One Gloucestershire
Transforming Care, Transforming Communities

Health & Wellbeing Board Joint Forward Plan 2024-2029

19 March 2024

@One_Glos
www.onegloucestershire.net

Reminder of strategic planning requirements

- We have a duty under the Health and Care Act 2022 to develop 5-year Joint Forward Plans (JFPs) before the start of each financial year. This will therefore be our second JFP.

- The One Gloucestershire JFP describes how we will deliver and improve the health and care elements of the county's Integrated Care Strategy. It is owned by the NHS Gloucestershire Integrated Care Board, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care Foundation Trust with contributions from other partners such as Gloucestershire County Council, primary care and the voluntary sector.

- The JFP also describes how we meet the seventeen legislative requirements of Integrated Care Systems and how we understand their impact.

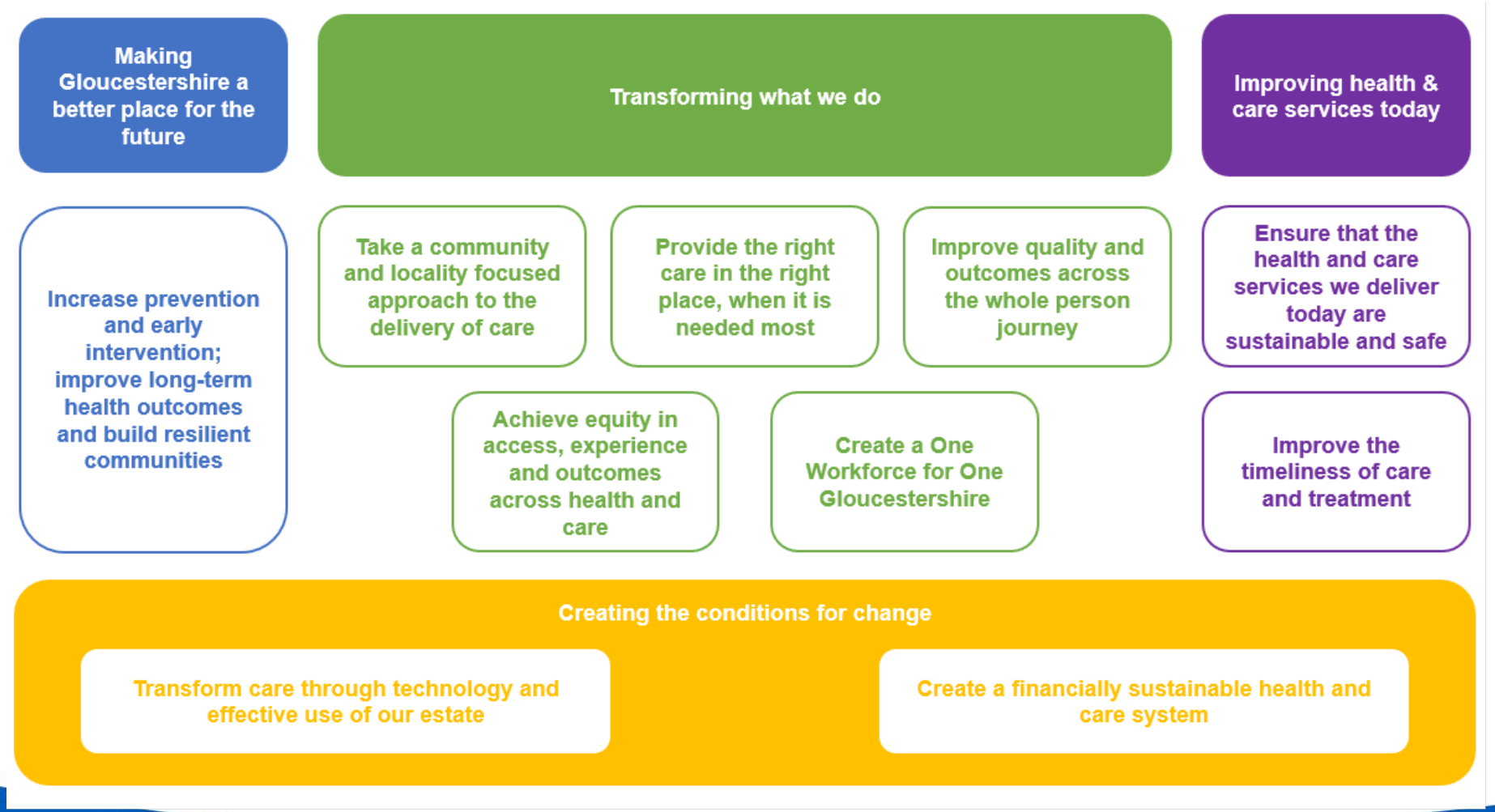
- Publication by 31st March of a light-touch reviewed JFP

Our approach

- **A plan of two halves**:
  - main narrative document which tells the story of our strategic objectives
  - supplemented by a more detailed appendix setting out what we have done, what impact it had and what we will do next

10 Strategic Objectives	
#1: Increase prevention and early intervention; improve long-term health outcomes and build resilient communities	#6: Ensure that the services we deliver today are sustainable and safe
#2: Achieve equity in access, experience and outcomes	#7: Improve the timeliness of care and treatment
#3: Take a community and locality focused approach to the delivery of care	#8: Create One Workforce for One Gloucestershire
#4: Provide the right care in the right place, when it is needed most	#9: Transform care through technology and effective use of our estate
#5: Improve quality and outcomes across the whole person journey	#10: Create a financially sustainable health and care system

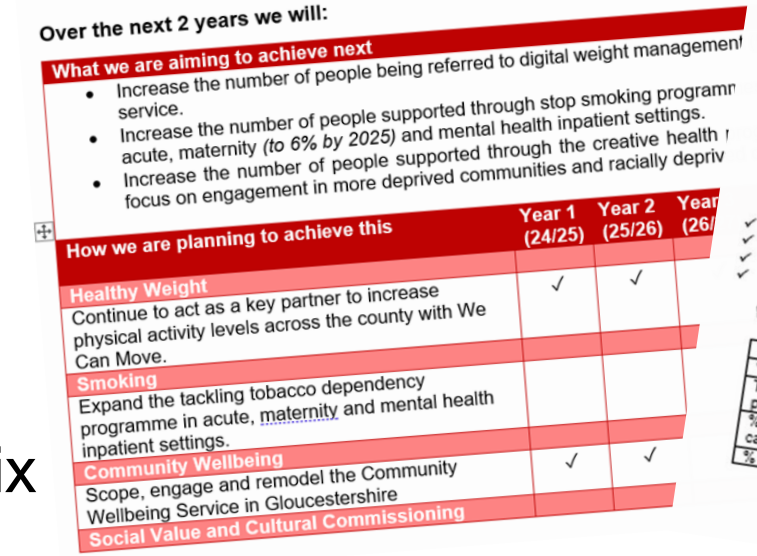
Aligning to the ICS Strategy



Each strategic objective section includes:

- Why is this important?
- What have we done?
- A short case study
- What are we going to do?
- What difference will it make?

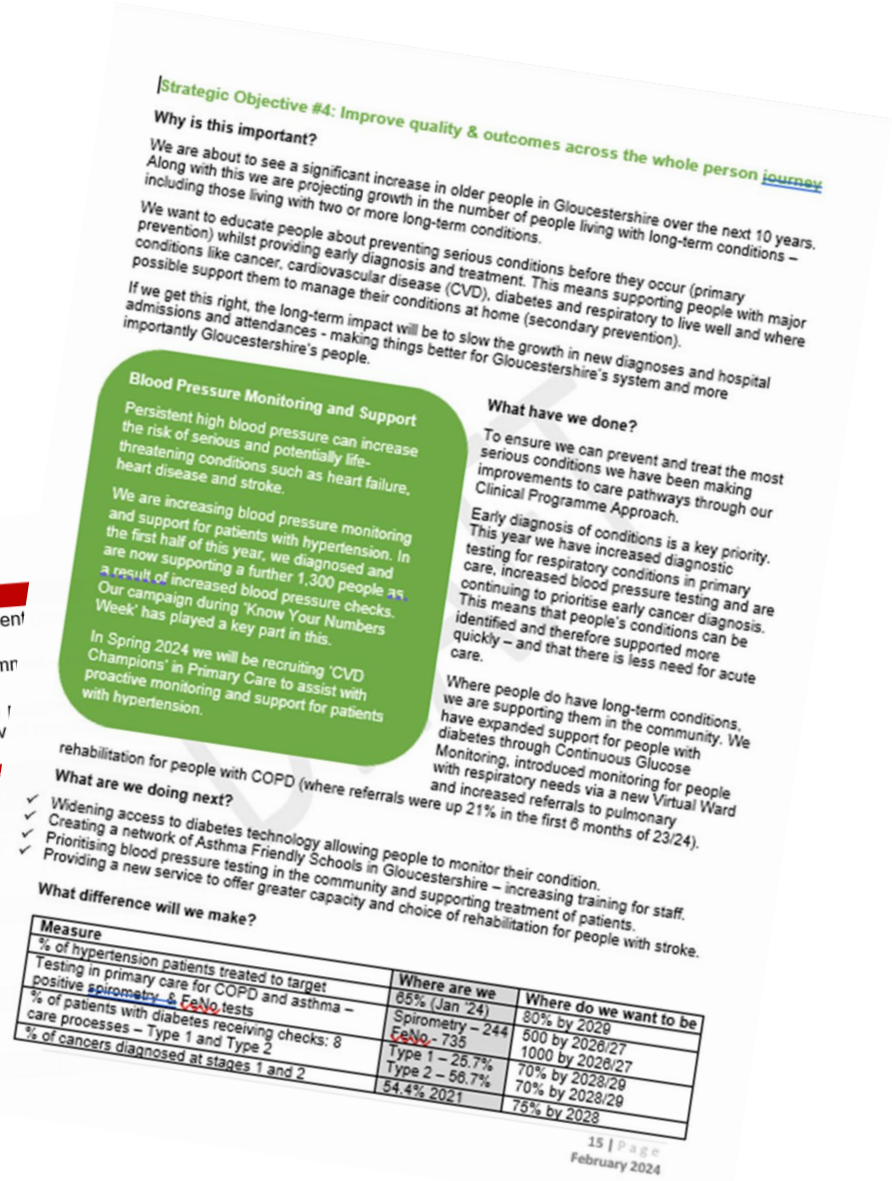
With more details about programmes' metrics and milestones in the appendix



Over the next 2 years we will:

What we are aiming to achieve next
• Increase the number of people being referred to digital weight management service. • Increase the number of people supported through stop smoking programm • acute, maternity *(to 6% by 2025)* and mental health inpatient settings. • Increase the number of people supported through the creative health focus on engagement in more deprived communities and racially depriv

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year (26/
Healthy Weight			
Continue to act as a key partner to increase physical activity levels across the county with We Can Move.	✓	✓	
Smoking			
Expand the tackling tobacco dependency programme in acute, maternity and mental health inpatient settings.			
Community Wellbeing			
Scope, engage and remodel the Community Wellbeing Service in Gloucestershire	✓	✓	
Social Value and Cultural Commissioning			



Strategic Objective #4: Improve quality & outcomes across the whole person journey

Why is this important?

We are about to see a significant increase in older people in Gloucestershire over the next 10 years. Along with this we are projecting growth in the number of people living with long-term conditions – including those living with two or more long-term conditions.

We want to educate people about preventing serious conditions before they occur (primary prevention) whilst providing early diagnosis and treatment. This means supporting people with major conditions like cancer, cardiovascular disease (CVD), diabetes and respiratory to live well and where possible support them to manage their conditions at home (secondary prevention).

If we get this right, the long-term impact will be to slow the growth in new diagnoses and hospital admissions and attendances - making things better for Gloucestershire's system and more importantly Gloucestershire's people.

Blood Pressure Monitoring and Support

Persistent high blood pressure can increase the risk of serious and potentially life-threatening conditions such as heart failure, heart disease and stroke.

We are increasing blood pressure monitoring and support for patients with hypertension. In the first half of this year, we diagnosed and are now supporting a further 1,300 people as a result of increased blood pressure checks. Our campaign during 'Know Your Numbers Week' has played a key part in this.

In Spring 2024 we will be recruiting 'CVD Champions' in Primary Care to assist with proactive monitoring and support for patients with hypertension.

What have we done?

To ensure we can prevent and treat the most serious conditions we have been making improvements to care pathways through our Clinical Programme Approach.

Early diagnosis of conditions is a key priority. This year we have increased diagnostic testing for respiratory conditions in primary care, increased blood pressure testing and are continuing to prioritise early cancer diagnosis. This means that people's conditions can be identified and therefore supported more quickly – and that there is less need for acute care.

Where people do have long-term conditions, we are supporting them in the community. We have expanded support for people with diabetes through Continuous Glucose Monitoring, introduced monitoring for people with respiratory needs via a new Virtual Ward and increased referrals to pulmonary rehabilitation for people with COPD (where referrals were up 21% in the first 6 months of 23/24).

What are we doing next?

- ✓ Widening access to diabetes technology allowing people to monitor their condition.
- ✓ Creating a network of Asthma Friendly Schools in Gloucestershire – increasing training for staff.
- ✓ Prioritising blood pressure testing in the community and supporting treatment of patients.
- ✓ Providing a new service to offer greater capacity and choice of rehabilitation for people with stroke.

What difference will we make?

Measure	Where are we	Where do we want to be
% of hypertension patients treated to target	65% (Jan '24)	80% by 2029
Testing in primary care for COPD and asthma – positive spirometry & FeNo tests	Spirometry – 244 FeNo - 735	500 by 2026/27 1000 by 2026/27
% of patients with diabetes receiving checks: 8 care processes – Type 1 and Type 2	Type 1 – 25.7% Type 2 – 56.7%	70% by 2028/29 70% by 2028/29
% of cancers diagnosed at stages 1 and 2	54.4% 2021	75% by 2028

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Sign-off

- GHFT Board: 14th March
- Health and Wellbeing Board: 19th March
- PCN Clinical Directors: Virtual Circulation
- NHS Gloucestershire Integrated Care Board: 27th March
- GHC Board: 28th March

Board are asked to:

Comment on the One Gloucestershire Joint Forward Plan for 2024-2029 and its contribution to the integrated care strategy.