SOMERSET
FIVE YEAR JOINT FORWARD PLAN
2023 TO 2028

V1.6

(This version has been approved by Somerset ICB Board 29.06.23. Letter of support from Somerset ICP is pending)

SOMERSET'S FIVE YEAR JOINT FORWARD PLAN

CONTENTS

Forward

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 have these ambitions because we know that the experience of all our people is not the same. Particularly in our most disadvantaged communities, people are the least likely to receive the support they need.

Somerset health and care partners have been working together for several years to make improvements and as the Integrated Care Board approaches its first anniversary, it is an important milestone that we are now able to set out our vision and ambition for the future.

We have seen many positive changes; however, there is much more we can do collectively, as employers, volunteers and volunteer organisations, communities, and unpaid and parent carers to improve the health and wellbeing of people.

Many of the changes needed are long term, but we must start now. If we want Somerset to be the best county it can be, our ambitions need collective action. This Joint Forward Plan sets out how we will build on the 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

Somerset Health and Wellbeing Board opinion statement

Introduction

The changes to the Health and Social Care Act 2022 enables health and care organisations to improve services and outcomes through stronger joint working, and to take shared responsibility for tackling growing health inequalities within their population.

The Act also made changes to NHS organisations and established Integrated Care Boards (ICBs) as statutory NHS organisations. The Act also required ICBs and partner local authorities to form a committee, the Integrated Care Partnership (ICP).

A key accountability for the ICP is to produce an Integrated Care Strategy, setting out how the assessed needs of the local population will be met, including that from the Joint Strategic Needs Assessment (JSNAs). This includes social care, primary and secondary care, physical and mental health, and health related services across the whole population.

The Act also requires ICBs and their partner NHS trusts to develop their first 5-year joint forward plans (JFPs). In Somerset, we have agreed that our JFP will be the delivery plan for our Integrated Care Strategy and will include our local authority social care partners.

This document is our initial Joint Forward Plan, we will continue to engage with our stakeholders and people of Somerset in the development of this plan. It has been developed to meet the triple aim for ICBs as set out by NHS England. Our plan will be published by 30 June 2023 and refreshed annually.

Developing Health and Care in Somerset

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 Health and Wellbeing Board, which 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.

Improving Lives in Somerset

County Vision

We have a vision for Somerset. Over the next ten years, we want all organisations to work together as a partnership to create:

- A thriving and productive Somerset that is ambitious, confident and focused on improving people's lives
- A county of resilient, well-connected and safe and strong communities working to reduce inequalities
- A county infrastructure that supports affordable housing, economic prosperity and sustainable public services
- A county and environment where all partners, private and voluntary sector, focus on improving the health and wellbeing of all our communities

The Improving Lives strategy has four strategic priorities:

Strategic Priorities:

Priority One:	A county infrastructure that drives productivity, supports economic prosperity and sustainable public services
Priority Two:	Safe, vibrant and well-balanced communities able to enjoy and benefit from the natural environment
Priority Three:	Fairer life chances and opportunity for all
Priority Four:	Improved health and wellbeing and more people living healthy and independent lives for longer

Our Integrated Care Strategy and subsequent Joint Forward Plan seeks to deliver priority four of our county's strategic priorities.

Our Integrated Care Partnership (ICP) Vision

Our Vision

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.

Our Integrated Care Strategy

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

This Joint Forward Plan articulates the steps will be take over the next five years to achieve our ambition.

Due to recent inception of ICSs, the recent merger of Provider Trust's and Council's within the county we anticipate that our plans will grow and mature quite quickly as these new organisations become established. For that reason, we anticipate that over the next 12 months our Joint Forward Plan may alter and will certainly require renewal each year.

This JFP should be read in conjunction with the context and drivers-for-change set out in the Integrated Care Strategy.

Our approach to working together in Somerset Integrated Care System (ICS)

Our overriding principle in Somerset is to work as one system, putting collaboration at the heart of all we do. This means that we commit to work as one health and care system, taking a single approach to strategy, planning, workforce and finance.

We are committed to improving the health and wellbeing of the people of Somerset at the heart of our approach and work together to address inequality by targeting our focus and resources towards prevention and early intervention, while ensuring the sustainability of our statutory services. We will underpin this with a wide approach to population health management and improvement.

- We will work as anchor institutions within our local economy and we commit to 'buy local, employ local and invest local' wherever possible, playing our part in workforce development and economic regeneration.

- We will make sure that the views of the people of Somerset are central within our decision making and that the voice of Somerset and the South West is strong nationally.

- We will enable partners across Somerset ICS to work as a single system; guided by our principles of working together where all partners commit to do things once.

- Professional and clinical leadership is vitally important to us. We will ensure that strong professional and clinical involvement is included in all levels of our ICS.

Our governance and obtaining advice

To ensure it can discharge its functions effectively, the Board of NHS Somerset ICB has been constituted as a Unitary Board with inclusive partner representation and expertise from across the Somerset health and care system including; strong clinical leadership, primary care, the voluntary sector and the system's Director of Public Health.

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

The Somerset Health and Wellbeing Board and ICP operate as a committee in common 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 whereby clinical and professionals' leadership is embedded within all layers of decision making.

Additionally, the Somerset ICS has a Clinical and Care Professionals Cabinet to support, oversee and recommend on matters where a clinical and care professional view is required. It is a space for clinical and care leaders to engage and bring together ideas as well as influence, challenge and support decision making across the Somerset ICS to effect change and improve the lives, health, and care outcomes for the population of Somerset.

System development

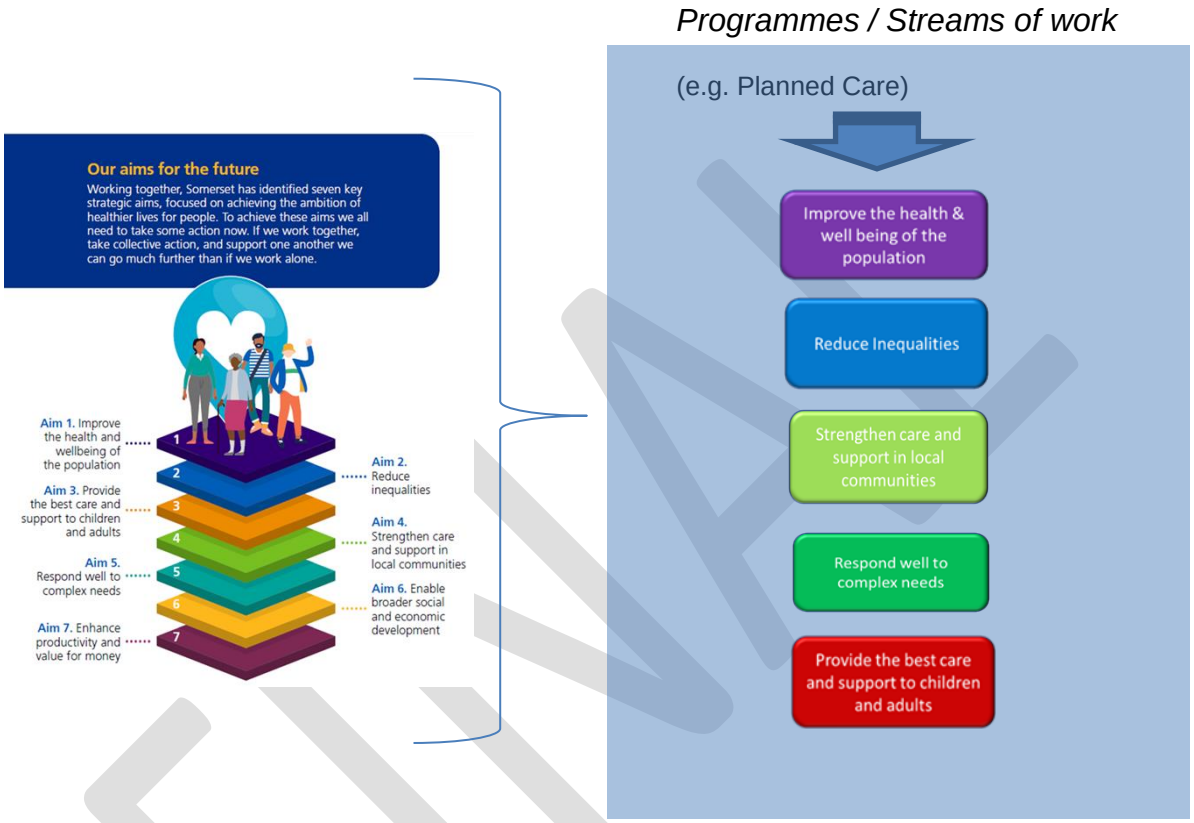
We are fortunate in Somerset that we are a relatively simple system as we have one Health and Wellbeing Board, one single tier unitary Local Authority, and one NHS Foundation Trust (following the merger between Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust).

Central to our plans is to develop a new way of working that enables Somerset ICS to unlock and develop the resource and talent that exists within our voluntary, community, faith and social enterprise (VCFSE) sector. This is central to our assets-based approach to improving health and wellbeing.

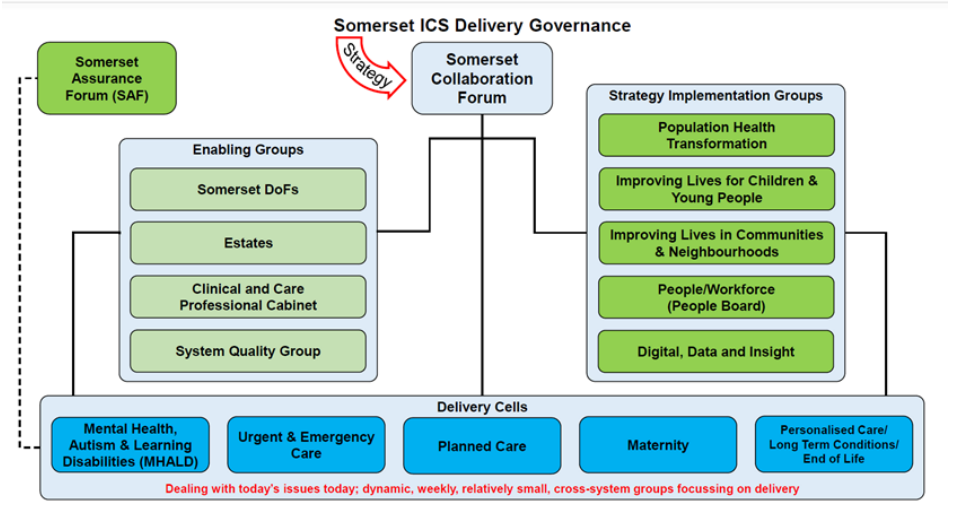
Within the ICB and the wider system we have embarked on a developmental programme to support us to work in a more integrated and effective way, with the leadership development aspect centred around the Arbinger Institute Outward Mindset approach.

How this document is structured

This remainder of this Plan sets out how the programmes of work across the ICS will deliver on the first five strategic aims set out within our Integrated Care Strategy. Each programme is sub-divided to reflect the actions that each aim. Pages 67 onwards focus on the actions we will take to enable delivery of strategic aims six and seven.



Monitoring Delivery and Review



In quarter 2 2023/24 the Somerset system will reset its governance to enable support to, and oversight of, the delivery of the Integrated Care Strategy. The agreed framework will establish Enabling and Implementation Groups to lead on key deliverables with overall coordination achieved through the Somerset Collaboration Forum.

Population Health and Addressing Health Inequalities

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 main focusses. 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.

Using comprehensive and timely population health data will be the foundation to indicate which communities we need to work with in the first instance and target resources accordingly.

In Somerset, the modifiable risk factors which drive these poor outcomes ordered in terms of impact on all causes of Disability Adjusted Life Years (DALYs) for our whole population in 2019 are shown below:

2019 Ranked risk factors for DALYs, Somerset 2019, both sexes, all ages

Rank	
1	Smoking
2	High fasting plasma glucose
3	High body-mass index
4	High systolic blood pressure
5	Alcohol use
6	High LDL cholesterol
7	Low temperature
8	Diet low in whole grains
9	Kidney dysfunction
10	Occupational carcinogens

The risk factors coloured green (2,3,4,6, and 9) are ones where early detection and treatment of conditions can improve outcomes. The risks in purple (1,5,8) indicate behaviours impacting on health where we can encourage people to adopt healthier lifestyles. Risks in grey (7, 10) represent environmental conditions where we can work to reduce population exposure.

Key risk factors generally impact on more than one of the top causes of DALYs; so, for example smoking is a risk factor for cardiovascular diseases like heart disease. Stroke and diabetes impacts on respiratory diseases like chronic obstructive pulmonary disease (COPD) and also cancers like lung cancer.

Here are some examples of work we are currently doing to address health inequalities, but we have so much further to go to create vibrant, connected, healthy and active communities.

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 through working with communities and our NHS Trust, Somerset Council and other partners though our Equality, Populational Health Management and Health Inequalities work programmes.

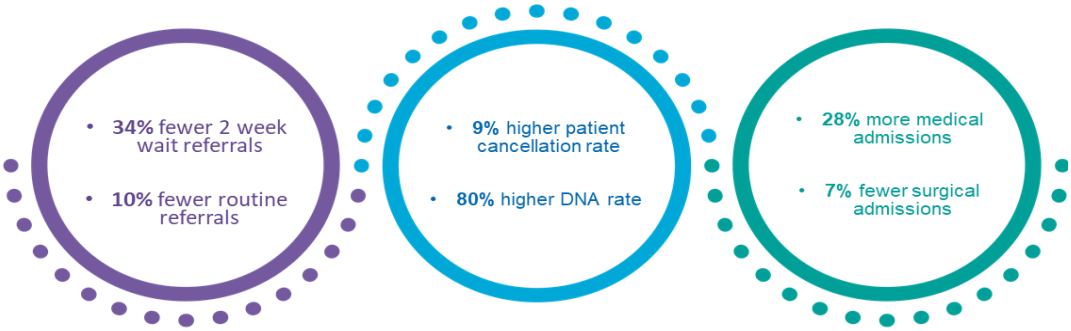
Hypertension treatment optimisation for those aged 60-79 has been identified as a system level population health priority. Work on a cardiovascular disease (CVD) data dashboard by the Somerset Council's Public Health team has enabled us to explore inequalities in outcomes and care in relation to CVD and some of the top causes of DALYs in the Somerset population. This work currently covers approximately a fifth of the Somerset population and we are working to extend this. This record level work enables us to drill from high level inequalities in risk factors to understanding inequalities in care processes which may drive these.

For example, we have been able to identify specific inequalities in records of blood pressure measurement for middle-aged males, those in non-white ethnic groups and those in Core20PLUS5 areas. This increased understanding has already been used to target interventions to promote awareness and access to blood pressure measurement. 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.

With regards to planned care recovery following Covid-19, we have built in the following criteria to prioritise patients on the waiting list for surgery/treatment:

- patients with learning disabilities;
- patients with an open mental health referral and living in one of the areas that are in top two deciles of social deprivation.

From undertaking a detailed review of our elective care activity against our Core20 population, we know:



As a system, we're committed to maintaining the offer of choice for patients in line with recent NHS England (NHSE) guidance.

Sector-Based Work Academy Programme (SWAPs)
In Somerset, we have seized upon the public's interest in the NHS during Covid-19 by creating a sector-Based Work Academy Programme (SWAPs) for health and care. SWAPs provides an entry level to clinical and non-clinical local employment opportunities at Agenda for Change Band 2 or 3 level.

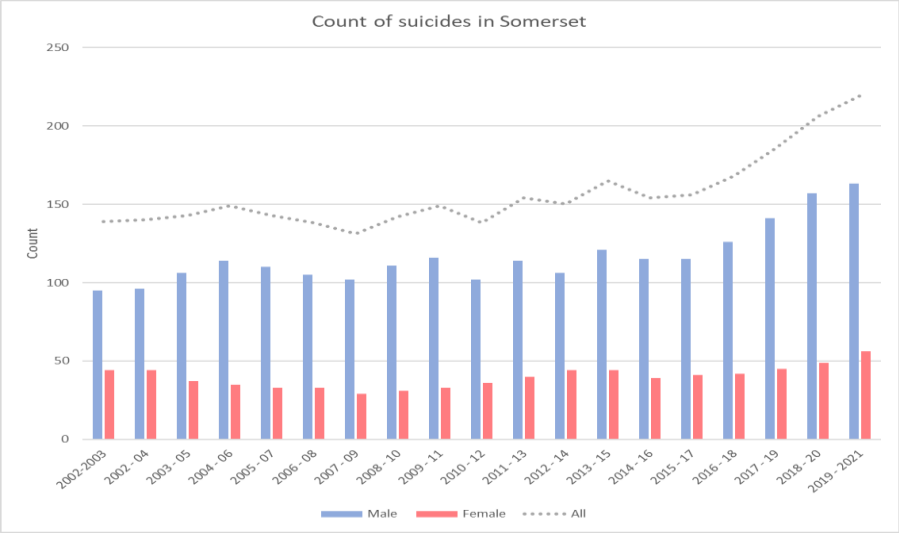
SWAPs consists of two weeks training with Weston College (virtually) and then week three takes place with Somerset NHS Foundation Trust (SFT) in Taunton. Future employees complete virtual and face-to-face training that will provide them with the foundation skills needed to enter into the NHS. Depending on future employee's interests, passions and goals, the SWAPs programme can include, but is not limited to:

- roles within Administration and Logistics;
- patient facing roles such as Health Care Assistants and Support Workers;
- roles within the Mass Vaccination Service;
- roles within our Primary Care Networks (PCNs);
- roles within our wider Health and Social Care system - such as home care in the community.

We are working with employment hubs across the county, to facilitate virtual events to promote and improve access to the SWAPs programmes for potential candidates. These include our most deprived communities. We are also running similar events for tenants within Abri Housing Association.

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.

Somerset, has seen an increase in the number of suicides each year as seen in the graph.



Between 2019 – 2021, the suicide rate in Somerset was **15.1 per 100,000**. This is higher than the national suicide rate which was **10.4 per 100,000**. Reflecting global trends, the suicide rate locally was higher in males at 22.8 per 100,000, compared to females 7.8 per 100,000 (Office for National Statistics).

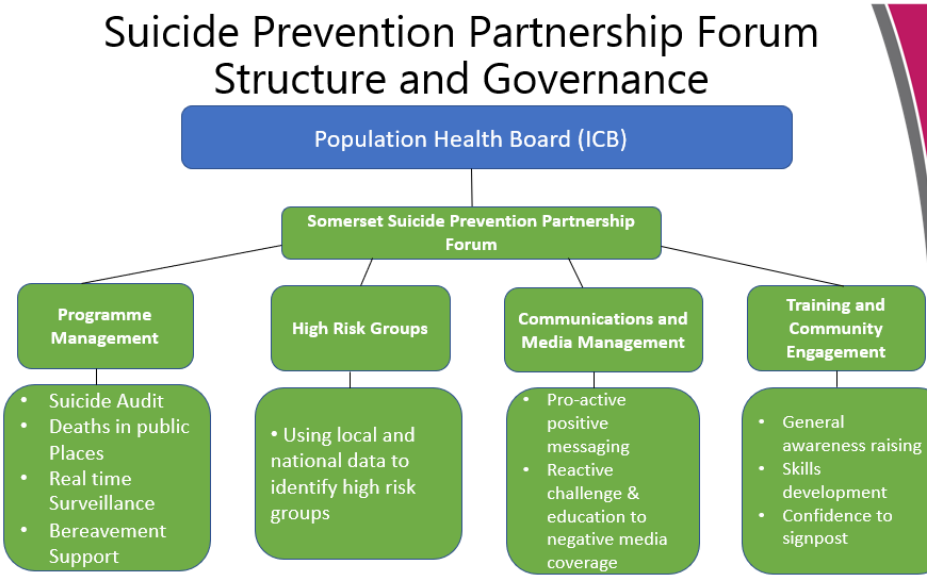
There are many factors that contribute to suicide rates, but our response in Somerset is to better understand the local factors and respond with targeted plans, initiatives, and services to help prevent as many suicides as we can.

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 approached is required to identify people at risk of suicide and support them to engage with services where necessary.

The creation of the ICS, the ICB, and the move to a Unitary Authority further provides us with the opportunity for better governance, collaboration and effectiveness.

The governance framework is set out below, with suicide prevention as a system workstream reporting into the new ICS Population Health Management Programme Board to ensure maximum exposure at an executive level across to a system level.

The multi-agency Somerset Suicide Prevention Partnership Forum manages the core workstreams of delivery that includes: 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.



Somerset Suicide Prevention Partnership Forum identified groups at high risk of suicide. This includes but is not limited to:

- Middle and older age males, especially when living alone and or with a long-term medical condition.
- People with debt and gambling issues.
- People with autism.

- People in contact with the criminal justice system.
- Displaced people.
- Agricultural workers and isolated people in rural areas.
- Bereaved people because of suicide.

Numerous targeted initiatives have been developed including:

- Stepladder a men's community engagement project.
- The delivery of training including Mental Health First Aid.
- Applied Suicide Intervention Skills Training.
- Every Life Matters Suicide Awareness courses.
- The Orange Button Community Suicide Awareness Scheme.
- The Walk for a Life event for World Suicide Prevention Day.
- Regular systemwide proactive media messaging campaigns.

A new Somerset Suicide Prevention Strategy is currently in development; however, later this summer the new National Suicide Prevention Strategy will be published. 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 the autumn.

Continuity of Carer in Maternity

Midwifery Continuity of Carer (mCoC) has been proven to deliver safer and more personalised maternity care. Whilst nationally Continuity of Care (CoC) has been temporarily paused, maternity services in Somerset are continuing to support existing CoC teams and for mCoC to be the default model of care of women from black and ethnically diverse communities.

Yeovil District Hospital (YDH) (as part of Somerset Foundation Trust) provides a team model of care (up to eight midwives), 43% of women are currently booked onto a CoC maternity pathway. Our workforce challenges have been Covid-19 isolation and sickness amongst midwives, which has limited our ability to sustain the number of midwives in each team and increase continuity of carer over the last 18 months to two years. Intrapartum care has been affected by this as two of the teams are only able to offer intrapartum continuity of carer 50% of the time in order to maintain continuity in the antenatal and postnatal periods.

Somerset NHS Foundation Trust (SFT) has merged its acute and community maternity services, with work undertaken to integrate community and hospital midwifery teams. In line with national guidance, SFT are in the process of establishing the building blocks for the successful implementation of mCoC. These building blocks involve procuring the correct estates for hub working, and future proofing the existing workforce arrangements to ensure stability of provision for intrapartum care across the region prior to the roll out of an mCoC model. The initial mCoC team deployment will mirror the areas of greatest deprivation geographically (planned team 1 for central Taunton, team 2 for central Bridgwater and team 3 for central Taunton) ensuring the right case mix for Midwives to ensure those with the greatest level of deprivation are targeted with this intervention.

Every parent and their baby in Somerset should have the opportunity to live a full and healthy life. Maternity care provides a unique window of opportunity to mitigate some of the factors that perpetuate health and social inequalities and to contribute to improvements in population health. This can be achieved through:

- early identification and intervention in cases of clinical or social concerns;
- promotion of positive health behaviour change;
- provision of the information, care and support necessary for recovery from birth; and,
- advice and support for good parenting.

We have developed a Maternity Equity Strategy that sets out how every parent accessing our maternity care should have a fair and just opportunity to have a healthy pregnancy, and a healthy baby. Where you live, what race/religion you are, what your living circumstances are should not affect how you are treated or access care.

Our aim is for a safe, personalised, physically and mentally healthy pregnancy with a safe birth, healthy parent, and baby for all. This includes parents from black, minority and ethnic communities and those from deprived communities.

Yeovil District Hospital maternity service has championed the delivery of a training programme to midwives to help understanding of implicit bias and care of babies with a variety of skin tones. This training programmed has been commended nationally and was presented at the National Maternity and Midwifery Festival. We are in the process of rolling out this training across Somerset.

We are aiming for 75% of all women/people from black and ethnically diverse backgrounds will have a continuity of carer during their pregnancy and birth.

Our refugee and homeless population

NHS Somerset has developed a proposal for sustainable GP-led refugee health checks, in line with government guidance. To further support this work Somerset Council and NHS Somerset are developing an online resource that will support practitioners with identified population need.

Somerset Council have commissioned services, including psychosocial support and emotional wellbeing interventions for adults and children.

We will work with VCFSE and local authority support services to ensure that displaced people receive a prompt, trauma-informed GP-led assessment of their health needs shortly after their arrival with timely referral to relevant health services.

Work is being done on Refugee Health Checks to develop a resource toolkit for GPs which provides information on the unique health needs of specific displaced groups (e.g. guides on Syrian, Afghan, Ukrainian health needs). Partnership work with supporting VCFSE groups is required to ensure that those who need support to register with GPs receive assistance.

We ensure the local homeless community have access to the care and support they need.

Our local homeless charity Arc supports around 200 people on any one night across Taunton, Sedgemoor and West Somerset, providing accommodation in their 15 properties. One of these properties is Lindley House, a 56-bed direct access hostel with Trust, Navigate (Navigate the Money Maze), the Department of Work and Pensions, SWISH, Forgotten Feet and a range of professional volunteers wanting to provide complementary support such as counselling.

Having access to this range of services in one easy to access location will benefit our homeless population and rough sleepers, allowing them to access services in a more flexible manner. Our homeless community will be able to receive the health care they need. This service will also enable individuals to engage and build trust with different agencies and; hopefully, gain in confidence and feel comfortable to continue accessing independently, further down the line in community settings, as people move on from Arc services.

Mortality among people experiencing homelessness is around ten times higher than the rest of the population and life expectancy is around 30 years less (NICE, 2021). Somerset is currently an outlier for the number of MRSA blood stream infections amongst our intravenous drug users.

The NHSE funded InHIP project is looking at CVD prevention and particularly improving access to novel lipid lowering therapies with a focus on inequalities for those who are homeless or insecurely housed, people in Core20 areas and those from South Asian ethnic groups who are at greater risk. This project will run to the end of 23/24.

Plans for 2023/24
Over the next 12 months we have committed to the following aspirations and expected outcomes for our population:

- Continue with our Peri-Operative Programme (a programme within our Somerset Elective Care Delivery Board) to ensure patients are fit and ready for surgery and/or treatment. An example is improvement in cardiovascular function for those waiting cardiac surgery.
- Work with primary care colleagues and communities to increase access to two-week wait pathways for our most deprived populations.
- Using our health inequalities analysis to apply composite risk factors against our planned waiting lists to prioritise patients accordingly based on a health inequalities composite risk score.
- Reaching out to areas of health inequalities with targeted communication to help reduce the cancellation rate and did not attend (DNA) rate.
- As an ICS use our ability as anchor institutions to create employment opportunities for our coastal communities.
- Working with homelessness charities, drug projects and VCFSE to support intravenous drug users (IVDU) on safer injecting methods and rehabilitation.

- Continue work on local dashboards to support population health management to understand inequalities in cardiovascular disease, learning disability, vaccination uptake and across the Core20PLUS5 clinical focus areas for adults, children and young people.

As an ICS we have committed to reducing health inequalities as a principal aim. 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 voice of our local communities is heard through our co-design approach and our Primary Care Network (PCN) health inequalities leads.

The Core20Plus5 programme has been adopted throughout Somerset ICS. A priority for us in Somerset is addressing the needs of coastal communities, which are in the 30% most deprived in the county.

Somerset is a Core20PLUS5 Accelerator site which will improve the health and wellbeing for people living with COPD in one of our most deprived communities in Somerset. This is a collaboration with the VCFSE sector, and we are learning how using a community approach, via community connectors, can reach out to people in a different way to improve health outcomes. This model will be extended to prevention schemes and to other groups living with a health condition.

Across Somerset, we have an agreed principle to work to address health inequalities at system level/place level and neighbourhood level. All system and neighbourhood level strategies will have arrangements for reporting of system level quality indicators across all age and all clinical pathways with the expectation that complementary place and neighbourhood level quality metrics will also inform service improvement.

Improving Quality of Services

As an ISC 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 Somerset Health and Wellbeing Board, the ICS Provider Board, the ICB Board and ICB Patient Safety and Quality Committee provides an escalation route for all systems risks. Any system risks are escalated to our Somerset System Quality Group.

The NHS Somerset ICB Patient Safety and 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 improvement. This information is available in the public domain.

The NHS Somerset Chief Nursing Officer chairs the Somerset Quality System Group and will ensure 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 to together to work together on a system-wide quality improvement project.

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), system 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 and factored into all commissioning and contracting quality outcome metrics.

Safeguarding

Our statutory duties
When we refer to safeguarding we refer to our statutory duties to the following areas: safeguarding children, safeguarding adults, children looked after, care leavers, domestic abuse, prevent, exploitation, serious violence, mental capacity, deprivation of liberty and liberty protection safeguards.

Somerset ICS will ensure all statutory duties relating to adults and children will be discharged. We will:

- 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.

To do this we have 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.

Somerset ICS will also work with partner agencies in addressing the priorities of local and regional safeguarding boards and partnerships.

We will discharge our 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.

Victims of Abuse

Somerset ICS will discharge our 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. We 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.
- Work with Relevant and Specified Authorities to collaborate on a multi-agency approach to prevent and reduce serious violence.
- Work with partners to ensure the effective implementation of the statutory requirements of the Liberty Protection Safeguards.
- 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.

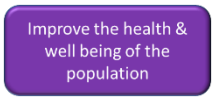
Commissioning services

As part of our commissioning function we will ensure safeguarding is embedded across the Somerset health and care economy. We will:

- 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.

We have a regional Quality Assurance network and local Somerset ICS governance arrangements in place and we have safeguarding schedules within NHS contracts.

Adult Social Care



We are proud of the work we have already done to support people to live well and more independently. This work includes:

- Somerset's Independent Living Centres in Wellington and Shepton Mallet where people can talk to our social care Occupational Therapy led teams and try out equipment and technology to make daily living easier.
- The launch of a new Community Equipment and Wheelchair Service to help people live more independently.
- Our continued commitment to ensuring unpaid carers are enabled to access free support and information, including through dedicated Village Agent support.

Prevention in social care is about encouraging people to be more proactive about their health and wellbeing. We recognise the need to make prevention and early intervention a strong element of our model of support and of care pathways as part of a decisive and shared focus towards improving population health.

What Actions will we take?

- 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.
- 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).

- 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.
- We will ensure unpaid carers are valued, recognised and supported to provide care in a way that supports their own health and wellbeing.
- 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.

What outcomes will we see?
We will see improved levels of satisfaction within the survey of adult carers in England dataset: e.g. % extremely or very satisfied with support/services received; % who felt they have as much social contact as they want; % who feel they have encouragement and support.

Despite the challenges facing the health and care system over recent years, we are proud of the work we have progressed in relation to ensuring we provide the right support, in the right place, at the right time, which includes:

- The focus and approach of our 'award-winning front door' (Somerset Direct), which helps people find solutions to their problems through strengths-based conversations and has demonstrated its impact in terms of the delivery of good outcomes and diversions away from formal/statutory care services where there are suitable alternatives to be found locally.
- The positive working relationships we've fostered with our care provider market and the system-wide efforts made to support the independent care sector through the pandemic and with their quality and sustainability.
- Our work undertaken to enable more people to benefit from direct payments, offering greater flexibility, choice and control of their care and support arrangements.
- Our hospital discharge pathways and intermediate care approach, enabling high proportions of people aged 65 and over to return home with no formal/statutory support.

Our commitment to 'Making Safeguarding Personal', ensuring we have conversations with people in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

What actions will we take?
- 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.

- 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.
- 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.
- We will continue to focus on preventing abuse and neglect and identifying risk early, ensuring adults at risk are supported to feel safe.

What outcomes will we see?

- Number of people supported by Direct Payments/accessing home care.
- % of active social care settings rated 'Good' or 'Outstanding' by the CQC.
- Reduction in levels of unmet need (homecare packages we have not been able to source in a timely fashion) and care package contract handbacks.
- Reduction in overdue care act assessments and reviews.
- Intermediate care data/pathway data.
- % of individuals for whom the safeguarding risk was reduced or removed following a Safeguarding Adults enquiry/intervention.
- % of stakeholders who rate service received from Adult Social Care as 'Good' or 'Excellent' (feedback forms).

Strengthen care and support in local communities

We are proud of the work we have progressed to date in relation to strengthening care and support in local communities which includes:

- Our investment in our Somerset Community Connect approach, focused on improving people's independence and improving people's lives by working with our communities, harnessing the skills and expertise of a wide range of organisations and volunteers.
- The work of Somerset's Community Connectors (Community and Village Agents) providing practical, community-based solutions for people across the county.
- Talking Cafes, which serve as important hubs in our communities for people to access information, advice and support.
- Our nationally recognised, award-winning micro-provider networks offering help and support for local people.

What actions will we take?

- 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.

- 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.
- 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.
- 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).

What outcomes will we see?

- Effective diversion (information, advice, guidance and signposting) away from statutory social care services (Somerset Direct).
- CCS data – talking cafes, village agents etc.
- Fewer acute discharges to community hospitals and interim beds.
- Fewer unnecessary days in an acute/community/intermediate care bed.

We are proud of the work we have done over recent years to ensure equal priority is given to physical and mental health which includes our ongoing work with partners to design the new Somerset Dementia Wellbeing model.

Also, the Somerset's Mental Health Alliance - developing and delivering new ways to enhance care in the local mental health system and already successful in helping remove many of the barriers to support and thresholds for treatment.

What actions will we take?

- 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).
- 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).
- 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.
- 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.

What outcomes will we see?
We want people's happiness, aspirations and achievements are never limited due to a disability of a mental health need.

We will work to ensure people with care and support needs, including those with learning disabilities or mental ill health, are better able to use mainstream routes to access housing options, giving them control over where they live, who they live with and how they are supported.

What actions will we take?

- 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.
- 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.
- 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.

What outcomes will we see?
We know we will have made a difference when people are able to tell us what good looks like for them and help design the support. We will also see a shifting of demand from costlier hospital/out of area care to community-based services.

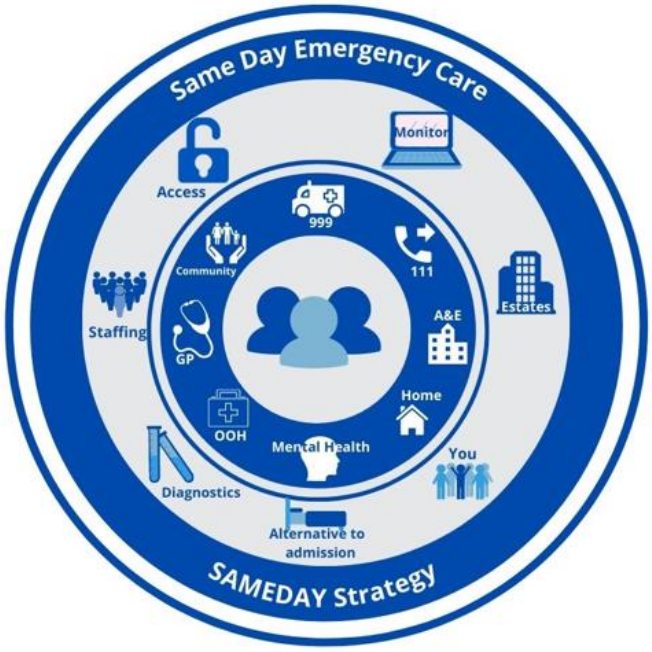
Urgent and emergency care

Same day emergency care (SDEC)
Same Day Emergency Care (SDEC) allows specialists, where possible, to care for patients within the same day of arrival as an alternative to hospital admission; removing delays for patients requiring further investigation and/or treatment. A further benefit of SDEC is in improving in-hospital flow including through supporting safe discharge earlier than previously planned for patients where clinically appropriate.

SDEC services already exist within Somerset at both Musgrove Park Hospital and Yeovil District Hospital. The local ambition is to:

- optimise the resource to enhance patient care;
- provide an alternative to Emergency Department (ED);
- avoid admissions; and,

- maximise direct referral routes from a range of healthcare professionals including paramedics as an alternative to ED.



We want to ensure that:

- Staffing must be safe and sustainable.
- Access to SDEC should be available across all parts of the healthcare system including 111, 999, primary care, community care and mental health so that patients are navigated to the right service, first time. Delivery should build on a whole-system response to improving patient flow.
- Monitoring and evaluation of activity should be counted and reported consistently to understand how to continually improve services to patients.
- Maximising physical space alongside virtual resources will ensure that patients can access SDEC services in and out of hospital across primary, community, mental health and secondary care.
- Diagnostics and testing capacity to support early review by senior decision makers, equipped with the necessary skills and diagnostic support, to effectively assess, treat and enable rapid assessment of patients.
- Alternative to admission (and support early discharge) where clinically appropriate. SDEC should be used to support patients to be discharged to their usual place of residence on the same day.
- Compassionate leadership to change the culture that enables health and social care to be delivered flexibly, supportively and inclusively across healthcare boundaries.
- SDEC aims to provide patients who require emergency care with a good experience of care in a healthcare setting appropriate for their needs.
- For SDEC to be delivered in a safe and effective way avoiding the need to attend ED.

- By utilising SDEC to its full potential enabling better patient flow within ED, thereby improving patient experience for those high acuity patients who do require such levels of care.
- By improving patient flow within ED, this will in turn support quicker ambulance/hospital handover delays, the impact of which will support ambulance response times to those patients in the community requiring 999 support.
- By ensuring access to SDEC via a range of referral/direct booking routes (including NHS 111 and 999 and primary care via Somerset Primary Link) reducing unnecessary clinical touchpoints within a patient's pathway.
- Seek to integrate SDEC with Virtual Wards and community services.

What actions will we take?

- Improve data recording in line with Emergency Care Data Set (ECDS).
- Support and protect ongoing SDEC provision particularly at times when other urgent and emergency care (UEC) services are under pressure.
- Work with SDEC and speciality clinicians to accept a wide range of referrals thereby reducing the number of clinical touchpoints required in a patient's journey, through the development of coordinated and effective patient pathways.
- Seek to consider and promote other services that follow the SDEC ethos though is provided outside of the physical SDEC clinic space.
- Optimise the Directory of Services (DoS) to support services to refer (including via direct booking capability) into SDEC services.

What outcomes will we see?

- Increased number of patients seen on the same day for emergency care.
- Patients are seen in the right place, first time.
- Patients report receiving a good experience of care.
- Reduced zero length of stay at acute trusts.
- Improved data reporting as SDEC activity links into the ECDS.
- Increased levels of referrals direct to SDEC from a range of health and care services across the system including NHS 111 and 999 as well as primary care.

Same day urgent care (SDUC)

Same Day Urgent Care (SDUC) is where there is an actual or perceived need for a person to seek same day medical/nursing or other health related care and attention for a health complaint. This includes physical injury and illnesses or mental health concerns.

There are a large number of different settings of care and services that can and do support same day urgent needs in Somerset. These include General Practice (GP), Minor Injury Units (MIU), Pharmacies, Optometrists, Urgent Community Response (UCR), ED, 111 (online and telephone services), out of hours GP services, the tele/virtual Clinical Assessment service (CAS), Open Mental Health Services, Crisis Safe Space as well as the 999-ambulance service.

With increasing pressures across health services, we need to ensure that patients are directed to or are accessing the services most suited to meet their needs, protecting ED for the highest acuity patients, and making sure that those with long-term, complex needs with urgent symptoms have access to GPs when they need it. A key focus of the Same Day Urgent Care Strategy will be to ensure that these services are offered as part of an easy-to-understand cohesive whole that is effectively communicated to the population of Somerset.

The SDUC strategy will build on present local Somerset services models as well as a number of national initiatives including, Urgent Treatment Centres (UTC), ED front door streaming, Community Pharmacy Consultation services (CPCS), Urgent Community response services (UCR) and the development of Primary Care Networks (PCN).

The NHS Long Term Plan, published in January 2019, set out the specific challenges relating to urgent and emergency care, and cited complex systems and confusion as one of the reasons people default to ED. To increase standardisation and reduce confusion, a national model for UTCs was developed in 2017 (Urgent Treatment Centres Principles and standards).

This was updated in the Summer of 2022 with an aim to increase the commonality of services across England with a standard UTC offer as well as reduce minor injuries and ailments traffic to A&E using Co-located UTCs as ED front doors. As a system we will work towards ensuring that patients are able to access the correct level of same day urgent care to meet their needs as close to home as possible.

When considering how best to implement the UTC model in Somerset, the system identified a need to look at the wider context of same day urgent care, especially as Somerset has a large number of differing same day services, as well having the benefit of seven well used and supported MIUs that closely align with the national UTC specification, spread across a large rural county. The analysis underpinning this strategy highlights the importance of our MIUs (and future UTCs). They are:

- Used and appreciated by the Somerset population, with over 105,000 episodes of care completed across them in 2018/19 and 2021/22 (Covid-19 restrictions created an artifice in 2020/21 activity).
- Good value for money (average around £35 per episode) compared to ED (£73 - £106 per attendance based on national tariff) and the Primary Care Minor Injury Local Enhanced Service (LES) (£156 per episode).
- Provide Care closer to home supporting 7 of Somerset's 13 neighbourhood areas (public engagement activities between 2017 and 2022 have shown the Somerset population consider urgent care services within their neighbourhoods to be a key priority.
- Our MIUs also cover a large geographical area with little by way of alternative provision within a reasonable travel time.

Somerset also needs to consider local SDUC/Minor Injury and Ailment services for those neighbourhoods, towns or rural communities not supported by access to an MIU, future UTC or A&E; as well as developing more focused and integrated local

primary care leadership in SDUC (Next Steps in Integrated Primary Care, Dr C Fuller 2022) by:

- **Streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it.**
- **Providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to**,** those with multiple long-term conditions.
- **Helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

Somerset ICS will ensure its SDUC and Primary Care strategies are aligned and delivering:

- An enhanced GP minor injuries service for neighbourhoods not directly supported by any MIUs or planned UTCs.
- Support to PCNs to develop same day care hubs and integrate with wider SDUC service offers.
- Support PCNs to deliver effective integrated anticipatory care to reduce complex same day urgent care demands.
- Expansion and development of the Community Pharmacy Consultation service (CPCS), which will ensure the Somerset population can book a same day appointment at a local pharmacy via 111 and their GP practice for treatment of some minor Injuries and ailments.
- Expansion and development of the Acute Community Eye Service (ACES), which will ensure the Somerset population can book a same day appointment at a local optometrist for the treatment of eye related minor Injuries and ailments.
- Crisis Safe Space Centres. Seven centres across Somerset providing direct bookable out of hours place based support for people with same day mental health needs.
- Mental health home treatment teams across four locations providing a 24/7 service.
- Development of co-located UTCs to manage the ED front door and support moving activity to more appropriate levels of same day services.
- 111 first and the use of 111 to book appointments in all same day services.

As well as ensuring high-quality local SDUC services developed at the neighbourhood level, equity and access will be supported by NHS Somerset maintaining and developing a number of countywide same day services including:

- The Somerset Integrated Urgent Care Service (as per the NHSE 2017 specification), this includes 111 online and via phone, the out of hours service and 24/7 clinical assessment service.
- The Urgent Community Response Service (UCR), providing a 2-hour response for older people and those with complex needs requiring urgent care in their own home, including access to physiotherapy and occupational

therapy, medication prescribing and reviews, and help with staying well-fed and hydrated (NHSE 2022/23 Community health service two-hour urgent response standards).
- Somerset Open Mental health phone line 24/7 mental health support and triage, provided by Somerset Mind.
- Shout, mental health 24/7 text support for individuals struggling to pick up the phone.

What actions will we take?
We will need to cost out the new model to see if additional investment in SDUC is required, supporting the development of UTCs as well as the development of greater integration at PCN and neighbourhood level. This will all be placed within a context of limited finances and workforce constraints. We need to look at how services are currently being used to ensure we are designing a system that was fit for purpose for the future needs of the population whilst delivering the core aim of simplification and reducing confusion.

Somerset faces significant workforce pressures with a lack of staff in specific staffing groups that support SDUC services such General Practitioners, Emergency Nurse Practitioners, Advanced Nurse Practitioners as well as other advanced practitioner groups such as Radiographers, Physiotherapists, and Paramedics. NHS Somerset will be developing a Same Day workforce strategy across the totality of provision. Staffing concerns have led to temporary closures of several MIUs between 2019 and 2022 as well as temporary closures of GP lists and a need for new ways of working in primary care.

One response to this has been to look at new roles that support service delivery e.g. First Contact Practitioner Physiotherapists or Advanced Practice Physiotherapists, which has had significant benefit to the system, and we need to ensure that we have the flexibility to innovate and build a more sustainable workforce. To support this NHS Somerset will work with providers to develop a sustainable SDUC workforce plan to work alongside this strategy, including:

- Development of a SDUC workforce stocktake, allowing the system to see what its present SDUC talent pool looks like.
- Mapping of SDUC workforce requirements needed in the short to long term (Medical, Nursing, and allied healthcare professionals). To understand its immediate deficits in its SDUC workforce talent pool as well as future deficits.
- Development of agreed Somerset-wide training pipeline for Advance Practitioners, Advanced Nurse Practitioners and Emergency Nurse Practitioners to ensure the Somerset workforce for these key roles is self-sustaining in the longer term (3-5 years). This will be based on the findings of the mapping and stocktake.
- Develop an innovative national campaign to attract talent into the county to support short- and medium-term goals (1-3 years).

As an immediate measure to alleviate workforce pressure as well as increase productivity and workforce satisfaction Somerset ICS will:

- Use the SDUC talent pool skills to our best advantage, with clinicians able to practice at the top of their licence.
- Workforce limitations mean that the provision of a resilient, walk in, accessible seven-day service is not necessarily achievable via the present model in all areas and localities and so we may well need to consider whether to manage demand and resources using a model focused booked and heralded same day services in some areas.

Our response to our analysis has been to support our local neighbourhoods to design a SDUC vision which will meet the needs of the neighbourhood populations by:

- Optimising clinical care.
- Reduced confusion: ensure clarity of same day and primary care services, with clear communication, access routes and pathways between services.
- Improved service offer: ensure patients have access to all levels of service offer.
- Improved patient flow into appropriate services for their needs.
- Improved consistency of provision in line with expected standards (via standardised clinical competencies).
- Consistent and fail-safe access protocols where required e.g. referral and reporting process for x-ray that is off site.

The models that underpin this vision are still evolving with the analysis within the SDUC strategy informing their development. This will be linked with an ongoing patient engagement programme.

What outcomes will we see?
The following objectives were developed at the outset of the SDUC strategy development process:

- Identify the population need for same day urgent care services now and over the next five years.
- Identify the current configuration and use of same day urgent care services and the influencing factors.
- Set out a vision for the future configuration and use of same day urgent care services including the role of emerging primary care models, integrated urgent care and UTCs that best meet the needs of the population.
- Work with neighbourhoods to identify local SDUC needs.
- Identify a range of potential options for the future of UTCs, MIUs and primary care led minor injuries services in Somerset.
- Demonstrate how we intend to meet the NHSE/I 2017/2022 UTC principles and standards, with a plan in place by 2024 for co-located UTCs in Somerset.
- UTC delivery and the changes to MIUs that are not being developed to meet the UTC specification.
- Set out an outline implementation plan for delivery of the SDUC Strategy.
- Development and delivery of an SDUC workforce strategy.
- Review of findings from ongoing patient engagement process.

Success will see a changing pattern of service usage:

- Increased usage of heralded/booked appointments across SDUC.
- Increased access and use of community pharmacy consultation service.
- Increased access and use of Acute Eyecare Service.
- Increased access and use of Urgent Community Response.
- MIUs and UTCs used to the maximize capacity.
- Alleviation of SDUC pressure from primary care allowing a focus on anticipatory and complex care.
- Alleviation of SDUC pressure from EDs allowing focus in emergency care delivery.
- Alleviation of SDUC pressure from ambulance service (cat 4-5) allowing focus on emergency care delivery.

Improve the health & well being of the population

Planned care, diagnostics and cancer

Due to the covid-19 pandemic, the existing programme of work overseen by the Elective Care Board (ECB) has a significant emphasis on addressing treatment backlogs and making sure patients are treated according to clinical priority. This includes a range of short to medium term plans related to three main priorities, which are:

- Increase service capacity (e.g. additional wards and theatres at acute hospital sites; expanding community diagnostic capacity).
- Treat patients sooner, in the most appropriate setting (e.g. Advice First which will allow significantly more patients to be managed by their GPs and receive treatment sooner).
- Increase the productivity of existing treatment resources (e.g. improving outpatients and theatre productivity).

There are a number of initiatives the ECB is implementing that are designed to promote early intervention and help to prevent (or delay) the need for surgical treatment. The ECB is also looking to improve outcomes for patients who require surgical intervention. The Cancer Board (which reports into ECB) also has a workstream looking at earlier diagnosis of cancer.

An overview of some of these initiatives are:

- The introduction of 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.
- A peri-operative project looking at intervention earlier in the surgical pathway to improve outcomes for surgery, reduce length of stay in hospital and offer alternatives to surgery where appropriate.
- Support primary care to identify and refer earlier for potential cancers using a digital system.
- Pilot self-referral for certain cancers to promote earlier identification of potential cancers.

- 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.
- Ensuring patients who are waiting for treatment can access information (My Planned Care).
- 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.
- Improve access to self-help and early intervention for patients who might need a surgical intervention.

We want to achieve the following for our population:

- Treat patients in the most appropriate setting as close to when the need arises as possible.
- Improve clinical outcomes for patients who require surgery by optimising their health whilst they wait for a procedure.
- Shared decision making as to whether a surgery is the right thing for the patient.
- Identify and treat cancers earlier.
- Patients understand the risks and benefits of surgery for them as individuals and are offered alternatives to surgery if that is what they want.
- Patients are optimised whilst they are waiting for surgery and have improved outcomes.
- Patients who can be diagnosed and managed in the community are managed there.
- People with a potential cancer are identified as early as possible and follow the new faster diagnosis pathway.

What actions will we take?

- Understand population need and the reasons why patients are presenting late with potentially life changing conditions such as cancer.
- Increased self-help and early interventions in the community for patients who traditionally would have been referred for surgery.
- Roll-out Advice First between primary and secondary care, for all appropriate specialties.
- Continue to support primary care to identify and refer potential cancers and increase self-referral pathways where appropriate.
- Rollout of peri-operative service.

What outcomes will we see?

- Cancers diagnosed and treated at earlier stages.
- Increased numbers of patients receiving treatment in the community and a concomitant reduction in patients needing referral for an outpatient appointment.
- Shorter waits for those patients needing outpatient appointments.
- Improved outcomes and length of stay for patients who require surgery.
- Reduced cancellations on the day of surgery.
- Reduction in numbers of patients requiring/choosing to have surgery.

Provide the best care and support to children and adults

Throughout the pandemic the system has worked together to offer safe and high-quality care in the most appropriate setting. There are challenges as to how person- centred this has been able to be with large backlogs in surgery to deal with. SFT and YDH worked together to manage waiting lists in a fair and equitable way, ensuring care is as efficient as it can be. The independent sector has also worked with us to offer alternatives for patients and to help manage long waiting lists. The ECB has a programme of work which is dedicated to theatre productivity and expanding our capacity, to continue to provide sustainable care in the most appropriate setting. This includes moving from inpatient to day case based care where possible and implementing the Get It Right First Time (GIRFT) High Volume Low Complexity recommendations to maximise the opportunities for treating patients as quickly as possible.

Somerset ICS has worked well with our independent sector providers throughout the pandemic and (as part of recovery) and is continuing to look at how we can maximise use of the sector to help reduce overall waiting times. Initiatives such as Single Point of Access will help to manage demand and ensure where appropriate for the individual, patients are seen at the provider with the lowest waiting time.

The introduction of the peri-operative service will help our offer to be more person-centred, focussing on the decision to proceed to surgery and whether it is the right thing for the patient, taking account of patients' existing health conditions, how their fitness for surgery can be improved, the risks and the likely benefits of the surgery. This will include where they might be able to receive their operation and considerations as to waiting times. Helping patients to optimise pre-surgery will also mean improved clinical outcomes and reduce length of stay.

The ECB has a number of initiatives that are looking to provide more sustainable services within Somerset and lessen reliance on out of county provision. This includes dermatology and ENT services.

A key strand of work for the ECB in 2022/23 has been beginning to review Musculoskeletal (MSK) pathways with a view to supporting patients earlier in the pathway and simplifying the offer to primary care. This includes understanding any gaps and duplication in the scale of service provision across different parts of the system and understanding what the value of each step in the pathway is for patients. Part of the MSK programme will also be looking at the front door for Somerset patients with MSK conditions, and how this will seamlessly link with the planned peri-op pathway for patients needing surgical interventions.

We want to achieve the following for our population:

- Patients are seen according to clinical priority, in the setting that is most appropriate and (where possible) in the place of their choosing.
- Offer alternatives to face to face care where appropriate.
- Change the way specialist clinical opinion is sought to an 'Advice First' method.
- Services are provided where possible within Somerset and without reliance on out of county provision.

- Our providers are as efficient as they can be, following GIRFT and HVLC recommendations.
- To have fit for purpose, future proof, surgical estate that allows us to deliver high-quality care.
- Secure the right workforce to deliver the best care for our patients.
- Patients are involved in/make informed decisions as to their care.
- Financial frameworks incentivise innovation.
- Reduce the overall number of patients requiring surgery by offering alternatives.
- Improve clinical outcomes for patients post-surgery.
- Outpatients are offered only where necessary and in a way that suits patients.
- Patients needing diagnostic tests are seen promptly and un-necessary hospital-based consultations are avoided.
- Improve patient experience of our services.
- Improve waiting times for routine surgery.
- Ensure services can be provided within Somerset where possible.
- Reduce travel time for patients where possible.

What actions will we take?

- Implement Advice First across primary care.
- Roll out single 'front door' to manage efficiency of services and ensure patients are seen according to where the capacity is.
- Further develop and deliver the Somerset Transformation of Outpatient Care programme.
- Redesign MSK pathways.
- Repatriate out of county activity and develop Somerset services to be sustainable.
- Develop our estate and additional capacity to meet demand.
- Roll out personalised care and support for cancer patients.

What outcomes will we see?

- Improved patient outcomes for surgery.
- Reduced did not attend rates in outpatients.
- Improved patient experience in our services.
- Reduce waiting times across key access standards.

Throughout the pandemic Somerset ICS worked together to offer safe and high-quality care in the most appropriate setting. The focus has been on ensuring patients are treated according to clinical need and reducing waiting times. The current approach has been to ensure services on our acute sites are as efficient as they can be whilst looking to develop community-based services where appropriate.

There have been increased offers within the community from a planned care and cancer perspective with additional providers setting up services and trusts expanding outpatient offerings within the community.

The ECB does have plans for the coming year to roll-out Advice First which will support more care being carried out in Primary care without the need for patients to travel to hospital sites.

In 2022, we opened the Taunton Diagnostic Centre which improved access to diagnostic testing in the community and have plans to open a similar facility in the East of the county in 2024. We have also begun operating Community Investigation Hubs within our PCNs to help with demand for phlebotomy in the community. In addition, two new Ophthalmology Diagnostic Centres in Yeovil and Taunton have been established to further increase services off our main acute sites for patients.

Through our cancer transformation work we have commissioned a number of Cancer Village Agents to provide enhanced support to cancer patients in their communities.

We want to achieve the following for our population:

- To provide choice for patients to receive their care as close to home as possible.
- Ensure patients only attend acute hospital sites where necessary.
- Enable patients to be referred straight to diagnostic test, where appropriate.
- People receive access to high-quality care in the most appropriate setting.
- People can access diagnostic testing closer to home where possible.
- Support for cancer patients is provided within their communities.

What actions will we take?

- Further roll-out of closer to home diagnostics.
- Review services provided in the communities and increase where possible.
- Offer alternatives to face to face appointments.

What outcomes will we see?

- Reduced travel times for patients.
- Increased offerings within the community.
- Improved patient experience.

Somerset ICS has an active programme of work on health inequalities which aims to understand how patients in Somerset are accessing health care. From the in-depth analysis undertaken to date we know, for example, that patients from more socially deprived areas are more likely to present via the ED than those from the least socially deprived and are also more likely to DNA (Did Not Attend) appointments. Analysis is underway to identify potential drivers of the patterns we are seeing, such that interventions to improve access can be co-designed.

Currently, we are testing different interventions with the aim of reducing DNA rates for patients from the most socially deprived areas of the county. These interventions include changing the timing of automated text reminders of appointments, phoning

patients to remind them of their forthcoming appointment, and booking patients into local hospital services for their follow-up appointments, where this is possible.

We are shortly aiming to pilot a way of prioritising particular groups of vulnerable patients who are awaiting surgery. This will increase the relative priority of patients with learning difficulties and those patients who both have an open mental health referral and live in one of the most socially deprived areas of Somerset. People with learning difficulties, mental health issues and people living in more socially deprived areas on average do not live as long as patients without these challenges. Expediting treatment for patients on the surgical waiting list with these characteristics therefore seeks to take positive action to address the inequity of the longer period of their life these patients proportionally spend waiting for surgery.

In cancer services we are about to pilot self-referral for certain cancers in areas where presentation for cancer symptoms is lower than the Somerset average.

Somerset ICS has been piloting peri-operative pathways, to optimise patients for surgery. This has identified high rates of unmanaged anaemia and diabetes. The roll-out will target GP practices in the most socially deprived areas.

The system is also supporting military veterans in accessing healthcare with the Gold and Silver standards having been achieved at SFT and YDH respectively.

For those patients on a waiting list, the risk of admission in the next 12 months will be assessed using BRAVE AI. Opportunities to limit deterioration/maintain or improve aspects of health will be provided through access to recommended apps (via ORCHA). For people who are digitally excluded (through access, connectivity, literacy) and would otherwise not have access to digital tools, support will be provided through digital inclusion initiatives including loan of IT equipment, digital skills development and access to recommended apps.

We want to achieve the following for our population:

- Reduce health inequalities in accessing and receiving treatment in our services.
- Implement initiatives in specific areas of deprivation to reduce health inequalities.
- Ensure all services are reviewed against the Core20PLUS5 standards.
- Measurably reduce health inequalities for patients referred for elective care, including reducing differences in rates of access (e.g. referrals), engaging with patients differently to encourage them to seek treatment, and actively seeking ways to identify patients with unmet health needs.

What actions will we take?

- Continue programme of work looking at understanding health inequalities relating to elective and cancer care, through the pro-active use and joining-up of all available health care data.
- Test and roll out initiatives to reduce health inequalities.

What outcomes will we see?
There will be a reduction in the gaps across key access standards for certain sections of our communities.

Somerset currently meets the needs of patients with complex needs through our main acute providers who in turn are part of larger networks of tertiary provision. With specialist commissioning responsibilities coming to ICBs from 2023, there will be greater potential for joined up commissioning of pathways which will reduce obstacles to meeting complex needs. More local commissioning of specialised services will also give us the opportunity to review out of county pathways and look to offer greater support to patients with complex needs in our area.

The merger between our two main provider trusts will ensure greater access to co-ordinated support across Somerset and combined services will offer greater flexibility for patients.

We want to achieve the following for our population:

- Improve pathways for complex patients.
- Where possible reduce travel for complex patients to tertiary centres.
- Ensure a personalised care approach for complex patients.
- Improve experience for complex patients.
- Provide more personalised and co-ordinated support for complex patients.

What actions will we take?
- Review specialist commissioned services and pathways and ensure these are joined up with local services.
- Review out of county/tertiary support and look to provide services within Somerset where possible.

What outcomes will we see?
- Reduced travel for complex patients.
- Improved patient experience measures for complex patients.

Mental health

Somerset's mental health programme aims to promote positive wellbeing for the whole population, reduce ill health, reduce inequalities, and provide high-quality support at the earliest possible opportunity. This is in line with the ambitions set out in the NHS Long Term Plan, particularly around prevention, and will build on our successes over the last five years across both adult and children's services.

Over the next five years, our ambitions for all mental health services are to:

- Continue to work to reduce health inequalities, with a focus on older people who are significantly under-represented in mental health services and the physical health of people with serious mental illness (SMI).
- Further embed co-production in all service development and improvement work.
- Develop new career pathways for people in Somerset, from peer volunteer to clinical professional roles, to ease recruitment and retention pressures, and add more local knowledge.
- Continue to increase the number of people accessing mental health services, supported by a sustained communications and awareness campaign co-produced with system partners, including VCFSE organisations who excel at outreach.
- Improve data quality, including the capture and reporting of patient experience and patient outcome measures across all commissioned services, enabling quality improvements at both service level.
- Increase our digital mental health offers, ensuring that people can access high-quality mental health support on demand from their devices, removing as many barriers as possible to people accessing mental health care.
- Increase the confidence of services to support people with learning disabilities and/or autistic people with mental health needs.
- Implement a mental health specific offer via NHS111.
- Ensure personalised services and expand the number of people utilising a Personal Health Budget, supporting patient choice.
- Work closely with our counterparts in Somerset Council, for example, ensuring health services are closely integrated with the emerging Somerset Connect offer to create a truly joined up ICS across health and social care.
- Reduce the number of people attending the ED for mental health need, and being admitted or readmitted to an inpatient setting, by ensuring appropriate crisis and community alternatives are in place.
- Upskill all parts of the health and care system in suicide prevention, working with our colleagues in public health.
- Work proactively with system partners to better inhabit the online space (in terms of search engine optimisation, collation of resources, community building on social platforms and on-demand content creation) so that when people search online for mental health, autism and learning disabilities support in Somerset, they quickly find trusted, reliable health information through our bespoke portals and channels (like the Somerset Emotional Wellbeing podcast).
- Move towards offering an all-ages service wherever possible to simplify access and messaging to build awareness of services and to create a better experience for service users.
- Work with academic, and technology, partners to explore the use of both generative Artificial Intelligence (AI) and machine learning in order to better target prevention, simplify processes, provide localised smart text support options and inform the commissioning of services according to population health management methodology.
- Evaluate services with academic partners in order to prove efficacy, and value for money invested to the ICS by focussing on qualitative feedback from

people so that value is created, and the cost benefits of early intervention and community support is realised.

- Continue to present, and promote, successes within adult mental health services (e.g. Open Mental Health) at local, regional and national, levels to share learning with other areas, counter negative portrayal of services within the media and on social media and raise awareness of mental health needs, to destigmatise them and encourage people to come forwards for support at the earliest possible time.

Specific ambitions for our children and young people services are to:

Years 1 and 2 programme milestones and trajectories

- Expand our offer to children and young people by developing existing partnerships with VCFSE providers in Somerset, recognising the local expertise and impact of our VCFSE providers.
- Implement a new, innovative therapeutic education offer in partnership between SFT, Somerset Council and our appointed provider (Shaw Trust).
- Implement a new referral portal for children and young people's mental health, enabling people to access self-help information on demand and easily identify what service or services might be appropriate to meet their needs.
- Launch our children and young people's crisis house, as an alternative safe space to ED and/or inpatient admission. This will offer a suite of wraparound interventions for both the individual, as well as support to their families.

Years 3 to 5 programme milestones and measures

- Develop clear assessments of need for our more marginalised and distant children and young people populations.
- Further roll out our evaluation and children and young people feedback opportunities to the entire community across the Somerset footprint.
- Based on our existing trauma-informed services, enhance and further develop our trauma-based therapeutic offer to children and young people.
- Scope out and develop a countywide response to those children and young people who present with neuro-developmental needs (relating to autism, ADHD, learning disability etc) who also have mental health needs.
- Ensure that our collaborative work with Youth Justice provides an early intervention approach to the physical and mental health support needs for our children and young people.
- Develop a collaborative offer with system partners for people experiencing multiple/lengthy exclusions from their place of education.

Specific ambitions for our adult services are to:

Years 1 and 2 programme milestones and trajectories

- Expanding the VCFSE offer ensuring joined up services across the system and continuing to deliver the Long Term Plan ambitions for perinatal and maternal mental health services, with a strong focus on delivery of accessible, high-quality services for birthing partners, non-birthing partners and families.
- Launch our Community Rehabilitation model as part of the wider Open Mental Health offer of care.

- Expand our support for people with dementia through the Somerset Dementia Wellbeing Service (SDWS), ensuring equity of access and provision across the county, and carers in terms of providing more support, access to trusted, localised information and peer networking opportunities. This will support us to keep as many people as possible close to home, for as long as possible.
- Formalise the VCFSE collaborative alliance at the heart of the SDWS, as we have in Open Mental Health, to ensure longevity of provision and provide a more joined up experience for people using the service.
- Reprocure our transformed community mental health service.
- Operationalise our mental health ambulance, working in partnership with our Home Treatment Team and the South West Ambulance NHS Foundation Trust (SWAST).
- Continue using roadshows as a vehicle to promote awareness of, and networking between related services across, the Somerset Dementia Wellbeing Service, Open Mental Health, eating disorders services and other service areas.
- 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 will offer a self-referral option and direct access from primary care.
- 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. The offer will provide a stepped care approach for people with emerging psychotic symptoms to delay or prevent the onset of severe mental health problems/psychosis by providing evidence-based care, treatment, and support.

Years 3 to 5 programme milestones and measures

- Continue to work collectively on addressing Somerset population need, ensuring clear pathways and pathways development to support quality, joined-up services for eating disorders and people of all-ages across Somerset.
- Expand our service provision for people with personality disorders/complex emotional needs.

Key risks:

The significant risks to delivery in the mental health programme area are:

- **Workforce:** workforce continues to be a challenge in Somerset, not least because there has been a significant increase in demand for mental health roles in line with the commensurate increase in investment into mental health services over the last five years. With our partners, we are already looking at ways to develop new career pathways, including apprenticeships and accreditations, to retain our existing working and recruit new staff. Of particular interest is how we can look to encourage the recruitment of people with lived experience.

- **Investment:** over the last five years, there has been significant growth in investment into mental health, supported by the expectations set out through the Mental Health Investment Standard. For 2024/25 onwards, there is no indication that additional funding will be made available to mental health services, limiting growth in mental health services.
- **Demand change:** it is likely with the ongoing economic uncertainty in the UK that there will be a rise in demand and/or complexity of patients seeking mental health support. This is accompanied by the recent observed increase in severity/complexity of need, including presentations of self-harm and eating disorders. We will look to manage this by increasing our early help offers across all ages as well as investing in our specialist services.

Learning disabilities and autism

We want to strengthen our communities to enable people with a learning disability (LD) and or people with autism to live as independently as possible. We want people with a learning disability and/or autism to be able to access high-quality specialist services when needed, and not experience having a learning disability and or being autistic as a barrier to accessing mainstream services (e.g. primary and acute care). We want people to be able to access timely support and early intervention to prevent them from tipping into crisis.

5 year programme actions:

Years 1 and 2 programme milestones and trajectories

- Develop a Learning Disabilities Strategy and an Autism Strategy, covering children and young people and adults.
- Embed and promote Somerset's Link learning disability and autism service.
- Enhance local dynamic support register and Care (Education) and Treatment Review processes in-line with new national policy and guidance.
- Develop a community health offer for children and young people with a learning disability and/or autistic children.
- Improve waiting times for autism assessment for children and young people.
- Improve information and support for people with autism and their families.
- Roll out Oliver McGowan training.

Years 3 to 5 programme milestones and measures

- We will work with partners to upskill professionals in mainstream services (statutory and non-statutory, physical health and mental health) to enable them to have the competence and confidence to provide high-quality support to people with learning disability and autism and to deliver their duty to make reasonable adjustments.
- We will support Somerset Council to develop and embed their new framework for learning disability and autism support, as well as a housing strategy for learning disability and autism.

- We want to strengthen the voluntary sector offer in Somerset, and develop peer mentor and self-advocate support offers.
- We will continue to work to improve the uptake of annual physical health checks for people with a learning disability and ensure that there are meaningful health action plans arising from these.

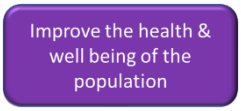
Key outcomes

- We will see fewer people with a learning disability and/or autism in inpatient settings of care, and a commensurate increase in people accessing community-based crisis provision.
- We will see continued high uptake of the annual health check for people with a learning disability, as we know people with a learning disability die prematurely, primarily due to avoidable physical health needs.
- We will see increased numbers of people with high-quality care plans.
- We will see more accommodation available to support people with a learning disability and autism to live well in the community.
- We will have an effective all age dynamic support register.
- We will support the implementation of actions from the learning disability and autism LeDeR process across the system.
- We will see improvements in waiting times for people awaiting autism assessments.
- We will see a reduction in restrictive practice and overmedication of people with a learning disability via STOMP/STAMP initiatives.

Key risks

- **Investment:** whilst there has been increased investment in learning disability and autism over the last five years, this has only gone part of the way in addressing the historic underinvestment into these services. Given the ongoing financial pressures affecting the Somerset system, it is unclear what funding will be made available to support further service development, e.g. community services.
- **Demand:** we are already experiencing high demand for assessments, resulting in long waiting times, and it is possible that this will continue. Without additional investment, this is likely to continue.

Children and families and women's health



Building on 2021/22 successes, we have continued to make progress towards realising the ambitions set out in the NHS Long Term Plan, ensuring that they are fit for purpose for the unique population of Somerset. Build and improve system relationships around children and young people

including shared governance and priorities. Examples include; the development of a Connect Somerset neighbourhood model of early help for families and communities to easily access the support and information they need to remain socially connected, healthy and independent.

Our governance includes a new ICS Children, Young People and Families Partnership Board with oversight of all services and responsibility for the outcomes for children and young people on behalf of the Integrated Care System. Our draft three priorities to work better together, be more child focused and to support families and communities will improve the whole system of support for Somerset children, young people and families.

Our Children and Young People's Plan 2022- 2024, written with input from over 10,000 children and young people sets out the clear outcomes that are prioritised for improvement. The eight priorities are:

- Early Help
- Safeguarding Children
- All Babies Have the Best Start in Life
- Mental Health and Wellbeing
- Education and Inclusion
- Reduce Bullying and Promote Positive Communities
- Poverty and Homelessness
- Climate and Transport

and the addition of Core20PLUS5.

Every woman, child and their family will have access to the information they need to enable them to make decisions about their care; their needs will be considered and assessed holistically to ensure that support is focussed on their individual needs and circumstances, no matter where they live in Somerset.

- Advocating for and prioritising universal health provision for children and young people to support prevention, help at the earliest identification of need

and to support healthy long-term outcomes for children and young people as they transition to adults.

- Supporting the development of system governance including joint and collaborative commissioning for children and young people and agreement of system priorities.
- Ensuring women and pregnant people receive safe, personalised maternity services, ensuring the best start in life for Somerset children. This includes a comprehensive plan for healthy lifestyle support, including smoking cessation, supporting healthy weight, and reducing alcohol and other substance misuse. Emotional wellbeing will be supported with the launch of new personalised care plans, implementation of the National Bereavement Care Pathway and the Best Start in Life programme.
- Delivering the program of work within the Children and Young People's Transformation Long Term Plan that looks from a population base at a range of medical conditions and ways of working.
- Develop the programme of work within the women's health strategy to reduce inequalities in access to health provision.
- Transitioning into a business-as-usual model for special educational needs and disabilities (SEND) focusing on continuous review and improvements to meet the needs of children and young people with SEND.
- Continuing to improve support and access to services for vulnerable children and young people, particularly for those with needs that sit outside commissioned health and care services.
- Coproduce and implement a coordinated early help system across health and care systems including the VCFSE sector.
- Supporting Covid-19 pandemic recovery, including elective and non-elective care, children and young people with needs related to long covid and support a continuous improvement plan to ensure young children impacted by the pandemic are school ready.

What actions will we take?

Continue to progress into year two of the integration project moving learnings from place into system, focussing on collaboration across health and social care services and taking a right time, right place, right person approach to delivering healthcare.

Continue to progress all workstreams of the children and young people transformation programme:

- Asthma
- Epilepsy
- Palliative care
- Transitions
- Diabetes
- Healthy weight
- Urgent care.

Embed principles of Core20PLUS5 to support equity and equality of access to care for children and young people.

For Maternity:

- Progress the nine areas of the maternity transformation plan.
- Embed the Maternity Equity and Equality Strategy.

In addition:

- Launch of maternity personalised care and support plans.
- Continue implementation of National Bereavement Care Pathway.
- Public Health midwife continues to work with our local authority colleagues, embedding prevention principles across maternity.
- Work with all partners implementing the Treating Tobacco Dependency plan in maternity services.
- 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.
- Pelvic health – we have successfully bid for funding to develop specific pelvic health clinics.

Our aims are:

- Continuing to embed neonatal colleagues into the local maternity and neonatal system (LMNS), with enhanced service user feedback via Somerset Maternity Voices Partnership.
- Full implementation of Ockenden, Saving Babies Lives v.2 and Periprem to reduce the numbers of babies born preterm or with ongoing medical needs.

Embed the principles of the national women's health strategy ensuring that women's health is recognised in all aspects of NHS care including urgent and emergency, long-term conditions, primary care, cancer pathways and community services.

Implementing a coordinated early help system 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. Working together this will become an enabler to help tackle the wider determinants of health and key needs which restrict the life chances of children and young people, such as poor housing school attendance, parental conflict and mental health.

What outcomes will we see?

- Women's health dashboard to include cancer, referral to treatment and outpatients to support monitoring and prioritisation of women's health services. Widen access to menopause services using data and learning from pilot project. Commissioning of TOPS service.
- User feedback from pan-Somerset roll out of paediatric HandiApp.
- Support development of the children and young people's long covid and chronic fatigue syndrome service diagnosis and post diagnostic support.
- Demand and capacity scoping to project future autism referral rates and mange current demand.

- Involve representatives from service users, strategic partners and Somerset Maternity Voices Partnership (MVP) in all stages of service development, to ensure the voice of Somerset families is included from start to finish. This includes feedback from a diverse range of families.
- SEND dashboard reviewed regularly at SEND Improvement Board.
- Somerset Connect dashboard.

Joint and collaborative commissioning governance and mechanisms are developing with a Children and Families Board in place.

Joint and collaborative commissioning governance and mechanisms are developing with a new ICS Children, Young People and Families Partnership Board in place. Developing relationships and close working between commissioners in the ICB and Council including children's services, adults and public health.

Procurement has jointly taken place to provide a parent carer view for SEND, specialist equipment and support and mediation for families through SENDIAS provision. Commissioning activity is underway to review an open mental health model. We have reviewed paediatric therapies successfully completing multiple areas of service improvement to align and provide advice and support at the earliest point of need.

The Community Equipment and Wheelchair Service has been jointly commissioned and implemented across the county. This now has a clear all age agenda with a focus on improving the services offered to children and young people.

Our aspirations are to develop a learning disabilities and autism keyworker model to prevent young people from going into hospital ensuring care and support in the community.

Clear system priorities agreed themed around:

- 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.
- Enablers – develop a children and family's joint system needs analysis, using data available from the developing shared data lake to better understand our joint priorities and to target our resources appropriately to have the most impact.
- SEND improvement – reset and continue the SEND improvement journey with the new SEND strategy. Ensure the needs of children and young people with SEND is embedded in everything we do.
- Explore and realise the benefits of assistive technology for children and young people with disabilities, or to help young people move towards independence.

What actions will we take?

- Develop the Homes and Horizons strategic partnership between Somerset Council and the Shaw Trust, with SFT, to embed high quality services and support for our most vulnerable children who have experienced placement breakdowns, are at risk of being placed in provision many miles from their homes in Somerset and/or are at risk of entering in patient CAMHS mental health wards. This will include:
    - Eight to ten small nurturing residential homes (each for two or three teenagers).
    - High needs fostering provision for up to 20 children. These will be integrated with our new homes, to ensure there are effective pathways for children out of residential homes into family settings in foster placements.
    - Therapeutic education, for 30 children aged 11 and over, at two Somerset sites. This provision will provide both therapeutic interventions and a robust education offer to support children who are out of education, and in care within Homes and Horizons provision and/or at risk of entering inpatient CAMHS provision.
- 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.

What outcomes will we see?
Service user feedback and school readiness data.

Connect Somerset is about improving early help in the community. Working together across health and care, voluntary, faith and community sectors, education and policing, children and adults, people and place to help more families and residents earlier.

A network of existing community hubs across the county will be used to deliver drop-ins and a little help earlier, before assessments. We have amazing local groups and community centres across Somerset that we can work with.

More early help will be offered through hubs and all frontline professionals – reducing inequality by helping everyone who needs help to access it. We will work more closely between schools, GP surgeries the community sector and other partners – getting to know each other and collaboratively wrapping support around families rather just referring to another agency.

We will aim to develop our social prescribing offer for children and young people, as an important way of supporting the most vulnerable with a little extra help that can build resilience and connections back into the community.

Through Connect Somerset, we are getting rid of barriers and making it easier for professionals and communities to work together. For example, by streamlining processes, sharing data between professionals working with families and residents,

developing the Transform app, aligning service areas so we're working with the same people, and getting information about local resources and services online in one place to search.

A new strategic partnership with the VCFSE sector will oversee early help service design and delivery. Putting the community in charge as equal partners to health and care.

What actions will we take?

- Aim to deliver through 12 core hubs and 100 other community hubs.
- Identifying 11 Champions from the community to change public sector practice and culture.
- Refreshed team around the school model to encourage relational practice.
- Universal offer of early help for all families.
- Joined up locality working with schools, GP practices, community groups.
- Refreshed Transform app for schools and social care to track who is receiving help and encourage joint working.
- Better information sharing between professionals including a shared case management system.
- Work with partners to understand how we can increase social prescribing for children and young people.
- Joined up database of community resources.
- Using data to understand who might need more help so we can offer support.
- Evaluation of impact.

The outcomes we will see

- More families and residents accessing early help.
- Growing resilience for the most disadvantaged families and residents.
- Reduced demand for more acute services such as ED, social care, children in care, and primary care.

The Somerset maternity equity and equality plan was submitted to NHSE in September 2022. This contains actions we will take to reduce inequity in maternity care in Somerset.

The publication of the NHS Long Term Plan in January 2019 built on the recommendations of Better Births. It focuses on meeting the national Long Term Plan ambitions and local needs, including; improving safety, postnatal and neonatal care, equity, diversity and inclusion, perinatal and infant mental health, prevention, personalised care, and improving the maternity experience.

The team will continue to develop positive relationships with the Parent Carer Forum and progress the delivery of the recently approved SEND strategy.

We have developed a 5-year strategic Local Maternity and Neonatal System plan for 2019-24 based on an analysis of need and in conjunction with clinicians, system partners, women/people and their families, and our Maternity Voices Partnership.

What actions will we take?
Transformation work continues at pace with particular focus on:

- Target Continuity of Carer to our communities where evidence shows inequity - targets have been eased due to the ongoing national recruitment issues but remains on our priority list when safe staffing allows.
- Aim services at the communities where evidence shows they are most needed e.g. smoking cessation support.
- Development of enhanced antenatal offer.
- Continue to increase engagement with communities that are frequently unheard to understand their aspirations for pregnancy care, and the issues they face.

The outcomes we will see

- Perinatal and Maternal Mental Health clinics are continuing to expand, now supporting partners and women up to 24 months after delivery.
- Working with NHSE to look at infant mental health, including trauma informed care during and following pregnancy and attachment.
- Development of the Women Requiring Extra Nurturing (WREN) team to support vulnerable women.
- Comply with all Ockenden and Saving Babies Lives requirements to ensure care for women with complex needs is supported and evidence based.
- Work closely with the regional Maternal Medicine Network for women with pre-existing conditions to give holistic care for mother and baby.

Respond well to complex needs

In May 2023, we published Somerset's new SEND Strategy. This sets out the priorities for the next three years to improve experiences and outcomes for children and young people with SEND and their families.

The strategy focuses on four key themes:

- Working together.
- Getting help as early as possible.
- Accessing the right information, support and provision.
- Preparing for the future.

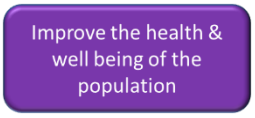
In 2023, the Government published its SEND and Alternative Provision Improvement Plan, which sets out actions that will inform the work of the Somerset SEND Partnership, including development of national standards, strengthened partnership arrangements and the requirement to publish a local inclusion plan that sets out how the partnership will meet the education, health and care needs within the area.

What actions will we take?

- Make it easier to access early advice, information and support for special educational needs through Connect Somerset, local community hubs and online guidance.
- Develop a joined up communication, positive attachment and communication offer which will improve support for children from birth, in their early years, at school settings, and at home.
- Promote clear and up-to-date information around mental health support and ensure our services are easily accessible, and work to ensure that gaps in mental health support are identified and addressed.
- We will invest in and develop a neurodevelopmental pathway so assessments are timely and families receive support throughout the process.
- Increase the number of specialist school places for children with social and emotional mental health needs available to meet needs.
- Recruit key workers to co-ordinate support for children and young people with a learning disability or autism and their families, so that they can receive the right support to live safely at home.
- Review and put in place a new short breaks offer and work with schools to put in place enhanced wrap around support for children with additional needs.
- Evaluate the support and guidance available to children and young people with SEND so that families can plan for adult life as early as possible, including if they will need to transfer to adult services across health and social care.
- Support young people to be as independent as you can be through work readiness and life skills programmes, and work with supported employment groups and key partners to improve the employment opportunities available to young people with SEND.
- Children and young people with SEND will be able to get support to be as healthy as you can be. This will be supported by local partnerships including; education, health, care and the voluntary, community, faith and social enterprise (VCFSE) sectors.
- As part of developing our housing strategies we will work with you to understand what you need to live as independently as possible, including in your own home, flat or shared living. Based on what you tell us, we will develop a refreshed and accessible housing offer in a location that is right.
- Less reliance on crisis provision due to a shift in focus on prevention and help at the earliest stage.

Neighbourhoods

Primary care



Primary Care services in Somerset have played a substantial part in fostering a connected, community-based approach, preventing avoidable illness (both communicable and non-communicable) and taking an early-intervention approach. We have some nationally recognised

examples of good practices, such as ‘Compassionate Communities’ in Frome, which Frome Medical Practice has played a leading role in.

We aim to develop a primary care sector over the next five years which can fully deliver all five aims. In relation to improving the health and wellbeing of the population, we want to develop outward-facing integrated neighbourhood teams which can work with community and VCFSE partners to identify opportunities for population health improvement.

People will report reduced loneliness and greater sense of inclusion. Avoidable illness rates both communicable and non-communicable will be lower than they would otherwise have been.

What actions will we take?
Invest in a fully integrated person-centred, community-based approach to healthcare. Investment phasing will depend upon the national financial position and its impact on our local allocations.

The outcomes we will see
- Integrated neighbourhood teams will exist in all 12 of our neighbourhoods, which will include VCFSE and community partners.
- Contracts will contain clear population health metrics with priorities developed from population health management data insights.

Primary care services are unable to meet demand, and patients are experiencing difficulty accessing services, particularly for dental care. Continuity of care is decreasing in GP services, which is leading to adverse individual and population health outcomes.

To ensure everyone is Somerset has access to primary care services, and to ensure those services are fully integrated and able to deliver the five aims of the ICS strategy.

A Modern General Practice Model, will be implemented. This will deliver both continuity and access through a skill-mix approach. Community pharmacy will play an increasing part in our communities through integrated neighbourhood teams. Dental services will also be drawn into integrated neighbourhood teams.

What actions will we take?
- Invest and develop GP services to deliver our agreed Primary Care Strategy, with its focus on access, population health and continuity of care.
- Invest and develop dental services to recover a position where all Somerset residents who wish to access NHS dental care can do so.
- 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.
- 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.

The outcomes we will see

- Improved patient satisfaction.
- Reduced trend of emergency admissions, particularly in last year of life.
- Improved access via one day and 14-day metrics.
- Increased pharmacy consultations.
- Improved dental access.
- Improved optometry integration.

Integrated neighbourhood teams are still a concept rather than a reality, although there are significant pockets of good practice to build on.

We want to fully develop the integrated neighbourhood team model with complete integration across providers around the needs of patients.

What actions will we take?

Programme of investment and development of integrated neighbourhood teams.

The outcomes we will see

- Reduced admissions against trend.
- Increased patient satisfaction.

Significant health inequalities affecting access to primary care services. This is mainly related to economic deprivation and poorer health outcomes in lower layer super output areas (LSOAs) with high indices of multiple deprivation (IMD). However, this also includes other vulnerable groups such as people experiencing homeless and vulnerably housed, refugees and asylum seekers. In addition, there is significant risk of digital exclusion as services move online.

We want to reduce mortality and morbidity from CVD and other preventable illness and reduce health inequalities through population health management and Core20PLUS5.

What actions will we take?

Implement Population Health Management and Core20PLUS5 through integrated neighbourhood teams.

The outcomes we will see

Reduced mortality and morbidity in target neighbourhoods.

Management of long-term conditions was heavily impacted by the Covid-19 response. The backlog is still being cleared, but the health impact for many patients is not recoverable. Same day demand is now compromising continuity and complex care capacity of GP services to respond to complex needs.

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.

What actions will we take?
Development of a Modern General Practice model which can deliver the right interventions in primary care while operating at a wider scale as part of integrated neighbourhood teams.

The outcomes we will see
- Reduced emergency admissions
- Improved patient satisfaction.

Aging well
Urgent Community Response (UCR) begins with a holistic assessment of a person's needs and ends with referral into services that can treat or support the underlying cause of the urgent need. This joins up with personalised care and anticipatory care, making every contact count.

NHSE are committed to developing a consistent NHS UCR offer nationally. As set out in the NHS operational planning and contracting guidance 2022/23, all ICSs must ensure UCR services (that improve the quality and capacity of care for people through delivery of urgent, crisis response support within two hours) are available to all people within their homes or usual place of residence, including care homes. This is a national standard which was introduced in the NHS Long Term Plan and builds on National Institute of Health and Care Excellence (NICE) guidelines.

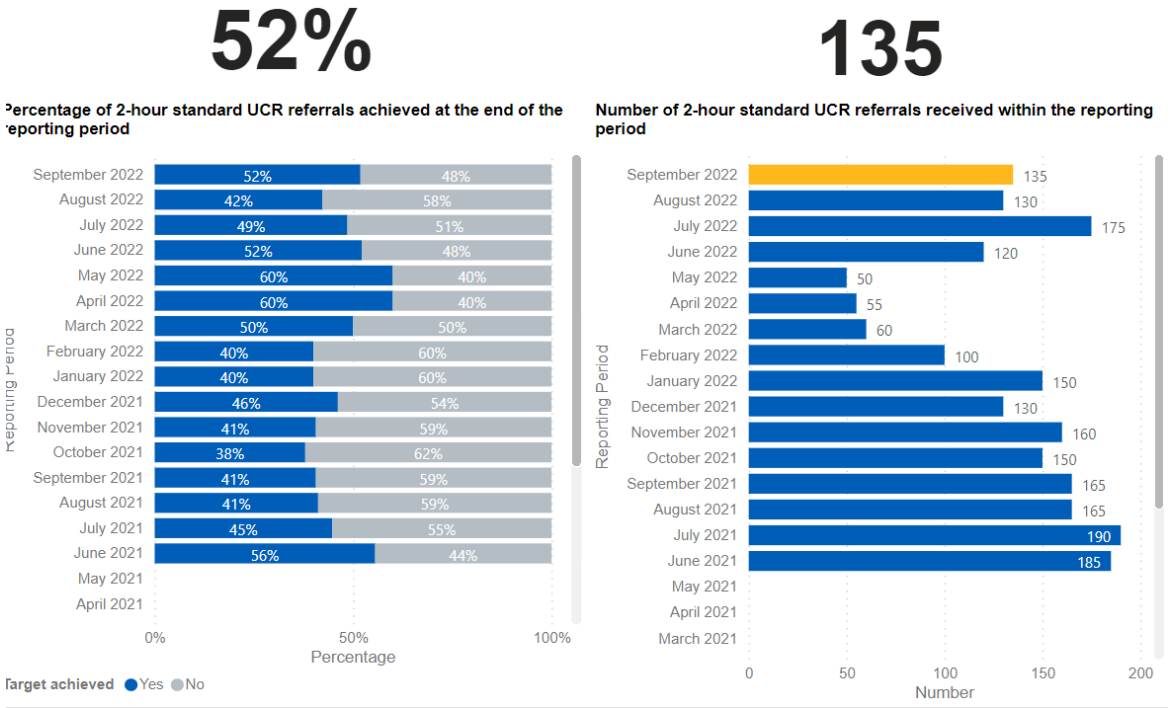
We want to meet our patients' urgent care needs at home as this is key in improving patient outcomes, delivering NHS strategic priorities, preventing avoidable hospital admissions and enabling people to continue to live independently.

A two-hour response is typically required when a person is at risk of admission (or re-admission) to hospital due to a crisis and they are likely to attend hospital within the next two to 24 hours without intervention to prevent further deterioration and to keep them safe at home.

What actions will we take?
- A direct referrals from residential homes pilot took place during October and early November 2022. We are now targeting top 10 care home ambulance see and treat direct referrals which we hope will see around eight referrals a week. By directly referring to a team of skilled health care professionals 's we aim to see a reduction in ambulance call outs, fewer long lies when a person has fallen and associated risks and a holistic review of a person's needs.
- 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 refer to UCR; however, this isn't available county wide or to all residents as it

is a paid for service. We also want to work with Aster to directly refer from the call centre where a person's key holder isn't available. This will reduce ambulance call outs and people will be safely assessed within two hours. We believe there is an opportunity to improve the assessments completed by responders and on ward referral and provides an opportunity to educate informal carers about safe lifting protocols and caring for people in their own homes.

- Current attainment can be tracked via NHS Futures [Microsoft Power BI.]



What outcomes will we see?

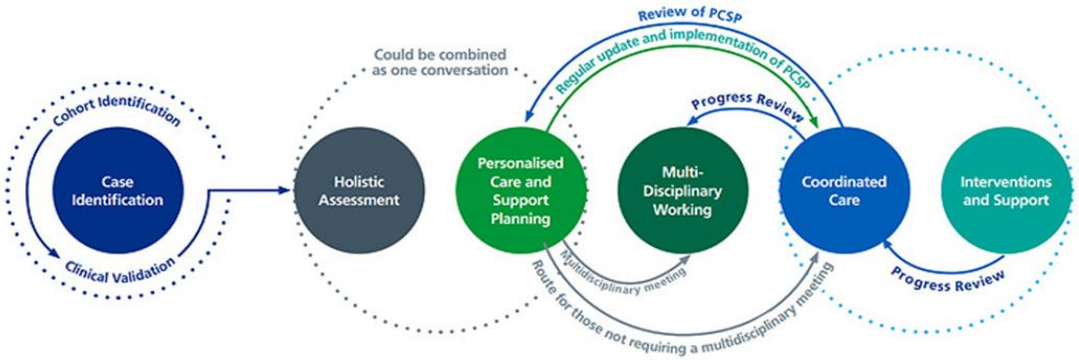
- A comprehensive operational performance report will demonstrate we have full geographical coverage, by breaking the data down to locality and health care partner that responded we can identify areas with greater need, seek to understand why this is and review core services for insight into why people are experiencing crisis.
- UCR local and national reporting will show increases in referrals and visits. Quarter one 2024 an evaluation of the impact of communications and UCR will take place. National evaluation is also taking place.
- Work with the PCN to identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows. We will work with the PCN to support discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27. Framework completion date is 2024.

Anticipatory care

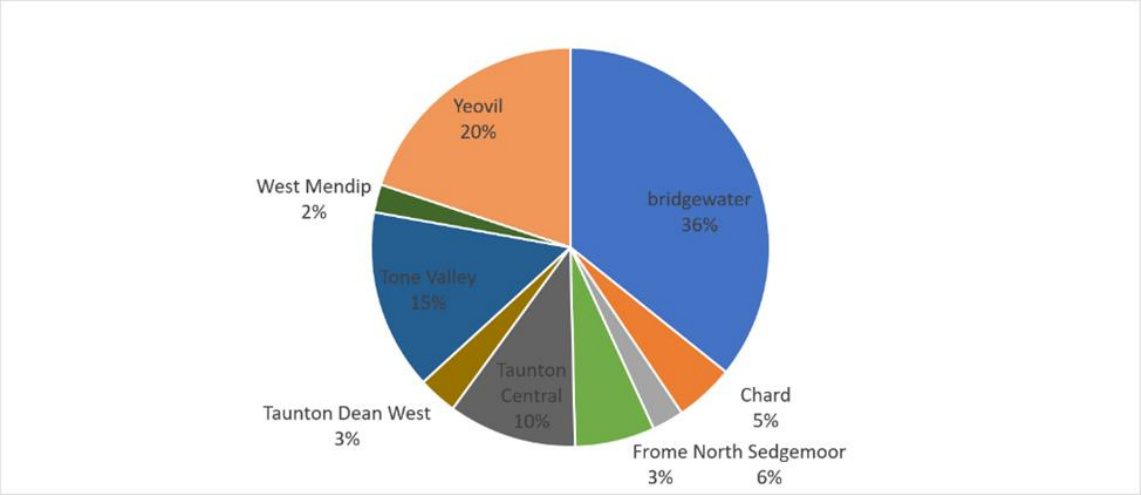
NHS Somerset is committed to levelling up anticipatory care across all PCNs against the Mendip model. An assurance document has been developed to ensure the core requirements are being met.

A Somerset ICS anticipatory care model has been developed to deliver against NHSE anticipatory care year one priorities focussing on the moderate and severe frailty, Core20PLUS5 and patients accessing unplanned services for established physical and mental health needs. The model is based on patient need, and does not rely on the traditional GP appointment method.

Anticipatory care process



Somerset are looking to work with two to three PCNs, dependent on local agreement, to address the key health indicators for unplanned hospital admissions. Targeting those individuals with two or more long-term conditions experiencing health inequalities (Core20PLUS5) with two or more emergency admissions in the last 12.



There are opportunities to strengthen anticipatory care pathways such as long-term conditions. Improving patient experience through ensuring individuals with multiple long-term conditions receive integrated health and care at home, which results in a better quality of life.

Anticipatory care aims to provide proactive and personalised health and care for a targeted subset of individuals living with multiple long-term conditions including frailty who could benefit most, delivered through multidisciplinary teams (MDTs) in local communities.

The care model aims to optimise use of the health and care system for individuals with multiple long-term conditions by intervening proactively and holistically while the patient is at home. This should reduce avoidable use of unplanned care and avoidable exacerbations of ill health.

By providing more proactive support to individuals with multiple long-term conditions, anticipatory care aims to optimise the use of the health and care system by intervening earlier, proactively and more holistically, while the patient is at home. The anticipatory care models aims to:

- Reduce health inequalities through improving access, experience and outcomes in line with Core20PLUS5 and the five priority areas in the 2022/23 priorities and operational planning guidance.
- Improve patient experience, through ensuring individuals with multiple long-term conditions receive integrated health and care at home, which results in a better quality of life.
- Improve staff retention and satisfaction, through opportunities for development, multidisciplinary working and effective co-ordination.
- Develop a stronger evidence base for proactive, integrated care delivered in community settings.

Expected outcomes for anticipatory care include:

- Hospital avoidance and/or unplanned care from primary care or district nurses.
- Patient remains stable (within patients own normal parameters) at home 30 days after discharge.
- Identified and onboarded to pilot within 72 hours of discharge from hospital following an unplanned admission.
- Regular reporting, including demand and capacity tracker, failed discharges, incident reporting, clinical discharges and onward referral pathways.
- Coproduced personalised care plan.
- Demonstration of wider MDT community health and social care support offered including GP, Matron, Care Coordinator, health coach social prescriber health coach and VCFSE, social care, county council - if has housing need.
- Patient goals achieved.
- Carers' assessment where appropriate.

Our aim will be to empower and enable individuals to take an active role in their care through shared decision-making conversations to identify what matters to them and their health and wellbeing ambitions. This includes;

- To be treated as a whole person by professionals they trust.
- To be involved in decisions about their health and care.

- To be supported to manage their own health and wellbeing, through health coaching, access to self-management programmes and to peer support in the community.
- Their care to feel co-ordinated.
- Patients' goals are achieved.
- Able to access information and advice that is clear, timely and meets their individual information needs and preferences.
- Be listened to and understood in a way that builds trusting and effective relationships with people.
- Be valued as an active participant in conversations and decisions about their health and wellbeing.
- Be supported to understand their care, treatment and support options and, where relevant, to set and achieve their goals.
- Have access to a range of support options including peer support and community-based resources to help build knowledge, skills and confidence to manage their health and wellbeing.
- Experience a coordinated approach that is transparent and empowering.

What actions will we take?

- There was a national requirement to submit anticipatory care plans in quarter three of 2022/23 with implementation in quarter one of 2023/24. The national team has now stood this down; therefore, we are awaiting further national guidance, aligned to the primary care strategic plan and Fuller report. Infection prevention and control (IPC) strategic plans are in development.
- Somerset are looking to work with two to three PCNs to pilot the anticipatory care model. We will undertake a review of the business cases against the national requirements, ensuring PCNs will achieve the aims of the model.
- 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.
- We will oversee the implementation and provide support where required and provide updates on national/regional briefings.

The outcomes we will see

- Reductions in unplanned hospital admissions.
- Reduction in exacerbation in long-term conditions.
- Reduction in health inequalities.
- Meeting the needs of patients much earlier in their health journey.
- Patient goals are achieved.
- Staff satisfaction.
- Demonstration of wider MDT community health and social care support offered including GP, Matron, Care Coordinator, health coach social prescriber health coach and VCFSE, social care, county council if has housing need.

Enhanced health in care homes

The NHS Long Term Plan (2019) contained a commitment as part of the Ageing Well Programme to roll out Enhanced Health in Care Home (EHCH) across England by 2024, commencing in 2020. The EHCH implementation framework supports the delivery of the minimum standard by PCNs described in the Network Contract Directed Enhanced Service (DES) for 2020/21 and the complementary EHCH requirements for relevant providers of community physical and mental health services included in the NHS Standard Contract.

The aims of the DES and NHS Standard Contract support the NHS Long Term Plan goal of 'dissolving the historic divide' between primary care and community healthcare services and sets a minimum standard for NHS support to people living in care homes. The framework sets out practical guidance and best practice for ICBs, PCNs and other providers and stakeholders as they work collaboratively to develop a mature EHCH service. The EHCH service applies equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority. Personalised care and support are at the heart of EHCH model.

EHCH framework priorities:

- People living in care homes have access to enhanced primary care and to specialist services and maintain their independence as far as possible by reducing, delaying or preventing the need for additional health and social care services.
- Staff working in care homes feel at the heart of an integrated team that spans primary, community, mental health and specialist care, as well as social care services and the voluntary sector.
- Budgets and incentives are aligned so that all parts of the system work together to improve people's health and wellbeing.
- Health and social care services are commissioned in a coordinated manner, and the role of the social care provider market is properly understood by commissioners and providers across health and social care.

The framework is being completed by system PCNs, interdependencies include UCR care home direct referral and the manger lifting equipment supplied to care homes (including required training). The framework covers all residential care setting including nursing and learning disability care setting for anyone over 18 years of age.

Baseline results indicate 100% of care homes are aligned with a PCN. The EHCH framework is being implemented across Somerset ICS. The minimum standards for the service, outlined in the Network contract DES are:

- Every care home aligned to a named PCN.
- Every care home has a named clinical lead.
- A weekly 'home round' or 'check in' with residents prioritised for a review based on care home advice and the MDT clinical judgement (this is not intended to be a weekly review for all residents).

- Within seven days of re/admission to a care home, a resident should have a person-centred holistic health assessment of need (which will include physical, psychological, functional, social and environmental needs of the person and can draw on existing assessments that have taken place outside of the home, as long as it reflects their goals).
- Within seven days of re/admission to a care home, a resident should have in place personalised care and support plan(s), based upon their holistic assessment.
- The Network Contract DES: structured medication reviews also has a contractual requirement to prioritise care home residents who would benefit from a structured medication review (SMR).

EHCH aims to:

- Deliver high-quality personalised care within care homes.
- Provide, wherever possible, for individuals who (temporarily or permanently), live in a care home access to the right care and the right health services in the place of they call home.
- Enable effective use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes environment.

The EHCH element of the Long Term Plan began roll out in 2020 to be fully implemented by 2024. The framework is being delivered with the next refresh expected at the beginning of 2023.

What actions will we take?

- Develop the role Social Prescribers, Health Coaches and Village Agents could play in facilitating EHCH framework requirements.
- 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 with Somerset Council, care home staff, and PCNs to develop an effective and engaging care home workforce training plan.
- Increase awareness of UCR to enable care home residents to remain in the place they call home, reducing unnecessary conveyance to hospital.
- 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.

The outcomes we will see

- People living in care homes have access to enhanced primary care and to specialist services which maintain and encourage resident's independence, delaying or preventing the need for additional health and social care services.
- Staff working in care homes feel they are at the heart of an integrated team that includes primary, community, mental health, specialist, social care and the voluntary sector.
- Budgets and incentives are aligned so that all parts of the system work together to improve people's health and wellbeing.

- Health and social care services are commissioned in a coordinated manner, and the role of the social care provider market is understood by commissioners and providers across health and social care.

Long term conditions

NHS Somerset is in the process of working with system partners to develop a holistic strategy for identifying, managing and supporting patients with long-term conditions in Somerset. This will be monitored by a newly established Long Term Conditions Board (LTCB), which will set priorities and oversee a range of improvement activities across the ICS. The priorities for this board, and what we want to deliver for population, will include:

- Increasing provision of services aimed at supporting patients with long-term conditions, particularly within community and primary care settings, and ensuring these services are both sustainable and efficient.
- Identifying and preventing long-term conditions earlier through screening programmes and initiatives, in order to detect health problems at an earlier stage where they are more amenable to intervention and before serious complications can develop.
- Increasing the integration of care for long-term conditions, both between primary and secondary care and other providers in the private and voluntary sectors, and developing robust care pathways for management of long-term conditions that links with transition from paediatric care to adult care, or transition to End of Life Care where appropriate.
- Working with Somerset Council to research and understand population health needs across Somerset, including those in hard to reach or higher risk groups, and then working to address gaps in services for patients in these groups.
- Ensuring that patient choice is respected and factored into all services for long-term conditions.

What actions will we take?
There are a number of different initiatives already underway targeting different long-term conditions, which will be monitored by the newly constituted LTCB to ensure they are working towards the overall strategy and achieving their stated goals. These actions will ensure the ICS is addressing those conditions outlined in the Core20PLUS5 as contributing to health inequalities. An overview of some of these, and future actions we are planning to take, is given below:

- An ongoing initiative for joint primary and secondary care virtual clinics for the management of patients with long-term heart conditions. This aims to provide expert input to care of patients who do not require hospital referral and improve partnership working between primary and secondary care.
- Development and trial of new screening programmes for patients with hypertension, Atrial Fibrillation and other CVD, in easily accessible community locations, building on previous work in rolling out of Blood Pressure at Home monitoring equipment. A Hypertension strategy for the prevention,

identification and treatment is currently in development. Two new Cardiovascular Lead Clinical Champions have been recruited within Somerset to undertake focused work around identification, treatment and support for patients.

- 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 focus on earlier diagnosis and management, particularly in hard to reach groups, and identification of patients at high risk for developing diabetes. Patients identified with diabetes will be given greater support for self-management, weight management and structured education in order to empower and support them in their care. A number of patient engagement events are planned to work with patients to identify their needs focussing on diabetes education and the current support within the system.
- 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.
- Conduct a population health review into respiratory disease, including reviewing access to pulmonary rehabilitation with a focus on areas of inequality to improve access to care. This will also involve working with primary care and diagnostic hubs to improve access to earlier diagnostics.
- Reviewing 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.
- Working with NHSE Specialised Commissioning to ensure that the identification of renal disease and ongoing treatment is meeting the needs of the population and working with external providers to improve services if there is identified need.

Expected outcomes for long-term conditions

- Earlier identification of conditions such as hypertension and diabetes, with a greater number of patients identified with mild disease before it has progressed.
- Greater provision for self-management, education and support in living with long-term conditions across the population.
- Introduction of pathways for management of long-term conditions that promote integrated care.
- Improved knowledge of health needs and health inequalities across Somerset for those patients at risk of developing, or living with, long-term conditions.
- Gaps in service provision for long-term conditions addressed.
- Ultimately, improved population health outcomes in patients with long-term conditions.
- Working with system partners to educate the population to prevent the development of long-term conditions.

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 in place.

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.

Integration and the Better Care Fund

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.

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 with oversight by the Somerset Health and Wellbeing 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.

Achieving our ICS vision will require us to focus on the following areas:

Prevention: directing 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.

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.

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.

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.

With continued socioeconomical pressures within communities there is a focus on continued support for communities through established community and VCFSE services. Examples of this included:

- Homes for Ukraine, support for Ukrainians and their hosts to access community support groups, healthcare, education and financial support. This was delivered through PCNs, VCFSE partners, Public Health and Somerset Council.
- Ongoing Vaccine delivery throughout the county is delivered through a well-established integrated community response involving PCN's, Public Health, and VSCE.
- Strategic development of Social Prescriber Link Worker (SPLW) role and integration into the wider ICS priorities.
- Strategic development of SIC Personalised Care.
- Opportunities to co-commission through the establishment of SIC Somerset Integrated Care), initially through community services such as the Cares contract and SPLW/Village Agents.

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.

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.

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.

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.

Workforce

Our ICS strategy describes our ambitions for improving the health and wellbeing of our whole population, especially for marginalised groups, and our aim to apply a population health management approach to plan and invest in services supporting prevention and delivery care closer to home. We are developing a wide range of integrated pathways across our NHS acute, community/neighbourhood and mental

health services, our primary care and out of hours services and the wider social care, independent and voluntary sectors. There are some key workforce transformation activities which will support health and care needs across our system. Examples of this include:

- The development of an intermediate care model as part of a system approach between NHS provider community services, PCNs, social care and independent/voluntary sector.
- Integrated support for marginalised groups such as refugees, the homeless and rough sleeper community.
- Diagnostic capacity including joint ventures with the independent sector and new diagnostic hubs.
- The deployment of NHS Reservists and other colleagues to expand capacity in the non-NHS settings.
- The provision of clinical skills training to carers to facilitate early discharge and support the management of people with significant health needs outside hospital.
- The transformation of same day urgent care services and workforce including GP out of hours services and the need to build workforce capacity and skills in primary care contractor services such as community pharmacy and optometry.

Virtual Wards and Hospital at Home

We continue to develop new pathways within Hospital at Home, the most notable at this point being paediatrics. We have a strong system-wide programme structure which will drive the programme forward and monitor progress. We plan to increase the ability to support admission avoidance through utilisation of this pathway and will do this by:

- Working closely with primary care, who at present represent a small proportion of referrals. We will do this in a number of ways including increased communications and close working with our PCNs. We have an excellent and successful model in North Sedgemoor that we propose to base our work on.
- Exploring how we can link with the Acute Respiratory Infection Hubs being developed.
- Build on our recent visits to the specialist paramedic hubs and Somerset Clinical Assessment Service by having a regular presence building relationships, team knowledge and confidence to support the successful triage of appropriate patients across to Hospital at Home.
- Working with SWASFT to undertake a quality improvement project focused on improved community integration. The key driver being to ensure people are treated in the most appropriate place.
- Working with care homes around how remote monitoring can be used to support early signs of deterioration and move across onto a Hospital at Home pathway as an alternative to hospital admission.
- Reducing the number of readmissions from Discharge to Assess, by implementing an assessment pathway via Hospital at home.
- Ensuring that a new community navigator role being employed within the Acute Trusts provides an essential link into Hospital at Home.

To improve the early discharge of patients we intend to:

- Expand the specialities which Hospital at Home can support for example to surgical.
- Continue to look for further opportunities to support a wider range of specialities e.g. cancer and endocrinology.
- Improve in-reach through a regular presence at board rounds in target wards for example (but not limited to) Acute Frailty Unit and Care of Older People.
- Improve knowledge and confidence through a targeted communications plan to both clinicians and patients.

We do not see Hospital at Home as a single and separate service across our System, rather as one element of a whole which is in place to support people in the most appropriate place, as such our teams are based and integrated at neighbourhood level, alongside our District Nurses, Rapid Response, UCR support, complex care GPs and many other planned and urgent care services.

Socio Economic Development

Stakeholders within the ICS recognise the importance of understanding the potential contribution the ICS can make to social and economic development of Somerset. In line with the NHS Confed 4 Step Model, partners will look to pool current information and map out the potential areas of impact, accepting there are direct and indirect areas of impact from the Integrated Care Strategy.

As reflected elsewhere in this plan, there is a commitment to developing the skills and career pathways within Somerset (as anchor institutions) as well understanding the potential benefit in areas such as research and development, procurement, estates, and contribution towards net zero. Clearly a significant area of interest lies in the potential impact of improving population health and reducing inequalities with consequent societal and economic benefit. Our work within communities will incorporate and asset-based approach as we seek to strengthen and develop people, families and their communities through our involvement model and resultant streams of work.

Promoting research and innovation

Peninsular Research and Innovation Strategy

During the last six months we have formed a partnership with research and innovation partners across the Southwest peninsula (Somerset, Devon and Cornwall & Isles of Scilly) to consider how as an ICB we can increase the impact of research and innovation in Somerset.

Working with NHS Cornwall & Isles of Scilly and NHS Devon, supported by the Southwest Academic Health Science Network, we have drawn on the experience of other more mature research and innovation systems to understand how to strengthen the conditions for research and innovation.

This work has resulted in the development of an ambitious and pioneering partnership for health and care research and innovation in the Southwest peninsula. The purpose of the partnership is to work in collaboration with NHS Cornwall & Isles of Scilly and NHS Devon to bring together the collective capability of the peninsula's two major universities (Universities of Exeter and Plymouth), the National Institute for Health and Care Research (NIHR) Clinical Research Network, the NIHR Applied Research Collaborative and the Academic Health Science Network to increase the impact of research and innovation.

We are working together as a partnership to develop a shared research and innovation strategy for the peninsula focused on our shared population health and system priorities. The aims of the shared strategy are to:

- ensure research and innovations supports NHS Somerset to improve population health and reduce health inequality;
- improve health and care system productivity;
- improve how we attract, grow and retain our workforce; and,
- increase external funding and investment into the region.

We have chosen to take a mission-based approach to our strategy, targeting a small number of major population health and system challenges for our region that provide the strategic focus for our work together on research and innovation.

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

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.

Furthering our research capacity and capabilities

While NHS Somerset ICB is a 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.

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 and Yeovil District Hospital NHS Foundation Trust (YDH) 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 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.

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 has an assessed exit underlying financial deficit at 2023/24 in the region of £75m.

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:

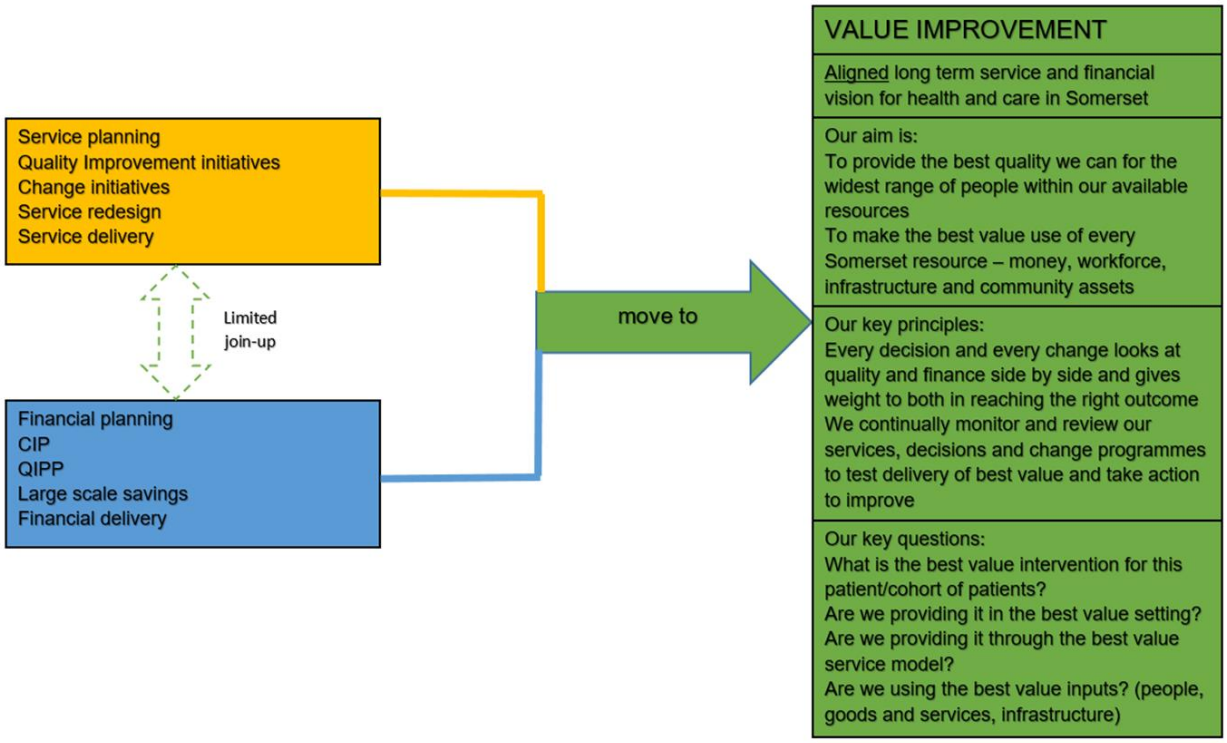
- Understanding and managing the interdependent and iterative relationship between the financial strategy, the emerging clinical and care model for Somerset and other enabling strategies is key to delivering a coherent and cohesive plan. The financial strategy and plan are shaped by the vision for services 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 system plan for 2023/24 already assumes challenging savings targets and a further £10m stretch target, so we need to start now.

Our strategic financial approach is summarised in the diagram below:



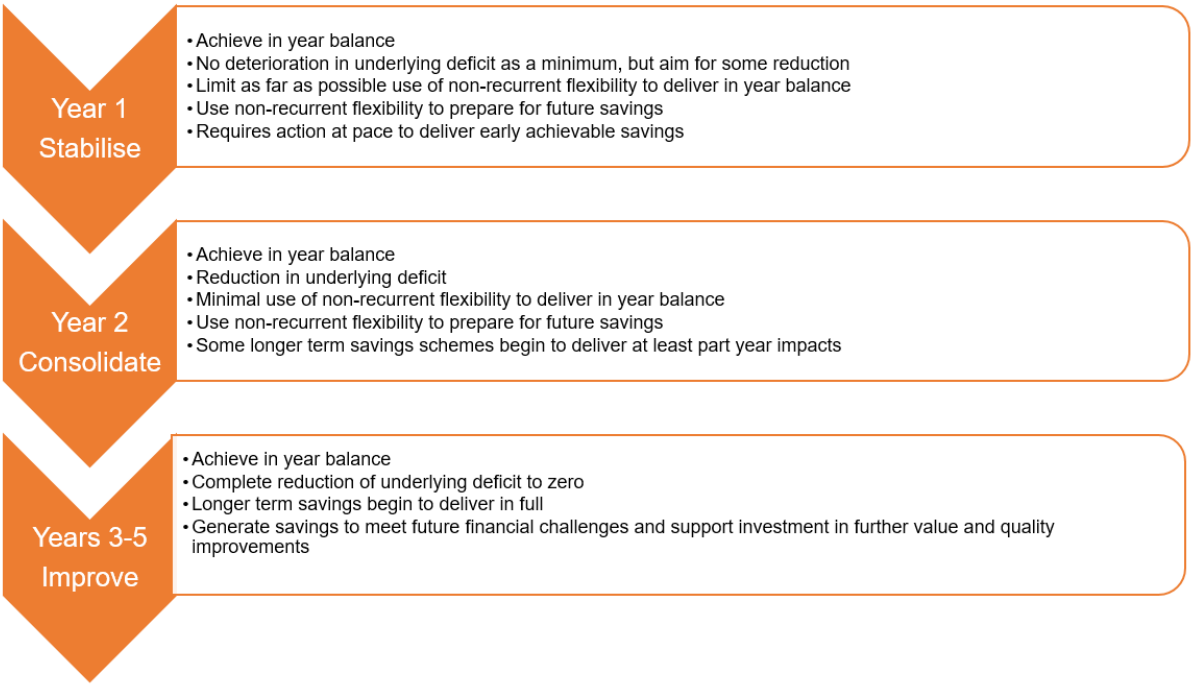
In pursuit of the twin objectives of best value and affordability leading to sustainable financial balance, we will work to the following key principles across revenue and capital:

- 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.



The current plan (Table 1) models the position assuming in year financial balance duties to be met through non-recurrent flexibility or delivery, as a result of limiting our ambition for in year recurrent savings to around 3%. The Somerset Finance Group have constructed a high level refresh of the system financial strategy plans, with a view to updating these when a more detailed Medium Term Financial Planning exercise is completed later this year. This high level refresh has included the following assumptions:

- Revised Exit ULP in 2023/24 as per the 2023/24 submitted plan.
- System to deliver recurrent balance in 2026/27, with ambitious recurrent savings programme 2024/25.
- All assumptions to be updated in more detail within Medium Term Financial Plan
- In addition, Somerset Council are currently predicting a £60m Underlying Financial Position in 2023/24. This could potentially increase to £100m in 2024/25. A work programme is in place to mitigate this position and future iterations of the Medium Term Financial Plan will include this in more detail to have a complete ICS position.

Table 1 – Current 4-year plan

Strategic Financial Plan	**23/24**	**24/25**	**25/26**	**26/27**
	£m	**£m**	**£m**	**£m**
System allocation	1,206	1,244	1,281	1,319
Assumed glidepath reduction		-14	-8	0
Other income to the system	294	294	294	294
System expenditure before savings	-1,612	-1,626	-1,625	-1,639
ULP Do Nothing	-112	-102	-58	-27
Realistic assumption - savings delivered recurrently	36	51	36	27
Revised Exit ULP	-76	-51	-21	0

Performance

The Somerset operational finance, activity and workforce plans for 2023/24 have been 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) have been 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 have all been 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 have been set out within the system Operational Plan. Development of future plans will be overseen through the System Assurance Forum.

Our People

Our Somerset 'One Workforce'
Our health and care workforce, which is made up of both paid and unpaid people contributing to the system, underpins the successful delivery of Somerset's Integrated Health and Care Strategy. The resilience of our care workforce which is 'capable, confident and collaborative' across our ICS is critical to delivering the ambitions and vision for integrated health and care services which will have a positive impact on population health.

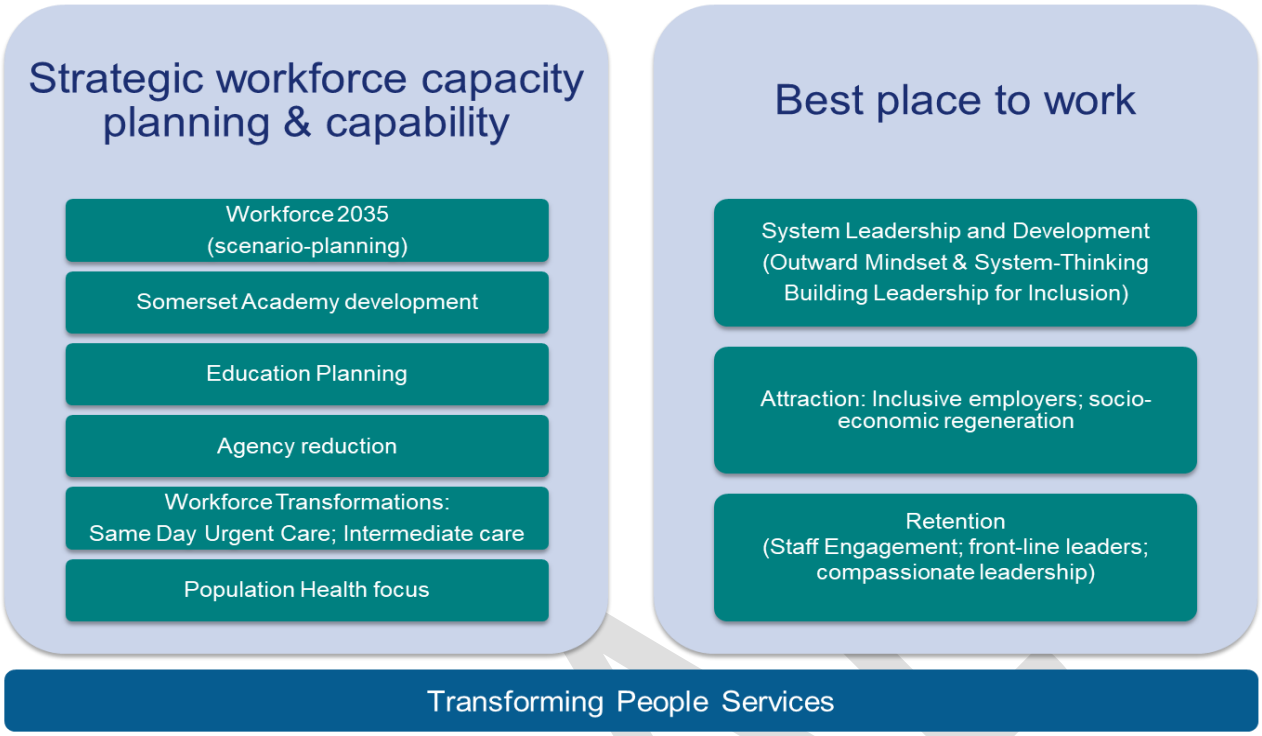
Ensuring we have the right workforce, in the right places, at the right time is critical to our performance as a system and excellent care services.

In Somerset the strategic direction of the future workforce is overseen by the Somerset People Board, a partnership collaboration, which also approves the wider aspects of the people agenda including health and wellbeing, inclusion and engagement.

The Somerset People Board's vision is

> 'to create a vibrant, resilient and agile health and social care sector, working collaboratively with the public, private, voluntary and community sector to attract, develop and retain talent in Somerset.'

The Somerset People Board has approved key priorities for 2023-24 within the Somerset People Plan and will regularly review progress. The priorities are:



Our **Somerset 5-year People Plan** was updated during the spring of 2022 in readiness for the launch of the ICB and can be seen below. There are eight strategic aims underpinned by a number of cross-cutting principles relating to equality, diversity and inclusion, widening participation, social/wider determinants of health (population health management) and digital as an enabler.

Activity covers primary, secondary and social care (independent and local authority) and the VCFSE sector and also captures the workforce which is outside of traditional care boundaries, such as local authority housing staff who have a major contributory

impact to those in receipt of health and/or social care services but are included in, for example our health and wellbeing programme and systems thinking (organisation development) work.

In order to achieve the vision, our plan provides a systemwide approach to workforce as well as being aligned to associated national, regional and local strategies (e.g. NHS People Plan, Adult Social Care People Plan, somerset primary care, population health management, digital strategies) to ensure maximum benefit to our system and efficiencies.

We will refresh our People Plan regularly to continue to meet the needs of the ICS Strategy and the context in which we work.

What actions will we take over the next 1,2 and 5 years?
Our current work programme includes, from the Board priorities:

- Workforce 2035: This is a collaborative project between Somerset ICS, NHSE (HEE) and the Staff College to develop a future Somerset workforce model aligned to our strategic principles, using 2035 Scenarios as a framework for debate, analysis and system development/transformation.
- 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.
- Workforce transformations within specific elements of the patient pathways where we have workforce shortages.
- Expanding pipelines of workforce supply, including increasing the number of clinical placements through our partnerships with local colleges and HEIs. By creating more entry-routes into health and care careers (e.g. apprenticeships, t-levels) accompanied by more structured work experience programmes and career insight work in primary and secondary school settings.
- Aligning employment and development routes into health and social care by working closely with partners such as DWP, Economy teams from the local authority, NHS etc focussing on unemployment and underemployment (e.g. Sector Work Based Academy programme, Reservists).
- Retention plans across the ICS workforce, and underpinning the NHS People Plan.
- Staff Experience and wellbeing which includes specific actions to address inequality and improve a sense of belonging and inclusion.
- System and organisation development with a focus on embedding cultural change across our system through system thinking, inclusive and compassionate leadership.
- Development of outcomes metrics.
- Integrating support strategies such as digital and estates.

How will we know we are making a difference?
We have a range of existing tactical people KPIs (such as turnover rates; absence figures and vacancy factors); however, as part of our transformation work we will also address the need to develop measures that focus on outcomes. The

development of measures for organisation and system development will be done with partners in the system as well as working regionally.

Enhance productivity and value for money

Digital and Data

Our strategic focus for Somerset over the last few years has centred on the following:

- 2016 Somerset Digital Roadmap - focus on clinically-led, digitally enabled systems.
- 2020-2022 switch to digital first, remote and virtual working.
- 2022 digital acceleration, data, and intelligence focus (including population health and health inequalities).

- Digitise
- Connect
- Transform

We are developing the Somerset Digital, Data and Inclusion Strategy which will cover four key elements People (User Centred Design), Place (Intelligence Function), Process (Information Sharing Panel) and Technology (Technical Design Authority), following the principles from the national framework below.

All four elements are inter-related, forming foundations and opportunity to support development, transformation, and acceleration to new ways of working.

Using our digital systems, we will:

- Continue to develop the Somerset Integrated Digital e-Record (SIDER), the shared care record, across the Somerset system making the right information available to the right professional at the right time.
- Use population health systemwide intelligence, harness data analytics and deliver evidenced based priorities to support improved outcomes and reduce inequalities.

- Enable people to access their health and care records securely, quickly and at when they want to see information or data.
- Support our workforce with clinical and strategic decision-making technology, providing health and social care organisations who deliver care to access relevant, accurate and up-to-date information.
- Ensure personal health and care information is safe and secure.
- 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.

Further, the newly merged SFT has developed its Outline Business Case for an Electronic Health Record that will replace three legacy systems following recent mergers. SFT has ambitious programme designed to improve data sharing between clinical teams, strengthen care pathways and improve the experience for its clinical teams and people they serve.

What actions will we take?

- Development of system-wide Digital Strategy (quarter 2 2023/24).
- Re-procurement of Somerset Shared Care Record (2023/24).
- Procurement Population Health management capability.
- Procurement of Single Electronic Health Record.
- Review of data capabilities.
- Technical infrastructure review.
- Expansion of Hospital at Home service.

How will we know we are making a difference?
The systemwide strategy development will include steps to embed digital within the development of the clinical model and ways of working. The strategy will also be driven by the Digital Maturity Assessment output which will act as a yardstick for enhancing digital capability across the system.

Estates

We are developing an ICS Estates Strategy which builds on a previous version produced in 2019. Many of the major estates' issues remain the same now as then, but there has been significant change in the provider landscape in recent years, as well as major progress with changing our estate to make it more modern and sustainable. Our ICS Estates Strategy will bring together the key themes from partners including:

- Somerset NHS Foundation Trust – SFT has an Estates Strategy that considers acute and community hospitals, other community health facilities and mental health.

    - Both acute hospitals are in the middle of significant estates changes which will deliver the Musgrove 2030 and Yeovil District Hospital 2030 programme.
    - For community services, key themes include the development of Community Diagnostic Hubs and the reconfiguration of community hospitals.
    - For mental health the trust will build on the outcomes of the inpatient unit reconfiguration, and develop further estates solutions for community mental health.
- Somerset Council – the new unitary authority is conducting a thorough review of its estate, bringing together the former County and District County estates under new unified management. The Council will use this to drive estates efficiencies and deliver more sustainable estate, as well as working with public sector partners as part of One Public Estate to deliver joined up services in existing and new buildings for the local population.
- Primary care – the complexities of the primary care landscape and the numerous partners involved in delivering these services means that this remains a complex picture. A detailed review of the condition and capacity of primary care estate is underway to inform the future strategic planning.

What we are seeking to achieve for our population

We want to ensure the delivery of high-quality public facilities which meet the needs of our population. We want to provide services that are as close to our communities as possible, giving easy access to all, in buildings which are well designed. We will ensure that our estates support the delivery of commitments in regard to net-zero carbon and local organisations' Green Plans.

Our key goals are to make sure that the public estate will:

- Work for the people that use public buildings.
- Help to deliver local organisational delivery strategies e.g. SFT's clinical strategy.
- Be safe, well maintained, effective and welcoming.
- Support our aim to value all people alike, and to recognise the diverse needs and wishes of our population.
- Be well designed, to ensure that buildings are efficiently used, welcoming and effective in promoting good service delivery.

We will deliver our estates strategy by adopting the following five principles:

- Promoting safe, effective, high-quality services delivered in the most appropriate setting, which enhances the local populations' wellbeing.
- Ensuring that the estate promotes colleague wellbeing and productivity.
- Ensuring that the estate is fully and effectively utilised and reducing estate where it is not required or not cost effective to maintain.
- Ensuring that the estate is fit for purpose.
- Reducing the running costs of the estate to enable better use of resources.

What actions will we take?

We will, wherever possible, transfer healthcare activity from hospitals to the community. We will support the development of new models of care by providing alternative settings of care to reduce dependence on hospital beds. This will include further investment in improved imaging and other diagnostic facilities in community venues, and the reconfiguration of beds across community hospital sites.

We will continue to maintain and enhance the estate for mental health services, reflecting the changing need for these services, both ensuring that inpatient facilities are suitable for modern standards and the community estate meets the need for the expanding and changing services and the ability to work closely with partners across the county.

We will continue the Council's progress towards an asset management approach known as the Corporate Landlord model. This manages assets owned by the Council centrally by one dedicated property department. This allows for improved corporate oversight by the Council of important issues such as compliance and financial management. The approach also drives improvement in the utilisation and long term value of the property estate, by enabling flexibility to adapt to changing requirements, driving the optimisation of properties through co-location, and improving the quality of decision making on asset management issues by bringing a professional, longer term focus.

We will continue to engage with primary care in the delivery of estates improvements, bearing in mind the needs of patients and the changes being made to public service provision in other sectors.

We will rationalise and reduce the number of buildings and areas of land wherever possible and appropriate, considering potential long- and medium-term needs, and ensuring assets are held for a clear purpose and provide best value.

We will continue our engagement work with communities and customers, using the insights of community representatives and customer intelligence data to understand how public sector assets can be used to meet the needs of the population of Somerset most effectively. This engagement will drive discussions about how asset devolution, or a greater community involvement in local assets, might drive better value and outcomes for communities and customers.

How will we know we are making a difference?
The estates needs of the ICS are determined by the design of the services which the estate supports. It is vital that we continue to factor in estates needs to the design of services as they change, and as part of public consultations. Where services are provided from is key to public satisfaction, and we want service users to feel comfortable with the buildings we ask them to go to.

We will monitor the impact of our work through existing metrics such as national and local performance indicators. We will also work with colleagues and service users to understand how they would like us to monitor our effectiveness, and how well we support them.

Key Risks

The age and functional suitability of the estate across the ICS is one of the key risks to the delivery of the strategy. The other key risks are outlined below:

- The backlog maintenance requirements have continued to grow over recent years impacting on the quality of facilities and current capital resource is insufficient to reduce this level significantly.
- The relatively small capital budget for the ICS limits the level of strategic change that can be undertaken.
- The geographic spread of our population and appropriate travel times provides additional challenges in delivery of high-quality estate across multiple locations.
- The workforce to maintain the estate and develop new projects is limited as a result of other infrastructure projects and the small population.

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 Nation 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 and make our contribution to the goal of a carbon neutral Somerset by 2030.

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.

In response to these challenges and opportunities, Somerset ICS recognises the climate emergency and is committed to achieving the national NHS target of net zero by 2040 and contributing to the goal of making Somerset a carbon neutral County by 2030. 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.

Procurement/Supply Chain

The NHS has set two national targets for its carbon footprint: net zero by 2040 for emissions under the direct control of the NHS and net zero by 2045 for the full carbon footprint including the whole supply chain and patient/visitor travel (known as NHS Carbon Footprint plus). To achieve this goal, we will require the support of all our suppliers.

In September 2021, one year on from the publication of the Delivering a net zero NHS report, the NHS England Public Board approved a roadmap to help suppliers align with our net zero ambition between now and 2030. This approach builds on UK Government procurement policy (PPN 06/20 and PPN 06/21).

Purpose of programme

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. The Somerset ICS recognises the climate emergency and is committed to

achieving the national NHS target of net zero by 2040 and contributing to the goal of making Somerset a carbon neutral County by 2030.

5-year programme aims and key outcomes

The priority areas addressed by the Green Plan are:

- Leadership and governance: how the Green Plan will be delivered.
- Awareness and engagement: it is critical that we engage with our employees to deliver the Green Plan.
- Sustainable healthcare: how our services will evolve to meet the sustainability challenge.
- Public health and wellbeing: how improved public health will mean a smaller carbon footprint.
- Estates and facilities: we will aim for net zero carbon emissions and zero waste from our estates.
- Travel and transport: we will aim for net zero carbon emissions for all aspects of travel relating to NHS.
- Supply chain, procurement and commissioning decisions: how we will drive sustainability down through our supply chain and commissioned services.
- Adaptation and offsetting: we will prepare for locked in climate impacts and offset or inset our residual carbon emissions once we have reduced them as far as possible.
- Decarbonisation through digitisation: a cross-cutting theme of the Green Plan.

Prioritisation:

Years 1 to 2 programme milestones and trajectories

- **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).

- **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.

- Every ICS member to develop a green travel plan by December 2023.

From April 2024:

- The NHS will extend the requirement for a Carbon Reduction Plan to cover all procurements.
- All Trusts and the ICS to have a climate change adaptation plan by 2024.

We will review care pathways and opportunities to increase digitisation of services and minimise patient travel. 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.

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.

Every ICS member to reduce its use of desflurane to less than 10% of its total volatile anaesthetic gas use, by volume.

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.

Years 3 to 5 programme milestones and measures

The ICS Green Plan commits to there being access to a nature/biodiversity area at every significant site in Somerset by 2025.

From April 2027: all suppliers will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for all of their Scope 1, 2 and 3 emissions.

From April 2028: new requirements will be introduced overseeing the provision of carbon foot printing for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.

The carbon footprint of the NHS estate in Somerset will be net zero by 2040 with a minimum 80% reduction in carbon emissions by 2030.

The carbon footprint of NHS-related transport will be net zero by 2040 with a minimum 80% reduction in carbon emissions by 2030.

From 2030: suppliers will only be able to qualify for NHS contracts if they can demonstrate their progress through published progress reports and continued carbon emissions reporting through the Evergreen sustainable supplier assessment.

Key risks

Even if the best-case Paris Agreement target of keeping average global temperature rises to 1.5°C above pre-industrial levels is met, significant climate related impacts are to be expected, including rising sea levels, flooding and increased incidents of extreme temperature. Public bodies, including the NHS, are required by Government to have an adaptation plan.

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.

We have established an ICS Engagement 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.

The purpose of the network is to:

- Provide a forum for collaboration between Engagement Leads working across the ICS in Somerset.
- Share learning, resources and approaches to improve regulatory compliance and quality of outcomes for patients and the public.
- Developing opportunities to work together to reduce duplication and co-ordinate public engagement.
- Be visible to, and accessible by, the wider system as a bridge to improving engagement in every part of health and social care.
- Contribute to building a culture of engagement across the Somerset health and care system.
- Feed into system-wide quality improvement by bringing the patient and public voice to the heart of decision making.

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:

1. Put the voices of people and communities at the centre of decision-making and governance.
2. Understand our community's needs, experience and aspirations for health and care, with a strong focus on underrepresented communities.
3. Involve people at the start in developing plans and feed back how their engagement has influenced decision making and ongoing service improvement, including when changes cannot be made.
4. 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.
5. Build relationships with underrepresented groups, especially those affected by inequalities, ensuring their voices are heard to help address health inequalities.
6. Work with Healthwatch and the VCFSE sector as key partners.
7. Through partnership working, co-production, insight and public engagement address system priorities in collaboration with people and communities, demonstrating accountable health and care.
8. Use community development approaches that empower people and communities, building community capacity.
9. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
10. 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.

Working with people and communities is important to us; by working together people can help us improve all aspects of health and care, giving people the power to live healthier lives.

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 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.

Our public Engagement and Communications Shared Purpose:

Fig 1: Public Engagement and Communications Shared Purpose

Engagement activity across Somerset ICS, involving public health, local authority and NHS colleagues, will be of significant importance if we are to empower local people to take shared responsibility for their health. We will do this by working together.

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 already have a number of methods and tools at our disposal to support our public engagement. We will continue to build on and review our structures for gathering public and patient insight and how these inform our programme of work.

We want to ensure we engage and strengthen existing networks. We will continue to work closely with local organisations and networks. They play a significant role in helping us to reach out to our local communities and groups, enabling meaningful public engagement to help shape services and improve health outcomes for the population of Somerset.

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

We aim to establish an NHS Somerset public insight mechanism which could be established across the Somerset ICS. We plan to establish mechanisms to gather insight across the Somerset system which can be utilised early on in programmes to inform engagement requirements, programme development and decision making. Reviewing existing information can save time and money, by reducing duplication of engagement and identifying gaps in insight.

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 continue to assess our approach so it is adaptive and flexible to the particular needs of children and young people by applying continuous learning. This will be supported by setting a clear measurement framework to assess our impact and taking an iterative approach to apply learning.

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.

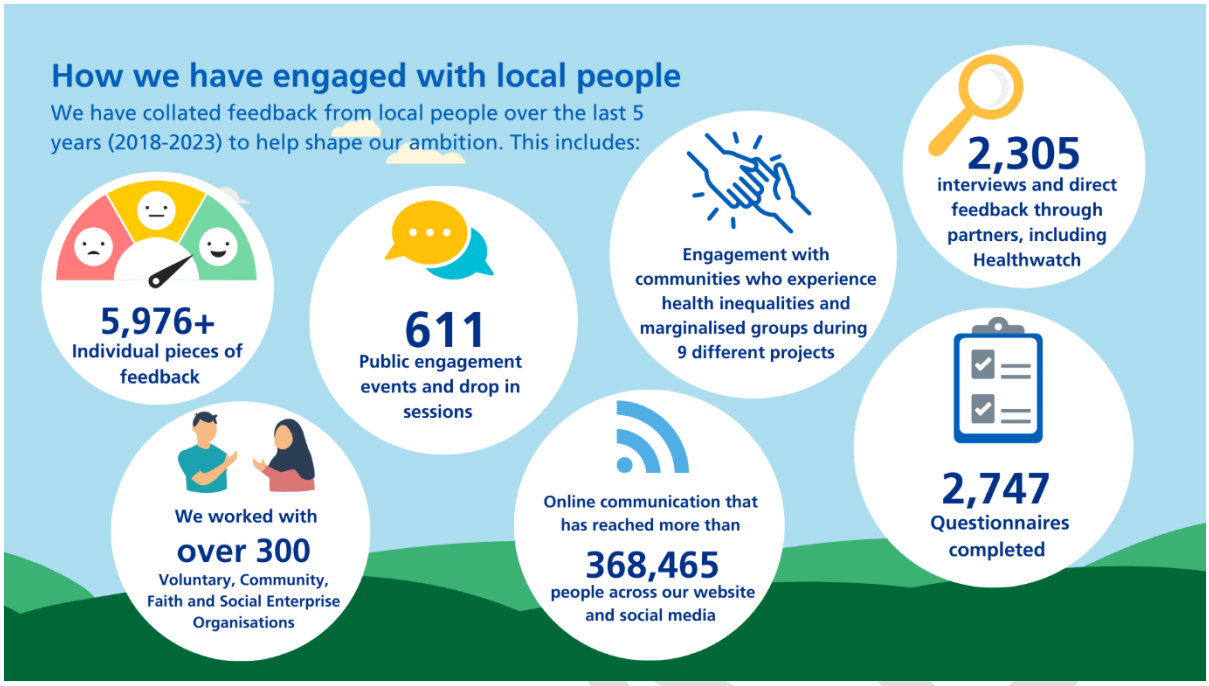
We will use the basic theory of change model to evaluate our engagement impact.
To inform the Joint Forward Plan we have specifically taken the following action:

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.