Healthier Together

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

BNSSG Integrated Care Partnership (ICP) Board meeting
Agenda

Date: 16 June 2023
Time: 13.30 – 16.20
Venue: The Bordeaux Room, City Hall, College Green, Bristol, BS1 5TR
Chair: Cllr Mike Bell

No.	Agenda Item	Purpose	Start time	Duration	Lead
1	Welcome, introductions and member updates		13.30	20 m	Chair
2	Bristol Music Trust's work with people with Dementia		13.50	10m	Samir Savant, Chief Executive of St George's Bristol
3	Apologies, minutes and actions from previous meeting		13.40	5 m	Chair
4	Public Statement and Questions		13.45	5m	Chair
5	Health and Wellbeing Board Updates	Item to update ICP on the work of the BNSSG Health and Wellbeing Boards	14.00	15m	Health and Wellbeing Board Chairs
6	ICB update	Item to update ICP on the work of the ICB	14.15	15m	Jeff Farrar, Chair - Integrated Care System for Bristol, North Somerset & South Gloucestershire
7	BREAK		14.30	10m	
8	Integrated Care Strategy	Item to update ICP on the CQC's approach to the Integrated Care Strategy	14.40	55m	Colin Bradbury, Director of Strategy, Partnerships and Population for the ICB
10	The CQC integrated care assessment		15.35	20m	Shane Devlin
11	Next agenda and AOB	Ask for any other business, content of next agenda and ask for venue suggestions.	16.05	5 m	Chair

Date of next meeting: 28th September
Time:

Venue: TBC

Healthier Together

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

Meeting of the BNSSG Integrated Care Partnership – 2pm on Friday 21st April 2023

Attendance List:

Partnership Board Leadership Group: Councillor Mike Bell (Chair) – North Somerset Council, Councillor Ben Stokes – South Gloucestershire Council, Councillor Helen Holland – Bristol City Council, Jeff Farrar – BNSSG ICB, Chair

Community And VCS Voices: Alison Findlay (Southern Brookes), Aileen Edwards (Second Step), Mandy Gardner (VANs), Fiona Cope (North Bristol Citizens Advice Bureau), Dominic Ellison (WECIL), Anndeloris Chacon sub for Sado Jirde (Bristol Black Carers), Tim Poole sub for Kay Libby (Age UK Bristol)

Voices in the Community: Alun Davies

Constituent Health and Care Organisations: Hugh Evans (Executive Director Adults and Communities, Adult Social Care), Chris Sivers (Director of Children's Services, South Gloucestershire), Matt Lenny (Director of Public Health, North Somerset), Charlotte Hitchings (AWP), Jonathan Hayes (Primary Care Services), Ruth Taylor (Primary Care Services), Gail Bragg (SWASFT)

Locality Partnerships: Steve Rea (South Bristol Locality Partnership)

Other Attendees: Shane Devlin (BNSSG ICP), Nicola Knowles (Policy and Public Affairs Manager), Seb Habibi (ICS Programme Director), Colin Bradbury (Director of Strategy, Partnership and Population – Bristol City Council), Dr Joanne Medhurst (Chief Medical Officer), Rosi Shepherd (Chief Nursing Officer) Ben Stevens (ICS Strategy Programme Manager), Claudette Campbell (Democratic Services Officer, Bristol City Council), Becky Balloch (ICB), Prof. David Wynick (Director of Bristol Health Partners), Steve Spiers (ICB)

Apologies for Absence: Chris Head (WERN), Jayne Mee (UHBW), Ellie Wetz (ICS Development Programme Manager), Georgie Bigg (Healthwatch), Kay Libby (Age UK Bristol), Mark Coates (Creative Youth Network), Mark Hubbard (VOSCUR), Matthew Jordan (ICS Development Programme Manager), Sado Jirde (Black South West Network, Bristol), Steve Curry (CVS)

1. Welcome Introductions and Chair Statements

Councillor Mike Bell (Chair of the BNSSG ICP Board) welcomed all parties to the meeting and asked everyone to introduce themselves.

The Chair gave the following notices:

- The development day scheduled for the 29th June will be moved to an alternative date, an updated appointment to be shared in the coming weeks.
- The chairmanship of the Board will pass to Cllr Helen Holland from June 2023

2. Apologies, Minutes and Actions

a. The apologies were given as noted above with the appropriate substitutions
b. The minutes of the meeting held on the 24th February 2023 were noted.

3. Public Forum

a. There were none

4. Health and Wellbeing Board Updates from the Chairs

Councillor Ben Stokes – South Gloucestershire

a. Outlined the challenges that the Board faced with the cost-of-living crisis that is impacting all
b. Review of frameworks and workstreams; data sharing and sharing of resources; corporate socially responsible programmes; the work being done to revitalise the drugs and alcohol services, the newly formed drug partnership, to move it to 'a people centre approached' that incorporated the impact on the wider family.
c. The board met to consider the joint health and wellbeing strategy and those related priorities, the progression of relevant issues in new and innovative way
d. They had received reports on the ICS Strategy review and Safeguarding reviews
e. Worked with locality partners to consider the Better Care fund resourcing

Councillor Mike Bell – North Somerset

f. Shared that in his absence the Vice Chair led the meeting
g. The Board received a report from the locality partnership that provided an update on the mental health and aging well programme. The intention is to strengthen relationships and integration provision
h. Discussed the review and refresh of the Strategy Action plan.
i. The Better Care Fund Grants are being reviewed.

Councillor Helen Holland – Bristol City Council

j. Confirmed that the work programme for Bristol ran along similar lines to the other boards and had also considered the following.
k. Had established development session with the One City Board
l. The Environment Board had fed into the work on the Good Food Plan that centred around locally produced, seasonal food

m. Sirona delivered a Stroke Pathway overview presentation
n. The Covid19 Steering group set up to consider racial disparity, presented and continues to meet to progress findings

The Chair invited comments but there were none.

5. Integrated Care Board (ICB) Update

Jeff Farrar provided an update and overview of the operations of the BNSSG ICB

a. The Statutory Board had been established for a year and were engaged in establishing and securing input from appropriate partners and the next step is to engage with the wider public
b. The Board had agreed a one year operation plan and Shane Devlin has met with the Chief Executive to finalise funding. The budget had balanced for the year but going forward there will be challenges due to the reduction in budget allocation. The consequence are that the budget reset had to;
c. Properly reflect the ICP Framework Strategy; the projected 13 key targets from the health perspective; but not the two concerned with 'waiting list' and 'moving patients on'; the Board's running cost will be lowered by 30%; the reduction will impact the Board and not the partnerships that work with ICB.
d. The focus is to firm up the ICB core purpose, to bring it into alignment with the ICP Strategy and then to reset with reduced budgets

The Chair invited questions from those present:

e. In answer to the question on the arrangements for locality partnership in the current financial constraints, the Board was advised that the budget reduction impacted only the ICB running cost and not the local partnerships which are not owned by the ICB. There are proposals being worked out and further conversations to be had but resourcing to them remains constant.
f. The projections on budget reduction to be applied, are 1/3 in year 1 and 2/3 in year 2.
g. The situation that has given rise to a pre-action notice being issued could not be referenced at this stage in proceedings.
h. All were asked to note that there were currently 135 Strategic priorities from the wider groups and choices must be made on what to prioritise. That this must be considered in parallel with the 30% reduction in the organisations running cost and the review underway on the functionality of the ICB.

6. <u>Joint Forward Plan and Strategic Development</u>

Colin Bradbury – Director of Strategy, Partnership and Population Health, BNSSG Integrated Care Board introduced the report and presentation. That are attached.

He thanked all for contributing to the process and for taking the time to feedback on the system strategy. Reminding all that it was and is a continuous process as the strategy develops and takes shape.

The next steps for the Board:

i. To feedback on the draft strategy issued on 31 March 2023

ii. Comment on and endorse the proposed prioritisation Process that is set out in Section 3 of the report
iii. Note the timetable in appendix 2 of the report

Professor David Wynick was invited to expand on the prioritisation methodology set out in section 3 of the report.

a. It was not possible to act on all priorities at the same time and a method must be established to identify the leading priorities and use mechanisms to drive them forward
b. Of the 21 issues identified in Our future Health, none can be ranked above the other; consideration must be given to the strategic end point and outcomes; to consider what programmes are required to deliver the outcome; when identified to establish a way forward, delivery, within the available resources and workforce capacity
c. Existing teams will be used to work through the priorities, with public input.
d. The proposed Health Care Improve Groups (HCIG) remit is to ensure that the strategy dovetails with wider, existing, strategies.
e. The first prioritisation panel will meet in June and will use the evaluation criteria listed in the report; each priority will be discussed and scored to generate a ranking.
f. The proposals selected will be worked into business cases with the HICGs leading the way in working through the solutions.
g. The ICB has identified sources of recurrent funding to support the successful proposals through to implementation and embedded as business as usual.

The following comments were noted:

h. The proposal was first circled to the Board for feedback with the ask that comments were received before the end of March; 20-30 Board members did engage in this process the feedback was said to have been varied and rich comments. That included.
i. An ask to broaden the focus and widen the solutions; to reconsider the use of terminology; that the prioritisation process outlined must work in line with the criteria list; that the programme board would be tasked to reference the right terms/components, in the document, to focus on and to ensure that it was children centred, feeding into the wider issues including Autism, early years development, childhood neglect.
j. Concerns was expressed about the strategy looking at specifics and not looking wider. How to ensure the partnership organisation worked in an integrated way.
k. It was explained that the 'The Editorial Groups' was the vehicle to enable real 'lived experiences' to feed into the programme.
l. A request was made that the strategy & priorities encompass the challenge 'that all are living longer but not living well'.
m. The question was asked on how, to identify the culture shift necessary to allow true integration. The challenge remains as to 'what & how' will things be done differently across so many organisations.
n. It was not possible to transform without incorporating the advances and advantages of digital technology into solutions.
o. The first community HICG group is to meet on the 23 May to consider the 21 priorities.

p. Assurances were sought that the HICG's were fully formed and would be made up of the right people equipped to undertake the evaluation criteria.
q. A further explanation was given on how the HICG's were structured and that they would be sympathetic to the strategic areas of the ICB, that spread into four themed channels.
r. Concerns that when using existing groups/programmes, to evaluate the 21 priorities, that they may produce the usual outcomes/take the same position expected from that body, an unintentional bias. The ask was for a mechanism in the process to avoid this outcome. All were referred to the process in the report and the steps proposed to ensure balance.
s. All were reminded that the ICB had to hear from the ICP on the strategy to enable the ICB to deliver; that the ICB improvement outcomes for public health is set down in statute; and at times determine such things as language that is the use of phrases and words; where to concentrate efforts and how the ICB held people to account.
t. Final comments were received on the document itself; noting that the primary audience are health professionals, partner organisation, councillors, health boards and programme boards; that there could be different versions of differing lengths to meet the differing requirements of the professionals and public

All were thanked for their input and reminded:

I. To note the timeline and the next reiteration of the strategy to be delivered 1 May 2023
II. That the strategy was a continuing process and not an event
III. That staff engagement and workforce development was key, that the strategy must be real and deliverable
IV. The priorities outcome aimed to cluster proposals and not to have too many standalone priorities
V. All encouraged to continue to feedback into the process as it develops
VI. Confirmed that the Delivery Plan will be shared

7. The Chair invited all to adjourn for a short break and advised that due to the constraints on time that they would move to agenda item 8 and defer item 9.

8. <u>Showcasing Social Prescribing in the VCSE Sector</u>

Alison Findlay, (CEO Southern Brooks), led introductions and invited all to view the presentation and listen to the video presentation showcasing social prescribing and a strong community offer in the VCSE sector.

The presentation is attached.

The following spoke to the presentation: Amy Kinnear - Southmead Development Trust; Fiona Cope - Citizens Advice North Somerset; Anya Mulcahy-Bowman - Wellspring Settlement; Mark Graham - For All Healthy Living Centre; Judy Oliver - Oliver and Co

The Board members were invited to move into a group exercise session.

The Board was asked to consider the following question:

- What do we, as the ICP, need to do to ensure our focus is on strengthening our communities, on prevention and on reducing health inequalities.

Unfortunately, due to time constraints at the venue full feedback on the exercise was not possible but a summary of the group outcomes are attached to the minutes.

The Chair thanked all for their involvement.

The next meeting of the Board will be on the **16 June 2023** at a venue to be confirmed.

The meeting ended by at 4.30pm.

Future Dates:

- Development Day 7th July
- 28th September 2023
- 29th November 2023
- 29th February 2024
- 25th April 2024

Showcasing social prescribing and a strong community offer in the VCSE sector

citizens advice North Somerset

HAPPY TO BE HEALTHY KNOWLE WEST HEALTH PARK CO.

VOLUNTARY ACTION NORTH SOMERSET

BS3 Community

SOUTHMEAD DEVELOPMENT TRUST

Wellspring Settlement

THE FOR ALL HEALTHY LIVING COMPANY

SOUTHERN BROOKS connect support thrive

Summary … The role of community anchors in Social Prescribing and prevention services across BNSSG

1. Our BNSSG Strategy and the problem we all have
2. How Social Prescribing within the Community Sector is delivering against the aims of our ICS strategy
3. How we deliver across the lifecourse framework – three focus sessions from colleagues
4. Facilitated discussion

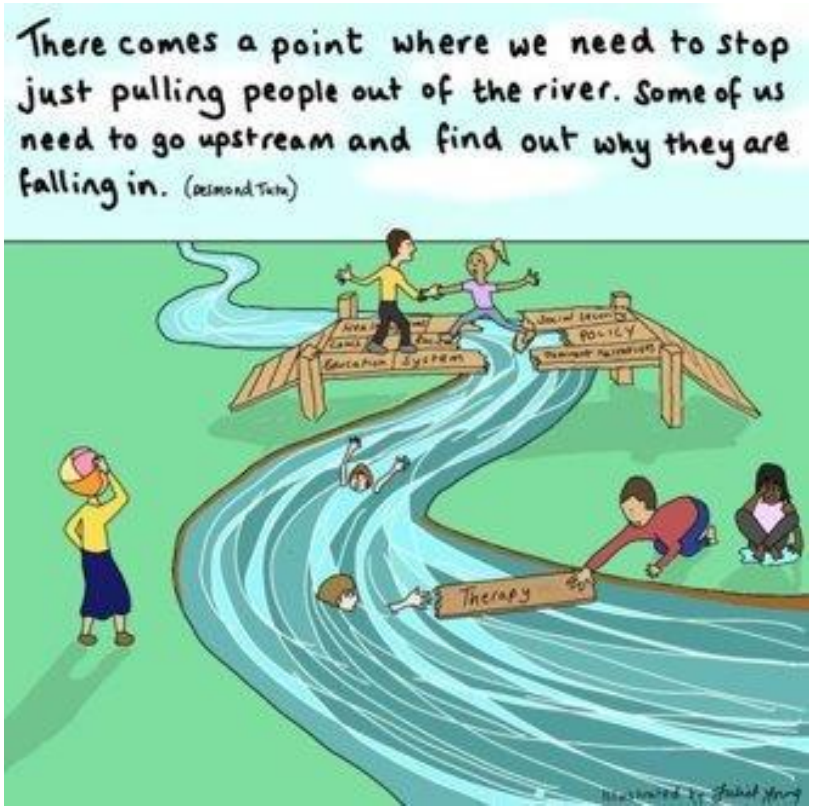
Improve outcomes in population health and healthcare

Tackle inequalities in outcomes, experience and access

Enhance productivity and value for money

Help the NHS support broader social and economic development.

What is the problem we have?



Vanessa Kisuule The Sum of Several Someones
https://www.youtube.com/watch?v=HPqDTHTmFI0

Social prescribing link workers are the bridge into community wellbeing support

Dr Richard Berkley, Orchard Medical Centre and Network 4 Clinical Director


Personal Action on Wellbeing
Link Workers
Reaching out for help (often through health and social care providers)

Reaching out for help (often through Primary and Secondary Care)

"I'm struggling with….."

1. Anxiety & depression
2. Loneliness and isolation
Bereavement
Benefits problems
Threat of homelessness
3. Unpaid bills
Debts
Substance addiction
Self harming
My weight
Poor physical health
Abusive relationship
No Motivation
Don't know what to do
Unemployed
Trauma from childhood
Overwhelmed
I'm a carer

Link Workers

The Link Worker

"The weekly calls are really helpful. You find what WE need and don't just tell us what you think we need"

"You were great at adapting to support me with my needs as they arose, from me crying in my room over my job to dealing with my son's eating disorder. Thank you so much for all you did."

"I can't thank you enough, you've not been telling me what to do, you've just been giving me opportunities and I've taken them, and I'm really proud of myself for that. You've helped me find the right niche".

Personal Action on Wellbeing

Walking Group
Open Water Swimming
Living with Chronic Pain
Healthy Lifestyles Group
SEN & Disabilities Info
Carers Drop In
Campfire
Housing Support
Gardening
Wellbeing Music
Wellbeing Arts
Wellbeing Movement
Debt & Budgeting Support
Anxiety Management
PIP Support
Qi-Gong

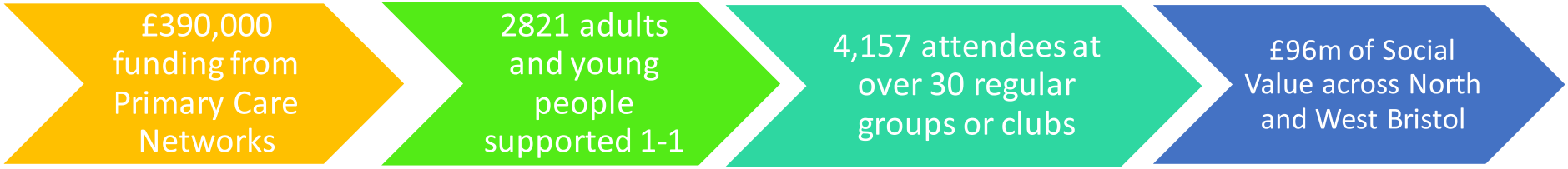
Office for National Statistics Wellbeing Questions: an illustration from Inner City & East

Measure	Question	% of clients showing improvements as a result of working with Social Prescribing Link Workers
Life Satisfaction	Overall, how satisfied are you with your life nowadays?	77%
Worthwhile	Overall, to what extent do you feel that the things you do in your life are worthwhile?	75%
Happiness	Overall, how happy did you feel yesterday?	72%
Anxiety	On a scale where 0 is “not at all anxious” and 10 is “completely anxious”, overall, how anxious did you feel yesterday?	50%

Cost and Social Value

Total number of social prescribing clients 22/23	Total Additional Roles funding from PCNs
8,092	£1,236,339

In North & West.....



Starting Well

Social Prescribing for Children and Young people

SOUTHMEAD DEVELOPMENT TRUST

SOUTHMEAD DEVELOPMENT TRUST

560 children and young people and their families

Return on investment of £55 for every £1 spent


PUMA


London
Shooters


Calvir

“I’ve learnt to look after Nature because it looks after us”

“It’s the first time I have enjoyed doing a sport, I hate PE at school but I can join in the kickboxing, I can feel my body getting stronger.”

Informal groups and clubs and volunteers

Open Access Youth and Play

Funding from PCNs

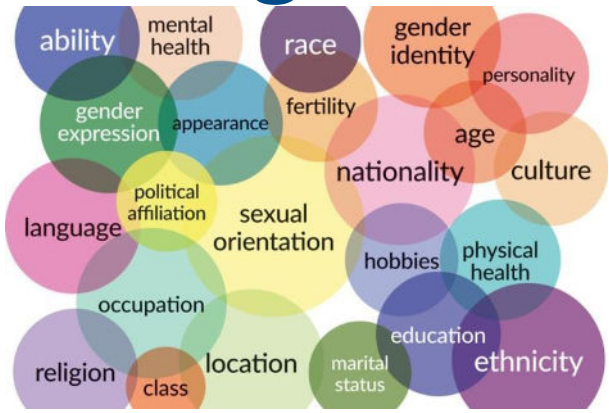
Voluntary Sector Organisations

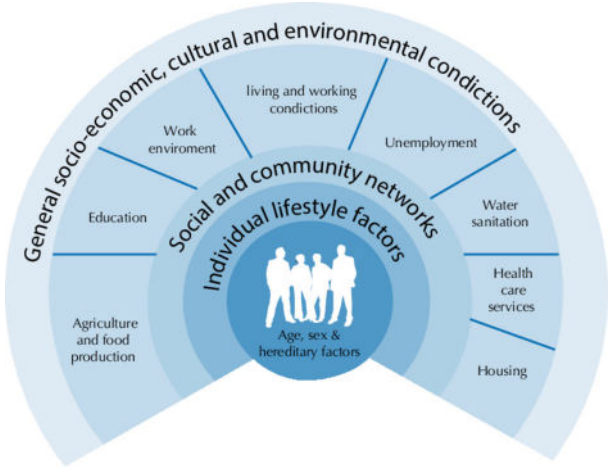
Community Buildings

Adventure Playgrounds

Community Gym

Living Well

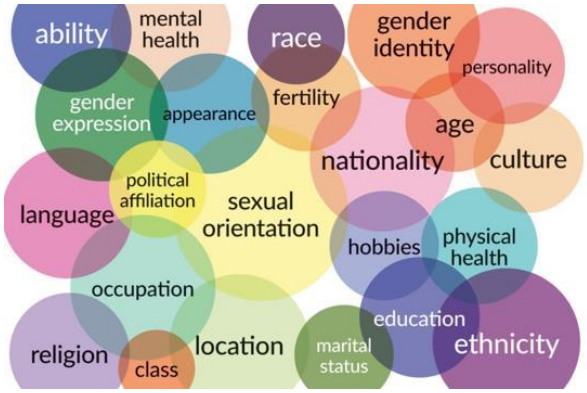


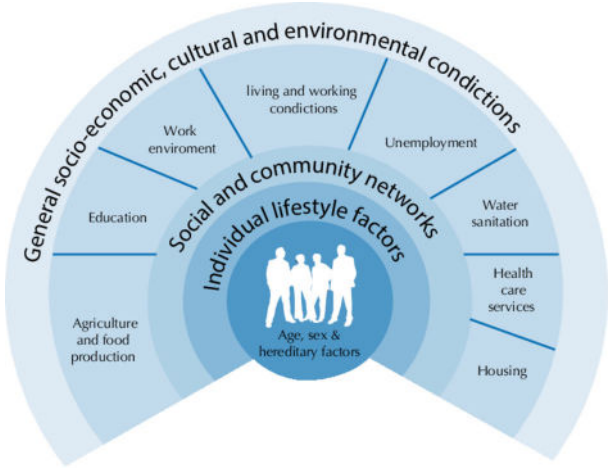


Meet Jason an ordinary 34-year-old married man with a young family

Through a holistic, wrap-around approach, both Jason and his family's wellbeing has improved, with better living conditions, greater household income, and improved happiness through community connection and activity.

Living Well





Meet Jason an ordinary 34-year-old married man with a young family

But …

- His family's home is mouldy and damp and they are facing homelessness
- They have mounting debts and struggling to make ends meet.
- Jason has multiple health issues including PTSD, Bipolar, IBS, fibromyalgia and long term depression
- Jason believes his health issues relate to childhood abuse and trauma
- Jason is feeling very low and feels that things just keep getting worse.

Jason was referred by his GP to the Pier Health Social Prescribing Service. Jason's Link Worker supported him to deal with the practicalities of his situation:

- A referral to Citizens Advice to deal with housing and income maximisation
- Support from Second Step with counselling and a referral to the Recovery Navigators (One Weston Mental Health Hub) to support him with his mental health.

Jason and his family were supported to find a new home, maximize their income through benefit take up and applying for grants, and manage their debts.

Through the *5 Ways of Wellbeing* and *What Matters to Me* Jason's Link Worker was able to help him think about things that he enjoyed and established that he loves the outdoors and nature. He also has a keen interest in music and would love to learn to play the guitar.

- Jason was supported to find groups to join. He is now involved with Osprey Outdoors and Friends of Grove Park which is helping him connect with nature.
- He has had a taster session with the Rock Choir and has opportunities to learn the guitar
- He has joined the fibromyalgia support group

Through a holistic, wrap-around approach, both Jason and his family's wellbeing has improved, with better living conditions, greater household income, and improved happiness through community connection and activity.

Aging Well

Meet Sue, who is 62. Sue was referred by her GP as she was lonely and wanted to do some physical activity, but problems with her back and legs made her nervous to go out.

- Has new medication which has reduced the swelling in her legs
- Engaging with 2 local history groups
- Engaging with a local book club
- Linked into BOOST Finance to ensure she was getting her full benefit entitlement
- Has signed up for a Gentle Exercise class.
- Has signed up for a Breath for Wellbeing course, developed in partnership between National Centre for Integrative Medicine and Wellspring Settlement
- Is due to start a computer course soon.

What do we, as the ICP, need to do to ensure our focus is on strengthening our communities, on prevention and on reducing health inequalities?

Next steps

1	2	3	4	5	6
total inclusion	Amplifying the value of social prescribing	We need to make it more real for the ICP – get out and about and see what we are doing.	Often we get caught up in the system conversation (e.g. freeing up beds) because of pressure from NHS England, but actually sometimes we need to challenge NHSE and come back with our priorities locally	Health Education across the board, from the professionals right through to community.	amalgamate ICB and ICP
listen and learn		Walk the floor	As an ICP we need to get away from measuring short term indicators related to behaviours or conditions (e.g. smoking levels) and move to a more complex understanding of inequality.	Insight and a greater breath of genuine involvement, including more service user/lived experience/carer/open door, there are too many voices missing.	peole at ICP board top get involved in delivery as well as defining the direction
hear and empower	be brave to move further upstream	Really listen to the community – as well as going out, invite people into our meetings e.g. young people – bring different voices 'into the room'	We need to start looking at how we measure change over the short, medium and long term, giving ourselves the trust and freedom to take an approach invests in and measures long term change across a whole population	Getting rid of the top down hierachy in the system.	Share power (and resource) with the community
effectively share information	everything should be developed from grassroots/community social prescribing	Learn from best experience and build on it e.g. health justice partnership used to work well but funding got pulled		ICP needs to align funding across the board so that we are targeting and utilising through pooling budgets to work together.	agree a small number of priorities but not everyone will work on everything together. Recognise that everyone has a role. Play to strengths.
Health inequalities must be taken seriously by all.	ensuring there are places to socially prescribe to	Be prepared to look and learn from what others are doing around the country		Stop talking process endlessly and get on with doing.	
We need to have stories and hear from the non-traditional voice, start ICP sessions with a story sharing how the system has helped or hindered them. The voice is important.				There is so much already happening, fund the voluntary sector to do more of what it is already doing.	
We must be innovative, learning from listening so that we do things differently.				Support the community infrastructure.	
The VCSE is a new element to the partnership and we need to make sure we are linked up better					

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Integrated Care Partnership Board

Agenda Item	Item 8	**Meeting Date**	16th June 2023

Title	**1st Edition of the BNSSG Integrated Care Strategy**			
Scope: System-wide or Programme?	Whole system		Programme area	Integrated Care Strategy
Author & role	Matt Lenny, North Somerset Director of Public Health Colin Bradbury, Director of Strategy, Partnerships & Population			
Sponsor / Director	Colin Bradbury			
Presenter	Matt Lenny			
Action required:	Approval			
Discussion/ decisions at previous committees	• *ICB Board – 1st June 2023* • *BNSSG Strategy Network – 5th June 2023*			

Purpose:

This paper aims to:

- Receive comments from the ICP Board on the draft BNSSG Integrated Care Strategy, including feedback on the specific questions and asks contained within the Discussion section below

- Secure agreement from the ICP Board for a final First Edition to be published on 30th June 2022, with sign-off of any final changes resulting from feedback being delegated to the ICP Board chair and vice-chair and the chairs of the other 2 Health and Wellbeing Boards

Summary of relevant background:

Following feedback from the last meeting of the ICP Board, and Editorial Group has drafted the attached document. There has been a wide range of feedback that has helped shape this document and Annex 2 contains a log of these for background information, along with the Editorial Groups responses.

Discussion:

Strategy guidance

1) There are recurrent themes that come through several chapters (key opportunities). Our aim is to make sure we cross reference effectively to make the narrative flow in the detailed editing process. Are the Board comfortable

with that approach or would they prefer description in only one section with a reference elsewhere as needed? Layer up the story or only in one place? Our suggestion is cross referencing to strengthen connection.

2) Do we have the balance right between system change ambition and the challenge of our current service pressures? Does this need to be pulled out more explicitly (current under how we will deliver change) or maybe we weave more references e.g. around JFP picking up that task and where we are implementing national guidance to ensure clear plans for improvement are in place?

3) Do we have the balance right around the number of commitments in the document listed under the opportunities? Too many, too little or about right? Do they feel strong and consistent enough or are there any other approaches which would help e.g. a summary of all commitments in one place?

4) Document has used the five opportunities from the strategic needs assessment rather than other frameworks because of a concern about using too many concepts in one summary version. One area others have asked about is the life course, which is more implicit than explicit. Does that matter? Do we need to bring that out in some way? For example, map the commitments by the life course, what are cross cutting, what target start/live/age/die well?

5) Acknowledge that some language used in this version may be more about the problem, risk of 'othering' rather than positive on what we can build on and do. We will adjust in editing with expert comms input. Does that sound OK?

Asks of Board members

6) We need to ask Board members and Strategy Network for exemplars to illustrated the key points in the document. Ask them to share the stories they are proud of and can pick from that list and/or actively fill any gaps. Can you help us to illustrate the change we are advocating and are you content if that expands the content within the document?

7) A good point has made about socialising with staff, volunteers, carers, public etc. - time constraints of strategy production have made this difficult but we need a communications and engagement plan for how to share and receive feedback. Can the ICP Board support our socialization and process to ensure this document will impact on supporting strategies and plans e.g. review own plans against the opportunities it sets out? If agreed, how can we best organize that approach?

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

Decisions required and recommendations:
The ICP Board is recommended to: 1. Comment on the draft Strategy, with particular refence to the seven issues listed in the Discussion section of this paper. 2. Agree for the final version of the document to be published on 30th June 2023 (subject to any amendments resulting from Recommendation 1 above). 3. Delegate sign-off of any final amendments to the ICP Board chair, vice-chair and the chairs of the other 2 HWBs

Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy

Version for ICP Board comment (16 June 2023)

Contents

Our vision: 'Healthier together by working together' People enjoying healthy and productive lives, supported by a fully integrated health and care system - providing personalised support close to home for everyone who needs it.

Foreword

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

We have a lot to be proud of in Bristol, North Somerset and South Gloucestershire (BNSSG). In recent years we have seen great improvements in areas like *(Note: will select from examples offered to exemplify change under chapters that follow).*

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

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

But there is more for us to do. Like other areas of the country, lives in BNSSG are being cut short and too many people are spending long periods of their lives in ill health. Local analysis shows concerning trends around the stalling or declining of life expectancy gains for some population groups and a growing impact of harm in areas like dementia and liver disease.

The burden of poor health is felt more by some communities. People in poorer areas are unfairly impacted, and we know that your ethnicity, gender and disability usually makes these issues even worse.

This is at a time when pressure on health and care services has never been greater. Things need to change.

We believe there are five opportunities that we need to focus on over the coming years which will help us to realise the better health and wellbeing and improved services our local population deserve. They are:

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

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

This document has been developed with input from many people and grown from analysis of local needs, public and staff views and evidence about how best to secure better outcomes. We'd like to thank everyone who has helped to shape and develop this work.

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

X3 Chairs of the Health and Wellbeing Boards

June 2023

Introduction

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

This strategy has been developed from several important sources. It includes public views, including those who have used our health and care services, information showing our communities' local health and care needs, and the insights of practitioners working in our organisations.

The strategy is overseen by the Integrated Care Partnership (ICP) for BNSSG and is delivered by a partnership of the voluntary and community sector, our three local authorities, our six locality partnerships and our Integrated Care Board (ICB) which includes representation from the providers of services in our area.

A Strategic Framework was published in December 2022, which set out ambitions for what we want to achieve as a health and care system. This strategy builds on the challenges set out in that document. It sets out our critical opportunities for improvement that we can deliver, together for the population of BNSSG when we work together effectively. It is essential to be aware that improvements happen in our system constantly. We have many important strategies and plans to address key issues, such as how we support the needs of people coming in and out of hospital and those plans remain essential. This strategy is setting out what we can do better together. This document is a reflection of our thinking at this point in time but as we have learnt over the last year of the ICS, we will constantly review and adapt what we do using the latest evaluation and intelligence about what we must prioritise and how best to implement change for better outcomes.

We want this strategy to improve both what we do and how we do it to help us further build the right culture and approach for securing sustainable positive change.

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

We will track our impact on people’s lives through our Joint Outcomes Framework, which describes what matters to keep us healthy and happy in our everyday lives.

What is driving our strategy?

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

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

A report into health and care needs, called *Our Future Health* (Appendix 1) and an extensive survey of people in BNSSG, *Have Your Say* (Appendix 2), have highlighted the key issues summarised below.

ICS AIM 1: IMPROVING OUTCOMES IN POPULATION HEALTH AND HEALTHCARE

We need to improve health and wellbeing for everyone in BNSSG. We also need to keep improving services and access to them, so that everyone can access the care they need.

Much of the ill health in BNSSG is preventable, and despite an ageing population, we can improve population health[1]. **A new approach to habits like smoking and obesity should be a focus**. We can improve outcomes and reduce the impacts elsewhere in the system.

The healthcare system could be providing better outcomes. Unfortunately, people are still waiting too long for care[2], and *Have Your Say* shows , for example, how much of a concern primary care access is for our residents. We need to understand how we can do better and how we can support people waiting.

During the pandemic, existing issues with health and healthcare got worse. For hospitals, this meant longer waiting lists. For local councils, it meant considerably more being spent on adult and children's social care. For people with anxiety or depression, it meant worsening mental health[3].

The pandemic also highlighted specific inequalities that need to be addressed.

In BNSSG, certain racial groups have worse outcomes than others, particularly Bangladeshi, Caribbean

ICS AIM 2: TACKLING INEQUALITIES IN OUTCOMES, EXPERIENCE AND ACCESS

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

[1] *Our Future Health,* BNSSG ICB (2022), page 23
[2] https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
[3] https://www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf

and Pakistani people[4]. This is often due to 'structural inequality' that needs to be broken down and addressed.

Deprivation also impacts health and well-being. For example, in the most deprived areas, people live 15 years less in good health than in the least deprived areas[5]. So we need to make it so that where you live or who you are stops defining your health and well-being.

This is especially true for disabled people. For example, people with learning disabilities die an average of 21 years earlier than the average person[6], and we also need to understand how we can provide better support and enable them to access services.

ICS AIM 3: ENHANCING PRODUCTIVITY AND VALUE FOR MONEY

The money that the NHS or local Councils spend comes from the taxpayer. Value for money means we are caring for as many people as possible in the best way.

We want to ensure that we can invest public money in a way that supports people to stay healthy in their own homes and communities, whilst also ensuring that services are available when they do need them. Proactive approaches and working with communities can help to reduce demand for complex care in the short, medium and long term and ensure that capacity is retained for high quality and easy to access support for those who need it most

Nothing we try to do in this strategy is possible without our staff, so we need to value them and make them central to our efforts for improvement.

The Voluntary, Community and Social Enterprise sector is vital in supporting social development. Proxy measures for community cohesion, such as crime rates or loneliness[7], demonstrate a need to do more. In *Have Your Say*, people listed family and community as the number one thing that keeps them happy, healthy and well.

ICS AIM 4: SUPPORTING BROADER SOCIAL AND ECONOMIC DEVELOPMENT

Our partnership employs 45,000 people and spends over £1bn (check). We need to use that power to grow the economy in BNSSG and understand our role in supporting stronger

Our system partners – civic, service and community - have the power and the responsibility to address the issues identified above. Focusing on what we can do together as an Integrated Care System can have a lasting impact on health and well-being in Bristol, North Somerset and South Gloucestershire, now and into the future.

[4] *Our Future Health,* BNSSG ICB (2022), page 16
[5] *Our Future Health,* BNSSG ICB (2022), page 14
[6] *Our Future Health,* BNSSG ICB (2022), page 17
[7] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/subnationalindicatorsexplorer/2022-01-06
Note: Check referencing

Key Opportunity 1: Tackling Inequalities

Why is this important?

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, people's work, and their homes. Differences in these things are a significant cause of health inequalities. Health inequalities are the unjust and avoidable differences in people's health across and between specific population groups.

Over time, organisations have planned opportunities (health, education, housing, jobs), organised our services and made value decisions (worthy or unworthy, full of potential or not) which led to bias based on race; ethnicity; gender; "disability"; sexual orientation; age; where people live; people's income; immigration status; language; housing status; criminal justice history. This has unfortunately had unintended consequences, meaning that we have:

- Unfairly disadvantaged some individuals and communities
- Unfairly advantaged other individuals and communities and
- Sapped the strength of the whole society through the waste of human resources [Reference - Professor Camara Phyllis Jones]

It often shows up as indifference and inaction by us in the face of need. This contributes to health inequalities

We are committed to correcting this.

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

In BNSSG, some children, young people, adults, families and communities do not get to (or find it much harder to get to) the support (education, health, housing) they need. If they get to the support, their experiences of using it, and sometimes the quality of that support are poorer than other people's. As a result of poorer access, the poorer experiences and the poorer quality of care, their outcomes (whether they achieve what matters to them) are poorer than other people's.

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

What needs to change?

1. The way that the unfair disadvantaging and unfair advantaging happens in BNSSG is through our:

- Structures – the who, what, when and where of decision-making
- Policies – the written how of decision-making
- Practices – unwritten how of decision-making
- Norms – how we expect you to do things
- Values – the why and things that matter to us

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

2. Equity means that we recognise that each person has different circumstances and gives the exact resources and opportunities needed to reach an equal outcome. "Equality is giving everyone the same pair of shoes. Equity is giving everyone a pair of shoes that fits". We need to use the following three principles to achieve health equity:

a) Valuing all individuals and populations equally
b) Recognising and rectifying historical injustices
c) Providing resources according to need

Achieving health equity will reduce or even eliminate health inequality.

What are our commitments?

Commitment	Short term impact	Medium term impact	Longer term impact
1. Decision-making as a way of valuing all individuals and populations equally Working with communities, continuously review the decision-making processes and groups and make necessary changes to ensure that people who experience health inequalities influence or are part of the processes.			
2. Valuing all individuals and populations equally Our system will routinely review quantitative and qualitative data that shows what patterns of fairness and unfairness exist and actively plan to close the gap for those experiencing poorer outcomes. We will consistently challenge ourselves to correct our course when patterns of injustice are clear.			
3. Recognising and rectifying historical injustices Health equity in all (not just health) policies – as we review and develop new approaches, we will check how they can improve health equity and that they won't make things worse. There will be many ways of doing this. For example, using our staff networks, supporting our staff to be 'ambassadors' within their teams/departments and improved ways of working with our communities to do this across all aspects of civic, service and community impacts. We will also look at the themes of what people and communities experiencing health inequalities have been telling us for many years, for example, giving people information in a way they can understand. Finally, we will invest time in fixing the problems.			
4. Providing resources according to need We will change how we spend money to provide funding in a way that supports people who			

experience health inequalities to get what they need so that they can achieve what matters to them. We will target resources to those most in need and who will benefit the most.			

Key Opportunity 2: Strengthening Building Blocks

Why is this important?

The foundations of good health and well-being are built upon a range of factors including: family and community relationships; a safe environment with quality housing, places to exercise and clean air to breathe; good education; meaningful work; and freedom from discrimination. Unfortunately, for too many people in BNSSG, these fundamental 'building blocks' of good health and well-being are missing. This worsens peoples' social and job opportunities, their habits, their well-being and ultimately, their health.

We want to see change where everyone in BNSSG will live in homes and communities where they feel connected with others, safe from harm, free from discrimination, and able to access nutritious food, physical activity, green space and clean air. We do not pretend to have everything in our power that is needed to address these wider determinants of health. However, we do have significant power to influence these issues for the better: as major local employers and purchasers with a large estate, and in our relationships with people as health and care providers, and as civic, community and professional leaders.

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

BNSSG residents have told us that positive social connections are the most significant contributors to health and well-being[8]. Yet in our Citizens Panel survey of a representative sample of BNSSG residents, 29% of people reported feeling lonely in March 2023.

Poverty and social exclusion are causing more people in BNSSG to die younger and to spend more years in poor health. For example:

- Early deaths from all causes occur most often in the most deprived areas of Bristol and Weston-super-Mare
- Local analysis has shown cold homes are linked to increased hospital admissions for COPD and CVD. These homes are also in some of the most deprived areas of BNSSG
- Research shows that people who experience trauma are more likely to experience poor physical and mental health in their lives

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

- About 25,000 children in BNSSG growing up in poverty are more likely to experience health problems from birth and throughout life
- Measures of school readiness at age five show a 20-25% gap between the most and least deprived areas of BNSSG
- More people in BNSSG aged 16-17 are not in education, employment or training compared with the national average

[8] *DN. Insert reference to Have Your Say thematic analysis, published as an Annex to the Strategic Framework in Dec 2022*

What needs to change?

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

- As the largest of all local employers, by recruiting a diverse workforce, treating our staff well and supporting staff in their roles as parents, carers, volunteers and as members of their local community;
- As large purchasers of goods and services, by buying from local suppliers and organisations with a social purpose and/or that can demonstrate ethical practices
- By lowering our carbon footprint and reducing air pollution;
- By providing early help to support families to give their children the best possible start in life; and,
- Working in partnership with voluntary, community and social enterprise organisations to support people whose health is at risk due to their social and economic situation or the impact of previous trauma and adversity.

What are our commitments?

Commitment	Short term impact	Medium term impact	Longer term impact
1. We will support the c45,000 people in our health and care workforce, c20,000 VCSE staff and c60,000 volunteers to live healthily well and to help make BNSSG a better place to live and work. This means we will work in partnership with staff to identify opportunities to support them in strengthening the building blocks for good health and well-being for themselves, the people that they care for, and the communities in which they live. We will then engage staff and volunteers to find out whether they feel we are listening and taking effective action.			
2. We will contribute to inclusive growth in our local economy by: • **Increasing recruitment from deprived communities and amongst under-represented groups** to levels that reflect the demographic distribution of BNSSG • **Increasing the proportion of spend on goods and services that are sourced locally**, and increasing the social return on investment			
3. We will embed trauma-informed practice in our approach to improvement, starting with training and development for ICS staff to			

strengthen a compassionate approach to how we understand what matters to people and how they can be supported to make changes they value most			
4. We will work with Voluntary, Community and Social Enterprise organisations to identify and support people most at risk because of their life circumstances, for example, financial or housing situation, social isolation, or caring responsibilities, by: • Providing targeted support for vulnerable people at risk due to cold or poor-quality homes • Increasing support for carers to enable more people in BNSSG to provide or continue providing informal care • Providing befriending support for vulnerable people that are living alone			
5. We will work together to provide support for families with children during the first 1000 days of life. We will prioritise support for households in the most deprived areas of BNSSG and we will work in partnership with communities to codesign this support so that it meets people's needs and is accessible and culturally appropriate			

Key Opportunity 3: Prevention and Early Intervention

Why is this important?

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

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

We all know that prevention is better than cure. This section pulls out where we believe, as partners, we can work together to improve the factors described earlier.. This focus will mean less reliance on our overstretched urgent and emergency services as more people remain well for longer and know how to manage their health in a planned and informed way.

We know we need to give children the best start in life; we will focus on the first 1000 days and work together seamlessly to help parents and children (note: make reference previous section commitment).

We know that heart disease is the single biggest condition where lives can be saved. Therefore, we will focus our joint efforts on heart disease. This condition alone is the top cause of years of lost life in BNSSG. Within our Citizens' Panel self-reported health status, cardiovascular disease is a main contributing factor to disability and poor health. For example, in Bristol, the rate of early deaths from CVD is around 2.6 times higher among people living in the city's most deprived areas, compared to the most affluent areas.

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

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

- **Focus on the care -** We need to relentlessly focus on doing the basics well for adults and children. This will include improvement in core 20plus5 outcomes and a commitment to adopt and implement across the system published high-impact approaches on modifiable risk factors, respiratory disease, diabetes and cardiovascular health. We will set targets higher than national expectations whilst, in parallel, using our research capability to investigate variation in uptake for interventions – starting with our most at-risk groups. In BNSSG, we know that we can further prevent heart attacks and strokes at scale in a short time frame - three years - by optimising the management of high blood pressure. This represents a significant opportunity to reduce acute care, discharge, and social care pressures through reduced strokes. To reach the target of 80% of people with high blood pressure diagnosed, we need to find/record an estimated 37,000 people with high blood pressure across BNSSG. For treatment, around 15,000 additional patients in BNSSG need to be managed to target levels to meet the national ambition of 80% treated to target.

- **Focus on the workforce -** The ICS could start by recognising the more than 45,000 people employed in health and care as 'our first community' and support their health and well-being, including stress and blood pressure, as means to improve their outcomes, create better workforce sustainability and impact of families and communities in our area. We will pull and train the prevention champions from this workforce.

What are our commitments?

We want a system where everyone involved in health and care understands their role within the complex interactions of factors that worsen health and can effectively support the population to live well.
We will form a system-wide prevention and reducing inequalities assurance group to understand and track the changes for person, care and workforce outlined above. It will focus on these four core principles:

Commitment	Short term impact	Medium term impact	Longer term impact
1. Health is everyone's business, and we will aim to develop a social movement led by prevention champions, understanding and addressing what causes the chronic stressors initially described in this chapter. When these improvements are within the gift of the partnership, they are rapidly adopted using an agreed improvement approach.			
2. Doing the basics well means a relentless focus on improvement in Core20Plus5 outcomes for children and adults and a commitment to adopt and implement across the system published high impact approaches that impact on modifiable risk factors for respiratory disease, Type 2 diabetes and cardiovascular disease, (NHS England » NHS Prevention Programme) and continued focus on infection prevention and preparedness for outbreaks of infectious diseases.			

3. Priority prevention for care and health workforce by supporting their health and well-being to help them, their family and their community and maintain high quality of care.			
4. Bespoke action informed by needs and the conversion of insight into action using our joint analytical capabilities across the partnership with a commitment to move human and financial resources to address these needs.			

Key Opportunity 4: Healthy Behaviours

Why is this important?

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

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

Our health-related behaviours and habits are not just about individual lifestyle choices. Healthy behaviours are underpinned by solid building blocks for good health, like family relationships, our communities and environments, good employment, and freedom from poverty and discrimination. Fragile building blocks and chronic stress mean unhealthy habits and behaviours are much more likely.

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

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

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

Smoking is the leading cause of preventable illness and early death, and the biggest driver of the inequality in health between most and least deprived. Smoking accounts for more years of life lost than any other modifiable risk for ill health. Whilst our overall smoking rate is around 13%, about one in three households in some areas of high deprivation include smokers. Bristol has the highest smoking rate in the southwest. Many smokers want to quit, and it may take numerous attempts. We have effective ways of supporting people to quit, but we need to ensure there are no gaps in support pathways and services available to people wanting to stop, and to take every opportunity to ask and offer help. Stop smoking interventions are among the most cost-effective of health services.

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

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

What needs to change?

We need to go further with action to support healthier behaviours, especially stopping smoking, addressing diet and inactivity leading to obesity, and tackling harm from alcohol and drugs. We must develop whole-system integrated approaches, embedding prevention at all opportunities and throughout all stages of an illness or condition, and coordinating this action across all system partners. This will include working with communities to develop different approaches that are relevant to them. Everyone involved with health, well-being and care has a role in supporting our population's well-being.

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

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

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

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

What are our commitments?

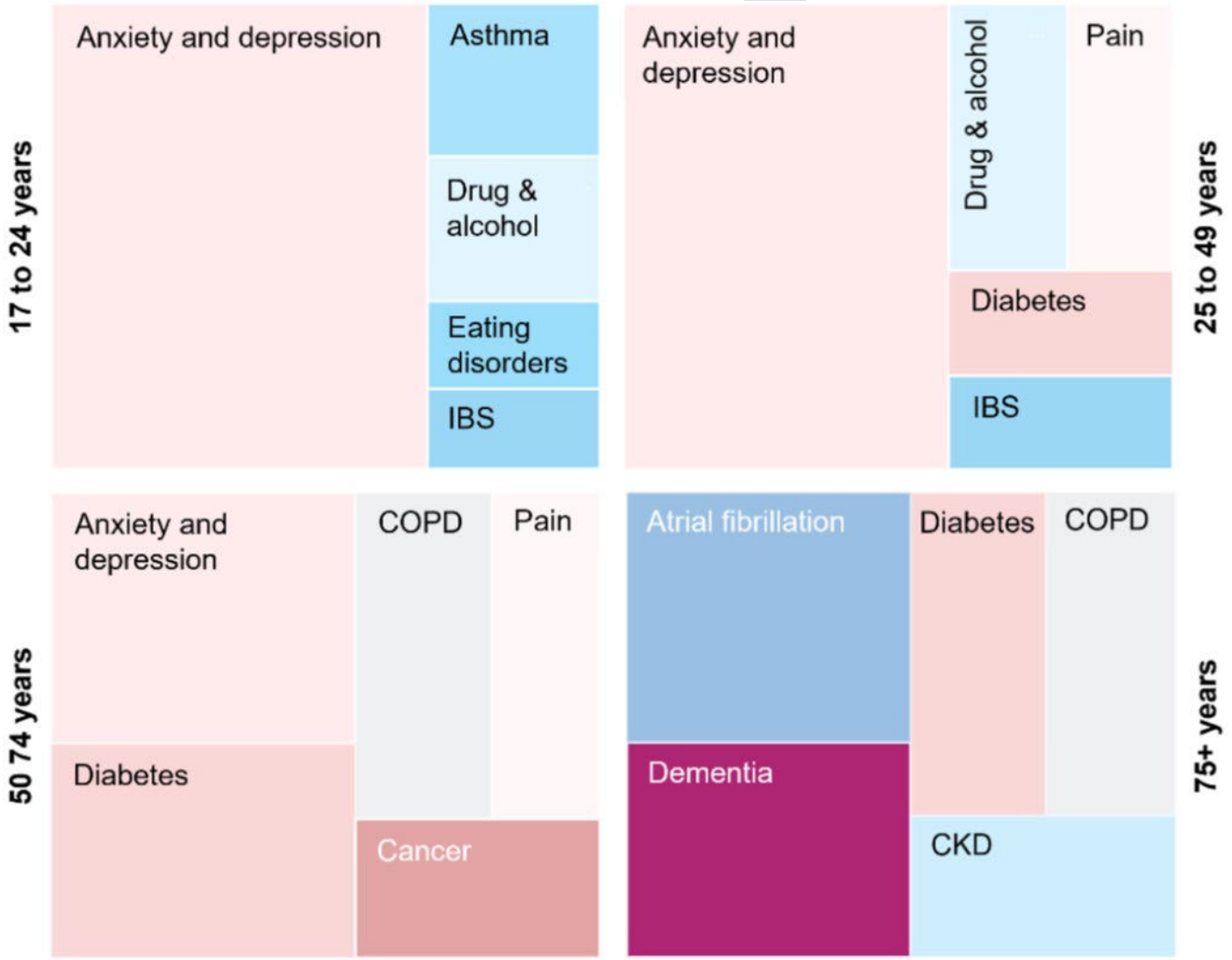
Commitment	Short term impact	Medium term impact	Longer term impact
1. Agree on a financial resource commitment to be explicitly focused on prevention.			
2. Focus early on health and well-being support for our health and care workforce			
3. Develop whole-system programmes for smoking, weight and alcohol/drugs with commitment from all system partners:			

Key Opportunity 5: Strategic prioritisation of key conditions

Why is this important?

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

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



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

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

This area of action around prioritisation will help us to deliver the challenges laid down in opportunities 1-4 above.

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

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

- Anxiety/depression affects adults under 50 the most out of all conditions in BNSSG, followed by alcohol dependency;
- There is a close link between unemployment, debt and mental health – particularly for depression and anxiety (Bungun, T., 2012);
- Suicide is our second most significant cause of years of life lost, after heart disease;
- Self-harm is a particular issue for people living across BNSSG, resulting in significant and rising numbers of emergency hospital admissions. There were 1320 emergency admissions for self-harm in 15-24-year-olds across BNSSG in 2020-21. This accounted for 40% of all emergency self-harm admissions during this period;
- There is an overlap between long term conditions such as diabetes, COPD and heart disease with mental health;

There is growing recognition of the impact of painful conditions/ mental distress. Painful conditions/ mental distress is in the top five most impactful conditions in BNSSG across the life course. More prescribing or faster access to treatment can support this but it is unlikely to resolve the issue completely. Instead, we must work with communities and the VCSE to develop new ways to help people prevent causes, offering psycho-social interventions to improve people's quality of life.

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

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

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

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

We need to:

- Focus on preventing the most impactful conditions and ensuring timely access to treatment/interventions and support when needed across the life course.
- Listen to what our communities have told us about their experiences of living with conditions and co-develop new approaches together.
- Learn from the Voluntary Community and Social Enterprise (VCSE) expertise in this area, enabling us to develop person-centred, asset-based, holistic approaches to support people with multiple needs. We can improve outcomes and experiences for people accessing care and support by joining services.
- We must work with a wide range of stakeholders including people with lived experience, carers, communities, primary and secondary providers, VCSE, local authorities.
- Relentlessly focus on closing the gap in healthy life expectancy between our poorest and wealthiest areas, working with communities and the VCSE. We should also remove disparities in health outcomes and experiences that exist by other characteristics, including gender and ethnicity.

What are our commitments

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

Commitment	Short term impact	Medium term impact	Longer term impact
1. Contribute to the government's development of a major conditions strategy, which focuses on the 6 most impactful conditions for the UK population. Working with our communities we have opportunity to amplify the voices of people with lived experience within this.			

2. Interrogate and make sense of BNSSG most impactful conditions data, Working with communities and a wide range of organisations to further.			
3. Undertake a 'most impactful conditions' analysis for children and young people which identifies opportunities for prevention and improving outcomes.			
4. Develop person-centred and asset-based approaches, with a particular focus on multi-morbidity and working with our communities			
5. Develop a system-wide approach for painful conditions, reducing the impact on health and wellbeing and unplanned service use. We must work with our communities and partners to develop new ways to support people to live well with pain and ensure consistent access to service provision across BNSSG.			
6. Support people with any level of mental illness – wherever they live in BNSSG, and whatever their age and background – to quickly access high-quality and personalised care close to home for improved experience and outcomes.			

How will we deliver our vision?

Prioritisation

We will identify a **smaller number of priority areas** where the best gains can be made by working together. We will do this through our new **Health and Care Improvement Groups** working across the life course. They will address the following:

1. Improving the lives of people in our community
2. Improving the lives of people with mental health, learning disabilities & autism
3. Improving the lives of our children
4. Improving our acute healthcare services

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

We commit to optimising use of the **Better Care Fund** as a mechanism to provide joined-up services across health and social care and to align its focus with this strategy's focus on the shift to proactive, personalised care, supporting the most disadvantaged. The combined value of the funds across Bristol, North Somerset and South Gloucestershire is £xm, providing significant opportunity.

Locality Partnerships

We will **further develop our six Locality Partnerships** as the vehicle to support our **commitment to subsidiarity** – decisions being taken as close to the ground as possible – and to lead delivery. The Locality Partnerships unite NHS, local authority and VCSE as equal partners around local 'neighbourhood' footprints. They use population health intelligence insights to identify and tackle local priorities for communities, aiming to join up services, simplify pathways and support a shift to earlier support and intervention. The Locality Partnerships work closely with the Health and Wellbeing Boards to deliver the Joint Health and Wellbeing Strategies alongside tailoring the ICS-wide pathways and models of care to local needs.

Workforce

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

Every success in health and care depends on people, whether in scientific discovery, innovation, or compassionate care. In order to achieve success through this strategy, prioritising workforce is essential.

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

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

- Engage with staff and volunteers to identify what's needed to empower and support them to deliver this strategy and improve outcomes
- Support staff and volunteers to improve their health and wellbeing
- Increase diversity so that our staff and volunteers are more connected to all of the communities we serve
- Provide a modern employment offer that is inclusive and flexible to support modern working lives
- Improve job satisfaction and increase opportunities for learning and development and career progression.
- Be guided by the voice of our staff and volunteers in determining where we are succeeding and where we still need to improve

Our shared aspiration to move to a more preventative, strengths-based approach that is embedded within localities gives us a great opportunity to capitalise on the untapped potential of the VCSE.

Service delivery and sustainability

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

The Fuller Report published by NHS England in 2022 made a range of recommendations for the improvement of primary care; we commit as a partnership to supporting the implementation of the BNSSG GP Strategy [REF/link] to embed Fuller recommendations, working closely with primary care networks to develop integrated models that support sustainability and resilience, particularly in our most challenged areas where staffing levels are lowest relative to population needs.

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

waiting longer than we would like for planned treatment, to ensure that people who meet an agreed criteria are identified and rapidly offered treatment.

Digital

Using technology effectively will be a key enabler to achieve our system's priorities, facilitating a smoother flow of people and patients around our region's health and care services. We will need to use more digital tools to do this, and a smarter use of patient data. This will create opportunities to enhance peoples' care, empower people to manage their own conditions well and reduce barriers that many people experience in accessing the care they need. Our system's Digital Strategy sets out the ambition to become an 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. To find out more about our Digital strategy please see [weblink]

Financial infrastructure

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

- Working towards an agreed system target for investment in preventative health and care
- Investments to be allocated in alignment with the needs of our populations, following a method of 'proportionate universalism'
- Re-allocation of investments if preventative initiatives are not resulting improved population health, acknowledging that some timescales for impact will be longer than others
- Investment decisions will consider our organisations' role as anchor institutions, including:
    a. Purchasing locally and with social benefit
    b. Using our estate to support communities
    c. Widening access to quality work
    d. Reducing environmental impact

Innovation and research

New technology and innovations must be implemented and scaled to address our health and care challenges, to deliver a new approach towards prevention and personalisation. For example, the use of genomic data is a potentially revolutionary use of patient data to identify risk and create highly personalised and specific patient interventions. In BNSSG we have the advantage of North Bristol Trust hosting the South West Genomics laboratory, alongside the University of Bristol's highly rated Centre for Genomics – this provides an exciting opportunity for Bristol to develop a centre for excellence in research and innovation in this field, which

would benefit thousands of children and adults in terms of reducing the impact of – or preventing entirely –certain predisposed genetic diseases.

To support and facilitate our ambitions, BNSSG will implement an Innovation Hub, in partnership with the West of England Academic Health Science Network in 2023/24 to develop a shared vision and supportive culture for adopting and development of innovation at scale that will support meeting the 4 ICS aims, and our system outcomes. This work will include:

- **Developing innovation mindsets and supporting culture** to facilitate an innovative ICS eco-system, creating a culture of learning from each other of innovative practices that can be shared, adapted and scaled in other settings. Working with local researchers and innovators and providing education and forums for people working across the system to understand the practice and principles of innovation, developing their innovation mindsets
- **Working alongside our Health Care and Improvement Groups to** increase awareness of opportunities coming up for innovation, embedding a process of identifying potential solutions through the Transformation Gateway process. Develop relationships and networks with local and national markets and academic institutions alongside a supportive commercial framework for securing new technologies
- **Harnessing innovation through partnership with our front-line staff** to enable staff to connect and network to innovate and build change. This may also include working with local industries and other statutory services to understand what works well in other contexts, for instance learning from police services to develop innovative recruitment practices for highly skilled data analyst and scientists.

10 ways to focus our efforts

The five opportunities, highlighted in this strategy make a clear case that things need to be different in our Health and Care System. As ICS Partners, we have summarised these as ten commitments that we are making to our population.

Over the length of our Strategy, we will work with the people of BNSSG to turn these into a reality. To help everyone in our system consider how they can support delivery of the things we can do together, we have identified 10 ways we can consistently think and act for better impact. **We will:**

IMPROVING POPULATION HEALTH AND HEALTHCARE

1. **Align everything we do to the outcomes we want.**
   If we are going to make a difference in the health of people in BNSSG, we need to align everything we do with the outcomes we want to achieve. This will help us be confident that we are doing what we set out to achieve.
2. **Demonstrate our system-wide commitment to prevention.**
   Prevention at all levels – primary, secondary and tertiary - has been highlighted as necessary for many years, but we will demonstrate commitment by actively funding prevention and creating prevention champions in every organisation.
3. **Focus on the first 1000 days to give our children the best start**
   The first 1000 days are vital in setting people on the right path for life. Our system will support the Health and Wellbeing Board's ambitions for these early years.

TACKLING UNEQUAL OUTCOMES AND ACCESS

4. **Change how we work to reduce health inequalities actively.**
   As organisational policies and practices are reviewed, partners will identify opportunities to change working practices to remove barriers. We will also proactively review how the system inadvertently increases health inequality so that those things can be changed.
5. **Prioritise the health impacts of poverty and disadvantage.**
   We also need to improve things for people already experiencing the ill effects of poverty and other structural disadvantages. We will use the

Health and Wellbeing Strategies and CORE20+5 framework as a starting point to develop supportive strategies around healthy habits.

ENHANCING PRODUCTIVITY AND VALUE FOR MONEY

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

HELPING THE NHS TO SUPPORT BROADER SOCIAL AND ECONOMIC DEVELOPMENT

9. **Support the economy with our purchasing and employment practices.**
   The partners in BNSSG have a responsibility to use their buying power to support local businesses to put money directly back into the local economy. We will also review how we can use our recruitment to support areas of deprivation, including targeted recruitment and apprenticeship schemes.
10. **Develop a better, healthier environment for people to live in.**
    We must acknowledge the impact of where people live upon their health. We will ensure a 'well-being first' approach to all policies on housing, transport, green space etc. We also support commitments around NetZero to reflect the need to take climate change seriously, including its effect on health.

Strategy on a page – Note placeholder only. This will be adjusted following ICP Board comments

BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE (BNSSG) INTEGRATED CARE SYSTEM

HEALTH AND CARE STRATEGY ON PAGE

5 OPPORTUNITIES

Our analysis of the health and care data in BNSSG has revealed 5 opportunities for improvement:

1. Not everyone has the same opportunity to be healthy. We need to **tackle inequalities.**
2. We can **strengthen the building blocks** of health.
3. Wherever possible, we need to **prevent illness and treat people earlier.**
4. We need to work alongside communities to encourage **healthy behaviours.**
5. And once people are ill, there are **long term conditions** that we could manage better.

OUR COMMITMENTS

To make health and wellbeing in BNSSG better, we will:

- Align everything we do to the outcomes we want
- Demonstrate our system-wide commitment to prevention
- Focus on the first 1,000 days to give children the best start
- Change how we work to actively reduce health inequality
- Prioritise the health impacts of poverty and disadvantage
- Build a workforce who are supported, skilled and healthy
- Focus on the whole person – not just the disease
- Work as equal partners to tackle our biggest problems
- Support the economy with our purchasing and employment
- Develop a better, healthier environment for people to live in

HOW WILL IT FEEL DIFFERENT FOR LOCAL PEOPLE?

- The health and care system working more closely together will make things more straightforward for you
- The health and care system will be more open about our plans and services

WHAT WILL BE THE SAME?

- **Access to good quality health and care.**

HOW WILL IT FEEL DIFFERENT FOR OUR STAFF?

- A modern employment offer with opportunities to work across organisations
- An system that embraces change creating opportunities to grow and develop
- A values driven culture, focussed on empowering staff and helping them succeed

Content/Chapter	Date of feedback	Colleague providing feedback
Foreword	20/05/23	David Wynick
Tackling Inequalities	20/05/23	David Wynick
Strengthening Building blocks	20/05/23	David Wynick
Prevention	20/05/23	David Wynick
Healthy Behaviours	20/05/23	David Wynick
Conditions	20/05/23	David Wynick
10 Commitments	20/05/23	David Wynick
Overarching	23/05/23	Shane Devlin

Overarching	23/05/23	Tina Cantelo
Overarching	23/05/23	Sarah Weld (annotated doc)
Overarching	23/05/23	Becca Dunn (emailed)
Overarching	23/05/23	Paula Clarke

Overarching	23/05/23	Becca Dunn (Strategic)
Overarching	23/05/23	Hayley Verrico
Overarching	23/05/23	Sarah Weld (strategic)
Overarching	23/05/23	Colin
Overarching	23/05/23	Dan Phillips
Overarching	23/05/23	Tim Keen
Overarching	23/05/23	Valerie Clarke
Overarching	23/05/23	Jo Medhurst
Overarching	23/05/23	Chris Head

What is driving our Strategy	24/05/23	Colin
Tackling Inequalities	24/05/23	Colin
Strengthening Building blocks	24/05/23	Colin
Prevention	24/05/23	Colin
Healthy Behaviours	24/05/23	Colin
How we will deliver	24/05/23	Colin

Overarching	25/05/23	Tim Whittlestone
Introduction	25/05/23	Tim Keen
Introduction	25/05/23	Tim Keen

Tackling Inequalities	25/05/23	Tim Keen
Prevention	25/05/23	Tim Keen
Healthy Behaviours	25/05/23	Tim Keen
Overarching	25/05/23	Tim Keen
Overarching	26/05/23	Aileen Edwards
Foreword	26/05/23	Jo Medhurst
Foreword	26/05/23	Colin
Foreword	26/05/23	Clare McInerney
What is driving our Strategy	26/05/23	Jo Medhurst
What is driving our Strategy	26/05/23	Becky Balloch
What is driving our Strategy	26/05/23	Aileen Edwards

What is driving our Strategy	26/05/23	Various
How we will deliver	26/05/23	Various
10 Commitments	26/05/23	Various
Foreword	27/05/23	David Wynick
Prevention	27/05/23	David Wynick
Overarching	01/06/23	ICB Board feedback

Overarching	02/06/23	Simon Davies (OneCare)
Overarching	05/06/23	Bryony Cambell

Overarching	07/06/23	Jo Medhurst

Feedback/Comments
"People in poorer areas are unfairly impacted, and we know that ethnicity, gender or disability has a consequence too." - Massive understatement. Reword and make harder hitting.
Commitment - No.1 Decision making - This feels like an enabler rather than one of the 3 and to note it is not in the above list No.4 Providing resources according to need - add in statement about targeting resources to those most in need and who will benefit the most?
Commitments feel little narrow and don't adequately address wider determinants of health. No.4 working with VCSE - include ACEs
"One of the reasons for this is the constant worry about unstable income, jobs, or housing puts strain on your body, translating into higher blood pressure and an impaired immune system. In addition, chronic stressors, like those described above, lead to an increased risk of illness and contributes to the fact that heart disease is the top cause of lost years in BNSSG." - It's far wider than that as you well know. surely we should explicitly say that deprivation poverty and poor education means people eat unhealthy food, are overweight and smoke, drink and use drugs all too commonly. Those collectively lead to poorer health, disease and early death "Prevention opportunities exist across all ages and communities in BNSSG, but we need to consider the challenge already identified around tackling inequalities. The greatest attention should be focused on those furthest from the better outcomes we would want for our family, ourselves and our community." - I am amazed. How can we have a section on prevention and commitments with ZERO
tobacco, eating a poor diet, being physically inactive, and harmful alcohol use." - Why is this numner 4 and below 3? Smoking - not as the last key opportunity Commitments - No.3 whole system programmes - need far more details and what sorts of
This section is all about prioritisation so it's NOT a key opportunity. This needs a separate heading entitled something like prioritisation of resources to maximally address the 4 key opportunities
No explicit mention of primary or secondary prevention
Firstly, there is a lot to like in the document. The connection between the success of the system and truly improving the health of the population is clear. The focus on primary prevention is right and I'm sure the document will give a good high level strategic direction to system players. However I also have a few thoughts that I hope will help to enhance. 1. There is little reference to digital. Given that all our lives are so entwined with the digital agenda, both personal and organisational, I would have expected to see a strong nod to the potential of digital. Whether that is the potential value of technology enabled care to support independence, the potential of technology in the area of social inclusion, or AI and machine learning. All of which could drive all of the four aims. 2. The strength of the focus on primary prevention is also potentially a bit of a blind spot. The strategy could be seen as being a little imbalanced as there is not a lot of direction with regards to the need to drive excellence in service delivery. I thought it was interesting yesterday to see the Labour parties statement on their vision for Health. There was a lot on secondary prevention but also a real focus on delivering services for our population. I could argue that the best thing we could

What works really well
-It's a really succinct read, with key messages standing out very clearly, supported by strong evidence
-Clearly linking the thinking to the ICS core aims
-Putting patients/ communities front and centre of the strategic focus
-Capturing the commitments clearly and showing the impact timing ie, short, medium, long term
-Calling out a close dependency/relationship to the culture/ behaviour asks (not sure if these are new or existing, read well, but 8 is a lot for folk to remember)

Thoughts re any builds you might want to consider
-Making it very clear what this strategy (the commitments etc) will deliver for key stakeholders - perhaps summarising in one place (ie patients, colleagues etc)
-Something very visual that helps our patients/ communities understand the system and provision available (perhaps aligned to a geographical map etc)
-A clear point of view about strategic workforce to enable delivery of the commitments and further

Foreword - can be strengthened, talk about the journey we've been on to develop this strategy, the importance of partnership working to delivering it. Build on what was said in Strategic Framework rather than rewriting it
Adding a vision in: Our vision 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.
Check accessibility of presenting 4 ICS aims in the boxes as hard to read

The bit in the middle is a bit confused – it says opportunities at the beginning and then it describes them as making a clear case that things need to be different at the end, it is repetitive and the commitments aren't always aligned to the heading e.g. building blocks and staff wellbeing – first commitment in this section but not really the first thing that springs to mind about communities.
I think the middle ought to be more focused on how (strategically) we meet the objectives of the ICS laid out on pages 4 & 5 and this could be a streamlined version of the following, that brings in a lot of what's there already:
-A new approach to improving equity for the people of BNSSG - using the data, not giving everyone the same pair of shoes (great quote!) etc
-Prevention, early intervention and embedding healthy behaviours (?from childhood)
-Looking after people with the most impactful conditions (not forgetting childhood obesity in this section too)
-Maximising the reach of our workforce (better words perhaps – but I mean in terms of keeping them well and exemplar type people, every contact counts type approach – what's our top two things we ask them to flag with every person they meet?!)
-Exploiting digital developments and what new technology can do for the people we serve
There could then be a section on partnership and collaboration being fundamental to delivery – the H&WB Board aspects and join up etc
The 10 commitments could be dropped into the different sections (I haven't tested this works though!) then brought back together at the end.

As general other points:

Sections 3, 4 and 5 had a lot of duplication - looks like we are looking at the same problem and opportunities from a population health perspective through different lenses
Is there a deliberate shift from the life course perspective? No mention of the starting well, living well, ageing well and dying well.
Need to make it clear on audience trying to land on. This needs to mean something to the

What is driving our strategy?
Lots of repetition in middle sections to be reviewed
Language in strengthening building blocks setion not quite right. It speaks of the wider determinants of health and when you read the rest of the narrative, the commitments do not neccessarily fit into that.
Prevention and early intervention and healthy behaviour to be more tightly combined
10 commitments at the end and commitments detailed in document to link up and reflect same language. Review whether they are commitments - check the language

Limited mention of workforce - could do more on workforce, recruitment, retention and career pathways
Add something around the use of information and people not having to tell their story multiple times.
Link up with work Debs El-Sayed is doing on shared information - need to be more ambitious and how we use it?

read in terms of what our intended outcomes are and what we are planning to measure. Does the OF still stand and should we include it?
Make reference in foreword that the document is an iterative process (NHS england reference), reflection strategy and how landed on this.

to achieve it?
Prevention -what it means. We are talking about only primary or primary, secondary or tertiary? If latter, need to be clear on this and provide a high level definition for the public
Consider financial reference - how far do we want to discuss this? What is our strategic position on this given it is a key enabler like workforce.

I would like to see less words and more visuals and photos, could we also add some case studies if v
Health inequalities thought bits missing but as read it came up so perhaps signposting to this – to provide further feedback.
10 commitments to be reviewed, some not clear. Need to be clear on impact.
Pulling out smoking is good. But not in 10 priorities.
Be bolder around looking after ourselves. Need to say looking after staff.
Reference to cancer as a public facing document - link to early diagnosis and screening and addressing this to health inequalities
Review the "unfair" terminology in the Inequalities section discussing disavantages/advantages. We

Good connections to the joint clinical strategy
Link the sense of the anchor in the community coming through, making it about wider role of health and social care. Good move away from crisis in the language
Need to stay aspirational and where the realism comes alongside that. the reality of the service delivery so completely committed to the prevention agenda. Need to reflect on what will be different, in the next 5 years and reference that into the joint forward plan.

Agreement on adding digital reference
Need explicit monitoring of variation and decreasing variation across the services, outcomes and experience
Including GP access to urgent emergency care. Dental access.
How do we build on what we have? Last pages referencing culture and principles, could we give examples for all the work for doing?

There is opportunity to be quite ambitious of work around wider engagement with communities and some of the wider determinants of health. Preventive outcomes - associate economic stuff e.g. NHS Confed guidance and link to assest based community development.

Outcomes - do we want to give any examples? "The pandemic also highlighted specific inequalities that need to be addressed." - This implies that we didn't know about the inequalities before - but we did of course. C19 exacerbated them. is that more what we mean here? Need to be careful that the reader doesn't think inequalities in our system have subsided because covid is receding in the memory. "Structural inequality" - if we're going to use terms like this in a public document we need to explain them. I don't think putting them in inverted commas is enough. "However, recent analysis shows inflation will reduce VCSE income by 25% " - you can have a low productivity sector in a low inflation economy, and vice versa. Not sure what point this is trying to make?
"What needs to change" bullet points - the section above talks about housing and education. Are we confident that this strategy has the reach to influence decisions in this area? If so, how do we demonstrate this?
parts of this introduction repeat things that are in opportunity 1 (eg housing and discrimination) "Poverty and social exclusion are causing more adults in BNSSG to die younger and to spend more years in poor health." - do we provide any detail anywhere about trends in LE and HLE? I think we should as it will help make the case for change. there is a style difference here, in that this section gives "facts and figures" to support the case, whereas the previous section uses prose
"We know we need to give children the best start in life; we will focus on the first 1000 days and work together seamlessly to help parents and children. " - what does that look like? How is it different from what we are doing already? Core20plus5 - this will need explaining for a public audience. Might be better to say what we are doing about the 3 elements of core20plus5 (for adults and children? Core 20 is about the most deprived quintile so they question is what are we doing differently for the 200,000+ people in our system who are in this category. Plus is about local focus (as speaks to the prioritisation issue) and
"Our health-related behaviours and habits are not about individual lifestyle choices" - on one level they kind of are!? The immediately preceding sentence talks about smoking, drinking, eating etc which a member of the public would naturally see as a choice. "However, we must also address the social, cultural and environmental conditions contributing to smoking. " - what does this mean in practice over and above what is already being done on smoking
"We will identify a smaller number of priority areas where the best gains can be made by working together." - but we've just made 21 "commitments" (some with sub headings) in the 5 sections above. Won't this seem anomalous to the reader? "We will work with renewed focus with the Bristol, North Somerset and South Gloucestershire Health and Wellbeing Boards..." - "we will work with" implies that the HWBs are somehow separate

There is rightly an emphasis on inequality/levelling up. The wording feels critical of the recent past and implies that 'we' (for which I took to mean the health system locally) has designed itself to disadvantage some people. I wonder if that is rather harsh? I think that in health we are maturing through data and entering into a conversation about what the data means, and in some aspects, planning targeted intervention. So for me at NBT, our approach to inequality is to further explore and react to data. Example: NBT operates the largest screening business in the south west (breast, cervical etc). We are starting to ask why some folks don't attend screening appointments, we find that practical issues such as language is a fixable problem and are looking at how to ensure our screening invitations are available in 30 languages. The current draft reads rather 'political'?
I can see that some conditions get a special mention but nothing specifically about cancer – we have good, bad and ugly cancer data in BNSSG – we need a cohesive strategic approach from prevention, responsive diagnostics, holistic care and research
I didn't find anything that inspired me. Bristol needs some inspiration be that through research, a tech vision or a centre of excellence. We could be a 'Shelford' system and we need to inspire our people to believe that?
Genomics – Bristol is spoken about as the potential leader for UK Genomics innovation. We have the largest lab, we are gene sequencing infants and we are bidding for cancer genomic vaccine status. We need to be part of that revolution and we will need every aspect of health and care to feel the potential and realise the benefit
Digital – dirty word I know but BNSSG needs a health and care future embedded with democratic technology – I think we all know that but again if I were a funder or a commercial partner I would not want to invest in BNSSG based on the strategy as it stands
Civil responsibility – major employer, massive public estates, influencer, income generator – something that brings together all our players to fulfil an obligation as a civil partner (even if its just a skateboard park or 2)?
Workforce: Kings Fund/Deloitte/NHSE – I think we are all agreed this is the battleground 2023-28. BNSSG has to have a front and centre strategic vision to inspire, train, recruit and retain through existing, pipeline and innovative jobs. I wonder where we collectively feel about training numbers (the strategy must make a statement about doctors in training given the focus of expansion of

services, not just in hospitals, so that everyone can access the care they need. " - Sounds paternalistic - could be balanced with we can better "support people to improve their health and wellbeing" - otherwise sounds like individuals have little influence over their own health and that they will be "done to" by the system. Also reference to "not just hospitals" - why not say this more

services." - Sounds like we are saying the health and care system is responsible for causing disabilities?

Section on unfairly disadvantaged/advatnged bullet points - This is not factually correct - organisations have historically not planned based on race/ethnicity/etc - the opposite is more likely the case, that organisations have planned and made decisions without sufficient understanding of the needs of communities. The wording of this section is quite political/emotive - it could make the same points in more neutral terms. The variation in health and outcomes is for a whole complex range of reasons - including economic, cultural, environmental reasons as well as individual behaviours. We, as a health and care system, need to understand the disadvantages people face in achieving better health outcomes and work with our communities to address those disadvantages.
Unclear what "rectifying historical injustices" means - quite emotive language.
Not sure health equity will eliminate health inequality? The same health outcomes is not always achievable - there will probably always be a gender gap in life expectancy for instance.

the "plus" are in BNSSG - this might be the time to do that? Which marginalised groups are we focussing on?

highest smoking rate in the region. Amongst routine & manual workers Bristol has the 2nd highest smoking rate of the 8 core cities (only Manchester is higher) in England, despite having the lowest

Workforce – could we strengthen what say on caring for our staff – an ambition to be an exemplar system for caring and support our staff with their health and wellbeing – recognising how much sickness they experience and that we need to care for them in order to care for the rest of the population
Cancer – outcomes are good for much of our population but really poor for our most deprived populations – the strategy could say more about how we can improve on this by diagnosing more cancers early and improving screening rates for all our communities.
Data – I think we have some good building blocks on data in terms of PHM but this data is only

"Power to improve lives" - is a good stand out statement but we need more emotional engagement throughout the document. Suggests call out boxes or calls for action - consider comms advice for this.
Collaborative advantage and working together - bring in throughout

Look at re-ordering the foreword, the first sentence comes across negative.
Add in mortality data/a story to connect with the reader. Bring in what we know and how we are acting. Consider linking a positive paragraph between the forword and the introduction

We need to find the balance, not alarm people. Consider bringing in national data and what we are doing locally. Following the power statement and articulating the solution. It will help to have an overarching story to tell through the document highlighting our key message. an ask for editorial group to working through the brief and guiding principle

The ICS vision and statement needs to be upfront and what it means as driver for the strategy.

Points 3 & 4 are much weaker and do not speak well to each other. We need to review and make clear what they are trying to say

Consider removing the pull out boxes with ICS aims - not a good design or colour

Review the VCSE section. Aileen to talk to Chris on how to strengthen this section.

Supporting the health & care system is hinted at but gets lost and needs to be pulled out - linking in with Health & wellbeing and phyiscal and mental wellbeing
Add innovation - working with university and showing economic values and impacts
Bring in digital strategy - but need to consier the inequality element/digital poverty

Need to capture the social change for prevention - addressing the outcomes and how they will change is lacking. Capture the different approaches.
Show not tell - real life examples - addressing outcomes and how they will change, explaining challenges and future.
Reference to medicine and technology advantages/apps to help intervene. Add vaccinations and immunisation

The 2nd half seems disconnected from the 1st half - review flow and language
Review the language of the commitments
Need a clear call out of commitments, talk in terms of what it means "for you"
Need to link back to other chapters to see the golden thread - what good looks like/avatar to tell stories

Consider Culture point - whether it is best placed internally and removed for public facing
"We can create conditions that keep people well and healthy, meaning a reduced reliance on our services" - better to say, need to or aim to. Can imply might not choose to.
"However, we want people who need support and treatment to come forward as early as possible." - It's not just them coming forward - we need to identify and target resources at those who don't know or are unable to ask

"This puts a strain on our bodies which, results in higher blood pressure and an impaired immune system. " - Is there really good hard evidence to support this statement and that it is directly related to the previous sentence?? I very much doubt it. Suggest remove this sentence

Agree need to keep 30th June document brief and high level.
Some of the language could be seen as politically charged.
Statement such as "indifference and inaction by us in the face of need" are problematic. Can we point to examples of where we have been indifferent to need?
We do not mention cancer, and how we benchmark poorly in outcomes for this disease. Strategy needs to talk about this and an aspiration to have top quality and innovative specialist services

Deficit based language – need to turn this on its head to build on strengths
Need more balance description of getting services right in the short term and also looking to long term outcomes. Other ICS's strategies have got a better combination of these two things
Document has 5 opportunities, 4 aims, 10 commitments etc so it gets confusing. Instead, a simple plan on a page would be better to get these sorts of ideas across – esp if document is limited to 10 pages

Document doesn't really tell a story yet and offer compelling vision
Quite paternalistic in tone, lacking the voice of the public
Digital needs to be couched as an enabler – wrapping around the core objectives of the document to enable delivery

Document has lost the patient and population voice. We've spent a lot of time asking people what is important to them, but this doesn't come through
Children, as a specific population group we are focussing on needs to be drawn out

We need to draw out international and national comparisons of outcomes. As well as cancer we are not where we want to be on mental health
Need to be realistic, as we are going to have less money in coming years and workforce will continue to be a challenge

Document too narrowly focussed on primary prevention/ public health. As well as primary prevention, we need to talk about secondary prevention and service delivery (for example, currently

Under Key Opportunity 3: Prevention and Early Intervention, in point four of the 'Our Commitments' table, where we mention moving resources according to need, it would be helpful to include something like 'evidence shows care closer to home leads to better health outcomes'. In the 'What is driving our strategy' section (page 4), we felt there was an unequal emphasis on the negative impact of difficulty accessing primary care. It would be helpful to recognise the impact of long secondary care waiting lists on primary care, as it leads to worsening conditions and demand on PC while patients wait for secondary care. In 'How we will deliver', we feel it would be worth adding a point about digital solutions to enable joined up care and efficiencies There is no mention of estates in the strategy currently. General practice in BNSSG has identified estates as a particular concern, so perhaps this could be referenced in 'How we will deliver' within 'a
Workforce - Under Key Opportunity 3: Prevention and Early Intervention, in point four of the 'Our Commitments' table, where we mention moving resources according to need, it would be helpful to include something like 'evidence shows care closer to home leads to better health outcomes'. Workload - In the 'What is driving our strategy' section (page 4), we felt there was an unequal emphasis on the negative impact of difficulty accessing primary care. It would be helpful to recognise the impact of long secondary care waiting lists on primary care, as it leads to worsening conditions and demand on PC while patients wait for secondary care. - In 'How we will deliver', we feel it would be worth adding a point about digital solutions to enable joined up care and efficiencies Estates - There is no mention of estates in the strategy currently. General practice in BNSSG has identified estates as a particular concern, so perhaps this could be referenced in 'How we will deliver' within 'a modern employment offer' by adding 'the workforce is able to work in fit for purpose estates with up-to-date equipment'. System Representation - Add a reference to the BNSSG GP strategy. It looks like this could best sit on page 3 "This strategy builds on the challenges set out in that document. It sets out our critical opportunities for improvement that we can deliver, together for the population of BNSSG when we work together effectively. It is essential to be aware that improvements happen in our system constantly. We have many important strategies and plans to address key issues, such as how we

Request to add the following somewhere appropriate:

1. Refence to the women's strategy

' in the summer of 2022 there was national strategy written describing improvements in women's health and wellbeing across their life course- Women's Health Strategy for England - GOV.UK (www.gov.uk). The strategy describe how although women live longer they spend more time in ill health than men, tha and how services for women in some places have become fragmented causing issues in access across a whole raft of pathways including contraception and management of symptoms related to the menopause. There is a national expectation that each ICB has one women's hub by end of year 2023/24 and the ICB is now working with system leads to address the needs identified.

2.Health and Care professional leadership

' The ICB as adopted an approach to health and care professional leadership aligned with national guidance .

The agreed framework aligns to NHSE's 5 principles as set out below.

•Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

•Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including people and local communities.

•Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support, and infrastructure to carry out this work.

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Action taken from feedback ***(Chapter author to acknowledge feedback and state steps taken to action feedback - accepted or disregarded/incorporated in different way & explain this decision)***
adjusted slightly but will test wording with ICP Board. ML 07.06
If "…one of the 3..." means 2a, b and c, then the way that decision making is done and who is involved is a marker for valuing all individuals and populations (their ideas, views and opinions) equally. It's also likely to be one way of helping partners to rectify some of the "historical injustices". Black South West Network's response to the House of Commons Commission on Race and Ethnic Disparities call for evidence included "Equity-focused Policymaking – the specific experiences of BAME communities should be reflected in all decision-making processes" in response to the question "Can you suggest othe ways in which racial and ethnic disparities in the UK could be addressed?" . I have added the suggested 'targeting resources' statement to No.4 in the table.
ACE widened to trauma and included. ML 08.06
Can consider reference to this description in other chapters? To show the links? ML 08.06
Addressed in the latest draft. ML 08.06
Have held in same place as a thread from the SNA. Can put in an explaining sentence to reflect the comment. ML 08.06
Included. ML 08.06
Digital reference in how we will deliver around innovation and technology. Need to consider if we have a section on improving current services? Or weave more reference e.g. around JFP picking up that element etc. Agree point about socialising with staff, volunteers, carers, public etc. - time constraints of strategy production but need a comms plan for how to share and receive feedback. Will adjust the HCIG wording. ML 08.06

Agree point about summarising what will be delivered for who - suggest this may come in a follow up set of comms materials to enable staff, public, civic and community engagement. That would include visual and video/animation resources. Workforce section has been strengthened. Digital and data also now referenced. ML 08.06
Adwoa 05/06 - Under 1. it says "These are elements of decision-making and we need to change how these are currently done…". Not sure how to make that clearer? I have added and additonal sentence to give an example / reason. Under 2. it says that we need to chose three principles in order to achieve health equity. I'm not sure how to make it clearer? Will review terms and reference to external glossary/documents where needed. Will also pick up accessbility issues in the final design work. Vision added in the foreword and have tried to say more about journey to this point here and in the introduction. ML 08.06
Acknowledge the editing bits around repitition. Have been adjusting chapter content over time but will improve using ICP Board comments to get comms input on final edit. Have picked up some of those suggestions in the rewording of sections e.g. more on workforce, the HAWB and locality partnerships. Worked examples will be included. Ongoing challenge around how prescriptive we are at this stage - setting direction - with more detail to come through other mechanisms below ICP Board system governance e.g. developing HCIGs, HAWB strategies etc. ML 08.06
Duplication issue picked up above. Will get overall steer from ICP Board on technique and edit accordingly. Life course not deliberately mentioned as concern about too many frameworks/structures within one document. Implicit in some elements but can ask ICP Board about how important this is. ML 08.06

Strategy being driven by needs assessment which identified 5 key opportunities for improvement. These are the things we will work on together. Repetition point picked up above around editing approach. Building blocks has been reviewed by author using feedback. Cross referencing between sections will pick up links for prevention and behaviours which do link. Have changed terminology for 10 commitments at the end to hopefully avoid confusion. ML 08.06
Digital reference is there in how we will deliver. Also more on workforce in new version. Data and intelligence point also picked up in how we will deliver. ML 08.06
Outcomes Framework stands and reference to it as is. Iteration point for strategy made in introduction. ML 08.06
Summary and other versions will be produced e.g. visual, easy read, animation etc. Can provide reference to prevention definitions as needed but not slow down reader in too much detail. Financial/resource shift referenced. ML 08.06
Case studies point picked up. Design needed to improve readability and flow.
Adwoa 05/06 - I think that some of the bits from the other sections might get moved around so once that's done, I can edit the inequalities section to signpost to other sections where relevant. 10 commitments now changed but further specific feedback helpful. Have said more about staff, and picked up smoking as key area for action. Have adjusted some of the wording around inequalities in light of others comments too. ML 08.06
Reality of service delivery challenge been picked up elsewhere. Will check how best to incorporate that into the final version using ICP Board input. ML 08.06
Digital included. Monitoring of variation key challenge for our system wide inequalities and prevention group. Have broaded out from just GP with broader community and primary care references. Examples point well made elsewhere too. ML 08.0
Have tried to set this up through the opportunities and how we will deliver sections. But welcome any more specific comments to make this clearer. ML 08.06

The strategy is an ICP strategy and the assumption is that the work of the ICP can cover / influence policies and actions in relation to housing and education given their impact on population health (as it probably is some some parts of England that may be a bit further ahead in their thinking about this?). Is that assumption incorrect? The commitment that relates to recognising and recitifying historical injustices talks about health equity in all policies which means not just health policies. In terms of the question about how it's demonstrated in the strategy, is it something that needs to be made clearer in the foreword or introduction?
Life expectancy point referenced in the foreword - stalling and/or falling to create urgency. For facts and figure
Translating the ambition into action will fall to the next stage of the strategy e.g. working with HCIGs, HAWBs and Localities to make a reality. May need to reference the how we will implement section or provide an overarching statement in the introduction to show this is the case? ML 08.06
Addressed in the latest draft. ML 08.06
have adjusted text to reflect this. ML 08.06

Adwoa 05/06 - The "Why is this important" bit of the inequalities section tries to explain why we are where we are, i.e. the way we've made decisions, what feedback and information we've decided to act on and what we haven't. It's really important to recognise that we made mistakes in the past and are continuing to make them. Agree that health and other organisations are maturing through data and conversations and that's to be celebrated. Health, education, housing, etc. are political (as referenced in Tim's feedback about including maternity and women's health) and I don't think we can or should shy away from that. Section adjusted slightly so should provide some challenge but frame more constructively. Cancer point raised elsewhere but look for some ICP Board steer on balance between prioritisation and how many things to reference - many important issues, with plans in place. Same for Maternity and women's health strategy. Workforce point has been strengthened as has the role of all partners - service, civic and community. Reference to innovation, research and genomics in the document - how we will deliver. ML 08.06
Adjusted text. ML 07.06
Adjusted text. ML 07.06

Section on unfairly disadvanted/advantaged bullet points - the sentence underneath the bullet points is important "It often shows up as indifference and inaction by us in the face of need". This means that we have sometimes heard and understood the needs of communities experiencing inequalities in access, experience and outcomes but have chosen not to acknowledge it or act or respond. This essentially means that we have planned and made value decisions based on people's characteristics. I agree that the wording of this section is quite political / emotive - that is deliberate. Health, education, housing etc. are political and when we speak to people who have and are experiencing inequalities, or to staff who are witnessing the way it plays out in our services and yet feel unable to change it, we often get an emotional response. Part of the issue that we have is that we often write in a very 'corporate' way which has the effect of communities and our own staff not feeling that we 'get it'. The content of the section is based on, among other things, research conducted by Professor Camara Phyllis Jones. I'd highly recommend watching the talks (https://www.youtube.com/watch?v=yEHXVUiUMtU and https://www.youtube.com/watch?v=lhH2CVKHMTk) that she gave as part of her visiting professorship to King's College Rectifying historical injustices - means we're going to put right the mistakes we've made. Is it the concept that's unclear or the words used? If it's the words, they could be changed to "Recognising and correcting past and present discrimination"? Health equity eliminating health inequality - the common definition of health inequalities says that they are avoidable differences. This infers that we can avoid them by doing different things/doing things differently. Part of doing things differently/doing different things is trying to achieve health equity.
Can reference Core20+5 and provide a brief explanation in next edit. ML 08.06
Addressed in the latest draft. ML 08.06
Workforce point picked up in how we will deliver. Cancer also picked up by others. Data has been included in how we will deliver. ML 08.06
Will pick up best way to 'call out' key messages in final design.
Adjustment made and referenced local analysis. Linking paragraph added. ML 07.06
Has balance in suggesting urgency around real problem but intro now more led by positive, challenges and back to what we are positively going to do.
ICS reference in first section after foreword and intro. Think this works OK. ML 07.06

New paragraph at the start of this section. Aim is to have those show and tell examples through a request to I
Will consider language and flow as part of final edit with expert comms input. Culture point feels like it needs to be acknowledged here as people value how we behave and work to meet their needs together. ML 08.06
Section has been reworded so think these changes have been made void or incorporated into new draft. ML 07.06
Working from the Health Foundation research so can reference that to provide assurance about reason for including. ML 08.06
Some language adjusted for political nuance but needs to be challenging. Indifferent to need picks up on national learning about how systems work. Often about unitentional impacts rather than planned - challenge is around acceptance of that. Cancer also mentioned elsewhere. Edit will review for deficit versus strengths based. Helpful challenge to motivate our system and show positive change to the people we support. Plan on a page will help to clarify the structure and flow of the strategy. Agree this could be clearer. Vision is hopefully the one we already have and the opportunities help us to achieve that? Other more specific input or suggested wording is welcome. There are references to children but can review in final edit again, aim was describe how public/patient voice has got us to this point and how we will prioritise the value of that direction going forward. Comparisons not included in this high level version but will be in supporting documents e.g. outcomes framework for the system and work to deliver the JFP. Aim was for more of simple narrative in the strategy but layer down into the detail. Secondary prevention has been referenced but may need to do more, will pick up under service issues question for ICP Board including choice and waiting lists. ML 08.06

Waiting lists bit has been widened out to more than primary care; can pick up more on the benefits of care close to home. Digital has been included. No estates so far but can consider within final draft, implicit in the social and economic value bit - sharing and making best use of our resources. ML 08.06
Some repitition of the points made above: prevention and early intervention; what is driving our strategy; how we will deliver etc. Have tried to make the reference to community and VCSE more equal partnership but will look to colleagues from that sector to help get the ethos and wording right. ML 08.06

Women's strategy also suggested elsewhere so will pick up. Same with health and care professional leadership points. Have included health and care professional leadership under how we will deliver with a summary of these points. ML 08.06

CP Board and Strategic Network. Have put in references to innovation, digital etc. Suggest more input from ICF

› Board will help to draw out more, especially how the VCSE feel we should describe our approach. ML 08.06

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ICB Chief Executive
ICB Chair
ICP Chair

1 June 2023

Dear

Integrated Care Board Chief Executive / Chair
Integrated Care Partnership Chair

Request for Integrated Care System CQC assessment - pilot volunteers

I am writing to provide an update on CQC's new powers under the Health and Social Care Act 2008 (as amended by the Health and Care Act 2022) to assess Integrated Care Systems (ICSs). For more information, please refer to our recent update.

Assessing Integrated Care Systems is a new duty for CQC. Before we can move to ongoing assessments, we need to complete an initial formal assessment for all ICSs to establish a starting point, or 'baseline'. We therefore expect to start our initial formal assessments from 2024.

From the 1st April 2023 we have been reviewing information to provide a national overview on how ICSs are working to support people to access the care, support and treatment they need, when they need it. This work will also report on how ICSs are responding to inequalities of access across their populations. This is under the quality statement 'Equity in access' and will be included in CQC's 2022/2023 State of Care report as a national overview.
https://content.govdelivery.com/accounts/UKCQC/bulletins/354386a

We have undertaken co-production to develop our interim methodology and, we intend to undertake pilot assessments, initially covering two ICSs between September and December 2023. The pilot assessments are a key activity to make sure our assessments are as effective as possible, to test the full methodology and ensure we can apply it to the wide variety of ICSs across England. We will incorporate any learning into our approach for formal assessments.

We are now seeking ICSs to volunteer be part of the pilot assessments and help to further develop and refine our methods. Pilot ICSs will have the opportunity to have a test run of the assessment process, ahead of a formal assessment.

What will the pilot assessment involve?

We will follow our interim guidance. This guidance explains the process and includes all the types of evidence we will need to gather.

In agreeing to the pilot programme, we will work closely with your ICS to plan, undertake, and report on the assessment while continually gathering feedback and learning to refine our process and methodology. Pilots will be run with the support of Specialist Advisors who currently deliver roles in ICSs and other specialist team members alongside our assessment team. We will be writing to ICSs separately to ask for members who are interested in becoming a Specialist Advisor for assessments. We will also include experts by experience to support gathering views from people who use services, contribute to reviewing the pathways and experiences people have using services, and to ensure our assessment and judgement is person centred.

For each pilot ICS, we will provide a report. The reports from the pilot assessments will be published externally in a single batch at the end of the pilot period. When we publish the reports, we will make clear that assessments are in pilot form and can be used by the ICS to inform improvement and share best practice. We will undertake internal quality assurance and ICSs will be able to check the factual accuracy of the evidence used in the reports to inform our judgements.

CQC are currently awaiting a final decision from the Department for Health and Social Care on whether assessments will include ratings. If asked to include ratings we intend to test a potential rating approach on these pilots, as included in the published interim methodology.

How will we select ICSs for the pilot assessments?

We are now seeking expressions of interest from ICSs who wish to volunteer to take part in the pilot assessments.

Of the ICSs that express interest in being part of the pilot assessments, we will select using the following categories to generate a sample:

- Geographical locations
- Rural Urban classification
- Indices of deprivation
- NHS oversight framework segmentation (1 – 4)
- Consideration of CQC Local Authority Assessment Pilots

To avoid creating unnecessary additional pressures for ICSs and to make sure key people are available during the assessment period of the pilots, we will undertake a review of other regulatory activity taking place between August and December 2023 before we confirm pilot suitability.

If your ICS would like to volunteer for the pilot assessments, **please confirm your interest no later than 21 June 2023.** Please provide the following information:

- Agreement from the Integrated Care Board and Integrated Care Partnership for participation
- ICS point of contact: name, job role and contact information.

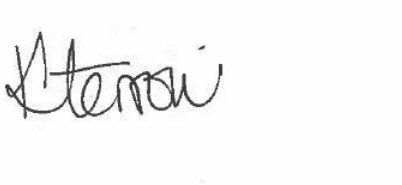
When we have selected ICSs for the pilot, we will contact the named person directly to discuss any queries and to confirm inclusion.

At the start of the assessment process CQC will gather, review, and assess publicly available information and CQC owned information (quantitative and qualitative data). We will gather feedback from people who use and access services, organisations that represent or act on behalf of the public, and key partners and stakeholders of the ICS. CQC will also use identified information from NHS England and Department of Health and Social Care to reduce duplication and provide a consistent approach to judgement. Information required directly from the ICS will be specified and requested in good time ahead of the assessment (we aim to keep this to a minimum). We will work directly with the ICS to decide on the best timings for the fieldwork activity including interviews with key staff and visiting any relevant locations.

Please reply to: CQCintegratedcaresysteminformation@cqc.org.uk

Thank you for your interest and support with this work.

Yours sincerely,



Kate Terroni
Deputy Chief Executive
Care Quality Commission