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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Bristol, North Somerset and South Gloucestershire Integrated Care System

2024-2029 Joint Forward Plan

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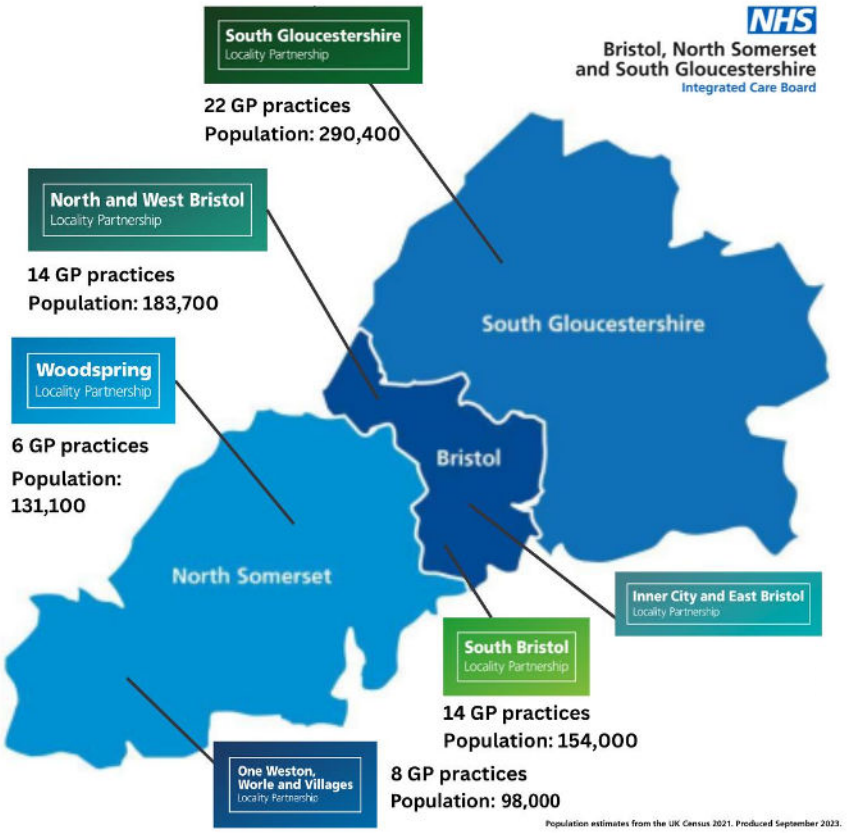
1. Introduction

1.1 Background to our Integrated Care System

Bristol, North Somerset and South Gloucestershire 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] 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 Joint Forward Plan

This is an updated version of the first Joint Forward Plan (JFP) set for our system, published in June 2023.

This Joint Forward Plan continues to set 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 and addresses objectives set out in the government mandate with regards to ambitions described in the NHS Long Term Plan and NHS planning guidance. This Joint Forward Plan describes how we plan to achieve and deliver the priorities set out in our strategy over the next five years and is structured around the responsibilities of the Health and Care Improvement Groups. See the Governance appendix (9.4) for more information on Health and Care Improvement Groups.

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.

1.2.1 First year look back - achievements since our last published plan

Looking back since our first iteration of our Joint Forward Plan, we are proud to report that we made significant progress towards most of the programme's deliverables due in 2023/24, including progress towards the national targets for the ICS, the NHS operational plans and the ICB statutory duties. Detailed information on the annual assessment can be found on the ICB website.

Localities
Over the last 12 months locality partnerships have continued to develop and implement plans for how to provide better integrated services for people in communities. There remains a strong focus on prevention and activities that support wellbeing and health promotion. The integrated mental health teams have been launched in three localities and the remaining three will follow in February and March 2024. We have secured funding to address health inequalities at a locality level and we have confirmed plans for the spend allocated in 2023/24 and we are planning for the funding that is available for the next three years. We continue to develop strong relationships within localities both with the communities we serve and with partners from NHS, local authority and Voluntary Community and Social Enterprise (VCSE) organisations and we value being members of local Health and Wellbeing Boards. We continue to ensure the role and importance of 'place' is understood in the system and work with many other programmes described in the Joint Forward Plan to ensure the most successful and effective use of resources.

Maternity and neonatal system
We implemented the electronic notes system, Badger Notes, in September 2023, improving accessibility and delivery of personalised care for all mothers and their families which will increase service user confidence in their maternal perinatal care. This will also improve the ability of the local maternity and neonatal system to understand the key issues in the maternity population, allowing the system to more effectively forward plan interventions, and necessary improvements tailored to their mothers and families in maternity unit areas.

Research and innovation
In line with our priority areas outlined in the Joint Forward Plan, significant achievements have been made across various domains. To address health inequality, the Research Engagement Network (REN) has successfully secured £253,000 to enhance diversity in research participation. The REN has over 100 members and has appointed 4 Health Research Ambassadors who are championing research in under-served communities and advocating for their communities with researchers. Progress includes:

- Terms of Engagement for "Community Ready Researchers" developed by community members of REN.
- A single register of engagement activities and insights across the ICS, sharing learning between ICS and research projects
- A project to comprehensively collect data on protected characteristics of research participants in studies across BNSSG is underway.
- Materials for research participants with low literacy levels are also under development.

We secured £4 million in funding to lead the South West Secure Data Environment. The Bristol, North Somerset and South Gloucestershire Impact Accelerator Unit (launched in 2023) is currently supporting 19 projects to implement evidence into Healthier Together, with more than 15 National Institute for Health and Care Research (NIHR) grant applications submitted including funding to sustain accelerated implementation of evidence within Bristol, North Somerset and South Gloucestershire (BNSSG).

Workforce initiatives include the appointment of a General Practice Nurse Research Clinical Fellow and support for NHS England South West's Allied Health Professions Faculty Programme, as well as a collaboration with the University of the West of England (UWE) and the University of Bristol for an NIHR grant application focused on staff retention, staff wellbeing and new workforce models.

Prevention
One of the key achievements is that ‘prevention’ was firmly embedded throughout the ICS Strategy, which was published in July 2023. There are sections on prevention and early intervention; strengthening building blocks and healthy behaviours which will all contribute to a focus on prevention. BNSSG Smokefree received funding to support people who currently smoke cigarettes to swap using vapes instead. The work will be implemented during 2024/25. A ‘Healthy Weight’ group (current name which may change) was set up as part of the whole system approach to prevention. The group has identified money to develop a ‘Healthy Weight Declaration’ across health and care partners. The declaration will be designed to commit partners to taking actions to support people to be a ‘healthy’ weight. As part of planning its finances for 2024/25 and beyond, the ICB committed a portion of its core funding to be used to support some of the system’s prevention work.

Children and young people

Since the publication of the first iteration of the Joint Forward Plan, the Children's Health and Care Improvement Group (HCIG); a collaboration of BNSSG ICS Partner Chief Executive Officers, Executive Directors, health and care professionals and senior system leaders, has been established. The Children's HCIG's primary responsibility is to drive improvements in ICS activity to deliver the ICS strategy and the Joint Forward Plan (JFP). Three key areas of focus for children and families have been agreed for the next 3 to 5 years:

1. Ensuring the needs of neurodiverse children and young people and their families are consistently met.
2. Improving health and development outcomes for early years children.
3. Addressing the challenges faced by children and young people with highly escalated psychosocial and emotional needs.

Children's mental health: Investment into the Child and Adolescent Mental Health Service (CAMHS) has resulted in increased access for children and young people for mental health support. However, though some improvements have started to be seen, challenges with recruitment have meant that the expected performance improvement has not yet been realised and access remains lower than the national target.

The mobilisation of Mental Health Support Teams in Schools has achieved over 50% coverage of our system and two additional teams will begin to be implemented from 2025. This will mean that more children and young people will have access to evidence-based interventions for mild to moderate mental health issues

The community naso-gastric feeding pilot for eating disorders has been effective at supporting young people and resulted in a significant shift in eating disorders presentation in Bristol Children's Hospital. The Home Treatment Team has supported over 39 high risk children and young people who otherwise may have been admitted into an acute hospital or tier 4 mental health hospital bed. The pilot has also led to a reduction in long lengths of stays and children and young people can be supported at home.

The children's transitions workstream has made significant progress over the last year through scoping current service provision and receiving patient and parent carer feedback through a children and young people survey. A draft service model is currently being developed, which will improve the provision of services for our young adults and provide a more supportive transition into adulthood.

The children's mental health programme for 2024/25 builds on the improvements made in 2023/24 and aims to address the challenges affecting access to mental health support and improve outcomes ensuring that children and young people are supported to meet their mental health needs earlier on, in their local community.

Children's learning disabilities, autism and SEND: Additional capacity has been mobilised via our commissioned community children's health provider, as well as a private provider, to undertake more autism assessments. This approach will feed into this year's plan to develop an interim model for autism support and assessment, whilst our longer-term neurodiversity system transformation is underway.

The recommissioning of the Autism Intensive Service (AIS) has seen significantly improved outcomes for young people. AIS intervention has shown:

- Improved relationships with families, peers and supporters
- Increased engagement in positive activities
- Re-engagement in education
- Improved emotional literacy, behavioural self-regulation and thoughts about future life directions.

In addition, parents experienced a range of positive outcomes all contributing to a feeling that their daily quality of life had improved. There were no exclusions or Tier 4 admissions for any young people working and engaged with the Autism Intensive Service during the intervention period. Around 70 children with a learning disability and/or autism now have a designated keyworker. The purpose of a keyworker is to ensure the child or young person and their family have the support they need to prevent inpatient admissions to a child and adolescent mental health service (CAMHS). Inpatient numbers remain very low with inpatient admissions being avoided.
There is only one remaining SEND Accelerated Progress Plan (APP) in place in our system. Bristol APP is focussed on repairing "fractured relationships with parent carers". A new co-produced SEND Strategy is under development together with a Memorandum of Understanding focussed on the local area working closely together in the future. Vastly improved working relationships have resulted in several very successful co-produced initiatives and projects, such as: Autism in Schools, Partnerships for Inclusion in Neurodiversity in Schools, and the Neurodiversity Transformation Project.

Children's community services: Improvements are being made to system arrangements for safeguarding children, including consistent health input to multi-agency safeguarding hubs across BNSSG, a focus on the timeliness of initial and review health assessments for children in care, and consistency and improved timescales of adoption processes.
A key challenge is the increasing need for autism assessments which significantly outweighs capacity. Progress has been made with the discovery phase of the system neurodiversity programme that aims to address this issue and the broader challenge of meeting the needs of neurodiverse children, young people and their families.
Alongside this transformation programme, additional capacity for autism assessments has been mobilised and a plan has been developed to implement an interim autism support and assessment model. This model aims to maximise current resources and ensure families can access support that is readily available to them in the short-term, while the longer-term sustainable transformation programme is underway.
The transformation of Public Health Nursing has achieved many of its planned milestones over the past year and is due to be completed in autumn 2024. Key achievements include:

- The THRIVE Framework for system change has been embedded, so services offered are person-centred and needs-led.
- More than 60 evidence-based pathways have been developed to support the delivery of the Healthy Child Programme and ensure an equitable and consistent service offer that has a focus on prevention, early intervention and reducing inequalities.
- The universal offer has been clarified so staff, families and system partners understand what services will be delivered, and a new website that was coproduced with children and young people has been created to ensure information and support is accessible to all.
- A single electronic record system will support the ability of the service to provide consistent, comparable, and good quality data to evidence performance and provide assurance.
- The Maternal Early Childhood Sustained Home Visiting (MECSH) programme has been launched to provide more intensive support to families at risk of poor outcomes, so families can receive the support they need at the intensity and scale that is proportional to their level of disadvantage
- A pilot service has been successfully mobilised to deliver end of life care at home for children and young people, demonstrating the benefits of a collaborative approach to delivering palliative and end of life care. The pilot service is offering 24/7 availability of specialist paediatric palliative care, nursing and medical support in the community, to families of babies, children and young people with palliative and end of life care needs. This approach is delivering a wide range of benefits including improved outcomes for children and their families, improved experience for palliative care staff and the ability to meet statutory and NICE guidance.

- The Children and Young People Vanguard has continued to deliver the aims of the framework for integrated care. An interim evaluation has found evidence that the vanguard presents a viable model to improving the overall trauma-informed network of organisations, as well as engagement with children and young people to reduce risks of school exclusion due to experiences of trauma. The Children and Young People Vanguard is moving into the final year of delivery and work is ongoing to establish sustainability plans alongside continued improvement against the established key performance indicators.

Children's acute services - The children's elective recovery programme has continued to support flow and provide additional capacity. This has resulted in a significant reduction in waiting time for elective care, with the majority of paediatric specialities eliminating 78 week waits by the end of 2023/24. This focus is maintained in the 2024/25 Joint Forward Plan, paying particular attention to cardiac surgery, dental and cleft that are facing specific risks and challenge.
A GP advice and guidance service has been fully implemented, with General Paediatricians supporting GPs to manage children in primary care and reduce referrals to secondary care services. Performance of the service exceeds the 80% target of advice and guidance delivered within two working days. Work is progressing with primary care around the development of paediatric hubs in three pilot sites in some of our most deprived Primary Care Network areas.
A new approach to supporting children and families with minor illness or injury when they attend the Bristol Children's Hospital Emergency Department was implemented in September 2023. The new approach:

- Creates additional capacity for the emergency department
- Reduces the risks associated with overcrowding
- Supports communication and integration across the general practice and emergency department workforce
- Delivers public health messaging and supports families to navigate urgent care services.

The children's hospital continues to work with BrisDoc to develop paediatric expertise to support care for children through 111 and the development of p-ACE (paediatric Assessment and Coordination of Urgent and Emergency Care).

Trauma-informed system: The BNSSG Trauma-Informed Practice Framework written by trauma leads and lived experience experts, was published at the end of 2023 as a system-wide resource to develop a shared language and approach across sectors. The framework includes guidance on trauma-informed practice and principles as well as examples of trauma-informed practice in action.
The BNSSG Trauma-Informed Practice Framework aims to increase understanding and confidence around implementing a trauma-informed approach at a system-wide level. It has already been used by Avon and Somerset Police and the Children and Young People Vanguard pathway organisations, including Youth Offending Teams, Bristol Drugs Project, Barnardo's and Forensic Child and Adolescent Mental Health service.
Best practice and evidence base surrounding trauma-informed practice has demonstrated that the support and commitment of organisational and system leaders is central to successfully embedding a trauma-informed approach. The Trauma-Informed Systems Programme has co-produced the 'Trauma-Informed Pledge for Partners', which is an opportunity for organisation and strategic leaders to demonstrate their active and ongoing commitment to embedding a trauma-informed approach within services and systems.
Trauma-Informed Pledge was launched in November 2023 and has already generated support from the Integrated Care Partnership (ICP) and the Integrated Care Board (ICB), the police Chief Constable and VCSE alliance organisations. A commitment to trauma-informed practice has been included within the ICS strategy, the Mental Health and Wellbeing Strategy, Bristol Youth Justice Strategy and the Protocol for Crisis Response for Children and Young People.
A key part of achieving trauma-informed systems change is supporting different parts of the system to connect to the relevance, importance and impact of trauma-informed practice within

their specific area. The Trauma-Informed Systems team works across a number of 'focused areas' supporting the development of trauma-informed practice, with a view to share this learning back to the system. These areas include: The Vanguard, the police, commissioners, HR managers, Community Mental Health Integrated Network teams, GPs and serious youth violence critical incident response.
The growing evidence base surrounding trauma-informed practice shows a range of tangible benefits of adopting a trauma-informed approach including: improved mental health and wellbeing, improved staff retention rates, and improved accessibility, experience, engagement and outcomes. The Trauma-Informed Systems Manager has been part of the evaluation planning and design of a system mapping piece of research, funded by Bristol City Council and hosted by the University of Bristol and Applied Research Collaboration (ARC) West This research will focus on how trauma-informed systems change can be achieved and its impact on a system-wide level across our system.

General practice achievements

- Our practices met the national target for increased number of appointments ahead of the March 2024 deadline. This is an increase of 4% on last year, with nearly 6 million appointments being delivered.
- The national target to increase the number of additional roles in general practice was also met, with nearly 700 roles in post.
- All our practices are on cloud based telephony, with 52% already using increased functionality of call back and call waiting.
- All practices have implemented and offer online consultations.
- At least one member of staff in all practices have received care navigation training.
- Community Pharmacist Consultation Service referrals continue to increase month on month, reaching 7000 in January 2024.
- Successful recruitment of three community pharmacies.
- Pharmacy First commenced in January 2024 with a successful training event launch.

Dental: A draft dental strategy has been created following engagement with stakeholders and a staff survey. Further public consultation is required to ensure that further patient involvement is incorporated and the staff working in BNSSG are aware of what this includes with a further opportunity to comment. The main aims of the strategy are:

- Reducing health inequalities by increasing access to NHS dental provision
- Developing the workforce, retaining staff and attracting more applicants
- Reducing the burden of dental disease through oral health promotion and integration with other services.

Other main areas of work in the shorter-term include:

- A review of all contracts and consideration of increasing Units of Dental Activity (UDA), rebasing and allowing a 10% overperformance threshold in line with national regulations
- Opening of St. Pauls in Bristol under a new provider
- Consideration of additional investment areas in collaboration with the Local Dental Committee
- Development of a Children in Care business case.

Personalised Care

Social Prescribing momentum continues to grow with some 91 staff providing Care Coordination, Social Prescribing and Health and Wellbeing Coaching to people in their place. The teams are receiving high quality accredited training and delivering support based on what matters to people.

Our Green Social Prescribing Programme called Healthier with Nature continued to have high uptake with over 3,000 people receiving support. The majority of referrals were either from primary care via link workers or supported self-referrals, but strong links have also been made with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and hospitals. Data indicates strong improvements in self-reported outcomes but also high levels of engagement from our target health inequality populations.
Personalised conversations with people to support future emergency care continue to grow. Data from ReSPECT Plus care plans within BNSSG has recorded that over 7,900 people have been offered and supported with Personalised Care Plans. Plans are recorded electronically and are provided to people but are also available through Black Pear electronic clinical systems, ensuring visibility across services and reducing the need for people to tell their story multiple times.
Recent analysis of Personalised Care Institute training data has shown that since June 2023 BNSSG have increased their distinct number of learners by 72 – the second highest we have seen in the region. The number of learners in Primary Care has continually grown, with significant progress in shared decision making and health coaching skills.
We know that we have to increase our offers and spread this learning across the whole system and have commenced a planning strategy for a system-wide training approach. The appointment of a named senior leader and a programme manager responsible for personalised care, who are working across the system from place base through to board level to support our Personalised Care delivery, is helping to pull together these approaches and continue the trajectory of personalised care being everybody's business and business as usual.
We are in the process of establishing a local steering group for Personalised Care and growing our skill sets and capacity to develop the support systems, structure and governance in a coordinated way to continue to develop this work.

Green Plan
Governance groups and workstreams have been established with a system-wide dashboard reporting progress. We are embedding sustainability in decision making, with a sustainability impact assessment and carbon calculator now part of the ICB gateway process.

The ICB allocation of resources has recognised the need for capital to be ring fenced for decarbonisation and that this will help unlock grant funding. There has been initial assessment of carbon impacts in the supply chain in acute hospital trusts and mental health trusts; but there has been limited progress on training and integrating sustainability into procurement processes.

Estates decarbonisation plans have been developed for the hospital trusts and energy surveys for GP surgeries. Transport progress has been made with moving to low and zero emissions vehicles in fleets. The Sirona care & health fleet has achieved net zero. Promotion of active travel has progressed with bicycle and electric vehicle purchase schemes and travel discounts. The introduction of the Clean Air Zone has been supported and we have seen improvements in air quality, particularly around our inner-city hospitals which will provide significant health benefits.

Waste plans have focussed on new waste contracts for acute Trusts, which will enable our zero waste to landfill target to be achieved and will support increasing recycling. A system-wide costed delivery plan has been produced, showing responsibilities, actions and timescales to realise our Green Plan targets going forward.

Workforce
We achieved our aim to create a sustainable workforce through a coordinated and collaborative approach, including:

- A focus on turnover rates and retention of staff system partners – a number of programmes have seen turnover rates reduce to the lowest levels experienced in the last few years. The healthcare workforce has effectively grown by 1,913 whole time equivalents.
- A pilot approach to running local recruitment events was tested in 2023/ 24 and was a success, with high attendance and staff being recruited at the event. This success has led to further events being planned in 2024/25, taking into account the learnings from the first few events.
- An ICB led Temporary Staffing Group has seen health partners work together to reduce the cost of agency staff through a single provider, with the creation of a collaborative bank and system agreed incentives framework.

Medicines Optimisation

In 2023/24, the Medicines Optimisation programme has continued to drive best value for medicines, including supporting prescribers to choose the most cost-effective medicines such as Direct Oral Anticoagulants (DOACs), diabetes medicines and best value biologics.

The programme embeds medicines optimisation drivers and principles within system priorities and works to reduce health inequalities, such as ensuring equitable access to medicines. Further work is planned to understand why in-treatment uptake and outcomes are lower in some areas than others and to do some targeted work on this.

Ensuring safe use of medicines continues to be a key priority. Areas of achievement in 2023/24 have been in embedding the ICB Medicines Safety Dashboard to support Primary Care practices to identify significant medication risks, which could lead to medication related harm and potential hospital admissions. A system-wide working group continues and will do further work to facilitate safer sodium valproate prescribing in line with the updated National Patient Safety Alert and will continue into 2024/25.

In a continued effort to support healthcare professionals to tackle inappropriate polypharmacy and overprescribing, a suite of training materials was completed in 2023/24 and work was undertaken with Primary Care Network (PCN) pharmacists to prioritise patients for structured medication reviews. This work will be evaluated in 2024/25. Ensuring the efficiency of antimicrobials is safeguarded continues to be high priority for the system. Bristol, North Somerset and South Gloucestershire ICB are one of 10 ICBs that have achieved national targets and are amongst the lowest prescribers of antibiotics in children. The ICB benchmarks in the top 5% based on evidence to reduce length of antibiotic courses in certain areas.

Great progress has also been made in supporting patients to access care in the right place for them, by expanding the range of services that are available from community pharmacies. This includes successfully completing the community pharmacy ear pilot, with over 2,000 referrals for otitis externa, which freed up appointments in other parts of the system. BNSSG is one of the top users of the Clinical Pharmacist Consultation Scheme within the country and, due to local services in place to provide medication under Patient Group Directives (PGDs) for some minor conditions, is well placed to deliver the national Pharmacy First scheme in 2024/25.

Mental Health

Talking Therapies (Increased Access to Psychological Therapies): We provided new training courses which meant we could employ more therapists. This, along with increasing the number of people that our therapists can work with, means that we can help more people receive support for their anxiety and depression and reduce the time that they wait for their treatment.

Dementia diagnosis rate: We are exceeding the target rate set by NHS England.

Perinatal access: We have employed more people who will work with parents to support them to improve their mental health during pregnancy and in the first year of their children's lives.

Early Intervention in Psychosis: We are already delivering NICE level 3 Early Intervention in Psychosis services in South Gloucestershire and have been allocated funding to increase staffing to bring North Somerset and Bristol to the same standard. Recruitment is underway and once services are fully staffed it is expected that Level 3 NICE concordance will be achieved.

Physical Health Checks for people with Serious Mental Illness (SMI): We increased the number of physical health checks completed through increased capacity in primary care, by expanding Avon Wiltshire Partnership's (AWP) physical health teams and targeted VCSE interventions, including peer support. By working together across GP practices, the mental health trust, local councils and voluntary organisations, we can monitor patients and address any physical health issues more promptly.

Individual Placement and Support (IPS) Service fidelity to model - We now have Individual Placement and Support Workers in all Bristol recovery teams, so more people with severe mental ill-health can find and maintain work.

Community Mental Health Services (CMHF) - We have established six new place-based Mental Health and Wellbeing Integrated Network Teams (MINTs) across Bristol, North Somerset and South Gloucestershire. These employ a range of staff from the NHS, social care and voluntary sector to provide better access to holistic support to improve people's mental health, close to home.

We appointed a partner, Rethink Mental Illness, and launched the new Sequoia Service. This is a co-produced service which offers treatment and support for anyone living in Bristol, North Somerset and South Gloucestershire who identifies with difficulties associated with mild to moderate personality disorder (complex emotional needs).

We implemented a voluntary sector-led eating disorder support service (SWEDA, resulting in a 50% reduction in our waiting list, meaning people can be seen and treated more quickly.

We have developed a shared care model between primary and secondary care to meet the physical health needs of people with eating disorders. Further work is underway to agree and implement this model.

A Community Rehabilitation Care Coordination team was rolled out to support the return of service users from out of area placements into the Trust footprint. There was a reduction from just over 30 to an average of 15 people in Occupational Therapy Placements. Work is underway to redesign the wider Community Rehabilitation pathway to offer consistent support across the system. Our new approach will mean that people with long-standing mental health issues can be supported to stay in their own homes and connected to their communities, instead of being sent to specialist hospitals, often for long periods of time.

Bristol Health and Wellbeing Board Strategy

- The Board looked at workforce issues and inclusive recruitment with the One City Economy Board, and examples of good practice are being shared across all sectors of the city
- The Good Food 2030 plan, which the Board jointly owns with the One City Environment Board, was launched. It aims to make Bristol's food system better for communities, climate and nature
- The Board also focussed on women's health with items on the needs assessment, the Women's Health Hub and Healthwatch's menopause project.

1.3 Our Strategy

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.

Integrated Care System (ICS) aims
Our Strategy and Joint Forward Plan (JFP) 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.

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

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. This jointly owned system strategy outlines the challenges and opportunities to meet the needs of the people living in Bristol, North Somerset and South Gloucestershire (BNSSG) at a population level over the next five years. The Strategy development was led by the principles and approach set out in the BNSSG Strategic Framework

that was published in December 2022. Contained in the strategy is a mandate for system change, with an increased focus on prevention and addressing health inequalities.

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 such as the Joint Strategic Needs Assessment and the insights of practitioners working in our organisations.

1.3.1 Outcomes Framework

Since 2021, BNSSG 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.

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.

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.

1.4 Our ways of working

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.

Bristol, North Somerset and South Gloucestershire ICB, NHS providers and other strategic partners such as the local authorities and the Voluntary, Community and Social Enterprise (VCSE) sector will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing.

Delivery of these strategies will require partners to work closer together as a system. Greater service integration and cohesiveness will ensure that individual needs are met on a more holistic basis. Thus, the wider determinants of health will be addressed while delivering improvements that matter to people on a population level.

1.4.1 Integration of Services and partnerships

Our Integrated Care System (ICS) effectively brings together organisations across the NHS, local authority, VCSE and wider partners, to plan and deliver health and care services for our population. By coming together, we will improve people's outcomes and experiences of care and support, by bringing services together around people and communities.

Through our Integrated Care Partnership (ICP), we are forming trusted relationships, listening and respecting different points of view, and we understand each organisation's pressures. Our common purpose is to improve the lives of our population, so we know we can do more for people and communities when we come together. We have seen evidence of this across our system from the work in locality partnerships, the closer working relationship with the VCSE, to better inform integrated decisions being made at the Health and Wellbeing Boards, the ICP and the ICB.

Developing effective and successful place-based locality partnerships is our priority. Locality partnerships are key to delivering our shared vision to transform the experience of health and care across our system to one of fully integrated, personalised services that focus on health promotion and proactive care, as well as supporting people in times of need or crisis.

To achieve our ambition of centring all we do around people and communities, we need to make changes in how services are delivered. We need to champion the development and adoption of integrated services by bringing about a change in how we design, deliver and commission services, as well as how we establish the culture that will allow robust partnerships with the maturity for place-based delivery of integrated care.

Our commitment is to continue to work closely with our system partners across the ICS to ensure that our services operate in an integrated way and ensuring that people and communities get the right support at the right time. We will listen to, and value, people with lived expertise to co-design new services, which put people and their carers at the centre of decision making.

1.4.1.1 Better Care Fund

The Better Care Fund (BCF) establishes pooled budgets between the NHS and Local Authorities, with the aim of reducing the barriers often caused by separate funding steams. The national vision of the BCF is to support people to live healthier, independent and dignified lives through joining up health, social care and housing services seamlessly around the person.
A BCF working group has been set up and further work identified to ensure that the annual BCF planning round continues to provide the opportunity to support delivery of the ICS and Health and Wellbeing Boards strategic priorities. The outcome of this work will be provided in the next iteration of this Joint Forward Plan, although it has been recognised that the BCF is a vehicle for delivery of the strategy:
'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.' - Bristol, North Somerset and South Gloucestershire ICS Strategy, page 25.

1.4.1.2 Voluntary community and social enterprise (VCSE) partnership

The ICS is an equal partnership between local authorities, the VCSE sector and the NHS. To date, there are examples of effective collaboration with the VCSE sector, including the vaccination programme, social prescribing and hospital discharge. There is also greater recognition of the value of the sector as a strategic voice, involved in service co-design and rooted in the heart of communities, tackling health inequalities.

It is also clear that many VCSE organisations have struggled to engage with the ICS and that standard ways of working are not commonly enabling diverse VCSE inclusion. Proactive and creative support, development, and integration of the VCSE sector is vital if we are to achieve our strategic objective of improving population health and wellbeing.

Several developments are seeking to make proactive strategic and operational changes to the engagement and inclusion of diverse VCSE organisations in the ICS Strategy and JFP. These include:

- Investment and collaboration on the establishment of a new Bristol, North Somerset and South Gloucestershire VCSE Alliance. Building on VCSE engagement infrastructure at locality and local authority levels, the Alliance aims to:

    - Encourage and enable the VCSE sector to work in a coordinated way to inform policy, strategy and decision making.
    - Provide the NHS, health, and social care colleagues with a single route of contact, engagement, and links to community.
    - Better position the VCSE sector to contribute to the design and delivery of integrated care.
- The creation of a new VCSE Lead role at the ICB – to strategically develop relationships and collaboration with the VCSE sector.
- Appointment of a VCSE representative on the ICB Board – to advise and guide strategic developments, providing a VCSE perspective and links to the Alliance.
- Co-design of a new model/framework for investment and collaboration with the diverse VCSE sector.
- Supporting VCSE leadership and participation in ICS developments.
- Generating income that builds on VCSE strengths and opportunities to invest in the VCSE and ICS.

1.4.2 Healthwatch

Healthwatch provides data at a system and area level across Bristol, North Somerset and South Gloucestershire (BNSSG), 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.

Examples of outcomes from the work we have done gathering public insights in 2022/23 include improved communication between patients, loved ones, and staff around the hospital discharge process, such as what pathway a patient is on and what this means for their care. This 'Discharge to Assess' work influenced the Every Minute Matters programme, which has brought in targeted support so that patients don't stay in hospital any longer than they need to. Outcomes from Healthwatch's engagement work around the health visiting service has led to new specialist staff and an emphasis on staff training. This has led to better support; particularly for mothers who have challenges with their mental health, and improved the questioning and recording of interactions with mothers to identify those who may be struggling, which means staff now have the information to link these mothers to relevant local services for help.

1.4.3 Engagement

During the review, update and further development of this Joint Forward Plan, local partners have been engaged via the relevant programmes within each of the Health and Care Improvement Groups, including local authorities, service providers, provider collaboratives, clinical networks, the voluntary, community and social enterprise sector and other alliances.

Our three Health and Wellbeing Boards were consulted and encouraged to feedback on how the plans take proper account of the Joint Strategic Needs Assessment as well as the Joint Local Health and Wellbeing Strategies published, they added:
'The Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy are well reflected in the Integrated Care System Joint Forward Plan (JFP). There is a clear connection with our local vision and strategic objectives, which focus on reducing inequalities and ensuring that all

people have the best start in life, live healthy and happy lives and age well in supportive, sustainable communities. The JFP also aligns well with our local commitments to deliver on this, via place-based working with the Locality Partnership and other local partners.'
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 BNSSG 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 ICS strategic framework, 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 summer 2024. This strategy sets out how we will keep people and communities at the heart of our work through effective use of insights, the inclusion of lived experience, co-production and user experience.

This Joint Forward Plan does not require public 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 ICB will ensure that public and patient consultation and engagement is completed as appropriate.

2. Population Health, Prevention and Inequality

2.1 Health and Wellbeing Boards

2.1.1 Bristol

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. Created in 2020, the Bristol Joint Local Health and Wellbeing Strategy 2020-2025 is owned by the Health and Wellbeing Board and sets out a strategic direction to 2025. Prioritisation has taken place in reference to the Joint Strategic Needs Assessment. It is aligned with the One City Plan and the BNSSG Integrated Care System Strategy. There is a strong focus on preventing ill health through addressing the wider determinants of health and growing the conditions for good health and wellbeing. The One City partnership provides a mechanism for collaboration with other sectors to achieve this aim, for example working with the Economy and Skills Board to increase opportunities for inclusive recruitment.
The priorities in the Strategy - shown in the figure below - are organised into five themes – healthy childhoods, healthy bodies, healthy minds, healthy places and communities and healthy systems.

Figure 3: Bristol Joint Local Health and Wellbeing Strategy priorities

Governance

The Bristol Joint Local Health and Wellbeing Strategy is owned by the Health and Wellbeing Board, a forum in which health and care leaders work together to improve health and reduce inequalities in the city.

The statutory duties of Health and Wellbeing Boards include publishing a Joint Local Health and Wellbeing Strategy, Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment and instilling mechanisms for joint working across health and care organisations.
In Bristol, the three Locality Partnerships are represented on the Health and Wellbeing Board and the Chair also currently chairs the Integrated Care Partnership. The Bristol Joint Local Health and Wellbeing Strategy has been aligned with the Integrated Care System Strategy.
The Health and Wellbeing Board leads the health and wellbeing theme of the One City Plan and therefore provides a bridge between the One City and Integrated Care System. Underpinning all is the commitment made to growing the power of communities. These relationships are depicted in figure below.

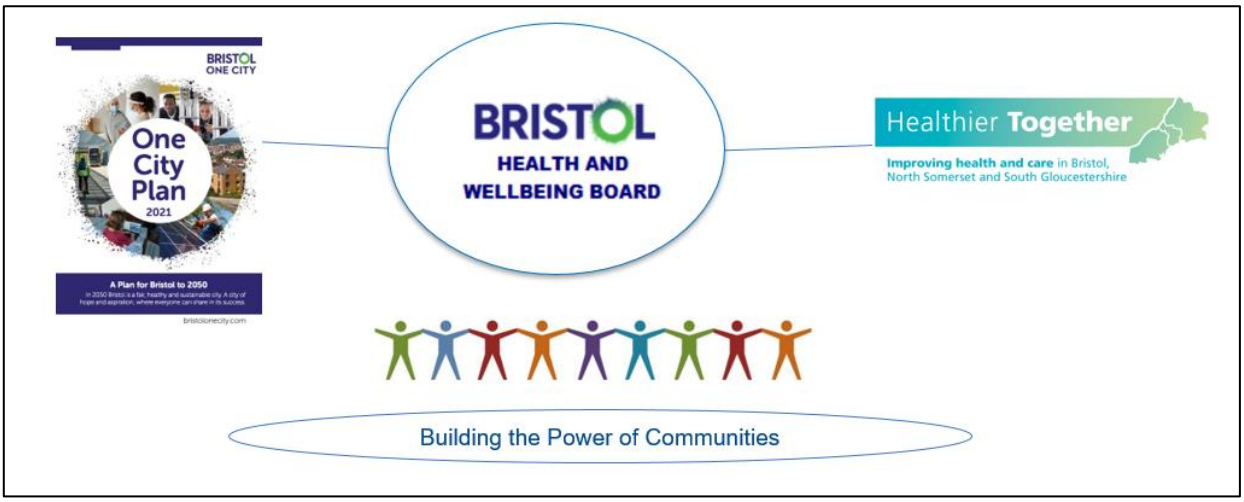


Figure 4: Bristol Bridges

Goals, indicators and workstreams
Data on all indicators can be found in the Joint Strategic Needs Assessment.

Healthy childhoods

One City Plan: 2024/25 ambition building on the partnership working during the pandemic Bristol has a better response to mental health, particularly in children and young people, to build resilience throughout the life course.

Priorities from the Integrated Care System (ICS) Strategy – Invest in the first 1,001 days of life, embed trauma informed practice. Workstreams include the Belonging Strategy and The First 1,001 Days.

Priority indicators – Percentage of children achieving a good level of development by the end of reception; % of children living in low-income families; number of first-time entrants to the youth justice system per year.

Healthy bodies

One City Plan: 2024/25 ambition – 30% more people living in the most deprived wards are doing more than 30 minutes physical activity per week compared to 2019.

Priorities from the ICS Strategy – Support people to be a healthy weight; reduce harm from tobacco and reduce harm from drugs and alcohol. Workstreams include Healthier People and Places (Public Health), the Drug and Alcohol Strategy, Smokefree Bristol and the Women's Health Hub.

Priority indicators – percentage of child and adult obesity; difference in % obesity between most and least deprived areas of Bristol; % of households with a smoker; % of Bristolians who smoke; % of women smoking during pregnancy; % routine and manual workers who smoke; number of dependent drinkers; number of opiate/crack users; number of drug related deaths per year; number of alcohol related hospital admissions; UNAIDS 95:95:95 HIV targets.

Healthy minds

One City Plan: 2024/25 ambition – 100 organisations in Bristol have signed Mind's Mental Health at Work Commitment and the work of Thrive at Night continues to support wellbeing in the night-time economy.

Priorities from the ICS Strategy – Early identification and support for people experiencing anxiety and depression. Workstreams include Thrive Bristol (Public Health), the Community Mental Health Framework and the Suicide Prevention Strategy.

Priority indicators: Quality of life survey wellbeing indicators; number of people admitted to hospital for deliberate self-harm; number of deaths due to suicide per year.

Healthy places and communities

Priorities from the ICS Strategy – develop community strengths and assets that support everyday health and wellbeing. Workstreams include health protection; Fuel Poverty Action Plan; One City Climate Strategy; One City Many Communities.

Priority indicators: % vaccine uptake; violent crime and sexual offences; % public sector fleet non-fossil fuel; % of fuel poor households.

Healthy systems

Priorities from the ICS Strategy – build a workforce who are supported, skilled and healthy; use purchasing and employment to support better health and wellbeing.

Priority indicators – % of working age adults unemployed; % of the city population living in the most deprived 10% of areas in England.

2.1.2 North Somerset

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 areas 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, the 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:

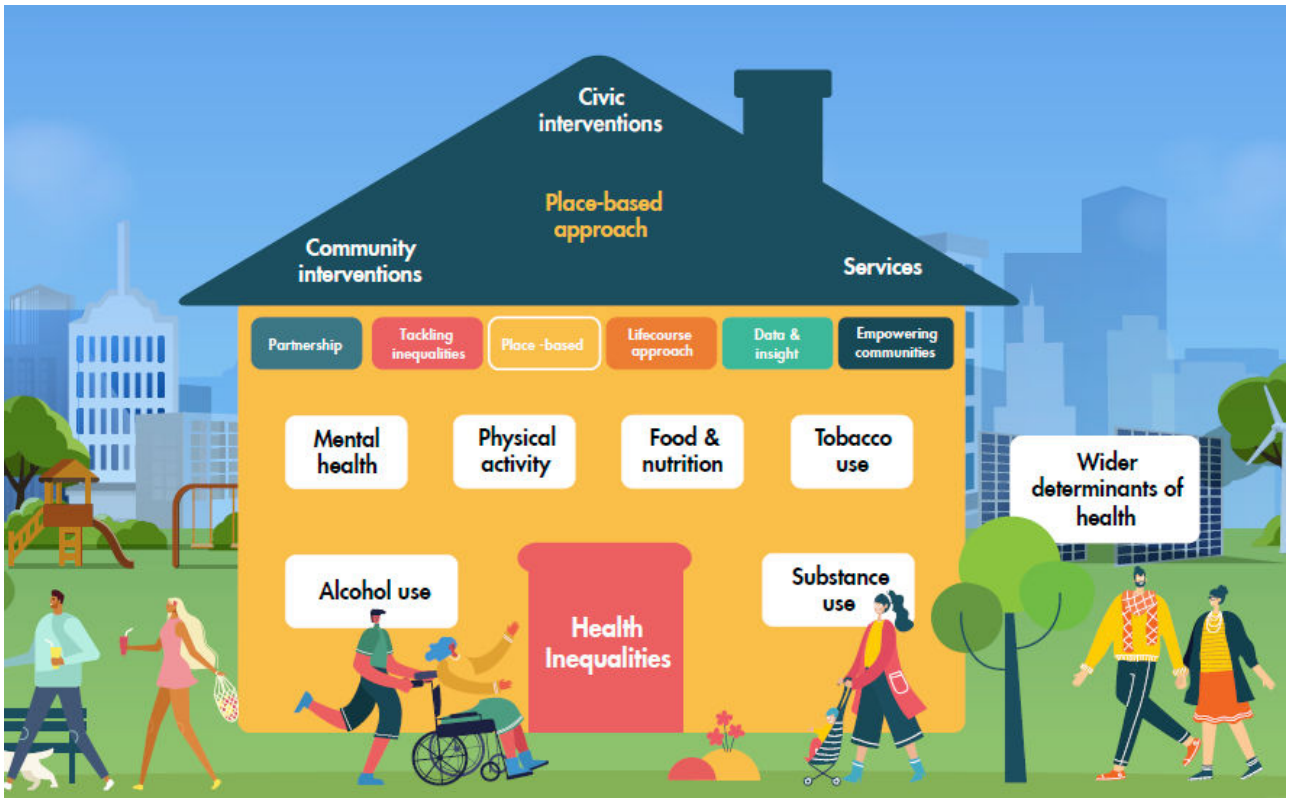


Figure 5: North Somerset Health and Wellbeing Board's approach and priority areas

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.
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 6: 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.

2.1.3 South Gloucestershire

The South Gloucestershire Joint Health and Wellbeing Strategy 2021-25 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 7: South Gloucestershire focus for collective action to improve health and wellbeing and reduce inequalities

The Joint Health and Wellbeing Strategy will be rewritten in 2024-25. In the meantime, the Health and Wellbeing Board has worked with the South Gloucestershire Locality Partnership to re-evaluate its relevance and ensure it reflects national and local developments in the health and care landscape. There have been development sessions to better understand issues and inform the work plan for 2024-25, e.g. work to address health inequalities. In addition, the Health and Wellbeing Board has held deep-dives into each strategic objective, which enabled members to hear from each other about specific pieces of work and create opportunities to collaborate and align workstreams going forward.

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

2.2 Prevention

Prevention encompasses the approaches and actions we can all take to increase the chances of people being in good mental and physical health. It can also reduce the risk of people deteriorating if they are in poor health and support quicker recovery. Prevention approaches and actions include the things we can all do to support people to be as independent as they want to be. There are opportunities to do these actions:

- throughout all the stages of someone's life
- during people's contact and interaction in and with their own communities
- during people's contact with services they use
- Methodically, and in a way that improves the lives of people who might benefit the most
- when decisions are made about how and where we spend money on services and support.

The plans detailed below describe our key steps to help people working in our health and care system to support this approach.

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Refresh and update the ICS Prevention Framework – include reference to the universal personalised care model and staff wellbeing.															
A written communication plan (what, when, who) for how the ICS Prevention Framework will be communicated.															
Implement communication plan for Prevention Framework.															
A written plan for delivering the support that organisations, system groups and teams that deliver care and support will be able to get so that they can use the prevention framework in their work (note: plan will include scoping/developing prevention champions).															
Implement the plan for delivering support to groups so that they can use the prevention framework in their work.															
Scope and plan for development of a system wide physical activity strategy, making links to healthy weight work and other relevant workstreams across the ICS to ensure a whole systems approach.															
Pull together the three whole systems approaches – smoke free, healthy weight and drugs and alcohol to identify what can be done in common which will support people in a more holistic way, e.g. addressing stigma, use of workforce.															

2.2.1 Smoke Free

Partners have set a vision for Smokefree where less than 5% of the population smoke by 2030. These are the next system-wide steps we will take towards achieving this vision.
It should be noted that:

- The system-wide plans included here are complementary to other Smokefree strategies/plans and services delivered across our wider system, for example Local Authority Stop Smoking Services. Our whole system approach to becoming Smokefree comprises both individual organisation and system-wide work.
- Embedded within each of the deliverables listed below will be a focus on reducing inequalities. We have identified some specific inequalities in relation to prevalence of smoking. For example, higher rates of smoking are seen amongst people in routine and manual occupations, people living in areas of poverty, and people who experience mental health issues.
- The activities of the alcohol and drugs, healthy weight and smoke free whole system approaches will have a lot of overlap / commonality and work will be done to align and reduce duplication in order to reflect a) what is important to people at any point in time and, b) limited capacity and varying priorities within services.

Metrics and trajectories

These metrics will be developed further as various projects scoped and develop.

Metrics	Contribution to Outcomes Framework
Progress towards our vision for Smokefree system (aim – less than 5% of population smoke by 2030): • Number/% of people who smoke • Number/% of people who stop smoking, including method.	POP1, POP2, POP4, POP6
Treating Tobacco Dependency Service: • Number/% of smokers in each Tobacco Dependency service pathway who are offered support • Number/% of people who quit/reduce smoking (target: 30% 4 week quit target [2]).	POP1, POP2, POP4, POP6, SER9
Workforce smoking cessation offer: • Staff smoking number/% by organisations • Number/% people supported to stop smoking by organisation.	POP1, POP2, POP4, STA11, STA12
Campaigns: • Number of campaigns delivered annually.	POP1, POP2, POP4, SER7, SER8,
Swap to Stop scheme: • Number of people who receive 'Very Brief Advice' (VBA) and vape quit rate (%) at 28 days.	POP1, POP2, POP4, POP6, SER8, SER9

[2] https://ash.org.uk/uploads/New-paths-and-pathways.pdf?v=1675686021

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Data and insights: Develop systemwide data recording, reporting and monitoring to track in real time progress towards our Smokefree vision and develop better qualitative insights about, and with people who smoke.															
Consolidate Treating Tobacco Dependency Service (TTD) across the three pathways of acute inpatients, maternity and mental health inpatients.															
Campaigns and communications: creation of shared assets and tools; joining up communications teams to co-ordinate campaigns to promote stopping smoking. Create an annual calendar of campaigns including Stoptober, No smoking day and holistic wellbeing focused campaigns. Develop a Swap to stop communications strategy.															
Workforce smoking cessation offer: Pilot at North Bristol Trust supporting staff is currently underway. We will evaluate this and scope how we offer support to our wider workforce. Roll out NHS staff smoking app offer when available.															
Smokefree generation funding: Cross system working in relation to uplift in Local Authority Stop Smoking Service funding.															
Develop a system-wide peer support service to sustain changes made to smoking.															
Implement the new swap to stop scheme which supports people to quit smoking with the use of vapes, combined with Very Brief Advice (VBA). Key deliverables include: recruiting a co-ordinator, establishing ordering and monitoring arrangements, workforce training, developing working practices and a communications strategy.															
Scope the development of a Smokefree Health Intervention Team (HIT) with Bristol Health Partners.															
Prevention intersection: Work with the healthy weight and alcohol and drugs programmes to identify what can be done in common which will support people in a more holistic way, e.g. addressing stigma, use of workforce.															

2.2.2 Drugs and Alcohol

We aim for a future system where the impact and harms of drugs and alcohol are minimised. Within our integrated care system, we envision a community where people affected by substance use are free from stigma and enabled to thrive. We want pathways, treatment, care, and support that are seamless and compassionate and that empower individuals affected, celebrate diversity, and foster understanding. Our vision is underlined by a united, resilient, society that is dedicated to reducing the harm and eradicating the stigma associated with substance use, and one that ensures equitable access, to create a healthier, thriving population.

Metrics and trajectories

Metrics	Contribution to Outcomes Framework
Number of emergency and unplanned admission episodes for mental and behavioural disorders due to use of alcohol or drugs.	POP1, POP2, POP5, POP6, SER7, SER8, SER9, STA11, STA12
Referral numbers from hospitals to substance use services.	POP1, POP2, POP3, POP5, SE7, SE8, SER9, STA11, STA12
Number of unplanned hospital admissions related to the health impacts of substance use.	POP1, POP2, POP3, POP5, SE7, SE8, SER9, STA11, STA12
Number of referrals from primary care to substance use services.	POP1, POP2, POP5, POP6, SER7, SER8, SER9, STA10, COM18
Obtain baseline coverage figures for audit C records in primary care and seek to increase where needs indicated.	POP1, POP2, POP5, POP6, SER7, SER8, SER9, STA10, COM18

Key Deliverables and Milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Data and insights: dashboard Scope the development of an NHS dashboard for drugs and alcohol.															
Data and insights: surveillance system Review the operability of the drug and alcohol related deaths and overdoses surveillance systems.															
Mental health: collaboration Develop the systemwide collaborations and interfaces between substance use and mental health service commissioners and providers.															
Mental health: audit Conduct an audit of treatment and support for co-occurring mental health and substance use.															
Acute: collaboration Develop the systemwide collaborations and interfaces between substance use and acute health service commissioners and providers.															
Acute: review part one Complete a review and mapping of current acute trust substance use provision across trust locations.															
Acute: review part two Delivery against recommendations within the review to improve care pathways for people accessing acute care who have a substance use need.															
Primary care collaboration Improve joint working with primary care to improve outcomes for people affected by substance use.															
Primary care: guidelines Review the implementation of clinical guidelines on alcohol and drugs within primary care settings.															
Primary care: guidelines Work with substance use treatment providers and primary care providers to ensure equitable access to prevention services (i.e. COPD, BBV's, sexual health) and treatment for physical health needs (i.e. wound care) for substance use clients.															

2.2.3 Healthy Weight

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. The plans detailed below describe our key steps to supporting people in our whole system approach to healthy weight.

Key Deliverables and Milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Talk with key stakeholders about the overarching principles and approach to healthy weight.															
Set up a system-wide steering group with key partners.															
Work with partners across the system to develop a healthy weight declaration.															
Agree a system-wide healthy weight declaration for all partners to sign up to.															
Implement the healthy weight declaration.															
Work with the smokefree and alcohol and drugs programmes to identify what can be done in common which will support people in a more holistic way, e.g. addressing stigma, use of workforce.															
Work with Health and Care Improvement Groups to review the offer and impact of the service model for weight management support / services for all ages at all tiers.															
Make recommendations for improvements to the offer and service model for weight management support / services for all ages and identify resources for implementation.															

2.2.4 Vaccination

Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death. In the last two and a half years, COVID-19 vaccines have saved tens of thousands of lives.

Our system has historically performed well across both life-course and seasonal vaccinations and has effectively responded to outbreaks of vaccine-preventable disease. We achieved among the highest rates of covid and flu vaccination in the country in autumn/winter 23-24. Our current offer within general practice and School Age Immunisation Service (SAIS) meets the need of the majority of our population.

In recent years, however, our performance alongside national performance has been in decline. We have not hit population coverage targets for childhood immunisations as a system and although we met the targets in some areas, there are significant inequalities evident that require further work. The World Health Organization (WHO) declared that the UK had eliminated measles in 2016 but we have since lost this status and we have of late seen a number of measles cases within our area, coverage in some areas is well below the 95% target.

Urgent action is required to bring parity to all vaccination programmes, and the learning from the successes of the COVID-19 vaccination within our system provide opportunities for translation of learning across other routine immunisation programmes. For example, the outreach and community based approach to addressing inequalities.

Our vaccination programme aim is to not only increase overall uptake and coverage of vaccinations, but to reduce disparity in uptake, so that every community in the country has the protection it needs. The programme will focus on collaboration with all partners delivering vaccinations, alongside the communities to develop a robust and forward-thinking approach to this important health protection intervention.

Metrics and trajectories

Metrics	Contribution to Outcomes Framework
Vaccination uptake within Bristol Inner City.	POP2, 3, 6
Measles, Mumps and Rubella (MMR) vaccination uptake across all age groups.	POP2, 3, 6
Human Papilloma Virus Vaccine (HPV) vaccination uptake across all ages.	POP2, 3, 6
Making Every Contact Count (MECC) opportunities delivered.	POP2, 3, 6

Key Deliverables and Milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Develop a local vaccination delivery plan.															
Develop clear leadership and governance for oversight of vaccination performance and delivery.															
To develop the role of the Immunisation System Oversight Group.															
To work with regional and system colleagues on the delegation of S7a vaccination commissioning to ICS/ICB.															
To continue working as one of 12 national demonstrator systems testing national improvements and outcomes that meet the strategy.															
Develop a system wide data set for all age immunisations.															
Develop a system recording improvement plan to ensure accuracy of data.															
Develop a robust outbreak management pathway.															
Develop a robust approach to improving access and reducing inequalities for vaccination.															
Develop a responsive and flexible workforce model.															

2.2.5 Secondary Prevention

See Long Term Conditions under section 4.5 below for further plans on secondary prevention.

2.3 Health Inequality

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." (Koenecke, 2019)

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 and 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.

We will establish a Health 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.

2.4 Women's Health

NHS England 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.

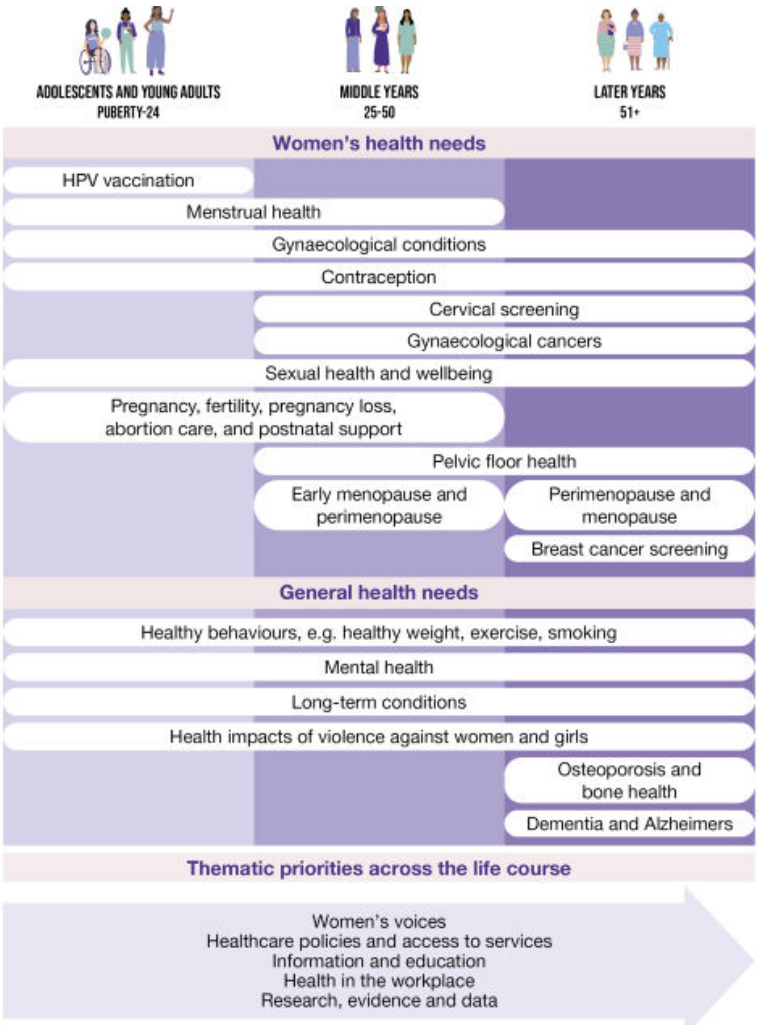


Figure 8: NHS England Women's Strategy

To note, we refer to women, but recognise that some people who do not identify as women also require access to women's health services. Women's health services are focused on the reproductive and sexual health lifecycle and include menstrual health, contraception, cervical screening, pelvic health, menopause, sexually-transmitted infection screening and treatment and HIV screening.

Key Deliverables and Milestones

Deliverables	2024/2025				2025/2026				2026/2027				2028/29	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4
Finalise plans for bringing together healthcare professionals and existing services to provide more integrated women's health services in the community.														
Implement plans.														

2.6 Sexual and Reproductive Health, Abortions and HIV

Poor sexual health disproportionately affects those already experiencing social exclusion through poverty, sexuality and race. Prevention and reducing inequalities are at the heart of our drive towards better care in BNSSG and the consequences of inadequate interventions impact most on our marginalised communities. Despite the evidence available to demonstrate the cost effectiveness of our sexual health preventative interventions, we are currently seeing increases in sexually transmitted infections (STIs) and a rise in abortions. The costs of the consequences of poor sexual health are mostly borne by the NHS and social care as well as the individual, their families and society and include:

- unplanned pregnancies and abortions, poorer maternity outcomes for mother and baby
- poor mental health including from stigma, coercion and abuse
- poor educational, social and economic opportunities for teenage mothers, young fathers and their children
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- cervical and other genital cancers
- hepatitis, chronic liver disease and liver cancer.

Sexual and reproductive services and abortion services are being recommissioned for 2025. The aim is to provide a much greater focus on prevention, working with marginalised communities, and providing efficient digital access to testing and treatment where appropriate. This will enable those who need to be seen in person to access services more easily within their community. We will retain a strong focus on the most effective forms of contraception (such as coils and implants) and on reducing inequalities in access including a system focus on providing contraception immediately after birth or abortion. HIV is preventable through condoms, PrEP and PEP (pre and post exposure prophylaxis), and anti-retroviral treatment to prevent transmission. Although new cases of HIV have been declining, and advances in treatment mean that people can live long healthy lives without passing on the virus, some groups of people are disproportionately impacted by HIV including African and Caribbean heritage communities. We still have too many people being diagnosed late with HIV, which has poorer outcomes for the patient and higher costs for the NHS and society. HIV treatment is currently commissioned by NHS England but will be delegated to ICBs in 2025. In 2024/2025 we will be introducing opt out blood borne virus testing (HIV, Hepatitis B and C) into emergency departments in our hospitals, this will help with diagnosing and treating people more quickly.

Metrics and trajectories

Metrics	Contribution to Outcomes Framework
Numbers/rates of sexually transmitted infections diagnosed in Sexual Health Services (SHS).	POP3, POP6
Numbers/rates of abortions.	POP1, POP5, POP6
Numbers/rates of long-acting reversible contraception (LARC) fitted in primary care.	POP1, POP6
Numbers/rates of emergency hormonal contraception (EHC) issued by pharmacists and GPs.	POP1, POP6
Numbers of pharmacists offering oral contraception without a prescription.	POP6
Numbers/rates of HIV new diagnosis.	POP1, POP2, POP3, POP6
Numbers/proportion of HIV late diagnosis.	POP1, POP2, POP3, POP6
Numbers/rates of HIV, Hep B and Hep C diagnosed in emergency departments.	POP1, POP2, POP3, POP6

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				2028/2029			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Refine service specifications.																				
Launch a tender for sexual reproductive health and abortion services.																				
Award contracts.																				
New contracts begin.																				
Distribute learning from PCN pilots for long-acting reversible contraception.																				
Develop and agree proposals for primary care delivery of sexual and reproductive health services.																				
Consult with GP Collaborative Board and Local Pharmaceutical Committee regarding intentions for primary care regarding proposals.																				
Develop contracts for GPs and pharmacies.																				
Direct award contracts to GPs and pharmacies.																				
Agree the system and ICB lead for HIV, and determine SRO for ED programme.																				
Develop an action plan, working with Bristol Fast Track Cities Steering Group.																				
Appoint project manager, and agree leads for hepatology, ED, training, pathology.																				
Develop steering group and working groups.																				
Develop ED staff training around HIV and stigma.																				
Develop project plan for ED opt out.																				
Implement ED opt out.																				
Determine timescales and plans for transfer of HIV treatment commissioning to ICB.																				
Develop plans (ICB and local authorities) for co-ordinated sexual health and HIV commissioning.																				
Agree governance mechanisms for HIV treatment commissioning.																				

3. Children and Young People

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 requirement to focus on the needs of children, young people and families to promote future health and wellbeing in a seamless way across services, as well as reducing 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.

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, the 2024/25 children's operational plan is focused on addressing the backlog in need for an autism assessment. Whilst additional 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 neurodiversity needs. Our 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.

Since the first iteration of the Children and Young People's Joint Forward Plan was published, the Bristol, North Somerset and South Gloucestershire (BNSSG) Children's Health and Care Improvement Group has established and agreed three key areas of focus for children and families:

- Ensuring the needs of neurodiverse children and young people, and their families are consistently met
- Improving health and development outcomes for early years children
- Addressing the challenges faced by children and young people with highly escalated psychosocial and emotional needs.

For children's mental health, we will align improvement plans to the all-age mental health strategy described in section 3.4 'Improving the Lives of People with Mental Health, Learning Disabilities and Autism' and develop 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).

Aims and objectives

We will maintain 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, mental health 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.

Governance

Health and care partners are responsible for agreeing and delivering the Joint Forward Plan via the Improving the Lives of Our Children Health and Care Improvement Group, part of the new delivery framework for BNSSG 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 Health and Care Improvement groups recognising that children live in families and communities. Close links are also 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.

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				2028/2029			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Children's Health and Care Improvement Group - key areas of focus for children and families																				
Develop and implement BNSSG system action plan to improve health and development outcomes for early years children.																				
Develop and implement BNSSG system action plan to address challenges for children and young people with highly escalated psychosocial and emotional needs.																				
Undertake system transformation to ensure the needs of neurodiverse children and young people and their families are consistently met.																				
2. Supporting children and young people with special educational needs, learning disabilities and autism																				
Implement local area SEND plans and learning from OFSTED / CQC SEND inspections.																				
Development of a multi-agency Dynamic Support Register (DSR) to improve early identification of children and young people at risk of admission to a mental health hospital, and their access to person-centred planning and community alternatives and support to prevent avoidable admissions.																				
Carry out pilot of an on-line Learning Disability Screening Tool for parent carers who have concerns about their child's development.																				
ICB and Sirona to jointly lead the development of an interim autism and ADHD support and assessment model to be implemented in the short-term whilst the longer-term neurodiversity transformation programme is undertaken.																				
Upskill children's workforce by developing & providing: Trauma informed training and Oliver McGowan training.																				
Deliver the Partnership for Inclusion of Neurodiversity in Schools (PINS) supporting neurodiversity and inclusion in at least 40 primary schools.																				
3. Children's community health services																				
Implement Sirona's children's development and improvement programme including improvement trajectories, demand and capacity analysis, waiting list management and service re-design within community paediatrics, autism and ADHD assessment and therapies.																				
Deliver public health nursing transformation.																				
Meet our statutory responsibility for adoption medical provision.																				
Meet our statutory responsibility for health contribution to safeguarding strategy meetings.																				

4. Children and Young People's Mental Health																				
Undertake assessment of community service provision to support the delivery of commissioner guidance for Children and Young People Mental Health, Learning Disability and Autism Inpatient Services (guidance currently in draft).																				
Develop and implement BNSSG mental health access improvement plan to include focus on recruitment, data validation and performance improvement.																				
Develop and implement and enhanced BNSSG transition service for young people with mental health difficulties moving on from CAMHS.																				
Continue naso-gastric feeding pilot for eating disorders.																				
Continue roll out of mental health support teams in schools.																				
Continue Autism Intensive Service.																				
Implement Framework for Integrated Care to improve outcomes for children and young people with the most complex needs in BNSSG.																				
Improve awareness of the impact of trauma and adversity and build knowledge into services and systems through a trauma-informed approach.																				
5. Children's acute services																				
Improve capacity for the Bristol Royal Hospital for Children, enabling it to provide timely and comprehensive emergency and elective care for local children in BNSSG and regional, tertiary care for children across the South West and beyond.	Plan in development.																			
Continue to improve referral to treatment (RTT) and time critical patient waiting times in line with national guidance with a particular focus on specific areas of risk and challenge within children's elective care (cardiac surgery, dental, cleft).																				
Maintain access and performance for children's urgent and emergency care.																				
Specialised commissioning: • Stabilise specialist services in the face of rising need • Ensure adequate and timely access to neonatal intensive care and paediatric critical care • Pilot complications with excess weight (CEW) hub and spoke model.																				

Metrics and trajectories

Metrics	Link to Outcomes Framework
1. Children's Health and Care Improvement Group - key areas of focus for children and families	
Priority areas are currently in discovery phase/scoping with metrics to be agreed: • Improve health and development outcomes for early years children; Address challenges for children and young people with highly escalated psychosocial and emotional needs; Ensure the needs of neurodiverse children and young people and their families are consistently met.	POP5&6
2. Supporting children and young people with special educational needs, learning disabilities and autism	
• 100% of requests for assessment are returned to Local Authority within six weeks • Health contribute to 100% of EHCP Annual Reviews where health have active involvement • Jointly planned and/or commissioned service by the ICB and local area partners; Co-produced services by the ICB with local area partners • Number of children and young people on Dynamic Support Register (DSR) • Number of agencies accessing and contributing to DSR • Number of primary schools involved in Partnership for Inclusion of Neurodiversity in Schools (PINS) project and qualitative school data measuring confidence and skills.	POP5&6
3. Children's community health services	
• Improvement trajectories agreed and mobilised to reduce waiting times for children's community services in line with National guidance, allowing for local delivery expectations • Effective health contribution to child protection strategy meetings • Performance against agreed standards and outcomes for all public health nursing.	POP5&6
4. Children and young people's mental health	
• Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (10,985 contacts per year) • Improved referral to treatment (RTT) performance (18 weeks) • Increased number of CYP being supported by Mental Health Support Teams in Schools • Reduction in children and young people requiring social care placements • Monitor urgent (one week) and routine (28 days) access to community eating disorder services • Evaluation of implementation of the framework for integrated care for children and young people with complex needs undertaken by University of the West of England: • Improved children and young people's wellbeing; Reduction in high-risk behaviours; Reduced mental health concern; Organisations that are more trauma-informed; Improved purpose/occupation; Improved stability of home. • Trauma informed training received by Vanguard pathways • Development of Trauma-Informed Practice Framework; Pledge taken by partners to become a Trauma-Informed system.	POP5&6, SER9, COM16, COM17, COM18
5. Children's acute services	
• Eliminate waits of over 52 weeks for planned care by March 2025 • Improve emergency waiting times so that no less than 83% of patients are seen within four hours by March 2025 (in draft - tbc).	POP6, SER8

4. Community and Primary Care

4.1 Primary Care

Background

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

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.

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.

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.

Spreading good practice and supporting continuous quality improvement - The support provided by Access Resilience and Quality Programme includes:

- Supporting the spread and adoption of best practice.
- Supporting practices and primary care networks with continuous improvement.
- Care Quality Commission (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.

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 and 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.

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 care optometry-based referral refinement services.
- An integrated service for children and young people and learning disabilities.

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 together with secondary care and Local Authority partners to take a collaborative approach to:

- Implementing a dental strategy which seeks to improve access, reduce inequalities, retain the workforce and increase oral health promotion.
- Develop service models for vulnerable groups e.g. migrant health, care homes, children looked after.
- Identify opportunities to apply flexible commissioning guidance to the contract to target local oral health priorities through the provision of new additional services.
- 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.

The collaborative work will include working closely with the Local Dental Committee, managed clinical networks, Bristol Dental School and ICBs across the South West region.

Workforce - We will develop and implement a general practice 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 and skills to enable ongoing development of a multi skilled primary care workforce.
- 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. In addition, poor quality estate has also been observed as a major barrier for the recruitment and retainment of general practice workforce.

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.
- 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.

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 Primary Care being part of the 'Improving the lives of people in our community Health and Care Improvement Group'.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Primary Care Workload	
Number of GP appointments.	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 7000 per month.	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
General Practice 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.	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.	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	2024/2025				2025/2026				2026/2027				2027/2028				2028/2029
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Deliver the Recovering Access to Primary Care Plan.																	
Continue to improve digital maturity and re-procure a digital platform for GPs.																	
Implement a suite of digital and business intelligence solutions to support the management of workload.																	
Provide practice support services to assist practices in addressing operational challenges.																	
Develop and implement a general practice workforce strategy.																	
Integrate primary care workforce strategy with the wider system workforce strategy and NHS Long Term Workforce Plan.																	
Deliver the Training Hub 5 Year Strategy.																	
Develop and implement a general practice Estates Strategy.																	
Establish a ten-year capital investment plan from 2025/26.																	
Set out the roadmap to net carbon zero for the general practice estate.																	
Community Pharmacy																	
To increase the number of pharmacies able to supply contraception to patients already prescribed oral contraception.																	
To pilot the use of an IP Community Pharmacist to prescribe for patients with minor ailments.																	
To increase the number of blood pressure checks taken in a community pharmacy to support risk identification and prevention of cardiovascular disease.																	
Community Optometry																	
Implement referral refinement schemes: a referral pilot between community practices and the local trust for macula referrals; glaucoma referral refinement; cataract pre-operative assessment.																	
Implement direct referral pathways from community optometrists to ophthalmology services for all eye consultations.																	
Embed system wide post-operative cataract service.																	
Implement Community Urgent Eyecare Service.																	
Community Dental																	
Develop and implement a dental strategy.																	
Address access issues through initiatives such as additional access sessions and dental helplines – improving the current 60% UDA achievement against contract.																	
Identify and develop service models for vulnerable groups e.g. migrant health, care homes.																	
Improve oral health in children.																	

4.2 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.

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 voluntary, community, faith and social enterprise (VCFSE) sector, 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).
- Develop a broad range of high quality and safe interventions to support personal patient choice responding to gaps where identified.

Governance

We are establishing a personalised care steering committee to oversee delivery of universal personalised care, 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. The steering committee will also network closely with the South West Integrated Personalised Care Team. Sirona care & health will continue to be 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 Chief Delivery Officer.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Number of staff/individuals completing Personalised Care Institute (PCI) accredited training. Having an agreed plan for sustainable train the trainer ICS wide training provision.	SER7, SER8, SER9, STA10
Number of coded care plans evidencing the link to the National Framework. Friends and Family Test feedback.	POP5, SER7, SER8, SER9, STA10
Increase number of people receiving personal health budgets to 3000 and establish targets for short and long term.	POP1, POP2, POP5, SER7, SER8, SER9, STA10
Increased number of people aware of and accessing resources such as PCI and HOPE (Supported Self-Management course), evidenced via data provided on courses completed.	POP5, SER7, SER8, SER9, ENV21, STA12, COM18
Number of completed NG197 baseline assessments. Staff and people reporting choice and information more available via audits Friends and Family Tests. Long Term: Auditing for Shared Decision Making.	POP6, SER7, SER8, SER9, STA10
Amount of joint investment in community wellbeing offer. Number of people taking part in community wellbeing programme baseline percentage of people reporting improvement in self-reported wellbeing.	POP5, SERV7, SERV8, SERV9 STA12, COM18, ENV21

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				2028/2029			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Personalised care communications plan - Develop a communication plan for personalised care so that services know who to contact. - Provide communications support to link together the national and international movement 'What Matters to You' to fit our place for a joint recognised approach to personalised care. - Develop a toolkit of comms resources to communicate key messages to a range of audiences.																				
Develop a Personalised Care Steering Committee: - Identify Senior Responsible officer, establish terms of reference, governance structure and membership. - Plan roll out and engagement strategy, mapping of services and interested parties. Identify readiness for change into Personalised Care Models. - Outline evidence for system support structures to attend as core members alongside that of operational services.																				
Ensuring personalised care training is available in a sustainable model for delivery via train the trainer model - To complete the current training needs GAP analysis and future provision scoping. - Establish link into system wide training discussions and funding provisions to support The South West Collaborative training model ICS wide. - Scope and understand funding bidding processes and secure funding for next year and future years delivery. - Complete scope of ICS offers to support staff availability for train the trainer model.																				

Deliver a consistent approach for development of personalised care and support plans to be used across all partners – in paper and digital format (e.g. Black Pear) - Map current care plans and work currently being scoped on care plans including EMIS care planning, Respect Plus and Orange Folder (Pier Health Vanguard) against About Me standards, EHCH, Care Coordinator framework etc. - Establish process for coding and reporting on personalised care plans. - Link with system work on carers and trauma informed practice to truly support whole person care planning.																			
Increase Personal Health Budget offers and uptake - Develop workstream and GAP analysis around current reporting process required. - Increase system wide knowledge of the range of work PHBs can fund and explore current offers to ensure reporting of provision is correct.																			
Embed Comprehensive Model of Personalised Care - Work with Health, Social Care and VCSE system partners to increase knowledge of the wide range of personalised care opportunities in our community and how to empower those they work with to access them.																			
Shared Decision Making - Scope baseline assessments for NG197 (NICE Guidelines for Shared Decision Making) across ICS. - Plan and seek agreement to support delivering Shared Decision Making model across the ICS. - Make information more accessible and freely available to people and staff to help them to understand the treatment choices, benefits and risks.																			

4.3 Continuing health care and funded care

Background to NHS funded care

Childrens continuing 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.

Continuing health care (CHC) - adults
NHS continuing healthcare is put in place following an eligibility assessment against the national framework. A package of 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 diagnosis, 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 ICB Chief Nursing Officer who works closely with partners from all local authorities and other service providers. A suite of funding panels in line with the standing financial instruction, risk and complexity are in place to support decision-making.

Metrics and trajectories

In order to consistently deliver against key national adult continuing healthcare key performance indicator standards, the following metrics will be monitored:

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
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
Number of fast-track end of life care in place within two working days of referral.	SER7, SER8, SER9
% of people in receipt of continuing healthcare at home to have their care via a form of personal health budget.	SER7, SER8, SER9
Completion of the Maturity Framework.	SER7, SER8, SER9,
Increase in the % of CYP reporting a positive experience of transitioning into adult CHC.	POP6, SER7, SER8, SER9,
Increase in capacity of specialist community care provision and suitable models of housing support.	SER7, SER8, SER9
Completion of a review of brokerage services, with a defined future model.	SER7, SER8, SER9
New brokerage model established.	SER7, SER8, SER9
Completed needs analysis for improved continuity of care for young people in receipt of CHC by Q2 2025/2026.	SER7, SER8, SER9

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
All Age Continuing Care Programme															
Continue to explore the viability of a seven-day working fast track service. **Update to 23/24 commitments:** • Test and learn project during industrial action with extended service hours on Saturdays. Nurses now in-reaching to acute hospitals. • Scoping alternative operating models is underway – liaising with ICBs across the South of England.															
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. **Update to 23/24 commitments:** • Adult CHC team split into case management and assessment functions, enabling dedicated focus on delivering each aspect. Preparing for place-based case management.															
Continue to 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). **Update to 23/24 commitments:** • Fast Track PHB Pilot evaluation completed in Q2 23/24. • Personalised ICB care plans being rolled out across the adult CHC team from Q3 23/24.															
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. **Update to 23/24 commitments:** • Refresh of the adults CHC maturity framework completed in Q3 23/24. • Reviewing the maturity framework to explore adapting it to apply to CYP and MH/LDA teams. • One of 7 ICBs piloting the Digital Capability Assurance Tool for NHSE in Q3 23/24.															
Continue to scope out gaps or misalignment in services that result in unmet need for individuals transitioning from children to adult services. **Update to 23/24 commitments:** • Work pushed back to Q1 24/25 due to limited senior management resource required to progress.															
Continue to scope out optimisation of technology enhanced care (TEC) to promote independence, support improved case management, reduce reliance on traditional care, and support admission avoidance. **Update to 23/24 commitments:** • Unable to recruit so far to the dedicated Occupational Therapist post to support this work programme. Reviewing this area of work to identify solutions.															
Continue to develop improved ways of commissioning care services and delivering efficiencies to support individuals with the most complex needs, in partnership with BNSSG local authorities. **Update to 23/24 commitments:** • Project has been initiated as a discovery exercise, with an initial focus in on the complex learning disabilities and autism cohort, supported by the ICB's transformation team.															
Identify the most appropriate model for brokerage. **Update to 23/24 commitments:** • Detailed briefing paper outlining options for the review has been developed, shared with ICB executives and Local Authority DASS for comment.															
Establish the most appropriate model for brokerage within BNSSG.															

4.4 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. In addition, we want 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.

Metrics and trajectories

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 the end of 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 230 beds per annum.

Metrics	Link to Outcomes Framework
Acute bed and bed days per month used by P0, 1-3.	SER8, SER9, STA10
Long-term care home (permanent placement of a person in a care home) - 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) – weekly care hours.	SER8, SER9, STA10
Pathway 2 and Pathway 3 - P2/P3 starts per year.	SER8, SER9, STA10
Pathway 1 – P1 starts per year.	SER8, SER9, STA10
40% reduction in "non ideal" pathway decisions across P1/2/3. Adult Social Care Outcomes Framework (ASCOF) reporting on the percentage of people at home 91 days post hospital discharge.	SER8, SER9, STA10
25% Length of stay reduction across acute bed days associated with P0, P1, P2 and P3, reduce Acute no criteria to reside (NC2R) rates. Save 200 acute beds vs. financial year 22/23.	SER8, SER9, STA10
Reduce P2 and P3 community Length of stay to target levels agreed in modelled scenarios. Reduce Community NC2R percentage of bed base and maintain community bedded capacity at 230 beds.	SER8, SER9, STA10
Reduce number of people receiving long term care placements (residence and nursing) following hospital stay.	SER8, SER9, STA10
Increase staff trust, relationship and understanding of discharge to assess pathways.	POP6, SER7, SER8, SER9, STA10
Increase number of people and carers reporting positive experiences of hospital discharge and discharge to assess discharge pathways.	SER7

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
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 to reduce Length of Stay and achieve pathway shift targets.																	
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 (Budget already agreed for 2023/24 and 2024/25, evaluation of new models of care will be completed in time for refreshed 2025/26 funding round with the aim of agreeing a medium-term deal i.e. three years).																	
Implement additional community capacity (voluntary sector, night sitting, reablement, domiciliary care) in support of acute length of stay reduction.																	
Standardise pathway 2 operational processes and increase assessment/therapy capacity, reduce P2 length of stay.																	
Standardise pathway 3 operational processes and increase assessment/therapy capacity, reduce P3 length of stay.																	
Design, scope and implement improved patient and system level data sharing.																	

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

4.5 Long Term Conditions

4.5.1 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, CVD 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. 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.

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

Metrics and trajectories

Metrics	Link to Outcomes Framework
Increase the number of patients with suspected heart failure seen for specialist assessment and transthoracic echocardiography by 2025/2026: - within two and six weeks of referral (within agreed parameters).	POP2, SER8, SER9,
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.	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
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

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
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 agreed based on recommendations provided in CVD Review paper.														
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 agreed based on recommendations provided in CVD Review paper.														
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.															
Cardiac Rehabilitation															
Design community cardiac rehab service.	To be agreed based on recommendations provided in CVD Review paper.														
Implement Community Cardiac rehab services.															
Programme – Heart Failure															
Implementation Heart Failure service phase 1 (referral and triage).															
Redesign Heart Failure service phase 2.															
Implementation Heart Failure service phase 2.															
Redesign Heart Failure service phase 3.															
Implementation Heart Failure service phase 3.															
Roll out Heart Failure virtual ward pathway at North Bristol NHS Trust.	TBC														
Roll out Heart Failure virtual ward pathway at University Hospitals Bristol and Weston NHS Foundation Trust.	TBC														
Implementation of system wide digitalised (Doccla) pathway.	TBC														

4.5.2 Respiratory Programme

Background

Our system has had a history of comparatively high admissions for chronic respiratory conditions and steady growth in those admissions year-on-year. We have 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 aims to reduce hospital admissions for the key respiratory conditions in our population. This includes for Chronic Obstructive Pulmonary Disease (COPD), asthma, pneumonia, and other respiratory infections.

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.

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.	POP3
Double the number of pulmonary rehab completions by 31 March 2026.	STA10, SER8
Increase the number of spirometry training completions.	STA10
Number of locations / programmes that the pulmonary rehabilitation programmes are running across the Bristol, North Somerset and South Gloucestershire.	STA10, SER8
The number of patients receiving FeNO tests (fractional exhaled nitric oxide).	SER8
Number of Acute Respiratory Infection appointments offered.	SER8, POP3
Increase pneumococcal vaccinations uptake rate for eligible patients over 65 years.	POP1, POP2, POP3
Reduction in inhaler waste.	
Reduction in bed days per admission.	

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Continue the targeted expansion and development of pulmonary rehabilitation in what is year three of a five year project.															
Continue the high uptake of those on the MyCOPD self-care app and plan for sustainability.															
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.															
Evaluate and agree new funding for myCOPD.															

4.5.3 Diabetes

Background

We aim to reduce 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.

One Care is leading 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.

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).	POP2, POP6, SER8
Achievement of NICE 9 care processes for patients with diabetes (national).	POP2, POP6, SER8
Increased referrals to support services including the Diabetes Prevention Programme and NHS Type 2 Pathway to Remission Programme.	POP2, POP6, SER8
Referral trajectory to Low Calorie Diet Programme (national).	SER8, SER9
Number of minor and major amputations for people living with Diabetes.	SER8, STA10
Emergency department attendances for diabetes-related primary diagnosis.	SER8
Non-elective admissions for hyper/hypo.	SER8
Admissions for appliance prescribing.	SER8
Increased number of people will be optimally managed for Diabetes as defined by both the person and their healthcare professional, reducing the possible harm caused by complications such as cardiovascular disease.	POP1, POP2, POP4, POP5, POP6, SER7, SER8, SER9, STA10
Increased prescribing for medicines and devices in accordance with national and local policy.	POP1, POP6, SER8
Ambulance conveyances and non-elective admissions for patients aged 18-39 living with Type 2 Diabetes.	POP1, POP6, SER8

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	Q1+2	Q3+4
Development and implementation of new model of integrated care.																
Complete footcare review recommendations Footcare sub-group in place and meeting bi-monthly (Chaired by Penny Agent as Sirona Executive Director for Therapies). Sirona have been leading a plan focused on primary care and community, the group includes secondary care and reviews the actions required from all areas. The main focus for the next quarter is structured case reviews to identify the main causes contributing to lower limb amputations.																
Evaluate pilots and make a decision on future approach to health inequalities voluntary sector grant scheme Grants provided to Let's Walk Bristol, Brunelcare, Southmead Development Trust, Caafi Health and Soul Trail Wellbeing At differing stages of delivery, Brunelcare started in late summer whilst Caafi Health's initiative has finished. A full evaluation has not been completed for these reasons and also resourcing constraints. Without programme management support it is unlikely a review will be undertaken.																
Deliver best value medicines and devices, to support patient outcomes As NICE Technology Appraisal and guidelines land the BNSSG formulary and guidelines continue to be reviewed collaboratively across the system to support the local implementation of these. There are three Prescribing Quality Scheme projects in the Prescribing Quality Scheme which promote the safe and cost-effective use of medications and devices, including the wider adoption of the more cost-effective biosimilar insulins. Patient outcome and prescribing data will be reviewed on an ongoing basis to review progress with delivery of this aim.																

4.5.4 End of Life

The end of life (EoL) network is focussing on the following areas:

- 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.

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, SER9, STA10
Number of with preferred place of care and death recorded.	SER7, SER8, 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, STA10
Number of people identified as at risk of death prior to dying, including the key metrics on the futures platform described below: - Number of deaths per financial year. - Average days known to services. - Average contacts per person in the last 90 days. - Place of death. - Age at death. - Cause of death.	STA10

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Implementation of ReSPECT Plus.															
Rollout of ReSPECT Plus to social care.															
Patient held ReSPECT Plus.															
Training and Workforce Education plan development Next steps under review and due for discussion in 2024. Next steps include the following key milestones: - Identifying training & support gaps for diverse EoL workforce, including informal carers. - Developing EoL core skills competencies, education & training framework. - Developing training plan to support workforce, wider professionals, patients and carers to have conversations about dying, including What Matters approach.															
Workforce education plan implementation. Next steps under review and due for discussion in 2024. This work also has co-dependency on the build of a BNSSG wide EoL website to provide a platform for everyone to access the training resources when ready.															
Development of online resource centre.															
Online resource centre live.															
Delivery of training, including communication skills, for end of life conversations. Next steps under review and due for discussion in 2024.															
Identification of Cambridge multi-morbidity score pilot (CMS) at North Bristol NHS Trust (NBT).															
Rollout of CMS and other agreed tools across setting to support identification. CMS pilot is on hold while data sharing agreement is being agreed between NBT and One Care GP services.															
Review of EoL contracts completed, the ambitions will now inform the ICS palliative and end of life care future strategy.															
Implementation of agreed PROMs.															
Review PROMs and dashboard data and plan for service developments.															
Implementation of service developments.															

4.6 Place-based - Localities

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 (ICE), Bristol South, Bristol North and West, South Gloucestershire, Weston, Worle and Villages and Woodspring.

Our 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' refers to the most deprived 20% of the national population
- 'PLUS' refers to 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.

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
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.	Outcomes tools used to measure improvements for individuals in their wellbeing are Dialog, ReQol-10 and GBO. We will seek to seek an increase in wellbeing and health through greater integrated working. Some measures such as relating to mental health will be expected to show improvements in the shorter term, however other measures about wellbeing and overall health will only be seen in the longer term.	POP1, POP2, POP5, SER9, STA10

To champion and continue to develop the role of place-based working in BNSSG through Locality Partnerships	The level to which health and care partner organisations and people in communities report improvements in health, wellbeing and connectedness of services. We will expect to see increases here in reported improvements.	POP1, POP5, POP6, SER7, SER8, SER9, STA10, COM16, COM18
To understand and address the inequalities that the population of each locality experience in access, quality of experience, and outcomes in health and social care	Individual projects will have specific measures however a key overall measure is the reduction in premature mortality in the under 75s.	POP1, POP6
Implement local interventions linked to pro-active care to tackle local needs, including enhanced health in care homes	Increases in the years of life lived in good health.	POP2, SER7, SER8, SER9

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
All Localities – overarching deliverables															
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.															
To champion and continue to develop the role of place-based working in BNSSG through locality partnerships.															
To understand and address the inequalities that the population of each locality experience in access, quality of experience, and outcomes in health and social care.															
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 the Community Link Workers Service.															
Develop biopsychosocial interventions to enhance the wellbeing and health of ICE populations (e.g. green and blue social prescribing, arts, physical activity).															
Gain a better understanding of, in order to reduce, the high prevalence of severe frailty in over 75s in Asian, mixed and Black communities in comparison to White communities.															
Slow the rate of increase in weight between reception and year 6 children in ICE (as recorded by the National Child Measurement Programme, 2019) in Eastville, Lawrence Hill, St. George Central and St George West via positive activities grant for small organisations working with CYP.															
Understanding and finding solutions to the barriers re accessing wellbeing/ mental health services in secondary school age for certain ethnic groups, age, gender, and deprivation via positive activities grant for small organisations working with CYP.															
Reduce preventable falls and harm from falls through strategic coordination and integration of efforts across organisations; working across localities and sectors through involvement in arenas such as Bristol Falls Collaborative.															
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. • 2023/24 – Focus on reducing the disparity and inequality in hypertension case finding and management in target areas of Inner City and East Bristol • 2023/4 and 2024/25 – Extension of above project is NHSE bid successful to wider CVD determinants and across localities															
South Bristol															
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.															
Co-produce an approach to reduce alcohol harms within our communities and align with the launch of the integrated mental health team.	Work plan to be developed further														

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 and Community Connector roles and build partnerships via the Community Anchor Organisation engagement.															
Support the roll-out of integrated community clinics to help people in South Bristol.															
Identify an approach to reducing the impact of COPD on health and wellbeing in South Bristol using data and input of those with lived experience.															
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.															
North and West Bristol (N&W)															
Target and reduce incidences of self-harm in children and young people (CYP) (10-24yrs). The Student Liaison Service will be integrated into North & West MINT service.															
Target and reduce incidences of self-harm in older adults (25+) in outer areas of N&W. And further develop the N&W mental health offer including links to police & non-custodial services.															
Implement services to improve CYP mental health and integrate eating disorder services.															
Working with partners we will apply systems thinking to develop support to children, young people and their families to move toward healthy weights, with ward specific focus.															
Improve the health of people in N&W with a COPD diagnosis. We will increase access to pulmonary rehab provision in BS11. We will work with communities and the voluntary sector to address the social determinates of health, with a primary focus on smoking, fuel poverty and housing. We will increase self-management of COPD in the community and reduce hospital admissions.															
Develop a targeted intervention to improve diabetes self-care and management in North & West.															
Work with communities and providers to co-design support for people in segment 2 and 3 to enable people to access community provision and reduce the need for unplanned care.															
South Gloucestershire															
CVD – prevention and health inequalities: Work to address CVD risk in defined population cohorts through proactive case-finding and intervention, community engagement and outreach and an integrated Partnership approach between NHS, Local Authority and VCSE partners. Address risk factors such as heathy weight, smoking and alcohol misuse.															
Community Prevention and Wellbeing Hubs: Through an innovative partnership between GP practices and VCSE, rollout Prevention & Wellbeing Hubs, underpinned by population health management and responding to local needs and accessible to local communities. The hubs will proactively support secondary prevention and tackle health inequalities, drawing on a community strength-based approach and addressing the wider determinants of health.															
Adult mental health and wellbeing: Support mental health and wellbeing for those experiencing mental illness or distress in the community, including those with problematic alcohol and drug use, and addressing the wider determinants such as poor housing, joblessness and debt alongside clinical interventions. Working as partners, address health inequalities for those with Serious Mental Illness.															
Children and young people mental health & wellbeing: Improve mental health and wellbeing in our Children and Young People including addressing self-harm, emotional-based school absence and anxiety, through integrated working with schools and wider Partners. Support vulnerable cohorts such as those leaving the care system and young homeless.															
Chronic pain and wellbeing: Improve the outcomes of those experiencing chronic pain, depression and/or anxiety in our communities through providing holistic, de-medicalised															

intervention and peer support. Explore insight and data on pain and Musculo-skeletal (MSK) conditions and scope further work.															
Age friendly: Support individuals to be active within their communities and maintain their independence as they age. Recognise and support those with caring responsibilities and address isolation and loneliness in our rural locations. Deliver improved outcomes for individuals at risk of falling through a preventative, proactive approach. Learn from local models that are being trialled in the community to improve outcomes for people who are frail with complex needs.															
Strengthening our communities: Grow our Asset-based Community Development (ABCD) approach by development and implementation of the South Gloucestershire ABCD Framework, supported by Community Inclusion Grants.															
Better Care Fund (BCF): Explore the BCF as a mechanism to support further joint working and a shift towards more personalised and proactive care.															
Weston, Worle and Villages															
Deliver a falls and frailty fast response service pathway to assess and keep people in their own homes.															
Creation of a Community Frailty Hub to deliver out of hospital care and reduce demand for acute and social care services.															
Creating a sustainable VCSE offer - Befriending Alliance/Falls Collaborative/Virtual Hub.															
Ensure families and health professionals understand, know and respect an individual's wishes regarding places of death. Create the opportunity for wellbeing conversations in the last 1000 days to understand and listen to an individual's needs and support planning.															
Implement brief interventions for children who are identified as being an unhealthy weight in the school nursing service.															
Reduction in hypertension/high cholesterol results that contribute to shorter life expectancy. Initial targeted approach on families that have hypertension / high cholesterol levels (pilot 50-100 families).															
Woodspring															
Support families, schools and services to manage the increased anxiety in Children and Young People in our communities.															
Phased roll out of the North Somerset Together Virtual Wellbeing Hub, including formal evaluation and development of a business case for future funding.															
Identify how we can support the 3,000 people aged 50-74 living with painful conditions.															
Mobilise of the Woodspring Ageing Well model focussed on prevention, pro-active and complex care in the priority areas: falls, complex care team, dementia, social isolation and loneliness.															
Increase the number of people discussing their end of life wishes and dying in their place of choice.															
Develop a targeted health inequalities strategy (and delivery plan) for Woodspring which includes addressing the inequity of opportunities and outcomes derived from our rurality and large, older population.															

4.7 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 continue to 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.

The service provides accessible GP medical services acting as a first point of contact offering a holistic assessment, initiation of treatment and stabilisation services for Bristol homeless population with complex health needs (chronic diseases as well as long term problems related to substance misuse and mental health). This is mainly for unregistered patients presenting with acute conditions to assess, treat or refer but with the aim to move them onto mainstream primary care medical services in a supported way when stabilised.

5. Mental Health, Learning Disabilities and Autism

5.1 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, best practice, and improve local performance.

Aims and objectives

Our vision for mental health is: **"Better Mental Health for All".** People having the best mental health and wellbeing in supportive, inclusive, thriving communities.

Our strategy has six ambitions:

1. **Holistic Care** - People of all ages will experience support and care which considers everything that might help them stay well
2. **Prevention and early help** - People of all ages, their families and carers will get the support they need in the right place and in a timely way, as early as possible
3. **Quality treatment** – High quality treatment is available to people of all ages as needed closed to home, so they can stay well in their local communities
4. **Sustainable system** - We will have an economically and environmentally sustainable mental system where maximum benefit is delivered to the community
5. **Advancing equalities** – We will reduce health inequalities by improving equity of access, experience and outcomes throughout people's lives
6. **Great place to work** – We will have a happy, diverse, inclusive, trauma-informed and stable workforce across 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.

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 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.

Workforce

The national NHS workforce plan covers the challenges facing the NHS with regards to staffing levels. Specifically for mental health, particularly since the pandemic, we have faced difficulties in recruiting sufficient numbers of psychiatric medical staff, registered mental health nurses and healthcare support workers. This has resulted in increased use of agency staff, which can challenge the consistency of team dynamics and retention of permanent staff. Avon and Wiltshire Mental Health Partnership (AWP) have developed several interventions to reduce the impact of this as well as improve staff retention, minimise the use of agency where it is safe to do so, and improve our ability to permanently fill vacant posts.

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.	POP5
Increase the estimated diagnosis rate for people with dementia. This includes the number of people aged 65 or over diagnosed with dementia.	POP1
Increase the number of women accessing specialist community perinatal mental health services.	POP1, POP5, SER7, SER8, STA10
Increase the number of people who receive two or more contacts from the NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses.	POP5, SER8, SER9, STA10
Interdependency with children's services:	
Increase access to children and young people's mental health services.	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 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.	POP1, SER8
Number of people accessing individual placement and support services.	POP5, SER8
Number of people with first episode of psychosis treatment within two weeks of referral.	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. The target for annual health checks is 6,024 (Primary Care: 4,352 and AWP: 1,672)	POP1, POP2, POP6, SER8
Individual Placement and Support (IPS) Service fidelity to model	
Increase the number of people accessing IPS. Target for 2024/25 is 1,113 people.	POP5, SER8
NHS Talking Therapies (IAPT)	
Reduction in the step three waiting list.	POP5
Increase the percentage of high intensity therapists in post 12 months following completion of their training; Increase the percentage of psychological wellbeing practitioners in post 12 months following completion of their training.	POP5
Community mental health services	
33% increase in the number of additional reimbursement scheme (ARR) roles across BNSSG by 2025.	POP5, SER8

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 three 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. Achieve a 5% year-on-year increase.	POP5, SER8, SER9, STA10
Increase the estimated diagnosis rate for people with dementia.	POP5
Perinatal access	
Increase the number of women accessing specialist community perinatal mental health services.	POP1, POP5, SER7, SER8, STA10
Completion of procurement of VCSE support contracts for perinatal services; contacts broken down by demographics and attended contacts by demographics.	POP1, POP5, SER7, SER8, STA10
Mental health and Wellbeing Integrated Network Teams (MINTs)	
Increase the number of Primary Care Networks (PCNs) delivering a transformed model of care. All PCNs to be delivering a transformed model of care by the end of 2024/25.	POP5, SER8, SER9, STA10
Reduction in inappropriate referrals to secondary mental health care.	POP5, SER8, SER9, STA10
DIALOG Patient Reported Outcome Measure improvements in mental health and quality of life. 80% of people connected with community groups to show improvement.	
75% increase in number of community partners.	
Reduction in admission episodes for mental and behavioural disorders due to use of alcohol or drugs. ICD10 codes to be agreed.	POP1, POP2, POP5, POP6, SER7, SER8, SER9, STA11, STA12
Inpatient mental health services – Out of hours support and out of area placement	
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 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
Personality Disorder (Complex Emotional Needs)	
Complete recruitment for Sequoia service.	POP5, SER8
Sequoia service launched in all localities, including the establishment of a training programme by the end of 2024/25.	POP5, SER8, SER9
Others related to service provider	
Great Place to work for Avon and Wiltshire Partnership: • Improvement in staff survey results overall and by department/role; Reduction in staff turnover; Reduction in sickness; Reduction in the number of grievances/disciplinaries; Increase in retention.	
Management Development: • Expectations of managers established and communicated across AWP; All line management roles have clear and consistent role and responsibility descriptions; Have a leadership programme in place; Have a development opportunities programme in place; Existing training has been benchmarked; Decision-making on whether management training is mandatory; Management competency framework in place for grievances and disciplinaries; Managers are better equipped and have the capability and confidence to deal with concerns before they escalate to more formal processes via grievances and disciplinaries.	
Agency reduction: • 90% of posts are filled by core staff, with the remaining delivered mostly by our internal staff bank by Q4 2027/28; and ICB price cap compliance by Q2 2024/25.	

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1&2	Q3&4	
Physical Health Checks for people with severe mental illness															
Continue to invest in and support general practice and voluntary partners, to ensure that people with severe mental illness (SMI) access an annual physical health check.															
Continue to invest in and support AWP, to ensure that people with SMI access an annual physical health check.															
Individual placement & support (IPS)															
Review the whole IPS service (with Richmond Fellowship) to determine improvements and associated investment required to meet the national access target (leading up to 2028/29).															
Work to promote the IPS model in host AWP community teams and mental health & wellbeing integrated network teams (MINTs) to achieve the 2024/25 national access rate.															
Start to implement the expansions required to achieve the national access target leading up to 2028/29.															
Achieve the 2025/26 national access rate.															
NHS Talking Therapies (IAPT)															
Reduction in the step three waiting list through additional trainee capacity.															
Retention of high intensity therapists (step three) and psychological wellbeing practitioners (step two).															
Perinatal access															
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.						Estimated timescale for redesign in line with ICB VCSE re-procurement exercise									
Community Mental Health Framework (CMHF) Additional Roles Reimbursement Schemes (ARRS)															
33% increase in the number of ARRs roles across BNSSG.															
Mental health and Wellbeing Integrated Network Teams (MINTs)															
Deliver mental health & wellbeing integrated teams at locality level across BNSSG.															
Local development of integrated mental health teams, linking in with wider system.															
Improve reach to diverse communities - locality partnerships investing in community partners such as Nilaari, Bristol Black Carers and Somali Resource Centre to improve culturally responsive support.															
Drug and alcohol treatment services are linked into MINT teams, with clear referral pathways between services and training and development provision implemented for staff.															
Personality Disorder (Complex Emotional Needs)															
Roll out the personality disorder service (Sequoia) including establishing a training programme.															
Review and analyse the impact on individuals, the system and identify unmet need to determine whether further service development is required.					Start pushed back from Q3&4 2024/25 to allow for service to be fully rolled out before evaluated										

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1&2	Q3&4	
Eating disorders															
Agree a plan with all stakeholders regarding primary care physical health interface work including physical health monitoring.															
Implement self-referral process (digital solution).															
Implement physical health interface (timescales depending on the model and funding).															
Review the provision for eating disorders and identify unmet need to determine whether further service development is required.															
Community Rehabilitation															
Agree a BNSSG-wide model.															
Implement an integrated mental health, social care and housing plan across BNSSG.															
Establish new community rehabilitation service.															
Older Adults pathway															
Redesign the front door and pathway for older adult functional services via the MINTs to be the same in all six localities.															
Early Intervention in Psychosis level three															
Level three NICE concordance achieved across BNSSG.															
Out of Hours mental health crisis support															
Mental health liaison services within general hospitals meeting the “core 24” service standard.	TBC – subject to funding														
Out of Area Placements															
Continue work of the Rightcare Programme and AWP inpatient review – Rapid Improvement Programme.															
Implement a complex discharge team to support people who are clinically fit for discharge but are unable to get home from inpatient settings without this support.	TBC – subject to funding														
Other															
Refine Health and Care Improvement Group report template to include co-production.															
AWP deliverables to improve the working environment, streamline corporate processes, improve communication and clarify decision-making.															
AWP review current job descriptions for managers and ensure expectations, roles and responsibilities of managers are clearly defined.															
AWP design and deliver leadership development programmes and activities benchmarking to establish mandatory or essential management training.															
AWP explore competency-based frameworks with a view to develop the essential capabilities and behaviours required for managers at all levels within AWP.															

5.2 Learning Disabilities and Autism

We want everyone with a learning disability and/or autism to live longer, healthier and happier lives. This means we need to ensure people are supported to have more choice, control and independence, and to always be treated with dignity and respect. We believe 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 high individualised quality care (in line with Long Term Plan commitments and the Building the Right Support national service model - in collaboration with NHS Lead 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
- Take a discovery approach to better understanding the challenges and opportunities affecting some of our most vulnerable people.

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 disabilities 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 (see Children & Young People’s Joint Forward Plan)

This section is aligned with the Children and Young People’s Joint Forward Plan which has been 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 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.

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, the 2024/25 Children's Operational Plan is focused on addressing the backlog for 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. Our 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.

Since the first iteration of the Children and Young People's Joint Forward Plan was published, the BNSSG Children's Health and Care Improvement Group has been established and agreed three key areas of focus for children and families:

- Ensuring the needs of neurodiverse children and young people and their families are consistently met
- Improving health and development outcomes for early years children
- Addressing the challenges faced by children and young people with highly escalated psychosocial and emotional needs.

For children's mental health, we will align improvement plans to the all-age Mental Health and Wellbeing Strategy described in section 3.4 'Improving the Lives of People with Mental Health, Learning Disabilities and Autism' and develop 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).

2a. 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.

2b. Governance

Health and care partners are responsible for agreeing and delivering the Joint Forward Plans via the Mental Health, Learning Disability & Autism Health and Care Improvement Group in conjunction with the Improving the Lives of Our Children Health and Care Improvement Group, both of which are part of the new delivery framework for BNSSG Integrated Care System.

This programme reports to the Learning Disabilities and Autism Operational Delivery Group (ODG) set up in January 2024. The ODG in turn reports into the Mental Health and Learning Disabilities & Autism Health and Care Improvement Group (HCIG) monthly. The deliverables reflect full integration and collaboration from all system partners to achieve the four key delivery programmes. A programme delivery plan and risk register will be reviewed by ODG to ensure the programme remains on track to deliver to time, quality and cost.

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.

2c. Neurodiversity

It is more important than ever to create a sustainable system that meets the needs of families, children and young people while also considering the resources of organisations linked to these pathway changes. The Neurodiversity Transformation Project (NTP) aims to co-design what a sustainable offer might be. With co-production and engagement at the heart of understanding the problem and designing a sustainable solution, we have been working closely with our three Parent Carers Forums across BNSSG to identify how we can ensure the child, parent or carer is at the heart of designing a future solution that takes a neurodiverse approach and identifies needs and provides support earlier, rather than waiting for a diagnosis.

This embraces other work that has already taken place and the project will capture the learning from:

- A sustained waiting list initiative including the commissioning of a private provider
- Autism assessment “User Experience” digital project
- Changing the assessment criteria
- Development and introduction of a keyworker team
- The testing of new or expanded “needs-led” neuro support projects.
- The BNSSG Autism Hub development
- Autism In Schools projects

The project is at gateway zero which solely focuses on discovery and understanding the problem. From the initial discovery phase, we will bring together all the insights work done which will highlight any gaps in information and what further engagement is needed within our education partners. The catalyst of the stage will be two conferences with wider stakeholders and the public, the first focussed on understanding and evidencing the problem through a mixture of organisational data as well as insights and engagement work previously carried out. The stakeholders will also be able to identify if any further engagement or data collection is required to fully understand the problem and people’s views. The second will bring everyone together again to

focus on “ideation”, taking into consideration the outputs from the discovery phase and identifying potential options to explore a “Test & Learn” pilot in gateway one.

The neurodiversity transformation work aims to support:

- Children having their needs met in school settings and consequent reduction in requests for education, health, and care needs assessments
- Increased system awareness and skills through training e.g. Oliver McGowan training
- Reduce the number of children and young people on assessment/profiling waiting lists
- Reduce length of time between identification, understanding need and intervention.

Several new or expanded test and learn projects have been piloted to provide support pre-autism assessment. For example, Neon Daisy is an online resource hub for young autistic girls and 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
- Provide a 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.

To alleviate some of the pressures and challenges being experienced now, following a significant increase in referrals for autism assessment, an interim model project is also currently underway to explore options to address the increased demand above commissioned capacity within the BNSSG system for ASD assessments, the interim model will factor in:

- Commissioned capacity will continue as normal, and the interim model is for the increased demand above capacity
- Any changes must undergo clinical scrutiny and prioritise meeting needs and reducing harm
- Be adaptable for a further increase in the monthly demand for assessments
- Cover a period of up to 18 months.

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 people with a learning disability and autistic people 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 a 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; supporting 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 BNSSG.
We will ensure seamless delivery of health and social care services improving the quality of care and support.
Co-production will be embedded in all our programmes of work.

Governance

This programme reports to the Learning Disabilities and Autism Operational Delivery Group (ODG) which was set up in January 2024. The ODG in turn reports into the Mental Health and Learning Disabilities & Autism Health and Care Improvement Group (HCIG) on a monthly basis.

The deliverables detailed below reflect full integration and collaboration from all system partners to achieve the four key delivery programmes. A programme delivery plan and risk register will be reviewed by ODG to ensure the programme remains on track to deliver to time, quality and cost.

Metrics and trajectories

Metrics	Outcomes Framework
Goal 1 Support people to move into their communities and thrive	
Delivery of the Population Health Management (PHM) review of learning disabilities and autism (no associated metrics).	Not applicable
Recommendation from the recently funded care discovery report. This project links to the ICB transformation work related to the funded care project, the benefits and workplan will therefore be similar.	Not applicable
Completion of Oldland Common. Metric 1: 30% less out of area placements for specialised housing by 31st March 2030.	SER8
Goal 2 Provide the best start in life for children and young people	
Conference data and ideation plan.	POP6
Number of Children and young people on Dynamic Support Register. Number of agencies accessing and contributing to Dynamic Support Register.	POP6
Access data.	POP6
Number of primary schools involved in Partnership for Inclusion of Neurodiversity in Schools (PINS) project. Qualitative school data measuring confidence and skills.	POP6
Stage one to agreed design principles; Shared problem statement and Long list of options. Stage two: Options appraisal (including clinical challenge and initial impact assessments – particularly healthcare inequalities, quality and finance); Recommendation of a preferred option; Action plan with agreed next steps and workstreams.	POP6
Quantitative access data.	POP6, SER9
Goal 3. Improve the healthcare of the most vulnerable	
Baseline and assess the number of completed health checks to look for increases. Baseline and review mortality (ages) data for any improvements in the management of condition. Baseline and review health check quality to look for improvements.	SER9 SER8
Fewer admissions for those with learning disability and autism for common associated conditions such as epilepsy/constipation/urinary tract infection.	SER7 SER8 SER9

Improved public health outcomes for those with learning disability and autism using the public health data set to track disease. Baseline and evaluation of waiting times.	
There will be a population health management baseline from this work to use as evaluation measures. Equalities metrics are collected on the NHS Digital national Mental Health Protected Characteristics Data Dashboard and advice is given on further suitable metrics for this strategy.	SER8 COM18
Number of contracts vs percentage of contracts completed. Baseline service user and carer feedback answers to set questions through agreed, established or new routes, and agree evaluation dates.	SER7 SER8
Goal 4. Give voice and influence to individuals, families and carers	
Baseline service user and carer feedback answers to set questions through agreed, established or new routes, and agree evaluation dates.	SER8
The metrics associated with the review implementation are likely to be connected to successful co-production, housing and other local placements developed by this plan and their associated feedback.	COM18

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Supporting people to move into their communities and thrive																	
Implement the revised system-wide Dynamic Support Register and Care (education) Treatment Reviews 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.																	
ICB Transformation Hub Discovery Project. Funded care for learning disability and autism with complex needs and/or 'behaviours that challenge'. Use discovery gateway to develop improved ways of commissioning care services and delivering efficiencies to support individuals with the most complex needs, in partnership with BNSSG local authorities.																	
Forecasting: Learning Disability and Autism Needs Analysis, Baseline Assessment and Psychological First Aid Forecasting. Undertake Population Health Management (PHM) review of learning disabilities and autism, including community mapping to identify gaps in provision (for example, forensic outreach service). It will also include capacity/eligibility/discharge pathways and a strategy to address removing barriers to prevent deterioration, expensive treatments and early death.																	
Flourishing Lives Tender – Positive Behaviour Support - Take a user centred design approach to developing a new model of high-quality health and social care services to better meet a range of common needs. The model will need to include crisis intervention for people experiencing escalation, and support care providers to deliver Positive Behaviour Support (PBS). Current provision mapping. Develop a new model of individualised, high quality community services underpinned by a baseline assessment of existing service provision and capacity in our system.																	
Concord Lodge Moving On Project.																	
Commissioning of Strategic Care Partner for Learning Disability and Autism.																	
New accommodation/specialist housing project - develop a housing plan to include learning from Learning Disability and Autistic People 2022.																	
Implement the revised system-wide Dynamic Support Register and Care (education) Treatment Reviews, 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.																	
Best start in life for children and young people																	
System change Neurodiversity Transformation Project through transformation gateways until implementation.																	
Development of a multi-agency Dynamic Support Register (DSR) to improve early identification of people at risk of admission to a mental health hospital and their access to person-centred planning and community alternatives and support to prevent avoidable admissions.																	
Carry out pilot of an online Learning Disability Screening Tool for parent carers who have concerns about their child's development.																	
Deliver the Partnership for Inclusion of Neurodiversity in Schools (PINS) supporting neurodiversity and inclusion in at least 40 primary schools.																	
Develop an interim model to address the increased demand above commissioned capacity within the BNSSG system for ASD assessments.																	
Upskilling children's workforce by developing and providing Oliver McGowan training.																	

Improving healthcare																		
Improving the uptake and quality of annual health checks with people with learning disabilities. Embed health check audit tools auditing five checks per practice to ensure they are comprehensive, actions identified and followed up, and Health Action Plans developed. Link health checks to medicines optimisation plans. Design an evaluation process that will enable us to understand the impact of annual health checks and link to data plans. ICB health inequalities reporting for people with learning disabilities.																		
Learning disability and autistic people (LeDeR). Continue to revise an approach in line with new NHSE guidance to ensure that autistic people 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 and quality assurance via local governance panel. Recommendations will be limited in number and inform the health inequality improvement plan.																		
Develop and Implement Physical Health Plan. Establish a robust and repeatable process to ensure LeDeR recommendations are implemented across the BNSSG system. Develop a system working group and increase the uptake of cancer screening opportunities for people with learning disabilities																		
Reasonable adjustments projects. Develop a programme that ensures digital reasonable adjustment flags are embedded into general practice. Explore digital solutions aligned with BNSSG Digital Strategy that will enable access. Develop PHM approach for learning disability and autism to tackle health inequalities.																		
Include learning disability and autism quality schedules in all contracts (ensure schedules have good recommendations).																		
Develop a new model and end-to-end pathway for managing people with ADHD and neurodiversity that includes greater partnership between general practices and partner providers.																		
Voice and influence																		
Develop a robust and inclusive model of co-production across the system (coordinated across health and care partners).																		
Implement recommendations of the Bubb review.																		
Establish a core group of experts by experience to test end-to-end learning disability and autism pathway journeys through services. It will include a range of approaches to gain insights, including 'secret shopper' audit of emergency departments, STOMP case reviews and engaging with parents/carers.																		

6. Acute Healthcare Services

6.1 Acute Provider Collaborative

Background

The Acute Provider Collaborative Board was established in May 2021 as a Trust Board Committee in Common across University Hospitals Bristol and Weston NHS (UHBW) Foundation Trust and North Bristol NHS Trust (NBT). This builds on a long and successful history of collaboration between the two organisations.

Underpinning the decision is the development and implementation of a Joint Clinical Strategy to deliver a shared vision for services, which are seamless, high quality, equitable and sustainable – unlocking significant benefits for patients, staff and communities. The Joint Clinical Strategy was launched in March 2024 and is the result of over 12 months' work by clinicians from across both organisations. It is designed to complement and be supported by the existing strategies and visions of both organisations.

In December 2023, NBT and UHBW announced the decision of their Trust Boards, and UHBW's Council of Governors, to have a Joint Chair and Joint Chief Executive to lead both organisations as the first step to form a Hospital Group within the next two years.
Working as a group will enable the trusts to join forces to address shared challenges around workforce, estates and finances, whilst remaining as independent organisations with separate oversight by NHS England and the Care Quality Commission.

Aims and objectives

The overall aim of the Acute Provider Collaborative is to deliver benefits at scale on behalf of the Integrated Care Board (ICB). The Group Model will support this and will unlock significant opportunities including:

- Improved access to services, shorter waiting times and enhanced patient experience
- Creating more sustainable services and seamless patient care, by leveraging the scale of both organisations, building on the different strengths of each trust
- Maximising opportunities for staff across both trusts
- Supporting population health management, moving to more proactive models of care and address inequalities
- Become national and international leaders in the delivery of research and early adopters of innovation
- Enabling the trusts to take advantage economies of scale to ensure sustainable use of resources
- Further placing the trusts at the heart of the community – investing in places and people to benefit the local economy and community.

Specialist regional services

The Acute Provider Collaborative Joint Clinical Strategy supports both organisations continuing to deliver regional specialist services for the Bristol, North Somerset, and South Gloucestershire (BNSSG) population and a population at a regional level and beyond.

Our tertiary services are currently 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. They are central to the emerging regional strategy, focusing on tertiary capacity across two regional centres, Bristol and Plymouth, to serve the South West.

Our 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 UHBW and NBT 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.

NBT Specialist Services

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

UHBW 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 work programme is designed and delivered through three workstreams: clinical services, corporate services and digital. Each workstream has joint executive senior responsible officers and its own programme board or steering group as appropriate. An additional workstream will be established to oversee the group development programme.

There is a Joint Executive Group (comprised of both Executive Teams) and a Strategic Oversight Group (Chief Executive Officers and their deputies), which are accountable for the programmes. They provide ultimate assurance to the Acute Provider Collaborative Board, which is jointly chaired by the two trust chairs. Membership of the board includes both Chief Executive Officers and some Executive and Non-Executive Directors from both organisations.

A monthly highlight report is provided to the ICB. The metrics will be developed on a project-by-project basis, and each will demonstrate how they contribute to the objectives highlighted above.

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Clinical services																	
Launch Joint Clinical Strategy.																	
Phase 1: All duplicated services to work together as Single Managed Services.																	
Phase 2: Every clinical service to consider how the opportunities of collaboration working as a Hospital Group can drive improved care.																	
Phase 3: Our clinical teams, working with patients and partners, to consider how we organise or cluster clinical specialties on each of our sites to bring maximum benefit to the acute care we provide.																	
Corporate services																	
Joint Resourcing Hub Implementation.																	
Finance priorities (joint approach to capital, business planning, savings and reporting).																	
Other finance projects and corporate functions (to be agreed as part of the Group Model Design Phase).																	
Other finance projects and corporate functions (to be implemented as part of Group Delivery Phase).																	
Digital																	
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.																	
Hospital Group Model Development																	
Phase 1: Initiation: Programme Plan for Design Phase and initial Business Case.																	
Phase 2: Design: Design the Group Model and develop the implementation Business Case.																	
Phase 3: Delivery: Implement the agreed Group Model through a significant change programme.																	

6.2 Healthy Weston

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.

UHBW 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 securing 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 is already helping more people go home quickly after going to hospital in an emergency, with dedicated units for assessing and treating people rapidly. It will:

- ✓ 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 was a particular focus on helping people get home faster after accidents and emergencies, supported where needed by closer working between hospital and community-based teams. Improvements include:

- ✓ Enhancement of the 24hour 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 is helping 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 2024, 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. This 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
27 bed benefits, equivalent to 15 bed escalation capacity cash savings by the end of 2024/2025.	POP1, SER8, SER9, STA10, STA12
10% reduction in length of stay by the end of 2024/2025.	POP1, SER8, SER9, STA10, STA12
10% improvement in 'time to be seen, treated and discharged' targets by the end of 2024/2025.	POP1, SER8, SER9, STA10, STA12
20% emergency department attendance through same day emergency care by 2025.	STA10, STA11, STA12, STA13
Improved workforce outcomes (decrease vacancy rate and reduce reliance on agency staff).	STA10, STA11, STA12, STA13

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	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 and Older Person's Assessment Unit.																	
Phase 2 and 3																	
Develop the operationalisation of the agreed clinical model and transfer of some medical in-patient pathways to the Bristol Royal Infirmary and other neighbouring hospitals.																	
Ensure standardisation of pathways and standards of care through ongoing integration of services across Bristol and Weston.																	
Define potential care mix and volumes for Weston General Hospital site (Phase 3) through the UHBW Surgical Strategy. NBT to develop the same assessment.																	
Develop and approve Healthy Weston 2 Phase 2 and 3 Full Business Cases. The expectation is that the acute capital prioritisation would ensure phase 3 stays in the priorities. We will be continuing to join up discussions with NBT as part of a single acute view of capital priorities and underpinned by the developing elective care strategy for the system.																	

6.3 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 BNSSG Maternity Voices Partnership. We aim to improve care for women, babies and their families, contributing to the personalised care agenda. Ongoing work with BNSSG Maternity Voices Partnership will allow us to co-produce with women from a wider range of backgrounds.

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 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, who report to the ICB as per national guidance.

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 and trajectories

Metrics	**Link to Outcomes Framework**
The number of women recorded as having informed consent information in their notes.	SER7, SER9, STA10
The number of women risk-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 (ethnic minority groups and those living in the most deprived areas).	POP1
100% of women up until 12 months postnatal have access to perinatal pelvic health information by Q2 2024/2025.	POP1, SER7, SER8, SER9
100% inclusion from all ethnicities (communities) in each maternity unit footprint, including neonatal voice partner representation by Q3 2024/2025.	POP1, POP2, POP5, SER7 SER9, COM18
90% compliance with saving babies lives version 3 framework by the end of 2024/2025.	POP1, POP2, POP6, STA10

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				2028/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Listening to and working with women and families with compassion																	
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 use audited. **Update to 23/24:** Care and Support plans have been in place since Feb 23 and auditing will commence in Feb 24.																	
Growing, retaining and supporting our workforce																	
Improve recruitment and retention as well as scope new roles via LMNS 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 and Advanced Clinical Practitioner roles to aid retention.																	
Developing a culture of safety, learning and support																	
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.																	
Standards and structures that underpin safer, more personalised, and more equitable care																	
Deliver robust maternity and neonatology monthly data report which accurately reflects activity.																	
Establish a rolling programme to standardise clinical guidelines across the system. **Update to 23/24:** Multi-Disciplinary Team group established to develop shared BNSSG Maternity Clinical Pathways.																	

6.4 Urgent and Emergency Care (UEC)

Background

The performance of urgent and emergency are 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.

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

- Improving accident and emergency (A&E) waiting times so that no less than 76% of patients are seen within four hours with further improvements to be confirmed
- Improve category two ambulance response times to an average of 30 minutes, with further improvement towards pre-pandemic levels in the long-term
- Reduce adult general and acute (G&A) bed occupancy
- 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.

Virtual Wards – NHS@Home

This programme has been established across our system and provides capacity of 100-120 virtual ward beds. We will continue to grow and develop our service offer, building up to 450 virtual ward beds. We will ensure capacity is utilised for alternatives to admission as well as enabling 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.

Governance

Delivery of the urgent and emergency care priorities is overseen by 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 ICB. Matrix working with the children's and mental health service leads will ensure opportunities are not missed for quality improvements, which span the urgent and emergency care elements of those services, for example the role of pediatricians in the system Clinical Assessment Service.

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, with further improvement towards pre-pandemic levels in the long-term.	POP2, SER8, SER9, STA10, STA12
Improve the accident and emergency (A&E) 4-hour target.	POP2, SER8, SER9, STA10, STA12
Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.	POP2, SER8, SER9, STA10, STA12
System Clinical Assessment Service (CAS) 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
Same Day Emergency Care (SDEC) 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
Same-day urgent community response (UCR) metrics:	
Type 1, 3 & 4 emergency department activity and performance metrics, including patient and staff experience data	POP1, POP2, POP6, SER7, SER8, SER9, STA10, STA12
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 an emergency department.	POP2, SER8, SER9, STA10, STA12
The number of ambulance see and treat and see and convey outcomes.	POP2, SER8, SER9, STA10, STA12
Other	
The number of patients attending emergency departments with mental health issues	POP2, POP6, SER7, SER8, SER9, STA10, STA12
Reduce attendances and admissions for complex frail individuals.	POP1, POP2, POP6, STA10
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

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

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				2028/2029
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Urgent and Emergency Care Recovery Plan																	
Develop plan to manage and absorb non-elective growth.																	
Implement same day emergency care across every hospital with a major emergency department.																	
Contribute acute clinical expertise to community-based remote access services e.g. the Community Emergency Medicines Service (CEMS) and Assessment and Coordination of Emergency Care (ACE) team.																	
Develop sustainable plan, in partnership with Avon Wiltshire Partnership (AWP) for increased demand for adult and paediatric mental health services in the acute sector, largely presenting through the emergency department.																	
System transformation schemes impacting plan																	
Maximise the impact of implemented transformation schemes and realising bed benefit.																	
Strategy Refresh																	
Develop (system to collaborate on) a joint five-year strategy for urgent and emergency care services.																	
Urgent Community Response																	
Review of type 3 and 4 emergency departments. Complete review of Urgent Treatment Centre, Minor Injury Unit and Walk In Centre provision based on population need and national guidance.																	
Evolve the remote community 'front door' and generate a plan to integrate remote assessment services for urgent and emergency care, which are accessible to patients and clinicians.																	
Virtual Ward – NHS@Home																	
Develop digital requirements into as few systems as possible. Work with digital partners to resolve digital challenges.																	
Continue to grow and develop service offer.																	

6.5 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 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 the children's section above.

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
- 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
- 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 September 2024 (except where patients choose to wait longer).	POP1, POP6, SER7, SER9
Reduction of follow up backlogs.	POP1, POP6, SER7, SER9
Diagnostics	
Recover waiting times for the sleep service.	POP1, POP6, SER7, SER9
No patients wait greater than 13 weeks for a diagnostic test (regionally set ambition).	POP1, POP2, POP6 SER7, SER9
Improvement in the percentage of patients needing a diagnostic test by receiving it within six weeks, with an ambition of 95% by March 2025.	POP1, POP2, POP6, SER7, SER9
Cancer	
Reduction of 62+day cancer backlog to nationally set targets.	POP1, POP2, POP6, SER7, SER9
77% of patients urgently referred by their GP for suspected cancer (FDS) are diagnosed or have cancer ruled out within 28 days.	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.	POP1 SER8 SER9
Increase Day Case rates from 75% to 80-85%.	POP1 SER8 SER9

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Core deliverables for Elective Programme																	
Develop System Elective Care Strategy.																	
Develop capital cases, as part of the System Elective Strategy development (Bristol Eye Hospital ground floor - outpatients, Bristol Royal Hospital for Childrens additional theatre, Healthy Weston phase 2/3 and major adult theatre upgrade. At Southmead site, the further development of Concord House to release capacity for outpatients and outpatient procedures).																	
Maximising opportunity associated with the Elective Care Centre, as an Acute Provider Partnership.																	
Maximise the opportunity to expand General Adult Intensive Care (GICU) to protect and enhance delivery of the elective care programme and ensure all non-elective demand can be met for both local and regional patients.																	
Develop sustainable plans to address FU backlogs across the Trust; develop sustainable plan for referral to treatment service, plastic surgery, deep inferior epigastric perforator, trauma and orthopaedic, high-risk bariatrics and paediatric cleft recovery; and deliver a further surgical robot as part of the System Elective Care Strategy.																	
Review how outpatient services are administered to maximise the use of available capacity and improving our patient experience of using our services.																	
Developing/improving pathways and models of care – e.g. testing new 23 hour hip/knee pathway (from May), robotic gynae day case (from September), improving skin pathway (phased from July), out of hospital ophthalmology care. 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. **Update 23/24:** Full Business Case approved.																	
Delivery of health inequalities projects (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. **Updates 23/24**: learning disabilities and homeless are two additional areas of focus.																	
Supporting 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 (did not attend). 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 the relevant section.																	

Core Deliverables for Diagnostics Programme																	
Deliver Community Diagnostic Centre in Weston at a location that will be easily reachable to those from one of the most deprived areas we serve and the delivery of mobile units in the Cribbs Causeway area for the population in the North of BNSSG from 1st April 2024/25.																	
Deliver recovery of current sleep service waiting times backlog.																	
CDC fixed site development (case / contract) Update 23/24: Now in build phase.																	
CDC mobile unit activity delivery (one endoscopy unit and two imagining units).																	
Estate works at UHBW to re-gain JAG accreditation.																	
Core Deliverables for Cancer Programme																	
Develop sustainable plans for cancer services. Key focus on skin, gynae, urology, thoracic services, and managing growth in oncology care.																	
Service developments to support earlier diagnosis and improve patient outcome and experiences. This deliverable will continue through to 2028, but specific projects/schemes will adapt to meet needs and priorities. Supports 2028 national ambitions of 75% or more of cancers diagnosed at stages 1 and 2.																	
Redesign and implementation of pathways; Priorities for 24/25 include skin and gynae pathways. Skin pathway improvement inc. focus on improving demand management through images with USC referrals. This implementation deliverable will continue through to 2028.																	
Delivery of personalised care projects (including for example: 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.																	
Health inequalities projects (including supporting inpatients with a SMI to access cancer screening; working with patients with a LD around symptom awareness and access to screening; community outreach; With VCSE and PCNs 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.																	
Programme of education for primary care including education events for clinical and non-clinical roles.																	
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).																	

6.6 Stroke

Stroke is both a sudden and devastating life event and a long-term condition. It is the fourth biggest cause of mortality in the UK, and a leading cause of disability. Over recent years there have been significant advances in proven, highly effective methods of stroke treatment and care.

In line with National guidance, and with the support of NHS England and Improvement, the BNSSG stroke programme proposed a transformed stroke service to realise the vision that **everyone in our system will have the best opportunity to survive and thrive after stroke**.

Reconfiguration of services took place in May 2023. Stroke provider organisations deliver the acute and subacute parts of the pathways: NBT delivering a hyper acute stroke unit (HASU) and acute stroke unit (ASU) and UHBW and Sirona care & health delivering stroke sub-acute rehabilitation care.

The operating and clinical model for the One Stroke Pathway is based on a collaborative approach. This pathway has been specifically designed and built to ensure that:

- Fewer people die from stroke each year
- Expert care is provided in the hospital, home and community
- Services are high quality and sustainable for the future.

Under this model of care, our population will have access to:

- Rapid and equitable life-changing specialist treatment, including thrombectomy and 24/7 access to HASU
- Improved outcomes associated with having well-equipped, well-staffed specialist care in the most intensive acute period of treatment
- Community based rehabilitation care provided in the home where possible and in a Stroke sub-acute rehabilitation unit (SSARU) where necessary
- 'Life After Stroke' support delivered by a partnership between health and voluntary sector providers.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Achievement of 'A' score on Sentinel Stroke National Audit Programme every quarter	TBC

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
One stroke: - To create a single joined-up stroke service 'One Stroke Pathway' for BNSSG - To create a unified approach to workforce 'One stroke Workforce' including education, skills and training and involving local educational partners - To develop unified digital pathway for patient record infrastructure and data.																	
Governance: - To create cross-organisational collaborative governance structure for the One Stroke Pathway to ensure operational oversight and accountability - To ensure cross organisational collaboration to adapt and change to deliver improved productivity, efficiency and financial sustainability - To embed processes for robust public and service user accountability in our governance structure.																	
Sustainability: - To sustain number of acute hospital stroke beds while accommodating increase in stroke incidents - To better understand the clinical and financial benefits of prevention in acute stroke care in downstream services and the impact of system wide prevention initiatives on stroke and cardiovascular disease services.																	
Improving outcomes: - To provide equity of access to stroke specialist care in BNSSG, improving quality and experience of care - To be able to measure quality of care of each part of the stroke pathway - To understand of impact stroke services on health inequalities to be able to address them.																	
System Impact: - To enable other systems to learn from the way stroke programme has been implemented - To develop a plan to become major centre for innovation in the stroke pathway.																	

7. Sustainability and Environment

See further sustainability plans under the Health and Wellbeing Boards section above.

7.1 Green Plan

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 (ICS), 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 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.

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 ICS, we aim to deliver a truly sustainable health and care system that will bring multiple mutually reinforcing benefits.

Governance

Quarterly meetings have been held by the executive-led ICS Green Plan Steering Group that reports directly into the System Executive Group.

The Green Plan Implementation Group meets monthly to monitor progress of workstreams that are working across the acute trusts and with representation from other organisations including AWP and Sirona care & health. The group also maintain a dashboard reporting into the Green Plan Steering Group.

General Practice and a 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 care & health to provide input and coordination for cross cutting areas such as climate change adaptation.

Within these groups, other system-wide workstreams 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

Workstream	Metrics	Contribution to Outcomes Framework
Procurement	Carbon footprint of supply chain will be reduced by 50% before 2028.	ENV19, ENV20, ENV21
Procurement	Carbon footprint of supply chain will be net zero by 2030.	ENV19, ENV20, ENV21
Estates	Carbon footprint of estates reduced by 80% by 2028.	ENV19, ENV20, ENV21
Estates	All capital projects will be achieving NHS Net Zero Building Standard.	ENV19, ENV20, ENV21
Estates	Our estates will be net zero by 2030.	ENV19, ENV20, ENV21
Travel, Transport and Air Quality	All new fleet vehicles owned and leased are zero emissions vehicles (ZEV) by 2027. The target is for 100% of fleet vehicles to be ZEV by 2027.	ENV19, ENV20, ENV21
Travel, Transport and Air Quality	50% of journeys to sites will be by sustainable and active means.	ENV19, ENV20, ENV21
Travel, Transport and Air Quality	Air quality will meet WHO standards (One City Plan target).	ENV19, ENV20, ENV21
Waste	Clinical waste ratio: reduce to maximum 20% high temperature incineration and 20% alternative treatment. Residual to offensive waste by weight achieved by March 2028.	ENV19, ENV20, ENV21
Waste	Recycling weight: 60% of all waste reused or recycled by March 2026, 80% by 2028, 100% by 2030.	ENV19, ENV20, ENV21
Medicines	Reduce carbon footprint from anaesthetic gases as far as possible to reduce abatement cost to get to net zero by 2030.	ENV19, ENV20, ENV21
Medicines	75% low carbon short-acting beta2 agonists metered dose inhaler (SABA MDI) use, 70% lower carbon preventer use and 30% v high carbon preventer use as per NHS Business Services Authority Respiratory Carbon Dashboard by 2025.	ENV19, ENV20, ENV21
Medicines	The number of people who access a nature and health intervention and measure the percentage of those people reporting reduced anxiety.	ENV19, ENV20, ENV21

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Green Programme																	
Monitor progress against delivery plan quarterly.																	
Review our Green Plan and 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.																	
Implement three projects to replace single use plastics with reusable alternatives per year.																	
Estates																	
Complete and cost estates decarbonisation plan for all organisations' sites.																	
Identify onsite renewable energy opportunities and renewable electricity supplies where onsite is not possible.																	
Complete electrical capacity assessments for all sites to enable heat pumps and electric vehicles charging infrastructure.																	
Develop and implement site specific air quality action plans.																	
Waste																	
Waste contracts in place that enable delivery of sustainable waste management.																	
Zero waste to landfill from our estates.																	
Implement NHS England Clinical Waste Strategy ratios.																	

Develop, plan and implement a plan to achieve recycling weight: 60% of all waste reused or recycled by March 2026, 80% by 2028, 100% by 2030.																		
Medicines																		
Decommission Desflurane in line with NHS England mandate.																		
Nitrous oxide destruction unit requirements identified and costed; Volatiles capture equipment installed.																		
Lower carbon inhaler switching project to achieve take up of lower carbon inhalers.																		
Sustainable Models of care																		
Use Sustainability Impact Assessment with carbon costing in decision-making across the system.																		
Biodiversity																		
Identify tree planting locations for NHS sites and integrated with West of England Nature Partnership landscape scale plans.																		
Ensure value of biodiversity is included in business cases.																		
Ensure all ICS estates are pesticide free.																		

Our detailed Green and sustainability plan can be found here: [Green Plan 2022–2025 - BNSSG Healthier Together]

8. Enablers

8.1 Safeguarding

The Integrated Care Board (ICB) 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 ICB 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 ICB is noted as a statutory partner within these. Therefore, the ICB 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 ICB 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 ICB 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.

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 ICB is a core statutory partner for safeguarding arrangements for children via the three 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 ICB safeguarding team contribute to the work of the partnership arrangements, boards and subgroups.

The ICB 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 ICBhas 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 ICB has a responsibility to support their own staff who may be experiencing abuse. The ICB 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 ICB'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 ICB staff to improve overall from 90% performance by end of 2025.	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).	POP1, 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
Monitor the numbers of individuals on waiting lists for therapeutic services relating to sexual abuse/serious violence in order that provider organisations feel supported, patients' needs are assessed and triaged, and referrals into these services are appropriate and of high quality.	COM16, SER8
90% of all holistic assessments for Unaccompanied Asylum Seeking Children combined with Initial Health Assessments to be undertaken within 20 working days as per statutory timeframe.	POP1, 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 ICB 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	2024/2025				2025/2026				2026/2027				2027/2028				2028/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
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.																	
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. **Update:** Rolled over into Systemwide Safeguarding Transformation Programme.																	
Continue to collaborate with system partners to monitor the performance of Initial Health Assessments and Review Health Assessments in line with statutory guidance, in addition to outcomes and experiences for this cohort.																	
Support and contribute to the Systemwide Transformation Safeguarding Programme - by co-developing a System Learning Assurance Approach and Network - which will consider themes and multi-agency improvement strategies to understand impact of safeguarding system change identified by statutory safeguarding reviews.																	
Work with the ICB People Directorate to improve performance of statutory and mandatory safeguarding training for staff including the level 3 compliance affecting those in patient facing or with clinical/professional registration requiring this training.																	
Work with NHS England, Office of Police and Crime Commissioner and other system partners to deliver the requirements of the Serious Violence Duty and contribute to system work under the Domestic Abuse Act 2021.																	
Develop and agree with system partners an enhanced pathway for Unaccompanied Asylum Seeking Children that is trauma-informed, meets the requirements of the cohort and reduces duplication.																	

8.2 Workforce

We have a well-established People Programme, bringing together health and social care providers to work in collaboration to deliver an integrated approach to workforce planning, recruitment, retention and development. This currently includes a Learning and Leadership Academy, which enables us to deliver in the long and short-term to support recovery, reform and resilience of services through workforce initiatives. Our health and social care partnership workforce accounts for 5.9% of the population with 57,626 people employed in part or full time.

The People Programme sits within the People Directorate of the ICB, headed by a Chief People Officer and is managed through a distributed leadership model which utilises the expertise of partner senior human resource (HR) and Organisational Development (OD) professionals as senior responsible officers (SROs). The People Programme is overseen by the People Committee of the ICB.

With the publication of the NHS Long Term Workforce Plan (LTWP) in the summer of 23 a key focus for the People Programme Board will be the creation of a People and Culture Plan – setting out the system response to the LTWP and the expansion of the Learning and Leadership Academy model into a wider system People Academy that will deliver the People and Culture Plan over the coming years. The key objectives for 2024/25 and beyond will incorporate:

1) **Supply:**
   - The People and culture Plan is our approach to the delivery of the NHSE LTWP, the LTWP is critical to ensuring an increased domestic workforce supply. This is a 15-year plan and focuses on increasing the number of students taking health and social care courses through higher education establishments and apprenticeships. To deliver this increase, a wide range of work is needed to deliver the plan, such as increased promotion and communication in schools to attract students into health and social care, increased clinical placements so they can gain experience while studying and mentoring and support during their training.
   - Our collaboration in local and national recruitment events allows us to target specific job roles that are needed in our system, promotes us as employers of choice for existing health and social care workers and the future workforce and allows wide range of partners to attend no matter how big or small the organisation is. Domestic recruitment within our population provides a wider benefit beyond just health and social care. Collaborative approach to international recruitment allows for shared learning and success across our partners which not only benefits the partner organisations but supports the international staff when they take up their roles.
   - To continue the successful apprenticeship programme that benefits primary care, secondary care and social care.

2) **Productivity and Performance**
   - The development of system banks across acutes, primary care and social care that will allow staff to work across multiple partner organisations.
   - The bank workforce is a vital contribution of the staff that work in health and social care across our partners. The development of collaborative bank system between two hospital trusts, the different social care providers and across the GP practices in primary care will allow staff to widen their work opportunities.
   - Local and regional action is being taken to reduce agency costs across health partners
   - Staff move between our partner organisations as part of promotion opportunity and learning. Our successful passporting approach allows staff to focus on their core role and avoid the need to repeat any duplicated training.
   - Delivering the important Oliver McGowen training across the entire workforce.

- Develop, deliver and monitor the achievements of workforce operational plans.
- Reduce sickness and vacancies.
- Development of a people academy.

3) **Retention**
   - Collaborative approach and implementation of legacy mentoring.
   - Reduction in turnover of staff between partners and leaving the system by making us the best place to work for existing health and social care workers.

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 our 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 WRES and WDAS and staff attitude surveys.
- Staff attitude survey outcomes review at ICS level.

Key deliverables and milestones

Deliverables	2024/2025				2025/2026				2026/2027				2027/2028				2028/2029			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop People and Culture plan																				
Implement actions of People and Culture plan																				
Collaborative domestic & international recruitment																				
Develop multi provider banks																				
Reduce agency costs																				
Training Passporting																				
Deliver Oliver McGowan training																				
Legacy mentoring																				
Reduction in turnover																				
Performance against workforce plan																				
Reduction is sickness and vacancies																				

8.3 Digital

The Digital Strategy is a key enabler for our integrated care system.

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.

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.

Governance

The ICB Director of Transformation and Chief Digital Information Officer is the executive lead for digital in our system.

Metrics

Workstream	Metrics	Contribution to Outcomes Framework
Connecting Care - Procurement / Deployment	5% Increase (c 10,500 additional staff/month) of frontline staff accessing shared care record via Connecting Care.	SER7, SER8, SER9, STA10
Digital Maturity in Care and VCSE	80% Care providers have a digital social care record.	SER7, SER8, SER9, STA10
Shared Data Planning Platform (SDPP)	Successful procurement of the ICS SDPP platform.	SER7, SER8, SER9, STA10
Work Anywhere in primary care	100% GP practices available to acute practitioners.	SER7, SER8, SER9, STA10
Expand Care Plans across integrated services	Full integration of read/write care plans with SWAST and Connecting Care. 1x care plan deployed for integrated service.	SER7, SER8, SER9, STA10
Increase digital inclusion via access to NHS App	Achieve national benchmarks for NHS App uptake.	SER7, SER8, SER9

Key deliverables and milestones

Deliverables	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Procure Shared Care Record with improved functionality								
Improve Digital Maturity (Care providers and VCSE)								
Procure & Deploy Shared Data Planning Platform								
Deploy Work Anywhere in Primary Care								
Expand care plans functionality								
Improve Digital Inclusion (via improving access to NHS App)								

8.4 Estates

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

1. **Utilise our assets: understand what we already have, use it fully and efficiently, or dispose of it.**
   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 and efficiency of existing estate, in addition to identifying opportunities for the disposal of estate if beneficial to do so.

2. **Prioritise our investment options: develop our evidence-base and identify our priorities.**
   We should ensure that we have a robust evidence-base to be able to identify our priorities for investment, ensuring they take into account the current and future needs of our population. The current NHS capital regime often requires quick turnaround times for bidding, and therefore having a list of system priorities for investment on a long-term scale will enable better value decisions.

3. **Secure funding: make sure we are bringing in as much funding as we can**
   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.

These three strategic principles will inform all ongoing programmes of work within the estates programme, in addition to forming the basis of our joint infrastructure strategy. The purpose of this strategy will be to enable and maintain infrastructure in our system that supports the delivery of the Integrated Care System (ICS) Strategy. Infrastructure in this instance predominantly refers to estates however there is the opportunity to draw together all capital-intensive enabling functions across the system such as digital requirements and medical equipment to support a more coherent, integrated approach.
It is understood that all integrated care systems will be expected to submit system-level infrastructure strategies to NHSE in early 2024, though NHSE has yet to issue guidance confirming requirements and deadlines. These ICS strategies will support NHS submission for capital ahead of the next HMT Comprehensive Spending Review (CSR) which is scheduled in Autumn 2024. We would like to advocate that more Capital Departmental Expenditure Limit (CDEL) is allocated locally to systems rather than for national programmes.
Our strategy will build on the work that has been undertaken by the ICB Estates Steering Group over the past 18 months to develop a process that will prioritise the allocation of system capital over the next 10 years. This 10-year capital plan will set the investment priorities, which will be aligned with system strategic priorities.

System Capital Prioritisation

In 2020/21, the NHS capital regime was amended to enable systems to have greater responsibility in deciding how system-capital funding is spent. In the previous regime, acute providers generated capital from a mix of cash from depreciation and surpluses, which created cash for reinvestment in capital. Capital is now allocated in system-wide envelopes for ICBs to sign-off how capital is allocated across all NHS providers each year. This means that capital can now be allocated to primary and community care, providing systems with the opportunity to take on a more targeted approach in capital spend to support the delivery of strategic and operational objectives.

ICS partners have been working collaboratively since summer 2022 to develop a process to determine how capital funding is allocated, using the Estates Steering Group as the primary forum for discussion with ongoing oversight from the system Directors of Finance (DoFs).
A set of principles were agreed that determined that all 'required' capital schemes (e.g. critical backlog maintenance and general equipment replacements) would remain at the discretion of organisations, whilst all other larger schemes (e.g. major redevelopments and new clinical/admin space) would be subject to system-level prioritisation and agreement.
With these principles in mind, a two-year capital plan was agreed for 2023/24 and 2024/25. In this two-year period, £8.68m was allocated to primary and community care schemes that were deemed to be of the highest risk, in the absence of any national funding allocation for these sectors in the current three-year HMT CSR period. The remaining capital budget was retained by the acutes to major diagnostic equipment replacement and critical backlog maintenance. Any schemes that were pre-committed by the system were also funded. £3m was ringfenced specifically for net zero schemes in 2024/25 and will be prioritised by the Green Plan Steering Group.
Learning from the development of the two-year capital plan has made it clear that the overall CDEL budget available to the system (circa £70m) is significantly oversubscribed, therefore should first and foremost be allocated for capital investments that address critical risks to the system, rather than the delivery of strategic ambitions. The priority for this funding is to prevent the deterioration of existing estate and that equipment is maintained at a reasonable standard.
The work to identify an approach of fairly assessing, comparing and prioritising risks requiring investment across different parts of the system has been very challenging, particularly across acute care and primary/ community care. There will be risks for all capital schemes that are not allocated funding, and therefore work needs to be done to assess the level of risk associated with all schemes and what level of risk can be deemed to be acceptable by the system.
The approach that system partners will be undertaking for 2025/26 is to produce their own organisation capital plans within their current organisational methods, assuming the budget that they have been allocated in previous years. These plans will then be shared and reviewed by a group of key system partners for review. Any unfunded schemes that are considered to be high priority will be assessed against some of the lower priority schemes to see if there is any need for budgets to be shifted.
Beyond 2025/26, it has been suggested that a joint ICS Capital Policy is developed to support the shift into this new collaborative way of system working. This new policy would ensure there is improved system governance around capital spend, and increased transparency between all partners, whilst ensuring best value is achieved on investments.

The overall objective will be to create new structures and processes to ensure decisions around our shared principles are implemented and the system will collaboratively take opportunities for equipment replacement, space sharing, etc. The ICS will need to agree a list of principles that organisations will abide by, including increased transparency of capital spend, and increased standardisation of internal processes.

10-year Capital Plan

Outside of the system CDEL allocation, there is a need to create a separate prioritised list of larger, strategic schemes will still need to be agreed by the system, because whilst they are currently unaffordable within the existing CDEL budget, there may be opportunities for funding to be made available in the future by NHS England.
The main purpose of this workstream is for the system to agree a list of prioritised schemes and to ensure that there will be no duplication in bids for national funding coming from our providers. The current NHS capital regime also often requires very short turn-around times for bidding, and having a prioritised list of capital schemes will help to ensure organisations have bids ready to be submitted.
This 10-year plan will be the bedrock of the joint ICS Infrastructure Strategy.

8.5 Medicines Optimisation

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 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 plan continues to set 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 had 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.

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 ICB medicines optimisation team and fed back to the Medicines Optimisation System Leadership Group. The plan will continue to be reviewed, modified, and updated as we progress year on year.

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 highlights these key areas.

Metrics and trajectories

Metrics	Link to Outcomes Framework
Deliver annual savings plan; monitoring medication budgets and cost savings.	POP1 POP6, SER7, SER8, STA10, ENV19, ENV20, ENV21
Increase patients' access to medication in a community pharmacy; increase in consultations in community pharmacies to support reduction in GP appointments required.	POP1, POP2; POP4; POP6; SER 7, SER8, SER9, STA10
Ensure prescribing is evidence based and cost effective. By aiming to continue to be the lowest 5-10% in the country for cost/1000 prescribing of low value medicines and aiming to achieve target of 90% formulary adherence across the ICS – primary care prescribing adherence is currently around 96%.	POP6, SER9, ENV19, ENV20, ENV21, STA10
Reduce the increased cost of the current and anticipated continued growth in prescribing in attention deficit hyperactivity disorder (ADHD) by agreeing and implementing a cost-effective treatment pathway.	POP6, SER8, SER9, STA10
Reduce the ordering and issuing of unnecessary prescription items reviewing costs and growth including reducing overall inappropriate spend on stoma appliances	POP1, POP6, SER7, SER8, STA10, ENV19, ENV20, ENV21
Improve efficiency in medication ordering by increasing the utilisation of the Proxy Ordering in care homes, electronic repeat dispensing (eRD) in GP practices and electronic prescription service (EPS) across the system.	POP1, POP2, POP6, SER7, SER8, SER9, ENV20, ENV21 ,STA10

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; have a system wide benchmarking tool to devise metrics in regard to MedSip targets such as reducing opioid use in chronic non-cancer pain, polypharmacy and overprescribing.	POP1, POP2, POP6, COM16
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
Reduce inappropriate polypharmacy and overprescribing by encouraging safe deprescribing where clinically appropriate and evidence based through SMRs. Measure using NHS Business Services Authority (NHSBSA) benchmarking tools i.e. polypharmacy dashboard.	POP1, POP2, POP6, COM16
Reduce carbon emissions related to medicines and prescribing e.g., aesthetic gases, inhalers Measure using NHSBSA Benchmarking tools- i.e., respiratory carbon impact dashboard.	ENV19, ENV20, ENV21
Reduce medication related administration error whilst identifying the type of error potentially avoided; improve workflows of admission and discharge between settings.	POP1, POP2, POP6, COM16
Increase the number of training positions for pre-registration pharmacy technicians (PTPTs) and trainee foundation pharmacists 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
Align acute trust (North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston Foundation Trust UHBW)) antimicrobial formularies.	POP1, POP3, SER9, STA10
Electronic Prescribing Medicines Administration systems (EPMA) rollout to commence in UHBW by Q1 24/25 and NBT Q3/Q4 delivering reduction in safety incidents and Datix reports relating to manual prescribing and record of administration; Staff satisfaction surveys; Patient experience surveys.	POP1, POP2, SER7 SER9, STA10, STA11, STA12, ENV19, ENV21
Increase number of Independent Prescribing (IP) pharmacists across the system including in community pharmacy.	POP1, SER8, SER9
Number of successful applications for new Advanced Therapy Medicinal Products (ATMP) relevant to Trusts clinical specialities; Number of pharmacogenic test requests in-line with eligibility criteria; number of participation in trials to generate evidence for Dihydropyrimidine Dehydrogenase (DPYD) pharmacogenomic testing in patients of non-European ancestry.	POP1, POP6, SER7, SER8, SER9
Awareness of antibiotic categories, hospital antibiotic consumption data, monitoring of resistance rates, and monitoring of infection rates.	POP1, POP2, POP3, POP6, SER 7, SER8, SER9, STA10
Referral numbers, waiting times, number of bariatric procedures, degree of weight loss and improvement in weight related co-morbidities.	POP1, POP2, POP6, SER 7, SER8, SER9, STA10
New pathway design for drug treatment of Alzheimer's disease; Metrics to include (not exhaustive): identification of stakeholders (old age psychiatry, neurology, geriatrics), referral numbers, waiting times, number of trained staff, number of patients with reduced cognitive decline, ability to remain independent etc.	POP1, POP2, POP6, SER 7, SER8, SER9, STA10
Ensure compliance with latest Medicines and Healthcare Regulatory Products Agency (MHRA) guidance around safe sodium valproate prescribing monitor incidents relating to valproate to ensure continual improvements. Reduce the number of patients prescribed valproate/valproic acid;	POP2, POP6,
Increase the rapid uptake of best value biologic (BVB) medicines across the ICS. Including biosimilar insulins.	POP1, SER7, STA10
Reduce health inequalities by ensuring equitable access to evidence-based medicines.	POP1, POP6, SER7, SER8, SER9, COM18
Assurance that strategies are in line locally and nationally. Review aims with benchmarking data.	POP1, POP5, POP6, SER7, SER8, SER9, COM18
Increase in specialist learning disability prescribing pharmacists. Implementation and review of national projects.	POP1, POP5, POP6, SER7, SER8, SER9, COM18
Ensure medicine optimisation drivers and principles are embedded within the BNSSG ICS joint forward plan priorities and aligned with National Medicines Optimisation opportunities 23/24 and benchmark against these. e.g. Stroke, Frailty, Diabetes, Cardiovascular Disease (CVD) including optimising lipid management for CVD prevention, Urgent care, Mental Health including addressing inappropriate antidepressant prescribing, Respiratory and Prevention.	

Key Deliverables and Milestones

Deliverables	2024/25				2025/26				2026/27				2027/28				2028/29			
	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]. System level work including linking in with localities to better understand local areas of need.																				
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 within the BNSSG ICS joint forward plan priorities e.g., Stroke, Frailty, Diabetes, Cardiovascular Disease (CVD) including identifying patients with hypertension and starting antihypertensives where appropriate and optimising lipid management for cardiovascular disease prevention, identifying patients with atrial fibrillation and using best value direct-acting oral anticoagulants (DOAC), Urgent care, Mental Health including addressing inappropriate antidepressant prescribing, Respiratory and Prevention. [1, 3] Including alignment with National Medicines Optimisation opportunities 23/24 and benchmark against these.																				
Right Place *Aim to ensure patients can access high quality care and pharmacy services at the right place for them*																				
Continue to support all GP practices to utilise and maximise benefit of the GP Community Pharmacist Consultation Service[1,2,4]. Working with Community Pharmacists and Practices to roll out Contraception initiation and supply (Live 1st December)																				
Roll out and maximise benefit of Community Pharmacy Consultation Service (CPCS) to other parts of the system e.g., Urgent Treatment Centre (UTC), Medical Assessment Unit (MAU)[1,2,4] NB from 31/1/24 CPCS will be incorporated in Pharmacy First (NHS referrals for minor illness)																				
Agree an ongoing funding to extend the range of conditions that can be treated under the Patient Group Directions (PGD) services in community pharmacy. Adhering to National roll out as part of Pharmacy First priority[1].Including expanding contraceptive service, expand Hypertension Case Finding service, Pharmacy First Launch- 7 common health conditions under national PGD already delivering 3 PGDs under a Local Enhanced Service (LES) (Sore throat, impetigo, urinary tract infection). New ones are for Sinusitis, infected insect bite, Otitis Media and shingles. Increase number of Patient Group Directions (PGD) delivered e.g., expand ear pilot (Otitis externa), hypertension																				
Explore the possibility to Pilot and extend the provision of a Community Pharmacy Consultation Service from the Childrens Hospital[1,2,4].																				
Developing proposals and delivery of additional services for community pharmacy to support the system during periods of high demand[1,4]. For example local PGDs e.g. hypertension, migraine																				

Increase independent prescribers within community pharmacy[1,4]. Continue to work with PCNs, Sirona and Community Pharmacists to provide Designated Prescribed Practitioners (DPP). Community Pharmacist Independent Prescribing (IP) Pathfinder might increase numbers.																					
Participate in the national IP Pathfinder. Three sites chosen Yate, Bedminster and Cotham, awaiting EPS to be signed off.																					
Work to standardise PGDs and adopt national templates to improve consistency, quality and increase organisational capacity by reducing duplication of work across the system																					
Maximising Benefits to the Patient and the Health Economy																					
Identify and implement cost savings work year on year in GP practices by the BNSSG Medicines Optimisation Team and Medicines Optimisation Pharmacists (MOPs). 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].																					
Deliver person-centred care and improved processes in GP practices, using repeat prescription hubs and including implementing continuation of proxy ordering across all care homes[4].																					
Reduce the environmental impact of medicines and medical devices on towards net zero by: - Ensuring delivery of decarbonising anaesthetic gases - Promoting use of lower carbon inhalers where clinically appropriate - Reduce carbon impact of overprescribing by reducing inappropriate prescribing through greater use of Structured Medication Reviews -Driving more effective medicines waste management Identify pipeline of future opportunities for greener alternatives and reviewing highest carbon impact medicines where possible[4].																					
Savings and Value *Allocation of a primary care prescribing budget, each year there is a programme of savings required to meet the budget. There are a number of direct and indirect projects set to try and achieve this including a cost saving dashboard to focus work of medicines optimisation team and to ensure the most cost-effective choice is being used.*																					
Continue to develop and update the Cost saving Dashboard (CSD) 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 identify medicines and pathways 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.																					
Continue to review 'items which should not routinely be prescribed in primary care' in line with the NHS England and Improvement guidance[3]. Empower people to self-care. The Medicines Optimisation Pharmacists work with GP practices to reduce low priority prescribing medicines. In addition, using GPCPCS/Pharmacy First will enhance Self Care.																					
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].																					
Ensure appropriate prescribing and supply of lowest cost blood glucose and ketone meters and testing strips[3] as per NHS England guidance.																					

Expand and continue to monitor the specialist nurse led stoma service across the Integrated Care System [1,3].																						
Enable formulary adherence to be monitored within secondary care post Electronic prescribing and medicines administration (EPMA) [3]. Deadline slipped will prioritise 24/25 (amber until Q3 then green until 25/26)																						
Standardising and aligning Shared Care Protocols (SCP) and adopting nationally developed protocols where appropriate [1,3]																						
Conduct multiple prescribing quality scheme projects annually across all GP practices to promote cost savings and quality [1,3]. Submitted, 23/24 underway. 24/25 projects now in development.																						
Continue to develop medicines pathways with ICS colleagues and relevant specialties [1,2,3,4]. Example priority 24/25 Weight management pathways- Tier 3 – implementation of NICE TA875 semaglutide (Wegovy) in obesity and weight management to include weight management referral pathway update and resource for Tier 3 services.																						
Best Value High-Cost Drugs and Devices																						
Plan and co-ordinate the rapid adoption of biosimilars as they come to market [3]. Prescribing Quality Scheme (PQS) and system wide e.g. immunotherapies. Work this year includes planning for introduction of biosimilar tocilizumab.																						
Support prescribers to prescribe the most cost-effective Direct Oral Anticoagulant (DOAC)[1,2,3]. Updating DOAC guidelines to promote this.																						
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]. To ensure best value biologic (BVB) medicines are used in line with NHSE commissioning recommendations and plan and co-ordinate the rapid adoption of biosimilars as they come to market.																						
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]. Ensuring secondary care medicines are obtained in line with commercial framework and procurement arrangements.																						
Establish a single procurement process for BNSSG and undertake diabetes technology review; insulin pumps, continuous glucose monitoring and consumables [1,3]. Plan to embed NHSE hybrid closed loop framework 2024/25.																						
Implementation of National Institute of Health and Care Excellence (NICE) technology appraisal in development for the treatment of mild cognitive impairment or mild dementia caused by Alzheimer's disease. Expected publication dates 17 July 2024 – lecanemab and 11 September 2024. Considerable investment required- New pathway for screening, diagnosis and treatment required. Expected high resource impact on staff and technology delivery.																						
Key Therapeutic Areas of Focus including prevention, inequalities, and population health management																						
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]including updating guidelines and pathways.																						

Working with Genomics leads to ensure any advancements are mainstreamed into practice to ensure patients are on appropriate medicines[3].	
Medicines Quality and Safety	
Agree a system benchmarking tool to highlight where we are with regards to MedSip 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].	
Roll out the BNSSG ICB 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].	
Implement processes to improve patient safety around sodium valproate and meet the requirements of the Valproate National patient Safety Alert (NPSA) issued in November 23. Also monitor incidents relating to valproate to ensure continual improvements. Valproate safety working group in place to support the work. Ongoing implementation of alert in 24/25, with new patients having 2 specialist review and existing women of childbearing age being reviewed at their next annual review appointment.	
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 (SMR). Priority areas include care homes, hospital at home, mental health, frailty, long term conditions and compliance aids[1,3,4] to address problematic polypharmacy. Polypharmacy PQS project planned for 2425 on Overactive Bladder (OAB) medications.	
Support the SMR directed enhanced service (DES) in Primary Care Networks and show where there is greatest value whilst working with clinicians[1]. Including evaluation (milestone).	
Continue to upskill all health care professionals (HCP) involved with polypharmacy [3].	
Antimicrobial Stewardship (Infection management and prevention) - *Aim of reducing antimicrobial resistance (AMR) ensuring that antibiotics remain effective so that healthcare in the future is as successful as it is today. To ensure good antimicrobial stewardship (AMS) across the system – antibiotics are prescribed only when appropriate, with the correct choice of treatment for the correct course length. Work includes review and writing of treatment guidelines, projects looking at course length, reviewing stewardship in new services such as NHS@Home, intravenous to oral switch of antibiotics, ensuring clear diagnosis. To ensure clear infection prevention and management processes across the system.*	
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 service[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]. Promote self-care and vaccination to prevent infections.																						
Continue to lead and deliver Covid-19 Medicines in the community ensuring it aligns with NICE and National policy.[1,2,3,4].																						
Ensuring consistent approach to intravenous (IV) to oral antibiotic switches across the ICS[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.																						
Implement the recommended approach to deliver technical services (hub and spoke model) (Dependent on national funding) [1]. Appraise aseptic facilities across the Southwest region, and commercial sector servicing the region and beyond, in order to identify challenges, gaps and unmet need to address these within a longer-term plan and align delivery of aseptic services within secondary care; Implement recommendations from the national NHS Infusions and Special Medicines Board Strategy of a hub and spoke model (national funding dependent).																						
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 medicines 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].																						
Ensure system wide support of national genomics strategy, including raising awareness of genomics across the system; Support acute Trusts to be well positioned to submit expressions of interest to provide services for new ATMPs relevant to their clinical specialities; Support system partners to continue to provide equitable access to patients to the available pharmacogenomic tests in line with eligibility criteria, to reduce the risk of adverse drug reactions; Support system partners to participate in clinical trials to generate evidence for Dihydropyrimidine dehydrogenase (DPYD) pharmacogenomic testing in patients of non-European ancestry.																						
Digital / Information Technology - *Aim to deliver an integrated single shared electronic patient medication record across the ICS 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 across the system[1].*																						
Adopt and roll out a dm+d 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]. A fully implemented ePMA solution will support trusts in their ambition to be a paper free organisation and could provide significant opportunities to transform care delivery, and give clinicians secure access to accurate, timely clinical information at the point of care.																						

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]in primary care.																						
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 utility with our ICB data protection leads, Eclipse and NHS Digital[1].																						
Rollout the interoperability of drug allergy alerts across BNSSG 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 (eRD) and meeting the minimum target (next 12 months) [1,4].																						
Implement Proxy Ordering across all care homes[1,4].																						
Pharmacy Workforce *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.*																						
Agree short- and long-term pharmacy workforce plans to meet the needs of the BNSSG healthcare system [4].																						
Ensure we have sufficient pharmacy resource to enable priorities such as hospital at home model [4].																						
Attract and retain pharmacy workforce within BNSSG 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 across the ICS for undergraduate pharmacy students [4].																						
Increase the number of independent prescriber pharmacists with a particular focus on Community Pharmacy [4].																						
Develop further highly specialist posts/consultant pharmacist posts in other key clinical areas across the ICS including primary care [4].																						
Increase pharmacists specialising in mental health to meet the requirements of the community-based offer to meet with locality priorities[1]. Including scoping 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].																						

9 Appendices

9.1 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, aligned to the Strategic Funding Principles approved by the ICB Board 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 and Health Education England.
- 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 the Integrated Care Board Finance, Estates and Digital Committee, who then recommend approval by the ICB Board. The Local Authority Medium Term Financial Plan is assured through separate local authority governance, and ultimately relevant mayor, cabinet and full council approval. The plan is also reported to the 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 (DDoFs) Group. ICB and LA DDoFs meet fortnightly.

At present there are separate models for system five year 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 10 year capital (Capital Departmental Expenditure Limit (CDEL) basis) [incorporating major medical equipment, digital, operational estates and strategy investments including those funding by NHS Programmes]; and three 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 Joint Forward Plan.

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. For example, 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, while maintaining 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 if 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 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.

The medium-term financial plan is developed by autumn of each year, and then year two is taken as the starting position for annual operating budgets and commissioning contracts in spring of each year, updating for confirmed NHSE funding allocations and any consequences of the current year outturn.

The System Executive Group have agreed a standing operating procedure known as the “Forecast Outturn Change Protocol” for reporting, escalation, peer-to-peer support and enhanced controls which is designed to provide an early warning system and enable corrective action to be taken to maintain spending in line with the approved NHS revenue medium term financial plan.

9.2 Procurement

Our Integrated Care Board (ICB) has a procurement policy for commissioning healthcare services. The ICB, through the objectives set within the policy, ensures that 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.

For the procurement of healthcare services, the ICB commissions NHS South, Central and West Commissioning Support Unit (SCWCSU) as an expert provider of procurement professional services, within the health and social care sectors.

In relation to the procurement of all goods and services the ICB has a procurement strategy and commissions Bristol and West Purchasing Consortium (BWPC) to deliver these services ensuring it complies with the law, regulations, and published guidance in relation to goods and services.

Regulatory environment – Health Care Services procurement

In partnership with the South Central and West Commissioning Support Unit (SCWCSU) team it is recognised that from a procurement perspective the working environment is facing its greatest challenge with the organisational system change delegation of elements of specialised commissioning, and the emerging role of provider collaboratives and neighbourhoods. This shift is coupled with the change of competition requirements in the Health and Social Care Act. As from 1 January 2024 NHSE, ICBs, NHS Trusts, NHSE Foundation Trusts and local authorities or combined authorities are withdrawn from the Public Contracts Regulations 2015 and and the NHS Procurement, Patient Choice and Competition Regulations 2013, and therefore relevant authorities, will secure the below services via the Provider Selection Regime (PSR):

- Health care services arranged by the NHS e.g., hospital, community, mental health, primary health care services
- Public health services arranged by local authorities e.g., substance use, sexual and reproductive health, and health visitors
- Several areas that were previously fully regulated under the previous legislation PCR2015 such as CQC registered service i.e patient transport services.

Provider Selection Regime - PSR

Under the new PSR, we recognise that there are various ways to secure healthcare services contracts as the regime provides ICBs greater freedom and flexibility to deliver integrated services locally. We understand that the legislated regime will still require the ICB to act with probity, transparency, and accountability. The ICB will be responsible for the decisions it makes in securing services and will need to demonstrate the robustness of decision-making including the identification of the most appropriate route to secure the best providers for services. As an ICB, it will keep records of all considerations throughout the award process. For the commissioning of health care services, the ICB will follow regulation 6 illustrated in the below flowchart to ensure the right decision is made as to the route taken to secure such services.

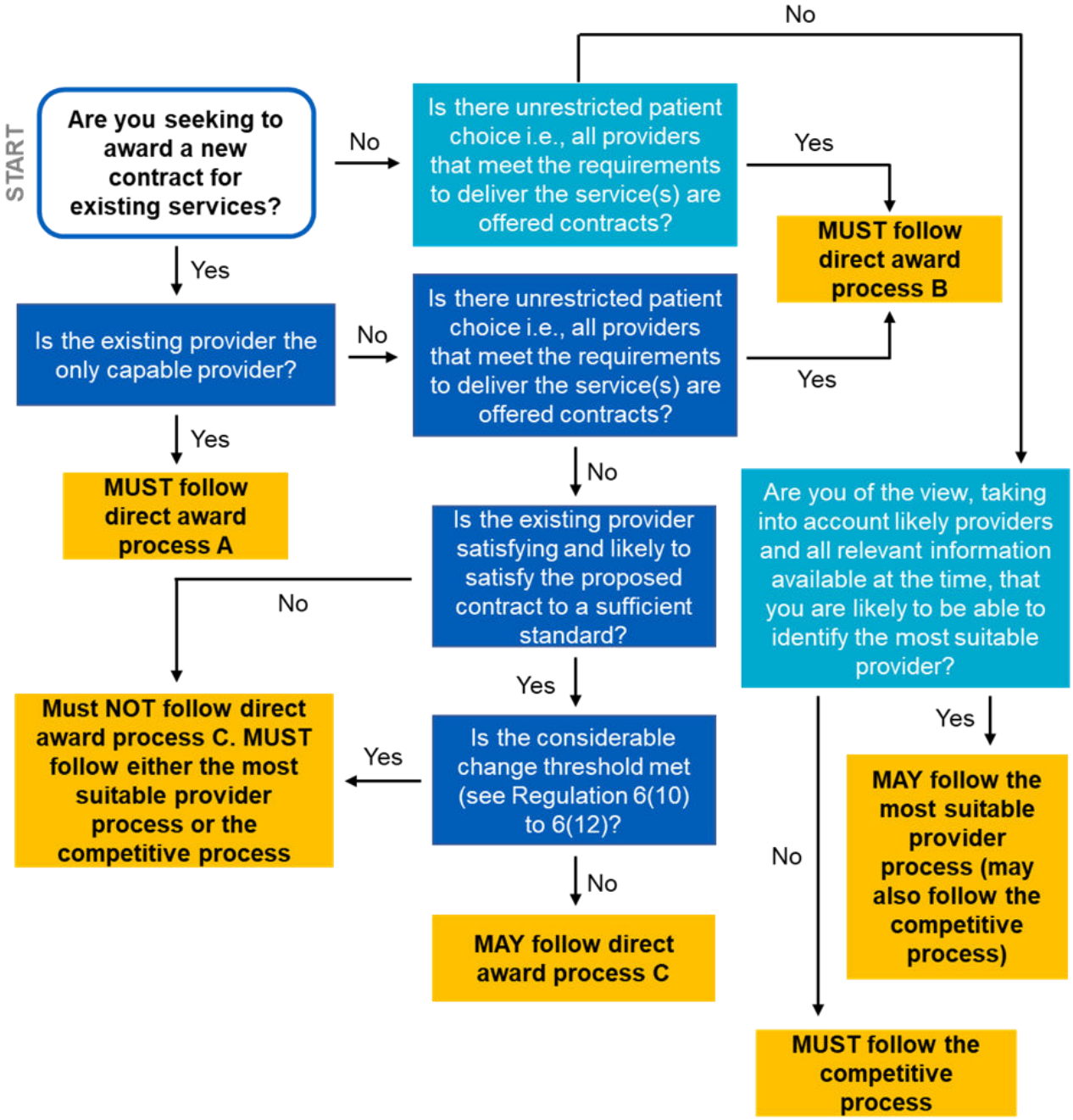


Figure 9: Procurement process regulation

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 including e-tendering, reporting, spend analysis and order management.

BWPC and our partners drive to ensure we get value from our goods and services spend as it is recognised that the demands of the modern health service require “value” that means much more than just buying more for less.

Regulatory environment - Goods and Services procurement

The ICB recognise that procurement rules for goods and services are changing. The new procurement act (expected 1 October 2024) will benefit suppliers of all sizes, particularly start-ups, scale ups and small businesses. These changes will drive innovation, deliver better outcomes, and embed transparency right through the commercial lifecycle, opening up procurement to new entrants such as small businesses and social enterprises. The ICB understands that the Procurement Bill, which will reform the existing Procurement Rules, received Royal Assent in October 2023. In early 2024 secondary legislation (regulations) will be laid out to bring some elements of the Bill and the wider regime into effect. It is anticipated the new bill will be brought into force in October 2024. The existing legislation will apply until the new regime goes live and will also continue to apply to procurements started under the old rules.

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 an 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
- Appropriate providers under patient choice are accredited via the ICB accreditation process.

Details and contact information can be found at https://bnssg.icb.nhs.uk/accreditation-of-independent-sector-healthcare-providers/.

9.3 Quality Assurance, improvement and escalation

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 (ICS) 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.

Systems are balancing and sharing risks in multiple areas across health and care settings and having to manage significant pressures in workforce, service capacity and finances. These challenging combinations result in complexities when deciding upon the best, or "least worse" course (or multiple courses) of action across system partners. The recent pandemic has changed the operational landscape, which requires provider and system leaders to take a different or additional pragmatic approach to effectively managing these risks. Regular static risk assessments will always be a valuable and legally required part of employment law. However, BNSSG is developing an approach to the Dynamic Risk Assessment allowing people to go further by assessing developing situations as they arise.

Figure 1: NQB Risk Response and Escalation in Integrated Care Systems[1]

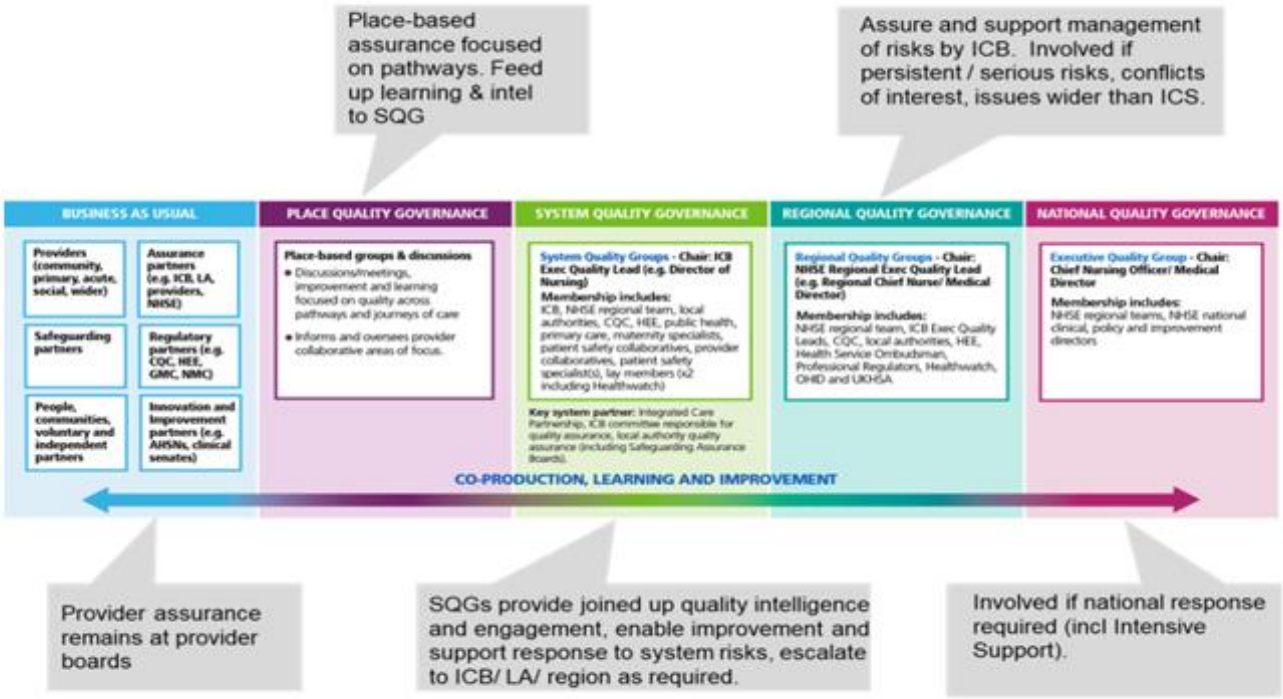


Figure 10: National Quality Board risk response and escalation in ICSs

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 NHS England 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 ICB 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, actions to 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

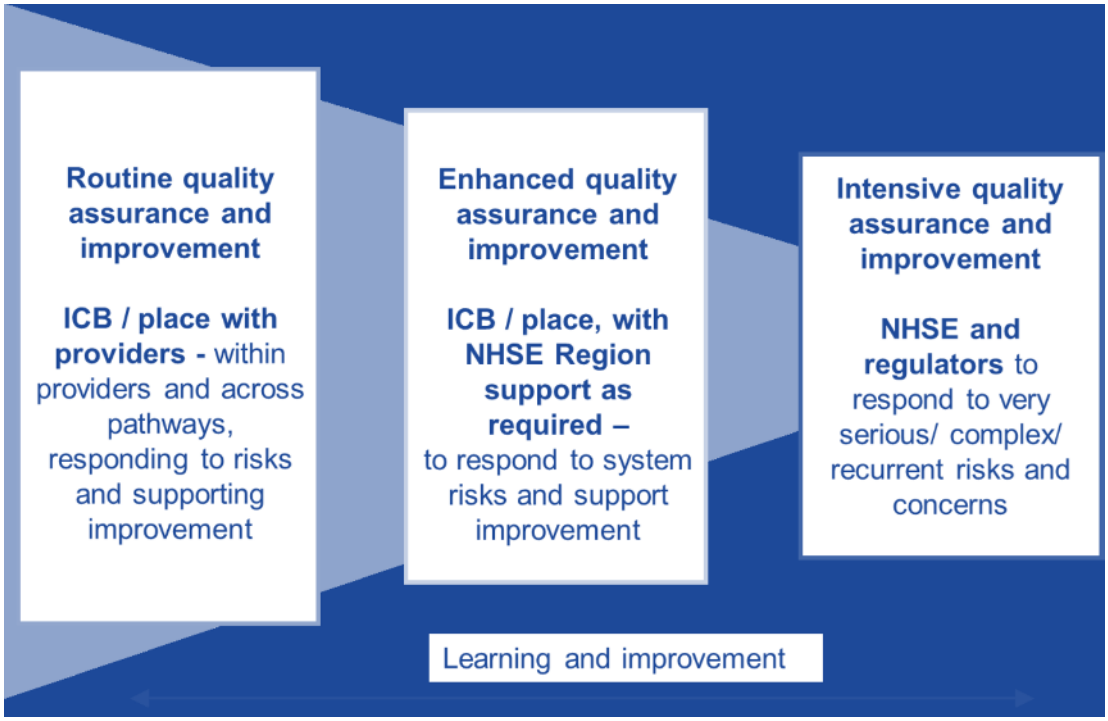


Figure 11: Overview of levels of quality assurance and improvement

1. Routine quality assurance and improvement

This level of assurance and improvement is a “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, coordinate 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.

9.3.1 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.

The Purpose of the Health and Care Professional Executive (HCPE) is set out below.

1. To provide a health and care professional interface locally generated change proposals and wider regional and national groups as appropriate e.g., Somerset, Wiltshire, Avon & Gloucestershire (SWAG) Cancer Alliance, Getting it Right First Time (GIRFT) etc.
2. To provide system wide senior health and care professional leadership and advice on strategic health and care professional matters, focusing on improving outcomes and the quality of health and care for its residents and will provide consistency in strategic health and care professional decision-making. This may require advising the system on resource allocation and risk across short-, medium- and long-term timescales, e.g., system pressures relating to winter, resource shift to address equity of service provision, the balancing of the day-to-day use of health service against the need to invest in the longer-term prevention agenda. It may also be required to provide professional advice when system functions are at risk of breaching their contractual, safety or quality tolerances.
3. To review and endorse health and care professional and clinical policies and changes in commissioning practice, recommendations from the Area Prescribing Optimisation Committee and Formulary group.
4. To oversee significant strategic transformation activities, providing challenge and insight to ensure ongoing clinically generated improvement.
5. Topic-based enquiry into key areas on a rotational basis, led by System Partners i.e., Children's, Learning Disability and Autism, Mental Health, Out of Hospital space, Workforce, Lessons from Winter, Safeguarding, Elective Recovery, End of Life Care, Fuller update etc.

The HCPE has no direct delegated authority within BNSSG ICS. The HCPE Chairs can exercise their Executive delegated authority set out in the ICB Scheme of Reservation and Delegation to discharge the collective decisions of the HCPE, which **includes requests for cessation of programme actions and rapid review of change initiatives** if there is sufficient clinical concern. The HCPE members will be responsible for escalating potential system risks from partner organisations and/or 'place' and agreeing mitigations.

The past year has been a year of building and strengthening relationships and beginning to work within a new operating model. The HCPE has worked well, to some degree, at bringing colleagues together as an information sharing and connecting space but there is potential for it to become more than that. There are some areas for improvement. More could be done to demonstrate the importance of equity of access for all clinical and care professional groups, ensuring the Voluntary, Community and Social Enterprise (VCSE) sector, local authorities, professional membership organisations, citizens, patients and carers and other partners remain engaged and represented. To engage with different professional groups, it is important to ensure there is a link between the care and clinical professional groups and chief executives (director of nursing, medical director, chief executive officer, etc.) ensuring engagement across the system.

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

9.4 Governance – 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[1] and created a process that could be embedded system-wide.**

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

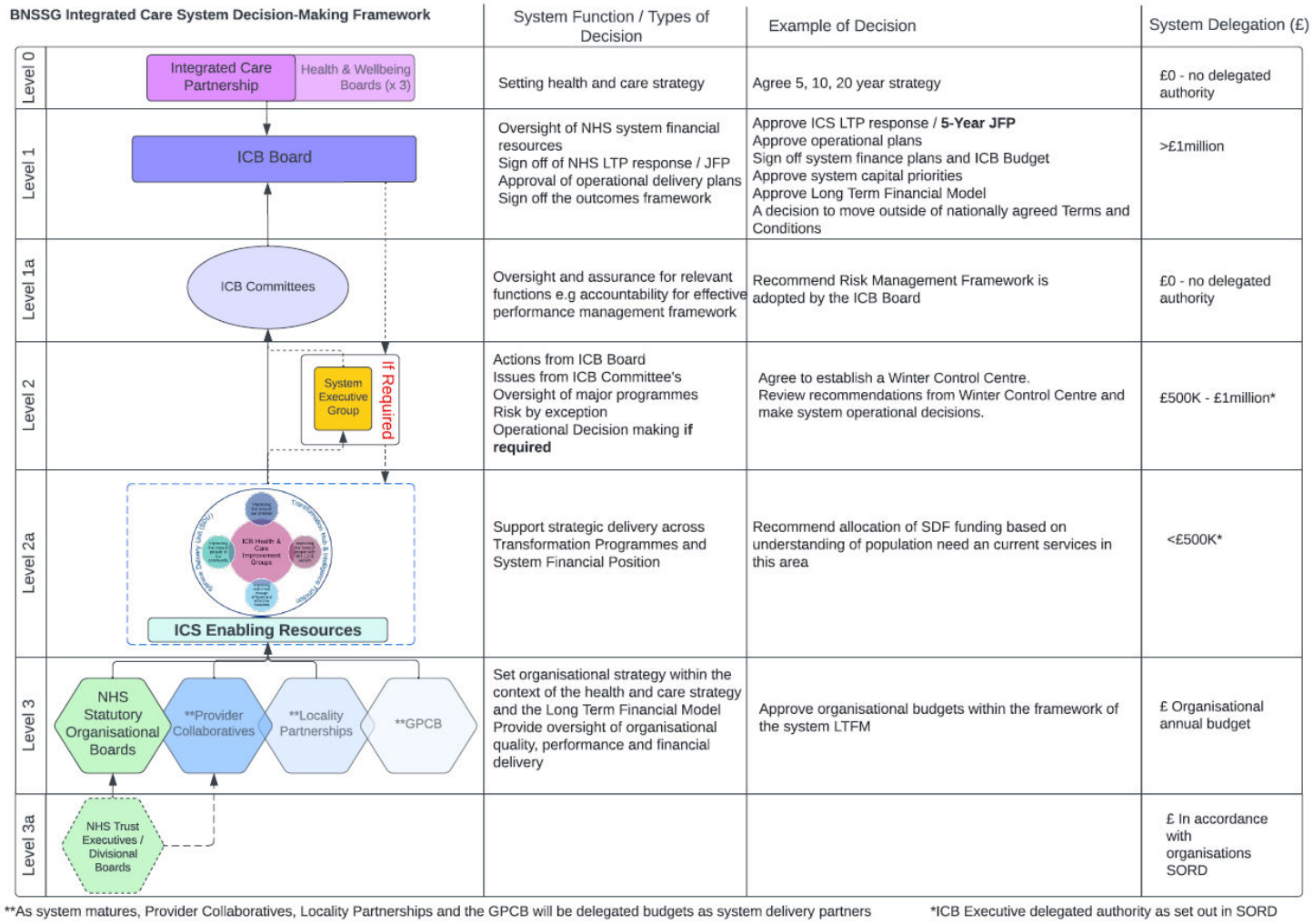


Figure 12: BNSSG ICB Decision Making

The ICB Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation (SoRD) have been updated.

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,

[1] 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.

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.

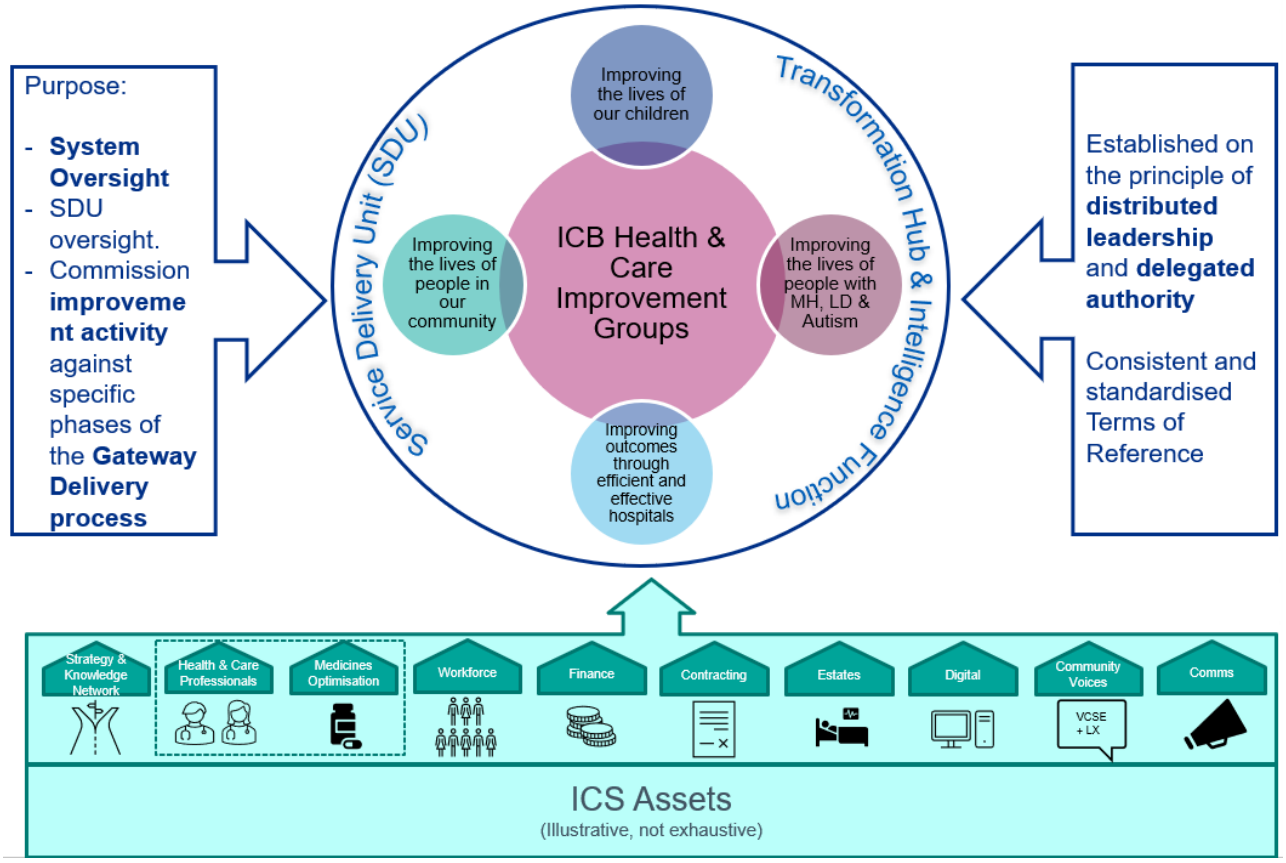


Figure 13: Integrated Care Board improvement groups that will deliver the Strategy

The **ICB Service Delivery Units (SDUs)** will be the substantive system architecture where ICS partners and ICS assets (enablers) collaborate to achieve 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.

To support collaborative system working, the System Executive Group has agreed the following ICS Partnership Principles. These are intended to enable delivery of health and care developments to benefit our population, and the delivery of our strategy.

1. ICS Groups (operational or oversight) are collaborations of ICS partner representatives.
2. ICS Groups will make decisions by consensus that best serve our population, not the interest of individual ICS partner organisations.
3. Decisions made by ICS Groups will require action from ICS partners organisations.
4. It is ICS partner organisations' responsibility to ensure that the right people with the appropriate delegated authority attend ICS Groups to agree and action the decisions.
5. If ICS partner representatives do not have delegated authority to agree and action ICS group decisions, they must escalate through their organisation's governance processes.
6. Hierarchy of decision-making to be respected.

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.

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,	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.

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.

9.5 Research and Innovation

Leadership and governance across the ICS
The ICS Research and Innovation Steering Group (RISG) is provided by Bristol Health Partners (BHP) and Academic Health Science Centre (AHSC). The Steering Group formally aligns and integrates academic expertise in population and applied health research with the ICS priorities.

Collaborations between academia and ICS
We will continue to build on 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 BHP delivery vehicle of our 20+ Health Integration Teams, is delivered across all our research development activities.

Addressing Health Inequalities
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 BNSSG Diverse Research Engagement Network (REN).

Research will be a mechanism for addressing health inequalities through encouraging skills transfer and access to courses and/or work experiences for communities as a benefit from participation in research, employing Community Research Ambassadors via research active VCSE partners, co-creating research with communities, employing Community Researchers to deliver research, analyse data and disseminate findings.

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
Our Impact Accelerator Unit (IAU), a partnership with the Universities of West of England and Bristol, will ensure evidence generated locally is embedded into practice as swiftly as possible, so that our population benefits from our local innovations.

9.6 Useful links

Strategic Framework and the Locality Partnership Plans

Health and Wellbeing Board Strategies: Bristol ; South Gloucestershire North Somerset ;

Green Strategy

Integrated Care Board open meeting papers

Primary Care Strategy

System Quality Group Terms of Reference

Workforce People Plan and deliverables

Digital Strategy and Digital Inclusion Strategy

Medicines Optimisation Strategy

Medium Term Financial Plan