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

Joint Forward Plan 2025-2030

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1. Background to the Integrated Care System

Our Integrated Care System (ICS) serves the areas of Bristol, North Somerset and South Gloucestershire (BNSSG). It is comprised of 10 partner organisations, including the three Local Authorities in our area, NHS Trusts, the Integrated Care Board and community and General Practice providers. It is also known as **Healthier Together**.

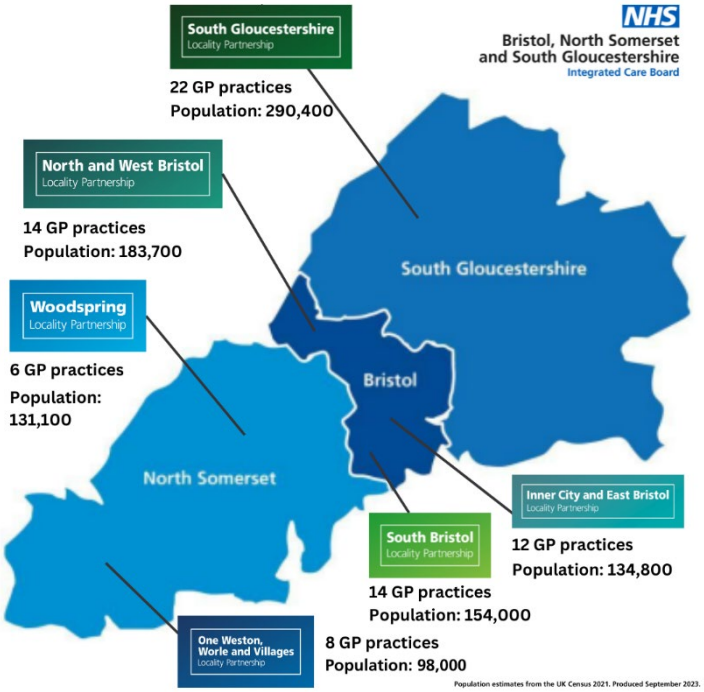

Figure 1 – Map of Locality Partnerships.

Population of one million people served by:

- Six Integrated Locality Partnerships
- Three local authorities and Health and Wellbeing Boards
- 56 children's centres
- 278 care homes
- One GP federation and one GP Collaborative with 78 general practices and 20 primary care networks
- One of each Medical, Dental, Optometry and Pharmacy Committees.
- One Primary Care 24/7 and 111 service
- 169 pharmacies
- 114 dental practices
- 79 opticians
- One community care provider
- One Healthwatch
- One mental health trust
- One ambulance service trust
- One Academic Health Science Centre
- Two acute hospital trusts
- Hundreds of voluntary and community sector enterprise partners

1.2 Joint Forward Plan

This is an updated version of the first Joint Forward Plan for the BNSSG system, originally 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 and described the 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.

During 2024/25 BNSSG ICS was either made aware of new information about particular outcomes or agreed that it needed to do work sooner to test the idea of moving more care into community settings. As a result, the following areas of work will start to be developed during 2025/26 with any implementation likely to happen in the years following:

- Chronic liver disease – Between 2020 and 2022, we found that people in the most deprived areas of BNSSG died from cirrhosis and other liver diseases at a median age of 55 years. In contrast, those in the least deprived areas had a median age of death of 71 years. This 16-year difference is more than twice the gap for diabetes, which is seven years.
- Frailty – We know that this is an area of care and support that needs to be more integrated and respond much better to people's specific needs and the outcomes they want for themselves
- Gynaecology and Diabetes – The partners of the ICS want to move more care to much more local settings. Our work on women's health over the last year means that there are opportunities to do with gynaecology. We also want to do this with diabetes as part of the work to improve outcomes for people with diabetes.

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 ICS 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 – Integrated Care Strategy on a page.

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 approaches set out in the BNSSG Strategic Framework which 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.

1.4 Healthier Together 2040

Healthier Together 2040 has been established to create a long-term strategic plan for the BNSSG ICS. Building on the system strategy published in 2023, it intends to be more than a written blueprint for the future set at a point in time; it represents a local approach and a dynamic process to shape health and care services and how they will adapt to current and future needs over time.

Healthier Together 2040 will provide a clear vision of the future of health and care locally, designed to address evolving needs and ensure the system is equipped for the challenges ahead.

The plan will outline how the ICS will work toward a sustainable, equitable future for the health system while improving the overall health and wellbeing of the BNSSG population and reducing gaps in healthy life expectancy. By focusing on redesigning services for current population health issues, the project seeks to deliver medium term improvements in integrated services, whilst also seeking prevention opportunities to avoid future generations facing similar health challenges in the longer term.

Healthier Together 2040 is an approach to work as a partnership to organise services around population cohort needs with a focus on preventing people living in poor health for extended periods of time. This approach will gradually inform decisions on where services, buildings, and infrastructure should be optimally located within the system. It will enable the system to focus on innovation aligned to the key strategic objectives for a long-term sustainable system.

The four population cohorts are as follows:

1. Preconception to under 25s
2. Adults with multiple health needs and experiencing disadvantage
3. People living with multiple health needs, caring and/or working
4. Older people living with multiple long-term conditions

Healthier Together 2040 will take each population cohort in turn and identify a set of strategic intentions for the system to work towards. Cohort 3 (People living with multiple health needs, caring and/or working) has been chosen as a pilot to this approach.

1.5 Voluntary, Community and Social Enterprise Sector

Voluntary, Community and Social Enterprise (VCSE) organisations across BNSSG make important contributions to our integrated care system. These include effective collaborations in the vaccination programme, social prescribing and hospital discharge. VCSE organisations are rooted in the heart of communities and provide community insights – acting as strategic voice in service co-design, the shift to prevention and tackling health inequalities.

Historic public sector approaches to including diverse VCSE have had varying results and the structural barriers to participation for smaller VCSE organisations remain. It was clear that we needed a different approach: the ICB Board has agreed new VCSE integration principles:

- Invest in VCSE activities as a positive action to address systemic and health inequalities
- 'Design for smaller' to enable micro and hyper-local VCSE activities
- 'Grant first' to enable appropriate investment in micro and hyper-local VCSE activities

These principles are being embedded in our collaborations with the VCSE sector, and the following developments represent changes to our approach and underline our intention to do things differently:

- 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 VCSE 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 simple route of contact, engagement, and links to community.
    - Better position the VCSE sector to contribute to the design and delivery of integrated care.
- 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 the new VCSE Brokerage Framework for investment and collaboration with the diverse VCSE sector.
- Supporting VCSE leadership and participation in ICS developments through the VCSE Alliance Ambassador network – 100+ VCSE leaders bringing diversity of thinking into strategic, planning and operational processes.
- Generating income that builds on VCSE strengths and opportunities to invest in the VCSE and ICS.

Our system approach to collaborating with the VCSE sector will be defined in a new, co-designed Healthier Together VCSE Integration Strategy.

2. Population Health, Prevention and Health Inequalities

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.

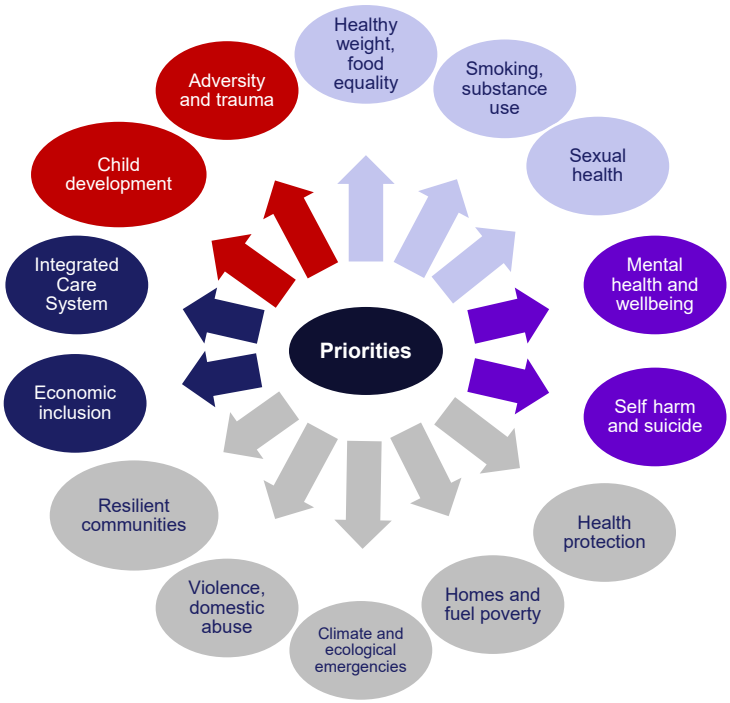

Figure 3 Bristol Joint Local Health and Wellbeing Strategy priorities.

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.

The three Locality Partnerships in Bristol are represented on the Health and Wellbeing Board and the Chair is a member of 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 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 2025/26 ambition: Children and Young People with Special Educational Needs and Disabilities (SEND) and their families have the support and information needed to thrive in education and employment.

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; Percentage of children living in low-income families; number of first-time entrants to the youth justice system per year.

Healthy bodies

One City Plan: 2025/26 ambition – Under 15% of Bristol adults smoke compared to 16% in 2021 One City Plan: 2025/26 ambition - Bristol has achieved the Fast Track Cities 95/95/95 targets on HIV.

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 percentage obesity between most and least deprived areas of Bristol; percentage of households with a smoker; percentage of Bristolians who smoke; percentage of women smoking during pregnancy; percentage 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

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: Percentage of vaccine uptake; violent crime and sexual offences; percentage of public sector fleet non-fossil fuel; percentage 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 – percentage of working age adults unemployed; percentage 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 ***Work together to ensure equality of opportunity for everyone in North Somerset to start, live, work, age and die well and to enjoy good wellbeing and health.***

The vision will be achieved through a focus on five ambitions for 2025-2028:

- **Prevention:** We will ensure children have the best start in life and focus on preventing health and wellbeing problems throughout the life course.
- **Early intervention:** We will improve outcomes by intervening as early as possible to address any health and wellbeing-related needs experienced during people's lives.
- **Holistic action and support:** We will implement person-centred action on all factors that influence people's health (the social, economic, and environmental determinants of health and wellbeing). This includes the social determinants of health that lead to avoidable health inequalities.
- **Healthy and caring communities:** We will empower people and communities to be connected, healthy and resilient through strengths-based approaches, trauma-informed practice, and engagement and involvement.
- **Tackling inequalities:** We will prioritise action to ensure equality of opportunity in access to services, experience, and outcomes to reduce inequalities between groups. We will also ensure a pro-equity and anti-racist approach through all that we do.

Six priority areas highlight the areas where action will be focused. These have been selected on the basis of data, engagement, and insight which show that acting in these fields will address the drivers of leading contributors to health inequalities and/or conditions that have the greatest impact on the health of our population.

- **Mental health and wellbeing**, incorporating social isolation and loneliness, suicide prevention, trauma-informed practice
- **Food, nutrition and oral health**
- **Tobacco, alcohol and drug use**
- **Being active**
- **Core determinants of health**: education, healthy and resilient homes, employment
- **Healthy places and communities**: starting, living, working and ageing well; long-term conditions including dementia, caring responsibility, addressing racism, stigma and discrimination, healthy, safe and caring communities, healthy relationships and sexual health, and women's health.

Within these six priority areas, the Health and Wellbeing Board have prioritised new strategy investment to focus particularly on mental health and wellbeing, and food, nutrition and oral health.

Through delivery of the strategy, the Health and Wellbeing Board will work to the following guiding principles for how the vision will be achieved:

1. Strong partnerships, collaboration, co-design and co-production
2. Tackling health inequalities
3. A place-based approach
4. Taking action across the life course
5. Use of data, insight and ongoing learning
6. Connecting people and building power in communities
7. Using trauma-informed and compassionate approaches
8. Being anti-racist and taking a pro-equity approach through all that we do

A model for the framework of the strategy is provided below.

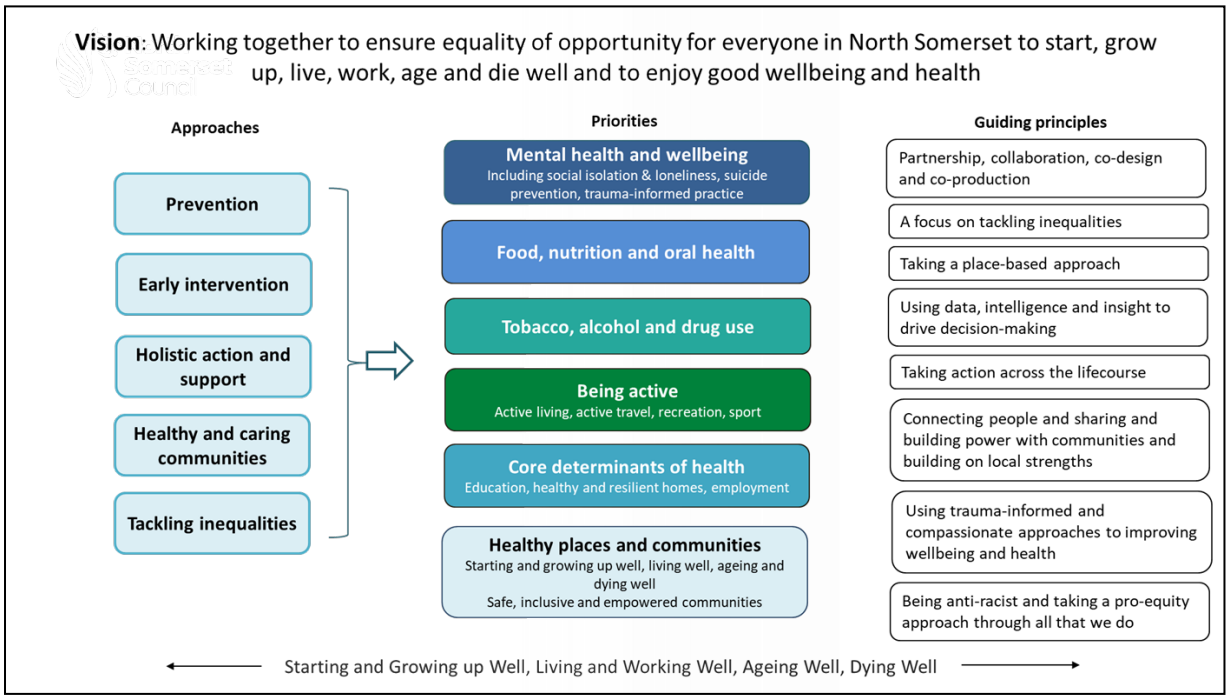

Figure 5 - North Somerset Joint Health and Wellbeing Strategy Framework 2025-2028.

Governance

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 Executive Member for Homes, Health and Equalities 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, Locality Partnerships, 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 engagement with a range of stakeholders to identify where we can make a difference to deliver short, medium and long-term benefits for local residents.

The board's new strategy will cover four years from 2025 to 2028 and will be published early in 2025. Progress will be monitored by the Health and Wellbeing Board on a quarterly basis with more detailed review of delivery and implementation on an annual basis. Recognising the complexity of the issues the strategy is trying to address and the speed at which circumstances can change, the action plan will be subject to a review process at the mid-point of delivery.

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

2.1.3 South Gloucestershire

The South Gloucestershire Health and Wellbeing Board is a statutory committee of South Gloucestershire Council. It brings together senior political, clinical, professional and community leaders from across South Gloucestershire. The Board aims to reduce inequalities and improve the health and wellbeing of our residents. It works with local partnerships to align strategies, integrate services, and address health priorities through a coordinated, multi-agency approach.

The Health and Wellbeing Board has statutory responsibilities to:

- Develop a Joint Local Health and Wellbeing Strategy
- Encourage and enable integrated working between health and social care
- Produce a Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment

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. The Health and Wellbeing Board and South Gloucestershire Locality Partnership hold joint development sessions on topics of mutual interest.

Joint Local Health and Wellbeing Strategy

During 2024 the Health and Wellbeing Board has collaborated with system partners to develop a new South Gloucestershire Joint Local Health and Wellbeing Strategy for 2025-2029. This included reflection about strengths and challenges of the previous strategy, the work of the board, the Joint Strategic Needs Assessment (JSNA) process and local priorities.

The new strategy will be rooted in an understanding of local data and insights set out in our JSNA and take an evidence-based approach. It will use the JSNA understand local needs and inequalities and respond to insights gathered by the council, Healthwatch and voluntary sector partners.

The final strategy will be agreed in May 2025 and will include a delivery plan each year setting out actions to achieve our vision that South Gloucestershire is a healthy and inclusive place for current and future generations.

Actions will be aligned to priorities set out in the BNSSG Integrated Care System Strategy, Joint Forward Plan and local plans including our Locality Partnership's delivery plan and will enable the Health and Wellbeing Board to work together to:

- Strengthen community involvement
- Build a programme of place-based working
- Reduce inequalities

- Shift resource upstream with a focus on prevention
- Strengthen our use data and insights in planning and decision making

2.2 Prevention

What do we mean by prevention?

Preventing ill health and strengthening wellbeing at community levels increases a person's ability to take action or choose what action to take. It builds and maintains resilience through strong, supportive connections with others. For example, being part of a community can enhance resilience by encouraging a sense of belonging.

Prevention covers a wide range of activities including:

- Improving various parts of people's lives that affect our health beyond just our personal choices and genetics. For example money and jobs; where people live and what it's like there; education; friends and family.
- Preventing disease by changing risk factors that people are able change. For example smoking is a risk factor and a person could choose to stop smoking. Age is also a risk factor for getting some diseases but it isn't possible to change someone's age. This is called primary prevention.
- Preventing the disease from getting worse or slowing down how it progresses. For example making sure that someone with Type 2 diabetes receives the care that is recommended so that they reduce the risk of losing their sight or having an amputation. This is called secondary prevention.

When we asked people who live in Bristol, North Somerset and South Gloucestershire what they need to be happy, healthy and well, they told us that they need:

- Better access to quality care, including helping people early and preventing disease.
- A healthier, more active lifestyle.
- Good relationships.
- Stable employment and good work-life balance - work-life balance was mentioned by racially minoritised people more often than average as a barrier to happiness, health and wellbeing.
- Reduced poverty and inequality / improved cost of living.
- Social factors such as climate, government and regulations.

When we focus on race equity

- Work life balance was mentioned by racially minoritised people more often than average as a barrier to happiness, health and wellbeing.
- An active lifestyle and community amenities were prioritised in greater proportions than average by racially minoritised people as a way of increasing the number of years.

We will need to take this into consideration when we are working with people and communities to design activities which will help improve prevention.

Who is accountable for prevention?

Local authorities and health are jointly accountable for prevention.

There are many things that have an impact on people's health. This means that we need a combination of prevention activities to make improvements and these activities need to work together to get the biggest impact. In BNSSG we are using the 'Star' model shown below to make sure that ICS partners are clear about roles and responsibilities. This mapping will also help us to understand how the whole system, places and communities, health behaviours and wider determinants of health, e.g. housing, employment, education all work and rely on each other to make improvement to people's health.

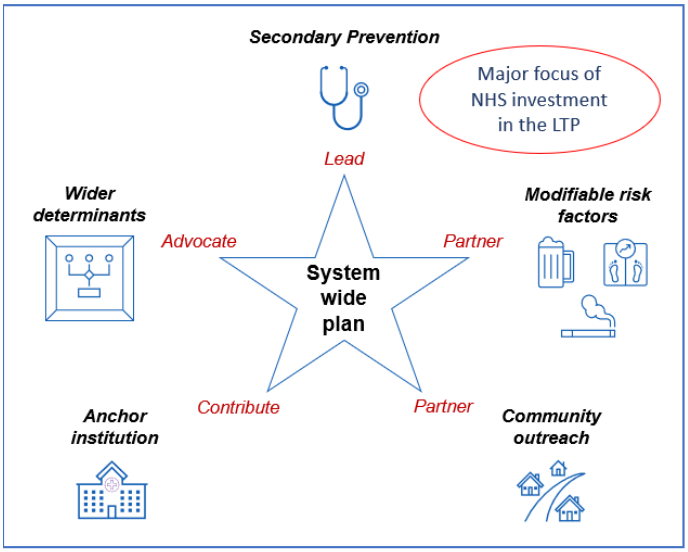

Figure 6 - System-wide roles and responsibilities.

(LTP = Long Term Plan)

We hope that this approach will help to reduce health and healthcare inequalities[1], mean that we do not have more deaths than we expect (known as 'excess deaths') and that we will reduce preventable admissions. We will focus on cardiovascular disease and diabetes because they are two of the conditions that have large inequalities in outcomes. They are also the main reason for the excess deaths.

How will we know that prevention work is happening and making a difference?

BNSSG ICB has set up a Strategic Health Inequalities, Prevention and Population Health committee which reports directly to the ICB Board. This group will:

- Seek assurance – The committee will ask system partners and groups whether they are delivering prevention activities and how well / effective the activities are. This includes work on:
    - Vaccinations and immunisations.
    - Making improvements in the support for people with long term conditions.

[1] Health and health inequalities are the systemic, unjust [or unfair] and avoidable differences in people's health across the population and between specific population groups

  - Improvements in the health of people in inclusion health groups[2] including migrant health.
  - Using data and insights to improve population health and reduce inequalities.
- Be accountable – for the delivery of the NHS Long Term Plan commitments on healthy weight, treating tobacco dependence and alcohol and other drugs. This will be reviewed once the new NHS 10-year plan is published.

The Strategic Health Inequalities, Prevention and Population Health Committee will have a particular focus on race equity when seeking assurance and being accountable for the areas listed above.

How will we know that we are making a positive difference to our communities?

BNSSG Integrated Care System has a set of outcomes that describe the changes and improvements we want that, taken together, will improve the health of the population in BNSSG. We have agreed a set of measures that will tell us in numbers what difference our work is making. However, we need to get much better at asking communities in a much more planned and consistent way, whether things are improving for them.

[2] Inclusion health groups include people who experience homelessness, people with drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, among others

2.3 Health Inequalities

The social, economic and environmental conditions in which people live have an impact on health. They include income, education, access to green space 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.

Plans to reduce health inequalities can be found within the relevant programmes under the relevant health and care improvement and other 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 ICB Board for approval by the Chief Medical Officer who has executive responsibility for health inequalities. During 2024/25, part of this money was allocated to the six Locality Partnerships and they decided how to use it to address inequalities in access, experience and outcomes in a way that reflected their specific community needs. Specific health services for migrants were also supported by this money.

During 2024/25, the ICB established a Strategic Health Inequalities, Prevention and Population Health Committee of the ICB Board, chaired by the Chair of the ICB. The purpose of the committee is to:

- Gain assurance on the ICB's, and where appropriate ICS's, actions and progress on addressing healthcare inequalities, increasing effective prevention activities and improving population health. In turn, the committee will provide assurance to the ICB Board.
- Be responsible for the delivery of the whole system approaches to smoke free, healthy weight and drugs and alcohol.

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.

2.4 Smokefree

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 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 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 what is important to people at any point in time and limited capacity and varying priorities within services.

2.5 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.

2.6 Healthy Weight

Improving our population's health by ensuring everyone can get affordable, healthy food and the right support when they need it has never been more important. Obesity is the most significant risk factor for disability in our area. It is the second leading cause of preventable cancers after smoking. It is closely linked with type 2 diabetes and that disease's complications.

We see increasing rates of children living with obesity in areas most affected by poverty and deprivation compared with the least affected areas. Too often, the most affordable food options are high in sugar and fat, and healthier affordable options are out of reach because of barriers such as public transport. Barriers like this lead to poorer health for people living in areas most affected by poverty.

Our plans describe our key steps to improving places and supporting people in our whole system approach to health and healthy weight.

2.7 Women's Health

The **Women's Health Strategy for England** was published in 2022. The strategy set out a ten-year plan for improving women's and girls' health and wellbeing, including developing **Women's Health Hubs** across England. We have talked with stakeholders in our area to develop and agree on priority areas and outcomes we want to achieve with the funding for 'Women's Health Hubs'. We established a Women's Health Working Group that has been busy developing plans to improve our services that will improve outcomes for women in Bristol, North Somerset and South Gloucestershire.

We are:

- Working with all Primary Care Networks in our area to improve quality and access to menopause care, and create better access to contraceptive implants and intrauterine devices (coils).
- Training staff to deliver trauma-informed care, improve their clinical skills and make services more accessible to meet the needs of different groups.
- Working with community organisations and groups and improve access and outcomes for migrants in vulnerable circumstances, Gypsy, Roma and Traveller people and people with complex needs.
- Working with the Well Aware signposting website to create new section on women's health to make it easier for people to access reliable and up to date information.

You can read more about our plans here - Women's health - BNSSG Healthier Together.

Note: although we use the term women we recognise that trans, non-binary, intersex and gender-expansive people require women's health services and we are working to ensure services are accessible and inclusive for all.

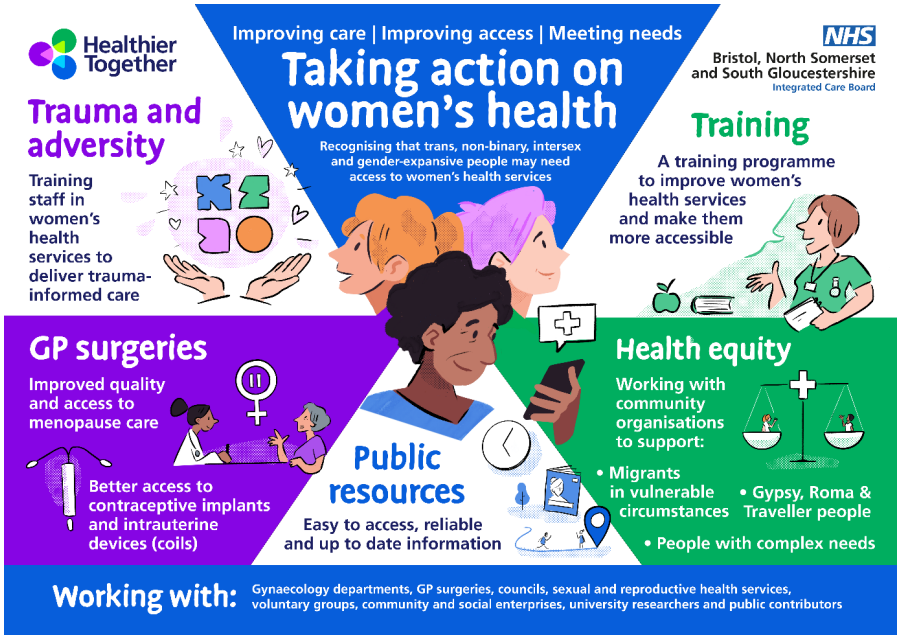

Figure 7 - Taking action on women's health.

2.8 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 will be 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.

January 2025

A new model of sexual health delivery was developed in 2024 to address the needs identified in the comprehensive sexual health needs assessment which included significant public consultation. Further to an extensive reprocurement exercise in 2024, providers for the digital front door, for clinical services, abortion services and health promotion, outreach and engagement have been identified. The new services commence from April 2025. GP and pharmacy sexual health services are currently being harmonised and recommissioned for Bristol and South Gloucestershire for April 2025. These services are aimed to improve

timely access to our services, and to support a much greater focus on prevention and meeting the needs of the most vulnerable. Alongside this, a number of research projects to improve sexual health have been undertaken in 2024.

HIV treatment services have been dealing with an increase in new cases, with many of those diagnosed previously abroad. Emergency Department opt out Blood Borne Virus testing (HIV Hep B and Hep C) commenced within our acute hospitals in October 2024 and has been accompanied by training for healthcare staff to reduce HIV stigma. Bristol is a Fast Track City for HIV with an action plan to end HIV by 2030. This involved committed collaborative working across a number of ICS partners. A particular focus has been on working with African and Caribbean communities to address HIV and sexual health and this project (Common Ambition Bristol) has won or been a finalist for four national awards in 2024. Common Ambition Bristol | Improving Sexual Health

The South West ICBs will have delegated responsibility for HIV treatment from April 2025 and will make joint decisions around services via the joint Directors group with the principal commissioner likely to be NHS Somerset. BNSSG Sexual health consultants are now working within the HIV treatment service at Southmead to improve joint working with HIV and plans are underway for closer future working.

3. Children and Young People

Second year look back

Children and young people

The Children's Health and Care Improvement Group (HCIG); a collaboration of Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) Partner Executive Directors, senior system leaders, and health and care professionals, continues to strengthen and this is demonstrated in its cohesive approach and maturity of system planning, oversight of performance improvement and transformation. 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).

Throughout 2024, we worked in partnership across the system to develop a framework that will enable BNSSG to improve outcomes for early years, from conception to age five. We identified four enablers and established four guiding principles, along with a clear five-year action plan as a roadmap to achieve these goals.

Children's mental health

Investment into the Child and Adolescent Mental Health Service (CAMHS) and Mental Health Support Teams (MHSTs) in schools has increased access to mental health support for children and young people. We remain below the national access target, however, and improvement in this area remains a BNSSG priority with service level improvement plans.

An enhanced transitions service for children moving on from CAMHS has been developed. The new service model will improve the provision of services for our young adults and provide a more supportive transition into adulthood.

A paediatric acute eating disorders service is now fully established with a full multidisciplinary team (MDT) based within the acute provider, and a joint virtual weekly meeting of MDT with CAMHS and local authority input is held to provide joined up care.

Children's learning disabilities, autism and SEND

An Autism Intensive Service (AIS) was jointly re-commissioned by BNSSG Integrated Care Board and local authorities. The service's annual report (2024) highlighted for most young people and their families working with AIS, that quality of life and psychosocial wellbeing improved, the frequency and / or intensity of behaviour that challenges reduced, and there were no exclusions from school or admissions for mental health support during the intervention period and maintenance of outcomes was high.

The ICS Neurodiversity Transformation Programme has made significant progress in developing a new needs-led approach to supporting children, young people and their families and has started testing various elements of the model. A three-year recovery plan,

to implement a needs-led approach and eliminate long waits for autism and attention deficit hyperactivity disorder (ADHD) assessments, is in development.

The Partnerships for Inclusion in Neurodiversity in Schools project has delivered bespoke support packages to 46 primary schools across BNSSG, aimed at improving the schools' awareness, knowledge and confidence in meeting the needs of neurodivergent pupils thus improving inclusion and reducing exclusion.

The one remaining special educational needs and disabilities (SEND) Accelerated Progress Plan (APP) in place in our system (Bristol) has been signed off with evidence that the "fractured relationships with parent carers" is no longer an area of significant weakness.

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

Investment in system arrangements for safeguarding children, including consistent health input to safeguarding strategy meetings across BNSSG, capacity for adoption medicals and continued focus on initial and review health assessments for children in care, has improved timeliness of assessments and strengthened overall safeguarding arrangements.

Continued focus on reducing long waits in community services has resulted in the stabilisation of waiting lists and long waits. However, the scale of the gap between demand and capacity means that children and young people are still experiencing excessive waits for autism and ADHD assessments, which will require a transformed approach to future service delivery. Investment in face-to-face speech and language therapy for early years children waiting for an autism assessment is preventing them from falling further behind their peers.

The transformation of Public Health Nursing was completed in 2024/25 and will continue to embed the benefits:

- The THRIVE Framework 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 co-produced 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 proportionate to their level of disadvantage

The Children and Young People Vanguard programme has continued to deliver the aims of the framework for integrated care. An interim evaluation 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 now in the final year and is focused on establishing sustainability plans alongside continued improvement against the established key performance indicators.

Children's acute services

The children's acute programme has continued to support flow and provide additional capacity. This has resulted in a significant reduction in waiting time for elective care, with most paediatric specialities eliminating 65 week waits by the end of 2024/25. This focus is maintained in the 2025/26 Joint Forward Plan, paying particular attention to cardiac surgery, dental and cleft that are facing specific risks and challenge.

The minor injuries stream and additional, temporary space created for the Emergency Department is supporting waiting times for urgent and emergency care and achieving the national target of <78% patients seen within four hours by March 2025.

A system partnership, led by the Bristol Royal Hospital for Children (BRHC), has set-up three pilot sites for integrated care for children across three Primary Care Networks in BNSSG. Patient and staff feedback has been excellent to date, and this pilot puts us in a strong position to share the learning around future 'Integrated Network Teams' for children, which have been highlighted in recent policy as the desired direction of travel nationally. A full evaluation of the pilot is underway and next steps are to be agreed.

Background

The children and young people's Joint Forward Plan is informed by qualitative insights from children and young people, our staff and partners. Quantitative data is 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 means partner organisations working in an integrated way to ensure that 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 further supports 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 2025/26 children's operational plan continues to focus on addressing long waits for children's autism and ADHD assessments. Whilst additional capacity will address the current backlog of assessments 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 has led to a comprehensive understanding of the challenges and the development of a needs-led approach to ensure the needs of children, young people and their families are consistently met.

The 2025/26 refresh of the children's Joint Forward Plan includes current commitments and resourced priorities. The Children's HCIG has identified many other priorities for children and young people in BNSSG and these aspirations will be prioritised and sequenced as part of the development of a shared system ambition and strategy for children, aligning with national and regional health, education and social care reforms, policies and strategies.

The Children's HCIG has committed to the following system-wide priorities for children and families:

- Continue the Neurodiversity Transformation Programme including testing of neurodiversity support hubs and agreeing a three-year plan to address waiting times for ADHD and autism assessments.
- Improving the health and development outcomes for early years children.
- Supporting children and young people with very complex needs at risk of deprivation of liberty.
- Co-ordinate action across system partners to improve outcomes for children and young people losing learning.
- Improving transition support for children moving to adult services/adulthood.

The children's Joint Forward Plan includes a new BNSSG-wide programme, supporting children and young people with SEND where co-ordinated action across the system will result in significant improvements for children and young people. Four other programmes of improvement remain in the Joint Forward Plan:

- Supporting children and young people with learning disabilities and/or autism
- Children's community health services
- Children with mental health needs
- Children with acute health care needs.

For children's mental health, improvement plans remain aligned to the ICS' All-Age Mental Health Strategy described in section 3.4 'Improving the Lives of People with Mental Health, Learning Disabilities and Autism'.

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 – strategy and 25/26 goals

- We will progress the children's community health services procurement in alignment with our system's ambition/strategy for children.
- We will improve access to and reduce waits for children's acute, community and mental health services in line with national standards.
- We will maintain our children's emergency and urgent care performance within the four-hour waiting time standard.
- We will continue to deliver the Neurodiversity Transformation Programme, including testing of neurodiversity support hubs and implementing a sustainable model to meet needs.
- We will support local area SEND plans with BNSSG-wide collaboration, learning and improvement.
- We will implement the maternity and early years strategic framework and begin delivery of system early years improvement plan.
- We will continue to develop a comprehensive Mental Health Support Teams in School service, including roll out of new teams increasing activity and impact
- We will work to develop our system approach to supporting children and young people through the recently published Neighbourhood Health guidance and with local authority partners as they develop MDT wellbeing teams and hubs.

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 delivery framework for BNSSG Integrated Care System.

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

The Children's HCIG works closely with other Health and Care Improvement groups recognising that children live in families and communities. The Local Maternity and Neonatal System now reports to the Children's HCIG, creating closer links between maternity and children's services, ensuring effective delivery of services and improvements to meet the needs of women and babies in our system.

3.1 Local Maternity and Neonatology

Achievements

We successfully recruited a full Maternity and Neonatal Voice Partnership (MNVP) Lead team consisting of a strategic lead, a community engagement lead, an acute trust lead and a neonatal lead. We are the only Local Maternity and Neonatal System in the South West that has recruited to the gold standard as set out in national guidance and has an MNVP that is more reflective of our local population.

We implemented the electronic notes system, Badger Notes, in September 2023, with the aim of improving accessibility and delivery of personalised care for all mothers and their families. We are now working closely with our MNVP to launch a widescale service user survey to find out whether our population is engaging with Badger Notes and experiencing the benefits we hoped to realise.

We are working with our business intelligence leads in both acute trusts supported by the Acute Provider Collaborative to develop a system wide maternity dashboard that will support identifying inequalities within our maternity outcomes.

The Local Maternity and Neonatal System is continuing to work alongside the Race and Health Observatory Learning and Action Network to reduce disparities in pre-term birth outcomes and experiences.

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 the BNSSG Maternity and Neonatal Voice 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 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 at the Local Maternity and Neonatal System Executive Board.

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 Executive Board.

4. Community Services

Communities Health and Care Improvement Group: Aims

The Communities Health and Care Improvement Group has identified five key aims to enhance health and care services at a community level:

1. **Deliver Integrated Community Services** – Co-ordinate care around individuals' health needs to improve their experiences and outcomes.
2. **Strengthen Proactive and Preventative Care** – Prioritise the development and sustainability of community services and activities that prevent ill health.
3. **Reduce Health Inequalities** – Ensure that community care actively addresses and mitigates disparities in health and well-being.
4. **Empower Local Communities** – Design and improve services by actively listening to, engaging with, and empowering local populations.
5. **Support Independent Living** – Enable people to stay well at home through accessible and effective community-based care.

Alignment with the Joint Forward Plan

The work programmes and priorities within the communities portfolio, as outlined in the Joint Forward Plan, are aligned with these aims. This supports the NHS vision of delivering care closer to home, improving access, health outcomes and patient experience.

Collaborative Approach to Delivery

Achieving these aims requires a collaborative approach across the entire health and social care system. Key stakeholders include:

- Primary and social care providers
- Community health services
- Mental health and acute trusts
- The voluntary, community, faith and social enterprise sector (VCSE).

By building on the strong foundation of existing work across neighbourhoods, localities, and the wider system, this partnership approach will ensure the effective implementation of neighbourhood health initiatives.

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.

General practice

Some of our achievements over the last year include:

- 4% more appointments delivered
- Clinical Leadership at system Level
- Improved general practice representation at system level, for example Urgent Care Network, Planned Care Network
- 81% Severe Mental Illness Health Checks completed
- Vaccination programme
- Practice Support Team helped 52 practices (490 queries)
- Diabetes Recovery Project
- Digital Transformation
- Development of General Practice Appointment Data (GPAD) slot analysis tool
- General Practice Workforce Strategy.

The work we will continue:

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.

Our aim is to ensure easier access to practices by patients and carers both for urgent appointments and routine appointments, ensuring people can more easily contact their GP practice (by phone, NHS App or online). We will also build on the learning for wider primary care services.

We will continue to work with our system partners through our Urgent Care Network, community 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. Co-ordinated 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 to general practice includes:

- The Access Resilience and Quality Programme
- Supporting the spread and adoption of best practice
- Supporting practices and primary care networks with continuous improvement
- CQC readiness support
- Escalation – short-term support for practices and general practice system representation
- Medium and long-term support for individual practices and primary care networks
- Responding to national requirements.

The Training Hub supports general practice training and development:

- We actively support practices to optimise their digital systems by conducting system reviews, sharing case studies and providing hands-on assistance.
- By holding contracts at the appropriate scale, we enable standardisation of systems while preserving practice autonomy, ensuring practices can effectively leverage digital tools to meet their population needs.

Community pharmacy

Over the last year we have achieved:

- Successful roll out of Community First – routinely over 10,000 referrals per month
- Increased numbers of Designated Prescribing Practitioners (DPPs)
- Successful expansion of Community Pharmacy LES PGD for Otitis Externa

We aim to transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Pharmacy First 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.

We will be live with our first Community Pharmacy Independent Prescribing Pathfinder site with an aim to expand the roll out of this to enable further patients, with increased complexity, to be seen in pharmacy by a prescriber. Furthermore, the Community Pharmacy Clinical Lead is working with Community Pharmacy Avon and the General Practice Collaborative Board (GPCB) to look at enhancing the number and type of community pharmacy patient group directions (PGDs) offered to support GP practices and patients.

Optometry

The implementation of a new referral pilot between community and local trust is progressing well with technical developments enhancing connectivity – a previously noted obstacle to collaboration between primary and secondary care. The pilot has demonstrable benefits to patients with key milestones such as:

- System and pathway requirements scoped
- Community system developed to allow connectivity to secondary care
- Pilot launch event meeting,

Future efforts will be focused on standardising pathways like post-operative care and refining referral schemes to ensure equity of access for the BNSSG population.

In addition, our optometry practices are conveniently located across our area. This enables the system to use both clinical skills and specialist equipment to alleviate unnecessary pressures from overburdened secondary care services, as well as GP practices, which 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 service's 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

An Oral Health and Dental Strategy for 2024-2027 has been developed, recognising the significant challenges with dental 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 an oral health and dental strategic plan that seeks to increase oral health promotion, improve access, reduce inequalities, increase recruitment and retain the workforce.
- Increasing access by procuring additional activity with consideration of increasing the rates paid to dentists (above national minimums), particularly in deprived areas with low access rates, where the national contract and funding allocation allows.
- Consider opportunities for targeted access continuing with children in care and considering other population groups such as those living in care homes, experiencing homelessness, asylum seekers and those with learning disabilities.
- Maintain and improve urgent care access and address unmet need.
- Increase the availability of stabilisation services to ensure patients are able to access care that stabilises their oral health and reduces demand on the urgent care system.
- Increase work on oral health improvement, especially for children, building on existing programmes such as supervised toothbrushing.

- Utilise digital innovation starting with electronic referrals from primary care dentists to hospital based dental services.
- Review opportunities to improve and increase Tier 2 / sedation services in the community, reducing the need for general anaesthetic and secondary care.
- Explore further opportunities for improving workplace health and wellbeing, starting with additional funding for training.
- Identify opportunities to increase career support post foundation training.

The collaborative work will include working closely with the Local Dental Committee, Managed Clinical Networks, Bristol Dental School and Integrated Care Boards 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:

- Establish and deliver general practice workforce strategy
- Embed primary care workforce as an integral part of system thinking, planning and delivery
- Improve workforce data – whilst we have access to NHS England South West regional workforce data, we still do not have accurate general practice workforce data other than that provided by the National Workforce Reporting Service (NWRS) and associated known constraints
- Support innovative employment models – looking to develop a bank of flexible admin workers to fill demand
- Support the development of training and supervision, recruitment and retention and increased participation of the workforce.

Primary Care Training Hub

Over the past year significant strides have been made in enhancing patient care and staff development. Funding was secured for cervical smear training, increasing service delivery through improved competency. More than 70 events were held, ranging from webinars to face-to-face meetings, these covered subjects such as women's health topics, babies, children and young people clinical topics, cancer topics (for example bowel and breast cancer screening sessions for both clinical and non-clinical staff), late career GP retention, dermoscopy, and simulation sessions. Additionally, the creation and distribution of eight 'good news' videos celebrated achievements within general practice, accumulating over 1,150 views. Whilst nine PaedsPod sessions shared since April 2024 have amassed over 2,175 views.

Our training hub will continue to facilitate access to high quality training and education for the primary care workforce, including:

- Delivery of the 3+1+1 Training Hub strategy: +1 contract for 25/26 confirmed in November 2024 and we await a decision regarding the final +1 for 26/27
- Building on the proven success and skills to enable ongoing development of a multi-skilled primary care workforce:
    - We are delivering a 12-month general practice core skills training programme for all general practice roles.
    - We have delivered training to 198 individuals in foundational skills, including immunisations, phlebotomy, infection control, ECG interpretation, basic wound care, and travel health.
    - We have provided updates to 114 non-clinical and 250 clinical staff with an improvement with uptake and course attendance. The total number of staff trained is 562.
- Supporting induction to primary care with support to the general practice induction video in collaboration with One Care and the GPCB.
- Supporting early and late career stage, including widening newly qualified GP fellowships for nurses – collaborative agreement to allocated funds to a local newly qualified GP and General Practice Nurse (GPN) scheme (in place of the cancelled national scheme). With over 40 GP and 29 GPN participants to date we have a track record of 100% retaining a salaried role in Bristol, North Somerset and South Gloucestershire and to do the same with this cohort. This also applies to the 37 mentors who support them and site this work as motivational and aiding their commitment to stay in role.
- Maximising recruitment and retention into Additional Roles Reimbursement Scheme (ARRS) roles – 121 support for new ARRS roles and ARRS community of practice groups to support new and existing people. Primary Care Network (PCN) education leads for all PCNs bar one, promoting and proactively enabling learning and development for ARRS colleagues.
- Supporting recruitment and retention for wider primary care roles including pharmacists, allied health professionals and non-clinical staff – commenced general practice non-clinical and management development project to develop career pathways and training material repository for these staff who make up 50% of the general practice workforce. 37-39 individuals funded £8,600 each for Advanced Practice Training for a maximum of three years. The highest in the South West and probably the UK.

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. It has been acknowledged that 25% of general practice estate in Bristol, North Somerset and South Gloucestershire is not fit for purpose.

We will continue to advocate for the provision of additional estate capacity required by general practice by April 2028. Through the estates strategy steering group, we aim to

ensure that general practice estate challenges remain visible and are appropriately prioritised when system and national capital is available.

Digital

In 2024/25 significant improvements progress has been made in advancing digital maturity within primacy care, focusing on improving efficiency, patient access and system resilience.

Key achievements and ongoing projects include:

- Robotic Process Automation (RPA) pilots: We have successfully piloted the use of RPA across practices for automating the filing of blood results. This initiative has streamlined administrative tasks, freeing up clinical staff time to focus on patient care. The next phase involves piloting RPA for automating patient registrations, further reducing the administrative burden and enhancing operational efficiency.

- GP Lab collaboration: With our support, the GP Lab at the University of the West of England is now operational. This innovative space has facilitated the testing and rollout of ambient voice technology, which is currently being implemented across our practices to improve consultation efficiency and reduce clinician workload.

- NHS App project: Leading the NHS App project through general practice, we have driven adoption and enhanced functionality to better meet patient needs and streamlined administrative workload for practices. Learnings from this work have informed best practices, with benefits including improved access to care and streamlined communication between patients and providers.

- Adoption of new technologies: General practice continues to adapt and integrate new technologies to improve care. This year, we prioritised addressing digital exclusion. Through targeted initiatives with practice participation groups and partnerships with local voluntary sector organisations, we have worked to ensure equitable access to digital tools and services, reducing disparities and improving inclusivity.

- Implement electronic referrals from primary care dental practices to hospital-based services.

Governance

General practice in our system has come together to form the 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.

Implementation of transformational change has been restricted by lack of access to recurrent funding for programme management resource. We will continue to seek ongoing funding for transformational change linked to GPCB and service development funding (SDF) priorities.

4.2 Discharge to Assess

System partners will continue to work together to:

- Reduce the amount of time that people spend delayed waiting in hospital and in the community for support to recover/regain their independence or to meet their long-term care and support needs.
- Support more people discharged from hospital to go home (on pathway 0) and be supported to regain their independence at home (on pathway 1) rather than in a community bed (pathway 2 and 3).

Alongside this, we will work closely with the Integrated Care at Home programme to manage the demand for complex discharge pathways by providing coordinated, preventative support that helps people stay independent, safe and well at home for as long as possible.

4.3 Community Collaborative Delivery Group

The Community Collaborative Delivery Group (CCDG) started meeting in November 2022 as a joint group to oversee the Sirona Community Model Review. All six GP locality leads are involved alongside voluntary, community and social enterprise (VCSE) representatives, BrisDoc, executives and operational leads from Sirona care & health, and social care.

This group is co-chaired by Sirona Chief Nursing and Allied Health Professional Officer and GPCB Medical Director.

This group is taking forward collaborative projects including domiciliary blood referral process, insulin delegation and urgent community response. The CCDG provides support and oversight of the delivery of Sirona's Community Model Programme (shifting to the Clinical Strategy from April 2025) and works to identify and develop collaborative opportunities across community based providers.

The CCDG is developing a more strategic approach in relation to support to care homes through a sub-group (Bristol, North Somerset and South Gloucestershire Strategic Care Provider Group), as well as partnerships and collaboratives to support the delivery of effective and efficient ways of working.

The CCDG has oversight of the End of Life Network and Personalised Care System Group.

4.4 Integrated Care at Home

The Integrated Care at Home (IC@H) Board was established in January 2024 to design and deliver a model of care for Bristol, North Somerset, and South Gloucestershire (BNSSG) to achieve the following benefits:

- **Improved efficiency** of service delivery through better integration of existing services
- **Better outcomes** for people with a specific focus on proactive care and managing risk in the community rather than secondary care
- Clear **priorities** for the use of any funding or resource availability
- Increased **confidence** in community-based provision.

The proposal is to roll out a community-based care co-ordination function, focussed on a specific cohort of patients first, to test and shape development of the full model. The core offer will be consistent across Bristol, North Somerset and South Gloucestershire, non-medical in its approach, complemented by a central team to link into more medical aspects of related services and provide support while coverage builds. By developing relationships with all system partners, care co-ordination teams will be the building block for locality-based integrated community frailty teams.

While embedding care co-ordination, we will work with our partners, initially social care, health and Voluntary Community Social Enterprise (VCSE) services, to:

- Understand the ambition around other elements of the model
- Clarify our vision to support people to stay well
- Prevent and manage crisis
- Understand where we have gaps between our ambitions and our current services.

An important function of the model will be to embed a “community pull” approach for those patients in hospital, facilitating appropriate and supported discharge. We will work with system partners and locality partnerships to embed the principles of the model, including improving continuity of care across all providers and focusing on getting things right first time for people.

4.5 Long-term Conditions

Background

Multi-morbidity, when patients have two or more long-term health conditions, is growing in the UK with one in four people now living with at least two health conditions[3]. In many cases people are living longer with these conditions.[4] They are chronic and lifelong, requiring a different approach to treatment centred around helping people live well with their conditions. For those who live with deprivation, healthy life expectancy has not improved.

In 2024, the Integrated Care Board (ICB) established a Long-Term Conditions Operational Delivery Group to bring together ongoing system-wide work to address these challenges. The group acknowledges the need to take a more holistic approach to the management of long-term conditions. We understand the need for greater focus on secondary prevention, such as managing hypertension to reduce the risk of further cardiovascular events, as well as a person-centred approach to care overall, providing a holistic and long-term approach, from prevention through to long-term treatment and end of life care.

Cardiovascular Disease (CVD)

The NHS Long-Term Plan commits to tackling the significant inequalities in mortality and morbidity due to CVD. CVD is one of the six long-term conditions included in the Department of Health and Social Care Major Conditions Strategy[5], which emphasises the overlap between diabetes and CVD specifically and multi-morbidity generally – a person with diabetes is twice as likely to have heart disease or a stroke than someone who does not, and at a younger age[6].

Within Bristol, North Somerset and South Gloucestershire (BNSSG), for men, 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 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.

Progress to date

Work has been ongoing at system, locality Primary Care Network (PCN) and practice level looking at the management of CVD and diabetes across BNSSG including, but not limited, to:

- Prescribing - optimisation of hypertension medication plus monitoring and a review of lipid lowering therapy for secondary prevention.
- Community Pharmacy Hypertension Case Finding – blood pressure monitoring services to support identification of hypertensive patients and reviews of existing patients.

[3] NICE (202) Multimorbidity | Health topics A to Z
[4] Summary | The State of Ageing 2023-24 | Centre for Ageing Better
[5] DHSC (2023) Major conditions strategy: case for change and our strategic framework
[6] NICE (2024) Risk factors for CVD | CVD risk assessment and management

- NHS health checks and community outreach health checks.
- Specific programmes, through locality partnerships, to address hyper-local health inequalities around CVD and diabetes.
- Blood Pressure Optimisation work with CORE20 PCNs.
- BNSSG Collaborative Lipid Fund focused on lipid optimisation for high-risk patients.

Looking ahead

The ICB conducted a deep dive review into CVD (December 2024) across BNSSG which highlighted that compared to the system median and national average:

- We have lower rates of people being treated for high blood pressure whose blood pressure reading is to the appropriate treatment threshold (CVDP007HYP)
- We have lower rates of people known to already have CVD whose blood pressure reading is to the appropriate treatment threshold (CVDP002CHD).

In BNSSG, people in the broad ethnic category black are less likely to be treated to the appropriate treatment threshold for high blood pressure. This gap between ethnic groups is greater than the gap for deprivation. We have also seen in local data that the Caribbean community are less likely to be treated to the appropriate threshold compared to all other ethnicities 24% vs. 5-14%.

Planning for 2025/6 and beyond will primarily be focused upon CVD and diabetes, with a specific emphasis upon the following:

- Reduce inequalities through improving the optimal management of hypertension for the Caribbean population by 25%.
- A review of health checks across BNSSG to see how we can improve outcomes. Better use of data and gather evidence around their impact.
- Optimal management of CVD within general practice.
- Continued work around medicines optimisation and community pharmacy.
- A deep dive review into diabetes and identification of key areas for prioritisation.

4.6 Locality partnerships

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 and community insights over the last five years means we have a better understanding of the needs of our population. The combination of data and insights enables a more informed, place-based, preventative approach to improving the lives of people in our communities. This approach supports a shift from sickness to prevention and from hospital to community, delivering better outcomes through targeted work in areas of higher need or risk, particularly those from deprived and underserved communities.

Locality partnerships work together with marginalised groups and communities to improve health and wellbeing by listening and involving people to develop solutions that will break the cycle of health inequality and poor outcomes. Community-developed solutions include:

- Community hubs incorporating a range of support for local people, such as debt, food banks and citizen's advice.
- Activities connecting people with nature such as Nordic walking, cold water swimming and gardening
- Hyper-local peer support groups
- Community clinics where people can access health checks and lifestyle advice
- Mental health support in youth centres and schools
- Outreach such as CVD case-finding and blood pressures in community settings such as supermarkets
- Immunisations in community settings, including mosques, churches and community centres.

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.	POP1, POP2, POP 5, 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. Progression on agreed Maturity Matrix and development and signing of an MOU between partners setting ambitions and commitments.	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 proactive 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

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 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.

4.7 Continuing Health Care / Funded Care

Background to NHS funded care

Children's continuing care

The Integrated Care Board (ICB) 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 that are routinely available from GP practices, hospitals or in the community or are 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 healthcare – adults

NHS continuing healthcare (CHC) 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 CHC 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.

5. Mental Health, Learning Disabilities and Autism

5.1 Mental Health

2024-25 Look Back

BNSSG All-Age Mental Health and Wellbeing Strategy 2024-29 published

Our All-Age Mental Health and Wellbeing Strategy was published in 2024. It underpins all aspects of mental health and wellbeing within our system and has been informed by local needs analysis including Our Future Health - the needs assessment accompanying the system's overarching strategy.

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 close to home, so they can stay well in their local communities
4. **Sustainable system** - We will have an economically and environmentally sustainable mental health 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.

The system leaders for the ambitions in our strategy report progress to the Mental Health, Learning Disabilities and Autism Healthcare Improvement Group each month, where delivery of the vision, ambitions and priorities set out within our strategy are overseen.

Mental Health, Learning Disabilities and Autism Inpatients Quality Transformation Programme 2024-27 began:

- We are working closely with people with lived experience to develop and deliver an ambitious programme to transform our inpatient services to deliver care closer to home, improve patient experience and outcomes and reduce reliance on out of area inpatient care.
- In 2024-25 our focus is on increasing the number of therapies staff on our acute wards so we can provide a therapeutic and trauma-informed approach.
- The aims of this plan focuses on trauma-informed care, implementing a consistent model of psychological therapeutic formulation and intervention, sensory integration and modulation training and improvement work, and close working with community services to have a consistent therapeutic model with our developing enhanced home treatment service for better continuity of care.

NHS Talking Therapies:

- The service has significantly reduced the size of their waiting lists and their waiting times this year, within existing resources and funding, so people can access the early help they need. The Step 3 waiting list reduced by 35% between July 2024 and January 2025.
- The service has introduced best practice and regularly checks in on patients' safety and wellbeing on the waiting lists to support them while they are waiting for treatment.
- NHS Talking Therapies achieved all their Operational Plan metric targets in Q1 and Q2; and are in the process of developing their model of care to increase their activity in completed courses of treatment by the end of the year. Their reliable recovery and reliable improvement rates are achieving national targets.
- This service remains innovative in its use of artificial intelligence and digital therapeutics, working hard to increase accessibility and acceptability of its interventions for the population of BNSSG.

Dementia diagnosis rate:

- We have consistently exceeded our Operational Plan metric target for providing more diagnosis for dementia.
- We are working to further increase the take-up of the dementia diagnosis Local Enhanced Service in North Somerset and South Gloucestershire which we hope will substantially increase the dementia diagnosis rate even further.

Perinatal access:

- We have consistently exceeded our Operational Plan metric targets to provide increased access to perinatal mental health support for our population.
- We have begun the procurement of a non-statutory perinatal mental health service to further increase access and improve sustainability of the perinatal provision. This will focus on those communities and groups who have an evidence-based high level of need, health inequality and under-representation in receipt of perinatal mental health support and interventions.

Early Intervention in Psychosis:

- We continue to meet our Operational Plan metric target to provide treatment within 2 weeks of referral.
- We are further developing our services to provide more early intervention support to the At Risk of Mental State cohort of people.

24/7 Crisis Support:

- Our 111 press 2 for mental health services went live this in 2024.
- We opened a men's crisis house in Bristol (AWP and Rethink) to support people in their community and to avoid admissions where possible.
- Our Integrated Access Partnership (IAP) continues to bring together SWAST, AWP, Brisdoc and the Avon and Somerset Police force to better support people in times of crisis and are working to implement a Right Care Right Person approach.

Increased access to transformed community mental health services:

We have consistently exceeded our Operational Plan metric target to increase access to our transformed community mental health services. Some of the ways we have achieved this is by:

Offering integrated care, including through Mental Health and Wellbeing Integrated Network Teams (MINTs) in every locality in BNSSG

- Mental Health and Wellbeing Integrated Network Teams (MINTs) are now in place across BNSSG's six Locality Partnerships. These bring together NHS, social care and VCSE partners to meet the varied mental health needs of our communities based within them.
- Initial impact data shows that this approach to reducing the need for wider health services is helping to meet people's needs. A full evaluation is being undertaken to capture impact, including qualitative data from those involved (staff, people with lived experience and partners).
- Additional capacity and interventions are being added into MINTs, e.g., Individual Placement Support (IPS) Employment Specialists in all MINTs, and from January 2025 Young People's Transitions Workers will be based in each MINT (provided by Off The Record), alongside access to new services (Sequoia Service for people with complex emotional needs).
- System-wide work (GPs, VCSE, AWP, people with Lived Experience) to redesign wider services to support an integrated model of care is underway.

Ensuring that everyone with a severe mental illness has access to an annual physical health check and support reducing the gap in premature mortality

- In 2024-25, BNSSG exceeded the national standard through 81% of this cohort receiving an annual physical health check. However, work is ongoing to align BNSSG and NHS England data due to changes in recording and we are therefore not currently achieving our target on this new data recording.
- Extensive work is being carried out with General Practice to undertake improvement projects to increase uptake of physical health checks, but also to ensure that when physical health needs are identified, they are quickly acted

upon.

- Significant improvement in AWP's levels of physical health checks undertaken (82%).
- Targeted work by Nilaari to support Black, Asian and racially minoritised communities in Inner City and East Bristol General Practices is being undertaken. This has sought to increase the checks being undertaken through a culturally sensitive approach; increase patient engagement with health care staff and improve health outcomes and overall quality of life. The evaluation is currently being completed.
- Improvements are being made to have clear demographic data to inform our focus on groups experiencing the worst outcomes.

Supporting people with mental illness to access training and employment

- The Individual Placement and Support (IPS) programme has had a considerable impact of the lives of those people with significant mental health issues.
- IPS Employment Specialists are AWP Community Teams and are now in the MINTs working at a primary care level and up to AWP eligibility.
- This service supports people who have been seen as unsuitable for employment being placed into chosen paid jobs with all the associated positive impacts that work brings.

Providing people with mental illness support to enable them to live in their community – including an integrated housing, care and mental health offer

- Work is underway for a new integrated Mental Health, Accommodation and Care offer across BNSSG. This will support:
    - New mental health, accommodation and care pilot in Bristol
    - New mental health Transfer of Care Hub
- System leads and new roles are recruited (e.g., social care, housing officers).
- The aim is for people who are in hospital, but clinically ready for discharge can move into community placements from the beginning of 2025.
- In addition, BNSSG's Community Rehabilitation Team (Second Step and AWP) have reduced the number of people in out of provider rehabilitation wards by 74%.

Ensuring transitions of care are well supported – young people and older people's pathways

- A new model of care to improve young people's transitions between children's and adults' mental health services has been developed and goes live at the beginning of 2025. This provides dedicated VCSE capacity in each MINT team (Off The Record).

Undertaking wider work to provide holistic care that meets people's needs

- We have established a new Student Liaison Service to support students experiencing mental health difficulties, integrating an offer between AWP, the University of Bristol and the University of the West of England.
- We have agreed a shared model for physical health monitoring of people with eating disorders, with new funding secured.
- We have secured national investment in Green Social Prescribing.
- We have funded targeted support for marginalised communities, e.g., mental health and ethnicity (Nilaari, Bristol Black Carers, Somali Resource Centre), mental health and LGBTQIA+ individuals through peer support (Changes Bristol), and training to support services to meet women's needs (Womankind and Missing Link).
- We have established the BNSSG Patient and Carer Race Equality Framework (PCREF) system-wide group, black mental health manifesto Southwest launch (Nilaari); the ICE MINT pilot in development which targets support for racialised communities.
- We have undertaken a review of our Assertive Community Outreach provision in BNSSG and have begun to act on our findings, including to integrate current provision and provide more holistic support for people with complex mental illnesses.
- We are responding to GP Collective Action to ensure that people with mental illness have their needs met across primary and secondary care.

Workforce

AWP have significantly reduced their percentage of agency staff usage from 8% in November 2023 to 3% in November 2024, (and their compliance with agency cap from 13.2% in November 2023 to 6.4% in November 2024), improving the consistency of team dynamics and retention of permanent staff, which is shown to improve patient outcomes and experience of care.

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. Commitments and priorities
B. Performance objectives
C. System-wide planning with four distinct but connected workstreams:
   Supporting people to move into their communities and thrive
   Best start in life for children and young people
   Voice & influence
   Improving healthcare
D. Performance metrics
E. Key deliverables

A. Learning disabilities and autism commitments and priorities

Health and social care partners are committed to making sure the voice of people with learning disabilities and autistic people help to inform, drive, develop, and deliver our strategy. In return, we will develop systems and processes to enable people to hold us to account.

The programme commits to:

- Championing and promoting patient voice
- Supporting people to live the best life they can, seeing the person, not the disability or diagnosis
- Working with our partners to make communities friendly, accommodating and safe
- Listening to and supporting carers and friends
- Supporting Learning Disabilities and autism organisations to do the best job they can
- Learning and improving when things go wrong
- Developing a Learning Disabilities and Autism Strategy
- Maintaining the reduction of health inequalities as a golden thread through all we do
- Developing pathways with partners to move activity into the community and closer to home
- Driving the digital agenda
- Addressing differential access to care and reducing variation

- Driving locality and community partnerships focussing on population health improvements

The priorities for BNSSG Learning Disabilities & Autism Programme are:

- All people on the Learning Disability Register aged 14 years and above to receive an annual health check
- Improve the autism and ADHD assessment pathways
- Reduce the number of people waiting for and improve timeliness of autism and ADHD assessments
- Reduce the number of people with a learning disability and/or autism in inpatient beds
- We are ambitious to support people to play a meaningful part in their local communities; to secure their own accommodation and in the long term to benefit from education and gain meaningful employment
- We are ambitious for community solutions and driving forward a programme of cross-sector transformation to get to where we need to be
- To develop robust engagement and co-productive ways of working
- To learn and improve following LeDeR reviews
- To develop and implement an all-age Dynamic Support Register

B. Performance Objectives

The Learning Disabilities & Autism Programme supports local achievement of national performance metrics. These are to ensure everyone who is eligible has an annual health check and to reduce the reliance on inpatient care. We will achieve our performance objectives by:

"Doing more" – 'Do more' has been a central tenet of recovery over recent years and has been underpinned by actions to increase capacity that has enabled us to do more for example, workforce recruitment and training, increasing delivery opportunities through waiting list initiatives, utilising capacity available through our local independent sector providers and developing our estate.

Examples: Children and Young People Autism Assessment waiting list initiative, Concord Lodge moving on project, roll out of Oliver McGowan training, improving uptake of annual health checks and the Oldland Common housing project.

"Doing more, better" – "Do more, better" describes how we aim to work efficiently, productively and proactively to achieve more and better patient experiences and outcomes including a continued focus on understanding needs better, supporting people to live locally, shifting focus from diagnosis by providing appropriate support and working with our population as equal partners.

Examples: Partnerships in Inclusion in Neurodiversity in Schools (PINS) initiative, development of the all-age Dynamic Support Register, increasing LeDeR review capacity to improve learning, implementation of the Reasonable Adjustments Flag for primary and community care providers.

"Doing more, differently" – 'Do more, differently' brings into focus our longer-term ambitions and more radical strategic intentions, our exploration and implementation of new ways of working, our approach to and delivery of innovation. This includes (but is not limited to) our commitment to learning from elsewhere, developing and improving placed-based models of care, providing care through community settings.

Examples: ADHD assessment pathway transformation, children and young people neurodiversity pathway transformation and an online learning disability screening tool.

C. Learning Disabilities & Autism System Plan with 4 workstreams

Supporting people to move into their communities and thrive
Specific workstreams within the programme aims to:

- Reduce reliance on inpatient care, while improving the quality of inpatient care
- Ensure comprehensive understanding of the different needs of people with learning disabilities and/or autism, and inequalities we need to address.
- Ensure that our provider market has the capacity and resilience to provide highly individualised quality care (in line with Long Term Plan commitments and the Building the Right Support national service model in collaboration with NHS 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 understand the challenges and opportunities affecting some of our most vulnerable people.

Best start in life for children and young people
Some of our children and young people will have a learning disability and/or autism. Support for these cohorts will fall under the auspices of the BNSSG Children's Organsiational Delivery Group and Health and Care Improvement Group which have been established and have 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.

The focus is on the needs of children, young people and families promoting future health and wellbeing in a seamless way across services and reducing the need for a diagnosis before they can access the help and support required. 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.

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) is co-designing 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. 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 numbers of children and young people on assessment/profiling waiting lists.
- Reduce length of time between identification, understanding need and intervention.

Improving healthcare

The aim is to strengthen our annual health checks to provide effective interventions and improved physical health to ensure that people aged over 14 on primary care learning disability registers receive an annual health check and health action plan.

We will ensure learning from LeDeR reviews is quickly and effectively used to improve care and support as well as tackling 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).

Voice and influence

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

We will ensure insights form a key part of our Autism Improvement Programme (identifying key areas for development).
We aim to remove barriers and increase employment opportunities for people with a learning disability across Bristol, North Somerset and South Gloucestershire.

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

Co-production will be embedded in all our programmes of work.

We fund and support the three Parent Carer Forums across BNSSG to ensure the voice of young people and their parent carers are heard strategically through engagement and co-production activities. Where possible we commission the Parent Carer Forums to lead the work. Recent examples are the Autism in Schools Project, the Neurodiversity Transformation work and the Partnerships in Inclusion in Neurodiversity in Schools (PINS) initiative.

Discovery & Insights
The ICB's Transformation Hub has led three important pieces of discovery work aimed at understanding the barriers and opportunities to improving care for individuals with learning disabilities and/ or autism. These pieces of work have focused on:

- Individuals requiring a higher level of support, often referred to as 'complex' cases.
- Children exhibiting behaviours associated with various levels of neurodiversity.
- Adults with ADHD.

The insights and recommendations from these projects are crucial for shaping the future ambitions and initiatives of the Learning and Disabilities and Autism Operational Delivery Group (LDA ODG) portfolio. As the portfolio evolves, it is essential to integrate these findings to ensure that services are designed to meet the needs of these groups, and that the workforce is supporting them effectively.

LDA ODG understands the importance of patient voice with a dedicated workstream aimed at embedding local patient and carer insights and a strong focus on coproduction. This will be achieved through the development of a robust and inclusive coproduction model for the system and the creation of a core group of experts by experience to help test and refine the end-to-end learning disability and autism pathway, ensuring it is responsive and effective across services.

Governance

This programme reports to the LDA ODG which was set up in January 2024. The ODG in turn reports into the monthly Mental Health and Learning Disabilities & Autism Health and Care Improvement Group (HCIG). 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 are reviewed by ODG to ensure the programme remains on track to deliver to time, quality and cost.

Additionally, the Learning Disabilities & Autism Service Delivery Unit was established in October 2024, which provides a learning disability and autism forum for ICB staff before issues are escalated to ODG and HCIG.

Health and care partners are responsible for agreeing and delivering the Joint Forward Plans via the Mental Health, Learning Disability & Autism HCIG 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 Bristol, North Somerset and South Gloucestershire Integrated Care System. This programme reports to the LDA ODG. The ODG in turn reports into the Mental Health and Learning Disabilities & Autism 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.

Helpful Links

Learning disabilities - NHS BNSSG ICB
Anyone over the age of 14 with a learning disability can have an annual health check.

Community Equipment Service - NHS BNSSG ICB
There is a wide range of equipment and technology available to make life easier and help people keep safe and independent.

LeDeR programme - NHS BNSSG ICB
LeDeR – Learning from the lives and deaths of people with learning disabilities and autistic people.

Reasonable Adjustments

The NHS must make it as easy for people with a learning disability and autistic people to use health services. This is called making reasonable adjustments. Under the Equality Act 2010, all people with a learning disability have the right to ask for reasonable adjustments when using public services, including healthcare. This poster poses key questions to ask: Reasonable-adjustments-poster.pdf

Autism Spectrum Assessment Service – Children and Young People's Services
Learn more about autism support and services available to you.

Bristol Autism Spectrum Service (BASS) :: Avon and Wiltshire Mental Health Partnership NHS Trust This information can help if you or someone you care about is autistic or might be autistic.

6.Acute Healthcare Services

6.1 Acute Provider Collaborative

Background

In December 2023, NBT and UHBW announced the decision of their Trust Boards and UHBW's Council of Governors to form a Hospital Group which builds on a long and successful history of collaboration between the two organisations.

Underpinning the decision to form a Hospital Group 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.

Aims and objectives

By working as a group, our aim is to ensure all patients receive the highest quality of care regardless of who they are, where they live, and where they are treated. Through delivery of the Joint Clinical Strategy significant opportunities will be unlocked on behalf of the BNSSG system including:

- Developing new models of care and pathways that are clinically led, evidence based, aligned to best practice and consistently implemented on all sites.
- Making best possible use of the collective capacity of all of our hospitals and all of our people to reduce waiting times.

- Keeping waiting times to a minimum through single points of referral access and joint management of waiting lists
- Delivery of care closer to home wherever possible and consolidating expertise and technology.
- Learning from each other to enhance quality and experience wherever possible.
- Developing new models of care that transform how we support patients with long-term conditions.
- Working together with partners in primary and community care to integrate services around the needs of patients not organisational boundaries.
- Moving from treating illness to preventing it, and playing a greater role in reactive monitoring helping patients to live well at home for longer.
- Working to deliver more targeted education that allows patients to better understand and take care of their health.
- Improving communication channels and referral pathways between organisations.
- Use the scale of both acute trusts to enable innovation, pioneering clinical practice and technology-enabled care.

Joint Clinical Strategy

The Joint Clinical Strategy has three phases that will be implemented over three years (2024-25 to 2027-28).

In Phase 1 (2024-25 to 2027-28) we will support all duplicated services to work together as single managed services. We have taken a not one-size fits all approach. These services, considering their patient and population need, will determine what is right for them. As the Group Target Operating Model has developed three clinical models that all duplicated services will follow have been further defined as illustrated in the below figure.

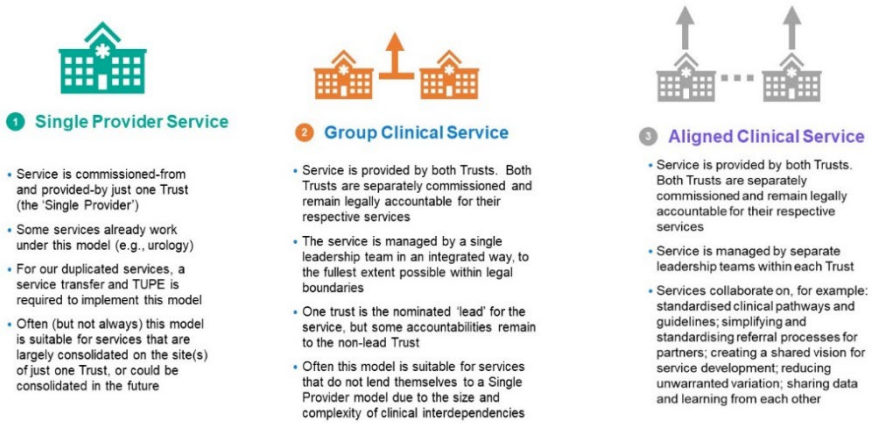

Figure 8 - Group Target Operating Model clinical models.

All 44 duplicated specialities across the two acute trusts will develop as one of these three models.

During Phase 2 (2026-27 to 2027-28) we will support every clinical service to consider how the opportunities of collaboration working as a Hospital Group can drive improved care. This will also provide an opportunity for enabling strategies such as digital and estates to be developed to support this transformation.

Phase 3 (2027-28) will create opportunities for our clinical teams working with patients and partners to consider how we organise or cluster clinical specialties on each of our sites to optimise delivery of acute care that can only be delivered on a hospital site.

A clinical capacity and productivity diagnostic will also be undertaken (Q1 & Q2 2025-26), to inform phases 2 and 3, that will give a clear view of how our combined resources could be used to deliver care more effectively as a Group.

Governance

The below figure summarises the governance that supports the delivery of the Joint Clinical Strategy in Phase 1.

Figure 9 - Joint Clinical Strategy Phase 1 Governance.

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.

6.2 Healthy Weston

Background
Healthy Weston 2 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 is also:

- ✓ Developing its specialised care of older people as well as continued delivery of a wide range of services for people of all ages; and
- ✓ Developing plans to 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 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 get home quickly after going to hospital in an emergency
From 2023/24 through 2024/2025, there has been a particular focus on helping people get home faster after accidents and emergencies, supported where needed by working closely with hospital and community-based teams. Improvements include:

- ✓ Enhancement of the 24-hour observation unit for adults providing rapid assessment, treatment and discharge.

- ✓ Extending same day emergency care provision and radiology access 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 NHS@Home 'virtual wards' pathways.
- ✓ A new Older People's Assessment Unit providing specialist rapid assessment and treatment for older frail patients alongside a refocused Acute Medical Unit for non-frail adults.
- ✓ Enhanced urgent care provision for children's and young people with extended hours for the Seashore centre.

This step change in provision is helping to avoid unnecessary admissions, reduce length of stay, improve 4-hour performance in the Emergency Department, improve patient outcomes and improve the quality and responsiveness of care. In the 2024 National Inpatient Survey, Weston General Hospital now ranks in the top 30% of all hospitals for positive feedback and is the highest scoring hospital in the BNSSG system.

Healthy Weston 2 Phase 2 – Creating a specialist centre for the Care of Older people and changes to inpatient care pathways

Throughout 2024, the hospital has been developing more specialist care for older, frail people who are less likely to make a full recovery after being unwell. Specialised clinics and doctors mean older people who are frail get even better care from hospital frailty experts, working closely with local GPs and community services. Recruitment is underway for a fracture liaison service at Weston General Hospital preventing fragility fractures and reducing hospital admissions for frail people. We have increased the number of Parkinson's disease clinics held in Weston as well as working with colleagues across BNSSG to deliver a more joined up service for Parkinson's disease patients across our system.

For most 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 of people 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. For example, we have started to transfer patients who need specialist cardiac care to the Bristol Heart Institute earlier in their pathway which means they receive swifter access to specialist diagnostics and treatment.

Healthy Weston 2 Phase 3 – Surgical Centre of Excellence

Enhancements to planned (elective) operations are a key part of the plans. The improvements in care at the hospital create the opportunity for a surgical hub, which means more adults of any age can have planned operations at the hospital, closer to home.

What comes next

- Continue to develop the specialist centre for the care of frail older people that takes a person centred, holistic and multi-disciplinary approach, delivering better outcomes.
- Create a surgical hub in Weston, as part of the broader UHBW Surgical Strategy and in partnership with NBT.
- Build on the progress made to further join up our services with our community and primary care partners through a home first and a hospital without walls approach.
- Continue to develop robust and sustainable workforce models which support wellbeing and attract new applicants.
- Continue to grow our children's Seashore Centre, providing paediatric expertise to the Emergency Department, urgent treatment and local access to specialist clinics.
- Continue to support our Transfer of Care Hub integrated team, linking services across Weston to speed up discharge and make sure people get the support they need when they leave hospital.
- Continue to improve how we maximise use of existing theatres to deliver more surgical procedures that are most relevant for our population needs.
- Using our Joint Clinical Strategy with NBT to ensure all of our services are integrated across Bristol and Weston.

6.3 Elective Care, Diagnostics and Cancer

Background

Elective care, including outpatients, cancer and diagnostics services in BNSSG were significantly impacted by the pandemic, causing backlogs of long waiting lists across many service areas. The elective programme over recent years has focussed on recovery, improving productivity and efficiency and progressing major strategic initiatives that will support the sustainability of recovery.

2024 saw a number of significant milestone achievements, both from a strategic and operational perspective, including, the appointment of Joint Chief Executive for UHBW and NBT Hospital Group, the publication of the Joint Clinical Strategy and establishment of active delivery groups taking forward the first phase of transformation in single managed services, the establishment of new estate and capacity in the form of two new Community Diagnostics Centres, offering diagnostic capacity closer to home, the construction of the BNSSG Elective Care Centre that will deliver 6,500 more operations a year for the population of BNSSG, the implementation and expansion of digital tools enabling effective and efficient ways of communicating with patients.

The BNSSG Elective Programme performed well against all national operational plan metric ambitions for 2024-2025 (as described in the Metrics section of previous versions of this plan), which provided a sound and positive foundation to begin the ambitious plans for 2025-2026 and beyond.

Our forward look, while shaped by the needs of our local population, our ICS strategy and the Joint Clinical Strategy described above, is set in the context of the recent Darzi report, that shares insights into important themes expected to be described in the new Governments forthcoming 10-year plan. In many of the areas described by Darzi, and the early messaging from the Government around elective care, work is long established and underway in BNSSG. Ambitions around driving productivity in hospitals have been a core and persistent priority for the BNSSG system, demonstrated by our commitment to Getting it Right First Time (GIRFT), and among the many examples of achievement in 2024 is implementation of the innovative new pathway pilot for short stay knee and hip joint replacements. The Government has been clear in its prioritising care closer to home and in the expansion and intelligent application of technology. In 2024, BNSSG has already made important strides in both areas for example, the piloting of a new model of care of Teledermatology with Primary Care partners.

Elective care pathways span across multiple system providers and aspects are described in other sections of this Joint Forward Plan, for example, children's elective care services are described in the Children's section.

Elective commitments and priorities from 2025

The BNSSG Elective programme in 2025 and beyond commits to:

- Developing the System Elective Care Strategy.
- Supporting (and being supported by) the progression of the Group model.
- Delivery of the Joint Clinical Strategy commitments, starting with single managed services (SMS) pathfinders - Cardiology, NICU, Maternity and Gynaecology
- Optimising the value of SMS as a vehicle through which to address inequalities in access and outcomes.
- Maintaining the reduction of Health Inequalities as a golden thread through all we do.
- Developing pathways with partners to move activity into the community and closer to home.
- Driving the digital agenda to improve patient experience and the quality of care delivered, with a focus on promoting the NHS App and opportunities for patient empowerment through digital tools.
- Addressing differential access to care and reducing variation.
- Driving locality and community partnerships, improving anchor status and focussing on population health improvements.
- Delivering estates and people strategies to support sustainability of services.
- Informing system level capital priorities relating to elective care.

The priorities for the BNSSG Elective Programme in 2025 and beyond include:

- Delivery of surgical priorities including optimising the BNSSG Elective Centre and refurbishment of major operating theatres across the system.
- Maximising capacity and productivity of outpatient facilities, including reviewing and addressing unwarranted variation in specialty clinic templates in line with the NHSE GIRFT Further Faster programme intentions.
- Delivering improvements in perioperative care and assessments, with a particular focus on prehabilitation and patient optimisation to drive better patient experience, outcomes and productivity.
- Driving technological innovation and new ways of working, including maximising robotic surgery across both acutes.
- Delivering the benefits of the SMS through reinforcing resilience in the workforce, implementing shared rotas, and establishing shared patient tracking lists.
- Firming up the sustainability of our pathways, which is in part dependent on the release of acute capacity. This will be achieved through collaborative, patient centred working with our system partners to move services into the community and closer to home.
- Establishing robust plans and oversight over the delegation of specialised commissioning with specific attention to fragile tertiary services.
- Establishing system principles and processes for managing the future innovative drugs and National Institute for Health and Care Excellence (NICE) Technology Appraisals (TA).

- Tracking growth in demand above population projection and seek solutions to growth in areas currently unmitigated.
- Driving efficiencies in the use of NHS estates, which will enable us to offer greater value to our patients and simultaneously reduce reliance on independent sector providers.

Performance - aims and objectives

The overarching aim of elective programme performance from 2025 is to shift focus from recovery and the stepping stones that have paved our recent years operational ambitions towards a return to the national constitutional standards for Referral to Treatment pathways, Diagnostics and Cancer.

The following objectives underpin our aim to return to the national constitutional standards for Referral to Treatment pathways, Diagnostics and Cancer. Our objectives are to:

"Do more" – 'Do more' has been a central tenet of recovery over recent years and has been underpinned by actions to increase capacity that has enabled 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 and developing our estates. We will continually look for opportunities to "do more".

"Do more, better" – 'Do more, better' describes how we aim to work efficiently, productively and proactively to achieve more and better patient experiences and outcomes. Improving efficiency and productivity has been central in our recovery, for example, our focus on 'getting it right first time' (GIRFT) including a focus on theatre utilisation, day case rates, scheduling and booking efficiencies; increasing throughout 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, 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 and through various projects and programmes as well as a drive a reduction in health inequality and inequity.

"Do more, differently" – 'Do more, differently' brings into focus our longer-term ambitions and more radical strategic intentions, our exploration and implementation of new ways of working, our approach to and delivery of innovation. This includes (but is not limited to) our commitment to learning from elsewhere, developing and improving system-wide clinical pathways and models of care, providing care through community settings.

6.4 Urgent and Emergency Care

For 2025/26 BNSSG is refreshing its five-year Strategic Plan for urgent and emergency care services, recognising changes to the urgent and emergency care landscape and population needs since the last strategy was published in 2018/19. In the intervening years several specific issues have arisen where agreement on the longer-term vision has been required to take steps forward with transforming existing services. These include:

- How best to deliver urgent and emergency care services for lower-acuity conditions, in the context of growing remote services such as 111 and 111 Online, seasonal overcrowding in A&E units, and high levels of growth in minor injuries units and urgent treatment centres.

- How best to deliver an integrated community 'front door' for urgent and emergency needs, building on the significant investments made to date in various services such as the Urgent Community Response teams, virtual wards, and the 'Frailty-ACE' remote multidisciplinary team used by GPs and the ambulance service. Joining these services together into a true 'single point of access' aims to deliver benefits to the quality of the wraparound response provided in the community as an alternative to hospital.

The plan will allow for these transformational service changes to be embedded and support delivery of improved ambulance and A&E waiting times.

Scoping work for the Strategic Plan has also newly identified variability in access to urgent and emergency care services from different social groups within the BNSSG population. For example, some geographies within BNSSG, and certain communities, appear to be very high users of all forms of urgent and emergency care services, while other communities are higher users of A&E but lower users of 111. The Strategic Plan will explore whether these differences in how people chose to access urgent and emergency care has an effect on their outcomes, and therefore may be leading to health inequalities which need to be addressed.

The Urgent and Emergency Care Five-Year Strategic Plan will be published in the first quarter of 25/26.

6.5 Stroke

Progress of the stroke reconfiguration in BNSSG

Sentinel Stroke National Audit Programme (SSNAP) ratings reflect how well services perform on key processes of care known to be associated with better patient outcomes. SSNAP data is collected through different teams across the stroke pathway.

Acute Care

An 'A' rating was achieved for the first two quarters of the stroke service reconfiguration, April-June 2023 and July-Sept 2023. This exceeded the highest SSNAP score previously achieved at NBT and demonstrated the benefits of the changes made. This however dropped to a 'B' in October-December 2023 and January-March 2024, and subsequently to a 'C' in the last two published reports, April-June 2024 and July-September 2024.

Key factors related to drop in performance are:

1. **Patient flow**

   This drop in results is predominantly due to impaired flow out of the acute hospital, while demand has remained within predicted levels. This has resulted in substantially higher patient numbers in acute beds which has had a knock-on effect on a large number of SSNAP scoring metrics and therefore patient outcomes, including:

   - Timely access to the specialist Hyperacute Stroke Unit (HASU) at Southmead Hospital: impacting delivery of stroke programme benefits of reduced mortality and improved independence after stroke.
   - Intensity of specialist therapy in Southmead Hospital: impacting delivery of stroke programme benefits of improved independence after stroke.

2. **Thrombolysis**

   A further factor impacting our SSNAP rating for acute care is access to intravenous thrombolysis. This depends on patients arriving in hospital quickly after the onset of their stroke, with efficient, standardised care for all patients with suspected stroke. This includes patients who have a stroke in hospital outside Southmead Hospital, those who arrive in emergency departments by routes other than emergency ambulance, and those arriving by ambulance with less typical stroke symptoms, where stroke was not suspected by the ambulance service.

Post-acute care and 6-month reviews

SSNAP data is not yet fully available for the post-acute part of the pathways, in part due to changes in datasets and data capture. A focus for the first half of Q1-Q2 of 2025/26 is to ensure SSNAP data is being recorded and reported across the pathway, from pre-hospital care (new reporting in SSNAP) to 6-month reviews. This will support oversight of service

quality through the One Stroke Pathway Clinical Oversight Group (COG), with prioritisation of improvements in subsequent years.

Improvement focusses for Q4 2024/25 and 2025/26

Two SSNAP Key Indicators are now included as focusses for improvement:

1. **Thrombolysis within 1 hour**

   Increasing access to thrombolysis is also a national priority through the Thrombolysis in Acute Stroke Care (TASC) Programme, in which NBT is participating. Improvement work across NBT and UHBW is being supported by the NBT Patient First team.

2. **Achieving an 'A' score on the 'Stroke Unit' SSNAP Domain**

   This is a demanding target that depends on flow through the stroke pathway. Data illustrates that the processes of referral and discharge from the acute hospital are functioning well, but that flow is impaired downstream in comparison with the capacity modelling for the original Stroke Improvement Programme Decision-Making Business Case (DMBC). The main contributor to this is the length of stay in community-based stroke sub-acute rehabilitation units (SSARUs) significantly exceeding that originally modelled. The ability to flex capacity in community beds as described in the DMBC has also not been consistently delivered due to pressures in the wider community rehabilitation bed base. Improving community length of stay is a key focus on the system in 25/26, using a 'cycle times' focus: understanding all of the smaller processes underpinning community rehabilitation and how we manage those according to robust timescales to support flow.

7. Enablers

7.1 Green Plan

Background

ICS partners across the system have been working to embed our ambitious sustainability goals and create a governance structure and delivery plan that sees us working together to achieve our immediate and future goals. This year has seen the publication of the ICS revised Green Plan, setting out our sustainability commitments and outcomes and confirming our aim to be a leader in delivering sustainable healthcare for our region. All ICS partners have signed up to the Green Plan, aligning our efforts and amplifying our action and outcomes. The ICS has also developed a delivery plan to drive implementation and monitor progress against the Green Plan commitments.

The Green Plan sets out three clear outcomes that we are working towards:

1. Net zero carbon by 2030 across all our emissions sources.
2. Improve the environment by reducing waste, improving air quality and restoring biodiversity.
3. Create a BNSSG wide movement to support a culture change amongst, staff, citizens and businesses.

Further development in the granularity of the delivery plan sets what our actions will achieve against these outcomes and identifies the gaps we need to focus on.

This year, North Bristol and University Hospitals Bristol and Weston have worked together as one sustainability team along with colleagues from Sirona care & health and Avon and Wiltshire Mental Health Partnership to achieve the Healthier Together Integrated Care System Green Plan objectives to mitigate the harmful impacts climate change will have on the health, wellbeing and livelihoods of the Bristol, North Somerset and South Gloucestershire population for generations to come. Achieving net zero, addressing the ecological emergency and building resilience to climate change through delivering our Green Plan will be crucial to delivering the best care for our patients now and in the future.

Throughout the year, our staff have reduced the environmental impact of their services whilst improving patient experience. Through conversations with our patients, we have learnt that reducing the carbon footprint of our services is important to them and their long-term health. We believe the way we deliver care to our patients should not harmfully impact the health of future populations and their ability to access outstanding levels of care.

This year we have refined our Green Plan Delivery Plan and prioritised projects for the future that will deliver the greatest carbon reduction and make best use of our resources. The Green Plan is delivered through six workstreams which are led by subject matter experts from each ICS organisation. The workstreams report into the Green Plan Implementation Group which reports into the Green Plan Steering Group of with ICS Executive Directors sustainability leads as members. Next year we hope to further embed

net zero into organisation processes and spread the innovation at North Bristol Trust such as carbon pricing, carbon budgets and headline objectives for divisions that can be monitored in Divisional Performance Reviews.

An essential element for achieving net zero will be to reduce the demand on high cost and high carbon hospital services; realising the co benefits of prevention in improving the health of our population whilst reducing carbon and costs.

Net Zero Carbon by 2030

The carbon reduction trajectory towards net zero of the main delivery plan workstreams is set out below. Our Delivery plan provides the detail of the carbon reductions that would be delivered by achieving the targets we have identified in our workstreams. To achieve net zero following the Science Based Targets Initiative approach we must reduce our emissions by 90% to 39,514 tonnes CO_2e. The remaining 10% is to be addressed by offset schemes - investing in projects that result in permanent carbon removal and storage to counterbalance the residual 10% of emissions that cannot be eliminated.

Current actions will deliver carbon reduction of 257,000 tonnes CO_2e, but this assumes there is capital funding available to decarbonise our buildings and energy. The gap remaining from our current delivery plan is 98,000 tonnes CO_2e for which we will need to identify further actions and funding. Without funding for buildings and energy decarbonisation the gap increases to 143,000 tonnes CO_2e.

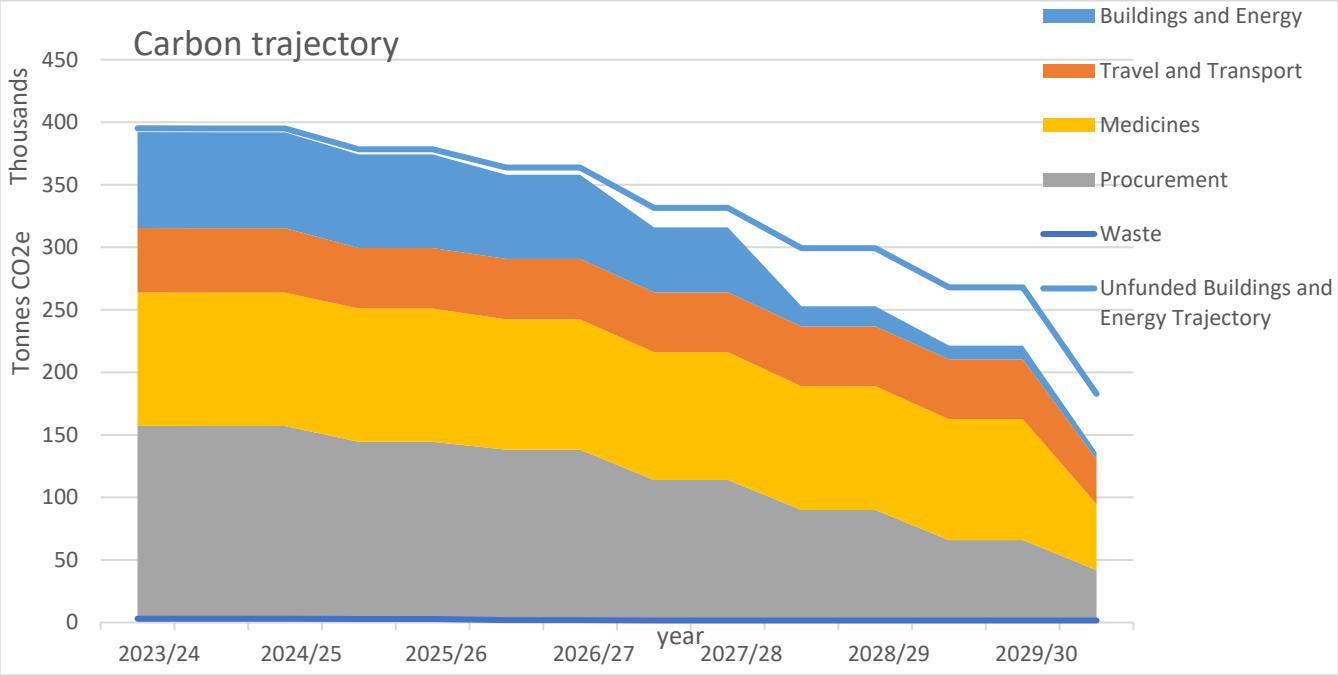

Figure 10 - Carbon trajectory with current identified actions.

We have identified routes to net zero for our buildings and energy, and waste which are areas under our direct control but subject to achieving funding. Transport reductions are less in our control and dependent on working with partners across the Integrated Care Partnership. Similarly, a substantial amount of our procurement is dependent on national approaches such as supplier carbon reduction plans and we are more limited in where we

can influence them. Medicines require further identification of reduction opportunities in reducing medicines waste and targeting high impact areas such as inhalers, but as with wider procurement, achieving net zero will be reliant on improving population health to reduce demand for pharmaceuticals and medical equipment.

Our delivery plan sets out the detailed deliverables against the targets for each workstream area and by organisation. We have added RAG rated progress updates against targets and expected carbon reduction trajectories.

Our current approach to calculating our procurement carbon footprint is based on spend. This spend-based approach is flawed as it doesn't reflect where we are reducing carbon in our supply chain. The procurement footprint is particularly distorted by the increased spend during covid and high inflation.

Despite the emissions we have most control for, energy, water and waste showing an overall 4% carbon reduction in 2023-24 compared with 2022-23 We have seen a 21% growth impact from increased spend driven by inflation and activity (including investment in buildings and diagnostic equipment).

Sustainable Healthcare

System wide collaboration on sustainability has been driven by the ICB, this has been clearly exhibited in developing the system capital prioritisation process. The ICS has recognised the importance of net zero by embedding it in this process and committing 10% of system capital in 2024/25 to a decarbonisation fund which partners can bid for and is overseen by the Green Plan Steering Group.

The ICS has incorporated a Sustainability Impact Assessment and carbon cost calculator into its project management gateway process ensuring net zero economic impact and social value are considered.

The ICS has embedded sustainability into the system strategic planning process with the Joint Forward Plan development requiring all areas to include how their plans contribute to the Green Plan. Net zero is a crucial inclusion in the emerging ICS Infrastructure Strategy. Our Green Plan is aligned with the development of our long term Heathier Together 2040 planning.

A key strategic approach to our system achieving sustainable healthcare and our net zero target is to support people to stay well and out of hospital. We need to bend the curve on the predicted rise in demand for high-cost and high carbon, reactive and hospital-based care and focus on prevention. That means supporting people to take care of their health and wellbeing, intervening early and keeping people healthy at home for as long as possible, focussing investment on primary and community services. Avoiding carbon intensive hospitals for issues that could have been prevented in primary care or managed better in the community.

We can't afford to build more carbon intensive hospitals as a way of dealing with increasing system demands, we need to do things differently which includes:

- Supporting our staff and working with partners

- Using our buildings and spaces – Supporting biodiversity
- Engaging our staff to lead change in our organisations and communities
- Building resilience to climate change

7.2 Trauma Informed System

Trauma-informed approaches realise the widespread impact of trauma, recognise the signs and symptoms, resist re-traumatisation and respond by integrating knowledge of trauma within services, organisations and systems and all aspects of the work that we do. Trauma-Informed Practice is underpinned by six key principles: Safety, Trustworthiness and Transparency, Choice and Clarity, Collaboration, Empowerment and Inclusivity.

Figure 11 - Six key principles of Trauma Informed Practice.

Experiences of trauma and adversity can have a profound and wide-reaching impact on the lives of individuals, families, communities and the workforce. These experiences can influence how we interact with others, how we interpret our surroundings and the world around us and how we access, engage with and experience services. While trauma can affect anyone in our population, people living in areas of deprivation, or who already experience health and social inequalities or multiple disadvantage, are more likely to experience trauma in their lives. Experiences of trauma and adversity are linked to poorer physical and mental health and poorer life outcomes. People who have experienced adversity within childhood are more likely to develop long-term physical health conditions, be involved in the criminal justice system and adopt health-harming coping strategies (such as smoking, problematic alcohol and/or drug use, self-harm and eating disorders). Our workforce encounter trauma on a regular basis, through seeing or hearing the trauma experiences of others or through involvement in traumatic incidents.

Embedding a trauma-informed approach has been identified as a key enabler to support how we will deliver our Integrated Care System (ICS) Strategy.

The Trauma-Informed Pledge for Partners represents an opportunity for organisations, strategic groups and boards serving the people and communities of BNSSG to make an active commitment towards embedding a trauma-informed approach across services and systems. The pledge has been supported by the Integrated Care Partnership Board, ICS and wider system partners including the ICB, Avon and Somerset Constabulary, Avon and

Wiltshire Mental Health Partnership NHS Trust, local authorities, education providers, voluntary community and social enterprise organisations, University Hospital Bristol and Weston and North Bristol NHS Trusts.

The BNSSG Trauma-Informed Systems Programme is based in the Integrated Care Board as a dedicated resource to support the development of trauma-informed practice and trauma-informed systems change across Bristol, North Somerset and South Gloucestershire.

7.3 Safeguarding

Background

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 NHS England » Safeguarding children, young people and adults at risk in the NHS.

The ICB works across three local authority areas who have all developed joint strategic needs assessments. 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. Our Chief Executive Officer is the Lead Safeguarding Partner and the two Deputy Chief Nursing Officers are the Delegated Safeguarding Partners for these three Local Safeguarding Children Partnerships as per the Working together to safeguard children - GOV.UK statutory guidance. The ICB is also a key statutory partner for 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 ICB has a clear line of accountability for promoting the welfare of and safeguarding children, young people and adults, this also includes addressing the particular needs of victims of abuse which is undertaken in partnership across the system. In addition, the 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.

7.4 Workforce

2024/25 Look Back

We have and continue to deliver a sustainable workforce through a coordinated and collaborative approach, including:

- Focusing on retaining our staff and reducing turnover. In our health care partners we have seen turnover reduce to lowest levels in the last five years. In social care turnover is below the national average and the lowest in the southwest region.
- Reducing vacancies. In social care vacancy rates are below the national average and BNSSG has the 10th lowest vacancy rate when compared to all ICSs across England. Vacancies in our healthcare system have continued to reduce since the peak in autumn 2022. Over 3,000 people have joined our health and social care workforce bringing the total to 62,204.
- Several local lead recruitment events have taken place in 2024/25 where all partners across the health and social care sector have been invited to attend. Developing our own recruitment events has allowed us to keep the costs as low as possible and supported smaller health and social care partners to be involved.
- Our ICB temporary staffing group has delivered considerable savings in our agency use and spend. Agency use by our health partners is 50% lower than last year.
- Our Oliver McGowen team has trained over 7,000 staff across both health and social care. The team won the Oliver McGowan Trainer Award at the National Learning Disabilities and Autism Awards. This award acknowledged the “professionalism and teamwork, supporting and encouraging one another to create an effective training environment. Their efforts have been instrumental in helping health and social care staff better understand learning disability and autism.”
- The BNSSG are one of 15 ICBs nationally that have been appointed to deliver Workwell. Workwell is a government programme to provide early intervention and health services to remove health related barriers to employment for people with disabilities or health conditions. In BNSSG, this is being delivered through collaboration of our health partners and Bristol City Council. This programme is working with and supporting the VCSE sector and with the Southwest Combined Authority. To date the programme has recruited 100 participants.
- BNSSG were a key member of the NHS England (NHSE) productivity vanguard. Working with NHSE to improve the productivity tool.

Background

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.

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.

The publication of the NHS 10-Year Plan and associated revised Long Term Workforce Plan (LTWP) is scheduled for publication in late summer / autumn of 2025. It is anticipated that the 10-Year Plan and LTWP will focus on training, apprenticeships, entry level access and staff experience. The 10-Year Plan and LTWP will be key in the creation of a People and Culture Plan – setting out the system response 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 2025/26 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 multi-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.
   - Continued 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 a 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. A 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.
   - To continue with our Workwell programme that then support the delivery of the governments ‘get Britain working’ objectives.

2) **Productivity and Performance**
   - Working with acute partners on productivity to support the delivery of a 5% increase.
   - Continued local and regional action plans to reduce agency costs across health partners.
   - To create a single workforce across health and social care. Allowing support between organisations but also to ensure we have the workforce in the services that our population needs, particularly at times when demand for these services is exceptionally high.
   - Continue to deliver 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.

7.5 Digital

Digital Vision and Strategy

The Bristol, North Somerset and South Gloucestershire ICS System Strategy highlights digital as a key enabler for our Integrated Care System.

Our Digital Strategy 2023-2025 set out our vision and roadmap for digital development:

Our Digital Vision

To become and exemplar of a digitally advanced ICS.

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 promoting 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. Our Digital Inclusion Strategy was published in 2023.

How we will deliver our vision

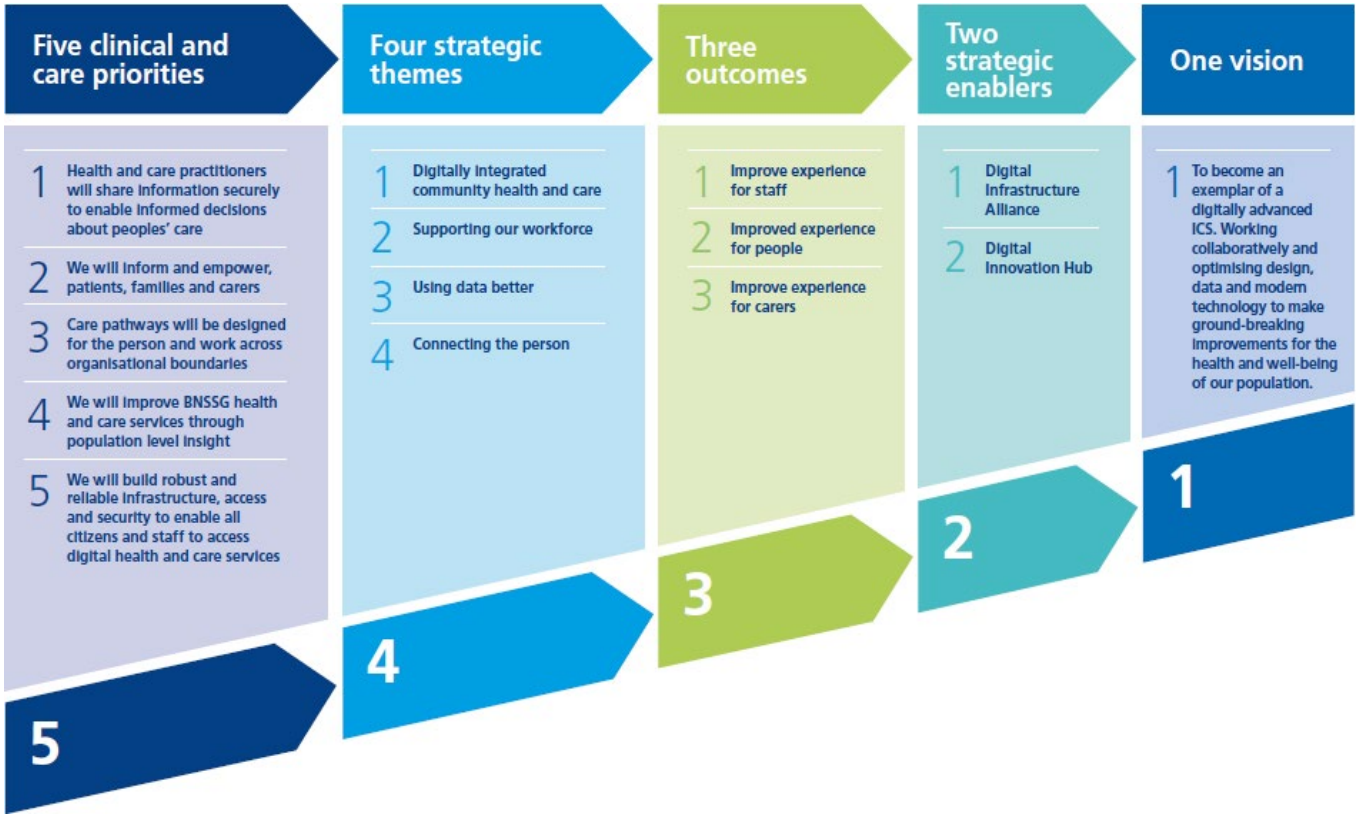

Figure 12 - Digital Vision delivery.

National policy drivers

The Digital Strategy responds to national policy and regulatory drivers:

- Key stipulations of the **NHS Long Term Plan**, that emphasises the need for local NHS organisations to increasingly focus on communicating health and care, population health and local partnerships with local authority-funded services, through Integrated Care Systems.
- **Priorities and operational planning guidance**, 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 NHS England **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.
- 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.

Delivering our Digital Strategy

Since 2023 our ICS Partners have worked together to build the foundations of our Digital Strategy. For example:

- **Health and Social Care Networks** and WiFi is being upgraded in all GP Practices, meaning that staff and patients are benefitting from improved internet connections and faster, more reliable and secure data transfer.
- **Electronic Patient Record** (EPR) systems have been implemented in all of our main healthcare providers and are being updated to integrate more services within fewer systems. This means that staff are better able to collaborate in delivering care to patients, with greater ability to share information.
- A new contract has been procured for the **Connecting Care: the BNSSG Shared Care Record** to enable health and social care staff to share care records across organisational boundaries. This an essential tool for delivering high quality, integrated care. The investment business case signed off by the ICB in February 2024, estimated that Connecting Care had helped to increase value by releasing over 25,000 hours of clinical time that may otherwise have been spent searching for information across multiple systems.
- **Patient Engagement Portals** have been implemented in our GP Practices and acute hospitals. As these systems are being developed this is enabling more patients and carers to access appointment information and test results and to communicate with clinicians online.
- A **single digital team** has been established for our acute hospitals, to improve standards of IT infrastructure and services for staff and patients at out hospital sites in University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust.

In 2024/25 we have gone on to deliver the digital commitments set out in our Joint Forward Plan:

Workstream	Metrics	Contribution to Outcomes Framework
Shared Care Records procurement/ deployment	Achieved target of 5% growth in records viewed per month New contract for Shared Care Record procured and went live on 27/11/24	SER7, SER8, SER9, STA10
Intelligence Centre ('Shared Data and Planning Platform)	Full Business Case for proceeding with procurement, due to be approved by ICB Board in Quarter 4 (Jan-Mar 2025)	SER7, SER8, SER9, STA10

Workstream	Metrics	Contribution to Outcomes Framework
Digital Maturity in Social Care	Achieved target of 80% of care home providers implementing digital social care record systems	SER7, SER8, SER9, STA10
Work anywhere in primary care	Proof of concept completed, providing secure connections for North Bristol NHS Trust midwives working offsite in 14 GP practice sites	SER7, SER8, SER9, STA10
Expand shared care plans across integrated services	Digital 'Respect Plus' shared care plans implemented, for people living with life limiting illness or approaching end of life. 'Respect Plus' provides a digital shared care record of advanced care plans, and a person's preferences for treatment in an emergency and/or if their condition deteriorates.	SER7, SER8, SER9, STA10
Increase uptake of the NHS App	Over 20,000 more adults registered to use the NHS App	SER7, SER8, SER9

Review of our Digital Strategy programme
During 2024, we have strengthened the role of clinical and care professional leaders in digital decision making, through the BNSSG Clinical Informatics Cabinet (CIC). The CIC has reviewed our Digital Strategy programme to determine where we should focus our efforts to move further forward towards achieving our Digital Vision so that:

1. The benefits and opportunities of digital and data are embedded in our integrated design process.
2. We have a robust collaborative digital infrastructure that allows frictionless working for our staff across the full range of care settings.
3. We avoid duplication by integrating and reusing systems, architecture, shared services, support and expertise.
4. The experience of integrated seamless care for the person is underpinned and enabled by digital functionality and infrastructure that supports staff working.
5. Digital first channels are available for our citizens, empowering them to self-serve and make choices about their care journey.
6. Our integrated data-sharing and planning platform helps us to make the right decisions for people and our system.

The CIC review highlighted areas of strength in the Digital Strategy programme where advances are being made in relation to digital infrastructure and cybersecurity, information governance, data sharing and data infrastructure. This will form the foundations of seamless pathways of care and frictionless working.

The CIC review advocates for data sharing across and between ICS partners as a necessary condition for addressing health inequalities and inequalities in access to care. The CIC review highlighted the importance of building public trust that we will use their data in their interests and that this requires developing and maintaining an ongoing, trusting relationship with the public and patients, with a focus on our values and trustworthiness.

The CIC review also recommended that there needs to be a clear focus on reducing complexity of digital systems, processes and information flows. We need to be able to do things once as a system, making the most of the systems we already have and avoiding introducing new systems or data flows except where this is essential.

Priorities for the year ahead

Firstly, we will continue to deliver on the digital commitments set out in our Joint Forward Plan of 2024.

In addition, we will focus on addressing the priorities identified by clinical and care professional leaders in reviewing our Digital Strategy programme, by:

- **Integrating digital infrastructure within a shared services organisation**, hosted by the acute hospital group. By integrating our IT infrastructure, we will be better able to deliver integrated care across organisational boundaries, resulting in improved outcomes and experience for patients and staff. We will start with the IT infrastructure for our shared care record system 'Connecting Care'. We will also design a proof of concept to extend the model to ICB and GP practice IT infrastructure.

- **Establishing a Data Sharing Charter for our Integrated Care System**. This will set out the joint commitment to share data safely and securely between services and across organisations, for the purposes of providing better care.

- **Refresh our Digital Inclusion Strategy**. Working with VCSE partners to update our Strategy to incorporate national best practice and learning from local experience in promoting digital inclusion.

Governance

The Integrated Care Board Director of Transformation and Chief Digital Information Officer is the Executive Lead for digital in our system and chairs our Digital Delivery Bord. This Board holds our Digital Strategy and has oversight of delivery of the digital commitments in our Joint Forward Plan.

7.6 Medicines Optimisation

In 2024/25, the Medicines Optimisation Programme has continued to drive best value for medicines, including supporting prescribers to choose the most cost-effective medicines such as diabetes medicines, direct oral anticoagulants (DOACs), and best value biologics. In addition to this we have supported clinicians with the numerous supply disruptions of medicines and shortages of medicines across the system. Putting appropriate support and guidance documentation in place where needed.

The programme embeds medicines optimisation drivers and principles within system priorities and works to reduce health inequalities, such as ensuring equitable access to medicines. Prevention is embedded in medicines optimisation programmes of work. Cardiovascular disease (CVD) Prescribing Quality Scheme (PQS) projects for 24/25 focussed on hypertension, lipid management and atrial fibrillation (AF) treatment optimisation which will further steer our prevention work in 25/26.

Ensuring safe use of medicines continues to be a key priority. Areas of achievement in 2024/25 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 teratogenic medicines safety working group continues, and we have implemented and reviewed processes to improve patient safety around sodium valproate, meet the requirements of the Valproate National Patient Safety Alert (NPSA) and other teratogenic medicines highlighted in safety alerts.

In a continued effort to support healthcare professionals to tackle inappropriate polypharmacy and overprescribing, a suite of training materials were compiled in 2023/24 and work was undertaken with Primary Care Network (PCN) pharmacists to prioritise patients for structured medication reviews. Joint targeted work with Health Innovation Network supporting Primary Care Networks informed by indicators on NHS Business Services Authority (NHSBSA) polypharmacy dashboard continued. An overactive bladder (OAB) review PQS project 24/25 aims to review OAB medications in elderly, frail or patients with cognitive impairment with a view to reducing anticholinergic burden.

Safeguarding the efficacy of antimicrobials continues to be a high priority for the system. BNSSG is meeting national targets for antimicrobial stewardship. In primary care overall prescribing and broad-spectrum antibiotic prescribing rates and in secondary care World Health Organisation (WHO) access antibiotics rates. Work on intravenous (IV) to oral switch led to the Commissioning for Quality and Innovation (CQUIN) being met in both trusts. Work on the course length of amoxicillin led to BNSSG positively benchmarking highest nationally for five-day prescribing.

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. The Pharmacy First scheme in 24/25 is delivering over 12,000 consultations per month for community pharmacy, which is freeing up appointments in other parts of the system. Within BNSSG, GPs are referring the highest number of referrals per month. Local Enhanced Services (LES) continues to be utilised, and Otitis Externa has been rolled out to all community pharmacies. We are looking to expand the LES's in 2025. The number of

independent prescribers (IP) in community pharmacy has increased significantly (September 2024: fifteen community pharmacists on independent prescribing course). We soon will be going live with the community pharmacy IP pathfinder in three sites within BNSSG.

In 24/25 we have expanded the specialist nurse led stoma service across the system to enable patients to have access to specialist stoma nurses for their prescribing of appliances and clinical queries. The evaluation of the stoma service in secondary care continues and is now live at both North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust.

In 24/25 we established a project with appropriate pharmacy professional leadership to ensure that all GP practices are using electronic repeat dispensing (eRD) and meeting the minimum target. Eleven practices were recruited into the project. One practice has significantly increased their uptake of repeat dispensing prescribing, the other participating practices have shown some gradual steady increases to varying extents. The learning and resources developed are being compiled into a toolkit to be shared and available for practices to use beyond the end of the project. We will look to share the outcomes of the project in early 2025.

Background

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.

Our plan continues to set out our ambitions to improve patient's outcomes, 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 secondary care services, community, primary care staff and representation from system groups. The success of this plan will be driven by strong clinical leadership, a focus on benefits to patient outcomes underpinned by evidence and data, and recognition of the benefits of working together.

The medicines optimisation team have a detailed implementation plan with key deliverables and milestones for the medicine's optimisation programme. Progress of the plan will be monitored by the ICB medicines optimisation team and fed back to the Medicines Optimisation and Pharmacy 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. The key work that is being undertaken to enable improvement in medicines optimisation across the system are highlighted within the Medicines Optimisation Strategy, which is currently being reviewed.

7.7 Estates

All Integrated Care Systems were required to submit joint Infrastructure Strategies to NHS England (NHSE) by 31 July 2024. NHSE's primary motivation for these strategies has been to support the development of a national business case for the NHS submission for the next Treasury Comprehensive Spending Review (CSR). It is likely these strategies will also enhance any future bids by Bristol, North Somerset and South Gloucestershire (BNSSG) for national funding as the system is able to demonstrate a comprehensive set of priorities with a clear evidence base.

Over the past two years, the ICB Estates Steering Group has made significant progress in developing this evidence base and setting out key estate priorities. The focus has been on strengthening collaboration across system partners, maximising the use of existing resources, improving transparency, and aligning internal processes to support joint objectives. These efforts have laid a foundation for a more integrated, efficient, and forward-looking estates strategy.

The work of the ICB Estates Steering Group is guided by three strategic principles, which underpin all current and future estate programmes:

1. **Utilise our assets: understand what we already have, use it fully and efficiently, or dispose of it.**
   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 we have a robust evidence-base to identify our priorities for investment, ensuring they take into account the current and future needs of our population. The 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 decisions.
3. **Maximise funding: make sure we are bringing in as much funding as we can.**
   Capital funding is required to deliver the key objectives. A number of options are available including NHS capital funding, local authority funding, Section 106 legal agreements, Community Infrastructure Levy contributions, charitable donations, private finance, and disposal capital receipts. We should work proactively with system partners to identify potential sources and opportunities to secure shared funding.

By focusing on these principles, the estates programme aims to not only address current challenges, but also positions the system to deliver sustainable and high-quality healthcare infrastructure in the future.

The ICS Infrastructure Strategy was developed by the ICB Estates Steering Group through a series of collaborative workshops with system partners. These partners included

representatives from workforce, digital, medical equipment, and sustainability functions. While the primary focus is on estates, the BNSSG strategy aims to integrate all capital-intensive functions into a single, coherent approach.

This strategy provides a roadmap for BNSSG Integrated Care System (ICS) to establish a resilient, effective, and sustainable healthcare infrastructure. A comprehensive baseline assessment of estates across the system forms the foundation of this work. The following actions represent the key priorities for the estates programme over the next year, as outlined in the Strategy:

- **Establishment of the ICS Capital Board**: Formed in December 2024, the ICS Capital Board provides a system-wide approach to capital planning and investment across BNSSG. Its primary responsibilities include managing the allocation of the system Capital Departmental Expenditure Limit (CDEL) through a transparent process that aligns with system priorities, overseeing in-year capital programmes to mitigate financial risks such as underspend or overspend, and developing a multi-year capital investment plan that supports the long-term strategic objectives of the ICS.
- **Town Planning and Health Infrastructure**: Increased collaboration with local authorities has enabled the ICB to contribute to local plan development and assess the health implications of housing and population growth. By modelling the impact of these changes on health services, the ICB aims to strategically engage with planning processes and secure funding for health infrastructure through Section 106 agreements and the Community Infrastructure Levy (CIL).
- **Development of Local System Specification Guidance**: Going above and beyond national requirements, local guidance has been agreed for the design and equipping of new-build projects. This guidance incorporates net-zero goals and utilisation monitoring to ensure sustainability and efficiency. Over the next year, all system partners will adopt this framework to promote consistency and future-proof healthcare developments.
- **Delivery of the Primary Care Investment Pipeline:** The ICB aims to leverage its new powers to advance the delivery of primary care schemes, using a delivery model and headlease arrangements as a template for future investments. This approach aims to support the PCN investment pipeline and address local priorities effectively.
- **Maximising Value from Existing Estate:** Increased collaboration with landlords NHS Property Services (NHSPS) and Community Health Partnerships (CHP) is central to ensuring value for money and optimising estate utilisation. The focus will be on increasing asset sharing, improving utilisation, and achieving system-wide savings through strategic oversight and control.

The Estates Steering Group is now developing a detailed action plan to ensure the successful implementation of these priorities. Given the current funding constraints, the primary emphasis over the next year will be on maximising the utilisation of existing assets. This includes adopting innovative asset management practices, prioritising shared use of facilities, and reinvesting savings into future system needs.

This approach ensures the estate aligns with the wider objectives of the ICS, delivering value for money, supporting local health priorities, and contributing to the NHS's net-zero and sustainability goals.

8. Appendices

8.1 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 local authorities, and provider

costs analysed between pay, non-pay, and financing costs]; System ten 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 income and expenditure, 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 to 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.

A full refresh of the Medium-Term Financial Plan will be carried out in the second half of 2025, following the summer spending review, at which point there will be more clarity on multi-year settlements to the sector.

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.

8.2 Procurement

Our Integrated Care Board (ICB) has a procurement policy that covers the commissioning healthcare services under the Provider Selection Regime (PSR) and goods and services under the Publics Contracts Regulation (PCR). The ICB, through the objectives set within the policy, ensures that in relation to the procurement of healthcare services the ICB 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
- Ensuring its procurement activities are undertaken transparently, fairly, proportionately, and where appropriate through integrated service delivery.

And in relation to the procurement of all goods and health care services that the ICB complies with the law, regulations and published guidance and its own standing orders.

For the procurement of healthcare services and goods and 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 addition, the ICB in some areas works with Bristol and West Purchasing Consortium (BWPC) to deliver procurement services. Similarly to the ICB working with the CSU, working with BWPC supports ensuring that procurements comply with the law, regulations, and published guidance.

Regulatory environment – Health Care Services procurement

In partnership with the South Central and West Commissioning Support Unit (SCWCSU) it is recognised that from a procurement perspective the working environment is facing its greatest challenge with the delegation of elements of specialised commissioning, and the continued 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 on 1 January 2024 NHSE, ICBs, NHS Trusts, NHSE Foundation Trusts and local authorities or combined authorities were withdrawn from the Public Contracts Regulations 2015 and and the NHS Procurement, Patient Choice and Competition Regulations 2013, and therefore all relevant authorities, have been securing 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. 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 six illustrated in the below flowchart to ensure the right decision is made as to the route taken to secure such services.

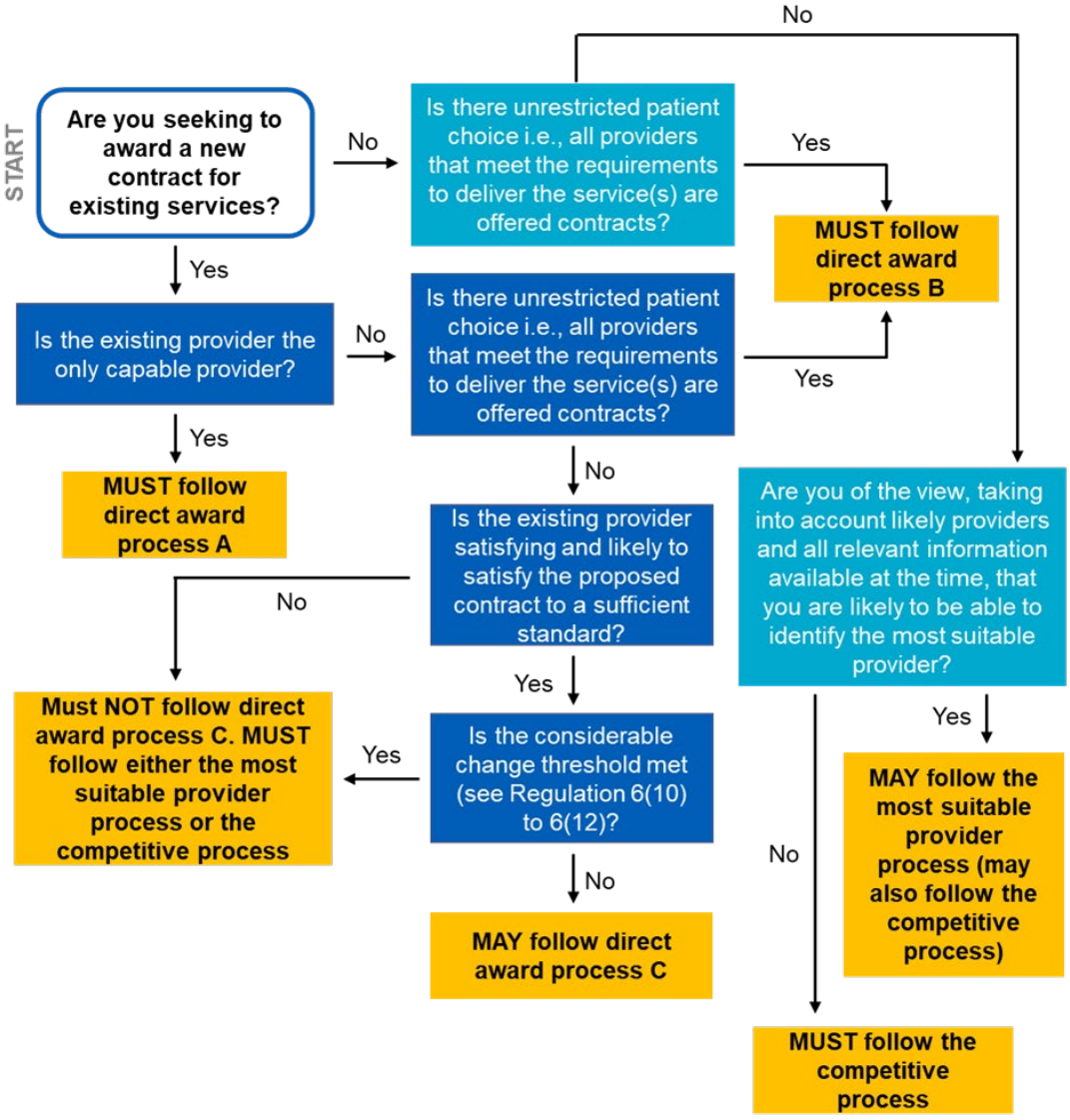

Figure 13 - Regulation six flowchart.

BNSSG ICB Goods and Services procurement

Our system has access to both SCWCSU and 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 the delivery of true value.

Regulatory environment - Goods and Services procurement

The ICB recognise that procurement rules for goods and services are changing. The new procurement act (expected February 2025) 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) was laid out bringing some elements of the Bill and the wider regime into effect. It is anticipated the new bill will be brought into force in February 2025. 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 2024/2025 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 on the accreditation of independent sector of healthcare providers page of our website.

8.3 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.

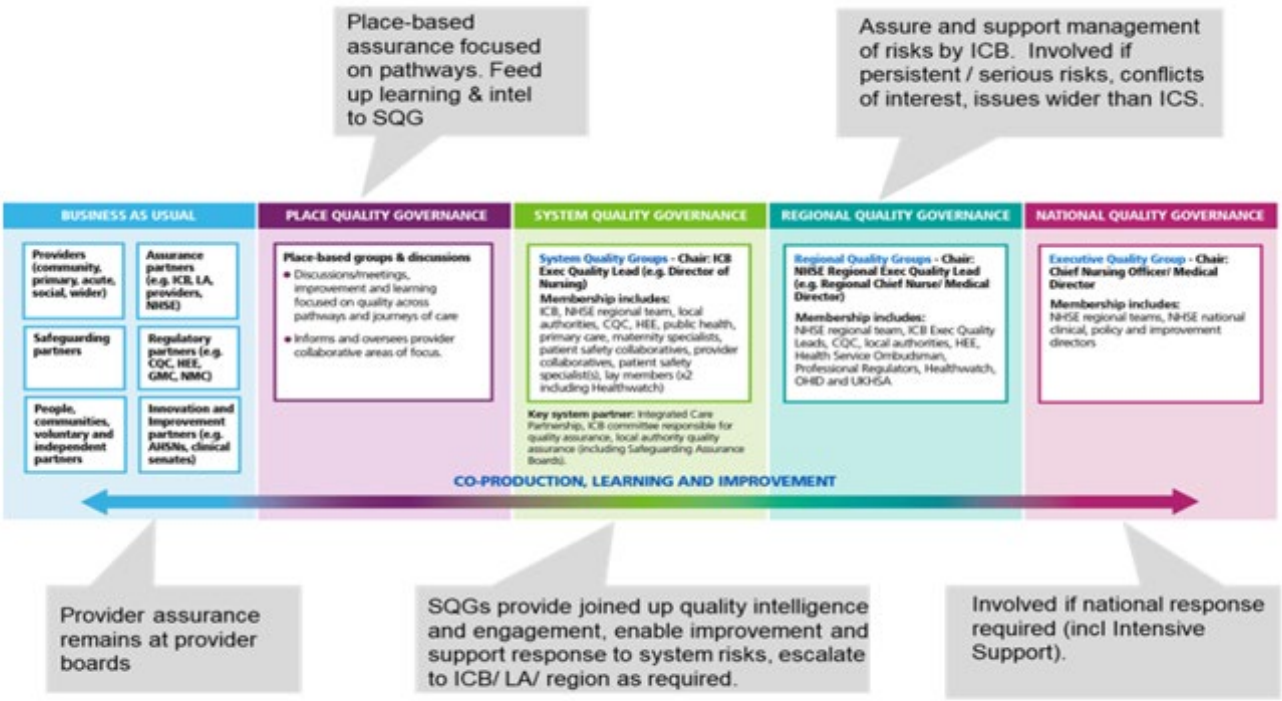

Figure 14 - National Quality Board risk response and escalation in ICSs.

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

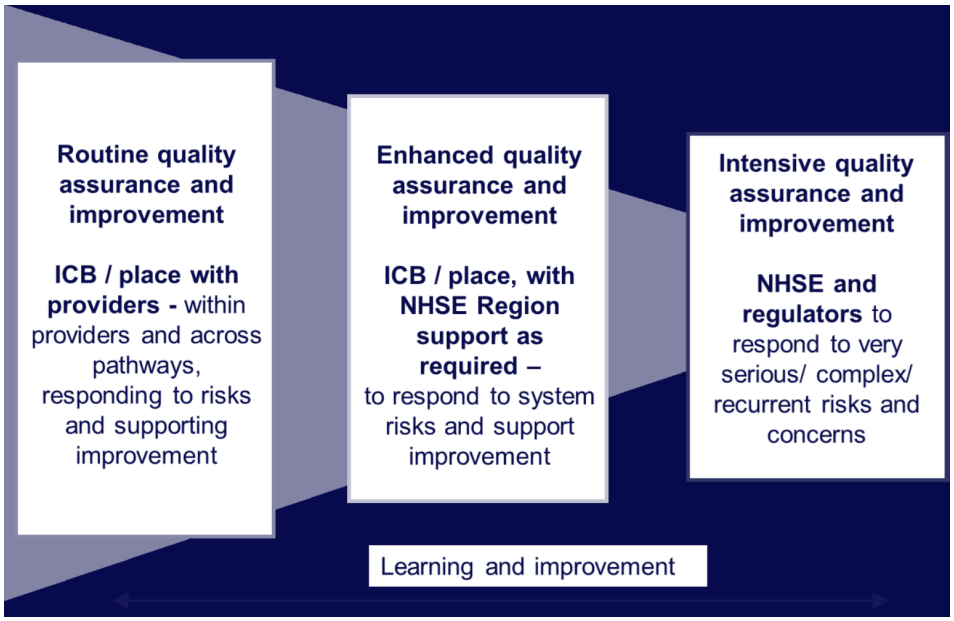

Figure 15 - Overview of levels of quality assurance and improvement.

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.

Within the ICB there is also an 'elevated' level of oversight within the routine parameters for if there are areas that need higher oversight temporarily but do not pose a risk to patient safety.

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.

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.

8.4 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 Health and Care Professional Executive (HCPE) in Bristol, North Somerset, and South Gloucestershire (BNSSG) provides leadership and advice on health and care matters, focusing on improving outcomes and quality for residents. This group meets monthly.

Purpose and functions of HCPE: The HCPE aims to provide a professional interface for local and regional change proposals, offer strategic advice on health and care matters, review and endorse policies, and oversee strategic transformation activities.

Authority and responsibilities: Although the HCPE has no direct delegated authority within BNSSG ICS, its chairs can exercise executive authority to discharge collective decisions and escalate potential system risks.

Challenges and areas for improvement: The use of ethics to inform some of the discussions has been invaluable and may be more essential as we enter a year of resource restraint. A conference in March has been designed to build understanding about how a multidisciplinary, multi-organisational group works together within a health and care system that has a population perspective whilst still advocating and focusing on the individual. This event outcome is to identify areas for development of the HCPE membership that will contribute to a development plan.

8.5 Governance

To support the delivery of our ICB functions and ambitions we have developed a series of principles with the System Executive Group which oversees the work of our Health and Care Improvements Groups (HCIGs). HCIGs comprise representatives from organisations from across our Integrated Care System (ICS) who come together in service of the BNSSG population we serve and to progress the activities associated with our system plan. The principles recognise the complexities of working across the ICS where individual organisations will have their own governance arrangements to follow. They are intended to promote timely and responsive ways of collaborative working.

Our principles:

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.

We have established the following groups:

- **Health & Care Improvement Group (HCIG)**
    - A System Level Oversight group with representation from appropriate system partners.
    - Four HCIGs established: Mental Health and Learning Disability & Autism, Children's Services, Acute Services, and Community.
    - Purpose:
        - To provide system oversight, ensuring system partners working together effectively, collaboratively and symbiotically.
        - Providing a key role in ICS Operating and Decision-Making Framework in oversight of services and making recommendations relating to resource and strategic developments.
        - Delegated responsibility from ICB Board for achieving specific outcomes, strategic and in-year plan objectives in pursuit of the ICS' vision and mission.
        - Commission ICB transformation and intelligence hub and Service Delivery Units against specific phases of Gateway delivery process.

        - Align and deploy activity across the system and partner organisations to achieve ICS vision and mission and ensure all activity contributes to delivering health and care services that meet the needs of our population.
        - Be gatekeepers of the ICB transformation and intelligence hub, supported by an ICB gateway panel that will undertake quality assurance checks at each gateway.
    - No delegated authority to make decisions on behalf of ICS or partner organisations. ICB lead executives can exercise decisions of this group on behalf of the ICB in accordance with delegated authority from ICB constitution, Standard Financial Instructions (SFIs) and schemes of reservation and delegation. All HCIG members will have delegated authority from their employing organisations constitutions, SFIs and schemes of reservation and delegation.

- **Operational Delivery Group (ODG)**
    - A multi-organisation meeting with representation from system partners
    - Purpose
        - Responsible for performance of services, delivery of service transformation priorities, development of operational and strategic plans. Supported by a Service Delivery Unit (SDU).
        - Forum for shared accountability against agreed performance, quality patient safety and safeguarding indicators, receiving action plans from organisations where required.
        - Tracking and monitoring progress, identifying risks and coordinating trouble shooting actions, where this is required by more than one organisation in the ICS. Sharing learning, successes and best practice.
        - Identifying risks and issues that require escalation.
        - Forum to lead long-term and annual operating planning processes for respective service area, ensuring system alignment and making recommendations for prioritisation of resources.
        - Manage cross-cutting issues, support matrix working to compliment Health and Care Improvement Groups.
        - Responsible for escalating to HCIGs emerging system risks or risks with proposed decision making.
        - Improvement activity recommended by ODGs and commissioned by HCIGs delivered by ICS/ICB transformation teams or SDUs.
    - ODGs established in the following areas: Urgent and Emergency Care, Discharge to Assess, Elective Recovery, Mental Health, Children's Services, Learning Disability and Autism, and Long Term Conditions.
- **Service Delivery Unit (SDU)**
    - Internal (ICB) monthly meeting.
    - Chaired by Performance & Delivery Directorate "Heads of".
    - SDUs established to cover: Elective Care, Urgent Care, Children's Services, Mental Health, Community, and Primary Care.
    - Membership: Performance & Delivery, Contracting, Finance, Workforce, Quality, Meds Optimisation, and Planning.

- Purpose
  - Bring together performance management and quality intelligence from across the ICB to provide a shared understanding from which to track recovery and delivery across the system, including the core metrics of the Operational Plan, Joint Forward Plan, System Outcomes Framework (SOF), and any other statutory, regulatory or otherwise mandated requirements.
  - Standing agenda to draw together timely data and intelligence from across all teams. This creates a shared understanding and narrative to support internally and externally, identify and manage interdependencies or escalations, early warning over trends and risks, identifies key messages and narrative for reporting into e.g. Power BI, Operational Delivery Groups, Outcomes, Quality and Performance Committee.
  - Support continuous improvement in services.
  - Develop and support the implementation of programmes exiting Transformation Gate 3.
  - Oversee delivery of mobilisation plan and on-going monitoring.

We have resourced a Transformation Hub which supports the delivery of work programmes through the application of structured methodology to ensure delivery of defined outcomes. This approach which utilises a series of gateways is shown below:

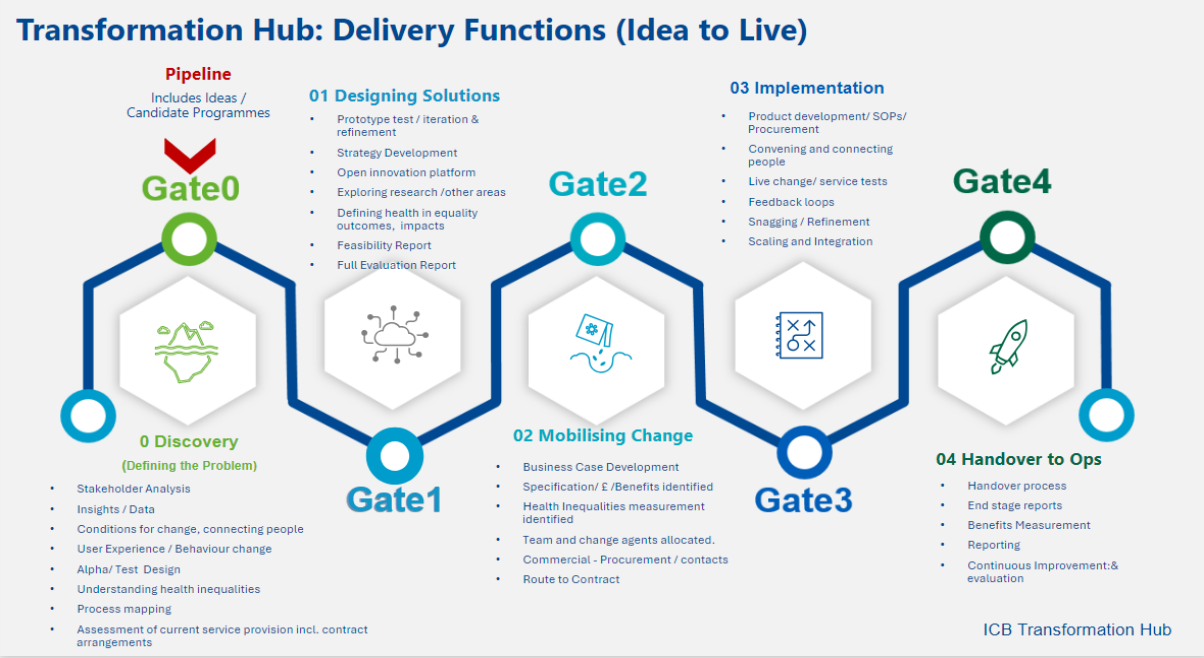

Figure 16 - Transformation Hub delivery functions (Idea to Live).

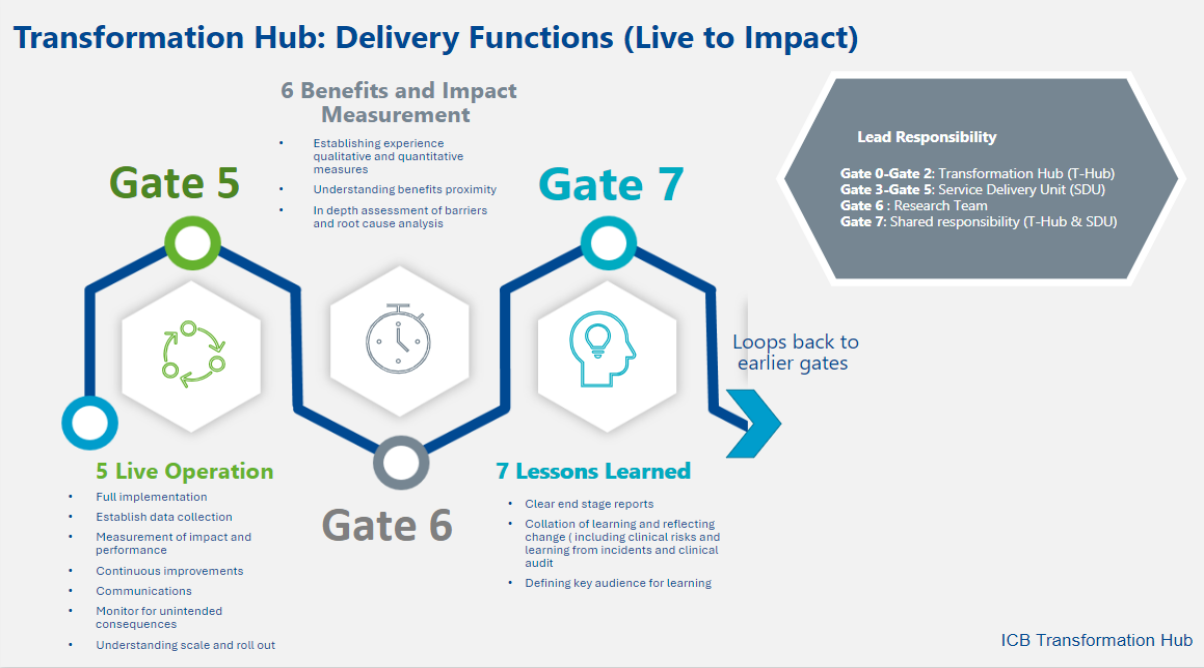

Figure 17 - Transformation Hub delivery functions (Live to Impact).

Our established Locality Partnerships will continue to drive collaboration in local areas and 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. We will use our Locality Partnerships and the established relationships to support the implementation of Integrated Neighbourhood Teams.

Innovation and our appetite for risks

In recognition of the challenges faced across the ICS, the ICB Board will, at its meeting in March 2025, review its appetite for risk. Based on the Good Governance Institute guidance on risk appetite, the ICB Board has previously agreed the appetite for risk across the ICS as shown below. It is anticipated that the appetite will increase to promote innovation whilst remaining alive to, and responsible for the management of associated risks.

RISK APPETITE LEVEL ▶ / TYPES ▼	0 NONE	1 MINIMAL	2 CAUTIOUS	3 OPEN	4 SEEK	5 SIGNIFICANT
	Avoidance of risk is a key organisational objective.	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently investfor the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risksrelating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Figure 18 - Risk appetite table.

Board and Committee Oversight

The ICB Board and its committees will receive updates on the delivery of our plans and reports associated with our Corporate Risk Register.

The ICB Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation (SoRD) have been updated. Changes to the SoRD recognise the establishment of the Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee as a formal committee of the Board. The purpose of the SHIPPH committee is to provide oversight, assurance and support for the ICS's efforts towards tackling health inequalities and embedding preventative approaches

The ICB Board will support the review of the Integrated Care Partnership to ensure that the collective authority of the partnership can support the delivery of health and care services to the BNSSG population aligned to the three shifts.

8.6 Research and Innovation

In line with our priority areas outlined in the Joint Forward Plan, significant achievements have been made across various domains.

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
As an Integrated Care System, BNSSG is performing very well in terms of research collaborations. As measured by NIHR investment, BNSSG is by far the most research active ICS in England.

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 that is not inclusive can exacerbate health inequalities, but well-designed inclusive research can be a mechanism for addressing, understanding and reducing health inequalities.

BNSSG processes to ensure cash payments are available to research participants who do not have a bank account, often the most vulnerable people in society, has been shared at national forums led by NHE England as best practice for inclusive research. Our Research Engagement Network, led by research active VCSE partners, are delivering co-created research with communities, and employing community researchers to deliver research, analyse data and disseminate findings. Our university partners and Applied Research Collaboration are providing training and support to VCSE organisations involved in research.

We have a growing portfolio of research development projects which originate from colleagues working with our most disadvantaged communities, as well as impressive growth of research delivery within disadvantaged primary care. Pioneer Medical Group in North West Bristol has doubled the number of NIHR projects they recruited patients into, becoming the leading NIHR recruiter in BNSSG, which is the most research-active ICB in England.

Secure Data Environments (SDE) for research
The South West SDE is an innovative and efficient approach to conducting research with millions of people's health and care records, while maximising privacy and security.

The SDE is a secure platform for research and data analysis, being developed to the highest security standards. It will enable trusted, appropriately qualified professionals to safely access data, including routinely collected data from the NHS and local government, for approved projects.

The South West SDE means we can all benefit from research using people's health and care records while providing strong safeguards that protect data security and privacy. It has the potential to revolutionise health research in the South West of England. The SDE design phase is complete and the build of the technology is underway. The SDE is planned to launch in the first half of 2025.

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

The IAU has appointed a full-time manager and is building a regional and national network of partner ICBs and Applied Research Collaborations (ARCs) who are looking to accelerate research in to practice. We have secured funding from ARC West to offer Knowledge Mobilisation Fellowships to ICS staff to provide them with time and support to embed research evidence into BNSSG.