Contact: Leo Taylor
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Date: Wednesday, 5 July 2023

Dear Sir or Madam

The Health Overview and Scrutiny Panel – Thursday, 13 July 2023, 2.00 pm – New Council Chamber - Town Hall

A meeting of the Health Overview and Scrutiny Panel will take place as indicated above.

The agenda is set out overleaf.

Yours faithfully

Assistant Director Legal & Governance and Monitoring Officer

To: Members of the Health Overview and Scrutiny Panel

Councillors:

Helen Thornton (Chairperson), Marc Aplin, Jemma Coles, Stuart Davies, Wendy Griggs, Ian Parker, Timothy Snaden, Joe Tristram.

This document and associated papers can be made available in a different format on request.

Agenda

1. Election of the Vice-Chairperson for the 2023/24 Municipal Year

2. Public Discussion (Standing Order SSO9)

To receive and hear any person who wishes to address the Panel on matters which affect the District and fall within the remit of the Panel. The Chairman will select the order of the matters to be heard. Members of the Panel may ask questions of the member of the public and a dialogue between the parties can be undertaken.

Requests to speak must be submitted in writing to the Head of Legal and Democratic Services, or the officer mentioned at the top of this agenda letter, by noon on the day before.

3. Apologies for absence and notification of substitutes

4. Declaration of Disclosable Pecuniary Interest (Standing Order 37)

A Member must declare any disclosable pecuniary interest where it relates to any matter being considered at the meeting. A declaration of a disclosable pecuniary interest should indicate the interest and the agenda item to which it relates. A Member is not permitted to participate in this agenda item by law and should immediately leave the meeting before the start of any debate.

If the Member leaves the Chamber in respect of a declaration, he or she should ensure that the Chairman is aware of this before he or she leaves to enable their exit from the meeting to be recorded in the minutes in accordance with Standing Order 37.

5. Minutes (Pages 5 - 8) (Pages 5 - 10)

Minutes of the Panel meeting held on 16 February 2023 – to approve as a correct record.

6. Matters referred by Council, The Executive, other Committees and Panels (if any)

7. Co-option of the Chairman of Healthwatch (Pages 11 - 12)

8. Role, Remit and Work Plan of the Health Overview and Scrutiny Panel (Pages 13 - 40)

9. Integrated Care Strategy (Pages 41 - 86)

10. Update on Weston General Hospital UHBW (Pages 87 - 90)

11. Recommissioning of the BNSSG Integrated Sexual Health Service (Pages 91 - 132)

Exempt Items

Should the Health Overview and Scrutiny Panel wish to consider a matter as an Exempt Item, the following resolution should be passed -

"(1) That the press, public, and officers not required by the Members, the Chief Executive or the Director, to remain during the exempt session, be excluded from the meeting during consideration of the following item of business on the ground that its consideration will involve the disclosure of exempt information as defined in Section 100I of the Local Government Act 1972."

Also, if appropriate, the following resolution should be passed –

"(2) That members of the Council who are not members of the Health Overview and Scrutiny Panel be invited to remain."

Mobile phones and other mobile devices

All persons attending the meeting are requested to ensure that these devices are switched to silent mode. The chairman may approve an exception to this request in special circumstances.

Filming and recording of meetings

The proceedings of this meeting may be recorded for broadcasting purposes.

Anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chairman. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting, focusing only on those actively participating in the meeting and having regard to the wishes of any members of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chairman or the Assistant Director Legal & Governance and Monitoring Officer's representative before the start of the meeting so that all those present may be made aware that it is happening.

Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting.

Emergency Evacuation Procedure

On hearing the alarm – (a continuous two tone siren)

Leave the room by the nearest exit door. Ensure that windows are closed.

Last person out to close the door.

Do not stop to collect personal belongings.

Do not use the lifts.

Follow the green and white exit signs and make your way to the assembly point.

Do not re-enter the building until authorised to do so by the Fire Authority.

Go to Assembly Point C – Outside the offices formerly occupied by Stephen & Co

Minutes

of the Meeting of the

Health Overview and Scrutiny Panel
Thursday, 16 February 2023

held in the Town Hall, Weston-super-Mare

Meeting Commenced: 14:00 Meeting Concluded: 16:42

Councillors:

P Ciaran Cronnelly (Chairman)
P Caroline Cherry (Vice Chairman)
Marc Aplin
P Andy Cole
A Hugh Gregor
P Karin Haverson
A Sandra Hearne
A Ruth Jacobs
P Huw James
P Ian Parker
P Timothy Snaden
P Roz Willis

Co-opted Member: P Georgie Bigg (Healthwatch)

P: Present
A: Apologies for absence submitted

Health colleagues in attendance:

Dr Cummings (Pier Health Group); Caroline Dawe (BNSSG ICB); Dr Christopher Chubb (Pier Health Group); Sebastian Habibi (BNSSG ICB); Tim James (BNSSG ICB); Kelly Smith (Pier Health Group); Becky Vallen (BNSSG ICB); Dan Wright (Pier Health Group).

North Somerset Council officers in attendance: Matt Lenny (Public Health); Rebecca Stathers (Public Health); Leo Taylor and Liz Godfrey-Day (Corporate Services).

HEA 9 **Declaration of disclosable pecuniary interest (Standing Order 37) (Agenda Item 3)**

None.

HEA 10 **Minutes (Agenda Item 4)**

Resolved: that the minutes of the meeting held on 13 October 2022 be approved as a correct record.

HEA 12 **Winter Planning 2022-23 (Agenda Item 7)**

[Items 7 and 8 were taken early in order to enable **Agenda item 6** to be taken later on the agenda].

The Deputy Director of Commissioning, BNSSG Integrated Care Board (ICB) gave a presentation updating Members on progress in the delivery of Winter 2022/23 planning and early lessons. This included updates on the following:

- tranches of funding;
- the Winter Board Assurance Framework;
- North Somerset Adult Social Care Discharge funding update;
- industrial action; and
- next steps.

In reviewing the information, Members sought and received clarification on the following:

- discharge funding for step down care and the reference to "additional spot purchase beds remaining open … with no care coordination";
- the potential to involve GPs in allocating care;
- addressing challenges around domiciliary care provision;
- progress on "call 111" early triage initiatives (Clinical Assessment Service).

In closing discussions, the Chairman recognised the considerable difficulties faced by health and social care services and whilst the initiatives discussed above would make a difference, the challenge was considerable and on-going.

Concluded: that the report be received.

HEA 13 ICB Estates and Graham Road Surgery Relocation (Agenda Item 8)

[This item was taken out of sequence]

The Estates Manager, BNSSG ICB gave a presentation outlining:

- the ICB Estates Management Plan, providing a broad overview of the national and local contexts and an update on NHS estates plans for the North Somerset area; and
- the Graham Road GP Surgery Relocation: Engagement and Consultation - Providing background details of the project, overview of the consultation and engagement plan, the engagement activities undertaken, feedback received from participants and next steps.

Members received for following responses to issues and concerns raised:

(1) New Parklands Surgery capacity – assurance was given that the new surgery would have sufficient capacity to accommodate proposed new housing development in the area but it was noted that there would need to be a prior consultative process if additional housing were to be proposed in the Local Plan currently under development with NSC.
(2) Capacity at proposed new surgery at the Rugby Club – assurance was also given that the capacity at the new site was sufficient to take on Graham Road patients and he also gave definitive assurance that there were no plans to close the nearby Horizon health centre. It was emphasised that this was a key asset for the local Bourneville community/

There was discussion about the acknowledged challenges around pedestrian and public transport access to the new site but notwithstanding these enduring concerns, Members acknowledged the urgent need to improve the quality and capacity of GP services in Weston-super-Mare, noting that provision in the town was recognised as being the least sufficient in the BNSSG area. Members therefore welcomed and endorsed the outlined public engagement plans for the proposed new surgery.

Concluded:
(1) that the report be received; and
(2) that the engagement activities undertaken in relation to the Graham Road GP Surgery Relocation project be endorsed.

HEA 14 Developing an Integrated Care Strategy for Bristol, North Somerset and South Gloucestershire (Agenda Item 6)

[This item was taken out of sequence.]

The Programme Director, BNSSG ICB gave a presentation updating Members on the cross-system efforts and progress to date in developing a system wide Integrated Care Strategy (ICS). The presentation focussed on:

- the purpose of the strategy;
- the current position;
- the delivery timeline; and
- a summary of the BNSSG Strategic Framework

Members noted the development of the BNSSG Outcomes Framework (as a means of measuring ICS delivery and the requirement that the ICB produce and consult on a Joint Forward Plan (JFP). It was suggested that the Panel may wish review to this plan annually.

In considering the Strategic Framework (to who how the system will plan to deliver strategic aims) Members provided the following feedback:

- areas of need emerging from the analysis: end of life care – Members felt there needed to be greater emphasis on the need for support for “informal” carers (family/friends);
- System Outcomes framework: ENV21 – more emphasis was needed on business engagement and the significant potential for positively influencing employees and contribution to enhancing the natural environment;
- the need to develop qualitative measures of the strategy’s impact on people’s health and wellbeing experience; and
- active travel and its contribution to improving public health and addressing climate emergency needed greater emphasis.

In bringing the discussion to an end it was agreed that the developing Integrated Care Strategy would be considered by all scrutiny panels when the process converged towards identifying key priorities.

Concluded: that the report be received and that Members feedback be provided in the form of the minutes.

HEA 15 Mental Health Strategy (Agenda Item 9)

The Director of Public Health presented the report highlighting how key findings from the adults and children and young people (CYP) mental health needs assessments and engagement activities were shaping emerging priorities to be addressed in the Mental Health Strategy.

The strategy would have a five-year timeline (2023-2028) and would be oriented around overarching themes of (i) Prevention, (ii) Early Intervention, and (iii) Supported and Living Well, to map to the overarching themes of the Health and Wellbeing Strategy 2021-2024.

In discussion Members commented and raised queries as follows:

(1) A national approach was needed to address impact of social and mainstream media on children's mental health – the Director confirmed that the Council was lobbying the Government on various related issues but there was much that was being done at local level to support parents.
(2) Youth services had provided a useful and positive support in the area but many of these had been closed – The Director acknowledged the impacts of ongoing budget challenges but emphasised the opportunities around leveraging and supporting community and third sector initiatives.

Concluded: that the report be received and that Members feedback be provided in the form of the minutes.

HEA 16 Physical Activity Strategy for North Somerset (Agenda Item 10)

The Physical Activity and Healthy Lifestyles Manager presented the report highlighting the current position with the development of the Physical Activity Strategy. The strategy would demonstrate how the Council and partners can contribute to improving the health and wellbeing of North Somerset residents and reduce health inequalities through increasing physical activity.

Members sought and received clarification on the following aspects of the strategy:

- encouraging organised activity with more focus on active travel to school
- the numbers of housebound people and carers in the district and work being done to encourage them to be more active; and
- work with Age UK and other partners on pulling together resources for older people

Concluded: that the report be received, and that Members feedback be provided in the form of the minutes.

HEA 17 HOSP Work Plan February 23 (Agenda Item 11)

In reviewing the Panel's workplan, the Chairman updated Members on progress with the implementation of Healthy Weston phase 2 – noting that both workstreams set out in Section 1 of the work plan were now complete and would be removed from the Plan.

Members then considered the appendix to the work plan setting out the Chair's recommended priorities (as set out in the report to Council on 21 February 2023) for the HOSP Panel that would be reconstituted with the new Council administration following the forthcoming election.

Concluded:

(1) that the work plan be received and updated accordingly; and

(2) that the following recommended work plan priorities for the new HOSP Panel (formed after the forthcoming elections) be endorsed:-

- **Priority 1**: Ensuring that North Somerset residents see the benefits of the new Integrated Care System and this is truly collaborative across all partners.
- **Priority 2:** Access to dentist across North Somerset needs to vastly improve and with the Integrated Care System taking on greater responsibility for this locally it offers an opportunity to influence. Working with Bristol and South Gloucestershire Councils via the Joint Health Overview Scrutiny Committee will be important.
- **Priority 3:** Weston General Hospital has made significant improvements in recent months following their latest CQC report. Continue to work closely with the Trust to ensure continued improvement in patient outcomes.
- **Priority 4:** Monitor the Healthy Weston 2 programme and whether this has delivered the benefits envisaged and influence the next stages of the strategy.
- **Priority 5:** Hospital discharge remains a challenge, so work closely with the Adult Services and Housing Policy Scrutiny Panel to provide assurance and scrutiny that steps are being taken to address this.
- **Priority 6:** The Joint Health and Wellbeing Strategy is relatively new across North Somerset and has the potential to reduce health inequalities across North Somerset, but it will only be effective if all partners fully embrace and commit to it. So engage with the Joint Health and Wellbeing Strategy Board, and use the Health Overview and Scrutiny Panel to support this.

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Chairman

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North Somerset Council

REPORT TO THE HEALTH OVERVIEW AND SCRUTINY PANEL

DATE OF MEETING: 13 JULY 2023

SUBJECT OF REPORT: CO-OPTION OF THE CHAIRMAN OF HEALTHWATCH

TOWN OR PARISH: N/A

OFFICER/MEMBER PRESENTING: LEO TAYLOR, POLICY AND SCRUTINY MANAGER

KEY DECISION: NO

RECOMMENDATION

That the Health Overview and Scrutiny Panel (HOSP) co-opt the Chairman of HealthWatch North Somerset, Georgie Bigg, as a non-voting member of the Panel.

1. SUMMARY OF REPORT

The Chairman of Healthwatch North Somerset was co-opted as a non-voting member of the HOSP Panel under the previous administration in September 2019.

2. POLICY

Draft Guidance from the Local Government Association to accompany new Local Authority Public Health, Health & Wellbeing Boards and Health Scrutiny regulations (which came into force on 1st April 2013) emphasises the importance of closer working between local authority scrutiny committees and HealthWatch.

3. DETAILS

Healthwatch is the independent national champion for people who use health and social care services. There is a local Healthwatch in every area of England looking to find out what people like about services and what could be improved. Nationally and locally, Healthwatch has the power to ensure that those in charge of health and social care "hear people's voices" as well as seeking the public's views and encouraging health and social care services to involve people in decisions that affect them.

Considering the statutory role of Healthwatch in respect of health and adult social care services and the wider trend toward increasing integration between health and social care service planning and provision, it is proposed that the Panel formally co-opt the Chairman of the Healthwatch organisation serving North Somerset.

Section 21(10) of the Local Government Act 2000 provides that overview and scrutiny committees (panels) may co-opt non-voting members.

4. CONSULTATION

None

5. FINANCIAL IMPLICATIONS

N/A

6. LEGAL POWERS AND IMPLICATIONS

N/A

7. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

N/A

8. RISK MANAGEMENT

N/A

9. EQUALITY IMPLICATIONS

N/A

10. OPTIONS CONSIDERED

N/A

AUTHOR

Leo Taylor, Policy and Scrutiny Manager
Tel: 01934 634621

BACKGROUND PAPERS

Draft LGA Guidance to accompany new Local Authority Public Health, Health & Wellbeing Boards and Health Scrutiny regulations

Local Government Act 2000

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North Somerset Council

Report to the Health Overview and Scrutiny Panel

Date of Meeting: 13 July 2023

Subject of Report: Role, Remit and Work Plan of the Health Overview and Scrutiny Panel

Town or Parish: All

Officer/Member Presenting: Policy and Scrutiny Manager

Key Decision: NO

Reason:
It does not meet the criteria for a key decision.

Recommendations
That the Panel:-

1. Receive the contents of the report and information provided on policy and scrutiny.
2. Develop and agree the Panel's Work Plan.

1. Summary of Report

1.1 The details of the role, remit and work plan of the Panel are discussed below.

1.2 Members will have this opportunity to begin the process of developing the Plan going forward.

2. Policy

2.1 A copy of the Corporate Plan 2020-24 can be found by following this link: https://n-somerset.gov.uk/sites/default/files/2022-03/corporate%20plan%202020-24.pdf This sets out the priorities and vision of North Somerset Council. Most reviews undertaken by this Panel contribute towards the council's corporate aim of being an open and enabling organisation.

3. Details

3.1 Members are referred to **Appendix 1** for an overview of the policy and scrutiny function and how it currently operates at North Somerset Council. At the panel meeting, Members will develop and agree the Panel's work plan. Effective work planning will lay the foundations for targeted, incisive, and timely work on issues of local importance, where scrutiny can add value. Members are referred to **Appendix 2** for guidance on developing the work plan. **Appendix 3** sets out the current work plan template and **Appendix 4** sets out current government guidance on the principles and powers underpinning Health Overview and Scrutiny Panels.

3.2 The remit of the Health Overview and Scrutiny Panel (as defined in the Council's Constitution): -

- National Health Service (NHS)
- Wider Health Issues apart from NHS – health promotion, addressing health inequalities, impact of local and national initiatives (drugs and alcohol, hospitals, mental health, primary care etc.)
- Public Health issues for both adults and children
- Regulatory services
- Emergency planning
- Public Health directorate finance and performance

3.3 Health Overview and Scrutiny Panel (HOSP) statutory role and powers (as set out in recent Government guidance - see below).

- review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services;
- require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny;
- require employees, including non-executive directors of certain NHS bodies, to attend before them to answer questions;
- make reports and recommendations to certain NHS bodies and expect a response within 28 days;
- set up joint health scrutiny and overview committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority;
- have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals [ie significant proposed changes to NHS services];
- have a mechanism in place to deal with referrals made by local Healthwatch organisations or local Healthwatch contractors; and
- report disputed reconfiguration proposals to the Secretary of State until the new reconfiguration provisions take effect

Further information about these powers in the wider context of recent Government guidance on evolving Health Overview and Scrutiny committee principles can be found in the Department of Health & Social Care document at appendix 4

3.3 The Panel's Work Plan summarises the activity that the Panel plans to undertake in its consideration of issues of significant public concern, areas of poor performance and areas where Members think the Council could provide better value for money. The work plan is a "live" document and is subject to change as priorities or circumstances change.

The Panel meets formally three times a year but its Work Plan is informed and supported by a range of on-going "informal" activity undertaken by Panel members - including task and finish working groups and briefings. See Appendices 1 and 2 for further information.

3.5 The Work Plan is reviewed at every formal meeting for review and update.

3.6 At its last meeting before the recent election, the Health Overview and Scrutiny Panel made a number of work plan priority recommendations for consideration by the new Panel that would replace it in the new Council administration. These are as follows:

- **Priority 1**: Ensuring that North Somerset residents see the benefits of the new Integrated Care System and this is truly collaborative across all partners.
- **Priority 2:** Access to dentist across North Somerset needs to vastly improve and with the Integrated Care System taking on greater responsibility for this locally it offers an opportunity to influence. Working with Bristol and South Gloucestershire Councils via the Joint Health Overview Scrutiny Committee will be important.
- **Priority 3:** Weston General Hospital has made significant improvements in recent months following their latest CQC report. Continue to work closely with the Trust to ensure continued improvement in patient outcomes.
- **Priority 4:** Monitor the Healthy Weston 2 programme and whether this has delivered the benefits envisaged and influence the next stages of the strategy.
- **Priority 5:** Hospital discharge remains a challenge, so work closely with the Adult Services and Housing Policy Scrutiny Panel to provide assurance and scrutiny that steps are being taken to address this.
- **Priority 6:** The Joint Health and Wellbeing Strategy is relatively new across North Somerset and has the potential to reduce health inequalities across North Somerset, but it will only be effective if all partners fully embrace and commit to it. So engage with the Joint Health and Wellbeing Strategy Board, and use the Health Overview and Scrutiny Panel to support this.

4. Consultation

Members will agree the Panel's work plan, taking into account any views that local constituents have expressed to them. Officers are encouraged to contribute their ideas, and the Panel is cognisant of the work being undertaken by the relevant Executive Members.

5. Financial Implications

There are no direct financial implications arising from this report. In undertaking future work, the Panel may make recommendations that have financial implications for the council.

6. Legal Powers and Implications

N/A

7. Climate Change and Environmental Implications

N/A

8. Risk Management

Risk assessments would be undertaken in respect of any future work.

9. Equality Implications

The work of the Panel is based on the council's commitment to ensure that the consideration of equality and diversity becomes a day-to-day part of decision-making to bring about positive changes that are felt by services users and employees.

10. Corporate Implications

Corporate implications would be dependent on the outcome of individual reviews.

11. Options Considered

N/A

Author:

Leo Taylor
Tel: 01934 634621
Policy and Scrutiny Senior Officer

Appendices:

Appendix 1: The Policy and Scrutiny Function
Appendix 2: Panel Work Planning guidance
Appendix 3: (attached separately) The Panel's Work Plan template June 2023
Appendix 4: Health Overview and Scrutiny Principles - Government guidance issued in 2022 (attached separately)

Background Papers:

North Somerset Corporate Plan 2020-24 (see link above).

Appendix 1

The Policy and Scrutiny Function

Policy and scrutiny is an essential part of ensuring that decision makers remain effective and accountable. It helps in ensuring that the Executive's decision-making process is clear and accessible to the public and that there are opportunities for the public and their representatives to influence and improve council policy and services.

Policy – examining the council's aims and priorities and considering whether or not they are being achieved. This provides a vital means of ensuring all councillors can take part in the development of council policy.

Scrutiny – questioning and challenging major decisions that are being made about delivering services in order to help drive improvement. This is the main democratic means of ensuring that the council and its partners are held to account for decisions made.

FOUR PRINCIPLES OF GOOD SCRUTINY:

1. Provides "critical friend" challenge to executives as well as external authorities and agencies.
2. Reflects the voice and concerns of the public and its communities.
3. Should take the lead and own the scrutiny process on behalf of the public.
4. Should make an impact on the delivery of public services.

[Centre for Governance and Scrutiny Good Scrutiny Guide]

WAYS OF WORKING:

- Formal work: Panel meetings (three meetings per year) – held in-person and in public to review issues and make recommendations.
- Informal work– a significant amount of Panel work will be done informally (typically – though not exclusively held virtually). This includes:
- Task and finish working groups - meetings involve small groups of Councillors who have been appointed by the Panel to investigate a given issue before reporting back to the Panel with recommendations for improvement or value for money. Topics are agreed and prioritised with the Chairman, taking account of officer resource to ensure capacity;

- Steering Groups – ongoing monitoring and policy development. These can be organised and progressed by identified lead members in direct consultation with the relevant directorate officer/team;
- Site visits / public consultation;
- Workshops – usually ad hoc sessions to receive information on a service or issue of concern to Members;
- Call-in – a formal challenge of a decision made by the Executive or Executive Member, undertaken at a panel meeting where the decision will be examined and recommendations sent back to the Executive or Executive Member; and
- Informal briefings or information sent to Members – can be done at any time in order to ensure that Members are aware of changes to services and are best placed to undertake meaningful debate and make informed recommendations.

Appendix 2

Work Planning Guidance

The work plan is a flexible document that is updated at each meeting to reflect progress and new developments.

Scrutiny is most effective when focusing on a limited number of in-depth topics, so it is important to prioritise suggestions put forward. When identifying topics to add to the work plan, the Panel should ask the following questions:

- Have Members or Officers identified the topic as a key issue for the public?
- Is it an area of poor performance?
- Has the topic been identified as a strategic risk?
- Is there new government guidance or legislation that will require a significant change to services?
- Has the external auditor or other inspection body highlighted concerns about the issue?
- Could scrutiny lead to increased value for money?
- Is there potential for policy development?
- Will the outcome make a difference?

Once topics have been chosen, brief terms of reference should be agreed at the panel meeting to address the basic questions of:

- What does the topic include?
- Why should the Panel consider?
- How should the Panel proceed? (such as working group, workshop, site visit, informal briefing, item for agenda)
- Who should be involved? (agree appropriate Members, Officers and witnesses)
- Timescale

Appendix 3

Current Panel Work Plan (template) – June 2024

The current work plan template is attached separately with the agenda papers.

Appendix 4

Health overview and scrutiny committee principles - this Government Guidance is attached separately with the agenda paper.

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Health Overview Policy and Scrutiny Panel
Work Plan July 2023

(to be updated following each Panel meeting)

The Panel will consider issues of significant public concern, areas of poor performance, and areas where Members think the Council could provide better value for money. This is a "live" document and will evolve as priorities or circumstances change.

SECTION ONE – ACTIVE & SCHEDULED projects identified in the overarching Strategic Work Plan

Topic	Reason for scrutiny	Method of scrutiny and reporting process	Timeline	Progress	Lead
Healthy Weston Phase 2	Statutory: to consider proposed service changes; determine potential "Substantial Variation" in service; and consider options for further engagement/consultation if appropriate	Preliminary briefings followed by substantial variation determination at full Panel on 20/04/22	Preliminary Briefing 25/03/22 Report to full Panel on 20/04/22. engagement plans at 23/06/22 panel Report to 13/10/22 Panel: engagement outcomes	See timeline	

SECTION TWO – proposed task and finish projects (listed in priority order). These must be agreed at Panel for inclusion within the Scrutiny Work Plan:-

Topic	Reason for scrutiny	Proposed method of scrutiny & reporting process	Timeline	Lead

SECTION THREE – planned briefings, workshops, and informal Panel meetings. Outcomes may, with Chairman's agreement, generate Panel agenda items (for inclusion in S4 below) or, with Panel agreement, escalation to S2 above:-

Topic	Reason for Scrutiny engagement	Date	Outcome	Progress
~~**Health and Wellbeing Strategy**~~ ~~HOSP-led all Member briefing~~	~~To brief Members on the development of the strategy vision and public consultation process~~	~~06/04/21~~	~~Progress reports to future HOSP meetings~~	Completed
~~**Track and Trace**~~ ~~All Member Briefing~~	~~Reference from full Council~~	~~07/07/21~~	~~Members' engagement~~	Completed
~~**Minors Programme and AWP Patient reconfiguration**~~	~~Sirona and AWP briefed Members on plans to reduce the numbers of patients dealt with at ED (Minors Programme): and the relocation of Mental Heath Services from Southmead to Callington Road~~	~~22/02/22~~	~~Members' engagement~~	Completed

~~**Quality Accounts 2022 (QAs)**~~	~~HOSP is a statutory consultee. QAs provide Members with opportunities to engage with providers on service performance and priorities going forwards~~	~~Various~~	~~To respond to QAs as appropriate~~	Completed
~~**Integrated Care System All Councillor Briefing**~~	~~Update on implementation of ICS and implications of the Government white paper/legislation.~~	~~05/10/22~~	~~Members' engagement~~	Completed
~~**Children and Young People Mental Health Needs Assessment**~~	~~Joint briefing for HOSP and CYPS – for Members' feedback on needs assessment findings~~	~~07/02/23~~	Members' engagement	Completed

SECTION FOUR - agenda reports to the Panel meetings as agreed by the Chairman. This section provides for the forward planning of agendas for the coming year and a record of recent panel meeting activity. Item outcomes may include proposing further work such as additional briefings or potential projects for inclusion on the STRATEGIC WORK PLAN (S2 above).

Item	Purpose	Outcome
HOSP: 13 July 2023		
Work Plan		
Dentistry update	~~To engage with and feedback on the development of plans to address issues around access to Dentistry services in the area~~	Item Withdrawn – to be rescheduled as panel briefing and formal progress report to October HOSP
ICB Integrated Care Strategy	To engage with and feedback on progress towards developing the strategy	
Update on Weston General Hospital UHBW	To receive and feedback on progress (including CQC inspection and Healthy Weston 2)	
Sexual Health Services Recommissioning	To receive with and feedback on recommissioning plans	
HOSP: 12 October 2023		
Dentistry update		
HOSP: 14 March 2024		

SECTION 5 - Recommendations - Response from Executive Member

Area for investigation/ Recommendations	When were the recommendations to the Executive agreed?	**Expect answer by** (first panel meeting after recommendations were submitted)

SECTION 6 - Progress and follow-up on implementing Panel recommendations

Panel Recommendation	Date of Response	Actions – implementation progress

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GOV.UK

Department of Health & Social Care

Guidance

Health overview and scrutiny committee principles

Published 29 July 2022

Applies to England

This publication is available at https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

Purpose of this document

In advance of the statutory guidance on the Secretary of State's new powers in relation to service reconfigurations, this document sets out the expectations of the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities.

HOSCs, local authorities, ICBs, ICPs and other NHS bodies should use this document to ensure that scrutiny and oversight are a core part of how ICBs and ICPs operate. Leaders from across health and social care should use these principles to understand the importance of oversight and scrutiny in creating better outcomes for patients and service users and ensure that they are accountable to local communities.

Further information on the role of health scrutiny can be found in the Local authority health scrutiny: guidance to support local authorities and their partners to deliver effective health scrutiny (https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services).

Integrated care systems

The Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) builds on the work of existing non-statutory integrated care systems (ICSs) to encourage more integrated system working, and to improve local population health outcomes through the planning and provision of services.

The act also provides for the creation of new NHS bodies, ICBs, and for each ICB and its partner local authorities to form a joint committee to be known as the ICP.

42 ICBs will be established, and the 106 existing clinical commissioning groups (CCGs) will be abolished. The ICB will take on the commissioning functions of the CCG and have a governance model that reflects the need for integration and collaboration across the system.

Each ICP will have, as a statutory minimum, a representative from the ICB and a representative from each of the partner local authorities. It may decide locally to include a broad range of representatives in its membership – including those from the independent and voluntary, community and social enterprise (VCSE) sector – concerned with improving the care, health and wellbeing of the local population. The ICP will be tasked with developing an integrated care strategy to address the health, social care and public health needs of its system. The ICB and local authorities will have to have regard to that strategy when exercising their functions. It is important to note that ICPs, as a joint committee between the ICB and partner local authorities as well as other members agreed by the ICP locally will be within the scope of HOSCs.

There will be a continuing role for HOSCs, health and wellbeing boards (HWBs) and the local Healthwatch as their roles are protected and preserved in the new system.

HOSCs will continue to play a vital role as the body responsible for scrutinising health services for their local area. They will retain their legal duties to review and scrutinise matters relating to the planning, provision and operation of the health service in the area. As is currently the situation, some local authority areas may have separate scrutiny committees for health and for adult social care. ICBs and ICPs should develop a trusting relationship with HOSCs to enable effective scrutiny.

HWBs will continue to bring together leaders at a place level to develop joint strategic needs assessments and prepare joint local health and wellbeing strategies for their local area. HOSCs should consider these strategies when scrutinising outcomes for their local area.

Local Healthwatch organisations will retain their statutory duty to obtain the views of people about their needs and experience of local health and social care services and will need to continue working with HOSCs to make these views known.

The benefits of scrutiny

Proactive and constructive scrutiny of health, care and public health services, done effectively, can build constructive relationships that deliver better outcomes for local people and communities; the people who represent them, and the commissioners and providers of health and care services. It also has other benefits including:

• providing an opportunity for local people and their elected representatives to contribute to and comment on the local priorities for improving health and care services and outcomes

• giving a voice to local people and communities on the quality, safety, accessibility and effectiveness of local health and care services

• assuring local elected members and the public that health and care services are safe and effective, address local health priorities and reduce health inequalities

• helping health and care providers and commissioners gain insight into the health needs and concerns of particular groups

• enabling health and care providers and commissioners to develop new services and care pathways to address local health priorities more effectively

While the procedures of review and scrutiny are at the discretion of the local authority, we recommend that each individual HOSC develops a framework to help them ensure that their scrutiny work is effective, focused and adds value. While this will be

informed by other partners in the system, the assessment of risks, effects and impacts should be the HOSC's own. In particular, we recommend that a framework should consider:

• risks, effects and impacts to individual populations

• risks, effects and impacts to the whole local population

• support and input from local health colleagues

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Responsibilities

HOSCs, HWBs, local Healthwatch and NHS bodies collectively have a role to play in good governance and accountability across the health and care system.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (https://www.legislation.gov.uk/uksi/2013/218/contents/made) will continue to apply although the formal statutory route for local authorities to report to the Secretary of State will be removed when the new reconfiguration provisions in the Health and Care Act 2022 take effect.

Local authorities

Local authorities will retain the power to:

• review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local

health services

• require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny

• require employees, including non-executive directors of certain NHS bodies, to attend before them to answer questions

• make reports and recommendations to certain NHS bodies and expect a response within 28 days

• set up joint health scrutiny and overview committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority

• have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals

• have a mechanism in place to deal with referrals made by local Healthwatch organisations or local Healthwatch contractors

• report disputed reconfiguration proposals to the Secretary of State until the new reconfiguration provisions take effect

NHS bodies

NHS bodies will retain the power to:

• provide information about the planning, provision and operation of health services as reasonably required, depending on the subject by local authorities to enable them to carry out health scrutiny

• attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny

• consult on any proposed substantial developments or variations in the provision of the health service

• respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, local authorities and joint health scrutiny committees or sub-committees

Health and wellbeing boards

HWBs will retain the power to:

• provide assessments of the current and future health and care needs of the local population

• develop joint strategic needs assessments

• develop joint local health and wellbeing strategies at a place level

Local Healthwatch

Local Healthwatch organisations will retain the power to:

• obtain the views of people about their needs and experience of local health and social care services, and to make these views known to those involved in the commissioning and scrutiny of care services

• make reports and make recommendations about how those services could or should be improved

• promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services

The design of new models of integrated care and support that are being introduced through the Health and Care Act 2022 will inevitably lead to changes in how and where services are provided.

HOSCs will have an invaluable role to play during the initial transition and implementation of ICBs and ICPs, and beyond, in scrutinising the impact and effectiveness of integration on health services and outcomes. Under this new structure, there will be a need for scrutiny of health services and outcomes at a local place-based level, as well as more strategic scrutiny of health services and system-level outcomes. Both levels of scrutiny are important; HOSCs should maintain an appropriate balance between the 2, and establish joint health overview and scrutiny committees (JHOSCs) where appropriate and necessary. Individual local authorities hold responsibility for carrying out scrutiny tests.

Scrutiny can play a valuable role in improving the evidence base for decisions about integration and in holding local authorities, NHS bodies, and health service providers to account for the level of local ambition to improve health and integrate services in ways that benefit people who use services and in the interests of taxpayers. It can

also help to ensure that the views of people in an area are fully reflected in the consideration of any proposals.

Principles and ways of working

The following 5 principles set out best practice for ways of working between HOSCs, ICBs, ICPs and other local system partners to ensure the benefits of scrutiny are realised and should form the basis of ongoing discussions between these partners about how they will work together.

The 5 principles are:

- outcome focused
- balanced
- inclusive
- collaborative
- evidence informed

1. Outcome focused

Outcome-focused scrutiny can provide a valuable and relevant platform for looking at cross-cutting issues, including:

- general health improvement
- wellbeing

- specific treatment services and care pathways
- patient safety and experience
- overall value for money

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working and in making recommendations on how it could be improved locally.

By focusing on outcomes, ICPs, ICBs, local political leaders, professionals and communities can explore and consider the complexities of health and wellbeing and help to evaluate the planning, delivery and reconfiguration of health and care services. A strategic approach should be taken to consider how best to apply scrutiny to evaluating key strategies and outcomes of the ICB and ICP, including the integrated care strategy and the ICB joint 5-year forward plan.

Within the wider ICB area, HOSCs will have a valuable role to play in scrutinising and evaluating place-based outcomes at local authority level. HWBs will continue to develop joint strategic needs assessments and establish joint local health and wellbeing strategies; HOSCs will continue to scrutinise place-based health services in relation to these.

However, HOSCs will also play a valuable role in scrutinising the health services of the wider ICB area and should work with other local authority areas, forming JHOSCs where appropriate, to scrutinise outcomes against the joint 5-year forward plan and the integrated care strategy.

2. Balanced

Good scrutiny needs to maintain balance between being future focused and responsive. When scrutiny is future focused it can help system partners to understand

how local needs are changing, as well as understand the issues that communities face and suggest and test solutions. Future-focused scrutiny can also add value to integration planning and implementation by improving the evidence base for holding local decision makers to account for the level of local ambition to integrate services and improve population health.

ICBs and ICPs should take an inclusive and future-focused approach to agreeing a clear set of arrangements for scrutiny to be built into the whole cycle of planning, commissioning, delivery and evaluation. Leaders from across health and social care should work with openness and candour to establish a clear shared set of priorities and a future work programme to improve health and social care outcomes.

Scrutiny also needs to be reactive and responsive to issues of concern to local communities, including service performance and proposed NHS reconfigurations, local authorities, and other system partners, should ensure that HOSCs have the capacity to respond reactively to public concerns and reconfigurations. ICBs can assist with this by working with HOSCs to shape their forward plans. ICBs should take a proactive approach to sharing at an early stage any proposals on reconfigurations, drawing a distinction between informal discussions and formal consultations. ICBs should also take a proactive approach to involving relevant bodies on any other matters which system partners expect to be contentious, to help navigate complex or politically challenging changes to local services.

With regard to concerns about service performance, ICBs should be open and transparent with HOSCs, bearing in mind that in some cases there may be legal or assurance proceedings. Equally, HOSCs must appreciate the need for regulatory and legal processes to run their course, but ICBs should update HOSCs on the progress of these processes.

3. Inclusive

The primary aims of health scrutiny are to strengthen the voice of local people and provide local accountability. They should ensure that local people's needs and experiences are considered as an integral part of the commissioning and delivery of health services, and that those services are effective and safe. Effective scrutiny allows for more inclusive public conversation than might be delivered as part of a formal consultation exercise. As such, it is important for scrutiny to engage the community, involving the right people at the right time in the right place.

HOSCs are a fundamental way for democratically elected local councillors to voice the views of their constituents, hold the whole system and relevant NHS bodies and relevant health service providers to account and ensure that NHS priorities are focused on the greatest local health concerns and challenges. Flexible and accessible arrangements to scrutinise integration issues provide the best opportunities for councillors to hear from people and groups with whom they may not have previously had much contact, for example primary care practitioners or people who use services. HOSCs, subject to time and resource constraints, may be well placed to engage with members of the public directly.

Systems and NHS bodies should form trusting working relationships with HOSCs, and work together to ensure that this important community intelligence is fed directly into system-wide decision making. Engaging with scrutiny is a way for ICBs and ICPs to add richness to their understanding of local need, and a way to connect strategic planning at system level to the nuances of local pressures and requirements.

4. Collaborative

Work plans that detail the future decisions and issues to be scrutinised by HOSCs should be informed by communities, providers and planners of health and care services to ensure that scrutiny is focused on achieving the most value for its population. Effective health scrutiny requires clarity at a local level about respective

roles between the health overview and scrutiny committees, ICBs, ICPs, the NHS, local authorities, HWBs and local Healthwatch.

Service change and integration are typically not challenges that are confined to one local authority's area; these are issues that can straddle one or more local authority population. Under the new system-level structures, health scrutiny may increasingly need to cover issues that cut across local authority boundaries. Therefore, local authorities on ICB boundaries, and neighbouring councils within an ICB area should take a collaborative approach in order to identify any strategic issues that would benefit from joint scrutiny. Under Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities must appoint a joint health overview and scrutiny committee where a relevant NHS body or health service provider consults more than one local authority health scrutiny function about substantial reconfiguration proposals; however local authorities also have the discretion to set up joint committees in other circumstances.

The role of JHOSCs is particularly important in assessing strategic issues that cover 2 or more local authority areas, and will be even more important under the new arrangements as ICB areas will span more than one local authority area in most cases. In particular, JHOSCs will have a strategic role to play in scrutinising the delivery and outcomes of the integrated care strategy.

It is important for ICBs, councils and scrutiny committees to develop joint protocols in advance of the need for any joint scrutiny arrangements, whether these arise under legislation or are optional arrangements. This includes having a clear view about how councils should work together, the structure of joint arrangements, and the time needed to establish these arrangements. JHOSCs will also need to recognise and take into account the potential difficulties of working together, particularly around the political balance between different local areas, as well as resourcing. Developing this shared understanding helps build the foundations for effective joint working. ICBs should have an active role in providing support in these situations and should recognise the complexity and time involved in establishing formal JHOSCs.

5. Evidence informed

Scrutiny informed by evidence can help make the case for better integration of services, better joint working around service improvements and better approaches to major service reconfigurations. Scrutiny adds value to decision making by ensuring that evidence is sound and based on the right insight, so that no voice is unheard or evidence overlooked. The types of evidence that aid effective scrutiny include evidence on quality and safety of services and evidence on population health needs. Qualitative evidence from those with lived experience – including patients, the public and those who are most likely to be excluded from services – are particularly valuable forms of evidence for aiding scrutiny.

Health scrutiny has a role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service locally and in testing this information by drawing on different sources of intelligence. Local Healthwatch are an important source of evidence and should work with HOSCs to pass on the views of people about their needs and experience of local health and social care services.

HOSCs can request evidence from systems and NHS bodies, and should ensure that their requests for evidence are reasonable, proportionate and relevant.

The health system has a responsibility to provide information needed for health scrutiny. Health and care providers and commissioners should respond positively and constructively to the requests for information from HOSCs. Where an NHS body cannot provide a response to a request for information, it should work with the HOSC to attempt to provide information and support where possible. ICBs should have plans and protocols in place for sharing information for the purpose of scrutiny, as this will avoid the need for continual ad-hoc decision-making when information is requested.

Next steps

The Health and Care Act 2022 introduces a power for the Secretary of State to call in and take decisions on or connected to reconfiguration proposals at any stage in the proposal's process. This does not change local authorities' scrutiny responsibilities for service change. To support this intervention power, the local authority referral power, which is set out in regulations, will be amended to reflect the new process.

DHSC will also issue statutory guidance on the new powers outlining how the Secretary of State proposes to exercise their functions during this new process, including the new Secretary of State call in power. This guidance will also include information for NHS commissioning bodies, NHS trusts and NHS foundation trusts about how they should be exercising their functions under the new reconfigurations process. We expect that these principles will complement the new guidance to help ensure that scrutiny is embedded across the new statutory system-level bodies.

Exact timelines are still to be determined; however, any changes to the reconfiguration process introduced through the Health and Care Act 2022 will not be implemented immediately following Royal Assent. We will work with the system to help prepare for any proposed changes and to develop the new statutory guidance.

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Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Report to the Health Overview and Scrutiny Panel

Date of Meeting: Thursday 13 July 2023

Subject of Report: Integrated Care Strategy

Officer Presenting: Ros Cox – Associate Director (Partnerships)

Recommendations

For information

1. Summary of Report

This paper summarises the work done to date by the Integrated Care Partnership (ICP) which is made up of the VCSE sector, representatives from the six localities and partners from all Integrated Care System organisations. This includes the Chairs from the three local authorities. Organisations are working together to develop a comprehensive strategic approach to improving the overall health and wellbeing of the residents of BNSSG. The first step on this journey, was to develop a Strategic Framework (which can be accessed here) which was approved and published by the Integrated Care Partnership in December 2022.

The system wide Editorial Group, which oversaw the production of the Strategic Framework, was reconvened to co-ordinate the development of the first edition of the Integrated Care System Strategy. It was approved by the Integrated Care Partnership board on 16 June, with the final document published on 30 June, in coordination with the Joint Forward Plan, and will be circulated to all partners.

The Joint Forward Plan sets out how the Integrated Care Board (ICB) and provider trusts intend to meet the physical and mental health needs of the population through arranging and/or providing NHS services, supported by local authority and VCSE partners.

The Joint Forward Plan is structured around the responsibilities of the Health and Care Improvement Groups (HCIGs) and describes how we plan to achieve and deliver the priorities set out in our Strategy over the next five years.

2. Details

Strategy

The Integrated Care System Strategy will focus on the delivery of four key aims:

Aim 1: Improve Outcomes in Population Health and Healthcare
Aim 2: Tackle Inequalities in outcomes, experience and access
Aim 3: Enhancing productivity and value for money

Aim 4: Supporting broader social and economic development

The Integrated Care Partnership requested we reintroduce work on system culture that was done for an earlier iteration of the process. The key proposition of this work is that, if we are going to deliver on the potential of our partnership, we need to adopt complementary cultures across our organisations.

The development of the Strategy provides an opportunity to develop, test and embed this. We have set out our culture change aspiration by articulating eight behaviours that we aim embody and embed through the strategy development process into ongoing collective decision making.

1) CLARITY
We will ensure that for any decision there will be a coherent, shared analysis of the key challenges, with an evidence-based agreement on our priority areas and mechanism for measuring impact. A key test will be that people within our partner organisations know the system vision, priorities and their contribution to delivering them.

2) CANDOUR
We will challenge ourselves to have honest conversations when working in partnership, addressing the root cause of any issues and developing solutions aligned to our vision and purpose. This will enable us to build trust and depth in our working relationships.

3) COMMITMENT
Each partner will sign up to do what is necessary to meaningfully address our shared key priorities even where this challenges established ways of working. We will also demonstrate a commitment to the partnership and the new ways of working. This will be driven from the top by our system leaders showing the way.

4) COLLABORATION
We will pool our resources to address the challenges we face together and tackle problems from the perspective of a rich pool of opportunities offered by having more organisations involved.

5) CONSISTENCY
There will be a recognisable thread between all partners that stems from the agreed system strategy. We will aspire for consistency in our approach to making decisions as a system with the aspiration that this will reduce variation for people receiving services.

6) CONSEQUENTIAL
The strategy, and the work that we do as a system, will have real, quantifiable impacts evidencing improvement in lives, health and wellbeing. To achieve this, an outcomes-focused approach is core to this strategy and the primary mechanism for measuring success.

7) CHALLENGE
We will hold each other accountable through constructive challenge to ensure that the best possible decisions and outcomes are drawn – debate will be encouraged and conclusions drawn which may be uncomfortable but enable progress towards the greater goals of our system.

8) COURAGE

Our stakeholders and partners have consistently expressed a desire that we show courage as a system. This will mean we take the bold decisions needed to deliver our vision and when the inevitable pressures come, we stick to our vision and these principles in how we tackle those problems.

Joint Forward Plan

The Joint Forward Plan follows national guidance and principles to ensure that it is:

- Fully aligned with wider system ambitions
- Supports subsidiarity by building on existing local strategies and plans, as well as reflecting the universal NHS commitments.
- Delivery focused, including specific objectives, trajectories, and milestones.

Key elements of our plan include:

- Improving the lives of our children
- Improving the lives of people in our communities
- Improving the lives of people with mental health conditions, learning disability, and autism
- Improving our acute healthcare services

3. Consultation

In the summer of 2022, we asked local people what helps them to be happy, healthy, and well. We had over 3,000 responses to the exercise, with over 21,000 different comments from those who completed an online survey or attended one of more than 50 community events. We worked with our local hospitals, community health, primary care, mental health, local councils, charities, community groups, the voluntary sector, and businesses to help gather these responses.

Many different people from our communities in Bristol, North Somerset and South Gloucestershire are represented in the findings and this includes different age groups, health needs, abilities, and people from a variety of backgrounds. The findings have been an integral part of shaping our Strategy, the Joint Forward Plan and Operational Plans, and we are continuing to involve stakeholders as this work develops.

4. Equality Implications

The Strategy will focus on delivering the four aims of the ICS, which includes tackling inequalities in outcomes, experience and access to healthcare. Identifying, understanding, and addressing the drivers of health inequalities within our diverse population is a fundamental reason as to why the System Strategy is being developed.

The Joint Forward Plan takes account of the Public Sector Equality Duty, Section 149 of the Equality Act 2010 and the NHS Act 2006.

Author:

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Associate Director (Partnerships)
Strategy, Partnerships and Population
BNSSG ICB

Appendices:

BNSSG Strategy
Forward Plan

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Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy

Contents

Our vision: 'Healthier together by working together'

People enjoying healthy and productive lives, supported by a fully integrated health and care system – providing personalised support close to home for everyone who needs it.

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

Foreword

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

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

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

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

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

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

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

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

They are:

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

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

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

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

June 2023

Introduction

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

This Strategy has been developed from several important sources. It includes public views, including those who have used our health and social care services, information showing our communities' local health and social care needs, and the insights of practitioners working in our organisations. Following this publication, each individual Integrated Care Partnership (ICP) partner organisation will need to approve through their own internal governance processes any specific commitments and actions that result from this document.

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

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

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

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

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

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

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

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

What is driving our Strategy?

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

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

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

ICS Aim 1: improving outcomes in population health and healthcare

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

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

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

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

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

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

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

In BNSSG, certain groups have worse outcomes than others, for example Bangladeshi, Caribbean and Pakistani people (Our Future Health, p16-17). People with learning difficulties also die an average of 21 years earlier than the average person, and we need to understand how we can provide better support and access to services. We need to address the structural inequalities that drive these differences.

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

ICS Aim 3: enhancing productivity and value for money

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

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

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

ICS Aim 4: supporting broader social and economic development

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

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

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

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

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

Key Opportunity 1: Tackling systemic inequalities

Why is this important?

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

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

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

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

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

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

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

What needs to change?

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

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

2. Equity means that we recognise that each person has different circumstances and gives the exact resources and opportunities needed to reach an equal outcome. "Equality is giving everyone the same pair of shoes. Equity is giving everyone a pair of shoes that fits" (Koenecke, 2019)[14]. We need to use the following three principles to achieve health equity:
    a) Valuing all individuals and populations equally
    b) Recognising and rectifying historical injustices
    c) Providing resources according to need.

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

What are our commitments?

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

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

Key Opportunity 2: strengthening building blocks

Why is this important?

The foundations of good health and wellbeing are built upon a range of factors including: family and community relationships; a safe environment with quality housing, places to exercise and clean air to breathe; good education; meaningful work; and freedom from discrimination. Unfortunately, for too many people in Bristol, North Somerset and South Gloucestershire (BNSSG), these fundamental 'building blocks' of good health and wellbeing are not meeting people's needs effectively.

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

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

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

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

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

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

What needs to change?

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

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

What are our commitments?

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

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

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

Key Opportunity 3: prevention and early intervention

Why is this important?

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

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

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

We know we need to give children the best start in life; we will focus on the first 1001 days and work together seamlessly to help parents and children (as set out in commitment five, chapter two).

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

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

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

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

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

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

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

What are our commitments?

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

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

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

Key Opportunity 4: healthy behaviours

Why is this important?

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

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

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

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

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

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

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

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

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

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

What needs to change?

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

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

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

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

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

What are our commitments?

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

Key Opportunity 5: strategic prioritisation of key conditions

Why is this important?

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

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

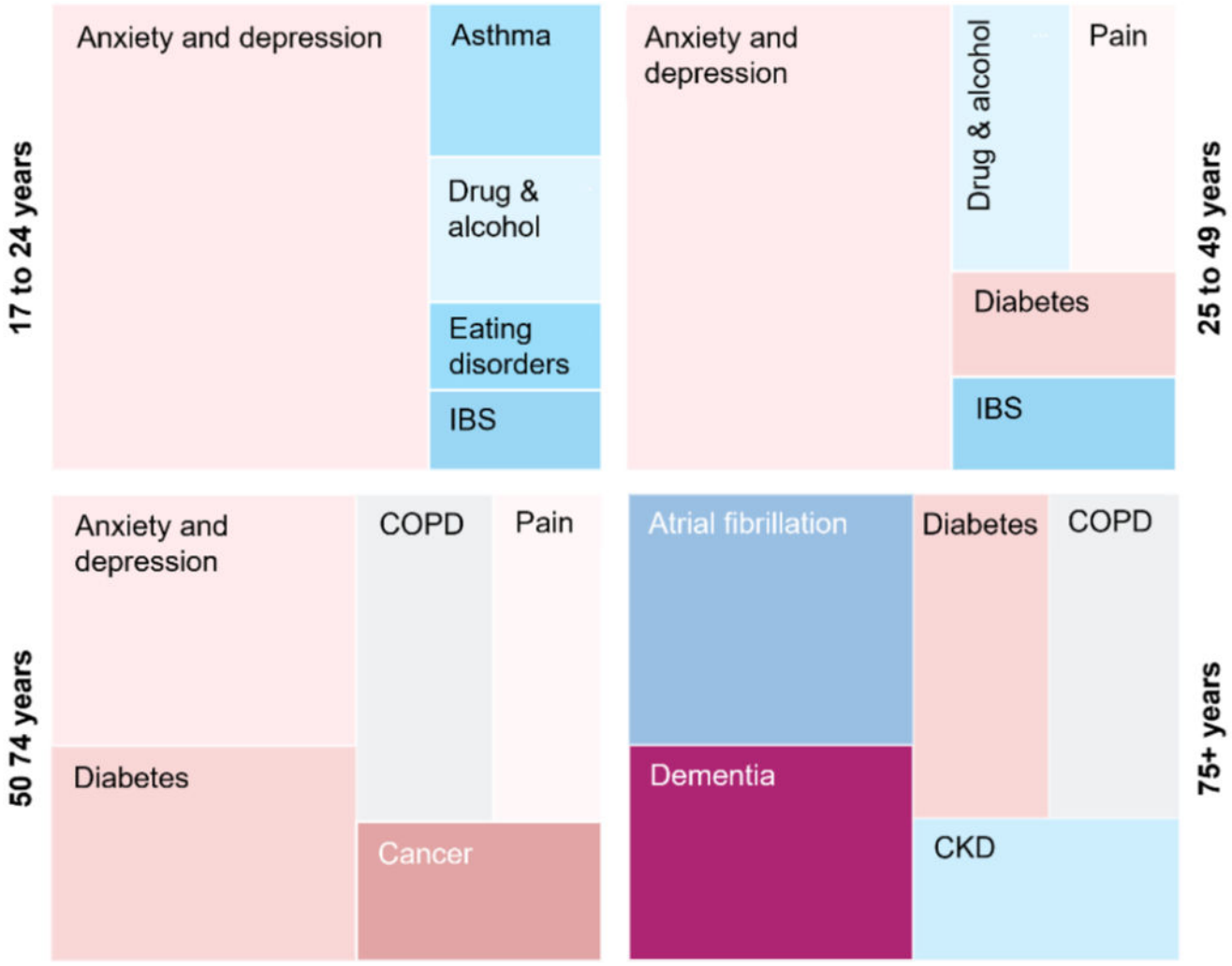

Figure 1: Our Future Health, conditions that impact our population most over the life course.

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

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

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

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

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

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

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

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

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

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

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

What needs to change?

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

We need to:

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

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

What are our commitments?

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

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

How will we deliver our vision?

Prioritisation

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

The HCIGs will address the following:

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

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

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

Locality Partnerships

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

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

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

Workforce

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

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

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

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

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

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

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

Service delivery and sustainability

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

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

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

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

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

Digital

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

We will look to recognise and address the barriers some people have in using digital solutions. Our system's Digital Strategy[21] sets out the ambition to become an exemplar of a digitally advanced Integrated Care System, working collaboratively and optimising design, data and modern technology to make ground breaking improvements for the health and wellbeing of our population.

Financial infrastructure

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

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

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

Innovation and research

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

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

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

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

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

Our BNSSG ICS vision for medicines optimisation is to implement a person-centred, collaborative approach to get the best value from medicines. This includes investing in medicines to improve patient outcomes, reduce avoidable harm and improve medicines safety, align, and simplify processes including the transfer of information, reduce wastage of medicines and avoid patients taking unnecessary medicines. This will be achieved through safe and evidence-based prescribing, increasing patient empowerment through shared decision making whilst ensuring a sustainable pharmacy workforce to support this. We will drive value through an evidence informed approach.

10 ways to focus our efforts

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

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

Improving population health and healthcare

We will:

1. Align everything we do to the outcomes we want.

If we are going to make a difference in the health of people in BNSSG, we need to align everything we do with the outcomes we want to achieve through our shared outcomes framework. This will help us be confident that we are doing what we set out to achieve.

2. **Demonstrate our system-wide commitment to prevention.**

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

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

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

Tackling unequal outcomes and access

We will:

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

   As organisational policies and practices are reviewed, partners will identify opportunities to change working practices to remove barriers. We will also proactively review how the system inadvertently increases health inequality so that those things can be changed.

5. **Prioritise the health impacts of poverty and disadvantage.**

   We also need to improve things for people already experiencing the ill effects of poverty and other structural disadvantages. We will use the Health and Wellbeing Strategies and CORE20+5 framework[22] as a starting point to develop supportive strategies around wider determinants of health and healthy habits.

Enhancing productivity and value for money

We will:

6. **Build a workforce who are supported, skilled and healthy.**

   We cannot achieve anything without our staff. We will work with staff to develop an inclusive, best-in-class retention strategy for all our people. We will also ensure that our staff are healthy, and able to work flexibly across the system, including closer alignment with care homes.

7. Focus on the whole person – not just the disease.

Alongside a focus on proactive care, we will also review how we can support people to solve multiple issues at once and work around their needs. For example, this approach to 'clustered' problems might be achieved through integrated care teams, like those piloted in Weston-super-Mare for mental health and wellbeing, and social prescribing.

8. Work together as equal partners to tackle our biggest problems.

If we get things right the first time, that is a much better way to do things. We will work with people with lived experience and communities to co-create solutions. We will also ensure that the VCSE sector, community leaders, community services, social care, and primary care are valued for their experience and local insight.

Helping the NHS to support broader social and economic development

We will:

9. Support the economy with our purchasing and employment practices.

The partners in BNSSG have a responsibility to use their buying power to support local businesses to put money directly back into the local economy. We will also review how we can use our recruitment to support areas of deprivation, including targeted recruitment and apprenticeship schemes.

10. Develop a better, healthier environment for people to live in.

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

Strategy on a page

Figure 2: Strategy on a page

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Healthier Together

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

ICS Strategy and Joint Forward Plan

July 2023

Context

The Integrated Care System Strategy will focus on the delivery of four key aims:

Aim 1: Improve Outcomes in Population Health and Healthcare
Aim 2: Tackle Inequalities in outcomes, experience and access
Aim 3: Enhancing productivity and value for money
Aim 4: Supporting broader social and economic development

- Identifying, understanding, and addressing the drivers of health inequalities within our diverse population is a fundamental reason as to why the System Strategy is being developed.
- This is a system effort.
- Two key documents 1) BNSSG ICS strategy and 2) The Joint forward plan
- This year, due to timing, the Joint forward plan has been produced first, as the strategy gets underway the intention is that the strategy will set the direction and the Joint forward plan will set out how this will be delivered.

Engagement with communities

- In the summer of 2022, we asked local people what helps them to be happy, healthy, and well. We had over 3,000 responses to the exercise, with over 21,000 different comments from those who completed an online survey or attended one of more than 50 community events.

- We worked with our local hospitals, community health, primary care, mental health, local councils, charities, community groups, the voluntary sector, and businesses to help gather these responses.

- Many different people from our communities in Bristol, North Somerset and South Gloucestershire are represented in the findings.

- The findings have been an integral part of shaping our Strategy, the Joint Forward Plan and Operational Plans, and we are continuing to involve stakeholders as this work develops.

Healthier Together

What happens next?

Strategy

- The system wide editorial group co-ordinated the first edition of the Integrated Care System Strategy.
- The strategy was reviewed by the Integrated Care Partnership board on 16 June and agreed with some tweaks to be signed off for the 30th June.

Joint forward plan

- The Joint Forward Plan sets out how the Integrated Care Board (ICB) and provider trusts intend to meet the physical and mental health needs of the population through arranging and/or providing NHS services, supported by local authority and VCSE partners.
- The Joint Forward Plan is structured around the responsibilities of the Health and Care Improvement Groups (HCIGs) and describes how we plan to achieve and deliver the priorities set out in our Strategy over the next five years.

The final documents will be published on 30 June, and will be circulated to all partners.

University Hospitals Bristol and Weston NHS Foundation Trust

Report to the Health Overview and Scrutiny Panel

Date of Meeting: 13 July 2023

Subject of Report: Update on Weston General Hospital UHBW

Officer Presenting: Paula Clarke, Executive Managing Director (Weston)
Judith Hernandez Hospital Director

Recommendations

Members to note and provide feedback

1. Summary of Report

The attached presentation includes key headlines that will be talked to at the meeting, including Investment arising from Healthy Weston 2, Recruitment, CQC, Training, Performance and Culture

2. Consultation

Health Weston 2 was subject to public engagement 18 months ago

3. Financial Implications

No financial decisions are required arising from this report. There are however future financial decisions that the ICB will need to take regarding the funding of Phase 2 and 3

Author:
Paula Clarke/Judith Hernandez

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University Hospitals Bristol and Weston NHS Foundation Trust

Weston General Hospital

Investment

HW2 Phase 1 Business Case agreed and funded
Now in Implementation phase with benefits being realised
Phase 2 and 3 planning in progress for submission Dec 2023

Training

Formal thanks extended to UHBW and commending of the work put into meeting NHSE Education South West and the GMC's requirements regarding foundation doctor training.
Trainess return for August rotas in most areas on the Weston site

Recruitment

Large scale recruitment in progress in line with HW2 funding across most professional groups with integrated approach
Nursing is fully established with some wards reporting a vacancy waiting list

Development of community links

- Primary Care
- College
- Councillor interface
- NS Council pilot
- Workforce partnership approach-HW2

Performance

SDEC in place since January
Sustained improvement in 4 hour ED performance
Reduction in 12 hour trolley waits
Significant reduction in diverts away from WGH
Decrease in risks and complaints regarding crowding in ED
Industrial action management

CQC

Stepped down from additional CQC scrutiny in March 2023
BAU organisational approach to action plan monitoring and management

Culture

Wellbeing Hub opened on Site in May
Active F2SU processes
Ongoing work to embed Organisational values through clear leadership

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North Somerset Council

Report to the Health Overview and Scrutiny Panel

Date of Meeting: 13th July 2023

Subject of Report: Recommissioning of the BNSSG Integrated Sexual Health Service

Town or Parish: All

Lead officer: Samuel Hayward, Consultant in Public Health

Key decision: Yes

Reason: The value of the decision is over £500,000 and will affect communities living or working in two or more wards in the area of the Local Authority.

Recommendations:

- TO NOTE the outcome of the key decision from the Executive on the 21st June 2023 which agreed to North Somerset Council participating in the recommissioning of the BNSSG integrated sexual health services (see section 1).
- TO NOTE the outcome of the related agreements from the Executive on the 21st June 2023 (see section 1 Summary of Report).
- TO NOTE the findings from the North Somerset Sexual health services workshop held on 9th June 2023 (see appendix 1).
- TO COMMENT on further consultation opportunities not identified within this report or within Appendix 1 (see section 4 Consultation).

1. Summary of Report

This report describes the commissioning plan for integrated sexual health services that North Somerset Council is a party to. The report summarises the approval for the recommissioning of the North Somerset elements of the BNSSG Integrated Sexual Health Service that was sought at Executive on 21st June 2023.

Good sexual and reproductive health matters to individuals and communities, whose needs will vary according to a range of physical, emotional, social, cultural and economic factors. Core needs common to all include the availability of high-quality information and education to make informed decisions, freedom from stigma and discrimination, and access to high quality prevention, testing, diagnostic and treatment services, and interventions[1]. Local Authorities (LA) have been responsible for commissioning integrated sexual and reproductive health (SRHS) services as part of their mandated public health responsibilities since 2013[2].

[1] ADPH (2019) What good sexual and reproductive health looks like. Online: https://www.adph.org.uk/wp-content/uploads/2019/10/What-Good-Sexual-and-Reproductive-Health-and-HIV-Provision-Looks-Like.pdf
[2] House of Commons (2014) Local Authorities public health responsibilities (England). Online: https://researchbriefings.files.parliament.uk/documents/SN06844/SN06844.pdf

LA commissioned services include testing and treatment for sexually transmitted infections (STI's), HIV prevention and testing, sexual health outreach and health promotion, contraception services, including long-acting reversible contraception (LARC), and emergency hormonal contraception (EHC). NHS Integrated Care Boards (ICB) are responsible for commissioning termination of pregnancy services (TOPS).

In 2017, Bristol City Council, on behalf of Bristol, North Somerset, South Gloucestershire, and Bath & North East Somerset Council's, and Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG) jointly commissioned University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) to fulfil the delivery of the Integrated Sexual Health Service. This is a robust example of system-level collaborative commissioning. The service is currently called Unity Sexual Health Service, it is led by UHBW and delivered by a number of providers. UNITY's role is to promote, improve and protect sexual health for the BNSSG population and reduce inequalities in that regard. The original contract commissioned in 2017 expires on 31st March 2024, and has now been extended to the 31st March 2025.

To complement the main services, primary care providers (GPs and pharmacists) are separately commissioned to deliver LARC, EHC, chlamydia screening and condoms.

As the existing contract with UHBW is due to end on 31st March 2025, there is a requirement for North Somerset Council, and fellow BNSSG commissioners, to deliver a recommissioning process to procure a service/s provider/s from 1st April 2025. This commissioning includes a comprehensive sexual health needs assessment, which will be added to the Joint Strategic Needs Assessment in due course.

A North Somerset sexual health services stakeholder workshop was held on the 9th June 2023. Stakeholders provided local insight and feedback on current provision, population health needs, the commissioning plan, the draft model of delivery, and consultations plans. Summary recommendations have already informed the Executive meeting on 21st June and will be incorporated into the ongoing recommissioning of this service area. Stakeholder partners will be also support the procurement consultation process when launched.

Update from Executive

On 21st June the Council Executive took a key decision and agreed to the recommissioning of the North Somerset elements of the BNSSG Integrated Sexual Health Service for up to a 10-year term. It was agreed that the Council will join Bristol City Council's procurement process (in collaboration with the NHS BNSSG Integrated Care Board, South Gloucestershire Council, and Bath and North East Somerset (BANES) Council) to deliver this tender.

To enable the alignment of decision making across the Collaborative commissioning partners the contract award has been delegated from the Executive to the Director of Public Health (this will also comply with Bristol City Council's procurement process).

Agreement was also made to anonymise the winning bidders' details on the Council website when Director award decision is published (to comply with Bristol City Council's procurement process). There was further agreement to follow Bristol City Council's Procurement Plan – so no separate NSC specific Procurement Plan will be produced by the Strategic Procurement Service for approval.

This was a key decision as the value of the decision was over £500,000 and will affect communities living or working in two or more wards in the area of the Local Authority.

2. Policy

National

The previous national Sexual and reproductive health and HIV: strategic action plan was published in 2015[3]. The new national Sexual and Reproductive Health Strategy is expected in 2023/24 and will inform this commission. The new national service specification for Sexual Health, which is required to inform the local specification, has recently been published[4]. New NHS procurement regulations, which will likely bring significant opportunities for these services is also expected during 2023/24[5].

BNSSG

As of 1st July 2022, the BNSSG CCG has been replaced by the new BNSSG Integrated Care Board (BNSSG ICB). Commissioning is no longer a core function within the new arrangement, with the focus being on collaborative system working, performance and delivery. Alongside the new ICB is our local Integrated Care System (ICS), the system is in its infancy, but there may be scope for a different system model for sexual health, as informed by the guidance. In accordance with the principles of the ICS this commission will bring together a range of partner organisations to help people stay happy, healthy and well for longer. Our integrated commission is designed to ensure that health and care services join up around individual sexual and reproductive health needs.

North Somerset

This commissioning plan for the BNSSG integrated sexual health services supports a number of the Corporate Plan priorities[6], including:

Being a council that empowers and cares about people:

- A commitment to protect the most vulnerable people in our communities.
- An approach which enables young people and adults to lead independent and fulfilling lives.
- A focus on tackling inequalities, improving outcomes.
- A collaborative way of working with partners and families to support children achieve their full potential.

Being an open and enabling organisation:

- Engage with and empower our communities.
- Empower our staff and encourage continuous improvement and innovation.
- Manage our resources and invest wisely.
- Embrace new and emerging technology.
- Make the best use of our data and information.
- Provide professional, efficient and effective services.
- Collaborate with partners to deliver the best outcomes.

[3] Public Health England (2015) Sexual and reproductive health and HIV: strategic action plan. Online: https://www.gov.uk/government/publications/sexual-and-reproductive-health-and-hiv-strategic-action-plan
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Provision of these services relates to meeting the challenges described in the Corporate Plan, including demographic change, inequalities and resource constraints. In particular new models of delivery will be more resource efficient and at the same time enhance accessibility to services.

Provision will support the priority of reducing the gap in life expectancy and healthy life expectancy between communities in North Somerset by supporting higher need populations with early intervention and prevention of disease. Further, the provision will be targeted through local area analysis to areas of deprivation and aim to tackle causes that drive inequalities, including disease diagnostics, and access and use of contraception. Underlying this commission is the collaborative approach to commissioning with BNSSG partners, with North Somerset Council having a key role in this strategic partnership of healthcare organisations and providers.

Service provision supports delivery of the vision in the North Somerset Health and Wellbeing Strategy through preventing health problems before they arise, intervening early in relation to existing health and wellbeing problems, and through supporting specific populations and communities to be connected, healthy and resilient[7]. Further, this commission will be delivered in accordance with the principles set out within the strategy.

The services in this commissioning plan are key to the commitments in PHRS ADS, including programme objectives related to the commissioning and provision of high-quality health and care services related to sexual health.

3. Details

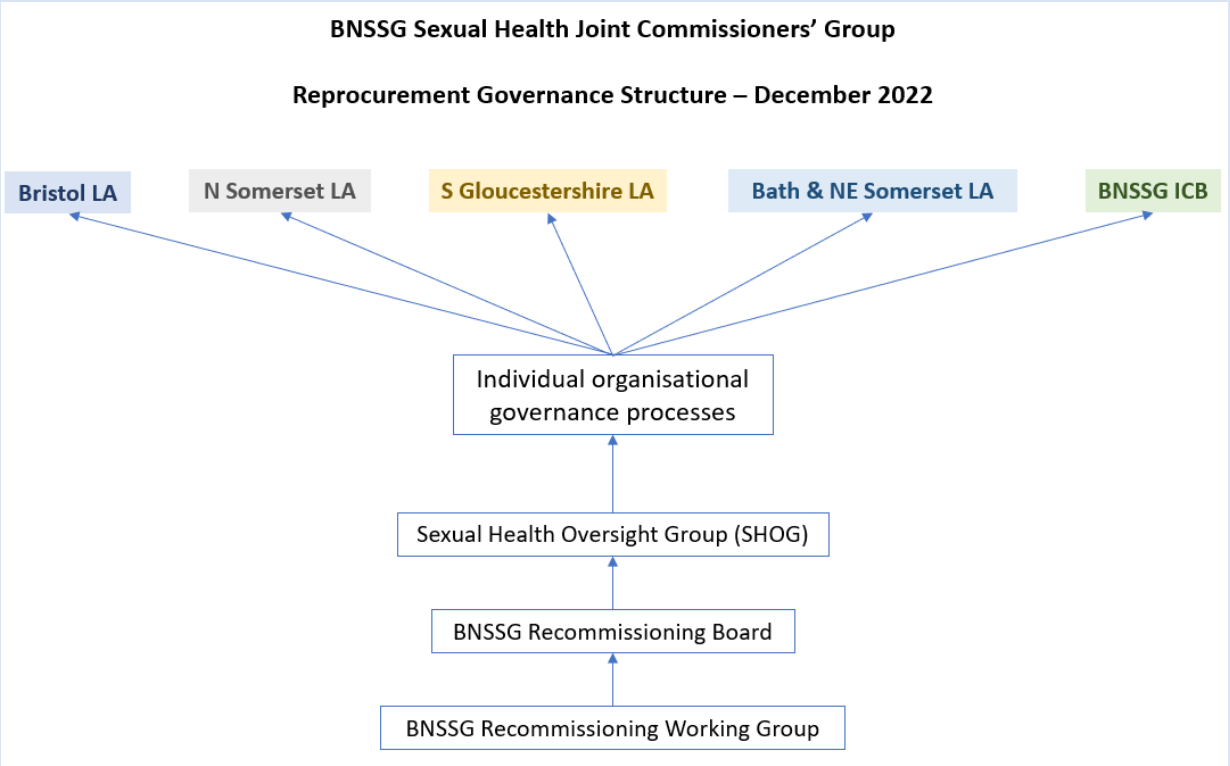
Governance

A collaborative commissioning agreement (CCA)[8] is in place between North Somerset Council, Bristol City Council, South Gloucestershire Council, BANES Council, and BNSSG ICB. The CCA sets out the terms under which Commissioners will collaborate in assessing the need for the Integrated Sexual Health Services, and how we will work together in procuring, negotiating and signing the commissioned contract for service provision. It also details how the contract and service will be managed throughout the term of delivery.

An integrated governance structure for the recommissioning has been put in place to oversee operational delivery of commissioning activity and to ensure clear lines of decision making and accountability are in place (Figure1).

[7]North Somerset Health and Wellbeing Board (2021) North Somerset Health and Wellbeing Strategy 2021-24. Online: https://www.n-somerset.gov.uk/council-democracy/priorities-strategies/health-wellbeing-strategy-2021-24

[8] BNSSG&BANES Councils and BNSSGICB (2023) Collaborative commissioning agreement for the commissioning of an Integrated Sexual Health Service for Bristol, North Somerset and South Gloucestershire (including chlamydia screening programme for Bath and North East Somerset). Unpublished.



(Figure 1. Reprocurement governance structure)

Scope of integrated commissioning for sexual health services

The commissioning and delivery of sexual health services is complex (Figure 2). There are 3 key commissioners of local sexual health services: Local Authorities, NHS ICB's and NHS England (NHSE). Responsibility and mandates for the commissioning of different elements of sexual health services sits within different parts of the local system[9].

Local Authorities are responsible for commissioning of comprehensive sexual health services including:

- Contraception, including LARC.
- Emergency Hormonal Contraceptives (EHC).
- Prevention, testing and treatment of STI's.
- Sexual health promotion.
- HIV prevention, including pre-exposure prophylaxis (PrEP).
- Chlamydia screening.
- C-Cards (condoms).

ICB's are responsible for:

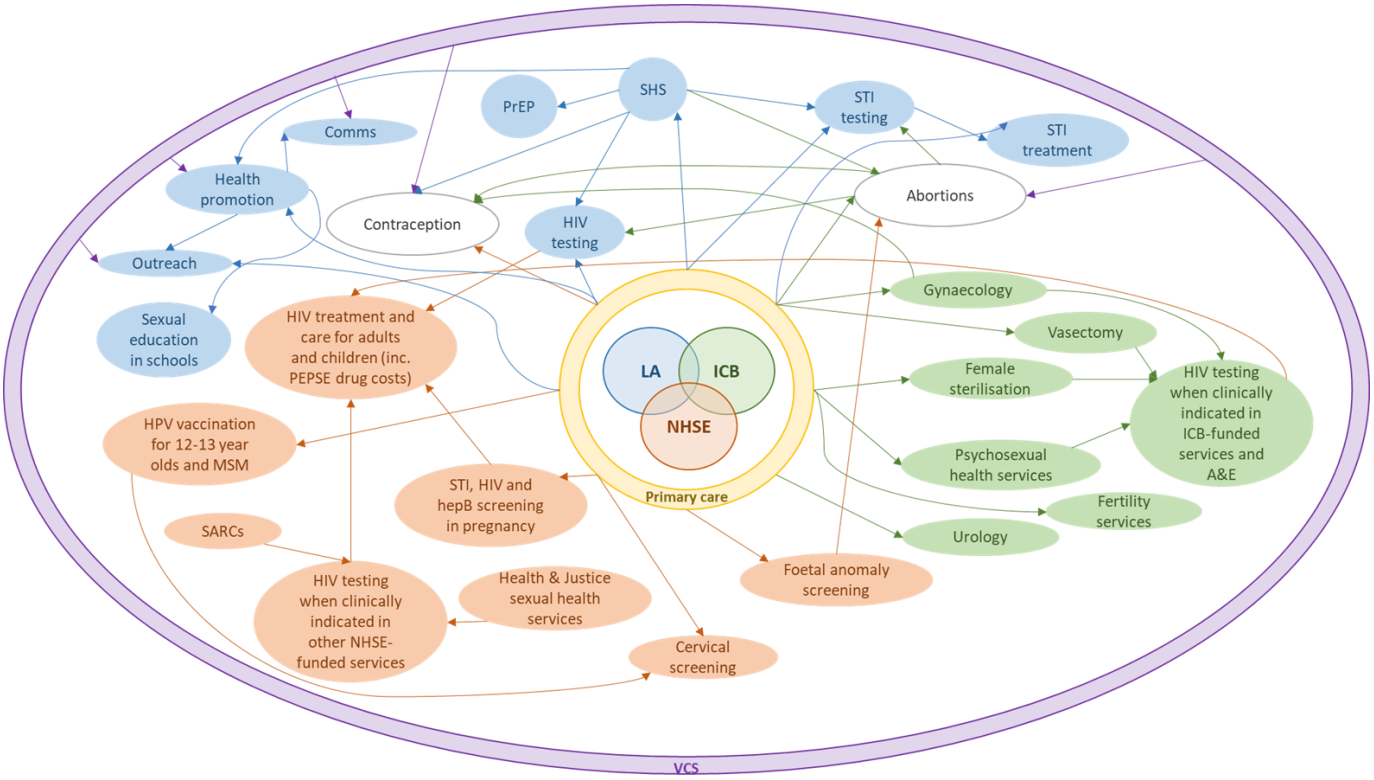
- Most termination services, including STI and HIV testing and post-termination contraception.
- Contraception provided as an additional service under the GP contract (including for non-contraceptive purposes).

[9] PHE (2014) Making it work. A Guide to whole system commissioning for sexual health, reproductive health and HIV. Online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf

- Opportunistic testing and treatment for STIs and patient-requested testing by GPs.
- Female sterilisation and vasectomy services.
- Psychosexual health services.
- Gynaecology services.
- HIV testing when clinically indicated in ICB-commissioned services (including A&E and other hospital department.

NHSE are currently responsible for the service listed below, some of these commissioning responsibilities are in the process of being transferred to NHS ICBs:

- HIV treatment and care for adults and children.
- Drug costs for HIV PrEP and post-exposure (PEP) prophylaxis.
- HIV testing when clinically indicated in other NHSE commissioned services.
- All sexual health elements of healthcare in secure and detained settings.
- Sexual assault referral centres.
- Cervical screening in a range of settings.
- Specialist foetal medicine services, including late surgical termination of pregnancy for foetal anomaly.
- HPV routine vaccination for school-aged children and opportunistic vaccination for men who have sex with men aged 45 and under.
- NHS infectious diseases in pregnancy screening programme, including antenatal screening for HIV, syphilis, and hepatitis B.



(Figure 2. System map of BNSSG sexual health services)

Recommissioning cycle

The recommissioning of the BNSSG Integrated Sexual Health Service is following a standard commissioning cycle for Public Health Services[10] (Figure 3), and covers the following way points:

[10]NHS England (Undated) What is commissioning? Online: https://www.england.nhs.uk/commissioning/what-is-commissioning/

- Sexual health needs assessment
- Designing the new service model and developing the specification,
- Market engagement,
- Public consultation,
- Revising and finalising the details of the new service model using the consultation and feedback.
- Procurement process, tendering and mobilisation,
- Contract award,
- New service set up and go live.

Figure 3. Commissioning cycle (NHSE)

BNSSG Sexual Health Needs Assessment (SHNA)

For the first time a sexual health needs assessment has been conducted for the combined Bristol, North Somerset, and South Gloucestershire area. The BNSSG SHNA aims to identify the sexual health needs of the population and how well these are being met. This is done by bringing together a wide range of evidence from published outcomes data, local service data, the views of the public, service users and professionals, and national policy and guidelines. Data analysis by demographics is carried out wherever possible, although the availability of data is sometimes a barrier to this.

A final draft of the BNSSG SHNA is due to be published, recommendations of which will be used to inform the design of services for the North Somerset population. However, key areas for action for North Somerset identified from the SHNA include:

- Reducing under 18 and 16 conceptions and Termination of Pregnancy (TOPs).
- Prevention / Relationships and Sex Education for young people in Weston-super-Mare, with focussed efforts in South Ward.
- Increasing service uptake from younger adults (18-24).
- Improving STI prevention work in young men (18-24).
- Improving access and uptake to HIV testing.

The draft SHNA also showed that current clinic provision does well to serve areas of deprivation in North Somerset, with higher uptake from areas of deprivation, and higher diagnosis in wards near to clinic sites (Uphill Ward and South Ward) (See Appendix 2).

Designing the new service model and developing the specification

Meeting the needs identified through the SHNA will be challenging, however with the aim of delivering the best outcomes for our population, the process to design the new service model and specification will ensure the most cost effective and affordable use of the available budget and incorporate the constraints of wider budget pressures. The service model will be evidence based and incorporate national guidance. It will also be benchmarked to comparable areas commissioned services and commissioning intentions. To balance competing population health needs, prioritisation for incorporation in the service model will consider criteria such as current and future level of need, demand, and inequalities.

Contract structure

The proposed contract will be between Bristol City Council (as the lead Commissioner) and the Provider. It will likely be based upon the national contract template for sexual health services. The current proposed term of the contract is up to ten years. As described, a collaborative commissioning agreement is in place between the Council and partner commissioners.

Robust contract arrangements and on-going contract management will be used to ensure proportionate delivery of services across different localities based on levels of investment and recognising distinct geographic needs. A multi-agency contract monitoring group will be established across all commissioners to lead this process.

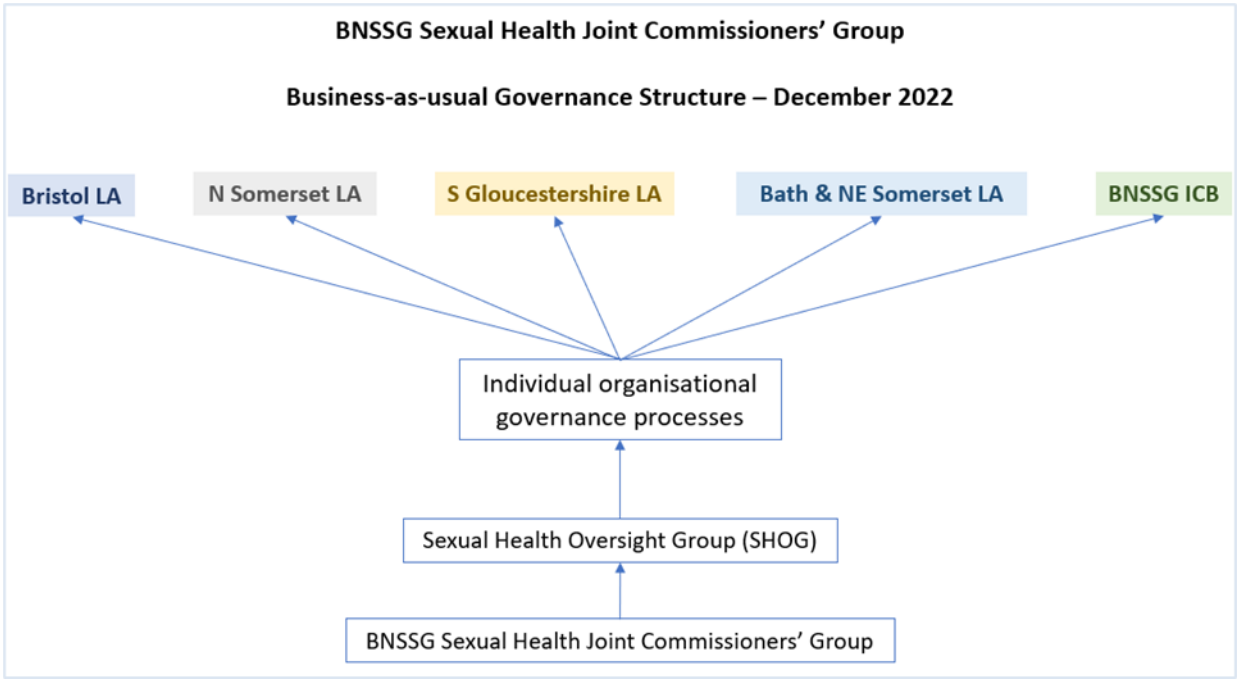


Figure 4. Governance for contract management

Draft procurement timeframe

Activity	Date (TBC)	Status
Complete a sexual health needs assessment for BNSSG	March 2023	Complete
Publish prior information notice (PIN) to alert the market of the planned reprocurement and invite expressions of interest to join a provider consultation group	April 2023	Complete
Agree services to be recommissioned	May – June 2023	In progress
Draft commissioning intentions developed	May 2023	In progress
Provider consultation group meeting to discuss proposed commissioning intentions	May 2023	In progress
Draft service specifications developed	May – June 2023	Proposed
Internal sign-off from each commissioning organisation	June – October 2023	Proposed
Consultation across BNSSG on commissioning intentions	November 2023 – January 2024	Proposed
Commissioning intentions and service specifications finalised	January – March 2024	Proposed
Market engagement event	March 2024	Proposed
Notice given to existing providers at least 12 months in advance of end of contract	March 2024	Proposed
Open tender process begins (8 weeks)	April – June 2024	Proposed
JCG evaluation of tender submissions (4 weeks)	June – July 2024	Proposed
Commissioning organisations complete internal governance processes (4 weeks)	August 2024	Proposed
Initial award of contract	September 2024	Proposed
Standstill period (10 days)	September 2024	Proposed
Full award of contract	September 2024	Proposed
Contract finalisation	September – October 2024	Proposed
Mobilisation/implementation (6 months)	October 2024 – March 2025	Proposed
New contract starts	April 2025	Proposed

4. Consultation

As we (commissioners) don't always know what works best, a bespoke consultation schedule will be developed within the commissioning process. The consultation will run for 6-12 weeks. Views of as many people and communities in North Somerset as possible will be sought, with a focus on those most vulnerable or at risk. Public views may be collected through a range of methods, including meetings, surveys, focus groups and drop-in sessions. As part of the consultation process local representative stakeholder organisations will be invited to inform on the service model development and the procurement plan.

Population groups, through representative organisations, to be engaged include, but are not limited to:

- North Somerset residents
- Children and Young People
- Sexual Health service users
- Homeless people
- Looked After Children
- Care leavers
- People with learning disabilities
- Commercial sex workers (male and female)
- People who misuse substances
- Migrants, asylum seekers and refugees
- Lesbian, gay, bisexual and transgender people (inclusive of people who identify with terminology other than cisgender and heterosexual)
- Men who have sex with men
- Informal carers
- Ethnic Minorities
- People with Black African and Caribbean ethnicity
- People with Roma, Gypsy, or Traveller ethnicity
- People living in areas of high deprivation
- People who have experienced or are at high risk of sexual coercion and/or violence, including trafficking
- People living with HIV
- Young people
- Offenders
- People with mental illness
- People representing diverse faith groups & religion
- People with a disability
- People who are 50+
- Children who are educated at home.

Stakeholder representative organisations include, but are not limited to:

- Healthwatch
- Local Medical Committee
- Local Pharmaceutical Committee
- Local schools, Sixth Forms, College and University
- SARSAS
- North Somerset Safeguarding Adults Board
- North Somerset Council Adult Social Services
- Neighbouring Councils, including Somerset Council
- Neighbouring ICB's including Somerset ICB
- OHID/UKHSA
- NHS Locality Partnerships

The proposed consultation groups, stakeholders and organisations will be amended with feedback from the North Somerset Sexual health service workshop (Appendix 1).

The Health and Wellbeing board members may have additional recommendations on who, and how to consult with individuals, groups, and organisations. Recommendations and opportunities can be shared with:

- Rebecca Keating, Health and Care Public Health Service Leader: Rebecca.Keating@n-somerset.gov.uk

From the period of engagement and consultation conversations we will identify key areas being raised. These key areas will be used to inform the service model and incorporated into the service specification/s.

5. Financial Implications

As this is recommissioning an existing service, there are no new spending commitments known. Consideration will be given throughout the procurement process as to how we commission contracts that achieve best value and will be set out in the Procurement Plan.

Costs

Previous budget envelope

The Council's current financial commitment to the Integrated Sexual Health Service is £1,142,540 per annum. The previous contract value for North Somerset was £7,997,780 for a period of 5 plus 2 years (April 2017-March 2024). This was extended by an additional year in 2024/25 at a cost to the Council of £1,142,540.

Across the three BNSSG partners the total contract value for the Integrated Sexual Health Service was £8.4million per annum. Since the original commission, new mandatory requirements have been embedded into the service provision, including the provision of HIV PrEP. Annual budget for PrEP in North Somerset has been approximately £50,000.

Projected budget envelope

The projected allocations for the Public Health Grant require spending constraints within this commission. For the new commission North Somerset Council's budget allocation will remain consistent with the current annual combined budget for the Integrated Sexual Health Service and PrEP. The available budget envelope is projected to be approximately £1.2million per annum.

Across the three BNSSG partners it is estimated that the available budget for the commissioning of the Integrated Sexual Health Service will be consistent with the current allocation of c£8.4million per annum.

On-costs

Further direct costs to the Council associated with the commission are acceptable and similar to those within the 2022-23 financial year. On-costs include but are not limited to: Member time; senior Public Health & Regulatory Services staff commissioning and contract management time; Legal & Governance; Finance; and Procurement staff time.

Funding

Delivery of the North Somerset Council elements of the Integrated Sexual Health Service will be funded by the Public Health ringfenced grant. It is anticipated that this will continue during the contract period. NHS commissioned elements of the service will be funded from the ICB budget.

6. Legal Powers and Implications

The services considered in this commission are statutory requirements, local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons, advice on, and reasonable access to, a broad range of contraception, and advice on preventing unplanned pregnancy.

In keeping with the Health and Social Care Act 2012, local authorities have been responsible for commissioning sexual health services as part of their mandated public health functions since 2013. Under Section 82 of the NHS Act 2006, NHS bodies and local authorities have a statutory duty to cooperate when exercising their functions to secure and advance health and welfare.

Statutory commissioning responsibilities for sexual health are currently under transition. The introduction of the Health and Care Act 2022 changed the commissioning landscape with the advent of Integrated Care Boards. In addition, the introduction of the NHS Provider Selection Regime is awaited and may influence this commission.

A new national Sexual and Reproductive Health Strategy is awaited, and a national sexual health service specification was published in March 2023[11].

7. Climate Change and Environmental Implications

A thorough risk assessment will be completed by the multi-agency procurement team, and the results will be threaded throughout the tender process (in line with Bristol City Council's Procurement Regulations).

Key examples related to climate change and environment appertaining to the current and future Integrated Sexual Health Services contract will be travel, transportation, and disposal of clinical waste and other equipment. In particular by ensuring efforts continue to be made to reduce the carbon footprint, such as:

a) Reducing the number of unnecessary patient/client journeys to clinics (by providing more services online).
b) Reductions in the number of frequent road transport deliveries for clinical supplies.
c) The appropriate collection and disposal of clinical and non-clinical waste and equipment.
d) Ensuring energy used on clinical sites is supplied from renewable energy sources.

The new national guidance and regulations may provide opportunity for further climate and environment action within this commission. Commissioners may also use this commission as a case study in decarbonisation through commissioning of sexual health services.

8. Risk Management

As this is an integrated commission the risk management process sits with Bristol City Council as the lead commissioner. An initial thorough risk assessment was completed by the joint project team across the authorities when setting out the Collaborative Commissioning Agreement (CCA). The resulting risks are reviewed and mitigated at each project board meeting. This is monitored and actioned through the relevant groups (Figures 1 & 4).

Internal risk governance sits within the Public Health and Regulatory Services, with the Sexual Health Commissioning Manager, Health and Care Public Health Service Leader, and Consultant in Public Health, forming the internal project team who contribute to the Joint Commissioning Groups (Figures 1 & 4).

[11]OHID (2023) Integrated Sexual health Service Specification. Online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1143246/Integrated-sexual-health-service-specification-2023.pdf

Identification, recording and reporting of North Somerset specific, and shared, risks will be delivered through the joint commissioning team/s and recorded in the integrated commission risk register. In accordance with the risk monitoring and reporting guidance within the local risk management framework risks will be reported from NSC officers through the PHRS governance structure and associated reporting and monitoring flow chart[12]. Where appropriate they will be escalated and added to Directorate and Corporate risk registers.

Assessment of risk within the integrated commission is delivered through a standardised risk management matrix of likelihood and impact. Risks associated with the recommission will cut across all risk themes including, finance and resources, transformational activity, the climate emergency, residents and communities, and corporate governance. Risk analysis and control measures will be implemented to remove, accept, mitigate and exploit risk as appropriate against individual risk items. The risk register will be maintained and updated through a process of re-evaluation.

Clinical risk
As a clinical service and as a collaborative commission with NHS partners, the design of the service model and specification will adhere to, and embed, requirements against the seven pillars of clinical governance, including:

1. Evidence based care and effectiveness.
2. Risk management.
3. Patient and public involvement (PPI).
4. Clinical Audit.
5. Staffing and staff management.
6. Education and training.
7. Information & IT.

9. Equality Implications

Commissioners are actively considering equality issues throughout this project as the provision of integrated sexual health services has a number of equality implications. Key equality issues will be considered and built into the commissioning process. As outlined for consultation, considerations for the project will be set out/summarised in the service specification and procurement plan. An Equality Impact Assessment (EIA) will be delivered at an appropriate stage within the commissioning and procurement cycle. As advised by the Inclusion and Corporate Development Manager there is no need to complete a separate NSC EIA at this stage.

10. Corporate Implications

There are no corporate implications.

11. Options Considered

The provision of Sexual Health Services is a statutory duty and therefore we must recommission these services.

Author:

Samuel Hayward,

[12] North Somerset Council (2022) Risk management strategy. Internal intranet: https://nsomerset.sharepoint.com/sites/the-source.authoring/Documents/Risk%20management%20strategy%202022_FINAL.pdf

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Appendices:

1. North Somerset Sexual Health Services Workshop summary report
2. Sexual Health Needs Assessment – North Somerset Summary
3. Glossary of terms

Background Papers:

- BNSSG Sexual Health Needs Assessment (Due to be published June 2023)

North Somerset Sexual Health Services

Workshop

North Somerset Council Health and Care Public Health team facilitated a workshop on 9th June 2023 to engage with local stakeholders on the recommissioning of the BNSSG Integrated Sexual Health services and the initial proposed model of delivery.

We invited stakeholders from a broad range of organisations with many attending, including local representatives of Unity our current service provider, Sirona, Children's services, Eddystone Trust, our Elected Member, Primary Care, Home education community, Substance advice services, UK Health Security Agency, and Bristol City Council.

We presented information on the National and regional context, current local sexual health service provision, North Somerset data and findings from the BNSSG sexual health needs assessment, and the draft service model/s. Links to sustainability and climate agenda were also highlighted.

We asked attendees to participate in tabletop exercises designed to elicit their views and seek suggestions to inform our integrated commissioning plan going forward.

Comments from tabletop exercises

Question: What is missing on our current system map?

Answers:

- Citizen advice bureau/hub type initiative missing?
- Missing formalised pathways into drug and alcohol services.
- Probation/prisons/children and youth offending team.
- Sexual health services in SEND.
- NEET young people / Home educated.
- Inconsistency to services based on geography, rural access.
- STI testing / Condom vending machines.
- Early help.
- Menopause support.
- Safeguarding services.
- Continuum of need.
- Further and higher education settings and how we work with colleges.

Question: Are there surprises from the data shared today?

Answers:

- Missing data on marginalised groups.
- Where are our increased numbers of students registering?

- Surprise around high levels of Sexually Transmitted Infections and repeat termination of pregnancy.
- More detail for all areas in North Somerset needed, could we break down further by ward or by even lower level e.g., MSOA / LSOA to show communities we recognise?
- What more can we do to understand from public health nursing services?
- How do we prioritise with lots of challenge areas?
- HIV testing, concern about late diagnosis – how to improve?
- System wide approach, who leads on what?
- Opportunities for co-production, not in silos.

Questions: Are there any gaps in our engagement plan, and what are the best methods to engage people in this proposal?

Answers

- **Groups:** Parents and carers, broad spectrum of students, not in education young people, Teachers, SEND leads, Head teachers, PHSE leads, Safeguarding leads, young farmers, Youth groups such as scouts, older adults, Childrens services, Barnardo's, SEND & You, faith groups.
- **Methods:** South-west skills campus, hospitals, QR codes on toilet doors, Sex on premises venues, Barbers, Gyms, VANS, NS Together, Town & Parish Councils, YMCA, Employers as access points, MAVIS bus, Creative arts approaches, children and family hubs - could Castle-batch be a location?

Question: What are your thoughts on the proposed model?

Answers

- **Digital**: Concerns around possible digital exclusion due to digital poverty (network reach or device) and barriers to services and information that exist with "firewalls" in school/employment settings. Some feedback that the proportion of digital activity seemed too high (50%).
- **Risk of market failure**: There are not lots of providers. Is this model deliverable? potential of service fragmentation through "lots".
- **Integration**: Check all the clinical pathways link to others too.
- **Community**: Could there be other ways to share knowledge through community networks?
- **Workforce challenge**: Could existing professionals be upskilled to be able to signpost when people are known to services.
- **Service demand**: Knowing there are increasing demands and population growth, will there continue to be difficulty accessing services for our local people? Do consultations give enough time?
- **Equality Diversity and Inclusion**: Map the model to vulnerable or poorly served groups - will this model serve them better? E.g., Bangladeshi & Eastern European migrant workers.
- **Opportunities**: Could there be an opportunity to help young people navigate services through an education "exit" interview with school nurses.
- **Feedback:** The condom provision for homosexual community is good, is there a similar access available for heterosexual community?

Summary and next steps

There was good energy and engagement in the room, with stakeholders understanding the importance of good Sexual Health Services for our local population. The feedback received

from stakeholders was informative and insightful. Contributions from stakeholders are appreciated by the NSC Public health team and wider collaborative commissioning group.

All feedback received will be shared with the Collaborative Commissioning Team to inform on the wider commissioning activity. With a focus on the needs of the North Somerset population, the feedback from this event will be used to inform and influence our consultation plans for the consultation process. We have had several offers from stakeholders to help with future engagement into their services and networks which will be utilised for this purpose. Further, pre-consultation engagement will be conducted with the two Locality Partnerships in North Somerset.

Feedback on the gaps in service delivery will be used to inform on the scope of the recommissioning and to identify opportunities for further integration.

Feedback on population health needs will be used to inform future needs assessment processes, the development of recommendations and future strategic action plans. In the immediate term elements of this data and feedback will be used in conversations with Public Health Nursing services to reset joint objectives.

Responses and insight to the proposed service model will be shared with the Collaborative Commissioning Team to be embedded into the development of the service specification and procurement and tendering processes.

Authors:

Becky Keating, Health & Care Public Health Service Leader
Kate Blakley, Sexual Health Commissioning Manager
Samuel Hayward, Consultant in Public Health
Directorate: Public Health & Regulatory Services

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North Somerset Council

Open, Fairer, Greener

Recommissioning BNSSG Integrated Sexual Health Services: North Somerset

Sexual Health Needs Assessment Summary

9th June 2023

Sexual Health Needs Assessment (SHNA)

For the first time a sexual health needs assessment has been conducted for the combined Bristol, North Somerset, and South Gloucestershire area.

The BNSSG SHNA aims to identify the sexual health needs of the population and how well these are being met.

The SHNA brings together a wide range of evidence from published outcomes data, local service data, the views of the public, service users and professionals, and national policy and guidelines.

Data analysis by demographics is carried out wherever possible, although the availability of data is sometimes a barrier to this.
The summary provides an overview of the SHNA data that relates to North Somerset.
The full SHNA report and findings are available upon request.

SHNA Findings summary

SHNA Limitations

- Information on the effect of rurality on sexual health
- Information on older age populations sexual health needs
- Limited demographic data available so information on minority population groups is also limited
- Disease/condition related outcomes related to STI's.
- Gaps in pupil voice / school age children surveys
- Only a 10% response rate from NS for the needs assessment consultation

Strengths

- Sector Lead Improvement (SLI) tool score of 63% for BNSSG services which indicates an overall mature achievement
- The WISH clinic does well to serve areas of deprivation in NS with higher uptake from areas of deprivation and higher diagnosis in wards near the site (Uphill and South Wards).
- LARC in GP has recovered to pre-pandemic levels, with high rates (15x higher than SRHS prescribing).
- Emergency Hormonal Contraception (EHC) in pharmacy is back to pre-pandemic levels in NS – approximately 30 consultations a month.
- U18 conception rates for NS have decreased (2021).
- U16 conceptions for NS was <5 in 2021 (a reduction from 10 in 2020).
- North Somerset had the lowest rate of new STI diagnoses (significantly better than England*)

Areas for action

Population

- Health promotion work needed on prevention / RSE for young people in WSM / Uphill Ward and South Ward.

- Action to increase service uptake from younger adults (18-24).
- STI prevention work in young men, including action to tackle high-risk sexual behaviours in young men in WSM and action to increase access and desire to test, for asymptomatic infections that are not being picked up.
- Although a greater proportion, still need to increase number of attendances at SRHS from people living in the most deprived parts of North Somerset.
- Focussed assessment of need and development of actions to address the ward-level variability in North Somerset is required.
- Maintain focus on under 18 and 16 conceptions and TOP's in WSM.

<u>STI's, Chlamydia and HIV</u>

- Improve chlamydia detection rate. NS has lowest detection rate in BNSSG, and 2nd worst detection rate after Solihull.
- Prevention work in young men, as men aged 15-19 in North Somerset have a higher estimated proportion of STI reinfection than in England.
- Focussed efforts in WSM and Uphill Ward as they fall into the highest national category for rates of new STI diagnoses.
- Compared to its nearest neighbours, North Somerset has one of the worst testing coverages across all HIV testing coverage indicators
- North Somerset had the biggest increase in proportion of HIV late diagnoses.

<u>Contraception and EHC</u>

- Proportion of women choosing injections in SRHS needs to be reviewed, and usage converted to more effective contraceptive options.
- Increase the number of young people choosing LARC.
- Improve access to emergency IUDs during week days.
- Review of attendances in under 15's for EHC at a pharmacy (more widely known or more young people having unprotected sex?).
- Review the number of condom collections after registering on the C-card scheme as it is low.

<u>Under 18's conceptions and abortions</u>

- Action to reduce the number of under-18 conceptions found in Weston-Super-Mare South and Weston-Super-Mare Hillside.
- Action to improve pathways to Public health nursing service and create parity to BNSSG teenage pregnancy outreach nurses.
- Review of the number of abortions after a birth in under-25s, as increased in North Somerset in 2021 despite the total number of abortions in under-25s decreasing (national trend)
- Review findings of the postpartum contraception pilot for business as usual
- Professionals want to improve abortion access / provision in North Somerset

Unity attendance and deprivation

Unity is the current provider of sexual health services in North Somerset (www.unitysexualhealth.co.uk). The chart below shows that the most deprived residents of North Somerset are over-represented in Unity attendances (people living in the most deprived quintile), but there are fewer overall attendances at SRHS from people living in the most deprived parts of North Somerset.

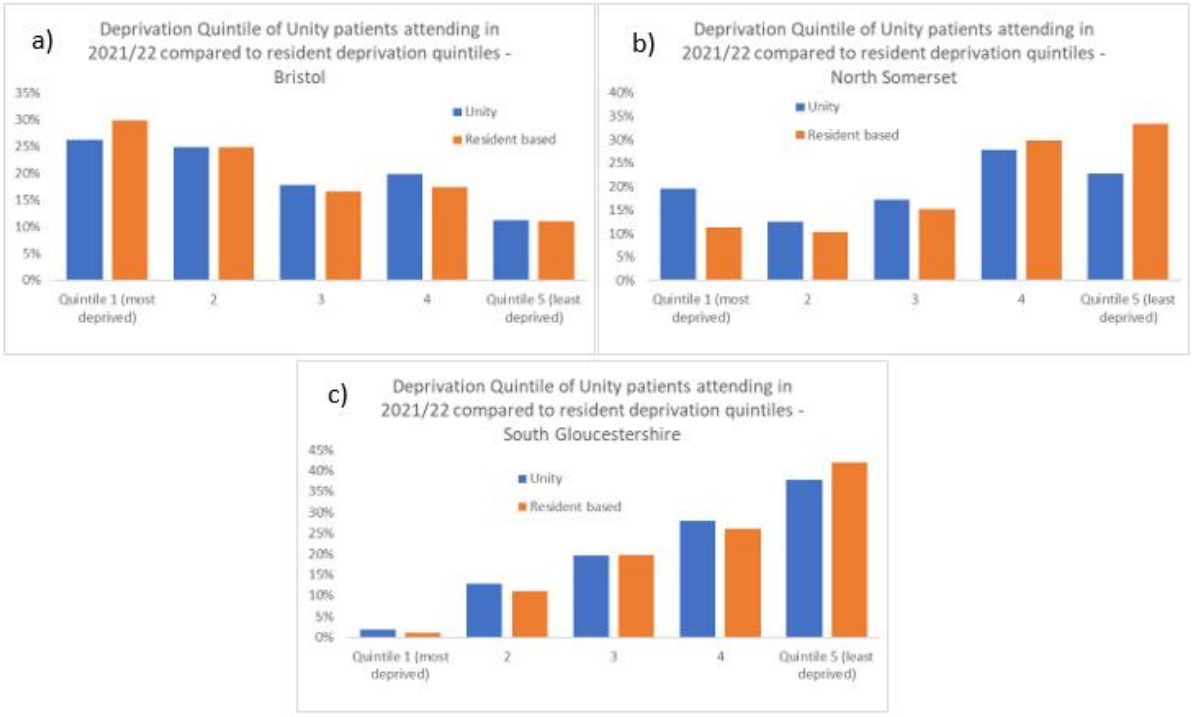


Figure 1. Unity attendances from BNSSG compared to the population as a whole by deprivation quintile, Bristol (a), North Somerset (b), South Gloucestershire (c), 2021-22

SPOT Tool
The SPOT tool is used to explore the relationship between council spend and associated outcomes. For sexual health, a total of 23 public health outcome indicators are used to map to council spend. These relate to service-level and population-level outcomes. Examples of this include: STI testing and diagnosis rates, spend on sexual health services, as well as outcome measures such as teenage conceptions.

Compared to England, North Somerset Council is also categorised as **'Same Spend, Worse Outcome'**, with an outcome score that is almost identical to Bristol's (-0.11). The categories for North Somerset compared to its 16 CIPFA neighbours are:

- 1 area had 'Same Spend, Better Outcome'
- 8 areas had 'Same Spend, Worse Outcome'
- 1 area had 'Lower Spend, Better Outcome'
- 6 areas had 'Lower Spend, Worse Outcome'

Of the 8 areas in the 'Same Spend, Worse Outcome' category, North Somerset is third from the top in terms of sexual health outcome score (-0.11). The area with comparatively the worst sexual health outcomes is categorised in the 'Lower Spend, Worse Outcome' group and had a score of -0.59. To understand how services could be delivered differently, it would be worthwhile contacting the two areas that achieve better outcomes with the same spend or less to find out how they deliver sexual health services locally (Central Bedfordshire and Bedford).

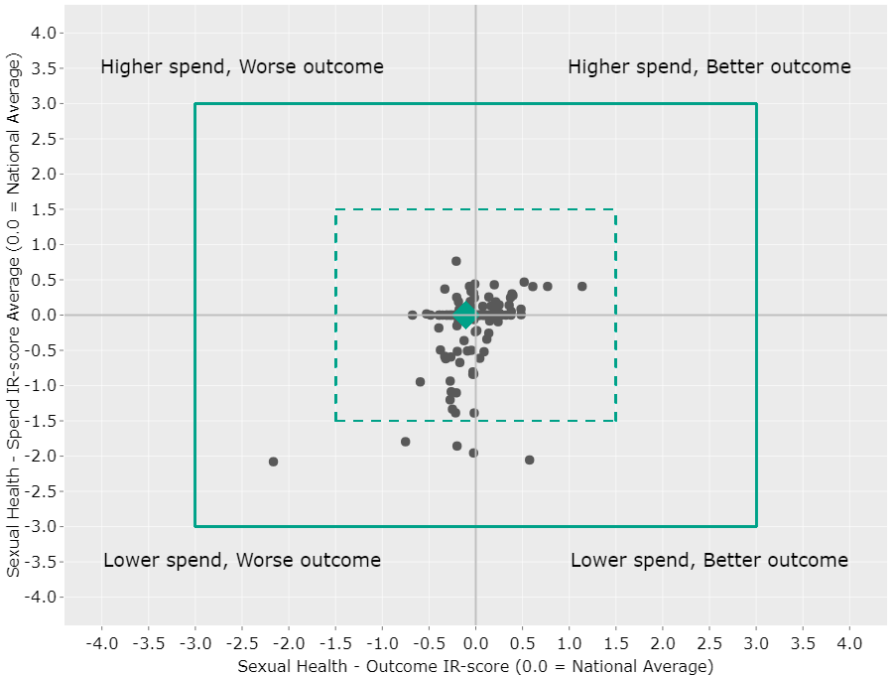


Figure 2: Spend versus sexual health outcomes for North Somerset Council compared to England (OHID SPOT 2022).

STI Diagnosis

North Somerset had the lowest rate of new STI diagnoses (excl. chlamydia in young people <25) when compared to its 15 nearest neighbours, with a rate of 158 per 100,000 residents of all ages (nearest neighbours range: 158-388 per 100,000), which is significantly better than the England rate.

The number of all new STIs diagnosed among residents of North Somerset in 2021 was 495, of which 153 were chlamydia diagnoses in 15-24-year-olds.

Area		All new STI diagnoses (%) breakdown by age group and gender (male, M; female, F), 2021													
		15-19		20-24		25-34		35-44		45+		N/K		Total	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
Bristol	%	5.6	16.3	33.4	40.3	41.6	32.8	11.8	7.5	7.4	2.9	0.1	0.0	100.0	100.0
	n	81	220	485	545	604	443	172	102	108	39	1	0	1,452	1,351
North Somerset	%	9.2	24.8	19.7	40.9	41.7	24.0	14.7	6.3	14.7	3.5	0.0	0.0	100.0	100.0
	n	20	63	43	104	91	61	32	16	32	9	0	0	218	254
South Glos	%	11.7	21.7	26.3	39.8	41.7	24.5	11.2	8.8	9.1	4.6	0.0	0.2	100.0	100.0
	n	45	99	101	182	160	112	43	40	35	21	0	1	384	457
BNSSG	%	7.1	18.5	30.6	40.3	41.6	29.9	12.0	7.7	8.5	3.3	0.0	0.0	100.0	100.0
	n	146	382	629	831	855	616	247	158	175	69	1	1	2,054	2,062
England	%	**7.2**	**20.2**	**23.9**	**36.4**	**39.4**	**29.7**	**17.6**	**9.1**	**11.8**	**4.5**	**0.0**	**0.0**	**100.0**	**100.0**

Table 1: All new STI diagnoses (%) made in SRHS and non-specialist SRHS, by age group and gender, BNSSG and England, 2021 (UKHSA GUMCAD)

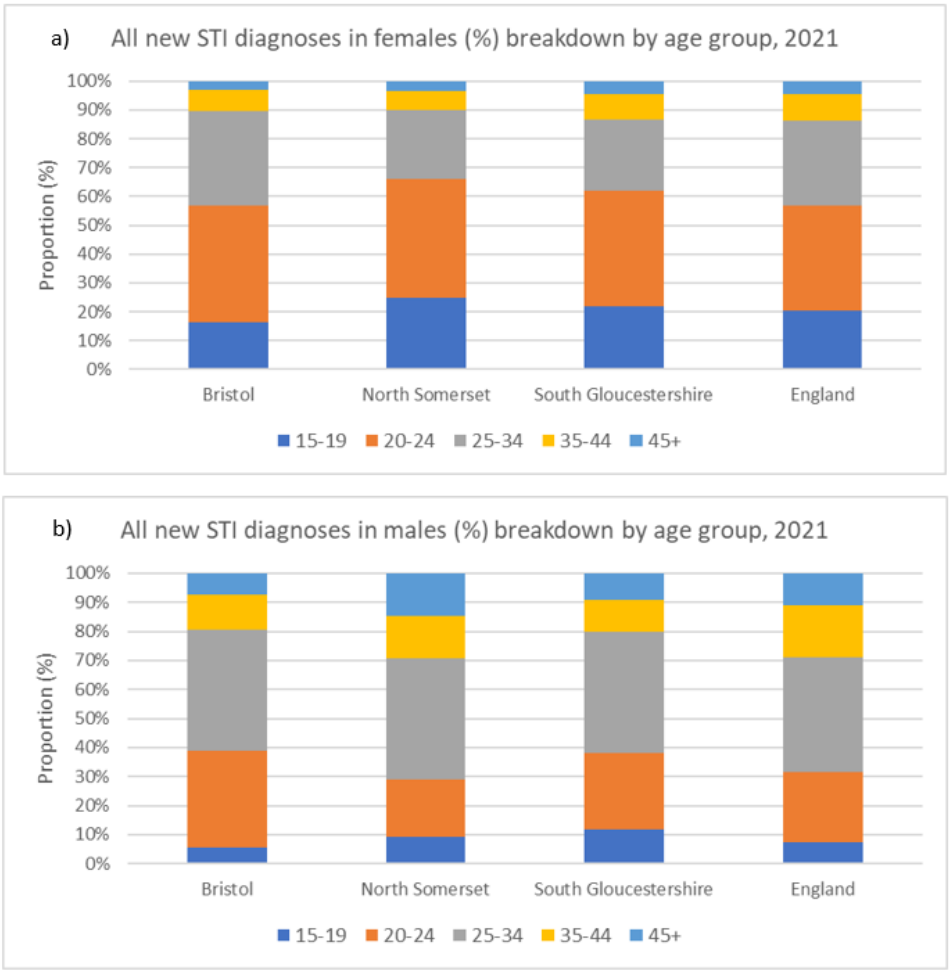
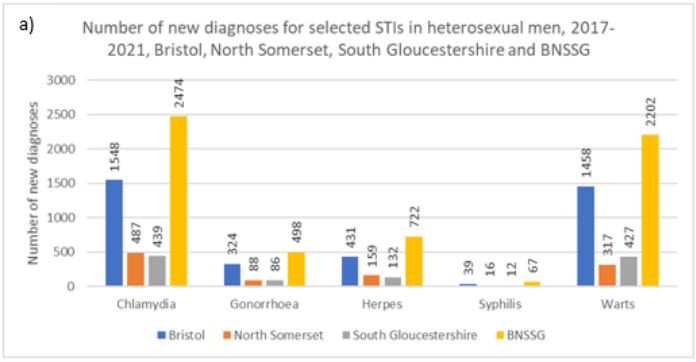
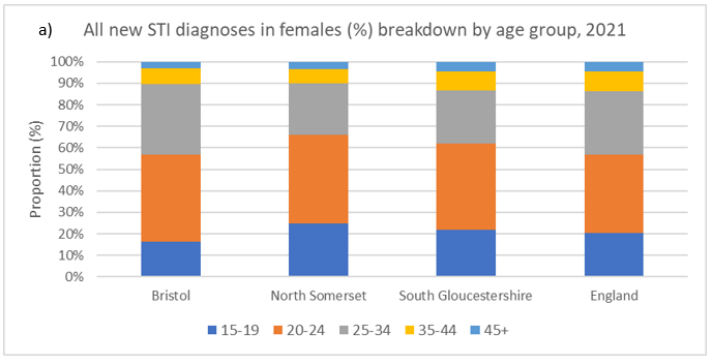
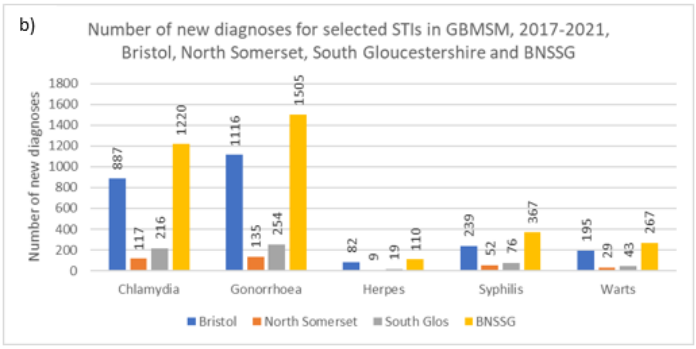
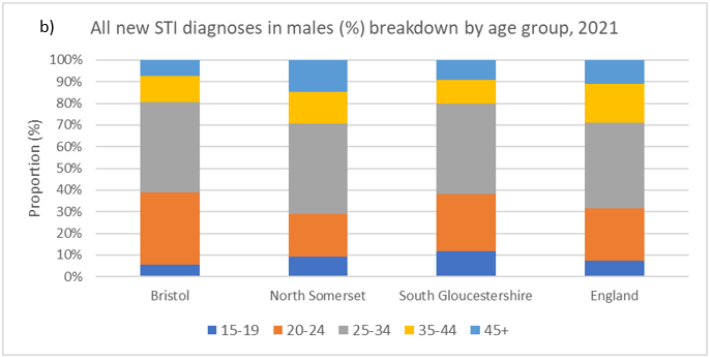


Figure 3: Scarf chart of all new STI diagnoses in a) females and b) males, by age group, Bristol, North Somerset, South Gloucestershire and England (UKHSA)









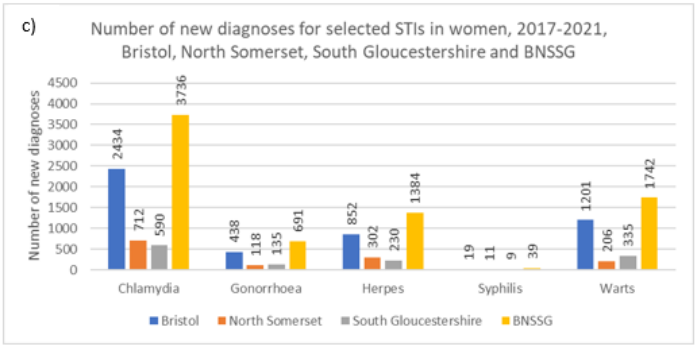


Figure 4: Number of new diagnoses for selected STIs in a) heterosexual men; b) GBMSM; and c) women, Bristol, North Somerset, South Gloucestershire, BNSSG, 2017-2021 (UKHSA GUMCAD

Deprivation category	Bristol			North Somerset			South Gloucestershire		
	Count	%	Pop. %	Count	%	Pop %	Count	%	Pop %
Most deprived	730	32.5	29.9	120	25.5	11.3	20	3.3	1.1
2nd most deprived	585	26.1	24.9	70	14.9	10.3	80	13.0	11.2
3rd most deprived	390	17.4	16.7	60	12.8	15.1	125	20.3	19.7
4th most deprived	365	16.3	17.4	105	22.3	29.8	170	27.6	26.0
Least deprived	175	7.8	11.1	115	24.5	33.5	220	35.8	42.0

Table 2: Number and proportion of new STI diagnoses (excluding chlamydia in <25 year olds) in SRHS, by deprivation category and compared to population deprivation, BNSSG 2020 (GUMCAD; IMD 2019)

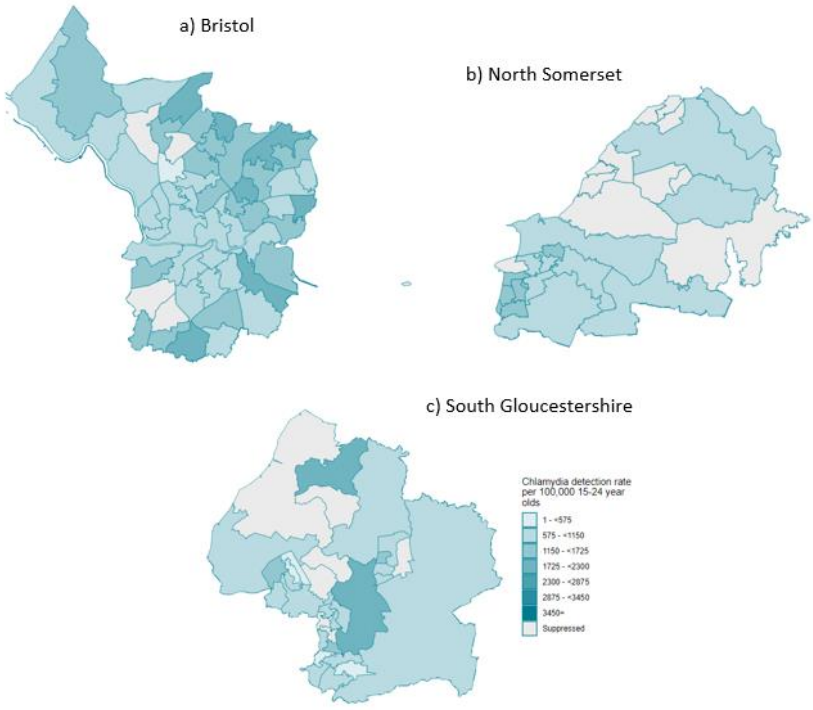
In North Somerset, there were 403 people with repeat infections reported within 12 months (35%) of a total 1,155 diagnosed STIs in 2021. Of note is that men aged 15-19 in North Somerset have a higher estimated proportion of reinfection than in England. Also, in England women aged 15-19 years had the higher proportion of reinfection to men aged 15-19, but the reverse is true for North Somerset. This could suggest greater high-risk sexual behaviours in young men in the area, a lack of access/desire to test, and potentially greater asymptomatic infections that are not being picked up.

Chlamydia

While North Somerset's positivity rate in 2021 is similar to the England average of 6.1%, Weston-Super-Mare – Uphill Ward falls in to the highest national category for rates of new STI diagnoses with >2,500 per 100,000 in people aged 25 to 64.

In 2021, 9.4% of North Somerset residents aged 15 to 24 years old were tested for chlamydia with an 8.0% positivity rate. Of the three BNSSG council areas, North Somerset has the lowest chlamydia detection rate at 752 per 100,000 in 2021 (153 positives out of 1,921 screened) and, compared to its 15 nearest neighbours (ranging from 735 to 1,768 per 100,000), also has the second worst detection rate after Solihull.

There is variation in detection of chlamydia in 15- to 24-year-olds within each council footprint as illustrated in these maps, which shows detection at ward level in 2021. Variation in rates of chlamydia detection may represent differences in prevalence but are influenced by screening coverage and whether most at risk populations are being reached (i.e. the proportion testing positive).



Map 1: Chlamydia detection rate per 100,000 population in 15 to 24 years in a) Bristol, b) North Somerset and c) South Gloucestershire by ward, 2020 (UKHSA).

There is no data presented on the impacts of Chlamydia, such as case rates of pelvic inflammatory disease, ectopic pregnancy, and tubal-factor infertility.

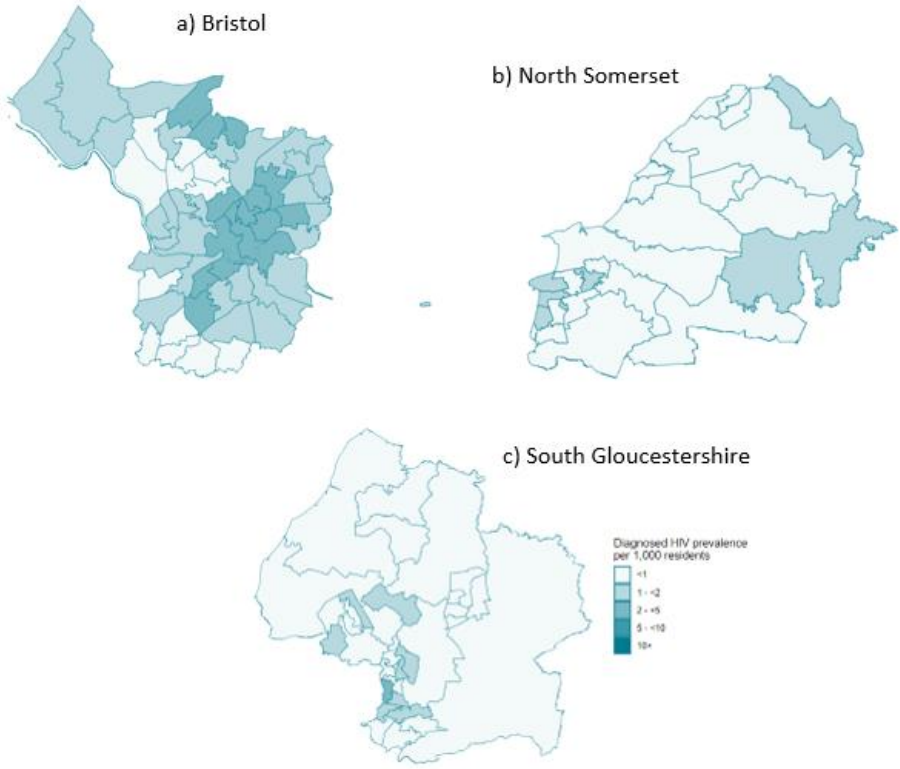
HIV

All three councils had decreased coverage across all HIV testing coverage indicators. Compared to its nearest neighbours, North Somerset has one of the worst, if not the worst testing coverage across all HIV testing coverage indicators. Of Unity service users attending for a new episode of care who accepted an HIV test in 2021 it was accepted by 26.5%, 1,285 service users, in North Somerset.

HIV testing coverage, 2021	Bristol		North Somerset		South Gloucestershire		BNSSG (calculated)		England
	Tests accepted	%	Tests accepted	%	Tests accepted	%	Tests accepted	%	%
Total	2,830	34.3	558	26.0	698	29.8	4,086	32.1	45.8
Gender									
Male	1,625	51.3	290	40.2	423	48.0	2,338	49.0	62.8
Female	1,120	34.8	236	23.8	252	31.5	1,608	32.1	36.6
Sexual risk									
GBMSM	793	76.3	108	61.0	219	79.9	1,120	75.1	77.8
Repeat testing (testing more than once in the previous year)									
GBMSM	303	38.4	38	36.2	93	42.5	434	39.0	45.3

Table 3: HIV testing coverage data (tests accepted and percentage of eligible attendees): total, by gender, by sexual risk, and repeat testing, Bristol, North Somerset, South Gloucestershire, BNSSG and England, 2021 (red shading = lower than England; amber shading = similar to England) (UKHSA)

HIV prevalence North Somerset (0.97 per 1,000 people aged 15-59) means North Somerset is a low prevalence area that is similar to our respective nearest neighbours' average.



Map 2: Maps of diagnosed HIV prevalence among people aged 15 and above in a) Bristol, b) North Somerset, and c) South Gloucestershire by Middle Super Output Area (approx. 7-10,000 population): 2021 (UKHSA)

In heterosexual men, late diagnosis of HIV was 5/7 new diagnoses in North Somerset (71.4%). The proportion of late diagnoses reported in North Somerset for GBMSM was 33.3%. On the whole, BNSSG and North Somerset is doing well in terms of HIV treatment and care.

Indicator, % (n)	BNSSG	South West	England	Bristol	North Somerset	South Gloucestershire
Prompt ART initiation, 2019-2021	85.5% (106)	87.2% (451)	**83.5% (6,887)**	86.0% (74)	75.0% (9)	88.5% (23)
ART coverage, 2021	99.0% (1,262)	98.9% (5,124)	**98.4% (89,926)**	99.1% (867)	99.3% (152)	98.4% (243)
Virological success, 2021	98.6% (1,128)	98.6% (4,781)	**97.8% (80,254)**	98.3% (774)	99.3% (133)	99.1% (221)

Table 4: HIV treatment and care indicators (UKHSA)

In 2021, 58.0% (65) people defined as having PrEP need initiated or continued PrEP use In North Somerset this proportion was higher than Bristol and the same as S.Glos but below the England average at 69.6%.

Contraceptives

LARC

In 2021, there was a marked increase in the proportion of women choosing injections in SRHS in BNSSG, largely driven by North Somerset which increased from 10% to 16% of women between 2019 and 2020. This is double the figure for England (8%) and more than double the near neighbours average for North Somerset (7%).

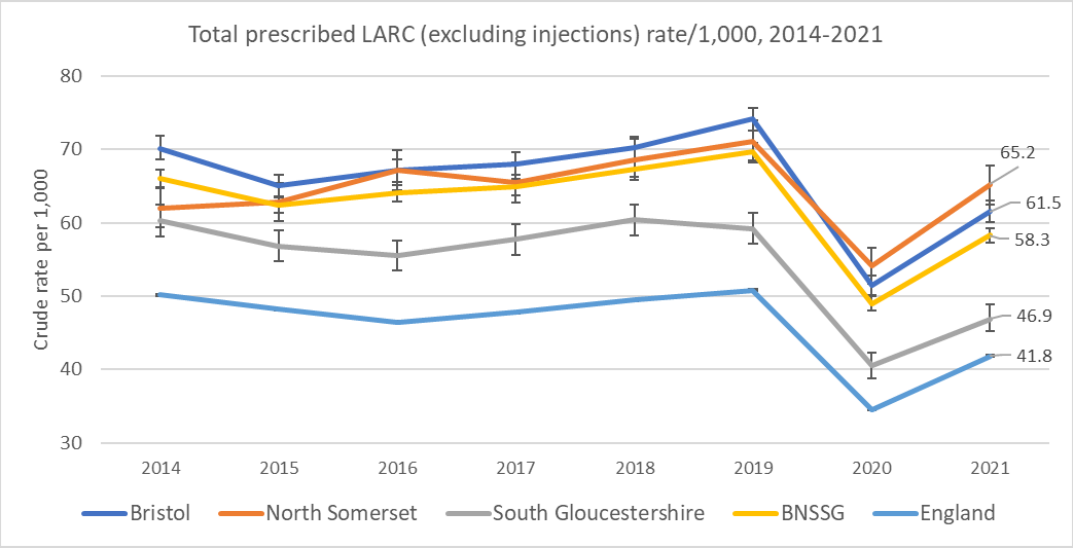


Figure 5: Total LARC prescribed in GP and SRHS (excluding injections) rate / 1,000, 2014-2020, Bristol, North Somerset, South Gloucestershire, BNSSG, SW and England (OHID)

In North Somerset, GP LARC prescribing is now over 15 times higher than SRHS prescribing (61/1,000 in GPs compared to 4/1,000 in SRHS in 2021). This is compared to 1.6 times in England (26/1,000 in GP compared to 16/1,000 in SRHS).

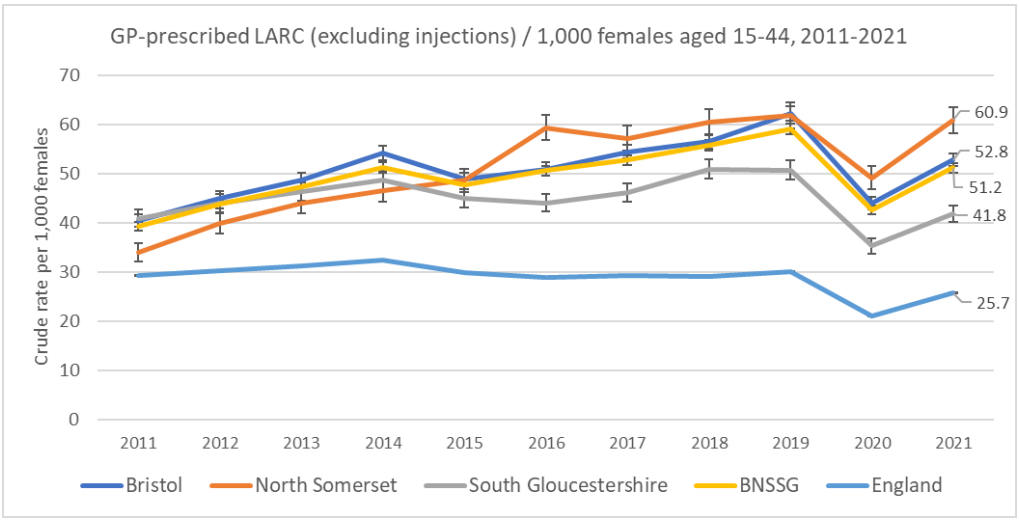


Figure 6: GP-prescribed LARC (excluding injections) / 1,000 females aged 15-44, Bristol, North Somerset, South Gloucestershire, BNSSG, England, 2014-2021 (OHID)

Differences in location of LARC fit are thought to be due to local service design and geography. In more rural locations, GP services may be used more frequently than SRHS as people live further from clinics. This is likely relevant in North Somerset, where the overall population density is 568 people/km^2, compared to Bristol's 4,026 people/km in 2010. The overall population density of North Somerset is similar to South Gloucestershire's 533 people/km^2 in 2010, but note the proportion of residents living in rural areas is higher in North Somerset (1 in 3 in 2012). North Somerset's high rates may also be secondary to different payment models across the region for GP LARC provision.

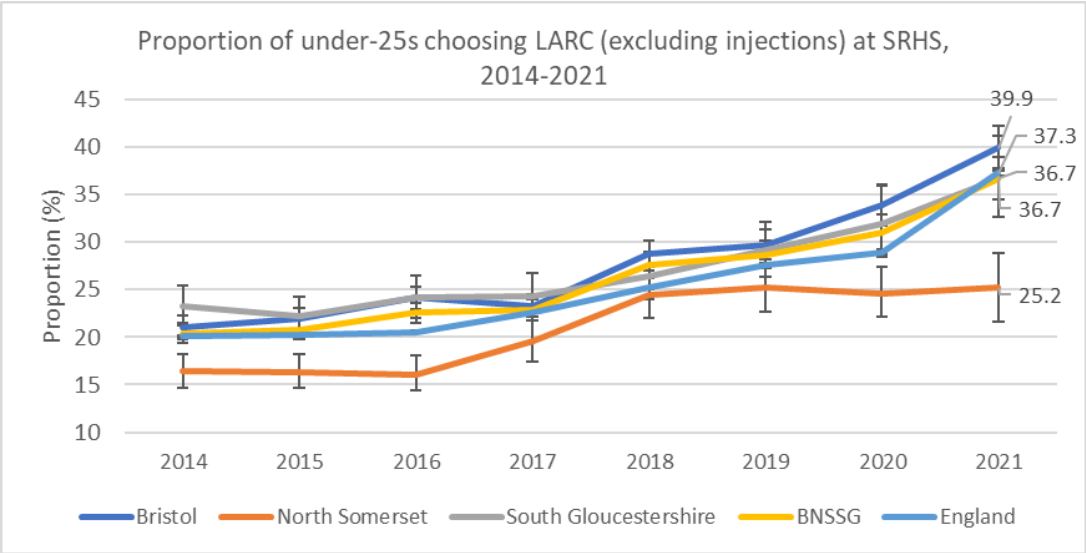


Figure 7: Proportion of under-25s choosing LARC (excluding injections) at SRHS, 2014-2021, Bristol, North Somerset, South Gloucestershire, BNSSG and England (OHID)

Nationally and locally more under 25s are choosing LARC (excluding injections) when they attend SRHS (figure below). A quarter of under-25s (25%) in North Somerset chose LARC (excluding injections) when attending SRHS in 2021, which is lower than the national average (37%) and has not been on an upward trend since 2018. This could suggest that young people are accessing LARC in GP settings, a greater preference for injections in this age group, or they are using user-dependent method or possibly no contraception at all.

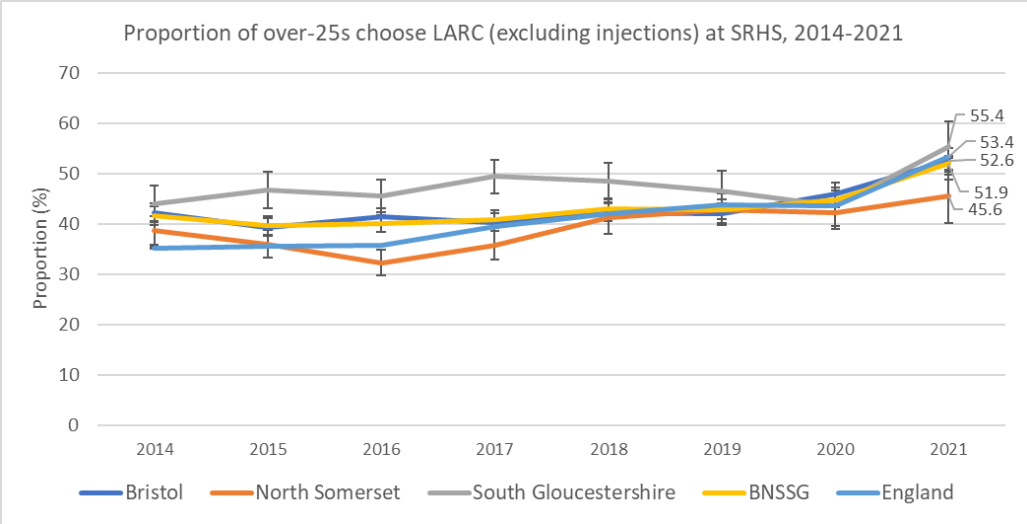


Figure 8: Proportion of over-25s choosing LARC (excluding injections) at SRHS, 2014-2021, Bristol, North Somerset, South Gloucestershire, BNSSG and England (OHID)

Lower proportions of young people are choosing LARC in North Somerset. Of interest, the proportion of LARCs and injections provided to under-25s within the service in 2021-22 as a proportion of all main method contraceptives is particularly high in North Somerset at 53%, but this should be interpreted with caution given small numbers and the inclusion of injections, as previously mentioned.

COVID impacts may have led to a slight increase in the use of user-dependent methods that could be dispensed by post, or LARC requiring lower-intensity clinical interaction (injection). This effect was more pronounced in North Somerset. However, LARC activity in North Somerset practices has already recovered to pre-COVID-19 levels. National LARC recovery strategies focus on improving access in primary care, and LARC prescribing performance for a region is dependent on primary care provision. In BNSSG, GP data suggests good recovery, with North Somerset reporting 101% of expected IUCD insertion activity in 2021/22.

Emergency Hormonal Contraception (EC)

The emergency contraception (EC) rate of North Somerset has a rate of 2/1,000 in SRHS. 26.0% (26 people) of those living in North Somerset and accessing EC at Unity accepted an emergency IUD. In 2021-22, a total of 5,626 EHC consultations took place within BNSSG pharmacies, with 73% occurring in Bristol, 6% in North Somerset and 21% in South Gloucestershire. The vast majority (5,558, 99%) were with young people aged 15-24 years old. There were a small number of consultations with young people under the age 15 years (29, 0.5%), and those aged 25 years and above (39, 0.7%), the latter of which are at the discretion of the pharmacist. In North Somerset 4% of people attending pharmacy for an EHC consultation were referred for an emergency IUD via a referral pathway into Unity

Condoms

The table below shows the number of C-Card registrations in North Somerset in 2021/22 and 2022/23 (Apr - Sep).

C-Card scheme data for 2021-22	Bristol		North Somerset		South Gloucestershire	
	2021-22	2022-23 (Apr-Sept)	2021-22	2022-23 (Apr-Sept)	2021-22[2]	2022-23[3] (Apr-Sept)
Number of young people registering on to the C-Card scheme	416	309	162	89	81	28
Number of condom collections after registration on the scheme	268	160	35	15	73	44
Number of active C-card outlets (for registration & pick up, and pick up only)	154	128	4*		35	41

* Does not include pharmacies, who report take-up through PharmOutcomes and not Therapy Audit. Includes Sirona as one active pick-up point covering all North Somerset schools.

Table 5: C-Card scheme data for Bristol, North Somerset and South Gloucestershire, 2021-22 (Unity / North Somerset Council / South Gloucestershire Council)

Under-18s conceptions and abortions

In North Somerset, rates of under-18s conceptions found in Weston-Super-Mare South and Weston-Super-Mare Hillside wards are higher than the England average (2018-2020).

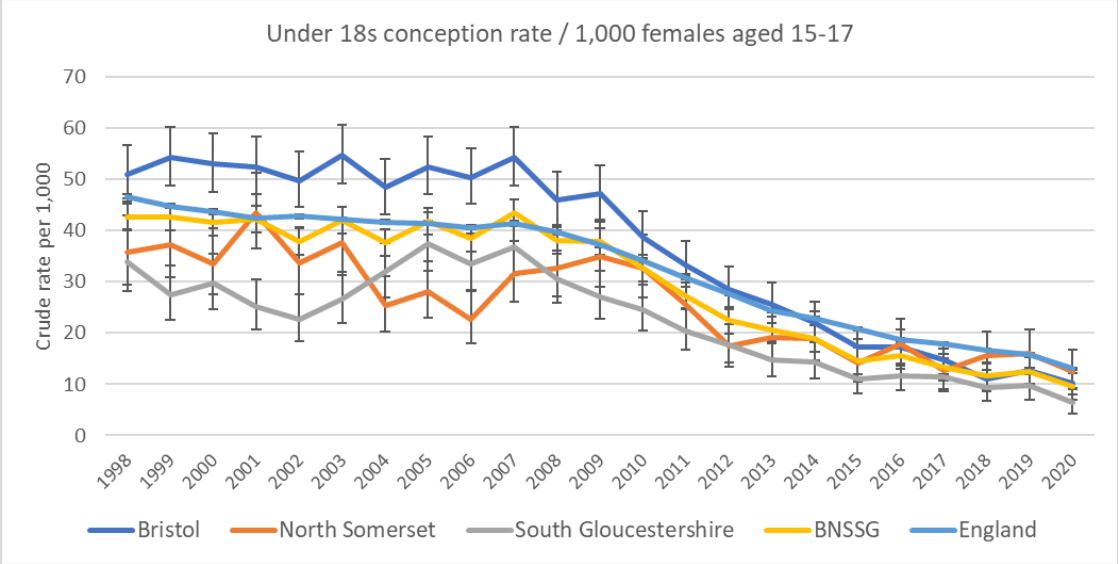
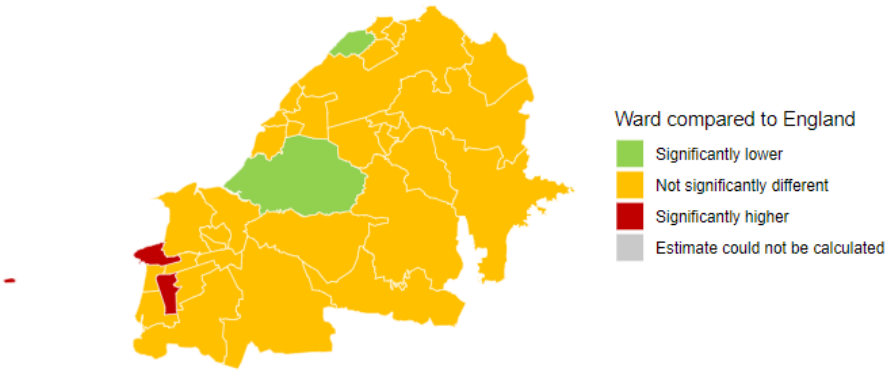


Figure 9: Under-18s conception rate per 1,000 (females aged 15-17) in Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

However, recently published under-18s conception rates for 2021 show North Somerset's rates have decreased. At ward level, further inequalities can be identified. Three-year data on under-18s conceptions in North Somerset from 2018-2020, when compared to the England average, shows that Weston-Super-Mare South and Weston-Super-Mare Hillside wards have higher rate of under-18s pregnancies (see map below).



Map 3: Under-18s conception in North Somerset by ward, compared to England: three-year period between 2018-2020 (OHID)

In North Somerset the rate of conceptions in under-16 year olds (13-15 years) has fallen from 2.8 to 0.8 per 1,000 (a decrease of 7 conceptions). New published data for 2021 shows that the percentage of under-18s conceptions leading to an abortion fell slightly in North Somerset.

Area	Under-18s conceptions leading to an abortion	
	Percentage, 2021	Percentage, 2020
Bristol	45.6	45.5
North Somerset	51.4	53.5
South Gloucestershire	52.3	48.3
England	**53.4**	**53.0**

Table 6: Percentage of under-18s conceptions leading to an abortion, 2020 and 2021, Bristol, North Somerset, South Gloucestershire, England (ONS).

Abortion

There may be an opportunity to improve abortion provision in North Somerset and potentially address lack of teenage pregnancy outreach provision in North Somerset. In 2021, 3,069 abortions were recorded across BNSSG, of these 547 were in North Somerset. Each of the three council areas have one of the lowest total abortion rates, and repeat abortion rates when compared to their respective CIPFA neighbours and are each lower than the England rate.

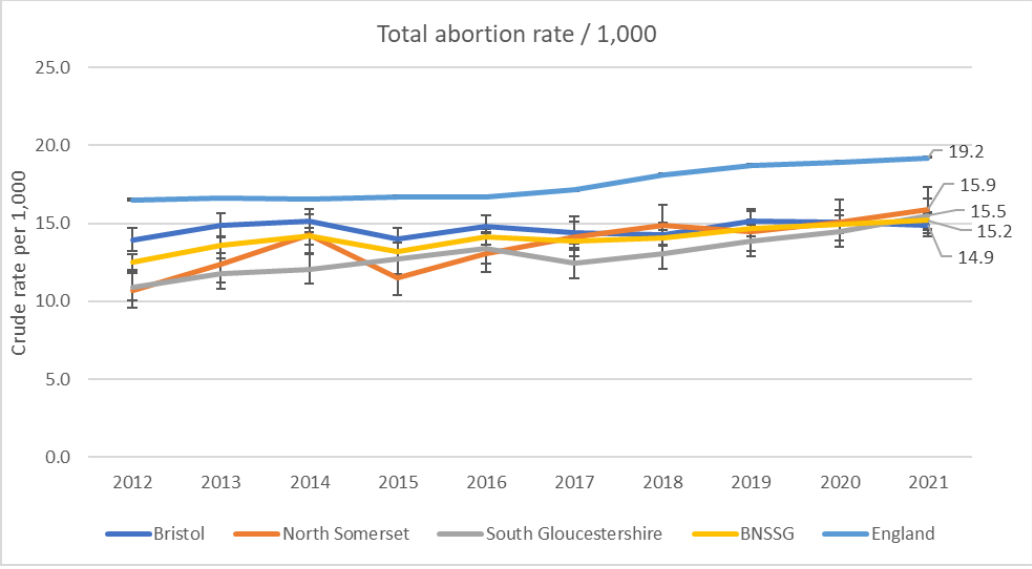


Figure 10: Total abortion rate per 1,000, 2012-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID).

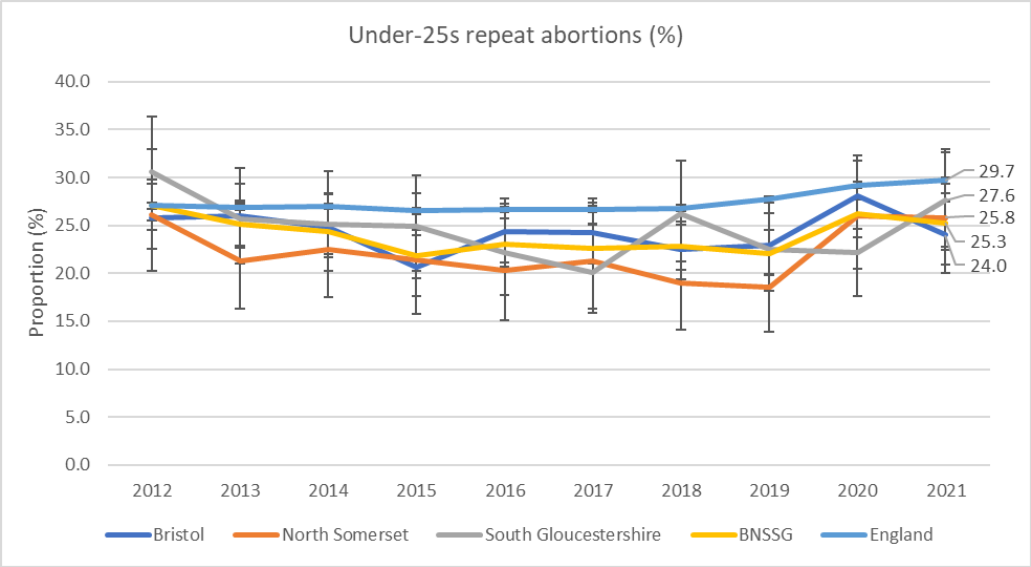


Figure 11: Repeat abortions in under-25s, 2012-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

Under-25s abortion after a birth

Locally and nationally there has been a general downward trend in the proportion of under-25s having an abortion after a previous birth since 2014, except in North Somerset which has seen an increase over the last couple of years. This may relate to fluctuations in the denominator for this indicator – the number of abortions in under-25s, which has fallen from that reported in 2020 in North Somerset while the number of abortions in under-25s following a birth in 2021 increased by 10 compared to 2020.

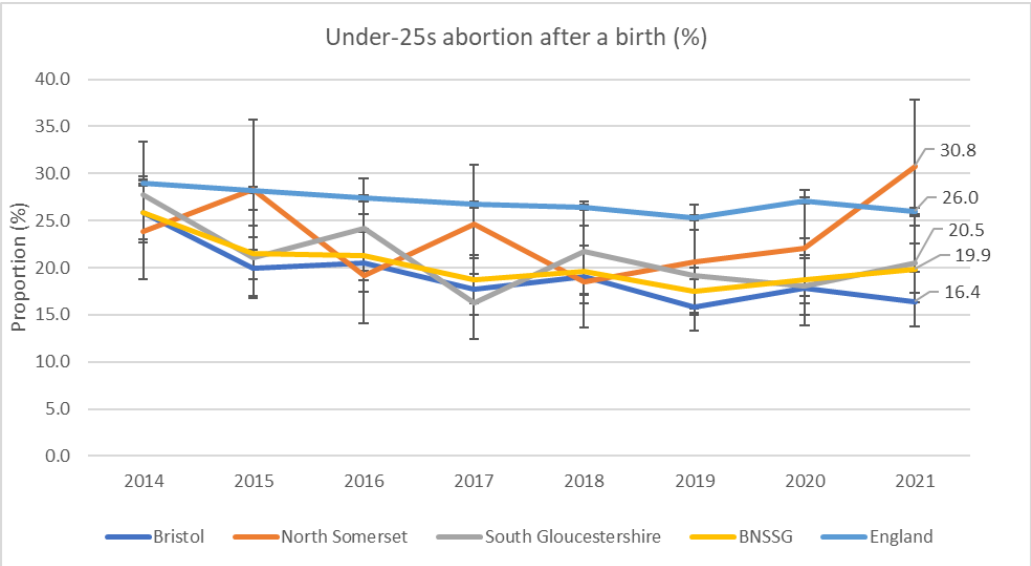


Figure 12: Proportion of women aged under-25 having an abortion who have previously had a birth, 2014-2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID)

In 2021, North Somerset had the highest proportion of under-25s abortions after a birth of the three councils at 31% (56 abortions), but Bristol had the highest number at 104. In recent years, Bristol and South Gloucestershire have been consistently lower than the England average while North Somerset has been similar.

Area	Abortions under 10 weeks that are medical, 2014		Abortions under 10 weeks that are medical, 2021	
	Number	Percentage (%)	Number	Percentage (%)
Bristol	691	52.5	1,356	92.9
North Somerset	189	45.3	445	94.9
South Gloucestershire	281	55.6	670	95.9
BNSSG	1,161	51.9	2,471	94.1
England	**82,185**	**57.9**	**169,729**	**93.1**

Table 7: Abortions under 10 weeks that are medical, 2014 and 2021, Bristol, North Somerset, South Gloucestershire, BNSSG, England (OHID; orange shading means the value is similar to England; red shading means the value is lower than England).

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Sexual Health Services Abbreviations

A&E	Accident and Emergency
ADPH	Association of Directors of Public Health
AGC	Advisory Group on Contraception
APPG (SRH)	All Party Parliamentary Group (on Sexual and Reproductive Health)
ART	Antiretroviral therapy
BaNES	Bath and North East Somerset
BASHH	British Association for Sexual Health and HIV
BBV	Blood-borne virus
BNSSG	Bristol, North Somerset and South Gloucestershire
CCG	Clinical Commissioning Group
COVID-19	Coronavirus
cuIUD	Copper intrauterine device
DHSC	Department of Health and Social Care
DI	Digital intervention
DNA	Did not attend
EC	Emergency contraception
EHC	Emergency hormonal contraception
FSRH	Faculty of Sexual and Reproduction Health
GBMSM	Gay, bisexual and other men who have sex with men
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HRT	Hormone replacement therapy
HSV	Herpes simplex virus
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IMD	Index of multiple deprivation
IUD	Intrauterine device

LARC	Long-acting reversible contraception
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more
LGV	Lymphogranuloma venereum
NCSP	National Chlamydia Screening Programme
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PEP	Post-exposure prophylaxis
PHE	Public Health England
PLWHIV	People living with human immunodeficiency virus
PrEP	Pre-exposure prophylaxis
PSHE	Personal, social and health education
RSE	Relationships and sex education
RSHE	Relationships, sex and health education
SEND	Special educational needs and disabilities
SHNA	Sexual health needs assessment
SPLASH	Summary Profile of Local Authority Sexual Health
SRHS	Sexual and reproductive health service
STI	Sexually transmitted infection
THT	Terrence Higgins Trust
UKHSA	UK Health Security Agency
UPSI	Unprotected sexual intercourse
WHO	World Health Organization