Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Board Meeting

Date: Thursday 2nd November 2023
Time: 12.00pm
Location: Somerset Hall, The Precinct, Portishead, BS20 6AH

Agenda Number:	11	
Title:	BNSSG ICS Strategy Update	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Discussion and approval		
Key Points for Discussion:		

- Process to agree and define the respective roles and responsibilities between this Board and the Integrated Care Partnership
- Adoption of a set of strategic financial investment principles
- A process to a agree a first round of Strategic Priorities for the system
- Development of a Community Health Worker model for BNSSG

Recommendations:	That the ICB Board: 1. **Approve** the approach set out in Section 2 to develop an agreed set of roles and responsibilities with the Integrated Care Partnership 2. **Adopt** as a first set of principles the investment approach described in Section 3 and Appendix 2 – to be refined in practice 3. **Approve** (subject to the agreement of Recommendation 2 above) the amendment of the Board's covering paper template to ask each author to explain how their proposal relates to the Board's Strategic Investment Principles 4. **Approve** the development of the system's first round of strategic priorities using the approach laid out in Section 4, to

	be implemented through the new system architecture and monitored through the Strategic Delivery Dashboard 5. **Note** the work to develop a proposal regarding a VCSE led Community Health Worker programme across BNSSG
Previously Considered By and feedback:	• BNSSG Strategic Network – 9th October 2023 • ICP Board – 5th October 2023
Management of Declared Interest:	No potential or actual Conflicts of Interests have been identified in the preparation of this paper.
Risk and Assurance:	There is a risk that the revised running cost envelope that is required of every ICB will mean that staff supporting the delivery of the strategy will be diverted/ distracted – both in transition and within the new permanent structure. Mitigations include the fact that delivery of the strategy is one of the key design principles that are guiding the process to readjust the ICB as an organisation to a new running cost budget.
Financial / Resource Implications:	A set of strategic investment principles that have been developed by NHS and LA Directors of Finance are contained in Section 2 of the main paper.
Legal, Policy and Regulatory Requirements:	Our Strategy references NHS England and national policy requirements (e.g. Core 20 Plus 5). No additional legal requirements have been identified so far.
How does this reduce Health Inequalities:	The ICS Strategy focuses on delivering the 4 aims of the ICS, which include tackling inequalities in outcomes, experience and access to healthcare, with an initial focus on the 9 shared commitments identified in the recently published ICS strategy.
How does this impact on Equality & diversity	Identifying, understanding and addressing the drivers of health inequalities within our diverse population is a fundamental reason as to why the ICS Strategy has been developed.
Patient and Public Involvement:	An ongoing and comprehensive programme of patient, public and staff involvement is key to the proposed approach to implementing and iterating the BNSSG Strategy.
Communications and Engagement:	The programme will continue to engage extensively with staff, system partners, patients and carers, stakeholders and community representatives.
Author(s):	Colin Bradbury, ICB Director of Strategy, Partnerships and Population Ros Cox, ICB Associate Director (Partnerships)
Sponsoring Director	Colin Bradbury

Agenda item: 11

Report title: BNSSG ICS Strategy Update

1. Background

Following the publication of the first edition of the BNSSG Integrated Care Strategy in the summer, this paper gives an update on the work to develop and implement the key themes and objectives contained within the document.

2. ICP and ICB Board roles and responsibilities

Like the ICB Board, the BNSSG Integrated Care Partnership (ICP) was established via the 2022 Health and Social Care Act. Chaired by the three BNSSG Health and Wellbeing Board Chairs on a rotational basis, the ICP Board consists of members drawn from across our Integrated Care System including Local Authorities, Lived Expertise, Social Care, Voluntary, Community & Social Enterprises (VCSE) and Health.

The core purpose of an ICP Board, as set out in national guidance, is to develop, agree and publish an Integrated Care Strategy. In BNSSG this objective was delivered in June of this year. ICP members have now turned their attention to the role and function of the Board going forward. As a first step, it is proposed that members of the ICP and ICB Boards come together to define and agree respective roles and functions. From that point, other key groups within our system operating model, such as Health and Wellbeing Boards, Integrated Locality Partnerships and Health and Care Improvement Groups can be included in this developmental process[1].

The Local Government Association (LGA) has been engaged to facilitate the first meeting, with a potential date for a "Board to Board" having been identified as 11th January 2024. The purpose of this session will be to set out the two Boards' respective roles; based on the high-level distinction of the ICP setting the "what" in terms of ICS strategy, and the ICB Board attending to the "how" in terms of its delivery. We can take this opportunity to agree how formal processes could be set up to ensure that the 2 groups keep each other informed and coordinate their respective work and complement each other's objectives of meeting the ICS 4 aims and the objectives of the ICS Strategy.

3. Financial Investment Principles

The ICS Strategy commits us as a system to "working towards a greater proportion of our system's investment going into preventative health and social care". To that end, the ICB Board commissioned a piece of work to develop a set of system wide principles to support this objective. Senior LA and NHS finance officers have developed a set of investment principles that are included in **Appendix 2**, which the Board is invited to adopt.

[1] A strategic development and delivery cycle, set out in **Appendix 1** has been produced on the back of an ICP away day held in July 2023.

Assuming that the Board is content to adopt these as a first set of principles, the covering paper template for Board reports (such as the one used on pp1-2 of this document) will be amended to include a new category of "ICS Strategic Investment Principles", with guidance for authors that asks them to "explain how this proposal relates to the ICS strategic investment principles". This is to enable the Board to scrutinise each proposal as to whether the investment principles have been considered and addressed.

4. Setting our Strategic Priorities

Leading up to the publication of the first edition of the Integrated Care System Strategy in the summer, there was a widespread consensus amongst system partners that it would make sense to prioritise a small number of strategic priorities for the system to collectively tackle at any one time. The Strategy made progress in this area, ultimately identifying 9 "commitments" which are listed below for reference:

1. Invest in the first 1,001 days of life
2. Early identification and support for people experiencing anxiety and depression
3. Support people to be a healthy weight
4. Reducing harm from tobacco
5. Reduce harm from drugs and alcohol
6. Improved prevention, detection and treatment of cancer
7. Tackle cardiovascular disease (CVD)
8. Better support for people with painful conditions
9. Support for older people towards end of life

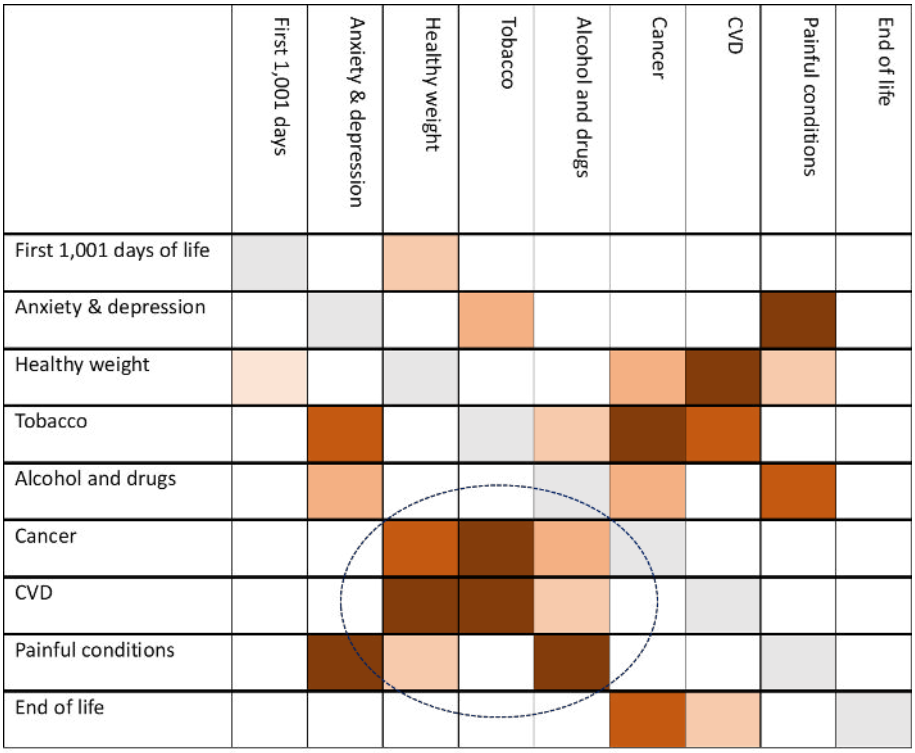
The ICS Strategy goes on to say that "we will identify a number of priority areas where the best gains can be made by working together. We will do this through our new Health and Care Improvement Groups (HCIGs), working across the life course." As the ICS Strategy is framed as a 5-year plan, it makes sense to concentrate on a subset of these Commitments at any one time. This will give system partners greater bandwidth by focussing on a limited number of delivery objectives at any given point.

Agreeing the need to prioritise raises the question as to how we might select the order in which we address the 9 Commitments. Attempts to develop an arithmetical scoring/ weighting system to identify a first wave of priorities has proved challenging. Chief amongst the reasons for this may be the fact that there is no common currency to use when making comparisons (e.g. how do you weight the benefit of interventions in the first 1,001 days of life compared to the harm from the misuse of alcohol and drugs?).

Secondly, our system needs assessment - *Our Future Health* – identified the phenomenon of *clustering.* This is where multiple health conditions often are found concentrated amongst the same individuals and communities, therefore driving and compounding health inequalities.

Thinking about our strategy, there are some of the 9 Commitments that have stronger associations with one another. **Figure 1** attempts to map the clustering effect. The darker the squares, the stronger the association between any two conditions in question, and the potential impact on the population.

Figure 1: clustering of need



For illustrative purposes only

From this exercise - and taking into account levels of performance, benchmarking with other systems and trend/ trajectory - it is possible to build an argument for focusing on a subset of Commitment in the first instance, as set out in **Table 1** below.

Table 1: potential first wave of Commitment Priorities

Suggested Priority	Rationale
Tackle cardiovascular disease	Heart Disease alone is the top cause of years of life lost in BNSSG. Analysis shows a significant opportunity to prevent strokes and heart attacks in BNSSG within the next 3 years. Further, the targeting of CVD will also encompass significant aspects of some of the other 9 Strategic Commitments (e.g. obesity and tobacco).

Suggested Priority	Rationale
Better support for people with painful conditions	Chronic pain is the second most impactful condition for our population according to the Cambridge Index analysis completed for *Our Future Health*. Of all the 9 Strategic Commitments, it is the area on which the least analysis and service development work has been done. Consequently, provision is the most underdeveloped in proportion to the condition's prevalence/ impact.
Support for older people towards the end of life	We know that for the average person, their need for health and care services rises markedly as they age and approach the end of their life. Our Future Health shows that the demographic group in BNSSG that will have by far the biggest proportional expansion between now and 2040 is the over 75's. The End of Life Care Programme Board have cited analysis that estimates that by 2040 the number of people reaching the end of their life expectancy in BNSSG will have increased by 44% from a baseline taken in 2021.
First 1,001 days	This is perhaps the widest ranging of the 9 Commitments. Therefore, there are a number of areas to consider as to where collectively we might concentrate first. Potential options include focusing on improving vaccination rates amongst the under 5's, mental health support in schools and addressing the rate of secondary care dental extractions in the under 5's (for which BNSSG is recorded as an outlier).

It is proposed that the process outlined in Section 2.1, 2.2 and 2.3 in the governance diagram in **Appendix 1**, is used to develop and agree our first wave of Strategic Priorities. Meanwhile, a Strategic Delivery Dashboard is in development which will allow tracking of progress against the priorities once agreed and the relevant HCIGs are taking the work forward.

5. Delivery against our Strategic Priorities

Once we have set our first wave of Strategic Priorities, drawn from the 9 Commitments (as outlined in Section 4 above), there is a question as to what we will do differently and additionally as a system to deliver them. Our ICS Strategy recognises that one way to do this is by, "investing more in our local communities, we can create better opportunities to build and maintain good health and wellbeing. The voluntary and community sector organisations are well placed to reach into communities of place and interest as well as providing community support before people's health deteriorates."

In June 2023, the ICB Board received a paper that built on this idea, identifying an opportunity to, "develop and embed a new team of VCSE employed peripatetic anticipatory care workers within integrated neighbourhood teams. These workers could seamlessly straddle health and social care to deliver services in communities, hospitals and homes".

New, recurrent funds have been allocated for Anticipatory Care and Health Inequalities to the ICB's Director of Integrated and Primary Care and Chief Medical Officer respectively. It is proposed that part of these new funds will – from 1st April 2024 onwards - be allocated to the recruitment, training and development of a Community Health Worker model, led by the Integrated Locality Partnerships, and coordinated under the umbrella of the new VCSE Alliance.

The idea of Community Health Workers (CHW) is based on a model first developed in Brazil during a rapid expansion of community-led health and care support services in that country in the 1990's[2]. It has been adapted and adopted in a number of areas across the UK, and the Academic Health Science Network (AHSN) has funded a pilot in the Weston locality. This project focusses on supporting and improving outcomes for Core20PLUS5 communities at increased risk of cardiovascular disease in two practices in one of the most deprived areas of BNSSG. Cardiovascular disease was chosen by the AHSN because there is peer reviewed evidence that this service delivery model is effective in reducing mortality and morbidity for this condition.

In essence, the CHW model - in coordination with primary care services - recruits people locally to provide a universal, comprehensive, and integrated geography-based outreach in communities experiencing high levels of health inequality. Figure 2 below summarises the model as it has been applied elsewhere.

Figure 2 – CHW model

The CHW model seeks to overcome the challenges experienced by people suffering from health inequalities by supporting them with health and social care system navigation, monitoring chronic disease and identifying new symptoms. They would also promote screening opportunities and preventative measures, as a key component is monthly home visits to every household in a CHW's catchment area.

[2] Britnell, In Search of the Perfect Health System. 2015

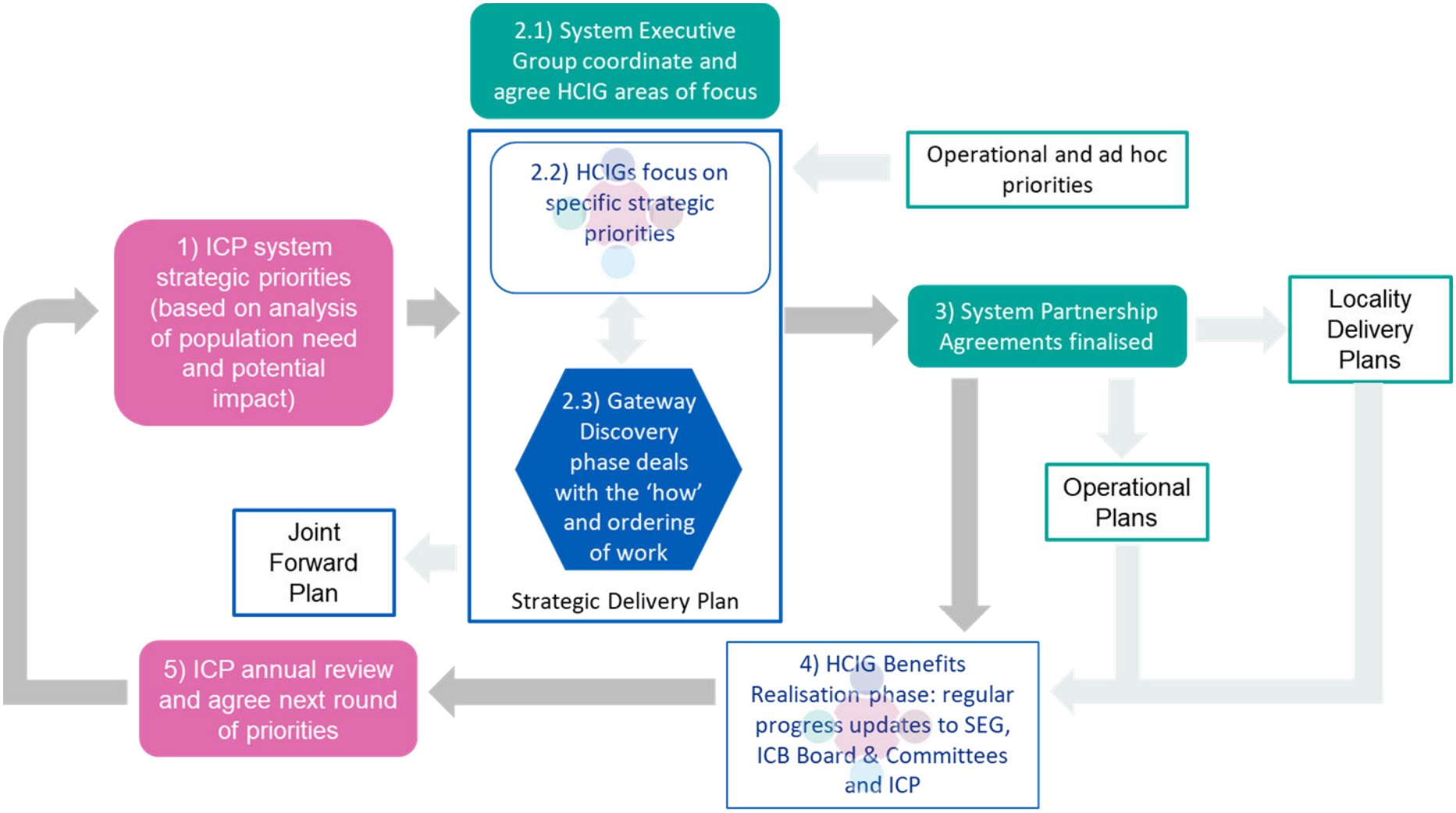
As a next step, it is proposed that a CHW model for BNSSG, drawing on the Anticipatory and Inequalities funding mentioned above, is developed. This work would be coordinated and shaped by our Integrated Locality Partnerships, guided by the following specification:

- VCSE Alliance managed, employing people locally recruited people living in the area they serve
- Targeted within areas of highest need, identified by Locality Partnerships using Population Health Management data
- Linked in with primary care and existing locality/ PCN roles such as the Additional Roles Reimbursement Scheme
- Service codesigned with local people
- Central recruitment and training programme, with locality driven implementation
- Build on AHSN pilot underway on the Weston locality
- Learning from other areas that have implemented this approach (e.g. London, North Wales and Cornwall)

6. Appendices

Appendix 1 – High level governance process for implementing and iterating the ICS Strategy
Appendix 2 – Strategic Investment Principles

Appendix 1 – high level governance process for implementing and iterating the ICS Strategy



Appendix 2 – Strategic Investment Principles

1. ICS Funding proposals will be assessed against four scales:
    a) Population targeted vs population wide.
    b) Inpatient/ residential vs community (Home First)
    c) Prevention vs reactive care
    d) Ensuring the right contact is had at the right time - Digital where appropriate vs additional face to face capacity

2. Investment decisions will focus on 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 opportunities both as large employers in the area and targeting recruitment in areas where health inequalities exist.
    d) Reducing environmental impact

3. Investment will focus on the small number of system strategic priorities that will be overseen by the Health & Care Improvement Groups of which Local authorities form a part.

4. Resources will be provided at a scale and intensity commensurate with need, through the method of "proportionate universalism". An assessment of any decision's impact on the system Core20plus5 population groups will be routinely considered across the ICB.

5. Reducing inequalities is central to all we do. We will continue to view this as everyone's business

6. Investment in anticipatory and preventative initiatives will be reallocated if the measurable outcomes agreed are not delivered (i.e. agility to "fail quickly" – noting that some timescales for interventions will be longer than others)

7. These principles will be included in Board and Committee Paper templates to consider how we can invest to deliver the strategic aims as a system. Each proposal to set out how it will satisfy one or more of the strategic investment requirements described above. This will apply to both revenue and capital investment decisions.

8. Investment decisions can still be made that do not satisfy any of the above requirements, but we should be clear on the reasons why, when we are diverging from our agreed strategic investment priorities.

9. The ICS will achieve a balanced budget across all the ICS organisations.

Specifically, the NHS organisations collectively will:

    a) Achieve in year financial balance in each year incl n/r savings
    b) Achieve recurrent financial balance within 3-5yrs

c) Maintain 0.5% uncommitted contingency
d) Aim for recurrent cash releasing savings of no more than 3% in any given year
e) Initially set aside up to 1% of ICB allocation for investment in anticipatory and prevention, as per latest MTFP and 23/24 budget
f) % of ICB allocation on Non-Acute Services will increase compared to Acute (as a proxy for Prevention vs Reactive Care)
g) Learning Disability budgets will grow in line with Mental Health Investment Standard (MHIS) target for Mental Health

Local Authorities will work in partnership to support the ICB to achieve these aims wherever possible.

ENDS