Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy

Contents

Our vision: '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.

This Strategy has been sponsored by the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Partnership (ICP) Board, which is made up of representatives from the voluntary community and lived experience sectors, our three local authorities, our six locality partnerships, Healthwatch, the social care sector and our NHS organisations including service providers. You can find out more about our Partnership on the Healthier Together website.

Foreword

Our work has the power to change lives and the opportunities for improving health, wellbeing and care are even greater when our organisations and communities work as one.

We have a lot to be proud of in Bristol, North Somerset and South Gloucestershire (BNSSG). In recent years we have seen great improvements, such as recognising the benefits of social prescribing and stronger collaboration across services. We are also doing more to value the voice of communities, seeing them as equal partners in realising health and care improvements.

But there is more for us to do. Like other areas of the country, lives in BNSSG are being cut short and too many people are spending long periods of their lives in ill health. Local analysis shows concerning trends around declining life expectancy for some people, and an increase in people being diagnosed with dementia and liver disease.

The burden of poor health is felt more by some communities. People in poorer areas are unfairly impacted, and we know that the combination of living in a poorer area for people from some ethnicities, genders, and impairments, for example, can make the impact even worse.

Good health and wellbeing requires us to work together to seek every opportunity to help people to build this into their lives. ‘Working together’ is about our relationships – whether that be between the staff that represent our organisations or with the communities and people that we serve.

More can and should be done to also identify people that need our support earlier on to help them keep as well as possible. We want to build a sustainable high-quality health and social care system founded on the strengths and assets of our local communities.

This is at a time when pressure on health and social care services has never been greater. We have urgent challenges with access and capacity within key services like general practice, social care, dentistry, planned treatment and emergency care.

We believe there are five opportunities for us to focus on over the coming years to help everyone to start well, live well, age well and die well. This will help us to realise the better health and wellbeing and improved services our local population deserve.

They are:

- Tackling inequalities
- Strengthening building blocks
- Prevention and early intervention
- Healthy behaviours
- Strategic prioritisation of key conditions.

Further details on each of these areas are provided in the corresponding chapters.

This document has been developed with input from many people and grown from analysis of local needs, public and staff views and evidence about how best to secure better outcomes. We'd like to thank everyone who has helped to shape and develop this work. We are committed to regularly reviewing the impact of this Strategy together and the Integrated Care Partnership Board will have an annual refresh of the Strategy which will seek a wide range of views across our communities.

We are committed to delivering on our vision and look forward to working with everyone to make our communities even happier and healthier places to live and thrive in.

June 2023

Introduction

The foreword of this document sets out the key challenges and opportunities we will embrace as a health and social care system. The rest of the document describes what has helped to inform the development of this Strategy, the five key opportunities that can support system change and improvement and how we will go about implementing those changes. There is recognition that there is more work to follow in making our broad commitments turn into detailed plans and measurements of success.

This 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 this publication, each individual Integrated Care Partnership (ICP) partner organisation will need to approve through their own internal governance processes any specific commitments and actions that result from this document.

In this document we have used the term ‘we’ in a very inclusive way as we want to build an approach where our communities, our staff and volunteers, as well as the people who plan and deliver services, can all understand and influence the part they play in securing better outcomes. We have used the term health and wellbeing in the document as it is recognised in many national strategies and guidance. However, in our Integrated Care System we recognise that health is about much more than experiencing physical and/or mental ill health. Strong ambitions around improving wellbeing through building on assets and strengths in people and communities are all part of the term health and wellbeing.

The Strategy is overseen by the ICP Board for Bristol, North Somerset and South Gloucestershire (BNSSG) and is delivered by a partnership of the voluntary and community and social enterprise (VCSE) sector, people with lived experience, our three local authorities, our six locality partnerships and our Integrated Care Board (ICB) which includes representation from the providers of social care services in our area.

Our Strategic Framework[1] was published in December 2022, which set out ambitions for what we want to achieve as a health and social care system. This Strategy builds on the challenges set out in that document. It describes our critical opportunities for improvement that we can deliver together for the population of BNSSG when we work together effectively. It is essential to be aware that improvements happen in our system constantly. We have many important strategies and plans to address key issues, such as how we support the needs of people

coming in and out of hospital and those plans remain essential. This Strategy is setting out what we can do better together.

This document reflects our current thinking at this point in time as we have learnt over the last year of the ICS. We will constantly review and adapt what we do using the latest evaluation and intelligence about what we must prioritise and how best to implement change for better outcomes. We want this Strategy to improve both what we do and how we do it across all ages and help us further build the right culture and approach for securing sustainable positive change.

How we will make these improvements and make the improvement set out in the NHS mandate will be set out in our Joint Forward Plan[2] and delivered through various partnership structures. More detailed planning documents will flow from this vision for change and the key opportunities we must embrace together. We will look to build on key strategies and plans for change that have already been developed. For example, the draft Acute Provider Collaborative Joint Clinical Strategy[3] and Primary Care Strategy[4]. We will also meet the challenge of new national guidance for improving poor health outcomes in our local population, for example, through the Women's Health Strategy[5].

We will track our impact on people's lives through our System Outcomes Framework[6], which describes what matters in keeping us healthy and happy in our everyday lives. This will help to guide our annual update and regular review processes considering updates from our Joint Strategic Needs Assessments (see references section for all document links)[7,8,9].

This Strategy will be available on the Healthier Together website and shared across the Partnership. A summary version and an easy read version will be published later this year. If anyone requires this document in an alternative format, for example, braille, audio or large print they can request this by contacting bnssg.communications@nhs.net.

What is driving our Strategy?

Our new Strategy describes how we will meet the specific challenges for our population while meeting the four national aims of an Integrated Care System (ICS). To do this, we need to know our population and understand what the aims mean for us.

Our area is home to a diverse population of around 1.1 million people. Roughly half live in Bristol; while the remaining half is split relatively evenly between North Somerset and South Gloucestershire. Bristol and its fringes have an urban character, and large rural areas are also punctuated by big towns such as Weston-super-Mare and Thornbury.

A report into health and social care needs of our population, called Our Future Health[10] and an extensive survey of people living, volunteering and working in BNSSG, Have Your Say[11], have highlighted the key issues summarised below.

ICS Aim 1: improving outcomes in population health and healthcare

We need to improve health and wellbeing for everyone in Bristol, North Somerset and South Gloucestershire (BNSSG). We also need to keep improving services and access to them, so that everyone can access the care they need.

Much of the ill health in BNSSG is preventable, and we can improve population health. We can support people to start, live and age well. A new approach to preventing harm from challenges like smoking and obesity should be a focus. We can improve people's outcomes and reduce impacts elsewhere in our health and social care system.

Unfortunately, people are still waiting too long for health and social care. As demonstrated in national data[12], and through feedback from Have Your Say. For example, respondents indicated how much of a concern primary care access is for our residents. We need to understand how we can do better and how we can support people waiting.

As a result of the Covid-19 pandemic, more people have experienced mental ill health, some existing health issues have worsened, and some families and communities have been put under significant strain. For health and social care services, this has meant longer waiting lists, considerably more being spent on adult and children's social care and considerable pressure on voluntary and service workers. For VCSE organisations it has meant increasing demand and complexity amongst people using their services.

ICS Aim 2: tackling inequalities in outcomes, experience and access

Some groups of people in BNSSG have worse health and wellbeing than others. This is unacceptable, and we need to pay special attention to improving this.

The pandemic brought into sharper focus the inequalities that must be addressed.

In BNSSG, certain groups have worse outcomes than others, for example Bangladeshi, Caribbean and Pakistani people (Our Future Health, p16-17). People with learning difficulties also die an average of 21 years earlier than people without learning difficulties, and we need to understand how we can provide better support and access to services. We need to address the structural inequalities that drive these differences.

Deprivation also impacts health and wellbeing. For example, in the most deprived areas, people live 15 years less in good health than in the least deprived areas (Our Future Health, p14).

ICS Aim 3: enhancing productivity and value for money

Value for money means we are supporting people in the best way to achieve what matters to them for their health and wellbeing.

We want to ensure that we can invest public money in a way that supports people to stay healthy in their own homes and communities, whilst also ensuring that sustainable services are available when they need them.

By working together as organisations in the Integrated Care Partnership we can find opportunities to do things more efficiently and effectively.

ICS Aim 4: supporting broader social and economic development

Our partnership can use our collective economic and social power better to help build stronger communities and to support sustainable local economies.

Everything we do in delivering this Strategy depends on our volunteer and paid workforce in our communities, health, and social care organisations.

In Have Your Say, people said family, relationships and community was the number one thing that keeps them happy, healthy, and well. By investing more in our local communities, we can

create better opportunities to build and maintain good health and wellbeing. The voluntary and community sector organisations are well placed to reach into communities of place and interest as well as providing community support before people's health deteriorates.

All organisations in our partnership can play a role in supporting local economic development through how they buy and run services. Our actions can also address wider social challenges like tackling our climate emergency and creating safe and accessible environments that support good health and wellbeing.

Key Opportunity 1: Tackling systemic inequalities

Why is this important?

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

Over time, our organisations have made decisions about important services like health, education, opportunities for employment and housing. They have also made value decisions (worthy or unworthy, full of potential or not) which have led to bias-based decisions on factors like; ethnicity; gender; disability; sexual orientation; age; where people live; people's income; immigration status; language; housing status; criminal justice history and other aspects of life. This has unfortunately had unintended consequences, which means that our organisations have:

- Unfairly disadvantaged some individuals and communities;
- Unfairly advantaged other individuals and communities; and,
- 'Sapped the strength of the whole society through the waste of human resources' (Professor Camara Phyllis Jones, 2022)[13] – i.e., if people aren't supported to know and develop their full potential and talents, our society won't thrive.

It can be seen as inaction by us in the face of need. This contributes to health inequalities. We are committed to correcting this.

Who is impacted and why does that matter to them, their communities, and our system?

In Bristol, North Somerset and South Gloucestershire (BNSSG), some children, young people, adults, families and communities do not get to, or find it much harder to get to, the support they need. For example, good education, health and housing. If they get to the support, their experiences of using it, and sometimes the quality of that support are poorer than others.

This poorer access, experience and outcomes often means that people don't have the opportunity to lead their lives in a way that matters to them.

What needs to change?

1. The way that the unfair disadvantaging and unfair advantaging happens in BNSSG is through our:
    - Structures – the who, what, when and where of design, decision-making and review
    - Policies – the written how of design, decision-making and review
    - Practices – unwritten how of design, decision-making and review
    - Norms – what we expect of each other
    - Values – the why and things that matter to us.

These are all elements of how we make decisions, and we need to change how these are currently made 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 and systemic inequalities. Our system will learn from those lessons.

2. Equity means that 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" (Koenecke, 2019)[14]. We need to use the following three principles to achieve health equity:
    a) Valuing all individuals and populations equally
    b) Recognising and rectifying historical injustices
    c) Providing resources according to need.

Achieving health equity will reduce or even eliminate health inequality ensuring that all services are accessible to everyone who needs to use them. Using processes of co-production and co-design will help to drive improvements to our policies and services. We will also use impactful learning from key sources, for example, publications from the Institute of Health Equity (led by Professor Sir Michael Marmot).

What are our commitments?

1. **Decision-making as a way of valuing all individuals and populations equally.** Working with communities to continuously review and improve decision-making processes and groups to ensure that people who experience health inequalities influence the decision.
2. **Valuing all individuals and populations equally.** Our system will routinely review quantitative and qualitative data that shows what patterns of fairness and unfairness exist and actively plan to close the gap for those experiencing poorer outcomes. We will consistently challenge ourselves to correct our course when patterns of injustice are clear.
3. **Recognising and rectifying historical injustices.** We need health equity in all (not just health) policies. As we review and develop new approaches, we will check how they can improve health equity and that they won't make things worse. There will be many ways of doing this. For example, using our staff networks, supporting our staff to be 'ambassadors' within their teams and departments, and improved ways of working with our communities to do this across all aspects of civic, service and community impacts.

   We will also look at the themes of what people and communities experiencing health inequalities have been telling us for many years, for example, giving people information in a way they can understand. Finally, we will invest time in fixing the problems.
4. **Providing resources according to need.** We will change how we spend money to provide funding in a way that supports people who experience health inequalities to get what they need so that they can achieve what matters to them. We will target resources to those most in need and who will benefit the most.

Key Opportunity 2: strengthening building blocks

Why is this important?

The foundations of good health and wellbeing are built upon a range of factors including: 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. Unfortunately, for too many people in Bristol, North Somerset and South Gloucestershire (BNSSG), these fundamental 'building blocks' of good health and wellbeing are not meeting people's needs effectively.

We want to see change where everyone in BNSSG will live in homes and communities where they feel connected with others, safe from harm, free from discrimination, and able to access nutritious food, physical activity, green space and clean air. As a partnership we have significant power to influence these issues for the better. As major local employers and purchasers with a large estate, and in our relationships with people through the voluntary and community sector, health and social care providers, and civic, community and professional leaders.

Who is impacted and why does that matter to them, their communities and our system?

Our residents have told us through Have Your Say that positive social connections are the most significant contributors to health and wellbeing. A Citizens' Panel survey[15] (a representative sample of BNSSG residents) reported 29% of people in that sample, felt lonely in March 2023. Financial hardship and social exclusion are causing more people in BNSSG to die younger and to spend more years in poor health. For example:

- Early deaths from all causes occur most often in the most deprived areas of Bristol and Weston-super-Mare.
- Local analysis has shown cold homes are linked to increased hospital admissions for chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD). These homes are also in some of the most deprived areas of BNSSG. Safe, accessible and healthy homes can deliver significant benefits for people's health and wellbeing.
- People who experience trauma are more likely to experience poor physical and mental health in their lives.

Where the building blocks for good health are weak or missing, this also has a detrimental impact on children and young people:

- About 25,000 children in BNSSG growing up in poverty are more likely to experience health problems from birth and throughout life.
- 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.

What needs to change?

We can strengthen the building blocks for good health by helping build a fairer, more inclusive, prosperous, socially cohesive, and greener society in BNSSG. Over and above our roles in providing health and social care services, we can make a difference:

- Across our partnership we have large local employers and by recruiting a diverse workforce including volunteers, treating them well and supporting their roles as parents, carers, volunteers and as members of their local communities.
- As large purchasers of goods and services, we can buy from local suppliers and organisations with a social purpose and/or that can demonstrate ethical practices.
- By lowering our carbon footprint and reducing air pollution.
- By working together to identify people whose health is most at risk, for example, due to financial hardship or unsuitable housing, and helping people to access the support that is available in the local community and through the benefits system.
- By providing early help to support families to give their children the best possible start in life.
- Our strong voluntary, community and social enterprise organisations can offer support to people whose health is at risk due to their social and economic situation or the impact of trauma and adversity.

What are our commitments?

1. **We will support the significant workforce and volunteers across our partnership and help them to achieve good health and wellbeing.**

- This means we will work in partnership with staff to identify opportunities to support them in strengthening the building blocks for good health and wellbeing for themselves, the people that they care for, and the communities in which they live.
- We will engage staff and volunteers to find out whether they feel we are listening and taking effective action.

2. **We will contribute to inclusive growth in our local economy** by:
    - Increasing recruitment from disadvantaged communities and amongst under-represented groups to levels that reflect the rich diversity of our local population.
    - Increasing the proportion of spend on goods and services that are sourced locally and increasing the social value of system funds.
3. **We will embed trauma-informed practice** in our approach to improvement, including training and development to strengthen a compassionate approach to how we understand what matters to people and how they can be supported to make changes they value most and building on the VCSE expertise.
4. **The Voluntary, Community and Social Enterprise organisations will guide the partnership in identifying and offering support to people most at risk** because of their life circumstances, for example, financial or housing situation, social isolation, or caring responsibilities, by:
    - Proactively identifying people whose health and wellbeing is at risk due to cold or poor-quality homes and helping them to access support.
    - Increasing support for carers to enable more people in BNSSG to provide or continue providing informal care.
    - Providing befriending support for vulnerable people that are living alone.
    - We will support volunteering across BNSSG led by the VCSE alliance to build on their track record and reach into their communities that experience inequalities.
5. **We will work together to provide support for families with children during the first 1001 days of life.** We will work together to provide support for families with children during the first 1001 days of life. We will prioritise support for households who are unfairly at risk of the poorest outcomes, working in partnership with families and communities to co-design this support so that it meets people's needs and is accessible and culturally appropriate.

Key Opportunity 3: prevention and early intervention

Why is this important?

Even before the pandemic, life expectancy was decreasing in parts of the UK, and in Bristol, North Somerset and South Gloucestershire, we know that some people are dying earlier than they should be. One of the reasons for this is the constant worry about unstable income, jobs, or housing that puts strain on a person's body, translating into higher blood pressure and an impaired immune system. In addition, chronic stressors, like those described above, lead to an increased risk of illness and contributes to the fact that heart disease is the top cause of lost years in BNSSG.

Who is impacted and why does that matter to them, their communities, and our system?

We all know that prevention is better than cure. This section pulls out where we believe, as partners, we can work together to improve the factors described earlier. This focus 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 we need to give children the best start in life; we will focus on the first 1001 days and work together seamlessly to help parents and children (as set out in commitment five, chapter two).

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 (CVD) is around 2.6 times higher among people living in the city's most deprived areas, compared to the most affluent areas.

"Cardiovascular health is impacted by modifiable factors, including access to health and care services and the social and economic conditions in which people live. Gender, age, ethnicity, and social deprivation all impact our chance of developing risk factors for heart disease, such as diabetes and high blood pressure". (Women & Heart Disease - BHF, paragraph 2)[16]

Prevention opportunities exist across all ages and communities in BNSSG, but we need to consider the challenge already identified around tackling inequalities. Our attention should be focused on those furthest from the better outcomes we would want for our family, ourselves and our community. This should include the following:

- **Focus on the person.** We need to invest in a network of prevention champions across health and social care, and the VCSE sector, to work with colleagues to understand the impact of chronic stress on people, carers and families and its links with ill health. This will help drive investment in interventions that address the factors that cause stress and blood pressure risk that people experience. These champions will be part of a social movement with a reach into the teams that work in health and social care and the VCSE sector and are a resource for communities.

- **Focus on the care.** We need to relentlessly focus on doing the basics well for adults and children. This will include improvement in core 20plus5 outcomes and a commitment to adopt and implement across the system published high-impact approaches on modifiable risk factors, respiratory disease, diabetes and cardiovascular health.

  We will set targets higher than national expectations whilst, in parallel, using our research capability to investigate variation in uptake for interventions – starting with our most at-risk groups, for example, people with learning disabilities or poor mental health. In BNSSG, we know that we can further prevent heart attacks and strokes at scale in a short time frame – three years – by optimising the management of high blood pressure. This represents a significant opportunity to reduce acute care, discharge, and social care pressures through a reduction in strokes. To reach the target of 80% of people with high blood pressure diagnosed, we need to find/record an estimated 37,000 people with high blood pressure across BNSSG. For treatment, around 15,000 additional patients in BNSSG need to be managed to target levels to meet the national ambition of 80% treated to target.

- **Focus on the workforce.** Our Partnership will support the health and wellbeing of our volunteers and workforce, including stress and blood pressure, as a means to improve their outcomes, create better workforce sustainability and impact on families and communities in our area.

What are our commitments?

We want a system where everyone involved in health and social care understands their role within the complex interactions of factors that worsen health and can effectively support the population to live well.

We will form a system-wide prevention and reducing inequalities assurance group to understand and track the changes for person, care and workforce outlined above. It will focus on these four core principles:

1. **Health is everyone's business, and we will aim to develop a social movement led by a partnership wide network of prevention champions**, understanding and addressing what causes the chronic stressors initially described in this chapter. When these improvements are within the gift of the partnership, they are rapidly adopted using an agreed improvement approach.
2. **Doing the basics well means a relentless focus on improvement in Core20Plus5 outcomes for children and adults** and a commitment to adopt and implement across the system published high impact approaches that impact on modifiable risk factors for respiratory disease, type 2 diabetes and cardiovascular disease, (as per the NHS England Prevention Programme[17]) and continued focus on infection prevention and preparedness for outbreaks of infectious diseases.
3. **Prioritise prevention for social care and health workforce** by supporting their health and wellbeing to help them, their family and their community and maintain high quality of care.
4. **Bespoke action informed by needs and the conversion of insight into action** using our joint analytical capabilities across the partnership with a commitment to move human and financial resources to address these needs.

Key Opportunity 4: healthy behaviours

Why is this important?

People in our area, particularly in the more disadvantaged areas, are dying early and spending more of their lives living with ill health, and much of this illness is preventable. However, we are missing opportunities to support healthier living and reduce the impact of preventable illness.

Our health-related behaviours and habits are not just 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.

The leading causes of this ill health and early death are heart disease, stroke, cancer (especially lung cancer), and chronic lung disease. These conditions are primarily the result of unhealthy habits and behaviours, such as smoking tobacco, eating a poor diet, being physically inactive, and harmful alcohol use.

Tackling the unhealthy behaviours that impact most on our health, alongside the drivers behind them, will improve health and wellbeing, prevent early death, and reduce inequalities in health.

Who is impacted and why does that matter to them, communities and our system?

Because of the connection between building blocks for health and healthy behaviours, unhealthy habits tend to cluster together, particularly in people from more disadvantaged groups, their families, and their communities.

Smoking is the leading cause of preventable illness and early death, and the biggest driver of the inequality in health between most and least deprived. Smoking accounts for more years of life lost than any other changeable factor that damages our health. Whilst our overall smoking rate is around 13%, about one in three households in some areas of high deprivation include smokers. Bristol has the highest smoking rate in the South West of England. Many smokers want to quit, and it may take numerous attempts. We have effective ways of supporting people to quit, but we need to ensure there are no gaps in support pathways and services available to

people wanting to stop, and to take every opportunity to ask and offer help. Stop smoking interventions are among the most cost-effective of health services.

Being overweight or obese significantly affects health. Obesity is the most significant risk factor for disability in our area, and the second leading cause of preventable cancers after smoking. It is closely linked with type 2 diabetes, and complications such as heart and kidney disease. Childhood obesity rates are increasing among children living in the poorest areas. Children who are obese have a much greater likelihood of being obese as an adult with consequent higher risks of conditions like heart disease, cancer and type 2 diabetes.

People in our area are experiencing an increasing level of harm from alcohol and drugs above the national average, including higher hospital admissions and alcohol-related deaths. Alcohol and drugs are among the most significant impacts on the health of our under-50 population and effects on the use of primary care appointments and urgent health care use. Those living in more deprived communities are impacted the most by drug and alcohol dependency.

What needs to change?

We need to go further with action to support healthier behaviours, especially stopping smoking, addressing diet and inactivity leading to obesity, and tackling harm from alcohol and drugs. We must develop whole-system integrated approaches, embedding prevention at all opportunities and throughout all stages of an illness or condition, and coordinating this action across all system partners. This will include working with people, carers and families to develop different approaches that are relevant to them. Everyone involved with health, wellbeing and care has a role in supporting our population's wellbeing. For example, we have an ambition to develop a system wide physical activity strategy given the multiple health and wellbeing advantages of being active throughout life.

Because of the link between our living conditions and health-related behaviours, we need the combined resource of all partners – communities, NHS, local authorities, and voluntary and community and social enterprise sectors to do this effectively and in ways that will address inequalities. Our approaches need to work with communities and foster neighbourhoods and places (such as healthy schools and healthy workplaces) that support, enable and encourage healthy behaviours, provide effective and accessible interventions for individuals and families. For example, help to stop smoking, eat well, keep healthy body weight, and to embed more robust prevention in policy and decision making as organisations.

A system-wide response to alcohol and drug harm would enable us to engage with people experiencing drug and alcohol harm in a more preventative and planned way, reducing the health impact and high cost of emergency use of health and social care services.

Being encouraged by a health and social care professional to stop smoking is one of the most motivational factors, so we need to take every opportunity to ask about smoking and offer support to stop. Even after many years of smoking, stopping smoking leads to significant health benefits – it is never too late to stop. However, we must also address the social, cultural and environmental conditions contributing to smoking.

Obesity is a complex issue with multiple causes, none of which can be resolved by a single intervention. Instead, a whole system approach to preventing and reducing obesity is needed, including coordinated working with communities and broader partners, including businesses, education and workplaces, to address the environments, culture and conditions driving unhealthy eating and inactivity across people's lives.

What are our commitments?

1. **Agree on a financial resource commitment to be explicitly focused on prevention**, including a focus on wider determinants and interventions that impact before health deteriorates.
2. **Focus early on health and wellbeing support for our volunteers and health and social care workforce** across our partnership.
3. **Develop whole-system programmes** for stopping smoking, staying at a healthy weight and alcohol/drugs support with commitment from all system partners.

Key Opportunity 5: strategic prioritisation of key conditions

Why is this important?

“Keeping people healthy and able to work helps people financially, socially as well as contributing positively to mental and physical health” – feedback from an individual as part of the Citizens’ Panel.

Our Future Health highlighted the conditions that impact our population most over the life course.

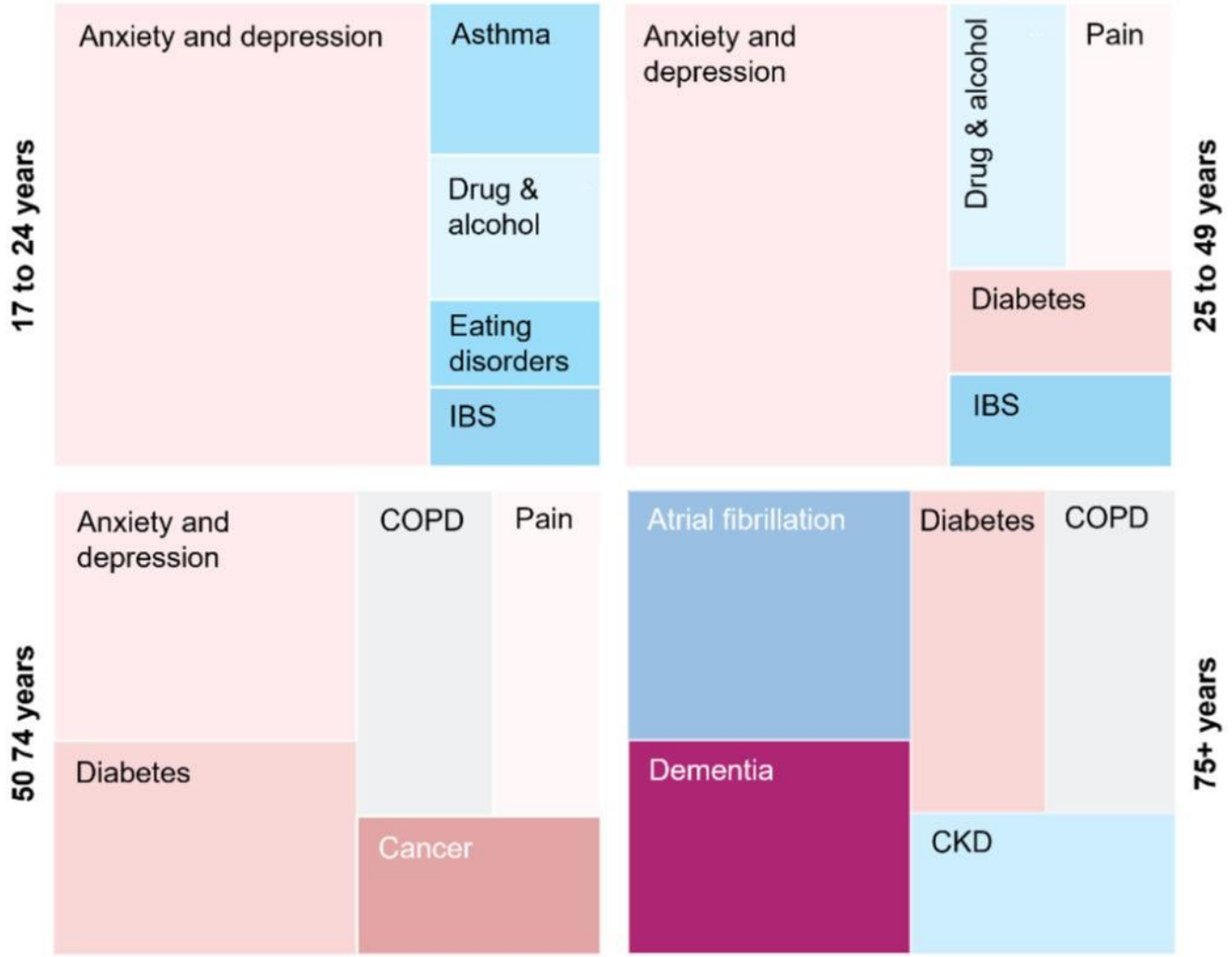

Figure 1: Our Future Health, conditions that impact our population most over the life course.

- Many of these conditions and their causes are preventable.
- Some people experience multiple conditions at the same time. This multi-morbidity becomes more common as we age.
- We live more of our lives in ill health than ever before.
- People in more deprived groups and certain ethnic groups experience poor health at a younger age and have higher levels of living with complex illnesses.
- People with a mental health need are more likely to have a preventable physical health condition such as heart disease (Mental Health Foundation, 2022)[18].

Increases in life expectancy over recent decades have not been matched by increases in healthy life expectancy – we live more of our lives in ill health. As noted before, people in more deprived groups and certain ethnic groups experience poor health at a younger age and have higher levels of living with complex illnesses.

This area of action around prioritisation will help us to deliver the challenges laid down in opportunities one to four above.

Who is impacted and why does that matter to them, communities and our system?

The impact of mental health conditions on our population is increasing:

- Anxiety/depression affects adults under 50 the most out of all conditions in BNSSG, followed by alcohol dependency.
- There is a close link between unemployment, debt and mental health – particularly for depression and anxiety.
- Suicide is our second most significant cause of years of life lost, after heart disease.
- Self-harm is a particular issue for people living across BNSSG, resulting in significant and rising numbers of emergency hospital admissions. There were 1320 emergency admissions for self-harm in 15-24-year-olds across BNSSG in 2020-21. This accounted for 40% of all emergency self-harm admissions during this period.
- There is an overlap between long term conditions such as diabetes, COPD and heart disease with mental health.

There is growing recognition of the impact of painful conditions/ mental distress. Painful conditions/ mental distress is in the top five most impactful conditions in BNSSG across the life course. More prescribing or faster access to treatment can support this but it is unlikely to

resolve the issue completely. Instead, we must work with communities and the VCSE to develop new ways to help people prevent causes, offering psycho-social interventions to improve people's quality of life.

Cancer is one the leading forms of early death in BNSSG. Nearly half of all cancers are preventable. Our strategic approach is to optimise prevention and early identification across the whole population through equitable uptake of screening programmes and to focus our efforts on awareness and education. As a system we will work collaboratively and innovatively to ensure that we offer faster diagnostic standards to the whole population.

We will combine our resources in population health research, population health management, disease expertise, screening and genomics to promote research into cancer treatments.

People are living with multi-morbidity (more than one long term condition such as diabetes and respiratory disease) and when conditions cluster in an individual, they often exacerbate each other. For example, depression can impact eating, which can exacerbate diabetes and worsen mental wellbeing. The most common clusters of three conditions in deprived areas in BNSSG are combinations of hypertension, depression/anxiety, diabetes, and painful conditions. People experiencing multiple needs can face challenges navigating numerous services.

What needs to change?

Tackling the factors that impact of the health of our population (the building blocks of health and prevention approaches) gives opportunity to improve the people's outcomes and experience. This will also support our efforts to increase healthy life expectancy, ease pressures on the health and social care system and reduce the number of people out of work due to ill health.

We need to:

- Allocate long-term resources to early intervention and prevention activities in communities to ensure that wider determinants of health are addressed before health deteriorates.
- Focus on preventing the most impactful conditions and ensuring timely access to treatment/interventions and support when needed across the life course. The development of a new national strategy led by the Department of Health and Social Care is an opportunity to use the latest evidence and guidance to help guide our work.
- Listen to what our communities have told us about their experiences of living with conditions and co-develop new approaches together.

- Benefit from our Voluntary Community and Social Enterprise (VCSE) expertise in this area, enabling us to develop person-centred, asset-based, holistic approaches to support people with multiple needs. We can improve outcomes and experiences for people accessing health and social care and support by redesigning services around people, families and communities and joining up services.
- We will use the breadth of experience in our Partnership, for example, people with lived experience, carers, communities, primary and secondary and social care providers and the voluntary and community sector.
- Relentlessly focus on closing the gap in healthy life expectancy. We should also remove disparities in health outcomes and experiences that exist by other characteristics, including gender and ethnicity.

What are our commitments?

Develop a BNSSG wide plan for conditions. This will include:

1. **Contribute to the government's development of a major conditions strategy and respond to its findings.** It focuses on the six most impactful conditions for the UK population. Working with our communities we can amplify the voices of people with lived experience and use that learning to improve outcomes in our area.
2. **Interrogate and make sense of BNSSGs most impactful conditions data**, working with communities and a wide range of organisations to further understand and respond to need.
3. **Undertake a 'most impactful conditions' analysis for children and young people** which identifies opportunities for prevention and improving outcomes.
4. **Develop person-centred and asset-based approaches**, with a particular focus on looking at need and working with our communities.
5. **Develop a system-wide approach for painful conditions**, reducing the impact on health and wellbeing and unplanned service use. We must work with our communities and partners to develop new ways to support people to live well with pain and ensure consistent access to service provision across BNSSG.
6. **Through a new system mental health strategy, support people with poor mental health and wellbeing** – to quickly access high-quality and personalised care close to home for improved experience and outcomes.

How will we deliver our vision?

Prioritisation

We will identify a number of priority areas where the best gains can be made by working together. We will do this through our new Health and Care Improvement Groups (HCIGs), working across the life course. We will evaluate how addressing the identified priorities will impact our populations within short (one to two years), medium (two to five years), and long-term (five years or more) timeframes.

The HCIGs will address the following:

1. Improving the lives of people in our community
2. Improving the lives of people with mental health, learning disabilities and autism
3. Improving the lives of our children
4. Improving outcomes through efficient and effective hospitals.

All partners will work with renewed focus with the Bristol, North Somerset and South Gloucestershire Health and Wellbeing Boards to collectively support the delivery of this Strategy and the Joint Health and Wellbeing Strategies to respond to the different needs of our communities, with a focus on tackling the wider determinants of health.

We commit to optimising use of the Better Care Fund and section 75 as a mechanism to offer joined-up support across health and social care and to align its focus with this Strategy's focus on the shift to proactive, personalised care, supporting the most disadvantaged. The combined value of funds spent on health and social care, including wider determinants, across Bristol, North Somerset and South Gloucestershire runs into billions of pounds, which provides us with a significant opportunity.

Locality Partnerships

We will further develop our six locality partnerships as the vehicle to support our commitment to subsidiarity – decisions being taken as close to communities as possible – and to lead delivery. The locality partnerships unite NHS, local authority, social care, people with lived experience and VCSE as equal partners around local 'neighbourhood' footprints. They use population health intelligence insights to identify and tackle different local priorities for communities, aiming to join up services, simplify pathways and support a shift to earlier support and intervention. The locality partnerships work closely with the health and wellbeing

boards to deliver the Joint Health and Wellbeing Strategies alongside tailoring the ICS-wide pathways and models of care to local needs. Their innovation in tackling local priorities can support innovation and learning across our wider system.

For example, the voluntary and community sector is helping to lead our locality partnership response around older peoples' health. We know that people live longer with more complexity in their health and social care needs. Many older people live long distances from family, friends and connections which can lead to people becoming increasingly lonely in later life. Loneliness has a big impact upon wellbeing and our overall health. We know that how we age has a relationship to where we live, and through our commitment to proactive and preventative care – and joining up that care well, closer to where people live – we can identify peoples' needs early so can anticipate what support they are likely to need, ensuring that medical and social care is personalised and responsive. This will mean that people can stay in their homes and communities, safely, for longer.

Workforce

Our work has the power to change lives. We need to create dynamic environments where our volunteers and workforce feel safe and secure, confident, empowered and valued. We will provide a wide range of employment prospects that present excellent possibilities for career advancement at every stage and across all health and social care sectors.

Every success in health social care and voluntary sector depends on people, whether in scientific discovery, innovation, or compassionate care. To achieve success through this Strategy, prioritising workforce is essential.

We believe that we will succeed by working collaboratively rather than in competition to attract, develop and retain the best people.

We aspire to be recommended as employers of choice and celebrated by the people who are employed and volunteer within our services. This means that we will need to:

- Engage with staff and volunteers to identify what's needed to empower and support them to deliver this Strategy and improve outcomes.
- Support staff and volunteers to improve their health and wellbeing.
- Increase diversity so that our staff and volunteers are more connected to all of the communities we serve.

- Provide a modern employment offer that is inclusive and flexible to support modern working lives.
- Improve job satisfaction and increase opportunities for learning and development and career progression.
- Be guided by the voice of our staff and volunteers in determining where we are succeeding and where we still need to improve.

Our shared aspiration to move to a more preventative, strengths-based approach that is embedded within localities gives us a great opportunity to benefit from the expertise of people with lived experience and voluntary and community sector as equal partners.

Service delivery and sustainability

The NHS provides patient care through primary care services like general practice, dentistry, optometry, and community pharmacy. However, in some areas, access to care can be difficult as a symptom of the challenges being experienced in primary care workforce, high levels of workload and poor estate and digital infrastructure. Primary care cannot function alone. Community services, such as mental health services, are crucial in addressing patient needs within the community and these services often collaborate with social care and the voluntary sector to meet the needs of the local population.

The BNSSG Primary Care Strategy which was developed with system partners including One Care and our patients and public Healthier Together BNSSG Primary Care Strategy 2019-2024 This is a 5 year strategy from 2019-2024 and we are working with wider primary care and Sirona to ensure a plan for this from March 2024.

The Fuller Report[19] published by NHS England made a range of recommendations for the improvement of primary care. We commit as a Partnership to working closely with primary care networks to develop integrated models that support sustainability and resilience, particularly in our most challenged areas where staffing levels are lowest relative to population needs. General Practice has a developed a 5 year general practice strategy BNSSG General Practice five-year strategy (2023 – 2028) [20] to support this.

Following the covid-19 pandemic, system partners are continuing to address the backlog of planned treatment such as operations, procedures and outpatient consultations to ensure that people have timely access to care. We know that delays to care can be most impactful for people in our most vulnerable population groups. To address this, we are developing an

approach to expedite care for people in vulnerable groups who have been waiting longer than we would like for planned treatment. This will ensure that people who meet an agreed criteria are identified and rapidly offered treatment.

Digital

Using technology effectively will be a key enabler to achieve our system's priorities, facilitating a smoother flow of people and patients around our region's health and social care services. We will need to use more digital tools to do this. A smarter use of data is essential, including future-focussed approaches, such as Artificial Intelligence. This will create opportunities to enhance peoples' care, empower people to manage their own conditions well and reduce barriers that many people experience in accessing the care they need.

We will look to recognise and address the barriers some people have in using digital solutions. Our system's Digital Strategy[21] sets out the ambition to become 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.

Financial infrastructure

To support and enable our partners to deliver the priorities and commitments set out in this Strategy, it is necessary to consider how we can make health and social care funding decisions that support the objective to deliver more preventative and personalised care across our communities. To do this, a set of financial principles are being developed. These include:

- Working towards a greater proportion of our system’s investment going into preventative health and social care.
- Investments to be allocated in alignment with the needs of our population, following a principle of ‘proportionate universalism’.
- Re-allocation of investments if preventative initiatives are not resulting in improved population health, acknowledging that some timescales for impact will be longer than others.

- Investment decisions will consider our organisations' role as anchor institutions, including:
    - **a)** Purchasing locally and with social benefit
    - **b)** Using our estate to support communities
    - **c)** Widening access to quality work
    - **d)** Reducing environmental impact.

Innovation and research

New technology and innovations must be implemented and scaled to address our health and social care challenges, to deliver a new approach towards treatment, prevention and personalisation. We want our patients to experience best value and effective care.

For example, the use of genomic data is a potentially revolutionary use of patient data to identify risk and create highly personalised and specific patient interventions. In BNSSG we have the advantage of North Bristol NHS Trust hosting the South West Genomics Laboratory Hub, alongside the University of Bristol's highly rated Centre for Genomics – this provides an exciting opportunity for Bristol to develop a centre for excellence in research and innovation in this field with an appropriate consideration of ethics. There is the potential to reduce the impact of, or preventing entirely, certain predisposed genetic diseases.

To support and facilitate our ambitions, BNSSG will implement an Innovation Hub, in partnership with the West of England Academic Health Science Network in 2023/24 to develop a shared vision and supportive culture for adopting and development of innovation at scale that will support meeting the four ICS aims, and our system outcomes. This work will include:

- **Developing innovation mindsets and supporting culture** to facilitate an innovative ICS eco-system, creating a culture of learning from each other innovative practices that can be shared, adapted and scaled in other settings. Working with local researchers and innovators and providing education and forums for people working across the system to understand the practice and principles of innovation, developing their innovation mindsets.
- **Working alongside our Health Care and Improvement Groups** to increase awareness of opportunities coming up for innovation, embedding a process of identifying potential solutions through the transformation gateway process. Develop relationships and networks with local and national markets and academic institutions alongside a supportive commercial framework for securing new technologies.

- **Harnessing innovation through partnership with our front-line staff** to enable staff to connect and network to innovate and build change. This may also include working with local industries and other statutory services to understand what works well in other contexts, for instance learning from police services to develop innovative recruitment practices for highly skilled data analysts and scientists.

Our BNSSG ICS vision for medicines optimisation is to implement a person-centred, collaborative approach to get the best value from medicines. This includes 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. We will drive value through an evidence informed approach.

10 ways to focus our efforts

The five opportunities, highlighted in this Strategy make a clear case that things need to be different in our health and social care system. As Integrated Care System partners, we have summarised these as ten commitments that we are making to our population.

Over the next few years, we will work with the people of Bristol, North Somerset and South Gloucestershire (BNSSG) to turn these into a reality. To help everyone in our System consider how they can support delivery of the things we can do together, we have identified 10 ways we can consistently think and act for better impact.

Improving population health and healthcare

We will:

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 through our shared outcomes framework. 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 at all levels – primary, secondary and tertiary – has been highlighted as necessary for many years, but we will demonstrate commitment by actively funding prevention, starting with people, families and communities, and creating prevention champions in every community and across our partner organisations.

3. **Focus on the first 1001 days to give our children the best start.**

   The first 1001 days are vital in setting people on the right path for life. Our system will support health and wellbeing board ambitions for these early years.

Tackling unequal outcomes and access

We will:

4. **Change how we work to reduce health inequalities actively.**

   As organisational policies and practices 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.

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 Health and Wellbeing Strategies and CORE20+5 framework[22] as a starting point to develop supportive strategies around wider determinants of health and healthy habits.

Enhancing productivity and value for money

We will:

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 and work around their needs. For example, this approach to 'clustered' problems might be achieved through integrated care teams, like those piloted in Weston-super-Mare for mental health and wellbeing, 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 people with lived experience and communities to co-create solutions. We will also ensure that the VCSE sector, community leaders, community services, social care, and primary care are valued for their experience and local insight.

Helping the NHS to support broader social and economic development

We will:

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 of where people live upon their health. We will ensure a 'wellbeing first' approach to all policies. Such as housing, transport and green space. We also support commitments around net zero to reflect the need to take climate change seriously, including its effect on health.

Strategy on a page

Figure 2: Strategy on a page

References

References with links to associated documents or websites where available:

1. Healthier Together (2022) *How will we deliver joint health and care priorities? Supporting everyone to live a long and healthy life – ICS Strategic Framework***.**
Available at: Microsoft Word - Strategic Framework v3.0.docx (bnssghealthiertogether.org.uk) (Accessed: 30 June 2023).

2. Bristol, North Somerset and South Gloucestershire Integrated Care Board (2023) *BNSSG Draft Joint Forward Plan.*
Available at: DRAFT-BNSSG-Joint-Forward-Plan-March-2023.pdf (bnssghealthiertogether.org.uk) (Accessed: 30 June 2023).

3. North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust (2023) 'Draft Acute Provider Collaborative Joint Clinical Strategy'. North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust. Unpublished.

4. Healthier Together (2020) *Healthier Together BNSSG Primary Care Strategy 2019-2024.*
Available at: Healthier-Together-BNSSG-Primary-Care-Strategy-2019-2024.pdf (icb.nhs.uk) (Accessed 30 June 2023).

5. Department of Health and Social Care (2022) *Women's Health Strategy for England.*
Available at: Women's Health Strategy for England - GOV.UK (www.gov.uk) (Accessed 30 June 2023).

6. Healthier Together (2022) *BNSSG System Outcomes Framework.*
Available at: Microsoft Word - Strategic Framework v3.0.docx (bnssghealthiertogether.org.uk) p22 (Accessed 30 June 2023).

7. Bristol City Council (2023) *Joint Strategic Needs Assessment.*
Available at: Joint Strategic Needs Assessment (JSNA) (bristol.gov.uk) (Accessed 30 June 2023).

8. North Somerset Council (2022) *Joint Strategic Needs Assessment 2022.* Available at: n-somerset.gov.uk/sites/default/files/2022-06/North Somerset JSNA overview_FINAL.pdf (Accessed 30 June 2023).

9. South Gloucestershire Council (2022) *Joint Strategic Needs Assessment.* Available at: South Gloucestershire Council (ourareaourfuture.org.uk) (Accessed 30 June 2023).

10. Healthier Together (2022) *Our Future Health.* Available at: Annex-1_OurFutureHealth-Sept-2022.pdf (bnssghealthiertogether.org.uk) (Accessed 30 June 2023).

11. Healthier Together (2022) *Have Your Say***.** Available at: haveyoursay - BNSSG Healthier Together (Accessed 30 June 2023).

12. NHS England (2022) *Cancer waiting times.* Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times (Accessed 30 June 2023).

13. Jones, C.P. (2022) *Anti-Racism and Health: Levels of Health Intervention.* 16 November. Available at: Anti-Racism and Health: Levels of Health Intervention by Professor Camara Jones - YouTube (Accessed: 30 June 2023).

14. Koenecke, L.A. (2019) *The letter "E"…Equality v. Equity.* Available at: https://lisakoenecke.com/2019/08/18/the-letter-e-equality-vs-equity/ (Accessed 30 June 2023).

15. Healthier Together (2023) *Healthier Together Citizens Panel – March 2023 survey results.* Available at: Healthier Together Citizens Panel - March 2023 survey results - BNSSG Healthier Together (Accessed 30 June 2023).

16. British Heart Foundation (no date) *Tackling health inequalities.* Available at: Women & Heart Disease - BHF (Accessed 30 June 2023).

17. NHS England (no date) *NHS Prevention Programme.*
Available at: NHS England Prevention Programme (Accessed 30 June 2023).

18. Mental Health Foundation (2022) *Physical health and mental health.*
Available at: Physical health and mental health | Mental Health Foundation (Accessed 30 June 2023).

19. NHS England (2022) *Next steps for integrating primary care: Fuller stocktake report.*
Available at: NHS England » Next steps for integrating primary care: Fuller stocktake report (Accessed 30 June 2023).

20. One Care and GP Collaborative Board (2023) *BNSSG general practice five-year strategy (2023-2028).*
Available at: 86b90277-1b06-420a-86b1-b02e00b6b990 (clarity.co.uk) (Accessed 30 June 2023).

21. Bristol, North Somerset and South Gloucestershire Integrated Care Board (2023) *Digital Strategy 2023-25.*
Available at: Digital-Strategy.pdf (bnssghealthiertogether.org.uk) (Accessed 30 June 2023).

22. NHS England (no date) *CORE20PLUS5 (adults) – an approach to reducing healthcare inequalities.*
Available at: NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities (Accessed 30 June 2023).