the ICS; **we understand how to engage to drive change and our role in it** 10. We engage in honest, respectful, and open dialogue amongst clinical and care professional leaders, and we strive to build confidence that we can **trust** one another's patient assessments and recommendations 11. We identify and develop clinical and care professionals at all levels in an **inclusive manner**

How we manage quality and risk	12. We are **committed to quality improvement** across all clinical and care professionals, and we embed this across the system (e.g., performance) 13. We manage quality at the right level (e.g., neighbourhood, place, provider collaboratives, system) to improve the health and wellbeing of the local population, following the principle of **subsidiarity** and acknowledging one-another's statutory responsibilities 14. We **collectively own, share and take accountability for managing risks**, particularly when serious quality issues arise 15. We **establish a just safety and learning culture**, enabling system-wide learning from serious incident, never events, and safeguarding issues.

The SROs for this work are Health and Care Professional (Leadership) Executive is the ICB CMO and CNO and, as co-chairs of the Health and Care Professional Executive, they ensure oversight and engagement is co-ordinated via this group.

This work contributes to most of the ICB statutory functions especially the duties to improve quality of services, to obtain appropriate advice, to promote integration and innovation, in respect of research and to promote education and training.

4.8.1 Safeguarding

The Integrated Care Board is accountable for delivering the statutory functions for safeguarding children under section 11 of the Children Act 2004 and the statutory functions for safeguarding adults under Chapter 14 of the Care Act 2014. In addition to this, the Integrated Care Board also has a duty to cooperate with and support the local authority who are Corporate Parents to the Children in Care under our local authorities.

The Statutory frameworks recognise that 'Safeguarding Is Everybody's Business' and the integrated Care Board is noted as a statutory partner within these. Therefore, the Integrated Care Board is responsible for ensuring that safeguarding principles are embedded across the workforce and within all workstreams it has responsibility for, as well as having oversight across the whole health economy. All staff employed by the Integrated Care Board also have a role in raising awareness of safeguarding concerns and connecting with the Safeguarding team for advice when required. This is all underpinned in the Safeguarding Accountability and Assurance Framework.

The Integrated Care Board works across three local authority areas who developed a Joint Strategic Needs Assessment. Consequently, the Joint Forward Plan does take into account the health and wellbeing needs of all children, adults, families and communities and highlights safeguarding priorities relevant for the population in which it serves. By contributing to the strategic plans of the safeguarding partnerships, using the joint strategic needs assessment and other safeguarding information and data will bring system partners together to improve the outcomes in population health. Particularly with the use of campaigns, to raise awareness of such safeguarding issues, we aim to prevent harm to children, young people, adults and communities.

Aims and objectives

We will:

- Deliver the safeguarding statutory duties of the Integrated Care Board, alongside the safeguarding arrangements and priorities

- Deliver safeguarding training and supervision to primary care – in particular to Safeguarding GPs across our system, including raising awareness of Children in Care and Care Leavers
- Implement recommendations from statutory safeguarding reviews and new legislative changes for example, Domestic Abuse Act 2021, Serious Violence Duty. This would also include how we support our staff who maybe experiencing domestic abuse for example.
- Establish a Safeguarding Learning Assurance Network across the system, subject to the Local Government Review to better understand the impact of improved practice in relation to safeguarding and establish an All-Age Safeguarding Health Professionals Network across to share learning from reviews, best practice and undertake Continued Professional Development to build the collective 'health' voice.
- Coordinate and contribute to a Systemwide Improvement Plan for Children in Care to improve the timeliness of Initial Health Assessments and Review Health Assessments.
- Support the implementation of Phase 2 of a nationally mandated programme of work: Child Protection-Information Sharing system with primary care.
- Contribute to the Migrant Health workstream across the system to ensure that safeguarding is core business to this programme of work in settling children, individuals and families into our system.

Governance

The respective safeguarding arrangements and boards within our system deliver key statutory mechanisms. Each local area co-operates to safeguard and promote the welfare of children, young people and adults at risk in that locality. The Integrated Care Board is a core statutory partner for safeguarding arrangements for children via the 3 Local Safeguarding Children Partnerships and also for adults via the Local Safeguarding Adults Boards. The Chief Nursing Officer is the executive safeguarding lead and the Integrated Care Board safeguarding team contribute to the work of the partnership arrangements, boards and subgroups.

The Integrated Care Board is also a core member of the Corporate Parenting Boards which exist across each of the Local Authority areas. The Local Government Association has been commissioned to review these arrangements with the aim of highlighting some good practice and creating opportunities to enhance the productivity in how safeguarding partnerships function and deliver in collaboration across the system.

The Integrated Care Board has a clear line of accountability for promoting the welfare of and safeguarding children, young people and adults, this also includes addressing the particular needs of victims of abuse which is undertaken in partnership across the system. In addition, the Integrated Care Board has a responsibility to support their own staff who may be experiencing abuse. The Integrated Care Board Safeguarding Team have created policies and user guides for managers on how to manage these incidents. Quarterly reports are submitted through the Board's Outcome, Quality and Performance Committee to provide assurance against its statutory duties. A Safeguarding Annual Report is also written each year to capture what has been delivered in line with the Integrated Care Board's statutory duties.

Metrics and trajectories

We will report on delivery of statutory duties through individual statutory duties and collective partnership contributions; by providing the narrative and any data available on the following:

Metrics	Link to Outcomes Framework
Review trends and themes emerging from statutory safeguarding reviews on a quarterly basis (Rapid Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews)	COM16, COM18
Safeguarding Training Compliance of Integrated Care Board Staff to improve overall from 79% to 90% performance by end of 2023-24 based on internal system records /e-learning packages.	STA10, COM16
Improvement in timeliness of Initial Health Assessments (90% to be undertaken within 20 working days) and Review Health Assessments for all children placed into care across the system as per statutory timeframe (90% to be undertaken every six months for under 5s and every year for over 5s).	POP5, POP6, COM14, COM16
Monitor numbers of GPs attending training/supervision meetings delivered by the Safeguarding team, ensuring that every GP Practice has engaged with the Primary Care Training/Supervision Offer at least 75% of the year.	STA10, COM16
Delivery of Health contributions to Children Multi-agency Safeguarding Hub arrangements:	
Percentage of information requests responded to in required timescales, including when health has no information to share - Divided into the three Local Authority areas (expected percentage is 90%)	POP5, POP6, COM14, COM16
Percentage of information requests that led to strategy meetings/ discussion/S47 enquires -Divided into three areas. (if available).	POP5, POP6, COM14, COM16
Twice yearly audit (supported by the Integrated Care Board Safeguarding team) looking at the type of information requests and timescales to respond to such requests;	POP5, POP6, COM14, COM16

Key deliverables and milestones

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Review the Integrated Care Board statutory duties against the safeguarding priorities set by the partnership arrangements across the system																				
Work with the integrated Care Board People Directorate to improve performance of Statutory and Mandatory Safeguarding Training for staff and oversee Level 3/4/5 training required by specific teams within the organisation																				
Design and Disseminate the Integrated Care Board's Safeguarding Team offer to Primary Care																				
Deliver the Safeguarding Training Offer to Safeguarding Lead GPs																				
Implement recommendations from safeguarding statutory reviews - including cascading the learning across the system (wider health economy and Primary Care), monitoring their effectiveness																				
Scope and review what is required for the Integrated Care Board to deliver new statutory duties including: Serious Violence Duty and Domestic Abuse Act 2021																				
Launch All Age Safeguarding Health Professional Network - to share learning, best practice, strengthen collective 'health' voice																				
Co-develop a System Learning Assurance Approach and Network - considering themes and multi-agency quality improvement strategies to understand impact of safeguarding system change identified by statutory safeguarding reviews																				
Co-develop and co-deliver a Children in Care and Care Leaver Improvement Programme Board to improve performance of Initial Health Assessments and Review Health Assessments, in addition to outcomes and experiences for this cohort																				

4.8.2 Women's Strategy

NHSE published a 10-year strategy in August 2022 (see figure below) that addressed the issues faced by women in accessing healthcare, acknowledging that while women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. Women make up 51% of the population, historically the health and care system has been designed by men for men. It is a 10-year strategy that sets out a range of commitments to improve the health of women everywhere, including a plan to transform women's health content on the NHS website, a definition of trauma-informed practice for the health sector and plans to increase female participation in vital research. We appointed the Chief Medical Officer as the champion for this policy and will begin a programme of work to review and implement recommended improvements under the leadership of the Health and Care professional Executive.

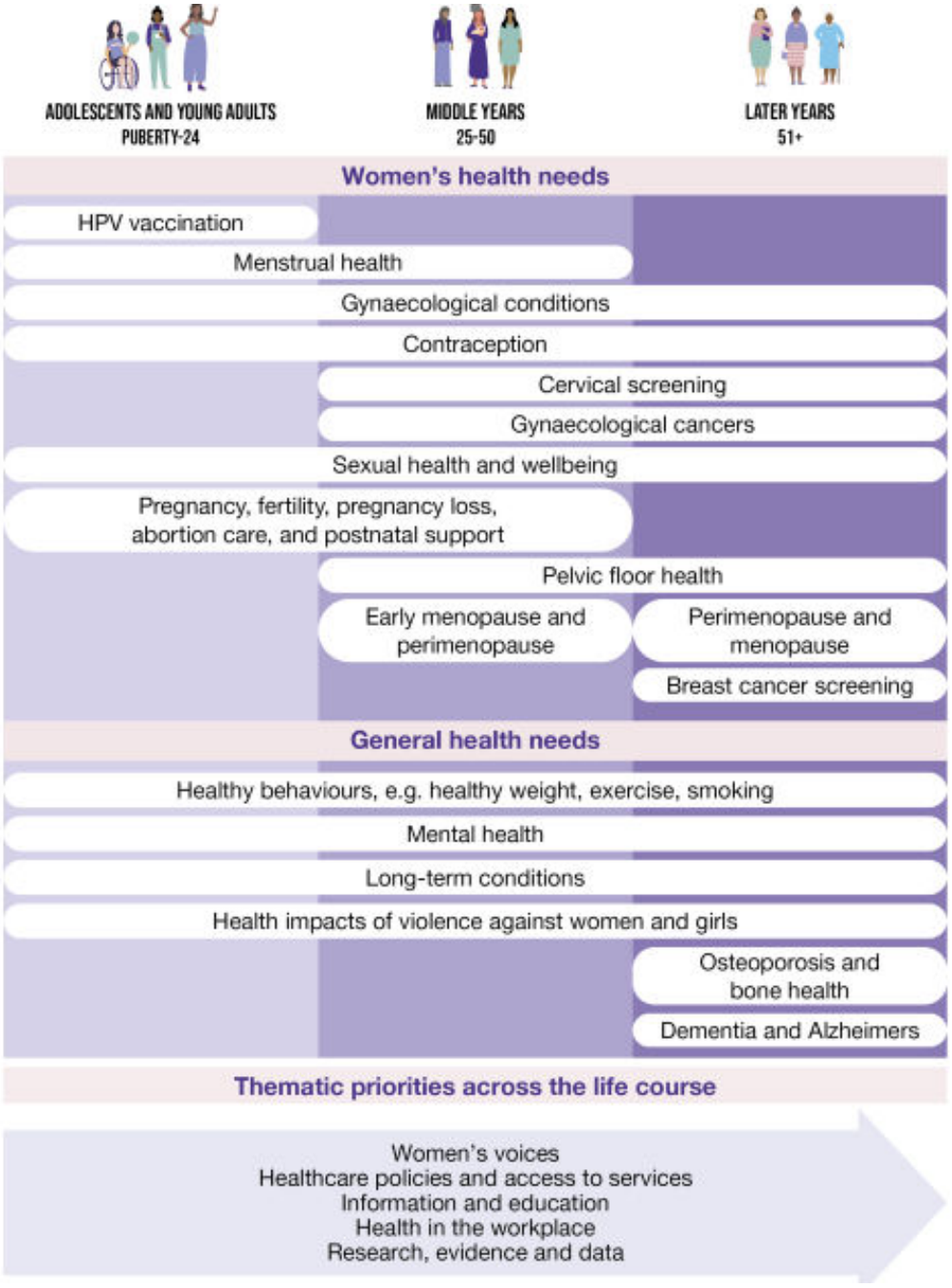


Figure 18: NHS England Women's Strategy

4.9 Integrating NHS Pharmacy and Medicines Optimisation (IPMO) Plan

Medicines are the most common therapeutic intervention and the second highest area of NHS spending. To improve health outcomes and ensure the most efficient use of NHS resources medicines optimisation is vital.

Within Bristol, North Somerset and South Gloucestershire Integrated Care System, the Medicines Optimisation vision is to implement a person-centred, collaborative approach to get the best value from medicines, investing in medicines to improve patient outcomes, reduce avoidable harm and improve medicines safety, align, and simplify processes including the transfer of information, reduce wastage of medicines and avoid patients taking unnecessary medicines. This will be achieved through safe and evidence-based prescribing, increasing patient empowerment through shared decision making whilst ensuring a sustainable pharmacy workforce to support this. Driving value through an evidence informed approach. In addition, medicines feature in the sustainability/ Green Plan for our system in which we are supporting the headline ambition to reduce the impact of medicines and medical devices on the environment.

Our refreshed plan sets out our ambitions to improve patient's outcome, aligning measurement and monitoring of medicines optimisation within health and care services across primary, secondary and community care, working collaboratively. The plan has been reviewed with input from several stakeholders including acute, community, primary care staff and representation from system groups. The success of this plan will be driven by strong clinical leadership, a focus on benefits to patient outcomes underpinned by evidence and data, and recognition of the benefits of working together.

The four main principles to be utilised are represented below:

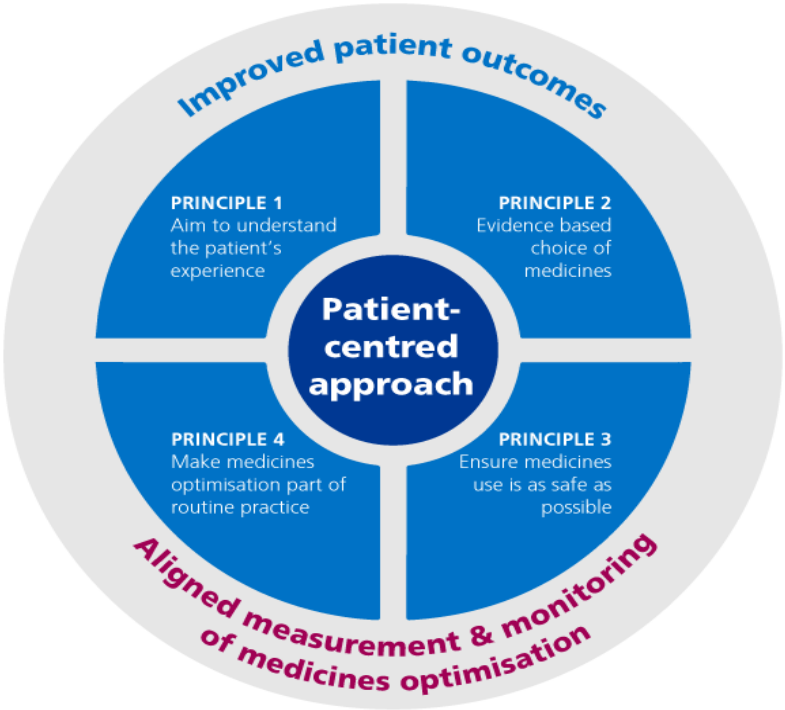


Figure 19: Medicines Optimisation four main principles

It should be noted that entities within our system will determine which areas they will focus on depending on the needs of the local population and that successes will be shared across the Integrated Care System.

The key medicines optimisation plan is focused on the key areas below:

- **Leadership and Governance:** Increasing awareness of the Medicine Optimisation agenda and implementing Medicine Optimisation principles across all sectors of health and care services which are key to achieving our vision and ambitions.

- **Safe Person-Centred Care:** Person centred, shared decision-making being central to all prescribing decisions to increase patient partnership, maximise health outcomes and ensure value.

- **Delivering Best Value including Best Value High-Cost Drugs and Devices:** Achieve financial balance through a value-based approach to medicines and strive to ensure we get the best value for every pound we spend. Develop, maintain, and review system-wide treatment pathways for high-cost drugs to ensure equity of treatment, reduce variation, identify best value interventions, and provide the best outcomes for patients.

- **Medicines Quality and Safety:** Ensure a system wide approach to medicines quality and safety which includes:
    - Delivery of the NHS Medicines Safety Improvement Programme (MedSIP) addressing the most important causes of severe harm associated with medicines.
    - World Health Organisation (WHO) Challenge target to reduce severe avoidable medication-related harm globally by 50% over five years and reduce hospital admissions due to medicines.
    - The WHO three priority areas include polypharmacy, high risk situations and transitions of care all of which link in with the current ICS work.

- **Polypharmacy and Overprescribing:** Assess and implement overprescribing review recommendations from a patient, health professional, environmental and value perspective.

- **Antimicrobial Stewardship:** System-wide approach to promoting and monitoring judicious use of antimicrobial drugs to preserve their future effectiveness.

- **Acute Trust Projects:** Our acute trusts are delivering some specific aims and objectives that only the acute trusts can deliver in terms of system efficacy, safety, and value.

- **Digital/Information Technology:** Our vision is to have an integrated single shared electronic patient medication record across the system so that when a clinician interacts with a patient they have the right access, to the right information, at the right time, as a single consolidated view of the information held for their patient.

- **Pharmacy Workforce:** Our model requires a highly skilled, sustainable, flexible and integrated pharmacy workforce embedded in multidisciplinary teams and enabled to deliver pharmaceutical care in all sectors including primary, community and secondary care.

Below is the detailed implementation plan with key deliverables and milestones for the Medicines Optimisation programme. Progress of the plan will be monitored by the Integrated Care Board Medicines Optimisation Team and fed back to the Medicines Optimisation Programme board. The plan will continue to be reviewed, modified, and updated as we progress year on year.

Governance

The Medicines Optimisation Governance arrangements in place in our integrated care system are reflected below and help to describe the ways in which we aim to work across traditional boundaries and have a collaborative approach to leadership, strategy, and service redesign.

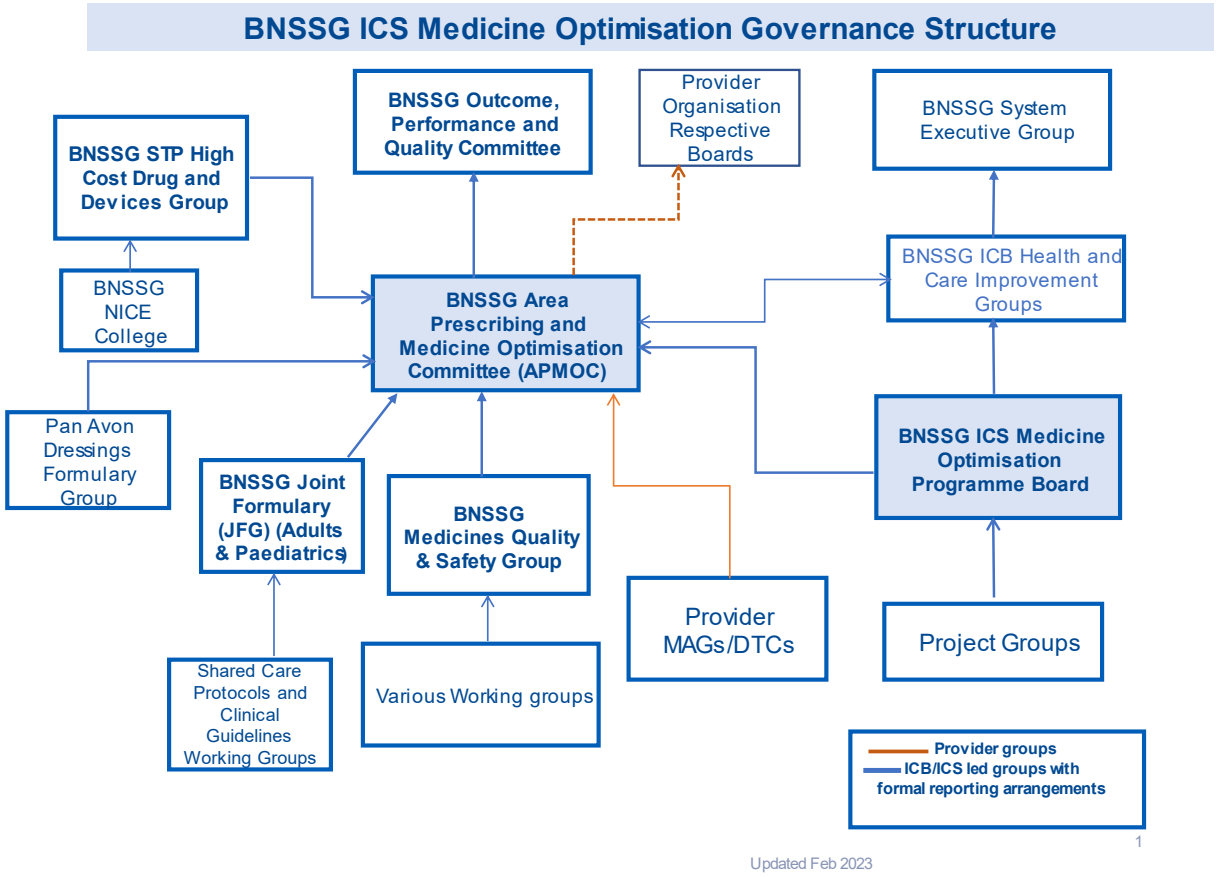


Figure 20: Medicines Optimisation Governance Structure

Within our plan, there are many aspects of routine work that is continued throughout the year to support system priorities. Listed below are key projects to enable improvement in medicines optimisation across the system further detail can be found within our full Integrated NHS Pharmacy and Medicines Optimisation plan. The Medicines Optimisation Strategy (Appendix 6) highlights these key areas.

Metrics and trajectories

Below are the list of metrics and trajectories for Medicines Optimisation and the alignment with the outcomes framework:

Metrics	Link to Outcomes Framework
Reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024.	POP1, POP2
Deliver annual savings plan	POP1
Increase the percentage of patients receiving advice through the GP Community Pharmacist Consultation Service using a Patient Group Directions (PGD) service as part of the consultation where appropriate	POP6, SER7, SER8, SER9, STA10, COM18

Reduce low priority prescribing medicines. Aiming to continuing to be the lowest 5-10% of the country for cost/1000 prescribing of low value meds based on Q4 2021/22.	POP6, STA10
Reduce the increased cost of the current and anticipated continued growth in prescribing in attention deficit hyperactivity disorder (ADHD)	POP6, SER8, SER9, STA10
Reduce the ordering and issuing of unnecessary prescription items reviewing costs and growth.	POP6, SER7, SER8, STA10, ENV19, ENV20, ENV21
Increase the utilisation of the Electronic Prescription Service (EPS) across the system.	POP6, SER7, SER8, SER9, ENV20, ENV21
Increase the utilisation of electronic repeat dispensing (eRD) in all GP practices	POP6, SER7, SER8, SER9, ENV20, ENV21
Reduce overall inappropriate Stoma spending on appliances	POP6, SER7, SER8, SER9, STA10
Increase formulary adherence, aim to achieve target of 90% across the ICS – primary care prescribing adherence is currently around 96%.	POP6, SER9, ENV19, ENV20, ENV21
Increase incident reporting in relation to 'no harm' or 'near miss by intervention' and decrease incidents reported with 'harm' or 'serious harm'	POP2, POP6, COM16
Increase the number of red alert reviews to achieve at least 85% as a minimum using the Eclipse RADAR within GP practices	POP1, POP2, POP6, COM16
Reduce the number of overprescribing to make patient care better and safer. Reduce inappropriate polypharmacy and deprescribing where clinically appropriate through SMR e.g., looking at anticholinergic burden or the number of collective medicines	POP1, POP2, POP6, COM16
Support the NHS, and reduce carbon emissions e.g., aesthetic gases, inhalers	ENV19, ENV20, ENV21
Reduce medication related administration error whilst identifying the type of error potentially avoided; improve in workflows to admission and discharge medicines between settings	POP1, POP2, POP6, COM16
Increase the number of care homes using Proxy Ordering	POP1, POP2, POP6, SER7, SER8, SER9, STA10
Increase the number of training positions for pre-registration pharmacy technicians (PTPTs) particularly in cross sector/integrated training posts; increase the number of trainees.	STA10, STA11, STA12, STA13
Increase the uptake of combined inhalers to ensure appropriate clinical choice for patients, cost savings and sustainability.	POP1, SER7, STA10, ENV19
Increase the uptake of biosimilar insulins across the ICS	POP1, SER7, STA10
Align acute trust (North Bristol Trust and University Hospitals Bristol and Weston Trust) antimicrobial formularies.	POP1, POP3, SER9, STA10
EPMA rolled out UHBW by March 2024 / September 2024	POP1, POP2, SER7
Increase number of Independent Prescribing pharmacists across the system	POP1, SER8, SER9

Key Deliverables and Milestones for Integrating NHS Pharmacy and Medicines Optimisation (IPMO)

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Leadership & Governance																				
Develop pharmacy workforce with the right knowledge and skills to deliver high quality patient care, supporting the ambitions to deliver exceptional patient care every day [4].																				
Change the culture relating to use of medicines, both with clinicians and the public, by increasing the understanding and impact of their use[1,3,4].																				
Undertake further work on health inequalities to improve medicines optimisation, access to services and understand the areas of need in relation to prescribing[2].																				
Review the Medicines Optimisation Strategy in line the system-wide joint forward plan[1,2,3,4].																				
Ensure medicine optimisation drivers and principles are embedded and aligned within the joint forward plan priorities e.g., Stroke, Frailty, Diabetes, Cardiovascular Disease, Urgent care, Mental Health, Respiratory and Prevention[1,3].																				
Right Place																				
Continue to support all GP practices to utilise and maximise benefit of the GP Community Pharmacist Consultation Service[1,2,4].																				
Roll out and maximise benefit of Community Pharmacy Consultation Service (CPCS) to other parts of the system e.g., Urgent Treatment Centre (UTC) and Medical Assessment Unit (MAU)[1,2,4].																				
Agree to extend the range of conditions that can be treated under the Patient Group Directions services in community pharmacy. Adhering to National roll out as part of Pharmacy First priority[1].																				
Explore the possibility to pilot and extend the provision of a Community Pharmacy Consultation Service from the Childrens Hospital[1,2,4].																				
Evaluate the Patient Group Directions (PGD) service[1].																				
Develop proposals and delivery of additional services for community pharmacy to support the system during periods of high demand[1,4].																				
Increase independent prescribers within community pharmacy[1,4].																				
Maximising Benefits to the Patient and the Health Economy																				
Identify and implement cost savings work year on year in GP practices by the Medicines Optimisation Team and Pharmacists. Practices will be allocated and supported to achieve financial balance of their indicative prescribing budget [4].																				
Identify medicines and pathways used across the system that have the greatest potential for efficiency savings and improved safety, aiming for consistent clinical pathways across acute trusts and other providers[4].																				
Empower people to self-care. The Medicines Optimisation Pharmacists work with practices to reduce low priority prescribing medicines[4].																				
Deliver person-centred care and improved processes in GP practices, using repeat prescription hubs and a focus on care homes including continuation of proxy ordering[4].																				

Identify pipeline of future opportunities for greener alternatives and reviewing highest carbon impact medicines e.g., anaesthetic gases and inhalers to low carbon alternatives where possible[4].																				
Strengthen networks with colleagues and Universities driving research into medicines optimisation [3,4].																				
Savings and Value																				
Continue to develop and update the cost saving dashboard to focus on simple switches ensuring the most cost-effective choice is being used [3].																				
Continual annual savings plan to be developed and delivered [3]. Exploring potential savings such as biosimilar insulins and lower cost branded generics[3].																				
Continue to review 'items which should not routinely be prescribed in primary care' in line with the NHS England and Improvement guidance[3].																				
Continue ongoing work with secondary care specialists to agree system wide appropriate choice of medicines and where appropriate lower cost items e.g. inhalers, diabetes medicines[1,3].																				
Continue to move patients over to lower cost choices of blood glucose testing strips[3].																				
Continue to implement and evaluate the benefits of Repeat Prescription Hubs[3].																				
Expand the specialist nurse led stoma service across the system [1,3].																				
Continue to update business intelligence reports regularly to keep in line with formulary updates and continue to monitor adherence monthly[3].																				
Enable formulary adherence to be monitored within secondary care. Post Electronic prescribing and medicines administration (EPMA) [3].																				
Review nationally published Shared Care Protocols and consider adopting them [1,3].																				
Conduct multiple prescribing quality scheme projects annually across all GP practices to promote cost savings and quality [1,3].																				
Reduce medicines waste, unnecessary prescribing and support the medicines optimisation elements of the Green Plan[1,3,4].																				
Continue to develop medicines pathways with system colleagues and relevant specialties [1,2,3,4].																				
Best Value High-Cost Drugs and Devices																				
Plan and co-ordinate the rapid adoption of biosimilars as they come to market [3].																				
Support prescribers to prescribe the most cost-effective Direct Oral Anticoagulant (DOAC)[1,2,3].																				
Ensure biologic pathways within the therapeutic area are reviewed in line with the best value biologic therapy and ensure best value prescribing of biologic therapy [3].																				
Engage with local, regional, and national procurement initiatives at a system level and develop local system procurement systems where appropriate, review devices to ensure a consistent approach, equitable prices, and best value [1, 3].																				
Establish a single procurement process for the system and undertake diabetes technology review; insulin pumps, continuous glucose monitoring and consumables [1.3].																				
Continue to implement and assess clinical and financial impact of NICE technology appraisals [1, 3].																				
Key Therapeutic Areas of Focus includes prevention, inequalities and population health management																				

Review outcome data of diabetes medications and technology and suggest priorities [1, 2,3].																					
Continue to link and lead on medicines optimisation for diabetes, respiratory, heart failure, atrial fibrillation, anticoagulation, ageing well to improve patient outcomes and ensure appropriate workforce and access to medicines including hospital at home [1, 2,3,4].																					
Clinical update on guidelines and pathways[1,4].																					
Identify new cases of hypertension using core20Plus5 approach as part of the core20plus 5 and community pharmacist project focusing on prevention and reducing health inequalities[2].																					
Increase pharmacists specialising in mental health to meet the requirements of the community-based offer to meet with locality priorities[1].																					
Link in with localities to ensure priorities align when considering medicines optimisation [1,2,3,4].																					
Scope the role/s of specialist learning disability prescriber pharmacists working across the system to implement the national projects: stopping over medication of people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in. Paediatrics (STAMP) [1].																					
Work with Genomics leads to ensure any advancements are mainstreamed into practice to ensure patients are on appropriate medicines[3].																					
Medicine Quality and Safety																					
Agree a system benchmarking tool to highlight where we are with regards to Medicines safety Improvement programme targets, polypharmacy and overprescribing for example linking in other areas such as anticholinergic burden, antimicrobial resistance (AMR)[1].																					
Align incident reporting systems across all providers including GP practices to improve reporting and surveillance of adverse events across the interfaces and identify high-risk areas[1].																					
Undertake shared learning to reduce patient harm and unnecessary admissions[1].																					
Roll out the Medicines Safety Dashboard to support Primary Care practices to identify areas of potential medication risk to link with the Eclipse RADAR system. Increase the red and amber alert review rates to improve patient safety, using the Eclipse RADAR tool within GP practices. (Regular annual review) [1].																					
Polypharmacy and Overprescribing																					
Consider more alternatives to medicines, such as physical, social activities and talking therapies[1].																					
Continue risk stratification/targeting to identify patients who would benefit most from structured medication review. Priority areas include care homes, hospital at home, mental health, frailty, long-term conditions and compliance aids[1,3,4].																					
Support the medication review directed enhanced service (DES) in Primary Care Networks and show where there is greatest value whilst working with clinicians[1].																					
Continue to upskill all health care professionals involved with polypharmacy [3].																					
Antimicrobial Stewardship (Infection management and prevention)																					
Continue to monitor antimicrobial prescribing including the impact of the covid-19 pandemic and other infection outbreaks and to act on changes identified[1].																					
Support the review of Clostridioides difficile infections acting on any identified interventions[1].																					

Produce an Antimicrobial stewardship (AMS) education strategy for the different sectors of the system[1,2,3,4].																					
Ensure appropriate recording and delabelling of penicillin allergy occurs across the system[1].																					
Align acute trust (North Bristol Trust and University Hospitals Bristol and Weston Trust) antimicrobial formularies[1,2,3,4].																					
Evaluate antimicrobial prescribing in the NHS@Home programme[1].																					
Continue to support the vaccination programme with specialist pharmaceutical advice and guidance, assurance processes and governance, safe systems, mutual aid processes and pharmacy workforce[1,4].																					
Continue to lead and deliver Covid-19 Medicines in the community ensuring it aligns with NICE and National policy.[1,2,3,4].																					
Ensure consistent approach to intravenous (IV) to oral antibiotic switches across the system[1].																					
Work towards national targets on antimicrobial prescribing[1].																					
Acute Trust Projects																					
Align secondary care approach to technical service delivery to guidance and outputs from the Infusions and Special Medicines board [1].																					
Implement the recommended approach to deliver technical services (hub and spoke model) (Dependent on National funding) [1].																					
Assess the homecare and outsourced pharmacy models to ensure value and business continuity (New contract with single provider across Weston and Bristol sites due to commence October 2023) [1].																					
Review and determine best approach for procurement and supply of fluids and explore system-wide procurement with potential for central storage facility[1].																					
Relocate and change the pharmacy department at University Hospitals Bristol and Weston Foundation Trust to support the redesign of part of the hospital[1].																					
Digital / Information Technology																					
Deliver an integrated single shared electronic patient medication record so that when a clinician interacts with a patient they have the right access, to the right information, at the right time, as a single consolidated view of the information held for their patient[1].																					
Adopt and roll out a dictionary of medicines and devices compliant Electronic Prescribing and Medicines Administration (EPMA) solutions to acute and mental health sectors, then interface and consolidate systems and processes across all areas including intensive care units, renal centres, chemotherapy centres, specialist operating areas (Bristol Eye Hospital) and Maternity services[1].																					
Complete interoperability of primary, secondary community health care services and mental health sector ePrescribing with our Local Health and Care Records system (Connecting Care) [1].																					
Review and improve digital platforms to support referrals to the Community Pharmacy Consultation Service and the new Discharge Medicines Service[1].																					
Improve secondary and primary care communication within the pharmacy profession surrounding patient discharges using CareFlow Connect[1].																					
Embed clinical decision support tools via electronic prescribing solutions and help to harmonise configuration to improve medicines safety as a deliverable for safe, person-centred care[1].																					

Activate Eclipse VISTA pathways utility with data protection leads, Eclipse and NHS Digital[1]. This will provide the organisation with a highly effective population segmentation, planning and validation solution.																				
Rollout the interoperability of drug allergy alerts in line with NICE quality Standard 97[1].																				
Implement Electronic Prescribing System compatible outpatient prescribing system at University Hospitals Bristol and Weston Trust, North Bristol Trust and Sirona[1].																				
Establish a project with appropriate pharmacy professional leadership to ensure that all practices are using electronic repeat dispensing and meeting the minimum target (next 12 months) [1,4].																				
Implement Proxy Ordering across all care homes[1,4].																				
Pharmacy Workforce																				
Agree short- and long-term pharmacy workforce plans to meet the needs of the local healthcare system [4].																				
Ensure we have sufficient pharmacy resource to enable priorities such as hospital at home model [4].																				
Attract and retain pharmacy workforce through innovative roles and maximise opportunities for funding that supports training [4].																				
Consider a central commissioning model which bases the numbers of trainee pharmacists by system based on a population commissioning approach [4].																				
Continue to develop portfolio working joint posts [4].																				
Ensure access to clinical placements for undergraduate pharmacy students [4].																				
Increase the number of independent prescriber pharmacists [4].																				
Develop further highly specialist posts/consultant pharmacist posts in other key clinical areas including primary care [4].																				

Key for 4 ICS aims: Improving outcomes[1] Reducing health inequalities[2] Enhancing productivity and value[3] Contributing to social and economic development [4].

5 Appendices

1 Strategic Framework and the Locality Partnership Plans

2 Health and Wellbeing Board Strategies
Bristol
South Gloucestershire
North Somerset

3 Green Strategy

4 Integrated Care Board open meeting papers

5 Primary Care Strategy

6 System Quality Group Terms of Reference

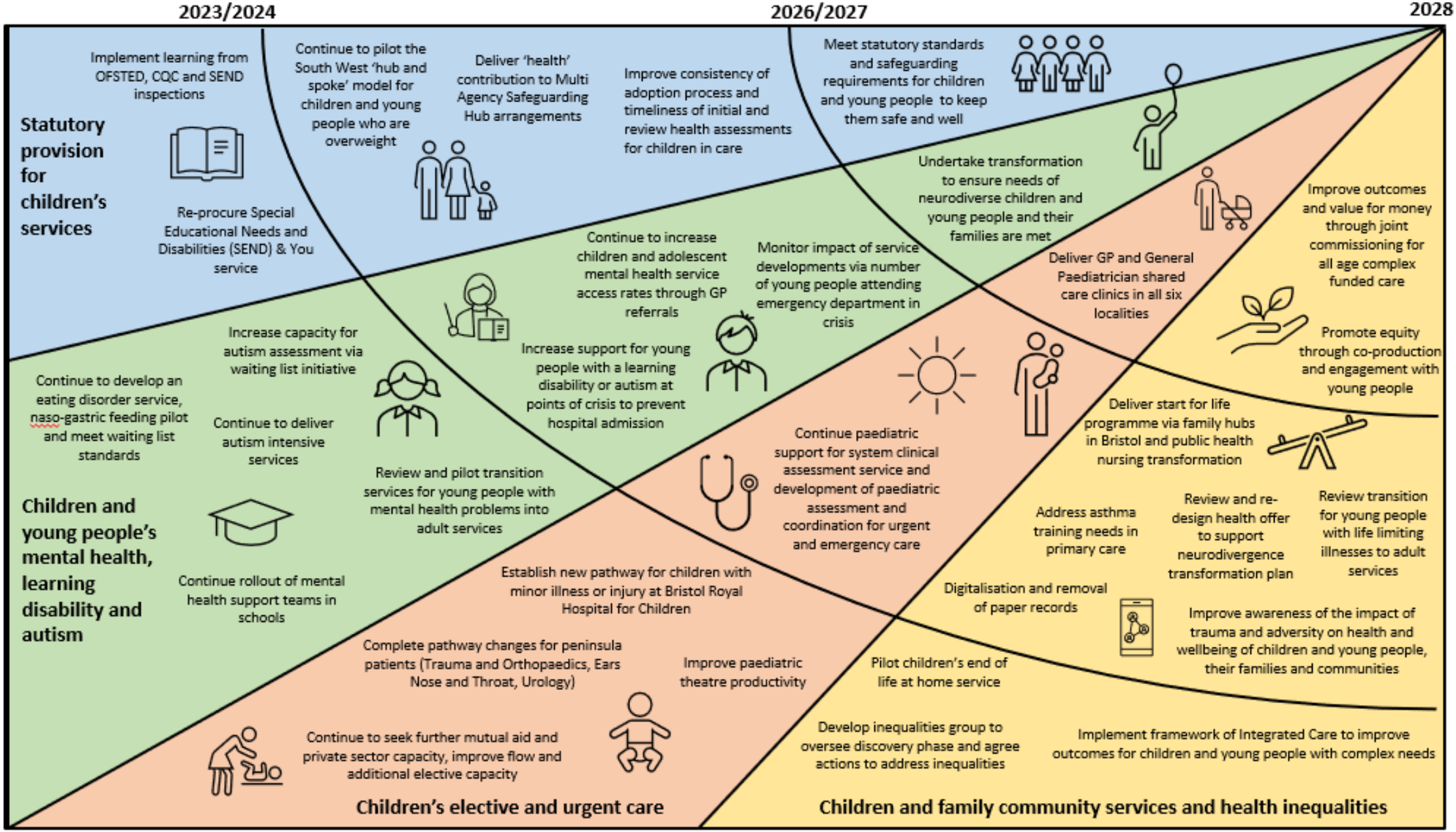
7 Workforce People Plan and deliverables

8 Digital Strategy and Digital Inclusion Strategy

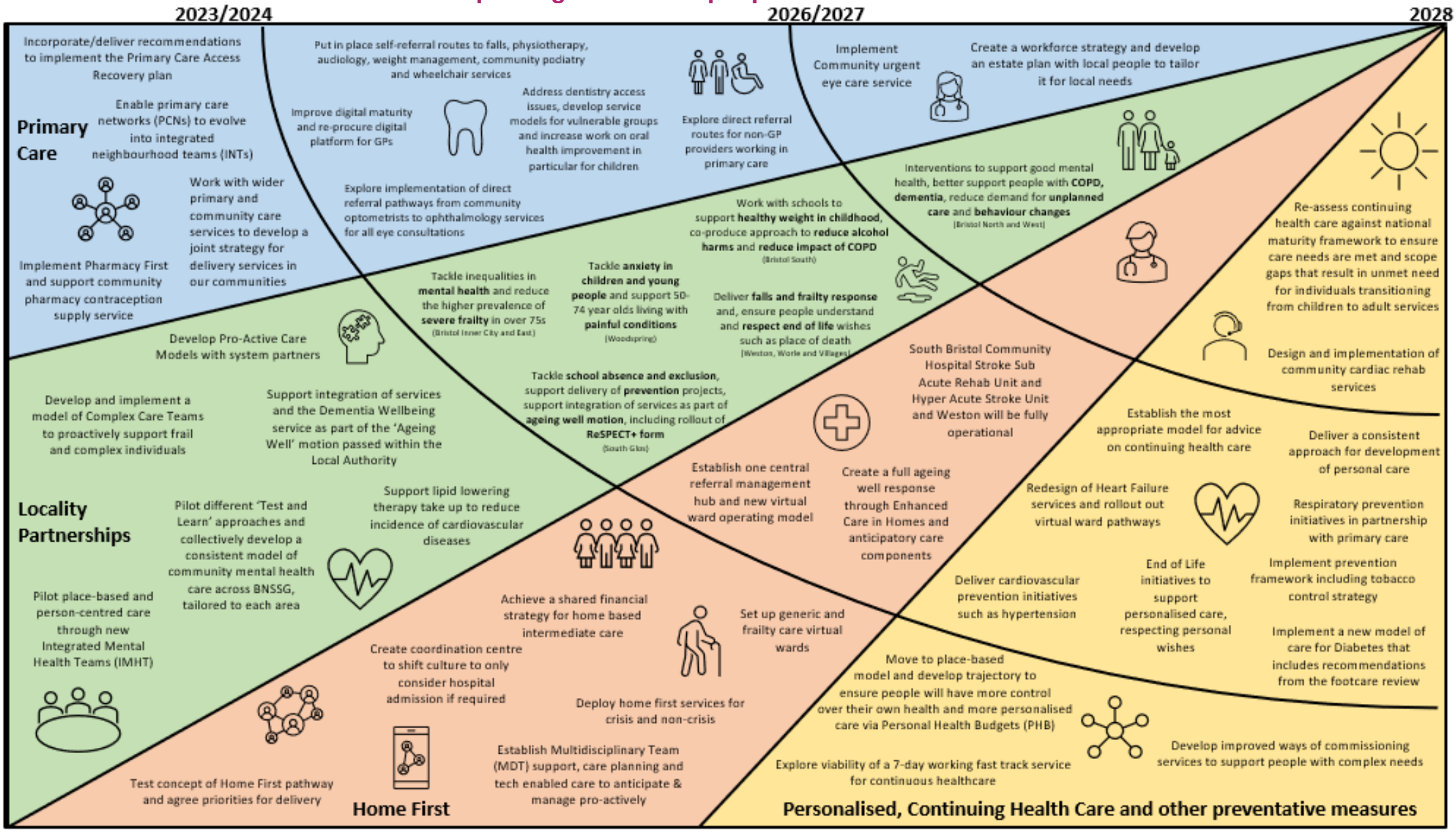
9 Medicines Optimisation Strategy

10 Joint Forward Plan on a page – see below

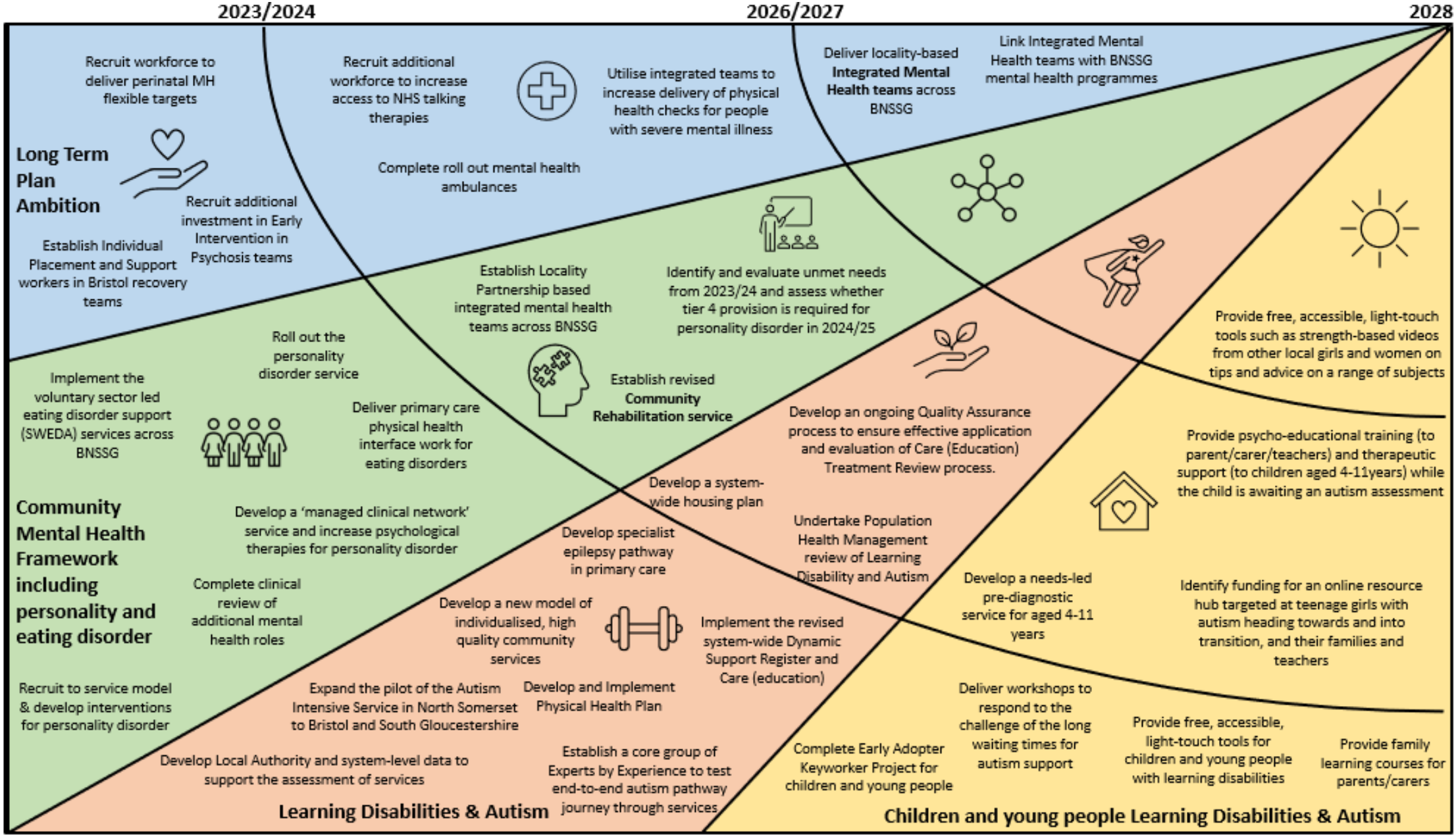
Improving the lives of our children and young people



Improving the lives of people in our communities



Improving the lives of people living with mental health issues, learning disability and autism



Improving our acute healthcare services