Healthier **Together**

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

Joint Forward Plan

Process, timeline and next steps

Cintia Faria, Programme Delivery Manager and System-Thinking Practitioner

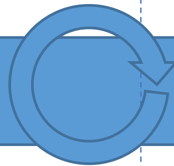
October 2023

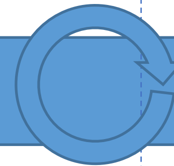
Healthier Together

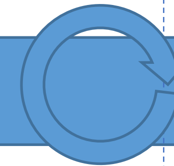
Improving health and care in Bristol, North Somerset and South Gloucestershire

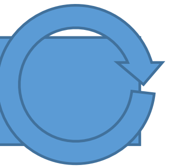
Context from national mandate

	2024/25	2025/26	2026/27	2027/28	2028/29
5yr	Integrated Care Strategy				
5yr	Joint Forward Plan				
2yr	Operational Planning				
1yr	Delivery Plans				









Purpose of the JFP

To describe how the 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

Address the four core purposes of ICS:

1. Improving outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money
4. Helping the NHS support broader social and economic development

Delivery of universal NHS commitments:

1. Long Term plan
2. Annual NHS Priorities
3. Operational planning guidance

Meet Legal Requirements:

1. Public Sector Equality Duty
2. Section 149 of the Equality Act 2010
3. NHS Act 2006

National guidance encourages systems to use the JFP to develop a shared delivery plan for the ICS Integrated Care strategy (developed by the ICP) and the Joint Local Health & Wellbeing Strategies (developed by HWBs)

Link to the published BNSSG JFP here

Principles of the JFP (awaiting guidance update)

National guidance sets out 3 principles describing the JFP’s nature and function

1. **Fully aligned** with the wider system partnership’s ambitions.

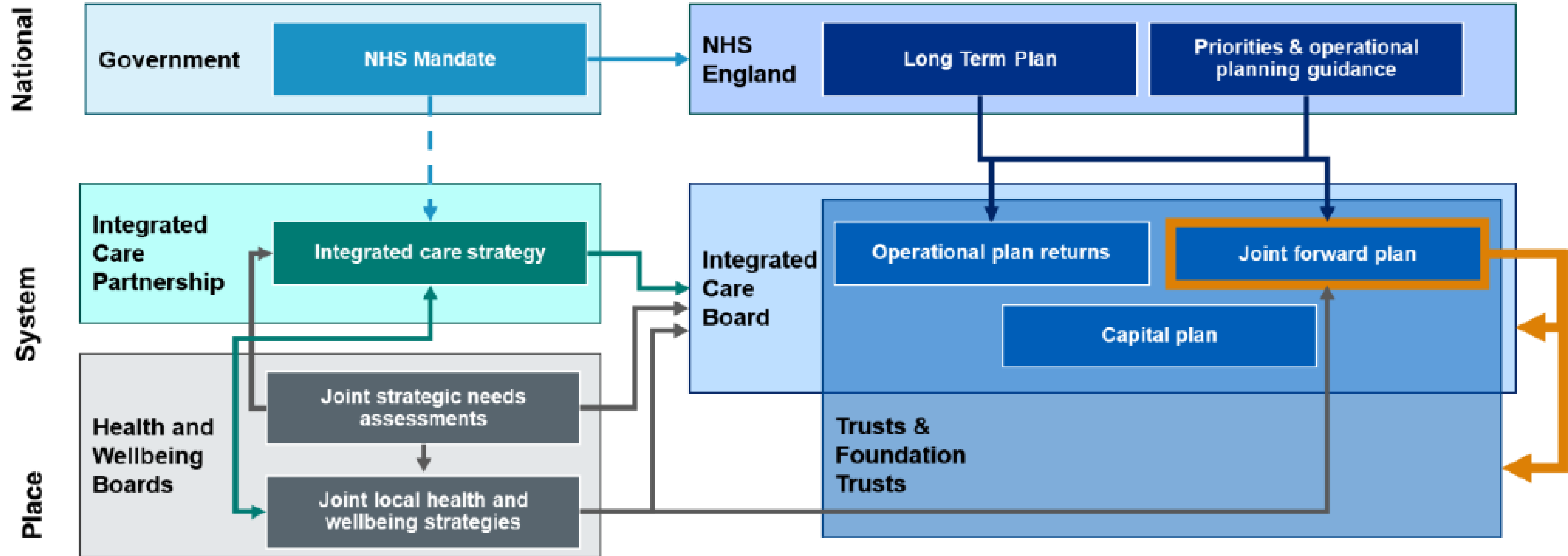
2. Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.

3. **Delivery focused, including specific objectives, trajectories and milestones as appropriate.**

Healthier Together

Link to the published BNSSG JFP here

Legislative Framework – relationship with other strategies and plans



BNSSG approach to update the first JFP - mandate

1. Alignment with system operational planning process.

2. Take opportunity to address feedback and lessons identified. We will reduce the contents of the JFP to be published, using a **visual format** that is easier for the public to read and understand; Include an explanation on **how** the plans will **benefit the population** with the new template provided by the planning team)

3. Focus on 5-year deliverables, trajectory and metrics, including assessment of first year delivery (partial assessment due to constraint timeline, update the original table for deliverables and metrics so it can be used internally for planning purposes).

4. Ensuring clearly articulated alignment with **BNSSG strategy, 4 ICS aims** and how plans will support the **outcomes framework**

Healthier Together

Link to the published BNSSG JFP here

JFP High Level Process Timeline

JOINT FORWARD PLAN	September				October					November				December				Jan-24					February				Mar-24			
	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	4	11	18	25
Stakeholders to address mandate																														
System Planning Day 1					3rd																									
System Planning Day 2												20th																		
Work with Strategy and Comms Team to ensure alignment																														
Drop-In Sessions to support relevant stakeholders on mandate	7th	11th	20th	25th	4th	12th	17th	26th	1st	6th	14th	23rd	29th																	
Deadline for final updates from programme leads																20th														
Protected time for Governance approvals																														
Final approval of the JFP by ICB Board																											7th			
Final sign off by relevant HCIG SROs																													20th	
Submission and publication of the final (updated) JFP																														28th

Link to drop-in sessions here

Healthier Together

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

Engagement and Governance Timeline

Sept - Oct 2023	November	December	January	February	March 2024

Locality Partnerships, Primary Care, H&C Professional Leadership, System Quality Group, VCSE Alliance…

Health and Wellbeing Boards x 3, Health and Care Improvement Groups x 4

Individual Organisation Trust Boards - if needed

7th - ICB Board Approval of process timeline and templates

7th - ICB Board
20th relevant SROs

Template

JFP template

Programme (new column)	Deliverables / milestones (The changes or improvements you are planning to complete based on the last JFP)	Timeline (Year and Quarter)	Metrics (to monitor progress and support evaluation/benefits realisation)	Which outcomes of the system outcomes framework will this contribute to?	Which of the 4 ICS aims will this support?	Which of the 9 ICS strategic commitments will this support?	Benefits to the population – in plain English and no acronym
Green Plan example	e.g. Ensure all new contracts with suppliers have plan to take their operations to net zero by 2030	25/26 Q2	Carbon footprint of supply chain will be reduced by 50% before 2028	ENV19, ENV20, ENV21	4	6,7	EXAMPLE - By the end of 2025/26, if all the health and care providers and suppliers are able to take their operations to net zero carbon, then the population will benefit from a reduced air pollution amongst other cultural changes and benefits. This will support our system to achieve a sustainable procurement, achieving the required social and economic development, which is one of the 4 ICS aims.
			Carbon footprint of supply chain will be net zero by 2030	ENV19, ENV20, ENV21	4	6,7	

Original table for key deliverables, milestones and timeline – **pls update this table for your programme if not included above so we can use it for internal planning and evaluation purposes (including reporting to NHSE). If the plans have changed and your commitments will not be the same, please ensure you include a narrative to explain that, including assessment of deliverables so far (up to Q2 23/24 if possible). Please note a new column has been added for 2028/29.**

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				27/2028		28/29
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1+2	Q3+4	
Programme – Green Plan example																			
To establish a system-wide dashboard – update required, example of completed tasks could be turned blue with narrative in small fonts	Completed, IMPACT: zxyz																		
Develop costed delivery plan to measure ourselves against - update required if possible, if slipped timeline pls confirm new deadline with different colour e.g dark green, darker amber or darker red, according to RAG, so we know there is a change					Deadline slipped?														

Original table for the metrics (and how they align with the outcome's framework) - **pls update this as well if not included above, so we can use it to support the benefits realisation process.**

Programme (new column)	Metrics	Contribution to Outcomes Framework
Green - Procurement	Carbon footprint of supply chain will be net zero by 2030	ENV19, ENV20, ENV21
Green - Estates	Our estate will be net zero by 2030	ENV19, ENV20, ENV21

For consideration by all members /partners

1. How can we effectively integrate the Local Authority's and VCSE's plans into this System-wide process?

2. Should the Health and Wellbeing Board plans continue to be presented separately or integrated with the Localities Partnership plans?

3. How can we improve visibility of the Health and Wellbeing Board, VCSE and Localities' plans impact system-wide? (Including the process to monitor and assess the plans)

4. There is an opportunity to address interdependencies and integration between relevant plans delivered by different partners at the next Planning Day on 20th November, please let the planning team know if this would be helpful/relevant.

Thanks

Contact us: **bnssg.planning@nhs.net**

Appendices

Locality Partnership and Health and Wellbeing Board Plans x 3 as presented at the first Joint Forward Plan

Summary of Bristol Localities and HWB draft Joint Forward Plan

Priority	Trajectories
Starting well Supporting children and young people who live with anxiety or depression or with risk factors for poor mental wellbeing	Bristol North & West - reduction in self harm admissions for N&W population
Starting well Enabling healthy weight	Bristol South - To reduce the number of children who are found to be overweight at ages 4-5 years old in Hartcliffe, Withywood and in Filwood from 360 to under 250 by 2028. Bristol North & West - To reduce the rate of children who have excess weight at age 10-11 (Year 6) in outer areas of North & West Bristol, particularly Avonmouth & Lawrence Weston, Henbury & Brentry, Southmead and Lockleaze. Bristol Inner City and East - Reduction in rate of obesity in Y6 children towards BNSSG overall rate, targeted to wards with the highest prevalence. Trajectory to be worked up as part of developing Locality Led Implementation
Living well People who might feel excluded from communities and/or are experiencing particularly poorer health outcomes	Bristol South - Increase the number of newly diagnosed patients who take part in education programmes to support better management of type 2 diabetes (in 2019 only 22.3% of newly diagnoses patients attended education programmes for type 2 diabetes) Bristol North and West - reduce HbA1c levels, blood pressure, cholesterol, weight and BMI for the cohort identified for the wellbeing coach.
Living well Reducing the harm from tobacco, alcohol and drugs	Bristol South - To reduce the admission episodes in South Bristol for alcohol-specific conditions to under 1,000 in 2027/28 (it was 1,364 in 2020/21 compared to 1,098 in Bristol).
Living well Supporting people with heart conditions, diabetes or stroke to keep healthy	Bristol Inner City & East - Reduction in rate of people who did not have a blood pressure reading suffering a negative cardiovascular event towards BNSSG rate. Trajectory to be worked up as part of Locality Led Implementation.
Ageing well People at high risk of having a fall	Bristol South - Reduction in falls attending ED in the over 65s by 770 - 50% over five years. Bristol North & West - Reduction in the number of conveyances to hospital by ambulance.

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Bristol Inner City & East																				
Tackle inequalities in mental health (In ICE Bristol there are more contacts with secondary care Mental Health services in Black / African / Caribbean compared to the white Mental Health population (BNSSG QOF SMI register)																				
Tackle the higher prevalence of severe frailty in over 75s in Asian, mixed and black communities in comparison to white communities																				
Bristol South																				
Work with schools, children's centres and families specifically in Hartcliffe and Withywood, Filwood and Bishopsworth to improve access to interventions which support healthy weight in childhood.																				
Roll out small grants scheme to enable community innovation and support healthy eating/active lives																				
Co-produce an approach to reduce alcohol harms with our communities and partners																				
Build the existing range of interventions to better meet the needs of those at risk by working with voluntary sector partners and drawing on expertise in frailty and the causes of falls																				
Develop plans to increase take up of lipid lowering therapies in South Bristol																				
Support the use of integrated community clinics to help people in South Bristol to age well																				
Identify an approach to reducing the impact of COPD on health and wellbeing in South Bristol, using data and input of those with lived experience.																				
Bristol North and West																				
Identify and target specific areas with the relevant self-harm reductions interventions to support children and young people who live with anxiety or depression or with risk factors for poor mental health.																				
Work with Sirona to utilise an identification tool to target Pulmonary Rehab provision to those communities most at risk of COPD including Avonmouth, Lawrence Weston and Shirehampton.																				
Improve the health and wellbeing of people with COPD/Diabetes and their families in North & West Bristol.																				
Understand the impact alcohol and substance misuse has on mental and physical health																				
Explore whether co-designed community interventions can reduce use of unplanned care before people get sick or frail																				
Ensure those with dementia have access to Psycho-social care, support and information when needed, so that people can, and will, live well with dementia for many years to come																				
Ensure the workforce receive training and are equipped to deliver care to those with dementia with kindness and empathy																				
Provide individualised 1:1 support, workshops and behaviour change support via education, motivational interviewing and peer discussions around what a healthy diet is, how GI affects blood sugar, understanding food labels, encouraging dietary changes, support to increase fitness levels and overcome barriers – We will work with Northern Arc PCN and Southmead Development Trust to identify people who would benefit from support from a Wellbeing Coach.																				

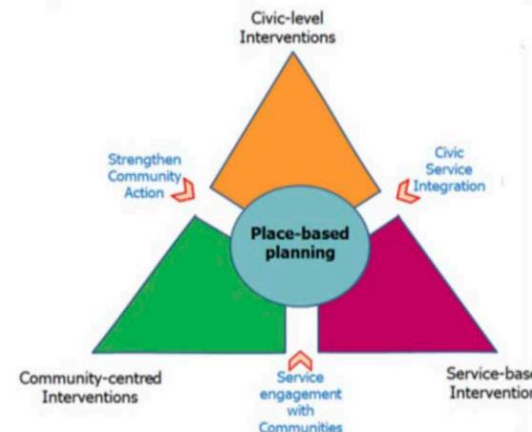
The Joint Strategic Needs Assessment can be found here.

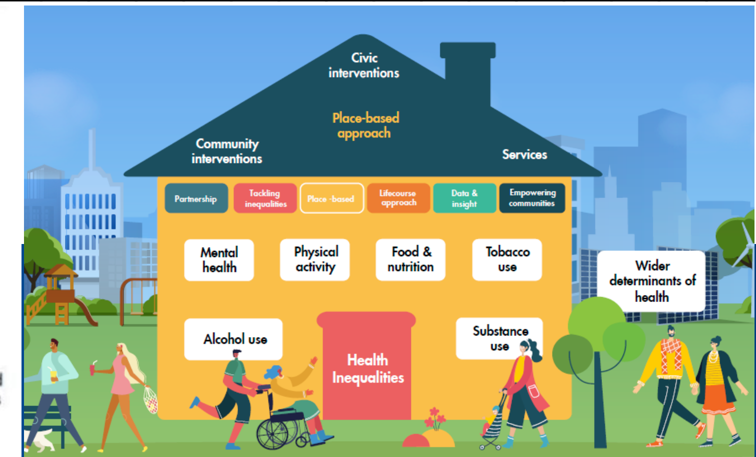
Details on deliverables and the Bristol Health and Wellbeing Board plan can be found here

Summary of North Somerset Localities and HWB draft JFP

Priority	Trajectories
Starting well Supporting children and young people who live with anxiety or depression or with risk factors for poor mental wellbeing	Woodspring – reduce the levels of anxiety in children and young people
Starting well Enabling healthy weight	Weston - Reduction in children at reception and year 6 being an unhealthy weight creating a longer-term platform of healthy eating
Living well People who might feel excluded from communities and/or are experiencing particularly poorer health outcomes	Weston - Reduction in Hypertension / high cholesterol results that contribute to shorter life expectancy and additional health problems
Ageing well People at high risk of having a fall	Weston - reduction in ambulance conveyance Woodspring – Increase older people's confidence to go out post pandemic reducing the risk of falls and social isolation
Dying well Ensuring that people are given the support to make an informed choice about the most appropriate place for their death	Woodspring – A reduction in people dying in hospital rather than their preferred setting. Trajectory and target to be determined as part of Locality Led Implementation Planning

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Weston, Worle and Villages																				
Deliver a falls and frailty fast response service pathway to assess and keep people in their own home's																				
Ensure families and health professional understand, know and respect an individual's wishes regarding places of death																				
Woodspring																				
Tackle increased levels of anxiety in children and young people																				
Support people aged between 50-74 living in Woodspring who suffer from painful conditions.																				
All localities																				
Develop integrated models of care bringing together primary care, secondary care and the voluntary sector together to better meet the needs of those with serious mental illness (SMI)																				
Pilot place-based and person-centred care through new integrated mental health teams (IMHT)																				
Pilot different Test and Learn Approaches and collectively develop a consistent model of community mental health care across BNSSG, which will be tailored to each area																				
Develop Anticipatory Care Models																				
Develop and implement Ageing Well Models and develop local interventions to tackle local needs, including Enhanced Health in Care Homes																				
Support lipid lowering therapy take up to reduce incidence of cardiovascular diseases.																				





Details of North Somerset Health and Wellbeing Board deliverables, metrics and action plan can be found here

Summary of South Glos Locality Partnership and HWB draft JFP

Priority	Trajectories
Starting well **Supporting children and young people who live with anxiety or depression or with risk factors for poor mental wellbeing**	South Gloucestershire - reduce emotional based school absence and exclusion
Living well **People who might feel excluded from communities and/or are experiencing particularly poorer health outcomes**	South Gloucestershire - reduce the need for more costly specialist services, NHS admissions, referrals to social care and reduce demand on the crime, justice and welfare systems.
Living well **We will improve everyone's mental wellbeing**	South Gloucestershire – reduce the impact of chronic pain and the impact it has on mental health outcomes
Ageing well **People at high risk of having a fall**	South Gloucestershire - 10% reduction in the number of falls requiring hospital admission within South Gloucestershire over the next 2 years, to bring the number of falls below the Southwest average (target -1918)

Deliverables	2023/2024				2024/2025				2025/2026				2026/2027				2027/2028			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All localities																				
Develop integrated models of care bringing together primary care, secondary care and the voluntary sector together to better meet the needs of those with serious mental illness (SMI)																				
Pilot place-based and person-centred care through new integrated mental health teams (IMHT)																				
Pilot different Test and Learn Approaches and collectively develop a consistent model of community mental health care across BNSSG, which will be tailored to each area																				
Develop Anticipatory Care Models																				
Develop and implement Ageing Well Models and develop local interventions to tackle local needs, including Enhanced Health in Care Homes																				
Support lipid lowering therapy take up to reduce incidence of cardiovascular diseases.																				
South Gloucestershire																				
Deliver actions to reduce emotional based school absence and exclusion																				
Support the 3 proposals around the Think Family Database, Family Link Workers and Health Promotion in Education settings under Start Well through the Prevention fund																				
Support delivery of 3 Prevention Fund projects – Cost of Living, transforming our approach to complex needs and Prevention of Violence Against Women and Girls (VAWG) inc. Drive programme.																				
Provide complex debt advice for patients experiencing mental health illness and distress compounded by financial worries. The service will offer direct referral to the specialist worker, who will be closely linked with the Integrated and Personalised Care Teams and the social prescribers																				
Support integration of services and the Dementia Wellbeing service as part of the 'Ageing Well' motion passed within the Local Authority																				
Roll out the ReSPECT+ form which is combined emergency care plan, based on the nationally endorsed ReSPECT process and an advance care plan for people who are dying.																				

The **SG HWB** plan can be found **here**.

Population outcomes and inequalities in outcomes are monitored through the JSNA, which includes a South Glos Our Population Dashboard. The dashboard provides a current and comprehensive overview of the health and wellbeing of the South Gloucestershire population, framed in the context of health inequalities and local strategies, and is regularly updated and reviewed. In addition, the Board undertakes a deep dive into one of the Joint Health & Wellbeing Strategy's strategic actions at each quarterly meeting.