Appendix 1 – Our achievements over the last 12 months

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

Adult Social Care (ASC)

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

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

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

Population Health Transformation

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

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

Urgent and Emergency Care

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

Planned care, diagnostics and cancer

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

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

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

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

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

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

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

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

Mental health, Autism & Learning Disabilities

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

Children, Young People and Families

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

Women's Health

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

Local Maternity and Neonatal System (LMNS)

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

Improving Lives in Communities & Neighbourhoods

Primary Care Services

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

Urgent Community Response (UCR)

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

Proactive Care (Anticipatory Care)

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

Enhanced Health in Care Homes (EHCH)

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

Major Conditions

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

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

Personalised care

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

Integration and the Better Care Fund

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

Our People

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

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

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

Digital, Data and Insights

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

Estates

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

Sustainability

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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

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

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

Procurement/Supply Chain

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

Progress Key	✓	Met	⇨	Working towards	✘	Not Met

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