REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A**	**ENCLOSURE: G**
DATE OF MEETING:	**28 March 2024**	
REPORT TITLE:	**Somerset's Joint Forward Plan Refresh**	
REPORT AUTHOR:	**Maria Heard, Deputy Director of Innovation and Transformation Robin Dowling, Strategy Delivery Programme Manager Simone Rooks, Health & Care Strategy Project Officer**	
EXECUTIVE SPONSOR:	**David McClay, Chief Officer for Strategy, Digital & Integration**	
PRESENTED BY:	**Alison Henly, Chief Finance Officer and Director of Performance and Contracting**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☒
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

PREVIOUS CONSIDERATION/ENGAGEMENT
The first Joint Forward Plan (JFP) was approved by the ICB Board at its extraordinary meeting on the 29 June 2023. The Plan was subsequently published on the ICB website as per national requirements. The ICB Board was asked to formally adopt the Health and Care Strategy at its meeting held on 27 July 2023. It was noted that the Strategy would evolve and develop as the Integrated Care Partnership strengthened and focused on priorities determined through the JFP. The ICB Board **adopted** the Integrated Care Strategy (2023-2028) at the meeting held 27 July 2023

Executive summary and reason for presentation to Committee/Board	The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Bards and their partner trusts to prepare their Joint Forward Plan before the start of each financial year i.e. by 1 April 2024. This is the second Joint Forward Plan and is written in collaboration with partners in recognition of both our shared legal responsibilities and our desire to come together to create a delivery plan which delivers the entirety of our Integrated Care Strategy. For this reason, in Somerset, we have agreed to incorporate our local authority adult and children's social care partners. It describes: • What has changed since we our last Joint Forward Plan was published

	• Some of our key achievements since our last Joint Forward Plan as published in 2023 • Our priorities for 2024-2025 • How we will deliver this joint forward plan • How we are meeting our statutory duties This JFP Refresh document should be read in conjunction with the context and drivers-for-change set out in the Integrated Care Strategy Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28) and the original Somerset Five Year Joint Forward Plan 2023 to 2028. To provide the opportunity to reflect the 2024-2025 priorities and operational planning guidance, once published, NHS England is setting 30 June 2024 as the date for ICBs to publish and share their JFPs with us, their integrated care partnerships and health and wellbeing boards.
Recommendation and next steps	Request for the ICB Board to formally receive, review and **approve** the Joint Forward Plan Refresh documents for publication to the ICB Website on 30 June 2024 as per the revised national timeline. Any final amendments to the Joint Forward Plan which enable alignment to the 2024-25 priorities and operational planning guidance to be achieved through Chair's actions.

Links to Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Objective 1: Improve the health and wellbeing of the population
☒ Objective 2: Reduce inequalities
☒ Objective 3: Provide the best care and support to children and adults
☒ Objective 4: Strengthen care and support in local communities
☒ Objective 5: Respond well to complex needs
☒ Objective 6: Enable broader social and economic development
☒ Objective 7: Enhance productivity and value for money

Impact Assessments – key issues identified **(please enter 'N/A' where not applicable)**	
Reducing Inequalities/Equality & Diversity	The Plan has been developed taking into consideration the aspects of the EIA which was undertaken to develop the Somerset Health and Care Strategy. More detailed Implementation Plans will be formally assessed for EIA and any differential impact on people with protected characteristics assessed and if needed, mitigated.
Quality	The Plan outlines our ambition and key strategic aims with regards to strengthening the quality of care provided to people within the

	county, principally through more integrated service provision and a shift towards a population health approach.
Safeguarding	There are no additional specific safeguarding requirements to this update.
Financial/Resource/ Value for Money	The Plan sets out a quantification of the system-level financial pressures.
Sustainability	The strategy outlines our collective commitment across the ICP to consider the impact of underpinning delivery plans with regards to sustainability.
Governance/Legal/ Privacy	The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards and their partner trusts to prepare their Joint Forward Plan before the start of each financial year i.e. by 1 April 2024. To provide the opportunity to reflect the 2024-2025 priorities and operational planning guidance, once published, NHS England is setting 30 June 2024 as the date for ICBs to publish and share their JFPs with us, their integrated care partnerships and health and wellbeing boards.
Confidentiality	The Plan refresh will be published on the ICB website.
Risk Description	Delivery risks will be assessed through the translation of the JFP into a delivery programme. Programme architecture has been developed to support the delivery programme.

Click or tap here to enter text.

SOMERSET FIVE YEAR JOINT FORWARD PLAN REFRESH 2024 TO 2029

V1.0

SOMERSET'S FIVE YEAR JOINT FORWARD PLAN REFRESH

CONTENTS

Appendices

Forward

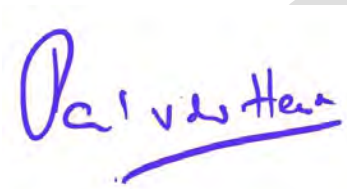
Organisations across Somerset have worked hard to improve the health and care services in Somerset. This commitment has significantly strengthened since becoming an Integrated Care System in July 2022 when statutory and voluntary sector organisations in Somerset formed a partnership to plan and pay for health and care services to improve the lives of people who live and work in their area.

Somerset's Integrated Care System (known as Our Somerset) brings together all the organisations responsible for delivering health and care within our communities. We believe that if we work together, we can intervene faster and earlier to keep people well and offer more joined up support for people facing significant challenges.

Significant progress has been made in the way we work together in Somerset, along with the improvements that we have made since publishing our original Joint Forward Plan in 2023. I'm pleased to see these achievements set out in this Joint Forward Plan.

Whilst we have made positive progress, we know there is more that we can do collectively as employers, volunteers and volunteer organisations, communities, and unpaid and parent carers to improve the health and wellbeing of people in Somerset.

This updated Joint Forward Plan covering 2024-2029 sets out the actions we will take as a system to jointly address our most pressing priorities, to build on the solid foundations already laid, and is our commitment to putting the person at the centre of our thinking and our actions.



Paul Von der Heyde

Chair: NHS Somerset
Deputy Chair: Somerset Board

Introduction

This is the second Joint Forward Plan published by Somerset Integrated Care Board (ICB) and is written in collaboration with partners in recognition of both our shared legal responsibilities and our desire to come together to create a delivery plan which delivers the entirety of our Integrated Care Strategy. For this reason, in Somerset, we have agreed to incorporate our local authority adult and children's social care partners.

It describes the priorities for the NHS in Somerset and articulates the steps that we will take over the next five years to deliver the actions required to achieve our vision for Somerset.

This JFP Refresh document should be read in conjunction with the context and drivers-for-change set out in the Integrated Care Strategy Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28) and the original Somerset Five Year Joint Forward Plan 2023 to 2028.

Improving Lives (2019 to 2028) Health and Wellbeing Strategy

Improving Lives is the Somerset Health and Wellbeing strategy. The strategy is owned by the Somerset Board and sets out how we will work to deliver improvements for our population. We take the Somerset Joint Strategic Needs Assessment (JSNA) into account when defining strategy and delivery of that strategy through our JFP.

The Improving Lives strategy has four strategic priorities. Our Integrated Care Strategy and Joint Forward Plan seeks to deliver priority four of our county's strategic priorities.

4 Priorities

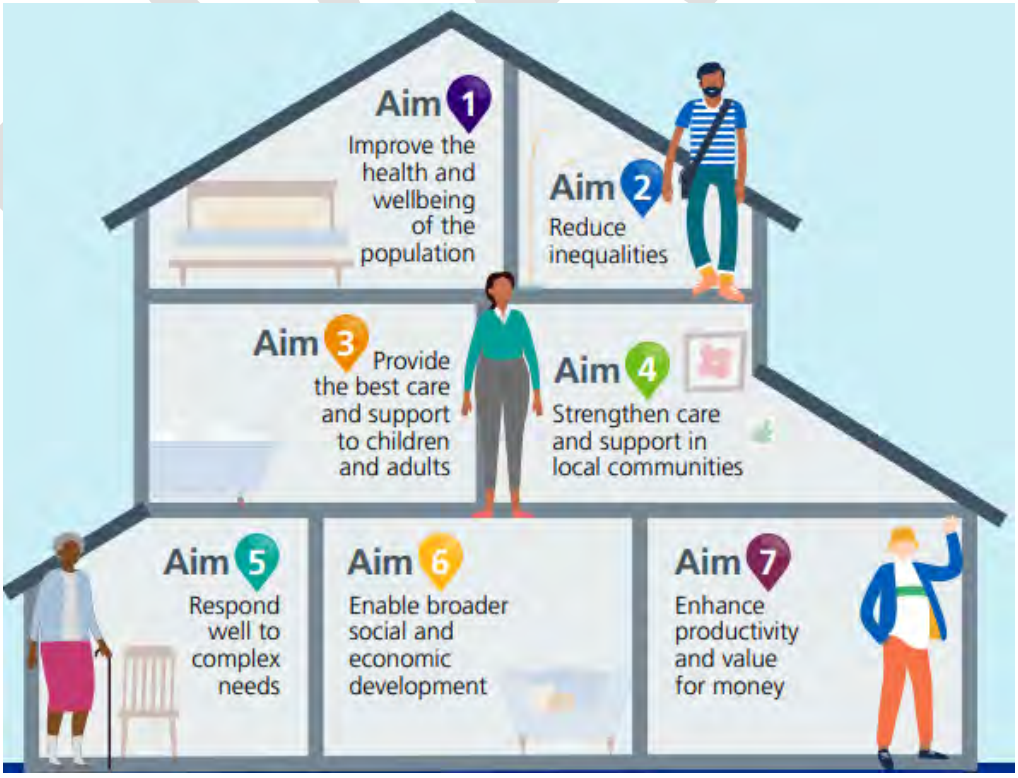
- A county infrastructure that drives productivity, supports economic prosperity and sustainable public services
- Safe Vibrant and well-balanced communities
- Fairer life chances and opportunity for all
- **Improved health and wellbeing and people living healthy and independent lives for longer**

Integrated Health and Care Strategy

As an Integrated Care System (ICS) we have set out how we will achieve our vision through our initial Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28).

Our vision for the Somerset health and care system is that:

Working together, Somerset has identified seven key strategic aims, focused on achieving the ambition of enabling people to live healthier lives. To achieve these aims we all need to take some action now. If we work together, take collective action, and support one another we can go much further than if we work alone.



How we have considered the views of people in Somerset

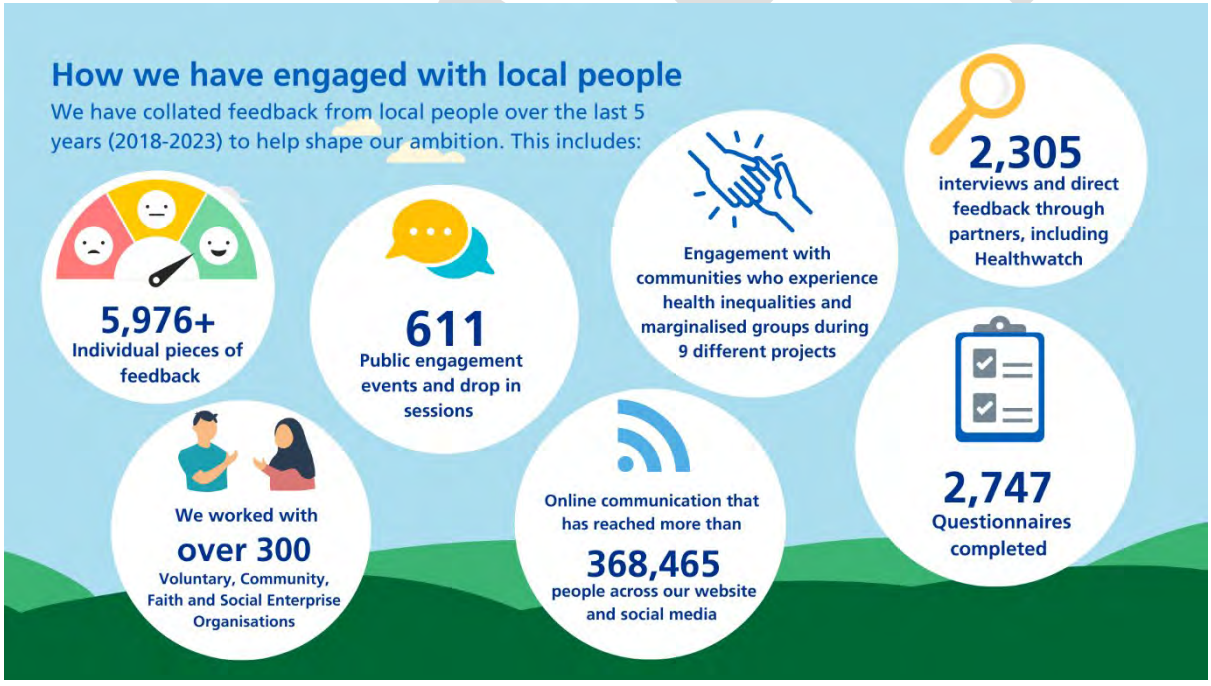
Public involvement is an essential part of making sure that effective and efficient health and care services are delivered with people and communities at the centre. By reaching, listening to, involving and empowering our people and communities, we can ensure that people and communities are at the heart of decision-making and that we are putting our population's needs at the heart of all we do.

The engagement work for this strategy has been done with the support of voluntary organisations including Healthwatch, Spark Somerset, and health and care professionals. We are grateful for all the support.

Working alongside Healthwatch Somerset, Somerset ICS asked local people to give their views on what matters most to them, to help them shape the Health and Care Strategy and Joint Forward Plan.

An online survey was developed and promoted to patients and the wider public. In addition, Healthwatch Somerset volunteers spent time at different sites across the county reaching out to members of the public to speak to them about their views.

An independent research company were commissioned to undertake analysis of insights gathered. These insights have informed the development of this plan.



We will continue to involve the people of Somerset as part of the delivery of this plan.

What has changed since our last Joint Forward Plan?

There have been a number of significant changes which have taken place since we published the Somerset Integrated Health & Care Strategy and our original Joint Forward Plan. These are:

- NHS services in Somerset are experiencing an increasingly challenging financial position
- Somerset Council have declared a financial emergency
- We have strengthened our commitment to the VCFSE through a shared vision and commitment to work more closely together to achieve better health and wellbeing for the people of Somerset
- Yeovil District Hospital NHS FT and Somerset NHS FT merged on 1 April 2024 and we are starting to see the benefits of this merger

Managing the significant financial pressures and supporting healthier lives

This year, more than ever, the financial pressure the NHS is experiencing is becoming increasingly challenging.

Of course, it's not unique to the NHS in Somerset. It is a situation which is mirrored across the country, within both healthcare and across the public sector. Somerset has one of the oldest populations in the country with 25% of the population currently aged over 65. This places additional pressure on the NHS. We are also still recovering from the impact of the Covid-19 pandemic, with a focus on ambitious targets around elective recovery and cancer waits. While improvements in healthcare mean people are living longer, many are living with long-term conditions like diabetes and dementia.

Financial Settlement

Over the coming three years we need to address our underlying financial deficit which stands at about £80 million. This will require us to think very differently about how we spend every penny of the £1.3 billion allocated to us to pay for the healthcare needs of our population. Some tough decisions will need to be made but we are committed to work with the people who live in Somerset and the staff working in our services to reimagine how we provide care in the future.

Our financial settlement this year is challenging, and savings will have to be made. We need to see these pressures in context; we have employed (over 2,000) extra staff since before the pandemic, this coupled with the national focus on delivering more efficiency for the taxpayer, means that we need to make tough decisions now, to safeguard our future. We are also committed to modernising our services and spending more of our resources on preventing people from becoming unwell, so we can do what is right for our people, communities and colleagues now and into the future.

Our integrated care system is under pressure

Everyone will be aware that Somerset Council recently declared a financial emergency due to the rising cost of caring for adults and children in the county.

Following this announcement, they have had to go through a rapid reduction in costs to deliver a 100-million-pound savings programme to avoid effectively declaring themselves bankrupt.

We know that many of our key partners across the VCFSE sector, who so many in communities rely on for support, are also facing reduced funding. This means it's never been more important for us to work together, across Somerset, to support communities.

Across the Somerset system, through the ICB Board, we are working to take the tough financial decisions that must be made in the NHS too, while trying to protect the most vulnerable in our communities.

Helping people to live healthier lives

Our health and care strategy sets a clear ambition to work to reduce the time people living in Somerset live in poor health. In Somerset this equates to an average of 17 years, with around 10% of our population accounting for approximately 70% of our health and social care resources.

If we are to really make the shift to prevention and earlier intervention it is crucial that we identify those with the most complex health needs and those most at risk of ill health and work with them earlier to help them live better lives for longer.

We also need to consider how best to support all our communities and people of Somerset to live healthier lives no matter their healthcare needs.

This will only be achieved by having a shared vision and focus across all parts of the Somerset system.

Somerset Council Financial Emergency

In November 2023, the Council declared a '**Financial Emergency'** which introduced significant local financial controls and moved the council to operating as if a section 114 notice had been issued and external commissioners appointed.

Somerset Council is a new unitary council, created less than one year ago and faces a very stark and challenging financial position. The scale of the financial challenge is significant and based upon the estimates of costs and income (as at February 2024), with the forecast budget gap predicted to increase to £147.9m in 2026/27 at the end of the Medium Term Financial Plan (MTFP) period if no further savings are identified. Despite making substantial savings, disposing of assets, using available reserves, and increasing Council Tax, the Council is unable to close the budget gap for 2024/25.

The Council's finances have been significantly impacted by national factors outside of its control such as inflation and interest rates, as well as having to deal with the challenges of Local Government Reorganisation and bringing the five predecessor councils into one new organisation.

The Council cannot continue to provide and operate services in their current format and rapid, radical, change is required if it is to become financially sustainable. To address this, the Council is developing a Transformation Programme to deliver its vision for the council to be a smaller, leaner council, employing fewer people, requiring fewer offices, focusing only on the unique value the authority can provide.

The financial emergency facing the council requires a change in thinking around the pace, scale, and structure of transformation to deliver a radically different way of working as a Council, operating with fewer staff, whilst increasing its influence and impact. Executive agreed a new 'vision for a sustainable Somerset Council' and associated organisational design principles on 6 December 2023 which will seek to deliver new, smaller, leaner, more productive Council.

Achieving this vision will be complex and require whole organisation transformation in order to maximise the opportunity of bringing together the five predecessor councils and meet the financial challenge. The new transformation approach will bring together transformation and change programmes across the organisation, under a single approach and governance to ensure whole council oversight, and prioritisation of resources and investment.

VCFSE Update

Strategic Partnership

We have continued to develop and strengthen links between the VCFSE sector and health and care over the past 12 months. In September 2023 leaders from the voluntary sector, NHS and Somerset Council, gathered to sign an historic document outlining a shared vision and commitment to work more closely together to achieve better health and wellbeing for the people of Somerset.

The event, attended by over 60 representatives from the county's charities, NHS and Somerset Council, was the first time that leaders have come together at such scale, to demonstrate their shared commitment to working together.

The signing of the Memorandum of Understanding formally recognises the voluntary, community, faith and social enterprise (VCFSE) sector as an equal and strategic partner and the important role it plays in providing key services and activities.

For more information: https://sparksomerset.org.uk/signing-MoU-agreement
This work is supported by a Steering Group, Leaders Group (comprising 40 VCFSE leaders) and a VCFSE Assembly, a regular open forum where VCFSE organisations meet to explore collaborative working opportunities with the public sector. An independent Chair is currently being recruited, who will work alongside Spark Somerset to progress this.

Challenges and opportunities

Funding challenges exist across the system – with sustainability proving to be a key issue for the VCFSE. Following a recent survey of the VCFSE sector:

- 40% reported their financial position as 'deteriorating' or 'critical'
- 51% are relying on reserves to deliver services
- 57% are not currently viable beyond 12 months

However, more than 80% of VCFSE organisations are keen to collaborate with others, so it is important that we create the conditions for effective partnership working. An event with VCFSE organisations and Commissioners is planned for April, where issues such as collaboration will be discussed. It will also provide an opportunity to agree how, collectively, we can 'bring the MOU to life', and consider how we can work together differently to better support the health and care needs of our communities in Somerset.

Collaborative Working

There are numerous examples of effective collaborative working across the system involving the VCFSE – a small number outlined below. These are all examples of both strategic and operational engagement that have improved outcomes for Somerset residents by system collaboration. These include:

- Development of Integrated Neighbourhood Teams – West Somerset is taking a lead on this work, with VCFSE organisations at the heart of the model

- Establishment of a Social Prescribing Collaborative – comprising colleagues from health, social care and the VCFSE, working together to co-design a holistic social prescribing model Somerset.
- VCFSE participation in Key Boards and working groups including ICB, Somerset Board, Population Health Board, Early Help, SEND, CYP Programme Board and Mental Health and Learning Disability Programme Board
- System-wide bid to the Volunteering for Health Fund – representatives from the VCFSE, adult social care, NHS and ICB submitted a collaborative proposal which will result in a more strategic and joined-up approach to volunteering across Somerset
- Conversations have begun around metrics, evidence of effectiveness, outcome measures, and a Somerset wide system of logging engagements with organisations for individuals
- High Dependency User support through Ubuntu project (Diverse Communities) which works with Health and Community Partners to support some of the most vulnerable parts of the community
- Re-conditioning exercises with older people in Musgrove and YDH to facilitate timely discharge and prevent blue light readmission (Age UK Somerset and ICB)

Somerset NHS FT Merger

Yeovil District Hospital NHS FT and the old Somerset NHS FT merged on 1 April 2023 to form Somerset NHS Foundation Trust. The aims of the merger were:

a. Patients
    i. More time in good health for patients, with a focus on population health and health inequalities
    ii. Easier focus on areas of county-wide clinical need
    iii. Broadening the availability of unified pathways across physical and mental health particularly to patients served by YDH
b. Colleagues
    i. More resilient services for colleagues, with more job flexibility, and time to focus on strategic transformation. Easier recruitment, better retention.
c. System
    i. Closer partnership working, reduction in duplication

Bringing clinical services together, especially different teams delivering the same service, has been challenging. There have been successes, but in some areas, progress has not been as quickly as anticipated.

Clinical Services

In Year 1 we have focused on the six “case study” clinical areas identified in the Patient Benefits Case that supported the merger business case. These case study services covered all of the types of service provided by the new trust, contributing to a variety of system-level strategic objectives.

Some of these services e.g. Homelessness have delivered new, fully integrated services. Others like Stroke and Cardiology have taken longer than we anticipated to fully integrate, but have still developed county-wide pathways. Some e.g. Maternity and Oncology have struggled balancing integration with BAU.

Significant initiatives across all the services have already progressed.

Maternity
- Integrated digital maternity care record, making it much easier for patients and clinicians to access clinical notes across the county
- Integration of supporting services across the county e.g. bereavement services which have been co-produced with service users

Oncology
- More Oncologists recruited, made easier by a county-wide model, stabilizing the service
- Expansion of Cancer Helpline county-wide
- New HOPE Somerset service, helping with the psychological aspects of cancer, has seen a 110% increase in activity

Cardiology
- New Rapid Access Referral to Heart Failure service county-wide

Stroke
- Better placed to be able to respond to outcome of ICB review into hyper-acute service
- Single team now means that experienced Consultants can work across both sites, addressing staffing issues

Peri-Operative Care
- This is a new service designed to broaden the care of surgical patients, including avoiding surgery altogether by focusing on wider care needs. We have specifically focused on it because of its potential to develop better in a county-wide trust
- Single community anaemia infusions service introduced
- Diabetes pathway introduced cross-county
- Dedicated frailty nurse, supporting a dedicated pre-operative pathway. 55% of patients on this pathway have voluntarily come off the surgical waiting list as a result

Homelessness
- Single approach to ward rounds, discharge and training
- New county-wide pathway for all vulnerably-housed patients

SFT have also used the advantages of merger to make progress in other clinical areas, for example, in Robotic Surgery, where there is now a general surgery robot at each hospital site. As a single trust, they have benefitted from a collaborative approach to training and patient selection for robotic surgery, and have now operated on well over 100 patients using the robot. In Infection Prevention and Control, YDH now has a 24/7 IP&C advice service for the first time, and there is harmonisation of outbreak control procedures.

Non-Clinical Services

Across Non-Clinical services, there have also been improvements. The trust has saved £700,000pa in Finance costs by merging teams and reducing audit fees by being a single organisation. It is now easier for YDH to attract capital funding as part of a larger trust, meaning that schemes such as the new operating theatre on site can progress. There are more combined digital services, making it easier for teams to operate across multiple sites. And our NHS National Staff Survey results look positive despite the challenges and changes involved in merging.

Our achievements over the last 12 months

We have reviewed everything we said we would do in our last Joint Forward Plan over the 12 month period from April 2023 to March 2024 (see appendix one). This section highlights some of the key achievements in Somerset over the last 12 months.

Population Health Transformation

Homeless Health

Hundreds of people in Somerset are affected by homelessness. They are some of the most vulnerable patients in our county, often with complex health needs, who struggle to access mainstream healthcare.

Many have mental Ill-health, drug and alcohol dependence and physical health needs and because they often struggle to access mainstream healthcare, can often end up going to A&E in a crisis.

Since 2021, the NHS in Somerset has been working in partnership with Somerset Council's Public Health Service and the voluntary sector to support the health of those experiencing homelessness, living in temporary or vulnerable accommodation and other vulnerable communities such as street workers.

This includes introducing a countywide Homeless and Rough Sleeper Nursing Service, made up of physical and mental health nurses, link workers and two Inclusion Health GPs (located in Taunton and Yeovil) with an additional short term funded GP in the Mendip area.

Working together the GP and nursing teams run a range of outreach drop-in clinics in Taunton, Yeovil and across Mendip in easily accessible venues.

The team offer on the spot care, giving healthchecks, blood tests, wound care, medication and sexual health advice, coordinating the care provided by other services and ensuring each client's personal safety and welfare is looked after. They also provide links to other vital services such as social care, Citizens Advice and food banks.

The programme won the NHS Parliamentary Awards for Health Equity 2023.

Know your numbers 'Take the pressure off' campaign

Around 3 in 10 adults in Somerset have high blood pressure but 1 in 10 do not know it.

The Integrated Care System (ICS) partners are currently involved in working collaboratively on our "Take the Pressure Off" campaign, an initiative dedicated to raising awareness about the importance of regular blood pressure monitoring. In Somerset, we believe in taking proactive steps towards a healthier community, and this campaign is at the heart of that belief.

In an important step to improve community health across the county, NHS Somerset and Somerset Council have partnered with Yeovil Town Football Club as part of their 'Take the Pressure Off' campaign, raising awareness of the importance of testing your blood pressure. They attended the match between Yeovil Town FC and Welling United at Huish Park Stadium on Saturday (9th) to host free community blood pressure checks to more than 3,200 fans that attended the match, and some of Yeovil Town's management team including Club Owner and Chairman, Martin Hellier.

Over half of all strokes and heart attacks in Somerset are caused by high blood pressure. Many people will have no symptoms of the condition, often termed the 'silent killer', but it can lead to serious health issues like heart disease, stroke, and kidney problems if left unchecked. The "Take the Pressure Off" campaign is designed to encourage residents, particularly those aged 40+, to regularly check their blood pressure and take necessary steps towards managing their health.

More information can be found at Blood pressure - Our Somerset.

Urgent and Emergency Care

Somerset Urgent Community Response

The NHS team at Somerset Urgent Community Response (UCR) brings together a range of skills including Advanced Clinical Practitioners (ACPs), district nurses and physiotherapists who can assess and treat an individual's urgent healthcare needs, along with pharmacy technicians who can review and help patients understand their medication.

The UCR team will come out within two hours of receiving a referral from a GP, 111, 999, a care home or pendant alarm response service.

The team won't just treat the symptoms, they will carry out an assessment to understand why the individual became unwell. Where necessary, a referral will be made to other heath and social care services for help, to try and prevent a crisis happening again.

Somerset Urgent Community Response - NHS Somerset ICB

Planned care, diagnostics and cancer

getUBetter

Over 30% of people have a musculoskeletal (MSK) condition and 1 in 5 adults a year will consult their GP for an MSK condition, but we know that most MSK problems can be treated with proper self-care, without the need for specialist treatment. getUBetter, a digital self-management tool for all common MSK conditions and injuries, was successfully piloted in the Community MSK Physio service, however, it was felt that access to the advice and information would be more beneficial earlier in the pathway. As a result, Somerset has purchased getUBetter to support the population of Somerset with their MSK problems. Developed with local clinicians, getUBetter provides safe advice and guidance and where necessary signposts to other services. getUBetter is being recommended by Somerset GP Practices and over 2,500 individuals have registered with getUBetter and are using the support available to self-manage their MSK conditions.

getUBetter - An app for all common muscle, bone and joint injuries and conditions. - NHS Somerset ICB

Learning Disability Specialist Screening Team

Screening is a way of finding out if a people have a higher chance of having a health problem, so that early treatment can be offered, or information given to help them make informed decisions. Yet, we know that those with a learning disability are less likely to take part in the NHS screening programmes (breast cancer, bowel cancer, cervical cancer, abdominal aortic aneurysm, and diabetic retinopathy screening).

In collaboration with NHS England and SWAG Cancer Alliance, Somerset has employed two specialist nurses to support those individuals with a learning disability and / or autism to access and take part in the screening programmes. The Specialist Screening Team offers a wide range of support personalised to the individual and their needs – from raising awareness of the reasons for and importance of screening with individuals, their families, and carers to liaising with the services to ensure adjustments are made e.g. longer appointments, appointment at a specific time of day, quieter environment, and attending appointments with individuals. Through the hard work of the team, over 20 individuals have engaged and attended their screening appointments having previously not participated.

Bleeding after Menopause Service

Showcased on ITV West Country News, Somerset patients can now self-refer into the Bleeding After Menopause service to get checked for a common type of cancer, which means they do not have to visit their GP in the first instance. Individuals experiencing bleeding after the menopause are asked to complete a form, either online or via the telephone, which is reviewed to determine the most appropriate way of providing support.

In some instances, patients may be advised to contact their GP for further help and support, but others may be offered an appointment at one of clinics held at a community hospital which will consist of an ultrasound, pelvic examination, and review by a health care professional. By removing the need to go to your GP and performing the relevant tests / investigations in this 'one-stop' clinic, the patient experience is significantly improved, and the waiting times considerably reduced. Most people attending these clinics can be reassured and discharged but some may need further tests.

Bleeding after Menopause - Cancer services (somersetft.nhs.uk)
Waiting times for womb cancer appointments cut by two months in Somerset | ITV News West Country

Mental health, Autism & Learning Disabilities

Somerset Dementia Wellbeing Service

Is a partnership that aims to improve diagnosis, enhance support in the community and provide excellent, consistent service for people with dementia and their carers.

The service has been developed by those living with dementia along with their carers, the voluntary sector, NHS Somerset, Somerset Council and Somerset NHS Foundation Trust.

Our Somerset Dementia Connect phoneline provides quick, convenient access to Dementia Support Workers (provided by the Alzheimer's Society). They can be called on 01458 251541.

The Dementia Support Workers team can offer information and practical guidance to help you understand the condition, cope with day-to-day challenges and prepare for the future.

www.somersetdementia.org

Children, Young People and Families

New Father's Project

When a new baby is expected, mums rightly get a lot of support before, during and after the birth. We know that dads often miss out on the same level of support and aftercare. We want to change this so that everyone can get the advice and guidance they need to enjoy parenthood. Even if you have been a dad before, every baby is different. Parenthood can be particularly hard if you are struggling with something else in your life – whether it's money worries, physical or mental health concerns or addiction. We want to make sure that all new dads and non-birthing partners are supported.

NHS Somerset are running an exciting new project at the Victoria Park Health and Wellbeing Hub. We are reaching out to all new fathers and will encourage you to come and meet with one of our health coaches. They will provide a one to one appointment with time for you to talk through any concerns or ask questions. They will also tell you about anything going on in the area that you might find helpful or enjoy doing with your baby. They can also help you make appointments with other professionals if you need more specialist support.

As this is part of a project to find the best way to support new dads we will collect some anonymous data about the outcomes and ask you for some feedback. If we are getting in right, then great, but if you think we can do better, then we want to know so we can make changes to the support we provide. We are hoping to offer this service to all new dads across Somerset in the future and your input into the development of this service will be invaluable.

New Father's Project – NHS Somerset ICB

Improving Lives in Communities & Neighbourhoods

Somerset Community Foundation cost-of-living awards

Somerset Community Foundation, in partnership with Somerset Council and NHS Somerset, recently awarded over £150,000 in grants to 44 local community groups in the latest round of Cost-of-Living grants this summer. The grants will help groups across the county cope with rising energy bills and offer more support to people in Somerset who are struggling to make ends meet.

Through the Cost-of-Living Fund, Somerset Community Foundation brings together diverse resources from local funders. To date, it has awarded a total of £350,000 of grants in response to the cost-of-living crisis, connecting other trusts, businesses and people.

Somerset Community Foundation awards over £150,000 to help local community groups survive cost-of-living crisis - NHS Somerset ICB

Armed Forces – Health and Wellbeing

NHS Somerset signed the Armed Forces Covenant in May 2023 and recognises the value and service of the whole Armed Forces community, both serving, families, veterans and reservists.

Within Somerset we have a large Armed Forces community population and recognise that you may have specific needs or queries.

Veteran Friendly Accredited GP Surgeries – Within Somerset we have a number of surgeries who have this accreditation. This means that someone within the surgery has a particular interest in the needs of the Armed Forces and takes responsibility for keeping the rest of the surgery staff updated with initiatives and services available.

Specific Armed Forces Services - There are a number of services which are specifically designed for veterans, details of these can be found below at

Armed Forces - NHS Somerset ICB

Integration and the Better Care Fund

Sloppy Slippers Campaign

We know that the risk of having a fall is a concern for many, especially as we age. Every day in Somerset, around 8 people are admitted to hospital because of a fall.

According to the University of Leicester, 24,000 over 65's in the UK fall over at home every year because of poorly fitting footwear.

Most of these falls are caused by wearing 'sloppy slippers': poorly structured and ill-fitting slippers.

This year, NHS Somerset and SASP are running a scheme to equip adults in the county with properly fitting footwear.

Adults can attend a series of roadshows across the county to collect a new, **free** pair of slippers to help keep them warm and, importantly, steady on their feet. Partner organisations will also be in attendance to provide information and support.

Falls Prevention - Our Somerset

Digital, Data and Insights

Brave AI Risk Assessment tool

The "Brave AI" risk assessment tool helps health professionals identify individuals who are at risk of going to hospital next year but who may otherwise go under the radar.

The tool works by using clever computer algorithms (machine learning AI) to look for patterns in registered patients' records, the technology assesses an individual's risk of unplanned hospital admission in the next year.

Those individuals identified can then be invited to take part in a holistic assessment so that local, integrated neighbourhood teams of health and care professionals (nurses, pharmacists, therapists, health coaches, social prescribers, and doctors) can work together to develop a personalised care and support plan, based on what matters to the individual.

The Brave AI device is being rolled out to over 30 areas in the South West, including practices in Somerset throughout 2024.

This is following a successful pilot in care homes in Somerset which reduced resident falls by 35%, attendances to Emergency Departments by 60%, and ambulance callouts by 8.7%

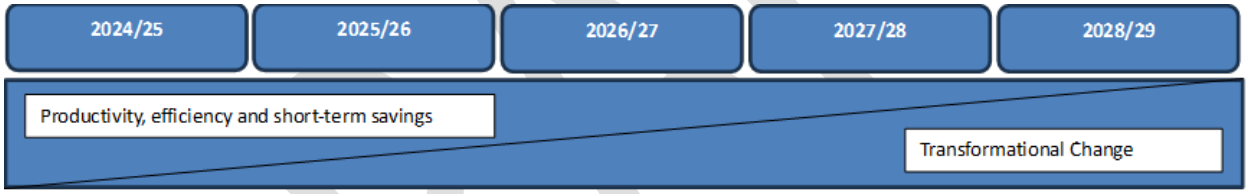
Using Artificial Intelligence to monitor wellbeing: BRAVE AI - NHS Somerset ICB

Priority Programmes

Over the coming three years we need to address our underlying financial deficit which stands at about £80 million. This will require us to think very differently about how we spend every penny of the £1.3 billion allocated to us to pay for the healthcare needs of our population. Some tough decisions will need to be made but we are committed to work with the people who live in Somerset and the staff working in our services to reimagine how we provide care in the future.

Our financial settlement this year is challenging, and savings will have to be made. We need to see these pressures in context; we have employed (over 2,000) extra staff since before the pandemic, this coupled with the national focus on delivering more efficiency for the taxpayer, means that we need to make tough decisions now, to safeguard our future. We are also committed to modernising our services and spending more of our resources on preventing people from becoming unwell, so we can do what is right for our people, communities and colleagues now and into the future.

This means that in the early years of our Joint Forward Plan, we will need to prioritise transformational change which delivers short-term savings in order to address the financial position. We recognise that alongside this short-term focus to address our financial position, we will need to deliver the foundations which are required to deliver longer term transformational change across Somerset. In the later period of this plan, we will be focusing on the transformational elements of our plan to deliver long lasting change to services in Somerset.



To support this, we have identified five system priorities which we will collectively work on in Somerset. These will deliver our system aims and are shown below:

- Priority 1: Efficiency, Productivity and short-term savings
- Priority 2: Workforce
- Priority 3: System Flow
- Priority 4: Integrated Neighbourhood Working
- Priority 5: Population Health Transformation

Both as a system and as individual organisations, there are many other projects we are undertaking to improve outcomes for the people of Somerset and the health and care services they receive.

Priority 1: Efficiency, Productivity and short-term savings

Why is it important?

As previously described, over the coming years we need to address our underlying financial deficit which stands at about eighty-million-pounds. This will require us to think very differently about how we spend every penny of the £1.3 billion allocated to us to pay for the healthcare needs of our population.

In the early years of our Joint Forward Plan, we will prioritise transformational change which delivers short-term savings in order to address the financial position. These are included within this priority and also throughout the remaining priorities. The short term actions have been highlighted throughout the plan.

What we are going to do?

	2024/25	2025/26	2026/27 to 2028/29
Efficiency , Productivity and short-term savings	**Deep dive into current spend** We will review all areas of spend as part of our financial position		
	Better care Fund - Review of Better Care Fund and explore opportunities to spend more effectively	Deliver a new BCF plan which reflects the opportunities to utilise the BCF allocation more effectively.	Continue to monitor effectiveness of BCF plan and identify new opportunities for closer working collaboration between system partners
	Ready to Go Wards - Close two temporary wards (ready to go wards) (April)		
	Elective Care Commissioning Strategy - Develop elective care commissioning strategy (Sept)	Implementing the elective care commissioning strategy	Implementing the elective care commissioning strategy
	Evaluation of last three years new initiatives - Evaluation of last three years new initiatives to estimate ROI, value add and consider future commissioning of these initiatives	Evaluation of initiatives to understand value add and future commissioning plans	Evaluation of initiatives to understand value add and future commissioning plans
	Reducing Variation in Healthcare		

	2024/25	2025/26	2026/27 to 2028/29
	- Clinical challenge into review of GIRFT/Model Hospital data - Address outliers in prescribing practices		
	Unsustainable Services – review services to consider whether these can be reconfigured or alternative commissioning solutions can be found (learning from the dermatology model of care)		
	Closer working with the VCFSE - **ASC** - Continue to invest in the development of voluntary/ community enterprises, and align micro provision with broader core provision of care at home to ensure vibrancy of the overall marketplace and care workforce. - **VCFSE Dementia Collaborative Partnership** - Continue to embed the new ways of working in dementia partnership. - **LDA** - Strengthen the voluntary sector offer in Somerset, and develop peer mentor and self-advocate support offers. - **VCFSE Partnership Offer** - Develop a model and procure a VCFSE partnership offer for CYP mental health early intervention and prevention.		
Learning Disability &	**Learning Disability and Acquired Brain Injury placements** – review of patients who are out of county with a		

	2024/25	2025/26	2026/27 to 2028/29
Brain Injuries	view to considering placements in Somerset		
	Individuals placed by systems outside of Somerset into Somerset Nursing Homes - Review of Funded Nursing Care (FNC) and Continuing Health Care (CHC) costs for individuals placed by systems outside of Somerset into Somerset Nursing Homes		
Planned Care	**Further Faster Programme** - Identify opportunities within specialties for optimising outpatient efficiency under the 'Further Faster' programme.		
	Theatre utilisation – Increase capped theatre utilisation rates to the national target of 85% and increase theatre session utilisation to 95% on both sites.		
	Day-case rates/Right Procedure Right Place – Increase the range of procedures undertaken as a day-case and the range of procedures undertaken as an outpatient procedure.		
	Peri-Op Pathways – Expand the perioperative service for providing interventions for preparing patients for surgery, to improve outcomes for surgery, reduce length of stay in hospital and offer alternatives to surgery where appropriate.		
Estates	**One Public Estate** - Review of estates options across the system and consider consolidation	Implementation of One Public Estate	Implementation of One Public Estate

	2024/25	2025/26	2026/27 to 2028/29
		Oversight of s106 projects and development	
Support Functions	**Support Functions** - Review of support functions to Somerset ICB		
Digital	**Single Electronic Health Record (EHR)** - Secure external capital funding for items such as Electronic Health Record		
	Automation - Exploration of opportunities for use of Digital Tools to support corporate functions (i.e. Robotic Process Automation (RPA) / AI processes)		
	Data Storage - Data Storage Consolidation		
	Shared Service for General Practice - Review Shared Service for General Practice		
Local Autonomy	**ICS Priorities** - Ensure focus is maintained on our priorities and implement national strategies where they add value to our priorities		

Priority 2: Workforce

Why is it important?

Somerset's Initial Integrated Health and Care strategy identifies the overarching approach and principles, providing the strategic direction and key aspirations. As an ICS we want to deliver a robust system wide strategy to inform what our workforce will look like in the next 10 years to meet the demands of the population and the demand and capacity model. The success of the Health and Care Strategy is heavily predicated on the maintenance and creation of a workforce that is responsive to the strategy and the developing needs of the population, that has the right skills, that works in the right place at the right time.

Health and Care in Somerset faces a number of challenges related to workforce performance and productivity. Improving efficiency and productivity is crucial for delivering high-quality patient care while managing limited resources effectively. In order to be able to achieve the Workforce of the Future (Scenario Planning 2035), we need to:

- Create a stable workforce from which we can begin to develop roles, transform roles and create new roles based on skills rather than qualifications
- To reduce the spend on temporary workforce where this doesn't align to strategic aims
- Create the right environment for new roles to be developed, facilitating a One Workforce for Somerset

What we are going to do?

	2024/25	2025/26	2026/27 to 2028/29
Workforce	**Agency Reduction** - Reduce the cost of agency used to eliminate all agency spend by X date	Maintain reduction in agency spend	Maintain reduction in agency spend
	Agency Reduction - Reduce demand for agency use		
	Collaborative approach to International Recruitment - Develop a collaborative approach to International Recruitment to ensure ethical and cost-effective supply routes		
	Reset staffing levels to 19/20 levels		
	Reduction in ICB running cost allowance of 20%	Reduction in ICB running cost allowance of 10%	
	Workforce 2035 (scenario planning) - Define programme of work & resource to implement future workforce strategy with key stakeholders.		

	2024/25	2025/26	2026/27 to 2028/29
	Somerset Academy - Development of the Somerset Academy in Bridgwater	Development of the Somerset Academy in Bridgwater	Open Somerset Academy in Bridgwater
	Somerset Academy - Undertake a test and learn of a Minehead satellite of the Somerset Academy		
	Education Planning - Develop a whole system approach to pre and post registration education planning	Deliver our approach to pre and post registration education	
	Workforce Transformation -Delivery of the Workforce transformation - Implement the workforce strategy for the Same Day Urgent Care (SDUC) delivery. - Expansion of advanced and enhanced practitioner roles - Deliver key objectives of Pharmacy workforce & IETS transformation programme - Advanced Practice Planning project - Deliver key objectives of Advanced Practice Planning project - New apprenticeship and degree routes to entry for registered social work, ODP and OT are developed	Delivery of the Workforce transformation	Delivery of the Workforce transformation
	Core system leadership offer - Development of a core system leadership offer which enables a system by default mindset and culture to grow tested through the Somerset Leadership Academy – including support to emerging integrated neighbourhood team development		
	Interventions to improve staff experience, retention and a sense of belonging - Design appropriate interventions to improve staff experience, retention and a sense of belonging		

	2024/25	2025/26	2026/27 to 2028/29
	following the Somerset pan-sector survey analysis and technical report		
	Retention Strategy Action Plan - Review & evaluate the effectiveness of programmes that form part of the system –wide retention strategy & define actions for the 24-25 retention strategy		

Priority 3: System Flow

Why is it important?

To ensure we are able to provide effective, joined up care and to improve the outcomes and quality of life of the population of Somerset, we need to prioritise the flow of people in and out of our services.

If patient discharges from an acute hospital setting are unable to be made in a timely way, there will be an impact on flow throughout the health and care system resulting in poor patient experience, a risk to patient safety as there is evidence to suggest that patients decondition and deteriorate the longer they stay in an acute hospital setting when they are optimised for discharge and financial impacts. Objectives are being prioritised across the system to enable people to be supported in the right beds, at the right time, supported by the right clinician, to improve facilitation of timely discharge to an appropriate setting to meet the persons need and to support more people to live independently at home for longer.

What we are going to do?

	2024/25	2025/26	2026/27 to 2028/29
System Flow	**Community Hospital** - Review community hospital operating model (March 2025) - Consider future of temporarily closed community hospital beds	Commence implementation of new operating model for community hospitals	Finalise implementation of new operating model for community hospitals
	Virtual Wards (Hospital@Home) - Increase capacity of virtual wards to reach 200 people to support admission avoidance and discharge - Expand Doccla remote monitoring to support patients with frailty, respiratory conditions, colorectal surgery and paediatric patients - Roll out of electronic prescribing	Monitor and evaluate virtual wards	
Adult Social Care	**Work in partnership with our care provider market** – we will work in partnership with our care provider		

	2024/25	2025/26	2026/27 to 2028/29
	market to ensure there are sufficient nursing places available to meet future demand, particularly for people living with dementia and other cognitive impairments		
	Development of viable care alternatives - We will invest in the development of viable care alternatives to reduce and delay the need for long-term care (such as extra care housing and a range of reablement and community services).		
VCFSE	**VCFSE** Continue to build on the VCFSE MOU through developing a commissioning framework to identify greater opportunities for joint working with the VCFSE sector (July)		
Urgent and Emergency Care	**Intermediate Care and Reablement Model** – co-design a high quality, responsive intermediate care and reablement service which allows people to return to their optimal independence and support timely hospital discharge. Will be implemented by September 2024	Complete implementation of a new model for intermediate care	Monitor and evaluate intermediate care model
	Transfer of Care Hubs - Embed transfer of care hubs across both acute and community hospitals	Monitor and evaluate transfer of care hubs	

	2024/25	2025/26	2026/27 to 2028/29
	Single Point of Access - Develop Single Point of Access for same day urgent and emergency care	Implement Single Point of Access for same day urgent and emergency care	Monitor and evaluate Single Point of Access for same day urgent and emergency care
	Criteria Led Discharge - Roll out systematically CLD to support weekend discharges.		
	7-day working - Improve weekend discharges, including criteria led discharge, 7 day working	Monitor and evaluate effectiveness of 7 day working and effectiveness of weekend discharges	
	Call Before You Convey - Test concept of call before you convey	Implement Call before you Convey if effective	
	Urgent Treatment Centres - Redesignation of MIUs to UTCs (October)	Monitor and evaluate effectiveness of UTCs	
	Urgent Treatment Centres - Feasibility study of UTCs in Yeovil and Taunton (March)		
Mental Health	**Integrated NHS111 and mental health crisis line** - Launch the integrated NHS111 and mental health crisis line		
	Mental Health Discharge - Develop and implement a plan to support people to move out of hospital-based care as soon as they are medically fit		
Children, Young People & Families	**Paediatric Virtual Ward/Hospital at Home Model** - Explore outcomes of the paediatric virtual ward/hospital at home model following its pilot phase.		

Priority 4: Integrated Neighbourhood Working

Why is it important?

Somerset in its ICS primary care strategy has pledged to deliver on the Fuller Stocktake. To do this there will need to be a specific piece of work therefore on developing those teams outlined within the Fuller Stocktake, those which deliver care:

- to those with the most complex needs
- for same day urgent care

We will deliver this commitment via Integrated Neighbourhood Teams who will work in *"A geographical area where there is a culture for multi-agencies and communities to co-design, co-create, co-deliver, work and learn together. Through this culture of collaboration, the community is supported to live the best and most fulfilling lives they can".*

An example of a geographical area is a primary care network footprint, a local community network footprint, a village, a town.

Multi agency working includes voluntary care/faith/social enterprise, social care, private partners e.g. local gyms, the local council and health.

What we are going to do?

	2024/25	2025/26	2026/27 to 2028/29
Integrated Neighbourhood Working	Develop evaluation methodology for existing Integrated Neighbourhood Working approaches in Somerset	Evaluation methodology confirmed & implemented Monitor and evaluate Integrated Neighbourhood Working	Monitor and evaluate Integrated Neighbourhood Working
	Map existing neighbourhood working operating models, (including workforce and frailty) to understand strengths, reduce duplication, identify potential for scaling and streamlining	Implement Integrated Neighbourhood Working through a joined up Somerset approach that supports local differences based on population health needs	Integrated Neighbourhood Working available to all people across Somerset
	Co-design approach to Integrated Neighbourhood Working which provides person centred equity of access across Somerset (to include Shared Decision Making)		

	2024/25	2025/26	2026/27 to 2028/29
	Co-design with Shepton Mallet, South Somerset West and West Somerset in 24/25		
	Digital Neighbourhood Programme - A catalyst for the ICS strategic priority around Integrated Neighbourhood Teams. The programme embraces the rollout of BRAVE AI, SIDeR+ and other digital, data and technology innovations enabling right care at the right time.		
	Map existing commissioning models (aligned with above) to understand potential for joint commissioning arrangements to support full integrated service delivery	Develop effective and aligned contracting and commissioning mechanisms to deliver the Integrated Neighbourhood Working	
	Identify workforce supply & OD needs, skills and capability gaps, and potential for new roles with different skills/competency mix	Support the resourcing & OD needs of identified Integrated Neighbourhood Teams based on workforce planning & gap analysis	
	Restructure adult social care teams around PCN boundaries as part of Somerset's ongoing commitment to integrated working with partners at neighbourhood level		
	Implement the Team Coaching programme in West Somerset as a test and learn pilot	Evaluate the team coaching programme test and learn pilot, share learning and consider further roll out	
	BRAVE AI Rollout - Continue the roll out and develop the risk stratification tool BRAVE AI to Somerset's 13 PCNs who, at	Continued Roll out of BRAVE AI	Continued Roll out of BRAVE AI (April 27)

	2024/25	2025/26	2026/27 to 2028/29
	present, are at varying stages of roll out.		
Primary Care	**Primary Care Strategy** - Deliver Primary Care Strategy		
	Modern General Practice Model - Support practices to deliver the Modern General Practice Model (March)	Continued focus on continuity of care	
	Community Pharmacy - Invest and develop Community Pharmacy, particularly the implementation of Pharmacy First and Independent Prescriber Pathfinder, building on the successful implementation of Community Pharmacy Consultation Scheme.		
	Dental Recovery Plan - Rollout and implementation of dental recovery plan focussing on access, Health Education and Workforce - Implement use of innovative dental contract models to encourage and optimise access and delivery		
	Optometry Services - Invest and develop Optometry services to achieve full integration with urgent care through development of the Acute Care Eyes Service and routine care through better integrated elective pathways		

	2024/25	2025/26	2026/27 to 2028/29
Personalised Care	**Embedding of true shared decision making and personalisation across all aspects of care and support**		
	Personalised Care and Support planning - Implementation of a consistent and joined up approach to personalised care and support planning		
	Further roll-out and consistency across the county of social prescribing and community-based support - Co-produce a Somerset Framework for Social Prescribing. Support the growth and resilience of social prescribing and community based support		
	Support self-management - Co-production and implementation of programmes to support self-management across the county for a range of conditions.		
	Personal Health Budgets/Integrated Personal Budgets - Increase the use of personal health budgets and integrated personal budgets through partnership working and a shared approach to existing budgets		
	Personalised Care Outcome Measures - Develop outcome measures that demonstrate impact of a personalised approach at		

	2024/25	2025/26	2026/27 to 2028/29
	person, community and system level.		
	Support Integrated Neighbourhood Team working - Supporting collaboration and learning through Integrated Neighbourhood team working across Somerset-connecting the learning from existing INT's such as South Somerset Complex Care team and current projects such as Shepton Mallet, SWS and West Somerset		
	Community Personalised Care Group - Work with the council and voluntary sector partners to develop a Community Personalised Care group to support and inform the Personalised Care steering group workstreams and develop a renumeration framework hosted by a voluntary sector partner.		
	Personalised Care Identity and Narrative - Develop a Somerset personalised care identity and narrative through a collaborative engagement approach		
	Tackling Inequalities through person centred approaches - Tackling Inequalities through person centred approaches - changing how and where services can be accessed, ensuring the focus is on		

	2024/25	2025/26	2026/27 to 2028/29
	the person and their needs and priorities.		
Urgent & Emergency Care	**Same Day Emergency Care** – Reducing variation in SDEC provision by operating a variety of SDEC services for at least 12 hours per day, 7 days a week.		
Urgent Community Response	- Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission. Continue above-target performance against the 2-hour response standard. - Link between 111/999 and UCR to enable electronic referrals to the most appropriate responder, enabling people to remain at home as long as possible	Monitor and evaluate effectiveness	
Proactive Care	Proactive Care will be an enabler to develop integrated neighbourhood teams across the Somerset system.		
Enhanced Health in Care Homes (EHCH)	**Role of Social Prescribers, Health Coaches and Village Agents** - Work with Somerset Council colleagues, Social Prescribing Link Workers (SPLW), health coaches and Voluntary Community Faith Social Enterprise (VCFSE) colleagues to highlight services available for care home residents within their community		

	2024/25	2025/26	2026/27 to 2028/29
	Improve access to and awareness of services to care home residents for example, urgent community response, lifting equipment etc	Monitor and evaluate effectiveness of support to Care Homes	
	Care Home Digital Maturity - continue expanding the digital maturity of Somerset care homes, so more care homes have access to NHS mail, Proxy medication and shared care records		
	Care Home Workforce Training Plan - Support PCNs and wider providers to develop packages of training for care homes teams. Increase awareness of free training available to the care homes teams and from PCN baseline feedback work with providers on possible challenges.	Review ongoing training needs	
Children, Young People & Families	**Integration** - Year 2 of Integration project paediatric ACP into the general practice urgent care hub - Learning and contributing to the development of a wider paediatric SDUC workforce approach for the county. - Delivery of a test paediatric triage model within community.		
	CYP Integration/Neighbourhood Team Model - Continue to develop the CYP integration/neighbourhood		

	2024/25	2025/26	2026/27 to 2028/29
	team model in one PCN (CLIC) as a Test and Learn.		
Women's Health	**Women's Health focussed Neighbourhood Teams** - Development of women's health focused neighbourhood teams, promoting increased integration across primary, secondary and community services in the NHS and local authority.		

Priority 5: Population Health Transformation

Why is it important?

We know that people living in Somerset with higher socioeconomic position have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. Health, care and unhealthy behaviours is one of the main focuses. It provides an opportunity to maximise our uptake of support for those with a long-term condition or mental health issue while also allowing our prevention programmes to help with modifiable risk factors. We want to give more people in Somerset the life chances currently enjoyed by the few. Our people would be better off in many ways: in the circumstances in which they are born, grow, live, work, and age. This will require joined up and integrated working with our partners in health, social care, housing, police, education, fire and rescue, town and parish councils, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners and our employers.

By doing this, people in Somerset would see improved wellbeing, better mental health and less disability. Their children would flourish, and they would live in sustainable, cohesive communities which they are proud of and care about where they live.

What we are going to do?

	2024/25	2025/26	2026/27 to 2028/29
Tackling Healthcare Inequalities	**Strengthening workforce** - Formalise Healthcare Inequalities Network as a Community of Practice - Develop a local Health Inequalities toolkit - Develop NHS Ambassador Programme focussing on inequalities	**Strengthening workforce** - Established Community of Practice - Local Health Inequalities toolkit being used to inform local decision making - Continue to develop NHS Ambassador Programme	**Strengthening workforce** - Established Community of Practice - Local Health Inequalities toolkit being used to inform local decision making - Continue to develop NHS Ambassador Programme
	Data & Evidence - Development of local Health Inequalities Dashboard including Core 20+5 metrics - Improve recording of ethnicity data - Development of PCN Data profiles to inform priority areas for	- Support use of dashboard to inform tackling inequalities through integrated neighbourhood working	

	2024/25	2025/26	2026/27 to 2028/29
	Population Health Management and PCN Inequalities plans - Undertake a Working Well Needs assessment to increase intelligence on people out of work for ill health		
	Tackling specific inequalities - Continue to develop SFT Inequalities focused Elective Care Recovery - Completion of Core 20+ 5 Connectors Project (COPD) - Evaluation of Homeless Health programme and development into Inclusive Health Programme	- Develop personalised care programme for people who experience multiple disadvantage	
Adopting Population Health Management approaches within neighborhood working	Alignment with the Integrated Neighbourhood Working priority to: - Support the development of work focused on improving health and tackling healthcare inequalities, including utilisation of BRAVE AI - Support the development of 18 Local Community Networks - Develop a system-wide approach to engagement with groups who experience inequalities	- Delivery of population health management through Integrated Neighbourhood working - Support the development of resilient and vibrant communities to improve health and tackle healthcare inequalities through Local Community Networks - Development of Community Ambassador Programme aligned to Local Community Networks	
Development of a Population Health Culture	- Launch of a public and population health training academy - Development of NHS Population Health Ambassador Programme, starting with social prescribers and AHPs	- Roll out of training programme - Expand Health Ambassador Programme to other professionals	- Roll out of training programme - Health Ambassador Programme expanded to all professionals

	2024/25	2025/26	2026/27 to 2028/29
	- Inclusion of Population Health Management and inequalities into ICB organisation development programme - Development of joint approach to health information, engagement and campaigns for staff and public		
Priority Population Health Programmes	Deliver 3 priority population Health programmes: - 'Take the Pressure Off' campaign to case-find and optimise treatment for individuals with hypertension. - Continued development of AI Fatty Liver Case Finding programme - Development of system-wide campaign to achieve smoke free by 2030	Deliver 3 priority population Health programmes: - 'Take the Pressure Off' campaign to case-find and optimise treatment for individuals with hypertension. - Continued development of AI Fatty Liver Case Finding programme - Development of system-wide campaign to achieve smoke free by 2030	Deliver 3 priority population Health programmes: - 'Take the Pressure Off' campaign to case-find and optimise treatment for individuals with hypertension. - Continued development of AI Fatty Liver Case Finding programme - Development of system-wide campaign to achieve smoke free by 2030
Develop use of Data & Intelligence	Delivering data and intelligence - Scoping and commissioning of cloud-based integrated data lake - Development of Data & Information Sharing governance for integrated cloud data lake - Agreement and development of Joint Intelligence Function for Somerset	- Embed the use of integrated data within the Health and Care System to support the growth of Population Health Management - Continue to develop skills and expertise required to support Population Health Transformation - Further development and Inclusion of additional data into the Integrated data function	- Embed the use of integrated data within the Health and Care System to support the growth of Population Health Management - Continue to develop skills and expertise required to support Population Health Transformation - Further development and Inclusion of additional data into the Integrated data function

	2024/25	2025/26	2026/27 to 2028/29
Align Commissioning, Policies & Resources	- Launch approach to commissioning Primary care services weighted towards inequalities - Build health improvement and tackling healthcare inequalities into financial processes and performance monitoring - Evaluation of the business cases funded by the health inequalities funding - Development of a local strategy for the movement of resources across the Somerset System - Expansion of Transformation Programme Capacity	- All services commissioned consider healthcare inequalities - Financial process and performance monitoring aligned to include and recognise health inequalities - Business cases found to be effective in reducing health inequalities resourced through the redistribution of funding.	

Delivering this Joint Forward Plan

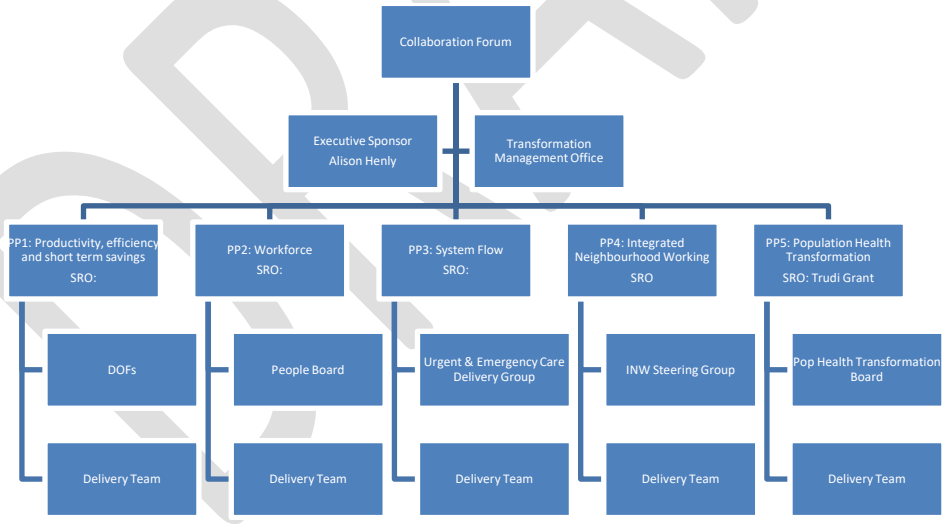
We are committed as partners to work together to deliver the commitments made within the Integrated Health and Care Strategy and taking forward the five priority programmes. Early in 2024/25 we will prioritise the actions within each priority programme, to ensure they are aligned to deliver the required outcomes, including financial savings.

We have a strong track record of working together to improve the health and care services in Somerset. Overall accountability within Somerset Integrated Care System for the plan rests with NHS Somerset (Somerset ICB). Somerset's Integrated Care System (known as Our Somerset) brings together all the organisations responsible for delivering health and care within our communities.

Governance and oversight for the delivery of this plan

The overall responsibility for delivery of this Joint Forward Plan rests with NHS Somerset ICB. The Collaboration Forum will be the committee that will oversee the delivery of the Joint Forward Plan on behalf of NHS Somerset.

- An Executive Sponsor will have overall responsibility for delivering the Priority Programmes, reporting into the Collaboration Forum
- Each Priority Programme will have:
    - A Chief Executive or executive level SRO
    - A transformation lead, identified from within the Somerset system to provide the expertise and knowledge to drive the programme forward.
    - A transformation manager working to deliver the programme
    - A delivery team comprised of colleagues from multiple organisations



We are in the process of establishing the Transformation Management Office who will provide the rigour around the Priority Programmes, ensuring that there are clear mandates, work programmes and there is regular reporting through to the SRO and Collaboration Forum.

System partners are committed to identifying and releasing people to be able to lead these priority programmes.

Next Steps

This Joint Forward Plan sets out the priorities for Somerset and articulates the actions required to deliver our Integrated Health and Care Strategy in Somerset.

Early in 2024/25 we will prioritise the actions within each priority programme, to ensure they are aligned to deliver the required outcomes, including financial savings

During 2024/25, we will consider refreshing our Integrated Health and Care Strategy, following receipt of the Joint Strategic Needs Assessment, updated NHS England planning guidance and any new policy announcements which may be made, for example, because of the forthcoming General Election.

There are two specific pieces of work we have planned for 2024/25, over and above reviewing our existing strategy. These are:

- Development of system outcome measures
- Working with people and communities - Somerset Big Conversation

Development of system outcome measures

Our strategy, with its seven aims, is well established within Somerset. We recognise that to make this real, we need to define why we are doing what we are doing and whether we are heading in the right direction to achieve it.

Working with partners from across the system, we are:

- Defining the overall outcome we want to achieve through the delivery of our strategy and how we will measure it
- Defining why each aim is important and identifying a headline measure which will help us understand if we are delivering each aim. We will set:
    - Level 1 outcomes – what are we trying to achieve over the next 10-20 years
    - Level 2 outcomes – what are we trying to achieve over the lifetime of the strategy (5 years)?
- Developing a suite of outcome measures - metrics or indicators which are used to evaluate our progress towards the outcome. We expect these to be different from our traditional performance Key Performance Indicators
- Developing the system wide baseline from which we will measure our progress

These outcomes and the metrics which support them will provide a future focus in our ICB Board Assurance Framework reporting.

Working with people and communities – Somerset Big Conversation

The ambition of this engagement project is to reach as many people as possible across Somerset, ensuring we involve those facing the most health inequalities. Our aim is to hear from people across the breadth of Somerset communities, by being visible and engaging at events, groups and venues across the country, covering all four geographical areas. We aim to use a wide range of engagement tools and activities this spring and summer to ask people - *what matters to you?* We will share what we hear by presenting the feedback to our colleagues and partners and sharing what we have learnt with the public. We aim to develop our findings into ‘Our Commitments’ and ensure that change happens as a result of these conversations.

Appendix 1 – Our achievements over the last 12 months

This section provides a review of what we said we would do over the 12 month period from April 2023 to March 2024 and what we have done.

Adult Social Care (ASC)

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Embrace more personalised approaches to health and care - We will work as part of Somerset's ICS to embrace more personalised approaches to health and care, investing in people's health and wellbeing when they are well and supporting them when they need it.	⇨	On-going development of the personalised approached to health and care, including personal health budgets, Direct payments and ILFs, to enable people to remain well, prevent deterioration and support the ethos of promoting independence and self-directive support through the customer journey.	**Yes**
Development of viable care alternatives - We will invest in the development of viable care alternatives to reduce and delay the need for long-term care (such as extra care housing and a range of reablement and community services).	⇨	Recommissioning of Extra Care Housing model started, with the aim to support more people to be able to access these facilities, with the ambition to prevent admissions into residential care. Focus will be on supporting people with a dementia diagnosis and open up ECH to working age adults. Continued working with the housing market, to develop a new ECH scheme in the Yeovil area. Further work being undertaken to ensure efficiency of ECH stock across the county, looking at reprovision of ex-care home site, to support ECH development. As part of My Life, My Future work stream, will support the ambition of the development of reablement services as part of the community offer, rather than just from a hospital discharge perspective.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Investment in technologies and community equipment - We will invest in technologies and community equipment to support and reduce demand for care, developing our assistive technology offer to enable people to remain as independent as possible within their own homes and promoting our Independent Living Centres.	⇨	Assistive Technology (AT) team developed, with experts in this field, supporting operational staff and enabling AT to be at the heart of practice. New training platform commissioned to ensure integration and on-going upskilling of workforce and users of service. Working with our existing community equipment supplier and in-house lifeline service to develop a comprehensive AT offer. A new independent living centre opened in Yeovil, now three centres active in Wellington, Shepton Mallet and Yeovil, with a fourth centre due to be developed in Bridgwater. A new AT suite has been developed as part of the independent living centres, significant financial investment into AT products.	**Yes**
Unpaid Carers - We will ensure unpaid carers are valued, recognised and supported to provide care in a way that supports their own health and wellbeing.	⇨	Launch of the revised joint commitment to carers taking place in March 2024 as part of the recommissioned carers services, aligning to community provision, enabling timely advice and information to carers. Increase in ASC carers assessment and on-going trajectory improvement plan in place.	**Yes**
Prevention, early help and wellbeing interventions are championed and supported - We expect that prevention, early help and wellbeing interventions are championed and supported, delaying and preventing social care needs and reducing the number of people with preventable illness or disease.	⇨	Continued development of our community offer, including agents' services, VCFSE, independent living centres enabling people to enable self-directive support opportunities.	**Yes**
People with care and support needs are triaged, assessed and reviewed in a timely and consistent way - We will ensure people with care and support needs are triaged, assessed and reviewed in a timely and consistent way, and that their care and support reflects their right to choice, builds on their strengths and assets and reflects how they wish to live their lives.	⇨	On-going process to triage and support people with care and support needs to be assessed. Embedding of new neighbourhood approach aligned to PCN areas, as part of the neighbourhood structure. Trajectory and improvement plan in place to reduce the number of outstanding Care Act Assessments, robust risk assessment process in place.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Promote Direct Payment options - We will promote direct payment options and improve processes for doing so, enabling people to maximise their choice and control about how to meet their support needs	⇨	ASC have a robust Direct Payment process in place. Current pilot being undertaken to enable people who previously have not been able to access direct payment to support equity of offer.	**Yes**
Intermediate Care and Reablement Services - We will continue to work with partners to deliver and develop high-quality, responsive intermediate care and reablement services to enable people to return to their optimal independence and support timely hospital discharge.	⇨	As part of My Life, My Future – focussed work being undertaken to support efficiency and optimise capacity to support people's reablement journey as part of pathway 2. Trial of live in care pilot being undertaken to provide more choice and optimise people to return home, preventing them from requiring bedded care. Review of bedded care to feed into future intermediate care development, with the emphasis of a home first approach and reduction on reliance of bedded capacity.	**Yes**
Preventing abuse and neglect - We will continue to focus on preventing abuse and neglect and identifying risk early, ensuring adults at risk are supported to feel safe.	⇨	Continue priority as part of the Somerset Safeguarding Adults Board, linked to strategic priorities of the board and outcome to support individuals.	**Yes**
Restructure adult social care operational teams around Primary Care Network (PCN) boundaries - We will restructure adult social care operational teams around Primary Care Network (PCN) boundaries as part of our ongoing commitment to integrated working with partners at a neighbourhood level.	✓	Restructure of adult social care operational teams completed, aligned to PCN areas, with specialist teams for LD, Preparing for Adulthood and Mental Health teams. Further imbedding of the new neighbourhood teams, to ensure efficiency and closer alignment with health.	**Yes**
Continue to invest in the development of voluntary/community enterprises - We will continue to invest in the development of voluntary/community enterprises, and align micro provision with broader core provision of care at home to ensure vibrancy of the overall marketplace and care workforce.	⇨	New homecare framework and block arrangements launches April 2024, aligning delivery to PCN areas, coterminous with neighbourhood teams. Alignment between homecare providers and micro-providers to support collective approach, working with community agents to develop resilience in local areas.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Promote diversity and quality in the provision of local services - We will promote diversity and quality in the provision of local services, and re-commission models of care as needed to ensure services are localised, integrated, sustainable and meet the changing needs of our population.	⇨	Combined approach between NHS Somerset and Somerset Council in-relation to quality assurance process. Modelling of current community assets and provision, supported with Accelerating Reform Fund (ARF) bid to support growth in local areas, focusing on areas of deprivation and inequalities.	**Yes**
Work in partnership to prevent avoidable admissions to hospital - We will work in partnership to prevent avoidable admissions to hospital by enabling people to get the care they need safely and conveniently at home (e.g. virtual wards).	⇨	Current pilot taking place in the South Somerset area, supporting complex care team and closer integrated working between health and social care. Independent living centres, enabling information and advice.	**Yes**
Digital Care at Home Programme - We will improve digital care for residents in care homes and in patients' own homes, and increase uptake and quality of annual health checks for people with a learning disability as part of the Digital Care at Home Programme (led by NHS Somerset).	⇨	ASC continue to support the digital care home innovative, being led by NHS Somerset. Continued promotion of digital care home records as part of system approach, supported by Registered Care Provider Association.	**Yes**
Liberty Protection Safeguards Scheme - We will respond to and implement activity associated with the (replacement) Liberty Protection Safeguards Scheme, providing protection for people aged 16 and above who are, or who need to be, deprived of their liberty in order to enable their care or treatment and who lack the mental capacity to consent to their arrangements (e.g. those with dementia, autism and learning disabilities).	✘	The **Liberty Protection Safeguards (LPS)**, which were intended to replace the existing **Deprivation of Liberty Safeguards (DoLS)**, have faced delays. The department of Health and Social Care (DHSC) announced that the implementation of LPS will not proceed before the anticipated general election in Autum 2024. Therefore, activity in this space has been put on hold until further directive from DHSC	-
Open Mental Health alliance - We will continue to work together with partners as part of our Open Mental Health alliance to improve the way people in Somerset receive support with their mental health.	⇨	ASC continue to work in-conjunction with system partners in relation to open mental health alliance and will continue to support the development of this collaboration in 2024/25.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Work in partnership with our care provider market - We will work in partnership with our care provider market to ensure there are sufficient nursing places available to meet future demand, particularly for people living with dementia and other cognitive impairments.	⇨	ASC commissioners continue to work in partnership with the care provider market to support capacity and sufficiency within the care home market. A new 75 bedded nursing home opened in March 2024, supporting individuals with cognitive impairment and expressive behaviours. Further work has been done with the market to ensure utilisation of bed capacity, securing a further 100 beds across Somerset within existing care home footprints. A general nursing home has opened in the Radstock area supporting additional 60 beds, 39 bedded dementia nursing home in Yeovil and plans for a further 25 bedded dementia nursing home in Burnham-on-sea that will open in the autumn of 2024. There are planning permissions granted for a further 5 care homes across the county.	**Yes**
Increase flexible, responsive community placement options - We will increase flexible, responsive community placement options for people with more complex needs, enabling people to live within, or as close as possible, to their communities.	⇨	As part of ASC community offer, mental health and learning disabilities commissioners are continuing to work with care and housing providers to develop bespoke supported living facilities to enable sufficiency of options available in community. There has been the development of two, six bedded supported living schemes, one open and one due to open in June 2024. with additional three schemes in the commissioning process. Further work is being undertaken in-relation to reprovision of existing supported living schemes, that will be converted into specialist services going forward.	**Yes**
Establish and maintain more efficient and effective systems of care - We will work with people and partners to establish and maintain more efficient and effective systems of care that support continuity when people transition between different services, settings or areas.	⇨	ASC has developed a preparing for adulthood teams, supporting individuals from the age of 14, while they transition from children's services, through to adult service at the age of 18. The team works in collaboration with commissioners, to plan and secure services and future housing needs of our transition cohort.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Improve opportunities for meaningful co-production - We will improve opportunities for meaningful co-production to ensure that the voices of those who draw upon care and support are involved in the ongoing design and implementation of local care and support services.	⇨	Somerset Council ASC has developed a Working Together board with participants with lived experience. The board will be co-chaired with the executive member for adults and board member with lived experience. The board is in its infancy, with the aim to develop subgroups to cover key ASC activity. As part of the commissioning directive, all service area recommissioning will be/are co-produced with people lived experience.	**Yes**

Population Health Transformation

The Population Health Transformation Programme has further developed this year and now focusses on 6 workstreams:

- Tackling Healthcare Inequalities.
- Priority Population Health Programmes.
- Develop use of data and intelligence.
- Development of a population health culture.
- Using population health management in locality working.
- Alignment of commissioning, policies and resources to improve health.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Tackling Healthcare Inequalities			
People experiencing homelessness - Working with homelessness charities, drug projects and VCFSE to support intravenous drug users (IVDU) on safer injecting methods and rehabilitation.	⇨	Significant work has been undertaken and this work has moved from pilot to an inclusive system of interventions. Governance is in place and the Inequalities in Healthcare group (IHG) is overseeing delivery and providing assurance, this includes evaluating the impact of the work. This evaluation will inform the system's overall delivery plan.	**Yes**
Health of displaced people	✓	A structure has been developed to oversee the health input to Displaced People in Somerset, this has continued to evolve.	-
Health of Coastal Communities - A priority for us in Somerset is addressing the needs of coastal communities, which are in the 30% most deprived in the county.	⇨	There is no national definition of coastal communities. Options for local definitions have been drafted and now require Population Health Management Board approval.	**Yes**
Develop Healthcare Inequalities & Inclusion Health training programme for the system	⇨	Training sessions and workshops have been carried out for ST1 & ST2 GPs, the Public Health Nursing Team and with VCFSE organisations working in mental health. The training with ST1 and ST2 will now be on regular rotation. Additional training is expected in the spring with both trainee and practice nurses and allied health professionals. More work is required to evaluate and measure the impact of the training in 2024/25.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Inequalities in Healthcare Group (IHG) - The Somerset Inequalities in Healthcare Group will lead on the development of a Health Inequalities Plan for the county and reflect the needs of our most deprived populations and our new migrant populations.	⇨	The IHG was established this year and co-developed a set of system priorities for Health Inequalities for an 18-month period.	**Yes**
Create community of practice via the Healthcare Inequalities network - The Somerset Inequalities in Healthcare Group will lead on the development of a Health Inequalities Plan for the county and reflect the needs of our most deprived populations and our new migrant populations.	✓	The Healthcare Inequalities Network was established in April 2023. While development of this network continues, this has now become an established network.	-
NHS Population Health Ambassadors	⇨	The first phase of development in this area has been the establishment of the Health Inequalities Network, established and with 80 active members.	**Yes**
Improving the recording of ethnicity data	⇨	Partners have agreed this is an area requiring further progress.	**Yes**
Core20+5 10 clinical areas and smoking cessation	⇨	SROs have been identified for all areas. The focus is now on creating a reporting structure to improve oversight and assurance of Core20 areas.	**Yes**
Anchor institutions to improve opportunities for those in Core20 areas - As an ICS use our ability as anchor institutions to create employment opportunities for our coastal communities.	⇨	Established links with our system People Delivery group to ensure this is a shared objective.	**Yes**
Priority Population Health Programmes			
System Hypertension Pathway	⇨	A significant whole system campaign to case finding and optimisation has been launched and will continue throughout 2024-25.	**Yes**
Liver Case Finding	⇨	Continued development of this programme with inclusion of deprivation into the AI modelling.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Developing use of Data & Intelligence			
Enabling workstream which aims to use systemwide intelligence, harness data analytics to deliver evidence-based priorities and is led by the Digital, Data & Insight Board. Current projects include:			
• **Cloud Data Platform**	⇨	The ICS agreed to support a focussed 15-week business case creation project for a Population Health Platform to enable the system to mobilise a solution in September 2024.	**Yes**
• **Information Sharing Panel**	⇨	The ICS used population health data to support the "Take the Pressure Off" campaign to combat high blood pressure and save lives. Over half of all strokes and heart attacks in Somerset are caused by high blood pressure.	**Yes**
Healthy Workforce Programmes			
This workstream requires the launching of the Ambassador Programme. This is supported by Population Health Transformation and being managed via the People Board.	⇨	With recent restructures of Somerset Council and the Integrated Care Board, this work has been paused but is expected to continue in 2024/25.	**Yes**
Development of Population Health Management through Localities			
Developing a local community approach to improving health and tackling inequalities. This workstream seeks to engage with local communities to understand their needs and priorities and work with and through local structures to improve health.	⇨	Visits to 7 Primary Care Network teams were carried out, which included exploring their local healthcare inequalities priorities. Through the Hypertension Campaign additional work has been undertaken to identify Hypertension Leads at all practices.	**Yes**
Align Commissioning, policies & £			
Enabling workstream which aims to influence local, regional and national policy to include greater focus on improving health and tackling inequalities. Seeks to support a cultural shift that is embedded at the most strategic level as well as at the tactical and operational level.	⇨		**Yes**

Urgent and Emergency Care

- The Somerset system has invested in the My Life, My Future Work Programme, with Somerset Council. Newton Europe are undertaking the programme. This programme includes a Reablement workstream which aims to achieve efficient processes and sufficient capacity to support more people with reablement potential through the service whilst opening access to the service for people in the community. This includes supporting individuals with greater starting needs to become more independent through the right therapy input at the right point for the person and multidisciplinary team (MDT) improvement cycles. So far the workstream has seen an increase in the number of people starting on the pathway each week, an increase in people on the caseload and the reablement length of stay has been trending positively throughout the trials. Further work will continue throughout 2024/25.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Same Day Emergency Care - Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days a week.	⇨	A new 7-day PAU established at MPH, New Surgical high intervention pathway piloted at YDH to see and treat preventing admissions, New Gastroenterology SDEC service at MPH established at the end of November, Gap analysis of MPH and YDH services undertaken, Additional Medical consultant piloted in YDH in SDEC.	**Yes**
Inpatient flow and length of stay (acute) - Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/ cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.	⇨	Average length of stay at MPH reduced from 8.6 days in 2022/23 to 7.7 days during 2023/24 so far. Average length of stay at YDH has stayed the same at 8.9 days. Flow was also an area of focus at the No Criteria to Reside Stocktake meeting in January 2024, improvements in flow will be linked to Transfer of Care Hubs, No Criteria to Reside improvement trajectory and redefining the Intermediate Care pathways – this work will continue through 2024/25.	**Yes**
Community bed productivity and flow - Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.	✓	The system has closed Intermediate Care surge capacity that was implemented throughout 2022/23 and there has been a focus on reducing length of stay within the bedded capacity. An oversight group is in place with an agreed improvement plan focussing on active reablement, assessment and sourcing. Length of Stay during Oct – Dec 2023 is 36 days, almost nine days shorter than the average for the rest of 2023.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Transfer of Care Hubs - Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	⇨	Two Transfer of Care Hubs were implemented within the Somerset Acute Hospitals on 1 December 2023 as part of Phase 1 of this implementation. An oversight group meets on a weekly basis to review progress. This learning will be used to inform Phase 2 where we develop a final model for the Somerset system further incorporating community services.	**Yes**
Intermediate care demand and capacity - Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.	⇨	My Life, My Future work programme has a focus on Pathway 1 reablement capacity and efficiency. Following a No Criteria to Reside stocktake in January 2024 there is agreement to review and redefine the Intermediate Care Pathways. This work will continue through 2024/25.	**Yes**
Single point of access - Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.	⇨	Regular meetings are taking place between SFT, ICB and HUC to review how SPL and the CAS can be more integrated. Some changes have been established to improve the flow of information between SPL and the CAS. A focus on implementing a regional model for Single Point of Access / Care Coordination Centres across the South West has commenced in January 2024. This work programme will accelerate learning from the regional systems already doing this work individually and collectively to support the rapid implementation of models within each of the seven systems.	**Yes**
Acute Respiratory Infection Hubs - Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.	✓	100% of GP practices signed up to providing appointments for acute respiratory infections (ARI) starting in November 2023. Point of care testing for ARI was implemented into Primary Care Networks. Data and evaluation will be reviewed after March 2024.	-
Criteria Led Discharge (CLD) - Roll out systematically CLD to support weekend discharges.	⇨	Launched on 20 November 2023 across 8 wards, now fully launched across YDH and MPH for both medical and surgical. Cardiology wards are leading on CLD 7 days a week. A trial is taking place in the Medical Services Group at YDH where nurses are transcribing the medications for the Doctors, which will free up Junior Doctor time to write discharge summaries. The aspiration is to implement this at MPH.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Process of discharge - Improve discharge processes. Review and improve.	✓	Lots of work has been taking place within the discharge space including weekly discharge improvement group meetings, Transfer of Care Hub implementation, Criteria Led Discharge.	-
7 day working - Review what is required for 7 day working across the system and define what this looks like for Somerset.	⇨	The system is working to improve 7 day working and system flow throughout the week, including expanding SDEC services 7 days a week, Criteria Led Discharge to be in place across all wards 7 days a week by March, Transfer of Care Hubs to support discharge throughout the week.	**Yes**

Planned care, diagnostics and cancer

- Overall, the elective portfolio is broadly on track. Four programmes are showing improvement, and the remainder showing a steady state, in terms of progress. There are a small number of delays to elements of a number of projects within programmes, including snagging issues with the Cinapsis system/pathway and resulting delayed uptake by GPs, the ongoing analysis of cancer access inequalities and the establishment of a monitoring report for expediting vulnerable patients. The portfolio is ahead of plan (i.e. better than) in terms of expenditure. No individual programme is significantly behind schedule.
- Limitations remain around project support to the work of the Elective Care Board as well as digital support to projects.

Progress Key	✓	Plan delivered	⇨	Plan delivered in part	✘	Plan Not Met

What we said we would do (April 2023 – March 2024)	Progress v. plan in 2023/24	What we have done	Ongoing project in 2024/25
MSK Services			
MSK Pathways – Define and redesign MSK pathways to minimise duplication and ensure all steps in the pathway add value; ensure the right level of capacity is available at each step of the pathway to meet demand.	⇨	Actions to smooth out pathway between First Contact Physiotherapists (FCPs) and Community Physio begun by providing MRI requesting for FCPs. Capacity & Demand dashboard under development.	**Yes**
Self-help App - Introduce a self-help app for musculoskeletal conditions to be prescribed by primary care as an alternative to physiotherapy referral and may also reduce urgent care presentations.	✓	Rolled-out successfully to 60 practices across Somerset. 3,689 individuals have been provided access to the app / clicked on the initial front page, of these, 2,689 have completed the registration process and are using the help and support available via the app. This means an overall adoption rate of 73% (which is higher than the getUBetter average of 66%). 21 x GP Practices have over 50 people registered and using the app.	**Yes**
Outpatient Waits			
Advice First - Roll-out Advice First between primary and secondary care, for all appropriate specialties.	⇨	Successfully procured Cinapsis as the new advice and guidance system. Dermatology has gone live, with a large number of specialties prepped for launch once residual process issues resolved.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress v. plan in 2023/24	What we have done	Ongoing project in 2024/25
Somerset Transformation of Outpatient Care (STOC) - Further develop and deliver the Somerset Transformation of Outpatient Care programme.	⇨	Clinic utilisation at 90%. DNA additional reminder messages being trialled since July appear to be having positive impact. Partial Booking - rolled out and live in med/surgical specialities. Validation now from 10 weeks for Outpatients and admissions across both sites.	**Yes**
Ensuring patients wait well			
My Planned Care - Ensure patients who are waiting for treatment can access information on their planned procedure, via My Planned Care to help them stay well whilst they are waiting.	✓	Gap analysis has been undertaken and there are only 9 or 10 more procedure guides to write in order to ensure that approx. 80% of patients looking for guidance will be able to find it on the platform (i.e. key procedures will be available).	-
Safety netting / Validation – Establish a process for safety-netting of patients waiting for treatment so that patients at the greatest risk of deteriorating whilst waiting are identified and have their treatment expedited.	✓	Safety-netting process in place. National validation processes established, with patients in scope being contacted digitally or by letter, or having administrative validation completed, down to 10 weeks on an RTT pathway. As of w/e 10/03/24 we reported 75% as validated against the national target of 90% - Amber rated).	-
Peri-Op Pathways – Establish a range of perioperative interventions for preparing patients for surgery, to improve outcomes for surgery, reduce length of stay in hospital and offer alternatives to surgery where appropriate.	⇨	Number of key posts within service now recruited to. Frailty joint decision making pilot has shown over 50% of patients chose not to go for surgery. Around a third of patients on the waiting list contacted to offer stop smoking advice take up offer.	**Yes**
Theatre Productivity			
Day-case rates / GIRFT HVLC – Deliver GIRFT and HVLC recommendations for theatre utilisation and day-case rates.	⇨	Capped theatre utilisation now reaching over 80% for the first two weeks in February, averaged across the two hospital sites against the national target of 85%. We are now ranked in the second quartile, compared with the fourth quartile in October.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress v. plan in 2023/24	What we have done	Ongoing project in 2024/25
Prioritising Children & Young People's (CYP) care			
Waiting list prioritisation/ management - Ensure CYP patients are prioritised whenever appropriate, and the technical monitoring tools/processes required to do this.	⇨	Processes to flag CYP patients on the waiting lists now in place. This allows CYP patients to be highlighted for prioritisation where possible. A more formal approach to prioritisation, which uses the Trust's policy to expedite vulnerable patients for certain cohorts of CYP patients, has now been written and will be considered by the medical leadership team once the 2024/25 planning guidance is released. Children Looked After (CLAs) have already been added to the vulnerable patient process. Using the vulnerable patient policy approach may, for example, mean that children sitting on adult surgical lists (e.g. T&O, ENT) are prioritised.	**Yes**
Validation / Safety-netting - Establish a process for safety-netting of CYP patients waiting for treatment so that patients at the greatest risk of deteriorating whilst waiting are identified and have their treatment expedited.	✓	Parents of all non-admitted CYP patients on the RTT waiting lists are now contacted when the patients have been waiting 10 weeks to ensure they have not already been treated, still require treatment and would consider transfer to another provider if they could be treated more quickly elsewhere. The exceptions are children from out of county as these are currently excluded due to a risk around contacting birth parents of CLAs (Children Looked After) from out of area.	**Yes**
Improving Cancer service access			
Operational Performance: Faster Diagnosis - Continue to support primary care to identify and refer potential cancers and increase self-referral pathways where appropriate.	✓	SFT has delivered compliance with the 28-Day Faster Diagnosis Standard for 6 months in a row (and for the year-to-date as a whole), supported by the Post Menopausal Bleed community clinics. The national target has now been re-set to 77% for March 25.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress v. plan in 2023/24	What we have done	Ongoing project in 2024/25
Early Diagnosis: C the Signs - Support primary care to identify and refer patients earlier for suspected cancers using a digital system.	✓	Continues to be used by all Somerset GP Practices to support decision making and referrals in relation to suspected cancer. Suspected cancer referral forms regularly reviewed to ensure aligned with NICE Guidance and best practice, with updates made as and when required. Regular communication and engagement with Practices regarding C the Signs functionality.	**Yes** – incorporate within wider earlier diagnosis plans
Early Diagnosis: Post Menopausal Bleed (PMB) Service – Self-referral pilot for PMB.	✓	Self-referral pilot for post-menopausal bleeding has gone live (the first of its kind in the country), across seven community sites in the county, enabling people to have a one-stop review of their symptoms within 14 days of referral.	**Yes**
Treatment & Care: Personalised Care and Support – Ensure personalised care and support is available for all cancer patients.	⇨	Somerset-wide Psychosocial Service: Hope Somerset Service developed and expanded. We have ensured fully operational, sustainable PSFU (Personalised Stratified Follow Up) pathways in place for suitable breast, prostate, colorectal and endometrial patients.	**Yes -** further tumour site roll out
Treatment & Care: Prehab – Provide dietary and exercise support to cancer patients between diagnosis and treatment to improve outcomes and overall health.	✓	Prehabilitation pilots now live at MPH and YDH.	**Yes**
Health Inequalities (Cancer) - Understanding the drivers for access to cancer care, including the factors leading to delayed presentations and how these might link to factors such as social deprivation or ethnicity.	⇨	Learning Disabilities (LD) Screening support nurses now in post and working to improve screening uptake in this population. Population Health Management (Commissioning Support Unit) has produced analysis on Health Inequalities and cancer outcomes, which will now be used to inform interventions moving forward.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress v. plan in 2023/24	What we have done	Ongoing project in 2024/25
Reducing Health Inequalities			
DNAs - Test and roll-out initiatives to reduce identified health inequalities, including reducing higher rates of Did Not Attends (DNA) for patients from more socially deprived areas.	⇨	Different intervals of automated appointment reminders have been trialled, and work on this continues to find a frequency that works in terms of reducing DNAs. The new survey module of Netcall has now been identified as the optimum method to understand why patients are DNAing. The survey has been built and is due to go live for a specific group of pilot patients, before the end of March. Due to challenges with digital resourcing, we can currently only use this survey module for Taunton patients. But the intelligence we gather will help inform the support we need to provide to patients.	**Yes**
Vulnerable patients - Prioritise the care of vulnerable patients assessed to be most likely to be harmed from long waits for treatment.	⇨	Prioritisation of vulnerable patients, defined as those patients with LD, and those patients with an open mental health referral who live in the most deprived areas of Somerset. This involves patients being expedited to the next highest level of clinical urgency on the waiting list.	**Yes**
Cancer Access – Identifying potential drivers of referral patterns for suspected cancer, to help us determine if interventions are required to support earlier presentation from specific groups of people in Somerset.	⇨	Analysis of cancer access patterns by level of social deprivation, age group, GP practice and PCN has now been completed and quality assured. The analysis will help us identify, by tumour site, age group and PCN, where we are seeing lower than normal levels of referrals, and/or high conversions to late-stage cancer diagnosis. The findings from this will now be used to inform our Cancer 'Front Door' strategy and 24/25 plan, which will likely include extension of national screening thresholds and/or age groups, in particular areas within Somerset. Self-referral is likely to be included as one of the options to increase the pick-up rate of early cancers.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress v. plan in 2023/24	What we have done	Ongoing project in 2024/25
Sustainable Diagnostic Services			
Community Diagnostic Centres - Obtain approval for a Community Diagnostic Centre in Yeovil.	⇨	Somerset successful with £13m revenue funding bid to the CDC programme. Yeovil Diagnostic Centre has had planning permission approved and all financial agreements are now in place. Site works commenced in February 24.	**Yes**
Service Repatriation			
Dermatology Service Transformation - Repatriate out of county activity and develop Somerset services to be sustainable.	⇨	All patients being referred with a suspected cancer are now being seen in Somerset following repatriation of this service from Bristol. Routine activity repatriation has also begun. A new service model has been developed, including teledermatology, the introduction of an Intermediate Service, run by GPs with Extended Roles. Geographic mapping, travel times and social deprivation indices analysis has informed where community clinics will be established.	**Yes**

Mental health, Autism & Learning Disabilities

- Across many of our services, capacity issues and workforce challenges have slowed the pace of delivery. We are exploring new workforce models, which includes new training offers and entry routes to help address this going forward.
- The significant financial challenge and associated uncertainty relating to the future Council service provision have caused some delays.
- Mental Health, Autism and Learning Disability team formally merged with Women and Childrens team in addition to ICB re-structure.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Adult Services			
Transformed community mental health service Reprocurement - Reprocure our transformed community mental health service. This is in line with the NHS England expectations set out in the Long Term Plan. In Somerset, this means a partnership between NHS services and VCFSE services to deliver a holistic suite of interventions, including peer support, psychological therapies, crisis support, community rehabilitation, eating disorder support and support for people with Complex Emotional Needs, under Open Mental Health.	✓	Community mental health services have been reprocured. The incumbent provider was successful in their bid, and the new contract is due to launch April 2024. As part of this work, significant engagement was undertaken with underserved communities to ensure that the new service was fit for purpose.	-
Mental Health Ambulance - Operationalise mental health ambulance, working in partnership with our Home Treatment Team and SWAST.	⇨	Mental health ambulance has launched in pilot as a collaboration between SFT and SWASFT. Work will continue in 2024/25 to embed the learning from the pilot.	**Yes**
Increase investment in existing Early Intervention in Psychosis Service - Increase investment in existing Early Intervention in Psychosis Service to implement an At Risk Mental State (ARMS) offer that identifies people, and in particular children and young people, who are experiencing an ARMS.	✓	An ARMS service has been commissioned, but due to recruitment challenges, this is not yet live. A pilot is underway in South Somerset to inform the wider Somerset approach. We continue to look to recruit to offer a county-wide service.	-
Community Rehabilitation Model - Launch our Community Rehabilitation model as part of the wider Open Mental Health offer of care.	✓	The community rehabilitation offer is now live as part of our Open Mental Health offer.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Increase access to the Individual Placement Support Service - Increase access to the Individual Placement Support Service, and thereby increasing the number of people with Serious Mental Illness (SMI) retaining or commencing employment.	✓	We have seen a 22% increase between 2022/23 and 2023/24 on the number of people accessing Individual Placement Support services.	-
Dementia Services			
Dementia System Strategy - Coproduce a system strategy for dementia.	⇨	A stocktake, risk and gap analysis is underway, which will inform the strategy work. This work is underway and anticipated to be complete by July 2024.	**Yes**
Somerset Dementia Wellbeing Service (SDWS) - Expand support for people with dementia through the Somerset Dementia Wellbeing Service (SDWS).	✓	11 Dementia Support Workers (DSW) are now in place, provided by the Alzheimer's Society. Ideally, there would be 13 DSWs in Somerset, aligning with the Primary Care Networks. However, there is no further funding to support expansion.	-
VCFSE Dementia Collaborative Partnership - Formalise the VCFSE collaborative alliance at the heart of the SDWS.	⇨	A formal alliance is not in place, however, more than 60 VCFSE organisations are working together informally as part of the Dementia Collaborative Partnership, spearheaded by colleagues at SPARK Somerset.	**Yes**
Learning Disabilities and Autism			
Learning Disabilities and Autism Strategy - Develop a Learning Disabilities and Autism Strategy.	⇨	Draft strategy has been coproduced, with further engagement ongoing. The strategy is expected to be published in September 2024.	**Yes**
Somerset's Link learning disability and autism service - Embed and promote Somerset's Link learning disability and autism service.	✓	Link LDA service is fully operational, delivering support to CYP on the Dynamic Support Register. New Keyworker Programme also fully operational.	-
Local dynamic support register and Care (Education) and Treatment Review processes - Enhance local dynamic support register and Care (Education) and Treatment Review processes in-line with new national policy and guidance.	✓	Dynamic support registers for both adults and children are fully operational, with cross-system action and review meetings in place. CETRs are offered in-line with policy. Multi-agency Dynamic Support Register operational.	-
Community Health Offer for CYP - Develop a community health offer for children and young people with a learning disability and/or autistic children.	✓	An expanded Link LDA offer has allowed more CYP to be supported in the community, with further expansion planned.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Autism Assessment waiting times - Improve waiting times for autism assessment for children and young people.	⇨	Autism assessment times continue to be a challenge, though additional investment has been made to improve these. There is an improved offer of support available whilst CYP await assessment.	-
Oliver McGowan training - Roll out Oliver McGowan training.	✓	Oliver McGowan training continues to be offered as mandatory training to all health and care staff in Somerset.	-
SEND			
SEND Strategy - Reset and continue the SEND improvement journey with the new SEND strategy.	✓	Strategy in place and actions progressing.	-
	-	A Somerset system Sensory Needs Position Statement launched including easy read version.	-

Children, Young People and Families

- Across many of our services, capacity issues and workforce challenges have slowed the pace of delivery. Paediatric workforce across Somerset remains challenged with issues around recruitment and retention, paediatric nursing and appropriate skill mix within acute trusts is a particular risk. Education Mental Health Practitioners are also a particular recruitment challenge. We are exploring new workforce models, which includes new training offers and entry routes to help address this going forward.
- The significant financial challenge and associated uncertainty relating to the future Council service provision have caused some delays.
- CORE20PLUS5 CYP priority areas launched.
- Mental Health, Autism and Learning Disability team formally merged with Women and Childrens team in addition to ICB re-structure.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Early Help System - Implement a coordinated early help system through Connect Somerset and neighbourhood working which enables children, young people and families to easily access the support they need when they need it, building on their strengths, to enable them to be resilient, happy and fulfilled.	⇨	12 Community Champions recruited.	**Yes**
Pathways to Independence - Re-commissioning for Pathways to Independence – youth housing for young people who are at risk of homelessness, with effective mental health provision and wrap around services to promote improved outcomes for our young people.	✓	New service is due to launch 1 April 2024.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Children and Young People Transformation Programme			
The NHS Long Term Plan sets out a vision for the future of the NHS and new action in relation to children and young people aged 0-25. To deliver these, a Children and Young People Transformation programme was established, bringing together key partners and programmes responsible for the delivery of our Long Term Plan commitments. We said we would continue to progress and deliver on the key regional priorities of the NHS Children and Young People Transformation Programme as outlined below:			**Yes**
• **Transitioning to adult services**	⇨	System group focusing on transitioning from children health services, and funded post to support pathways and engagement around transitions in health.	**Yes**
• **Palliative care**	⇨	Recruitment of joint post with NHS and Children's Hospice South West (CHSW) to improve pathways for children's palliative care. New Psychology service launch following workforce redesign.	**Yes**
• **Epilepsy**	⇨	Benchmarking exercise to ensure all CYP with epilepsy have timely access to an epilepsy specialist nurse, in line with CORE20PLUS5. Development of new psychology service access for CYP with epilepsy.	**Yes**
• **Diabetes**	⇨	Establishment of a CYP Diabetes Transformation Group with representation from across the system. Successful bid of £40k to engage with diabetic teenagers via the SICB commissioned Tellmi app – a peer support app for CYP aged 11-18.	**Yes**
• **Asthma**	⇨	Progress on the asthma care bundle including data dashboard, roll out of national training, in patient bundle in progress.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
• **Complications of Excess Weight**	⇨	Developing a whole system compassionate approach to weight management across adult and children's services. Recruitment of system lead (jointly commissioned post) Tier 2 obesity service in place and under continuous review. Entering Year two of funded tier 2 complications of excess weight service (Links to family focused pathway).	**Yes**
• **Integration**	⇨	Piloting a 2-year post in the Chard area to employ a paediatric ACP into the general practice urgent care hub to improve integration, focus on proactive management and reduce inappropriate ED attendances. Learning and contributing to the development of a wider paediatric SDUC workforce approach for the county. Develop a 7 day a week paediatric assessment service to ensure consistency across county.	**Yes**
Health Inequalities			
Embed principles of CORE20PLUS5 to support equity and equality of access to care for children and young people. 5 Clinical areas of focus - Asthma, Diabetes, Epilepsy, Oral Health & Mental Health overlap with NHS long term plan as above.	⇨	Working with ICS colleagues to develop a comprehensive and consistent approach to reduce health inequalities across high-priority clinical areas, optimising clinical management and embedding best practice. Working to align data flows to ensure we have a system level understanding of population needs.	**Yes**
Mental Health Transformation			
Improve the social, emotional wellbeing and mental health pathway for children and young people with clear links to the Open Mental Health approach, which includes the following elements:	⇨	A significant number of transformation programmes have been delivered as per the below. There has also been an associated improvement in Somerset's performance against the national CYPMH access target.	**Yes**
• **Homes and Horizons Strategic Partnership** - Implement a new, innovative therapeutic education offer in partnership between SFT, Somerset Council & Shaw Trust, called Homes & Horizons.	⇨	Our therapeutic education offer is in progress. One of our two planned sites, in Misterton, has been opened and capital work is ongoing for the launch of the second site. Considerable work in partnership with the Department for Education (DfE) who have approved the school.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
• **Referral portal for Children & Young People's Mental Health** - Develop and implement a new referral portal for Children & Young People's Mental Health.	⇨	The referral portal is currently in development, and is expected to be live by December 2024.	**Yes**
• **Children & Young People's Intensive Treatment House** - Establish a Children & Young People's Intensive Treatment House.	⇨		-
• **VCFSE Partnership Offer** - Develop a new VCFSE partnership offer	⇨	The new VCFSE partnership offer is currently in development. An interim offer was put in place this year via a Grant Agreement to enable partners to engage with the development work and improve their data capture.	**Yes**
Physical Health			
Best Start in Life ➢ Develop enhanced antenatal and early years support package to support our most vulnerable families (Best Start in Life). ➢ Further increase the uptake of Healthy Start vitamins, particularly targeting women most in need owing to ethnic background.	⇨	Successful NHSE bid to pilot 2-year enhanced parent child pathway, providing targeted preventative activity across antenatal and postnatal period to reduce health inequalities and improve outcomes for our vulnerable families. (FOREST) Facilitate integration of FOREST, healthier lives community groups and emerging antenatal educations programmes. Recruitment of a project manager to review the current parent-infant relationship offer in Somerset, develop parent-infant relationship service aiming to develop system relationships, map and coordinate the workstream and provide recommendations to commissioners. Work is being coordinated and overseen through the Education for Life Strategy Board.	**Yes**
Assistive Technology - Explore and realise the benefits of assistive technology for children and young people with disabilities, or to help young people move towards independence	✓	The Council and NHS have worked together to jointly commission Augmentative Assisted technologies for children and young people who need support.	-

Women's Health

- NHSE funding received for 2-year delivery of women's health hubs has enabled a focus on the programme of work.
- Employment of Women's Health Lead Project Manager to oversee programme delivery has enabled significant increase in focus on the challenges faced by women in accessing healthcare.
- Launch of the perinatal pelvic health service has highlighted a need to develop pelvic health structures across the lifespan more broadly.
- The launch of the women's health strategy has resulted in increased alignment across women's services to include contraception, sexual health, maternity, safeguarding and justice services.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
National Women's Health Strategy - Embed the principles of the national women's health strategy ensuring that women's health is recognised in all aspects of NHS care. The Women's Health Strategy is informed by the life course approach. Unlike a disease-orientated approach, which focuses on interventions for a single condition often at a single life stage, a life course approach focuses on understanding the changing health and care needs of women and girls across their lives. It aims to identify the critical stages, transitions and settings where there are opportunities to: ➢ promote good health. ➢ prevent negative health outcomes. ➢ restore health and wellbeing.		Establishment of ICS women's health governance structures to undertake engagement activity with system partners and oversee delivery of the Women's Health Strategy and development of women's health hubs	
• **System Pathways**	⇨	Through collaboration with system partners we have identified priority areas of endometriosis, menopause, LARC and pelvic health and started to develop system pathways, education resources and service delivery structures.	**Yes**
• **Women's health survey**	⇨	Launch of women's health survey to better understand the needs of our local population.	**Yes**
• **Women's Health Needs Assessment**	⇨	We have initiated development of women's health needs assessment in conjunction with partner agencies.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
• **Menopause Service**	✓	We have secured funding for specialist menopause service for an additional 2 years.	-
Pelvic Health Clinics - Develop specific pelvic health clinics	⇨	Launch of the perinatal pelvic health service has highlighted a need to develop pelvic health structures across the lifespan more broadly.	**Yes**

Local Maternity and Neonatal System (LMNS)

- Leadership changes in maternity across the trust with two new Heads of Midwifery and the Director of midwifery retiring in September.
- Actions resulting from CQC visit a priority.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Maternity Transformation			
Maternity 3 Year Delivery Plan – Continued implementation of the requirements in the Maternity three year delivery plan 2023 – 2026. Includes four main themes, each of which contains 3 objectives: 1. Listening to, and working with, women and families with compassion 2. Growing, retaining, and supporting our workforce with the resources and teams they need to excel. 3. Developing and sustaining a culture of safety, learning, and support. 4. Standards and structures that underpin safer, more personalised, and more equitable care.	⇨	1. Personalised care plans launched and in use. Feedback being gathered. Further work needed to embed and develop a digital offer. 2. Further progress on achieving county wide BFI gold status. 3. Perinatal Pelvic Health Service launched and receiving referrals. 4. Perinatal and Maternal Mental Health services both fully implemented. 5. Maternity and Neonatal Independent Senior Advocate in post, not yet seeing patients due to NHSE delays. 6. Continue implementation of equity and equality plans. 7. The MNVP are fully embedded in maternity and neonatal, and funded appropriately, to ensure the voice of the pregnant person is always heard. 8. Recruitment and retention lead midwife in post, developing a retention plan. 9. Workforce planning in progress. 10. Preceptorship support offered to every newly qualified midwife. 11. Continuing equity work with better coding of ethnicity being used to identify Serious Incidents where ethnicity / deprivation may be a factor. 12. Leadership quads participating in national leadership and culture programme. 13. Obstetric and neonatal leads in post.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
		14. PSIRF implementation in progress. 15. Saving Babies Lives 3 implemented. 16. LMNS dashboard in place and reviewed regularly with action taken when appropriate. 17. Core competency framework developed and signed off by LMNS board. 18. New maternity software system in place across both units, to comply with requirements for an electronic patient record.	
Equity & Equality			
Equity and Equality Strategy - Embed the Maternity Equity and Equality Strategy.	⇨	There is an emphasis on equality and equity throughout the three year delivery plan, so many objectives overlap.	**Yes**
Continuity of Carer - Target Continuity of Carer to our communities where evidence shows inequity.	⇨	Core 20+5 requirement to provide Continuity of Carer to pregnant people from an ethnic minority background or living in a deprived area. The Cochrane review (2016) found that women who received midwife-led continuity of care were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth: • 16 per cent less likely to lose their baby. • 19 per cent less likely to lose their baby before 24 weeks. • 24 per cent less likely to experience pre-term birth. https://publications.parliament.uk/pa/cm5803/cmselect/cmwomeq/94/report.html	**Yes**
Enhanced Antenatal Offer - Development of enhanced antenatal offer.	⇨	Launch of the FOREST early help offer across maternity and Public Health nursing. To support families with additional needs, that don't meet the requirements of the specialist support services. Currently in pilot phase with full evaluation planned.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Engagement with Frequently Unheard Communities - Continue to increase engagement with communities that are frequently unheard to understand their aspirations for pregnancy care, and the issues they face.	⇨	The Maternity and Neonatal Voices Partnership (MNVP) have been given additional funding to recruit an engagement officer with the remit of collating information from our seldom heard communities to steer the equity work.	**Yes**
Personalised Care			
Personalised Care and Support Plans - Launch of Maternity personalised care and support plans.	⇨	Personalised Care and Support Plans launched with ongoing feedback being collected. Work ongoing to fully embed.	**Yes**
National Bereavement Care Pathway			
Continue implementation of National Bereavement Care Pathway.	✓	National bereavement care pathway implemented.	-
Treating Tobacco Dependency Plan			
Work with all partners to implement the Treating Tobacco Dependency plan in maternity services.	⇨	Successfully reducing the number of women smoking at time of delivery. This work is ongoing, led by the Public Health team.	Yes
Ockenden, Saving Babies Lives v3 and Periprem			
Full implementation of Ockenden, Saving Babies Lives v.3 and Periprem to reduce the numbers of babies born preterm or with ongoing medical needs.	⇨	Compliant with Saving Babies Lives v3. Compliant with Ockenden 1. Continue to improve compliance with Periprem. Continue to improve compliance with Ockenden 2.	**Yes**

Improving Lives in Communities & Neighbourhoods

Primary Care Services

- 2023/24 saw commissioning responsibility for pharmacy, optometry and dental services return to Somerset, and the immediate focus has been to build relationships with stakeholders including the representative committees, create common goals and identify innovation. Both dental and pharmacy services have been challenged, with a number of pharmacy closures and dental providers ceasing NHS care. In both areas we are now implementing national recovery plans with a local approach to ensure that an optimal approach is taken for Somerset.
- The national Primary Care Access Recovery Programme was also launched, which focuses on GP services but has significant implications for Community Pharmacy including the new Pharmacy First service which offers patients with seven common conditions the option of being treated in a local pharmacy. The Access Recovery Programme introduces the Modern General Practice concept, which we are now following, rather than the Modern Family Doctor approach described in our primary care strategy.
- 2023/24 was the final year of the five-year GP contract deal 'Investment and Evolution' which created PCNs and additional roles (the ARRS scheme). The government confirmed that PCNs and associated funding would continue into 2024/25 while a review of the future of General Practice takes place.
- The overall direction and priorities set out in our primary care strategy however remain fundamentally unchanged for 2024/25.

Urgent Community Response (UCR)

- The delivery of UCR in Somerset, led by Somerset NHS Foundation Trust, will be jointly delivered alongside the local virtual ward offer 'Hospital @ Home'. This approach has been agreed with leads from NHS England as it enables shared resources, a clear route for avoiding admissions and keeping people safe at home through the availability of more intensive support from Hospital @ Home teams.

Proactive Care (Anticipatory Care)

- The programme team planned to work with 3 PCNs to implement the proactive care model. We have been successful in working with all of the 13 PCNs and are implementing the proactive care model systemwide.
- BRAVE AI is being implemented across the Somerset system to facilitate risk stratification to identify the most at risk patients. The roll out of Brave AI is currently in 11 of the PCNs, with the remaining 2 PCNs in further discussions.
- Taunton Deane PCN was selected as a Digital Neighbourhood Vanguard. The following PCNs were selected as Digital Neighbourhood Innovator sites and will receive a 12-month licence for the AI risk stratification tool and invitation to join the community of practice group. North Sedgemoor PCN, Bridgwater Bay PCN, West Mendip PCN, West Somerset PCN, Rural Practice Network-South Somerset East, Taunton Central PCN and Tone Valley PCN (joint EOI).

Enhanced Health in Care Homes (EHCH)

- NHSE released version three of the Enhanced Health in Care Home Framework V3 (EHCH) Dec 2023. We are working with ICB and system providers to ensure all EHCH provision across Somerset is aligned to the refreshed framework.
- Summary of Contractual requirements: -
  - Every care home is aligned to a PCN
  - has a named clinical lead (who is responsible for overseeing implementation of the framework).
  - weekly home round supported by the care home MDT.
  - established protocols between the PCN, care home and system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.
  - Every person living in a care home, within 7 working days of admission or re-admission: has participated in a comprehensive personalised assessment of need undertaken by the MDT.
  - participated in the development of their personalised care and support plan (PCSP) with a member of the MDT.
  - care home residents should be identified and prioritised by their PCN as people who would benefit from a structured medication review (SMR).

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Frailty - Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	⇨	Continued focus on support; Acute Frailty unit at Musgrove, links with wider community services and also Clinical Service Manager reviewing Frailty provision at Yeovil. Building close links with PCNs who have continued focus on Frailty.	**Yes**
Virtual wards (Hospital @ Home) - Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.	⇨	Year to Date (December 2023) Hospital at Home have achieved 81.5% occupancy against a national target of 80%. However, the availability capacity was only at 98 compared to a target of 200. The focus now is to increase this.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Integrated Neighbourhood Teams (INTs)			
Outward-facing Integrated Neighbourhood Teams - Develop outward-facing integrated neighbourhood teams which can work with community and VCFSE partners to identify opportunities for population health improvement.	⇨	We have continued our work to support integrated neighbourhood team development. **West Somerset PCN** - Joint development work is ongoing in West Somerset PCN to form an INT, bringing together the local primary care and community teams from SFT and VCFSE partners. This has most recently focused on a programme of team coaching to instil the benefits of joint and person-centred approaches to enable true cultural change.	**Yes**
Population Health Management and CorePLUS5 - Implement Population Health Management and CorePLUS5 through integrated neighbourhood teams.	⇨	We have continued to develop our approach, including development of a population health data platform to inform work at neighbourhood level.	**Yes**
Primary Care Services			
Primary Care Strategy - Invest and develop GP services to deliver our agreed Primary Care Strategy, with its focus on access, population health and continuity of care.	⇨	A new Funding Framework is due to be implemented from April 2024, which will explicitly address these priorities.	**Yes**
Modern Family Doctor Model - Development of a modern family doctor model as proposed by the Health Select Committee which can deliver the right interventions in primary care while operating at a wider scale as part of integrated neighbourhood teams.	⇨	This work has now changed slightly to align with the requirements in the national Access Recovery Plan to implement the 'Modern General Practice' model, this has resulted in GP appointment numbers being higher than pre-pandemic.	**Yes**
Dental Services - Invest and develop dental services to recover a position where all Somerset residents who wish to access NHS dental care can do so.	⇨	We will implement the national Dental Recovery Plan during 2024/25.	**Yes**
Community Pharmacy - Invest and develop Community Pharmacy, particularly the implementation of Pharmacy First and Independent Prescriber Pathfinder, building on the successful implementation of Community Pharmacy Consultation Scheme.	⇨	Patients can now access care for seven common conditions at community pharmacies in Somerset. Pharmacy First has now been launched but successful implementation will be a key area of focus during 2024/25. The Independent Prescriber Pathfinder has begun and the results will feed into the national plans for all new pharmacists to be independent prescribers.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Optometry Services - Invest and develop Optometry services to achieve full integration with urgent care through development of the Acute Care Eyes Service and routine care through better integrated elective pathways.	⇨	Work on optometry in 2023/24 was limited by the need to focus on dental and pharmacy closures and contract resignations, however optometry will be a key area of focus in 2024/25.	**Yes**
Urgent Community Response (UCR)			
Urgent Community Response - Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.	⇨	Year to Date (December 2023) UCR are performing above the operational plan of 3600 at 4000 2-hour UCR first care contacts. Performance against the 2-hour response target has been sustained at over 90% throughout the year, with the most recent published data reflecting 91% performance.	**Yes**
Direct Referrals from Residential Homes – Target top 10 care home ambulance see and treat direct referrals.	✓	Developed a memorandum of understanding with South Western Ambulance Service NHS Foundation Trust in order to enable a referral pathway between UCR and 999 calls.	-
Pendant Alarm Providers - Work with pendant alarm providers to refer (initially with a pilot in working with responders who have concerns once they have made a person safe) directly to UCR.	✓	Supported care homes and pendant alarm providers to understand the UCR offer and enable direct referral pathways into the service to enable that residents receive the right care in the right place for them as quickly as possible.	-
Proactive Care (Anticipatory Care)			
Proactive Care Model Pilots - Work with two to three PCNs to pilot the Proactive care model. We will undertake a review of the business cases against the national requirements, ensuring PCNs will achieve the aims of the model.	✓	All 13 PCNs are currently working towards aligning their current complex care services to the national Proactive Care model. 10 PCNs implementing dedicated Proactive Care teams to deliver complex care services. SFT are working with the remaining 3 PCNs to establish roles and responsibilities for delivery of Proactive Care services.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Somerset Proactive Care Toolkit - Working with the PCNs in the pilot we will set up a task and finish group to develop a Somerset toolkit which will support the remaining PCNs in developing anticipatory care across their system.	✓	Developed an assurance template to track progress against proactive care guidance which enables PCNs to monitor and escalate elements of the proactive care work. Personalised Care template - Test and learn across 5 PCN's using SIDeR. The programme team have been working with the PCNs and Matthew Dolman to promote the use of SIDeR within PCNs for improved information sharing and access to wider MDT members such as Health Coaches and Social Prescribing Link Worker (SPLW). BRAVE AI is being implemented across the Somerset system.	-
Enhanced Health in Care Homes (EHCH)			
Role of Social Prescribers, Health Coaches and Village Agents - Develop the role Social Prescribers, Health Coaches and Village Agents could play in facilitating EHCH framework requirements.	⇨	Conversations have taken place to facilitate SPLW, health coach and village agents working with care homes.	**Yes**
Care Home Digital Maturity - Work with the NHS Somerset digital team on the expansion of NHS mail, falls prevention technology, care home digital maturity and shared care records.	⇨	Work is ongoing with Somerset care homes and the NHS Somerset digital team on the expansion of NHS mail, proxy medication ordering, falls prevention and care home digital maturity.	**Yes**
Care Home Workforce Training Plan - Work with Somerset Council, care home staff, and PCNs to develop an effective and engaging care home workforce training plan.	⇨	We continue to work with care home teams, PCN's, Somerset County Council and other providers to deliver packages of training for all care home teams.	**Yes**
Increase Awareness of UCR - Increase awareness of UCR to enable care home residents to remain in the place they call home, reducing unnecessary conveyance to hospital.	⇨	Direct referral to UCR is available for all care homes and pendant alarm providers. Working with the ICB Comms team and delivered an extensive UCR Comms campaign, raising awareness of the care home and pendant alarm provider direct referral to UCR pathway.	**Yes**
Increase awareness of manger lifting equipment offer - Increase awareness of manger lifting equipment offer for care homes to increase the number of care homes with effective lifting equipment to help residents who have experienced a witnessed non-injury fall.	⇨	A large number of Mangar lifting chairs are available for use in Somerset Care Homes, the last few homes that have expressed an interest are being contacted.	**Yes**

Major Conditions

- Implementation of the new Major Conditions Delivery Group to provide strategic oversight and link-up between different strands of work relating to Long Term Conditions.
- The Somerset ICS has recognised the priority of Cardiovascular disease (CVD) and Metabolic workstreams, with agreement for these to be brought together and prioritised under the Major Conditions Delivery Group. This is a model which has been replicated regionally and nationally.
- Agreement to prioritise and implement changes to the delivery of community Weight Management support services.
- NICE TA regarding Hybrid Closed Loops – major national change with a 5 year implementation timescale to improve diabetes care for all type 1 diabetics.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Diabetes			
Commissioning and development of an integrated model of care for diabetes which seeks to provide joined up care for patients and to enable patients to successfully manage, improve and reverse their diabetes. This will include:			
NHSE Diabetes Prevention Programme - Identification of patients at high risk for developing diabetes.	⇨	Provided a system for the automation of invites for patients with a diagnosis of prediabetes meeting the requirements set out by NHSE. Development of a package to work with hard to reach population and provide support working with the wider determinants of health, to enable support for people to access services and empowering them to make lifestyle changes to reduce the risk of developing diabetes.	**Yes**
Diabetes Recovery Programme - Focus on earlier diagnosis and management particularly in hard to reach groups.	⇨	As with above.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Primary Care Diabetic Management • Focus on earlier diagnosis and management particularly in hard to reach groups. • Patients identified with diabetes will be given greater support for self-management.	⇨	Work with practices has been undertaken focusing on areas that sit within Core20+5 to work with improving earlier diagnosis and management of people with diabetes. Wider support has been given to practices including training and education on pathways to support patients who are newly diagnosed. Further work will be undertaken to provide additional support to patients to support them in self-management of their condition and to help them understand the complexity and risks associated with diabetes and the long term outcomes if the condition is poorly managed.	**Yes**
Diabetes Community Team / Structured Education - Weight management and Structured Education in order to empower and support patients in their care.	⇨	The current structured education provision has been reviewed across Somerset to review why patients are not currently engaging in the process. 2024/25 will look at how patients can be engaged with the process and addressing the wider determinants of health preventing them from managing their condition.	**Yes**
Provision and prescriptions for structured education alongside analysis of wider determinants of health to help with wider aspects of self-management.	⇨	Aim for 2024/2025.	**Yes**
Type 2 Diabetes Path to Remission	⇨	Continued recruitment and expansion of the Type 2 Diabetes Path to Remission Programme, which continues to support people to significantly improve diabetes control and in many cases reverse their diabetes entirely. Provided a system for the automation of invites for patients with a diagnosis of prediabetes meeting the requirements set out by NHSE. Development of a package to work with hard-to-reach population and provide support working with the wider determinants of health, to enable support for people to access services and empowering them to make lifestyle changes to reduce the risk of developing diabetes.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Secondary Care Diabetes Development of a system-wide implementation plan for the introduction and expansion of Hybrid Closed Loop systems for patients with insulin-dependent Type 1 Diabetes. Roll-out is to begin from April 2024 over 5 years nationally.	⇨	Implementation plan has been developed and submitted to NHSE in line with NICE Guidance with planned role out from April 2024.	**Yes**
Diabetic Foot Service • Delivery of training to Primary Care • Evaluation of current provisions and pathways	⇨	Training has been delivered to primary care staff on the management of diabetic foot. Pathways are currently being developed with SFT to address the gap in current service provision.	**Yes**
Respiratory			
Population Health Review - Conduct a population health review into respiratory disease.	⇨	Currently on hold due to pressures within the local Government system.	**Yes**
Pulmonary Rehab Service - Review access to pulmonary rehabilitation with a focus on areas of inequality to improve access to care.	⇨	Procurement of new Pulmonary Rehab service which became live on 01/12/2023. The service is focusing on inequality and access to services across Somerset.	**Yes**
COPD Health Inequalities - Core20PLUS5 analytical work focusing on COPD as a major example of health inequalities.	⇨	Core20Plus5 work ongoing in the Bridgwater area and evaluation is planned to take place June 2024 for roll out to other areas.	**Yes**
Nebulizer/Inhaler Guidance - Development of detailed guidance on nebulizer/inhaler use in primary care with integration of secondary care support across the system.	⇨	Aim for 2024/2025.	**Yes**
Lung Health at Home Pilot - Lung health at home pilot in Mendip locality to address local inequalities in access to healthcare.	⇨	Aim for 2024/2025.	**Yes**
Lipids			
Service Development - Developing the service and care model for patients identified with high cholesterol associated with familial hypercholesterolemia and ensuring patients receive appropriate genetic counselling including for family members who also require testing.	⇨	Service is now operational across Somerset. Further work to be undertaken with Primary Care Commissioning to identify a route for Incliseran prescribing.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
CVD and Metabolic			
Virtual Clinics - Ongoing initiative for joint primary and secondary care virtual clinics for the management of patients with long-term heart conditions.	⇨	Virtual Clinics are ongoing and additional practices are being sought to join the scheme and improve the management of patients within Primary Care.	**Yes**
Weight Management Pathway - Review of current weight management pathways and provision to support localities and primary care teams in delivering personalised care and support close to home for patients who wish to lose weight and live healthier lifestyles.	⇨	Review has been undertaken, with work ongoing to update pathways and provide training, education and support across the system. Temporary additional community support has also been commissioned while the work is ongoing.	**Yes**
Screening Programmes - Development and trial of new screening programmes for patients with hypertension, Atrial Fibrillation and other CVD.	⇨	Commencement of work on CVD screening alongside Public Health and Secondary Care teams to improve early identification of chronic conditions to allow earlier intervention and improve long term outcomes.	**Yes**
Hypertension Strategy - Development of Hypertension Strategy for the prevention, identification and treatment of Hypertension.	✓	Hypertension Strategy has been developed and is currently being piloted within a Somerset PCN.	**Yes**
Current Priorities - Review of current priorities linked to CVD and metabolic to set workstreams for future planning.	⇨	Aim for 2024/2025.	**Yes**
End of Life Care			
Enhanced End of Life Care - Ensuring that people are provided with enhanced personalised end of life care close to home.	⇨	Undertook a Health Needs Assessment for EoL Care in collaboration with Public Health. A new iteration of the Somerset Treatment Escalation Plan has been created and is hoped to launch this summer. The Group updated the Just in Case medicines policy. The EoL Education Group continues to support ACP and TEP workstreams. This group continues to maintain and develop the Somerset End of Life Website.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Long Covid CFS & ME			
Long Covid, CFS and ME Service Review - Review the current service provision and access across areas such as long covid and chronic fatigue to ensure that these services are meeting the needs of the population and implementing plans to improve where they do not.	⇨	Service is currently under review and a plan is being developed on linking the Long Covid Service to the CFS and ME pathway to build more capacity and improve patient outcomes.	**Yes**

Personalised care

- Current lack of clarity around governance and reporting structure for outputs of the Personalised Care Steering group due to restructuring of Boards and workstreams.
- An awareness of the need for join up across the system and how to ensure integrated working across all workstreams - more collaboration and join up across workstreams e.g. Health Inequalities, Population Health, Integration and Better Care fund, Proactive, Improving Lives in Communities and Neighbourhoods.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Embedding of true shared decision making and personalisation across all aspects of care and support.	⇨	**Personalised Care Steering group** - Development of a representative, decision making body that is committed to working together under a co-created vision statement - Our connected Somerset system will enable individuals to be equal partners in decision making, based on what matters to them - making this the golden thread that runs through everything we do. There is a broad scope of work captured in the Personalised care project plan with identified workstream leads. The Personalised Care Steering group supports the SFT personalised care working group. Collaborative working and connections have developed across all parts of the system, fostering a shared narrative around personalisation and how we can learn from each other.	**Yes**
Personalised Care and Support planning - Implementation of a consistent and joined up approach to personalised care and support planning for our most complex individuals and across maternity services in the first instance.	⇨	Development of PCSP working group. SiDER PCSP being piloted by South Somerset Complex Care team and Proactive PCN teams with a view to using feedback to inform next steps. Working with maternity services to co-produce a personalised care toolkit.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Support access to accredited Personalised Conversations training to enable shared decision making conversations – develop training trajectory.	⇨	Personalised Conversation and Care training is pivotal to the spread of a personalised approach and a key component of delivering to the personalised care agenda. Our system is dependent upon a train the trainer model of delivering personalised conversation training. Somerset currently has 14 train the trainers - an increase of 30% since Jan 2023. Our current training trajectory is roughly 200 people/year - an increase of 45% since Jan 2023. We have developed an introduction to personalised conversation elearning module which is currently accessible to SFT, primary care and council colleagues.	**Yes**
Further roll-out and consistency across the county of social prescribing and community-based support.	⇨	Commitment of social prescribing providers (including Social Prescribing Link workers, Health Connectors. Health Coaches, Village agents and Community agents and Green social prescribing) to co-produce a standardised approach to deliver a joined up, sustainable, outward facing narrative for Somerset social prescribing, with the flexibility to protect and promote what is unique and working well in local models, according to the locality's population strengths and needs. Framework being developed with clear actions and timelines. Working with the high intensity user group to explore partnership working to support personalised approaches and community based options for individuals who access ED with a non health presentation. HIU leads and Ubuntu agents have all completed personalised conversations training. Part of the accelerating reform fund working group. Part of the digital vanguard: supporting Brave AI and its application through a 'what matters to you' lense; supporting the JOY app pilot in south somerset west; supporting wider application of digital solutions to enable person centred approaches.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Support self-management - Co-production and implementation of programmes to support self-management across the county for a range of conditions.	⇨	Development of a chronic pain community of practice to support an equitable approach to chronic pain management across Somerset. Increase in provision of pain cafes. Supporting healthy weight pathways for all ages through health coaching and social prescribing. Working with major conditions delivery group to ensure the 6 components of personalised care are part of all programme approaches. Personalised Conversation training being rolled out across the major conditions teams through the train the trainer model.	**Yes**
Personal Health Budgets/Integrated Personal Budgets - Increase the use of personal health budgets and integrated personal budgets.	⇨	Development of PHB working group. PHB strategy drafted.	**Yes**
Personalised Care Outcome Measures - Develop outcome measures that demonstrate impact of a personalised approach at person, community and system level.	⇨	£50,000 secured from NHSE to support evaluation framework for Personalised Care and Integrated Neighbourhood working. Recognition that this needs a collaborative approach to evaluate new ways of working that will involve all system partners - the Council have agreed to contribute to the £50,000 and the VCFSE are keen to be part of the development of an impact framework.	**Yes**
	⇨	**Support Integrated Neighbourhood Team (INT) working** - Joint development work is ongoing in West Somerset Primary Care Network to form an INT, bringing together the local primary care and community teams from Somerset NHS Foundation Trust and VCFSE partners. This has most recently focused on a programme of team coaching to support the benefits of joint and person-centred approaches to enable true cultural change.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
	⇨	**Community Personalised Care Group** - Initial personalised care survey carried out and report shared. Learning around next steps and working with SPARK Somerset, Community Council for Somerset, Somerset Community Foundation and Diverse Communities to develop relationships with representative communities and individuals who may be digitally excluded or unable to engage through mainstream channels. Working with SFT and community partners to develop a questionnaire to establish a baseline understanding of what personalised care means to our workforce. Working with the council and voluntary sector partners to develop a community co-production group and framework for renumeration.	**Yes**

Integration and the Better Care Fund

- Community Equipment Service: Overall demand has increased significantly over the last year for equipment and adaptations. This is monitored closely to ensure appropriate scrutiny of equipment orders and prescriber and budget spend. We recognise that initiatives to support reduction in care result in corresponding provision of appropriate equipment. This will inform projections for 2024-25.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Prevention - Direct more resources and attention towards prevention and the underlying and wider drivers of health and wellbeing outcomes including the wider determinations of health: isolation, loneliness, relationships, poor housing (including poor insulation and energy efficiency, hazards which lead to slips trips and falls, dementia friendly alterations to the home), education, healthy lifestyle behaviours, and employment. A focus on community development will be adopted to maximise resilience within individuals, families, and communities.	⇨	Focus on prevention through increase in wellbeing and support initiatives, including development of a chronic pain community of practice to support an equitable approach to chronic pain management across Somerset, supporting healthy weight pathways for all ages, Personalised Conversation training being rolled out across the major conditions' teams, commitment to social prescribing (including Social Prescribing Link workers, Health Connectors. Health Coaches, Village agents and Community agents and Green social prescribing) and to co-produce a standardised approach to deliver a joined up, sustainable, outward facing narrative for Somerset social prescribing, with the flexibility to protect and promote what is unique and working well in local models, according to the locality's population strengths and needs. Learning around next steps and working with SPARK Somerset, Community Council for Somerset, Somerset Community Foundation and Diverse Communities to develop relationships with representative communities and individuals who may be digitally excluded or unable to engage through mainstream channels.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Tackling Inequalities - Tackling inequalities of outcomes, experience, and access by changing how services can be accessed, where they can be accessed, how they are delivered and who they are delivered by. This also includes greater targeting and tailoring of services to people and groups who are the most affected by health inequalities.	⇨	Health inequalities are primarily driven by differences in the basic building blocks for a healthy life such as income, housing, education or transport. Many of the population who are at greatest risk of the worst health outcomes are not likely to contact health or social care services until they need urgent or unplanned care. Through greater support of our discharge and admission avoidance services through our BCF schemes we are proactively responding to presenting need. We know that we see more acute presentations from areas of greater deprivation, so our additional capacity sourced from the BCF enables us to better meet this need where people live and deliver integrated health and social care for our entire population. The schemes within our BCF plan enable better saturation of services from adult social care and intermediate care which interrupts the inequalities caused by deprivation.	**Yes**
Person-centred approaches - Ensuring that the person receiving help and care is at the centre. This requires that care, support, and treatment plans are codesigned with people and that they are delivered in a tailored way, reflecting what matters most to the person, their life, their strengths, and their aspirations. Achieving this will involve an ongoing focus and further cultural change.	⇨	The Somerset programme leading cultural change around Personalised Care has identified the building blocks to progress change and the work needed to embed person-centred approaches in health and care. This includes a project to identify current and best practice of Personalised Care & Support Planning with a view to develop a Somerset template. Elsewhere within the BCF we have also shared a case study from the Somerset Carers service which demonstrates the impact of person-centred approaches. Through tailoring support to the person, the service enables service users to access the support available to them in a way that works for them, in this case without having internet access and empowering the user to build their own confidence and knowledge to continue as a primary carer.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Community based support - Enabling more people to engage with support in their community (where the solutions to the wider determinants of health and wellbeing often lie). This includes our investment in Community and Village Agents, Social Prescribing Link Workers, and investment in VCFSE partners. It also recognises that many very important community assets are not and do not need to involve statutory organisations.	⇨	We have continued investment in social prescribing which provides tailored individualised support and improves independence, health and wellbeing. This is available countywide, connecting with upwards of 2000 people in 2023/24. Social prescribing also supports community generation and connection through groups, events and network building, providing hubs in communities tackling loneliness and isolation.	**Yes**
Multi-disciplinary working - Enabling greater opportunities for local professionals to know each other, work collaboratively, share resources and information as part of local integrated community teams. This includes PCNs, community health and care teams, social prescribers, and local VCFSE sector partners.	⇨		**Yes**
Support to enable people to remain or go back to their own home - Strengthening the support available to people to enable them to remain in their own homes or return home after a stay in hospital or a short-term care placement. In Somerset this suite of services is known as Intermediate Care and includes Rapid Response, Home First, community nursing, voluntary sector partner involvement, Somerset Independence Plus Independent Living Officers, housing advice and lifeline services.	⇨	Services in Somerset have supported 92.1% of discharges to their usual place of residence (Nov 2023) enabling people to receive care in the right place for them. The combined response across all discharge pathways draws on Intermediate Care and Home First capacity as well as from the VCFSE sector, with additional support from community equipment teams and the Somerset Independence Plus Independent Living Officers. Our combined virtual ward and Urgent Community Response (UCR) offer has enabled people to be supported at home and avoid hospital admission, with over 90% achievement of the 2-hour UCR response standard in 2023-24.	**Yes**
Joined up strategic planning and commissioning - Somerset is in a good position to build on the strong tradition of joint working by strategic partners across social care and health. Our ambition, where in the public interest, is to integrate and streamline the commissioning and provision of services further under strong and stable governance structures and public accountability**.**	⇨	We have established the Joint Commissioning Steering Group which enables operational oversight between commissioners and further integrate and streamline the commissioning and provision of services.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Stability and security for system partners - To improve how we work with and invest in services provided by VCFSE partners we are moving towards the use of more proportionate forms of contract and longer-term agreements. This is essential to provide greater stability for these crucial services, support and teams and enable the development on longer term, high trust strategic relationships.	⇨		**Yes**
Virtual Wards and Hospital at Home - Continue to develop new pathways within Hospital at Home.	⇨		**Yes**

Our People

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Workforce 2035 (scenario planning)			
Develop and implement our 2035 Scenario Planning Programme with key stakeholders to deliver future workforce strategy.	⇨	Phases 1-3 complete; 200 participants engaged in immersion and future planning workshops, Somerset "5th Scenario" confirmed based on workshop outputs.	**Yes**
Somerset Academy Development			
Building our place-based training offer by working with local colleges as well as the redevelopment of the Grade 2 listed old Bridgwater Hospital as a future training hub for social care and health.	⇨	5 project workstreams established with ToRs. Governance & reporting arrangements established. Shared Prosperity Bid (for revenue funding) successful enabling the resourcing of a training pilot in West Somerset and innovation work. Design team commissioned and draft design plans produced for the main Bridgwater site. Financial model developed in draft ready – financial assumptions ready for testing with stakeholders, including the social care provider market and local colleges.	**Yes**
Education Planning			
Whole-system approach to pre- and post-registration education planning - Develop a whole-system approach to pre- and post-registration education planning and oversight of key projects.	⇨	308 nursing students enrolled at the University Centre Somerset on our local nursing degree programme.	**Yes**
InPlace Placement Capacity Management System - Implement the InPlace Placement Capacity Management System across all learner groups.	✓	Clinical Placement Expansion project delivered - over 80 new placement areas opened for learner placements including Taunton School, the Manor Care Home and with SASP.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Agency Reduction			
Actions as described in Operational Plan narrative to include: • Deliver reduction in sickness absence compared to 22/23. • Deliver reduction in turnover (see also Retention programme). • Deliver International Recruitment, Undergraduate, Apprentice and RTP targets (all staff groups). • Harmonise temporary staffing processes and bank optimisation/bank remuneration across NHS trust (all staff groups) including use of reservists and other surge capacity solutions. • Deliver action plan to review medical locum contracts and introduce Direct Engagement for all locums. • Deliver strategy to review agency rate cards and migrate all agency staff to on-framework or bank contracts. • Implement dedicated medical rota teams at service level to manage rostering, annual leave and temporary shifts. • Implement director oversight of roster management and agency control protocols.	⇨	NHSE Workforce Productivity Programme embedded in Somerset with high engagement. Data insights driving actions – range of interventions to reduce/eliminate high cost off/framework agency and increase bank participation.	**Yes**
Workforce Transformation			
SDUC Workforce Strategy - Develop future workforce strategy for whole system Same Day Urgent Care (SDUC) delivery.	⇨	SDUC programme scoped and underway.	**Yes**
Expansion of advanced and enhanced practitioner roles - Expansion of advanced and enhanced practitioner roles where these offer greatest benefits to patient care.	⇨		**Yes**
Pharmacy workforce & IETS transformation programme - Deliver key objectives of Pharmacy workforce & IETS transformation programme.	⇨	Successful bid for 5 new cross-sector pharmacy technician apprenticeships in Phase 5 of NHSE programme. Implementation of community pharmacy independent prescribing teach and treat via HUC services.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Advanced Practice Planning project - Deliver key objectives of Advanced Practice Planning project.	⇨	Intermediate Care: Advanced Practice programme progressing to plan with ongoing expansion in trainee numbers and scope.	**Yes**
New apprenticeship and degree routes to entry for registered social work - Develop new apprenticeship and degree routes to entry for registered social work across health and local authority.	⇨	Apprenticeship sub-group of People Board reviewing data and blockers for OT, Social Work and ODP for next University Centre Somerset programme & work ongoing with HEI providers to achieve accreditation for all 3 staffing groups. SFT and Somerset Council working to increase practice educator capacity so that local delivery expands the workforce.	**Yes**
System Leadership and Development			
Developing advanced system thinking practitioners - Increase our capabilities in system thinking by developing advanced system thinking practitioners to work alongside, support and guide our Integrated Care strategic priorities.	⇨	Phase 1 of the advanced system thinking practitioner programme delivered to a cohort of 14 across our Integrated Care System, including regional NHSE with positive evaluation and learning for phase 2. Work has begun to use new capabilities and capacity to support Integrated Neighbourhood Working and High Intensity Users of services. Learning feeding into development of core leadership offer for the system.	**Yes**
Core system leadership offer - Development of a core system leadership offer which enables a system by default mindset and culture to grow tested through the Somerset Leadership Academy.	⇨	System OD 'Think tank' partnership established and system-wide offer being scoped with system partners integrating key topics such as Personalised Care, Population Health to create consistency & equity of access across the health and care workforce. Project around system development scoped with investment from NHSE/People Board & in partnership with Spark, SASP, Somerset Council, and the CCS with plans to form facilitated groups at place and empowering them to make changes in their local system – building capacity within our communities to enable local decision making.	**Yes**
Team Coaching Programme - Develop and deliver our team coaching programme across multi-disciplinary teams (health, social care and VCFSE) to support the development of integrated neighbourhood teams.	⇨	47 sessions of group coaching have been delivered across all parts of the system.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Attraction: Inclusive employers; socio-economic regeneration			
Coordinated system approach to work experience and work within schools - Design and implement a coordinated system approach to work experience and work within schools (primary/secondary).	⇨	Care Leavers Covenant partnership established, programme scoped, with £40k received from NHSE.	**Yes**
Collaborative approach to International Recruitment - Develop a collaborative approach to International Recruitment to ensure ethical and cost-effective supply routes.	⇨	Exploratory conversations and sharing of learning has taken place between SFT, social care and other organisations across the ICS.	**Yes**
ICS Housing & Community Services Hub - Create an ICS Housing & Community Services Hub in conjunction with NHSE to support those moving into Somerset to settle and access vital services.	⇨	Somerset Housing Hub partnership formed with business case for HomeShare and SupportMatch options scoped. Continued work to align Somerset's requirements and identify resource to formalise an ICS Housing Hub. Connection has been made with the work of One Public Estate in terms of identifying estate and land suitable for future keyworker accommodation development for health and social care workers. Corporate ICS risk developed and on ICB Risk Register and socialised with key anchor organisations.	**Yes**
Co-design collaborative interventions to address discrimination - Co-design collaborative interventions to address discrimination through EDI Fellowships, Equality, Diversity Inclusion Representative Project.	⇨	Identification of Equality, Diversity & Inclusion Representatives to support colleagues across the system and address inequality.	**Yes**
Workforce requirements for the digital and data strategy requirements of the new ICB - Identify the workforce requirements for the digital and data strategy requirements of the new ICB.	⇨	Actions are outstanding.	**Yes**
Retention			
Interventions to improve staff experience, retention and a sense of belonging - Design appropriate interventions to improve staff experience, retention and a sense of belonging following the Somerset pan-sector survey analysis and technical report.	⇨	Pan-sector survey with full technical report delivered.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Strengthen collaborative promotional work around health and care careers - Strengthen collaborative promotional work around health and care careers within secondary education by developing cross sector train-the-trainer package, Proud to Care teacher information and year 8 NHS work experience.	⇨	Year 8 project has now been completed. Banners co-designed with young people and produced which will be used as career resources in schools.	**Yes**
Retention Strategy Action Plan - Implement the Retention Strategy Action Plan for 23-24 which includes developing system wide standards around flexible working, career support through legacy mentoring, career navigation and AHP Action Learning Sets.	⇨	Career Navigator and Nursing and AHP Legacy Mentoring programme leads in place (SFT): tangible correlation between the work and the attrition rate of newly qualified nurses (down by 40% at SFT). 14 referrals to the Career Navigator service. 14 referrals to the Career Navigator service. AHP Faculty funded projects are underway to strengthen recruitment and retention of AHPs in Somerset.	**Yes**
System wide OH and EAP service - Explore feasibility of creating a system wide OH and EAP service.	✓	Feasibility explored but this won't be taken forward in 24/25 (may be actioned in following years).	-

Digital, Data and Insights

- **Single Electronic Health Record (EHR):** there is a refresh of the timeline due to the new joint approach with Dorset, details from Trust and any other significant changes.
- **System Governance structure:** reviewed and changed to reflect new staff and different ways of working.
- **Hospital at Home:** broadening to reflect right care at the right time, recognising the importance of neighbourhoods.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Digital Strategy			
Development of system-wide Digital and Data Strategy - Development of system-wide Digital Strategy	⇨	The system digital strategy was not completed and is a priority for 2024/25	**Yes**
Somerset Shared Care Record			
Re-procurement of Somerset Shared Care Record	✓	The ICS procured an extension to the Somerset Shared Care Record for 5 + 2 years and awarded the contract to Insight, working with Black Pear. This was a highly effective system collaborative exercise that positions us well for more joined up, shared care for citizens and teams.	-
Continue to develop the Somerset Integrated Digital e-Record (SIDeR) - Further develop across the Somerset system, to ensure the right information is available to the right professional at the right time	⇨	Increased use by 35% in comparison to 2022/23. Launched improved access to SIDeR via links in the GP Practice system and Acute hospital system. Released Personalised Care and Support Plan, About Me and Comprehensive Assessment Form to further enhance person centred care services. Provided access for Trusts outside of Somerset that see and treat people who live in Somerset.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Population Health			
Procurement Population Health management capability	⇨	The ICS agreed to support a focussed 15-week business case creation project for a Population Health Platform to enable the system to mobilise a solution in September 2024, this is again a cross system project.	**Yes**
Population Health systemwide intelligence - Use population health systemwide intelligence, harness data analytics and deliver evidenced based priorities to support improved outcomes and reduce inequalities	⇨	The ICS used population health data to support the "Take the Pressure Off" campaign to combat high blood pressure and save lives. Over half of all strokes and heart attacks in Somerset are caused by high blood pressure.	**Yes**
Single Electronic Health Record (EHR)			
Procurement of Single Electronic Health Record	⇨	The Trust EHR remains a priority programme for the system but has been pushed forward due to financial challenges and a National decision that Somerset has to work with the Dorset system to make the programme viable.	**Yes**
Investment in Infrastructure and Technologies			
Enable people to access their health and care records securely, quickly and when they want to see information or data.	⇨	Countywide primary care agreement to publish all person-centred care forms created from November 2023 onwards, via the NHS App. Promotion of NHS App through GP practices and location based events throughout the county.	**Yes**
Technical Infrastructure Review			
Ensure personal health and care information is safe and secure.	✓	The technical infrastructure review is continuing to support the safe use of health and care information. Extra Information governance support has been sourced to enable faster turnaround of projects.	-
Enable health and care staff and services to provide the best care in all settings by investment in infrastructure and technologies needed to support diagnostics.	✓	The Diagnostics programme is continuing to accelerate more effective diagnostic architecture and technology.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Hospital at Home Service			
Expansion of Hospital at Home.	⇨	Hospital at home is increasing the scope and pace of spread across different teams and the number of people being supported is being constantly reviewed to try and optimise the safest and most effective cohorts.	**Yes**

Estates

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
One Public Estate			
Keyworker accommodation and developments.	⇨	Sourcing of Key worker accommodation from independent sector whilst a sustainable solution for accommodation can be found through one public estate.	**Yes**
Levelling up programme and development in Bridgwater and Minehead.	⇨	Programme in progress, building design is the current key constraint which is being worked through prior to construction.	**Yes**
Oversight of s106 projects and development.	⇨	S106 projects reviewed on a monthly basis by ICS estates Group. Initial discussions held with planning authorities to develop a revised process for developer contributions in Somerset.	**Yes**
Consolidation of public estate.	⇨	The One Public Estates (OPE) programme has been reinvigorated and partners working together to consider options for consolidation.	**Yes**
Detailed review of the condition and capacity of primary care estate to inform future strategic planning.	⇨	This work has been picked up as part of the PCN phase 3 toolkit which is due to be completed at end of 2024.	**Yes**
Estates Strategy			
Development and review of Overall ICS Estates Strategy (Due Early 2024).	⇨	Strategy under review and due for sign off later in 2024.	**Yes**
Capital prioritisation (estate and equipment).	⇨	The strategy identified the priorities for capital development but options for capital availability have been limited. Prioritisation undertaken for 2024/25 programme.	**Yes**
Primary Care and Neighbourhoods			
Primary Care estate plans – outcome of recent review and link with community working.	⇨	This work has been picked up as part of the PCN phase 3 toolkit which is due to be completed at end of 2024. Links also being made into the OPE planning.	**Yes**
Reconfiguration of Community Hospitals.	⇨	Awaiting outcome of local engagement process.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Develop further estates solutions for community mental health.	⇨	Redevelopment of community property ongoing with Bridgwater opening in April 2024. Frome Property still in development.	**Yes**
Overview of System Capital Estates Plans			
Musgrove 2030.	⇨	Surgical Centre in construction and due for completion in 2025. New hospital programme scheme currently at Strategic Outline Case stage in line with national programme timelines. Updated case to be submitted in Spring 2024 and OBC later in financial year.	**Yes**
Yeovil District Hospital 2030.	⇨	Breast Care unit in construction and opening in Autumn 2024. Elective Care development in construction, first phase opening in Autum 2024 and Second phase in 2025.	**Yes**
Development of Community Diagnostic Hubs.	⇨	Yeovil Diagnostic Centre in construction with completion in November 2024. Other development now complete and in operation.	**Yes**
Mental Health – Build on the outcomes of the inpatient unit reconfiguration.	⇨	Reconfiguration of inpatient mental Health Wards to conclude in Spring 2024.	**Yes**
Somerset Foundation Trust			
Critical Infrastructure risk management and Backlog Maintenance.	⇨	Ongoing Programme of Work – prioritised subject to available resource.	**Yes**
Somerset Council			
Conduct a thorough review of its estate, bringing together the former County and District County estates under new unified management.	⇨		**Yes**
Understanding of Somerset Council Estates Strategy Plan.	⇨		**Yes**

Sustainability

- No significant changes, but there has been significant progress across the ICS in terms of delivery of the Green Plan.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Green Travel Plan - Every ICS member to develop a green travel plan by December 2023.	⇨	Established a Net Zero Transport Action Group. ICB Travel Plan subject to final governance Cycle to Work scheme. For new purchases and lease arrangements, the ICS and Trusts solely purchase and lease ULEV or ZEV cars (this is reported through Greener NHS quarterly return).	**Yes**
Climate Change Adaptation Plan - All Trusts and the ICS to have a climate change adaptation plan by 2024.	⇨	NHSE Guidance expected Q3 2024. Adaptation plan in progress, working with ICS partners.	**Yes**
Digital Transformation - Review care pathways and opportunities to increase digitisation of services and minimise patient travel.	⇨	Digitisation of services - to help interoperability and promote record sharing across the system; NHS App rolled out with digital support and inclusion sessions at all GP sites across Somerset. SIDeR the Somerset Integrated Digital e-Record, a shared care record system, which gives an overview of patient health and social care information in one digital record launched. Whilst we have largely met this objective, we continue to review care pathways to increase digitisation until it becomes BAU. Telemedicine has the potential to decrease travel mileage for patients needing to attend primary care appointments. The continued uptake of Brave AI across our PCNs will provide more positive outcomes for patients and deliver significant carbon savings. Data to support efficiencies in delivery of patient appointments and subsequent carbon reduction, this will be reported annually to the Board.	**Yes**

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Remote delivery of outpatient delivery - The NHS has suggested that where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.	✓	Recent data (Jan 2024) demonstrates there has been a shift in the delivery of appointments, there has been a reduction in F2F appointments from around 80% pre-pandemic to around 50% in 2023. There has been moderate growth in telephone appointments, and very minimal growth in video appointments. Continue to monitor.	-
Minimise Over-prescribing - It has been estimated that 60% of the carbon footprint of primary care is due to prescribed medicines, the Green Plan sets out the importance to minimise over-prescribing. Somerset ICB has already made substantial progress in tackling over-prescribing and the ICS will continue this work.	✓	Every ICS member has reduced its use of desflurane to less than 10% of its total volatile anaesthetic gas use.	-
ICS Green Plan - Produce ICS Green Plan (next iteration) 2025-2028.	⇨	Working with ICS partners to produce next iteration.	**Yes**
EV Charging Points - Develop network of EV charging points across major ICS sites for patients and staff.	⇨	Working with ICS partners to develop EV charging points. This has been delayed due to partner budget constraints.	**Yes**
Green and Social Prescribing - Cutting carbon through green and social prescribing.	⇨	Working with ICS partners to develop an equitable and cohesive social prescribing model. Data to support avoided GP appointments, reduction in prescribed medicines and growth in Social Prescribing referrals, will be reported annually to the Board.	**Yes**
Procurement Social Value Outcomes - Embed and monitor social value outcomes across all new and existing procurements.	✓	Incorporated key sustainability targets into our commissioning decision making, contractual arrangements and procurement processes. All members have embedded sustainability into their procurement processes (PPN 06/20; 06/21). Joint procurements and collaborative procurement system (Atamis) also introduced. Worked with ICS partners to launch a monitoring and measuring tool.	-

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
Nature and Biodiversity Access - There will be access to a nature/biodiversity area at every significant site in Somerset by 2025.	⇨	Carried out a review of access to biodiversity on significant sites (as part of collaborative bid).	**Yes**

Procurement/Supply Chain

- No significant changes, but there has been significant progress across the ICS in terms of delivery of the Green Plan.

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

What we said we would do (April 2023 – March 2024)	Progress	What we have done	C/F to 2024/25
From April 2022: all NHS procurements will include a minimum 10% net zero and social value weighting. The net zero and social value guidance for NHS procurement teams will help unlock health-specific outcomes (building on PPN 06/20).	✓	10% weighting for Social Value included in all procurements.	-
From April 2023: for all contracts above £5 million per annum, the NHS will require suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum (aligning with PPN 06/21). The Carbon Reduction Plan (CRP) requirements for the procurement of NHS goods, services and works guidance outlines what will be required of suppliers and how it will be implemented.	✓	Carbon Reduction Plan requested as pass/fail requirement for all procurements over £5m per annum.	-
From April 2024 a tiered approach will be introduced as follows: • a full CRP will be required for procurements of high value (£5m per annum exc. VAT and above) and new frameworks operated by in-scope organisations, irrespective of the value of the contract, where relevant and proportionate to the framework. • a Net Zero Commitment will be required for procurements of lower value (below £5m per annum exc. VAT and above £10k exc. VAT).	⇨	We continue to support suppliers to understand and be compliant with this requirement. A number of support measures are in place (via NHSE guidance and supplier relationship management). We're currently working towards introducing the Evergreen Supplier Assessment, this is a self-assessment for suppliers to measure and monitor their own carbon reduction, and can be accessed via our procurement portal, Atamis.	**Yes**

Appendix 2: Delivering our Statutory Functions

This section of our Joint Forward Plan describes how we have delivered our legal requirements as set out by NHS England.

1. Describe the Health Services for which the ICB proposes to make arrangements

Our Joint Forward Plan explains the health services we have in place and will arrange to meet the needs of the people living in Somerset.

Our operational plan sets out more detail about how the system is performing and the actions we are taking to improve performance within our services.

Detailed information about services can be found on our websites:

- NHS Somerset Integrated Care Board
- Somerset NHS Foundation Trust
- Somerset Council
- South Western Ambulance Service NHS Foundation Trust

The combined information in this Joint Forward plan, our operational plan and on our websites fulfils our duty to describe the current and planned health services to meet the needs of the people living in Somerset.

The NHS is also responsible for responding to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease such as Covid or a major transport accident. This is referred to as emergency preparedness, resilience and response (EPRR). The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded services, to show that they can deal with such incidents while maintaining services.

The ICB is known as a Category 1 responder which means we must:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans and business continuity management arrangements
- make information available to the public, including warning and informing in the event of an emergency
- co-operate with and share information with other local responder.

We coordinate the activities of all providers of NHS funded healthcare to plan for and respond to emergencies. The ICB has an Accountable Emergency Officer (AEO) for EPRR, who is responsible for discharging the ICBs responsibilities around EPRR and providing assurance to the board.

2. Duty to Promote Integration

Integration

For Somerset, integration and collaboration is a key priority. We want to support people to live independently in their own homes for longer and take a joined-up approach to improving outcomes across health, social care, and housing. In simple terms, it refers to the bringing together and joining up of services and support, processes, and ways of working which improve outcomes for local people and local services. Integration relates to several important interdependent domains:

- **The person*:*** Integrating care and support around what matters most to the person and their life situation and enabling people to engage with resources in their local community. We believe that integration and person-centred care are closely linked.
- **Services*:*** Integrating health and care services where this will improve outcomes for local people and make better use of local resources
- **Systems*:*** Integration of governance, commissioning, or provider functions where this brings about a more efficient and effective use of public money and better outcomes for local people.

The Somerset health and care community acknowledge that structural and process change needs to be accompanied by cultural change. This is fostered by ensuring we are always listening to the people we service and making sure they are at the heart of our strategic plans and service development. This is also achieved by enabling teams to work together, to form trusting, psychologically safe joint working arrangements in which different perspectives can be considered and shared. It involves enabling culture change using IT, training and support and most importantly through leading by example.

Better Care Fund

The Better Care Fund within Somerset is a joined-up plan between health and social care. There are plans to strengthen this further within the county through a newly formed Joint Commissioning Steering Group with oversight by the Somerset Board. The plan contains some key areas of joint working including intermediate care services, carers services, community based schemes, Disabled Facilities Grant related schemes and home care or domiciliary care.

Pharmacy, Ophthalmic and Dentistry Services

Since April 2023, NHS Somerset has been responsible for the commissioning of community pharmacy, ophthalmic and dental services, in addition to its preexisting responsibility for the commissioning of services in general practice. Whilst this has created some short-term challenges, the benefits of having greater autonomy and strategic focus for the entirety of primary care services provides opportunities for a more cohesive approach to service transformation and clinical pathway development.

NHS Somerset is fully committed to the wider integration of the four areas of primary care service delivery, the benefits of which are clearly articulated within the Fuller Stocktake Report (Dr Claire Fuller, May 2022), and further underpinned as a key part of an effective Integrated Care System in The Hewitt Review (Rt Hon Patricia Hewitt, April 2023).

NHS Somerset fosters a collaborative approach to primary healthcare service delivery, encouraging general practice, community pharmacy, ophthalmic, and dentistry to work cooperatively to ensure that care is effectively delivered by the most appropriate healthcare professional. The development of integrated care pathways ensure that patient care delivery is efficiently coordinated and sufficiently comprehensive to meet the needs of the individual. The successful delivery of this model of care is predicated on the seamless sharing of patient information between healthcare professionals, supported by a robust integrated digital information platform.

Throughout 2024/25, NHS Somerset will continue to build on this model of integrated primary care, supporting with the training and education of professionals across different sectors; supporting public awareness campaigns regarding access to, and the benefits of the new models of care; supporting quality improvement initiatives to ensure the continuation of high standards of care, and; supporting investment in areas of integration that provide the biggest benefit to communities across Somerset.

Example: NHS Pharmacy First

Following the launch of the NHS Pharmacy First Advanced Service on 31 January 2024, general practice is now able to refer eligible patients to participating community pharmacies for advice and treatment of seven minor healthcare conditions (acute otitis media, impetigo, infected insect bites, shingles, sinusitis, sore throat and uncomplicated urinary tract infections). NHS Somerset has ensured that these referrals are sent via an integrated digital platform, which securely transfers care from general practice to the community pharmacy of the patient's choosing. Following a consultation with the pharmacist, a record of the consultation (including any medications supplied by the pharmacist) is electronically returned to the general practice for inclusion of the patient's GP record. This integrated care pathway helps to ensure that patients experiencing one of the seven common conditions can conveniently access safe, high-quality healthcare services delivered by a highly trained healthcare professional, whilst simultaneously reducing the demand for appointments in general practice for patients who are in greatest need.

3. Duty to Have Regard to Wider Effect of Decisions

We want to make decisions on and provide health services in an integrated way. Our Constitution NHS-Somerset-ICB-Constitution-01.04.23-v1.2.pdf (nhssomerset.nhs.uk) and Governance Handbook Our Constitution and Governance - NHS Somerset ICB explains how we work together to make decisions.

In making decisions about the provision of healthcare, the ICB must consider the wider effects of its decisions on the health and wellbeing of the people we serve (including by reducing inequalities in respect to health and wellbeing), the quality of services provided or arranged by both ourselves and other relevant bodies and the sustainable and efficient use of resources. This is known as the 'triple aim'.

a) Health and wellbeing of our population (including by reducing inequalities with respect to health and wellbeing)
b) The quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
c) Sustainable and efficient use of resources by NHS bodies

Our Joint Forward Plan describes the priority work programmes that have been identified to support the delivery of the strategic aims set out within the Integrated Care Strategy, aligned to the Health and Wellbeing Board's Improving Lives Strategy, ensuring that as a health and care system we have a common set of aims and objectives that explicitly reflects this 'triple aim'.

4. Financial Duties

Living Within Our Means

Somerset has a history of financial challenge in both Foundation Trusts (prior to merger) and the CCG, now ICB. Prior to the Covid-19 pandemic the system was developing plans to address a significant underlying deficit position and ongoing in year deterioration. Work had been undertaken to assess the causes of the deficit in Somerset, and a recent refresh confirms that the following factors remain key:

True structural costs, predominantly the unavoidable inefficient cost of sub-scale services which are necessary to ensure appropriate provision and access across the geography of Somerset and Private Finance Initiative costs at SFT.
Challenges in recruitment and retention has led to premium-rate workforce costs to cover gaps in substantive.
Workforce availability to support sustainable primary care services.
Inefficiencies created by the existence of sub-scale and duplicate services which are not attributable to geographical necessity and could therefore be eliminated through redesign.

Historic non-delivery of recurrent efficiency savings and reliance on non-recurrent solutions to achieve in year balance.
The productivity and cost impacts of underutilised and expensive estate.
In some areas corporate services costs which benchmark highly compared with other systems and organisations.
Resources not being used to achieve best value as a consequence of historic investment and/or underinvestment decisions.

In 2023/2024, we have returned to a national financial framework which has reintroduced with a funding allocation based on fair shares for each system and a trajectory for return to this value from the exit level of funding from the 2021/22 pandemic financial regime over the next few financial years.

The national and regional expectation for Somerset, as for all systems, is to plan for and deliver aligned financial, workforce and service sustainability in the medium to long term, implementing such changes as are necessary to ensure this is achieved through wise and affordable use of resources.

NHS Somerset will deliver all its financial duties in 2023/24 and has an assessed exit underlying financial deficit at 2023/24 in the region of £83m, which is £7m adverse to the original MTFP assumption.

This analysis of drivers and value of the Somerset deficit provides useful context and baseline information for future planning but does not generate solutions. Factors driving the deficit are not necessarily the same as solutions to achieve balance and improve value for money, although there will be significant overlap. The historic analysis of value is of limited future use due to the complex impacts of Covid-19 and the construct of the funding model within the new financial framework.

What we are seeking to achieve for our population:

Our strategic financial aim as set out in the overall system strategy from 2022 is:

'To live within our means and use our resources wisely to create a sustainable system'.

This sets twin objectives at both organisational and system level of affordability and value for money, which align well with both the overall Somerset system strategy and with regulatory and statutory expectations:

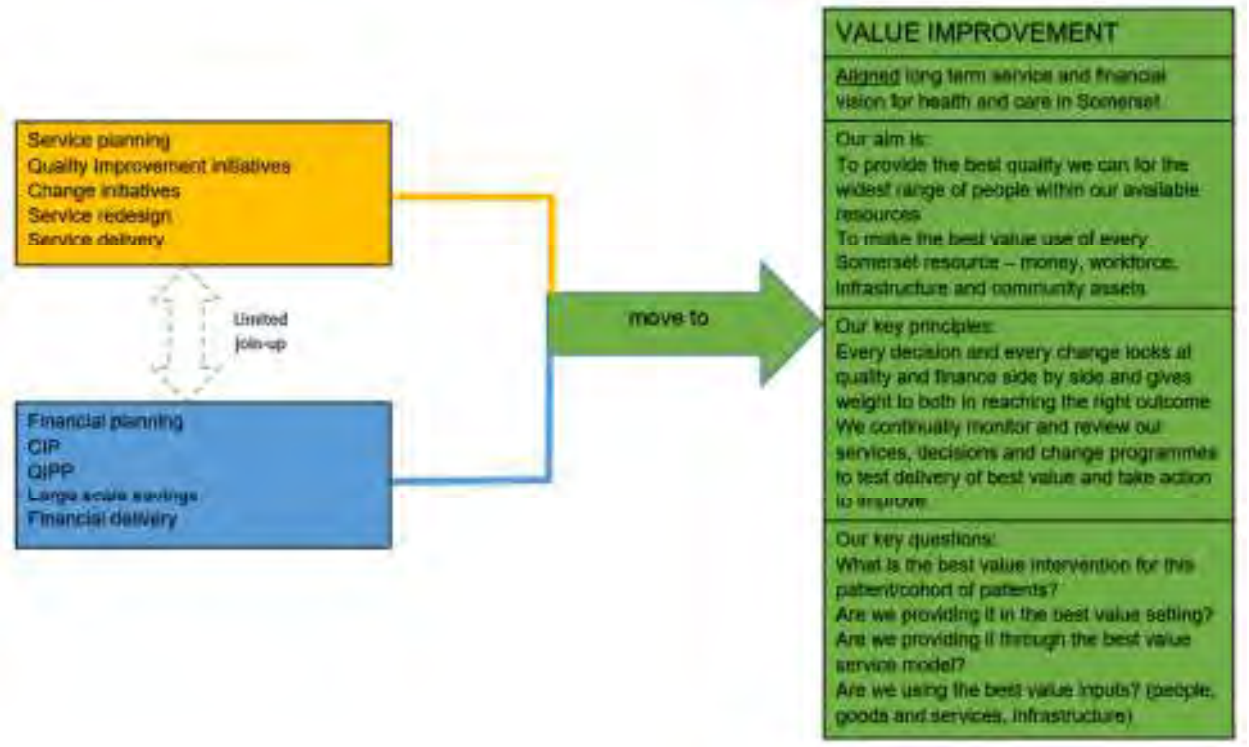
- Understanding and managing the interdependent and iterative relationship between the financial strategy, the emerging clinical and care model for Somerset and other enabling strategies is key to delivering a coherent and cohesive plan. The financial strategy and plan are shaped by the vision for services and the constraints and opportunities of workforce, infrastructure, and community assets. Financial constraints and opportunities inform and affect choices on delivery of the service vision.

- Under the new financial framework, regulatory and statutory expectations for both the system as a whole and individual partners are focussed on managing within the nationally determined allocation for our population and maximising the productive use of our resources, obtaining best value for every pound spent and optimising our use of workforce, infrastructure, and community assets.

In both contexts, expectations and detail are still emerging but we have sufficient information already to plan and make early decisions and progress, confident that we are pursuing the right direction.

We believe our quantified target financial position should be to achieve recurrent underlying financial balance by the time we exit 2026/27. This will need to be delivered through a renewed approach within the system and each partner organisation. This would include clarity on how the true structural elements of the Somerset deficit are recognised and managed.

Our strategic financial approach is summarised in the diagram below:



In pursuit of the twin objectives of best value and affordability leading to sustainable financial balance, we will work to the following key principles across revenue and capital:

- Establish and promote clear ownership and accountability for wise use of resources and securing financial balance.
- Maintain and enhance our focus on financial governance and cost control.
- Monitor and challenge value for money in all our investments, expenditure, and income contributions.
- Enhance and develop our use of benchmarking, analysis, and soft intelligence to identify and pursue financial and productivity improvement opportunities.
- Set and adhere to a robust framework for investment decisions which prioritises, within an affordable limit, only those investments which deliver a high rate of return in value for money terms, or which are truly unavoidable for safety or legal reasons.
- Monitor investments and change projects for delivery and effectiveness of impact and disinvest where outcomes are not being achieved, resulting in poor value for money.
- Invest in a balance of evidenced savings schemes with a reliable rate of return and higher risk or novel schemes which offer greater potential reward.
- Optimise the use of non-recurrent financial flexibilities to develop and support delivery of savings and cost avoidance schemes.
- Incentivise and support the pursuit of new efficiency, productivity, and savings opportunities throughout the year.
- Seek opportunities to maximise income and net contribution from NHS-funded initiatives and non-NHS sources.
- Maintain and enhance our robust and collaborative approach to financial risk management and mitigation.

We will develop granular underpinning arrangements and processes for the system and each partner within it, to ensure these principles drive and are embedded in our financial activities, decisions and behaviours and provide a framework for all activities which have a financial impact.

The strategic financial plan proposes a three-phase approach over the 4-year period 2023/24-2026/27, taking into account both the scale of the challenge in the earlier years and the scale of opportunity at the same time to use non-recurrent flexibility to greatest effect. This is set out in the diagram below.

NHS Somerset submitted the Somerset Medium Term Financial Plan 2024/25 – 2027/28 in September 2023, which was developed collaboratively by partners from across our system, led by the System Finance Group, which includes the Chief Finance Officers of Somerset Integrated Care Board and Somerset NHS Foundation Trust (SFT) and a finance representative from Somerset Council. Submission of the MTFP was approved by the NHS Somerset Integrated Care Board and was considered by the SFT Board. Board discussion recognised the submission as being underpinned by a set of assumptions that will be further worked through as further clarification becomes available. Specifically, concerns were raised that there were few plans that underpin the level of savings contained in year 1, however these have been largely delivered by the system in 2023/24. The MTFP was submitted with a £11.3m deficit in 2024/25 and a £13.8m deficit in 2025/26, as per the table below. The MTFP anticipated that from 2026/27 the Somerset system can deliver a financial balance, returning to a recurrent balanced position by the end of 2027/28.

MTFP Summary Table	2024-25 £'000	2025-26 £'000	2026-27 £'000	2027-28 £'000	2028-29 £'000
Exit Previous Year Underlying Position	**78,233**	**53,213**	**35,662**	**17,870**	**18,591**
Total Movements		**9,244**	**6,532**	**(8,835)**	**(25,886)**
Opening Underlying Position	**78,233**	**62,458**	**42,194**	**9,035**	**(7,295)**
Total Sources of Funds	**(50,842)**	**(47,280)**	**(58,013)**	**(59,637)**	
Total Mandatory Tariff/Inflation Uplifts	**38,072**	**37,450**	**38,010**	**38,867**	
Total Cost Pressures	**10,358**	**12,065**	**7,177**	**7,102**	
Total Inflation Pressures	**9,364**	**9,217**	**8,251**	**8,158**	
CIP / QIPP					
Total CIP / QIPP	**(51,024)**	**(50,594)**	**(49,139)**	**(49,338)**	
Total Other Investments	**19,052**	**12,346**	**29,389**	**64,404**	
Revised Recurrent Position	**53,213**	**35,662**	**17,870**	**18,591**	
N/R Adjustments to Achieve Financial Balance					
Utilising of Non Recurrent funding	(26,000)	(4,000)	(3,000)	(2,000)	
ERF Benefit	(12,000)	(12,000)	(12,000)	(12,000)	
Slippage on Investments	(1,500)	(1,500)	(1,500)	(1,500)	
Additional EHR Funding Sources / Additional Cash Releasing Savings	(2,408)	(4,335)	(1,370)	(3,091)	
Final Position - Deficit/(Surplus)	**11,305**	**13,827**	**0**	**0**	

Performance

The Somerset operational finance, activity and workforce plans for 2023/24 were developed collaboratively across the system, led by the System Finance, Workforce and Activity Planning Groups which includes Executive Level membership from partners across Somerset ICS (Somerset ICB, Somerset Foundation Trust and Somerset Council). System leads ~~have~~ worked collaboratively to provide assurance around the triangulation of activity, workforce and finance.

The Plans (activity, finance and workforce) were signed off by the ICB Board (which includes system-wide membership) and also approved (for the UEC metrics) by the A&E Delivery Board.

The final activity, finance, workforce and narrative plans were reviewed and refined accordingly to ensure that:

- all assumptions continue to be tested to ensure they are as accurate as possible;
- factor in the current bed modelling taking place across the acute trusts and will incorporate any analysis from the ongoing review of A&E and MIU attendances by GP Practice to understand the patterns and drivers of demand;
- review inflationary and other cost pressures to develop mitigations to achieve a balanced financial plan;
- continue to drive productivity improvements across specialities to maximise investment;
- address capacity of our intermediate care service.

23/24 detailed plans were set out within the system Operational Plan. Development of future plans will be overseen through the System Assurance Forum.

5. Improving any Joint Local Health and Wellbeing Strategy (JLHWS)

Somerset is a low complexity system. We have:

- 1 “place” – Somerset.
- One Integrated Care Board (ICB) “NHS Somerset”
- One Unitary Authority, “Somerset Council”.
- One Health and Wellbeing Board (HWBB). We are developing proposals for the HWWB to operate as a Committee in Common with the ICP.
- One statutory NHS foundation trust, Somerset NHS Foundation Trust (SFT) providing all of Somerset’s acute, community, mental health and learning disability services, and around a fifth of primary care services
- 13 primary care networks, working over 12 neighborhoods
- Strong relationship with VCSE partners.

This low complexity allows us to better understand, plan and deliver improved health and wellbeing outcomes for Somerset.

During 2023, we chose to combine the Health & Wellbeing Board and the Integrated Care Partnership into one Somerset Board as a committee in common Somerset Health and Wellbeing Board and Integrated Care Partnership (Committee in common).

The committee in common looks at people's health and social care needs together, as well as taking into account the bigger picture – things like transport, housing, jobs and leisure – so that services truly help people stay healthy and independent. Members of the committee in common must look at the evidence of what works best to help target plans and resources.

The following strategies drive forward the work of the committee in common:

Improving Lives Strategy 2019-2028
Integrated Health and Care Strategy for Somerset

Improving Lives
Improving Lives is the Somerset Health and Wellbeing strategy. The strategy is owned by the Somerset Board and sets out how we will work to deliver improvements for our population. We take the Somerset Joint Strategic Needs Assessment (JSNA) into account when defining strategy and delivery of that strategy through our JFP.

The Improving Lives strategy has four strategic priorities. Our Integrated Care Strategy and Joint Forward Plan seeks to deliver priority four of our county's strategic priorities.

Integrated Health and Care Strategy
As an Integrated Care System (ICS) we have set out how we will achieve our vision through our initial Integrated Care Strategy: our ambition for a heathier future in Somerset (2023-28).

Our vision for the Somerset health and care system is that:

In Somerset we want people to live healthy independent lives, supported by thriving communities with timely and easy access to high quality and efficient public services when they need them.

Working together, Somerset has identified seven key strategic aims, focused on achieving the ambition of enabling people to live healthier lives. To achieve these aims we all need to take some action now. If we work together, take collective action, and support one another we can go much further than if we work alone.

6. Duty to Improve Quality of Services

Improving Quality of Services

As an ICS we will ensure all our statutory duties relating to improving the quality of services are met.

We will agree a set of outcome measures to evidence successful and sustained delivery of the services developed and delivered across our geographical boundaries. This will be detailed in a number of overarching and interconnected strategies. The 5-year ICS Quality Strategy will be informed by Somerset Improving Lives, Integrated Care Strategy and others as required. The objectives within the strategy will address our current risks and strategic aims of the ICS.

We will have a clear quality governance structure, which supports the identification of system intelligence, risks and concerns. The Quality Committee provides the governance and compliance function for the ICB, processes are in place for escalation and reporting to the ICB Board and to Regional and National Quality and Safety Boards.

The NHS Somerset ICB Quality Committee has a set of clearly defined metrics, supported by performance dashboards and quality reporting to provide assurance whilst also highlighting those areas that require further insight, acknowledge improvement opportunities in order to demonstrate impact on quality outcomes.

The NHS Somerset Chief Nursing Officer alongside the Chief Medical Officer ensures that clinical and care professional leadership is embedded at all levels of the system.

Somerset has a system-wide quality improvement training offer called the ‘Seven Steps of Quality Improvement’. There are three levels of training; bronze, silver and gold, with the opportunity for health and care staff to come together to work on a system-wide quality improvement project.

Somerset has a range of tools and training opportunities to support the development of competencies and skills in quality improvement, working in partnership teams can access training according to need.

We ensure that all staff are aware of their statutory and contractual duties and responsibilities. The uptake of statutory mandatory training is monitored by NHS Somerset as well as provision of dedicated sessions on patient safety and quality improvement on the induction programme for new staff. At NHS Somerset we have mandated Level 1 of the patient safety syllabus training for all staff.

As part of the implementation of a Patient Safety Incident Response Framework (PSIRF), patient safety leads will be able to access formal training and adopt a ‘just culture’ to raise awareness in response to patient safety incidents.

We are committed to co-production in the review and development of existing and new services, working with partner agencies such as Maternity Voices, Healthwatch and the development of Patient Safety Partners. The voice of the child and those from inclusion health groups, where equitable access to health and care services is also a priority are factored into all commissioning and contracting quality outcomes.

7. Duty to Reduce Inequalities

Population Health and Addressing Health Inequalities

We know that people living in Somerset with more social capital have more opportunities to lead a flourishing life; they also have better health. The two are linked: those who have access to more resources experience better health outcomes. A principle of Population and Public Health is that the primary determinants for health and wellbeing are the wider influences on people's lives, the environments in which they live, their relationships, employment and finances, and many other factors. This does not remove the responsibility for the health and care system to address those factors over which it has primary control and play its part in tackling inequity and inequality.

Evidence shows us that those populations most impacted by health inequalities experience or share the following characteristics: they live in areas of multiple disadvantage, they are influenced by geographical factors that affect access to services, and they are part of groups who have protected characteristics or are in inclusion health groups. Often these needs can overlap and intersect, further compounding the risk of poor health outcomes.

Of the 327 LSOAs in Somerset, 29 are within the most deprived **20%** in England, up from 25 LSOAs at the time of IMD 2015. The "Somerset North" area has the highest number of LSOAs in this category (13), followed by Somerset West (8), Somerset South (6) and Somerset East (2). These neighbourhoods have a combined population of approximately 46,000. Additionally, the county experiences unique challenges with rurality and data shows that coastal communities can be unfairly impacted (Chief Medical Officer's annual report 2021: health in coastal communities - GOV.UK (www.gov.uk). However, health inequalities aren't just defined by geography or postcode; there are multiple inclusion health groups impacted by health inequalities. The county has seen a 15-fold increase in refugees and asylum seekers since Autumn 2021. Estimates show us that approximately 600 people are experiencing homelessness. Gypsy, Roma, Traveller and other vulnerable migrant populations have been identified as living on sites that have direct impact on health outcomes. We want to give more people in Somerset the best healthy life chances currently enjoyed by the few. This will require joined up and integrated working with partners across various departments and agencies including housing, police, education, fire and rescue, town and parish councils, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners and our employers.

Somerset's Population Health Transformation Management Board has prioritised health inequalities as a core workstream. This is enabling system implementation of national guidance, including the Core 20+5 programme, and legal requirements, taking a system assurance role in

line with the responsibilities of the Joint Director of Public and Population Health, the new health inequalities legal requirements and priorities identified from analysis of local data. As a result, with the ambition of strengthening leadership and accountability in the system, ICB have worked with colleagues from Public Health to establish the Inequalities in Health Group (IHG). The four priorities set by IHG and agreed by the Population Health Transformation Management Board are:

1. Building workforce knowledge of health inequalities through workforce development – This has involved establishing our Healthcare Inequalities Network which comprises of approximately 60 members and continues to grow. This network forms a Community of Practice that explores best practice locally, regionally and nationally, shares updates and emerging guidance and policies, and covers thematic topics such as inclusion health groups, working with the voluntary, community, faith and social enterprise sector, and exploring quality improvement projects to improve healthcare inequalities across the system.

2. Improving the data and evidence - Using comprehensive and timely population health data will be the foundation to indicate which communities we need prioritise. Senior Responsible Officers have been established for all Core20+5 areas for both adults and children and young people. While Core20 provides guidance on approach, it does not set specific benchmarks for all areas. For this reason, SROs have set benchmarks to establish how to measure progress for their priority area. They will report into the IHG's project steering group which is outlined below under Priority 4.

3. Engaging localities and communities – Data and evidence and identified need has allowed us to identify inclusion health groups in the county who experience higher risk of poor health outcomes. The Core20PLUS5 'PLUS' groups that have been identified for adults are coastal communities, people experiencing homelessness, people with learning disabilities and asylum-seeking children. More about the work taking place with some of these groups can be found below.

4. Providing direction and oversight of health inequalities projects – An audit of existing projects undertaken in 2022-23 identified many projects and interventions that had been developed with a brief around tackling health inequalities. Our system has been active in this space and the development of the governance and assurance structure has not removed the impetus for action. Evaluation of existing projects has been undertaken. We are now in the process of separating the IHG into a strategic steering group and a sub-group to monitor health inequalities projects. A reporting template has been agreed and projects that have a specific health inequalities focus will report to the Project Steering Group quarterly.

In Somerset, as nationally, Covid-19 further exposed some of the health and wider inequalities that persist in our population. Recovery across our health and care system has focused and continues to be planned in a way that inclusively supports those in greatest need.

Here are some examples of areas of work, projects and interventions as described above:

1) Elective Care Recovery and Expediting Care for Vulnerable Patients

Patients were waiting longer than we would like them to in many specialities, both to be seen and assessed and to have a surgical procedure. The standard approach to managing waiting lists is by clinical priority and then chronological order, but Somerset Foundation Trust, as an integrated provider, is in a unique position to be able to easily identify potentially more vulnerable patients who are more likely to deteriorate whilst waiting. A process using key factors to flag the most vulnerable was initiated so that treatment could be expedited. Three factors were identified: patients with a known learning disability, patients with a current mental health referral, patients living in one of the two most socially deprived areas. These factors were weighted and patients scoring more than 3 were flagged as vulnerable. This is because there is evidence that patients with these characteristics on average live shorter lives. This means they spend a disproportionately longer part of their life on our waiting list.

Outpatients

To date (since January 2023) 306 patients waiting for their first routine outpatient appointments have been upgraded so that they are managed as if urgent. Of these:

- 284 routine patients received 'urgent' appointments on average 7.6 weeks after being flagged, and 86 were seen within a month (versus typically 6 months without intervention).

Specific support for patients with learning disabilities

Patients with learning disabilities are also flagged to the Learning Disabilities Liaison Teams (both acute and community) so that additional support can be put in place if patients require it when they attend for their appointments. This was initially restricted to just 2 high-volume specialities but is gradually being expanded as the team's capacity allows, and they now support 5 specialities in this way*. Patients will frequently decline the offer of support, but the phone call itself can highlight specific needs that can be sorted in advance e.g., the need for an interpreter or specialist equipment.

Surgery

Flags highlighting patients on the surgical waiting lists have also been in place since January 2023, and Admissions will try to expedite vulnerable patients' surgical dates wherever possible. A report is being developed to determine how quickly the flagged patients are being treated against non-flagged patients waiting for similar procedures.

Patient/Carer Experience

'*We brought our son Tom to see Mr D in the ENT dept. In the same appointment we were able to meet with Louise from the Learning Disability Liaison team, and with an audiologist. I can't thank you enough for this multi-disciplinary approach. It made the visit very easy and very successful.'*

2) Homeless Health / Inclusion Health Service

The development of this GP offer across Somerset has been incremental, starting in 2021 following the identification of presentations in A&E by people experiencing homelessness. The service started with the development of the Homeless and Rough Sleeper Nursing Service . Delivered in hostels, community hubs, on the street and in fields, this service is an 'in-reach' programme where a general nursing team, mental health nurses and peer support workers provide services in the places they can access people experiencing homelessness. Other funding streams allowed for the appointment of Inclusion Health GPs in Taunton, Yeovil and Somerset East who work closely with the nursing service. This has been nationally recognised at NHS 75th celebrations earlier this year Homelessness Health in Somerset wins prestigious NHS Parliamentary Award and - following a visit to Somerset by Professor Bola Owolabi - this approach formed part of the narrative used to launch the NHS Framework for Inclusion Health in Autumn 2024. NHS England » A national framework for NHS – action on inclusion health

We have recognised for some time that there was inequity in this provision and have worked with the Population Health Management Transformation Board to deliver an equitable GP offer across Somerset which is the approach taken by the Homeless and Rough Sleeper Nursing Service. The number of referrals received by the nursing service across the county, for example, is equal in all four of the (old) council districts of Somerset. A funding proposal to the Population Health Board to pilot a countywide GP offer is currently taking place with scope to baseline the offer once evaluated.

3) Hypertension campaign

The system has launched a collaborative hypertension campaign 'Take the Pressure Off' which expands on the work from last year to optimise treatment for those aged 60-79. This campaign has a two-pronged approach which engages directly with communities and aims to optimise treatment through primary care pathways. Public Health are leading community blood pressure checks which focuses on employers in Core20 areas. Primary care are working to develop CVD Hubs which will allow for those who have high blood pressure to be treated or optimised. This work is supported by the CVD dashboard, which will allow us to better identify populations and geographies to target and to measure improvements. We are now using this data to evaluate whether we are seeing narrowing or widening inequalities as we recover the position in regard to routine blood pressure measurement post Covid-19.

Suicide Prevention

Every death by suicide is a personal tragedy and invariably preventable. The devastating affect when someone takes their own life can have an impact on families, friends, colleagues, and communities for many years.

During 2022, the multi-agency (including VCFSE partners) Somerset Suicide Prevention Partnership Board reviewed its activities and structures to raise the profile of suicide in the system with a clear emphasis on moving to a position that 'suicide is everyone's business'. One of the key drivers for this change is the recognition that around 70% of people who take their own lives are not known to mental health

services at the time of their deaths. Therefore, a more proactive preventative and community-based approach is required to identify people at risk of suicide and support them to engage with services where necessary.

The multi-agency Somerset Suicide Prevention Partnership Forum manages 4 core workstreams of delivery: the programme management function; high risk groups; communications and media management; and training and community engagement. Each of these workstreams have subgroups with targeted activities as required.

Since our last report, Somerset has seen an improvement in deaths by suicide. From 2019 – 2021, deaths by suicide were 14.8 per 100,000. Recent figures show that from the period including 2020 – 2022, deaths by suicide dropped to 12.6 per 100,000. This is slightly higher than the national average (10.3) and the regional average (11.9).

A national Suicide Prevention Strategy was published in Autumn 2023 and a consultation is currently underway to develop the new Somerset Suicide Prevention Strategy. We will seek to align our local priorities to national objectives, priority areas and the best evidence base. We expect our revised local strategy will be published in Spring 2024. This work was identified as a priority at the outset of the Population Health Management Transformation programme but has now been pushed forward to 25-26.

8. Duty to Promote Involvement of Each Patient

Personalised care

Somerset ICS will ensure the implementation of a comprehensive model of personalised care to ensure the duty to promote the involvement of each patient.

We will:

- Ensure that the application of a personalisation approach is embedded in the business as usual of all clinicians and care and support givers in Somerset.
- Ensure that the voice of the person is heard and acted upon across all treatment, care and support pathways.
- Ensure that clinical, care and support professionals are trained and equipped to recognise the need to hear the voice of the person and are supported to act on the wishes of the person as required.

We have in place both regional and national Integrated Personalised Care boards.

The ICS Personalised Care Steering Group's programmes, led by the Head of Personalised Care, include:

- The embedding of true shared decision making across all aspects of care and support.
- The implementation of formal personalised care and support planning for our most complex individuals and across maternity services in the first instance.
- Implementing a comms, training and engagement programme to ensure understanding of enabling choice, including legal rights to choice.
- Further roll-out and consistency across the county of social prescribing and community-based support.
- The implementation of programmes to supported self-management across the county for a range of conditions.
- The increased use of personal health budgets and integrated personal budgets.

We will implement a set of key performance indicators (KPIs) to enable the monitoring of progress, oversight of effectiveness and to continually seek feedback from health, care and support professionals and those individuals that they serve.

9. Duty to Involve the Public

Engagement and Involvement

Public involvement is an essential part of making sure that effective and efficient health and care services are delivered with people and communities at the centre. By reaching, listening to, involving and empowering our people and communities, we can ensure that people and communities are at the heart of decision-making and that we are putting our population's needs at the heart of all we do.

Our Working with People and Communities Engagement Strategy outlines our strategic approach to involving people and communities.

Our strategy is aligned with the aims of the ICS strategy.

ICS Strategy - Somerset-Health-and-Care-Strategy-compressed.pdf (nhssomerset.nhs.uk)

We have established an ICS Engagement Leads Co-ordination group as the mechanism to co-ordinate and deliver our people and communities work across Somerset ICS. This group includes membership from across the ICS, Healthwatch and VCFSE partners.

We work closely with all our partners, patients, public, carers, staff, and stakeholders to continue to build on our existing relationships across Somerset. We are committed to making sure that our focus is to involve and engage people in a variety of different ways and are committed to transparency and meaningful engagement.

Our 10 principles for effective public involvement

Our 10 principles for working with people and communities have been developed through engagement with Engagement Leads across the ICS including Healthwatch and with our Somerset Engagement Advisory Group (SEAG). These principles outline our shared principles for effective public involvement across the ICS.
These principles build on the ten principles outlined in the working with people and communities section of the ICS design framework by NHS England and Improvement.

Somerset's ICS 10 principles of working with people and communities:

- Put the voices of people and communities at the centre of decision-making and governance.
- Understand our community's needs, experience and aspirations for health and care, with a strong focus on underrepresented communities.
- Involve people at the start in developing plans and feedback how their engagement has influenced decision making and ongoing service improvement, including when changes cannot be made.
- Ensure that insight from groups and communities who experience health inequalities is sought effectively and used to make changes in order to reduce inequality in, and barriers to, care.
- Build relationships with underrepresented groups, especially those affected by inequalities, ensuring their voices are heard to help address health inequalities.
- Work with Healthwatch and the VCFSE sector as key partners.
- Through partnership working, co-production, insight and public engagement address system priorities in collaboration with people and communities, demonstrating accountable health and care.
- Use community development approaches that empower people and communities, building community capacity.
- Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
- Learn from what works and build on the assets of all ICS partners – networks, relationships and activity in local places - to maximise the impact of involvement.

Read more about our approach to working with people and communities.

As set out within our Integrated Care Strategy, we want all people of all ages who live and work in Somerset to live healthy and fulfilling lives. We want people to live well for longer, and for Somerset to be a fantastic place to raise families, create employment, and support one another to be the best they can be. We want communities in Somerset to be supported to create positive and sustainable futures for all people.

We work with our communities to ensure improved, person-centred care, to reduce health inequalities, to raise quality and standards in a way which is efficient and financially sustainable, and to empower people to manage their care and conditions.

We want to make use of the skills of people, groups, and organisations. We want to listen, hear, and tell your stories about your everyday lives so that we can make better decisions every day and get the big decisions right.

We want the people of Somerset to work with us to help us develop their local health and care services and have meaningful involvement in decision making, where people have a genuine opportunity to influence services and decisions.

We continue to work hard to find inclusive ways of reaching and listening to people, specifically those with poor health and the greatest needs, so we can better understand how to improve their access and experience of services and support their health and wellbeing.

We want to make use of the skills of people, groups, and organisations. We want to listen, hear, and tell your stories about your everyday lives so that we can make better decisions every day and get the big decisions right.

We will continue to work collaboratively with Healthwatch Somerset, Spark Somerset and other voluntary, community and social enterprise organisations to maximise the opportunity to reach deep into communities and influence the planning and delivery of services.

We will work to see if we are making a difference, not only by looking at facts and figures, but also asking people how well we are doing.

What actions will we take?

We will continue to ensure we have clear routes for people to get involved. We will continue to review and develop these routes for involvement as we grow as an ICS.

We will map and review our current engagement networks across the ICS to identify gaps, reduce duplication and ensure our engagement is joined up.

We have access to a wealth of existing information and feedback from patients, their families, and carers, stakeholders and the wider public. This insight data could be from national surveys, local reports and public health work. We want to establish simple mechanisms across the ICS so we can easily access this existing insight. As we consider any service change or development, we will ensure that we take account of what people have already told us.

A strong focus of this approach will be working with existing networks and forums to seek existing insights. By building on our existing relationships and networks, we want to help strengthen the voice of underrepresented groups, including young people and carers.

We will also look at what additional tools we could utilise to support this approach, including reviewing social listening platforms which could enable us to join more conversations and engage with a wider range of people.

Supporting the use of a variety of methods for gathering insight, will help to encourage a move away from a reliance on surveys to methods that promote and use existing relationships.

The outcomes we will see

Achieving effective working with people and communities will mean that we will:

- Achieve representative views and feedback from our populations and utilise them to inform our work.
- Effectively embed public involvement throughout our work to deliver services focused on the needs of local people.
- Use patient feedback to triangulate intelligence on people's experience to improve people's experience of health and care.
- Help our residents and stakeholders understand our objectives and priorities.
- Build trusted relationships with people and communities in Somerset empowering people to reduce health inequalities.

We will consistently review how we involve people and communities and assess the effectiveness of our approach. This will form the basis of continually improving our public involvement work.

We will undertake an effective formative approach to our engagement activity evaluation which will enable us to:

- Demonstrate the impact of working with people and communities.
- Learn as we develop as an ICB and ICS.

- Be held accountable.

To inform the Joint Forward Plan we have specifically taken the following action:

The engagement work for this strategy has been done with the support of voluntary organisations including Healthwatch, Spark Somerset, and health and care professionals. We are grateful for all the support.

Working alongside Healthwatch Somerset, Somerset ICS asked local people to give their views on what matters most to them, to help them shape the Health and Care Strategy and Joint Forward Plan.

An online survey was developed and promoted to patients and the wider public. In addition, Healthwatch Somerset volunteers spent time at different sites across the county reaching out to members of the public to speak to them about their views.

An independent research company were commissioned to undertake analysis of insights gathered. These insights have informed the development of this plan.

We will continue to involve the people of Somerset as part of the delivery of this plan.

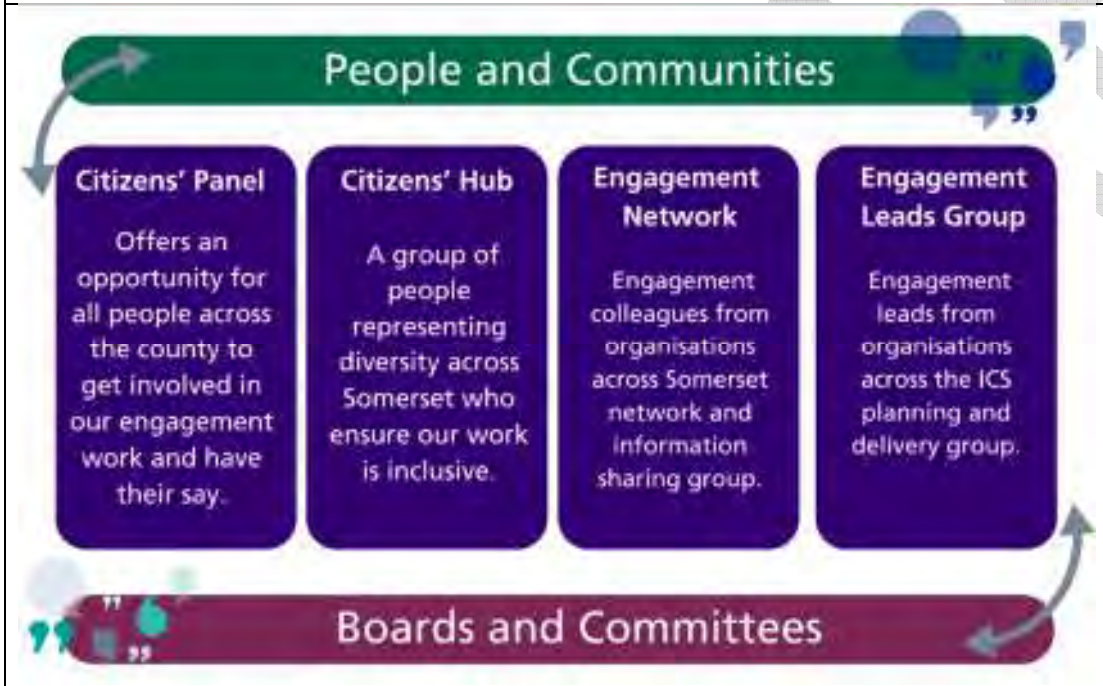
Our progress in 2023/24

Our work with people and communities in 2023/24 builds on the approach outlined in our 'working with people and communities' strategy. It has been an opportunity to refine and develop our approach as we bring the aims to life.

Refresh of our working with people and community structures

During 2023/24, we have renewed our engagement structures to ensure that they align with and help us to achieve our strategic aims. This helps to ensure that the voices of different communities are heard and we can work collaboratively to improve health and care in Somerset.

Find out more about our engagement structures and how we involve people and communities.



We continue to produce our spotlight reports for the NHS Somerset Board which highlights our activity working with people and communities and highlights key themes from our work.

We supported and led a number of engagement programmes. Examples of these can be found on our website: https://nhssomerset.nhs.uk/my-voice/our-work-with-people-and-communities/ and for more information about our work with our Citizen's Panel, please visit: Citizens' Panel - NHS Somerset ICB

Working with people and communities 2024/25

In 2024/25 we will continue to focus on building valuable relationships with our local people and communities and working together across the ICS, to make sure we continuously hear from people and work collaboratively to continue to achieve our aims.

We are currently involved in providing engagement support, planning and activity, for a range of health projects. Examples include:

- **Personalised Care –** looking to put this first and foremost, asking people about what matters to them and feeding back into commissioning teams & strategy.
- **Hypertension –** support for the Somerset "Take the Pressure Off" campaign, an initiative dedicated to raising awareness about the importance of regular blood pressure monitoring.
- **Cancer screening -** support for a project examining the decline in people, particularly women, taking part in the NHS cancer screening programmes (breast, cervical and bowel) and we want to take action to change this.

We will continue to work to ensure that our work with people and communities continues to:

- Every contact counts.
- We listen.
- We take what people have told us back to the right people and teams.

We feedback to people about how their feedback around what matters to them, and how it has made a difference to how we work and what we do. We will also be open and honest when we cannot take something forward and explain why. We continue to be committed to working closely with our colleagues and partners across the Integrated Care System (ICS) providing engagement support, advice and training for colleagues.

We also aim to develop two new key projects for 2024:

- **Somerset Research Engagement Network (REN)** – An NHS England (NHSE) & Department for Health and Social Care (DHSC) funded Integrated Care Service (ICS) collaborative project, taking place from Oct '23 to Apr '24, examining how to improve participation in health and social care research. Following the project, there will be ongoing work in Somerset, throughout the year, around the sustainability of the project's outcomes, such as continuation of networks, relationships with diverse communities, engagement conversations and activities with people & communities around research participation and opportunities in Somerset.

- **Somerset's Big Conversation –** The ambition of this engagement project is to reach as many people as possible across Somerset, ensuring we involve those facing the most health inequalities. Our aim is to hear from people across the breadth of Somerset communities, by being visible and engaging at events, groups and venues across the country, covering all four geographical areas. We aim to use a wide range of engagement tools and activities this spring and summer to ask people - *what matters to you?* We will share what we hear by presenting the feedback to our colleagues and partners and sharing what we have learnt with the public. We aim to develop our findings into 'Our Commitments' and ensure that change happens as a result of these conversations.

Over the next five years we will continue to review and refresh our approach and expand our work with local communities and focus on our place-based working, strengthen our community asset approach.

10. Duty to Patient Choice

NHS Somerset is committed to ensuring the right to patient choice is upheld and we have worked with NHS England to develop our choice plan. We regularly communicate with our GPs to remind them of ensuring all relevant choice options are selected for our patients. This is supported by the commissioning support unit who provide a GP Liaison and e-RS support service. This includes providing advice and support on where waiting times might be less for a particular service. Through the PIDMAS process, we have also been encouraging patients who are already waiting to exercise the choice to be seen elsewhere where waiting times are less.

We have published our provider accreditation process to ensure any providers who wish to provide services know how to approach us to be accredited to increase the offer for our patients.

This includes:

- Primary Care engagement to ensure patients are offered a minimum of 5 providers to choose from at the point of referral (where clinically appropriate) encourage greater patient use of eRS Manage Your Referral
- Review all Referral Management Centres, Clinical Assessment Services and Referral Assessment Services to assure compliance with patient choice requirements

- Review existing and/or develop an ICB Provider Accreditation Process for services in scope of patient choice which is publicly available
- Develop an ICB-level communications plan to support the national campaign to raise the profile of patient choice
- Ensure 100% of ICB contracted providers are registered and utilising DMAS by 31st August 2023
- Ensure 100% of ICB contracted providers confirm their SRO for DMAS/PIDMAS and share with region
- ICB to nominate DMAS/PIDMAS Lead to support on roll-out of Patient Initiated requests to move provider
- Choice Programme Governance – Confirm ICB level arrangements

11. Duty to Obtain Appropriate Advice

To ensure it can discharge its functions effectively, the Board of NHS Somerset ICB has been constituted as a Unitary Board (collective accountability) with inclusive partner representation and expertise from across the Somerset health and care system.

NHS Somerset Integrated Care Board Membership
Ordinary Members (Voting)
Chair
Chief Executive
Non-Executive Director x4 (Including Deputy Chair)
Chief Finance Officer (and Director of Performance)
Chief Medical Officer
Chief Nursing Officer (and Chief Operating Officer)
Foundation Trust Partner Member
Local Authority Partner Member (inc. Adults and Children's Social Care)
Primary Care Partner Member
Director of Public Health
Participants (Non-Voting)
Additional Executive Directors x 4 - Corporate Affairs, People, Communications and Engagement, Strategy, Digital and Integration
Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector
Healthwatch

The Somerset Health and Wellbeing Board and Integrated Care Partnership (the ICP) operate as a committee in common (known as the Somerset Board) consisting of senior representatives from key organisations, agencies and sectors that have an impact and influence upon the health and wellbeing of the Somerset population. Its purpose is to understand the needs of the population and, collaboratively, with our community, determine and agree the longer-term strategic vision for the county, pushing forward agreed priorities to improve the lives of the Somerset population and directing how the assessed health and care needs for the population of Somerset are to be met.

The ICB and ICP are underpinned by organisational and system governance arrangements with embedded clinical and professionals' leadership and decision making.

12. Duty to Promote Innovation

Peninsular Research and Innovation Strategy

Somerset ICB is a founder member of the Peninsular Research and Innovation Partnership (PRIP) which was established in July 2023. The Partner's (3 x ICBs - Somerset, Devon and Cornwall & Isles of Scilly; 2 x Universities - Plymouth and Exeter; 2 x National Institutes for Health and Care Research - Applied Research Centre (ARC) and Clinical Research Network (CRN); and Health Innovation South West) shared ambition is to create an impact from research and innovation that is greater than the sum of its parts, by working together to establish the South West peninsula as a leading research and innovation system focused on improving health in rural and coastal communities.

The PRIP strategy sets out how the partnership will strengthen the conditions for research and innovation (inputs and outputs) in the South West peninsula to increase the collective impact (outcomes and impact) of the region's research and innovation assets on the five missions. This mission-based approach to research and innovation, determined in consultation with stakeholders, will focus on a number of major population health, care and system challenges with the aim of increasing the collective impact of the region's research and innovation assets.

The five shared R&I missions focus on specific rural and coastal health and care needs of the peninsula

1. Improving the lives of people living with long term conditions, multiple conditions and frailty
2. Promoting and enabling quality care for mental health and preventing ill health
3. Immediate, compassionate and cost-effective urgent care
4. Prevent, detect and treat cancer
5. Addressing inequities in maternal and neonatal care

And will be delivered through shared governance and operating model, systems, tools, methods and research capacity, communications, partnership development and resources.

The outcomes of this work will be a project portfolio that will:

- Improve population health outcomes – delivered through a portfolio of projects for each R&I mission aligned to ICB transformation plans
- Improve health & care system productivity – delivered through a portfolio of projects for each R&I mission aligned to ICB transformation plans

And provide the following systems outcomes:

- leverage investment into R&I missions and local system capability and research capacity
- improve workforce capacity and capability through new opportunities to work on R&I projects
- improve reputation by demonstrating the ability to deliver Research and Innovation in the region and the partners
- generate learning from the R&I strategy to inform approach to ICB transformation plans
- Improve the experience for innovators with reduced friction for innovators accelerates the R&I projects and partnerships

The strategy will result in increased participation in research from public and professionals and increased number of research studies and clinical trials; improved population health and reduced health inequalities; improved health and care system productivity; Improved health and care workforce recruitment and retention; better integration of research into clinical settings and commissioning; increased investment into the region; and the spread of R&I projects and learning from our portfolio into other rural and coastal areas.

Working in partnership at the level of the peninsula, will enable us to integrate the latest evidence, innovation and improvements into our transformation plans for Somerset. We also believe that by working in a partnership approach, it will increase the likelihood that we can draw in greater additional investment into Somerset and make faster progress than might be possible otherwise.

To support this partnership working, we have appointed to a joint post between the two organisations, ensuring we have dedicated resource to integrate the Peninsular Research and Innovation Strategy into our Joint Forward Plan.

13. Duty in Respect of Research

Please see 12: Duty in respect of developing our partnership approach to delivering innovation and research.

Furthering our research capacity and capabilities

While NHS Somerset ICB is a relatively new organisation, there are firm foundations in our constituent organisations that make up Somerset ICS and a strong history of supporting, leading and delivering research activity in Somerset.

NHS Somerset has brought together professionals from partner organisations who each individually have an interest and responsibility for research, and together are committed to developing a Somerset Research Strategy. Membership forms a multi-professional group including NHS Somerset's Chief Medical Officer, Somerset NHS Foundation Trust Research Director, Associate Clinical Director for Research and Innovation, research nurses from Somerset NHS Foundation Trust, a public health consultant from Somerset Council, representation from primary care and other interested parties. Together, we are developing our strategic approach to research and innovation.

Within our partnership the organisations have and bring extensive experience. For example, Somerset NHS Foundation Trust (SFT) has a track record of successful local, national and international collaborations to support improving practice in research delivery. SFT developed a collaboration agreement to mutually deliver neurodegenerative and stroke research across the patient's pathways at different sites by all sites staff, under one agreement. This has created a flexible workforce and increased research capacity and capability to deliver research closer to patient's homes.

SFT have also collaborated with Symphony Healthcare Services on mental health projects and worked closely together to undertake collaborative reviews and feasibility for potential Covid-19 vaccine studies to be delivered in Somerset.

In 2015/16, SFT developed the first Practice Development (PD) post in the South West Peninsula. This has now expanded into a small team with scope to develop further in order to support the development of research delivery skills across the wider healthcare workforce. The PD team are able to provide quality induction programmes, coaching, mentoring for students, AHPs, nursing associates, new Principal Investigators and department of research staff requiring support, undertaking post graduate research, or extended learning programmes. The overall aim is to ensure a continuous improvement approach to enable workforce flexibility and agility in a rapidly changing research landscape, and to ensure and maintain overall standards of research delivery in practice to ensure high-quality care and excellence.

For many years SFT has hosted National Institute for Health and Care Research (NIHR) design service staff and SFT currently hosts the regional agile workforce who deliver research across primary care. It is anticipated that the agile delivery workforce will grow and develop to support research within social care as the NIHR portfolio develops.

Somerset Council in partnership with the University of West of England has established a PhD studentship and associated support programme to develop data recording and research capacity in public health.

Somerset Council has received NIHR funding for a Public Health Research Support Officer post and are currently in the process of recruiting.

Somerset Council's Public Health team provide support for Bristol University Centre Public Health Research for two PhD studentships and the Director of Public Health Is a Visiting Professor at the University for the West of England and other staff hold honorary contracts across other institutions.

14. Duty to Promote Education and Training

Education and training are a key component of our plans and are essential for the successful delivery of this Joint Forward Plan.

The People Board, reporting to the Somerset Collaboration Forum are responsible for ensuring that education and training are built into everything we do.

Somerset does not have a university within it's borders and we are working to address how we train and develop our workforce.

Workforce 2035 Scenario Planning

We have developed and implemented our scenario planning which will help us to deliver our future workforce strategy.

Somerset Academy Development

We are building our place based training offer by working with local colleges as well as the redevelopment of the Grade 2 listed old Bridgwater Hospital as a future training hub for social care and healthcare. The academy is expected to be open in 2026/27.

Education Planning

- Whole system approach to pre and post registration eduction planning. 308 nursing students have been enrolled at the University Centre Somerset on our local nursing degree programme
- Inplace Placement Capacity Management system across all learner groups. Clinical Placement Expansion Project has delivered over 80 new placement areas opened for learner placements including school, care home and VCFSE sector placements
- Expansion of in education pipelines to support the Long Term Workforce Plan

Workforce Transformation

- Expansion of the Advanced and Enhanced Practitioner roles
- New apprenticeship and degree routes to entry for registered social work with planned routes for ODP and OT

Attraction: Inclusive employers/ Socio economic regeneration

- Co-ordinated system approach to work experience and work within schools – we have established a Care Leavers Covenant partnership
- Collaborative approach to international recruitment which we are looking to expand to social care and other organisations in the ICS
- Development of a housing hub to support recruitment
- We will be targeting a system wide Sector Work-Based Academy to areas with high Core20 population or large scale redudancy e.g. Chard, Langport, Ilminster and Crekerne (CLIC), West Somerset, North Sedgemoor and West Mendip PCNs

15. Duty as to Climate Change

Sustainability

In Somerset, we have made some good progress on sustainability. We have led the way on prescribing Easyhaler®, the first certified carbon neutral inhaler. Frome Medical Practice and PCN has received a National Award for Sustainability from the Royal College of General Practitioners (RCGP) three years running and is regarded as a forerunner in primary care sustainability. SFT has developed a joint green plan setting out how they will meet national NHS targets.

The Somerset system adopted a Somerset ICS Green Plan 2022-2025 on 31 March 2022 which sets out how we will meet NHS national targets of net zero carbon emissions by 2040 for Scope 1 and 2 emissions, and by 2045 for scope 3 emissions.

The challenge of tackling the climate crisis cannot be met without substantial changes to the way every organisation operates and health services are no exception. Therefore, the ICS will need to develop low carbon, sustainable models of care. As with many elements of sustainability, there is a substantial opportunity to improve health outcomes while cutting carbon, for example through green social prescribing.

The Covid-19 crisis has demonstrated that the NHS can deliver many health services remotely. This provides the opportunity to identify which services can be effectively delivered remotely post-pandemic. Digital delivery of care presents a good opportunity to further embed sustainability across the ICS, from digital services to supply chain. In Somerset we have just launched SIDeR the Somerset Integrated Digital e-Record, a shared care record system, which gives an overview of patient health and social care information in one digital record. An integrated care system is a fundamental part of the **NHS Long Term Plan**. GP practices, acute and community hospitals, community health, mental health, hospice and social care teams could all hold important information about patient care, but this is often not immediately available to people working in other parts of the local NHS and care community. SIDeR ensures the right information is available to the right person, at the right time, enabling health and social care professionals in Somerset to see the most up-to-date information about patients for their direct care.

Somerset ICS believes that an environmentally sustainable society is a healthier society, and we will embrace the synergies between the sustainability and health agendas in everything we do.

Climate change is undoubtedly one of the biggest health challenges of the 21st Century. As the NHS represents 4% of the UK's carbon footprint, we are morally obliged to show leadership in rapidly cutting carbon emissions. However, the sustainability agenda is much more than that to us; many of the solutions to climate change also represent an opportunity to improve public health by promoting active lifestyles, improving air quality and embracing the mental health benefits of spending time in natural environments.

The NHS has suggested that where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.

The NHS has targeted two medicines with a high global warming potential (GWP), anaesthetic gases and metered dose inhalers, which between them represent 5% of the NHS-plus carbon footprint. In addition, the manufacture and supply of all medicines represents 20% of the NHS-plus carbon footprint. NHS Somerset has developed the Somerset Medicines Green Carbon Footprint Strategy which covers a wide range of greener medicine projects.

How will we know we are making a difference?

The carbon footprint of the NHS is fundamentally determined by the design of its care services. Therefore, we will factor sustainability considerations into the design of future services. As well as choosing low carbon care options, future care needs to adapt to the challenges of 'locked-in' climate change impacts, for example:

- The health impacts of excess heat and cold.
- Higher incidences of certain contagious diseases such as Dengue fever.
- Mental health issues, e.g. eco-anxiety.

We will monitor impacts through public health metrics. We will monitor medicines targets and though NHS performance indicators.

16. Addressing the Particular Needs of Children and Young People

Our vision is that Somerset children and young people grow up in a child friendly county that supports them to be happy, healthy and prepared for adulthood. Our vision will help keep our children and young people safe and be ambitious - building a county that encourages equality and diversity, protects the environment and is ambitious on climate change for future generations, and increases social mobility that in turn will build a more prosperous county. We aim to improve outcomes for all our children whilst recognising the need for outcomes to improve faster for vulnerable children and young people.

This rights- based plan centres around the rights of children and young people to expect that they will be safe, have good health and be able to learn and thrive. It focuses on eight priorities, of which we have provided some of the examples of work we are doing:

- **Early Help**
  Recruitment of 12 community champions to implement an early help system through Connect Somerset and neighbourhood working which enables children, young people and families to easily access the support they need when they need it, building on their strengths to enable them to be resilient, happy and fulfilled

- **Safeguarding from birth to adulthood**
  See statutory duty 17
  The ICB is committed to working collaboratively with our statutory, non-statutory and VCFSE partners to effectively safeguard our population. Safeguarding is the "golden thread" that runs through all our services, and we are determined to ensure we fulfil all of our statutory duties utilising a transformational approach that ensures learning is fully understood and embedded across our system.

- **All babies have the best start in life**
  We have developed enhanced antenatal and early years support package to support our most vulnerable families. Alongside, we have further increased the uptake of Healthy Start Vitamins, particularly targeting women most in need owing to their ethnic background

  We have embedded the principles of CORE20 Plus 5 to support equity of access to care for children and young people. The 5 clinical areas of focus include Asthma, diabetes, epilepsy, oral health and mental health

- **Better support for social, emotional mental health and wellbeing**
  Children and young people transformation includes programmes which support transitioning to adult services, palliative care, epilepsy, diabetes, asthma, complications of excess weight, integration

  We have improved the social, emotional wellbeing and mental health pathways for CYP with clear links to our Open Mental Health approach. There have been associated improvements in our performance against national CYPMH access rates.

- **Support for education and inclusion**
  We are planning to implement a new innovative therapeutic education offer in partnership with SFT, Somerset Council & Shaw Trust called Homes and Horizons.

- **Reduce bullying and promote positive communities**

- **Reduce poverty and homelessness**
  Pathways to independence provides youth housing for young people who are at risk of homelessness with effective mental health provision and wrap around services to promote improved outcomes for young people

- **Tackle climate and transport**
  Please see 15: Duty as to Climate Change.

17. Addressing the Particular Needs of Victims of Abuse

NB for the purposes of this plan safeguarding includes but is not limited to: Safeguarding Children, Safeguarding Adults, Children Looked After, Care Leavers, Domestic Abuse, Prevent, Exploitation, Sexual Safety, Serious Violence, Anti-Social Behaviour, Mental Capacity, and Deprivation of Liberty

AIMS	OBJECTIVES	PROGRAMMES OF WORK
Somerset ICS will ensure all statutory duties relating to adults and children will be discharged	• Ensure that statutory safeguarding functions receives sufficient focus in the ICS so that it is clearly identifiable within the ICS geographical footprint and accountability structure. • Ensure there is appropriate delegated authority for safeguarding at strategic, tactical and operational levels across the ICS. • Ensure all staff are aware of their statutory and contractual duties and responsibilities to safeguard individuals. • Ensure all staff access comprehensive training on issues relevant to the support and safeguarding of victims of abuse, which include addressing the health inequalities they face. • Ensure all providers of NHS care, public health and social care are working effectively together to safeguard individuals including addressing the particular needs of victims of abuse.	Regional and National Safeguarding Boards, Forums, Networks, and Clinical Reference Groups. The ICS Safeguarding Strategic Steering Group's programmes of strategic, tactical and operational work includes actions to address the strategic aims and objectives in the following areas: • Safeguarding across the lifespan • System Learning • System Reform and Service Development • Statutory Safeguarding • Workforce The ICS will work with partner agencies in addressing the priorities of local and regional safeguarding boards and partnerships. Somerset ICS Governance Arrangements.
Somerset ICS will discharge their duty to address the particular needs of victims of abuse, (including domestic abuse, honour-based abuse, sexual abuse, assault, exploitation and coercion) and the multiple health inequalities they face.	• The ICS will further improve the effectiveness of the multi-agency approach to support victims, tackle perpetrators and prevent domestic abuse in accordance with the requirements of the Domestic Abuse Act 2021 • The ICS, as Specified Authorities, will work with Relevant and Specified Authorities to collaborate on a multi-agency approach to prevent and reduce serious violence	Local, regional and National Safeguarding Boards, Partnerships, Forums, Networks, and Clinical Reference Groups. The ICS Safeguarding Strategic Steering Group's programmes of work includes strategic, tactical and operational actions to address the strategic aims and objectives of the ICS and to ensure

	• The ICS will work with partners to ensure the continued effective implementation of the Mental Capacity Act, including Deprivation of Liberty Safeguards and the Court of Protection • Develop and analyse a suite of safeguarding quality data that clearly demonstrates how the needs of vulnerable victims of abuse have been met and reflects system intelligence. • Ensure the ICS and its partners hear and understand the lived experience of victims of abuse, including staff. • Secure continuous improvement in identifying and embedding learning from statutory and local reviews, incidents, risks, and complaints across the ICS. • Ensure the ICS, through the Safer Somerset Partnership, effectively use new powers to tackle anti-social behaviour through the Anti-social Behaviour, Crime and Policing Act 2014 • Ensure the ICB is compliant with all elements of the NHS Sexual Safety Charter by 1st July 2024	partners are focused on their own and each other's safeguarding risks. The ICS will work with partner agencies in addressing the priorities of the local and regional safeguarding boards and partnerships. Somerset ICS Governance Arrangements Ensure the ICB and ICS are compliant with the broad themes of the NHS Sexual Safety Charter, for both their own workforces and the population they serve.
As part of its commissioning function the ICS will ensure safeguarding is embedded across the Somerset Health and Social Care economy	• Ensure services are appropriately commissioned and developed to specifically address the needs of victims of abuse within existing funding allocation. • Ensure services are appropriately commissioned and developed which focus on early intervention and prevention. • Incorporate more sustainable and efficient use of safeguarding resources within the ICS.	Regional Quality Assurance network. Somerset ICS Governance Arrangements. The ICS Safeguarding Strategic Steering Group's programmes of work includes strategic, tactical and operational actions to address the strategic aims and objectives of the ICS.
		Safeguarding schedules within NHS contracts. The ICB will continue to hold all parts of its organisation to account ensuring safeguarding is considered in all ICB workstreams. Assurance

		will be sought at the ICB Safeguarding Assurance Meeting

Appendix 3 - Glossary and Abbreviations

Term / Abbreviation	Definition
A&E	Accident and Emergency department (interchangeable with ED)
ACP	Advanced Clinical Practitioner
AI	Artificial Intelligence
ARRS	Additional Roles Reimbursement Scheme
ARF	Accelerating Reform Fund
ARI	Acute Respiratory Infections
ARMS	At Risk Mental State
ASC	Adult Social Care
AT	Assistive Technology
BAU	Business As Usual
BCF	Better Care Fund
CAS	Clinical Assessment Service
CCU	Coronary Care Unit
CESR	Certificate of Eligibility for Specialist Registration
CESS	Children's Epilepsy Surgery Service
CETR	Care (Education) and Treatment Review
CFS	Chronic Fatigue Syndrome - ME
CHC	Continuing Health Care
CHSW	Childrens Hospice South West
CLD	Criteria Led Discharge
CLIC	Chard, Ilminster and Langport Primary Care Network
COPD	Chronic Obstructive Pulmonary Disease
COVID	Coronavirus Disease
CPD	Continuous Professional Development
CT	Computerised Tomography
CVD	Cardiovascular Disease
CYP	Children and Young People
DCC	Direct Clinical Care
DDaT	Digital Data and Technology
DfE	Department for Education
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
ECH	Extra Care Housing
ED	Emergency Department (interchangeable with A&E)

Term / Abbreviation	Definition
EHCH	Enhanced Health in Care Homes
EHCP's	Education and Health Care Plans
EHR	Electronic Health Record
EIA	Equalities Impact Assessment
ESD	Early Supported Discharge
FCP's	First Contact Practitioners
FNC	Funded Nursing Care
GIRFT	Getting It Right First-Time programme
GP	General Practitioner
HCL	Hybrid Closed Loops
HEAT	Health Equity Assessment Tool
HEE	Health Education England
HEI	Higher Education Institutiion
HUC	Herts Urgent Care
HVLC	High Volume Low Complexity
ICB	Integrated Care Board
ICS	Integrated Care System
IETS	Initial Education and Training Standards
IHG	Inequalities in Healthcare Group
IMD	Index of Multiple Deprivation
INT	Integrated Neighbourhood Team
IVDU	Intravenous Drug Users
LD	Learning Disability
LDA	Learning Disability and Autism
LoS	Length of Stay
LPS	Liberty Protection Safeguards
LTC	Long Term Conditions
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
ME	Myalgic Encephalomyelitis also known as Chronic Fatigue Syndrome
MH	Mental Health
MHSDS	Mental Health Services Data Set
MIU	Minor Injury Unit
MPH	Musgrove Park Hospital
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal

Term / Abbreviation	Definition
NEWS 2	National Early Warning Score
NEWTT	Newborn Early Warning Trigger and Track
NHS	National Health Service
NHSE	NHS England (merged with NHSI 01/07/22)
NICE	National Institute for Health and Care Excellence
OD	Organisational Development
ONS	Office for National Statistics
OOH	Out Of Hours
OT	Occupational Therapist
PA	Programmed Activities
PAU	Paediatric Assessment Unit
PCN	Primary Care Network
PCSP	Personalised Care Support Planning
PHB	Personal Health Budget
PMB	Post Menopausal Bleed
RTT	Referral to Treatment
SASP	Somerset Activity and Sports Partnership
SDEC	Same Day Emergency Care
SDUC	Same Day Urgent Care
SDWS	Somerset Dementia Wellbeing Service
SEND	Special Educational Needs and Disabilities
SFT	Somerset NHS Foundation Trust
SIDeR	Somerset Integrated Digital e-Record
SLT	Speech and Language Therapy/Therapist
SMI	Serious Mental Illness
SPL	Somerset Primary Link
SRO	Senior Responsible Officer
STOC	Somerset Transformation of Outpatient Care
SWASFT	South Western Ambulance Service NHS Foundation Trust
TEP	Treatment Escalation Plan
UCR	Urgent Community Response
UTC	Urgent Treatment Centre
VCFSE	Voluntary, Community, Faith and Social Enterprise
YDH	Yeovil District Hospital

Key term	Definition/Description
Additional Roles Reimbursement Scheme (ARRS)	The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 as a key part of the government's manifesto commitment to improve access to general practice. The aim of the scheme is to support the recruitment of 26,000 additional staff into general practice.
Advanced Clinical Practitioner (ACP)	Advanced Clinical Practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients. (As per Health Education England HEE definition)
Armed Forces Covenant	The Armed forces Covenant is a promise by the Nation that those who serve or have served and their families are treated fairly. The Armed Forces Covenant is a part of the NHS Constitution. In relation to healthcare the Covenant states that the Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live and that Veterans should receive priority treatment where it relates to a condition that results from their service in the Armed Forces, subject to clinical need.
Artificial Intelligence (AI)	Artificial Intelligence (AI) is the use of a non-human software package to interpret brain imaging, even if the imaging is also subsequently interpreted by a radiologist.
BLISS	Bliss is a UK-based charity for infants. Bliss supports the families of babies in neonatal care and works with health professionals to provide training and improve care for babies.
BRAVE AI	A risk assessment tool that helps health professionals identify individuals who are at risk of going to hospital next year but who may otherwise go under the radar. The tool works by using clever computer algorithms (machine learning AI) to look for patterns in registered patients' records, the technology assesses an individual's risk of unplanned hospital admission in the next year. Those individuals identified can then be invited to take part in a holistic assessment so that local, integrated neighbourhood teams of health and care professionals (nurses, pharmacists, therapists, health coaches, social prescribers, and doctors) can work together to develop a personalised care and support plan, based on what matters to the individual.
Call before you Convey	A single point of access for 111, ambulance, primary care and rapid response referrals to an emergency medicine physician for triage/remote consultation so people can be treated by skilled paramedics at home, or in the most appropriate setting outside hospital whenever it is safe to do so.
Carer	A person (commonly the patient's spouse, a close relative or friend) who provides on-going, unpaid support and personal care at home.
Commissioners	Funding bodies of NHS services.
Continuing Health Care (CHC)	Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as NHS continuing healthcare which can be provided in a variety of settings outside hospital, such as in your own home or in a care home.

Key term	Definition/Description
Core20Plus5	Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
CT angiogram	Uses a CT (computerised tomography) scanner to produce detailed images of both blood vessels and tissues in various parts of the body.
CT scan	A CT (computerised tomography) scan X-rays the body from many angles. The X-ray beams are detected by the scanner and analysed by a computer. The computer compiles the images into a picture of the body area being scanned. These images can be viewed on a monitor or reproduced as photographs.
Direct clinical care (DCC)	Refers to the time a doctor spends on direct patient contact and/or management. DCC is work directly related to preventing, diagnosing, or treating illness, including emergency work carried out during or arising from on-call work.
Deprivation of Liberty Safeguards (DoLS)	The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.
Education and Health Care Plans (EHCP's)	Where a child requires additional support that goes beyond what a school, college, or nursery can typically deliver from their own budgets or staffing then they may need an Education Health and Care Plan (EHCP). An EHC plan is a legally binding document outlining a child or teenager's special educational, health, and social care needs. The document has to list all of the child's special educational needs, provision to meet each of the needs and that provision has to be specific, detailed, and quantified. The plan names the school/setting which is to provide the provision and the plan is legally enforceable ultimately through Judicial Review.
FOREST	Enhanced Parent Pathway, now known as the FOREST team, which provides a more targeted midwifery and health visiting offer.
Funded Nursing Care (FNC)	NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.
Further Faster Programme	The work brings together clinicians and operational teams with the challenge of collectively going 'further and faster' to transform patient pathways and working to reduce unnecessary appointments and improve access and waiting times for patients.
Getting It Right First Time (GIRFT) [1]	Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.
Healthwatch	The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch organisations are a statutory service commissioned by local councils as part of the Health and Social Care Act 2012.

[1] https://gettingitrightfirsttime.co.uk/

Key term	Definition/Description
Hybrid Closed Loop (HCL)	Hybrid closed loop (HCL) technologies are the next phase of technical advancement linking continuous glucose monitoring (CGM) and insulin pump technology to provide people living with type 1 diabetes with support 24 hours a day. Sometimes referred to as an 'artificial pancreas'.
Herts Urgent Care (HUC)	A social enterprise providing NHS services who specialise in both primary care and urgent care services. HUC currently provides the Somerset NHS 111 service.
Hospital @ Home	Enabling people to receive acute care and treatments in **home** surroundings with support from a team of health and care professionals.
Liberty Protection Safeguards (LPS)	LPS (Formerly DoLS) rooted firmly within the Mental Capacity Act 2005 (MCA) and all the key principles of the MCA will be about safeguarding the rights of people who are under high levels of care and supervision, but lack the mental capacity to consent to those arrangements for their care.
Long Term Plan[2]	The NHS long Term Plan launched in January 2019. It sets out a plan for the NHS to improve patient care and health outcomes in the future.
Mental Health Services Data Set (MHSDS)	The Mental Health Services Data Set (MHSDS) is a PATIENT level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for PATIENTS who are in contact with Mental Health Services. The Mental Health Services Data Set covers Mental Health Services located in England, or located outside England but treating PATIENTS commissioned by an English Integrated Care Board, NHS England specialised commissioner or an NHS-led Provider Collaborative. As a secondary uses data set, the Mental Health Services Data Set re-uses clinical and operational data for purposes other than direct PATIENT care, and defines the data items, definitions and associated value sets to be extracted or derived from local information systems.
Multi-disciplinary	A team or service which is composed of staff from different healthcare professions with specialist skills and expertise. The members work together to ensure patients receive comprehensive, coordinated treatment.
NEWS 2	National Early Warning Score NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes
Ockenden Maternity Review	This Review has been established by NHS England in May 2022, following significant concerns raised regarding the quality and safety of maternity services at Nottingham University Hospitals NHS Trust (NUH) and concerns of local families. This review replaces a previous regionally led review after some families expressed concern and made representation to the SoS at DHSC.
One Public Estate (OPE)	One Public Estate is an established national programme delivered in partnership by the Office of Government Property (OGP) within the Cabinet Office and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners.

[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Key term	Definition/Description
Population Health Management (PHM)	Population Health Management will be a core enabler and function of integrated care systems in helping drive a data led focus on person-centred care. It can help local integrated teams to reduce health inequalities and offer targeted proactive, personalised, and preventative healthcare for every community.
Sessions	A term used to describe a junior doctor's time. One session represents half a day.
SIDeR	Somerset Integrated Digital e-Record A shared care record system, which gives an overview of patients health and social care information in one digital record. This combined information is not stored anywhere and is read-only. Only an audit trail remains once the page has been closed. This makes it easier and quicker for care professionals, to access the right information at the right time to provide patients with the right care without the need for patients to repeat their past medical information to each doctor or carer that they see and will provide more time to talk about what is important to them.
Social Prescribing	Social prescribing is a key component of Universal Personalised Care. It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. In social prescribing, local agencies such as local charities, social care and health services refer people to a social prescribing link worker. Social prescribing link workers give people time, focusing on 'what matters to me?' to coproduce a simple personalised care and support plan, and support people to take control of their health and wellbeing.
SWAG Cancer Alliance	The **Somerset, Wiltshire, Avon & Gloucestershire Cancer Alliance** is the forum to bring providers and commissioners together with patients, to co-design services to optimise pathways, ensure effective integration and address variation, and are the vehicle that leads the activity required at a local level. The Cancer Alliance puts clinical leaders across primary, secondary, and tertiary care in the driving seat for improving quality and outcomes across cancer pathways, based on shared data and metrics. Continuing to deliver the strategy and its programmes will require committed leadership, smart choices around investing to save, and a firm intent to try new approaches and test new models of care.
Telemedicine	The remote diagnosis and treatment of patients by means of telecommunications technology
Treatment Escalation Plan (TEP)	A Treatment Escalation Plan is a tool which records and communicates the personalised and realistic goals of treatment. It should reflect the values and preferences that are important to the person receiving care if their condition should deteriorate.
Trusts	In the context of the UK's National Health Service (NHS), trusts are organisational units, e.g., hospital trusts, community trusts, primary care trusts or combinations thereof. In this report it usually refers to hospitals.
Urgent Community Response (UCR)	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and hydrated.

Key term	Definition/Description
Virtual Wards (Hospital @ Home)	Virtual wards (also known as hospital at home) allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most. Just as in hospital, people on a virtual ward are cared for by a multidisciplinary team who can provide a range of tests and treatments. This could include blood tests, prescribing medication or administering fluids through an intravenous drip. Patients are reviewed daily by the clinical team and the 'ward round' may involve a home visit or take place through video technology. Many virtual wards use technology like apps, wearables and other medical devices enabling clinical staff to easily check in and monitor the person's recovery.