



*National Institute for
Health Research*

NIHR CLAHRC West Stakeholder Priorities for Health and Wellbeing

Date: 30 July 2014
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Plain English Summary

An innovative collaboration, funded by the National Institute for Health Research (NIHR) has recently been set up to improve the health and wealth of people living in the West. The NIHR Collaboration for Leadership in Applied Health Research and Care West (CLAHRC West) brings together highly experienced health researchers and front line NHS staff to work with partners in local government, industry, and the voluntary sector and particularly with patients and the public to carry out research focused on the health priorities of the West. The partnership will also support the NHS in establishing the most efficient and effective ways of turning evidence into benefits for patient care and public health. NIHR CLAHRC West covers the following areas: Bath and North East Somerset, Bristol, Gloucestershire, North Somerset, South Gloucestershire, Swindon and Wiltshire.

This report has been produced to give a better understanding of the West's population's current health needs and priorities. This will enable us to identify where we need to concentrate our research efforts and help plan new partnerships with a view to bringing about service improvements.

The report findings suggest that health in the West is on average better or similar to the England average. Areas that are consistently better than the England average are Bath, North East Somerset, and Wiltshire. Bristol has the highest levels of poverty and South Gloucestershire the lowest. Several health priorities have been identified. These include developing strategies aimed at preventing people from becoming ill, as well as long term improvement for those already using services. Although some people need to be cared for in hospital, many could remain in their own homes with the necessary help and support. Providing help and support at home or close to home was identified as a high priority across the board, along with the paramount concern of keeping patients safe.

Effective communication is also an important priority. This includes improving communication to enable patients to live independently for as long as possible, increasing communication between GP practices, hospitals and social services to improve care coordination, and sharing patients' electronic health records to make sure care given is safe and appropriate. Improving patient and carer experiences and encouraging values such as dignity and respect are also high priorities.

Current arrangements for partnerships are well placed to meet the challenges posed. However, further exploration of possible partnerships to be considered include those to improve the care for people at the end of life, pregnant women, as well as driving developments in patient information and communication. Key functions for NIHR CLAHRC West will be to ensure that people and organisations can learn from each other to spread best practice, inform service improvements and provide care that is safe, fair and sustainable.

Executive summary

1. This document reports on an analysis of regional stakeholder priorities across the geographical area covered by NIHR CLAHRC West which includes Bath and North East Somerset, Bristol, Gloucestershire, North Somerset, South Gloucestershire, Swindon and Wiltshire. The aim of the analysis is to aggregate publicly available information about the population's health needs in general, and more specifically in relation to public health and long term conditions (LTCs). To this end, we collated population level health information for the West; identified current priorities at regional, local, and organisational levels; and synthesised and mapped priorities to produce a composite picture across the area, to identify potential new collaborations and partnerships and to enable strategic priority-setting.
2. Results suggest that the overall health of the population in the West is generally better or comparable to the England average. Levels of deprivation range from 0.5% South Gloucestershire to 25.9% in Bristol. Life expectancy is similar or better than England average (with exception of Bristol where male life expectancy is lower). In some areas in the West, infant mortality, diabetes, self-harm and suicide, injuries among young people, smoking, depression, detentions under Mental Health Act were higher than the English average; rates of adult obesity, child mortality, and teenage pregnancies were comparable to the English average while performing better regarding breastfeeding initiation, mental health problems, obesity in children, and children living in poverty (except in Bristol).
3. Through our analysis of publicly available data on population health profiles, Joint Strategic Needs Assessments, Health and Wellbeing Board Strategies, NHS and Local Authorities organisations' annual reports and business plans, we have identified a wide range of priorities which are broadly aligned with the NHS and Public Health Outcomes Frameworks. The most prominent area of convergence of priorities across the geographical area is the shift of focus from delivering services to developing strategies aimed at prevention and sustainability. The theme of **prevention** extends beyond usual definitions of prevention of illness –although this obviously remains an important priority- but includes broader concerns around avoidable harm reduction and increase in time spent living independently for older adults and those with long term conditions and multi-morbidities. Under this theme, we located the following strategic priorities adopted by Local Authorities and Clinical Commissioning Groups:
 - Prevention of avoidable deaths and ill health (related to behavioural factors such as diet, physical activity, participating in social activities, risky behaviours around sex, drugs and alcohol, as well as wider social determinants of health)
 - Prevention of ill health (screening, early diagnosis and early intervention)
 - Prevention of ill health related dependence on services, and exacerbation or deterioration of long term conditions
 - Prevention of avoidable health care related harm, especially infection and management of sepsis, and medication errors
 - Prevention of avoidable admission to hospital.
4. The aims of these strategies focus on effective self-care for individuals and families, and resilience for communities. The avoidance of emergency admissions is one of the most pressing priorities because the current system that is in the process of being reviewed and redesigned is unsustainable. Plans for community-based facilities to meet people's urgent

care needs and prevent escalation especially for those living in rural communities are very high on the agenda at this level.

5. Strategies to address this priority are grouped in the second theme of convergence which is about **effective communication** at a number of different levels from individual to organisational and sectorial levels to achieve a more integrated system that is wrapped around patients and service users with the aim of avoiding multiple contacts with different services and different points of access. Under this theme, we located the following strategic priorities:

- Improvements in communication with the public, patients, service users and carers to bring about a shift of focus away from a purely clinical focus on managing or treating symptoms, to supporting patients and carers to become more functional, independent and resilient;
- Staff enacting values of compassion and care in their contact with patients, service users and carers;
- Improvements in communication between sectors, primary and secondary/tertiary care, services for mental health and physical health, and between professionals to challenge silo-based working;
- Shared electronic health records and data linkage across IT systems to support cross-sectorial and inter-agency working and enhance patient and service safety.

Other broad themes include:

- Quality and safety (medicines management, patient safety in hospital, safety in primary care, reducing risks to mental health)
- Care closer to home (appropriate care at the right time as close to home as possible)
- Organisational learning at the 'sharp' and 'blunt' end from patient/ carer feedback, adverse events, reviews and incidents
- Sustainability at a time of financial austerity where services need to be appropriately delivered (best person/ least cost)

6. At organisational level, in relation to patient safety, the avoidance of hospital or healthcare related harm featured prominently among Trusts as did the need to minimise risk of harm to people who use services. Priorities in this category clustered around the need to reduce hospital acquired infections, medication errors and other incidents resulting in harm as well as to effectively manage sepsis and rapidly deteriorating patients. In terms of clinical effectiveness, the reduction of variations in clinical outcomes, and a focus on quality and safety was among the most frequently listed issues. Patients with dementia and LTCs as well as the frail elderly were identified as requiring particular consideration with an emphasis on improvements in care planning and shifting services closer to home to avoid admission to hospital. The need to improve 'patient flow' was a frequently listed priority. Improving the patient and carer experience was also a common concern, and it was seen as imperative to enact values such as dignity, compassion, kindness and respect in every contact of care and service delivery. Designing innovative ways of capturing patient experience and crucially, developing ways of learning from what patients and carers tell staff and managers about their experience was identified as a priority by some Trusts.

7. Along the lifespan, the groups being prioritised were pregnant women; children and young people; people with long term conditions/ mental health problems/ learning disabilities; people who are frail and elderly; and those at the end of life. Crosscutting groups are minority ethnic groups and those living in deprived urban areas. Addressing health inequalities was among the highest priorities in many strategies. However, along with a number of prioritised groups, much of the information provided was around aspirations and

espoused priorities for these groups, or the importance of planning future provision, with few concrete and explicit strategies for action. This highlights the challenging nature of some of the social and health problems the UK and the region are facing at a time of financial constraint and economic austerity. The responsibility for tackling these problems through addressing amenable social determinants and health system factors is widely dispersed and will require continued collaborative working between all public and voluntary sector agencies as well as policy interventions. However, it is evident from this priorities analysis that at national, regional, local and organisational levels public health responses are being proposed and facilitated.

8. On the basis of existing research and implementation team working in Bristol and across the West, and the leadership role of the West England Academic Health Science Network, a number of strategic priorities are being covered such as patient safety and harm prevention; avoiding hospital admissions, and care closer to home; the integration of care pathways, and cross-sectorial working and planning; improving care for those with LTCs and for the frail elderly; and improving the conditions for and uptake of measures to ensure healthy lives and to prevent ill-health and harm. The areas that are currently not explicitly addressed in the publicly available documents we analysed are around maternity care and care for people at the end of life; patient information and communication systems such as electronic health records and the computerised care processes such as electronic prescribing and observations; issues relating to patient flow, variations in quality of care and health outcomes, and organisational learning.
9. Although some of these areas are already receiving attention and are being advanced, they offer the potential for further strategic development work that could be supported through the NIHR CLAHRC West. Moreover, NIHR CLAHRC West could have a key role in ensuring that opportunities for shared learning across different services, organisations and specialities are realised and that system-wide concerns are addressed in collaboration with the WEAHSN and partner organisations.

Introduction and background

The NIHR CLAHRC West Board has requested an overview of regional stakeholder priorities to assist in the process of collaboration for research and implementation across the geographical area covered by NIHR CLAHRC West includes Bath and North East Somerset, Bristol, Gloucestershire, North Somerset, South Gloucestershire, Swindon and Wiltshire. The aim of this report is to aggregate publicly available information about the population's health needs in general, and more specifically in relation to public health and long term conditions (LTCs) in order to

- Enable more accurate mapping of areas and groups requiring specific consideration for interventions and services
- Produce meaningful intelligence on existing and predicted needs
- Identify where needs and priorities are 'clustered' even if geographically removed from one another, suggesting possibilities for collaboration and joint research and implementation strategies
- Provide assistance to the NIHR CLAHRC West Research Advisory Panel for prioritisation RAP(p) in the evaluation of proposals
- Produce accurate baseline intelligence against which to measure NIHR CLAHRC West impact over the next five years.

The NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) have been established to contribute to the vision of the National Institute for Health Research (NIHR¹) to improve the health and wealth of the nation through research. While there have been nine previously funded CLAHRCs in England, NIHR CLAHRC West is a new collaboration with funding for five years from January 2014. The NIHR CLAHRC West is hosted by University Hospitals Bristol NHS Foundation Trust, acting on behalf of the collaborative partnership between local providers of NHS services and NHS commissioners, universities, local authorities and social organisations, and the West of England Academic Health Science Network (WEAHSN²). It is a national scheme that is funded to undertake research that is generalisable, focused on the needs of patients, supports the translation of research evidence into practice, and has wide applicability across the NHS and in public health, as well as within the WEAHSN. They create and embed approaches to research and its dissemination that are specifically designed to take account of the way that health care is increasingly delivered across different sectors and wide geographical areas. The aims of the CLAHRCs are to:

- Develop and conduct applied health research relevant across the NHS, and to translate research findings into improved outcomes for patients;
- Create a distributed model for the conduct and application of applied health research that links those who conduct applied health research with all those who use it in practice across the health community;

¹ The NIHR is a large, nationally distributed organisation which funds health and clinical research. It provides facilities and systems which represent the most integrated clinical research system in the world, driving research from bench to bedside for the benefit of patients.

² AHSNs are collaborations between the NHS and universities, covering a large geographical area. Their aim is improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems. Their core purpose is to enable the NHS and universities to work collaboratively with industry to identify, adopt and spread innovation and best practice.

- Create and embed approaches to research and its dissemination that are specifically designed to take account of the way that health care is delivered across the local AHSN;
- Increase the country's capacity to conduct high quality applied health research focused on the needs of patients, and particularly research targeted at chronic disease and public health interventions;
- Improve patient outcomes locally and across the wider NHS;
- Contribute to the country's growth by working with the life sciences industry.

The geographical area covered by the NIHR CLAHRC West and West of England AHSN includes Bath and North East Somerset, Bristol, Gloucestershire, North Somerset, South Gloucestershire, Swindon and Wiltshire. The overall mission of the NIHR CLAHRC West is to actively engage its academic, NHS and local authority partners in the conduct of applied health research and the implementation of relevant research evidence to improve health and healthcare across its area. Its ethos is to focus on research and implementation that is equitable (fair), appropriate (providing optimum advice or care at the right time and place for prevention or care), and sustainable (taking account of resource-use and future continuation). There are two broad thematic areas of 'improving the management of chronic diseases' and 'public health interventions and population health'.

High quality applied health research will be directed and integrated through research and implementation themes encompassing the major methodologies needed for applied health research including evidence synthesis, health economics, epidemiology, medical statistics, evaluation science, and qualitative and other social science approaches. Strategies for implementing research findings and innovation will be developed in partnership with the WEAHSN and put into practice by designated multidisciplinary teams and Health Integration Teams (HITs) – groups comprising commissioners, NHS clinicians and allied health professionals, and academics who have come together to improve public health and healthcare in specific contexts across the West. Patient and public involvement and engagement (PPIE) is included throughout the research and implementation processes, and there is a programme of training and capacity-building for research and implementation – both with joint strategies for the NIHR CLAHRC West and WEAHSN. The NIHR CLAHRC West partner organisations are listed below:

Local Authorities:

Bath & North East Somerset Council
 Bristol City Council
 Gloucester City Council
 North Somerset Council
 South Gloucestershire Council
 Swindon Council
 Wiltshire Council

NHS Trusts:

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
 Bristol, North Somerset and South Gloucester Clinical Commissioning Groups (BNSSG CCGs)
 North Bristol NHS Trust (NBT)
 Public Health England (Avon Gloucester and Wiltshire)
 University Hospitals Bristol NHS Foundation Trust (UH Bristol)

Partnerships:

Bristol Health Partners (Bristol HP)
 West of England Academic Health Science Network (WEAHSN)

Higher Education Institutions:

University of Bath (UoBath)
 University of Bristol (UoBristol)
 University of the West of England (UWE)

Other NHS organisations within NIHR CLAHRC West and WEAHSN boundaries:

Gloucestershire Clinical Commissioning Group
 Swindon Clinical Commissioning Group

Bristol Community Health
 Gloucestershire Care Services

Wiltshire Clinical Commissioning Group
Gloucestershire Hospital NHS FT (Cheltenham
General and Gloucestershire RI)
Weston Area Health NHS Trust (Weston General)
The Great Western Hospital NHS FT (Swindon)
Royal United Hospital Bath NHS Trust
2gether NHS Foundation Trust (Mental Health
Trust, Gloucester)

North Somerset Community Partnership
SEQOL, Swindon
Sirona Care and Health CIC
South West Ambulance Service NHS FT

Methods

Publicly available data on population health profiles, Joint Strategic Needs Assessments (JSNAs), Health and Wellbeing Board Strategies, NHS and Local Authorities (LA) organisations' annual reports and business plans were accessed through NHS and LA websites. Data were extracted to identify:

- Population characteristics and public health data
- Needs of populations and groups, and challenges for local services
- Priorities in addressing needs and challenges, as identified by Health & Wellbeing Boards
- Strategies for meeting these, as developed by service providers in NHS and LAs

The data were analysed against the current health policy background which sets the strategic direction at a time of unprecedented financial challenges for the NHS in the context of growing demands on services and sustained constraint in public expenditure.

Objectives:

1. *To collate population level information for the NIHR CLAHRC West region*
 - Key population
 - Health statistics
 - Public Health data
 - Health Inequalities and quality of life
 - Long term conditions data
 - Public Health data on mental health, obesity, breastfeeding etc. in the West
2. *To identify regional and local priorities*
 - Joint Strategic Needs Assessments and Health and Wellbeing Strategies
 - West of England Academic Health Science Network
3. *To identify organisation level priorities*
 - Publicly available information on organisation websites, annual reports and business plans where published
4. *To map information for analysis and comparison to produce a composite picture of local and regional problem areas, priorities, good practice and interventions, potential collaborations and partnerships*
 - Extract information from documents and websites and input into NVivo Data Management software
 - Code and thematically analyse data
5. *To generate report(s) of findings, analysis and interpretation*

- High level findings and recommendations (Executive summary)
- Short plain English summary
- Detailed information and analysis providing tables of data according to LAs and CCGs (Appendix 1 and 2), organisations (Appendix 3) and specific groups across the lifespan (Appendix 4).

Findings

Population level information for the West

Population level statistics have been provided for each of the seven regions within the West and have been compared against the England average where possible. These include health profile statistics, child health profiles and community mental health profiles. Tables 1, 2 and 3 provide a summary ‘snap-shot’ of the health performance and outcomes for each of the regions in relation to the rest of England.

Overall health within the West was generally better or comparable to the England average (Table 1). Bath and North East Somerset and Wiltshire were consistently scoring significantly better than the England average, closely followed by South Gloucestershire. Deprivation varied across the regions, with South Gloucestershire having the lowest levels of deprivation (0.5%) and Bristol the highest (25.9%). However, all regions, apart from Bristol, had a deprivation score significantly better than the England average. Life expectancies throughout the regions of the West were similar and frequently better than the England average. Bristol was the exception, with a reduced life expectancy in men (78.3 years) compared to the England average (79.2). In relation to overall health, the majority of regions were similar or above the England average. Swindon had a significantly worse percentage of smoking prevalence and diabetes rates. Gloucestershire also had worse diabetes rates than the England average. All regions had a similar percentage of obese adults, with none of the regions being significantly worse or better than the England average. Breastfeeding initiation was significantly higher than the England average in all regions, apart from Gloucestershire, which was similar to the average.

Table 1. Health profile statistics (2014) for each geographical area within the West

| County | Deprivation (%) [*] | Life expectancy ^{**} | | Smoking prevalence (%) | Obese adults (%) | Diabetes rate (%) ^{***} | Breastfeeding initiation (%) ^{****} |
|------------------------|------------------------------|-------------------------------|-------------------|------------------------|------------------|----------------------------------|--|
| | | Male | Female | | | | |
| <i>England average</i> | 20.4 | 79.2 | 83 | 19.5 | 23 | 6.0 | 73.9 |
| Wiltshire | 2.0 [#] | 80.4 [#] | 83.9 [#] | 17.2 [#] | 22.3 | 5.4 [#] | 81.0 [#] |
| Swindon | 14.4 [#] | 79.3 | 82.7 | 21.5 ⁺ | 22.6 | 6.4 ⁺ | 76.8 [#] |
| South Glos | 0.5 [#] | 81.0 [#] | 84.6 [#] | 17.5 | 21.1 | 5.2 [#] | 77.3 [#] |
| Nth Somerset | 9.6 [#] | 79.6 | 83.5 | 14.8 [#] | 22.7 | 5.5 [#] | 81.4 [#] |
| Gloucestershire | 7.2 [#] | 80.0 [#] | 84.1 [#] | 17.5 [#] | 22.9 | 6.1 ⁺ | 74.3 |
| Bristol | 25.9 ⁺ | 78.3 ⁺ | 83.0 | 21.3 | 23.8 | 4.7 [#] | 80.7 [#] |
| Bath & NE Somerset | 4.0 [#] | 80.6 [#] | 84.4 [#] | 16.7 [#] | 19.2 | 4.6 [#] | 83.9 [#] |

^{*}% people in this area living in 20% most deprived areas in England, 2010

^{**}At birth, 2010-2012

^{***}% people on GP registers with a recorded diagnosis of diabetes

^{****}% of all mothers who breastfed their babies in the first 48hrs after delivery

⁺Significantly worse than the England average

[#]Significantly better than the England average

NB. It is not advised to make an arbitrary division of results into 'significant' and 'non-significant'. However, confidence intervals were not given; therefore the information provided in this table is that which has been reported in the corresponding documents.

Community mental health profile

Mental health profiles varied across the regions in relation to the England average (Table 2). The prevalence of mental health problems was significantly lower in all regions, except Bristol. Swindon, South Gloucestershire, North Somerset and Bristol had significantly higher prevalence of depression than the England average. However, all regions had a high number of people assigned to a mental health cluster, suggesting that people are receiving mental health care within the West. Moreover, all areas show significantly lower attendance at Emergency Departments for psychiatric disorders compared to the England average. North Somerset, Bristol and Bath and North East Somerset had a significantly higher number of detentions under the mental health act than the England average, with Gloucestershire being the only region to have significantly fewer numbers. Many regions had higher emergency hospital admissions for self-harm, with Bath and North East Somerset also having high admission rates for injuries in young people which were unintentional or deliberate. The suicide rate was significantly higher than the England average in North Somerset and Gloucestershire, with all other regions being comparable to the England average.

Table 2. Community mental health profile (2014) for each geographical area within the West

| County | Mental health problem: QOF prevalence (%) [*] | Depression: QOF prevalence (%) | Detentions under the mental health act, per 100,000 | Attendance at A&E for a psychiatric disorder, per 100,000 | Emergency hospital admissions for self-harm, per 100,000 ^{**} | Suicide rate ^{***} | Hospital admissions caused by unintentional and deliberate injuries 0-24 yrs, per 10,000 | People assigned to a mental health cluster (%) |
|--------------------|--|--------------------------------|---|---|--|-----------------------------|--|--|
| England average | 0.84 | 5.8 | 15.5 | 243.5 | 191 | 8.5 | 116.0 | 69.0 |
| Wiltshire | 0.71 [†] | 4.8 [†] | 15.3 | 93.3 [†] | 234.8 [#] | 7.1 | 120.7 | 78.0 [#] |
| Swindon | 0.72 [†] | 6.2 [#] | 12.5 | 8.3 [†] | 308.0 [#] | 8.8 | 115.2 | 81.7 [#] |
| South Glos | 0.52 [†] | 6.3 [#] | 13.9 | 3.0 [†] | 140.6 [†] | 7.0 | 100.0 [†] | 77.7 [#] |
| Nth Somerset | 0.79 [†] | 7.0 [#] | 26.5 [#] | 16.6 [†] | 168.0 [†] | 12.6 [#] | 90.2 [†] | 77.5 [#] |
| Gloucestershire | 0.72 [†] | 5.5 [†] | 4.2 [†] | 132.4 [†] | 235.1 [#] | 11.9 [#] | 99.4 [†] | 71.4 [#] |
| Bristol | 0.88 [#] | 6.2 [#] | 28.3 [#] | 5.8 [†] | 276.2 [#] | 10.0 | 120.2 | 72.3 [#] |
| Bath & NE Somerset | 0.80 | 5.6 [†] | 28.5 [#] | 12.9 [†] | 298.1 [#] | 8.7 | 126.8 [#] | 78.8 [#] |

^{*}% adults with a serious mental illness (schizophrenia, bipolar disorder or other psychoses, or on lithium therapy)

^{**}Directly standardised mortality rate for suicide and undetermined injury, 2010-2012

^{***}Directly standardised rate for emergency hospital admissions for self harm

[†]Significantly lower than the England average

[#]Significantly higher than the England average

NB. It is not advised to make an arbitrary division of results into 'significant' and 'non-significant'. However, confidence intervals were not given; therefore the information provided in this table is that which has been reported in the corresponding documents.

Child health profile

Child health within the West was generally better than the England average (Table 3). South Gloucestershire performed better overall than the England average, with Bristol falling significantly behind the England average in some areas. Swindon and South Gloucestershire had the highest percentage of children as part of their population, with Bristol having the highest percentage of children from minority ethnic groups. Infant mortality was significantly above average in Swindon, South Gloucestershire, Bristol and Bath and North East Somerset and child mortality rates were similar to the England average for all regions. The percentage of children living in poverty was the highest in Bristol. All the other regions had significantly better percentages of children living in poverty compared to the England average. Overall obesity levels in the West were typically better

than the England average. This improved as children got older; the numbers of obese children aged 4-5 were generally around the England average, with levels of obesity likely to be significantly better than average for children aged 10-11. The number of children in care was better or similar to the England average for most regions, with Bristol having the highest number of children in care. 'Under 18' conceptions were either better or similar to the England average throughout the West.

Table 3. Child health profile (2014) statistics for each geographical area within the West

| County | Children as percentage (%) of population (up to 20 years) | School children from an ethnic minority group (%) | Infant mortality rate in comparison to the England average* | Child mortality rate in comparison to the England average** | Children under 16 years living in poverty (%) | Children aged 4-5 years who are obese (%) | Children aged 10-11 years who are obese (%) | Children in Care (Rate per 10,000)*** | Under 18 conceptions (Rate per 1,000)**** |
|------------------------|---|---|---|---|---|---|---|---------------------------------------|---|
| <i>England average</i> | - | - | 4.3 | 12.5 | 20.6 | 9.3 | 18.9 | 60 | 30.7 |
| Wiltshire | 23.9 | 8.6 | 4.0 | 15.7 | 11.9 [#] | 7.6 [#] | 15.0 [#] | 43 [#] | 22.9 [#] |
| Swindon | 24.6 | 20.3 | 2.8 [#] | 16.8 | 17.3 [#] | 10.0 | 19.4 | 53 [#] | 30.8 |
| South Glos | 24.1 | 11.0 | 2.0 [#] | 13.0 | 11.9 [#] | 6.0 [#] | 15.2 [#] | 29 [#] | 20.5 [#] |
| Nth Somerset | 22.5 | 8.1 | 4.2 | 9.7 | 14.9 [#] | 8.1 | 16.4 [#] | 60 | 25.6 [#] |
| Gloucestershire | 22.8 | 11.9 | 3.4 | 11.1 | 14.7 [#] | 9.8 | 17.5 [#] | 43 [#] | 21.5 [#] |
| Bristol | 23.6 | 32.7 | 3.1 [#] | 9.6 | 25.3 [†] | 9.0 | 19.9 | 82 [†] | 33.2 |
| Bath & NE Somerset | 22.8 | 10.0 | 1.3 [#] | 9.6 | 13.1 [#] | 8.5 | 14.8 [#] | 42 [#] | 16.2 [#] |

*Per 1000 births, children under 1 year

**Direct standardised rate per 100,000

***Rate of children looked after at 31 March per 10,000 population aged under 18

****Under 18 conception rate per 1,000 females age 15-17 years

[†]Significantly worse than the England average

[#]Significantly better than the England average

NB. It is not advised to make an arbitrary division of results into 'significant' and 'non-significant'. However, confidence intervals were not given; therefore the information provided in this table is that which has been reported in the corresponding documents.

Documentary analysis

In this section, high level priorities are outlined at national, regional and local levels to give an overview of the direction of travel. A more fine grained thematic analysis is then presented to highlight the areas in which focused work is being undertaken and where further partnerships, alliances and collaborations might be developed. Organisational priorities by NHS providers in acute care and mental health to meet local needs are presented to highlight convergences with and divergences from regional level priorities and how they map against each other. Population groups that have been prioritised for particular attention are identified across the lifespan and across Health & Wellbeing Boards, alongside the strategies developed to meet these groups' needs at regional and organisational level.

National level

At national level, the NHS Outcomes Framework 2014/15 provides a useful starting place for identifying priorities for improving and protecting the health of people in England. It forms an essential part of the way in which the Secretary of State for Health holds NHS England to account and sits alongside the outcomes frameworks for Adult Social Care 2014/15 and Public Health 2013-16. The latter frameworks reflect the different delivery systems and accountability models for public health and adult social care, but have the same overarching aim of improving the health outcomes and reducing health inequalities. While the NHS Outcomes Framework indicates the direction of travel, it is the responsibility of NHS England to work with clinical commissioning groups (CCGs) and partner organisations, to determine how best to deliver improvements.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

These are broadly aligned with the Public Health Outcomes Framework which is grouped around the following four general objectives:

- Improvements against wider factors which affect health and wellbeing and health inequalities
- People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
- The population's health is protected from major incidents and other threats, whilst reducing health inequalities
- Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

The three Outcomes Frameworks are systematically aligned to encourage collaboration and integration. A number of key indicators in all the Outcome Frameworks are shared, highlighting shared roles in producing improvements while others are complementary. All indicators specify where measurable improvements are sought. They are related to the outcomes from commissioned services, not for the commissioning process itself. Their function is to support clinical commissioning groups and Health & Wellbeing Boards to identify local priorities and demonstrate progress in improving outcomes. Another function is to focus resources on the improvement of outcomes, rather than on processes of service delivery, ensuring that priorities are aligned with the needs of local communities and service users and that progress can be measured against them. As such, they provide a mechanism for accountability.

Regional level

In May 2013 NHS England licenced fifteen Academic Health Science Networks (AHSNs) for a period of five years with a brief to align education, clinical research, informatics, innovation, training and education, and healthcare delivery. They fulfil a constellation of functions to ensure the speedy adoption and diffusion of innovation across a large number of organisations with the aim of improving patient and population health outcomes through integrated health services. They are predicated on partnership working and collaboration between the NHS, universities, the private sector and other external partners within and across AHSNs. They are also charged with supporting wealth creation and economic growth. Alongside education for the NHS workforce and service provision, world-class research through increased translation of research findings into tangible benefits for patients and populations is a cornerstone of partnerships with universities and clinical-academic collaborations.

The WEAHSN serving the needs of the population in the West have identified priorities related to the needs of patients and local populations as **patient safety** in primary care, mental health and secondary care, and connecting patient data across the region between all organisations in health and social care, specifically related to discharge. With regard to evidence-based commissioning, activities will be conducted around preventing cerebral palsy in pre-term babies, improving

outcomes for patients undergoing hip replacements, and anticoagulation for atrial fibrillation and stroke prevention. These clearly map against domains in the NHS Outcomes Framework and the Public Health Outcomes Framework:

- Treating and caring for people in a safe environment and protecting them from avoidable harm (NHS)
- Ensuring that people have a positive experience of care (NHS)
- Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities (Public Health)

Local Authority level

Recent NHS re-organisation arising from the Health and Social Care Act 2012 has led to a system in which no organisation has a clear mandate for strategic planning at regional level. Responsibility for commissioning transferred to GP led clinical commissioning groups at local level, while specialist services are commissioned by NHS England which is also responsible for the oversight of CCGs.

Health & Wellbeing Boards (HWBs) are new bodies which were established as part of the NHS re-organisation to lead the assessment of the needs of the local population in an attempt to address the perennial problem of the health and social care divide, and to deliver effective leadership across local systems of care. They are part of the new system with the explicit aim of bringing together different organisations and interests to promote local collaboration and integration, informing both the NHS via the clinical commissioning groups (CCGs) and Local Authorities (LAs) via social care commissioners. HWBs were designed to foster partnership working and the integration of health and social care services in order to develop a holistic approach to health and wellbeing, bringing into the partnership additional LA areas such as crime prevention, education, transport and urban planning. They are charged with producing Joint Strategic Needs Assessments (JSNAs) which analyse the health needs of populations and underpin and guide commissioning decisions of health, wellbeing and social care services within LA and CCG areas. The JSNA provide the evidence for the health and wellbeing strategies, a new statutory requirement, and commissioning plans. Thus through the Health and Wellbeing strategy, the HWBs provide leadership for resource allocation and service integration, driving local commissioning of health care, social care and public health. The priorities of the in the WEAHSN/ NIHR CLAHRC West geographical area are presented in Appendix 1, summarising publicly available data from the HWBs strategies (or equivalent) and the CCG reports. We used the most recent publicly available data some of which refers to the years 2012/2013.

Through our analysis of these data, we have identified a wide range of priorities which are broadly aligned with the NHS and Public Health Outcomes Framework outlined in the previous section. The most prominent area of convergence of priorities across the geographical area is the shift of focus from delivering services to developing strategies aimed at prevention and sustainability. The theme of **prevention** extends beyond usual definitions of prevention of illness –although this obviously remains an important priority- but includes broader concerns around avoidable harm reduction and increase in time spent living independently for older adults and those with long term conditions and multi-morbidities. Under this theme, we located the following strategic priorities adopted by LAs and CCGs:

- Prevention of avoidable deaths and ill health (related to behavioural factors such as diet, physical activity, participating in social activities, risky behaviours around sex, drugs and alcohol, as well as wider social determinants of health³)

³ Social determinants of health are the collective set of conditions in which people are born, grow up, live and work, including housing, education, economic security, the environment and the health care system. They shape access to material, social and personal resources to maintain health and wellbeing.

- Prevention of ill health (screening, early diagnosis and early intervention)
- Prevention of ill health related dependence on services, and exacerbation or deterioration of long term conditions
- Prevention of avoidable health care related harm, especially infection and management of sepsis, and medication errors
- Prevention of avoidable admission to hospital.

The aims of these strategies focus on effective self-care for individuals and families, and resilience for communities. Self-care is seen to prevent disease and harm, slow down the progression of existing disease and reduce the need for specialist medical interventions and services. Community resilience refers to the capacity to use local resources and knowledge to meet the needs of local people. While many recent documents referring to resilience relate to communities coping in times of emergency, the term is increasingly being used to describe the role of communities in supporting those with enduring health needs. The avoidance of emergency admissions is one of the most pressing priorities because the current system that is in the process of being reviewed and redesigned is unsustainable. Plans for community-based facilities to meet people's urgent care needs and prevent escalation especially for those living in rural communities are very high on the agenda at this level.

Strategies to address this priority are grouped in the second theme of convergence which is about **effective communication** at a number of different levels from individual to organisational and sectorial levels to achieve a more integrated system that is wrapped around patients and service users with the aim of avoiding multiple contacts with different services and different points of access. Under this theme, we located the following strategic priorities adopted by LAs and CCGs:

- Improvements in communication with the public, patients, service users and carers to bring about a shift of focus away from a purely clinical focus on managing or treating symptoms, to supporting patients and carers to become more functional, independent and resilient;
- Staff enacting values of compassion and care in their contact with patients, service users and carers;
- Improvements in communication between sectors, primary and secondary/tertiary care, services for mental health and physical health, and between professionals to challenge silo-based working;
- Shared electronic health records and data linkage across IT systems to support cross-sectorial and inter-agency working and enhance patient and service safety.

Other broad themes include:

- Quality and safety (medicines management, patient safety in hospital, safety in primary care, reducing risks to mental health)
- Care closer to home (appropriate care at the right time as close to home as possible)
- Organisational learning at the 'sharp' and 'blunt' end from patient/ carer feedback, adverse events, reviews and incidents
- Sustainability at a time of financial austerity where services need to be appropriately delivered (best person/ least cost)

Organisational level

Accessing organisational priorities through publicly available web-based sources proved to be the most challenging aspect of this work, for the following reasons: (1) Trusts publish a range of

documents for public scrutiny and it is not always clear where strategic priorities are explicitly addressed – we accessed all documents available, and extracted and coded any text that indicated particular prominence and direction to the organisation; this has led to the identification of priorities that relate to different parts of the organisation and therefore to considerable heterogeneity in the data we were able to extract and code – we have tried, where possible, to group priorities around the themes of ‘patient safety’, ‘clinical effectiveness’ and patient and ‘carer experience’. (2) Not all Trusts had published relevant and up-to-date information on their websites and annual reports and business plans for the most recent years 2013/14 at the time of searching were being produced and therefore not yet available. (3) NHS organisations face a wide range, diversity and complexity of external expectations and requirements, or what Dixon-Woods *et al* (2014) termed ‘priority thicket’ – ‘dense patches of overlapping or disjointed goals that commanded very substantial attention and resources, but did not necessarily provide clear direction or facilitate the development of clear goals, internally coherent visions or strategies linked to local priorities.’ A lack of clarity about priorities and even competing priorities can be the result and this may be why we found such a high level of heterogeneity in the publicly available texts we extracted and coded. (4) Internally sourced data about organisational priorities might be a more fruitful method of accessing relevant information.

However, we have been able to generate a number of themes within the categories of ‘patient safety’, ‘clinical effectiveness’ and patient and ‘carer experience’ (see Appendix 3). In relation to patient safety, the avoidance of hospital or healthcare related harm featured prominently among Trusts as did the need to minimise risk of harm to people who use services. Priorities in this category clustered around the need to reduce hospital acquired infections, medication errors and other incidents resulting in harm as well as to effectively manage sepsis and rapidly deteriorating patients. In terms of clinical effectiveness, the reduction of variations in clinical outcomes, and a focus on quality and safety was among the most frequently listed issues. Patients with dementia and LTCs as well as the frail elderly were identified as requiring particular consideration with an emphasis on improvements in care planning and shifting services closer to home to avoid admission to hospital. The need to improve ‘patient flow’ was a frequently listed priority that referred to the systems, services and processes that are part of patients’ care pathways because how services are accessed, when and where assessment and treatment is available, and who it is provided by, can have as significant an impact on the quality of care as the actual clinical care received (Health Foundation, 2013). Improving the patient and carer experience was also a common concern, and it was seen as imperative to enact values such as dignity, compassion, kindness and respect in every contact of care and service delivery. Designing innovative ways of capturing of patient experience and crucially, developing ways of learning from what patients and carers tell staff and managers about their experience was identified as a priority by some Trusts.

Prioritised population groups

Along the lifespan, the groups being prioritised were pregnant women; children and young people; people with LTCs/ mental health problems/ learning disabilities; people who are frail and elderly; and those at the end of life. Crosscutting groups are minority ethnic groups and those living in deprived urban areas. Addressing health inequalities was among the highest priorities in many of the JHWP strategies of the HWBs. However, along with a number of prioritised groups, much of the information provided was around aspirations and espoused priorities for these groups, or the importance of planning future provision, with few concrete and explicit strategies for action. This highlights the challenging nature of some of the social and health problems the UK and the region are facing at a time of financial constraint and economic austerity. The responsibility for tackling these problems through addressing amenable social determinants and health system factors is widely dispersed and will require continued collaborative working between all public and voluntary sector agencies as well as policy interventions. However, it is evident from this priorities analysis

that at national, regional, local and organisational levels public health responses are being proposed and facilitated. In this section, each of the prioritised groups will be addressed in terms of the strategies put forward while providing some indicative evidence of interventions.

Pregnant women:

Improving maternal health especially in relation to reducing obesity, diabetes and smoking as well as increasing emotional health and wellbeing in pregnancy were desired outcomes. The evidence relating to obesity in pregnant women in order to improve pregnancy outcomes (Oteng-Ntim *et al*; 2012, Agha *et al*, 2014; Thangaratinam *et al*, 2012) has highlighted that dietary interventions were most effective for reducing obesity and improving obstetric outcomes. Regarding mental health and wellbeing for pregnant women, Alderice *et al* (2013) suggest the need for robust evidence to provide a more strategic midwifery led approach to improving mental wellbeing for pregnant women. The importance of introducing further antenatal screening policies to identify those women at risk of psychiatric disorders during pregnancy has also been highlighted by Paschetta *et al* (2014). Patient safety was not specifically addressed in the documents we reviewed. However, although labour and delivery are as safe as they have ever been, maternal deaths occur and around half of these are avoidable (Cornthwaite *et al*, 2013). Although there has been an overall reduction in maternal deaths, fatal outcomes from sepsis caused by Group A streptococcal disease (CMACE, 2011) have increased. The report authors advocate ten recommendations that should be implemented into maternal care provision to continue the reduction in maternal mortality.

Children and young people:

Recent evidence suggests that the UK has fallen behind other comparable European countries in child, adolescent, and young adult mortality from non-communicable diseases, including neuropsychiatric disorders (Viner *et al*, 2014). Infant mortality is of particular concern, attributable mainly to low birth weight and prematurity, both problems that are preventable and related to social determinants of health. Poor outcomes have also been identified for infants, and for children and young people with chronic disorders, and there is a disproportionate burden of death for young adults due to substance abuse, compared to comparable European countries. Regional and local priorities reflect this deficit. Upstream drivers of health were the focus in many areas, targeting childhood poverty, and poor opportunities and life chances for young people. Increasing levels of fitness through providing opportunities for taking part in physical activities such as swimming, increasing awareness about healthy diets to tackle childhood obesity, and improving the health of young people more generally were important strategic priorities alongside the prevention of use of drugs, alcohol and cigarettes. The Department of Health Children and Young People's Health Outcomes Forum (2013/14) has highlighted the importance of promoting the health of children and young people because risk factors for disease burden in adults often have their roots in early life and are usually related to amenable socially determined behaviours. In terms of health system priorities, improving child and adolescent mental health through better access to psychological therapies and specialist Child and Adolescent Mental Health Services is a national priority that is also reflected in the regional and local strategies. Public health responses to improve mental health and resilience include suicide prevention and educational interventions to increase effective parenting. Other priorities included increasing levels of childhood vaccination uptake, better access to specialist services, and local paediatric urgent care alternatives to secondary care admissions. Evidence around reducing the burden of emergency hospital admissions suggest that a more integrated approach to paediatric care should be a priority to allow children to be treated for a greater range of conditions within primary care settings (Wolfe *et al*, 2011).

People with long term conditions:

Long terms conditions are health problems which cannot effectively be cured at present. However, they are amenable to treatment with medication and other therapies. Among these conditions are

diabetes, coronary heart disease, chronic kidney disease, stroke, chronic obstructive pulmonary disease, asthma, heart failure, epilepsy and dementia. Apart from being associated with human distress and suffering, these conditions are inexorably driving up health service utilisation costs. The need to contain these costs by decreasing patients' dependence on services and promoting independence and self-management while increasing families' and communities' capacity to support these patients and promoting their resilience, is clearly reflected in the strategic priorities at all levels in the health and social care system. Self-management as a tool to enable patients to care for themselves at home and moderate their health related behaviours such as diet and physical activity has dominated health policy for over two decades. Educational programmes to deliver short training interventions designed to reduce hospital admissions and reliance of health care professionals have been designed to enhance patients' self-efficacy. They place responsibility for the management of their condition firmly on the individual. This focus is also reflected in the regional and local strategies in terms of improvements in the provision of information, advice and signposting to services for patients with LTC and their carers. Mobile technologies to support 'Telehealthcare' for patients with LTC have also been advocated although current evidence is equivocal and 'Telehealthcare' may have unintended consequences (Fairbrother *et al*, 2013; Bardlsey *et al*, 2013). Short training courses for primary care based staff, even when combined with local managerial support and additional resources, have also been shown to be largely ineffective in supporting individual patients to enhance their self-management and self-efficacy (Kennedy *et al*, 2013). On the other hand, there is growing evidence to highlight the capacity of social networks and social involvement with community groups and resources to improve the ability of patients with LTCs to cope with their health problems both practically and emotionally and to engage in healthy behaviours (Jeffries *et al*, 2014).

Dementia is a complex LTC requiring the skills and knowledge of a broad range of medical and nursing staff and therapists to achieve a good quality of life for patients. Early diagnosis is important to facilitate access to information and support, but detection in primary care is low (Russell *et al*, 2013). There is a firm commitment at all levels in the health and social care system in the West to prioritise this group to enable patients to live independent lives for as long as possible, to have access to the services they need and to be treated with kindness and respect within their communities and while receiving services in the community, in their own home or in hospital. Early diagnosis, high quality support and follow-up after diagnosis, personalised care planning and partnerships with local third sector organisations were strategies to be employed to meet these aims. Primary care based diagnosis and treatment, access to specialist care and the development of specialist nursing/ therapist roles to undertake advisory functions were also proposed especially in relation to preventing admission to hospital. On a wider community level, the creation of dementia-friendly communities who understand and support those living with dementia was high on the agenda.

People with mental health problems:

Reflecting national policy imperatives, there was evidence across the board of strategies to achieve parity in the level and quality of services for physical and mental health problems through the reconfiguration of mental health services (Centre for mental health, 2012 & 2014). Tackling stigma and discrimination which significantly compound the difficulties that many people experiencing mental health difficulties face in terms of access to employment and participation in social and leisure activities were on the agenda of some of the HWBs in the West. Awareness-raising and anti-stigma campaigns have been advocated in some of the areas. Recent evidence suggests that despite some improvement, mental health related stigma and discrimination continue to be big concerns in the lives of affected people, particularly during this time of financial constraint and economic austerity (Corker *et al*, 2013). Negative experiences deter people from seeking help with adverse consequences for their mental health, suggesting that interventions to increase access to services as

well as anti-stigmatising care are required for vulnerable groups (Clement *et al*, 2014). Other strategies include the improvement of follow-up for people who self-harm, clearer and more effective liaison between primary and secondary care, and the development of new roles to provide better coordination between services.

People with learning disabilities:

People with learning disabilities are much more likely to have poor health than others. The health inequalities they face are a function of increased risks of exposure (and possibly greater vulnerability when exposed) to well established social determinants of poorer health; increased risk associated with specific genetic and biological causes of learning disabilities; communication difficulties and reduced health 'literacy'; personal health risks and behaviours; deficiencies in access to and the quality of healthcare and other service provision (Emerson *et al*). There are a number of initiatives in the West to improve access to health services for people with learning disabilities and to their increase autonomy, control and independence through supportive living in the community. Recent evidence highlights the need for health promotion interventions for people with cognitive and physical limitations, including sensory impairments, especially as they advance in age, and stress the importance of tailoring these interventions to incorporate the specific needs of this population (Heller *et al*, 2014). Furthermore, while personalisation of health and social care in the UK has been developing rapidly over the past 5 years to create a more flexible model of provision based upon greater choice and control for service users, there is little research evidence on how this process can be supported to avoid adverse consequences for people with learning disabilities (Sims *et al*, 2014).

People who are elderly and frail:

For some people, increasing age is associated long-term conditions, frailty, dementia, disability, dependence or social isolation. Many of the people affected have a very poor quality of life. A recent policy initiative by NHS England (2014) advocates a shift away from services designed for single conditions to one in which patients are seen not as a collection of conditions, but as individuals requiring person-centred, coordinated care that recognises the unique challenges of frailty. Frailty develops as a consequence of age-related decline in multiple organs, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home. National and regional policy is aimed at reducing the risk of fragmented care and poor communication between health and social care staff which often leave frail elderly and their carer poorly served. The prevention of hospital admission for this group is a priority for many, if not all of the areas in West because of the high risk of harm as a result of their stay in the Emergency Department, waiting for specialist medical review, and admission related distress and disorientation. The need to enable older people to remain as well and independent as possible and to avoid deterioration or complications was reflected in the majority of strategic priorities as were the key components addressed in a recent report by the King Fund (Oliver *et al*, 2014):

- healthy, active ageing and supporting independence
- living well with simple or stable long-term conditions
- living well with complex co-morbidities, dementia and frailty
- rapid support close to home in times of crisis
- good acute hospital care when needed
- good discharge planning and post-discharge support
- good rehabilitation and re-ablement after acute illness or injury
- high-quality nursing and residential care for those who need it
- choice, control and support towards the end of life
- integration to provide person-centred co-ordinated care.

People at the end of life:

Increasing choice and improving the quality of care at the end of life is high on the national agenda and a national review has been launched at the beginning of July 2014, with findings to be reported in February 2015. Good end of life care has been described as care that is delivered, if possible, in the place preferred by the patient with respect and dignity, enabling people to live in as much comfort as possible until they die, while making choices about symptom and pain management and practical support. It has been recognised that organisations responsible for the care of people approaching the end of their life need to improve the planning and delivery of services particularly support in the community. This is clearly reflected in the strategic priorities we have reviewed.

Implications for NIHR CLAHRC West

The WEAHSN has adopted patient safety as a priority programme of work and taken a clear lead in this area. The themes include identifying and treating the deteriorating patient; getting medicines right; avoiding pressure ulcers; preventing falls and venous thromboembolism, and observations and general ward care. Perioperative and critical care as well as mental health services are specific areas of concern in relation to patient safety around which collaboratives are being established.

A number of other priorities identified above are being addressed by the cross-organisational, inter-sectorial and interdisciplinary groups ('Health Integration Teams' – HITs hosted by Bristol Health Partners - BHP⁴) that bring together healthcare professionals, managers, patients and members of the public, commissioners, researchers and educationalists to tackle the pressing public health challenges and to improve health outcomes. The HITs are aligned with their partners and although they are currently concentrated around Bristol, existing HITs are reaching out beyond their present partners to achieve wider regional alliances. Furthermore, the model may be taken up by other interdisciplinary groups working in areas –both geographical and topical- not covered by existing HITs.

The 18 current HITs are working in the following areas:

- Musculoskeletal HIT⁵ (MUSK@B)
- Integration to avoid hospital admission (ITHACA)
- Sexual health improvement for populations and patients (SHIPP)
- Improving care pathways for self-harm (STITCH)
- Dementia
- Supporting healthier and inclusive neighbourhood environments (SHINE)
- Reducing the burden of respiratory infections in the community and the NHS (RuBICoN)
- Retinal outreach, integration and research (RENOIR)
- Child injury prevention and injury care (CIPIC)
- Partnership for Parkinson's and other movement disorders (MOVE-HIT)
- Chronic kidney disease
- Bristol network for equality in early years health and wellbeing (BoNEE)
- Active people: promoting healthy life expectancy (APPHLE)
- Addictions (AddHIT)
- Pain management
- Immunisation and vaccines

⁴ Bristol Health Partners is a collaboration between six NHS organisations serving the area, the city's two universities and its local authority. Their mission is to generate significant health gain and improvements in service delivery in Bristol by integrating, promoting and developing Bristol's strengths in health services, research, innovation and education. For more information see <http://www.bristolhealthpartners.org.uk/>.

⁵ Concerned with conditions affecting muscles, bones and joints.

- Psychological therapies
- Perinatal mental health

On the basis of these existing teams, a number of strategic priorities are being covered such as avoiding hospital admissions, and care closer to home; the integration of care pathways, and cross-sectorial working and planning; improving care for those with LTCs and for the frail elderly; and improving the conditions for and uptake of measures to ensure healthy lives and to prevent ill-health and harm. The areas that are currently not explicitly addressed in the publicly available documents we analysed are around maternity care and care for people at the end of life; patient information and communication systems such as electronic health records and the computerised care processes such as electronic prescribing and observations; issues relating to patient flow, variations in quality of care and health outcomes, and organisational learning.

Although some of these areas are already receiving attention and are being advanced, they offer the potential for further strategic development work that could be supported through the NIHR CLAHRC West. Moreover, NIHR CLAHRC West could have a key role in ensuring that opportunities for shared learning across different services, organisations and specialities are realised and that system-wide concerns are addressed in collaboration with the WEAHSN and partner organisations.

The ethos of strategic priorities identified at national, regional, local and organisational levels clearly chime with those developed by NIHR CLAHRC West of equity, appropriateness, sustainability⁶ and patient/public centeredness. Moreover, the initiative of a joint approach for PPI between the WEAHSN and the Local Clinical Research Network (CLRN), Bristol Health Partners (BHP) and NIHR CLAHRC West facilitates regional developments in PPI opens up new opportunities for generating approaches and methods for listening to patients and the public and using their views in designing or redesigning services, and for learning from their feedback and for designing and promoting methods for routine patient outcome measures.

⁶ These terms are defined here in the widest sense: 'equity' to include methods to assess and tackle inequalities in access, provision and utilisation of healthcare and public health interventions that promote health. The net effect of this work is to identify if service provision or health-promoting interventions are provided at an appropriate level commensurate to health need. Where inequitable provision is identified, it is necessary to determine what the barriers are to equitable provision and which interventions are most likely to be effective in addressing them. 'Appropriateness' includes research and implementation activities that aim to ensure that interventions reach the individuals who could most benefit at the optimum time. Whilst auditing equity may identify relative under-provision, appropriateness can determine unmet need or over-provision because of unnecessary assessments or treatments. 'Sustainability' includes both the concept of attention to the environment and use of resources, as well as the capacity to support changes or interventions in the medium to long term that will be self-supporting.

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Appendix 1

Health & Wellbeing Boards' and Clinical Commissioning Groups' priorities

BRISTOL

Bristol Health & Wellbeing Strategy priorities:

- Create a high quality and well-connected built and green environment, and manage the health impacts of Climate Change
- Achieve a healthier, more sustainable, more resilient food system for the city to benefit the local economy and the environment.
- To reduce all forms of domestic, gender-based, and racially based violence and abuse, including sexual exploitation
- Reduce the prevalence of smoking, reduce illicit tobacco availability and increase smoke free areas within the city
- Reduce the harm caused by alcohol misuse
- To give children the best start in life
- Improve mental wellbeing and reduce social isolation
- To better meet the needs of people with dementia and their carers through improved services and dementia friendly environments
- To improve the clinical quality of and satisfaction with maternity services
- Take every opportunity to improve specific outcomes and quality in the delivery of services for adults, children and vulnerable people through integrated care and support

Bristol CCG commissioning priorities:

- Urgent Care including Frail and Elderly Patients
- Long Term Conditions: more support at home, reduced rates of hospital admissions for these conditions, reduced rates of diabetic amputation.
- Dementia Care: everyone who wants a diagnosis receives one, carers and families as partners in care - able to access carer breaks, reduction in hospital stays, Bristol as a dementia friendly city, more access to innovative treatment and research.
- Elective care (routine operation or treatment): Operations only when patients have followed agreed pathways developed by their GP (primary care) and supported by hospitals (secondary care) increased range of local services where safe and cost effective
- Children: Improve the health of vulnerable and excluded children and young people, reduce childhood obesity reduce infant mortality, improve access to health services and experiences for children with complex health needs, improve emotional health and wellbeing, improve the physical health of children.
- Maternity: Improve maternal health and reduce infant mortality rates, reduce risk taking behaviour which impacts on health, improve emotional health and wellbeing, reduce rates of infant mortality.
- Mental Health: Increased quality of service, improved access to mental health services
- Cancer: Reduce the mortality rate of people with cancer under the age of 75, improving access to earlier diagnosis for the less advantaged, achieve earlier diagnosis of cancer to increase the scope for successful treatment
- Learning Difficulties: Improved standards of care: improved health outcomes for people with learning difficulties, fewer people in high cost provision away from their local communities, compared to 2012/13, implement the Winterborne View recommendations with Bristol City Council

- Medicines Management: Support quality and cost effective prescribing, deliver a locally agreed agenda helping to improve health outcomes as well as achieve a financial balance, specific work with nursing homes to improve the quality of medicines management, ensure patient agreement with their oxygen prescribing.
- End of Life: A programme of support for patients with end of life needs and their family and carers, 5% reduction in the number of palliative care patients dying in hospital, increase in the number of people on the palliative care register.

NORTH SOMERSET

North Somerset People and Communities Strategy:

- Reducing Alcohol Related Harm - Increase access to alcohol screening and brief intervention and onward referral to specialist alcohol treatment services when needed, especially for those people with the poorest health outcomes; Provide education and awareness-raising for safer drinking with:
Social housing/private sector rented housing clients, particularly those living alone; parents with children who are at risk of neglect or harm as identified by children's services and partner agencies; Establish information sharing and collaborative working between health services and community safety agencies, particularly in relation to night time violent offences and anti-social behaviour in order to promote community safety.
- Improve health outcomes and reduce health inequalities – tobacco and alcohol consumption and associated harm reduction; improve breastfeeding rates; increase physical activity levels; reduce STIs and unwanted pregnancy; integration of mental health services in secondary and primary care; suicide risk reduction; improve dementia services; single point of access and joint health and social care for frail elderly, people with long term conditions and children with complex needs
- Improve outcomes for adults by promoting independence and more choice and control over services - Ensure all service areas across council and health partners incorporate an early intervention and prevention focus to the services they deliver including access to telecare; develop the Community Connect partnership; fully embed the provision of personal budgets into mainstream adult care services; further develop and improve rehabilitation and enablement services; ensure people have information and advice needed to make care and support decisions regardless of who pays for care; supporting prevention and avoiding crisis admissions to hospital earlier and person centred planning for those in transition from children's to adult services; increased options for people to live at home that enable a planned reduction in the use of Residential and Nursing Care Homes.
- Improve outcomes for children by enabling early help alongside greater choice and control over services –focus on these groups: parents suffering domestic abuse parents with mental health issues; parents with substance misuse issues; vulnerable young people (including teenage parents, young carers and those committing anti-social behaviour)

North Somerset Clinical Commissioning Group Priorities:

- Reduce under 75s mortality rate from cancer
- Reduce under 75s mortality rate for cardiovascular disease

- Improve health related quality of life for people with long term conditions
- Reduce emergency admissions for alcohol related liver disease

BATH & NORTH EAST SOMERSET

Joint Health and Wellbeing strategy - Bath and North East Somerset:

- Helping people to stay healthy – childhood overweight and obesity; support for families with complex needs; alcohol abuse; healthy and sustainable places
- Improving the quality of people’s lives – long term conditions; mental health; dementia; older people (quality of life and end-of-life care)
- Creating fairer life chances- skills, education and employment; domestic violence; social isolation

BANES CCG priorities:

- Promoting self-care which includes healthy lifestyles and improved wellbeing
- Improving the mental health and wellbeing of the population
- Improving quality and patient safety
- Improving consistency of care
- Responding to the challenges of an aging population
- Reducing inequalities and social exclusion
Reducing the number of years of life lost by the people of England from treatable conditions (e.g. including cancer, stroke, heart disease, respiratory disease, liver disease);
- Improving the health related quality of life in the 15 million+ people with one or more long-term conditions;
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;
- Increasing the proportion of older people living independently at home following discharge from hospital;
- Reducing the proportion of people reporting a very poor experience of inpatient care;
- Reducing the proportion of people reporting a very poor experience of primary care;
- Making significant progress towards eliminating avoidable deaths in our hospitals
Further developing a sustainable urgent care system, that supports the management of the frail elderly in the community where appropriate
- Enhancing services for people with Long Term Conditions including those with a mental health condition
- Further improving End of Life Care
- Supporting our local population to self-care and improving wellbeing
- Ensuring effective working between primary and community services

SOUTH GLOUCESTERSHIRE

Joint Health and Wellbeing strategy – South Gloucestershire:

- Making the healthy choice the easy choice - Creating the right conditions so that everyone is able to lead a healthy lifestyle throughout their life course

- Tackling health inequalities - Reducing the disparity in health outcomes faced by the most disadvantaged and vulnerable
- Making the best start in life - Enabling every child and young person to thrive and develop skills to lead a healthy life and achieve their full potential
- Fulfilling lives for all - Enabling people with long-term conditions, physical disabilities and mental health problems to lead independent, fulfilling and dignified lives
- Ageing well - Enabling older people to maintain independence and live longer, healthier lives while also supporting people with dementia and at the end of life
- Accessing the right services in the right place, at the right time - Enabling people to get the care they need in the best place for them when they need it

South Gloucestershire Clinical Commissioning Group Priorities:

- Community Health Services: to improve the quality of services provided by community health services, deliver seamless services in the community which wrap around the patient, ensure a robust set of community services to care for patients in the community unless admission to hospital is clinically necessary; increase the overall proportion of care which is provided in a community setting; improve capacity and capability of nursing homes to care for more complex patients in the community; Improve discharge practice at NBT.
- Promoting Independence: This area has 3 key themes; Self-care and management; Out of hospital care and Reduction in hospital services and cost. In order to achieve this there is a Focus upon the following long term conditions: COPD, fracture Injury, diabetes, spinal care, ophthalmology, heart failure, stroke and neurological conditions
- Cancer: Earlier detection of cancers with increased diagnosis through the elective rather than emergency route. Improved public knowledge and awareness of how lifestyle changes can reduce risk of developing certain cancers. Creation of personalised care plans for all patients with new diagnoses of cancer. Supporting the Cancer Clinical Site Specific Groups to continue their work
- End of Life Care: Communication – communicating with patients to decide their plan and between healthcare professionals to ensure everyone knows the plan. Co-ordination – ensuring everyone is organised in order to provide the best possible care for the patients. Education – Educating the staff enabling them to properly carry out the above actions.
- Rehabilitation and Reablement: Enhanced opportunity to live more independently for longer. Accessible services, with care being provided closer to home. A greater emphasis on returning home as soon as possible, with an associated reduction in the time spent in hospital. More co-ordinated care through the whole system, ensuring that they access the right services, at the right time, all the time. A more responsive pathway flexible to individual needs. Patients better informed about their rehabilitation and reablement goals and therefore able to work towards them
- Children and Maternity: Children and young people should have access to complete evidence-based care pathways for the treatment of obesity. Increase emotional and behavioural support service capacity within mental health service for primary and secondary school-age children. 24-hr community paediatric nursing service to meet the needs of acutely unwell children. Commission services that fully understand their roles and responsibilities in relation to early intervention for safeguarding children and that processes support the use of the Common Assessment Framework. Identify the mental health needs of young mothers and service development to meet these needs. Increase the availability of talking therapies within secondary mental health providers. Work with local providers of primary care to ensure that patients with ambulatory care sensitive conditions receive timely and appropriate care to manage their conditions outside of an acute hospital setting. Work with emergency departments to ensure that they see patients who are clinically

appropriate for emergency departments and patients with primary care needs are redirected to their GP. Commissioners to ensure that children and young adults are treated in the clinical environment that is most suited to their condition and maturity GP Membership priorities: Improvements in mental health services for adults should be extended to children and young people, including primary care liaison service.

- Mental Health: Attention deficit-hyperactivity disorder (ADHD). Autism diagnostic service with specialist assessment and provision of on-going therapy, support and practical assistance. Increase the availability of talking therapies within secondary mental health services. Suicide and self-harm prevention via a new SG suicide prevention partnership and strategy led in partnership with Public Health. Improved safeguarding practices within mental health services. Improve access to mental health services, including for people with learning difficulties. Services for mental health should also take into consideration the additional impact of sensory loss.
- Learning Difficulties: Improve access to health services for people with learning difficulties, including mental health services. Ensure safeguarding practices are improved within the mental health and learning difficulties services. Services for dementia, mental health and learning disabilities should also take into consideration the additional impact of sensory loss.
- Dementia: Improve physical activity services for people with long term conditions and those with physical and mental disabilities. Personalised care planning for all patients with long term conditions, including dementia. Respite care for 'unseen carers'. Service consideration of additional impact of sensory loss. Improved provision of information and advice during the weeks after diagnosis. Partnerships with local voluntary organisations. Partnership between the local authority and health commissioners to support local care homes to provide a quality service for residents with dementia. Make South Gloucester more 'dementia friendly'. Increase the capacity of health services to meet needs of people with dementia and improved capacity in dementia nursing support.
- Medicines management: Provide clinically appropriate, evidence based and cost effective prescribing advice. Effective budget management. Safe introduction of medicines into the care pathways and management of long term conditions

SWINDON

Joint Health and Wellbeing strategy – Swindon:

- Every child and young person in Swindon has a healthy start in life (Improve the mental wellbeing of children and young people; reduce risky behaviours amongst our children and young people such as smoking, drinking and self-harm; keep all children and young people safe; improve educational attainment of children and young people; reduce the number of young people not in education, employment or training)
- Adults and older people in Swindon are living healthier and more independent lives (Strengthen integrated working between health and social care; reduce the number of people suffering from long term conditions through promotion of health lifestyle choices; promote independence and reduce the need for hospital services and long term care; ensure that carers' needs are met)
- Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems, offenders) (Ensure access to information and advice that supports choice and control; ensure from disadvantaged communities receive good quality care for their physical health; local economic and social policies are developed to strive to narrow social

inequalities rather than widen them; prevent early death and disease through healthier lifestyle choices, early detection and screening)

- Improved mental health, wellbeing and resilience for all (develop effective pathways for people with mental health problems; increase the opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery (including education, debt management, housing, leisure services, health promotion); promote positive mental health and recognise that mental health is everyone's business ; reduce the stigma and discrimination associated with mental ill health
- Creation of sustainable environments in which communities can flourish (build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion and promote social inclusion of marginalised groups and individuals; work with our local communities to develop creative solutions for local issues; ensure that housing and development strategies for new and existing communities identify the health and wellbeing impacts for residents in the short and long term; promote the use of green, open spaces and activities such as walking and cycling; promote effective public transport and transport networks which ensure access to services and activities; and encourage permeability within communities

Swindon CCG commissioning priorities:

- Child obesity – as the key priority for investment by Swindon Borough Council using their public health funds
- Risk stratification – locally enhanced service models need to be put in place to ensure the roll out of risk stratification and that investment is available to each practice to test and evaluate which interventions make a difference to overall population risk
- Diabetes – the models of care within the approved business case need to be taken forward to complete implementation.
- Dementia – services need to be put in place to meet the demand created through better registration
- Self-care and prevention/community coordination – locally enhanced service models on a pilot basis to be put in place to test the N.E. London case worker model for long term conditions
- Paediatric admissions – investment in alternatives to admission
- Urgent care – re-commissioning of urgent care pathway
- Cancer

WILTSHIRE

Wiltshire Health and Wellbeing Board Strategy:

- Prevention – Support to live healthily (providing the best start in life; eating well and exercising more; helping people make informed choices about drugs, alcohol and cigarettes; helping people make informed decisions about relationships; enabling people to access emotional support; enabling current and former armed forces personnel and their families to access support; ensuring people live in safe and warm home; ensuring serious illness is diagnosed early and people are supported to live a long, healthy life
- Supporting people to live independently - Ensure those who use care services have a good quality of life; ensure those caring for others have a good quality of life; make help available

so people can live at home rather than in a care home; access to urgent support at times of crisis such as when leaving hospital

- Getting involved and being listened to - Enabling children to help develop services; help people commission care and support services for working age adults; make it easy for people to find out what help is available; Enable people to make the important decisions about their care and support; ensure carers are involved in care decisions for the person they look after; ensure people know how much the council will pay towards their care; enable people at the end of their lives to decide where they want to die
- Being safe from avoidable harm - Ensuring children can live, study and play in safe environments; providing support for parents and carers to enable them to look after their children or those in their care; minimising the impact on children and their families at times of crisis such as domestic violence, mental health issues or substance abuse; enabling children to remain with their family when they are safe from abuse and exploitation; ensuring the needs of domestic abuse victims are understood and they are offered the right support; People with alcohol and/or drug problems are supported into treatment and helped to a sustained recovery; investigations into attacks and attempted attacks are carried out sensitively and quickly

Wiltshire CCG commissioning priorities:

- Staying health and preventing ill health – activity targeted to improve the overall health of the whole population through a variety of public health initiatives delivered in partnership with local surgeries, local voluntary and community sector organisations.
- Planned care – closely monitor patient flow through hospitals
- Unplanned care and frail elderly – vision for urgent and emergency care is of universal, continuous access to high quality services. In practice this will mean that whatever a patient’s urgent or emergency care need, whatever the location, they get the best care from the best person, as close to home as possible in a timely way
- Mental health – mental health promotion and prevention of mental health problems are crucial and practices have a role to play in the local population through support for improved wellbeing at community level, promoting volunteering other forms of social inclusion and development of social capital, supporting asset-based community development strategies and linking good mental health with good physical health through lifestyle improvement programmes
- Long term conditions (including dementia) – changing the way we provide care for these patients, particularly in relation to reducing the necessity for emergency care. Underpinning the new models of care is the further development of neighbourhood support teams to support patients with complex needs in their own home.
- End-of-life care - improve the management of people with LTC, leading to greater life expectancy, so the end of life planning and care will become important.
- Community services and integrated care – older people will feel more secure and supported by greater coordination between social care and NHS community services and integrated care.

GLOUCESTERSHIRE

Gloucestershire Health and Wellbeing strategy:

- Starting well – with a focus on pregnancy and early years to give every child the best start in life

- Developing Well – a focus on children and young people maximising their capabilities and control over their own lives
- Living and Working Well – a focus on promoting healthy lifestyles; equitable access to ill-health preventative services; healthy and sustainable physical environments; building social networks and communities and access to good employment opportunities
- Ageing Well – promoting independence, physical and mental health and wellbeing post-retirement

Gloucestershire CCG priorities:

- Tackling health inequalities
- Improving mental health Reducing Obesity (promoting healthy weight)
- Improving health and wellbeing into older age
- Reducing the harm caused by alcohol.

Appendix 2

Thematic analysis of Health & Wellbeing Board strategies in WEAHSN/CLAHRC West geographical area

| | WEAHSN | Bristol | North Somerset | Bath & NE Somerset | South Glos | Swindon | Wiltshire | Glos |
|---|--|---|---|---|---|---|--|---|
| PREVENTION | | | | | | | | |
| Avoidable deaths and ill health related to behavioural factors and wider social determinants | <p>Patient safety – mental health, primary care, critical care, peri-operative care, VTE, recognition of deteriorating patient</p> | <p>Reduce the prevalence of smoking, reduce illicit tobacco availability and increase smoke free areas within the city</p> <p>Reduce the harm caused by alcohol misuse</p> <p>To give children the best start in life</p> <p>Long Term Conditions: more support at home, reduced rates of hospital admissions for these conditions, reduced rates of diabetic amputation</p> <p>Cancer: Reduce the mortality rate of people with cancer under the age of 75, improving access to earlier diagnosis for the less advantaged,</p> | <p>Reducing Alcohol Related Harm - Increase access to alcohol screening and brief intervention and onward referral to specialist alcohol treatment services when needed, especially for those people with the poorest health outcomes;</p> <p>Provide education and awareness-raising for safer drinking</p> <p>Improve health outcomes and reduce health inequalities – tobacco and alcohol consumption and associated harm reduction; improve breastfeeding rates; increase physical activity levels; reduce STIs and unwanted pregnancy; suicide risk reduction</p> <p>Reduce under 75s mortality rate from cancer</p> <p>Reduce under 75s mortality rate for cardiovascular disease</p> | <p>Helping people to stay healthy – childhood overweight and obesity; support for families with complex needs; alcohol abuse; healthy and sustainable places</p> <p>Promoting self-care which includes healthy lifestyles and improved wellbeing</p> <p>Reducing the number of years of life lost by the people of England from treatable conditions (e.g. including cancer, stroke, heart disease, respiratory disease, liver disease)</p> | <p>Making the healthy choice the easy choice</p> <p>- Creating the right conditions so that everyone is able to lead a healthy lifestyle throughout their life course</p> <p>Tackling health inequalities - Reducing the disparity in health outcomes faced by the most disadvantaged and vulnerable</p> <p>Making the best start in life</p> <p>- Enabling every child and young person to thrive and develop skills to lead a healthy life and achieve their full potential</p> <p>Improved public knowledge and awareness of how lifestyle changes can reduce risk of developing certain cancers</p> <p>Children and young people should have access to complete evidence-based care pathways for the treatment of obesity.</p> <p>Increase emotional and behavioural support service capacity within mental health service for primary and secondary school-age children</p> <p>Suicide and self-harm prevention via a new SG suicide prevention partnership and strategy led in partnership with Public Health</p> | <p>Every child and young person in Swindon has a healthy start in life (Improve the mental wellbeing of children and young people; reduce risky behaviours amongst our children and young people such as smoking, drinking and self-harm; reduce the number of people suffering from long term conditions through promotion of health lifestyle choices</p> <p>Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems, offenders)</p> <p>prevent early death and disease through healthier lifestyle choices</p> <p>promote positive mental health and recognise that mental health is everyone's business ;</p> <p>reduce the stigma and discrimination</p> | <p>Prevention – Support to live healthily (providing the best start in life; eating well and exercising more; helping people make informed choices about drugs, alcohol and cigarettes; helping people make informed decisions about relationships; enabling people to access emotional support; enabling current and former armed forces personnel and their families to access support; ensuring people live in safe and warm home; Staying healthy and preventing ill health – activity targeted to improve the overall health of the whole population through a variety of public health initiatives delivered in partnership with local surgeries, local voluntary and community sector organisations</p> | <p>Starting well – with a focus on pregnancy and early years to give every child the best start in life</p> <p>Developing Well – a focus on children and young people maximising their capabilities and control over their own lives</p> <p>Living and Working Well – a focus on promoting healthy lifestyles; equitable access to ill-health preventative services; Tackling health inequalities</p> <p>Improving mental health</p> <p>Reducing Obesity (promoting healthy weight)</p> <p>Improving health and wellbeing into older age</p> <p>Reducing the harm caused by alcohol</p> |

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| | | | | | | n associated with mental ill health | | |
| Ill health or ill health related dependence (also screening and early diagnosis) | | Cancer: achieve earlier diagnosis of cancer to increase the scope for successful treatment | Ensure all service areas across council and health partners incorporate an early intervention and prevention focus to the services they deliver including access to telecare | | Earlier detection of cancers with increased diagnosis through the elective rather than emergency route Ageing well - Enabling older people to maintain independence and live longer, healthier lives while also supporting people with dementia and at the end of life; Promoting Independence through self-care and management | prevent early death and disease through early detection and screening Risk stratification – locally enhanced service models need to be put in place to ensure the roll out of risk stratification and that investment is available to each practice to test and evaluate which interventions make a difference to overall population risk Self-care and prevention – case worker model for people with LTCS | ensuring serious illness is diagnosed early and people are supported to live a long, healthy life Long term conditions (including dementia) – changing the way we provide care for these patients, particularly in relation to reducing the necessity for emergency care. Underpinning the new models of care is the further development of neighbourhood support teams to support patients with complex needs in their own home | |
| Avoidable admission to hospital | | | supporting prevention and avoiding crisis admissions to hospital earlier increased options for people to live at home that enable a planned reduction in the use of Residential and Nursing Care Homes Reduce emergency admissions for alcohol related liver disease | Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital | Promoting independence: Out of hospital care and Reduction in hospital services and cost. In order to achieve this there is a focus upon the following long term conditions: COPD, fracture Injury, diabetes, spinal care, ophthalmology, heart failure, stroke and neurological conditions Rehabilitation and re-enablement: Enhanced opportunity to live more independently for longer. Accessible services, with care being provided closer to home A greater emphasis on returning home as soon as possible, with | Promote independence and reduce the need for hospital services and long term care; ensure that carers' needs are met Paediatric admissions – investment in alternatives to admission | Unplanned care and frail elderly – vision for urgent and emergency care is of universal, continuous access to high quality services. In practice this will mean that whatever a patient's urgent or emergency care need, whatever the location, they get the best care from the best person, as close to home as possible in a timely way | Ageing Well – promoting independence, physical and mental health and wellbeing post-retirement |

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| | | | | | an associated reduction in the time spent in hospital | | | |
| Avoidable (also healthcare related) harm reduction, especially in relation to infection and management of sepsis, and medication errors | | Medicines Management : Support quality and cost effective prescribing, specific work with nursing homes to improve the quality of medicines management | | Making significant progress towards eliminating avoidable deaths in our hospitals Further developing a sustainable urgent care system, that supports the management of the frail elderly in the community where appropriate | Medicines management: Provide clinically appropriate, evidence based and cost effective prescribing advice. Safe introduction of medicines into the care pathways and management of long term conditions | | | |
| Avoidable harm reduction, social causes | | Reduce all forms of domestic, gender-based, and racially based violence and abuse, including sexual exploitation Improve mental wellbeing and reduce social isolation | Establish information sharing and collaborative working between health services and community safety agencies, particularly in relation to night time violent offences and anti-social behaviour in order to promote community safety | Reducing inequalities and social exclusion | | keep all children and young people safe; improve educational attainment of children and young people; reduce the number of young people not in education, employment or training) | Being safe from avoidable harm - Ensuring children can live, study and play in safe environments; providing support for parents and carers to enable them to look after their children or those in their care; minimising the impact on children and their families at times of crisis such as domestic violence, mental health issues or substance abuse; enabling children to remain with their family when they are safe from abuse and exploitation; ensuring the needs of domestic abuse victims are understood and they are offered the right support; People with alcohol and/or drug problems are supported into treatment and helped to a sustained recovery; investigations into attacks and attempted attacks are | Living and Working Well - healthy and sustainable physical environments ; building social networks and communities and access to good employment opportunities |

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| | | | | | | | carried out sensitively and quickly | |
| <p>Communication (improvements in communication between sectors, primary and secondary care professionals, between patients and professionals, data linkage)</p> | Data linkage | | <p>integration of mental health services in secondary and primary care; single point of access and joint health and social care for frail elderly, people with long term conditions and children with complex needs</p> | <p>Ensuring effective working between primary and community services</p> | <p>deliver seamless services in the community which wrap around the patient, ensure a robust set of community services to care for patients in the community unless admission to hospital is clinically necessary; increase the overall proportion of care which is provided in a community setting; improve capacity and capability of nursing homes to care for more complex patients in the community; Improve discharge practice at NBT.</p> <p>End of Life Care: Communication – communicating with patients to decide their plan and between healthcare professionals to ensure everyone knows the plan. Co-ordination – ensuring everyone is organised in order to provide the best possible care for the patients. Education – Educating the staff enabling them to properly carry out the above actions.</p> <p>Improved provision of information and advice during the weeks after diagnosis of dementia. Partnerships with local voluntary</p> | <p>Improved mental health, wellbeing and resilience for all (develop effective pathways for people with mental health problems; increase the opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery (including education, debt management, housing, leisure services, health promotion); promote positive mental health and recognise that mental health is everyone's business; reduce the stigma and discrimination associated with mental ill health</p> | <p>People who use services have access to urgent support at times of crisis such as when leaving hospital</p> <p>Unplanned care and frail elderly – vision for urgent and emergency care is of universal, continuous access to high quality services. In practice this will mean that whatever a patient's urgent or emergency care need, whatever the location, they get the best care from the best person, as close to home as possible in a timely way</p> <p>Community services and integrated care – older people will feel more secure and supported by greater coordination between social care and NHS community services and integrated care.</p> | |

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| | | | | | <p>organisations. Partnership between the local authority and health commissioners to support local care homes to provide a quality service for residents with dementia. Make South Gloucester more 'dementia friendly'. Increase the capacity of health services to meet needs of people with dementia and improved capacity in dementia nursing support.</p> | | | |
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Appendix 3

Acute Care Trust and Mental Health priorities

Acute Care Trusts Priorities

| | University Hospitals Bristol NHS FT | North Bristol NHS Trust | Weston Area Health NHS Trust | Gloucestershire Hospital NHS FT | The Great Western Hospital NHS FT | Royal United Hospital Bath NHS Trust |
|-------------------------------|--|-------------------------|--|---|---|---|
| Patient Safety | <p>Reduce hospital or healthcare acquired infections</p> <p>Medication errors</p> <p>Medicines reconciliation</p> <p>Early identification and escalation of care of deteriorating patients</p> <p>Improve levels of nutritional screening and specifically 72 hour nutritional review of patients</p> <p>Reduce the number of clinical incidents resulting in moderate or significant harm to patients and successfully communicate our learning from such events to all our staff</p> <p>Further reduce the incidence of Health Care Acquired Infection with the aim of eliminating MRSA and achieving, at least, the required 35% reduction in C Difficile</p> <p>Increase the proportion of patients who experience "harm-free care" through further reductions in the incidence of pressure ulcers, falls, VTE and medication errors</p> | In development | <p>Provide a safe environment for patients</p> <p>Reduce the incidence of avoidable harm</p> | <p>Management of sepsis</p> <p>(To deliver safety and effectiveness objectives: AKI, COPD, pressure ulcers, dementia and delirium, missed doses, never events, sepsis)</p> <p>Improving patient flows</p> <p>Reducing violence and aggression</p> <p>To safeguard all who are in our care</p> | <p>Manage demand for urgent care</p> <p>Provide consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable acute trusts in delivering Hospital Standardised Mortality Rates (HSMR), patient satisfaction and staff satisfaction.</p> <p>To provide consistently high quality, safe services which deliver desired patient outcomes</p> <p>Treating and caring for people in a safe environment and protecting them from avoidable harm⁶</p> | <p>Reduce health care associated infection rates (management of sepsis)</p> <p>Promote organisational learning (Increasing the rate of reporting of patient safety incidents by staff)</p> <p>Deliver NHS South West Patient Safety programme¹²</p> <p>Continue to reduce infection rates and harm events¹²</p> |
| Clinical effectiveness | <p>At least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward</p> <p>Best practice tariff for hip fractures (this involves achieving eight</p> | | <p>Deliver a clinically effective service through implementation and audit of evidence based practice</p> <p>Ensure efficient use of resources through service redesign across</p> | <p>Dementia and delirium</p> <p>Acute kidney injury</p> <p>COPD</p> <p>Reducing variation</p> <p>(To improve the care for people with dementia and delirium)</p> | <p>To adopt new approaches and innovate to promote health and improve services as healthcare changes whilst continuing to become even more efficient</p> <p>To work in</p> | <p>Improve the experience of patients at the end of their life and to support their carers (To improve identification and management of patients who are reaching the end of life, with specific</p> |

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| | <p>indicators including surgery within 36 hours of admission to hospital)</p> <p>Patients with diabetes have improved access to specialist diabetic support</p> <p>Patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan</p> <p>Implement dementia action plan</p> | | <p>elective and emergency care</p> <p>Implement best practice in the delivery of services</p> <p>Ensure local access for patients to high quality core services</p> | <p>Harnessing the benefits of information technology to improve the quality of care</p> <p>Continuing to align our services between our sites to ensure we can deliver consistent quality of care</p> <p>Making sure we get the basics right to deliver good quality, compassionate care</p> <p>Seeking to expand the scope of the services we offer</p> <p>To improve the flow of patients through the emergency pathway</p> <p>To move towards achieving the standards for seven day working</p> <p>To reduce variations in clinical care</p> | <p>partnership with others so that we provide seamless care for patients, more systematically identifying and supporting those individuals at most risk of ill health and delivering closer to home in rural areas</p> <p>To adopt new approaches and innovation so that we improve services as healthcare changes whilst continuing to become even more efficient</p> <p>Service innovation – identifying new ways of working</p> <p>To develop services which shifted the setting of care delivery.</p> <p>To further integrate community and hospital services</p> <p>Preventing people from dying prematurely²</p> <p>Helping people to recover from episodes of ill health or following injury⁴</p> | <p>focus on ensuring appropriate conversations are had with all relevant parties, via the implementation of the End of Life Care and pathway framework)</p> <p>Improve care pathways, supporting the development of new, integrated services⁷</p> <p>Strong operational performance, in particular the reduction in waiting times, supports our aims for the repatriation of elective work⁵</p> <p>Delivery of the five year QIPP Programme supports the commissioner and Trust ambition to reduce the bed-base of the RUH⁸</p> <p>Build Cancer Centre¹²</p> |
| Patient experience | <p>Implement NHS Friends and Family Test</p> <p>Patients continue to be treated with kindness and understanding</p> <p>Explain medication side effects to inpatients when they are discharged</p> <p>Focus on improving the experience of maternity patients</p> | <p>Improving patient documentation at the bedside – increasing individualised care with more bedside information available including when patients will be discharged</p> <p>Improved nutrition – making sure 100% of patients are eating and drinking well during their stay in hospital</p> | <p>Deliver dignified care that is responsive to patients’ personal needs</p> <p>Implement a patient experience strategy to ensure that people have a positive experience of care</p> | <p>Friends and family test</p> <p>Learning from feedback</p> <p>Involving patients in service improvements</p> <p>Delivering compassionate care cancer wait times</p> <p>(To deliver national access targets, with a particular emphasis on cancer waits)</p> <p>To ensure all our patients are treated with care and compassion</p> <p>To extend the implementation of the Friends and Family Test to outpatients, day cases and staff</p> <p>To put in place processes that enable our patients, carers and staff to tell us about their experiences and for us to learn from</p> | <p>Improve patient and carer experience of every aspect of service and care</p> <p>(To improve the patient and carer experience of every aspect of the service and care that we deliver)</p> <p>To work in partnership with others so that we provide seamless care for patients</p> <p>Integrated care – making the patient the focus of everything we do</p> <p>Enhancing quality of life for people with long term conditions³</p> <p>Ensuring people have a positive experience of care⁵</p> | <p>Targeted investment in the buildings to improve the quality of the patient environment, improving patient experience so that the Trust is the hospital of choice strengthening our ability to retain and attract new business¹¹</p> <p>Increase number of single rooms with en-suite facilities¹²</p> <p>Achieve ‘Excellent’ PEAT scores rating for Food & Nutrition and Cleaning & Environment¹²</p> |

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| | | | | <p>them</p> <p>To involve service users in education, training and service redesign</p> | | |
| Other | <p>Apply for capital monies in order to replace aging items of equipment</p> <p>Register interest in applying for Government funding to implement an IT system for Surgical Site Infection working with North Bristol NHS Trust</p> <p>Address deficits in minimum standards of performance and strive to exceed these standards¹</p> | <p>Working with clinical audit and IM&T to create an 'antibiotic' hub on the trust intranet site for all antibiotic audit and usage data. This will facilitate antibiotic usage reporting and target messages</p> <p>Antibiotic guidelines revised in early 2013 to ensure that they meet all recommendations. These will also be adapted to cover new specialties and areas within the NBT such as trauma and sepsis.</p> | | <p>Investing in clinical leadership</p> <p>Developing our contribution to the wider NHS</p> <p>To improve the reputation of our organisation</p> | <p>Secure Long term financial health (To secure the long term financial health of the Trust)</p> <p>To ensure that staff are proud to work at GWH and would recommend the Trust as a place to work, or to receive treatment</p> <p>Transformational cost efficiency – working smarter not harder</p> <p>Building capacity and capability – investing in our staff, infrastructure and new partnerships.</p> <p>To view the trust as three 'business units' (Planned care, Unplanned Care and LTCs) recognising the impact of frail older people who are more complex</p> <p>To recognise the shifts would have an impact on activity, capacity and finances</p> <p>To develop a better understanding and plan for market and competition issues</p> | <p>Supporting ambition to be the hospital of choice for our local population⁷</p> <p>Improved leadership and management capacity and capability to ensure the Trust is fully equipped to respond to a rapidly changing and financially challenging health service⁹</p> <p>Implementation of Service Line Management in support of national policy to ensure that clinicians are at the heart of decisions in shaping healthcare⁹</p> <p>Developing strong clinical relationships with CCGs and GPs and improving our reputation within the health community and the wider public, supports the aim to maintain and regain market share¹⁰</p> <p>Deliver high impact innovations as per Department of Health 'Innovation Health & Wealth' publication¹²</p> <p>Achieve NHS Litigation Authority (NHSLA) level 3¹²</p> <p>Deliver Monitor Quality Governance Framework¹²</p> <p>Deliver operational performance¹²</p> <p>Develop strong clinical relationships with Clinical Commissioning Groups (CCGs) and GPs¹²</p> <p>Improve reputation within the health community and the wider public¹²</p> <p>Achieve planned levels of public FT members¹²</p> <p>Develop communication and marketing strategy to</p> |

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| | | | | | | support reputation ¹² Reduce Trust's carbon footprint by 2016/17 and improve energy efficiency ¹² Reduce backlog maintenance to sustainable level ¹² |
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¹Address deficits in minimum standards of performance and strive to exceed these standards:

- Restore and sustain A&E 4 Hour Performance;
- Significantly reduce ambulance handover delays;
- Resolve inherited Head & Neck RTT issues and address speciality level RTT compliance, notably cardiology and rheumatology;
- Strive for a maximum 40 week wait for admitted care as a key stretch target for 2013/14;
- Deliver sustainable 62 day cancer standard performance
- Restore 6 week diagnostic performance, notably endoscopy and sleep services;
- Reduce scale of last minute cancellations and improve rate of re-booking within 28 day standard.

²-Hospital Standardised Mortality Ratios (HSMR)/Summary Hospital-level Mortality Indicator (SHMI)

- Early recognition of the deteriorating patient

³-Dementia

- Safeguarding adults and children
- Review of patients who are being readmitted to hospital within 30 days of discharge

⁴-Nutrition and hydration

- Stroke care
- Compliance NICE Publications

⁵-Friends and family test – patient recommendations

- Reducing complaints
- Equality and Diversity

⁶-Reduce Healthcare Infections

- Never events
- Reduce Incidents and associated harm
- Patient safety thermometer - continue to reduce pressure ulcers, falls, Catheter Associated Urinary Tract Infections (CAUTIs), VTE

⁷Key priority:

Continuously improve the quality of services, focusing on patient safety, clinical outcomes and patient experience.

⁸Key priority:

Demonstrate strong clinical and financial performance, delivering services to national and local standards, moving from process-based to outcome-based indicators.

⁹Key priority:

Develop our workforce to support the delivery of our strategy, through optimising the skill mix and professional mix of staff, increasing productivity and delegating local control and authority.

¹⁰Key priority:

Strengthen our local and national reputation as a provider of quality care, building relationships with patients, staff, members and commissioners through working effectively as part of a system.

¹¹Key priority:

Continue the rationalisation and improvement of our estate so that by the end of 2016/17 we have reduced our backlog maintenance to an appropriate amount and supported the development of the clinical strategy through improved utilisation, functionality and sustainability of our buildings.

¹²Five year plan 2012/13

Mental Health Trusts Priorities

| | Avon & Wilts Partnership Trust | 2Gether NHS FT |
|-------------------------------|---|--|
| Patient safety | | <p>Safety (minimise the risk of harm to people who use our services, ensure the safety of patients detained under the Mental Health Act)</p> <p>Preventing people from dying prematurely (minimise the risk of suicide of people who use our services; ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm; improve the physical health of patients with mental health problems)</p> <p>(Ensuring that premature death in people with serious mental illness and learning difficulties is reduced)¹</p> <p>Treating and caring for people in a safe environment and protecting them from avoidable harm⁵</p> |
| Clinical effectiveness | <p>Working more efficiently so that staff have more therapeutic time to spend with service users</p> <p>Reorganising our services to provide more effective, recovery focused treatment</p> <p>Improving access to our services through improved ways of working with GPs and other healthcare providers.</p> | <p>Helping people to recover from periods of ill health (ensure appropriate access to psychiatric inpatient care)</p> <p>(Helping people to recover from episodes of ill health or following injury)³</p> <p>Enhancing quality of life (improve the experience of people with dementia in Gloucestershire and Herefordshire; People will feedback to us whether the service they have received has improved their quality of life; children and Young Peoples Services will use mechanisms to gain feedback on whether the service has improved their quality of life.)</p> <p>(Enhancing quality of life for people with long term conditions)²</p> |
| Patient experience | | <p>Improve patient, service user and carer experience</p> <p>Ensuring people have a positive experience of care⁴</p> |

¹-Minimise the risk of suicide amongst those with mental disorders through a systematic implementation of sound risk management principles

- Promote healthier lifestyles amongst service users through positive smoking and alcohol interventions
- Improve the health of prisoners through accessible primary and mental health services

²-Improve dementia services:

- Through staff training
- Ensuring that more people with a diagnosis of dementia can access appropriate services
- Providing appropriate assessments of need
- Improve services for people with a learning disability in Gloucestershire by further developing the reasonable adjustment tools
- Improve access to services for adults in Gloucestershire
- Improve access to psychological therapy services for the wider populations in Gloucestershire and Herefordshire (IAPT) In line with 'No health, without mental health (2011)'

³-Ensure we follow people up when they leave our inpatient units within 48 hours

- Ensure effective and responsive services for people with a first episode of psychosis
- Ensure appropriate admission to psychiatric inpatient care
- Ensuring that inpatients are transferred from hospital beds swiftly when they are fit to leave hospital
- Develop effective recovery services within Herefordshire
- Reduce waiting times for children and young people within Gloucestershire

⁴-Improve the experience of expectant mothers in need of mental health support in Gloucestershire

- Gain feedback from service users and carers to determine satisfaction with the care they are receiving
- Promote dignity in care
- Ensure compliance with the national NHS "Equality Delivery System" covering all nine protected characteristics
- High quality inpatient services
- Improve service user experience

⁵-Minimising the risk of venous thromboembolism (VTE)

- Minimise the risk of harm to inpatients
- Monitor and report the numbers of serious incidents for the purpose of improving safety of services
- Promote service user safety

Appendix 4

Detailed information on prioritised population groups and strategies

Challenges, priorities and strategies stratified by people group and cross cutting groups

The following people groups with specific challenges and priorities have been identified from the stakeholder priority literature,

- Pregnant women
- Children & young people
- People with long term conditions, mental health and learning disabilities
- The frail elderly
- Those at the end of life

Two cross cutting population have also been recognised,

- Minority ethnic groups
- People living in deprived urban areas

In the following text, each of the six stakeholder areas are presented alongside the challenges, priorities and strategies for each people and population group identified within the individual geographical area literature. A broad country wide approach to the challenges and priorities will be included following the six specific geographical areas.

Regional/national level

Challenges

People with long term condition, mental health and learning disabilities

- In common with many other diseases, there are no function- related data to enable planning of services for patients with sensory impairment (beyond synthetic estimates), and no comprehensive data on the extent to which services meet the needs of the large number of people with sensory impairment. The association between sensory impairment and dementia provides an example of one area in which improved data quantity and quality could be used to improve our understanding of the causes and treatment of a disease which extends beyond the population of people with sensory impairment (CMO)

Priorities

Children & young people

- Preventing cerebral palsy in pre-term babies (WEAHSN)

People with long term condition, mental health and learning disabilities

- Further exploration of the association between sensory impairment and dementia (including Alzheimer's disease) may help to reveal more about the causes of dementia (CMO)
- Improvements to data quality and quantity for sensory diseases, and all diseases associated with high morbidity and low mortality, are needed (CMO)
- The Mandate sets an objective to make measurable progress towards making the NHS among the best in Europe at supporting people with ongoing health problems to live healthily and independently, with much better control over the care they receive (NHS outcomes)

- Enhancing quality of life for people with long-term conditions (NHS outcomes)

People living in deprived urban areas

- Further investigation into the apparent association between deprivation and blindness or deafness should help the development of preventative strategies (CMO)
- Closer investigation of the association between fast food outlets and deprivation may help to inform local and national policy (CMO)
- The gap in cancer mortality between the most and least deprived areas of the country is widening. Further exploration of this trend is needed (CMO)

Strategies

Children & young people

- Children and Young People's IAPT is implementing a transformation programme to Child and Adolescent Mental Health Services (CAMHS) and the IAPT severe mental illness project has launched a small number of demonstration sites (NHS outcomes)

People with long term condition, mental health and learning disabilities

- Enhancing quality of life for people with long-term conditions (NHS outcomes)
- The Department of Health has commissioned a research team at the London School of Hygiene and Tropical Medicine to investigate the potential for a routine Patient-Reported Outcome Measure for dementia, including where necessary a measure for completion by a relevant person other than the patient (NHS outcomes)
- Work is still ongoing to develop the learning disability indicator with NHS England, Public Health England and the HSCIC to identify an appropriate data source. A test data extract on learning disabilities from the General Practice Extraction Service (GPES) has been commissioned from the HSCIC (NHS outcomes)
- Supporting mental health trusts in their leadership of and commitment to a South of England wide mental health patient safety collaborative (WEAHSN)
- Initiatives such as Time to Change which aims to reduce mental health stigma and discrimination (CMO)
- The burden of disease may be substantially reduced by employers working hard to reduce the level of work-related mental health problems in the workforce (CMO)

Bristol

Challenges

Children & young people

- Levels of teenage pregnancy and GCSE attainment are worse than the England average

People living in deprived urban areas

- There are significant inequalities in outcomes across the city, including some that are hidden
- Deprivation is higher than average

Priorities

Pregnant women

- Improve maternal health and reduce infant mortality rates, reduce risk taking behaviour which impacts on health, improve emotional health and wellbeing, reduce rates of infant mortality. (BHP)

- Identify the mental health needs of young mothers and service development to meet these needs

Children & young people

- Reduce infant mortality (BHP)
- Increase emotional and behavioural support service capacity within mental health service for primary and secondary school-age children (BHP)
- Improvements in mental health services for adults should be extended to children and young people, including primary care liaison service (BHP)
- Reduce childhood obesity
- Children and young people should have access to complete evidence-based pathways for the treatment of obesity
- Improve the health of vulnerable and excluded children and young people, reduce childhood obesity reduce infant mortality, improve access to health services and experiences for children with complex health needs, improve emotional health and wellbeing, improve the physical health of children.
- Giving children the best start in life

People with long term condition, mental health and learning disabilities

- Improve physical activity services for people with long term conditions and those with physical and mental disabilities. Personalised care planning for all patients with long term conditions, including dementia. Respite care for 'unseen carers'. Service consideration of additional impact of sensory loss. Improved provision of information and advice during the weeks after diagnosis. Partnerships with local voluntary organisations. Partnership between the local authority and health commissioners to support local care homes to provide a quality service for residents with dementia. Make South Gloucester more 'dementia friendly'. Increase the capacity of health services to meet needs of people with dementia and improved capacity in dementia nursing support (BHP)
- Improve access to health services for people with learning difficulties, including mental health services. Ensure safeguarding practices are improved within the mental health and learning difficulties services. Services for dementia, mental health and learning disabilities should also take into consideration the additional impact of sensory loss (BHP)
- Suicide and self-harm prevention via a new SG suicide prevention partnership and strategy led in partnership with Public Health.
- Attention deficit-hyperactivity disorder (ADHD). Autism diagnostic service with specialist assessment and provision of on-going therapy, support and practical assistance. Increase the availability of talking therapies within secondary mental health services. Suicide and self-harm prevention via a new SG suicide prevention partnership and strategy led in partnership with Public Health. Improved safeguarding practices within mental health services. Improve access to mental health services, including for people with learning difficulties. Services for mental health should also take into consideration the additional impact of sensory loss (BHP)
- Priorities include improving mental wellbeing
- Long Term Conditions: more support at home, reduced rates of hospital admissions for these conditions
- Focus upon the following long term conditions: COPD, fracture Injury, diabetes, spinal care, ophthalmology, heart failure, stroke and neurological conditions
- Improve health related quality of life for people with long term conditions

The frail elderly

- Urgent Care including Frail and Elderly Patients (BHP)

Those at the end of life

- A programme of support for patients with end of life needs and their family and carers, 5% reduction in the number of palliative care patients dying in hospital, increase in the number of people on the palliative care register
- Communicating with patients to decide their plan and between healthcare professionals to ensure everyone knows the plan. Co-ordination –ensuring everyone is organised in order to provide the best possible care for the patients. Educating the staff enabling them to properly carry out the above actions.

There were no strategies presented for the individual people and population groups from the Bristol within the literature.

Wiltshire

There were no challenges presented for the individual people and population groups from Wiltshire within the literature.

Priorities

People with long term conditions, mental health and learning disabilities

- Priorities in Wiltshire include mental health

Strategies

Children & young people

- Enabling children to stay fit and healthy through Healthy Schools programme, child obesity pathway, referral to MEND (from January 2013), slimming and physical activity on referral and initiatives such as free child swimming

People with long term conditions, mental health and learning disabilities

- Embed opportunistic health promotion in all health contacts across community services, primary care and secondary care
- To complete the dementia pilot in South Wiltshire and begin rolling out benefits as appropriate across Wiltshire
- Improving support for dementia sufferers and their families through the role out of Dementia Advisors, (working with the third sector)
- Robust community based care pathways will be developed for dementia and diabetes
- Roll out of Sarum dementia pilot across Wiltshire
- The Devon risk stratification tool will be introduced to identify complex patients
- People will be given information, skills and relevant technology for self-management so that they understand what to do when their condition is exacerbated e.g. Chronic Obstructive Pulmonary Disease (COPD)
- Explore options for telehealth and telecare
- Supporting communities and individuals to maximise local assets, social capital and inclusion to sustain good mental health
- Community based campaigns to raise awareness of public health mental health and actions communities and individuals can take to improve resilience and good mental health

- To develop and implement a robust all age mental health liaison service

The frail elderly

- Provision of proactive and supportive care by all health care providers to care homes and their residents
- Advanced care plans will be in place for care/nursing home residents
- Evaluate the nursing care home local enhanced service with a view to continuation and potentially expanding into residential homes
- Setting up mechanisms to support further care homes in Wiltshire towards GSF accreditation

Those at end of life

- All end of life patients to have an advanced care plan in place
- Ensuring that all surgeries are utilising GSF tools and having monthly multidisciplinary end of life care meetings involving neighbourhood teams and other specialists
- GSF meetings held in each care home, to ensure comprehensive plan for each patient at the end of their life
- Engage practices in the Find Your 1% campaign run by Dying Matters www.dyingmatters.org/gp
- Improving skills in primary care to undertake advance care planning discussions with patients and their families
- Ensure all primary care clinicians know about the mechanism for securing 24/7 specialist palliative care advice e.g. pain control
- Electronic Palliative Care Coordination System (EPaCCS) is embedded across all organisations to ensure patients are managed appropriately in the right setting
- Ensure interagency agreement on Do Not Attempt resuscitation (DNAR) documentation

People living in deprived urban areas

- Reducing health inequalities through referral to Health Trainer programme, where available and as appropriate

Swindon

There were no challenges presented for the individual people and population groups from Swindon within the literature.

Priorities

Children & young people

- Increase the number of unemployed 18-25 year olds
- Priorities include increasing the uptake of childhood immunisations
- Child obesity
- Targeted Early Help for children- a different balance weighted toward practical, direct, targeted support when parents most need help, and to support parent carers so that disabled children are supported at home or live in supported accommodation where possible
- Paediatric admissions – investment in alternatives to admission.
- Children with special educational needs and transition – Implementation of the Children & families Bill including a single Health, Education and Care Plan for

children with special educational needs and improved planning between children and adult services

People with long term conditions, mental health and learning disabilities

- Dementia – services need to be put in place to meet the demand created through better registration
- Learning disability
- Mental health
- Improving mental wellbeing
- Below average numbers with long term condition feel supported
- Long term conditions: - diabetes - dementia - cancer - COPD - heart failure – stroke

Strategies

Children & young people

- Implementation of the Children & families Bill including a single Health, Education and Care Plan for children with special educational needs and improved planning between children and adult services
- To support parent carers so that disabled children are supported at home or live in supported accommodation where possible
- Paediatrics: reduction of emergency admissions through locality based urgent care alternatives e.g. hot tot clinics, stream cases away from adult ED

People with long term conditions, mental health and learning disabilities

- Dementia – services need to be put in place to meet the demand created through better registration.
- Learning disability: shift towards supportive living model by stimulating local market and expanding employment, occupational and educational opportunities
- Roll out single point of access for long term conditions
- Self-care and prevention/community coordination – locally enhanced service models on a pilot basis to be put in place to test the N.E. London case worker model for long term conditions including older people. Reshaping of provision in the voluntary and third sector to improve health and well-being, improved advice and information so that people can make plan and make choices for themselves
- Mental health and wellbeing coordinators
- Mental health: revisit local capacity model, protect and enhance IAPT model, strengthen crisis resolution and MH liaison with both primary and secondary care, implement health and wellbeing coordination

North Somerset

Challenges

People living in deprived urban areas

- North Somerset has the seventh largest inequality gap in the country, which has worsened from the eleventh largest gap in 2007 (calculated using the difference between the highest and lowest score in a unitary authority).

Minority ethnic groups

- There is a need to understand the outcomes for the black and ethnic minority population, particularly in relation to health and social care.

Priorities

Pregnant women

- Reducing the number of abortions
- Improving breastfeeding rates, especially in younger mothers, those in low incomes, and those living in Weston-Super-Mare
- Reducing the rising levels of obesity, particularly in deprived areas and high risk groups, including pregnant women and diabetes

Children & young people

- Improving the outcomes of children by supporting the whole family, especially in relation to alcohol, mental health and substance misuse (Think Family)
- Levels of alcohol specific hospital stays among those under 18
- Stopping young people smoking, particularly in deprived areas
- Reducing teenage pregnancy rates, particularly in areas of Weston-Super-Mare with high levels of teenage conceptions

People with long term conditions, mental health and learning disabilities

- Supporting the needs of the increasing numbers of people with sensory impairment, with a specific focus on those young people in transition
- Further reducing deaths from coronary heart disease, particularly in deprived areas
- Addressing the needs of the growing numbers of older people with Dementia and continue to support people to self care and thereby manage their own long-term condition
- Enabling a greater proportion of older people and people with learning disabilities to live independently in the community and reducing the over reliance on residential and nursing care
- Reducing the number of those who die as a result of suicide

The frail elderly

- Planning for a growing population, particularly the increase in the number of older people and growth around Weston-super-Mare
- Enabling a greater proportion of older people to live independently in the community and reducing the over reliance on residential and nursing care

Bath and North East Somerset

Priorities

Children & young people

- Helping children to be a healthy weight

People with long term conditions, mental health and learning disabilities

- Enhanced quality of life for people with dementia
- Hospital admissions for self-harm
- Reduced rates of mental ill-health

Strategies

People with long term conditions, mental health and learning disabilities

- Improved support for people with long term health conditions

The frail elderly and those at the end of life

- Improved services for older people which support and encourage independent living and dying well

Gloucestershire

Challenges

Children & young people

- The future numbers of children, young people and working-age people are subject to some uncertainty, as the pending agreement and delivery of District Councils' Core Strategies could affect the growth trajectory through their impact on inward migration. The uncertainty will affect how the council plans its service provision for these population groups.
- We may need to address the issue of access to opportunities and services by the increasing number of children and parents from single-parent households, as their income level is only around a third of that of couple families

The frail elderly

- We will increasingly see greater numbers of older people living alone. Some of these will be without local family support, increasing the need for care services

Minority ethnic groups

- The ethnic structure of the population will also change, as the natural growth from within the current minority ethnic population is expected to increase. This will result in increasing proportions of children of early years and school age from minority ethnic groups, and over time an increasing representation of minority ethnic population in the local labour force.

People living in deprived urban areas

- Older people have high levels of income deprivation and where the need for care services is likely to be highest

Priorities

Pregnant women

- Smoking in pregnancy

Children & young people

- Numbers of children living in poverty
- Children who eat well and maintain a healthy weight
- Young people not in education, employment or training
- Improving the sexual health of young people – including reducing the numbers of people with Chlamydia
- Children and young people leading positive lifestyles

People with long term conditions, mental health and learning disabilities

- Improving the life of those with dementia
- People that self-harm or die by suicide
- Improving mental health

The frail elderly

- Improving health and wellbeing into older age

- Hip fractures in older people
- Excess winter deaths

There were no strategies presented for the individual people and population groups from Gloucestershire within the literature.

South Gloucestershire

There were no challenges or strategies presented for the individual people and population groups from South Gloucestershire within the literature.

Priorities

Children & young people

- Better educational and training outcomes at 16-18 yrs
- Enabling every child and young person to thrive and develop skills to lead a healthy life and achieve their full potential

People with long term conditions, mental health and learning disabilities

- Mental health problems to lead independent, fulfilling and dignified lives
- Enabling people with long-term conditions, physical disabilities and mental health problems to lead independent, fulfilling and dignified lives.

The frail elderly

- Better care for elderly in hospital
- Enabling older people to maintain independence and live longer, healthier lives while also supporting people with dementia and at the end of life

Table 1. Priorities identified for people and cross cutting groups listed by geographical area

| Area | People groups | | | | | Cross cutting groups | |
|--------------------|----------------|-------------------------|---|-------------------|--------------------------|------------------------|---|
| | Pregnant women | Children & young people | People with long term conditions, mental health and learning disabilities | The frail elderly | Those at the end of life | Minority ethnic groups | People living in deprived urban areas (Deprivation) |
| Regional/national | - | ✓ | ✓ | - | - | - | ✓ |
| Bristol | ✓ | ✓ | ✓ | ✓ | ✓ | - | - |
| Wiltshire | - | - | ✓ | - | - | - | - |
| Swindon | - | ✓ | ✓ | - | - | - | - |
| North Somerset | ✓ | ✓ | ✓ | ✓ | - | - | - |
| Bath & NE Somerset | - | ✓ | ✓ | - | - | - | - |
| Gloucestershire | ✓ | ✓ | ✓ | ✓ | - | - | - |
| South Glos | - | ✓ | ✓ | ✓ | - | - | - |

Table 2. Strategies proposed for people and cross cutting groups listed by geographical area

| Area | People groups | | | | | Cross cutting groups | |
|--------------------|----------------|-------------------------|---|-------------------|--------------------------|------------------------|---|
| | Pregnant women | Children & young people | People with long term conditions, mental health and learning disabilities | The frail elderly | Those at the end of life | Minority ethnic groups | People living in deprived urban areas (deprivation) |
| Regional/national | - | ✓ | ✓ | - | - | - | - |
| Bristol | - | - | - | - | - | - | - |
| Wiltshire | - | ✓ | ✓ | ✓ | ✓ | - | ✓ |
| Swindon | - | ✓ | ✓ | - | - | - | - |
| North Somerset | - | - | - | - | - | - | - |
| Bath & NE Somerset | - | - | ✓ | ✓ | ✓ | - | - |
| Gloucestershire | - | - | - | - | - | - | - |
| South Glos | - | - | - | - | - | - | - |