Meeting in common – Bristol City Council People Scrutiny Commission, North Somerset Health Overview and Scrutiny Panel and South Gloucestershire Health Scrutiny Committee.

Agenda

Date: Thursday, 1 December 2016

Time: 2.00 pm

Venue: The Council Chamber - City Hall, College Green, Bristol, BS1 5TR

Distribution:

Bristol City Council People Scrutiny Commission Councillors: Brenda Massey (Chair), Jos Clark (Vice-Chair), Lesley Alexander, Mark Brain, Eleanor Combley, Anna Keen, Gill Kirk, Cleo Lake, Ruth Pickersgill, Celia Phipps, Liz Radford

North Somerset Health Scrutiny Committee Councillors: Roz Willis (Chair), Ruth Jacobs (Vice-Chair) Mike Bell, Sarah Codling, Andy Cole, Bob Garner, Ann Harley, David Hitchins, Reyna Knight, Tom Leimdorfer, Ian Parker, Liz Wells

South Gloucestershire Health Scrutiny Committee Councillors: Toby Savage(Chair), Sue Hope (Lead Member), Ian Scott (Lead Member), Kaye Barrett, April Begley, Janet Biggin, Robert Griffin, Paul Hardwick, Shirley Holloway, Marian Lewis, Sarah Pomfret, , Gloria Stephen and Erica Williams

Copies to: John Readman (Strategic Director - People, Bristol City Council), Alison Comley (Strategic Director - Neighbourhoods, Bristol City Council), Becky Pollard (Director - Public Health, Bristol City Council), Mark Pietroni (Director of Public Health, South Gloucestershire Council), David Jones (Interim Assistant Director, Adults' Support and Safeguarding, North Somerset Council), Karen Blong (Policy Advisor, Bristol City Council), Claire Rees (Health & Wellbeing Partnership Support Officer, South Gloucestershire Council), Joshua Van Haaren (Democratic Services Officer, Bristol City Council), Leo Taylor (Scrutiny Officer, North Somerset Council)

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Date: 22.11.2016

Agenda

1. Welcome, Introductions and Safety information

The Bristol City Council People Scrutiny Commission, North Somerset Health Scrutiny Committee and South Gloucestershire Health Scrutiny Committee have agreed to hold a meeting in common to consider the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (BNSSG STP). This is an informal arrangement and each committee remains independently constituted.

2. Apologies for Absence and Substitutions

3. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a disclosable pecuniary interest.

Please note that the Bristol City Council Register of Interests is available at https://www.bristol.gov.uk/councillors/members-interests-gifts-and-hospitality-register

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Chair's Business

To note any announcements from the Chair

5. Public Forum

Up to 30 minutes is allowed for this item.

Any member of the public or Councillor may participate in Public Forum. The detailed arrangements for so doing are set out in the Public Information Sheet at the back of this agenda. Public Forum items should be emailed to democratic.services@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in

this office at the latest by **5 pm on 25th November 2016.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest by **12.00 noon on 30th November 2016.**

6. Sustainability & Transformation Plan (STP) for Bristol, North Somerset and South Gloucestershire

(Pages 4 - 294)

To receive the Sustainability and Transformation Plan for Bristol, North Somerset &
South Gloucestershire and to:

- note that the STP in its current stage of development as the basis for further

detailed work leading to implementation of specific proposals

- consider the preferred approach to receiving further updates as this work is
progressed

(Robert Woolley, Chief Executive University Hospitals Bristol NHS Foundation Trust & Senior Responsible Officer for the local STP).

Bristol City Council People Scrutiny Commission, North Somerset Health Scrutiny Committee and South Gloucestershire Health Scrutiny Committee meeting in common

1st December 2016

Report of: Robert Woolley, Chief Executive University Hospitals Bristol NHS Foundation Trust

Title: Sustainability & Transformation Plan (STP) for Bristol, North Somerset and South Gloucestershire

Ward: City Wide

Officers Presenting Report: Robert Woolley, Chief Executive University Hospitals Bristol NHS Foundation Trust (* other attendees to be confirmed)

Contact Telephone Number: 0117 947 4459

RECOMMENDATION

- Note the STP in its current stage of development as the basis for further detailed work leading to implementation of specific proposals
- Consider the preferred approach to receiving further updates as this work is progressed

Summary

The purpose of this report is to receive the Sustainability and Transformation Plan for Bristol, North Somerset & South Gloucestershire

The significant issues in the report are:

The local STP is being organised across three broad, interrelated themes

- Prevention, early intervention and self-care
- Integrated primary and community care
- Acute care collaboration

This work is being supported by a number of enabling work-streams particularly including workforce, digital and finance

The STP in its current stage of development includes; a shared assessment of the service and financial challenges facing the local health and care system, a summary of the case for change and our vision for working together and working differently to meet this challenge.

Following a 'checkpoint' review by NHS England, the STP will now be progressed leading to the development of specific plans and proposals.

Consultation

1. The development of the STP to date has been undertaken with reference to existing information on people's view of local health services. This includes; feedback through public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports.

There will be opportunities for local people, patients and carers, and other stakeholders to get involved and have their say in the development of specific plans and proposals, and where a significant change is involved there will also be formal public consultation before changes are made.

Context

2. Following on from the publication of the Five Year Forward View for the NHS in England, the development of Sustainability and Transformation Plans (STPs) are a new approach to planning health and care services across over the next 5 years.

Local organisations are required to work together to develop a shared understanding of the challenges and to agree joint plans for addressing these.

The principal aims are to:

- Improve the health and wellbeing of local people
- Improve the quality of local health and care services
- Deliver financial stability and balance throughout the local health care system

Locally, *Bristol, North Somerset and South Gloucestershire* (BNSSG) are working together as one of 44 agreed local areas across the UK.

The initial development of the local STP has involved15 local organisations responsible for planning and providing your health and social care services (see table below).

Table: Local STP partners for Bristol, North Somerset & South Gloucestershire

- Bristol City Council, North Somerset Council, South Gloucestershire Council
- Bristol CCG, North Somerset CCG, South Gloucestershire CCG
- North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, Weston Area NHS Health Trust, South West Ambulance NHS Foundation Trust, Avon and Wiltshire Partnership
- Bristol Community Health, North Somerset Community Partnership, Sirona care & health
- NHS England (as the commissioners for Primary Care and for Specialised Services)

The development of the STP is overseen by an executive programme board on behalf of the existing BNSSG System Leaders Group, and is led by the Chief Executive of University Hospitals Bristol NHS Foundation Trust in the role of 'Senior Responsible Officer' for the local STP.

Proposal

3. Every day our local health and care services successfully see and treat thousands of people. They are important services that all of us, our families and our friends will rely on at

one time or another.

Across the country and also locally throughout Bristol, North Somerset and South Gloucestershire, these health and care services are under significant and sustained pressure which continues to increase.

The reasons for these growing pressures are well known. As our population ages the number of people requiring care for life changing diseases such as diabetes dementia and other long term conditions continues to rise.

With sufficient and well organised services this care can be provided effectively in the community supported by specialist services in hospital when required. But where this isn't the case people with these conditions are more likely to end up being admitted to hospital for an extended period leading to a loss of independence.

Although significant progress has been made in modernising and improving local services, many services both in hospital and in the community continue to be organised around historical patterns which can be less efficient and which can give rise to duplications and gaps in coverage.

With total annual expenditure for local NHS services of around £1.5 billion, our local combined financial position is not in balance. If demand for services continues to grow in the way we expect, this combined deficit will continue to increase. Local authority budgets for social care are also reducing.

This combination of growing demand and increasing financial deficit is not sustainable.

We need to work together and work differently - between health and social care, between hospital and community services and with local people - in order to continue to meet the health needs of our local population

The STP describes our assessment of the local challenge in further detail.

It explains our approach to securing a step-change in the way health and care works across Bristol, North Somerset and South Gloucestershire.

It outlines of our vision for; a substantive programme of *prevention, early intervention and self-care*; for a dynamic new model of *integrated primary and community health services*; and for a *new collaborative approach to the way our local hospitals services work together*.

It affirms our commitment to achieving parity of esteem, the principle by which mental health is given equal priority to physical health in the way local services are planned and delivered.

These draft proposals have already been shaped by the feedback that we receive from people about their experiences of using current services, and from our own staff involved in organising and delivering care.

We will continue to involve local people and our workforce as specific proposals for change emerge, and where a significant change is involved there will also be formal public consultation before changes are made.

Risk Assessment

4. A high level assessment of risks and mitigations is included in the STP. Risk identification and risk management will be undertaken through the STP programme management arrangements.

Public Sector Equality Duties

5. There are no specific implications for equalities arising from the recommendations in this report.

Further consideration of any implications for equalities will be undertaken where indicated as part of specific portfolios and programmes of work arising from the further development of the STP

Legal and Resource Implications

Legal

6. There are no specific legal implications arising from the recommendations in this report.

Financial

7. There are no additional resource implications arising from the recommendations in this report.

The STP includes an assessment of the combined financial challenge for the whole health system both in terms of revenue and capital, together with an assessment of the workforce issues relating to the further development of the STP.

Appendices:

A – STP October 2016 submission
B – STP summary

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985

Background Papers:

- STP June 2016 submission

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Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

October 2016 Submission

KEY INFORMATION SUMMARY

FOOTPRINT AREA: Bristol, North Somerset & South Gloucestershire (BNSSG)

FOOTPRINT LEAD: Robert Woolley,

Chief Executive University Hospitals Bristol FT

PARTNER ORGANISATIONS:

CCGS/COMMISSIONERS: Bristol, South Gloucestershire and North Somerset CCGs, NHS England

LOCAL AUTHORITIES: South Gloucestershire, Bristol and North Somerset Local Authorities which includes the West of England Public Health Partnership

PROVIDERS: Weston Area Health NHS Trust, North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, Sirona Care and Health, Bristol Community Health, North Somerset Community Partnership, South Western Ambulance Service NHS Foundation Trust

Version: 1.1

Date: 21 October 2016

Contents

Appendix

1. Introduction

1.1 Key messages

Our Sustainability and Transformation Plan (STP) has evolved from the Checkpoint submission made in June. In developing our October submission, we have drawn upon the feedback received from NHS England and have described the progress we have made in defining and developing our interventions.

The focus of our STP remains on achieving the triple aims of improved population health, quality of care and cost-control, by successful integration and removal of the boundaries between mental and physical health (Parity of Esteem), primary and specialist services, health and social care.

1.2 NHS England Feedback

Set out below is the feedback we received following our June submission. We have highlighted how this submission addresses the feedback received and referenced the relevant sections for easy identification.

NHS England feedback	**BNSSG Response within this submission**	**Section**
Great depth and specificity, with clear and realistic actions, timelines, benefits, resources and owners.	Articulation of the key priority projects that we are taking forwards in years 2 & 3 of the STP and inclusion of summary business cases for each of these. Finance & workforce schedules	Sections 4.1, 4.2 & 4.3 Appendix B
Year on year financial trajectories.	Finance schedule	Chapter 7.2 & Separate Financial Templates
Articulate more clearly the i**mpact on quality of care.**	We are developing our approach to the management of quality with the support and participation of the Academic Health Science Network.	Section 5.2
Include **stronger plans for primary care and wider community services** that reflect the General Practice Forward View, drawing on the advice of the RCGP ambassadors and engaging with Local Medical Committees.	We have established an Integrated Primary Care portfolio within our Integrated Primary and Community Care Workstream, which details how we are tackling the General Practice Forward View.	Chapter 4.2
Set out more fully your **plans for engagement.**	Engagement approach and materials included in the submission.	Chapter 6.1 & Appendix E
Trajectories for performance on A&E, RTT and GP Access	This information is work in progress and trajectories are being developed as part of the Operational Planning process.	N/A

NHS England feedback	BNSSG Response within this submission	Section
Capital funding	Finance section on expectations around capital funding.	Chapter 7.2
Information technology investment	LDR submission due 31/10/16 Short update on LDR development, governance and resourcing included in this STP submission.	Chapter 6.4 & Appendix H
Mental Health Plans and Investment	Explanation of our approach to redesigning and increasing investment in Mental Health Services.	Chapter 5.5 & Appendix D
Governance arrangements to ensure strong collective leadership for the STP	Outline of our emerging Governance Framework for delivering the STP.	Chapter 3.1 and Appendix A
Recommend that all **organisations contribute an equitable level of resources** to the programme to support leadership and ensure sufficient capacity to accelerate implementation.	Outline of our approach to resources.	Chapter 3.1 and Appendix A
Pathways for acute and specialised services	Updates on the key programmes within the Acute Care Collaboration are set out in this document. This includes the work being undertaken with regards to specialised services.	Chapter 4.3 & Appendix B and C
Workforce implications of the plan and how they will be managed.	Approach to full integration of the workforce programme within the core STP is set out in our response.	Chapter 5.2 & Appendix G

1.3 Context and approach

The development of our STP is being undertaken in a difficult organisational context, with a number of our partners currently subject to external intervention as a consequence of the financial challenges they face. Aligning these interventions with the development of the STP is critical if we are to optimise their impact and create a successful and sustainable system for the future.

In our original submission we defined and acknowledged the scale of the challenge in delivering a sustainable health and care system and set out the case for change. Since then, we have been working together to establish the new relationships, behaviours, systems and processes that will be required to address the "wicked issues" we face. The STP approach has created a new culture and environment within which our organisations need to operate and we recognise that we are at the start of our collaborative journey. As we progress the STP, we will develop our approach further and learn new ways of working together for system benefit.

This submission reflects the progress we are making and recognises the challenges that lie ahead. Our intention is therefore to:

- Reaffirm the model of care we are developing;
- Demonstrate how the programmes and projects we are undertaking will contribute to the delivery of the model of care;
- Provide greater detail on the projects we are undertaking, the outcomes they are seeking to achieve and their relationship to the overall model of care;
- Begin to illustrate the impact these projects will have on the experience and outcomes for our population, the quality and accessibility of our services, the roles and opportunities for our staff and the financial sustainability of our care system;
- Describe the way we will enable change through the transformation of our service delivery, workforce, our deployment of technology and the optimal use of our estate; and
- Articulate how we will use the operational planning and contracting processes to embed the STP approach and incentivise the delivery of the model of care.

Since our June submission, we have continued to develop our new model of care through three major transformational workstreams: Prevention, Early Intervention and Self-Care; Integrated Primary and Community Care; and Acute Care Collaboration. Our focus in the last three months has been on defining and initiating our short and medium term priority projects within each of these programmes and assessing the impact these will have on the overall sustainability challenge. We have also sought to ensure that mental health is effectively integrated within all three workstreams.

In developing our STP, we are building on the advances we have made in our local infrastructure. These include our use of digital technology to support care, the redesigned estate at the Bristol Royal Infirmary campus, South Bristol and Southmead hospitals and the combination of general, specialist and tertiary services that we offer and help to make BNSSG an attractive place to work.

The analysis required to estimate the impact of the new model of care is ongoing and we are using the Operational Planning timetable and requirements as the framework through which the intended impacts will be built into service contracts. At this stage of the process our planned interventions will only generate part of the financial savings we need. This reflects two things:

- The limited evidence base that exists for achieving the scale of change needed; and
- The multifactorial influences that determine the demand for care services.

At the heart of our STP will be a drive to improve our collective understanding and analysis of the influences on demand for our services and how the respective interventions that we make (e.g. shared decision making or self-care) can positively influence these at a scale previously not achieved. We also acknowledge the evidence around the influence that 'supply' can have on the demand for a service and will seek to take bold collaborative decisions to manage supply in areas where there is unwarranted variation in demand.

We know from the scale of our quality, accessibility and sustainability challenge that there is more we need to do to identify and define the significant transformational changes that are required. In support of this, we are evolving our governance structures to facilitate effective decision making. We are also utilising the opportunities presented by the two year Operational Planning process to ensure organisations are incentivised to operate in a manner which aligns with the goal of our STP.

Our discussions around the organisational forms that will be required in the future are still in progress, as our focus at this moment is on delivering the short to medium term changes we have defined. We will, however, increasingly focus our attention on the implications of the changes in our model of care for existing organisations and the opportunities presented by organisational reform.

In this regard, our STP is deliberately both ambitious and pragmatic, ensuring that we build momentum through our new ways of working, strengthening our relationships and improving our effectiveness as we create the model of care for the future.

1.4 Case for change update

In our original submission we set out the case for change which largely remains as previously described. Where our thinking has developed further we have included short updates.

Health and Wellbeing Gap

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

Care and Quality Gap

Our care system continues to experience the significant performance challenges that were set out in our original submission. We recognise that addressing these performance challenges is central to the development of our STP and are using the Operational Planning process to help define and embed the performance improvement measures that we will collectively pursue.

Affordability Gap

Since our submission in June we have reviewed and refined the financial and activity modelling that underpins the 'Do nothing' option in the STP. The most significant factor in this change was to update the modelling from its original baseline of 2015/16 forecast activity, to the 2016/17 operating plans that BNSSG organisations are now working to. The 'Do Nothing' positions and financial savings for the period to March 2020/21 were signed off and

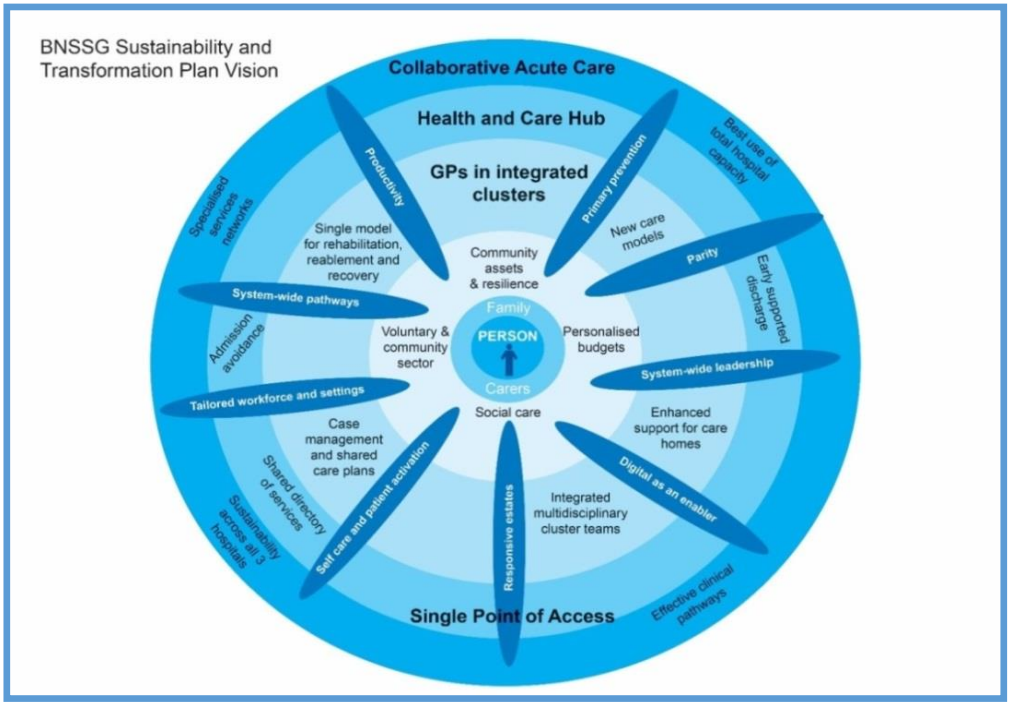
submitted by Directors of Finance on the 14th October 2016. The 'Do Nothing' deficit across the BNSSG STP as at 31st March 2021 totals £305.5m as reflected below.

Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**
Providers	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)
North Bristol NHS Trust (NBT)	(80.6)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)
South Western Ambulance Service (SWAST)	(3.2)
Community Interest Companies (CiCs)	(15.0)
Sub-total Providers	**(184.3)**
Commissioners	
Bristol CCG	(60.9)
North Somerset CCG	(30.3)
South Gloucestershire CCG	(30.0)
Sub-total Commissioners	**(121.2)**
System Wide	
Total Organisational Financial Plans	**(305.5)**

2. Vision

"Health is made at home; hospitals are for repairs" – African Proverb

In our June submission we defined the model of care that we are aspiring to create using the image on the right.



Our model of care starts with people in families and communities; with individuals encouraged and enabled to care for themselves; services delivered locally by integrated teams focused on the needs of the individual; and simplified access points to acute care and specialised services.

In our model, prevention, early intervention and self-care will be targeted on areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across commissioners, service providers, the wider workforce and stakeholders including local government, public /community representatives, and the voluntary sector.

The design of our model, the principles on which it is based and the key programmes through which it will be delivered remain the same as in our previous submission, but since June we have been working to better define, design and assess the impact of the changes that will make the model reality.

3. Our programme approach

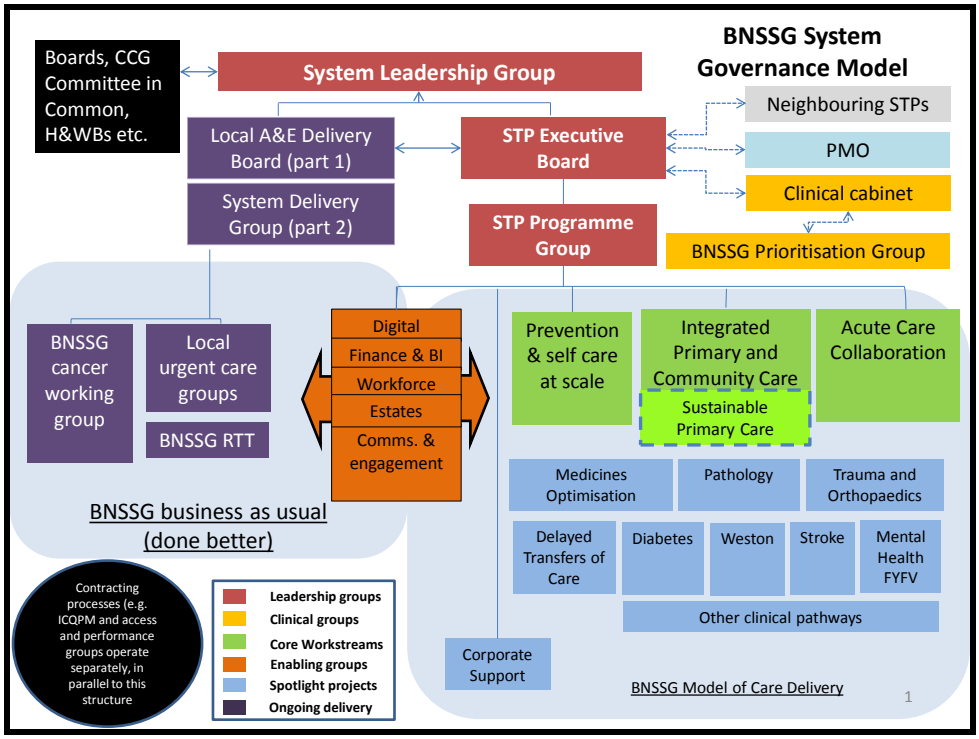
3.1 Governance & Leadership

With the recent appointment of an STP Programme Director, further development of the governance structure has been initiated. The STP Governance will soon be further strengthened, we hope, by the appointment of an independent Chair.

In further developing the STP governance we are using the following elements as our design principles to establish our Governance:

- **Shared common purpose:** A core shared purpose that is understood, owned and rigorously followed by all organisations. This needs to be owned by all the organisations involved and incorporate all of their objectives.
- **Mechanisms for managing financial risk and benefit:** Local agreements that govern financial flow to ensure that all organisations are incentivised to achieve the shared goal of service model redesign
- **Shared understanding of where we are competing and collaborating:** Failure to have a shared understanding of this can cause whole system working to collapse. This is particularly true for systems that are attempting to reconfigure acute services with multiple current suppliers, or where there are opportunities to compete for community services between acute, community and primary care providers.
- **Process for escalation, resolution / arbitration**: Systems need to agree upfront, prior to any disagreements, how disputes will be resolved. Failure to agree this causes systems working to fail at the points of greatest tension.
- **Clinical defensibility**: It is essential for sustainable change that any plans are based on the best available clinical evidence and knowledge.
- **Quality of interpersonal relationships**: Strong interpersonal relationships between organisational leaders are essential and can secure success even when fault lines appear in the five areas above. Whilst it must be acknowledged where there have been rapid and frequent changes to leadership, it is still possible to galvanise relationships in new groups of leaders.

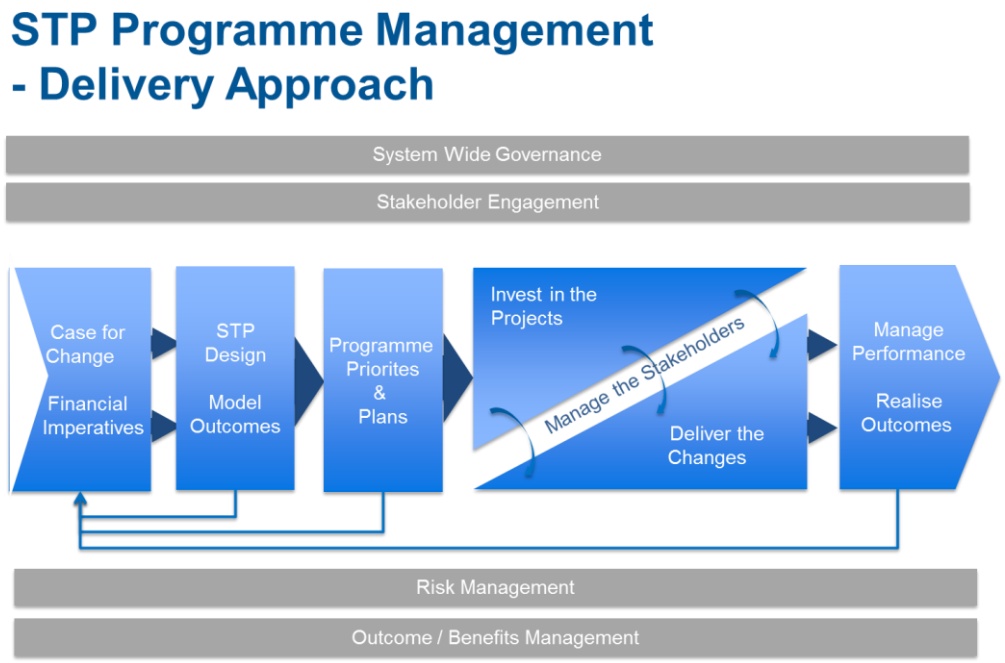
BNSSG STP Programme Governance Structure



Programme Management Environment – Key Elements

In developing the STP programme we have used the following to guide the creation of the right programme environment for success:

- Create and articulate a shared understanding/common narrative;
- Allocate the time for people to focus on the transformation (small, purpose built and dedicated teams);
- Reset the balance between organisational sovereignty and doing the right thing;
- Unblock the money, by not letting the contractual framework be a barrier to change;
- Listen and respond proportionately/appropriately to the feedback from stakeholders involved and / or impacted by change.

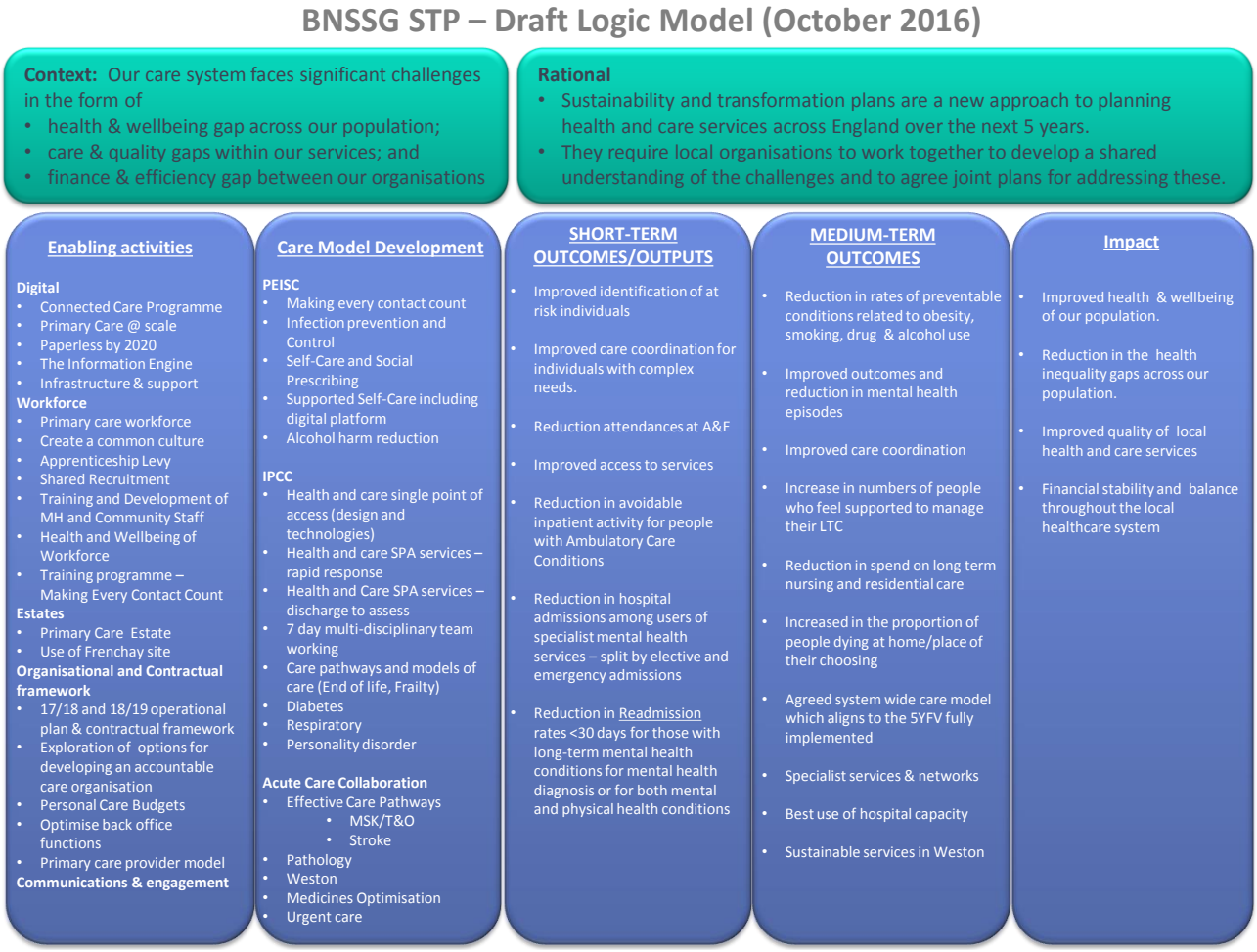


Our programme management approach will enable us to have full line of sight of our Development, Enabling and Delivery projects for Case for Change to Realisation.

See appendix A for Governance and Resourcing.

4. BNSSG overview

Our June submission included a Plan on a Page as a mechanism for providing an overview of how our STP would operate. We are currently transitioning the Plan on a Page into a Logic Model to more explicitly demonstrate how the projects that we are prioritising in the early years of our STP will lay the foundations for achieving the outcomes described.



Our STP initiatives are coordinated through three core transformation portfolios:

- Prevention, Early Intervention and Self-Care
- Integrated Primary and Community Care
- Acute Care Collaboration

We are also undertaking a range of enabling programmes (Digital, Estates and Workforce) which will underpin delivery.

Set out in the following chapter is a summary of each Portfolio, Programme and Project that we are taking forward. The projects selected at the start of our STP have been chosen because of their potential to either unlock further improvement opportunities or deliver early wins. Underpinning our redesign approach will be a focus on tackling unwarranted variation within our care system. This will be reinforced by putting *'individual goal setting'* and *'shared decision making'* between individuals and the care providers who support them at the centre of every care conversation (Making Every Contact Count).

4.1 Prevention, Early Intervention and Self-Care

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

The model is based on four principles:

1. Resource: Ensure that strategic initiatives are costed and adequately resourced.
2. Enable: The population and patients need to be enabled to adopt healthy behaviours.
3. Align: Alignment of strategies and pathways ensuring consideration of the wider determinants of health.
4. Innovate: Finding new and better ways of achieving outcomes through making the best use of available resources (including workforce) and ensure co-production (community involvement in the development of initiatives).

Transformation

We have identified the key decisions necessary to deliver a radical shift towards prevention. These are:

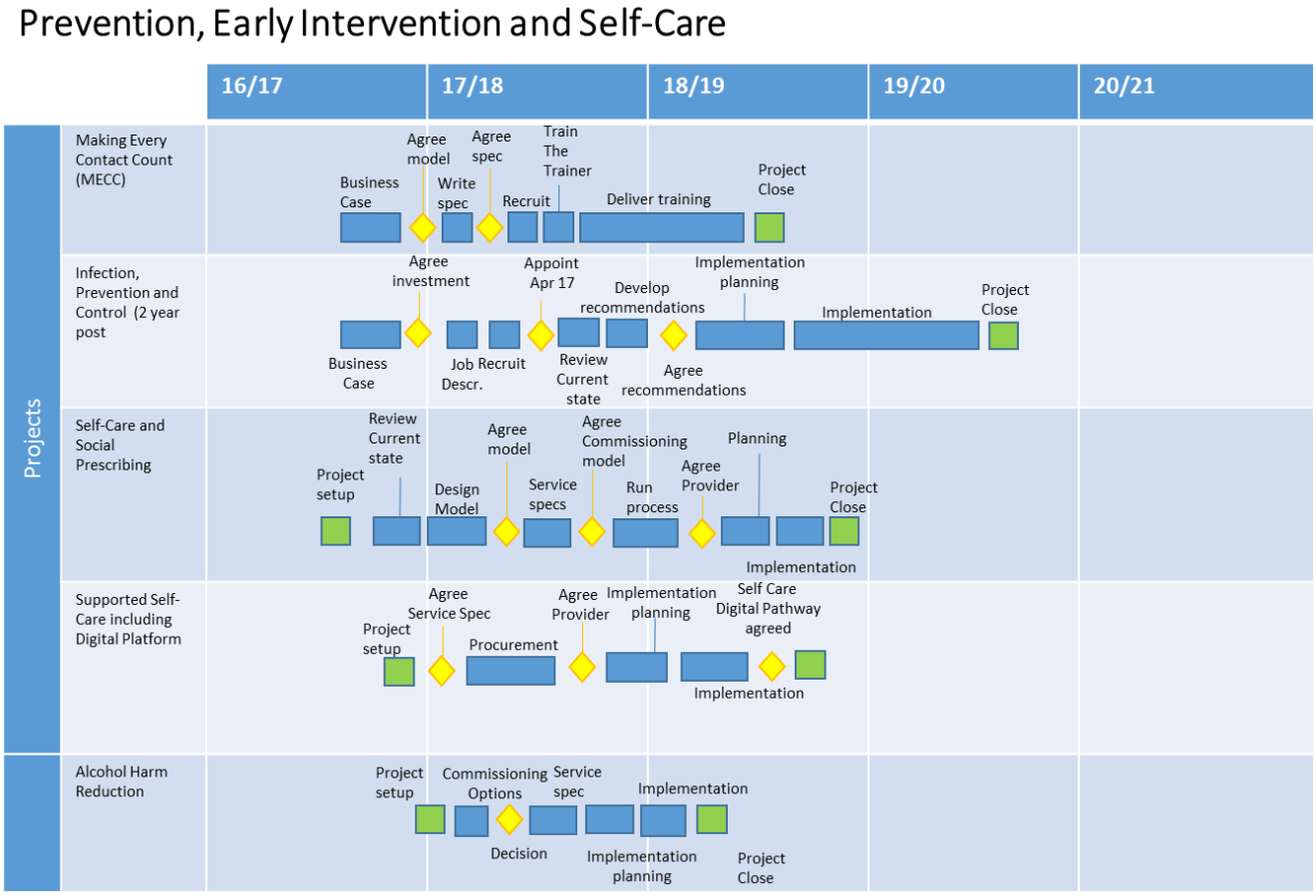
- Self-care and patient activation will be implemented at scale with consistent delivery across our system.
- A population health approach will be embedded across pathways (activate the population, carers and health professionals; reduce admissions; increase proactive prevention across the pathway).
- We will enable care settings to be innovative and effective e.g. using digital technology to support self-care.
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties).
- In order to achieve the short and medium/long term priorities investment is required for prevention, early intervention and self-care at scale. Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years. Through the Operational Planning process we will assess the realism of BNSSG transitioning to achieving this level of investment in prevention and wellbeing.

Initial projects

Our initial priorities are:

- Making every contact count
- Infection prevention and control
- Self-care and social prescribing
- Supported self-care (digital)
- Alcohol harm reduction

These have been chosen because they are evidence based, will improve the health of the target population, have an impact across the system and will reduce hospital admissions. They have been developed based on a life course approach and the need to embed prevention and self-care across the pathway taking into account primary, secondary and tertiary prevention opportunities.



Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.

4.2 Integrated Primary & Community Care (IPCC)

The overarching objectives of the new IPCC model are to improve peoples' care and experience through:

- Early intervention and management to keep people as well as possible, improving the stability of their health and wellbeing.
- Supporting independence, so that people enjoy the best quality of life possible in their places of residence.
- Personalising care and support planning to ensure patients and their families have increased choice, flexibility and control over their health, care and wellbeing.

Programme outcomes

The expected outcomes of the IPCC Programme and new model are both quantitative and qualitative:

Quantitative

- Delivering a best case 15% avoidance of primary and community health contacts.
- Overall 30% reduction in admissions and attendances by STP year 3 for certain LTCs, from care homes and at end of life.
- Reduced Length of Stay and Pre-Operative Assessment in acute hospitals for people with mental health issues
- Reduction in outpatient appointments by 15%
- Reduction in LOS of 20%
- More effective utilisation of community beds by streamlining access via the Health and Care Single Point of Access.
- Savings in consolidating and reducing premises

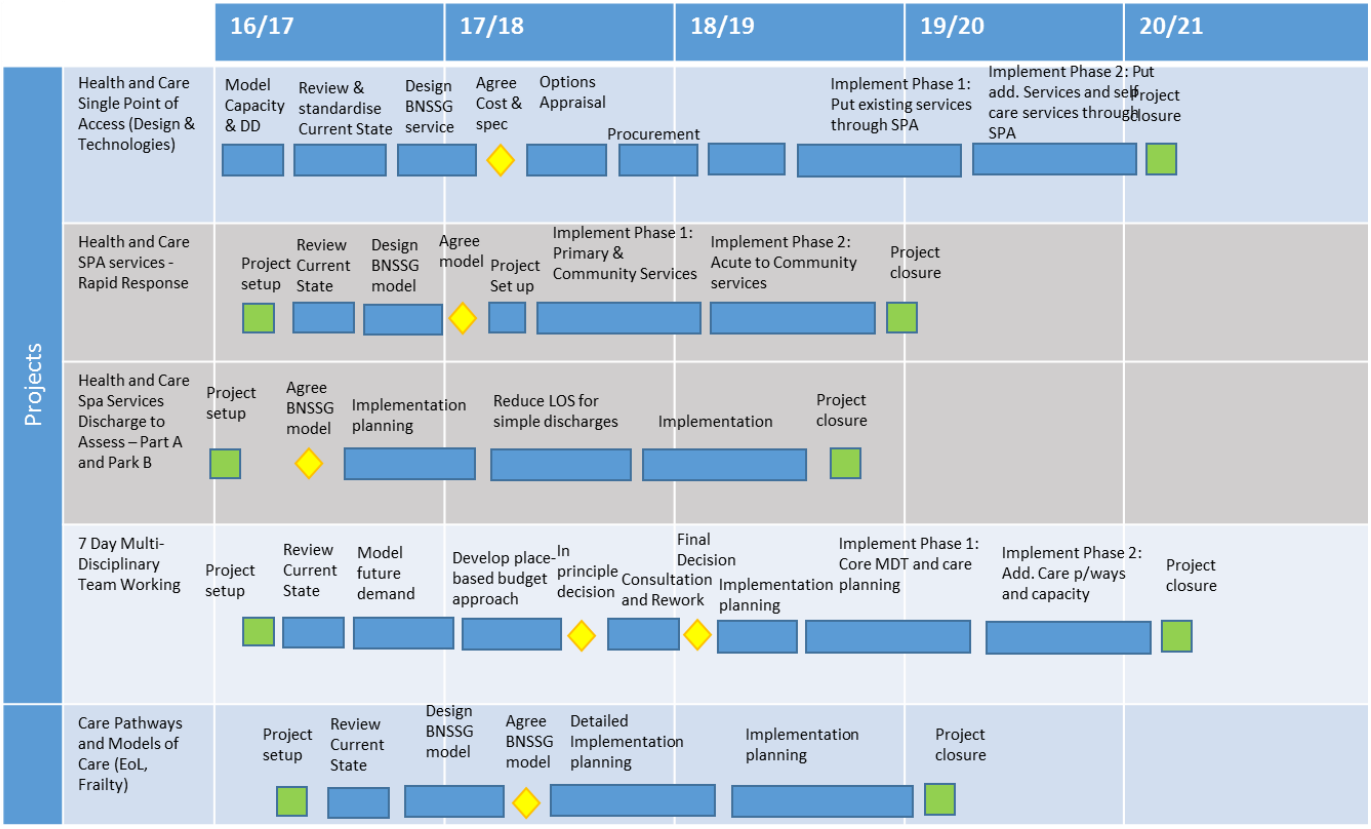
Qualitative

- Addressing health inequalities across BNSSG.
- Increased independence and improved patient and carer satisfaction.
- More people achieving their preferred place of death.
- Improved GP and health and care staff satisfaction.
- Improved health outcomes for people with LTCs.
- Reduced variation in practice across clusters and localities, leading to improved efficiency.

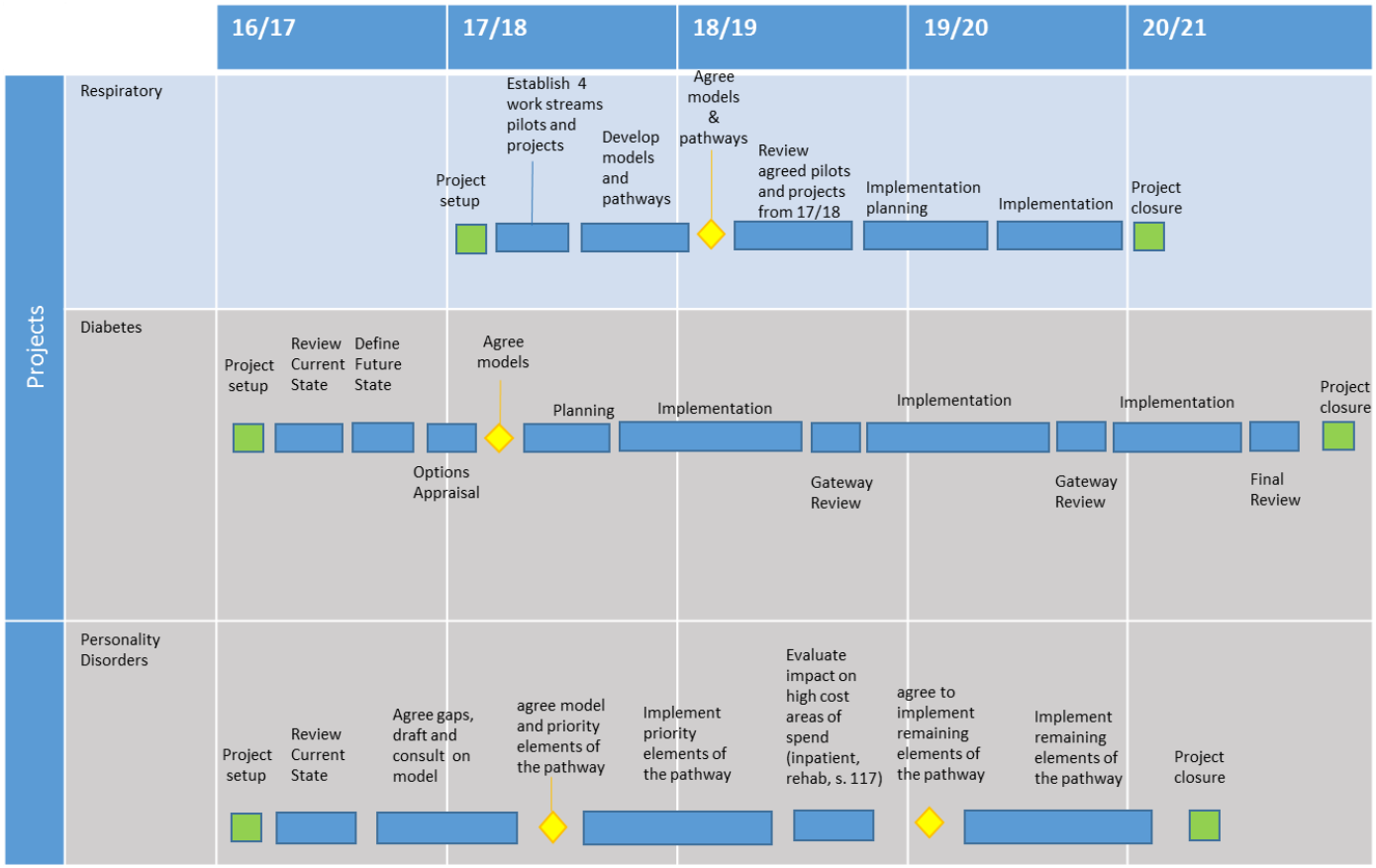
This includes the following projects:

- Sustainable Primary Care (Timeline to be developed shortly by NHS England)
- Health and Care Single Point of Access (Design & Technologies)
- Health and Care SPA services - Rapid Response
- Health and Care Spa Services -Discharge to Assess – Part A and Part B
- 7 Day Multi-Disciplinary Team Working
- Care Pathways and Models of Care (End of Life, Frailty)
- Diabetes
- Respiratory
- Mental Health

Integrated Primary and Community Care

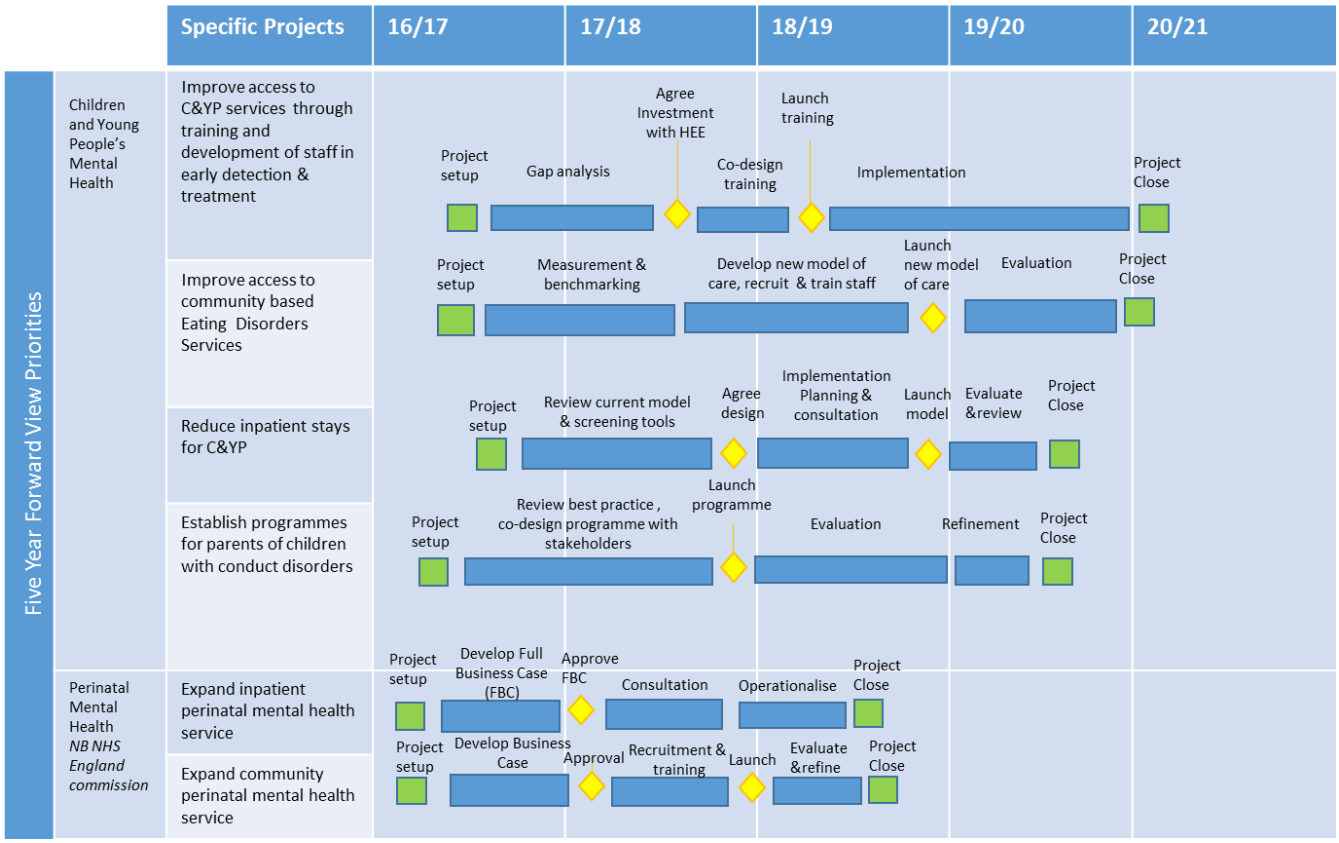


Integrated Primary and Community Care - Clinical Pathways

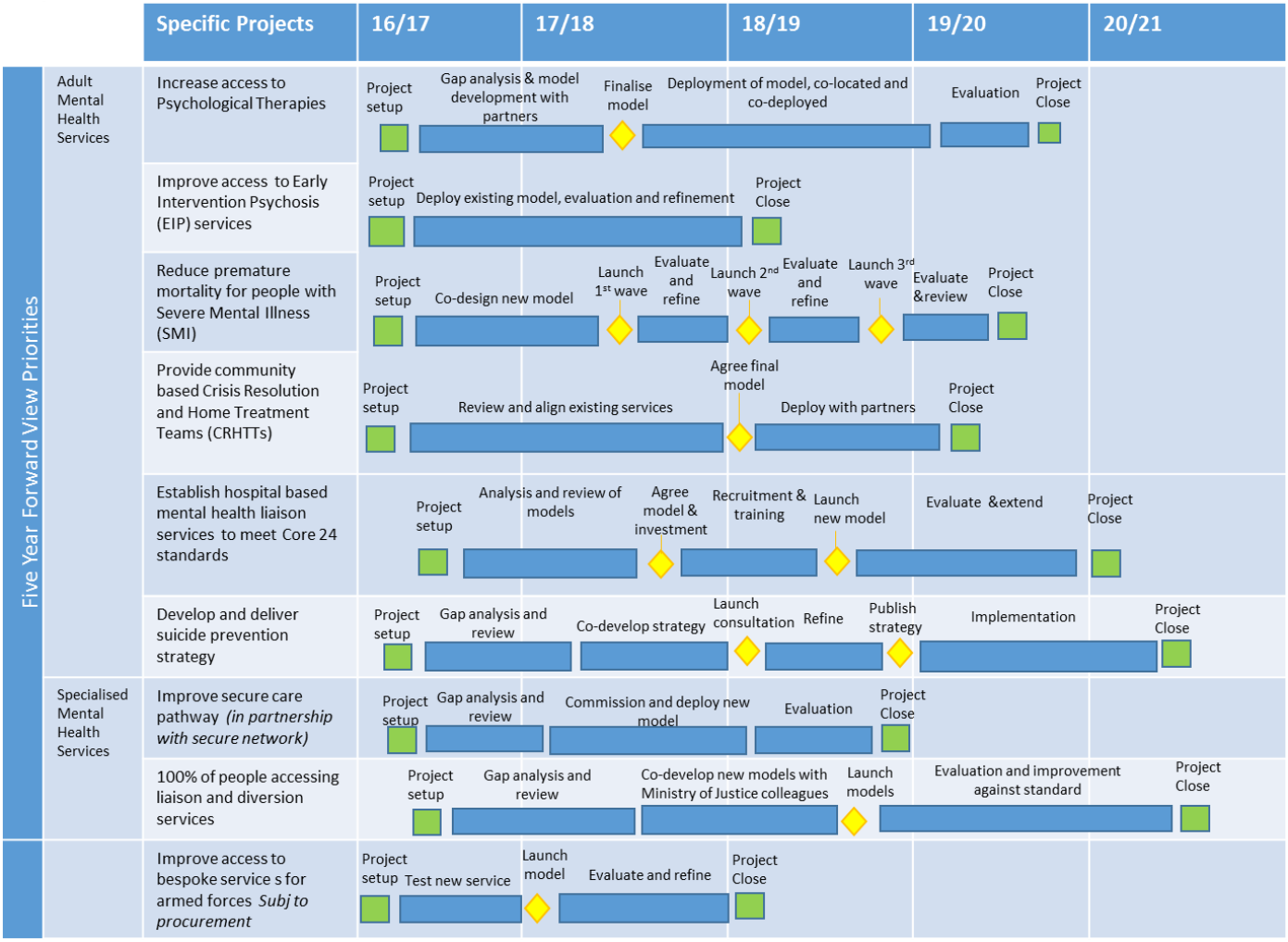


Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.

Mental Health – Women, Children and Families



Mental Health – Adult Mental Health & Specialised Services



4.3 Acute Care Collaboration

The overarching objectives are:

- Best use of hospital capacity
- Effective clinical pathways
- Specialist services and networks
- Sustainable services at Weston General Hospital

These themes have been converted into specific and deliverable projects. Each project has been selected as a priority based on the scale of opportunity and potential to impact on reducing our known gaps in Care and Quality, Finance and Efficiency and Health and Wellbeing.

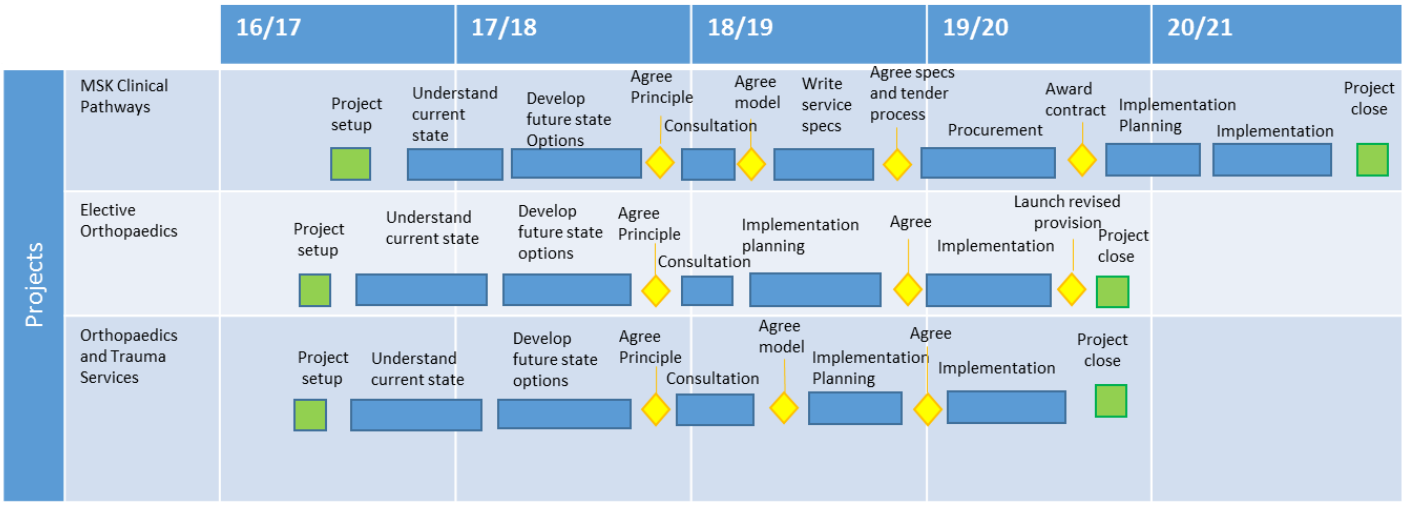
The phase one priority projects identified are;

- Effective Care Pathways
  - Musculoskeletal (MSK) / Trauma & Orthopaedic
  - Stroke
- Pathology
- Weston
- Medicines optimisation
- Corporate services consolidation
- Urgent Care
- Specialised Services

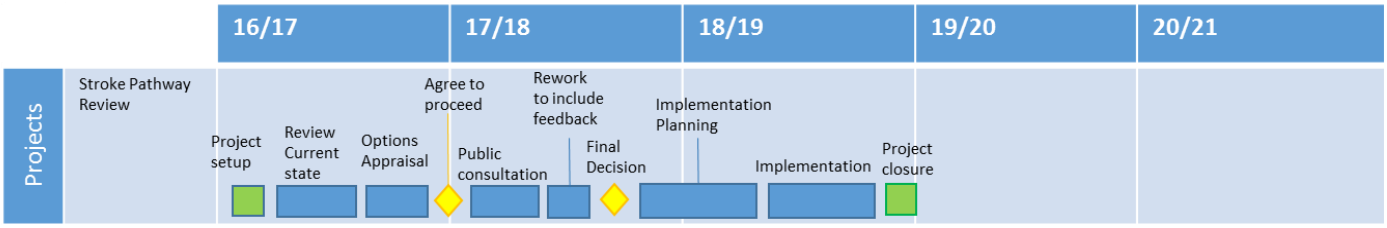
Example – Urgent Care:
The STP approach will ensure the system undertakes a comprehensive review of urgent care services so that it delivers for patients in need of urgent care. This will include:

- Effective and responsive NHS 111 service and primary care out of hours provision - a functionally integrated urgent care service, primarily through the establishment of a "clinical hub", in line with recommendations from NHS England.
- A single point of access for BNSSG that provides professionals with one number to support access to rapid responses and crisis services, supporting the community. This will support coordinated discharge and access to rehabilitation, recovery and reablement services. This will combine health and social care professionals, using up to date IT to enable rapid response.
- Links from that single point of access to a joint "front door" at the acute hospital staffed by primary and acute care clinicians, enabling appropriate streaming of care and comprehensive assessment for frail older people .
- Achievement of the 4-hour emergency access standard through:
  - **Admission avoidance and prevention**: Ensuring community alternatives to hospital admission are easily accessible by patients and Primary Care and other healthcare professionals in their local communities.
  - **Improving flow through hospitals** by ensuring the patient journey through hospital is efficient and the patient is not subjected to any unnecessary delays.
  - **Enabling discharge**: Ensuring that patients are discharged as soon as they are no longer in need of acute hospital care
  - **Frail & elderly care**: Ensuring there is holistic, multi-disciplinary end-to-end care for people living with frailty and complex conditions.

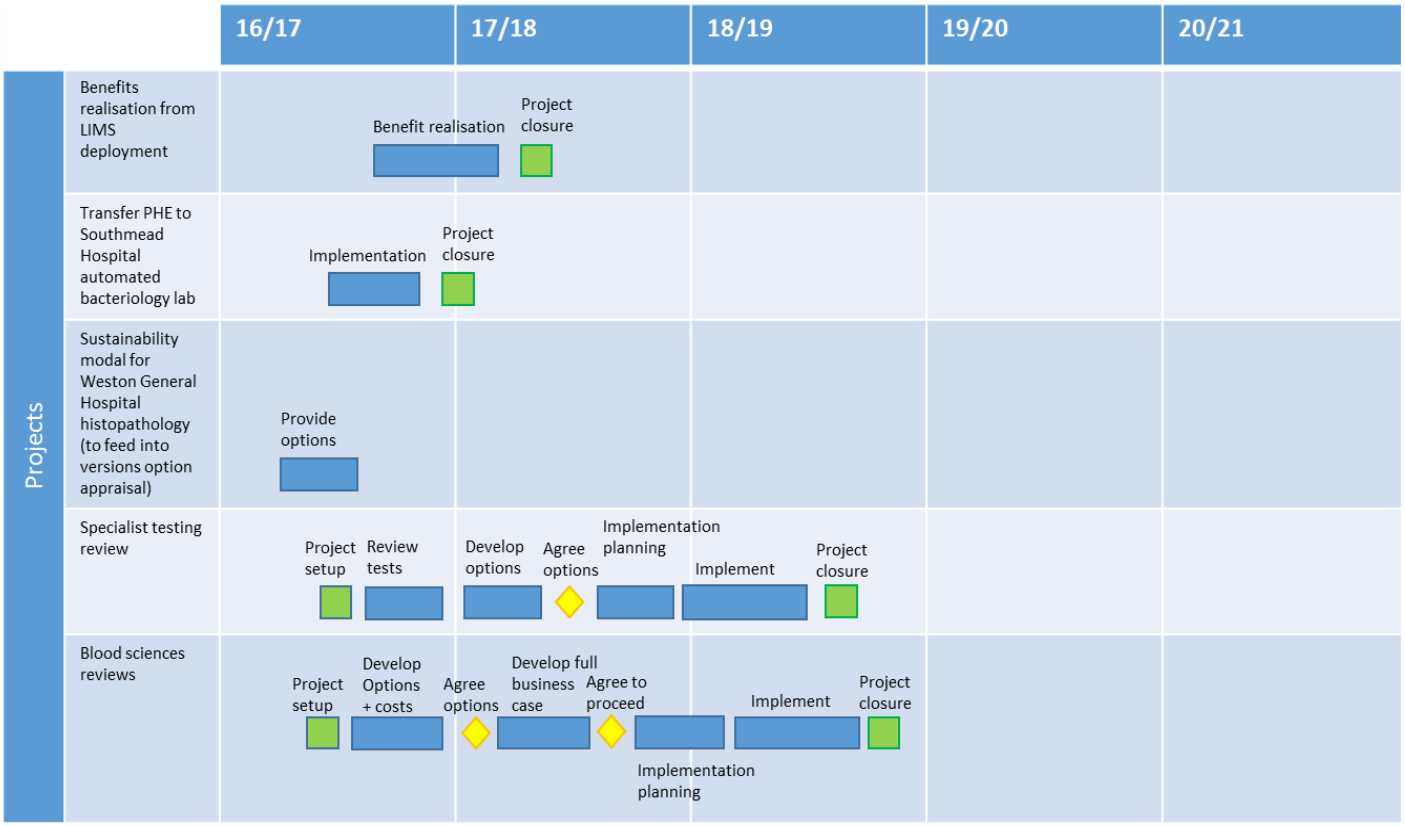
MSK Programme



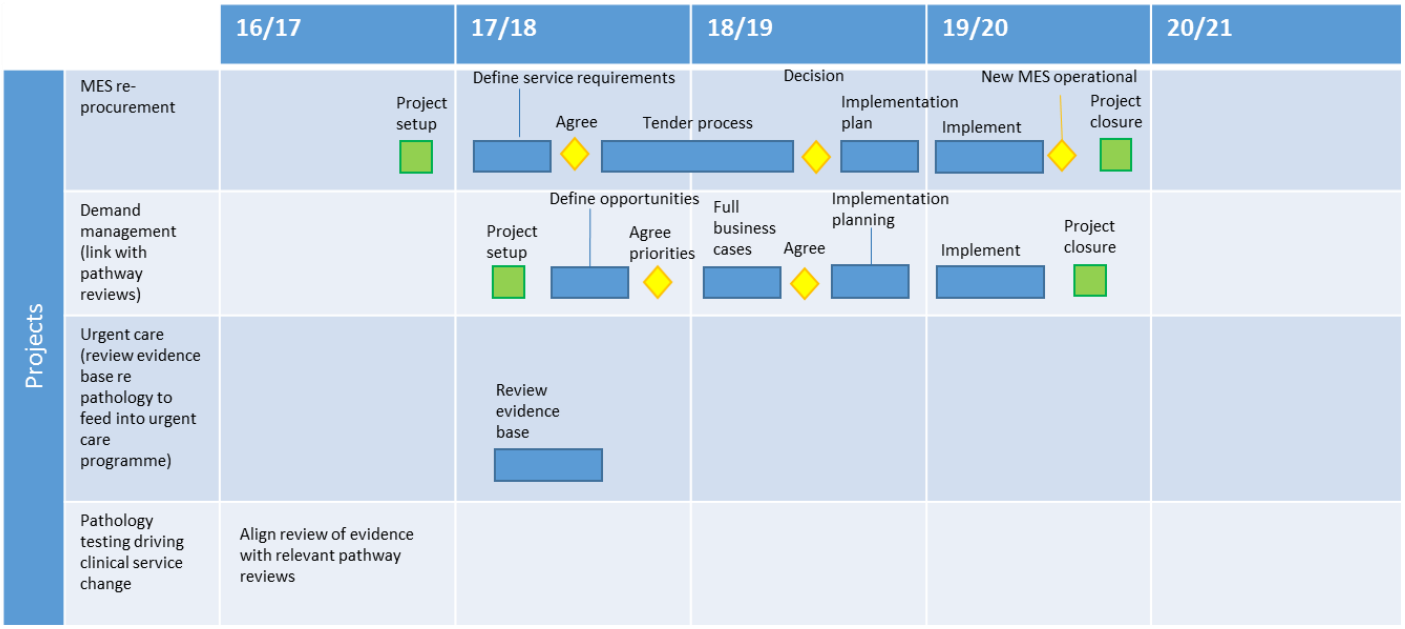
Stroke Pathway Review



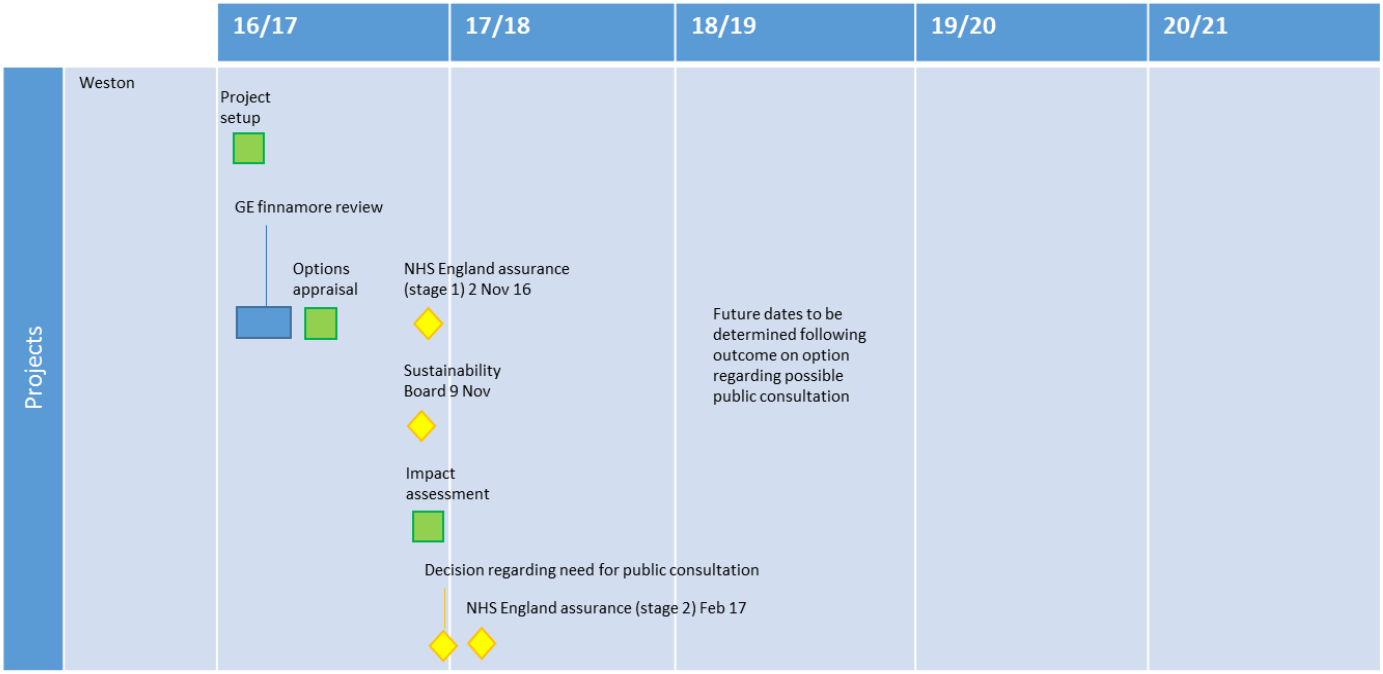
Pathology Programme



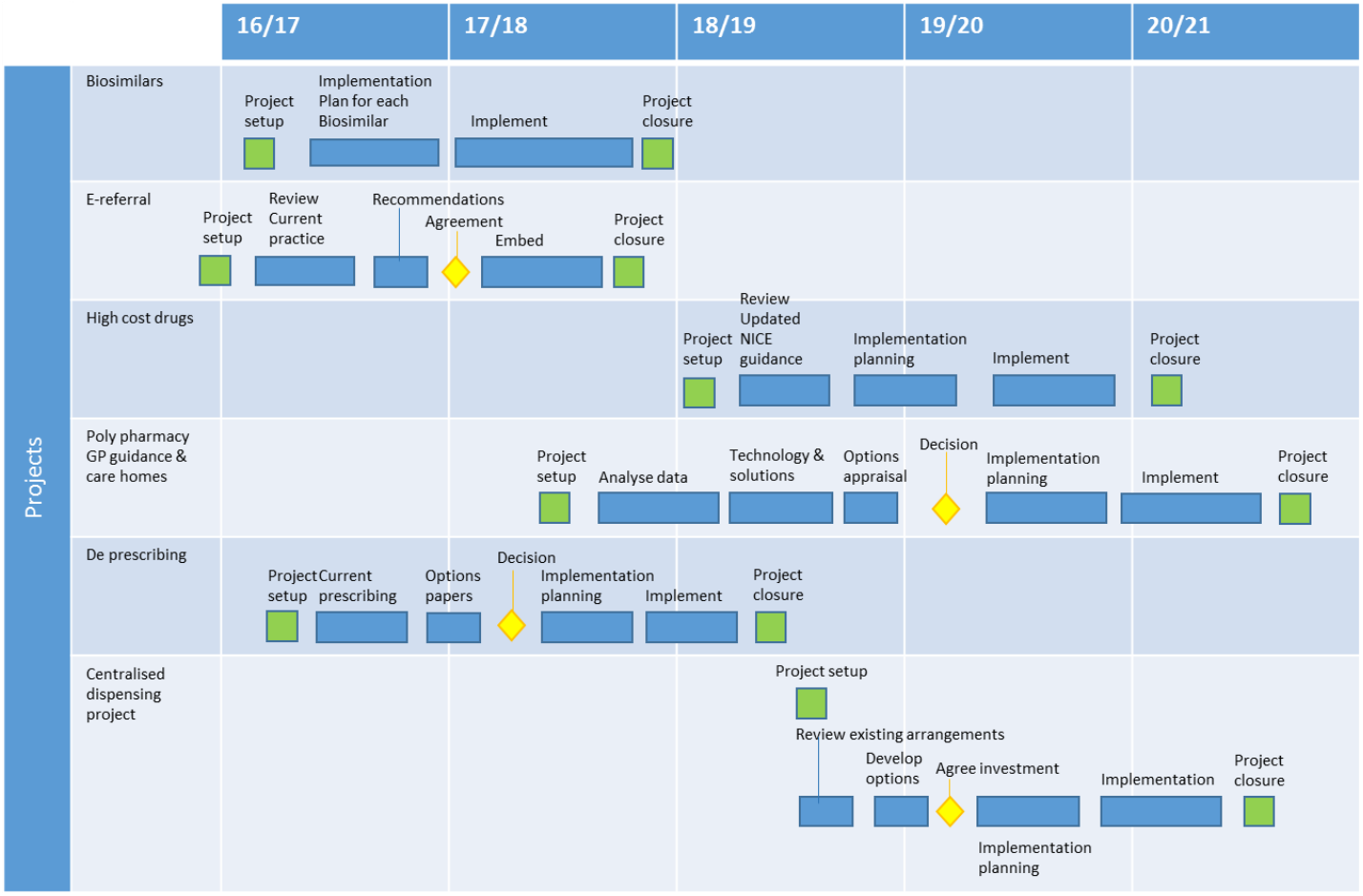
Pathology Programme continued



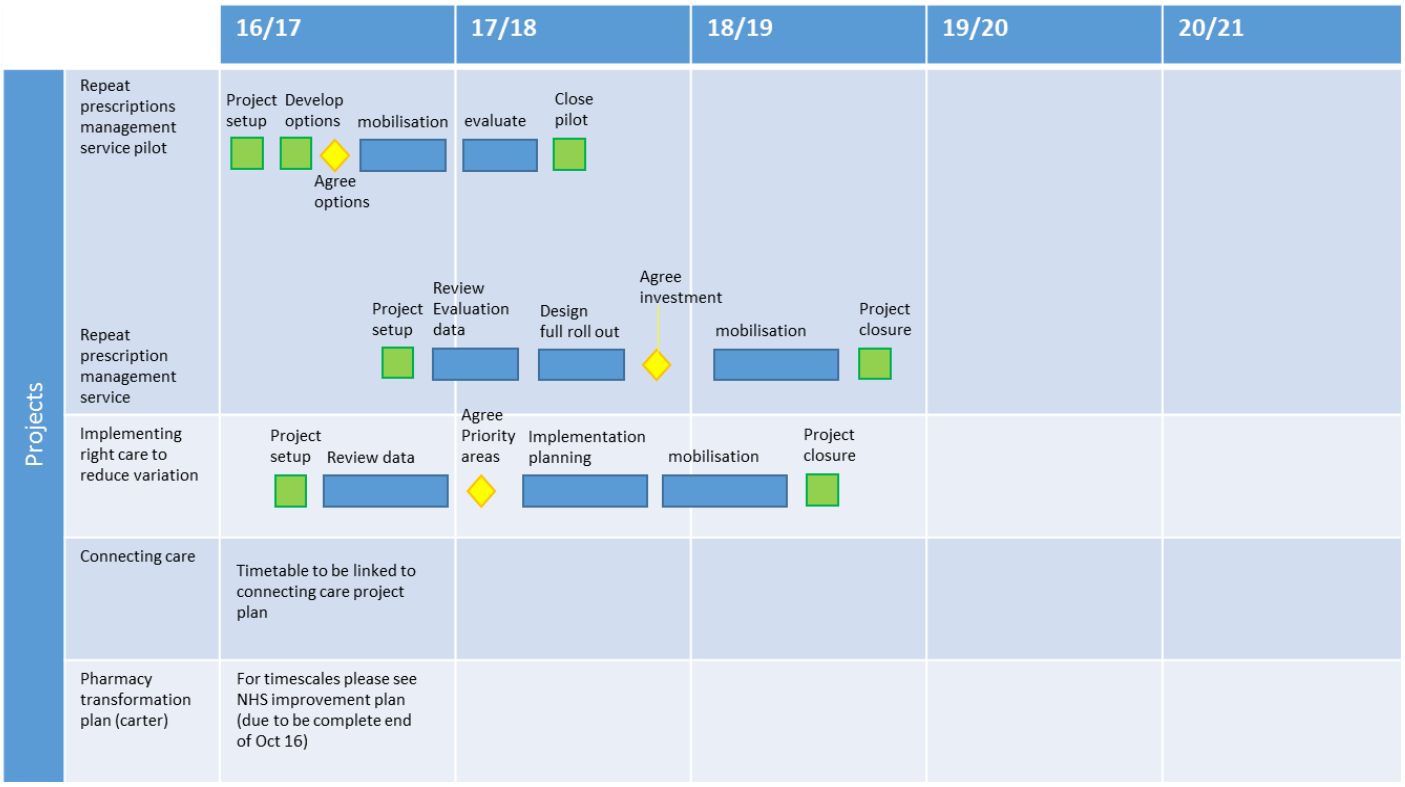
Weston Sustainability



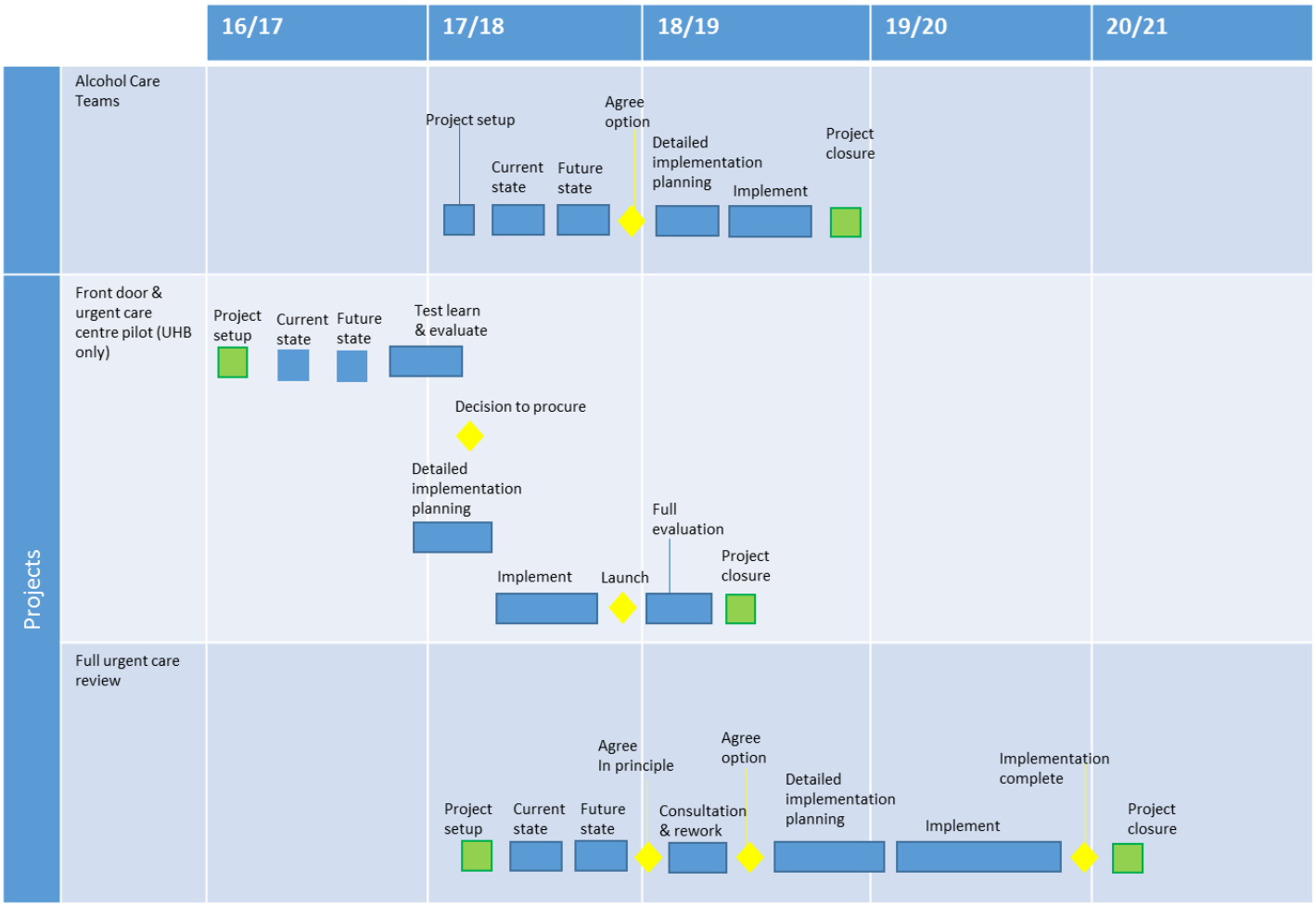
Medicines Optimisation Programme



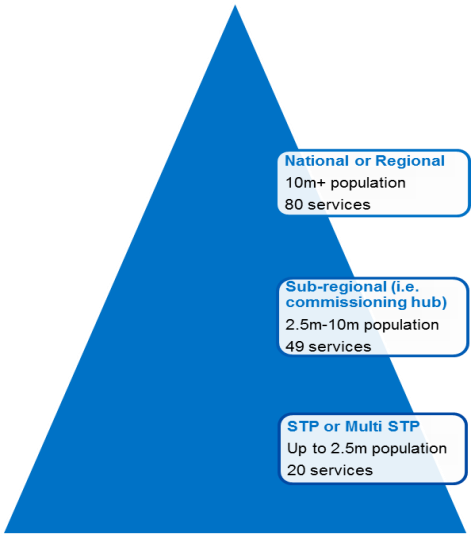
Medicines Optimisation Programme continued



Urgent Care Programme



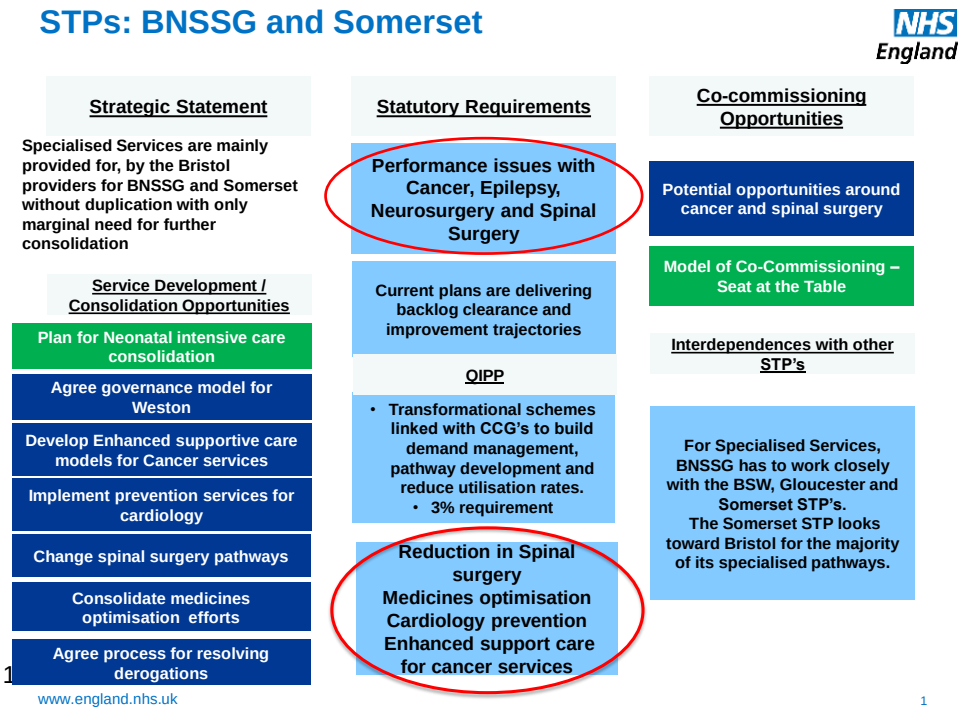
Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.



4.3.1 Specialised services

More than 30% of the capacity of the acute hospital Trusts in Bristol is occupied with specialist commissioned services which support care for a large regional population. Most specialist services in Bristol are delivered by a single provider working at scale. The specialist capacity needs protection so that it is available for delivering urgent and complex care beyond the STP foot print boundaries. This requires effective networks, endorsed by specialist commissioners, that ensure rapid repatriation of patients to local settings and rehabilitation pathways of sufficient capacity to avoid delays.

The STP will collaborate with Specialised Commissioners to deliver the approach to specialist service provision illustrated below.



Please see appendix C for more information regarding specialised commissioning.

5. System approach to our challenges

5.1 Health & Wellbeing

The table below illustrates the prevalence of lifestyle and mental health issues within our STP area. This highlights the importance of working across our core programmes (PEISC, IPCC, ACC and MH) to ensure a coordinated response.

		Bristol	North Somerset	South Glos
Smoking	Prevalence (av) (QOF)	21.5%	17%	15.9%
	Prevalence (highest)	38.6%	42.3%	24.6%
	Ex-smokers (GP survey data)	25.5%	32.1%	27.9%
Alcohol	Estimated risk drinkers	79,387	39,762	49,068
	Alcohol related admissions	3018	1387	1641
Weight	Obese	21.7%	22.2%	23.3%
	Overweight	56.9%	62.7%	63.2%
Mental Health	Depression (av)	7.6%	9.2%	7.7%
(All QOF)	Depression (highest)	13.7%	5.9%	14.7%
	Long term MH condition (av)	5.9%	5.3%	4.3%
	Long term MH condition (highest)	14.7%	11.9%	9.7%

5.2 Care & Quality

As an STP we will:

- Adopt a system-wide methodology for quality improvement working with the Academic Health Science Network (AHSN);
- Recognise the need for a system wide approach to health and wellbeing for our workforce;
- Address mental and physical health and wellbeing in every pathway; and
- Assign a board champion for mental health on each provider board.

The business case templates we are using for STP initiatives specifically ask project leads to describe how they impact on the three elements of quality:

1. On the clinical effectiveness/clinical outcomes expected,
2. How the case supports a safe system of working and to ensure that the experience of the user/patient is considered alongside their engagement.
3. Having the right intervention first time, at the right time benefits the individual as well as promoting better efficiencies within the system.

5.3 Health & Social Care

At the core of our approach to integration of health and social care is the development of cluster based care, operating with community multi-disciplinary teams and improved care coordination, focused on proactive case management of those at greatest risk within our population.

Our principles for integration are that health and social care organisations will:

- Share common objectives and pursue common outcomes, working together effectively
- Build services around people and communities at both efficient and effective scale that enable their needs, aspirations, capabilities and skills and build up personal autonomy and resilience;
- Prioritise prevention and rehabilitation, reducing inequalities and promoting equality and independence;

- Constantly seek to improve performance and reduce costs;
- Are open, transparent and accountable;
- Adopt a commonality of structure that works for local communities and for all commissioning and provider partners in BNSSG.

North Somerset, South Gloucestershire and Bristol City Councils are seeking to create a Social Care Collaborative based on a commitment to working together:

- **With individuals** as partners in planning their own care and support.
- **With carers and families** as partners in the support they provide to the people they care for. We will ensure the support carers and families can sometimes require for themselves is recognised.
- **With communities** as partners in shaping the care and support available and in providing opportunities for people to get involved in their communities.
- **With organisations** across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.
- **With our staff** as partners in developing and delivering our vision, valuing their knowledge, skills and commitment to health and social care.
- **To improve** demand management across the system and make best use of technology and on line digital services

5.4 Mental Health

BNSSG leaders recognise that the STP presents an opportunity to address the holistic health and care needs of our populations, including mental health and wellbeing. Current mental health service commissioning arrangements result in variable access, varying service specification, waiting times and treatment outcomes across the three CCGs. We have not yet developed fully integrated social, mental and physical health care, focussed in the community and pro-actively delivered at the earliest opportunity. There are fragmented care pathways, with both duplication and gaps in provision.

In BNSSG we are committed to achieving an uplift in mental health investment over the next four years to bring spend in line with the national benchmark.

Our aim is to ensure that all forms of care consider and value mental and physical health equally, so that people receive the treatment to which they have a right and are supported effectively in their recovery.

Our approach for mental health rests on the five core principles we have established for the STP:

1. We will standardise and operate at scale:
   The move to a single commissioning voice enables mental health to standardise service specifications, for example, a single 'offer' from IAPT for long term conditions. We will develop regional specialist provision such as perinatal inpatient care and will work in partnership to create maximum impact for the most vulnerable populations across the region, including Secure Services and other specialised services.

2. We will develop system-wide pathways of care:
   For mental health, this means we will address the current commissioning gaps in service lines across the three CCGs. We will act positively to ensure equity of access to services, prioritising investment in those areas with least access. Starting with prevention, and through closer working with Public Health and primary care, our actions to reduce harm from alcohol and smoking will improve population mental wellbeing yet will include targeted attention for those with severe mental disorder (SMI). Similarly, screening programmes will proactively identify mental ill-health in schools, acute hospitals, care homes and pregnant women, and will positively target those with SMI. In year one, our plan begins to address geographical disparities in specialist provision for

children and young people, perinatal women, early intervention in psychosis, liaison services and crisis services. The five year plan will refocus provision away from hospitals and into the community.

3. We will develop a new relationship with the population:
   Simplifying access to all services through a single point of access ensures the earliest, most appropriate signposting to care. Staff and patients will perceive fewer interfaces in their health and social care pathway and the implicit cultural message is inclusive, reducing stigmatisation.

4. We will develop new relationships between organisations and staff:
   We will increase and simplify access, reduce stigma and improve health outcomes through a deliberate focus on integration of physical and mental health provision. Early success with control room and street triage has created common understanding and has changed behaviour in favour of least restrictive interventions. Inter-organisational, multi-disciplinary teamwork in liaison, services for medically unexplained symptoms, and perinatal and primary care will defend against 'diagnostic overshadowing', will encourage mutual aims in prevention and early intervention, will reduce duplication and will result in 'whole person' care.

   Our workforce enablers include IT and shared HR systems but a more radical change comes from the focus on staff development, retention, health and wellbeing. STP partners are developing the mechanisms: harmonised terms and conditions, training passports and core skill sets enable staff to work and move across organisations. Training for all staff groups in brief intervention and psychologically minded treatment will equip our workforce for the future as will training to work with older people. Apprenticeships, roll out of STP-wide quality improvement training, extended, rotational and innovative roles will attract and retain staff for whom the workplace offer includes stress reduction, psychological support , weight reduction and clinical supervision.

5. We will build on our existing digital work as a driver and enabler of cultural change:
   Access to care records across STP partners will facilitate safe, coordinated care planning and delivery for all patients and will promote integrated care, including shared and co-created risk assessment. For staff, access permits targeted intervention in keeping with our principle of 'least intervention at the earliest opportunity', including opportunity in years two and three for online and virtual therapy and symptom and medication monitoring.

5.4.1 STP Governance and Mental Health

Our governance structures are designed to ensure we deliver:

- parity of esteem, investment and innovation between mental and physical health, to improve the mental health, wellbeing AND physical health of the population;
- increasingly integrated services;
- national mental health indicators;
- the five year forward view for mental health; and

The Clinical Cabinet of key senior clinical experts will apply a 'parity test' to new developments and will assess pathways against the aims of integration and the Five Year Forward View for Mental Health.

All STP partners commit to assign board-level champions for mental or physical health and a board champion for mental health in a provider of physical healthcare.

As the largest NHS provider of mental health services across two STP footprints, Avon and Wiltshire Mental Health Partnership will work with accountable officers through the Mental Health Strategy Group, to advise both on strategy for local and specialist regional and national provision and to align trust clinical strategy appropriately.

As we review our plans, we will be assessing how effectively they support the Five-Year Forward View for Mental Health and how the STP will bring local spend on mental health up to national benchmarks, by demonstrating percentage growth year-on-year.

See appendix D: Mental Health - Parity

5.5 Commissioning Approach

Commissioning & Contracting 2017/18 & 2018/19

In preparing our STP submission, our System Leadership Group have considered how the evolution of commissioning and contracting processes will accelerate delivery of our STP in the short and longer term.

Desired future state

There is agreement that the current model of contracting does not support our agreed long term goals of system outcomes and financial balance. We recognise that we need to achieve improved system (patient) outcomes and reduced health inequality, supported by a financial framework that rewards parties for doing this. Achieving this will take time, trust and collaboration between partners, necessitating its inclusion within the wider STP.

Single version of the truth

There is a need for a single agreed version of the truth in relation to system finances. This includes an open and transparent approach to understanding system income and expenditure, including:

- Risks (to individual organisations & patient care)
- Constraints
- The existence of and approach to managing perverse incentives
- The existence of and approach to managing 'subsidies'
- Sunk costs resulting from changes in the Model of Care

System control total

The development of a system control total is recognised as a potential way to move towards our desired end state, with agreement that a necessary pre-condition would be the single version of the truth described above.

Consistent approach

The adoption of a consistent approach between all 3 commissioners is an essential element of our approach and should be extended to include specialised commissioning. In the short term, we are not intending to adopt multilateral negotiations (all providers in the same room) but will implement a consistent, open book approach between all providers and commissioners.

Key steps for 17/18 & 18/19

Our aim is to divert the energy consumed in taking the traditional annual approach to contracting into creating a 'good enough' understanding of system finances to ensure that the contract settlements move us towards a desired future state. System leaders have committed to:

- consider how multiple contracts create additional system financial risk when there is a finite pot of money and how these risks might be shared;
- continue the development of a single system savings plan; and
- achieve contract signature in a way that moves us towards a system financial framework that safeguards individual organisations and rewards the achievement of patient outcomes.

5.6 System Governance

As system leaders, we recognise that organising ourselves on lines closer to an accountable care system may bring significant benefits in the delivery of the vision we have set out in this STP. Our consideration of these opportunities is at a formative stage, but we are building specific activities into our STP programme to ensure we address them at the appropriate time ('form follows function').

As an early step towards supporting system change the three CCG's have embraced the need for a single commissioning voice and have already taken steps to establish a Joint Commissioning Structure across BNSSG. The two major acute providers in Bristol have also announced their intention to look at options for formalising a closer collaboration between them (that does not involve a merger).

6. Enablers

6.1 Engagement & Communication

As an STP Partnership we are committed to public and patient involvement. We will continue to listen and act upon public, patient and carer feedback at all stages of the STP development cycle because of the evident added value of commissioning and providing services that are informed by the experiences and aspirations of local people.

Within the individual projects, patient and public involvement that is proportionate to the changes that are being considered will be undertaken. In the case of any significant changes to services, appropriate formal public consultation processes will be implemented.

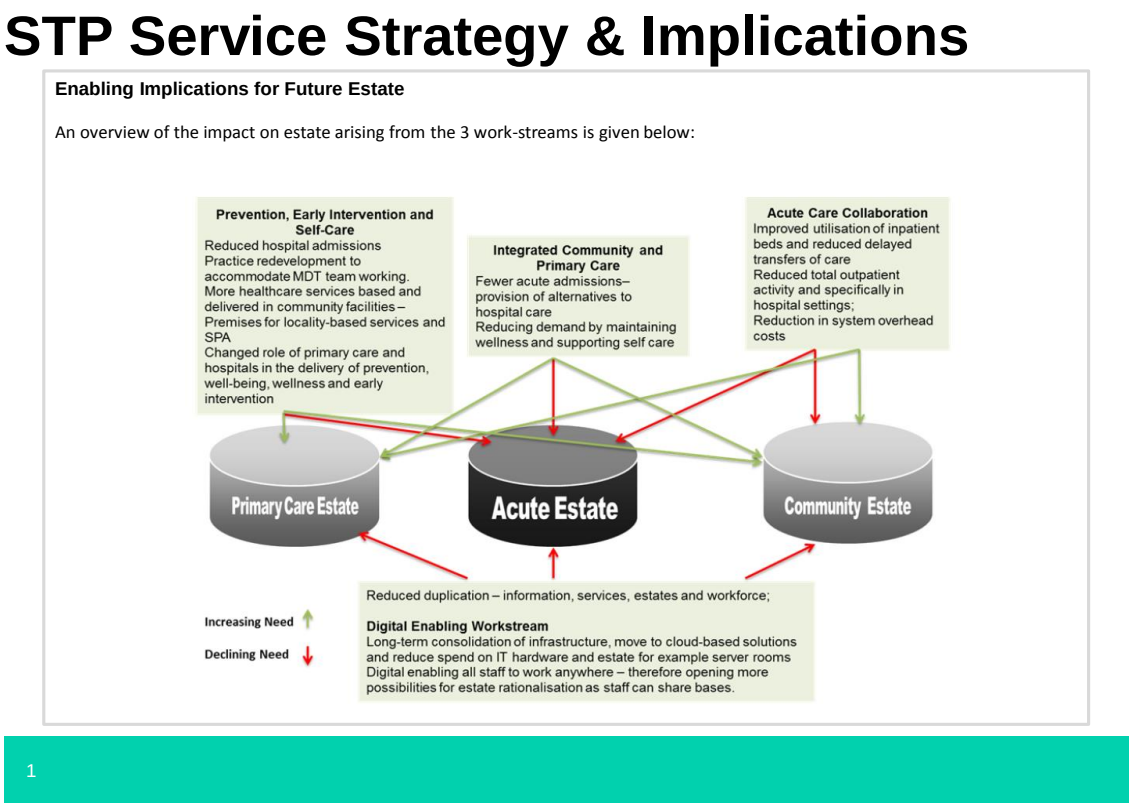
The emerging STP plan has been informed by existing feedback from service users, carers and the public. This includes information from recent public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports. This ensures that our thinking is being shaped by the issues that the people who rely on our services have told us is important to them**.**

- Phase one of this plan outlines how we will further our conversations and engage locally to ensure stakeholders understand the case for change. This plan will evolve as more detail emerges from the STP to ensure timely and meaningful engagement with all stakeholders.
- Phase two of the plan will look at key tactics used to engage with others, including MPs, Councillors and influential groups.
- Phase three of this plan will evolve as we move into the engagement phase should there be any proposed changes to the way services are delivered across BNSSG. Specific consultation and engagement plans will be developed in response to these.

Further detail on our Communications and Engagement approach is set out in Appendix E.

6.2 Estates

Our estates strategy is being developed to both enable the delivery of our new Model of Care and optimise the efficiency of our estate. Set out below are the priorities that we will be undertaking.



Enabling implications for future estate

1. Integrated primary and community care:
    - Transformation of community facilities to allow mental and physical health services to be delivered locally from “Clustered” GP Premises.
    - Efficient use of joint estate options with other public sector bodies, by maximising utilisation across the wider public estate.
    - Surplus or expensive estate rented from the private sector is removed from the system, where possible to support a reduction in estate running/operating costs and estate delivers value for money.
    - Investment in the estate with poorer quality buildings that are no longer fit for purpose replaced with new facilities where appropriate funded by a reduction in the overall estate to support the cost of future investments.
2. Prevention, Early Intervention and Self Care
    - Shift of care from an acute setting to primary and community care making best use of available resources.

3. Acute care collaboration

    - Utilisation of fit for purpose existing estate is maximised (Lord Carter targets) with consolidation of activity and sharing of premises.
    - Sharing the acute and mental health hospital facilities and physical assets.

Supplementary information relating to existing estates projects, STP estates initiatives, implementation priorities and financial impacts are contained in Appendix F.

6.3 Workforce

The engagement of our workforce is key to the delivery of all aspects of the STP. The introduction of new models of care, new roles (including the Nursing Associate and Physician's Assistant, using our workforce as advocates of the prevention agenda and changes to how and where staff work require considerable adaptability and careful engagement and change management. Workforce transformation also requires detailed baselining of data across the footprint, which has started, as well as collaborative working across organisations and work streams. We have also developed a modelling capability in BNSSG to respond to change and produce detailed implementation plans.

> Better use of data and technology has the power to improve health, transforming the quality and reducing the cost of health and care services. It can give patients and citizens more control over their health and wellbeing, empower carers, reduce the administrative burden for care professionals, and support the development of new medicines and treatments".
>
> *Personalised Health & Care 2020 – Using Data & technology to Transform Outcomes for Patients and Citizens* – A Framework for Action

Project objectives and desired outcomes

The workforce work stream is an enabling work stream and as such will respond to the outcomes of the three care model work streams (Prevention, Early Intervention and Self Care, Integrated Primary and Community Care and Acute Care Collaboration). This response will include project management of transformational changes to workforce and also scenario modelling to support the cases for change. In addition a number of workforce projects have been defined to contribute to the STP approach to the challenges of wellbeing, quality and affordability of care.

In addition to joint workforce planning, the workforce work stream has identified six projects which support the BNSSG STP. These are:

- Collaborative working on apprenticeships
- Development of shared training of Mental Health and Community Staff
- Improve Staff Health and Well-being
- Shared Recruitment
- Create a common culture
- STP Workforce Transformation

The workforce work stream is working closely with Health Education England (HEE) and AHSN, and increasingly with colleagues in other work streams, including links into the Community Educational Provider Network (CEPN) initiative, to determine the timescales required to achieve workforce change. The requirement for consultation, the length of medical training pipelines and the visibility and clarity of the changes required dictate the timescales for change. The workforce work stream is therefore setting the conditions for success by developing a joint workforce planning capability, progressing the defined projects and building the relationships across the STP community and with other key stakeholders.

The purpose of the CEPNs is to:

- Support workforce planning by responding to local workforce need.
- Co-ordinate educational programmes and ensure educational quality with a faculty of trainers.

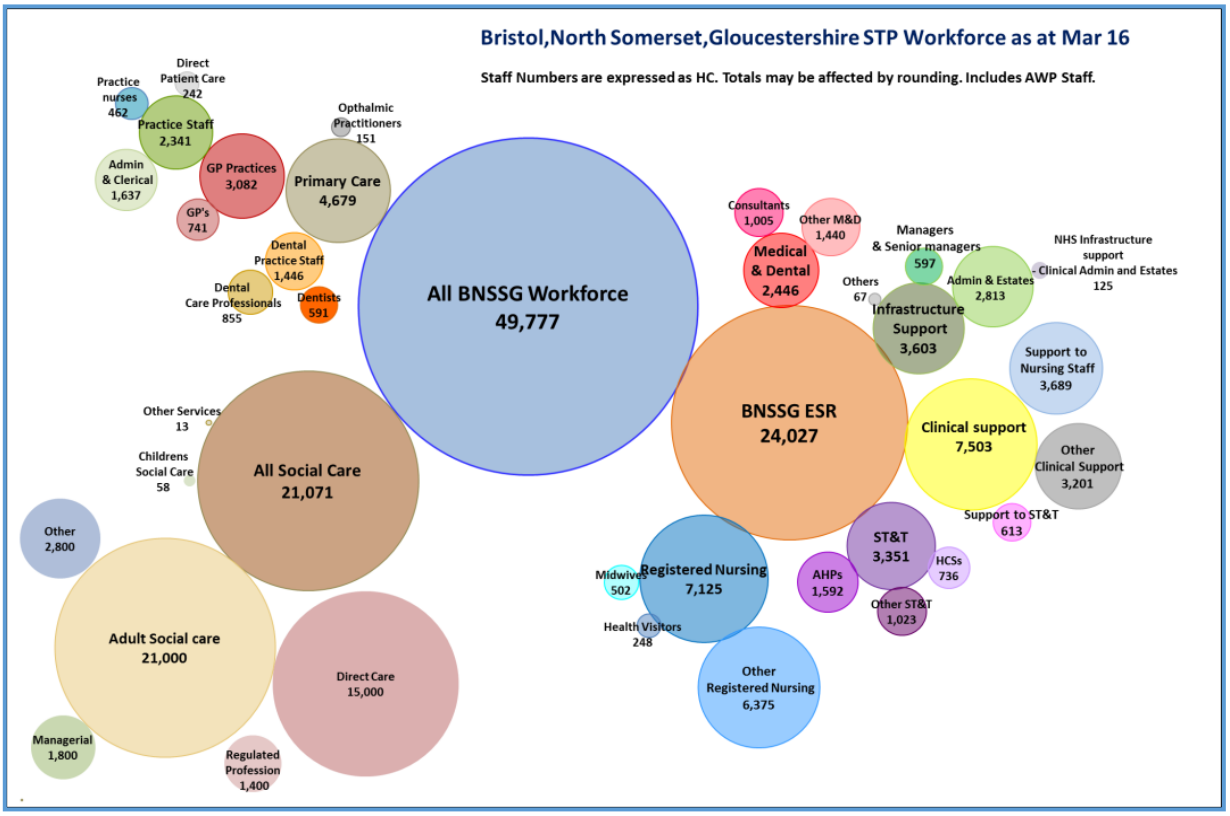
Promote and plan for the development of the existing workforce. We have also undertaken to convene a Social Partnership Forum (SPF) in order to facilitate early engagement with Trades Unions on the STP.

The workforce work stream has identified that Organisational Development facilitation is required to support transformational change and deliver continuous improvement. HEE funding is being used to resource facilitators to support all work streams to deliver change. The facilitators will utilise existing programmes, such as the Calderdale Framework, and 'train the trainer' packages..

The Calderdale Framework is a tool to develop and manage a consistent competence level among practitioners. The original focus of the tool was to provide a level of assurance and risk management for those tasks delegated to the unregistered workforce in clinical settings. The framework seeks to reduce risk ratings, increase patient satisfaction, increase activity, improve attendance and support organisational reviews of skill mix. It has been backed up by research and has been introduced in a number of Trusts in the country as well as in Australia and New Zealand.

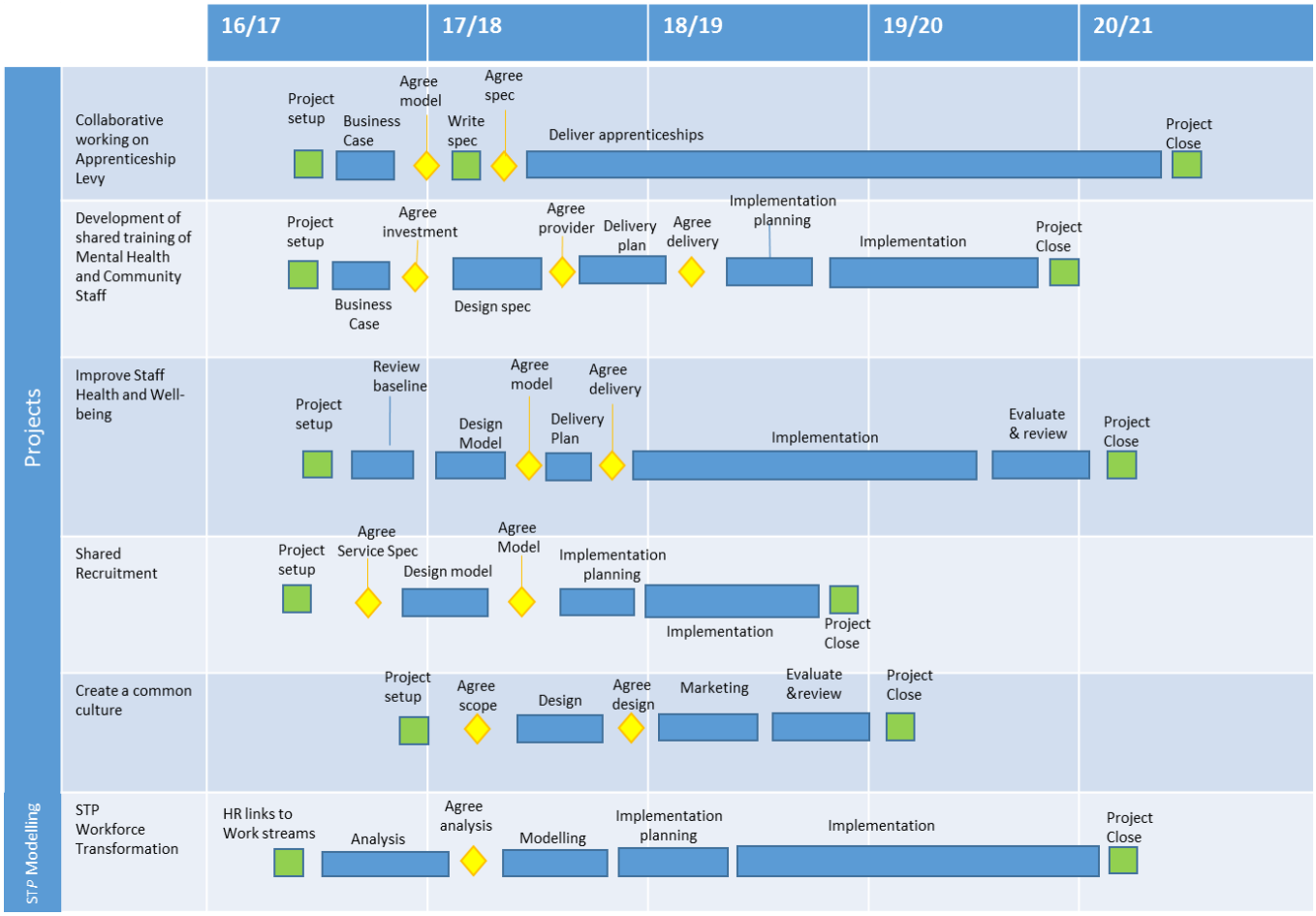
http://www.calderdaleframework.com/

Illustrated below is the workforce across our STP. The independent and voluntary sector makes a significant and valuable contribution as part of this workforce. As the STP develops the workforce work stream will develop further links with these sectors to both better understand the baseline data and ensure coherency in terms of workforce development.



The timeline for delivery can be seen below:

Workforce



For more information about each of the projects and further workforce please see appendix G.

6.4 Digital

Introduction

We understand that technology has a key part to play in helping us **meet our financial challenges** – as well as **improving efficiency**, enabling **better care and quality**, and **closing the wellbeing gap**.

Like the rest of England, we have some significant challenges to overcome if we are to deliver the standard of health and social care that our population requires and deserves, within the very real operational and financial constraints that exist. Our work together on digital transformation has proven that we can collaborate to deliver real, system-wide transformation.

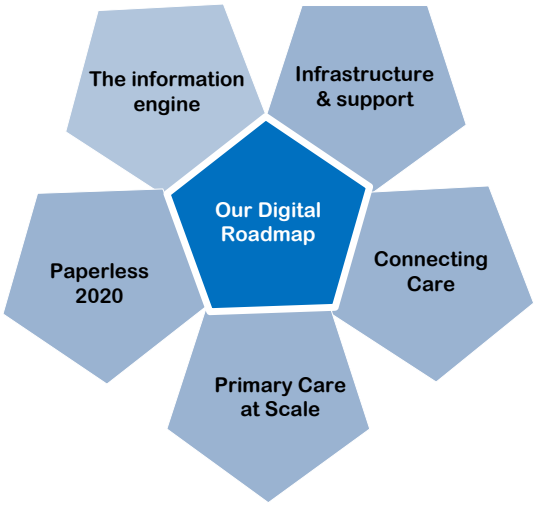
Local Digital Roadmap - building blocks

Our focus in our roadmap is on five key building blocks –

1. Primary Care At Scale – focus on maximising digital across GP practices and Out of Hours services.
2. Paperless 2020 – Embedding digital records in acute, community, mental health and social care.
3. Connecting Care - Information sharing to include putting citizens at the heart of their 'personal health records'.
4. The Information Engine – Fully utilising our electronic data to power our planning and delivery engine.
5. Infrastructure & Support - Ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism that enables mobile working.

We will deliver these five major themes locally, but in full alignment with our local *Sustainability and Transformation Plan* and the *National Information Board* strategy.

- Primary Care At Scale – focuses on maximising digital across GP practices and Out of Hours services. Supporting primary and community care reconfiguration, new integrated team working and maximising efficiency of practices through shared ways of using technology. This is also about how we can better support people and communities out of hospital



- Paperless 2020 – Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records to support mobile working.

- Connecting Care – Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care

- The Information Engine – Fully utilising our electronic data and intelligence to power our planning and delivery engine. Devising new and innovative ways to use information, integrated population analytics and data driven decision making.

- Infrastructure & Support - Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes).

For more information about Digital please see appendix H

7. Impact of our STP

The introduction of our new model of care will have significant impacts across our care system. Where evidence of improvement is available from elsewhere, we have utilised this to help us estimate the impacts we might achieve.

Set out below is a summary of the impacts modelled so far as part of the STP. These are being further developed as part of the Operational Planning process, which provides the mechanism for embedding intended improvements within contracts.

7.1 Performance impacts

The NHS organisations within our partnership are mandated to achieve all NHS performance standards and it is a key expectation that the STP ensures they are met on a sustainable basis. Presently provider contract management processes monitor in-year performance and improvement trajectories where in place. Where providers are under-performing they are being reviewed and recast. This process will feed into the operational planning process to inform CCG and provider plans for 2017/18 and 2018/19, which will be incorporated into the STP. The need to monitor performance and respond at the STP level is critical with the creation of an STP dashboard for 2017/18 identified as a priority.

7.2 Financial modelling update

The approach and methodology

Finance Directors and Chief Officers have been meeting for three months to support the STP process pro- actively.

The methodology used is as follows:

- Director of Finance review and sign off of 2016/17 position for all bodies in accordance with the recent guidance issued by NHS England;
- Assess the underlying position and document the drivers for any declared underlying deficit;
- Document the medium term financial plans for the period 2017/18 – 2020/21 including underlying positions, inflation, cost pressures, savings, activity growth, sustainability funding, cost of activity and other factors specific to individual organisation. Recurrent and non-recurrent cost analysis was included; and
- The impact of 2017/18 tariff changes and SLA changes have not been included.

The assumptions used include the following:

For Providers

- Inflation at 2.1% from 2017/18 onwards;
- National efficiency requirement of 2.0% pa from 2016/17 to 2020/21;
- General assumption that changes in activity volume require 85% cost of delivery and therefore provide a margin contribution toward Providers financial positions.
- Corporate overhead savings are assumed and included within the identified savings plans; and
- Pathology savings and productivity are assumed and included within the identified savings.
- The Community Interest Companies (CICs) combined deficit (assessed as £15m in June 2016) are included in the overall STP financial position.

For Commissioners

- CCG and NHS England allocation assumptions including growth and distances from target were published in January 2016 for the period 2016/17 to 2020/21, the first three years are fixed, the final two years are indicative.
- The accumulated commissioner RAB outstanding on exit of 2016/17 is not considered in the financial savings plans.
- CCG expenditure plans include national expenditure growth assumptions for demographic growth, tariff price inflation, non-demographic activity and quality cost pressures and nationally mandated priorities.
- CCGs are committed to funding activity volume growth at 100% of National Tariff.
- Corporate overhead savings are assumed and included within the identified savings plans.

What is the financial position?

2.1 'Do Nothing' and 'Do Something' Position

The 'Do Nothing' positions and financial savings for the period to March 2020/21 were signed off and submitted by Directors of Finance on the 14th October 2016. Across the BNSSG STP, the position can be summarised as follows:

1. The 'Do Nothing' deficit as at 31st March 2021 totals £305.5m;
2. Sustainability and Transformation Funding of £61m is received;
3. Savings of £138.9m have been identified to date;
4. Savings of £7.4m are assumed relating to the Weston Sustainability plan;
5. The level of unidentified savings to date is £104.4m; and
6. System wide Transformation savings schemes are work in progress. These solutions require further development including triangulation with provider income and capacity plans. These will be subject to verification and sign off by nominated Director of Finance leads as part of the Operational Planning process.

The overall position is summarised in the table 1 below.

Table 1: Overall BNSSG STP Position

		"Do Something" Solutions				
Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**	**STF Funding**	**Identified Savings**	**Unidentified Savings**	**Weston Sustainability**	**Total BNSSG STP**
Providers	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)	13.3	36.1	4.4		6.2
North Bristol NHS Trust (NBT)	(80.6)	14.0	65.0	1.6		(0.0)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)	3.1	10.1	0.0	7.4	(0.0)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)	0.7	4.6	12.0		(0.0)
South Western Ambulance Service (SWAST)	(3.2)	1.5	1.6	0.1		0.0
Community Interest Companies (CiCs)	(15.0)			15.0		0.0
Sub-total Providers	**(184.3)**	**32.6**	**117.4**	**33.1**	**7.4**	**6.2**
Commissioners						
Bristol CCG	(60.9)		8.0	52.9		0.0
North Somerset CCG	(30.3)		3.7	26.6		0.0
South Gloucestershire CCG	(30.0)		9.8	20.3		0.0
Sub-total Commissioners	**(121.2)**	**0.0**	**21.5**	**99.8**	**0.0**	**0.0**
System Wide		28.4		(28.4)		0.0
Total Organisational Financial Plans	**(305.5)**	**61.0**	**138.9**	**104.4**	**7.4**	**6.2**

'Do something' solutions

The £305.5m 'Do Nothing' deficit can be tackled by the following measures

1. Organisational savings (including corporate overheads, pathology, productivity)
2. Major, system wide transformational changes.
3. Receipt of Sustainability Funding

Organisational Savings

The summary below in table 2 shows, by organisation the identified savings for the period 2020/21. To date BNSSG STP has identified £138.9m savings to the period 2020/21.

It needs to be noted that these savings are subject to organisational risk assessment using the normal processes both in terms of delivery and the impact on clinical services. Consideration still needs to be given to the impact on workforce, activity and any capital investment requirements to deliver. The BNSSG footprint has not progressed this required level of detail yet.

It is recognised that the delivery of these organisational savings are, in part, facilitated by the major system wide transformational changes, which will themselves cause us to alter our model of commissioning care delivery.

Regarding methods of payment to be adopted, these will be developed in line with the new commissioning approach as described in paragraph 4.5

Table 2: Organisational Identified Savings for the Period 2020/21

Organisatonal Savings	UH Bristol	NBT	Weston	AWP	SWAST	NHS Bristol CCG	NHS North Somerset CCG	NHS South Glos CCG	Total
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Continuing Care	-	-	-	-	-	3.0	-	4.4	**7.4**
Corporate / Commercial Opportunities	10.3	11.0	0.6	1.1	1.6	-	-	-	**24.6**
Corporate Overheads	1.7	-	0.6	0.8	-	1.0	0.5	1.0	**5.6**
Facilities and Estates	4.0	0.7	0.7	0.4	-	-	-	-	**5.8**
GP Prescribing	-	-	-	-	-	4.0	3.2	4.4	**11.6**
Medicines Savings	5.9	-	0.4	-	-	-	-	-	**6.3**
Operational Productivity	1.8	35.3	2.5	1.2	-	-	-	-	**40.7**
Other Pay (Not Included in Productivity)	-	8.2	3.2	0.5	-	-	-	-	**11.8**
Pathology	-	-	-	-	-	-	-	-	**-**
Reducing and Conrolling Non Pay	12.5	9.7	1.8	0.7	-	-	-	-	**24.7**
Technology	-	0.1	0.3	-	-	-	-	-	**0.4**
Grand Total	**36.1**	**65.0**	**10.1**	**4.6**	**1.6**	**8.0**	**3.7**	**9.8**	**138.9**

Major System Wide Transformation Changes

The system wide workstreams (PEISC, IPCC and ACC) have been tasked with identification, design and development of cross organisational transformation opportunities. These workstreams are led by a Senior Responsible Officer and supported by their respective Director of Finance. The projects within these workstreams are at various stages of development, but are not yet at the level of maturity required that we can include any numbers to the detail and confidence expected to date. We are working to ensure that where the impacts of system wide changes occur in 2017/18, the required modelling and assumptions are developed sufficiently for inclusion within the Operational Planning submissions in December. These system wide changes will be further developed thereafter as the route to addressing the £104m in savings over the whole period.

There is an indicative capital requirement of circa £60m, which is over and above any business as usual requirement. The requirement for capital funding will be further developed in light of the STP transformational goals, aligned with any NHSE Estates and Technology Fund (ETTF) submission.

Sustainability Funding

Sustainability funding of £61m has been notified by NHS England and included in the STP financial position accordingly.

For further financial information please see the separate financial templates, which have been sent separately to NHSI and NHSE

8. Key risks

Our STP represents an ambitious and challenging transformation programme. In this context the risks associated with the programme are significant and will need careful management by the programme leaders. Set out below in the table below are the key risks identified to date and the initial mitigation plans that we are developing in order to manage these risks.

Description of risk	Proba-bility	Impact	Risk Score (P x I)	Decision made or mitigating action to be taken	Mitigated Risk Score and RAG rating
Benefits The system is unclear about the impact of the proposed changes as the programmes and projects move into start up or design phase, leading to difficulties aligning with required enabling workstreams of finance, estates, workforce and/or digital	5	4	20	Put in place appropriate governance and dedicated resources ensure programmes and projects are progressed quickly with dedicated finance resource are able to assess their impact	8
Leadership Organisational alignment is insufficient to deliver the system transformation at pace	4	5	20	Undertake a review of the governance and decision making alignment to be undertaken, which includes a formalised assurance process	8
Communications and Engagement Failing to bring public, communities, patients and staff with us in developing and delivering system transformation, resulting in resistance to change implementation	4	4	16	Implement communication and engagement plan and continually review and develop in response to stakeholder feedback	10
Capacity Insufficient resources are dedicated to programme and project delivery, resulting in projects not being able to deliver at the pace required	5	3	15	STP Programme Director to scope out resourcing requirements with support from programme and project leads across the organisations and agree a resourcing approach with SLG	10
Capability Staff involved in transformational change have not got the skills or knowledge to deliver or support the required transformation changes at scale	5	3	15	Workforce SRO to develop a system-wide approach to system transformation and start to implement	10

9. Conclusion - Our Way Forward

The STP approach has created a new culture and environment within which our organisations have started to operate. We recognise the three gaps cannot be achieved by working within our organisational boundaries and we need this new collaborative way of working to deliver system wide improvements.

This submission reflects the progress we are making and recognises the challenges that lie ahead. In our submission we have:

- reaffirmed the model of care we are developing;
- demonstrated how the programmes and projects we are undertaking will contribute to the delivery of the model of care;
- provided greater detail on the projects we are undertaking, the outcomes they are seeking to achieve and their relationship to the overall model of care;
- begun to illustrate the impact these projects will have on the experience and outcomes for our population, the quality and accessibility of our services, the roles and opportunities for our staff and the financial sustainability of our care system;
- described the way we will enable change through the transformation of our service delivery, workforce, our deployment of technology and the optimal use of our estate; and
- articulated how we will use the operational planning and contracting processes to embed the STP approach and incentivise the delivery of the model of care.

Our STP builds on a successful track record of delivering major change, including the centralisation in Bristol of ENT surgery, OMF surgery, Breast and Urology Services, specialist paediatrics and cellular pathology, of using digital technology to support shared care across BNSSG through the Connecting Care Programme, as well as the redesigned estate at the Bristol Royal Infirmary campus, South Bristol Community and Southmead hospitals. The learning from these has reaffirmed that clinical leadership is a key success criterion and we will ensure our continuing transformational change is clinically led, focused on people and not organisational boundaries.

Our next steps are to ensure our organisations are fully aligned to support our priority programmes and projects. Our enhanced governance arrangements will ensure we are able to manage and track progress and provide focussed support, as required. We will ensure our early priority projects start to deliver benefit and build confidence in our ability to deliver system wide change.

We do not underestimate the scale of the challenge but across the STP footprint we are strongly committed to delivering the transformation needed for the people of Bristol, North Somerset and South Gloucestershire.

Appendix A – Programme Approach

Programme Governance Key Terms of Reference

System Leadership Group (SLG) – Key role

The overall owner of the STP, the SLG steer and make decisions on the development and delivery of the STP. Members of the SLG have the authority to make decisions on the scope of the programme on behalf of their respective organisations. All work stream SROs within the programme are accountable to the SLG for delivering their agreed share of the benefits of the programme.

STP Executive Board (STP EB) – Key role

The STP EB supports the development of the STP, providing oversight of planning, implementation, benefits realisation and assurance. It membership is drawn from the System Leadership Group and will be supported by an STP project group.

Clinical Cabinet – Key role

The Clinical Cabinet provide a forum where collective knowledge on clinical issues can be shared and provided to the BNSSG system leadership group (SLG) and for SLG to seek clinical views across the system. It also creates a mechanism for increased participation in and advice from clinicians and other health and social care professionals in developing the Five Year Forward View strategy and model of care for BNSSG as part of the emerging sustainability and transformation plan

STP Programme Group (STP PG) – Key role

The STP PG bring together all the delivery work streams and ensure a coherent direction. The STP PG act as the conduit for project work streams, such as tracking of progress, monitoring benefits realisation, managing dependencies and interdependencies and identifying mitigating actions for issues and risks.

Prioritisation Group - Key role

The Prioritisation Group will report to the clinical cabinet and thus has a clinical focus (i.e. will not look at issues such as back office, estates, workforce, etc.).

The group is expected to review the existing prioritisation tools that CCGs, Public Health Departments and Providers have developed and also existing benchmarking tools developed by NHS-E and PHE e.g. Right Care although it is recognised that these often focus on cases for investment only and comparisons of activity without reference to outcome or need.

The focus should be two-fold:

1. Identify areas for disinvestment / resource reduction based on an evaluation of local and outside area comparable data
2. Identify priorities for investment and service re-design based on population need and whole system cost.

Programme Resourcing

The resources required for the STP programme that will span the BNSSG footprint, are identified below. The full resource requirements for all of the STP specific transformation programmes / work streams are being identified in line with the development of their delivery plans that are still to be formally confirmed and agreed. The expectation

is that each programme / workstream will require full-time dedicated programme and project team resources, which will either comprise of new recruits, or provided by the reprioritisation & reallocation of existing staff working on transformation opportunities within the organisations across the BNSSG footprint.

Summary of dedicated resource requirement - Initial BNSSG STP programme level

Governance level	Status
STP Executive Board	
✓ Independent Chair	In progress
✓ STP Senior Responsible Officer	In post
STP Programme Group	
✓ Programme Director	In post
✓ Programme Manager	In post
✓ Finance Officer	In progress
○ Engagement Officer	To be agreed
✓ Programme Support Officer	In post
BNSSG PMO	
○ PMO Manager	To be agreed
✓ Business Analyst	In progress
○ PMO Support Officer	To be Agreed

To help ensure there is an equitable level of programme resources from across the BNSSG footprint, the key leadership roles within the STP Programme have been filled from the commissioner and provider organisations affected.

Table of Key STP Roles and Individuals involved

BNSSG STP Portfolio	Organisation	Job Title	Organisation	Job Title
Overarching STP Programme	University Hospitals Bristol Foundation Trust	Chief Executive	BNSSG STP	**STP Programme Director**
Integrated Primary Care	Bristol Community Health	Chief Executive	Bristol CCG Bristol Community Health	Head of Strategic Planning Head of Business Development
Sustainable Primary Care	NHS England	Director of Commissioning & Assurance	NHS England	Head of Primary Care
Prevention, Early Intervention and Self Care	West of England Public Health Partnership	Chair	West of England Public Health Partnership	Consultant in Public Health
Acute Care Collaboration	North Bristol Trust	Chief Executive	University Hospitals Bristol Foundation Trust Bristol CCG	Head of Strategy and Business Planning Head of Strategic Planning
Workforce	Avon & Wiltshire Health Partnership	Chief Executive	Avon & Wiltshire Health Partnership	
Estates	To be Confirmed	To be confirmed	University Hospitals Bristol Foundation Trust	Director of Facilities & Estates
Digital	University Hospitals Bristol Foundation Trust	Chief Executive	South West Commissioning Unit	Connecting Care Programme Director
Engagement	South Gloucestershire CCG	Chief Officer	South Gloucestershire CCG	Director of Strategic Projects
Finance and BI	Weston Area Health Trust	Chief Executive	Bristol CCG Bristol CCG	Head of Strategic Planning Head of Performance and Information

Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

Appendix B1 – Plan on Page

***Please note this documented has been formatted to print on A3.**

Publication November 2016

Prevention, Early Intervention and Self Care

Making Every Contact Count (MECC) Project

Aim

To champion a culture and environment of health improvement where health becomes everyone's business.

Current State

Unhealthy lifestyles are a significant contributor to premature death, disability, inequalities and NHS costs. Almost 75% of premature mortality is due to 4 main diseases- cancers, cardiovascular disease, respiratory disease and liver disease. The main risk factors for these diseases are lifestyle related- smoking, poor diet, lack of physical activity and alcohol. These 4 lifestyles contribute to around 50% of premature death from these diseases alone.

Evidence from the JSNAs for BNSSG have shown that lifestyle behaviours are not equally distributed, and that socioeconomic status and lifestyles behaviours are clearly correlated with those from the most deprived backgrounds suffering the worst consequences.

Figure 1: Percentage of adults with unhealthy lifestyles in BNSSG.

Objectives

- To ensure that the prevention of poor physical and mental health becomes everyone's business within key provider organisations.
- To promote health and healthy lifestyles and wellbeing to all staff working with adult patients

Projects

- Making Every Contact Count (MECC) is an approach to behaviour change that utilises day to day interactions to support people in making positive changes to their physical and mental health and wellbeing.
- The project will ensure that each organisation has a 0.5 MECC co-ordinator in each of our main provider organisations for 12 months
- The role of the co-ordinators would be to work with senior leaders and workforce leads within their organisations to champion a culture and environment of health improvement where health becomes everyone's business.
- They will develop a sustainable MECC programme, rolling out MECC training to all frontline staff to ensure they have the skills and confidence to have opportunistic and sensitive conversations about healthy lifestyles and wellbeing.
- The co-ordinator will monitor and evaluate the impact of MECC and will, with partners across other providers, the local authorities and the South West region, ensure a consistent and system wide approach to MECC.
- They will be supported by MECC leads within local authorities and Public Health England and provided with tools, training and resources to support the delivery within their organisations.

Risks

- It is difficult to estimate the exact financial benefits from MECC at this stage
- The evidence base for outcomes from MECC programmes is still in its infancy.

Benefits

- Senior leaders will champion the importance of prevention across their organisations, building a culture and environment that supports health improvement
- Staff will be trained in the skills and will confidently and sensitively deliver brief healthy chats around smoking, diet, physical activity, alcohol and mental wellbeing to the patients they come into contact with and signpost patients to support where needed
- The lifestyles and health of the workforce and the patients they come into contact with will be improved and inequalities in health will be reduced.

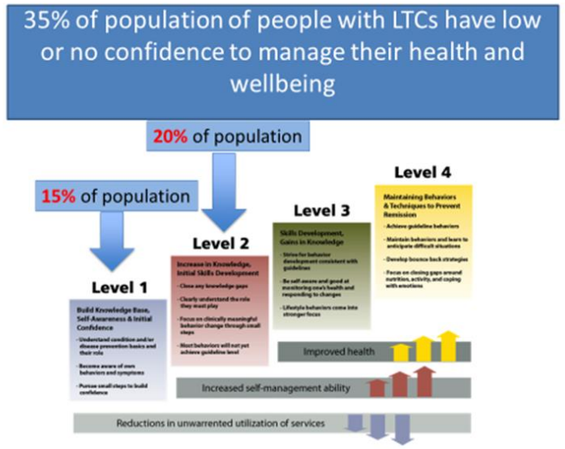
Self-Care and Social Prescribing

Aim

To deliver social prescribing, based on effective models of social prescribing and self-management at scale across BNSSG targeting the population at risk of emergency admission and ED attendance due to long term conditions.

Current State

There are currently a number of initiatives already in place that could be up-scaled across BNSSG - including Bristol Community Resource leads based in primary care, South Gloucestershire Community Connectors and Health Champions. The potential to self-care has been defined in terms of 'Patient Activation', which describes the knowledge, skills and confidence a person has in managing their own health and health care. It has been robustly demonstrated that levels of patient activation are related to most health behaviours, many clinical outcomes, health care costs and patient experiences.



Project

This project will:

- Coordinate, align and upscale existing initiatives such as SG Community Connections, Health Champions and BCH Community Resource Leads to ensure equity of access across BNSSG
- Deliver using a cluster model of service delivery outlined in the IPCC workstream
- Develop links to MECC, Healthy Living Hubs, Healthy Living Pharmacies and Voluntary and Community Sector

Objectives

- to activate patients with Long Term Conditions to make their care more effective, increase wellbeing, and make better use of NHS resources
- To address low levels of patient activation; social isolation/loneliness and low activity levels
- To reduce avoidable emergency appointments and OP appointments
- To reduce DTOCs
- To reduce re-attendances within 30 days

Risks:

- It is difficult to estimate the exact financial benefits from social prescription at this stage

Outcomes

- A range of interventions to enable self-care with a focus on social prescribing
- Upscaling of work shown to reduce demand on health and social care services across BNSSG
- A network of community health champions
- A network of peer led self-management groups

Supported Self-Care (Digital)

Aim

To improve people's ability and confidence to self-manage, through information, participating in a structured educational and monitoring programme, or by receiving and responding to text messages designed to support positive behaviours, co-ordinated through a clinically staffed, central 'hub'.

Current State

In the UK, 80% of GP consultations, 60% of days spent in hospital and two thirds of emergency admissions are related to long term conditions. However more than 80% of the care is undertaken by the patient or their carer. A small scale, eight month 'Champion' project in Bristol with one surgery and a total of 93 patients in three cohorts, tested how a range of people with varying health needs and preferences could be supported to better manage their conditions. While not designed as a statistically significant study, outcomes of the project showed a reduction in secondary care emergency attendances, admissions and out-patient appointments as well as reduced primary and community care contacts.

This local work is complemented by intelligence gained form a similar, larger scale service currently running in Liverpool which evidenced reductions in emergency admissions by a cohort of patients with LTCs of between 22- 32%.

Objectives

- to activate patients with Long Term Conditions to make their care more effective, increase wellbeing, and make better use of NHS resources
- To address low levels of patient activation; social isolation/loneliness and low activity levels
- To reduce avoidable emergency appointments and OP appointments
- To reduce DTOCs
- To reduce re-attendances within 30 days

Project

The project will deliver a range of interventions as part of a structured programme to enable self-care across BNSSG, focussing on those with Long Term Conditions at the highest risk of emergency admissions, using risk stratification, complex case management, traditional healthcare, information, education and signposting and, including the use of technology.

It will use the infrastructure and clinical workforce located in the Health and Care Single Point of Access (SPA) (see Integrated Primary and Community Care business case), from where patient alerts and data will be monitored and responded to, and technical and healthcare advice and support provided. The Health and Care SPA will work with GPs, case managers and other staff in the Multi-Disciplinary Teams (see Integrated Primary and Community Care business case) , including mental health staff, who will provide the hands-on care and treatment for patients on the programme.

Risks

- Full savings may not be realised
- Project has critical dependencies on other workstreams such as procurement of risk stratification and case finding tools, which may not be realised at speed required of the self-care programme
- Model and financial assumptions have not yet been fully described

Outcomes

- Improved clinical outcomes for patients
- Improved knowledge, skills and confidence to self-manage
- Improved quality of life and better experience for patients and carers
- Improved communication between care teams and breakdown of organisational silos
- Better care coordination
- Increased capacity through greater productivity and efficiency

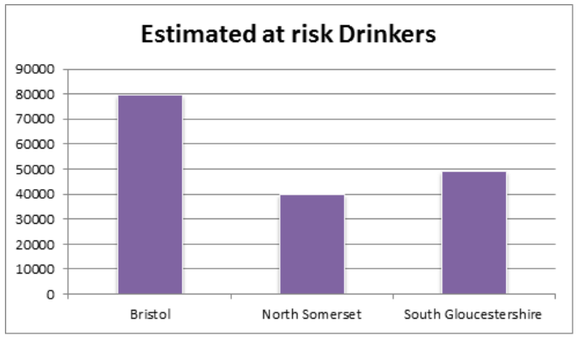
Alcohol Harm Reduction

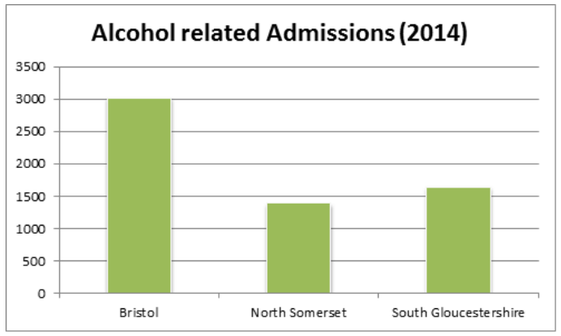
Aim

To reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions.

Current State

Current provision of Alcohol Identification and Brief Advice (IBA) across Bristol, North Somerset and South Gloucestershire (BNSSG) is variable across primary, community and secondary care. It is estimated there are the following:-





Objectives

- to strengthen the provision of Alcohol IBA across Bristol, North Somerset and South Gloucestershire (BNSSG) to ensure a consistent approach to IBA commissioning
- to improve the links between primary, secondary and community care including the wider workforce eg pharmacists
- to contribute to Alcohol harm reduction, which is a key priority for the STP within the Prevention, Early Intervention and Self Care (PEISC) workstream
- to reduce alcohol related hospital admissions, re-admissions, length of stay and ambulance call outs as well as the reduction in the burden of excessive alcohol consumption on the NHS, police and social care from high volume service users
- to tackle the poor understanding of alcohol-related health risks among patients and health care professionals
- to develop a more proactive approach to the earlier identification of people with chronic liver disease
- to explore opportunities for alternative ways to deliver diagnostic tests

Project: Alcohol IBA

The Alcohol Identification and Brief Advice (IBA) programme aims to reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions. The main objective is to tackle the poor understanding of alcohol-related health risks among patients and health care professionals using the following methods:

- Training of healthcare staff working in primary and secondary care settings (GP practices, hospital wards and community pharmacies)
- Increasing screening of patients (for example by use of the Audit-C scratch cards)
- Providing simple brief advice on alcohol consumption to cover potential harm and strategies to reduce alcohol intake
- Referral for specialist treatment where relevant

The two primary workstreams in this project are as follows:

- New primary care liver/alcohol pathway to identify those at risk of significant health and psychological issues caused by alcohol. The new liver/alcohol pathway seeks to standardise investigation and treatment of liver disease across the region and ensure equity of treatment. It would also ensure that liver referrals are appropriate and reduce hospital admissions and attendances for those in crisis by enabling earlier recognition and care planning of these high risk patients. Currently, more than one million liver function tests are requested a year, 70% of which are requested from primary care. Savings will also be obtained from a reduction in ultrasound scanning.
- Alternative pathways for diagnostics in primary care (for example testing for liver fibrosis using fibroscans) to identify those patients at highest risk of liver cirrhosis. This is expected to save significant resource in secondary care. The fibroscan service will be piloted in Bristol before the eventual roll out of the service across BNSSG.

Risks

- Full savings will not be realised

Outcomes

- Consistent approach to Alcohol IBA provision across BNSSG
- Improved links between community, primary, secondary care and auxiliary healthcare professionals
- Reduced systems costs from avoidance of or reductions in alcohol related admissions, readmissions, Length of Stay and ambulance call outs
- Better understanding of alcohol related risks
- Earlier diagnosis of chronic liver disease and improved long term health outcomes

Integrated Primary and Community Care

Sustainable Primary Care Programme

Aim

- Sustainable, effective and accessible primary care
- Absorb the expected rise in demand by 2020/21 through new ways of working that include supported self-care, an MDT approach and deployment of non-clinical services.
- Make Primary Care a satisfying career choice

Current State

- Deficit of Clinical workforce availability to continue to provide care in its current form. Need to consider new models of care and meet increasing needs of the population
- Difficulties for patients in accessing primary care services
- GP estate is not fit for purpose in many cases given practice mergers and the percentage of work needing to move into an out of hospital setting current and this is causing system wide pressures.
- Variations in quality of care provision

Objectives

- Absorb the expected 12% rise in demand by 2020/21
- Management of patients as risk of admission in the community setting
- Delivery of primary and secondary prevention interventions
- Early identification and intervention to manage demand for both urgent and elective care
- Reduce variation of practice and improve consistency of outcomes by operating standardised policies, processes, procedures and documentation, including the digital record. Right care first time.
- Patient education, activation and involvement are in planning and delivery
- Reduce the need for patients and carers to repeatedly tell their story. This will be enabled through regular MDT meetings, health passports, close working relationships and enabling IT
- Promote and develop inter-professional team-working in order to achieve a multi-disciplinary service delivery
- GPs day de-cluttered so that they do what only they can do
- Move non-medical appointments from Primary Care to the voluntary / community sector, freeing high cost resource and capacity
- Maximise contribution of Community Pharmacy sector
- Maximise contribution of voluntary sector and other community assets
- Ensure the first care / treatment option offered is the most cost effective which delivers the identified health, care and wellbeing outcomes
- Provide training which is consistent across BNSSG, supporting the delivery of clinically effective intervention and care without variation
- Driving improvement through innovation and research
- Enable inter-professional collaboration and decision making by blurring organisational boundaries
- Ensure MDT workforce is appropriately skilled and trained to manage the local population's health, care and wellbeing needs
- Digital enablement to the above
- Buildings that enable the above
- An organised Primary care sector with a single provider voice

Projects

- A patient and their GP will be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This will occur in general practices which are recognised as places in each community, developing community resilience and supporting our citizens to stay as well and as healthy as possible.
- High quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home as well as general medical services.
- To be organised in different ways depending on local circumstances but based on a defined geographical patch, reflecting natural communities of 30-50k, within which they are responsible for the health and wellbeing of the population. The units (circa 18 across BNSSG) will be large enough to be organisationally resilient whilst hosting smaller clinical teams at a local level of different specialisms. They will form the basis for delivery of seven day services and enhanced primary care, including Mental Health.
- Local care organisations will work with similar organisations across the BNSSG system to provide a seamless service to patients through defining new community care pathways and sharing a common patient record.

General Practice Pilots

These pilots are underway and include:-

- Piloting mental health workers, physiotherapists and pharmacists to develop multi-disciplinary teams to support better patient access to services and GP workload
- Developing a 7 day access model in primary care across BNSSG
- Piloting use of web based technology for GP consultations and improving patient access to web based self-help information
- Improving telephone access through the review of telephony systems
- Reviewing back office functions and processes to improve practice efficiency

The GP sustainability and transformation of general practice programme will be responsible for reviewing the evaluations and business cases of the above pilots to understand whether these initiatives are something the system may wish to take a view on continuing or not in the longer term.

Temperature Check Project

This project aims to work with GPS across BNSSG to undertake a 'temperature check' of general practice in November 2016. This will put together data and understanding of the current system. The project will then meet with groups of practices to discuss their results from the temperate check, to have proactive discussions and develop a 'resilience and transformation plan for the local area' with go live on a number of initiatives from December 2016. This will also help inform the programme plan further for the GP sustainability and delivery programme.

Development of Primary Care Capacity

This project aims to maximise benefits of Clinical Pharmacy Pilot, spread of pilots relating to practice based physio, mental health nurses, IAPT, health trainers and introduce new partnerhsips with community pharmacies for both urgent care and LTC management. It will work closely with with 7 day working multidiciplinary work project and the development of the SPA project to ensure the work delivers a clear offer for patients and staff working within the system.

Risks

- Lack of a 'Primary Care ready' MDT workforce
- Current contracting arrangements
- Project management and business case development resource
- Expertise on new funding models
- Funding for transformation and investment in technology
- Baseline data for demand and activity across both community services and primary care

Benefits

- Improved health outcomes and reduced inequalities
- Reduce demand for secondary care services
- Reduce the number of consultations conducted by GPs by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Decrease the number of home visits, surgery visits and outpatient appoints by up to 15% through the use of home monitoring and remote consultation
- Reduced admission to care homes.

Health & Care Single Point of Access (Design and Technologies)

Aim

The aim of this project is to replace the current multiple points of access to health & social care for adults by establishing one BNSSG SPA for professionals (and possibly patients on care plans and their carers) to support admission avoidance and discharge to underpin the Urgent Care System to meet the aims, objectives, and outcomes outlined in the STP.

Current State

Currently the process of referring people to the most appropriate services in the community is not very easy to navigate and lacks consistency of approach, where the physical, mental and social health teams work quite separately.
Other issues with the current model include problems with technology and information sharing, inconsistent call handling timescales and processes (it can take anything from 5 minutes to 1.5hrs for a community referral to be processed, depending on the time of day), duplication of work and repeat assessments, inefficient use of clinical time (often spent trying to identify and then get through to the most appropriate person), fragmented and complex system, with no single call to access clinical advice, lack of consistency in accessing community services every day of the week and significant costs associated.

Objectives

- Provide a sustainable, high quality service that enables Bristol, North Somerset and South Gloucestershire population to receive the right care, in the right place, at the right time by providing seamless coordinated care;
- Design a service specification and model of care that meets the requirements of IPCC model in the STP and delivers the savings and benefits assumptions;
- To enable the appropriate, effective and timely sharing of relevant user data across and between providers;
- To improve clinical decision making through access to user records;
- Improve the co-ordination of services between primary, community, social and secondary care provision;
- Increase cost effectiveness by bringing functions together and working in a new way to achieve the economies of scale, which can be done by maximising the use of existing services in terms of workforce skill mix, knowledge and competencies;
- To provide a service that can respond to a user's needs early in the pathway, linking into services across the community without the need for repeated assessments and information at each stage;
- Assist in increasing the accessibility to right services based on need;
- Improve appropriateness and the quality of care provision as well as releasing clinical time;
- Improve pathways for high intensity users;
- Work with the providers of community beds and acute providers in relation to step-up and step-down provision;
- Deliver a rich set of information on unmet need, demand and capacity gaps and so contribute to workforce development by shaping/reshaping the workforce to meet user's needs and delivery of the urgent care model now and in the future;
- Reduce conveyances by linking the SWAST clinical desk function provided by the Ambulance Service with the BNSSG SPA to ensure patients are cared for in the most appropriate place (including at home or within the community), reducing the need for conveyances and emergency admission to hospital;
- To ensure changes to urgent care services in BNSSG are coordinated with the work led by the Severn Urgent & Emergency Care Network;
- Support delivery of cluster working & MDTs in the community.

Project

The project will:-

- To identify all current SPA services in BNSSG (pop. C900 000);
- To identify all SPA related projects and work streams in progress or planned across BNSSG, and their underpinning assumptions/benefits, delivery mechanisms, timeframes and membership;
- Establish a common service specification for a BNSSG SPA for adults, which takes into account current local services and all future aspirations;
- Develop an outline service model in response to the agreed output specification;
- Identify the required workforce and skills, whether they are currently in the system and where there are gaps;
- Identify the underpinning infrastructure likely to be required to deliver the functions (a strategic outline business case for capital has been submitted to NHS England as part of a call for applications under the Urgent Care Review recommendations. The £3 457 300 submitted was done at short notice and requires validation);
- Identify the membership and governance arrangements for this project;
- Review STP assumptions and work up a SPA activity model to inform an indicative cost (capital and revenue);
- Identify funding/resources across organisations which could be diverted to fund the BNSSG SPA;
- Profile the delivery of the SPA incrementally in line with the current STP Plan, which sees the SPA fully implemented in 2018/19;
- Develop a detailed implementation plan.
- Commission and implement the new service.

Risks

- There is a risk that we will not have sufficient capital to invest in establishing a SPA, including accommodation and technology solutions to enable the service to be established.
- There is a risk that the contract expiry dates across the BNSSG may not be aligned and may result in double or over paying for services.
- Conflicting local priorities and inability to agree on a service specification and scope among providers and commissioners.

Outcomes

- Reduction in emergency admissions
- Reduction in ED attendances
- Reduction in re-admissions
- Reduction in length of stay
- Reduction in excess bed days
- Reduction in conveyances
- Increase utilisation of Community Beds
- Increase telehealth usage
- Also several other qualitative benefits e.g. improved patient and service user's experience & outcomes by better coordinated care with a single contact, provision of alternatives to emergency admissions to avoid older people deteriorating during extended stays in hospital and with no need for repeat assessments

SPA Services Rapid Response

Aim

To deliver an expanded Rapid Response service accessed via the health and care hub, with support from the full multidisciplinary team this will include rapid access for diagnostics, prescribing of medication, urgent social care and nursing support, all community and primary care based.

Current State

The mounting pressures on Emergency Departments across the BNSSG geography illustrates the need to transition to a more sustainable model of care, which may involve caring for more patients in the community and preventing unnecessary deconditioning of patients.

Bristol, North Somerset and South Gloucestershire are also experiencing significant challenges in terms of demand for urgent care services. This is impacting on the quality of care and delivery of key performance targets and, most importantly, on patient experience and outcomes.

Nationally, Better Care has set out the need for services provided by health and social care to be better co-ordinated and integrated and concentrate on strengthening clinical triage and advice service to allow for smoother pathways for both clinicians and patients navigating the complex system.

Objectives

- Reduce the number of unnecessary non elective admissions to hospital.
- Reduce the number of readmissions to hospital
- Define equitable good quality 7 day services available on the basis of need
- Provide care that centres on patient needs with timely interventions**.**

Projects

- To identify all current Rapid Response services in BNSSG (pop. C900 000);
- To identify all related projects and work streams in progress or planned across BNSSG, and their underpinning assumptions/benefits, delivery mechanisms, timeframes and membership;
- Develop an outline service model in response to the agreed output specification;
- Identify the required workforce and skills, whether they are currently in the system and where there are gaps;
- Identify the membership and governance arrangements for this project;
- Review STP assumptions and work up an activity model to inform an indicative cost (capital and revenue);
- Develop a detailed implementation plan.

Risks

- There is a risk that investment in diagnostic services and step up beds is reliant exclusively by disinvestment from the acute providers. The Primary and Community care providers are unable to assume that risk unless agreement can be reached.
- It is not possible to rain workforce and recruit to new roles to deliver new models of care
- Existing community services do not have the capacity to meet increasing demand. Lack of capacity could effect ability to achieve outcomes.

Outcomes

Direct shift of appropriate activity from A&E

There are additional savings to be made in mental health, dementia, diabetes and respiratory emergency admissions.

Also qualitative benefits including:

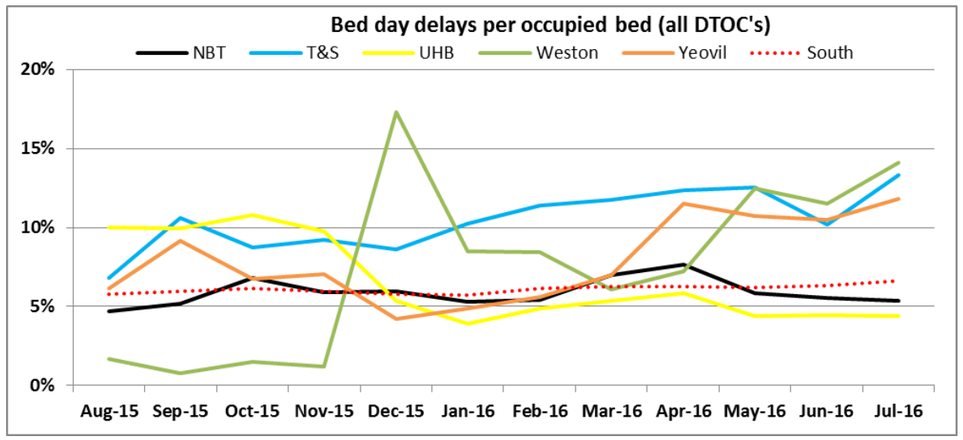
- Improved patient and service user's experience & outcomes by better coordinated care with a single contact, provision of alternatives to emergency admissions to avoid older people deteriorating during extended stays in hospital and with no need for repeat assessments;
- Immediate advice and basic treatment to enable the patient to remain in their home.
- For those experiencing a short term crisis immediate health intervention or support during breakdown of care.
- Improved system resilience by operating at larger scale across the three geographies resulting in improved use of services and the skills of all staff;
- ensuring a robust interface for emergency services, acute hospitals and primary care;
- Increased number of people being treated in their own home or closer to home in community facilities;
- Improved the effectiveness of health interventions and wellbeing and management of mental alongside physical health;
- Reduced duplication and fragmentation by standardising processes and criteria, reduced variation in access and referrals, integrated teams and development of trusted assessor roles and procedures;
- Closer working and understanding between the health and social care staff working together.

Health and Care Single Point of Access – Delayed Transfers of Care (Part A)

Aim

Requirement to have a consolidated plan to ensure that Delayed Transfer of Care (DTOC) levels are within 2.5-3.5% parameters & address longer term issues re bed utilisation, length of stay (LOS) and model of care for Frailty. To ensure that plans for community and primary care developments are aligned with wider BNSSG Transforming Care Plan (TCP) requirements.

Current State



Objectives

To maximise opportunities for patients to go directly home to their usual place of residence, spending the shortest time possible within a hospital or inpatient setting.

To standardise, simplify and reduce variation within our approach to discharge, maintaining configuration for individual patient need but simplifying and reducing processes, options and decision making at key points in the patient journey.

To maintain and develop the current D2A pathways across BNSSG to ensure that DTOC levels are reliably and consistently within the national 2.5%- 3.5% parameters.

- One key element of addressing LOS and expanding the principles of D2A will be a restructuring of all therapy services to create a new flexible clinical and operational model. This model will include all current therapy resources distributed across health and social care to support early discharge and prevention of readmission.
- To reduce overall LOS within hospitals for all patients including 'simple' discharges with a target of approximately 200 beds across the local system.
- To ensure there is optimal use of current bedded assets footprint wide including South Bristol Community Hospital, North Somerset (Clevedon) Community Hospital, the proposed developments at Frenchay and Thornbury, other rehabilitation settings and D2A Pathways 1-3.This will include establishing what facilities will be required to support a sustained reduction in LOS across a broad range of patient pathways
- To integrate within the proposed locality/cluster and MDT models across BNSSG and supporting admission avoidance work and long term conditions management.
- To make optimal use of other related service elements such as long term residential care beds , homecare, voluntary sector services and also self-care/support for carers especially in the context of extreme pressure on social care budgets

Projects

Work to continue to reduce DTOC's to the 2.5/3.5% national target as part of a BNSSG-wide Discharge to Assess (D2A) programme.
Formalise the discharge to assess pathways provided by North Somerset
Work across BNSSG on flexible use of all (bedded) pathways based on need rather than GP registration.
Maximise the discharge to assess offer at the front door, including the inpatient assessment units
Embedding of trusted assessment across the patch is also key, and links to the business case submitted by the Local Authorities

Focus on simple / routine discharges and overall reductions in length of stay
A change is culture and understanding by staff and patients will be required to embed these new ways of working.
Individual pathways reviews will show areas of opportunity for length of stay reductions though increased use of MDT working and targeted application of the agreed operational standards for discharge. Known areas for development currently include stroke, MSK, neurology and medicine.
A review of end of life care pathways will be required and will link with the STP business cases related to frailty and end of life. This needs to include work on care home market management and quality assurance.
A focus on criteria-led discharge, earlier in the day discharges and weekend discharges, and routine use of discharge / transfer lounge facilities.
Utilising structured supported self-care programmes (see separate IPCC business case) to support earlier discharges for people with Long Term Conditions.
Utilising the expertise and information in the Health and Care Single Point of Access to facilitate early discharge to the right place, with the right support.

Transformation of secondary/primary/community care at scale
Scoping and provision of step up/ step down requirements across BNSSG.
Active case management through the STP proposal of Community MDTs (see separate IPCC business case)
Linked to this would be a transformation of the way therapies are delivered across the system.
Assertive discharge procedures would centre around the board round, which would become the hub and driving force of all discharges
Unbundling of tariff and other funding structures to support financial flows through the system would be required.
A focus on the requirements of mental health DTOC patients, including working with local authority colleagues on suitable housing options and the provision of care home beds for people with complex needs, such as advanced dementia.
A review of staffing ratios and use of bank and agency staffing would be needed, and reduction in use of non-substantive roles would be supported through unification of pathways / providers.
Standardisation of supplies would generate efficiencies and savings for example in community equipment, dressings etc.

In summary, there will be three broad strands to this work, as follows:

1) Simple Discharges– efficiency and productivity will be maximised through changes to internal flow within the hospital systems (including mental health). This element will be largely cost neutral / cost saving.
2) Complex Discharges– efficiency will be maximised through the at scale provision of discharge to assess pathways. For Bristol and South Gloucestershire provision currently matches demand (taking into account developments already underway to increase discharges across all pathways). As discussed, further work is required to understand the needs of North Somerset patients, though systems and processes can be shared easily which would simplify future implementation and aid alignment across the patch.
3) Early Supported Discharge – efficiency would be facilitated through the discharge of patients who, whilst still within tariff structures, can be safely cared for in a lower intensity (cost) setting. This would be a balance between a virtual ward type scenario and convalescence. Obvious examples include fractured neck of femur patients and people ready for stroke rehabilitation.

Risks

- Resources, particularly workforce
- Ability and will of organisations to work collaboratively to develop new models of care and to share risks and benefits
- Work will be required to change patient and carer perception of the best setting for care, particularly during the post-acute phase.
- Transformation and development capacity within organisations to implement and embed the required changes
- Political and public attachment to current operational configuration, especially locality specific services

Clinical 'buy in' to a significantly transformed model of care which will challenge current ways of working and organising our services.

Outcomes

- Reduced risk of decompensation and loss of independence
- Positive patient stories & single, patient-focused assessments, joint decision making in out of hospital settings,
- A sustained and permanent shift activity from the acute sector to the primary and community sector community
- Flexible, people rather than estates based model that can flex with changes in demand, presentation and patient expectation
- Patients return home more quickly to their place of residence and reduced readmission rates
- Reduced hospital bed days and improved internal flow within hospital which will support the consistent delivery of NHS Constitutional standards.
- Better use of current and future workforce especially registered staff & sustainable and skill orientated work plans for staff
- Improved access to beds to support elective programme and fewer patient ward moves and outlying patients
- Assessment in out of hospital settings which provide a more accurate picture of patients' needs
- Decreased requirement for long term, high cost packages of care following successful periods of reablement at home

Health and Care Single Point of Access – Delayed Transfers of Care (Part B)

Aim

Partners within the STP collaborate to avoid admissions, reduce length of stay for patients, improve patient experience and improve the efficiency of patient flow/discharge processes. Improvements will be achieved through a more consistent, responsive and collaborative team approach to patient flow and hospital discharge at all the acute trusts in the STP area.

Current State

Average LOS are:

- 10.1 days unplanned/ 4 days planned at Bristol,
- 8.6 days unplanned/ 3.7 days planned a North Somerset,
- 8.8 days unplanned/ 3.3 days planned at South Gloucestershire.

The mapping exercise also found that:

- Each of the 3 areas has different weekend and bank holiday cover arrangements.
- Variable amounts of progress in the development of Discharge to Assess (D2A) pathways e.g. North Somerset has still not fully implemented D2A pathways 2 and 3.
- Different processes/paperwork are used for discharge by each of the 3 STP areas even though patients from each area are regularly treated in hospitals in all three areas.
- Different hospital social work models exist in the STP area e.g. with some social workers attached to wards and others operate a referral and allocation model.
- That delays in discharge sometimes occur because likely discharge complexity is not always identified at admission.

Objectives

- Avoid unnecessary admissions to hospital
- Improve patient flow after admission
- Ensure prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.
- Achieve a reduction in the LOS of at least one day for between 10% and 20% of all unplanned spells in hospital by patients aged over 65 in the BNSSG STP area and so save between £1m and £2m p.a.

Projects

Increase the Social Care staff presence within wards and within ED and Medical Assessment Units. The aims are to sign-post people to non-statutory support when it is appropriate to do so, facilitate a prompt and safe discharge process and expedite the assessment of patients as soon as they are “medically optimised”.

Design a single and consistent 7 days a week Hospital Discharge process to operate in each of the 3 main acute hospitals in the BNSSG STP area. The aims are to eliminate waste and duplication, save staff time as they will not have to use different systems/processes depending on which area the patient is resident in, and ensure the patient experience is consistently good.

Consider options for, develop and pilot “Trusted Assessor” arrangements with a sample of large residential/nursing care homes. Aim is to establish if the pilot arrangements are justified by a reduction in discharge delays due to waiting for an assessment by a care provider.

Undertake an analysis of care/nursing home placements made on discharge from hospital by each of the 3 local authorities and CHC funded placements made by the 3 CCG’s in the STP area. The aim is to establish whether there is a business case for a joint BNSSG STP area care home commissioning and brokerage service is justified.

Risks

- **Inability to recruit into the posts** – Posts may not appear attractive in particular into the evening posts and therefore it is possible that high quality staff may not be recruited.
- **A lack of available service provision outside of hospital for people to be discharged to** – This could still limit the impact of this work stream even if patient flow and hospital discharge processes are ideally designed and operate to their optimum.
- Different ICT systems at each hospital may make having 100% identical processes at each hospital difficult. A possible constraint is the extent to which local work arounds that preserve the same overall process at each hospital, but allow staff to use local ICT systems can be developed and will be allowed/supported by Corporate ICT colleagues.
- **A lack of available res/nursing places for people to be discharged to** – This could still limit the impact of this work stream i.e. even if “Trusted Assessment” was in place a delay in discharge could occur while a suitable vacancy was located.
- It is difficult to demonstrate why **c**hanges in admission numbers and LOS occur as they are multi-factorial i.e. isolating the “cause” and the “effect” will be difficult. Proving value for money maybe a challenge.
- A lack of available service provision outside of Hospital for people to be discharged to – This could limit the impact of the work streams even if patient flow and hospital discharge processes are ideally designed and operate to their optimum.
- Although a joint unit should be able to maximise placements that are close to patient’s homes and lower the overall average price paid there is a risk that the lowest payer currently will have to pay higher prices.

Outcomes

- Give a financial payback of between 2.667 times and 5.333 times the level of the expenditure proposed.
- Contribute to the acute trusts maintaining patient flow through system and reduce occupied bed days and so ease capacity issues.
- Help to develop the knowledge of acute staff around social care, community health and community support through more contact with social care staff.
- Improve experience for patients with complex needs and achieve a far more consistent experience regardless of where they are treated.
- Support the achievement of the 4 hour target for Emergency Department.
- Support an increase in the numbers of safe evening discharges.

7 Day Multi-disciplinary Team Working

Aim

Our vision is for more care and support to be delivered in the community / primary care setting under the guidance of well-informed, highly skilled Multidisciplinary Teams (MDTs) at GP cluster level. This will improve efficiency, reduce duplication and improve patient experience.

Multidisciplinary teams (MDT) will underpin our new models of care and enable the delivery of the overall STP benefits.

Current State

MDTs are a key enabler for the delivery of the overall STP financial savings target. As an individual way of working, MDTs will create sufficient efficiencies to absorb the expected increase in demand of 12% by 20/21.

Objectives

- Be the expected and primary way of working across BNSSG, community and primary care
- Absorb the expected 12% rise in demand by 2020/21 through;
- Reduce GP appointments by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Reduce the cost of supporting those with Long Term Conditions by 7% through a People Powered Health approach
- Additional capacity of 1 visit per day for field-based workforce through provision and access to fully functioning mobile IT
- Reduce variation of practice and improve consistency of outcomes by operating standard BNSSG wide policies, processes, procedures and documentation (including care plan), using the Fundamental Standards to underpin delivery and monitoring
- Provide the best possible care and support for those with the most complex needs by drawing on the most appropriate MDT expertise and the available community resources
- Support people to remain well through self-care programmes and early intervention and prevention thus preventing or delaying future high cost intervention
- Plan for long-term health and wellbeing at a population and individual level with a focus on achieving personal goals and objectives
- Reduce the need for patients and carers to repeatedly tell their story. This will be enabled through regular MDT meetings, health passports, close working relationships and enabling IT
- To improve clinical decision making through inter-professional collaboration in MDTs
- Engage local people with the development of their local MDT and ensure their views help shape services and service configuration
- Promote and develop inter-professional team-working in order to achieve a multi-disciplinary service delivery
- Move non-medical appointments from Primary Care to the voluntary / community sector, freeing high cost resource and capacity
- Ensure the first care / treatment option offered is the most cost effective which delivers the identified health, care and wellbeing outcomes
- Provide training which is consistent across BNSSG, supporting the delivery of clinically effective intervention and care without variation
- Driving improvement through innovation and research
- Through accurate data and analytics, provide MDTs the information, in real time, which allows them to make the most informed decision possible during patient consultations
- Enable inter-professional collaboration and decision making by blurring organisational boundaries
- Ensure MDT workforce is appropriately skilled and trained to manage the local population's health, care and wellbeing needs.

Projects

The project will work to developed a shared understanding of the current arrangements including financial, operational, IMT, Estate and Workforce, Patient and Staff feedback arrangements which are currently in place and then work up the detail of how a new MDT model could be implemented across BNSSG. This will link closely with the Sustainable Primary Care Model.

Operations

This element of the project would work through the operational detail of how any MDT team might operate including forms of multidisciplinary working; improved access to care through seven-day working; risk stratification, management of people with complex multi-morbidity, approach to care planning and standardising processes and pathways across BNSSG, integrated discharge; Integrated Personal Commissioning (IPC) and Personal Health Budgets (PHB); approach to working with care home residents and links with other project such as social prescribing and health and wellbeing services.

Funding Model

This element of the project will responsible for developing and understanding of the current financial flow and activity and then develop an understanding the financial impact of the model and funding flows which would be required to deliver the model

Governance

This element of the project will work though the clinical, organisational and information governance issues and develop solutions to support the implementation of the new model.

Workforce

The element of the project will work to gain an understanding of existing workforce, consider skill mix and new staffing models

Technology

This element of the project will gain an understanding of the IMT systems in use across the existing organisations and respond to the requirements coming out of the model to consider how to ensure staff have access patient information and link with the supported self care project which include remote monitoring etc

Risks

- Current contracting arrangements
- Project management and business case development resource
- Expertise on new funding models
- Funding for transformation and investment in technology
- Baseline data for demand and activity across both community services and primary care

Outcomes

- Reduce the number of consultations conducted by GPs by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Reduce the cost of supporting those with Long Term Conditions by 7% through a People Powered Health approach.
- Decrease the number of home visits, surgery visits and outpatient appoints by up to 15% through the use of home monitoring and remote consultation
- Additional capacity of 1 visit per day for field-based workforce through provision and access to fully functioning mobile IT
- Reduced admission to care homes will create additional capacity in the system, removing a key block to effective system flow
- Gains in capacity within community services through diversion of activity, focused on early intervention and prevention, via social prescribing
- Increased care in the community / primary care (driven through upskilled GPs, development of specialist health care professional roles and rapid response) will reduce incidents of unrequired acute admission, incurring savings accordingly. This could be a cashable benefit if the bed base could be safe reduced accordingly. (Additional community resource would be required)
- Reshaped pathways will standardise the most clinically effective approaches and appropriate resources, driving down the overall cost of care
- Population profiling enables better decision making on intervention and support. This will enable the delivery of the right care to the right person at the right time, driving down the overall cost of care
- Reduced admission to care homes. This could be a cashable benefit if the bed base could be safely reduced accordingly. (Additional community resource would be required)

End of Life Care Services

Aim

To enable the consistency of service provision for End of Life Care Services across BNSSG, avoid unplanned admissions and to ensure that peoples wishes at end of life with respect to place of death are respected.

Current State

Current providers of End of Life Care Services across BNSSG include Bristol Community Health (BCH), North Somerset Community Partnership (NSCP) and Sirona Care & Health CIC (Sirona).

BCH are currently commissioned to run the Bristol Care Co-ordination Centre (BCCC) service. This service provides a single point of access for end of life care services, as well as signposting and some advisory functions. These services include: -

Palliative Care Home Support (PCHS) – This service is a nurse led service that provides personal and nursing care for patients who have a prognosis considered to be within last days/weeks of life, have a preference for care at home and have a preference for to die at home. BCH provide this service in Bristol (9am – 9pm) and South Gloucestershire (9am – 5pm) seven days a week.

Hospice at Home (HaH) - This service is a nurse-led service which provides night care, plus some day shifts, at home, for patients within their last few weeks of life.

Marie Curie Care (MCC) – This is coordinated by the BCCC service to provide overnight care at home for patients at end of life stage.

The BCCC service currently provides a 'funnel' system designed to capture all referrals to the above services (PCHS, HAH and MCC) with the aim of providing clinical triage, appropriate prioritisation of care and effective coordination.

NSCP are commissioned to provide the Care Co-ordination Centre and Palliative Care services for North Somerset patients.

Sirona are commissioned to provide an End of Life Care Co-ordination Centre service for South Gloucestershire patients.

Objectives

- Provide easily accessible, locally appropriate support for G.P's and hospitals, to prevent admission, expedite discharge and deliver peoples' wishes at the end of life.
- Provide information and guidance to service users and carers to support self- management and self-care, and support for GPs (and MDTs) in their roles as complex case managers.
- Improve co-ordination of care from both a patient and carers' perspective
- Achieve a % reduction on the 2015/16 rate of the number of non- final emergency admissions for people identified as at End of Life across BNSSG.
- Achieve a % reduction on the 2015/16 rate of patients dying in hospital for BNSSG.
- Increase the number of people that have had the opportunity to discuss and agree their preferences for their end of life care.

Projects

End of Life Care Co-ordination – A function within the Health and Care Single Point of Access (see separate business case) to co-ordinate the required End of Life Care service provision across BNSSG. This will be for health professionals, health and social care staff, patients and their families and carers across BNSSG. The service will take responsibility for coordinating the patient's care and services through existing providers.

Palliative Care Home Support (PCHS) – To provide a consistent PCHS service across BNSSG to patients from 9am to 9pm seven days a week all year round. This will include up to 3 visits a day to provide personal care and emotional support for patients who wish to be at home as they approach the end of their lives.

Improved working with the Hospice Sector – Through expanding equitable palliative care services across BNSSG and working in partnership with the Hospice sector, hospital emergency admissions will be reduced and patients are kept out of Hospital, if that is their wish.

Fast Track Nurse Assessor (FTNA) – To provide a consistent FTNA service across BNSSG to work with Acute Hospitals/Care Homes and relatives to ensure that patients who have been identified as approaching end of life are discharged as quickly as possible from Hospitals to Care Homes or their home in accordance with their wishes. This service could be operational seven days a week, 9 – 9, provided that discharges could be arranged from hospitals to care homes during these extended hours, and provided there was sufficient demand. Analysing this data will be part of the project.

Risks

- Current contract and staffing arrangements.
- Care and nursing home placement availability.

Outcomes

Financial Benefits

- Reduction in non-elective admissions and AvLoS: frailty, respiratory, End of Life and from care homes.
- A reduction to unplanned admissions to hospital during the last 12 months of life.

Non-Financial Benefits

- More people to achieve their preferred place of care at the end of their life by establishing an integrated care pathway that is recognised across all services.
- Equitable access to services and expertise.
- Provision of expert end of life advice, training and support to health and social care professionals.
- Ensure that most care and support at end of life is delivered locally, ensuring continuity of care, enabling shared decision making, and providing a whole person/multi-disciplinary approach. This will ensure the best outcomes and experience and achieve our goals of keeping people as well and independent as possible even as they age and develop long term conditions, and even at the end of life.

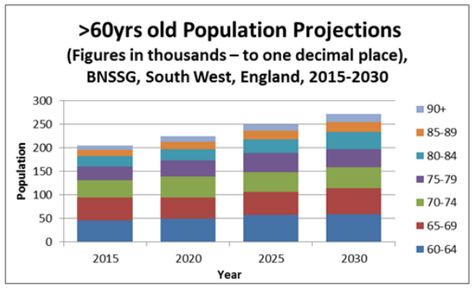
BNSSG Frailty Model of Care

Aim

To provide equity of care across BNSSG for our frail population.

Current State

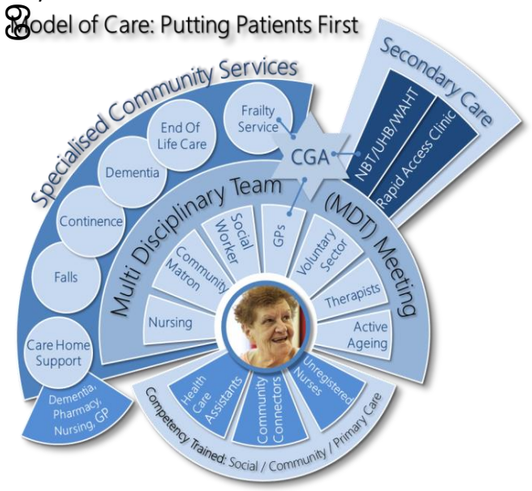
On average the frail population has a larger impact upon all health and social services, in comparison to those aged under 65 years. Across BNSSG the expected population growth for those over 60.



With the average length of stay with BNSSG acute services being 9.45 days for those >65, and an expected increase in this population (>60yr olds) by 32.68%. This can be approximated as an approximate additional 325 bed days per day, across BNSSG by 2030.

Objectives

The primary objective of this scheme is hospital admission avoidance through increasing the quality of care within the community. It focusses support towards Care Homes and aims to work collaboratively with our acute organisations to build upon trusted assessment and provide timely and appropriate access to expertise. This proposed model of care (below – Fig 1) will keep the patient at the centre of all services and undertake a holistic approach for the management of frailty across BNSSG.



Projects

1. **GP Based Multi-Disciplinary Team (MDT) meetings**.

2. **Falls including Multi-Factorial Risk Assessment, Community Based Falls Service, Strength and Balance Training, SWAST pathway people who do not need medical attention**

3. **Dementia Navigators/Advisors**
   Consistent model to be used across BNSSG, building upon current resourced posts from Alzheimer's Society and CCG. Subject to separate business case "Dementia Advisors (Post Diagnosis Support)
4. **Care Home Support**
   A bundle of carehome support has ensured a reduced rate of admissions within some localities in BNSSG. A standardisation of support is required across the BNSSG area.

5. **Competency training across BNSSG**. Upskilling our community teams (registered and no-registered nurses) in frailty care with the following topics

6. **A standardised frailty assessment within Primary Care**. Working upon the principles of completing a <TBD: comprehensive geriatric assessment (CGA)> within primary care. Ensuring GPs with specialist interest are equipped to adequately assess patients and that the wider system is able to act upon this information where required. This is to standardise and instigate the gold standard of care in the community and ensure the use of a common frailty indicator.

7. **Carer Support**. Supporting GP practices to support carers. Immediate identification of carers through Primary care offering double appointments, degree of flexibility. £40k for South Glos.

8. **End Of Life** – End of life care co-ordination centre (described under different business case)
9. **Rapid Access Admission Avoidance Clinics**. MDT with rapid access to diagnostics. The same model of care to be provided across BNSSG.

10. **A&E Front door**, Acute Trust based early senior assessment and access to CGA. [ref. A&E DB Streaming workstream] – please see urgent care project for more detail

11. **Acute Frailty Short stay units:** Standardised across BNSSG.

Risks

- Recruitment to specialist physio and nursing posts
- Nursing homes closing due workforce storage
- Nursing and care homes do not engage with the project

Outcomes

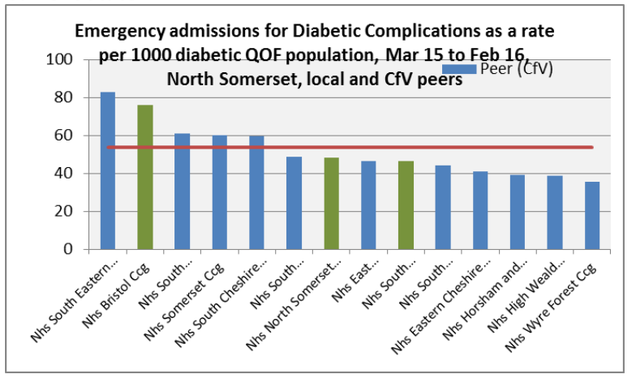
The CCGs recognised this is largely quality driven and the estimation on hospital admissions avoided is conservative. Each one of these directly stated financial benefits is stated within individual CCG business cases, but scope and build up across the BNSSG footprint is required.

Diabetes Programme

Aim

A new efficient model of delivery of diabetes care is proposed; a proactive, integrated, patient-centred service with "barrier-free" working between providers.
The reconfiguration would have an emphasis on delivering as much care as possible in the community setting with the use of care planning and robust, accessible support from specialist expertise.

Current State



The rise in diabetes prevalence between 14/15 and 15/16 across the patch is 4.26%

People with diabetes are also getting older and increasingly have other comorbidities which compound the complexity of caring for these people.

Objectives

- To provide a person with an individualised community diabetes service which is consistent, proven, and effective that optimise both access and sustainability of service.
- Decreased A+E attendances for all diabetes patients
- To decrease the number of lower limb amputations by proactive care planning and early diagnosis and integrated services that meet national and local guidance
- Improved number of patients achieving treatment targets in Hba1c, BP and cholesterol
- An increase in people offered a personalised care/self-management plan which empowers the patient to take an active role within their care.
- Improving the overall quality of diabetes care delivered in primary care
- Reducing variations in the delivery of diabetes care across GP practices
- Up-skilling of practices in delivering diabetes care
- On-going educational support for people, GPs and Practice Nurses
- The start of a reduction in the increase in type 2 diabetes within the lifetime of the programme and the years to come
- Less than 7% growth (current trend) in referrals to Diabetic Medicine (outpatients) by year 5
- Addressing existing health inequalities
- Improved patient and staff experience
- Improved compliance with NICE guidance (as clinically appropriate).
- Reduce the number of acute admissions and early discharge for people with diabetes and other related co morbidities
- Proactively manage patients in community settings when acute exacerbations of a co morbidity impact upon diabetes management.
- Increased uptake of retinal screening

Projects

Prevention

The programme will implement the national diabetes programme.

Primary Care

Reduction of variation in diabetes care across all GP Practices. Continued up-skilling of GPs and PNs with support from secondary care consultants and both secondary care and community DSNs and dietetics. Identification of diabetes complex patients within GP registers and promote the use of virtual wards with diabetes clinical specialists to ensure better patient outcomes.
Seek funding from the diabetes prevention programme and other educational funding available to improve identification and prevention of those patient who are viewed as pre-diabetes
Look into ways of delivering better personal care plans and how these could link into educational courses.
Seek ways of enhancing advice and guidance between GPs and diabetes specialists where needed.
For practices to follow NICE guidelines and improve coding where appropriate and submit data to the NDA on a yearly basis.
For GPs to follow enhanced guidelines on referring diabetes patients with lower limb complications to the podiatry/foot clinic.

Community Care

To increase diabetes care within the community by working with providers. To reduce diabetes care within secondary care. To promote patient diabetes education within the community and tailor education according to the needs of the community. To understand capacity versus demand and ensure patients referred to education are able to attend a course within a reasonable timeframe. To work with Local Authority/Public Health to identify where closer working could promote better ways of self-management and sign post patients appropriately to local services

Foot Care

To improve the current foot care service between primary care and the foot clinic provider. To enhance referral guidelines and up-skill GPs in understanding appropriate referral and where early intense intervention can reduce unnecessary lower limb amputations. To put into place capacity versus demand so that all patients that need an urgent 24hr consultation are seen within the service level agreement

Risks

- The main constraint is a financial one. As CCGs are required to deliver transformation change across the health economy, there is only so much money available within the envelope to deliver wide scale change. Significant investment is required to improve the service with the majority of savings only being realised after five years.
- Given the fact that the 3 CCGs have already introduced diabetes pathways, there may be a reluctance to change those already entrenched due to time and investment already undertaken
- Individual CCGs are not in a financial position to invest in new collaborative diabetes pathways.
- That individual CCGs do not have the resource or capacity to deliver the programme

Outcomes

- Reduced lower limb amputations (Service Specification and improved pathway)
- Enhanced GP and PN Diabetes education
- Increased patient education and uptake of courses
- Increasing diabetes care within the community whilst decreasing secondary care
- Practice review and standardised NICE guidance for yearly patient review
- Reduced number of complications leading to savings across primary, secondary and pharmacy
- Reduced secondary care costs (Surgery and OP)
- Reduced number of referrals to secondary care
- Reduced number of complications leading to savings across the health economy (including primary, secondary and pharmacy)
- Decreased patient treatment costs

BNSSG Respiratory Programme

Aim

The aim of the project is to establish standardised respiratory services across BNSSG that provide consistent, equitable, comprehensive, clinically and cost effective appropriate services for patients with a respiratory condition.

Current State

- Variation in practice
- Gaps in provision
- Discrepancy in estimated prevalence 'v' actual prevalence of COPD
- High emergency admission numbers
- Excess bed day figures
- Benchmarking results (in particular influenza and pneumonia admissions along with respiratory outpatients benchmark high and provide the best opportunity)
- 2016/17 onwards delivery requirements

Objectives

- Agree and implement an integrated approach to both acute and chronic respiratory disease management
- Improved early identification of COPD, self-management and intervention to improve wellbeing of patients with respiratory disease
- Enable multi-disciplinary assessment and treatment, providing seamless care for people with respiratory conditions
- To reduce non-elective admissions and outpatient appointments
- Ensure that for this cohort of patients' admission to hospital is minimised but when it does happen their length of stay is as short as possible
- Improve the patient experience. Maximising a patient's physical and psychological health through lifestyle advice and education on medication, exercise and breathlessness
- To upskill primary care services to ensure potential to support the patient population is maximised
- Ensuring medicines optimisation so the most cost effective therapy is provided at the right time without compromising care whilst reducing admissions e.g. step down programme to reduce pneumonia
- Agree performance measures

Projects

Prevention and Self Care

Education, Self Care, Vaccinations, Smoking cessation

Early Diagnosis

Primary care education, Education course alignment, Spirometry, FEV1 check, Case finding

Ongoing Management

Pulmonary Rehabilitation, Annual reviews, Meds review, O2 therapy, ICS transfer, Inhaler retrieval

Exacerbation Management

Rescue packs, HOT clinics, Pulmonary rehabilitation refresher

Inpatient Management

COPD Bundle, Education, Smoking status recording, Smoking cessation, Meds review, NRT provision, Pulmonary rehabilitation

Early Supported Discharge

Early Supported Discharge, Appropriate follow up, Self Care

Risks

- Inequality in provision of care for patients with respiratory conditions continues
- The number of undiagnosed patients has the potential to increase
- Admission rates continue to increase
- Disease progression rates have the potential to increase.
- This is an incredibly ambitious programme with a significant amount of work to be delivered within the current financial envelope. There are several unknowns and it is therefore very difficult to identify potential costs at this time.
- Variability in stages of progress and services available across BNSSG may hinder momentum of work for individual CCGs.
- Likely shift in activity between providers without processes in place for resource to follow this activity in a timely manner.

Outcomes

- Improved outcomes for patients with respiratory conditions
- Improved patient experience
- Improved prevention and early diagnosis of COPD
- Emphasis of care in the community and self care
- Patients will be consulted and have a better understanding of their condition which will facilitate self-care of their respiratory condition.
- Decreased A+E attendances
- Savings will be derived from the reduction of patients requiring hospital care. Admissions will be avoided and people will spend less time in hospital.
- Savings will be derived from the reduction of inappropriate use of Oxygen

Developing Personality Disorder Pathways for BNSSG with Avon and Wiltshire Partnership

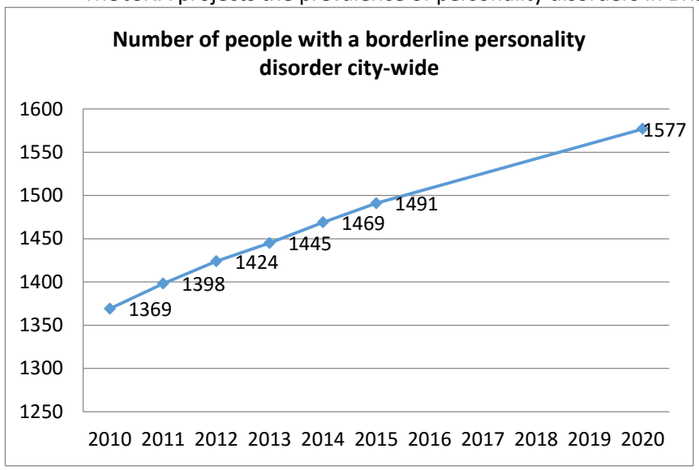
Aim

To scope and develop a personality disorders care pathway for BNSSG as part of the mental health work within the Sustainability and Transformation Plan.

Current State

Cost avoidance

- The JSNA projects the prevalence of personality disorders in Bristol will rise over the coming year as follows:



Source: PANSI; based on the report Adult psychiatric morbidity in England, 2007

In addition to this rising need Avon and Wiltshire Partnership have completed a skill mix review which indicates the caseloads for the Assessment and Recovery service (which currently care co-ordinates people with personality disorders) is operating at 25% above capacity. Whilst these two pieces of evidence are limited to Bristol but in discussion with neighbouring CCGs and AWP, the issues are similar. Unless a prevention focussed pathway is developed to ensure people with personality disorders get timely and effective treatment there will be we can project increased cost pressures on secondary care, crisis services and out of area placements.

Objectives

The aim of this business case is to ensure that across BNSSG people living with a personality disorder are supported to get timely and high quality support to help them stay well.

The objectives are:

- That professionals within the BNSSG System have access to training around personality disorders
- That there are specific interventions available within primary care to avoid people being unnecessarily referred to secondary services or to allow people to be supported to step down from secondary care
- That there is a clear pathway and interventions available within secondary care
- That there is intensive specialist personality disorder interventions available locally so people do not require out of area inpatient support or those who are already out of area can be repatriated.

Risks

- It has not yet been possible to scope the funding requirements of a specialist PD pathway across BNSSG but it is likely this will require an invest to save. Funding is therefore likely to be a constraint
- It is not possible to firmly cost projected savings from a PD pathway
- Developing closer collaborative working across provider and commissioners

Projects

Areas for scoping

The areas to be scoped across BNSSG are as follows. Scoping will include analysis of what is already in place across BNSSG and what needs to be developed:

<u>Training & staff development</u>

- Structured clinical management – supports MH professionals in care co-ordinating people with personality disorder. This will build on work already in place in North Somerset.
- Knowledge and Understanding Framework - training for professionals and non-professionals that explains personality disorders as a condition and identifies techniques for working with people with personality disorders

<u>Enhance primary care support</u>

- Mapping and evaluating and potentially expanding the STEPPS programme across BNSSG
- Consideration of how mental health professionals embedded in primary care could specifically support maintenance of people with PD in primary care

<u>Early intervention</u>

- Scoping a young people's service or early intervention for emerging personality disorders service to support prevention

<u>Secondary care interventions</u>

- Ensuring there is timely access to specialist interventions such as Dialectical Behavioural Therapy (DBT) across BNSSG

<u>Intensive support service to prevent out of area placements</u>

- Scoping an intensive support service that specifically acts as an alternative to or prevention of out of area placements

Once there is clear understanding of current state including patient experience, finance, activity and patient flows, reviewing the evidence base and best practices from other parts of the county we will work up a new service model and then work up the supporting financial model. A decision would then be taken to commission the new service and detailed implementation planning would then lead to a full implementation.

Outcomes

- People with personality disorder have been identified as being 50 times more likely to complete suicide than the general population and therefore an effective local pathway should support a reduction in the suicide rate across BNSSG which will support the five year forward view aspiration for a reduction in suicide rates across the country by 10% compared to 2016/17 rates
- People with personality disorder will be able to be effectively supported within primary care
- Staff across the mental health system will be able to support people with a PD more effectively through increased knowledge, understanding and improved attitudes following KUF training.

Acute Care Collaboration

MSK/T&O

Aim

The brief of the project is to evaluate, develop and implement a revised clinical pathway and service delivery model for MSK services, including acute Trauma and Orthopaedics within BNSSG.

Current State

- Reference Cost Index (RCI) analysis indicates that there are significant excess costs (£13.75m) within T&O in the three acute providers. High elective and non-elective length of stay across all three providers, with 12,730 beds days, or 34 beds opportunity across NBT and UH Bristol between current and upper quartile performance
- £7m Right Care opportunity across BNSSG CCGs
- RTT targets for Orthopaedics have not been sustainably achieved in BNSSG.

Objectives

- Agreement of outcomes which matter to patients
- Agreement of a vision and model for MSK/T&O services across BNSSG
- Ensure that MSK/T&O patients have a positive experience of care
- Improve productivity and efficiency of current service delivery model
- Address issues of sustainability, with a focus on matching capacity to demand across the service

Projects

MSK Clinical Pathways

This project will create a model of MSK care that will integrate and streamline the delivery of services, providing an aligned service for anyone who has an MSK condition. It will enable a greater proportion of patients to self-manage and have their care managed in a community setting. The review will include all MSK services including Core Physio, Enhanced Physio, Podiatry, Orthotics, Orthopaedics, Pain and Rheumatology Services. The first year the project will also seek to deliver some quick wins to reduce demand.

Elective Orthopaedics

This project will focus on the optimal distribution of services across the three acute providers and the independent sector, in order to maximise quality, productivity and efficiency and to realign capacity across the system to meet demand and sustainably deliver improved access for patients.
The project will seek to determine future demand and to develop the required capacity accordingly, in the most appropriate location.

Orthopaedics and Trauma Services
This project will consider how to deliver orthopaedics and trauma services. It will need to consider the interdependencies with other Major trauma services and the extent that it competes for resource with other services i.e. ED, theatres, beds, radiology and staffing.

The project will establish the optimal view of the specific volume and location of the capacity required to deliver the work in this health economy. It will also provide modelling of tariff and pathways that demonstrate a financially viable case mix and will include capacity in terms of theatres, beds and staffing.

Risks

- Failure to deliver RTT constitutional standards
- Poorer clinical outcomes as a consequence of extended waiting times
- Unaffordable clinical model
- Fragmentation of service provision

Outcomes

- Improved sustainability of existing services, including a significantly improved Reference Cost Index across all acute providers.
- Sustainable RTT performance across the providers driven by realignment of capacity, including best use of existing capacity to sustainably balance capacity and demand across the acute providers.
- Increase in proportion of NHS activity delivered in NHS organisations.
- Reduction in use of premium rate sessions to deliver elective activity.
- Sustainable and affordable workforce across all providers – to include a reduction in nursing and medical agency costs, through improved recruitment and retention.
- Reduction in acute Length of Stay across providers.
- Reduction in repatriation delays across the Trauma Network.
- Improvement in performance against fractured NOF Best Practice Tariff across the acute providers.

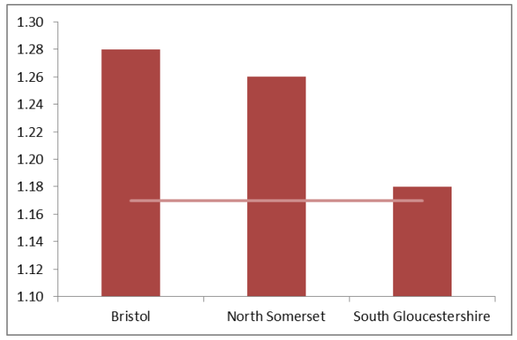
Stroke

Aim

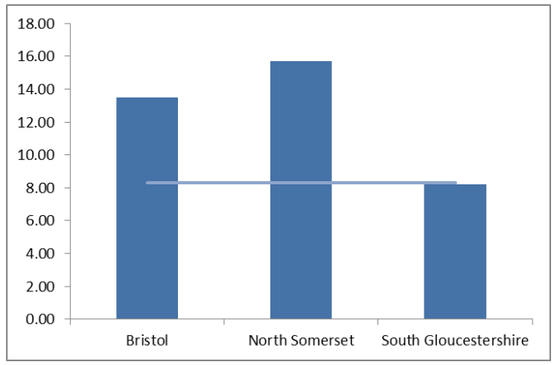
The aim is improve quality, equity and sustainability for stroke care across BNSSG.

Current State

Ranges of benchmarking indicators have identified that Stroke Provision is an outlier when compared to our comparator CCGs. At present there is a plethora of stroke provision across the BNSSG footprint with many services and organisations, including tertiary services that provide stroke care with a variety of different specifications and facilities.



Meeting a benchmark of 75th percentile of similar CCG's might save approx. 30 lives per year.



Meeting a benchmark of 75th percentile of similar CCG's might lead to approx. 100 more patients going home after stroke each year.

Objectives

- Reduce mortality following a stroke
- Reduce the incidence of stroke
- Centralise stroke services
- Improve the quality of care for patients
- Provide an equitable service across the BNSSG footprint
- Ensure a financially sustainable service

Projects

There are three main projects following the patients care journey

Prevention and Primary Care

This project aims to reduce the incidence of stroke by reducing risk factors. The initial focus is to improve detection and treatments for patients with Atrial Fibrillation (AF) and hypertension, and timely attendance at seven day a week Transient Ischaemic Attack (TIA) clinics.

Acute Care

This project aims is to provide an excellent centralised seven day a week acute stroke service in a HASU with step down for those patients who have ongoing acute medical needs to an acute stroke unit(s) (ASU).

The Rehabilitation and Living with Stroke

This project aims consider how to provide out-of-acute hospital rehabilitation for all patients no longer in need of acute hospital care in their own homes or if necessary in bedded community facilities.

Risks

- Finance risk - lack of available data from various sources to inform acute and rehabilitation work streams
- Operational risk - Capacity within programme management and reduced workforce to support projects and admin
- Operational risk - failure in agreement of organisations and adherence to timescales and transfer of bed capacity

Outcomes

Quality

- Reduce mortality following stroke in BNSSG.
- Prevention of stroke leading to a reduction in incidence.
- Patients offered specialist stroke rehabilitation as close to home as possible.
- Reduce long term packages of care and placements.
- Improve care for patients living with stroke.
- Increased evidence of improved performance as measured by SSNAP.
- Conform to national and local drivers and best practice.

Equity

- Provide equitable stroke services across BNSSG.

Sustainability and Finance

- Increased effectiveness, efficiency and economy resulting from centralising stroke services.
- Reduce length of stay in acute hospitals.
- More effective use of scarce specialist workforce.

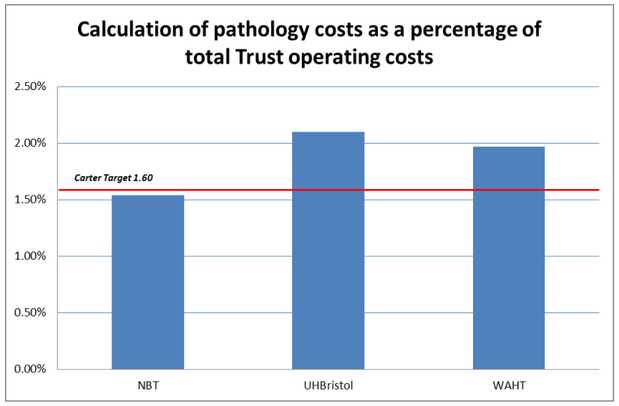
Pathology Programme

Aim

To create a maximally effective pathology service across BNSSG through enhanced networking and support between the three existing providers

Current State

We currently spend more on pathology as a percentage of the total trusts operating costs than the Carter Target at UHB and Weston Area Health Trust.



Objectives

- Ensure pathology services are configured to support delivery of safe and most cost effective clinical pathways
- Minimise cost per test of pathology services
- Maintain quality of pathology results at reduced cost
- Reduce or minimise growth of pathology testing by avoiding non-value add testing
- Drive cost effective clinical pathways through rapid adoption of new pathology testing as the evidence develops
- Ensure Weston has a sustainable pathology service
- Establish BNSSG pathology to enable early adoption of personalised medicine approach as they develop of the Genomic Project and Personalised medicine Strategy

Projects

Cellular Pathology

In May 2016 Cellular Pathology services were centralised at NBT.

Benefits Realisation from LIMS

There is already collaboration underway between providers and a shared LIMS system is currently being deployed. Work is currently underway to ensure this is used effectively across the healthcare system to maximise the benefits.

Transfer PHE to NBT automated bacteriology Lab

From November 2016 PHE bacteriology services will co-locate with NBT bacteriology services at NBT under an agreed collaboration, this will bring all bacteriology from both Bristol and Bath onto a new fully automated system going live early 2017. The remaining PHE services will move to the NBT site from spring 2017

Sustainable model of Weston Histopathology

This will be one element of the Weston Sustainability Model. We will feed in options into the wider Weston Project, in the right timescale to support their programme delivery.

Specialist Testing Review

We will review all the tests currently being sent out of area to identify if any of these could be delivered in BNSSG at a lower cost

Blood Sciences Review

We will consider if there are options for closer collaboration or consolidation of blood sciences services across providers

MES Re-procurement

The MES contract expires and with closer collaboration and consolidations service we will consider what equipment is now needed and what will be needed over the next contract period to deliver services

Demand Management

Reduce inappropriate or no value investigations, ensure repeat testing is correctly timed and promote testing where linked to decision points in care pathways.

Urgent Care Pathways

Develop plan for appropriate support for primary care to maximise care in the community speed urgent pathways

Clinical Service Change

Utilise current and new pathology tests to influence care pathways where reduced overall cost, delayed progression and/or better outcomes can be demonstrated.

Risks

- Individual organisational interest clashes with STP interest preventing maximum benefit being realised
- National storages in specialist staff impact the ability to deliver high quality services
- Excessive reductions in infrastructure reduce resilience resulting in service failure

Outcomes

- Ensure sustainable services with respect to cost and staffing
- Reduce cost per pathology test
- Minimise growth of pathology testing
- Enable access to specialist reporting where appropriate
- Share risks between providers to create resilience and reduce risks of service failure
- Support develop of new care pathways and drive beneficial changes resulting from new pathology testing
- Maintain sufficient resourcing to manage rapid technology change as genomics and personalised medicine develops

Weston Health

Aim

The overall purpose of the North Somerset Programme for Sustainable Services is to redesign and strengthen the Weston and North Somerset health & social care provision models so that they are:

- Fit for the future to meet the changing needs of local patients and communities
- Clinically safe. No proposals will be put forward that clinicians have not agreed are clinically safe and appropriate for the population. Any solution will also need to give assurance that recruitment and retention of the necessary clinical staff is feasible
- Financially sustainable in terms of North Somerset and the wider BNSSG systems, and also for the relevant parts of Somerset

Current State

- Waiting times for urgent and emergency care are not being met and there are high levels of bed occupancy within Weston General Hospital
- Between April-December 2015/2016 there were 27% more patients waiting for community packages to be in place before they could be discharged from Weston General than for the whole of 2013/14. This reflects the high degree of pressure on social care services
- A number of GP practices around the Weston area are under significant pressure
- The Care Quality Commission has highlighted a number of areas for improvement at Weston Area Health NHS Trust, including reducing the numbers of long term locum and agency doctors in certain specialities by ensuring that there are suitable numbers of permanent doctors in post
- A recommendation from the GMC was for the trust to continue to provide effective support, training and supervision to junior doctors. Overnight FY2 A&E doctors been withdrawn
- Both Weston Area Health NHS Trust and North Somerset CCG have recurrent financial deficits and the position is forecast to worsen significantly in a "do nothing" scenario

Objectives

We are currently in the second phase of a 3 phase programme:

- GE Finnamore (health consultancy) was commissioned in early 2016 to complete a review of all the previous assessments of the local system's challenges
- The Programme for Sustainable Services is currently developing a set of options/ proposals based on the Finnamore's work to put to the Sustainability Board. These will be drafted in December
- Once agreed by the Board's/ Governing Bodies of the organisations who make up the Sustainability Board, we will move into a phase of engagement, consultation and implementation

Projects

The purpose of the project is to consider the service configuration options which would allow Weston Area Health Trust to be clinically and financially viable. The process to find a solution is financially driven but clinically led. A Clinical Leadership Group has set up four expert clinical sub-groups to examine the key elements of the system and develop proposals for improving patient care and service pathways. The Expert Clinical sub-groups are made up of senior clinicians/ practitioners from all the service providers who are members of the Sustainability Board. The clinical groups are supported by groups for Analytics, Finance and Communications. Again, these enabling groups are drawn from the membership of the Sustainability Board

A full project for implementation would be developed following public consultation if change is substantial and therefore required In Phase 3 of the Programme. The length of time it takes to complete Phase 3 will depend on the nature and complexity of the changes being proposed. Although this work has its origins in the challenges faced by a single organisation, it is clear that the answer lies in a system solution. We need to make the best use of the vital capacity that the Weston site offers. The live issues that we are currently working on include:

- Leaders in the health and social care system are strongly in of retaining a 24-7 urgent/ emergency care service on the Weston site
- Redirection of elective work to optimise use of the facilities at Weston is likely to be a big part of ensuring the financial viability of the site
- Both University Hospitals Bristol and North Bristol trusts have expressed a commitment to closer working with and at Weston to help deliver the objectives in 1 and 2 above. We also continue to work closely with Taunton & Somerset FT
- Although increased use of Weston elective facilities could be part of the solution, we will still need to take significant costs out of the system to make this programme a success
- Ways to achieve this include reducing delays/pinch points in the patient's journey as they pass from one health or care organisation to another. Another way is to get better at working together to avoid admissions to hospital in the first place, and when patients are admitted help them get home as soon as it is safe to do so
- Clinicians think that a major way to achieve these goals could be closer working between local community, acute and primary care services
- We have included the issue of commissioning sufficient numbers of community hospital beds in our system, given the closure for repairs of part of the Clevedon community hospital site

Risks

- A solution cannot be identified that both balances financially and meets the needs of a relatively geographically isolated population that is growing faster than the national average
- Limited programme management capability and capacity risks the proposals developed by December not being robust enough for engagement and consultation, thereby delaying the timetable for implementation
- Current - There is a risk that appropriate clinical staff cannot be attracted to work at the Weston site, both as part of a long-term solution but also in the meantime as proposals are consulted upon and then implemented
- Proposed - There is a risk that appropriate clinical staff cannot be attracted to work at the Weston site due to uncertainty as proposals are developed and consulted upon.

Outcomes

The Weston/ North Somerset system has been operating under a label of "not sustainable" for a number of years now, with all the attendant instability and uncertainty for staff and patients that this brings with it. There have been a number of previously unsuccessful attempts to reform the health economy over the past few years. The overarching aim of this programme is not to create the perfect system, but instead to remove the label of unsustainably by addressing the structural problems in the current configuration of services, thereby putting the health economy on a level playing field with our peers

- Safe and effective clinical services for the population served by Weston Area Health Trust and the population of North Somerset
- Models of care that are financially suitable and are likely to be able to recruit and retain the necessary clinical staff to deliver them
- Much closer working between acute, primary and community health and care systems – potentially supported by organisational integration as an enabler

Medicine Optimisation

Aim

The aim is to deliver transformational improvement in medicines optimisation in BNSSG. This will deliver cost savings, improve efficiencies, maximise benefits from medicines including cost avoidance, and improve patient outcomes.

Current State

More than £250m pa is spent on medicines in BNSSG; are we really making the most of this investment?
The following information is extracted from national data:

- Do patients take their medicines?
  - Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.
  - Ten days after starting a medicine, almost a third of patients are already non-adherent - of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent.
- How well do we use medicines?
  - A study conducted in care homes found that over two thirds of residents were exposed to one or more medication errors.
  - Over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.
  - In hospitals the General Medical Councils EQUIP study demonstrates a prescribing error rate of almost nine percent.
  - In general practice an estimated 1.7 million serious prescribing errors occurred in the NHS in 2010.
- Is the NHS getting best value from medicines?
  - In primary care in England around £300 million per year of medicines are wasted (this is likely to be a conservative estimate) of which £150 million is avoidable
  - At least 6% of emergency re-admissions are caused by avoidable adverse reactions to medicines
- Are patients getting the right medicines?
  - Analysis of the NHS Atlas of variation highlights unwarranted variations in the prescribing of some medicines across England.

Objectives

The Medicines Optimisation Transformation Programme incorporates a wide range of projects, all of which result in financial and patient benefit. Objectives include:

- Maximisation of biosimilar implementation
- Embedding of e-referral to Community Pharmacy
- Efficiency improvements in high cost drug delivery
- Reduce polypharmacy in care homes
- Implement BNSSG de-prescribing protocols
- Implement centralised dispensing of unlicensed medicines pilot
- Implementation of repeat prescription project
- Improve outcomes from RightCare
- Technology linkage regarding medicines data and information
- Acute service centralisation project efficiencies from Carter
- Centralisation of aseptic dispensing services

Risks

- Risk that the BNSSG Pharmacy services (and clinical colleagues) do not have the capacity or project management support to implement the identified projects.
- Risk that the cost avoidance savings from medicines optimisation (eg improved patient safety, reduced admissions, reduced length of stay) are not recognised as they are not readily measurable.
- Risk that the underlying financial impact of activity increases and the cost of new innovative medicines will mask the direct cost savings available and delivered.

Projects

Biosimilars

To work with medical teams (GI, Rheumatology, Dermatology) and patients to implement the more cost-effective biosimilar pharmaceutical products and manage the transfer to these drugs where clinically appropriate.

E-Referrals

To use available technology to transfer discharge information to community pharmacists to provide follow up care for patients taking complex medicines.

High Cost Drugs

To review the use of the most expensive drugs and ensure they are being used appropriately and consider if improvements could be made.

Polypharmacy (GP guidance & care homes)

To review medicines being taken by the frail elderly, particularly within the care home context, in order to ensure that all medicines are necessary and appropriate.

De-Prescribing

To identify and agree medicines that are considered to have no proven benefit and implement de-prescribing protocols.

Centralised unlicensed medicines dispensing project

To develop a project to manage all unlicensed medicines through a central hospital based service in order to avoid high commercial charges.

Repeat Prescriptions management service pilot

To manage repeat prescription services in order to avoid provision of unnecessary medicines and reduce wastage.

Implementing Right Care to reduce variation

To apply RightCare medicines data on variation to BNSSG to focus on areas for improvement and implement change.

Connecting Care

To develop utilisation of Connecting Care in the context of sharing information and data concerning medicines in order to improve efficiency.

Pharmacy Transformation Plan (Carter)

To implement changes through the acute Trusts' Hospital Pharmacy Transformation Programmes in order to improve service efficiency across BNSSG.

BNSSG aseptic pharmacy services

To plan a BNSSG wide aseptic dispensing services facility to meet strategic STP requirements.

Outcomes

The benefits include the following, (with the assessment in the Carter efficiencies, that for every £1 that is spent on medicines optimisation there is a £5 benefit to the NHS).

- Cost savings; eg Biosimilar implementation results in reduced medicines expenditure; better management of medicines results in reduced wastage
- Cost avoidance; eg Improved medicines optimisation results in reduced readmission rates and reduced length of stay
- Patient harm reduction; eg medicines safety improvements have a direct impact on avoidance of harm and therefore also result in cost avoidance
- Service efficiencies; eg service centralisation in order to focus attention on medicines optimisation

Urgent Care

Aim

To ensure the public get the rapid response to an urgent care need and get to the right service first time.

Current State

The national target is for 95% of people attending ED to be seen within 4 hours, the following table illustrates the current performance for NBT, UH Bristol and WHAT and therefore the need to make change within the BNNSG urgent care system

Trust	April 16	May 16	June 16	July 16	August 16
NBT	77.1%	76.2%	82.2%	80.1%	78.6%
UH Bristol	87.2%	91.7%	89%	89.3%	89.9%
WAHT	76.3%	89.4%	88.1%	84.6%	82%

Objectives

- To ensure the public know where to seek help when they have an urgent need
- To ensure a consistent response regardless of where a patient presents
- To ensure effective assessment and treatment are delivered in a timely way
- To reduce demand on A&E
- To reduce inappropriate presentations at A&E
- To ensure effective use of the whole urgent care system

Projects

Alcohol care teams

The aim of this project is to introduce alcohol care teams in A&E to reduce admissions. Alcohol care teams will be part of multidisciplinary teams which combine clearly defined alcohol pathways with referrals to and from the community, a seven day service with particular focus on Friday, Saturday and Sunday

Urgent Care Pilot

The aim of the project is to establish a primary care led streaming hub and urgent care centre at the front door of the Bristol Royal Infirmary. The evaluation of this pilot will feed into the broader urgent care review.

Urgent Care Project

The aim of the project is to develop a comprehensive understanding of the urgent care system including whole range of providers including 111, pharmacy, GPs, mental health crisis teams, mental health sanctuary/crisis cafes, ambulance service, community optometrists, minor injury units, A&Es, social care duty teams etc. This will include understanding current patient flows, activity, finance and patient experience and the evidence base of what is effective and best practice from other parts of the county. The project will then work with stakeholders to develop the future model of care and ensure consultation with public before making a decision. This will be followed by detailed implementation planning before making the change to the new arrangements. In parallel with the main work programme quick wins will be identified and implemented where it is appropriate to do so.

Risks

- Complexity of a large programme to deliver
- Difficult to get agreement across 3 CCGs and all providers
- Improving urgent care services and informing the public about the changes may create 'provider induced demand' rather than reducing demand on urgent care

Outcomes

- People will be treated in a service that matches the level of acuity for their condition
- Service users and carers will have an improved experience of urgent and emergency care that meets their needs in a more appropriate setting
- Providers will deliver against the 4 hour national target
- The cost of care will be reduced

Appendix B2 Additional Programme Narrative

Prevention, Early Intervention and Self-Care

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

The model is based on four principles:

1. Resource: Ensure that strategic initiatives are costed and adequately resourced
2. Enable: The population and patients need to be enabled to adopt healthy behaviours
3. Align: Alignment of strategies and pathways ensuring consideration of the wider determinants of health
4. Innovate: Finding new and better ways of achieving outcomes through making the best use of available resources (including workforce) and ensure co-production (community involvement in the development of initiatives).

Transformation

We have identified the key decisions necessary to deliver a radical shift towards prevention. These are:

- Self-care and patient activation will be implemented at scale with consistent delivery across our system
- A population health approach will be embedded across pathways (activate the population, carers and health professionals; reduce admissions; increase proactive prevention across the pathway)
- We will enable care settings to be innovative and effective e.g. using digital technology to support self-care
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties)
- In order to achieve the short and medium/long term priorities investment is required for prevention, early intervention and self-care at scale. Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years.

Impact

Our initial priorities are:

- Alcohol harm reduction
- Falls
- Diabetes
- Self-care at scale

These have been chosen because they are evidence based, will improve the health of the target population, have an impact across the system and will reduce hospital admissions. They have been developed based on a life course approach and the need to embed prevention and self-care across the pathway taking into account primary, secondary and tertiary prevention opportunities.

Our priorities are enabled by:

- an established patient-centred Bristol, North Somerset & South Gloucestershire health and care partnership approach
- the development of a new relationship with the public and the delivery of the shift of care from an acute setting to primary and secondary and self-care with a reduced dependency on beds and increased use of health and social care hubs and signposting

- wider definition of workforce to include for example voluntary sector, police, housing, pharmacy; and a non-differentiated workforce across BNSSG with common training and standards.
- digital platforms and technologies such as personal health records, telehealth and app development.

Priority	**Impact**	**Methods to measure impact**
Alcohol - reduce excessive alcohol consumption and associated burden on NHS and Local Authorities (LAs) and wider society	Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs by 2020/21 Reduce the burden on NHS, police and social care services from high volume service users Reduce the impact of parental alcohol misuse on children	Alcohol-related hospital admission (narrow measure): number of admissions (by CCG and LA) Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission (by CCG) For every 3 IBA interventions delivered 1 alcohol-related admission will be avoided[1] Ambulance call-out data
Falls - reduce fractures from repeat falls.	10% reduction in the number of injuries due to falls in people aged 65+ by 2020/21, through improved and more coordinated preventative services	Emergency admissions due to hip fractures in people aged 65+ per 100,000 Patients with fragility fracture and confirmed osteoporosis treated with bone-sparing agent Fracture liaison services can reduce risk of second fracture by up to 50%[2]
Diabetes – prevent cases of Type 2 diabetes and improve management of those with diabetes	Reduce the projected growth in incidence of diabetes Improve support for self-care in people with a diagnosis of diabetes Improve the treatment and care of people with diabetes	Uptake of the NHS Diabetes Prevention programme Incidence of diabetes

[1] Public Health England

[2] Nakayama et al 'Evidence of effectiveness of a fracture liaison service to reduce the re-fracture rate' Osteoporosis International March 2016, Vol 27, Issue 3, pp873-879

Supported self-care at scale	Reduction in emergency admissions of Long Term Conditons (LTC) group with above average risk of admission Develop training for health professionals and population Self care enabled via digital supports	22-32% reduction in emergency admissions of LTC group with above average risk of admission (25%)[3] Patient Activation Measure

Medium and long-term priorities

Our medium and long term priorities for prevention, early intervention and self-care are summarised below. Specific interventions will build upon the implementation of the short term priorities during year 1 and implementation of the medium/long term priorities will begin in year 2. The priorities have been aligned to pathway priorities including those identified within the Integrated Primary and Community Care and Acute Care Collaboration workstreams and with wider determinants of health.

Activity / initiative	**Description**	**Impact**	**Alignment to Drivers of Change**
PATHWAYS			
Healthy lives	Obesity reduction, smoking cessation and continue work on alcohol harm reduction	Reduce related hospital admissions	Consistent pathways A new relationship with the population
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG and build on self-care work already underway*		
Primary prevention - adults	Dementia and stroke prevention	Consistent pathways across BNSSG with prevention integrated across pathway	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on atrial fibrillation and impact on stroke prevention & return on investment*		

[3] BCH/Philips project

Mental health - Children and young people	Provide appropriate support and services focusing on the emotional wellbeing and mental health of children and young people Work with schools, Children's Centres etc.	Consistent pathways across BNSSG with a strong focus on prevention and early intervention prior to any formal diagnosis	Relevant to all 5 drivers
Intervention	*Ensure services reflect need particularly for those sub-threshold in terms of clinical diagnosis.* *Ensure consistent offer across BNSSG and access to appropriately designed prevention and self-care initiative in appropriate settings – base on existing examples of good practice.* *Reduce attendances due to self-harm.*		
Secondary prevention - adults	Secondary prevention: atrial fibrillation, hypertension, hypercholesterolaemia, LTCs (multi-morbidities), cancer prevention via a range of health professionals	Ensure consistent pathways across BNSSG	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on evidence for return on investment for health and social care*		
Ambulatory care	Develop/build on prevention and self-care services	Reduce ED attendances and admissions.	Consistent pathways A shift to digital A new relationship with the population
Intervention	*For example develop/build on self-management for COPD; rapid response teams at home; End of Life Care*		
Sexual health	Focus on contraception and return on investment	Reduce associated costs of less effective contraception	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Increase take up of more effective contraception (LARC)*		

Health protection	Flu programme Antimicrobial resistance and link to self-care	Reduced primary and secondary care attendances	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Focus on potential to reduce:* *GP consultation rates for influenza-like illnesses; A&E attendances for respiratory conditions; Emergency admissions for confirmed influenza* *Impact of health and social care reduced capacity and performance due to staff absence; Antibiotic prescribing for secondary bacterial pneumonia (and resultant risk of a rise in antimicrobial resistance); Outbreaks in acute and community settings requiring special management arrangements; Parental leave to care for ill children; Excess winter mortality, particularly in identified at-risk groups.*		
WIDER DETERMINANTS OF HEALTH			
Reduce harm caused by social isolation	Provide adequate support for the frail elderly and reduce the harm caused by social isolation	Reduce ED attendances and admissions.	Consistent pathways A new relationship with the population
Intervention	*Ensure consistent support and signposting across BNSSG with a focus on evidence for return on investment, building on existing support services and social prescribing*		
Expand prevention activities within NHS providers	Create healthier environments in health and care providers and local employers.	Healthier workforce – positive impact on workforce retention	A new relationship with staff and organisations
Intervention	*Ensure consistent messaging conveyed to the workforce. Include link to enabling those with LTCs to work. Consistent approach to workplace health across BNSSG starting with health and care providers and broadening out to other employers*		

Inequalities	Take a BNSSG approach with a focus on inequalities within BNSSG rather than regional comparisons	Equal access to the right prevention/early intervention/self-care initiative in the right place at the right time	Relevant to all 5 drivers
Intervention	*For example review excess winter deaths and link to inequalities*		

1. Agreement that PEISC stakeholder group is overseen by WoE PH Partnership and that the STP and prevention is a new workstream within this partnership. This will ensure close working and allocation of BNSSG DsPH and PH Consultants as appropriate to STP-related work.

2. As agreed at WoE PH Partnership business cases submitted to the STP/CCG commissioning process are based on the initial priorities as above but MECC and health protection also included in this first tranche:

- Alcohol harm reduction
- Falls
- Diabetes
- Self-care at scale
- Making Every Contact Count
- Health protection (flu vaccination and AMR).

Alongside the above first tranche of business cases from this workstream we have submitted an overarching PEISC covering business case that highlights the need for dedicated funding for prevention in order to deliver not only the immediate priorities but to also deliver the medium/long term priorities and support those cross-cutting pathway focused workstreams currently under review (diabetes, MSK, stroke) and other pathways reviewed going forward as agreed by the Clinical Cabinet and prioritisation forum – dedicated investment is required if the system is to reduce demand on the health and social care system that it cannot support in the future.

Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years. It is proposed that rather than being reliant on individual business cases submission that a resource/fund is identified for prevention to enable delivery of STP prevention, early intervention and self-care priorities and cross-cutting pathway reviews across the three STP workstreams.

Integrated Primary and Community care

IPCC programme has agreed the delivery structure, developed the overarching PID and relevant terms of reference for the proposed programme board and strategy and design group. The programme board has met twice and the steering group has not yet met but the focus has been on testing with key stakeholders the elements of the model and the development of project briefs in support of the overall target impacts previously set out in the June submission.

There has been significant engagement across commissioners and providers to consider at a high level the component parts of the model. This has involved recognising the different starting points across BNSSG in each of the areas, understanding the shared BNSSG blueprint or end point for the model and considering the high level milestones to achieve this. Encouragingly , there has been a very high degree of consensus for each area and a good platform has been developed for moving this forward into project delivery.

There have been the beginnings of greater engagement with mental health colleagues and a testing of where mental health needs to be integrated into the overall model and where it needs to be specifically represented a particular pathway or model.

Given the degree of engagement that has been required to date to develop this consensus, the normal timeline associated with understanding properly the evidence base, engaging with clinicians developing complex transformation and the lack of resources specifically allocated to this work, the following represents the progress to date in developing the impacts further:

- We are unlikely to shift the numbers in this iteration for this element of the model and therefore these remain as high level targets based on high level evidence.
- activity and finance impacts remain group for the whole model but could be disaggregated t if useful with efficiency benefits hanging off the model and specific numbers for avoided admissions etc hanging off the pathways which would enable incorporating any cross over with ACC or prevention (e.g., diabetes pathways)
- we note the email in which the risk rating on IPCC projects was lifted so we are now theoretically aiming at maximum saving
- individual business cases may have better, more accurate costing models to get underneath the 40% reprovision assumption but it is unlikely
- the next stage will be to resource and deliver the required project work to develop the granularity required and in some cases this will take a considerable level of engagement based on the suggested programmes of work.

The key impacts modelled for the IPCC workstream were:

The impacts of the integrated, cluster based teams on:

- Admissions and;
- Outpatients and associated follow-ups for key conditions/patient groups.

This was also tested against national evidence as outlined in background information and to a degree local experience where that existed.

A further potential efficiency impact from new ways of working (including diverting activity away from primary care e.g. social prescribing) on future projected activity was worked up, including:

- Impact on primary care and community care contacts and;
- Community beds efficiency improvements.

The SPA and any other elements of the new IPCC model were considered to be wrapped up in (or enablers to) the above – and therefore no additional impacts were calculated for these.

The acute care collaboration workstream similarly has 40% reprovision which might be regarded as potential investment within IPCC and needs clarifying, attributed to:

- Reductions in bed days (elective and non-elective)
- MH reduction in admissions and LOS

General Practice Sustainability and Transformation Delivery Programme

Sustainable primary care, what is the problem we are trying to fix

Primary care continues to be the foundation on which healthcare has been provided since the inception of the NHS in 1948. We know that high-quality primary and community services is the key that unlocks the potential for preventative, proactive management of patients, reducing the need for acute and bed-based care, and addressing many of the health inequalities that exist across our population. However, there are significant challenges being faced by primary care and General Practice in particular. The growing workload and need to manage increasing numbers of patients with multiple and complex health needs, coupled with the uncertainty of future workforce, means we need to radically rethink the model of General Practice if we are to make it sustainable beyond the current decade.

The current state of play in primary care across BNSSG:

- With practice mergers and the percentage of work needing to move into an out of hospital setting current GP estate is not fit for purpose in many cases and this is causing system wide pressures.
- The biggest issue facing all contractor groups is the availability of the clinical workforce to continue to provide primary care in its current form lending us to consider new models of care.
- We know from feedback from Healthwatch, MPs and patients there are problems getting access to primary care services in some parts of our patch,– this challenge will continue as we have seen the number of patients making contact about waits to see their GP and dentists growing.

Our top five challenges are:

1. Urgent action is needed to tackle significant variations in quality.
2. Challenges including an increasing workload; an expanding population; people living longer and with increased care needs.
3. We need to see significant changes to the numbers, skills and roles in the workforce that are needed across our primary care system.
4. We need to get better at educating our systems about pharmacies and other resources to divert large numbers of patients from GP surgeries and service such as A&E.
5. We recognise the problems facing primary care cannot be solved by silo working and wish to see pharmacy being considered as part of the solution.

We must collectively across the system ensure that our primary care colleagues possess the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our population and we set out within this section our plans to support this more suitable future both in general practice. With the issue of key policy documents such as the 'General Practice Forward View' a burning platform like never before places emphasis on a programme of rapid transformation that drives quality and sustainability.

It is clear that general practices in BNSSG are under strain and are bearing the brunt of pressures to meet increasing and changing health needs. Our vision for general practice is that it operates without borders, and in partnership with the wider health and care system. A patient and their GP will be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This will occur in general practices which are recognised as places in each community, developing community resilience and supporting our citizens to stay as well and as healthy as possible.

We think that new models of general practice can in the main only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations which we are already seeing happen across the SW, with 40 general practices merging with others already over the course of the previous 12 months to create larger and more resilient providers. This really gives rise to us turning our heads and focusing effort into re-energising primary care and GPs in the main to sustaining an area of our system that provides a service for over 80% of our population not simply the most costly 2%..

We have created a BNSSG wide primary care strategy, initially focussing on general practice. This sets a clear direction of travel towards integrated service delivery by local care organisations covering a geographical footprint with small enough teams to retain the GP practices' very personal relationship with patients and a sense of continuity of care, whilst being large enough to assure long term sustainability and capacity to meet the demands of the wider system. We want to see these primary care at scale organisations providing high quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home as well as general medical services. They will be organised in different ways depending on local circumstances but will be based on a defined geographical patch, reflecting natural communities, within which they are responsible for the health and wellbeing of the population. They will be large enough to be organisationally resilient whilst hosting smaller clinical teams at a local level of different specialisms. Local care organisations will work with similar organisations across the BNSSG system to provide a seamless service to patients through defining new community care pathways and sharing a common patient record.

As mentioned above we are currently working across BNSSG to define the GP localities. North Somerset and South Gloustershire CCGs are more advanced in their configurations than Bristol. During October and November Bristol CCG are working with their GP members and Governing body to move this conversation on, the GP localities will be built around the following principles:

1. Based on population health needs, with weighted populations of circa 30-50k;
2. Demarcated geographical footprints;
3. Will provide a platform for delivery of GP Forward View, including seven day access;
4. Will provide a platform for delivery of mental health and integrated community services;
5. Will provide a basis for commissioning of enhanced primary care services.

These footprints will be the basis for the planning and delivery of services, irrespective of who owns or operationally runs a general practice. If a GP practice sits across a border in it will be expected to organise delivery of care according to the needs of the population within that defined geography.

In BNSSG the CCGs, working in collaboration with NHS England South (South West) are supporting a number of initiatives which will deliver a sustained transformation of primary care via the funding a three year programme which facilitates the coming together of various organisations and arm's length bodies to support local areas to sustain general practice not just for tomorrow but for the coming years. New roles in primary care will be critical to its sustainability and this programme of work will focus its efforts on exploring this concept in more detail to build a programme of delivery including community education provider

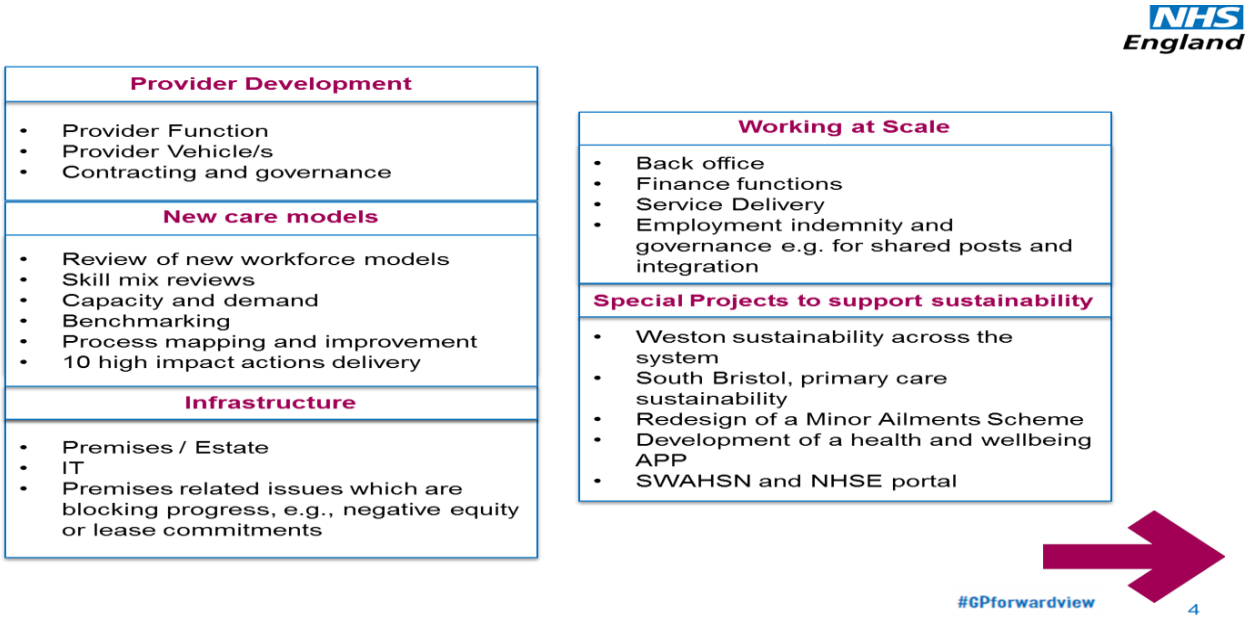
networks. We will also work with providers to explore more efficient ways of working across clinical, management and administrative functions by sharing expertise and resource throughout the SW, which will strengthen the capacity of practices to develop new services out of hospital. We recognise that greater integrated working particularly in primary care could yield significant benefits in terms of efficiency effectiveness and patient outcomes.
The way general practice is organised will need to change; this applies to the standard GP contract timing 0800am-18.30pm and out of hours. This programme will also take a view on organising care and delivery of the GP access fund for 16/17 and 17/18. Already across BNSSG new and innovative access to general practice pilots have been established by One Care Consortium who nationally obtained £9.6m of new monies via the GP Access Fund.

This money has been used over the previous three years to pilot new ways of working including:

- Piloting mental health workers, physiotherapists and pharmacists to develop multi-disciplinary teams to support better patient access to services and GP workload;
- Developing a seven-day access model in primary care across BNSSG;
- Piloting use of web based technology for GP consultations and improving patient access to web based self-help information;
- Improving telephone access through the review of telephony systems;
- Reviewing back office functions and processes to improve practice efficiency.

The GP sustainability and transformation of general practice programme will be responsible for reviewing the evaluations and business cases of the above pilots to understand whether these initiatives are something the system may wish to take a view on continuing or not in the longer term.

The immediate priorities for action and oversight of the GP sustainability and transformation delivery board are:



Temperate check of general practice

Across BNSSG in November commissioners will undertake a 'temperate check' of general practice throughout November, this will also include the bringing together of denoted 'resilience areas' via the national £40 resilience of general practice fund launched as part of the GP Forward View announcements recently. The resilience areas will be brought together to discuss their results from the temperate check, to have proactive discussions and develop a 'resilience and transformation plan for the local area' with go live

on a number of initiatives from December. This will also help inform the programme plan further for the GP sustainability and delivery programme.

The temperate check will collect the following data (per practice) via a web tool:

- Number of appointments available for the week (by professional working at the practice);
- Demand for appointments for the week (by professional working at the practice);
- What the gap is between capacity and demand;
- What happens to the patients when demand is reached;
- How much of the demand (by Health Care Practitioner) could have been delivered by another member of the team or moved to self-care.

Developing System indicators - helping STP's understand what is going on in primary care

- Number of GP practices
- Number of potentially vulnerable GP practices: (looking for downward trend) *
- % GP practices working in a formal collaboration (looking for upward trend) *
- % vulnerable GP practices working towards sustainable solution (looking for upward trend and any that are not named and identified as a key risk)*
- Workforce (from national return) -number (? and %) practices with combined clinical staffing numbers/1000 practice population (think this is probably more useful than no of GP's) below national average (looking for downward trend)*(AHSN)
- Workforce (from national return) % clinical staff >age 55 (potential risk identifier)*(AHSN)
- No and % of practices with CQC requires improvement rating (risk identifier/looking for downward trend)**
- No and % of practices with CQC inadequate rating (risk identifier/looking for downward trend)**
- No and % of practices identified for GPOS review (Risk identifier/Looking for downward trend) **
- No and % of practices >6 GPHLI > 6 outliers (Risk identifier/Looking for downward trend) **
- No and % of practices with application for list closure in last 6 months (Risk identifier/Looking for downward trend)**
- No and % of practices with QOF score<80% (Risk identifier/Looking for downward trend) *
- No and % GP practices with referral rate increasing by (?) >5% (System outcome indicator/Looking for downward trend)***
- No and % GP practices with referral rate reducing by (?) >5% (System outcome indicator/Looking for downward trend)***
- No and % GP practices with unplanned admission rate increasing by (?) >5% (System outcome indicator/Looking for downward trend)***
- No and % GP practices with unplanned admission rate reducing by (?) >5% (System outcome indicator/Looking for downward trend)***

Source of data: * - PMO ** - NHSE Primary Care contracting team *** - CCG/STP

13

Estates and technology transformation funding (ETTP)

In 2015 NHS England released details of a 'Primary Care Infrastructure Fund' which is a four year £1billion investment programme to accelerate improvements in GP premises and infrastructure like Information Technology. CCGs in BNSSG are currently in the process of finishing their 'strategic estates plans' to inform the release of monies attached to any strategic priorities identified. This is creating opportunities for collaborative work between providers and local communities to identify the best way of utilising/developing existing infrastructure.

Technology

- Technology is a key enabler for delivery of a transformed and sustained primary care and currently we are not doing enough to really bring the NHS into the modern era via use of modern methods of technology.
- There is a BNSSG Digital Road Map and IT strategy for BSG and NS CCGs. These need to be aligned to this piece of work to ensure focus is in the agreed areas to enable achievement of key priorities.
- The ETTP process is a potential source of funding, that could fund some of the areas to move at pace, however although CCGs will work together with Avon IM&T Consortium to put bids forward that are a priority to the system, there is no guarantee that bids will be successful .
- Summary Care Record (SCR) is in the process of roll out to community pharmacy its introduction will be of particular benefit to the South West where there is a high population of visitors and this introduction will support greater safety in the delivery of emergency supplies and in general dispensing. It is recognised however to realise our ambition of fully integrating community pharmacy with practices read write access to patient records will be necessary and all of this looks set to support General Practice sustainability.

Estates

How we will improve General Practice Infrastructure in 2016/17

- Premises play an important role in the delivery of healthcare historically, GP premises have not been developed at the same pace as modern General Practice and Primary Care. Some premises are barely fit for purpose, lacking facilities for disabled patients, have no additional capacity or are poorly located.
- Where development has occurred much of it has been excellent-however, there has not been enough development, and the growth in demand means that the developments don't have the necessary capacity to deal with the increased number of patients and additional service requirements.
- GP premises could be ideally placed within their communities to develop as hubs, coordinating care across health and social provision. The identification of the needs of the community should drive the development of premises within the broader locality setting, rather than the responsibility resting with contractors alone.
- If premises were located on the basis of population need and were centres for wellbeing, they could contribute significantly to addressing the inequalities in health outcome however due to lack of land and lack of capital and revenue costs we are constrained slightly by what the future could look like for delivery of out of hospital care in BNSSG.
- We are also aware of low occupancy rates of some existing buildings with potentially high patient access in community pharmacy that could further support the wider system in its estate utilisation and ongoing estate issues.

What the programme aims to deliver

1. Baseline capacity, demand audit of all BNSSG practices
2. A resilience plan for each area
3. A training needs analysis to support delivery of a new workforce model across primary care supported by partners Health Education England (HEE), Wessex Academic Health Science Network (WAHSN) and South West Academic Health Science Network
4. Test different organisational forms across the spectrum from informal collaborations through to formalised new business models
5. Testing of new models of care and services configurations
6. Create a more sustainable and resilient primary care through eradication of contractual silos especially across Pharmacy and General Practice
7. Development and testing of new roles in Primary Care
8. A range of case studies which can support delivery in other areas of the SW

9. Roll out across general practice of the 10 high impact actions.

With the above in mind the general practice sustainability and transformation delivery programme will discuss and formulate answers too:

- How we will reduce variations in quality.
- How we will make significant changes to the numbers, skills and roles in the workforce that are needed across our primary care system working with partners such as HEE and AHSNs.
- Education of patients – how we do this better to divert large numbers of patients from GP surgeries.
- Provider Development – how we work with providers to explore more efficient ways of working across clinical, management and administrative functions by sharing expertise and resource throughout the network, which will strengthen the capacity of practices to develop new services out of hospital.
- Where areas in the UK have explored and adopted social prescribing to support a reduction in demand on GP appointments – (in Rotherham for example 21% of A&E and use of GP appointments reduced by introducing a social prescriber to the PC team.
- To explore and develop the idea of care coordination in primary care.

Provider voice – moving to one provider "voice" to represent for General Practice providers across BNSSG was established in the summer of 2016 with One Care being asked by all member practices to act as its provider voice at the BNSSG systems leaders group.

Acute Care Collaboration (ACC)

The STP foot print has agreed a series of principles as part of our model of care, which is about the acute care system and not individual providers. These principles were outlined in the 30th June checkpoint submission and can be summarised as follows;

A collaborative provider model, supported by a single commissioning approach.

- Eliminate variation from best practice for both quality and efficiency
- Provide services locally where possible, centralised where necessary making best use of available estate and workforce
- Work together across care pathways so that patients receive right care first time in the most appropriate setting
- Support primary and community care with a consistent offer from all Trusts
- Improve patient care across pathways by improving speed and quality of information sharing

Reducing utilisation of acute hospital bed base

- Ambulatory care maximised (all Ambulatory Care Sensitive conditions to be reviewed and harmonised across Acute Trusts)
- Hospitals including paediatric and acute mental health have bed occupancy that allows efficient flow of patients
- Best practice in whole hospital flow embedded to include optimal theatre utilisation, avoiding cancellation and flow from acute hospital to mental health settings
- Immediate discharge or transfer when acute hospital based care (including mental health) is no longer required
- Lean outpatient work delivered in a place that patients want which avoids waste and supports community based care

Using our acute hospital resources to support the wider health and care system.

- Sharing the acute and mental health hospital facilities, physical assets, clinical skills and staff to support patients to stay out of hospital when possible.
- Utilising our scale to provide resilience to the health and care system including infrastructure, shared corporate services and workforce development.

Building on Principles to Establish New Ways of Working

Notable progress has been made in developing the outline principles above into the consideration of new ways of working. University Hospitals Bristol, North Bristol Trust and Weston Area Health Trust have agreed that working together to improve services and pathways for patients is a primary aim of the STP ACC workstream. We want to ensure we deliver the most effective and efficient configuration of services for patients, by collectively using the resources at our disposal.

BNSSG has already delivered a very ambitious change plan over the period 2005-15 which saw major service transformation, including the transfer of services between UH Bristol and NBT to consolidate services in the right place together with a new PFI at Southmead and a new Community hospital in South Bristol. We have delivered big change to the benefit of patients and commissioners on a wide range of services such as trauma outcomes, children's services, the vascular network model, urology, breast, ENT, head & neck and pathology. They were well

considered/planned and executed changes which also make us fit for the new NHS England South specialised commissioning proposals around Major Trauma Centres and Cancer alliances.

Therefore, the BNSSG system has a strong track record of working together to achieve significant change and - through the Sustainability Transformation Planning process - we intend to develop closer working at a range of different levels, such as specialties, clinical support services and corporate support services

We want to build on this track record of success through continuing to develop our ways of working together. In practice this means there needs to be a consistent emphasis on those working within the acute sector thinking and working on a system basis, to design service configurations that meet the needs of local populations in an equitable, high quality and efficient way. This will importantly include clinical teams joining up to deliver pathways of care, irrespective of location or organisation.
This could lead to more standardisation across three or more sites, or it could be differentiated/ graduated between sites as circumstances require. In some cases we may supplement this model by agreeing joint appointments and changes to referral flows and case mix. We would also like in some cases to see these new networks extend into primary and community care; for example in respiratory, diabetes and cardiology.
We do not want to see services constrained by the buildings that they have historically been delivered in. Naturally we will engage and consult with all staff to ensure that this work is done in an appropriate and constructive way.
We believe that services should be driven by what makes sense clinically, rather than by what has grown up historically. We want form to be shaped by function, rather than the other way round. We understand that we may have to consider changing or challenging some payment approaches and funding flows to support delivery of a model that makes best clinical sense rather than allow this to be a major constraint to change. Consideration will be given to alternative models of joint working and learning will be sought from the 13 Acute Care Collaboration Vanguards who are at various stages of developing and implementing alternative models of working.

It is acknowledged that Acute Care Collaboration Vanguards are designed to spread excellence in hospital services and management across multiple geographies and that some of these approaches could present significant benefits and opportunities for the acute sector within BNSSG.

It is understood that three of the key approached being taken within the Vanguards are;

1. Excellently-performing individual NHS hospitals able to form NHS Foundation Groups to raise standards across a chain of hospitals (a model of hospital ‘chains’).

2. Individual clinical services at local District General Hospitals being run on site by specialists from regional centers of excellence, where a smaller trust draws in expertise from larger and surrounding trusts through a mixture of both networking and franchises.

3. Forming ‘accountable clinical networks’ integrating care across District General Hospitals and teaching hospitals for key services, including cancer and mental health.

It is acknowledged that these are just three of the approaches being explored nationally and the BNSSG leadership will develop learning from the Acute Care Collaboration vanguards to develop new arrangements between hospitals for staff, services and resources to improve the quality of care provided to patients, the clinical viability of smaller hospitals, and the productivity of each participating hospital.

Transformational Change - Themes to projects

The BNSSG acute sector transformation plan has four major work streams:

- Best use of hospital capacity
- Effective clinical pathways
- Specialist services and networks
- Sustainable services at Weston General Hospital

Emphasis is now being placed on building on the actions outlined in the previous submission, to develop these themes into specific and deliverable projects. Each project has been selected as a priority based on the scale of opportunity and potential to impact on reducing our known gaps in Care and Quality, Finance and Efficiency and Health and Wellbeing.

It is well understood that the acute care asset base in BNSSG is expensive, with city centre estates and state of the art modern hospital facilities contributing to a higher cost base. Improved productivity is therefore a key focus of the developing projects, with specific emphasis placed on the need to maximise the use of acute facilities through improved productivity at all levels, reducing costs, duplication and variation where possible and potentially reconfiguring or redistributing services between the three acute providers, using the principles outlined above, if this provides greater opportunity for services to develop and thrive. The new and developing ways of collaborative working are providing a new framework in which models for the provision of services in BNSSG can develop with the common and shared agenda of improving pathways for our patients.

Common principles for acute care services have been agreed and are jointly owned by the system. The approach taken in developing these principles and themes into action is to start by establishing a smaller number of high impact projects to both realised ‘quick wins’ in closing the gaps, but also to establish and build confidence in new ways of working and collaborating as a system.

The phase one priority projects identified are;

1. Stroke pathways
2. Trauma and Orthopaedic and Musculoskeletal services
3. Pathology consolidation
4. Medicines optimisation
5. Corporate services consolidation
6. Weston sustainability

It is recognised that the following five areas are also clear priorities within BNSSG. There is significant work and energy across the system already focussed on improving services in these areas, however, the role of the STP and Acute Care Collaboration work stream will be to harness this existing energy to provide a point of focus to maximise the benefits afforded by a whole system view and to provide joint leadership where required.

1. Mental Health – Personality Disorders
2. Acute mental health beds and out of area placements
3. Developing Specialised Services and Networks
4. Urgent and Emergency Care – Including Urgent Care Network
5. Cancer – Development of Cancer Alliances

Projects are also developing within the workstream in the following areas and will be scoped and implemented using the same common principles as the phase one projects;

1. Cardiology
2. Neonatal Intensive Care
3. Interventional Radiology
4. Optimising outpatients

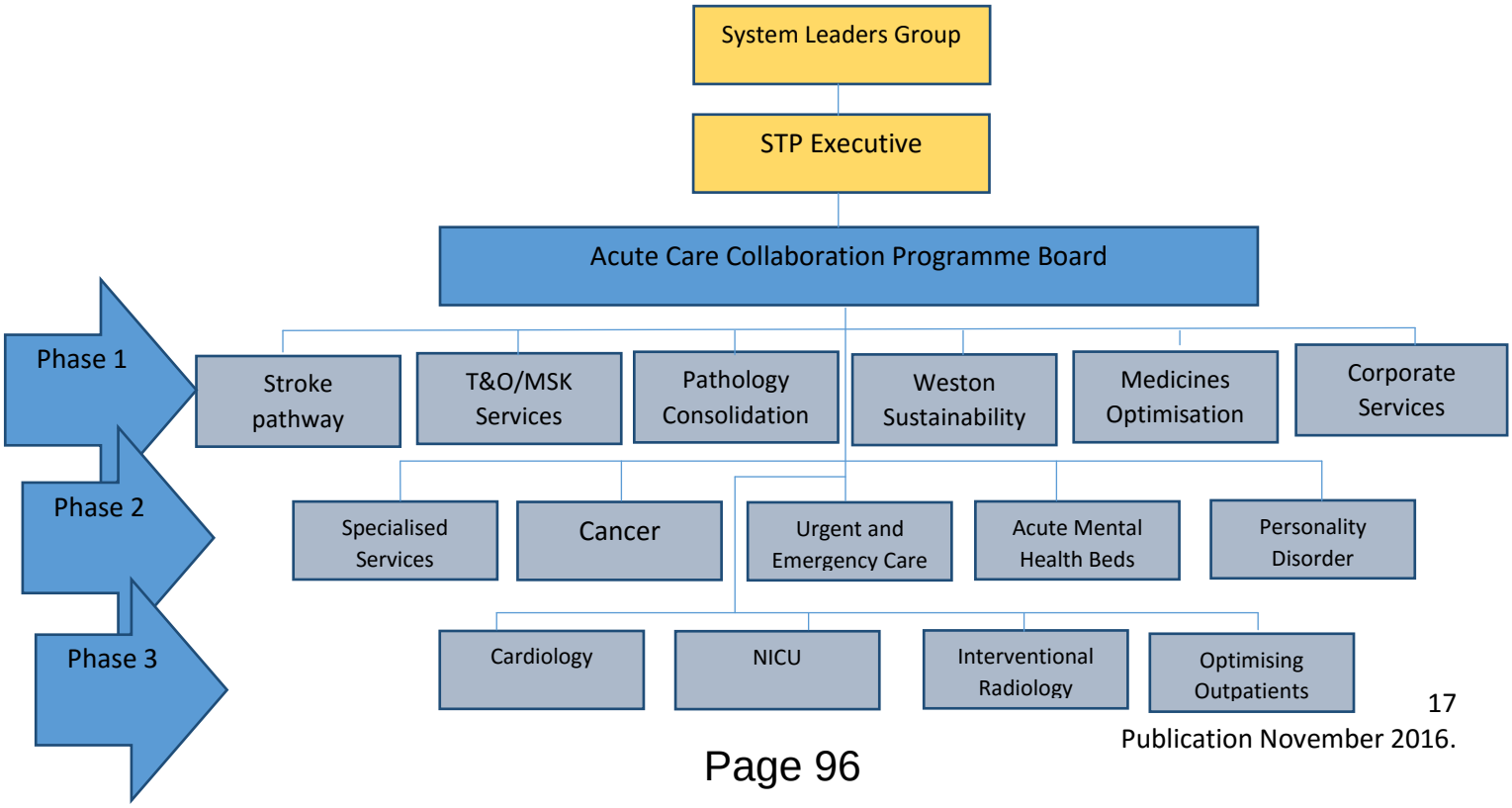
In addition, there are a number of projects developing in the other two STP model of care workstreams which are key enablers to improving utilisation within the acute sector and importantly to ensuring that only the patients who require treatment in an acute setting are in hospital. These projects include specialty pathway work in respiratory, diabetes and the frail elderly, as well as reducing delayed transfers of care, primary care sustainability and self-care initiatives. The role of digital will also be fundamental to realising innovations in the acute sector, with UH Bristol recently being identified as a National Digital Exemplar presenting further opportunity to maximise the benefit over the next five year period.

Acute Care Collaboration – Governance, Delivery and Impact

There has been a clear focus on the rapid development of the phase one projects outlined above. These are all now at the stage of having produced a project initiation document, or outline business case, outlining the high level milestones and delivery plans, including how each of these projects contribute to the overall planned impacts on the systems. Leadership teams have been established and project teams are being mobilised, ensuring plans for stakeholder engagement as required.

The Acute Care Collaboration work stream project structure is outlined below, with multidisciplinary, senior membership from across the system holding to account the delivery of each of the projects.

STP Acute Care Collaboration – Proposed Structure



The table below outlines the proposed membership and required roles within the ACC programme and each of the constituent project groups.

It is proposed that each of these roles hold clear accountability and responsibilities and that each of the key roles for delivery are appointed to, or allocated as dedicated roles. This would include Programme and Project management roles (recommended at least 0.5-1wte for the ACC programme manager role and 0.5 wte for each of the projects, with supporting administration, depending on scale of project). These may come from existing roles from within the organisations in the system, or through realigning those already engaged in delivering work in these areas. It is recommended however, that by allocating specific roles, there will be the capacity to deliver the scale of change required and post holders will be clear on the requirements of the role and accountability for delivery.

Consideration needs to be given to BI, finance, communications and workforce capacity to undertake roles and clinical time may need to be freed up through allocating Pas to dedicate to specific stages of the projects.

ACC Programme Board Membership

- Chair – SRO
- Programme Manager
- Administration
- Medical Directors – All Acute
- Directors of Strategy – All Acute
- Leads/SROs for each project
- Finance Lead
- Estate Lead
- Digital Lead
- Workforce Lead
- Commissioning Lead (CCG)
- Specialised Commissioning Lead
- Community Care Lead
- Mental Health Lead
- Communications Lead
- Local Authority Lead

Project Groups (minimum)

- Chair – SRO
- Project Manager
- Administration
- Clinical Leads
- Operational/Business Leads
- Finance Lead
- BI Lead
- Estate link (as required)
- Digital link (as required)
- Workforce link(as required)
- Communications link
- Representation from key stakeholders, to include Commissioning, Acute, Community Care, Mental Health, Authority as required.

Specialised Services STP Plans

More than 30% of the capacity of acute hospital Trusts in Bristol is occupied with specialist commissioned services which support care for a large regional population. Most specialist services in Bristol are delivered by a single provider working at scale. The specialist capacity needs protection so that it is available for delivering urgent and complex care beyond the STP foot print boundaries. This requires effective networks supported by specialist commissioners that ensure rapid repatriation of patients to local settings and rehabilitation pathways of sufficient capacity to avoid delays.

The key actions within the STP plans, which may have a consequence for specialised commissioned pathways are as follows:

- Support commissioner led review of specialist rehabilitation pathways focussed on neurosurgery, trauma, vascular and stroke patients (largely NBT based).
- Support continued development of the Operational Delivery Networks and a Cancer Alliance hosted by the acute Trusts to enhance their ability to deliver effective pathways.
- Review clinical leadership and management oversight for the level 3 neonatal units (NICU) in Bristol so that they meet the required designation standards within available resources.
- Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services with a new provider partnership model including third sector members.
- Review the capacity, demand and cost profile of Trauma and Orthopaedic services to manage the increasing demand in a system that already has a back log of work and high reference costs
- Develop stroke pathways that provide the highest quality care in the hyper-acute setting and rapid discharge to an out of hospital rehabilitation environment at the earliest opportunity
- Address the poor outcomes of diabetic care that result in increased amputation rates and other complications
- Maximise care in the community for patients with respiratory disease with pathways that reduce the seasonal increase in admissions in the winter
- Address the high cost and variation in hospital length of stay in cardiology
- Work with Mental Health providers, acute Trusts, community and primary care to make most appropriate use of acute mental health bed capacity and ensure patients receive physical and mental health care rapidly in the most appropriate setting, aiming for care close to home whenever appropriate, avoiding out of area placements.
- 10% reduction in patients treated out of area (specifically at London Trusts at a higher MFF) on specialised pathways.

UH Bristol Potential Plans (Not covered above)

- **Clinical Genetics** – discussions with Taunton and Somerset NHS Foundation Trust regarding transfer of Clinical Genetics activity to UH Bristol.
- **Genomics** – Potential future changes to commissioning following 2 year project.
- **Paediatric Emergency activity** – significantly high recent growth levels.
- **Adult oncology and haematology** – significantly high recent growth levels.
- **Neonatal Surgery** – National review to be conducted, may impact on other units ability to deliver activity if standards not met, resulting in increased flow of activity to UH Bristol.
- **Thyroid surgery** – Potential redistribution of activity between NBT and UH Bristol (Head and Neck activity).
- **HPB surgery** – Potential transfer of RUH patients currently going to Basingstoke for surgery, to UH Bristol.

- **Congenital Heart Disease** – Impact of recent designation exercise. May see impact of increased flows from other providers.
- **PICU** – Associated impact of any increase in CHD activity, but also potential growth to meet current standards, not associated with CHD.
- **SRT** – Delivery of impacts of recent tender.
- **Intestinal Failure** – Tender.
- **Complex Cancer Surgery –** Thoracic, HPB, OG, Colorectal, H&N, Gynae. Need to understand potential changes in demand and patient flows across region associated with Specialised Commissioning STP briefing.

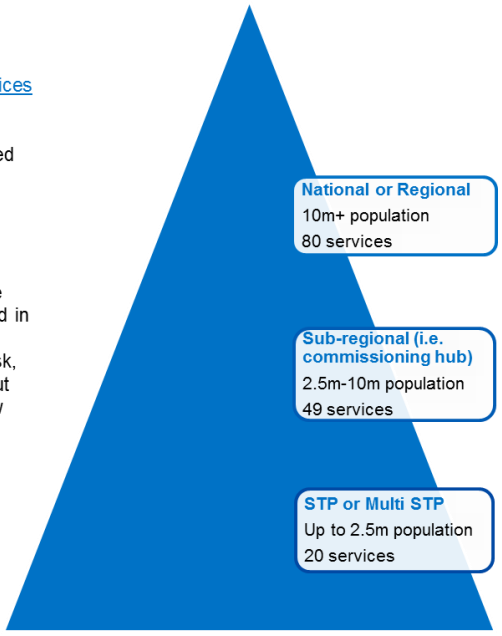
Appendix C – Specialised Commissioning

South of England – Specialised Commissioning and STP's:

Next Steps following Triangulation events

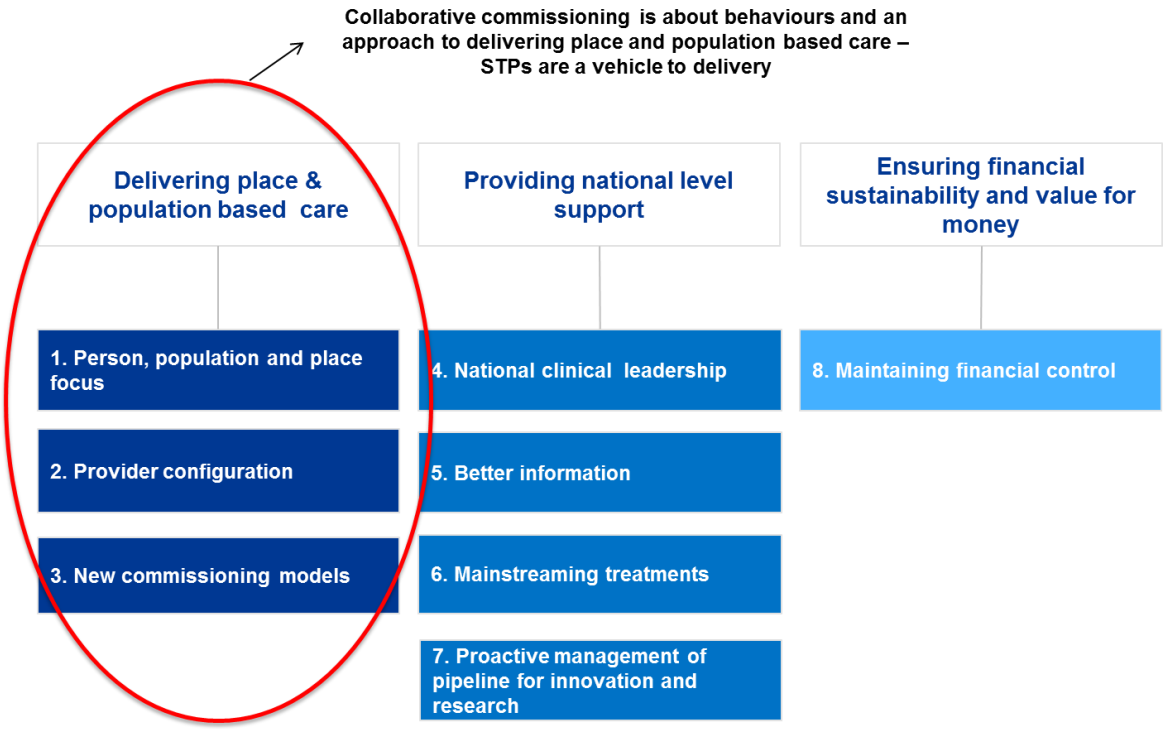
Background: For specialised services, appropriate commissioning levels might vary

- To support the move to place and population-based approaches for specialised commissioning we have differentiated the 149 specialised services by population footprint. This can be found in the Specialised Services Commissioning Intentions for 17/18-18/19.
- This exercise has suggested which services could be planned and delivered at the:
  - National/regional level
  - Sub-regional/collaborative hub level
  - STP or Multi STP footprint level*
- All four regions were engaged in this exercise to determine the appropriate segmentation into the commissioning levels. The North region was involved in the original national exercise. This involved use of a segmentation tool to classify, based around five factors (patient numbers, provision, financial risk, service specifications and strategy. The other three regions then carried out their own exercises independently and used these to collaboratively review the national exercise. Programme of Care Boards were also invited to comment on the initial list.
- The focus of the collaborative commissioning programme is on supporting STPs and Regional Teams to adopt population based approaches for the commissioning of specialised services.
- There is an exercise still to be done to develop a policy position as to the commissioning models on the place-based spectrum that would be appropriate for individual specialised services regardless of which commissioning level they sit within – particularly in relation to full devolution. We are working closely with the devolution programme on this and the development of the policy framework.



*For the purpose of this exercise we have not explored services which could be planned and delivered on a CCG footprint level.

Strategic Framework for specialised commissioning centred around place-based care



Four options being developed to support the move to place-based commissioning

Below is the spectrum of options available within the current legislative framework to support a move to placed-based commissioning of specialised services.

National Service Specifications will still apply regardless of which model of place-based commissioning is pursued.

We expect all STPs to have a 'seat at the table' by 2017/18

By 2020 we expect all STPs to take on greater responsibility for relevant services

Spectrum of place-based commissioning

Model 1 - 'Seat at the table'
- No legal change, or material organisational impact across the parties involved
- Decisions about a function are taken by the function holder but with input from another body
- Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)

Model 2 – Joint arrangements
- Two or more bodies with separate functions that come together to make decisions together (e.g. S.75 partnership arrangements)
- Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)

Model 3 – Delegation
- Exercise of the function is delegated to another body (or bodies)
- Decision-making and budget rest with the delegate(s)
- Ultimate accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)

Model 4 – Devolution
- Function transferred to another legal body on a permanent basis (meaning responsibility, liability, decision-making, budgets and everything else) by a transfer instrument under the Cities and Local Government Devolution Act provisions.
- Accountability and responsibility for those functions transfers to the new 'owner' (including budgetary responsibility and funding for overspends) who will be accountable to the relevant national body for the function in question

STP's and Specialised Commissioning in the South of England.

Specialised Commissioning (South) Delivery Director is now a part of the STP

NHS England recently held 7 triangulation events across the South of England (Exeter, Bristol, Oxford, Southampton, Brighton and London), including one for all Mental Health Trusts. These events highlighted:

- Areas of alignment between STP planning and that of Specialised Commissioning
- Areas where further work will be required in order to coordinate pathways across different STP footprints and NHS England regional boundaries
- Areas where alignment of commissioning within STP's brings about opportunities to improve planning, contract and transformational delivery.

The Vision for Specialised Services in the STP:
Through collaborative work within and across STPs to develop plans to commission high quality, evidence based, patient focused and efficient models of care to enable the delivery of high performing specialised services. **This supports:**

The STP Ambition:
Equity and excellence to the provision of specialised care through patient-centred, outcome based commissioning processes. This requires coordination between provider organisations to ensure that care is delivered in specialist departments where necessary with local repatriation where possible. **Which will be:**

Based on clear principles:
- High quality care
- Focus on outcomes
- Planning 'footprints' determined by evidence base
- Minimise pathway variation within & between providers
- Eradication of occasional practice
- Network solutions to address access and
- Optimise use of existing infrastructure
- Strong clinical leadership
- Multidisciplinary design
- PPV engagement.

To support our:

Proposal:
Through collaborative work within STPs to develop plans to commission high quality, evidence based, patient **focused** and efficient models of care – enabling the delivery of high performing specialised services grounded in:
- Catchments
- Consolidation
- Clustering
- Compliance

To address ….

The challenges we recognise:
The STP must
- Address variation
- Resolve derogations
- consolidate provision where required
- The current state is inefficient (Carter) and not sustainable
- Specialised Commissioning within and across STPs needs to deliver an ambitious QIPP to support financial recovery
- Service fragility and fragmentation must be addressed where required
- Services must be compliant with specifications and deliver the best outcomes
- Change will result in better training opportunities
- We must plan for the future and drive required changes collaboratively

Finance and QIPP Delivery

NHS England Specialised Commissioning (South) has calculated financial allocations based on the utilisation of Specialised Services by the STP (constituent CCGs) population. These allocation will contribute to the STP control total

The do nothing scenario for Specialised Commissioning within the STP sets out the financial impact of assumed growth based on national indicators for population growth for the CCGs in the STP

In order to close the gap (to break even) and deliver against its element of the financial gap Specialised Commissioning is planning for both Transactional and Transformational QIPP which will be cumulative over the duration of the STP

- Transactional QIPP will include areas that have historically delivered savings for example High Cost Drugs and Devices
- Transformational QIPP will include areas covered in the draft document attached and are intended to come into effect mid-way through 2017/18 (part year effect assumed as 1.5%)

QIPP has been set at c3% for all providers across the STP and for the duration of the plan. This is split down as follows:

- Transactional – For year one, this will be 1.5% inclusive of c1% for High Cost Drugs and Devices – leaving a balance of 0.5% to be delivered via other transactional means . In future years, we would anticipate transactional QIPP at no more than 1%.
- Transformational – For year one this will be 1.5%, increasing over time

The split is even across providers at the moment but Transformational schemes may have a greater impact on certain services and this will be reflected in reporting during the course of delivery of the STP The split is even across providers at the moment but Transformational schemes may have a greater impact on certain services and this will be reflected in reporting during the course of delivery of the STP

Transformational QIPP Scheme Development

- **Referral Support pathways for surgical pathways**
- **Health Coaching prevention in cardiology**
- **Spread use of GS1 and PEPPOL standards for HCD's and devices**
- **Medicines optimisation**
- **Enhanced supportive care for cancer pathways**

Specialised Commissioning Key Lines of Enquiry

✔Does the plan provide evidence that they are looking to take more responsibility/decision making for the planning and commissioning of specialised services?

✔Have they indicated a plan to pool budgets for specialised services, and have they considered risk/gain share as part of the solution?

✔Does the plan for specialised services focus on the clinical priority areas OR Does the plan for Cancer/Mental Health/Learning Disabilities include specialised services as part of the solution?

✔Does the plan have realistic/credible financial assumptions for specialised services (that are whole pathway inclusive, realistically deliverable, and include robust financial impact assessment) in the context of regional plans?

✔Does the plan provide sufficient assurance around how they have/will engage patients and the public on decisions that will have an impact on specialised services?

STPs: BNSSG and Somerset

Appendix D – Mental Health

Mental Health - Parity

"In the context of primary and community services, as in others, 'parity' between mental and physical healthcare is best achieved through integrated delivery. This will require a change in resourcing and skills to ensure that physical and mental health needs of patients are addressed fully and together.

Integrated delivery will be achieved in the following ways:

- We will include mental health professionals in the locally-based multi-disciplinary teams at 'GP cluster' level. As we improve productivity through technology and adjust skill mix towards non-medical health professionals (nurses and therapists, mental health nurses, pharmacists), we will create efficiencies. These resources will be redeployed to increase mental health capacity

- All staff within multi-disciplinary teams will have skills to provide psychologically informed interventions and signposting to community and voluntary sector support. Some will additionally provide talking therapies, counselling and social prescribing to address mental health issues, including depression and anxiety. These steps will improve mental health and wellbeing directly, will improve physical health through increased resilience and through better compliance with lifestyle advice and treatment regimes, and will reduce GP, outpatient and ED attendance.

- Mental Health professionals will provide training, advice and guidance to colleagues, in particular healthcare assistants and assistant practitioners, who will develop skills to recognise where mental health support is needed and skills to address the needs of individuals with co-morbid mental and physical health problems.

- The Integrated Health and Care Single Point of Access, (which will provide complex case co-ordination to avoid admissions and facilitate discharges), will include mental health professionals. The mental health and wellbeing needs of patients who present at ED, who are at risk of admission, or who require specific support on discharge will be met in an integrated, timely way.

- Urgent care services for admission avoidance – Rapid Response teams– will also include mental health support.

- Co-ordinated induction and training for all staff in BNSSG will ensure a psychologically minded workforce with core skills to promote mental wellbeing, and staff who recognize their role in prevention and facilitating people to care for themselves."

Appendix E - Engagement & Communications

Updated public narrative

The earlier public narrative has been updated and expanded to accompany the October checkpoint.

The focus of this is on:

- The case for change - rising demand for services at time of ongoing resource constraint leading to a requirement for significant changes in the way we plan, organise and provide services in order to continue meet the health needs of our local population. The STP as an opportunity to work together including with local people and with our workforce in order to develop a shared understanding of the challenges and to agree joint plans for meeting these
- An explanation of the three core and interdependent themes within the STP and the emerging details of the scale and scope of these

Audiences

For the June checkpoint we outlined three broad target audiences groups and how we would engage with them pre and post the 30 June.

- Internal: defined as: all 15 partner organisations involved in the BNSSSG STP
- Stakeholders: defined as: all local groups, organisations, scrutiny panels, boards
- The Public: defined as: service users, local population, general public

As STP plans develop we are now evolving these conversations and taking a more targeting approach to engagement to ensure we establish a two way dialogue with interested parties. Using some of the tactics outlined later in this section: we have, and continue to, proactively engage with all three audiences, starting the awareness raising phase by sharing of the emerging thinking via a designed power point slide deck. Our approach is outlined below.

Internal

Engaging staff

Our workforce is central to the successful implementation of the local STP.

Employees within each of the 15 organisations are the most important stakeholder group; and act as brand ambassadors, sharing the positive message of change with other stakeholder groups.

With over 25,000 working for the local NHS and an extended workforce involved in health and care services beyond this, we need to ensure they understand the STP and how they can get involved and inform the big picture. Research from the Kings Fund (2014) shows that engaged employees lead to better outcomes for NHS organisations and patients. Engaging with staff forms a key part of the strategy between now and the New Year.

The plans we are developing will involve both clinical and non-clinical staff working in new and different ways for example to support the centralisation of support functions or to enable staff and expertise to be shared between hospitals, between hospital and community and across the wider system

The definition of workforce for our STP extends beyond the 15 partner organisations to encompass, for example, the voluntary sector and the police.

Clinician leaders and operational managers are already playing a role in shaping the STP and considering the implications and requirements for our workforce.

A specific staff awareness raising campaign will be undertaken in parallel with the campaign being progressed with local people and other external stakeholders. This will focus on raising awareness of the high level principle underpinning the STP (e.g. operating at scale, eliminating variation, local where possible/centralised where necessary).

Subject to the outcome of the October checkpoint our staff and their representatives will have an opportunity to be involved in development of specific proposals for changes to services.

As plans proceed to detailed development stage it is anticipated that individual bespoke staff communication and engagement plans will be developed in respect of specific projects or programmes of change.

As part of this appropriate consideration will be given to any requirement for formal staff consultation where indicated.

Engagement Activity and Channels – Communications & engagement

INTERNAL ENGAGEMENT ACTIVITY TO DATE

- Collated all partner established communications channels
- Internal update issued to all staff via established channels
- Summary presentation of the emerging thinking shared internally via established channels for reference only
- Second more detailed version of the slides shared via established channels and uploaded to intranet sites, included in staff bulletins and newsletter.
- Presentation of slides by SROs at team meetings.

STAKEHOLDER ENGAGEMENT TO DATE

- Two meetings with the three Healthwatch organisations to discuss emerging thinking and how they can support with ongoing engagement
- Briefing with Karin Smyth, Bristol MP
- Presentations of the emerging STP presented at:
    - Bristol CCG AGM
    - South Gloucestershire CCG AGM
    - North Somerset CCG Stakeholder Event
    - North Somerset HOSP closed session
    - South Gloucestershire HOSP closed session
    - Academic Health Science Network Annual Conference
    - Health and Well Being Chairs Board

PUBLIC ENGAEGMENT ACTIVITY TO DATE

- Each of the BNSSG STP partner organisations have created a page for the STP on their websites and uploaded an introductory narrative
- An updated narrative and the summary STP slides were uploaded to the website and included in established stakeholder communication channels.
- A feedback box and details on how to register interest to be kept informed on further developments was added to the website
- Slides have been shared with Matthew Hill at BBC Points West
- Background briefing with Sid Ryan at Bristol Cable.

Tactics - Channels

The table below outlines the communication and engagement channels and tactics available to us. The table has been designed to help understand the values behind the tactics. For each area of engagement we will assess which tactics are the most appropriate to target specific audiences we need to reach to ensure that engagement is relevant and proportionate.

Channel	Tactic	Rationale
Website	Having the same content across all 15 partner sites shows partnership working.	Planned news updates will ensure that information is easily accessible and will show openness and transparency. Content and documents will be updated and uploaded as there is new information that requires communication. NOTE: As this is a five year plan there will become a point when a dedicated website for the BNSSG STP will be required given the volume of information this is likely to hold. The pages on the CCG website will then be used to signpost to the external website.
Social Media	Established a hashtag for the BNSSG STP that keeps online content grouped together and shows partnership working. As the STP evolves consider benefit from a dedicated twitter account to help give the STP its own voice as a project that has many partners. This account would need to be managed as a dedicated communications channel and is one that all key partners can follow and share content with	Proactive social media management using the key messages will allow for the targeted promotion of any consultations. It also provides an opportunity to share content across multiple platforms. This channel allows for two-way engagement, which will help to ensure audiences are involved in the process We can more effectively disseminate important messages and receive views on what people think, firmly establishing our social media communication as a two-way process. We can use social media to provide opportunities for open, honest and transparent engagement with stakeholders, giving them a chance to participate and influence decision making.

Channel	Tactic	Rationale
	their own followers. Other tactics to be explored to raise awareness include: Facebook content Live Twitter Q&A Sharing key content. Video online NOTE: Someone would need to be appointed to manage the account in order to respond to questions, and manage any reputation risk.	
Blog networking	Identifying and engaging with influential bloggers who write for our key audiences will help raise awareness of any engagement activity. These will need to be researched and contacted to promote engagement with the project. Traffic will be driven from blogs to the online content to promote the work of the STP, and encourage participation in surveys and the consultation process.	Bloggers are influential with their readers, thus securing their third party endorsement will raise awareness and encourage participation.
Survey management	The editing, uploading, promotion, reporting and closing of surveys.	For each area of the STP that requires consultation, surveys can be created to gather feedback. Ensuring consistency in messaging across all surveys and platforms will help understanding of the work being undertaken. We will use plain English increase understanding of the surveys which will support informed feedback. Timely creation, sign-off and upload of the surveys will ensure no delays affect audience participation.
Video(s)	A welcome video is a good way to increase engagement and help explain complex initiatives.	Video(s) can be uploaded to each partners website and shared across social media platforms, and made available for engagement events organised by the PPI teams.

Channel	Tactic	Rationale
	It will help embed the key messages and will humanize the project. Video can be used to put a face to key players within the process, humanising and providing credibility.	This channel will also allow for engagement of audiences through sign language and other languages. In addition (for extra cost), videos can be created or subtitled in minority languages.
Case Studies	Case studies help to humanise a story and create engagement. Audiences find them easier to identify with, thus helping to explain a situation or explain and complex scenario.	Case studies can be used to detail a patient journey within the five year STP. These will be useful later in the strategy and will form a key part of the strategies that support the individual areas of consultation.
Infographics	Infographics are a great way to visually communicate complex data in a meaningful and memorable way.	Infographics would be a useful tool to communicate some of the complex messaging around pathways. They can also be used to visually explain the STP and what it will achieve. These make complex information more digestible for a range of audiences.
Media relations	Development of a briefing document, including FAQs, to prepare project staff for interviews.	Identify key BNSSG commissioner staff for interview opportunities. Interview time with local media will need to be booked to coincide with key periods of engagement and consultation.
	Writing, sourcing quotes, editing and distributing press releases announcing the consultation and soliciting engagement.	This tactic will be most useful once we start raising awareness of specific areas for engagement within the STP. Creating carefully crafted press releases using the key messages will help share the work that we are doing with a wide range of stakeholders via local newspapers, broadcast media, websites.
Newsletter	Develop a list of all stakeholder newsletter distribution dates. It is important to use these channels to provide regular updates to	Key messages will be used in the content to support the STP messaging and promote ongoing consultations. To maximise engagement instead of full articles teasers would be included with links to drive audiences back to the main site. This will remain the central information source.

Channel	Tactic	Rationale
	ensure the STP is kept front of mind. As the STP becomes more established create a newsletter dedicated to the STP that can be sent to all Stakeholders for cascade within their organisations.	
Power Point Presentation	To support engagement activity one power point presentation that provides the narrative that can be shared across all partner websites. Inclusion of a feedback or comment function will also enable people to engage with us.	This will ensure all partners are sharing the same information and speaking with one voice.
Budget dependent ideas:		
Online Advertising	Online pay-per-click (social media) advertising Note: There is a cost attached to this tactic and therefore the ROI needs to exceed that achievable by other means.	Management of a targeted, flexible advertising campaign promoting consultation and engagement from very specific target audiences. Adverts would drive traffic to each CCG website and can be targeted at specific audience groups. This is a very flexible way of advertising and will allow for the targeted engagement of minority groups, as well as other desirable audiences. It's also an effective cross-promotion tool for offline marketing (i.e. print advertising), utilizing similar creations and providing a secondary reinforcement of a campaign by targeting our demographic online.
Marketing materials	Leaflets Note: There is a cost attached to this tactic and therefore the ROI needs to exceed that achievable by other means.	The main purpose of a leaflet would be to raise awareness of the overall STP. It would be a timeless piece of collateral that can be created to last the duration of the project. This will make it more cost effective. The collateral would be designed to direct readers to the CCG websites where they would be able to find out more about any specific consultations. It will also ensure consistency of messaging when partners are engaging with stakeholders.

Channel	Tactic	Rationale
		Leaflets can be handed out at PPI events, sent to GP surgeries, acute trusts, community care facilities, voluntary organisations, local authority direct mail, parish magazines, door drops etc …

For each target audience we will look at the most appropriate channels and tactics to reach them. We will also ensure that we meet the requirements of the easily accessible information standard and will work with our equalities colleagues across all partner organisations to achieve this.

Appendix F – Estates

Supplementary information relating to existing estates projects, STP Initiatives, implementation priorities and financial impacts.

Estates Efficiency Themes:

The majority of Estates efficiencies will be generated through improvements within the Reference Cost Index (RCI) Benchmarking and Carter recommendations as required for Acute Trusts. In most cases, land disposals will enable reinvestment into higher quality and a more efficient estate to meet demand.

Estates leads are now working with the Model of Care (MoC) groups to ensure that the planned estates mapping best meets the demand mapping.

Our Estates Strategy poses a number of significant questions that we will need to address as an STP in order to achieve the optimum value from our estate. These are set out in the table below.

Bristol, North Somerset and South Gloucestershire STP Estates Workbook
October 2016 Submission

STP Estates Workbook - Contents

STP Service Strategy & Implications

Key STP Service Strategy Themes:

In order to avoid the need for 240 more acute beds, almost 600,000 more GP contacts and 12% more capacity in community services, estates will need to generally provide a higher efficiency.

The new MoC that will enable providers change how healthcare services are delivered. This will be implemented through three major transformational work-streams:

1. Integrated primary and community care
   - 7 day model of care
   - Delivery of specialist care in the community
   - Reduction of inappropriate use of hospital beds
   - More efficient use of digital solutions and joint estate options at scale
2. Prevention, Early Intervention and Self Care
   - Reduce dependency on acute beds
3. Acute care collaboration
   - Best use of hospital capacity

Estates Efficiency Themes:

The majority of Estates efficiencies will be generated through improvements within the Reference Cost Index (RCI) Benchmarking and Carter recommendations as required for Acute Trusts. In most cases, land disposals will enable reinvestment into higher quality and a more efficient estate to meet demand. Estates leads are now working with the Model of Care (MoC) groups to ensure that the planned estates mapping best meets the demand mapping.

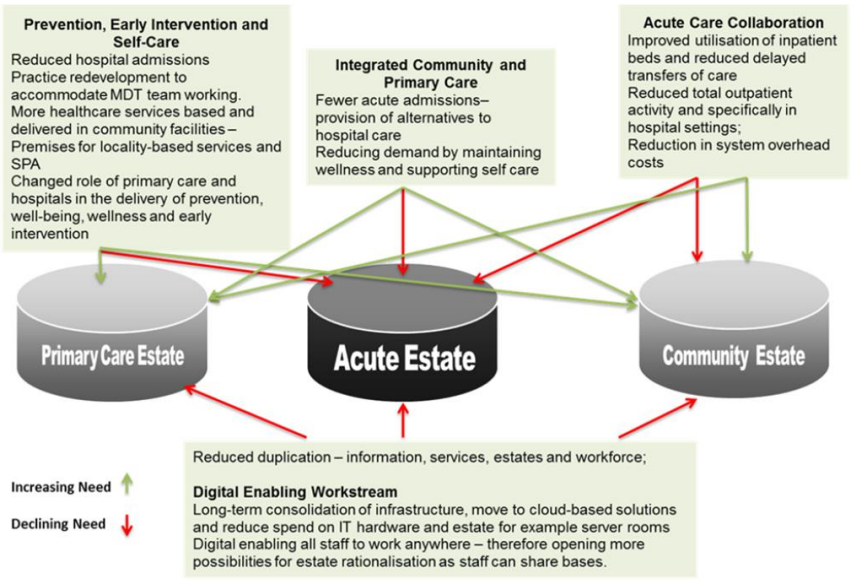
Enabling Implications for Future Estate

1. Integrated primary and community care:
   - Transformation of community facilities to allow mental and physical health services to be delivered locally from "Clustered" GP Premises.
   - Efficient use of joint estate options with other public sector bodies.
   - Surplus estate is removed from the system, estate running/operating costs are reduced and estate delivers value for money.
   - Investment in the estate with poorer quality buildings that are no longer fit for purpose replaced with new facilities.
2. Prevention, Early Intervention and Self Care
   - Shift of care from an acute setting to primary and secondary care making best use of available resources.
3. Acute care collaboration
   - Utilisation of fit for purpose existing estate is maximised (Lord Carter targets) with consolidation of activity and sharing of premises.
   - Sharing the acute and mental health hospital facilities and physical assets.

STP Service Strategy & Implications

Enabling Implications for Future Estate

An overview of the impact on estate arising from the 3 work-streams is given below:



Performance Indicators:
2020/21 Success Metrics (STP Footprint)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£187m pa for 475,216 sqm (£394/m2)	Rationalisation of estate and subsequent increased efficiency	STP wide response. Metrics for the individual organisations can be found in Annex 2
Non-Clinical Space (%) (Carter Metric max 35% for Acute)	164,558 sq metres, equivalent to 34.6%	Continued compliance with Carter metric	STP wide response. Metrics for the individual organisations can be found in Annex 2
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	10,495 sq metres, equivalent to 2.21%	Continued compliance with Carter metric	STP wide response. Metrics for the individual organisations can be found in Annex 2
Functional Suitability	75% of the assets are in an acceptable condition / satisfactory performance	Improvement in estate and subsequent improvement in Functional Suitability	STP wide response. Metrics for the individual organisations can be found in Annex 2
Condition	6% of estate is pre 1948 22% of estate is '65 – '74 58% of estate is '85 –'94 4% of estate is '95 – '04 10% of estate is '05 to '14 Back-log maintenance of £27.3m	Rationalisation of fit for purpose estate and reduction of backlog maintenance	STP wide response. Metrics for the individual organisations can be found in Annex 2

Estates projects

Supplementary information relating to existing estates projects, STP Initiatives, implementation priorities and financial impacts.

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Southmead site rationalisation and re-provision of Mental Health services	AWP	Acute Care Collaboration	Critical	-£360k	-£3m	Project Implementation Stage	2018/19	Yes
Part disposal part development of Frenchay Hospital	NBT	Acute Care Collaboration	Critical	£0	-£45k	Final stages of sale	2017/18	YES
Improve utilisation of Core Estate (SBCH / LIFT / PFI)	All	Integrated Primary and Community Care	Critical	TBC	-£100k	Project Implementation Stage	2017/18	YES
Additional GP facilities in Weston Villages (New Build)	NS CCG	Integrated Primary and Community Care	Critical	- £360k to - £600k	-£3m to -£5m	Awaiting ETTF decision due Oct-16	2018/19	YES
Disposal and re-provision of Thornbury Hospital	NBT	Acute Care Collaboration	Critical	+£800k	-£125k	Negotiating with Sirona	2017/18	YES

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Consolidation of Back Office Functions	All	Integrated Primary & Community Care	High	TBC	TBC	Project Implementation stage	2018/19	Yes
Re-provide Central Health Clinic building	UHB	Acute Care Collaboration	High	TBC	TBC	Project Implementation stage	2018/19	Yes
Weston / Worle / Urban (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes
Nailsea and Long Ashton (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes
Mendip Vale, Congresbury (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes
Clevedon, Portishead, Pill (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Banwell and Winscombe (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Lawrence Weston Community Hub (New Build)	Bristol CCG	Integrated Primary & Community Care	High	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2018/19	YES
Bishopston Medical Centre (New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2018/19	YES
North and West Locality Strategy (Extension / New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Inner City and East Locality Strategy (Extension / New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
South Locality Strategy (Extension / New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Thornbury, Pilning and Almondsbury (Extension / New Build)	SG CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Filton, Cribbs Causeway and Patchway (Extension / New Build)	South Glos	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Yate (Extension / New Build)	South Glos	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Charlton Hayes (Extension / New Build)	South Glos	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
BNSSG Health & Care Single Point of Access (This may cross many sites, but mapping is yet unknown)	BNSSG	Integrated Primary & Community Care	High	-£420k	-£3.5m	Operational development	2017/18	YES
Bentry - Disposal	AWP	Acute Care Collaboration	Medium	TBC	+£800k	Early stages	2018/19	YES

Sustainability & Transformation Initiatives

In order of priority - X new projects identified where implementation required to enable wider STP strategy (revenue savings >£1m pa)

STP initiative	Estates Impact and Enablers	Est. Net Revenue Benefits (£m pa)	Project Status	Est. Deliver Year	Gross Capital Required (£m)	Disposal receipts (£m)	Comments and Interdependencies
1. Acute Care Collaboration	Rationalisation of Southmead site and re-provision of Mental Health services	-£360k	Identified as opportunity only	2018/19	-£3m	£0	Land to be transferred from AWP to NBT at Net Book Value
2. Prevention, Early Intervention and Self Care	Part disposal part development of Frenchay Hospital	TBC	Outline planning consent. Final stages of sale	2018/19	-£45k	+£3.5	Sale is currently in abeyance as Council have publicly consulted on a condition precedent for 'Town and Village Green' status of a large part of the site. Decision due Nov-16
3. Integrated Primary and Community Care	Improve utilisation of Core Estate (SBCH / LIFT / PFI)	+£1.5m to +£2m	Identified as opportunity only	2017/18	-£100k	£0m	Utilisation studies to be undertaken within LIFT buildings
4. Integrated Primary and Community Care	Additional GP facilities in Weston Villages to accommodate growing population	-£360k to -£600k	ETTF bid submitted. NHS England decision due end of Oct-16	2018/19	-£3m to - £5m	£0	Option appraisal required to determine capacity and condition of neighbouring estate
5. Prevention, Early Intervention and Self Care	Disposal and re-provision of Thornbury Hospital	+£800k	Negotiating with Sirona	2017/18	-£125k	+£3m	Site to be sold to Sirona for nursing home and extra-care housing

Implementation priorities

Key next steps towards delivery

Key next step	Challenges	Resources	Indicative timeline	Comments
Rationalisation of Southmead site and re-provision of Mental Health services	AWP / NBT combined Estates Strategy to be agreed for non-PFI areas of estate	Specialist resource (1 No Project Manager and £100k budget). To develop masterplan that meets need of both organisations	Within 6 months (by Apr-17)	Discussions have commenced between AWP and NBT
Part disposal part development of Frenchay Hospital	Planning is currently in abeyance	1 No specialist planning consultant is required to assist with complex planning issues	Within 12 months	Community site is not linked to the remainder of the site. Negotiations are on-going with Sirona
Improve utilisation of Core Estate (SBCH / LIFT / PFI)	System is requesting additional space but Core Estate is not being fully utilised	Utilisation surveys of all Core Estate is required (£100k plus implantation and delivery team). 1No Project Manager	Utilisation of LIFT buildings to be undertaken within 6 months. Strategy to utilise space to be undertaken in 2017/18	Surveys of all core estate is required, not just CHP property
Additional GP facilities in Weston Villages to accommodate growing population	Additional GP facilities may be required in Weston Villages area to cope with significant increase population	Appointment of 1 No Project Director and 1 No Project Manager and £250k budget for technical support team to undertake option appraisal / Business Case	ETTF due diligence decisions are anticipated by Oct-16	Option appraisal must take into account wider implications of Weston Town and Weston General Hospital Sustainability issues
Disposal and re-provision of Thornbury Hospital	Disposal opportunity	1 No specialist planning consultant (could share with Frenchay disposal) is required to assist with complex planning issues	Within 12 months	Negotiations are on-going with Sirona
Capacity and implementation of ETTF bids	Fund is not sufficient to cover all projects. Management arrangement required to ensure delivery	1 No Project Director, 1 No Project Manager (could be shared with Weston Villages) and £500k budget to manage ETTF programme and ascertain non-ETTF options	ETTF due diligence decisions are anticipated by Oct-16	Alternative funding route required to pick up short fall in ETTF funding

Headline Financial Impacts

Investment Pipeline summary

Investment requirement (strategic objective)	Estimated investment capital £m	Committed (OBC stage)	Uncommitted (Pre OBC)	Estimated timeline	Capital Proceeds £m	Gross Estate Running Cost Savings £m pa	Service savings £m pa
High risk back-log maintenance programme	£6.1m	£3.1m	£3.0m	2018/19	£0	£0	£0
Service re-configuration/ consolidation	£6.77m	£0	£5.97	2020/21	£7.3	TBC	TBC
Estate subject to ETTF funding	£27.4m to £44m	£0	£27.4m to £44m	2019/20	TBC	TBC	TBC
Other	£0	£0	£0	N/A	£0	£0	£0
Totals	**Dependent on Control Totals**	**Dependent on Control Totals**	**Dependent on Control Totals**	**As above**	**£7.3m subject to Control Totals**	**TBC**	**£0**

Disposal Opportunities

Disposal Status	No. of sites	Land Area (Ha)	GIA (m)	Estimated disposal value £m	Timeline for disposal (year)	Estimated Housing Units	Gross Running Cost reduction £m	Cost to Achieve (where known) £m
1. Marketing ongoing	3	4	2,500 to 3,500	£7.3m	2018/19	32	£1m	£220k
2. Declared surplus / OBC approved	0	0	0	£0	N/A	0	0	0
3. Feasibility Stage	**0**	**0**	**0**	**£0**	**N/A**	**0**	**0**	**0**
Totals	**3**	**4**	**2,500 – 3,000**	**£7.3m**	**2018/19**	**32**	**£1m**	**£220k**

Critical Decisions

Critical Decisions:

Decision Required	Significance/ impact on STP strategic objectives	Owner	Action By:
Rationalisation of Southmead site and re-provision of Mental Health services – Co-ordination between acute and central commissioners for specialist Mother & Baby unit to provide additional beds that can not be economically provided on site combined with quality of existing inpatient environment	Rationalisation of estate and reduction in non-functional space	AWP / NBT	Within 6 months
Part disposal part development of Frenchay Hospital – Outcome of local planning decision required to allow disposal of site allocated to Health and Social Care Centre. Decision is due by November 2016	Disposal of surplus land	NBT	Nov-16
Improve utilisation of Core Estate (SBCH / LIFT / PFI) – Commissioners to confirm requirement for additional space within Core Estate following outcome of utilisation surveys	Rationalisation and best use existing core estate	Bristol CCG	Within 12 months
Additional GP facilities in Weston Villages to accommodate growing population – Funding to be confirmed to allow appointment of Project Director and Technical Support team	Provision of integrated primary and community care services at scale	North Somerset CCG	Within 2 months
Disposal and re-provision of Thornbury Hospital – Negotiations between NBT and Sirona to be completed to allow transfer of land between the two organisations	Disposal of surplus land	NBT	Nov-16

Annex 1: STP Estates Data Summary

Estates Composition (1 of 4)

Portfolio Summary

Portfolio	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m) (rent, s'charge, FM)	Back-log Maintenance £m
GP owned	124	Not available	76,484	54%Freehold 8.9% Leasehold 37.1% Unknown	Not available	Not available
NHS PS	54 All properties	Not available	57,528	53% Freehold 47% Leasehold	8.39	Not available
CHP	5	Not available	20,215	100% Leasehold	8.94	£0
Provider estate	83	99	440,971	24% Freehold 14.5% Leasehold 61.5% Unknown	203.25	42.01
Mental Health Trusts	23	16.59	41,266	95.5% Freehold 4.5%Leasehold	10.35	2.48
Public Health Estate	16	Not available	6,876	31.25% Freehold 68.75% Leasehold	Not available	Not available
Other (SWAFT)	13	contained with aggregated data in ERIC	Contained with aggregated data in ERIC	Contained with aggregated data in ERIC	Contained with aggregated data in ERIC	Contained with aggregated data in ERIC
Totals	**318**	**115.59**	**643,339**		**230.93**	**44.49**

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Estates Composition (2 of 4)

Functional Use Summary

Functional Uses	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £m
Clinical/clinical support	76	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC Incomplete data	contained with aggregated data in ERIC
Back Office (self contained unit)	7	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC
Other (eg w'house or workshop)	No Data	No Data	No Data	No Data	No Data	No Data
Totals	**83**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Estates Composition (3 of 4)

High Cost Sites: Estate Running Costs

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £k	Cost per sqm	Current Site Strategy
Southmead Hospital	6.8	174,930	Freehold/PFI	100.3	11,500	573.37	Retain
Bristol Royal Infirmary	10	192,342	Freehold	72.4	19,971	284.36	Retain
Weston General Hospital	10.6	36,825	Freehold	14.7	9,060	233.67	Retain
Callington Road Hospital	4.8	12,095	Leasehold/ PFI	6.21	PFI	513.77	Retain
South Bristol Community Hospital	13.5	11,000	leasehold	6.11	PFI	556	Retain

Highest Cost Locations : Backlog Maintenance

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £k	Cost per sqm	Current Site Strategy
Bristol Royal Infirmary	10	192,342	Freehold	72.4	19,971	284.36	Retain
Southmead Hospital	6.8	174,930	Freehold/PFI	100.3	11,000	573.37	Retain
Weston General Hospital	10.6	36,825	Freehold	14.7	9,060	233.67	Retain
Drove House	0.4	1190	Freehold	.006	141.2	5.1	Retain
Long Fox Unit	3.14	4,439	Leasehold	1.8	18.9	403.51	Retain

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Estates Composition (4 of 4)

PFI and LIFT Utilisation

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Estimated Utilisation (%)	Estate Running costs pa (£m)	Cost per sqm (GIA)	Proposed STP Site Strategy
Southmead Hospital PFI	6.8	174,930	Not available	100.3	573.37	Retain
Callington Road Hospital PFI	4.8	12,095	Not available	6.21	513.77	Retain
Hampton House health Centre LIFT	Not available	3,261	40% (assumed)	1.17	359.7	Retain
Fishponds Primarycare Centre LIFT	Not available	2,313.4	40% (assumed)	1.05	454.7	Retain
Shirehampton Healthcentre LIFT	Not available	1,854	40% (assumed)	.79	426.9	Retain

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Annex 2: Performance Indicators for Individual Organisations

Performance Indicators: 2020/21 Success Metrics (AWP)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£14.1m pa for 51,704 sqm (£273/m2)	Currently no board agreed target. No Carter target for mental health	Further cost improvements desired, but limited by 35% PFI estate, and high private leasehold costs following disposals. Therefore costs must reduce by consolidation on existing owned estate and vacating leases.
Non-Clinical Space (%) (Carter Metric max 35%)	23,929 sq metres, equivalent to 31.7 % of occupied space	No board agreed target Estate Strategy under review	No Carter target for mental health
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	2,650 sq metres, equivalent to 5.5 %	Currently no board agreed target. Previous AWP strategies targets similar to Carter . Current schemes in progress will reduce this to 3.8%.	Remaining reduction will require AWP Southmead services redesign
Functional Suitability	96% of the assets are acceptable for functional suitability	Investment / build addressing functional suitability and improved space utilisation of the Long Fox facility on the WAHT main site	Key development requirement
Condition	Almost all estate post-1985. 14% at condition C. Back-log maintenance of £2.7m	Investment / build addressing operational viability and backlog of services currently at AWP on the Southmead site	Key development requirement

Performance Indicators: 2020/21 Success Metrics (BCH)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£2.76m pa for 6,992 sqm (£395/m2)	Reduce absolute by 10% by 2020/21 (£0.276/m)	The only method BCH have of reducing cost is by reducing space occupied
Non-Clinical Space (%) (Carter Metric max 35%)	4,055 sq metres, equivalent to 58%	Reduce to 10% by April 2020	Not all relevant information is available. Also, BCH deliver the majority of its clinical services in patients homes so the Carter metric is not totally appropriate
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0 %	Maintain 0% by April 2020	All BCH leased space is occupied, success for BCH will be in reducing space by optimising use of existing space
Functional Suitability	50% of the assets are in an acceptable condition / satisfactory performance	See Comments	BCH have little direct impact on investment in the sites they occupy.
Condition	TBC	TBC	TBC

Performance Indicators: 2020/21 Success Metrics (NBT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£102.93m pa for 196,646m2 (£523.41/m2)	Reduce cost of retained estate (see comments)	Benchmarking and the Lord Carter Dashboard shows that this is in the upper quartile – the retained estate has a total E&F cost of £389/m2 which we will aim to reduce to £360/m2 – however the PFI Brunel building is over inflating the costs of the estate compared to larger freehold estates
Non-Clinical Space (%) (Carter Metric max 35%)	54,794 sq metres, equivalent to 27.9%	To remain under 35%	The development of the Pathology phase 2 expected this year is expected to further decrease Non-Clinical Space
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0%	To remain under 2.5%	There is currently a building unoccupied and part demolished to facilitate further development but isn't classed as unoccupied space within the ERIC definitions
Functional Suitability	70% of the assets are in an acceptable condition / satisfactory performance	Replace unsuitable space (see comments)	The Women and Children's Hospital is due to replacement.
Condition	82% age between 1985 and 2014 Risk Adjusted Back-log maintenance of £5.1m	See comments	At this stage the potential replacement of the Women's and Children's Hospital has not been included in these figures but is projected to be required for replacement

Performance Indicators: 2020/21 Success Metrics (NSC-P)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£1.75m pa for 4,967m2 (£381.83/m2)	Reduce costs by £500k per annum. Reduce £381.83/m2 to £251.16/m2	NSC-P are required to make 30% on its annual estate costs equivalent to £500,000
Non-Clinical Space (%) (Carter Metric max 35%)	3,632 sq metres, equivalent to 73%	Non-Clinical space may reduce if total floor spaces reduces by April 2020	Carter metric is not applicable to NCS-P
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0 %	Maintain 0% by April 2020	All offices and clinical space are fully occupied. There are no regularly vacant offices/clinic rooms within NSC-P estate
Functional Suitability	60% of the assets are in an acceptable condition / satisfactory performance	See Comments	NSC-P have little direct impact on investment in the sites they occupy.
Condition	TBC	TBC	TBC

Performance Indicators: 2020/21 Success Metrics (SWAFT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	Unknown	Unknown	Unable to break down at the moment
Non-Clinical Space (%) (Carter Metric max 35%)	Unknown	Unknown	Not applicable
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	524 sq metres, equivalent to 5.36%	Reduce to 2.5% by April 2020	Figures are for the whole Trust
Functional Suitability	97% of the assets are in an acceptable condition / satisfactory performance	To be confirmed	3.21% below condition B currently. Target to be set.
Condition	To be confirmed	To be confirmed	6 facet survey about to be undertaken

Performance Indicators: 2020/21 Success Metrics (UHBT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£58.7m pa for 206,690 sqm (£284.36/m2)	2% annual year on year revenue saving required	E&F Annual savings within 2017/18 Operating Plan - £623k to be submitted December 2016
Non-Clinical Space (%) (Carter Metric max 35%)	68,527 sq metres, equivalent to 33%	Reduce to 35% by April 2020 – Target met	Target met
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0% following disposal of Old Building	Less than 2.5% by April 2020 – Target met	Target met
Functional Suitability	70% of the assets are in an acceptable condition / satisfactory performance	See comments	Lifecycle capital needed as per current plan to reduce risks of estate not sustaining stability as non PFI
Condition	13.5% of estate is pre 1948 52% of estate is '65 – '74 6.5% of estate is '85 –'94 6.5% of estate is '95 – '04 21.5% of estate is '05 to '14 Back-log maintenance of £10.5m	Reduction in backlog maintenance	

Performance Indicators: 2020/21 Success Metrics (WAHT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£7.1m pa for 30,409 sqm (£233.67/m2)	Trust is planning to remain as per the recommendation of under £320 m2 Estates running costs by 2020/21	Figures provided and verified by WAHT
Non-Clinical Space (%) (Carter Metric max 35%)	9,621 sq metres, equivalent to 33.2%	Trust is planning to remain as per the recommendation of under 35% for non-clinical space by 2020/21	Figures provided and verified by WAHT
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	7,845 sq metres, equivalent to 1.79%	Trust is planning to remain as per the recommendation of under 2.5% for unoccupied floor space by 2020/21	Figures provided and verified by WAHT
Functional Suitability	75% of the assets are in an acceptable condition / satisfactory performance	Estates capital programme will prioritise investment to remain above 75%	Figures provided and verified by WAHT
Condition	82% of estate is '85 – '94 12% of estate is '95 –'04 6% of estate is '05 to '14 Back-log maintenance of £9m	The Trust has occupies 3 buildings. The main part of the estate is the General Hospital. The 2 other buildings are part of the children's services. This service is currently out to tender and potentially they may not be part of WHAT by 2020/21	Figures provided and verified by WAHT

Annex 3: Summary of transformation by sectors

Summary of transformation by sectors

Model	Secondary	Community	Primary	Admin
ESTATE TO REDUCE / DISPOSE	No plans	Part disposal part development of Frenchay Hospital Disposal and re-provision of Thornbury Hospital Brentry Hospital	Outputs from Option Appraisals (possible 6 No practices)	Back office functions being review may impact on future of South Plaza
ESTATE TO INCREASE (by 2020/21)	No plans	Outputs from Option Appraisals. Primary and Community services to be delivered at scale	Outputs from Option Appraisals. Primary and Community services to be delivered at scale	3 No CCG's forming one organization. New Head Quarters needs to be identified
ESTATE TO OPTIMISE	Southmead site	CHP Estate (5 No) AWP Mental Health Estate (PFI)	Outputs from Option Appraisals.	CCG and other admin functions moving out of clinical space

Appendix G – Workforce

Structure

The Chief Executive at Avon & Wiltshire Mental Health Partnership Trust (Hayley Richards) is the Senior Responsible Officer for workforce and, as such, represents workforce at the STP Senior Leadership Group. She co-chairs the fortnightly workforce programme board with Health Education England (HEE). The aim of the board is to:

- Engage all STP footprint organisations (and other work streams) in STP workforce development.
- Provide an STP Local Workforce Action Board (LWAB).
- Coordinate representation to support care model work streams (Early Intervention, Proactive and Preventative Care, Integrated Primary and Community Care and Acute Care Collaboration) and other enabling work streams (Estates, Digital, Finance) and spotlight areas.
- Facilitate the detailed modelling of changes to workforce which will result in proposals from other work streams.
- Manage the defined projects which resulted from specific direction in the Five-Year Forward View, the STP senior leadership group and the June 2016 submission.

Project Method

HEE will support the STP through provision of a part time workforce programme manager. The workforce programme board provides STP information, develops HR links to work streams and progresses workforce projects. Other work streams are invited to send representatives. The meetings are part information sharing and part workshop in order to make best use of the Human Resource (HR) and Leadership Development (LD) expertise in the room. As part of the HEE requirement for STPs to participate in Local Workforce Activity Boards (LWABs) the workforce programme boards subsumes this role and HEE co-chair the meetings.

Data & Intelligence

HEE have provided workforce data for health and social care providers within the STP footprint and provider organisations have also supplied 'plan on a page' workforce data. Additionally staff have been trained on workforce planning tools including WRaPT and SWiPE. With support from HEE the STP has recently employed a part time project manager to support all provider organisations to use the workforce tools and to facilitate workforce modelling of STP outcomes.

Key Stakeholders

All organisations within the STP footprint including Academic Health Science Network (AHSN) and HEE, Primary Care representatives, Service User/Patient groups, voluntary sector and private provider organisations and Trade Unions, Training Providers.

Co-Production

Workforce projects are assigned to leads from across the STP. Project leads have access to colleagues within the workforce programme board in order to develop projects in consultation with other providers. HEE and the workforce programme manager are co-producing a ready reckoner of HEE support to the STP.

Communications

It is recognised that failure to engage staff, trades unions and other stakeholders presents a risk to achieving workforce transformation. Disaffected staff will have a negative impact on productivity and could threaten the ability to change at pace. The workforce work stream will therefore work closely with the communication and engagement work stream to develop engagement plans. HEE funding has been allocated to support staff engagement activities. Additionally providing opportunities for staff to participate in the development of the workforce transformation programme is a key tenet in the programme methodology.

Workforce Projects

There are a number of workforce projects to support the STP and these are detailed below. In addition AWP are leading on joint workforce planning for the STP. This will focus on the use of the WRaPT tool which is supported by HEE and the interpretation of existing data. HEE will fund a part time project manager for workforce planning who will support organisations' workforce planning leads in creating STP system-wide modelling outcomes demonstrating the impact of activity changes as a result of STP plans. These outcomes will then inform (and are essential to) more detailed workforce transformation planning.

. **Project**	**Project Description**	**Outcomes**
Collaboration working on Apprenticeships	System wide approach to support increased collaboration on apprenticeship schemes. Development of new apprenticeships to ensure opportunities presented by Levy optimised.	HEE funding has been allocated to provide project management resource. . • Will include new roles.
Development of Shared Training for MH and Community Staff	Collaborative working in LD departments. Includes provision of mental health training to staff in all STP organisations including ability to provide psychologically informed interventions. Identify Training Needs Analysis for skills gaps. Alignment of core training standards and alignment to MECC	• Reduces duplication. • Increased quality and consistency of care • Improved relationship with our staff.
Improve Staff Health and Well Being	Project to be run in conjunction with Prevention and Proactive Care Work stream and MECC. Improve baseline data on staff health and wellbeing. Building on organisations' work to achieve CQUINS Define the minimum standard for staff health and wellbeing provision.	• Reduced sickness and turnover. • Increases participation and engagement of staff.
Shared Recruitment	To extend the existing recruitment passport arrangements already in place between NBT, Weston and UHBristol to other NHS organisations across the BNSSG STP.	• Avoids duplication and is an early STP win. • Increases cross organisational collaboration • Signposts further HR streamlining opportunities.
Create a common culture	To provide a common vision and purpose for our workforce to support recruiting and retention on a footprint basis. To provide for staff engagement events in conjunction with the communications work stream. Develop opportunities for staff participation in STP development and workforce transformation. Up-skilling staff to deliver continuous improvements within their own teams and deliver and participate in transformation projects To provide OD facilitation to support workforce transformation.	HEE funding has been allocated to support staff engagement and to resource OD facilitators. • Vital for workforce change management • Supports STP work streams in delivery of projects • Support system leadership
STP Workforce Transformation	In addition to skills, scope and generic HR support to the STP a number of new workforce projects will be undertaken in conjunction with other work streams and these will include (but are not limited to): • 7 Day primary care and multi-disciplinary team working • Workforce as advocates of population health approach including MECC • Supporting new ways of working resulting from single point of access, enabling discharge and increased care out of hospital.	• Reduced sickness and turnover. • Increases participation and engagement of staff. • Increased quality and consistency of care • Improved team working and collaboration

Appendix H – Digital

STP Themes

STP Theme *(Includes some references from slides)*	**Local Digital Roadmap links to the STP Theme**
Prevention, early intervention and self-care *Achieving a radical shift towards prevention, early intervention and self-care across the patient pathway.* Enabling care settings and workforce to be innovative and effective in supporting self-care e.g. using digital technology A system-wide approach that takes account of the needs of specific groups	• **Connecting Care** Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care • **The Information Engine** Fully utilising our electronic data and intelligence to power our planning and delivery engine. Devising new and innovative ways to use information, integrated population analytics and data driven decision making.
Integrated primary, community and social care *Improve resilience of local primary care services* *Integrated health & social care teams* *An integrated health and care single point of access* A single integrated approach with multi-disciplinary teams based around the primary care clusters A single service provided across BNSSG and aligned to each acute hospital, preventing admissions and supporting timely discharge, including for	• **Primary Care At Scale** Focuses on maximising digital across GP practices and Out of Hours services. Supporting primary and community care reconfiguration, new integrated team working and maximising efficiency of practices through shared ways of using technology. This is also about how we can better support people and communities out of hospital • **Paperless 2020** Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records. • **Infrastructure & Support** Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes). This will include a strong focus on enabling mobile working across our community teams.

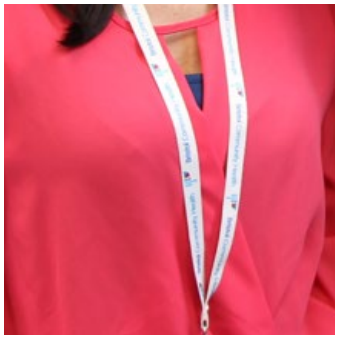
STP Theme *(Includes some references from slides)*	**Local Digital Roadmap links to the STP Theme**
people at end of life who wish to return home	
Acute care collaboration *A collaborative approach to acute care for both mental and physical health* Providing services locally where safe and effective to do so; centrally where necessary for quality and effectiveness Achieving a step-change in the speed and quality of information sharing Simplifying arrangements for sharing buildings, equipment, staff and expertise	• **Infrastructure & Support** Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes). • **Paperless 2020** Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records. • **Connecting Care** Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care












Sustainability and Transformation Plan for Bristol, North Somerset and South Gloucestershire

A summary for local people

2016

The BNSSG STP is a collaboration between the health and care organisations across BNSSG.
Bristol Clinical Commissioning Group, South Gloucestershire Clinical Commissioning Group, North Somerset Clinical Commissioning Group, NHS England (for primary care and specialised commissioning), Bristol City Council, North Somerset Council, South Gloucestershire Council, Avon & Wiltshire Mental Health Partnership NHS Trust, Bristol Community Health, North Bristol NHS Trust, North Somerset Community Partnership, Sirona care & health, South Western Ambulance Service NHS Foundation Trust, University Hospitals Bristol NHS Foundation Trust, Weston Area Health NHS Trust.

CONTENTS

WHAT IS THE SUSTAINABILITY AND TRANSFORMATION PLAN?

1

The Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (STP) sets out a vision of future heath and social care for our population for the next five years.

It has been developed by the health and social care community bringing together the leaders of our hospitals, community providers, commissioners and GPs, ambulance service and mental health NHS organisations and the local authorities.

The aim of the Bristol, North Somerset and South Gloucestershire STP is to design a health and care service which is able to deliver care for local people that is affordable, and can be sustained, for years to come.

Demands on the NHS are increasing and we are no longer able to continue delivering health and care in the same way and still meet those needs.

Our services are better than ever and people are living longer with more complex health conditions, such as diabetes or dementia, and these conditions need to be carefully managed, sometimes for decades.

The cost of care is also increasing and sometimes the way we deliver care is not the most efficient. We also know that the availability of services can vary depending on where you live and which organisation provides your care, and we want to change this.

Our Key Priorities

Empowerment

- Individuals can look after their health and long term wellbeing preventing illness, and know where and how to find the information, tools and resources to stay well.
- Individuals with long term conditions have the confidence to manage their condition independently and know where to go to get help when needed.

Equity

- Every resident in Bristol, North Somerset and South Gloucestershire can access services based on need and not location.

Balance

- Our health and social care service is affordable for the long term and can meet the needs of the population.

Partnership

- The health and social care system works together, with both mental and physical health needs being recognised equally.
- Care is centred around the patient and not restricted by organisational or geographical boundaries.

WHY DO WE NEED TO DO THIS? 2

Growing, ageing population

The population of Bristol, North Somerset and South Gloucestershire is due to grow significantly in the next few years, with a large increase in people aged over 75. This will add more pressure to our health and social care services which are already struggling to meet demand.

We also know that as people live longer they are more likely to develop one or more long term conditions, such as cancer, diabetes, and heart disease. And over the next 12 years the number of people over 65 with dementia is expected to increase in males by 49% and 32% in females.

Avoidable illness

We see an increasing number of conditions linked to people smoking, exessive alcohol consumption and poor diets all of which can be prevented.

Around one in six people in Bristol, North Somerset and South Gloucestershire live in some of the most deprived areas of England; this has an impact on life expectancy.

Men living in the most deprived areas die eight years earlier and women six years earlier.

The most common causes of death amongst those living in the most deprived areas are heart, stroke and breathing diseases, cancer and digestive disorders. People with severe mental illnesses will also die on average 20 years earlier than the general population. People with these conditions are more likely to end up being admitted to hospital for an extended period leading to a loss of independence.

Pressure on services

NHS and social care services are strugglying to keep pace with the changing and growing needs of the population.

The number of people treated in A&E, being assessed by a consultant, having an operation or receiving tests is rising faster than the growth of the population. As a result services are finding it tougher to meet demand.

Local authorities are also under pressure and are struggling to provide the care required to keep elderly and vulnerable people living independently at home. As a result more people are going into hospitals, and they are finding it increasingly difficult to find enough beds to accommodate these patients – meaning they are often forced to cancel planned appointments and operations - and cannot discharge those who no longer need hospital care.

Another pressure is that we cannot recruit enough doctors, nurses and carers.

Organisation of services

We have a confusing health care system that is disjointed; we have three hospitals, three community providers, 99 GP practices, three separate NHS organisations commissioning health care, mental health providers and three local authorities. This can create inefficiencies, duplication and variation and a complicated puzzle of services for patients and staff to navigate.

Overspending

Already, our local NHS organisations are overspent by around £72m, while local authority budgets are expected to reduce by 35% over the next four years. If demand for services continues to grow in the way we expect, the existing £72m gap will grow bigger and in five years' time will be hundreds of millions of pounds.

Our position at the moment is not sustainable. Health and care organisations and the public need to work together and start thinking differently about the way in which services are organised and operated and our approach to local health needs.

We all have to think responsibly about how we use services, and how we organise services to meet the needs of our population.

A SNAPSHOT OF THE HEALTH AND CARE SYSTEM IN BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE

Population of nearly 1 million across Bristol, North Somerset and South Gloucestershire.

The population is **projected to grow by 43,000** by 2021. 15.9% growth in 74-84 year olds & 17.6% growth in those aged over 85.

Every year we spend nearly **£1.5 billion** on local health services.

In 2015/16 local NHS was £72 million in deficit which is set to grow to +£300million by 2020/22 if we don't change.

Demand for GP services rose by 13% between 2008 and 2013/14.

Local NHS successfully sees and treats **1000s of patients** every day.

90% of consultations occur in **primary care**, which includes GPs, pharmacists and dentists.

Consultations with nurses rose by 8% and with other professionals in primary care including pharmacists, grew by 18% in the same period.

22% of the population are **obese** and **61%** are **overweight**.

19.1% of the BNSSG primary care workforce is now **over 55 years of age**, which means we need to recruit and retain more GPs, pharmacists and dentists.

WHAT YOU TOLD US

3

We have begun to describe our approach to this challenge, starting with what you told us is important to you.

Bringing together your feedback from public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports we can identify key themes.

The key themes which we hear consistently include:

- You want understandable information for both services users and their families and carers.
- Professionals and organisations should be better at sharing information so that people don't have to negotiate organisational boundaries or have their needs assessed multiple times by different professionals.
- You want help understanding and navigating the 'system' and want to be kept informed from the outset about what you should expect during your health care journey.
- Self-care and self-management plans need to be arranged around the needs of the individual. Families and carers are also central to the success of self-care, and it is important we keep them informed.
- Services should be provided as locally as possible and access to GPs should be improved.
- Transport to hospital is a key issue especially for those living in rural areas.
- Access to health services is sometimes particularly challenging for people with disabilities.
- A key area of feedback centres around people's experience of discharge from hospital, this is a time when people feel that issues often arise.

HOW ARE WE GOING TO DO THIS? 4

Our focus will switch from treating illness to keeping people well.

In the future, it will be easier for people to receive good quality information about health and health services. They will be able to chose how to receive this information just like in other areas of life. For example printed leaflets, email, video, apps or podcasts.

When people need care they will get a consistent response regardless of whether they have looked on the internet, called 111, gone to their pharmacist or had an appointment with their GP.

Services will focus care around people, and not geographical boundaries, individual clinical conditions or organisations.

The quality of care and speed of access will be the same for mental health needs as for physical health needs.

We will do less organisation or condition-specific assessments, and have access to shared information so we can build on the work done by other teams, rather than duplicating the work done by others.

Primary and community care will be arranged around where people live, linking closely with charities and local groups.

When people need specialist care, they will be able to access staff with this expert knowledge, working together in the same hospital. Research and expertise will be developed so people get the best possible care.

People will continue to live longer and they may continue to have long term conditions. However, expectations will be challenged. People will be asked to consider what is important to them as an individual to enable them to achieve their health and wellbeing goals.

OUR PRIORITIES

5

Preventing illness and injury

We want to support local people to lead healthier lives and avoid getting preventable illnesses and injuries. We will make it the business of everyone working in health and social care to consider how they can give people the best chance at a healthy, independent, active life.

We will improve our links with the voluntary sector, local charities and groups which empower people to take more responsibility for their health. We will embed a shared set of preventative health objectives across all organisations which create a consistent network of advice and support, and help to reduce inequalities between the healthiest and least healthy communities.

Providing care closer to home

We want to provide easier access to care and care closer to home, making services more adaptable to people's needs, with more support in the community, and better use of technology. We believe people shouldn't always need to attend a large hospital to see a consultant or other specialist, so we will work together to bring these skills into the local community. We want to enhance the teams in GP practices with new roles, such as practice-based pharmacists and physiotherapists, as well as health coaches, leaving our GPs to handle the most complex cases. We also want to make it easier for people to get advice when they need it.

Many people, particularly the elderly, stay in hospital longer than is medically necessary so we want to provide much more hands-on specialist care to help people return home quicker, regaining their mobility, confidence and independence. That means nurses, doctors, social workers, therapists, pharmacists, families, and patients, working together and maximising the quality of care.

Personalised care

We need to care for the person, not the "patient", creating a truly collaborative system of care in which the person is at the centre. We want care to be better coordinated with teams of physical and mental health professionals working flexibly to meet individuals needs. We need to join up access to individuals' information (with consent) so that all those involved in planning, managing and providing care understand their needs, their history, and what is important to them. And for those who are living with multiple complex conditions, we will increase access to specialist complex care support which will help them to navigate services and remain out of hospital.

Hospital should be the last resort, and if you are admitted we want to get you home as quickly and safely as possible.

WHAT DOES THIS LOOK LIKE?
STEVE'S STORY

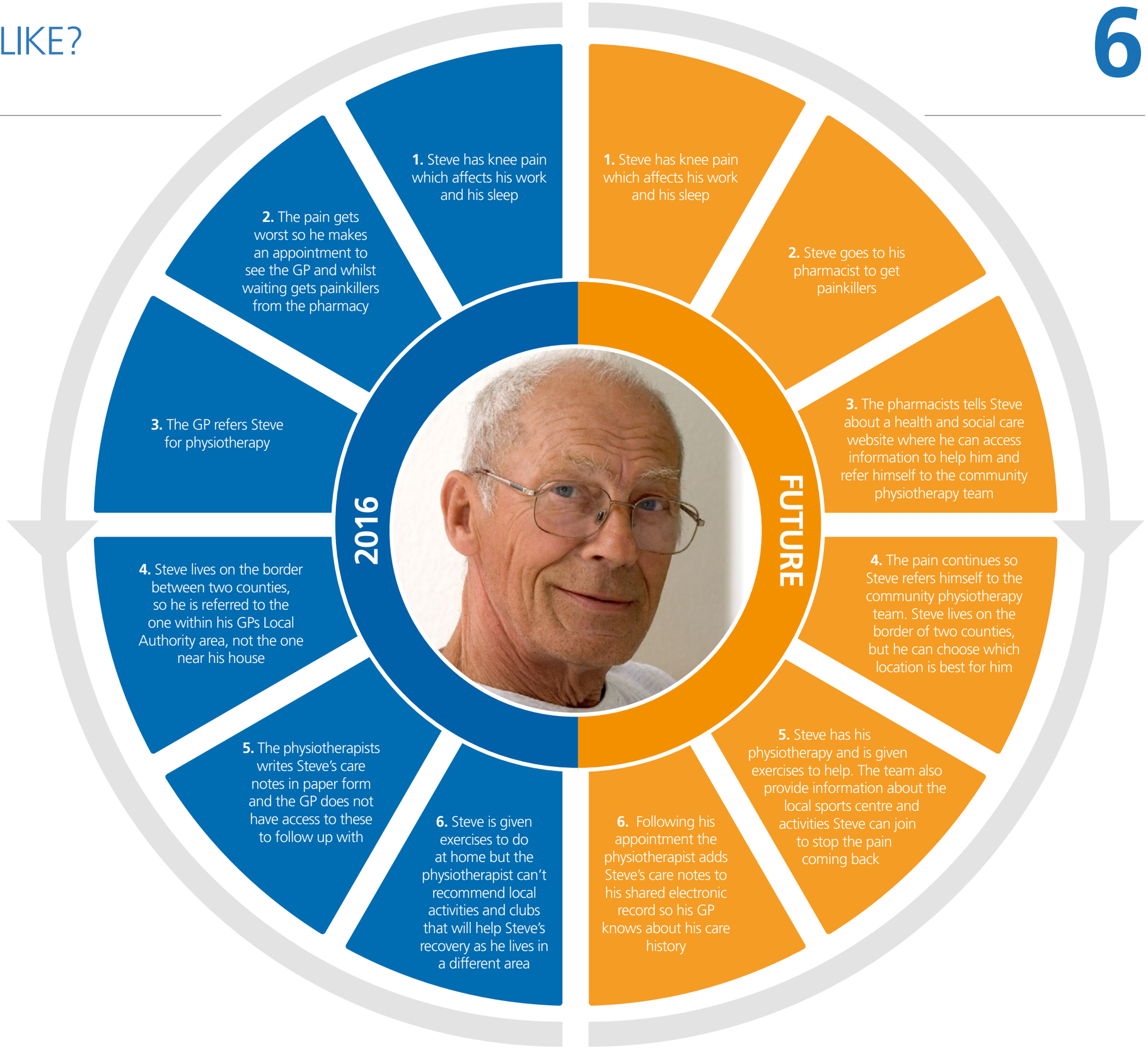
Steve's story illustrates the complexity within the Bristol, North Somerset and South Gloucestershire health and social care system.

Knee pain, is one example of over 200 musculoskeletal (MSK) conditions. These conditions include injury or disorder that affects the human body's movement; it can include problems with muscles, tendons, ligaments, nerves and discs. These conditions affecting millions of adults and children in the UK and include all forms of arthritis, back pain and osteoporosis. They are the most commonly reported type of work related illnesses and make up 1 in 4 of all GP consultations. They can limit daily activity and impact on quality of life for many individuals, however there is limited information available to empower individuals to manage the condition themselves.

Depending on where you live within Bristol, North Somerset and South Gloucestershire access to services is variable and people have to wait longer than they should to access treatment.

Due to rising demand the local NHS is paying the private sector to carry out orthopaedic operations because the hospitals are not arranged in the most efficient way to be able to deliver them. There is also a difficulty in recruiting and retaining staff.

We want to change this, in the future it will be easier for people to access the information they need to manage their condition, refer themselves to community services and get the support they need faster and it won't matter which area you live in.



HOW CAN I GET INVOLVED AND FIND OUT MORE?

7

We are inviting you to get involved in the ongoing development of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan. The publication of the draft STP is your chance to get involved at this early stage. Your feedback is important.

We don't yet have all the answers but this is the start of a conversation to develop the plan with your input.

You can find our STP documents online at:

www.bristolccg.nhs.uk

www.northsomersetccg.nhs.uk

www.southgloucestershireccg.nhs.uk

The plan brings together a few projects which have been under development for some time, whilst others are yet to be formulated or started. For projects which are already underway we will continue our engagement with the people and patients who have been involved and widen participation as more people express an interest. For projects which are not yet started we will be looking to involve people from the start in developing the ideas and plans.

We strongly believe in co-production, we can't achieve our vision without your help. The real engagement will come when we start to get to the detail of these individual projects and programmes. If you are interested in a specific topic then it would be helpful for you to let us know so we can involve you from the start.

You can register your interest by emailing us at bnssg.stp@nhs.net and we will contact you in due course.

We look forward to working with you on the ongoing development of our plans so that together we can find long term solutions to ensure a sustainable health and social care system that meets your needs and your family's, for years to come.

For further copies of this document or if you would like it in another format, please contact one of the Clinical Commissioning Groups below:

Bristol Clinical Commissioning Group
South Plaza, Marlborough Street
Bristol, BS1 3NX
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Designed by South, Central and West Commissioning Support Unit

Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

Checkpoint submission - June 2016

KEY INFORMATION SUMMARY	
FOOTPRINT AREA: Bristol, North Somerset & South Gloucestershire (BNSSG)	**FOOTPRINT LEAD:** Robert Woolley, Chief Executive University Hospital Bristol FT
PARTNER ORGANISATIONS: **CCGS/COMMISSIONERS:** Bristol, South Gloucestershire and North Somerset CCGs, Bristol, NHS England **LOCAL AUTHORITIES:** South Gloucestershire, Bristol and North Somerset Local Authorities which includes the West of England Public Health Partnership **PROVIDERS:** Weston Area Health NHS Trust, North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, AWP Mental Health Trust, Sirona, Bristol Community Health, North Somerset Community Partnership, South Western Ambulance Service NHS Foundation Trust	
Version: 7.5	
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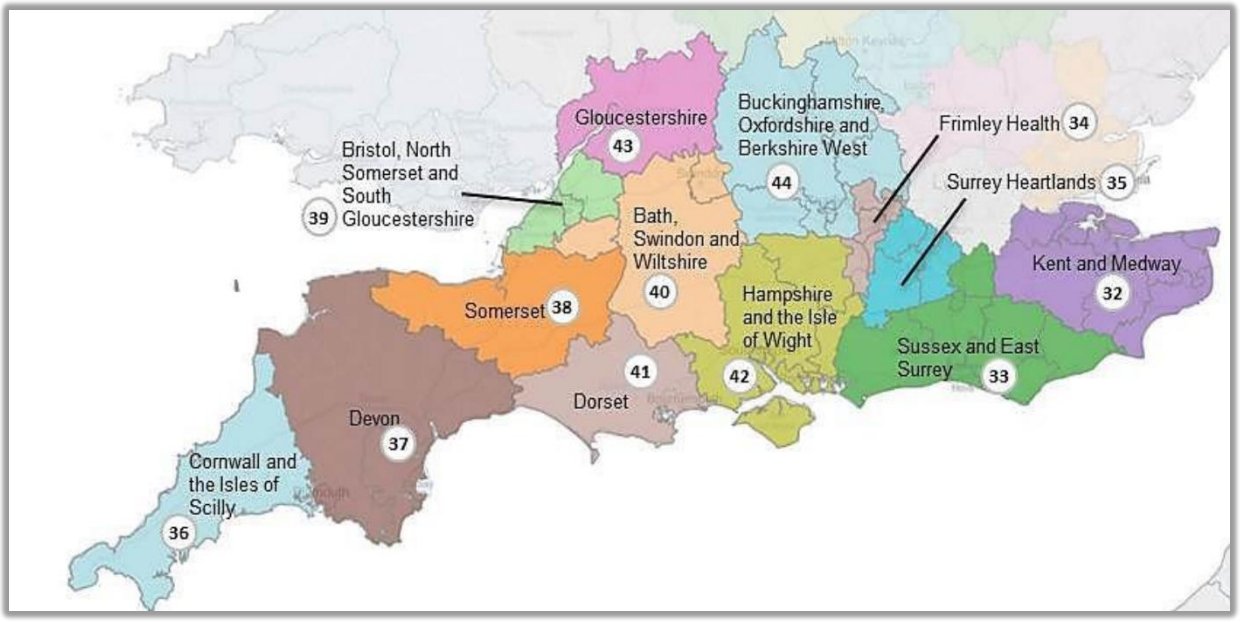

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Introduction

The BNSSG footprint covers a complex heath and care system in which a large number of organisations need to work together to meet the needs of the population. Leaders need to collaborate and share responsibility to avoid silo working. Despite the difficulties, we have already delivered significant change: moving from 4 acute sites to 3, rationalising specialities to single sites and implementing Connecting Care - an award winning digital programme that enables health and social care information to be shared between every health and social care organisation in BNSSG including all 99 GP practices.

The footprint has an established System Leadership Group (SLG) in place with wide institutional representation, including local government (social services and public health) which had already agreed a shared vision prior to the STP planning process. We adapted this governance structure to develop our STP and have discussed how we need to further develop our leadership and governance processes to effectively implement our plans at pace.

We understand our locality in detail and have set out the size of the challenge we face. If we carry on as we are today just to meet increased demand we will have to provide almost 240 more acute beds, almost 600,000 more GP contacts and 12% more capacity in community services such as district nursing. Our NHS financial challenge is forecast to increase from £72.4m in 2015/16 to £415.5m in 2020/21 while Local Authority budgets are expected to reduce by 35% over the same period.

Our new model of care starts with people in families and communities. Individuals will be encouraged and enabled to care for themselves; services will be delivered locally by integrated teams focused on the needs of the individual; and access points to acute care and specialised services will be simplified. In order to deliver the change required we will need to behave differently. We have agreed that there are five key drivers that together will enable us to develop and implement our new model of care. These are: Standardise and operate at scale; System-wide pathways of care; A new relationship with the population; A new relationship between organisations and staff; and Build on our existing digital work as a driver and enabler of cultural change.

We have set out how we will implement our new model of care in three major transformational workstreams: Integrated Primary and community care; Prevention, early intervention and self-care; and Acute care collaboration. We have identified short and medium term priorities and analysed the impact they will have on reducing the financial challenge we face. BNSSG STP is determined to embed parity between mental and physical health care throughout all future investments, innovations, service and workforce developments. This document should therefore be read with the implicit assumption that all initiatives relate equally to mental and physical health and social care, unless otherwise specified.

We know we will face difficult challenges and will need to openly surface and confront our “wicked issues” and commit to sharing and managing risk across the system. The big decisions we need to take in the short and medium term to make a paradigm shift are agreeing:

- The most effective governance structure to implement our plans at pace and ensure we can manage the inevitable conflict from decisions that bring short term adverse impact for individual organisations but achieve system and patient benefit.
- How we will move money across our system, fund the proposed transformation and maintain individual organisational financial credibility

- How quickly we can agree a strategy for closer acute working and specifically implement a sustainable urgent care model for Weston General Hospital.

Chapter 1 – Case for Change

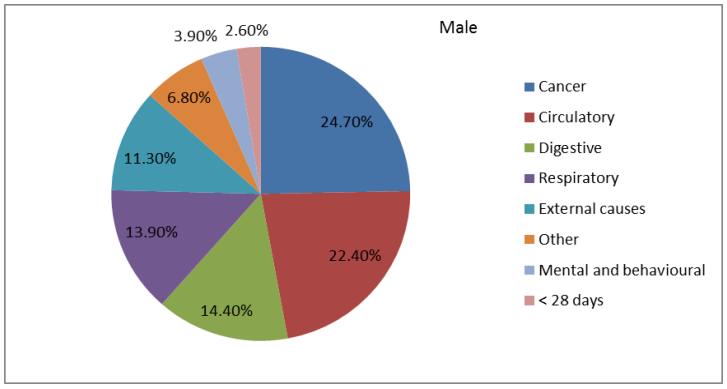
Our health and wellbeing gap:

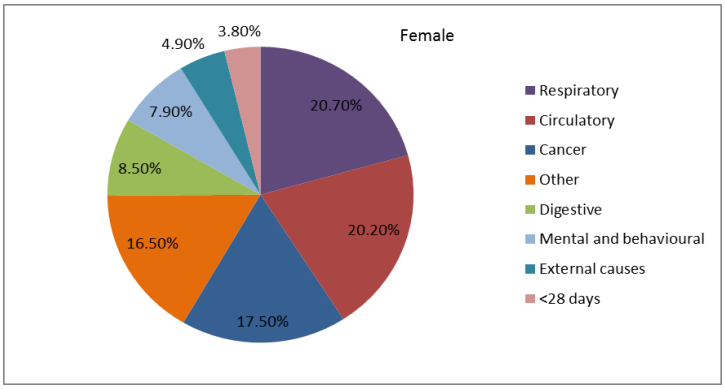
Our population is 968,314, with 17.5% (164,613) of the population living in the most deprived quintile areas of England (IMD, 2015). The population is projected to grow by 43,000 by 2021 with significant growth in both the under 15 and over 75 age groups.

Expected population changes over the next five years by age bands across BNSSG

Age	Current population (2015/16)	Five year predicted change (20/21)	Additional population by 20/21
0 to 14	165,737	7.1%	11,767
15 to 44	407,959	2.6%	10,606
45 to 64	234,326	2.8%	6,561
65 to 74	86,453	2.3%	1,988
75 to 84	51,234	15.9%	8,146
85 plus	22,605	17.6%	3,978

The average life expectancy at birth for men is 80.1 years and women 83.8 years with corresponding healthy life expectancies of 66 years and 65.7 years. This means on average men are living 14.1 years in poor health and women 18.1 years. The average difference in life expectancy between the least and most deprived 10% of the population is 8.6 years for men and 6.2 years for women. Years of life lost in the most deprived areas of the South West are more than double the respective figure for the least deprived areas. Between 2009-11 and 2011-13, healthy life expectancy (years spent in good health) for women fell by 3.7 years in South Gloucestershire. This contrasts with a fall of 0.3 years in England.





BNSSG level data has been used to identify the causes of death that are the largest contributors to life expectancy inequalities and these are summarised in the pie charts. They illustrate the need to focus on pathways relating to circulatory, cancer, respiratory and digestive disorders.

People with severe mental illnesses will die on average 20 years earlier than the general population (SG JSNA 2016). The number of people over 65 with dementia (2014) in BNSSG was 4,059 males and 7,448 females. Over the next 12 years the number will increase in males by 49% and 32% for females.

The prevalence of mental health conditions and the leading risk factors for the diseases that contribute to premature death and to the gaps in life expectancy for our population are given below:

		Bristol	North Somerset	South Glos
Smoking	Prevalence (av) (QOF)	21.5%	17%	15.9%
	Prevalence (highest)	38.6%	42.3%	24.6%
	Ex-smokers (GP survey data)	25.5%	32.1%	27.9%
Alcohol	Estimated risk drinkers	79,387	39,762	49,068
	Alcohol related admissions	3018	1387	1641
Weight	Obese	21.7%	22.2%	23.3%
	Overweight	56.9%	62.7%	63.2%
Mental Health	Depression (av)	7.6%	9.2%	7.7%
(All QOF)	Depression (highest)	13.7%	5.9%	14.7%
	Long term MH condition (av)	5.9%	5.3%	4.3%
	Long term MH condition (highest)	14.7%	11.9%	9.7%

A detailed public health analysis is provided in the annex with further data on projections relating to key aspects of health including disease prevalence modelling, life expectancy, healthy life expectancy, disability adjusted life years, years of life lost and health inequalities.

Our care and quality gap:

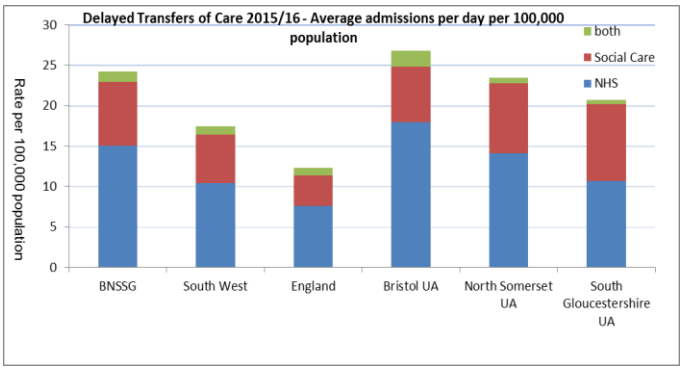
People who live in BNSSG and use our services tell us that they want integrated services closer to home; they don't want to have to negotiate organisational boundaries or have to repeat their story many times; they find it hard to understand how or where to access urgent care; and they don't understand why services can be different depending on where they live.

We know that around 90% of consultations occur in primary care and that demand for GP services rose by 13% between 2008-2013/14. Consultations with nurses rose by 8% and with other professionals in primary care including pharmacists, grew by 18% in the same period. There have been equivalent increases in demand for community services such as district and school nursing. Despite this resources allocated to primary and community care fell as a proportion of overall health spend.

We struggle to attract and retain the necessary work force. In BNSSG, we have had list closure applications and there are significant levels of vacancies in primary care and community care as well as difficulties in recruiting to social care. 19.1% of the BNSSG primary care workforce is now over 55 years of age. 10% of our spend on staff is on agency or bank staff which impacts on quality and costs. The National Apprenticeship Levy and National Living Wage will increase staff costs and community contracts are being renegotiated in some areas to ensure that care homes remain financially sustainable (e.g. Fair Price for Care in South Gloucestershire).

In Bristol and in South Gloucestershire there are significant gaps in care home provision for those with dementia and provision of sufficient domiciliary care is a problem in all three Local Authority areas.

Current commissioning arrangements for mental health services result in variable access, service specification, waiting time and treatment outcomes across BNSSG. The focus on reactive, crisis response rather than on fully integrated social, mental and physical health care in the community, delivered at the earliest opportunity, results in fragmented care pathways, with both duplication and gaps in provision.



We struggle with delays in social care discharges from acute hospital settings, although significant progress has been made through the new Integrated Discharge Service.

A lack of residential and nursing home beds impacts on the timeliness of hospital discharge and we project a net shortfall in residential and nursing home capacity of 1,770 beds in South Glos by 2020, especially dementia nursing beds.

Rehabilitation and Reablement services are crucial in enabling patients to regain optimal function following impairment due to illness or injury and form an essential part of our Better Care Fund transformation plans. We continue to be a high performer in the key success criteria of effectiveness of reablement and the number of people who are still at home 90 days after completing reablement.

Too many people in BNSSG are being cared for in hospital which results in all of the hospitals operating at inefficient levels of bed occupancy for the majority of the year. 10% of admissions account for 60% of bed days. Hospital admission rates in BNSSG are high particularly for End of Life care and Ambulatory Care Sensitive conditions. Admissions for those with chronic ambulatory conditions is variable with pockets of good practice but significant potential for improvement to top quartile. Urgent care sensitive unplanned admissions are higher in Bristol city than in other areas. The number of deaths in hospital varies across BNSSG and where we have done work to coordinate better end of life care, fewer than 39% of people die in hospital. This is closer to the 29% of people who would prefer to die in hospital rather than at home.

There is variation in care pathways and preventative/support services depending on provider and place of residence. The result is that expensive acute care capacity is being utilised inappropriately and the system has to purchase additional elective capacity from the independent sector (£14.6m for Trauma & Orthopaedics 15/16). Similarly, poor access to bed capacity in the mental health sector results in the need to spend £3.3m on out of area placements each year.

Our system fails to deliver 4 hour emergency performance consistently and there is underperformance against 18 week Referral to Treatment standards in all three commissioner areas. Performance against cancer standards is improving but not yet meeting requirements and the six week diagnostic standard is not being met in all areas. All three acute hospital providers have been rated as 'Requires Improvement' by the Care Quality Commission.

	18 week RTT	A&E 4 hour access	62 Day Cancer	6 Week Diagnostic
UH Bristol	92.24%	82.49%	84.70%	99.20%
NBT	88.59%	74.99%	85.90%	97.80%
Weston	93.96%	72.43%	84.10%	100%
Standard	92%	95%	85%	99.50%

We face specific challenges at Weston General Hospital which is a small Trust but serves a growing population with significant health care needs. Creating a service configuration that is financially and clinically sustainable has been

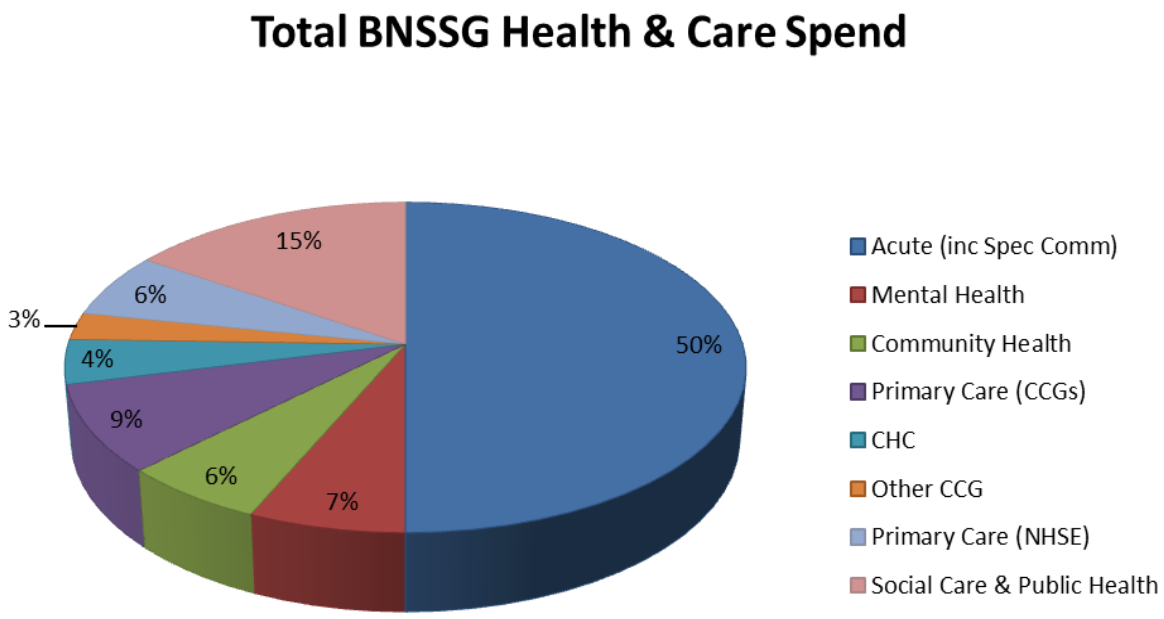
challenging, resulting in significant excess staff costs, under-utilised theatre capacity and a continuing risk to maintaining services.

Our Affordability Gap

The breakdown of our current spend confirms the over reliance on hospital services and under investment in primary, community and preventative care for both mental and physical health services. One consequence is that people are often poorly activated to take personal responsibility for their own health and well-being.

We have a fragmented and complex system with 10 separate NHS commissioning and provider organisations and 3 Local Authorities. This creates inefficiencies, duplication and variation and unnecessary boundaries and interfaces for patients and staff to navigate as well as difficulty in moving money to the right place. Some of our specific challenges include:

- The weighted average unit cost varies between our hospitals from average to very high. RightCare analysis demonstrates an opportunity for improvement in a number of specialty areas.
- Local Authority budgets are expected to reduce by 35% over the next 4 years and the public health grant by 17%.
- We have difficulty recruiting and retaining staff in some key service areas contributing to spend of £87.3m on agency and bank staff and we duplicate of effort in some HR functions including temporary recruitment, training and pre-employment checks.
- Significant differences in per capita funding for the 3 BNSSG areas has made consistency in commissioning acute and community providers more challenging.



If we carry on as we are today just to meet increased demand we will have to provide almost 240 more acute beds, almost 600,000 more GP contacts and 12% more capacity in community services such as district nursing. Our NHS financial challenge is forecast to grow from £72.4m in 2015/16 to £415.5m in 2020/21.

The financial plans of the footprint are summarised below. The projected 20/21 deficit position of £41.5m reflects underlying positions, inflation, cost pressures, activity growth, cost of activity, other factors specific to each organisation, sustainability funding (UHB £13m) and savings plans (recurrent CIPs and QiPPs of £360.9m). To assess

our "do nothing" organisation based gap, the net income and expenditure position is "grossed up" by removing the assumed sustainability funding and savings plans. The "do nothing" gap is therefore £415.5m.

Surplus / (Deficit)	2015/16 Actual £'m	2016/17 Plan £'m	2017/18 Plan £'m	2018/19 Plan £'m	2019/20 Plan £'m	2020/21 Plan £'m
Providers						
University Hospitals Bristol NHS FT (UHB)	3.5	14.2	6	5.7	5.9	7
North Bristol NHS Trust (NBT)	-51.6	-39.5	-39.5	-39.5	-39.5	-39.5
Weston Area Healthcare NHS Trust (WAHT)	-7	-3.2	-8.8	-9	-9.3	-9.6
Avon & Wiltshire Mental Health Partnership (AWP)	0.1	0.1	0.1	0.1	0.1	0
South Western Ambulance Service (SWAST)	0	0	0	0	0	0
Community Interest Providers	-0.2	-0.8	-0.6	1	0.8	0.5
Sub-total Providers	**-55.2**	**-29.2**	**-42.8**	**-41.6**	**-41.9**	**-41.5**
Commissioners						
Bristol CCG	5.7	-2.2	1.9	2	2.3	0
North Somerset CCG	-13.6	-13.7	-10	-7.2	-3.8	0
South Gloucestershire CCG	-9.3	-6.5	-7.2	-3	0	0
NHS England (Specialised Commissioning)	0	-0.5	0	0	0	0
NHS England (Mandated Primary Medical Care)	0	0	0	0	0	0
Sub-total Commissioners	**-17.2**	**-22.9**	**-15.3**	**-8.2**	**-1.5**	**0**
Total Organisational Financial Plans	**-72.4**	**-52.1**	**-58.1**	**-49.7**	**-43.4**	**-41.5**
Convert to 2020/21 "Do nothing"						
Remove sustainability funding assumed (UHB only)						-13
Remove CIP/QIPPS 2016/17 to 2020/21						-361
Total BNSSG "Do nothing" Position						**-415.5**

NB: The CCGs positions exclude Recovery of Annual Borrowing

This 20/21 position includes significant sustained deficits within NBT (£39.5m) and Weston (9.6m) reflecting specific drivers as follows:

NBT	**Weston**
Additional PFI costs £20m Impact of contractual levers CQUIN £1.5m Income shortfalls £10m Balance due to activity / emergency pressures £8m	£9.6m deficit mainly due to clinical sustainability issues

Summary

We have a clear shared understanding of the gaps in our system and their key drivers. Our agreed approach to addressing these issues and accommodating future growth in demand within available resources involves containing

and reducing costs individually and collectively, targeting productivity opportunities and transforming the way we plan, commission and deliver care over next 5 years. We need to invest in technology, self-care, prevention, and workforce to enable productivity initiatives. This is described in the next chapters.

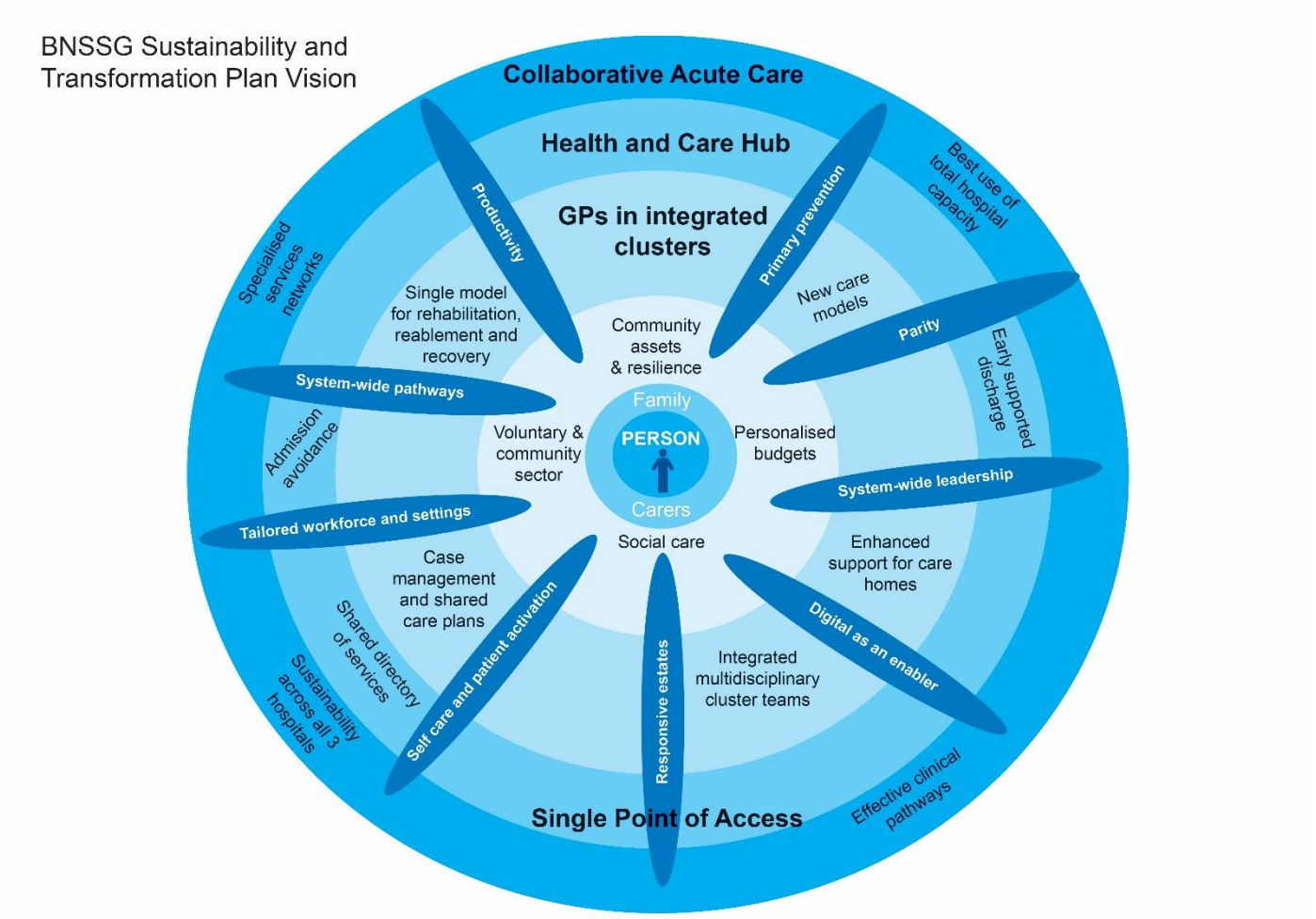
Chapter 2 – New Model of Care

Health is made at home; hospitals are for repairs – African Proverb

Our current system is one in which hospital care is seen as the apex of the health and care system and people are seen as a collection of illnesses or problems usually dealt with separately.

Our new model of care starts with people in families and communities. Individuals will be encouraged and enabled to care for themselves; services will be delivered locally by integrated teams focused on the needs of the individual; and access points to acute care and specialised services will be simplified.

In our model prevention, early intervention and self-care will be targeted on areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.



We will deliver care consistently and at scale across our footprint as part of a fundamental change in the way we respond to demand. We will remain responsive to individuals and local communities and ensure appropriate care and support in the right place at the right time.

Disparities in care for physical and mental health conditions are everybody's business. Our model will ensure that parity is a golden thread running through the whole of health and social care provision. All forms of care will consider and value mental and physical health equally, so that people receive the treatment to which they have a right and will be supported effectively in their recovery. We will apply a 'parity test' to our services and developments and will challenge professional behaviours, attitudes and policies that stigmatise mental illness. Our staff will show the same respect for each other, wherever they provide health or social care or treatment.

Drivers of change in our new model of care

In order to deliver the change required we will need to behave differently. We have agreed that there are five key drivers that together will enable us to develop and implement our new model of care.

1. We will standardise and operate at scale:
   We need to standardise the care that is delivered across our system to reduce variation and reduce fragmentation. At the same time we need to work at scale. This means developing a single commissioning voice, increasing collaboration across our acute hospitals and operating at scale in primary and community care around defined populations.

2. We will develop system-wide pathways of care:
   We need to address the variation in pathways across our system. This means redesigning pathways from a population perspective in a way that is clinically led, includes prevention and self-care at all stages, and ensures consistent quality and access across our footprint.

3. We will develop a new relationship with the population:
   We need to simplify access to the health and care system for our population and deliver services predominantly in the community that appear seamless. At the same time we need to enable people to care for themselves. This means developing single points of access, multidisciplinary teams and a shift to prevention and early intervention.

4. We will develop new relationships between organisations and staff:
   We need to remove organisational boundaries that impede integrated working and support our staff to deliver better services. This means developing interoperable IT and HR systems, aligning resources with individual need and system efficiency rather than organisational priorities and promoting the health and wellbeing of our staff.

5. We will build on our existing digital work as a driver and enabler of cultural change:
   We need to use technology to drive a cultural change in the way we work. This means developing mobile working for staff, digital medical records, and solutions for self-care and prevention.

Our plans are articulated in more detail in the chapter below setting out how our drivers will deliver change in three key areas;

- Integrated primary and community care
- Prevention, early intervention and self care
- Acute care collaboration

This approach is summarised on our Plan on a Page below. We believe this approach allows us to address the '10 questions' to achieve the 5 Year Forward vision and have summarised these below.

	Standardise and Operate at Scale	New Relationship with population	New Relationship with staff and organisations	Care pathways	Digital as a driver and enabler
Preventing ill health and reduce demand		X		X	X
Engage communities and staff	X	X	X	X	X
Support and improve general practice	X	X	X		X
Implement new models of care	X	X	X		X
Achieve and maintain performance against core standards	X			X	X
Achieve national clinical priorities by 2020		X		X	X
Improve quality and safety	X			X	X
Use technology to accelerate change		X	X		X
Develop the necessary workforce	X		X		X
Achieve and maintain financial balance	X	X	X	X	X

Our Plan on a page

Our case for change

Our health & well-being gap
Premature mortality, the burden of disease and mental health conditions is increasing demand for health and care , with limited patient activation and continued inequalities

Our care & quality gap
Unacceptable variation in care and quality outcomes and under investment in primary, preventative and community care resulting in fragmented, poorly integrated and complex system focused on acute care

Our finance and efficiency gap
increasing pressure on resources due to demographic changes, recruitment and retention issues , financial constraints and cost variations. Our "do nothing" gap will be £415m by 2020/21

What we will do differently

- **Standardise and operate at scale**
- **Consistent pathways**
- **A new relationship with our population**
- **A new relationship with organisations and staff**
- **A shift to digital**

Our Service Model Focus

Prevention, Early Intervention & Self-Care	**Self-care and patient activation** will be implemented at scale with consistent delivery across our system	**Population focussed standardised pathways** to reduce variation, activate the population and increase proactive prevention	**Innovative care settings and digital reach** to enable self care and maximise use of all community assets	**Targeting and reducing health inequalities** with a focus on key at risk groups to make early impact
Integrated Primary & Community Care	**Stable and sustainable primary care at scale - cluster based primary care** to deliver a 7 day service model and facilitate delivery of the 10 high impact actions within the GP 5 Year Forward View	**Integrated cluster-based care and support** through one integrated model of care based on health and social care multi-disciplinary teams operating at scale, supporting primary care clusters and targeting support through population based, risk stratification.		**Health and Care Single Point of Access** to simplify and standardise emergency and urgent pathways
Acute Care Collaboration	**Specialist services & Networks** developed to consolidate and network Bristol hospitals for specialist services avoiding unnecessary travel for patients to more costly providers out of region.	**Effective Clinical Pathways** across our provider landscape to improve quality, reduce costs and variation with a focus in the short term on high volume and high-cost services.	**Best Use of Hospital** capacity to maximise bed productivity, achieve a sustainable level of acute occupancy and release capacity to reduce unit costs and secure sustainable delivery of constitutional standards.	**Sustainable acute services including Weston General Hospital** through collaboration and clinical networking.
Enabling the Change	**Leadership & Governance** to share and build capacity and capability, achieve balance between system priorities and benefits and individual organisations and manage risks	**Working together to develop our workforce and deliver productivity** collaborating to build new skills, reduce duplication and support collaborative working	**Engaging and communicating with our stakeholders**	**Making best use of our collective estate**	**Driving our Digital ambition** to fundamentally change how we work, doing things differently and working together differently.

The impact we will make

Our collaborative working and new models of care will enable us to develop and sustain appropriate capacity across all parts of health and care to ensure we can effectively and affordably respond to growing demand and achieve greater productivity and efficiency than working alone. Specific impacts we will deliver will include increasing the appropriateness and effectiveness of interventions in the right setting; reducing hospital admissions, readmissions and ED attendances; increasing resilience and capacity in primary care; achieving standardisation of pathways and processes that improves patient flow, reduces duplication, improves quality outcomes and increases efficiency and performance against standards; developing our staff to work in an integrated way with parity and trust across all teams; maximising use of our collective estate; and a digitally enabled system.

Through this plan we have the opportunity to reduce our affordability gap to £60m and we will continue to work to build evidence for achieving balance.

Chapter 3 –Delivering the New Model of Care

3.1 Integrated Primary and Community Care

In our new model, clusters of GP practices will be responsible for the health and wellbeing of their populations 7 days a week. They will be responsible for coordinating the mental and physical health and social care and support of populations, operating within larger multispecialty community providers, primary and acute care systems, or other appropriate models.

The required level of care for individuals and populations will be identified using risk stratification, and delivered through multidisciplinary working and integrated systems of care.

General practices - as key assets in their community - will support community resilience, link with community and voluntary sector groups, and support local people to stay as well and as healthy as possible. Clusters will vary in size depending on the requirements of their populations but will serve approximately 30 to 50 thousand people.

A range of different collaborative arrangements are already under discussion across BNSSG. At present, GP practices in South Gloucestershire are arranged into 6 clusters; North Somerset has 4 localities; and Bristol has 3 localities within which there are a number of emerging clusters.

The integrated model of primary and community care will enable:

- A sustainable 7 day model of primary care for BNSSG, facilitating delivery of the 10 high impact actions within the GP 5 Year Forward View
- Delivery of more specialist care in the community by moving whole elements of routine and urgent care out of hospital e.g. for those with long term conditions and frail older people
- Reduction of inappropriate use of hospital beds by a standardisation of systems across organisations and levels of care including delivery of community based routine care in place of traditional outpatients, urgent and planned admission avoidance support and supported discharge
- More efficient, integrated health and social, primary and community care through application of consistent best practice, use of digital solutions, joint estate options and integration and delivery at scale
- A holistic person-centred approach encompassing physical and mental health needs with social care and community support

The central theme is ‘person-centred, coordinated care’, bringing together services and health and social care professionals from across the health and care systems.

Transformation

The key elements of the new model for integrated primary and community care are:

1. Sustainable primary care at scale – cluster based primary care
2. Integrated cluster-based care and support
    a. Population based, risk stratified care and support – one integrated model of care based on health and social care multi-disciplinary teams operating at scale, supporting clusters
    b. Targeted support for those at risk of admission or following discharge or towards end of life, through case management or a virtual ward model and holistic care planning

   c. Rapid response for urgent care needs, consistent across BNSSG, including community based crisis support for those with mental health conditions preventing avoidable admissions
   d. One model of sustainable rehabilitation, reablement and recovery supporting a return to independent living and enabling use of personalised care budgets.
3. An integrated health and care single point of access (SPA)
   a. One single standard service provided across BNSSG, which is aligned to each acute hospital, to prevent admission and support early and effective discharge.

Sustainable primary care at scale – cluster based primary care

In order to deliver sustainable primary care 7 days a week, core primary care will become more multi-disciplinary. Work has already started across BNSSG, using the Prime Minister's Challenge Fund and the National Primary Care Home Initiative to test new ways of working. Options including direct access physiotherapy, clinical pharmacist pilots, integrated primary and community nursing, multi-disciplinary community teams, social prescribing and community navigators are being tested within BNSSG.

Greater use of technology to change the way care is provided will be facilitated by easier communication between primary and secondary care and by access to records held outside practices.

The recent decision to adopt a single voice for primary care providers within BNSSG provides a significant opportunity to help practices collaborate and consider how they will implement the GP five year forward view.

Integrated cluster-based care and support

a. BNSSG will jointly work on a population risk based approach, identifying the required levels of care and whether these can be delivered at an individual GP, cluster or integrated multi-disciplinary team (MDT) level. This will build on existing integrated models of care which support those with respiratory conditions; diabetes; frail older people and those living in care homes. Bringing mental health into the MDT approach means better access to appropriate advice and guidance.
b. A single model of enhanced care for residents in care homes will be developed working with care homes to improve staff clinical, management and leadership skills through training and supervision/support and to deliver new shared models of care e.g. enhanced community matron support to Extra Care Housing.
c. In consultation with the urgent and emergency care network, we have aligned our plans with the key priorities for the urgent and emergency care system. This includes the development of one health and care SPA, and also a multi-disciplinary approach to developing urgent primary and community care e.g. mental health, pharmacy, social care. This will facilitate direct referrals between services and is likely to include the ability to make direct bookings into primary care and community services such as Rapid Response from Emergency Department (ED) and 111 as part of joint front door arrangements as well as an increase in capacity in mental health crisis teams.
d. There has already been considerable work to align discharge pathways across BNSSG using a Discharge to Assess model. Models of reablement, rehabilitation and recovery are in place and capacity being brought on line across BNSSG. Further work will be done to ensure the capacity required is available those with dementia.
e. This approach provides a platform for patient education and activation, encouraging prevention through improved lifestyle choices, more self-care, more appropriate use of health services and choices which are both better for patients and families and can be delivered at reduced cost. Individualised commissioning, or personal health budgets, based on more meaningful conversations with patients and families will support this.

An Integrated Health and Care SPA

A Single Point of professional Access (24/7) with underpinning technology and information sharing, will be linked to all of our acute hospitals, connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

This will integrate as required with the proposed urgent and emergency care network integrated clinical hubs and will be underpinned by a shared directory of services to ensure consistency of approach and integration where this makes sense.

It will operate under single management and to common Standard Operating Procedures, staffed by care co-ordinators working with their cluster practices and hubs, with access to capacity including community beds across the system, and deploying in-reach clinical staff into hospitals.

The focus will be to ensure the most appropriate care in the community to prevent admission and facilitate discharge through:

Prevention of Admission

- Co-ordination of urgent care case management including improved responses for those presenting with mental health crises and dementia.
- A standard integrated offer to people presenting at ED at risk of admission or for whom an alternative to admission would be a better option, including ambulatory care.
- Co-location with Out of Hours service call-handlers and the supported self-care hub, and potentially with 111 and ambulance services.

Supported discharge

- Supporting wards to discharge simple and complex patients and enabling service users or their carers to arrange their own discharge so that no medically fit person need remain in a hospital bed for more than 24 hours.
- Maintaining links with practices during a hospital stay, with GPs as the main co-ordinator after discharge, supported by a single model of rehabilitation and reablement services.

Supported self-care

- Early intervention, prevention and supported self-care in primary and community settings e.g. supporting people using technology, motivating, coaching and activating people to self-care and improve their lifestyles or comply with their agreed care plan.

Non clinical interventions, signposting and community assets

- Delivering a social prescribing model to harness existing local resources in the community and voluntary sector e.g. reducing social isolation.

Impact

We expect this model to support delivery of care in more cost effective settings, in particular preventing future reliance on acute physical and mental health beds, but also to ensure more efficient and consistent delivery of care in primary and community settings. Specifically we expect the model to have the following impacts:

Activity / Initiative	Description	Impact	Alignment to Drivers of Change
Integrated cluster based care and support	More efficient primary and community care through delivery of integrated, digitally enabled working and greater reliance on alternatives such as social prescribing and self-care	An overall 15% avoidance of future primary and community contacts.	Relevant to all 5 drivers
	Coordinated care for those with long term conditions, multi-morbidity, frailty including dementia and for those who live in care homes and those with end of life care needs	An overall reduction in admissions of 30% and of ED attendances by year 3, modelled for very specific long term conditions or population groups e.g. those in care homes, reflecting Right Care approaches to maximising value across the pathway. Length of stay reductions are modelled within the Acute care workstream so not duplicated Elements of this reduction has been tested to a degree in a number of smaller scale QiPP initiatives and can be scaled up	Consistent pathways New relationship with population New relationship with staff and organisations
	Coordinated crisis support and care for those with mental health conditions including specific pathway work for those with personality disorders	2.5% reduction in admissions and free up capacity for increased demand to an equivalent value of £1m	Consistent pathways New relationship with population New relationship with staff and organisations
	Reduced outpatient attendances for defined cohort (first and follow up) by providing alternatives via cluster based MDT or through self-care, group delivery and digitally enabled care	Relevant specialties will have their first attendances reduced by 30% and their follow-ups will match national first to f/up ratios. The counter-balance will be approximately 1 in 3 of the reduced activity will require some form of community activity	Relevant to all 5 drivers
Health and care hub	An integrated BNSSG health and care hub at Hospital level	All modelled activity reductions are set out above in the Cluster-based care initiative to avoid double-count	Relevant to all 5 drivers
	More efficient utilisation of community beds by streamlining access and “type”	Reduction in length of stay to best for bed “type”. Releasing further beds to the system and a small saving	Relevant to all 5 drivers

3.2 Prevention, Early Intervention and Self-Care

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

The model is based on four principles:

1. Resource: Ensure that strategic initiatives are costed and adequately resourced
2. Enable: The population and patients need to be enabled to adopt healthy behaviours
3. Align: Alignment of strategies and pathways ensuring consideration of the wider determinants of health
4. Innovate: Finding new and better ways of achieving outcomes through making the best use of available resources (including workforce) and ensure co-production (community involvement in the development of initiatives).

Transformation

We have identified the key decisions necessary to deliver a radical shift towards prevention. These are:

- Self-care and patient activation will be implemented at scale with consistent delivery across our system
- A population health approach will be embedded across pathways (activate the population, carers and health professionals; reduce admissions; increase proactive prevention across the pathway)
- We will enable care settings to be innovative and effective e.g. using digital technology to support self-care
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties)
- In order to achieve the short and medium/long term priorities investment is required for prevention, early intervention and self-care at scale. Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years.

Impact

Our initial priorities are:

- Alcohol harm reduction
- Falls
- Diabetes
- Self-care at scale

These have been chosen because they are evidence based, will improve the health of the target population, have an impact across the system and will reduce hospital admissions. They have been developed based on a life course approach and the need to embed prevention and self-care across the pathway taking into account primary, secondary and tertiary prevention opportunities.

Our priorities are enabled by:

- an established patient-centred Bristol, North Somerset & South Gloucestershire health and care partnership approach
- the development of a new relationship with the public and the delivery of the shift of care from an acute setting to primary and secondary and self-care with a reduced dependency on beds and increased use of health and social care hubs and signposting
- wider definition of workforce to include for example voluntary sector, police, housing, pharmacy; and a non-differentiated workforce across BNSSG with common training and standards.
- digital platforms and technologies such as personal health records, telehealth and app development.

Priority	Impact	Methods to measure impact
Alcohol - reduce excessive alcohol consumption and associated burden on NHS and Local Authorities (LAs) and wider society	Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs by 2020/21 Reduce the burden on NHS, police and social care services from high volume service users Reduce the impact of parental alcohol misuse on children	Alcohol-related hospital admission (narrow measure): number of admissions (by CCG and LA) Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission (by CCG) For every 3 IBA interventions delivered 1 alcohol-related admission will be avoided[1] Ambulance call-out data
Falls - reduce fractures from repeat falls.	10% reduction in the number of injuries due to falls in people aged 65+ by 2020/21, through improved and more coordinated preventative services	Emergency admissions due to hip fractures in people aged 65+ per 100,000

[1] Public Health England

Publication November 2016.

		Patients with fragility fracture and confirmed osteoporosis treated with bone-sparing agent Fracture liaison services can reduce risk of second fracture by up to 50%[2]
Diabetes – prevent cases of Type 2 diabetes and improve management of those with diabetes	Reduce the projected growth in incidence of diabetes Improve support for self-care in people with a diagnosis of diabetes Improve the treatment and care of people with diabetes	Uptake of the NHS Diabetes Prevention programme Incidence of diabetes
Supported self-care at scale	Reduction in emergency admissions of LTC group with above average risk of admission Develop training for health professionals and population Self care enabled via digital supports	22-32% reduction in emergency admissions of LTC group with above average risk of admission (25%)[3] Patient Activation Measure

Medium and long-term priorities

Our medium and long term priorities for prevention, early intervention and self-care are summarised below. Specific interventions will build upon the implementation of the short term priorities during year 1 and implementation of the medium/long term priorities will begin in year 2. The priorities have been aligned to pathway priorities including those identified within the Integrated Primary and Community Care and Acute Care Collaboration workstreams and with wider determinants of health.

Activity / initiative	**Description**	**Impact**	**Alignment to Drivers of Change**
PATHWAYS			
Healthy lives	Obesity reduction, smoking cessation and continue work on alcohol harm reduction	Reduce related hospital admissions	Consistent pathways A new relationship with the population
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG and build on self-care work already underway*		
Primary prevention - adults	Dementia and stroke prevention	Consistent pathways across BNSSG with prevention integrated across pathway	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on atrial fibrillation and impact on stroke prevention & return on investment*		
Mental health - Children and young people	Provide appropriate support and services focusing on the emotional wellbeing and mental health of children and young people Work with schools, Children's Centres etc.	Consistent pathways across BNSSG with a strong focus on prevention and early intervention prior to any formal diagnosis	Relevant to all 5 drivers
Intervention	*Ensure services reflect need particularly for those sub-threshold in terms of clinical diagnosis.* *Ensure consistent offer across BNSSG and access to appropriately designed prevention and self-care initiative in appropriate settings – base on existing examples of good practice.* *Reduce attendances due to self-harm.*		

[2] Nakayama et al 'Evidence of effectiveness of a fracture liaison service to reduce the re-fracture rate' Osteoporosis International March 2016, Vol 27, Issue 3, pp873-879

[3] BCH/Philips project

Secondary prevention - adults	Secondary prevention: atrial fibrillation, hypertension, hypercholesterolaemia, LTCs (multi-morbidities), cancer prevention via a range of health professionals	Ensure consistent pathways across BNSSG	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on evidence for return on investment for health and social care*		
Ambulatory care	Develop/build on prevention and self-care services	Reduce ED attendances and admissions.	Consistent pathways A shift to digital A new relationship with the population
Intervention	*For example develop/build on self-management for COPD; rapid response teams at home; EOLC*		
Sexual health	Focus on contraception and return on investment	Reduce associated costs of less effective contraception	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Increase take up of more effective contraception (LARC)*		
Health protection	Flu programme Antimicrobial resistance and link to self-care	Reduced primary and secondary care attendances	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Focus on potential to reduce:* *GP consultation rates for influenza-like illnesses; A&E attendances for respiratory conditions; Emergency admissions for confirmed influenza* *Impact of health and social care reduced capacity and performance due to staff absence; Antibiotic prescribing for secondary bacterial pneumonia (and resultant risk of a rise in antimicrobial resistance); Outbreaks in acute and community settings requiring special management arrangements; Parental leave to care for ill children; Excess winter mortality, particularly in identified at-risk groups.*		
WIDER DETERMINANTS OF HEALTH			
Reduce harm caused by social isolation	Provide adequate support for the frail elderly and reduce the harm caused by social isolation	Reduce ED attendances and admissions.	Consistent pathways A new relationship with the population
Intervention	*Ensure consistent support and signposting across BNSSG with a focus on evidence for return on investment, building on existing support services and social prescribing*		
Expand prevention activities within NHS providers	Create healthier environments in health and care providers and local employers.	Healthier workforce – positive impact on workforce retention	A new relationship with staff and organisations
Intervention	*Ensure consistent messaging conveyed to the workforce. Include link to enabling those with LTCs to work. Consistent approach to workplace health across BNSSG starting with health and care providers and broadening out to other employers*		
Inequalities	Take a BNSSG approach with a focus on inequalities within BNSSG rather than regional comparisons	Equal access to the right prevention/early intervention/self-care initiative in the right place at the right time	Relevant to all 5 drivers

Intervention	*For example review excess winter deaths and link to inequalities*		

3.3 Acute Care Collaboration

This part of our model is about the acute care system and not individual providers. The following principles for how we commission and deliver acute physical and mental health care have been agreed:

A collaborative provider model, supported by a single commissioning approach.

- Eliminate variation from best practice for both quality and efficiency
- Provide services locally where possible, centralised where necessary making best use of available estate and workforce
- Work together across care pathways so that patients receive right care first time in the most appropriate setting
- Support primary and community care with a consistent offer from all Trusts
- Improve patient care across pathways by improving speed and quality of information sharing

Reducing utilisation of acute hospital bed base

- Ambulatory care maximised (all Ambulatory Care Sensitive conditions to be reviewed and harmonised across Acute Trusts)
- Hospitals including paediatric and acute mental health have bed occupancy that allows efficient flow of patients
- Best practice in whole hospital flow embedded to include optimal theatre utilisation, avoiding cancellation and flow from acute hospital to mental health settings
- Immediate discharge or transfer when acute hospital based care (including mental health) is no longer required
- Lean outpatient work delivered in a place that patients want which avoids waste and supports community based care

Using our acute hospital resources to support the wider health and care system.

- Sharing the acute and mental health hospital facilities, physical assets, clinical skills and staff to support patients to stay out of hospital when possible.
- Utilising our scale to provide resilience to the health and care system including infrastructure, shared corporate services and workforce development.

Transformation

The BNSSG acute sector transformation plan has four major work streams:

- Best use of hospital capacity
- Effective clinical pathways
- Specialist services and networks
- Sustainable services at Weston General Hospital

3.3.1 Best use of hospital capacity

Within our system at the moment all of the hospitals operate at inefficient levels of bed occupancy for the majority of the year. During winter months elective cancellations are high. BNSSG has high hospital admission rates with inappropriate use for Ambulatory Care Sensitive conditions and End of Life care. The aim is to reduce bed occupancy to average 90% over the year and maximum 95% at times of peak demand.

Our key actions to address this will be to:

- Improve bed use through reduction in delayed discharges and achievement of upper quartile length of stay
- Work in partnership with primary, community and social care to improve assessment processes in acute and mental health hospitals to minimise delay to complex discharges
- Support development of capacity and capability of community services with delivery of hospital based services such as 'Hot clinics' and diagnostics so that patients are only in hospital beds when necessary
- Embed best practice in managing hospital patient flow in all providers
- Maximise ambulatory care pathways that avoid hospital admission in all health communities, sharing best practice between providers
- Develop high quality care 7 days per week sharing hospital resources and work force to provide a consistent offer whilst minimising additional investment
- Enhance partnership working between clinical staff and patients so that interventions are only undertaken when they will add value to an individual's quality of life. Share provider's experience in creating this culture change

3.3.2 Effective Clinical Pathways

The vision for the whole system is to make best use of hospital capacity and ensure that patients receive the right care first time. Although described here effective clinical pathways will need changes across the system and not just in hospital.

Highest impact pathways will be chosen from a review of Getting it Right First time (provider focus) and Right Care (commissioner focus) data as well as the Optimal Care tool developed by the CLAHRC-West. Pathway reviews will be guided by our newly established Clinical Cabinet and all new pathways will be evaluated to ensure elimination of unwarranted variation in practice and to avoid unintended consequences.

Urgent and Emergency Care

The paediatric major trauma centre is at University Hospitals Bristol and the Adult MTC is at North Bristol Trust. All of the acute Trusts in the foot print are members of the Severn Urgent and Emergency Care Network (SUECN). The network is developing a Delivery Plan that will support further development of the STP urgent services;

Our key actions will be to:

- Create a Clinical Cabinet and process to prioritise pathways for review and to ensure reviews are clinically led and involve clinicians from within hospitals, community and primary care, and public health
- Review the capacity, demand and cost profile of Trauma and Orthopaedic services to manage the increasing demand in a system that already has a back log of work and high reference costs
- Develop stroke pathways that provide the highest quality care in the hyper-acute setting and rapid discharge to an out of hospital rehabilitation environment at the earliest opportunity
- Avoid admission for end of life care where possible and provide early discharge to a place of the patients choice by enhancing care in the community
- Address the poor outcomes of diabetic care that result in increased amputation rates and other complications
- Maximise care in the community for patients with respiratory disease with pathways that reduce the seasonal increase in admissions in the winter
- Address the high cost and variation in hospital length of stay in cardiology

- Work with Mental Health providers, acute Trusts, community and primary care to make most appropriate use of acute mental health bed capacity and ensure patients receive physical and mental health care rapidly in the most appropriate setting, aiming for care close to home whenever appropriate, avoiding out of area placements.
- Focus work with Bristol Children's Hospital through the emergent Children's Community Health Partnership, to increase community based care and ensure that growing demand can be accommodated within current resources
- Review the infrastructure for Radiology and centralised Pathology to support rapid access for primary and community care, specialist services in hospitals 7 days a week and make best use of future opportunities for personalised medicine

3.3.3 Specialised Services

More than 30% of the capacity of acute hospital Trusts in Bristol is occupied with specialist commissioned services which support care for a large regional population. Most specialist services in Bristol are delivered by a single provider working at scale. The specialist capacity needs protection so that it is available for delivering urgent and complex care beyond the STP foot print boundaries. This requires effective networks supported by specialist commissioners that ensure rapid repatriation of patients to local settings and rehabilitation pathways of sufficient capacity to avoid delays.

Our key actions will be:

- Support commissioner led review of specialist rehabilitation pathways focussed on neurosurgery, trauma, vascular and stroke patients
- Support continued development of the Operational Delivery Networks and a Cancer Alliance hosted by the acute Trusts to enhance their ability to deliver effective pathways
- Review clinical leadership and management oversight for the level 3 neonatal units in Bristol so that they meet the required designation standards within available resources
- Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services with a new provider partnership model including third sector members.

3.3.4 Weston Sustainability

The specific issues with the sustainability of services at Weston General Hospital are being addressed through a North Somerset Sustainability board within the auspices of the STP. The three acute Trusts in the STP together with commissioners are committed to working together to describe models that provide high quality care to residents of North Somerset maximising the value of available resources. The solutions will be aligned with the recommendations in 5 Year Forward view for smaller hospitals

Key actions and opportunities for the system in achieving a sustainable model at Weston are:

- Support the ongoing resilience of the emergency services ahead of winter 2016/17
- Work with the North Somerset Sustainability Board to identify future models of care during 2016/17
- Agree models to maximise use of the Weston hospital estate for example, operating theatre capacity to meet elective demand across BNSSG.

Impact

Activity / initiative	Description	Impact	Alignment to Drivers of Change
Best Use of Hospital Capacity	Reduce bed day demand and improve bed productivity through a reduction in delayed discharges and achievement of upper quartile LOS. Address the volume of patients currently experiencing a delayed discharge across our acute mental health bed base, resulting in out of area placements, to the potential value of up to £3.3m per year. Improved partnerships with primary, community and social care to improve assessment processes in hospitals, complex discharges, support increased assessment out of hospital and enhance community based capacity. Achieve reduction in admissions through development of self care and prevention and community / primary care based intervention, through driving a 'single front door', as part of the Urgent Care Network delivery plan, and enhancement and development of ambulatory care pathways. Development of 7 day services across the system.	Achievement of upper quartile LOS in top 3 impact areas (not linked to DTOC). 50% reduction in current level of patients in acute beds who are Medically Fit For Discharge (MFFD), which includes an 85% reduction in the number currently meeting the national DTOC definition Potential impact of bed day activity released in the region of 200-300 acute beds, including acute mental health beds. Reduction in out of area mental health placements. To the potential value of £3mReduction in admissions linked to self-care work stream and Urgent Care Network Delivery Plan. Sustainable delivery of access standards. Decreased use of outsourcing to independent sector for elective activity. 7 day coverage for emergency care. Increase in ambulatory care pathways	Standardise and operate at scale Consistent pathways A new relationship with our population
Effective Clinical Pathways	Year one focus on MSK/T&O pathways, building on BNSSG T&O Steering Group and supported by the Intensive Support Team (IST). Stroke Care –for acute stroke and minimum hospital stay during stroke rehabilitation. End of life care –Reducing unnecessary admission at this time and support early discharge to community care where possible. Diabetes –address our outcomes and reduce the cost of managing complications. Cardiology and Respiratory – further understand opportunity to manage demand with out of hospital solutions. Emergency paediatrics– Manage current high level of growth in demand. Radiology and Pathology diagnostic services – to support in and out of hospital care. Urgent Care Pathways – Develop sustainable in and out of hospital pathways, with the Urgent and Emergency Care Network.	30% reduction in excess costs relating to RCI in T&O, cardiology and respiratory. Reduced admissions and LOS for stroke. Increase in early discharge to community for patients in end of life care and reduction in admissions. Improved outcomes and reduction in admissions resulting from diabetes related complications. Reduction in variation between pathways across local providers, including LOS, operational performance and cost base. Reduction in current levels of growth in emergency paediatric at tendencies and admissions. With focus on UH Bristol and Bristol. Rapid access to diagnostics to enable community and primary care to manage patients at home and to enable efficient self-care and personalised medicine. Sustainable urgent and emergency care pathways, including a standardised front door.	Standardise and operate at scale Consistent pathways A new relationship with our population

Specialist Services and Networks	Year one focus to develop a single provider model for NICU in BNSSG High quality provider of specialist services for catchment ensuring patients are not travelling unnecessarily to alternative, more expensive, providers out of the region Provide leadership in clinical networks that support the sustainability of services in local providers. Address delays in repatriating patients to their referring provider or rehabilitation – 16/17 focus on delays in accessing Neuro and Spinal rehabilitation. Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services in BNSSG through a new CCHP provider partnership model. Focus on contributing to the developing Cancer Alliances, led by the Cancer Network, to provide effective cancer pathways that meet the national quality and access standards. Establish potential impact in terms patient volume, of commissioner stated intention to further evaluate the number and configuration of specialist units in the region	Development of single provider model for NICU. 10% reduction in patients treated out of area on specialised pathways. Only planned increase in BNSSG demand resulting from any change in configuration of specialist units in the region and support local providers to deliver 7 day services where required. Reduced delays in repatriation of patients on specialist pathways. Implementation of new integrated, partnership based community paediatric services (CCHP). Development of cancer alliances to improve quality and access. Reduction in bed days associated with delayed repatriation to referring provider or rehabilitation for patients on specialised pathways. NHSE modelled potential change in flows associated with consolidation of providers. Capacity developed accordingly to manage demand within available resources.	Standardise and operate at scale Consistent pathways A new relationship with our population
Sustainable services at Weston General Hospital	Priority focus on a solution for the short term sustainability of ED and developing an alternative model for the provision of emergency care. Phase 2 – Evaluation of full options and development of medium to long term plan for Weston Hospital, which secures a sustainable solution for acute services within North Somerset. Phase 3 implementation of full plan.	Clear plan in place ahead of winter 2016 to address the current sustainability issues associated with Weston ED and emergency care pathways. Medium to long term plan in place, which establishing the long term service profile of Weston General Hospital. New model in place.	Standardise and operate at scale Consistent pathways A new relationship with our population

Chapter 4 – Enabling Change

Enabling workstreams are described in detail in the annexes. The key points are:

Leadership and Governance

While we have good foundations in place through our established System Leadership Group, for working collaboratively in BNSSG, we know we need to invest time and leadership to deliver on our STP ambitions. In particular we need to establish mechanisms that support us to achieve balance between priorities and benefits for the whole system, while maintaining stability and meeting the requirements of individual partner organisations with whom final authority currently remains.

The Senior Responsible Officer (SRO) for the STP was agreed by the SLG and an SLG Executive Group was established with cross-sector representation to act as the programme steering group for the STP. Each STP workstream is led by a Chief Officer or equivalent from the System Leadership group as SRO. Budget pooling arrangements were agreed to fund capacity associated with development of the STP including the Project Management Office (PMO), modelling support and external consultancy.

Going forward we will draw on lessons learned from the development of the STP, from other footprints and vanguards and maintain the involvement of SLG members to ensure that pace is maintained and obstacles addressed. We will consider how we can redirect existing resource within organisations and in the system to minimise additional cost, reinforce collaborative working and provide credible leadership.

Engagement

Although no formal consultation has taken place a large number of partners and stakeholders have been involved in the development of our plan. Existing feedback from service users, carers and the public from across BNSSG has informed the development of the STP. This includes information from public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports. This has helped to ensure that our thinking is being shaped by the issues that the people who rely on our services have told us is important to them.

A joint working group has been set up by the 15 partner organisations (including health and LA partners) and a communication and engagement plan has been agreed in outline. An initial stakeholder mapping exercise has been undertaken in order to identify target audiences for communication and engagement and support the development and implementation of the STP. Subject to any feedback during July from the initial submission and agreement on the national timetable for further development, discussions with the three local Health Watch organisations and other stakeholder organisations, the working group will finalise arrangements for local engagement using existing patient, public and staff networks and fora over the next 5 years.

Workforce

Within BNSSG there is a system wide commitment for a more joined up, co-ordinated, digitally enabled and flexible workforce which delivers increased productivity and meets the changing health and social care needs of the local population. Each of the new models of care described in this STP rely on the requirement to have the right staff with

the right skills, values and behaviours in the right place at the right time to deliver respectful, compassionate and expert professional service.

As part of the on-going STP planning there will be a requirement to confirm the size and shape of the workforce particularly in the children and adolescent social care services, the Ambulance Service, the primary care sector and the voluntary sector – all of which have key enabling roles within the STP.

Workforce is identified as key to the implementation of our new model of care. This will require a flexible workforce focused on providing care out of hospital wherever possible, building centres of excellence and able to share core capabilities across organisations.

Workforce transformation takes time, involves complex stakeholder engagement and negotiation, lengthy redesign and delivery of training and it requires strong leadership to ensure that commitment (and therefore retention) is achieved across all services. We will build on our expertise and partnerships in research to develop OD and leadership capability to support us in this journey of change, continuing to work with AHSN and CLARH to achieve this. We will undertake further work to evidence the opportunity for collective efficiency impact from our workforce working differently in the new model of care. Our key areas of immediate focus will be:

- Improving Health and Wellbeing of workforce to reduce sickness, broaden skill sets and improve participation rates
- Analyse the potential for shared Recruiting and Training to support a reduction in temporary staff costs and drive down agency supported by shared bank.
- Explore collaboration on the National Apprenticeship Levy, e.g. a sector wide Apprenticeship provided collaboratively to optimise the national offer through sharing of training and mentoring and avoiding external training costs.
- Creating a Common Culture with more understanding and engagement across and between our teams
- Making every Contact Count by training for frontline staff in brief interventions around specific lifestyle issues such as alcohol and smoking.

Estates

A new approach to estates provision and coordination across the whole health and social care system is an essential component of ensuring that we can deliver our shared vision from a property base that is fit for purpose in terms of location, configuration and specification.

The 2004 Bristol Health Services Plan 10 year plan resulted in significant strategic estates investment. Building on this our priorities and action plan have been aligned to the drivers of change identified in this document, relevant national guidance, an overview of the current estate and know risks to sustainability**.**

Our draft estates strategy is flexible so that it can adapt as circumstances dictate and support the intended strategic approach to shifting the balance of care from hospital to community, primary, social and self-care.

Digital

We are in the midst of a digital revolution. In the last 20 years, the way we live our lives, support our recreation and leisure, read and share news, shop, bank and communicate have changed beyond all recognition.

We do not believe that our digital roadmap is about automating existing processes or making it go more quickly - rather it is an opportunity to change how we work fundamentally by doing things differently and working together differently. We have closely aligned the formation of the Local Digital Roadmap priorities with the key areas of the STP, as well as closely linking it to the national needs from the Local Digital Roadmap (Universal Capabilities) and the domains and work streams of the National Information Board.

The Local Digital Roadmap vision has been drawn from the Connecting Care Vision, whose core principles and ambitions remain relevant and applicable in describing a vision for the future in delivering change driven by a channel-shift to digital ways of working.

The ability to operate efficiently, share information and support people and develop society is now a **digital first** activity for most of the population and we aim to drive this attitude into all aspects of health and social care. We shall deliver this through our five key building blocks:

1. **Primary Care at scale** – focus on maximising digital across GP practices and Out of Hours services.
2. **Paperless by 2020** – Embedding digital records in acute, community, mental health and social care.
3. **Connecting Care** – Information sharing to include putting citizens at the heart of their 'personal health records'.
4. **The Information Engine** – fully utilising our electronic data to power our planning and delivery engine.
5. **Infrastructure and support** – ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism.

Chapter 5 – Addressing Our Affordability Challenge: Financial Analysis

We have carried out analysis to identify our key areas of opportunity for efficiencies and savings and undertaken initial modelling to estimate the impact of our actions on reducing demand through our new model of care, reducing variation and improving productivity and quality by working collaboratively. We will continue to develop the detail and confidence behind these assumptions and opportunities including risk assessment using normal processes both in terms of delivery and the impact on clinical services. However, we believe we have made significant progress in reaching a single system view of how to address our 20/21 "do nothing" affordability gap of £415.5m.

The assessed level of potential savings delivery and opportunities that reduce the affordability gap to £60.6m are show below:

Delivery	**Solution per Financial Excel submission**	**Status per Excel Submission**	**Providers £m**	**Commissioners £m**	**Total £m**
2016/17 identified schemes	Solution 1 & 3	b	(45.7)	Note 1 (44.3)	(90.0)
1% Business as usual savings	Solution 2 & 4	e	(54.8)	(10.0)	(64.8)
RCI Benchmarking/Carter (estimate)	Solution 5	d	(100.0)	0.0	(100.0)
Corporate costs/% reduction of 10%	Solution 6	d	(10.0)	(2.0)	(12.0)
Margin on net activity growth @ 10%	Solution 7	d	(7.0)	0.0	(7.0)
System Transformation savings (risk assessed at 50%)	Solution 8	d	0.0	(20.0)	(20.0)
Subtotal – Delivery			**(217.5)**	**(76.3)**	**(293.8)**
Sustainability & Transformation Funding			0.0	(61.0)	(61.0)
Unidentified			(25.7)	(35.0)	(60.6)
Total			**(243.2)**	**(172.3)**	**(415.5)**

Key: b = Detailed plans in place but not all elements or organisations; d = Savings estimate based on baseline modelling and the potential size of the prize; e= No detailed plans in place yet.

Note 1: 2016-17 QIPP schemes are predominantly identified

These opportunities can only be delivered by the BNSSG system working in a more coherent, coordinated and collaborative way and by individual organisations delivering on the 2016/17 identified schemes included in current organisational financial plans and their specific "business as usual" efficiency and cost reduction opportunities. Reference cost indices demonstrate significant variation in opportunity between organisations and there is clear commitment to secure these savings opportunities through rigorous cost containment at individual organisation level alongside the collective approaches outlined in the previous chapters.

Our plans are based on the following:

- The assumption that 1% savings can be delivered through normal organisational processes
- That we will be able to address the difficulties of converting opportunities for savings indicated through the Carter work on 'unwarranted variation'/ benchmarking into cash savings by working collectively to transform delivery of the outlying services rather than adopting a simple cost reduction approach, with a target of £100m

Based on 2014/15 Reference Cost Index data for relevant providers, our opportunity to reduce variation for speciality lines with actual cost over £100k where the RCI is over 100	**UHB**	**NBT**	**Weston**	**AWP**	**TOTAL**
As submitted to National Reference Cost	£443.0m	£472.0m	£95.0m	£177.0m	£1187.0m
Overall organisational RCI	98	113	108	128	
Excess costs for specialties over 100 RCI	£27.0m	£68.0m	£11.0m	£48.0m	£154.0m

- That we can realise real savings from corporate costs for the whole footprint (excluding NHS England) either from sharing services or organisational change with a conservative target of 10% assumed while we develop more detailed proposals.
- That a margin of 10% can be made on increased acute activity after allowing for an assumed reduction in acute demand from our system transformation schemes
- That some of the specific impacts from our new care model approach as identified in the chapters above, will deliver additional savings. We have modelled out some specific impacts at a 'first cut' level which indicates net savings of £39m and will continue to analyse and risk assess to build confidence in deliverability. Until this is completed a 50% risk assessment has been applied.
- Sustainability and Transformation funding of £61m has been notified by NHS England. This is in excess of the potential sustainability fund of £32m available in 2016/17. Whether this sustainability funding will be able to be applied towards organisations savings requirements remains unclear. Our access to the transformation element of this funding to pump prime the transition to new models and ways of working and invest in transformational enablers such as digital change, will equally require discussion.

The system transformation we have identified does not fully resolve our financial gap but is essential to ensure the projected level of demand in the footprint can be managed – in particular by ensuring patients do not access acute services where they do not need to and ensuring that scarce capacity in acute services (workforce and buildings) is used where it is needed. We will continue to build on the significant progress we have made in securing transparency and ownership of our challenge and understanding our opportunities to address our residual gap of £61m.

Conclusion - Our Way Forward

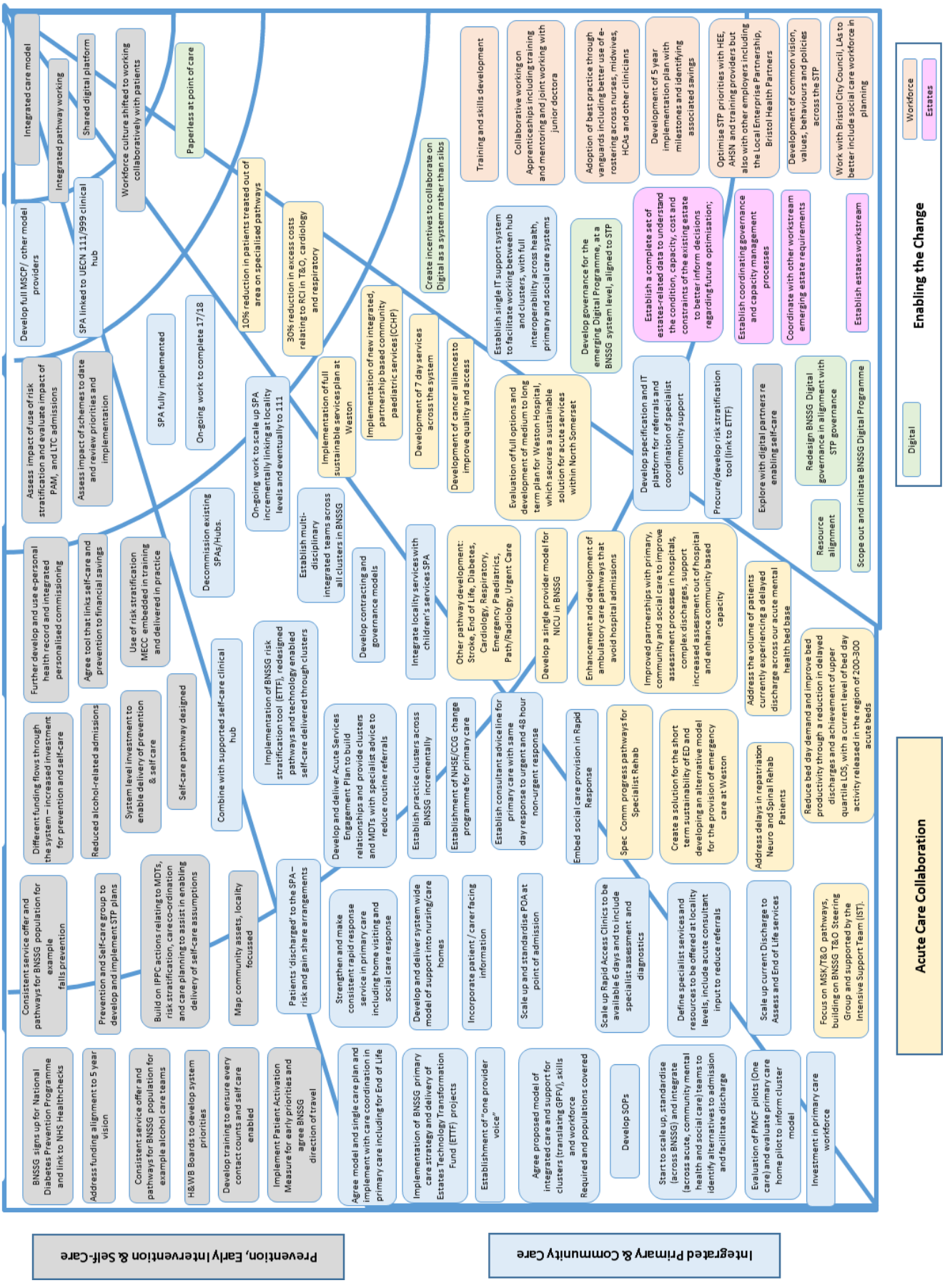
There are very significant challenges to be addressed in BNSSG now and into the future. Our plan has described the way we intend to approach them. If we are to be successful, we must first look to ourselves to ensure that we work together for our whole population and in the best interests of patients and service users rather than working in silos and within organisational boundaries. We have described the ways in which our behaviours need to change and be aligned in order that can provide the leadership needed to effect significant change across our teams and that we work openly together to share and manage risk.

We have started to identify specific actions for our model of care with a focus on securing early wins and scaling up existing, evidence-based approaches in 2016/17. This is set out in our transformation map below. We want to continue to work with our service users, staff and wider public in developing clear implementation plans around these actions.

Our immediate focus will be on continuing to work to build confidence and detail behind our modelling and affordability assessment, to build on this to address our £61m gap and to progress delivery against our existing 2016/17 savings plans.

We require support in this endeavour. Within the footprint we have unanimously agreed our system leadership going forward, committed to resourcing a dedicated Programme Director and PMO and to securing the requisite capacity and capability we need by pooling and realigning resources. In the wider system, we need a facilitative environment within which to work. If we are to behave as one system then we will need to consider the implications for how, over time, we can be treated as one system with incentives that align to system priorities rather than organisational priorities. We will want to access rapid learning from vanguard and success regimes to short-circuit our journey and discuss how we can access sustainability and transformation funds to lever early change.

T-Map


2016/17
2017/18
2018/19
2019/20
2020/21
Prevention, Early Intervention & Self-Care
Integrated Primary & Community Care
Acute Care Collaboration
Enabling the Change
Digital
Workforce
Estates
BNSSG signs up for National Diabetes Prevention Programme and link to NHS Healthchecks
Address funding alignment to 5 year vision
Consistent service offer and pathways for BNSSG population for example alcohol care teams
H&WB Boards to develop system priorities
Develop training to ensure every contact counts and self care enabled
Implement Patient Activation Measure for early priorities and agree BNSSG direction of travel
Investment in primary care workforce
Evaluation of PMCF pilots (One care) and evaluate primary care home pilot to inform cluster model
Establishment of "one provider voice"
Implementation of BNSSG primary care strategy and delivery of Estates Technology Transformation Fund (ETTF) projects
Agree model and single care plan and implement with care coordination in primary care including for End of Life
Required and populations covered
Agree proposed model of integrated care and support for clusters (translating GPFV), skills and workforce
Develop SOPs
Start to scale up, standardise (across BNSSG) and integrate (across acute, community mental health and social care) teams to identify alternatives to admission and facilitate discharge
Focus on MSK/T&O pathways, building on BNSSG T&O Steering Group and supported by the Intensive Support Team (IST).
Define specialist services and resources to be offered at locality levels, include acute consultant input to reduce referrals
Scale up current Discharge to Assess and End of Life services
Scale up Rapid Access Clinics to be available 6 days and to include specialist assessment and diagnostics
Address delays in repatriation Neuro and Spinal Rehab Patients
Reduce bed day demand and improve bed productivity through a reduction in delayed discharges and achievement of upper quartile LOS, with a current level of bed day activity released in the region of 200-300 acute beds
Address the volume of patients currently experiencing a delayed discharge across our acute mental health bed base
Improved partnerships with primary, community and social care to improve assessment processes in hospitals, complex discharges, support increased assessment out of hospital and enhance community based capacity
Create a solution for the short term sustainability of ED and developing an alternative model for the provision of emergency care at Weston
Spec Comm progress pathways for Specialist Rehab
Embed social care provision in Rapid Response
Scale up and standardise POA at point of admission
Incorporate patient / carer facing information
Develop and deliver system wide model of support into nursing/care homes
Strengthen and make consistent rapid response service in primary care including home visiting and social care response
Patients 'discharged' to the SPA – risk and gain share arrangements
Map community assets, locality focussed
Establish consultant advicaline for primary care with same day response to urgent and 48 hour non-urgent response
Establishment of NHSE/CCG change programme for primary care
Establish practice clusters across BNSSG incrementally
Develop and deliver Acute Services Engagement Plan to build relationships and provide clusters and MDTs with specialist advice to reduce routine referrals
Develop a single provider model for NICU in BNSSG
Enhancement and development of ambulatory care pathways that avoid hospital admissions
Develop contracting and governance models
Integrate locality services with children's services SPA
Other pathway development: Stroke, End of Life, Diabetes, Cardiology, Respiratory, Emergency Paediatrics, Path/Radiology, Urgent Care
Establish multi-disciplinary integrated teams across all clusters in BNSSG
Implementation of BNSSG risk stratification tool (ETTF), redesigned pathways and technology enabled self-care delivered through clusters
Combine with supported self-care clinical hub
Decommission existing SPAs/Hubs.
Self-care pathway designed
System level investment to enable delivery of prevention & self care
Use of risk stratification MECC embedded in training and delivered in practice
Reduced alcohol-related admissions
Agree tool that links self-care and prevention to financial savings
Further develop and use e-personal health record and integrated personalised commissioning
Different funding flows through the system – increased investment for prevention and self-care
Consistent service offer and pathways for BNSSG population for example falls prevention
Prevention and Self-care group to develop and implement STP plans
Build on IPPC actions relating to MDTs, risk stratification, care co-ordination and care planning to assist in enabling delivery of self-care assumptions
Resource alignment
Procure/develop risk stratification tool (link to ETTF)
Explore with digital partners re enabling self-care
Redesign BNSSG Digital governance in alignment with STP governance
Scope out and initiate BNSSG Digital Programme
Develop specification and IT platform for referrals and coordination of specialist community support
Evaluation of full options and development of medium to long term plan for Weston Hospital, which secures a sustainable solution for acute services within North Somerset
Develop governance for the emerging Digital Programme, at a BNSSG system level, aligned to STP
Establish single IT support system to facilitate working between hub and clusters, with full interoperability across health, primary and social care systems
Development of cancer alliances to improve quality and access
Development of 7 day services across the system
Implementation of new integrated, partnership based community paediatric services (CCHP)
Implementation of full sustainable services plan at Weston
On-going work to scale up SPA incrementally linking at locality levels and eventually to 111
30% reduction in excess costs relating to RCI in T&O, cardiology and respiratory
10% reduction in patients treated out of area on specialised pathways
Create incentives to collaborate on Digital as a system rather than silos
Establish estates workstream
Establish coordinating governance and capacity management processes
Establish a complete set of estates-related data to understand the condition, capacity, cost and constraints of the existing estate to better inform decisions regarding future optimisation;
Coordinate with other workstream emerging estate requirements
Training and skills development
Collaborative working on Apprenticeships including training and mentoring and joint working with junior doctors
Adoption of best practice through vanguards including better use of e-rostering across nurses, midwives, HCAs and other clinicians
Development of 5 year implementation plan with milestones and identifying associated savings
Optimise STP priorities with HEE, AHSN and training providers but also with other employers including the Local Enterprise Partnership, Bristol Health Partners
Development of common vision, values, behaviours and policies across the STP
Work with Bristol City Council, LAs to better include social care workforce in planning
Assess impact of use of risk stratification and evaluate impact of PAM, and LTC admissions
Assess impact of schemes to date and review priorities and implementation
SPA fully implemented
On-going work to complete 17/18
Develop full MSCP/ other model providers
SPA linked to UECN 111/999 clinical hub
Integrated pathway working
Shared digital platform
Workforce culture shifted to working collaboratively with patients
Paperless at point of care
Integrated care model

Bristol, North Somerset & South Gloucestershire

Sustainability & Transformation Plan

Annex A – Supporting Information

Table of Contents

A. Governance arrangements

i. Organisations within the BNSSG footprint

The BNSSG footprint has an established System Leadership Group (SLG) in place with wide institutional representation, including local government (social services and public health). The Group have agreed a shared vision around the areas of improving experience of care, improving services, making better use of existing capacity and resources, and developing a sustainable, well-managed health and social care system.

The table below outlines the organisations currently represented at the System Leadership Group and who form the BNSSG planning footprint. Further stakeholder analysis is currently underway, with a particular objective of ensuring inclusion of patient, public, voluntary and independent sector representation.

BNSSG System Leadership Group Representation

Commissioners		Providers	
Organisation	**Function**	**Organisation**	**Function**
South Gloucestershire CCG	NHS Commissioner	North Bristol NHS Trust	Acute Provider
Bristol CCG	NHS Commissioner	Weston Area Health Trust	Acute Provider
North Somerset CCG	NHS Commissioner	University Hospitals Bristol NHS Foundation Trust	Acute Provider
Bristol City Council	Local Authority (social care and public health)	Bristol Community Health	Community Care Provider
North Somerset Council	Local Authority (social care and public health)	North Somerset Community Partnership	Community Care Provider
South Gloucestershire Council	Local Authority (social care and public health)	Sirona Care and Health	Community and social Care Provider
NHS England	NHS Commissioner (Primary Care & Specialised)	Avon and Wiltshire Mental Health Partnership NHS Trust	Mental health & LD provider
		South Western Ambulance Service NHS Foundation Trust	Ambulance service provider

ii. STP Planning Phase Governance Structure

In order to secure an at-scale level of ambition and associated practical delivery roadmap to address the significant challenges reflected in the Five Year Forward Vision, the BNSSG organisations have built on this collaborative foundation:

- An STP Executive Board was established beneath the System Leadership Group, with cross-sector representation, including local government, to act as the programme steering group for the STP. This also included our local West of England Academic Health Science Network (WEASHN), who will be key partners in the development and implementation of the plan.

- Cross-sector planning expertise was identified and pooled to form a Project Group which co-ordinated the development of the STP through the following workstreams:
    - Integrated health and care operating model core themes
    - Stakeholder engagement
    - Finance, analytics and capacity modelling
    - Clinical strategy
    - Workforce
    - Digital roadmap
    - Estates

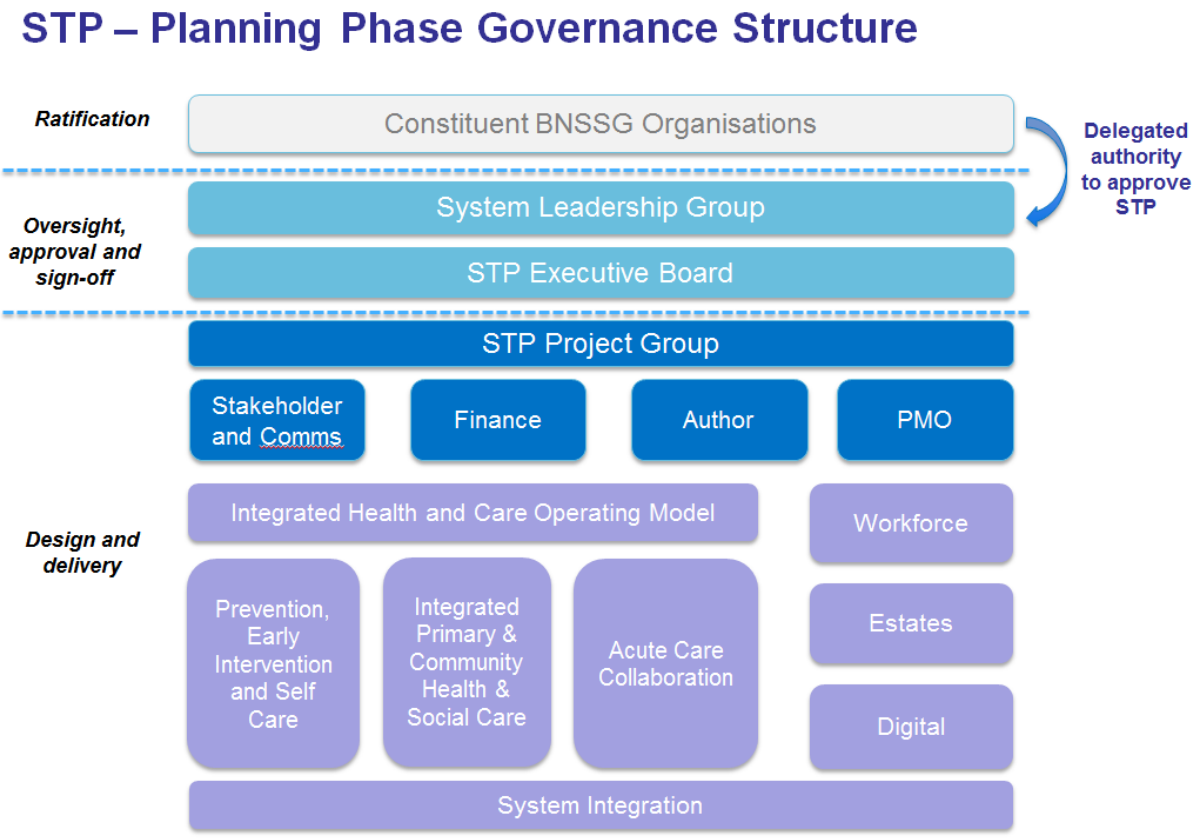
  Each workstream was allocated a Project Lead and a Chief Officer or equivalent from the System Leadership Group as SRO. Clinical and Mental Health Leads were identified to work with the Operating Model workstreams.

- External consultancy support was commissioned from PWC to support STP development through:
    - Senior 'check and challenge' facilitation and strategic advice to System Leader discussions.
    - Programme assurance and overall co-ordination of the process.
    - Strategic review of the baseline position of the BNSSG system and existing transformation initiatives.

- South, Central and West Commissioning Support Unit (SCW) provided Senior Consultancy resource to establish a PMO function, and provide leadership and management for the PMO until early July 2016.

- Budget pooling arrangements were agreed to assist development of the STP.

STP Planning Phase Governance Structure



iii. Delivery Phase Governance Principles

In establishing an appropriate governance structure for the future STP work and delivery of the Five Year Forward View, the following principles have been agreed:

- The governance structure should be commensurate with the needs and scale of the programme.
- The ways of working should be focussed on supporting delivery and minimising bureaucracy.
- The arrangements will be based on trust and collaboration, and where possible the roles within the structure should be filled by individuals with the appropriate skills who are already working within the local care system.
- To identify the leadership and delivery capacity required partner organisations will need to ensure alignment of current processes, and build upon existing programmes of work within the system.
- The interdependencies between the different programmes within the STP will be defined and managed.
- The full engagement of clinical, finance and analytical leads from across the organisations will be essential.
- Effective leadership of the programme will be critical to its success; a Programme Director will have sufficient authority and status within the care system to drive the programme forwards.

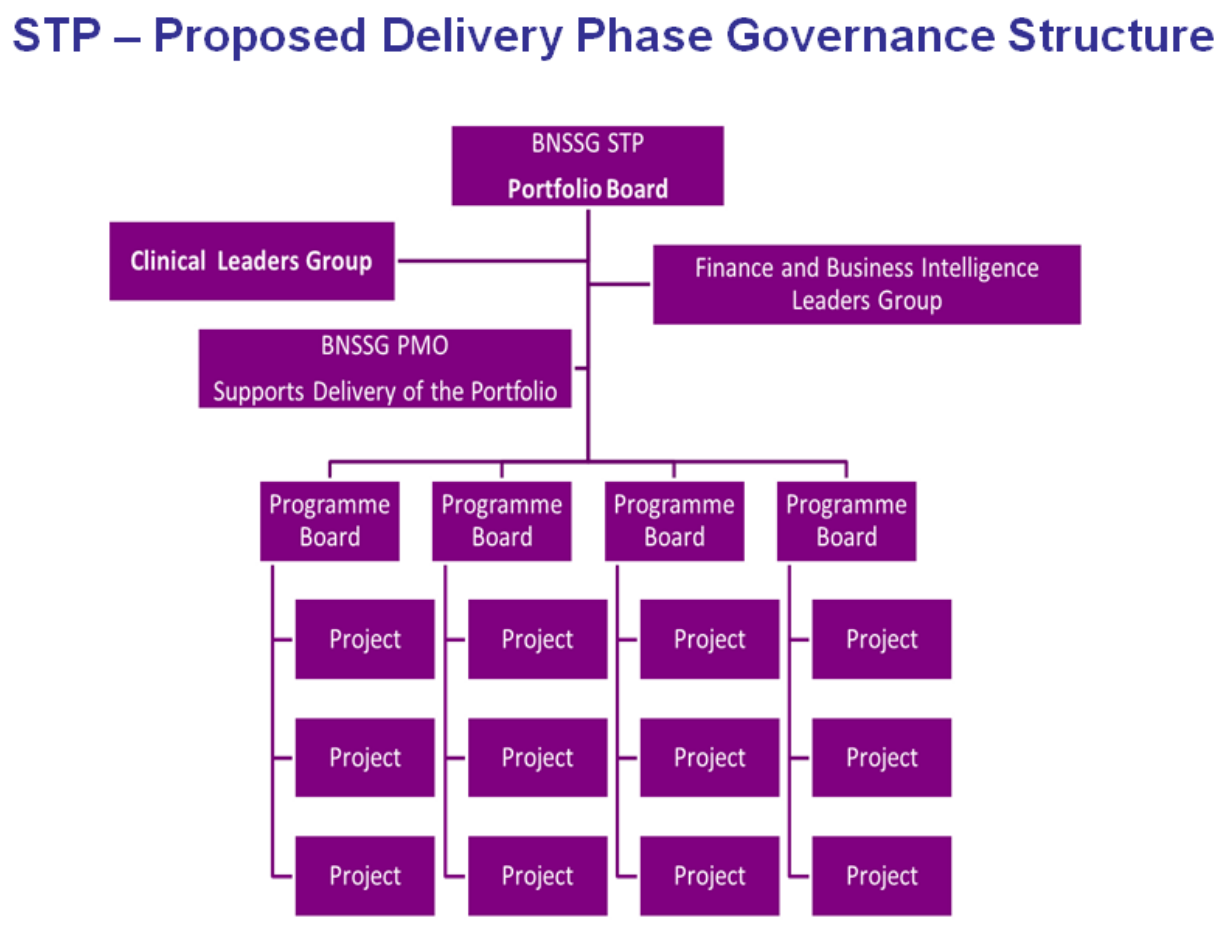
iv. Delivery Phase Governance Structure

The BNSSG STP is expected to consist of a number of large scale change programmes. In order to ensure effective delivery across the programmes, a Portfolio Management approach will be adopted. Key elements of this will include:

- The establishment of a BNSSG Portfolio Board to oversee delivery of STP programmes and ensure ongoing alignment with system strategy.
- A series of programmes which combine related projects within integrated governance arrangements.
- Arrangements which ensure programmes are coordinated with related activities that are not directly within the STP, for example the annual commissioning cycle;
- A BNSSG STP PMO to support delivery; and
- The Portfolio Board could operate as an executive sub group, with delegated authority from, and reporting links into a revised System Leadership Group. (The role of the System Leadership Group should be reviewed in the context of the future governance needs of the STP).

A proposed outline structure for delivery phase governance arrangements is illustrated below.

Proposed Delivery Phase Governance Structure



Immediate Next Steps

- Design and implement stakeholder engagement plan, including (clinical) staff, communities and local government.
- Appoint to key programme management positions and mobilise all workstreams.

B. Engagement process

i. Introduction

Bristol, North Somerset & South Gloucestershire is an established health and care partnership with a track record for designing and delivering transformative change.

An established shared governance arrangement including a System Leadership Group involving executive and senior clinical leaders from all of the local partner organisations has been in place locally for a number of years and has formed the basis for the Executive Board that is overseeing the development of the local STP.

During the last decade we have worked together to progress a system wide vision based of care closer to home and reduced reliance on acute services which is based on a local clinical consensus.

The development of the Sustainability and Transformation Plan will help us take the next steps in this journey, working together to further transform local health services in order to be able to continue to provide high quality care that we can sustain for the future.

The improvements achieved over the last 10 years have been informed by substantial public, patient and stakeholder engagement, undertaken both on a BNSSG whole-system basis and also at a 'sub-system' level. It has also encompassed major changes to local services that have been subject to formal public consultation.

This has required close working with the health scrutiny committees of each of the local authorities both individually and where appropriate through the formation of joint health scrutiny committees.

This track record of designing and executing engagement and consultation including on a whole system basis, together with the lessons learned from all of this, has provided a platform for this plan for communication and engagement.

This Annex sets out the plan for communication and engagement to support the development and implementation of the local Sustainability and Transformation plan for Bristol, North Somerset & South Gloucestershire. It describes the approach to engagement within partner organisations that has been undertaken in the initial development of the STP and how these existing insights have been used to inform the initial design of the future operating model.

At this stage, as the STP represents 'work in progress' it will therefore remain subject to further engagement, and where indicated formal consultation processes.

Subject to any feedback from this initial STP submission and agreement on the national timetable for further development, we will engage more formally with the Boards and Governing Bodies of partner organisations including the three local Health and Wellbeing Boards.

In parallel with this we will continue to work with the three local Healthwatch organisations and other stakeholders to agree arrangements for more local engagement, and the scope of future engagement will encompass clinicians and social care professionals, service users and carers as well as the wider public.

ii. Development of the communication and engagement plan

The communication and engagement plan has been agreed in outline by the 15 partner organisations

The objective of this communication and engagement plan is to ensure that partners, stakeholders and local people are kept informed about the development of the local STP and are given the opportunity to be involved in the development and implementation of the plans.

Communication and engagement expertise from across the 15 partner organisations including NHS England, have contributed to the development of this plan through a joint working group. There has also been early face to face engagement with the three local Healthwatch organisations to inform design of future engagement and agreement to continue to involve them

We will continue to harness all of this knowledge and experience in further development of the plan and throughout the implementation.

iii. Stakeholder mapping

An initial stakeholder mapping exercise has been undertaken in order to identify target audiences for the development and implementation of the STP. This analysis will be further refined subject to confirmation of the specific elements of the local STP. In broad terms the mapping exercise has identified the following broad segments:

Partners – the 15 local organisations working together to establish the local STP, including staff and their representative organisations

Stakeholders – including the 3 local Healthwatch organisations, Health and Wellbeing Boards, Health Scrutiny Committees and other standing committees and groups; local Councillors and MPs,

Service users and carers - including local and national organisations that represent service users and carer interests

The wider public – including through community organisations and groups representing local people and specific local interests as well as groups representing our diverse community and also ensuring that we used our established mechanisms to ensure we are able to listen to those that are seldom heard.

iv. Using existing insights to inform the initial design of the future operating model

There will be opportunities for service users, carers and the public to have their say on the emerging plan, and to continue shaping the development and implementation of the plan during the next 5 years.

In addition to this and for this initial phase of STP development, existing feedback from service users, carers and the public from across BNSSG has informed the development of the draft STP. This includes information from public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports. This has helped to ensure that our thinking is being shaped by the issues that the people who rely on our services have told us is important to them.

v. Agreement of a single, shared public narrative

The local STP encompasses a health and care system serving a population of around 1 million local people and partnership spanning 15 commissioner and provider organisations together with 99 GP practices, as well as the numerous local voluntary organisations involved in health and care.

In this context, the development of a single shared public narrative will help all of the partner organisations to articulate their shared vision for working together to further transform local health services based on a positive case for change.

In response to this, agreement has already been reached on an initial public narrative for Bristol, North Somerset & South Gloucestershire, which sets the scene for the further development of the STP and establishes a shared commitment to patient, public and stakeholder engagement.

The content of this shared public narrative and the FAQs will be further developed as the STP is developed.

vi. Methodologies for communication and engagement

Locally there is agreement across the 15 partner organisations about the range of methods we will use when engaging with service users, carers and the public.

Recognising that there is no 'one size fits all' approach to engagement, and that plans need to be proportionate and appropriate to the needs of those being engaged with, taking into account a range of factors.

The three local Healthwatch organisations are already involved in the design of the engagement plans and they will have a central role in informing the development and implementation of the engagement to support the further development and implementation of the STP.

STP leaders will be personally involved in presenting strategy to stakeholders and senior clinical and social care professionals will contribute significantly to engagement with peers and with service users and carers. Engagement plans will be also shared with Health Scrutiny Committee members for their comments prior to implementation.

The Executive Board for the STP will be responsible for ensuring that appropriate monitoring and assurance is in place for communication and engagement.

To this end a Chief Executive member of the Executive Board, supported by a senior Director has already taken a lead role in overseeing the development of this communication and engagement plan and this will continue during the implementation.

vii. Branding and visual identity

Bristol, North Somerset & South Gloucestershire is an established health and care partnership which is generally recognised by partners and stakeholders and to a greater or lesser extent by the public at large. Subject to further development of the local STP it is proposed to proceed on this basis and avoid the cost or delay in establishing alternative bespoke branding or identity at this stage.

viii. Approach to major service change

There is considerable system wide experience of undertaking substantial public, patient and stakeholder engagement which has also encompassed major changes to local services that have been subject to formal public consultation.

The extent to which major changes to services will arise will be subject to further development of the local STP. However, there will be a shared approach to any such changes which will be undertaken with reference to the established NHS England assurance process and with reference to the four tests, specifically: strong public and patient engagement; consistency with current and prospective need for patient choice; a clear clinical evidence base; and support for proposals from clinical commissioners.

C. Enabling Workstreams

C.1 STP Estates Enabling Strategy

i. Case for change and evidence base

The NHS estate is a key enabler to the delivery of the objectives set out in this plan through its potential to impact positively on quality and patient experience and support delivery of clinical and financial sustainability and system transformation.

A new approach to estates provision and coordination across the whole health and social care system is an essential component of ensuring that we can deliver our shared vision from a property base that is fit for purpose in terms of location, configuration and specification.

A review of available evidence clearly demonstrates that strategically:

- Estates-related initiatives are likely to be more important for their contribution to creating capacity to deal with increases in demand from changing demographics over the longer term and to avoiding the creation of new facilities, thereby avoiding costs to the local health economy in the longer run rather than saving money for the local health economy immediately;
- Even well designed and operationally efficient community-based initiatives are unlikely to break even within 5 years and although offering more flexible capacity and potentially lower fixed costs need to form part of a longer-term planning horizon.

This strategy is intended to align the estate with the strategic goals of the emerging BNSSG STP service transformation strategies in order to support the delivery of effective and high quality services to our patients. This requires that our estate strategy is flexible so that it can adapt as circumstances dictate and support the intended strategic approach to shifting the balance of care from hospital to community, primary, social and self-care.

This strategy is therefore intended to ensure that, based on best evidence, value for money and identified BNSSG priorities:

- Patients' experience of care is enhanced;
- The estate supports delivery of intended new models of care;
- Utilisation of fit for purpose existing estate is maximised (Lord Carter targets) with consolidation of activity and sharing of premises where this better meets future needs and supports the delivery of community and primary care based initiatives that would otherwise have required additional capital investment;
- Surplus estate is removed from the system, estate running/operating costs are reduced and estate delivers value for money;
- There is effective future investment in the estate with poorer quality buildings that are no longer fit for purpose replaced with new facilities that can support a wider range of services.

ii. Relevant National Guidance, current estate overview and risks to sustainability

In January 2015, all GP practices were advised of the availability of and opportunity to submit bids against a new primary care infrastructure fund, targeted at increasing capacity in primary care, enabling better access, reducing unnecessary demands on urgent care services and building the foundations for more integrated care.

A key national priority for NHS organisations is that estate should be used effectively. In 2015, Lord Carter of Coles established a number of targets relating to running costs, maximum non clinical floor space, maximum unoccupied or under-used space and facilities management cost of NHS Trusts to be achieved over the next two years.

The 2004 Bristol Health Services Plan 10 year plan which involved wide stakeholder, including public, engagement has led to some significant strategic estates investment, including the development of new community facilities, a reduction in Emergency Departments in Bristol from three to two, closure of an acute hospital site and relocation to a new PFI build at Southmead. However, many of the existing estate locations remain a result of history as opposed to strategic planning and design. Estate is generally well or over utilised (as far as this can be determined at this time) with acute hospitals already operating at or above the capacity of their estate and facing increasing challenge in managing fluctuations in demand. Similarly, some community and primary care premises are operating at or near capacity, although there is also clear evidence of underutilisation of some estate.

Together, the total occupied floor area across the health estate within BNSSG is estimated to be circa 603,000 m2 with a total annual cost of the BNSSG health economy properties of in excess of circa £134m (excluding some Primary Care premises rates, service charges and running costs and currently unknown community estate costs).

Summary of BNSSG Site Types

Site Type	**Overview**
Primary Care	
Locations 22 North Somerset 57 Bristol Circa 26 South Gloucestershire	Operate from a mix of old and new properties in varying conditions and ownership including freehold and lease often in NHS health centres. Range of conditions from very good in newer properties to very poor with poor functional suitability in older, less well maintained properties. Geographical access to GP practices across the area is generally good. Requirement to consolidate and collocate practices where possible or practical or consider alternative methods of delivery.
Community Services	

North Somerset Community Partnership (operates from circa 17 premises) Bristol Community Health (operates from circa 29 premises) Sirona Care and Health (operates from circa 59 premises)	Operate from a variety of estate including health centres, general practices, NHS PS, Local Authority sites, CHP LIFT and privately owned freehold properties. Range of physical conditions, space utilisation and functionality from very good in newer properties to very poor in older, less well maintained properties.
Mental Health Services	
Avon and Wiltshire Mental Health Partnership NHS Trust Circa 23 Sites	Operate from freehold premises, or under lease arrangements including PFI leases. Properties in generally good condition. Key focus on access, utilising other healthcare estate, optimising PFI premises and releasing leased properties where possible.
Acute Services	
Weston Area Health NHS Trust University Hospitals Bristol NHS FT North Bristol NHS Trust	Operate from a mix of freehold, lease (non-clinical) and PFI and \lift lease premises. Physical condition, functional suitability, compliance and quality generally good (A,B or B/C). Focus on de-commissioning and disposal of older estate, improving adjacencies and co-location of key services, expansion of core clinical accommodation, elimination of nightingale ward environments and improvement in the built environment of services.
Clinical Commissioning Groups	
North Somerset CCG Bristol CCG South Gloucestershire CCG	Operate from leased premises

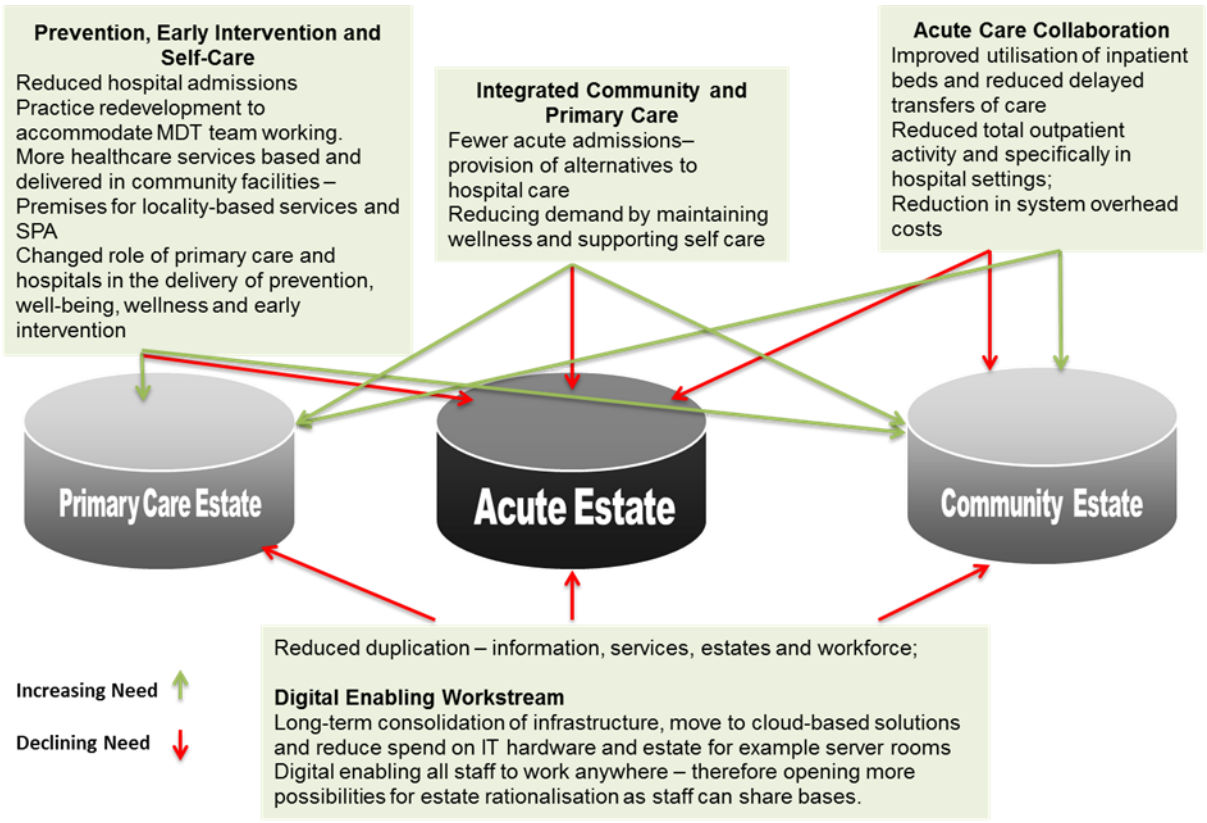
Key risks identified to the sustainability of the estate include:

- Lack of building maintenance, capital investment and poor environmental conditions in some primary and community estate could lead to unforeseen closures, staff being unable to work and a reduction in service delivery;
- Inflexibility of space/estate management leading to increased costs as services take on more space to enable delivery but space becomes underutilised;
- Rising cost of space leading to pressures to reduce occupation with consequent space underutilisation and reduction in service delivery;

- Short termism in estates planning and investment due to service provider change arising from procurement processes and often short term (5 year) contract award;
- Short term local/organisation based decisions potentially compromising longer term efficient use of estate;
- Increasing requirements to rent off site non-clinical/office space to manage flexibility;
- Risk of change of standards, forcing non complaint areas to be downgraded and underutilised.

iii. Key challenges

Overview of impact on estate arising from workstreams



The challenges for the estate of these impacts and the risks identified above (2.4), are that:

- Planning for acute capacity remains challenging. Acute capacity requirement are likely to increase by circa 237 beds in the next five years due to population growth and development of 85,000 new homes (by 2026). However, as the service portfolio with acute Trusts changes in response to new models of care and a national focus on the provision of care in fewer centres, the requirement for acute capacity should decrease and enable the requirement for additional bed requirements to be met within existing capacity;
- Closure of acute capacity is challenging, particularly in the short-term whilst alternative, community or primary care-based schemes are being established. Stranded costs associated with un-utilised clinical space within acute Trusts – a particular challenge taking into account

investment in Private Finance funded estate – will continue to represent a significant cost to the local health economy whether or not it is used;

- Potential investment requirements in primary and community services at a time of limited availability of capital funding are such that simple disinvestment in acute estate and re-investment in primary and community estate is not affordable; nor does it offer best value for money.
- It is essential that utilisation of existing fit for purpose estate is maximised. There is therefore a need to plan and coordinate estate development priorities to ensure that short term imperative does not compromise longer term efficient and effective use of estate.

iv. Proposals for change, links to BNSSG priorities and system benefits

Standardising and Operating at scale and building on existing digital work offers the opportunity to co-locate health, social care, therapies, pharmaceutical staff and potentially diagnostics in real or digitally supported virtual clinical hubs and to support GP practices to more efficiently at scale enabling consolidation or disposal of existing surplus or substandard estate.

In supporting the development of a new relationship with the public and the delivery of the shift of care from an acute setting to primary and secondary and self-care with a reduced dependency on beds, the estate will enable:

- Delivery of the ambition that our population should be treated within the BNSSG footprint;
- Management of the expected increases in demand for acute care over the longer term.

The estates enabling strategy has the potential to release some costs within local health economies by utilising released acute capacity to repatriate some work, including tertiary service delivery, currently being undertaken by the independent sector at higher cost to support referral to treatment constitutional standards.

Developing new relationships between organisations and staff offers the opportunity to;

- Ensure strategic system oversight, cross organisational management and delivery of the estates function, delivering integrated services rather than organisational ambition, ensuring that shorter term investments do not compromise longer-term estate reconfiguration potential;
- Ensure capacity optimisation, avoid stranded costs, reduce lease costs and deliver value for money from the estate;
- Relocate services into fit for purpose premises so improving functionality and working environment for staff;
- Develop managed spaces, centrally monitored and managed, maximising space utilisation and reducing overhead costs;

Developing pathways of care provides opportunities to reduce the rate of capital expenditure growth potentially required in community and primary care premises and to create economies of scale within these services by maximising the utilisation of potentially stranded acute estate in particular and other fit for purpose available premises with the aim of ensuring full utilisation and maximisation of value from the estate.

Short-term Estates priorities (year 1)

Individual organisation responsibilities	○ Continue to ensure that the environment which is used to deliver care to patients: • meets relevant statutory compliance requirements; • meets the essential standards of quality and care specific to Estates and Facilities Operations required by the CQC; ○ Meet Lord Carter of Cole required efficiency improvement targets; ○ Continue to work with local partner organisations to refine local estates strategies and identify ongoing opportunities arising out of local PLACE workstreams to ensure compliance with requirements of the One Public Estate initiative; ○ Continue to deliver existing estate development and transformation activities including: • Phase 2 of the Southmead PFI project to create a new onsite SSD, additional car parking and new pathology suite (NBT); • Development of new primary care premises on land vacated by NBT (Sirona); • Development of a new rehabilitation/health centre on land vacated by NBT (Sirona); • Replacement and extension to multi-story car park including demolition of flats beyond useful life (UHB); • Demolition of non-fit for purpose ward (Sirona); • Move of corporate teams to a new building by end of 2017 (BCH)

BNSSG responsibilities	○ Establish an integrated workstream to develop a strategic framework for transforming the estate and maintaining system oversight: • establish coordinating governance and capacity management processes to overcome the fragmentation and complexity of health estate ownership and management; • take into account emerging requirements from clinical workstreams, ongoing local One Public Estate opportunities, development of Local Estates Strategies and the outcome of proposals submitted as part of the new Primary Care Infrastructure fund. • ensure that short-term local expediency within organisational plans does not compromise longer-term estate reconfiguration potential. ○ Establish a complete set of estates-related data to understand the condition, capacity, cost and constraints of the existing estate to better inform decisions regarding future optimisation;

v. <u>Medium and longer term priorities (years 2 – 5)</u>

Future estate infrastructure development/realignment proposals will be developed as plans for new models of care delivery mature and will take full account of the opportunities presented by investment in and utilisation of technology rather than buildings to support service delivery.

C.2 STP Workforce Enabling Strategy

i. Vision

Within BNSSG there is a system-wide commitment for a more joined up, co-ordinated, digitally savvy and flexible workforce which delivers increased productivity and meets the changing health and social care needs of the local population. Each of the new models of care described in this STP rely on the requirement to have the right staff with the right skills, values and behaviours in the right place at the right time to deliver respectful, compassionate and expert professional service.

ii. Case for change

As part of the on-going STP planning there will be a requirement to confirm the size and shape of the workforce particularly in the children and adolescent social care services, the SWAFT, the primary care sector (limited data was available) and the voluntary sector – all of which have key enabling roles within the STP. The HEE data provided a baseline as follows:

Workforce excluding non-adult social care is 44,347. Of this there are 2,780 medical staff; 20,567 non-medical and GPs; 21,000 social care staff.

The cost of our workforce is significant and as an indication the costs of the workforce in the three Acute trusts, Mental Health Trust (60% of AWP business) and three of the community providers is as follows[1].

Workforce Costs in BNSSG

Workforce (less agency and bank)	£829,459,279
Bank	£41,001,791
Agency Spend	£52,742,080
Total	£923,203,150

iii. BNSSG Challenges.

The workforce challenges for BNSSG are:

- Retention of key and experienced staff is an issue and this includes clinical and managerial staff across all sectors (social care, primary, community and acute). Staff empowerment and engagement (linked to productivity and retention) is a concern.

- Significant variation in employment offer across organisations and a fragmented approach to the design, development and training of our workforce. Partnership working across existing organisational boundaries is complex.

[1] Not all organisations within the STP were able to provide data within the

- There is a finite supply of appropriately trained and experienced staff within the geographical area and turnover is high. There is a particular issue with GPs and practice nurses.

- There is a prevalence of part time working within the geographical area and this increases costs.

- Recruitment against a number of key specialities is challenging as is offering attractive placements for junior doctors.

- Rising workforce costs including the high costs of temporary staffing and meeting the Weston sustainability challenge.

- Meeting the challenge of the national Apprenticeship levy.

iv. Understanding pressures in General Practice:

Recent findings from the King's Fund report 2016 'Understanding Pressures in General Practice', huge growth in GP workload, both in volume and complexity are described. The research sample shows a 15 per cent overall increase in contacts, a 13 per cent increase in face-to-face contacts and a 63 per cent increase in telephone contacts. Population changes account for some of this increase, but changes in medical technology and new ways of treating patients also play a role.

Wider system factors have compounded the situation. For example, changes in other services such as community nursing, mental health and care homes are putting additional pressure on general practice. Communication issues with secondary care colleagues have exacerbated GP workload, and increases in workload has not been matched by a transfer in the proportion of funding or staff. As well as this, the number of GPs has grown more quickly than the population but has not kept pace with groups most likely to use primary care (over 65's and over 85's). GPs are increasingly opting for 'portfolio careers' or part-time work. Only 11 per cent of GP trainees surveyed intend to do full-time clinical work five years after qualification.

At a regional level, two GP Practices have closed in the South west in the past 12 months, nine practice mergers took place during 2015/16, with another seven anticipated in 2016/17.

v. Links to core workstreams

The table below shows the generic impact on workforce of the 5 STP priorities:

BNSSG Priorities	Generic Impact on workforce
Standardise and operate at scale	This will result in changes to where workforce is based and as such the workforce must become increasingly flexible and work across multiple settings. Development of new roles and responsibilities across the footprint area.
A new relationship with our population	Alternative settings for care based on the health and care needs of the individual. Partnership working – particularly targeting areas which are heavy users of health and social care.
A new relationship with organisations and staff	Joint specifications across BNSSG will require not only

	strong System Leadership but common training standards, values and behaviours.
Consistent pathways	Care coordination across the whole pathway requires a workforce committed to cooperation, using shared information and having clear responsibility. There will be a requirement to support and resource joint structures for delivery and accountability across the population. Through care management will lead to some new/developed roles.
A shift to digital	Joint and flexible workforce operating across organisational boundaries Innovation and learning across the system.

vi. Analysis of Workforce Transformation by Care Model workstream

- **Prevention:** Workforce is identified as key to the implementation of a new model of prevention, early intervention and self-care. Specifically:

A joined up team of people working across a range of services, including social workers based alongside primary care.
Wider definition of workforce focussed on this area to include voluntary sector, police, housing, pharmacy, secondary care consultant and social workers.
Non-differentiated workforce across BNSSG with common standards.
Behaviours of the current workforce will be developed to enable prevention, early intervention and self care and to increase appetite for risk.
Better use of voluntary organisations and resources to increase impact and reduce duplication.
Workforce will be able to work at multiple sites through integrated technology.
This also impacts on the configuration of services – for example practices may need to operate at a bigger scale to deploy extended teams and release GP capacity. Secondary care will have a commissioned role to support prevention and early intervention.

- **Integrated Primary and Community Health and Care:** The new model of care will be supported by a flexible workforce that can:

Operate across settings of care, with integrated IT, data and care records and budgets.
Work from care coordination hubs which support the local population and are staffed with multi-disciplinary teams. Delivering new and expanded roles (e.g. advanced practice nursing, pharmacists, physician assistants, more generalist HCA type roles) where additional numbers and higher skill levels are required.
Maximise support from the voluntary and community sector to complement and enhance care and support provided by healthcare and social care professionals.
Deliver a workforce strategy for GPs and other HCPs that supports more sustainable careers and career preferences.
Develop competency frameworks and training for new and expanded health, care and generic roles across services and share training programmes and criteria for trusted assessment.
Develop common culture and values – we will treat staff with kindness and respect so that they feel valued and supported, as we would want to be treated ourselves. Align objectives across the system to build trust.
Strong change management leadership – support our teams through the change so that they embrace the

opportunities and we thrive as a health and care community

.

- **Acute Care Collaboration.** A new model of care focussed on providing care out of hospital wherever possible, building centres of excellence and joint core capabilities across organisations will require a workforce which is:

Mobile, particularly across the hospital/ community divide.
Not tied to organisation but to capability.
Supported by transformation of some back office functions to allow wider transformation of the system.
Centrally managed in terms of demand and capacity across the whole system and not just individual organisations.

vii. Workforce Transformation- STP Commitments

Workforce transformation takes time, involves complex stakeholder engagement and negotiation, lengthy redesign and delivery of training and it requires strong leadership to ensure that commitment (and therefore retention) is achieved across all specialities. Efficiency benefits realised from workforce are predominantly medium and long term and there is a requirement for some up-front investment in most cases.

Workforce STP Commitments

	Commitment	Comment
1	**Improve Health and Wellbeing of workforce**	Our workforce as advocates of self-care and prevention in the population. Invest in mental health and resilience and stress training for all staff to reduce sickness, broaden skill sets and improve participation rates. Improve the OH offer for staff, provide a common standard across the workforce, ensuring high quality and value for money. Sharing OH contracts where possible and including primary care. Providing inclusive and non-discriminatory opportunities and supporting employees to raise concerns. Promote healthy lifestyles amongst staff through workplace health initiatives. **Medium term return on investment through reduced sickness rates, lower turnover, increased engagement.**
2	**Shared Recruiting and Training**	Sharing recruitment and training functions where practicable. Includes shared DBS, assigning leads for particular functions (recruitment, statutory/mandatory, digital and leadership training etc. Re-focus on core skills framework/minimum training standards. Whilst ensuring better development prospects for clinicians and managers, better peer support and mentoring. Enabling staff rotations, flexible retirement and improving retention. Provide a common offer and banding harmony across organisations – including medical and locum costs. Pooling expertise where appropriate. Achieve reduction in temporary staff costs and drive down agency

		supported by shared bank. Demonstrate effective use of E-rostering for nurses, midwives, HCAs and other clinicians as part of showing greater consistency between financial and workforce plans in 16/17. Commissioners to direct community providers to train care home and domiciliary staff to a shared standard include acute and mental health in the dialogue. **Short term return through reduction in duplication and also increasing consistency and standards (quality).**
3	**STP Collaboration on the National Apprenticeship Levy**	Provide a sector wide Apprenticeship collaboratively. Optimising the national offer through sharing of training and mentoring and avoiding external training costs.
4	**Create a Common Culture**	"We work for BNSSG" Create a common culture (including lexicon) around ways of working, patient assessments, policies etc. Orientation away from organisations into sector. Developing the caring culture, professional commitment and strong leadership across the STP to best serve patients. Ensuring that care {and therefore workforce} is joined up and well co-ordinated. Including with primary and community care providers working together to deliver locally available integrated multi-disciplinary care that maintains and promotes independence, health and well-being. Ensure and establish staff engagement in all aspects of workforce transformation including rapid improvement events, with nominated leads for different aspects Developing new roles to support new models of care including 'expert generalists' within Multi-speciality Community Providers (MCPs), associate nurses, physician associates, community paramedics and pharmacists in general practice. **Medium term benefits through improved staff experience and reduced turnover and increased participation.**
5	**Making Every Contact Count**	Supporting the Prevention, Early Intervention and Self Care agenda through promoting 'Making Every Contact Count'; with training for frontline staff in brief interventions around specific lifestyle issues such as alcohol and smoking. Health coaching. Supporting self care through training and on-going support for primary care and community teams in effective goal setting and encouraging self-care. Providing comprehensive multi-disciplinary assessments, enabling a holistic approach, and using home based, "care navigators". Delivering an urgent and emergency care system that delivers measurably high quality care, by the person with the right skills, in the right place, first time. Integrate the health and social care assessments through broadening the tools and developing protocols. **Short and medium term benefits through hospital admission avoidance. Reducing duplication.**

viii. Action Plan – next 6 months

Immediate Actions for STP Workforce

- Complete baseline data collection
- WRaPT modelling of STP
- Write PID for Workforce programme and assign project leads.
- Develop workforce programme board

C.3 Digital Enabling Strategy

i. Introduction

We are in the midst of a digital revolution. In the last 20 years, the way we live our lives, support our recreation and leisure, read and share news, shop, bank and communicate have changed beyond all recognition.

Our ability to operate efficiently, share information, support our fellow humans and develop society is now a 'digital first' activity for most of the population. In Bristol, North Somerset and South Gloucestershire we have a rich and impressive heritage of digital vision and delivery. Our 2016 Local Digital Roadmap is not simply a point in time assessment of 'what to do next' but a continuation of a long and proud journey.

We do not believe that our digital roadmap programme is about automating existing processes or making it go more quickly - rather it is an opportunity to change how we work fundamentally by doing things differently and working together differently.

Our Local Digital Roadmap was produced through a series of workshops and with close engagement of Executive Director, Programme Director, Chief Information Officer and Chief Clinical Information Officer level representatives from all the STP partners. Since April, leads for the Local Digital Roadmap have also attended STP Project Group meetings and workshops to define and develop the overall STP scope and plans in order to align digital within them.

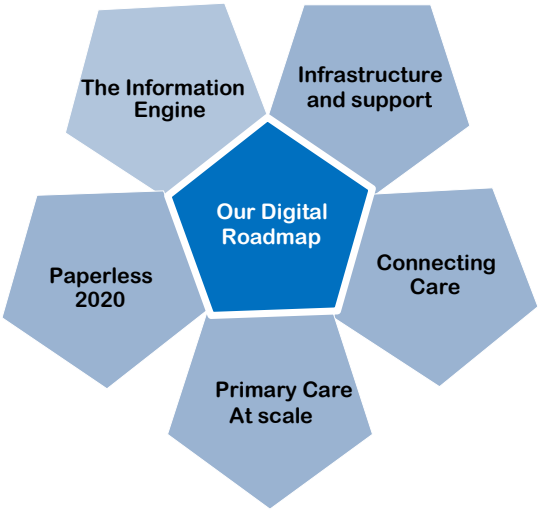
The first edition of LDR was first endorsed on 21 June 2016 by our Connecting Care Programme Board, before being endorsed again as an annex to the STP on 27 June by the System Leadership Group.

ii. Vision

The Local Digital Roadmap vision has been drawn from the Connecting Care Vision, whose core principles and ambitions remain relevant and applicable in describing a vision for the future in delivering change driven by a channel-shift to digital ways of working.

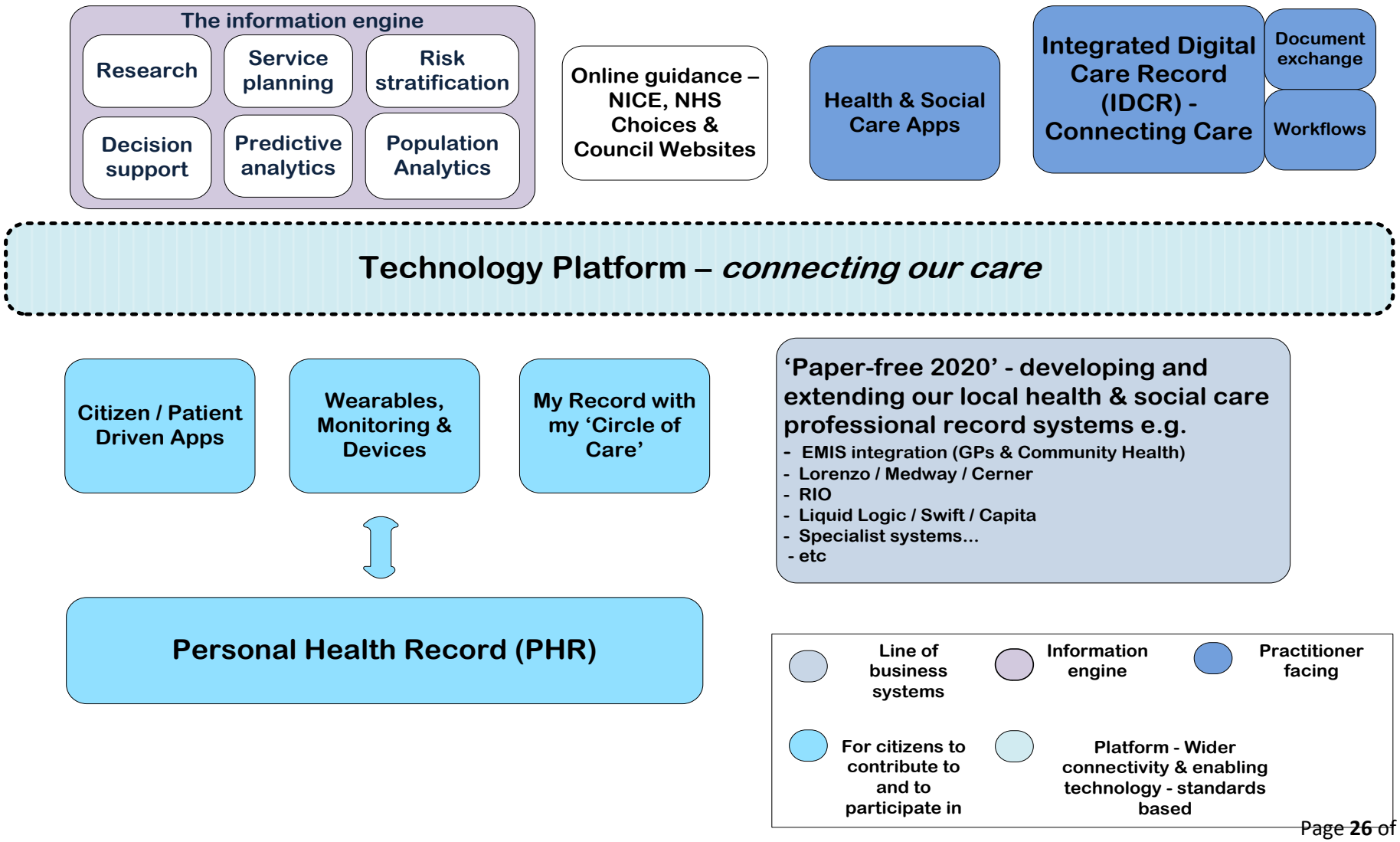
The ability to operate efficiently, share information and support our fellow humans and develop society is now a **digital first** activity for most of the population and we aim to drive this attitude into all aspects of health and social care. We shall deliver this through our five key building blocks:

STP Digital Building Blocks



1. **Primary Care at scale** – focus on maximising digital across GP practices and Out of Hours services.
2. **Paperless by 2020** – Embedding digital records in acute, community, mental health and social care.
3. **Connecting Care** – Information sharing to include putting citizens at the heart of their 'personal health records'.
4. **The Information Engine** – fully utilising our electronic data to power our planning and delivery engine.
5. **Infrastructure and support** – ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism.

Bristol, North Somerset & South Gloucestershire - Digital 2020 – *Connecting our Care*



iii. Driving delivery of the Local Digital Roadmap and the STP models of care

We have closely aligned the formation of the Local Digital Roadmap priorities with the key areas of the STP, as well as closely linking it to the national needs from the Local Digital Roadmap (Universal Capabilities) and the domains and workstreams of the National Information Board.

Our digital work	Our STP priorities	Universal Capability Alignment[2]	NIB Domain	NIB Workstream		
				National	Both	Local
Primary Care At Scale	1 2 3 4 5	②③⑨⑩	A C F	1 20		8 9 10 11 12
Paperless 2020	3 5	① ② ④⑤⑥⑧⑨	A B D E G		17 18 20 21	5 6 7 13 15 19 22 23
Connecting Care (& PHR)	2 3 4 5	① ② ④⑤⑥⑦⑧	A D G	1 2	3 4	13 14 15 16
Information Engine	1 4 5		C I H	25	26 27	12 18
Infrastructure & Support	1 3 5		A B G I J	28 29 30 33	24 32	14 31

Specifically the work of the Local Digital Roadmap will drive change in the STP areas of:

Prevention, Early Intervention and Self-Care

- Start the Person Held Record (PHR) journey and extend the Connecting Care platform to include citizen access and ownership. This is a key area of focus and one that we think will be a potentially massive lever in terms of how "ownership" of care shifts.
- Develop the use of PHR to enable communications with 'my circle of care' to support early interventions and self-care.
- App development and telehealth – "prescribing of apps" and driving the use of remote consultations; understanding their role in the PHR. Exploring the use of real time and robust sensors, monitoring / alerts to enable people to live at home well.
- New platforms to support information being used for decision support and artificial intelligence to transform our services.

[2]These Capabilities are:

1. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions.
2. Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
3. Patients can access their GP record.
4. GPs can refer electronically into secondary care.
5. GPs receive timely electronic discharge summaries from secondary care.
6. Social Care receives timely electronic Assessment, Discharge and Withdrawal Notices from acute care.
7. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.
8. Professionals across care settings made aware of end-of-life preference information.
9. GPs and community pharmacists can utilise electronic prescriptions.
10. Patients can book appointments and order repeat prescriptions from their GP practice.

Integrated Primary & Community Care

- Supporting the ongoing use of digital *best practice* within primary care – coming up with standards and rolling them out.
- Interoperability – through EMIS Web and Connecting Care to enable real time information capturing and sharing to transform staff working, ensuring the patients/citizens receive greater quality of care.
- Infrastructure – through mobile working, all staff can work in all sites with all their digital hardware and software driving productivity and financial benefits for the system.
- Real time data and decision support – digital management of flow across the BNSSG system and providing intelligence to transform our services.

Acute Care Collaboration

- Fuller, richer and more contemporaneous electronic record keeping, held in fully interoperable systems.
- Delivering Paperless 2020 – our services becoming truly paper-free at the point of care. Full plans for this are described in more detail in our Capability Deployment Schedule held in our Local Digital Roadmap.
- Real time data and decision support – digital management of flow across the BNSSG system and providing intelligence to transform our services.

iv. <u>Driving delivery of the Local Digital Roadmap and the STP enablers</u>

Digital will also drive change in the other "Enabler" workstreams

Estates

- Long-term consolidation of infrastructure, opportunities to reduce estate. In our Local Digital Roadmap we commit to exploring and developing system wide initiatives when rationalising estates. This includes moving to cloud-based solutions and reducing spend on IT hardware and estate for e.g. server rooms, help desks.
- Digitally support the consolidation of estate across the system by enabling all staff to work anywhere – therefore opening more possibilities for estate rationalisation

Workforce

- Digital will provide recruitment specifications and training support to ensure that we are recruiting and developing a "digital savvy" workforce across BNSSG.
- The programme will drive culture change for a complete "channel shift" to digital ways of working. Partner organisations have committed to ensure that use of digital solutions is not a choice but the default and becomes "the way we do things round here"

v. Conclusion

The Local Digital Roadmap therefore is all encompassing with the STP. The Local Digital Roadmap takes pride of place in already demonstrating that the BNSSG are very capable collaborators and that we can work together across the system when we commit to doing so. But so far we have only just scratched the surface with the potential of what can be achieved.

To see our plans to start reaching this potential then see annex A which provides the BNSSG Local Digital Roadmap.

The BNSSG Local Digital Roadmap will give further detail than listed here in the following areas:

- Commitment to Partnership working
- More detail on the strategic context
- Our Vision in full
- Baseline Position
- Recent and Current achievements in the areas of the five key building blocks.
- How we work together now and moving forwards, including detail on investment; benefits and change management, as well as our governance processes.
- Digital programme in full as detailed in the Capability Deployment Schedule and Universal Capability Delivery Plans.
- Our work on sharing information and agreement of standards.
- Developing our infrastructure
- Managing risk

C.4 STP Finance and BI Enabling Strategy

i. Approach

The case for change was developed as follows:

- The Directors of Finance (DOFs) and Chief Financial Officer group across the footprint developed the high level financial plan, including identifying the key drivers of cost.
- The Business Intelligence work stream collated information across the footprint to benchmark our position as a system to inform analysis of the efficiency and the care and quality gap, building on and interrogating the national STP packs and using Right Care commissioner information and relevant provider benchmarking.
- The Rubicon model was commissioned to construct the activity baseline "do nothing" position to feed the financial model, to test the impacts of our proposed solutions to close the gap and to assess system affordability and impact on the do nothing baseline.

ii. Output - Section 1: Finances

The approach and methodology

1.1 Membership

Finance Directors and Chief Officers have been meeting for three months to support the STP process pro- actively.

1.2 Methodology

- Undertake a comprehensive stocktake of the 2015/16 outturn and 2016/17 plan position for all bodies;
- Assess the underlying position and document the drivers for any declared underlying deficit;
- Document the medium term financial plans for the period 2017/18 – 2020/21 including underlying positions, inflation, cost pressures, savings, activity growth, sustainability funding, cost of activity and other factors specific to individual organisation. Recurrent and non-recurrent cost analysis was included; and
- Use this analysis to populate the NHS England / NHS Improvement templates using the "do nothing / do something" approach advocated. The two presentations have been fully reconciled.

1.3 Assumptions Used

For Providers

- Inflation at 2% from 2017/18 onwards;
- National efficiency requirement of 2% pa from 2016/17 to 2020/21;
- Cost pressures of 0.5% pa require an additional level of savings; and

- General assumption that changes in activity require 100% cost of delivery – however the potential savings section subsequently includes a revision to include a cost of delivery at 90%.

For Commissioners

- CCG and NHS England Allocation assumptions including growth and distances from target were published in January 2016 for the period 2016/17 to 2020/21, the first three years are fixed, the final two years are indicative.
- The accumulated commissioner Resource Accounting and Budgeting (RAB) outstanding on exit of 2016/17 is a net £26.5m, this is not considered in the financial savings plans.
- CCG expenditure plans include national expenditure growth assumptions for demographic growth, tariff price inflation, non-demographic activity and quality cost pressures and nationally mandated priorities.

1.4 Additional analysis undertaken

- Productivity opportunities using reference costs showing all specialties with an RCI over 100 for Acute and Mental Health Providers;
- No financial productivity information was available for Community and Primary Care.
- Corporate overheads and clinical support cost analysis for all organisations (Excluding NHS England) by functional area using normal categorisation of costs.

2. What is the financial position?

2.1 The financials of the footprint as described by DoFs

2.1.1 Footprint Financial Plans

The financial plans of the footprint as described by DoFs are summarised below. The CCGs positions exclude RAB.

The 2020/21 BNSSG footprint deficit is £41.5m.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	Actual	Plan	Plan	Plan	Plan	Plan
Surplus / (Deficit)	£'m	£'m	£'m	£'m	£'m	£'m
Providers						
University Hospitals Bristol NHS FT (UHB)	3.5	14.2	6	5.7	5.9	7
North Bristol NHS Trust (NBT)	-51.6	-39.5	-39.5	-39.5	-39.5	-39.5
Weston Area Healthcare NHS Trust (WAHT)	-7	-3.2	-8.8	-9	-9.3	-9.6
Avon & Wiltshire Mental Health Partnership (AWP)	0.1	0.1	0.1	0.1	0.1	0
South Western Ambulance Service (SWAST)	0	0	0	0	0	0
Community Interest Providers	-0.2	-0.8	-0.6	1	0.8	0.5
Sub-total Providers	**-55.2**	**-29.2**	**-42.8**	**-41.6**	**-41.9**	**-41.5**
Commissioners						
Bristol CCG	5.7	-2.2	1.9	2	2.3	0
North Somerset CCG	-13.6	-13.7	-10	-7.2	-3.8	0
South Gloucestershire CCG	-9.3	-6.5	-7.2	-3	0	0
NHS England (Specialised Commissioning)	0	-0.5	0	0	0	0
NHS England (Mandated Primary Medical Care)	0	0	0	0	0	0
Sub-total Commissioners	**-17.2**	**-22.9**	**-15.3**	**-8.2**	**-1.5**	**0**
Total Organisational Financial Plans	**-72.4**	**-52.1**	**-58.1**	**-49.7**	**-43.4**	**-41.5**
Convert to 2020/21 "Do nothing"						
Remove sustainability funding assumed (UHB only)						-13
Remove CIP/QIPPS 2016/17 to 2020/21						-361
Total BNSSG "Do nothing" Position						**-415.5**

The underlying deficit at the end of 2015/16 has been assessed at £94.2m. This included £32.5m of non-recurrent mitigating actions and the repayment of the net CCG historic debt (RAB) of £10.3m. The net RAB repayment in 2016/17, as a consequence of the 2015/6 outturn, is £17.2m rising to a forecast £26.5m in 2017/8, this is in addition to the recurring savings challenge. By 2020/21 the footprint recurring deficit position is £41.5m.

The drivers for this system deficit are shown below:

- North Bristol Trust - £39.5m deficit (excluding performance fines of £8.5m) – the declared drivers are:
    - Additional costs of PFI - £20m
    - Impact of contractual levers CQUIN - £1.5m
    - Income shortfalls - £10m
    - Balance due to activity / emergency pressures - £8m

- Weston - £9.6m deficit
    - Due to clinical sustainability issues as already recognised from previous and current reviews.

2.1.2 Recurring Savings Requirement

The level of savings required to deliver the financial plan described in section 2.1 are shown in the table below:

		Recurring CIPs and QiPPs				
	2016/17	2017/18	2018/19	2019/20	2020/21	Total
	Plan	Plan	Plan	Plan	Plan	Plan
CIPs / QIPPs	£'m	£'m	£'m	£'m	£'m	£'m
Providers						
University Hospitals Bristol NHS FT (UHB)	17.4	11.5	11.9	12.2	12.6	65.6
North Bristol NHS Trust (NBT)	22.0	14.7	12.4	12.9	17.8	79.8
Weston Area Healthcare NHS Trust (WAHT)	4.1	2.4	2.4	2.6	2.7	14.2
Avon & Wiltshire Mental Health Partnership (AWP)	3.4	2.0	1.9	2.0	2.3	11.6
South Western Ambulance Service (SWAST)	0.0	0.0	0.0	0.0	3.8	3.8
Community Interest Providers	0.9	4.9	4.2	2.8	3.0	15.8
Sub-total Providers	**47.8**	**35.5**	**32.8**	**32.5**	**42.2**	**190.8**
Commissioners						
Bristol CCG	26.9	10.7	10.8	10.0	9.6	68.0
North Somerset CCG	5.2	7.2	7.2	7.2	6.0	32.8
South Gloucestershire CCG	10.9	7.0	7.0	6.1	0.0	31.0
NHS England (Specialised Commissioning)	9.8	7.8	8.1	9.1	10.4	45.2
NHS England (Mandated Primary Medical Care)	0.0	0.0	0.0	0.0	3.7	3.7
Sub-total Commissioners	**52.8**	**32.7**	**33.1**	**32.4**	**29.7**	**180.7**
Grand Total	**100.6**	**68.2**	**65.9**	**64.9**	**71.9**	**371.4**

Note – The 2016/17 planned savings position include £10.6m non-recurring savings.

2.2 'Do Nothing' and 'Do Something' Position

2.2.1 'Do Nothing' Analysis

To convert the above position to 'Do Nothing' the net income and expenditure position is 'grossed' up by removing the sustainability funding assumed and the savings plans. This is shown below:

	Providers	Commissioners	Total
Savings requirement	**£m**	**£m**	**£m**
Organisation Deficit	41.6	0.0	41.6
Remove STF (UHB £13m)	13.0	0.0	13.0
2016/17 CIP/QIPP	45.7	44.3	90.0
2017/18 CIP/QIPP	35.5	32.7	68.2
2018/19 CIP/QIPP	32.8	33.1	65.9
2019/20 CIP/QIPP	32.5	32.4	64.9
2020/21 CIP/QIPP	42.2	29.8	72.0
Total - Savings requirement	**243.2**	**172.3**	**415.5**

Note – The 2020/21 savings requirement of £72.1m includes £0.2m of non-recurring savings.

2.2.2 'Do something' solutions

The £416m 'Do Nothing' deficit can be tackled by measures which range from routine savings, receipt of sustainability funding to major transformational changes. The summary below describes a footprint wide plan for this using a number of measures. It needs to be recognised however, that the savings for future years are not worked up and are in effect, only opportunities which will need to be agreed as appropriate, developed in detail and finally implemented. This should also be subject to risk assessment using normal processes both in terms of delivery and the impact on clinical services.

The assessed level of potential savings delivery and opportunities are show below:

Delivery	Solution per Excel submission	Status per Excel submission	Providers £m	Commissioners £m	Total £m
2016/17 identified schemes	Solution 1 & 3	b	(45.7)	(44.3)	(90.0)
1% Business as usual savings	Solution 2 & 4	e	(54.8)	(10.0)	(64.8)
RCI Benchmarking / Carter (estimate)	Solution 5	d	(100.0)	0.0	(100.0)
Corporate costs / % reduction of 10%	Solution 6	d	(10.0)	(2.0)	(12.0)
Margin on net activity growth @ 10%	Solution 7	d	(7.0)	0.0	(7.0)
System Transformation savings (risk assessed at 50%)	Solution 8	d	0.0	(20.0)	(20.0)
Subtotal - Delivery			**(217.5)**	**(76.3)**	**(293.8)**
Sustainability & Transformation Funding			0.0	(61.0)	(61.0)
Unidentified			(27.7)	(35.0)	(60.7)
Total			**(243.2)**	**(172.3)**	**(415.5)**

Key

b = Detailed plans in place but not all elements or organisations

d = Savings estimate based on baseline modelling and the potential size of the prize

e = No detailed plans in place yet

As can be seen c. £61m of the £416m deficit is unidentified. However, the measures shown all need to be worked up in detail with only 2016/17 identified schemes being able predominantly to be relied upon.

2.2.3 Description of 'Do Something' measures

2.2.3.1 2016/17 identified schemes - £90m

These schemes are included in current organisational financial plans – these are subject to risk assessment at various levels in organisations.

2.2.3.2 1% 'Business as Usual' - £65m

The assumption that 1% savings can be generally delivered through normal processes feels a relatively realistic approach.

2.2.3.3 Benchmarking / Carter Savings - £100m

The Carter work focuses on 'unwarranted variation' - essentially this means benchmarking. For the purpose of this report, the prime source of benchmarking data remains the National Reference Cost Index (RCI). The latest data available is for 2014/15. The table below shows a summary of the RCI data for the provider organisations in our footprint, UH Bristol, NBT, Weston and AWP. No easily accessible data is available for the Community providers and Commissioners.

The analysis has been filtered to show the following;

- All speciality lines with actual cost over £100k where the RCI is over 100 (i.e. national average)
- A total cost submitted for the whole organisation
- A total for all specialty lines with a RCI of over 100 – to show scope for productivity improvements

The results can be summarised as follows:

	UHB	NBT	Weston	AWP	TOTAL
Costs submitted to National Reference Costs	£443.0m	£472.0m	£95.0m	£177.0m	£1187.0m
Overall organisational RCI	98	113	108	128	
Excess costs for specialties over 100 RCI	£27.0m	£68.0m	£11.0m	£48.0m	£154.0m

More work on benchmarking is needed taking into account the other sources of benchmarked data including:

- National Reference Costs Financial Group
- Lord Carter model hospital Financial Group
- PCB Albatross Financial Group

The £154m shown has been reduced to an estimate of £100m which seems a relatively realistic assumption, particularly with AWP's savings needing to be attributed to other footprints.

It needs to be noted that identifying opportunities for such savings is relatively easy but converting them into cash savings is far harder. To deliver this requires transformation in the delivery of those services rather than a simple cost reduction approach.

2.2.3.4 Corporate Costs – reduction of 10%

An analysis of corporate costs for the whole footprint (excluding NHS England) and clinical support costs has been undertaken at a functional level. The results show that the footprint spends c £120m on corporate costs and c £65m on clinical support costs. These costs need to be finalised and

reviewed with a view to realising real savings either from sharing services or organisational change. A target of 10% saving on corporate costs is conservative.

2.2.3.5 Activity Growth

The levels of activity growth are still subject to verification but an assumption of margin of 10% has been made on increased acute activity of c £120m. This will need to be re-assessed in light of the system schemes designed to reduce activity. However, to do this the net analysis by speciality is required and this has not yet been undertaken in detail. The saving has therefore been reduced to allow for the system transformation schemes that should reduce/mitigate the £120m income growth by c.£50m leaving a net £70m growth on which the 10% margin is applied.

2.2.3.6 System Transformation Savings

The system transformation savings have been created in 'first cut' form. They require further analysis and risk assessment. The current version of the Finance and Activity Model provided by Rubicon shows a gross saving of £59m with an assumed re-provision at 40% therefore a net saving of £39m. For the purpose of this report a 50% risk assessment has been applied. Therefore a c. £20m net saving is assumed. The schemes will require detailed work up and risk assessment including phasing over the period of the STP. This work will commence in July 2016.

2.2.3.7 Sustainability Funding

Sustainability funding of £61m has been notified by NHS England. This is in excess of the potential sustainability fund of £32m available in 2016/17. Whether this funding will be able to be applied towards organisations savings requirements remains unclear.

3. The Way Forward

System Deficit

The system deficit (defined in 2020/21) of £41.5m needs to be seen in the context of turnover.

2020/21	Deficit	Turnover	Percentage
	£'m	£'m	
Providers	(41.5)	1,611.0	-2.6%
CCGs	0.0	1,701.0	
Footprint Total	(41.5)	3,312.0	

It is clear that the real solutions involve the following key features

- NBT – a combination of recognising the unavoidable excess cost of the PFI combined with a resolution of the residual deficit cost reduction through productivity / benchmarking and improvements to the system to minimise DTOC etc.

- Weston – changes to the clinical configuration to enable specialties to operate in links to other acute services to avoid cost levels associated with clinical services which operate below a viable scale of provision.

The system transformation schemes identified do not resolve fully the issues described above but are essential to ensure the projected level of demand in the footprint can be managed – in particular by ensuring patients do not access Acute Services where they do not need to and ensuring that scarce capacity in Acute Services (workforce and buildings) is used where it is needed. This avoids acute demand outstripping the supply of capacity and potentially leading to clinical risk and cost premiums.

iii. Output - Section 2: Activity benchmarking

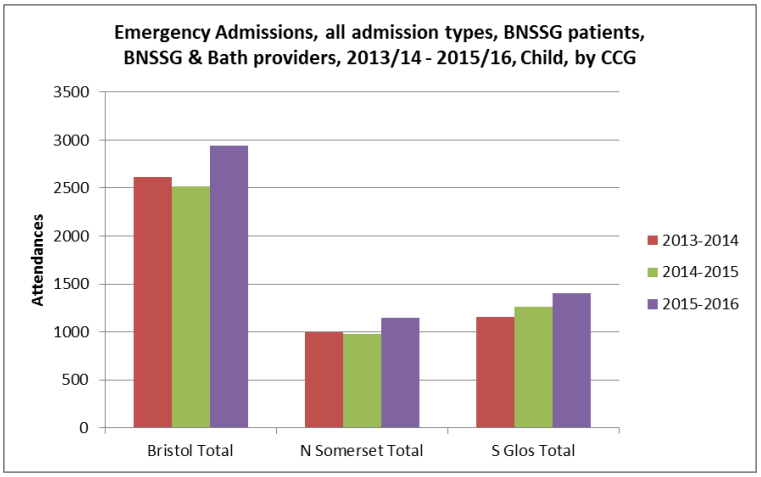
1. Activity

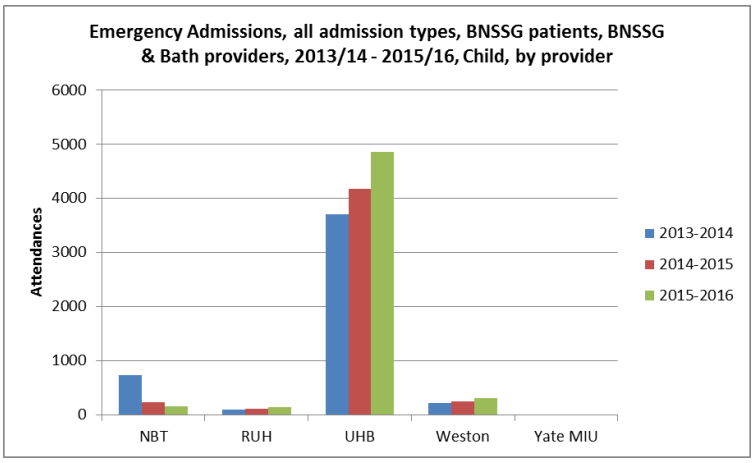
1.1 Trends

Generally, the system wide BNSSG activity trends are not showing marked increases or decreases, masking within that peaks and troughs and variation within particular groups of patients. There has been a steadily increasing number of emergency admissions. A&E attendances across the system as a whole have remained relatively flat but there is a very slight decrease showing for South Gloucestershire CCG population.

There are, however, considerable capacity issues and an impact on the ability to deliver elective performance and A&E performance.

Within the above trend, there has however been significant growth in paediatric emergency activity over the past 3 years. This has been seen in both emergency attendances and admissions and predominately relates to the Bristol CCG population and UH Bristol as a provider.



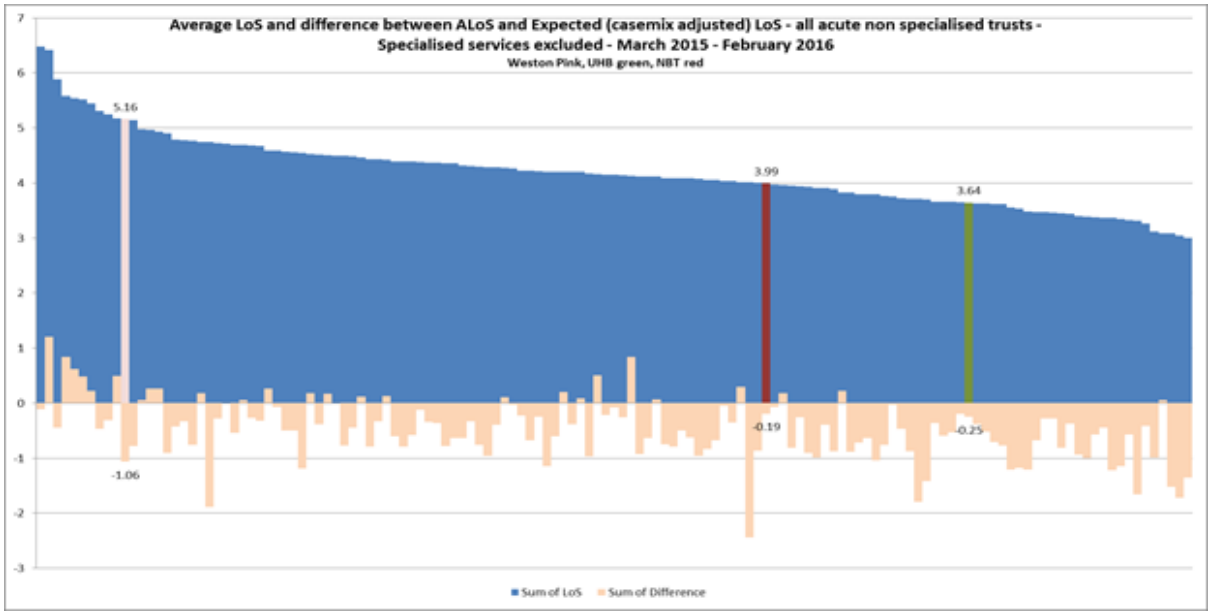


1.2 Urgent and emergency care

The greatest challenge in terms of delivering Constitutional Standards across the STP Footprint is in relationship to the 4 hour standard.

The average length of stay for all three trusts is less than their case-mix adjusted expected length of stay. Weston is more than a day less, while both UHB and NBT are just under or at a quarter of a day less than expected.

1.3 Non-Elective Length of Stay



North Somerset CCG has the greatest challenge in relation to DTOCS but Bristol CCG is also challenged. The providers most affected are Weston AHNHST and AWP. Each of the two acute hospitals has a similar proportion of DTOCs. Bristol CCG population has the biggest opportunity to reduce emergency bed days for its residents.

The table below demonstrates the bed day opportunity associated with delayed discharges. The data considered is the national DTOC data and the full potential opportunity using the acute Trust internal databases (G2G/LHPD).

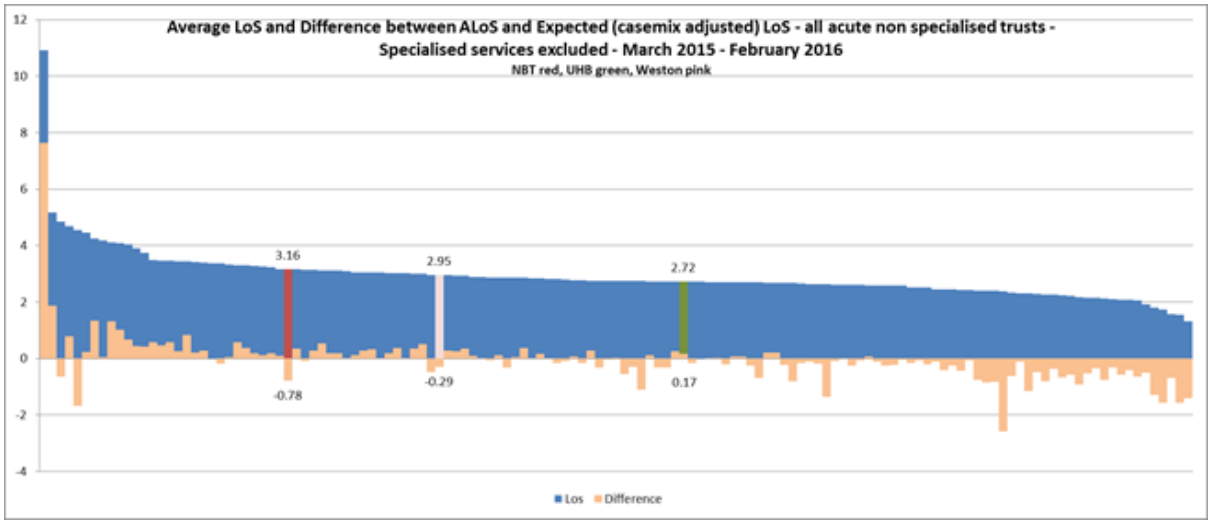
	Scenario 1 DTOC	**Scenario 2 Acute view - G2G/MFFD**
NBT	16949	45888
UHB	18322	38816
Weston	3165	14228
AWP	5649	5649 (at DTOC)
TOTAL	46569	104,581
Beds (at 92% occupancy)	**138**	**309**

Benchmarked admissions for urgent care sensitive conditions is high for Bristol CCG and increasing in all 3 CCG areas. Admissions for ambulatory care sensitive conditions increased in South Gloucestershire in 2015 but offers opportunity throughout BNSSG for improving models of care in the community to keep people at home and prevent admissions. Deaths in hospital could also be reduced although North Somerset residents experience is better than elsewhere.

1.4 Elective care

Referral to treatment incomplete pathways - patients waiting 18 weeks or less from referral to hospital treatment is a significant issue within for the health economy and in particular for NBT. The day case rate for NBT is in the worst quartile, Weston the best quartile, UHB is below average but not significantly

For elective admitted care both NBT and Weston are in the top half of average length of stay compared to English acute non specialised trust. However, when case-mix adjustment is taken into consideration both these trusts have a length of stay less than expected, NBT 0.78 days less and Weston 0.29 below. UHB in contrast have a lower length of stay but have a higher length of stay than expected when adjusted for case-mix. See below:



By CCG the areas of concern in relation to RTT delivery are similar and the specialities are:

- cardiology;
- gastroenterology
- general surgery;
- neurological problems and neurosurgery;
- Trauma and Orthopaedics

Urology and thoracic medicine as specialties are starting to show issues from a commissioner perspective.

From a provider perspective, gynaecology and oral surgery at UHB are also issues. Gastroenterology, neurology; Trauma and Orthopaedics are an issue for both UHB and NBT.

Spend on private and independent sector providers on behalf of the BNSSG population, is notably high in Trauma and Orthopaedics. The table outlines that £14.6m was spent on elective orthopaedics in the private and independent sector in 2015/2016.

	Sum of Spells		Sum of Cost inc MFF		Total Sum of Spells	Total Sum of Cost inc MFF
	CCG	**non-CCG**	**CCG**	**non-CCG**		
EMERSONS GREEN NHS TREATMENT CENTRE	1,925		6,734,474		1,925	6,734,474
SPIRE BRISTOL HOSPITAL	1,173	1	4,975,648	2,563	1,174	4,978,210
CIRCLE BATH	339		1,311,026		339	1,311,026
SOMERSET SURGICAL SERVICES	232		367,811		232	367,811
NUFFIELD HEALTH, BRISTOL HOSPITAL (CHESTERFIELD)	225		788,744		225	788,744
BMI - BATH CLINIC	126		275,932		126	275,932
SHEPTON MALLET NHS TREATMENT CENTRE	49		225,364		49	225,364
				TOTAL	**4070**	**£14,681,561**

Generally BNSSG acute providers first to follow up ratios are good and they have better than average DNA rates. However, ophthalmology, T&O, ENT show some opportunity across all CCGs for reducing activity in outpatients.

Cancer

There is an ongoing challenge around delivering the first definitive treatment for cancer within 62 days of referral. UHBristol are particularly challenged in the delivery of 62 days because of the specific portfolio of tumour sites they deliver. There is also, however, an opportunity to off-set underperformance in complex pathways with delivery above the 85% standard in urology in NBT.

Diagnostics

Access to key diagnostics within 6 weeks is a problem for colonoscopy, flexi sigmoidoscopy, sleep studies and gastroscopy. NBT performance is the most challenged.

Mental health

IAPT recovery rate is lower for Bristol residents but improving. The dementia diagnosis rate is good for Bristol residents and North Somerset requires improvement. In 15/16 there were 3662 dementia related admissions in BNSSG.

End of life care

Currently there is a differential across BNSSG but if we were to move to the North Somerset position we would see fewer than 39% of people die in hospital. This is closer to the 29% of people who would prefer to die in hospital rather than at home. Local work in North Somerset has demonstrated that emergency hospital admissions in the last month of life were 51% lower amongst those who received a "Delivering Choice" option, the care coordination centre being the most effective element. In BNSSG there were 2253 emergency admissions where the patient died in hospital

1.5 Frailty services and care homes

The ECIS review of the frailty pathway in North Bristol states that people over 85 years account for 25% of bed days and that the same cohort of patients tend to spend around 8 days longer in hospital than those under 65 – 11 days compared to 3. Areas with integrated services for older people have lower rates of bed use, lower rates of admission and delver good patient experience.

Quality watch published data (January 2015) which showed that people in care home postcodes account for 13.4% of over 75 admissions, this is 13.74% for BNSSG. In the BNSSG footprint, in 2015/16, there were 3978 admissions and 4909 attendances at ED from care home.

A frailty team model in Ashford and St Peter's Hospitals NHS Foundation Trust (2013) achieved between 35% and 50% reduction in admissions from care homes. Local work underway in BNSSG suggests that this could be replicated.

1.6 Specialised commissioning

The provider template for 2016/17 will be based on agreed contracts and QIPP plus aligned other budgets (such as RTT and contingency) as already provided. The CCG template will be based on:

- Income: CCG/STP Specialised Commissioning allocations
- Expenditure: Specialised Commissioning Plans attributed to CCGs using the 2014/15 spend analysis to identify spend per head, and applying this spend per head proportionately to the 2015/16 population and 2015/16 actual spend.

(The above (for 2016/17) will be calibrated to the plan without (do nothing- deficit £146.7m) and with (BAU) QIPP of £143m (deficit £3.7m) across the South.

Note that the CCG spend (and overspend) are attributed entirely to South STPs, and the Provider spend/overspend is attributed entirely to the STP in which it sits- there are no inflows/outflows of spend/over/underspend. This is the agreed (with NHSI and NHSE) methodology.

It is noted that there is a reasonably high level of specialised activity undertaken out of the region and most notably at a higher cost to the commissioner in the London.

The table below outlines, for 14/15 the value of Specialised activity treated in London Trusts.

Provider Name	Sum of 1415 Total Costs
Frimley Park Hospital NHS Foundation Trust	21,760
Barts Health NHS Trust	90,458
East London NHS Foundation Trust	7,561
Epsom And St Helier University Hospitals NHS Trust	5,762
Great Ormond Street Hospital For Children NHS Foundation Trust	501,168
Guy'S And St Thomas' NHS Foundation Trust	297,783
Imperial College Healthcare NHS Trust	600,155
King's College Hospital NHS Foundation Trust	210,229
Moorfields Eye Hospital NHS Foundation Trust	11,354
Royal Free London NHS Foundation Trust	826,921
South London And Maudsley NHS Foundation Trust	77,071
The Royal Marsden NHS Foundation Trust	64,094
University College London Hospitals NHS Foundation Trust	326,516
West London Mental Health NHS Trust	3,307,614
	6,348,447

The table below outlines the specialised specialties with high level of spend out of South (14/15)

Row Labels	Sum of Out of South spend
A04 - Vascular	216,538
A09 - Complex Invasive Cardiology	213,396
A10 - Cardiac Surgery	149,311
A11 - Pulmonary Hypertension	341,619
B02 - PET-CT	453,271
B03 - Cancer	684,500
B05 - Haemophilia	108,086
B06 - HIV	334,488
C04 - Gender Identity	293,163
C06 - Tier 4 CAMHs	2,637,771
D02 - Brain Injury and Complex Rehab	2,253,416
D03 - Adult Neurosurgery	349,392
E03 - Paeds Medicine	431,215
E05 - Paeds Cardiac	232,152
TOTAL	**8,698,318**

It has been identified that there is a high level of out of area mental health placements for acute mental health beds, to a value of over £3m.

The table below outlines for 15/16 the total value of out of area mental health placements.

	N Som	S Glos	Bristol	Total
PICU	£204,024	£197,324	£802,334	£1,203,683
Mental Illness	£0	£0	£101,035	£101,035
Acute	£104,970	£512,589	£1,285,510	£1,903,069
OP	£6,925	£57,162	£49,525	£113,612
Total	£315,919	£767,075	£2,238,404	**£3,321,398**

1.7 Primary care

We know nationally that:

- Around 90 per cent of care takes place in primary care.
- Demand for GP services rose by 13 per cent between 2008-2013/14.
- According to a recent National Audit Office report, out-of-hours GP services handled around 5.8 million cases including 800,000 home visits.
- Consultations with nurses rose by 8 per cent and with other professionals in primary care, including pharmacists, grew by 18 per cent

1.8 Commissioner benchmarking

1.8.1 Right Care and Dr Fosters and other commissioner benchmarking

BNSSG CCGs are each benchmarked according to their peer group which is different in all 3 cases. Commissioners have utilised range of Commissioning for Value benchmarking tools which support identification of unwarranted variation and opportunities for improving spend and/or outcomes and identified some common areas of interest. The national information to date includes acute inpatients and primary prescribing but has not included:

- Outpatients and A&E (these have been benchmarked locally)
- Primary, community and mental health data
- Non PbR points of delivery

To note, in addition:

- Some elements of the suggested overspend has been investigated and is beneficial e.g. prescribing to prevent stroke so the whole pathway approach will need to be taken to review
- Some of the identified opportunities are already within existing plans or have been addressed through contractual changes
- The opportunity does not take into account cost of reproviding care
- Packs were issued to CCGs but not to specialised commissioning but they include specialised data

Each of the CCGs in BNSSG is benchmarked against comparable CCGs elsewhere and these will be a different group for each CCG. Nevertheless, the CCGs in BNSSG have opportunities identified in common as below:

Spend	**Cancer; Circulation; MSK; neurological problems, trauma**
Spend and outcomes	**Endocrine**
Outcomes	**Endocrine and respiratory**

Total identified opportunities are set out in the table below:

Spend Opportunity (£000s)		CCG			
DiseaseArea	Point of Delivery	Bristol	N Som	S Glos	Grand Total
Cancers & Tumours	Elective	904	1,963	2,124	4,991
	Emergency	311	356	344	1,011
	Primary Prescribing	12	29	123	164
Endocrine, Nutritional and Metabolic Disorders	Elective	150	168	138	456
	Emergency	323	225	166	714
	Primary Prescribing		0		0
Maternity & Reproductive Health	Primary Prescribing	362		155	517
Mental Health Problems	Primary Prescribing			22	22
Neurological problems	Emergency	2,241	990	1,452	4,683
	Primary Prescribing		202		202
Problems due to Trauma and Injuries	Elective	425	306	274	1,005
	Emergency	826	531	452	1,809
	Primary Prescribing		53	189	242
Problems of circulation	Elective		0		0
	Emergency	1,983	1,230	1,148	4,361
	Primary Prescribing	881	430	1,512	2,823
Problems of the gastro intestinal system	Elective		273		273
	Emergency	615	287	634	1,536
	Primary Prescribing		55	408	463
Problems of the genito urinary system	Elective	332	465		797
	Emergency	535	418	166	1,119
	Primary Prescribing		0	263	263
Problems of the Musculo skeletal system	Elective	2,089	2,381	1,317	5,787
	Emergency	518	423	306	1,247
	Primary Prescribing		274	445	719
Problems of the respiratory system	Elective	108	123	319	550
	Emergency	827	318	332	1,477
	Primary Prescribing		0	760	760
Grand Total		**13,442**	**11,500**	**13,049**	**37,991**

Summary by point of delivery and CCG

BNSSG CCGs - Commissioning for Value (Rightcare) Spend Opportunities

Spend Opportunity (£000s)	CCG			
Point of Delivery	Bristol	N Som	S Glos	Grand Total
Elective	4,008	5,679	4,172	13,859
Emergency	8,179	4,778	5,000	17,957
Primary Prescribing	1,255	1,043	3,877	6,175
Grand Total	**13,442**	**11,500**	**13,049**	**37,991**

In addition the STP packs provided nationally drew attention to a number of clinical areas where the population outcomes could be improved or care processes could be improved in relation to other areas of the country. The findings around diabetes are reinforced by the data in the overall STP pack around secondary prevention, structured education and amputations. The more detailed packs have been used to analyse the specific opportunities across care processes e.g. improving secondary prevention within general practice for diabetes care (see clinical pathways section)

The CCGs have clinically reviewed the opportunities and have to date identified the following specific immediate joint areas for action in total, however, this only provides £12m of opportunity prior to more extensive pathway work being undertaken.

- Knee replacement
- Elective neoplasms
- Non elective pneumonia
- Non elective non-specific chest pain
- Blood withdrawals
- IV infusions

Further work is required to identify further clear opportunities in particular with specialised commissioning colleagues and providers as part of the broader pathway work.

RCI Provider benchmarking idicates that there are excess costs across a number of specialty areas within the acute provider sector. The tables below identify for the 3 acute hospitals the highest cost areas using RCI benchmarking.

NBT		
Speciality	**Excess Cost**	**RCI**
Health Visiting and Midwifery	£5,645,359	183
Geriatric Medicine	£4,019,259	140
Neonatal	£3,456,878	140
Trauma & Orthopaedics	£10,150,629	124
Neurosurgery	£4,526,836	120
Urology	£3,490,149	119
General Surgery	£5,408,011	118

Weston		
Speciality	**Excess Cost**	**RCI**
Allied Health Professionals	£1,322,663	381
Physiotherapy	£1,478,590	274
Gynaecology	£1,088,577	140
General Medicine	£1,305,525	107
Grand Total Organisation	**£7,190,882**	**108**

UH Bristol		
Speciality	**Excess Cost**	**RCI**
Chemotherapy	£4,595,355	128
Trauma & Orthopaedics	£3,027,236	122
Cardiology	£3,076,926	111

iv. Output - Section 3: Activity modelling – the "Do nothing" base case position

The 'do nothing' scenario

The detailed assumptions underpinning the baseline Rubicon modelling are outlined below:

- The scope of the model is all CCG and NHS England commissioned health services provided to people registered with Bristol, North Somerset and South Gloucestershire CCGs, and adult social care and public health services commissioned by Bristol, North Somerset and South Gloucestershire unitary authorities;
- The model reflects 100% of the activity, income and expenditure for the following NHS providers; University Hospitals Bristol, North Bristol Trust and Weston Area Health Trust;
- Avon and Wiltshire Partnership is reflected in the model in proportion to its income from in scope CCGs;
- Costs relating to the local community providers are reflected from a commissioner perspective only since each is a social enterprise;
- The model is based on data for the last 12/ 24 months as far as this exists and is considered robust;
- The model projects activity and financials forward for the period 2016/17 to 2020/21;

- Demographic change is applied to activity using ONS forecasts for each CCG and divided by the age bands set out below;
- An allowance is made for non-ONS demographic growth based on historic trends.
- Inflation of 2% is applied on all provider costs in all years. The tariff efficiency factor is -2% resulting in net tariff change of 0% in all years.
- Marginal costs of 100% is used for all services;
- Where possible activity is divided and shown in output tables by:
    - Specialty;
    - Locality;
    - The following age bands – 0-19, 20-64, 65-79 and 80 and above;
    - Point of delivery (acute only): elective day cases, elective inpatients, non-elective zero day admissions, non-elective inpatients, maternity, first outpatients, follow-up outpatients and A&E;
    - The top-3 providers plus 'others';
    - The number of long-term conditions (0, 1, 2-4, 5 or more).
- Admission avoidance assumptions are applied on the basis of 'shortest length of stay' first for; all elective patients; all non-elective admissions for patients aged under 64; and non-elective admissions for over people aged 65 and over who have 0 or 1 long-term conditions;
- Admission avoidance assumptions are applied on the basis of 'average length of stay' for all other admitted patients;

The summary assumptions used to calculate the activity growth over the period to the end of 2020/21 are as follows:

- ONS forecast demographic change which has been applied at HRG level for acute activity (admitted patients, A&E and outpatients) or service line level for non-acute services (e.g. adult mental health, community nursing, community therapies etc);
- Plus 1.5% on all activity types except;
- 4.4% applied to specialised commissioning.

The national guidance suggests the use of IHAMs forecasts which are based on ONS demographic change applied at a 'high level' (acute, MH, community etc) plus an additional allowance for non-demographic growth based on national trends. We have compared the results of our methodology with the IHAMs numbers and there is no material difference, so we have maintained our approach

Our model also has the functionality to replace the global 1.5% assumption with historic speciality-level growth rates. We will not be using this option for the 30th June return because of coding and specialty-level changes which make some of the specialty figures unreliable. We will, however, work to adjust known problems with these numbers to make sure that future iterations of the whole system model can use speciality specific growth rates as appropriate.

The do nothing activity modelling highlighted the scale of challenge for the next five years

Projected activity growth – key services

Acute	16/17	17/18	18/19	19/20	20/21
None-elective OBDs	0.00%	2.59%	5.38%	8.37%	11.18%
Elective IP OBDs	0.00%	2.60%	5.26%	7.91%	10.51%
Elective Day cases	0.00%	2.62%	5.28%	7.93%	10.51%
Outpatients	0.00%	2.59%	5.19%	7.79%	10.32%
A&E	0.00%	2.53%	5.06%	7.63%	10.15%

Acute NEL OBDs	16/17	17/18	18/19	19/20	20/21
0 LTCs	0.00%	2.60%	5.37%	8.30%	11.07%
1 LTCs	0.00%	2.61%	5.47%	8.60%	11.50%
2-4 LTCs	0.00%	2.60%	5.51%	8.74%	11.67%
5+ LTCs	0.00%	2.51%	4.99%	7.57%	10.29%

Acute OBDs	16/17	17/18	18/19	19/20	20/21
0-19	0.00%	2.45%	4.89%	7.46%	10.14%
20-64	0.00%	2.52%	4.96%	7.32%	9.59%
65-79	0.00%	2.77%	5.68%	8.47%	11.27%
80+	0.00%	2.56%	5.59%	9.22%	12.43%

Community Contacts	16/17	17/18	18/19	19/20	20/21
Integrated care	0.00%	2.92%	6.00%	8.93%	11.63%
Community thearpies	0.00%	2.93%	6.03%	8.96%	11.67%
Specialist Nursing	0.00%	2.67%	5.56%	8.43%	11.06%

Primary Care	16/17	17/18	18/19	19/20	20/21
Bristol	0.00%	2.67%	5.56%	8.43%	11.06%
N Somerset	0.00%	3.46%	6.88%	9.73%	12.83%
S Glos	0.00%	2.84%	5.92%	8.98%	11.50%

Occupied Bed Days rise more than admissions reflecting a slight shift towards more complex admissions. 237 more beds would be needed to meet demand from the three CCGs.

Avoiding the need to open this additional capacity is a goal of the transformation programme i.e. cost avoidance rather than cash savings.

Acute	16/17	17/18	18/19	19/20	20/21	%
Admissions	228,026	233,987	240,082	246,235	252,178	10.6%
OBDs	657,912	675,130	693,603	713,233	731,632	11.2%
AvLoS	2.9	2.9	2.9	2.9	2.9	0.6%
Beds	2,121	2,176	2,236	2,299	2,358	11.2%

Community & Primary Care	16/17	17/18	18/19	19/20	20/21	%
Community Contacts	695,507	715,796	737,229	757,570	776,405	11.6%
Priamry Care Contacts	5,126,684	5,276,025	5,433,777	5,583,513	5,722,438	11.6%

Spend by Service (£m)	BCCG	NSCCG	SGCCG	NHSE	Councils	Total	%
Acute	£334	£177	£187			£698	36%
Mental Health	£77	£27	£25			£129	7%
Community Health	£63	£33	£22			£118	6%
Primary Care (CCGs)	£81	£42	£44			£167	9%
CHC	£41	£17	£27			£85	4%
Other CCG	£25	£11.51	£14.86			£51	3%
Spec Comm				£279		£279	14%
Primary Care (NHSE)				£124		£124	6%
Social Care/Public Health					£303	£303	16%
Total	**621**	**307**	**319**	**403**	**303**	**1,952**	**100%**

Totality of spend

The review of the whole spend across footprint, suggests that the whole system will need to become more efficient as the required demand will not be met simply by containing acute activity.

Modelling the assumptions for our high level initiatives

High level assumptions are outlined in the plan. Assumptions were adjusted to remove duplication and efficiencies reduced by 40% to allow for the costs of reprovision. All savings were risk adjusted down by 50%.

D. Public Health Intelligence

i. Population projections

Population projection data for Bristol, North Somerset and South Gloucestershire (BNSSG) is provided in annex B. Housing numbers are allocated on the basis of population projections so to some extent the numbers of people moving to the area are captured within the population projections. The exact number of people per household and demographic profile of people moving into new housing however is not known. Population estimates for housing developments are based on 2.3 persons per household.

South Gloucestershire is predominately rural although most of the population live in the urban areas. The South Gloucestershire population has grown over the past decade by 10% and is projected to rise by a further 17% by 2037. The biggest increases will be in the older age groups. At least 30,000 new homes are planned to be built by 2036 in South Gloucestershire.

The figures in annex B cover North Somerset local authority area but it is worth considering in addition the North Sedgemoor area of Somerset as it forms part of the Weston General Hospital catchment population. North Somerset and North Sedgemoor face significant demographic pressures with a population which is both ageing and growing. Longer term projections suggest the population of North Somerset and North Sedgemoor is set to increase at an annual rate of 1% across all age groups, reaching an estimated 300,000 by 2030. The largest increase over the next ten years is set to be identified in the 75-84 age group (5% per annum), followed by the over 85s (4.6% per annum). In respect to the younger age group (0-14), the population is projected to rise by 12% (an additional 5,000 children) in the next 15 years. The 'Weston Villages' are the main strategic growth area for North Somerset and are forecast to deliver 6,200 new homes.

The population of Bristol has grown 11.8% since 2004 (compared to 8% in England and Wales) mainly due to the high number of births relative to deaths. This growth has been mainly concentrated in the inner city. The birth rate is high but has plateaued. The population is young, with a median age of 33.4 compared to 39.9 in England. Around 16% of the population are from BME backgrounds but amongst children it is 28%. The city is increasingly diverse, with significant differences in ethnicity between areas. There are 58,800 older people 65 years and over in Bristol. This proportion (13.3%) is lower than nationally but has risen in the North & West (inner). There are projected to be 8,100 additional older people by 2022, a 14.2% rise.

The Population total across BNSSG is 968,314, with 17.5% of the population living in the most deprived quintile areas of England (IMD2015), this equates to 164,613 people across BNSSG.

Expected population changes over the next five years by age bands across BNSSG

Age	Current population (2015/16)	Five year predicted change (2020/21)
0 to 14	165,737	7.1%
15 to 44	407,959	2.6%
45 to 64	234,326	2.8%
65 to 74	86,453	2.3%
75 to 84	51,234	15.9%
85 plus	22,605	17.6%

ii. Life expectancy

The overall life expectancy (from birth) in Bristol is 78.4 years for males and 82.9 years for females, in North Somerset it is 80.3 years for males and 83.8 years for females and South Glos 81.5 years for males and 84.8 years for females.

The corresponding healthy life expectancies for Bristol is 63.3 years for males and 64.2 years for females, North Somerset 66.8 years for males and 64.6 years for females, and South Glos 67.8 for males and 68.2 for females.

Therefore across BNSSG the average life expectancy at birth for males is 80.1 years and females 83.8 years with corresponding healthy life expectancies of 66 years and 65.7 years. **This means on average across BNSSG males are living 14.1 years in poor health and females 18.1 years.**

iii. Inequalities

The slope index of inequality measures the difference in life expectancy across deprivation deciles in an area. For 2012-2014 the gap for males in Bristol was 9.6 years and 7 years for females, in North Somerset it was 9.1 years for males and 6.5 years for females and in South Glos it was 7.1 years for males and 5 years for females. This results in a BNSSG average difference in life expectancy of 8.6 years for males and 6.2 years for females across the least and most deprived 10% of the population.

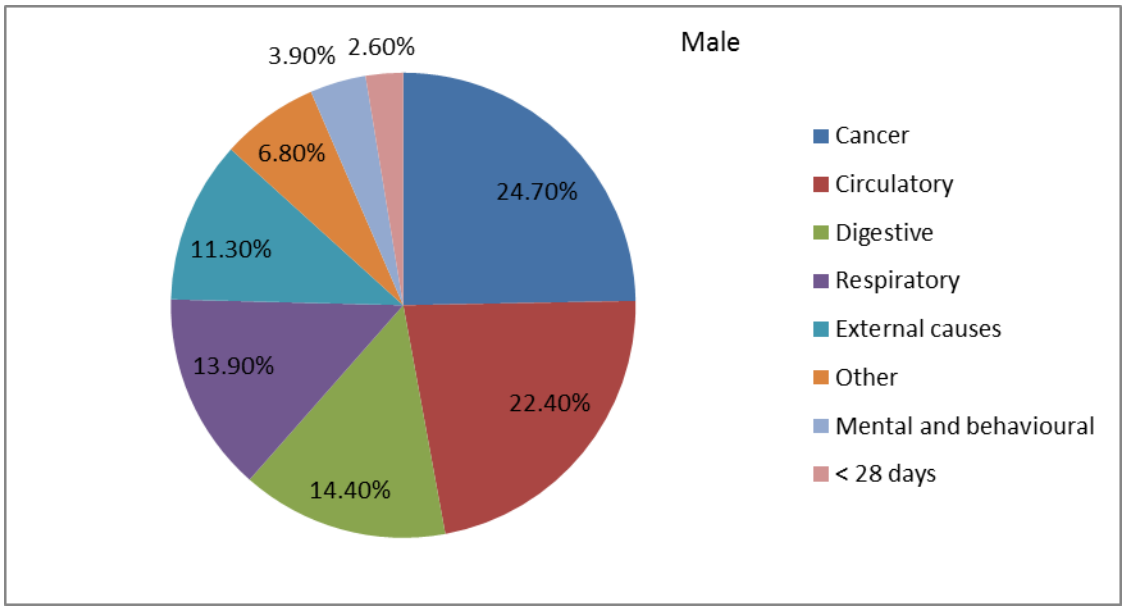
It has been estimated that 20% of healthcare costs are due to the manifestations of inequalities (WHO 2014). The leading causes of disease and death that contribute to the gap in life expectancy across deprivation deciles reflect the higher risk factor profile and clustering of multiple risk factors (Kings Fund 2014). It has been demonstrated that people in lower socio-economic groups are more likely to have multiple lifestyle risk factors. Based on the health survey for England data the Kings Fund demonstrated that in the 2003 survey people in lower socioeconomic groups were 3-times as likely as higher socioeconomic groups to have a combination of 3 or 4 risk factors from smoking, excessive alcohol consumption, poor diet and low physical activity and when this was re-examined in the 2008 survey the figure had risen to 5-times as likely (Kings fund 2014).

iv. Contributors to life expectancy gaps

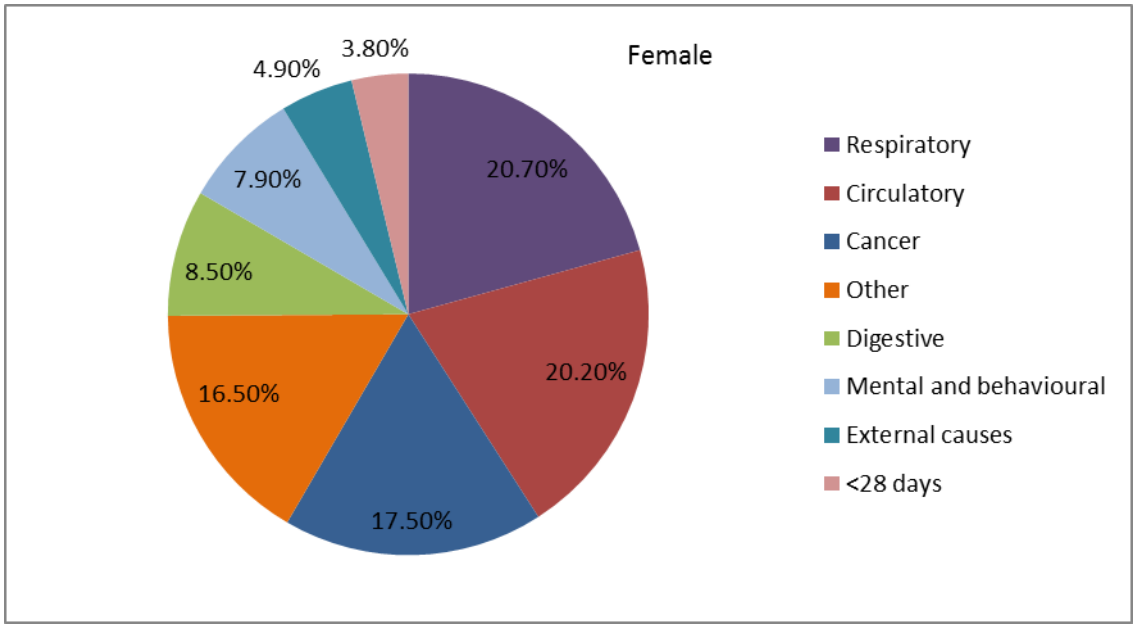
Local authority level data can be used to identify the causes of death that are the largest contributors to life expectancy inequalities. The diseases driving inequalities can then be targeted in order to reduce the gap in life expectancy between the most and least deprived areas across BNSSG. Based on data for 2012-2014 (PHE Segment tool 2016) in males the leading causes of the inequality gap are cancers, circulatory diseases and digestive disorders, and for females respiratory diseases, circulatory and cancers. [3]

[3] Digestive diseases include alcohol-related chronic liver disease. External causes include injuries, poisoning and suicide. Other includes benign neoplasms, metabolic diseases, diseases of the nervous system, eye, ear, and skin; musculoskeletal diseases, perinatal conditions, congenital diseases and conditions related to pregnancy and birth.

Contribution to the gap in life expectancy (Males) across BNSSG.



Contribution to the gap in life expectancy (Females) across BNSSG.



v. <u>Years of life lost</u>

Years of life lost (YLL) is a measure of premature mortality (deaths before the age of 75). It takes into account the age at which a person died, giving a greater weight to deaths occurring at an earlier age. For a death under the age of 75, the number of years of life lost is calculated as 75 minus the age at death. So if a person died at age 35, they would be considered to have 40 years of life lost.

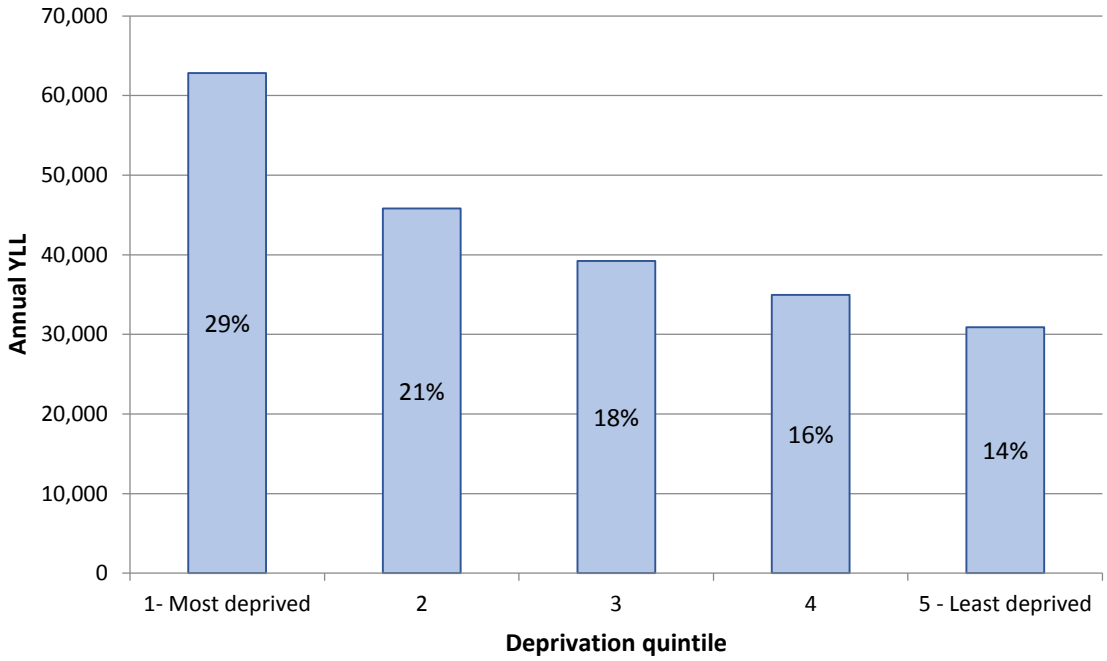
This means that we can assess the extent to which a death is premature, rather than just noting that it occurred before the age of 75. We can calculate years of life lost for different causes of premature death to compare the relative importance of different conditions.

In the South West, causes such as suicide, transport accidents, accidental poisoning, drug use and congenital anomalies affect relatively few people, however a large proportion of deaths from these conditions occur in those under the age of 75. The number of years of life lost per death is high, indicating that people dying from these causes die relatively young.

Fairly high numbers of people die from causes such as stroke, influenza and pneumonia however only a small proportion of deaths occur under the age of 75. The number of years of life lost per death is reasonably low, indicating that these conditions are not principal causes of premature death.

Due to more deaths in younger people being associated with causes that are linked to deprivation (see gap analysis) the number of years of life lost increase with deprivation. Years of life lost in the most deprived areas of the South West are more than double the respective figure for the least deprived areas. Almost 3 out of each 10 years of life lost in the South West during the time period used were in those living in the most deprived areas.

The percentage of annual number of years of life lost in the South West, by deprivation quintiles, 2008-2012



vi. Future demands across BNSSG (disease prevalence models)

The health needs of a population derive from the prevalence of diseases, i.e. the numbers of people suffering from different types of illness. Looking only at the numbers of patients currently being treated for a disease does not show the true prevalence and impact on the population's health. At any given time, there are many people who have a disease but are not aware of it because they have

not yet been diagnosed. A robust and well-researched disease prevalence model can help commissioners to assess the true needs of their community, calculate the level of services needed and invest the appropriate level of resources for prevention, early detection, treatment and care. Prevalence models provide estimates of underlying prevalence derived from population statistics and scientific research on the risk factors for each disease.

The following shows the expected increase in disease prevalence for various causes of death for Bristol, North Somerset and South Gloucestershire including:

- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Dementia
- Diabetes
- Obesity

It is worth noting that a number of assumptions were made in creating the following prevalence models. They are based on old mid-year estimates (previous to 2010) and therefore may now have changed. It is important to remember that the prevalence figures generated by the models are estimates of the expected prevalence of disease. The subnational population projections (SNPP) were taken from ONS, which were created based on 2012 population data and does not take into account any more recent increases. For a full list of caveats, please refer to the APHO website http://www.apho.org.uk/diseaseprevalencemodels.

Cardiovascular Disease (CVD)

CVD includes both coronary heart disease (CHD) and stroke. The prevalence of CHD is almost double that of stroke in the over 75s and double/treble as prevalent in the 65-74 age group.

Prevalence of Cardiovascular disease, coronary heart disease and stroke for Bristol, North Somerset and South Gloucestershire, by age categories

Prevalence of CVD (%) (persons)			
Age Group (years)	Bristol	North Somerset	South Gloucestershire
16-44	3.86	3.97	3.95
45-64	9.81	9.69	9.63
65-74	28.61	27.65	27.98
75+	39.72	38.63	39.02
Prevalence of CHD (%) (persons)			
16-44	0.37	0.43	0.36
45-64	6.12	5.60	4.83
65-74	17.27	15.18	13.75
75+	23.16	20.75	18.92
Prevalence of Stroke (%) (persons)			
16-44	0.32	0.31	0.30
45-64	1.92	1.78	1.71
65-74	6.82	6.14	6.08
75+	11.64	10.64	10.51

Source: APHO: 2011

According to the disease prevalence models, CVD is set to increase across all age groups, with the biggest increase occurring in the over 75 year olds. This is a consistent finding across BNSSG. Over the next 12 years an annual increase of 2.3%, 4.7% and 4.0% respectively in the over 75s compared to 0.8%, 0.7% and 0.9% respectively in the 16-44 age group is expected. North Somerset in particular shows the greatest increase in the number of over 75s with CVD, followed by South Gloucestershire. In an ageing population in North Somerset this in part explains the high disease predictions as the prevalence of disease increases with age.

Predicted prevalence of cardiovascular disease in Bristol, North Somerset and South Gloucestershire, by age categories, 2014-2026.

		Bristol		North Somerset		South Gloucestershire	
Year	**Category**	**No.**	**% Δ from 2014**	**No.**	**% Δ from 2014**	**No.**	**% Δ from 2014**
2014	**16-44**	8,072	-	2,619	-	3,951	-
2014	**45-64**	8,985	-	5,483	-	6,906	-
2014	**65-74**	8,754	-	7,121	-	7,549	-
2014	**75+**	11,189	-	8,519	-	8,786	-
2021	**16-44**	8,594	6.5%	2,747	4.9%	4,096	3.7%
2021	**45-64**	9,426	4.9%	5,775	5.3%	7,290	5.5%
2021	**65-74**	9,584	9.5%	7,579	6.4%	7,946	5.3%
2021	**75+**	12,273	9.7%	10,932	28.3%	10,964	24.8%
2026	**16-44**	8,895	10.2%	2,854	9.0%	4,242	7.4%
2026	**45-64**	9,690	7.9%	5,824	6.2%	7,290	5.5%
2026	**65-74**	9,785	11.8%	7,496	5.3%	8,198	8.6%
2026	**75+**	14,299	27.8%	13,327	56.4%	13,032	48.3%

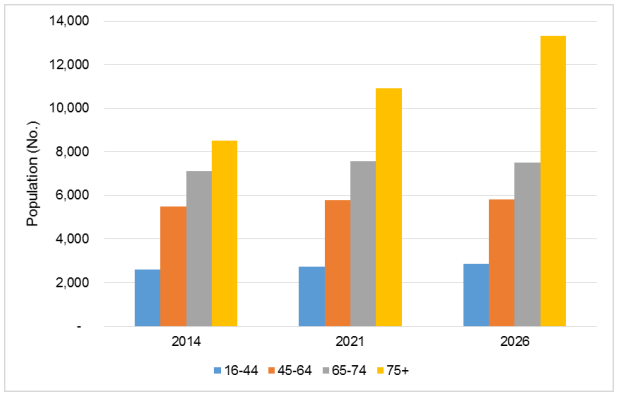
NB/ Figures may not add up due to rounding

Source: APHO, 2011

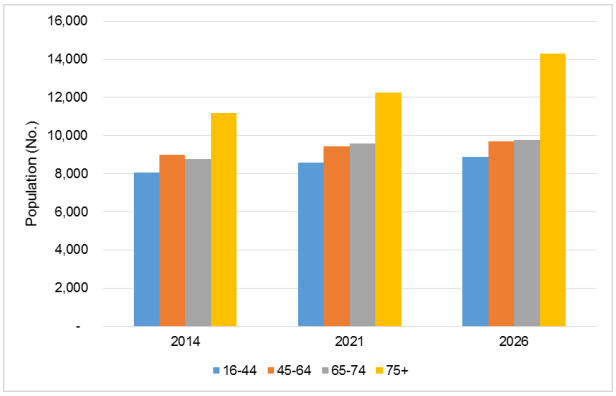
The graphs below highlight the increase in the number of people predicted to have CVD across BNSSG. It suggests that both North Somerset and South Gloucestershire have a similar age structure with an ageing population and fewer younger people. In comparison Bristol has a higher proportion of younger people, therefore the difference between the number of people with CVD in the 16-44 and the 75+ age group is not as stark as North Somerset and South Gloucestershire.

Predicted prevalence of cardiovascular disease in Bristol, North Somerset and South Gloucestershire, by age categories, 2014-2026.

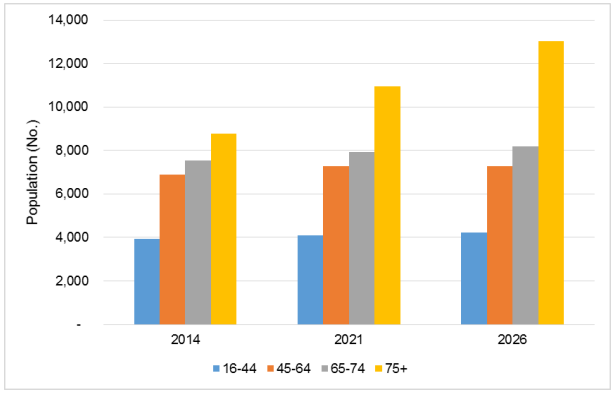
North Somerset



Bristol



South Gloucestershire



Source: APHO, 2011

Chronic Obstructive Pulmonary Disease

Predicted prevalence of chronic obstructive pulmonary disease in Bristol, North Somerset and South Gloucestershire, by age categories, 2014-2026.

		Bristol		North Somerset		South Gloucestershire	
Year	**Category**	**No.**	**AGR from Baseline**	**No.**	**AGR from Baseline**	**No.**	**AGR from Baseline**
2014	**16-44**	3516	-	594		1250	-
2014	**45-64**	5011	-	1771		2948	-
2014	**65-74**	3329	-	1658		2245	-
2014	**75+**	3214	-	1544		2045	-
2021	**16-44**	3743	0.9%[1]	623	0.7%[1]	1296	0.5%[1]
2021	**45-64**	5257	0.7%[1]	1865	0.8%[1]	3111	0.8%[1]
2021	**65-74**	3645	1.4%[1]	1765	0.9%[1]	2363	0.8%[1]
2021	**75+**	3526	1.4%[1]	1981	4.0%[1]	2551	3.5%[1]
2026	**16-44**	3874	0.7%[2]	647	0.8%[2]	1343	0.7%[2]
2026	**45-64**	5404	0.6%[2]	1881	0.2%[2]	3111	0.0%[2]
2026	**65-74**	3721	0.4%[2]	1745	-0.2%[2]	2438	0.6%[2]
2026	**75+**	4108	3.3%[2]	2415	4.4%[2]	3033	3.8%[2]

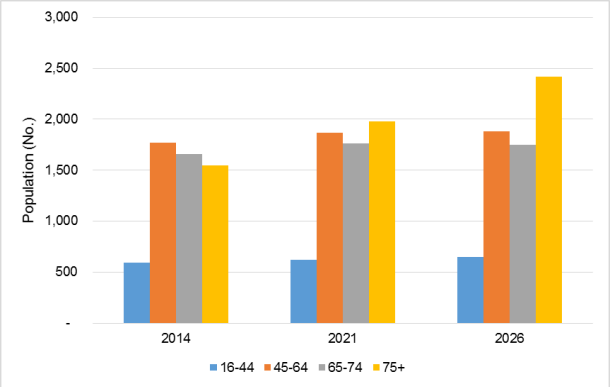
AGR – Annual Growth Rate; 1 – Annual increase from 2014 to 2021; 2 – Annual increase from 2021 to 2026; Figures may not add up due to rounding

Source: APHO, 2011

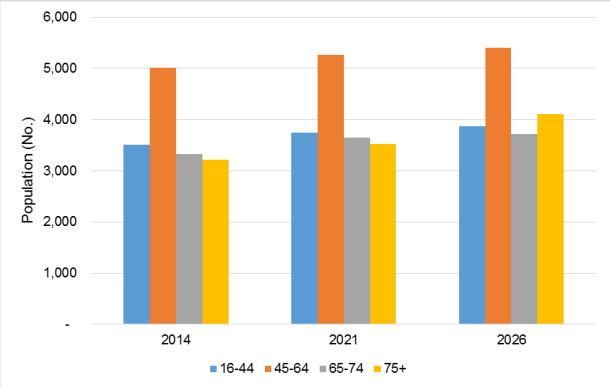
The graphs below show the predicted prevalence of chronic obstructive pulmonary disease (COPD) across BNSSG. A greater number of males suffer from COPD but the predicted increase in prevalence is similar across genders. In Bristol it suggests that the age group with the largest number of sufferers will be in the 45-64 age group, which is also the case in South Gloucestershire. In North Somerset however, the graph shows a greater issue among the over 75s.

Predicted prevalence of chronic obstructive pulmonary disease in Bristol, North Somerset and South Gloucestershire, by age categories, 2014-2026.

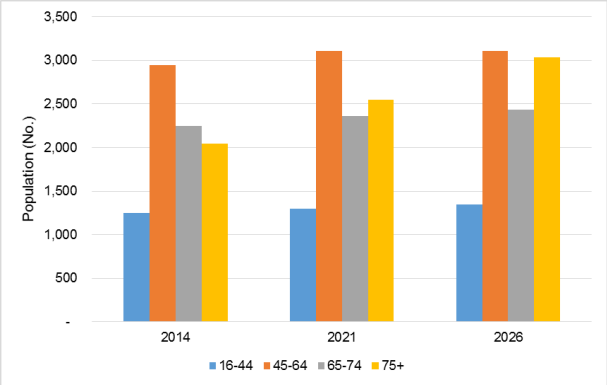
North Somerset



Bristol



South Gloucestershire



Source: APHO, 2011

Dementia

The predicted increase in the prevalence of dementia over the next 12 years for males and females separately. What is clear is that many more females will develop dementia and the older ages are at a greater risk. The data for 2014 suggests that there were 1,540 over 65 year old males and 2,975 females with dementia in Bristol. For North Somerset these figures were 1,237 and 2,278 and for South Gloucestershire they were 1,282 and 2,195. These numbers increase in males by 35% in Bristol, 60% in North Somerset and 54% in South Gloucestershire over the 12 years and by 18%, 42%, 41% for females respectively.

This is important to highlight as a public health concern as dementia costs the UK economy approximately £23 billion per year, which is higher than both cancer (£12 billion per year) and heart disease (£8 billion per year) combined (Alzheimer's Society, 2014).

Predicted prevalence of dementia in Bristol, North Somerset and South Gloucestershire, for males, 2014-2026.

Age Bands (years)	Bristol			North Somerset			South Gloucestershire		
	2014	2021	2026	2014	2021	2026	2014	2021	2026
60-64	84	91	103	56	60	73	65	73	86
65-69	131	126	138	107	93	102	110	102	117
70-74	193	248	229	164	208	189	177	211	195
75-79	255	302	366	213	292	329	228	292	329
80-84	362	402	474	284	361	484	313	371	474
85-89	301	347	408	234	317	393	236	332	393
90+	215	294	362	179	294	407	152	271	384

Source: Alzheimer's Society, 2014

Predicted prevalence of dementia in Bristol, North Somerset and South Gloucestershire, for females, 2014-2026.

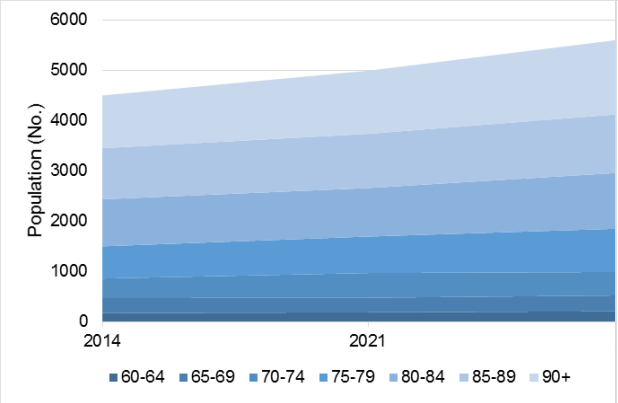
Age Bands (years)	Bristol			North Somerset			South Gloucestershire		
	2014	2021	2026	2014	2021	2026	2014	2021	2026
60-64	85	93	104	61	67	76	66	76	92
65-69	159	157	171	139	122	135	139	131	148
70-74	204	252	240	168	225	204	186	225	210
75-79	387	422	502	308	396	475	332	409	462
80-84	576	562	644	438	503	644	457	515	632
85-89	720	727	747	525	626	707	481	606	687
90+	845	957	1,089	639	792	990	534	660	858

Source: Alzheimer's Society, 2014

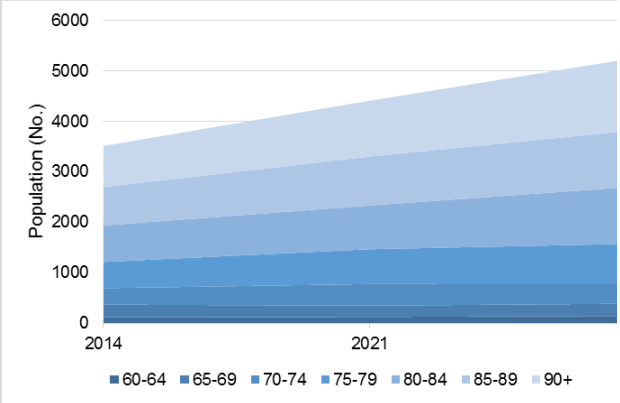
The graphs below highlight the increase in dementia prevalence across BNSSG. Due to North Somerset and South Gloucestershire's ageing population it is not surprising that there are steeper increases in dementia compared to Bristol.

Predicted prevalence of dementia in Bristol, North Somerset and South Gloucestershire, all persons, 2014-2026.

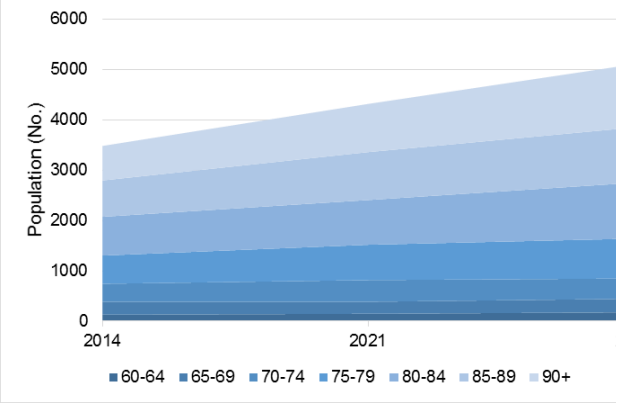
Bristol



North Somerset



South Gloucestershire



Source: Alzheimer's Society, 2014

Diabetes and Obesity

The projected NHS's annual spending on diabetes in the UK will increase from £9.8 billion to £16.9 billion over the next 25 years. This increase would mean that the NHS would be spending 17% of its entire budget on the condition. As the tables show, the prevalence of diabetes is set to increase and so too obesity in Bristol, North Somerset and South Gloucestershire.

Predicted prevalence of diabetes in North Somerset, 2015-2030

Year	Number	Prevalence	Lower uncertainty limit	Upper uncertainty limit
2015	14,437	7.6%	5.6%	11.7%
2020	16,334	8.0%	5.9%	12.3%
2025	18,333	8.4%	6.1%	12.9%
2030	20,483	8.8%	6.4%	13.6%

Source: APHO, 2011

Predicted prevalence of obesity in North Somerset, 2015-2030

Year	Obesity continues to rise at current rate		2010 obesity levels maintained	
	Number	Prevalence	Number	Prevalence
2015	14,437	7.6%	14,341	7.6%
2020	16,334	8.0%	15,864	7.8%
2025	18,333	8.4%	17,417	8.0%
2030	20,483	8.8%	19,045	8.2%

Source: APHO, 2011

Predicted prevalence of diabetes in Bristol, 2015-2030

Year	Number	Prevalence	Lower uncertainty limit	Upper uncertainty limit
2015	23,736	5.9%	3.9%	9.1%
2020	26,333	6.2%	4.1%	9.6%
2025	29,303	6.6%	4.3%	10.2%
2030	32,622	6.9%	4.5%	10.8%

Source: APHO, 2011

Predicted prevalence of obesity in Bristol, 2015-2030

Year	Obesity continues to rise at current rate		2010 obesity levels maintained	
	Number	Prevalence	Number	Prevalence
2015	23,736	5.9%	23,578	5.9%
2020	26,333	6.2%	25,576	6.0%
2025	29,303	6.6%	27,841	6.2%
2030	32,622	6.9%	30,335	6.5%

Source: APHO, 2011

Predicted prevalence of diabetes in South Gloucestershire, 2015-2030

Year	**Number**	**Prevalence**	**Lower uncertainty limit**	**Upper uncertainty limit**
2015	14,748	6.4%	4.7%	10.2%
2020	16,318	6.8%	4.9%	10.8%
2025	17,960	7.1%	5.1%	11.4%
2030	19,670	7.4%	5.3%	11.9%

Source: APHO, 2011

Predicted prevalence of obesity in South Gloucestershire, 2015-2030

Year	Obesity continues to rise at current rate		2010 obesity levels maintained	
	Number	Prevalence	Number	Prevalence
2015	14,748	6.4%	14,651	6.4%
2020	16,318	6.8%	15,849	6.6%
2025	17,960	7.1%	17,064	6.7%
2030	19,670	7.4%	18,291	6.9%

Source: APHO, 2011

vii. Risk factors analysis

The leading risk factors for the diseases that contribute to premature death and to the gaps in life expectancy across deprivation quintiles, are smoking, alcohol and obesity due to poor diet and a lack of physical activity (3:4:50 San Diego Report)

Smoking

Smoking-related illness is estimated to cost the NHS £5.2 billion a year, representing a significant burden on the health service (Kings Fund 2014).

Prevalence across BNSSG varies.

	Smoking prevalence (QOF)	Highest practice recorded prevalence (QOF)	Ex-smokers (GP survey data)
Bristol	21.5%	38.6%	25.5%
North Somerset	17%	42.3%	32.1%
South Glos	15.9%	24.6%	27.9%

Alcohol

Alcohol misuse costs the NHS approximately £3.5 billion per year, equivalent to £120 per tax payer (Department of Health 2013). Over three quarters of adults drink regularly and more than one million people in England have mild, moderate or severe alcohol dependence (LGA 2013).

The majority of individuals suffering from alcohol abuse or dependence do not access treatment (Cunningham 2004). Current estimates for high risk drinkers across BNSSG and numbers of alcohol related hospital admissions.

	Bristol	**North Somerset**	**South Glos**	**BNSSG**
Estimated risk drinkers (>19 units per week)	79,387	39,762	49,068	168,217
Alcohol related admissions	3018	1387	1641	6046

Obesity/diet

Being obese reduces life expectancy by between 3 and 13 years and directly contributes as a risk factor to two of the leading causes of premature death, cancer and heart disease. 13.9% of the attributable proportion of myocardial infarction and 25.8% of the attributable proportion of stroke are due to obesity.

Overweight and obesity (Active People Survey 2012-2015)

	Obese	**Overweight**
Bristol	21.7%	56.9%
North Somerset	22.2%	62.7%
South Glos	23.3%	63.2%

Physical Activity

Physical inactivity is estimated to cost the NHS £1.6 billion per year (Department of Health 2011). There is good evidence to suggest that being physically active can help us to lead healthier, happier lives. Regular physical activity can reduce the risk of developing numerous chronic health conditions, including mental health problems, type 2 diabetes, coronary heart disease, cancer and musculoskeletal conditions. Studies have shown that even a small increase in physical activity can provide protection against chronic diseases (I-Min Lee 2012)

The advantages of exercise extend beyond health. Increasing the number of people that cycle or walk to work would decrease costs associated with transportation, reduce traffic and help the environment. Participating in sports helps children and young people to develop important social skills such as teamwork, as well as reducing antisocial and criminal behaviour. Physical activity is a vital part of a child's early growth and development and establishing physical activity as a habit at an early age can lead to a physically active lifestyle in adulthood.
A recent study has found that inactivity is responsible for almost one fifth of premature deaths in the UK and more than 10% of cases of coronary heart disease. (I-Mine Lee 2012)

In addition physical activity is important in older people to help with balance and stability and reduce the risk of falls. Below table shows the average numbers of hospital admissions for fractures due to falls in older people per year.

	Fractured neck of femur (male)	Fractured neck of femur (female)
Bristol	99	255
North Somerset	78	212
South Glos	80	192
BNSSG	257	659

PHOF 2014/2015

viii. Disability adjusted life years lost

Depression and long term mental health conditions (QOF 2014/15)

	Depression	**Highest practice depression prevalence**	**Long term mental health condition**	**Highest practice long term mental health condition**
Bristol	7.6%	13.7%	5.9%	14.7%
North Somerset	9.2%	17.6%	5.3%	11.9%
South Glos	7.7%	11.8%	4.3%	9.7%

Hospital admissions for unintentional and deliberate injuries in people aged 15-24 (QOF 2014/2015)

	Hospital admissions for unintentional and deliberate self-injuries in people aged 15-24
Bristol	1070
North Somerset	357
South Glos	419
BNSSG total	1846

ix. Return on investment for public health interventions

Public health interventions offer good value for money. Based on a thorough analysis of 200 public health interventions considered by NICE in forming public health guidance it was found that 89% were cost-effective at NICE thresholds (85% at the lower threshold rising to 89% at higher threshold) with 15% of those cost-saving and only 11% either above the cost-effectiveness threshold or more expensive and less effective than the comparator (Owen 2011).

Within the subsequent NICE guidelines, the following example interventions were found to offer cost-effective returns for smoking, alcohol and physical activity:

NICE guidance	Intervention	Cost per QALY (range)
Smoking: Brief interventions and referral for smoking cessation	Brief intervention only (5 minutes) Brief intervention (5 minutes plus nicotine replacement therapy) Brief intervention (5 minutes plus self-help)	£732 (£577 - £1677) £2,110 (£1664 - £4833) £370 (£292 – £847)
Alcohol: preventing harmful drinking	Screening and brief advice at GP registration Screening and brief advice at GP consultation Screening and brief advice during A+E consultation	£6500 £3300 (0-£6600) £10,400
Physical activity	Exercise prescriptions Exercise prescription and exercise information	£77 (£20 - £159) £425

The WHO produced an assessment of the evidence base for public health/prevention programmes with 'quick wins,' returns on investment within five years, these were:

Focus	Intervention
Environmental	Road traffic injury prevention Active transport Safe green spaces Heat wave plan
Social	Health employment programmes Insulating homes Housing ventilation for asthma Community falls prevention
Resilience	Violence prevention legislation Prevention of post-natal depression Family support projects Social emotional learning Bullying prevention Mental health in the workplace

	Psychosocial groups for older people Parenting programmes Depression prevention
Behaviour change	Lifestyle diabetes prevention programmes Restricting alcohol availability Community based youth tobacco control intervention Workplace obesity intervention Tobacco legislation, taxation and control Alcohol legislation, taxation and control Nutrition, reducing salt, trans-fats, promoting healthy diets Physical activity media awareness
Vaccination	Norovirus, pneumococcus, rota virus and influenza in children
Screening	Abdominal aortic aneurysm Depression in diabetes Cervical cancer
Treatment	Depression in diabetes Treatment of CVD

WHO 2014

x. <u>NHSE/PHE best buy public health interventions</u>

- Providing targeted advice and integrated care to tackle excessive alcohol consumption and smoking
- Creating healthy environments in health and care settings to improve diets and keep people in work, and support action to reverse trends in childhood and adult obesity
- Intervening earlier and managing conditions better to keep healthier for longer and reduce their care needs

Health and Wellbeing gap	**Interventions**
Unhealthy Behaviours	• Reduced alcohol consumption and associated hospital admissions through alcohol care teams • Brief advice and screening for alcohol consumption through GPs • Smoking cessation support in secondary care pathways • High quality local stop smoking services
Heathier Environment	• Implementation of healthier food buying standards and catering to reduce obesity

	• Weight management services • Sign-up to the workplace wellbeing charter, healthy workplaces and active travel • Employment opportunities for people with mental health needs and learning disabilities • Staff support for mental health, physical activity and access to physiotherapy for MSK
Improved patient pathway	• NHS health check and referral to the national diabetes prevention programme • Optimal detection and care for hypertension and AF • Self-referral schemes for physiotherapy to manage MSK conditions • Strength and balance programmes for falls prevention • Fracture liaison services and pathways for patients following first fall

NHSE prevention quick guide.

xi. Current return from public service example: Smoking cessation

As described above smoking related disease contribute a significant burden to the NHS. NICE have produced return on investment tools that enable quantification of savings made by current services and where costs occur in the system.

Based on analysis for BNSSG, smoking related illness currently costs the NHS £27.9 million per year and results in lost productivity and other costs amounting to over £45 million to the system. Services currently reach around 28% of the population. Reducing smoking prevalence has the potential to impact on over 140,000 GP consultations and 5,746 hospital admissions which the local health system is experiencing per year. The average smoking prevalence across BNSSG is 17%, PHE have set an aim for reducing this to 13%.

Current savings from smoking support services (from NICE tobacco ROI tool V3.05, October 2015)

	Bristol	North Somerset	South Glos	BNSSG combined costs/savings
Smoking prevalence in tool	18.2%	16.3%	16.7%	Av 17%
Total costs of smoking	£22,144,099	£10,653,104	£12,561,260	£45,358,463
Direct healthcare costs	£13,229,546	£6,907,398	£7,764,339	£27,901,283
Current reach of service	28.6%	31.5%	25.6%	Av 28.6%
Current saving GP and nurse consultations (2 years)	4490	1804	2081	8375
Current Saving outpatients (2 years)	607	535	275	1417
Current saving avoidable admissions (2 years)	122	86	57	265
Current saving on prescriptions (2 years)	1853	1055	902	3810
Current saving to NHS (2-years)	£639,734	£391,327	£297,402	£1,328,463

Where are current costs to the system from smoking related diseases?

	Bristol	North Somerset	South Glos	BNSSG
Lost productivity days (per year) from smoking related sickness	94,875	36,634	51,345	182,854
GP consultations (estimated number of GP consultations due to smoking related illnesses)	69,996	30,821	40,135	140,952
Nurse consultations (estimated number of practice nurse consultations due to smoking related illnesses)	17,517	9,414	11,785	38,716
Outpatients visits (estimated number of outpatient visits due to smoking related illnesses)	12,373	5,523	7,124	25,020
Hospital admissions (estimated number of hospital admissions due to smoking related illnesses)	2,654	1,542	1,550	5,746
Prescriptions (estimated number of smoking related prescriptions)	36,106	18,179	22,584	76,869

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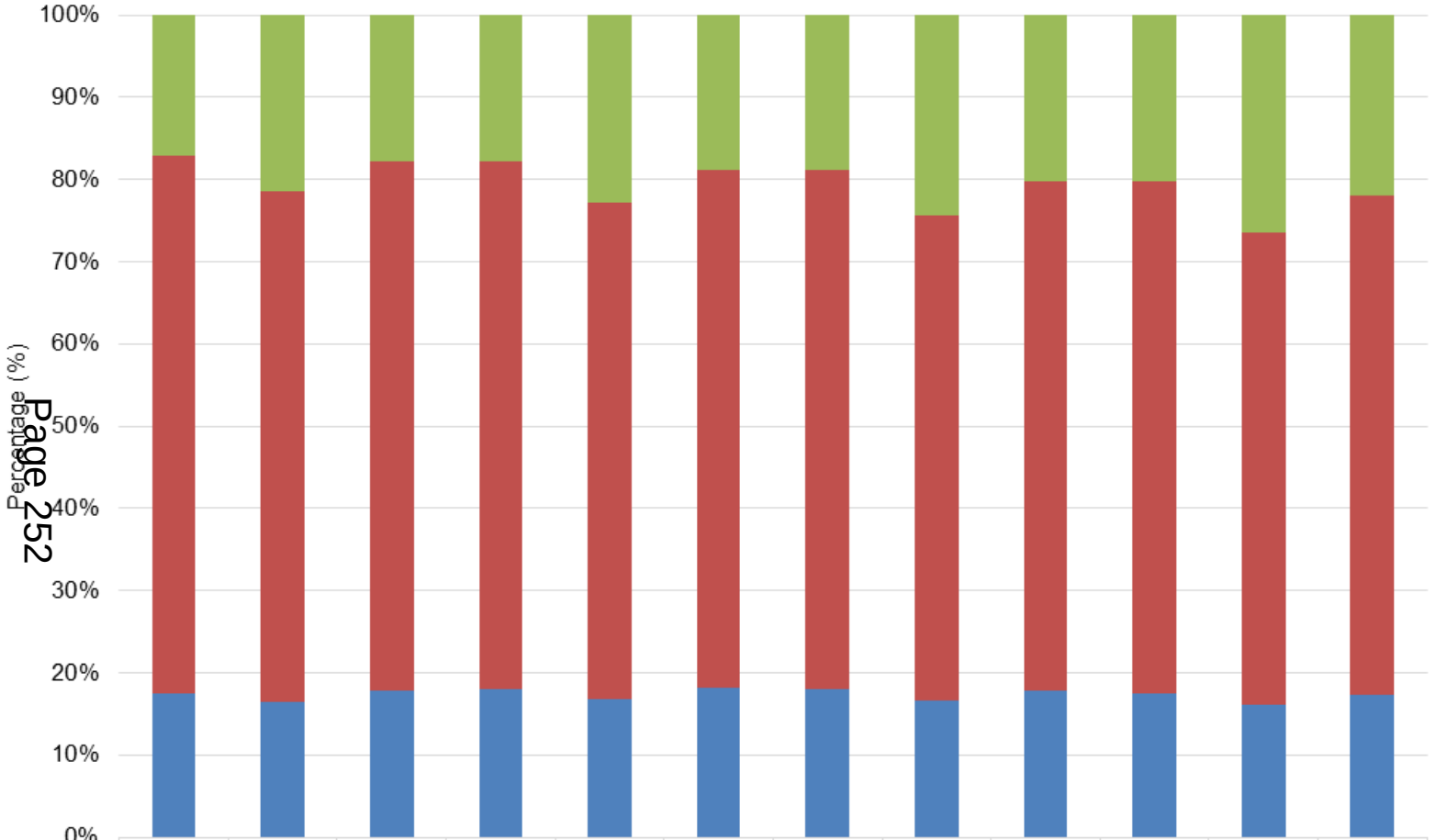
The overall picture for Bristol, North Somerset and South Gloucestershire (BNSSG) shows the younger population (0-14) is increasing at a quicker rate than the South West and England. There is a substantial increase in the elderly population with 20.3% over 65 by 2030.

xiii. Population Projections

Population projections for BNSSG, South West and England, by age categories, 2015-2030. (Figures in thousands – to one decimal place)

Area	Age Grp	2015	2020	2025	2030	% Change from 2015	% Change from 2015 South West	% Change from 2015 England
BNSSG	0-4	60	62	63	63	5.18	-0.36	-0.79
BNSSG	5-9	56	59	61	62	10.81	6.31	5.08
BNSSG	10-14	48	55	58	60	26.32	20.00	19.00
BNSSG	15-19	54	52	59	63	15.87	10.60	11.59
BNSSG	20-24	73	73	69	78	7.27	2.44	1.12
BNSSG	25-29	70	73	72	69	-1.85	-6.05	-6.95
BNSSG	30-34	67	71	74	72	6.98	3.09	0.99
BNSSG	35-39	61	66	69	72	17.99	14.33	13.94
BNSSG	40-44	60	59	64	67	11.67	1.80	6.18
BNSSG	45-49	64	59	58	63	-1.57	-11.89	-5.18
BNSSG	50-54	61	62	58	57	-7.98	-17.41	-11.19
BNSSG	55-59	52	60	61	56	9.30	2.98	7.05
BNSSG	60-64	46	50	58	59	27.61	23.53	27.20
BNSSG	65-69	48	44	48	55	15.90	12.04	16.48
BNSSG	70-74	37	45	42	45	20.91	22.73	27.14
BNSSG	75-79	29	34	41	38	31.83	35.70	31.85
BNSSG	80-84	22	24	29	36	59.91	69.69	63.47
BNSSG	85-89	14	16	18	22	60.43	61.16	57.69
BNSSG	90+	9	11	13	17	90.91	92.68	100.51
BNSSG	**All ages**	**930**	**973**	**1,013**	**1,052**	**13.17**	**10.04**	**10.06**



	BNSSG	South West	England	BNSSG	South West	England	BNSSG	South West	England	BNSSG	South West	England
	2015			2020			2025			2030		
65+	17.1%	21.5%	17.8%	17.8%	22.9%	18.9%	18.8%	24.4%	20.2%	20.3%	26.5%	22.0%
15-64	65.4%	62.1%	64.4%	64.1%	60.2%	62.9%	63.3%	58.9%	61.9%	62.2%	57.3%	60.6%
0-14	17.5%	16.4%	17.8%	18.1%	16.9%	18.2%	17.9%	16.7%	17.9%	17.5%	16.2%	17.4%

BNSSG has a lower proportion of over 65s in comparison to the South West and similar to England, which remains throughout the projections.

The percentage of elderly is increasing across BNSSG at a similar rate to England, reaching 20.3% by 2030, in comparison to 26.5% in the South West and 22.0% in England. However, as seen from the previous figures there is variation among the different areas that make up BNSSG.

E. Clinical Pathways Strategy

i. Key Pathways

As part of the development and delivery of the STP, key pathways requiring a more strategic, cross system review have been identified using:

- Right care benchmarking and Commissioning for Value tools
- Public Health intelligence and evidence of impact
- Provider benchmarking and performance

Based on our analyses, the following pathways have been identified as potential priority areas:

Model of care element for which identified	**Self care and prevention**	**Integrated primary and community care**	**Acute care collaboration**
MSK/Trauma and orthopaedics		X	X
Stroke	X	X	X
Cardiology			X
CVD: including Atrial Fibrillation; hypertension and hypercholesterolaemia	X	X	
Diabetes	X	X	X
Respiratory including COPD	X	X	X
Frailty	X	X	X
Urgent Mental Health		X	X
Dermatology			X
Pain management		X	X
Cancer	X	X	X
Neurology			X
Alcohol	X	X	X
Falls			
Children and Young People Mental Health	X	X	
Sexual health	X		
Dementia		X	X

These will be prioritised according to impact using:

- Right Care
- Getting it Right First Time
- Optimal tool (CLAHRC – West.

ii. Work Programme

The work programme will be developed that prioritises clinical leadership and supporting resource to the relevant pathways, combining existing work in individual CCGs and providers into one consistent approach for BNSSG.

The STP footprint leadership has agreed the following in support of this:

- The establishment of a "clinical cabinet" of clinical and care leaders across organisations that supports the clinical strategy and is accountable for delivery of that element of the STP. Its role will be to:
    - sponsor the work programme
    - support the principles and ways of working
    - agree priority areas (with priority given to areas that support the developing STP model of care work and more cost effective clinical care that delivers value to the system)
    - ensure learning is incorporated into future work programme and BNSSG ways of working
    - be supported by:
        1. BNSSG transformation resource
        2. programme and project management (BNSSG PMO) to ensure pace and oversight.
    - provide focal point, links to and commission work from organisations such as Bristol Health Partners, Avon Primary Care Research Collaborative for work they are doing in support of clinical redesign.
    - work across BNSSG to resource management support.
- A jointly held (provider and commissioner) list of priorities and work programme that requires clinical pathway work at a more strategic level that is identified using:
    - Benchmarking tools such as Atlas of Variation, Right Care etc.
    - Clinical evidence base and best practice reviews.
    - known system issues with quality, performance and delivery, or demand and capacity

- Commitment to involving all the relevant commissioners and providers for any pathway or element of pathway to address the outcomes and spend on a population basis and realise benefits to the system.
- An agreed approach to resourcing and using evidence based, systematic change methodologies for delivering rapid improvement and project management of these.
- An agreed approach to embedding pathways and making them visible to clinicians and patients across the system including running relevant education events.
- A simple, web based repository for holding and maintaining version controlled pathways and forms and making consensus adjustments as required e.g. when new NICE guidance is issued where this does not require significant change that enables rapid consultation with clinicians in BNSSG.
- Referrals management software in GP practices and elsewhere as possible.

iii. Principles for pathway development

Principles for pathway development include:

- Addressing the needs of the whole population including those at risk of disease now and in the future not just those currently in the system;
- Affordable pathways that promote value for the system, the population and the patient
- Ensuring that there is a focus on creating sustainable clinical and care systems where any waste / unwarranted variation is minimised - right care, right time for patients;
- Ensuring the 'patient voice' informs the case for change and opportunities for improvement;
- Get it right first time;
- Minimise use of professionals time;
- Use the most cost effective professional for every contact;
- Minimise use of hospital (and other nursed) beds;
- Minimise administration costs;
- A consistent offer across all of BNSSG;
- Embedding shared decision making tools within key pathways or decision points within pathways;
- Maximising opportunities for prevention, use of self-care and technology;
- Agreeing clear outcomes and methods for measuring "success";
- Identifying opportunities for innovative approaches to commissioning or contracting needed to support delivery.

Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

STP ANNEX B - Population Projections – BNSSG

Source

2012-based Subnational Population Projections for Local Authorities in England by sex and 5 year age groups, all local authorities and higher administrative areas within England, Population Projections Unit, ONS 2014

Information

Long-term subnational population projections are an indication of the future trends in population by age and sex over the next 25 years. They are trend-based projections, which means assumptions for future levels of births, deaths and migration are based on observed levels mainly over the previous five years. They show what the population will be if recent trends continue.

The projected resident population of an area includes all people who usually live there, whatever their nationality. People moving into or out of the country are only included in the resident population if their total stay in that area is for 12 months or more, thus visitors and short-term migrants are not included. Armed forces stationed abroad are not included, but armed forces stationed within an area are included. Students are taken to be resident at their term-time address.

The projections do not take into account any policy changes that have not yet occurred, nor those that have not yet had an impact on observed trends. They are constrained at the national level to the national projections published on 6 November 2013.

These projections published on 29 May 2014 are based on the 2012 mid-year population estimates published on 26 June 2013.

Note

Figures may not add exactly due to rounding.

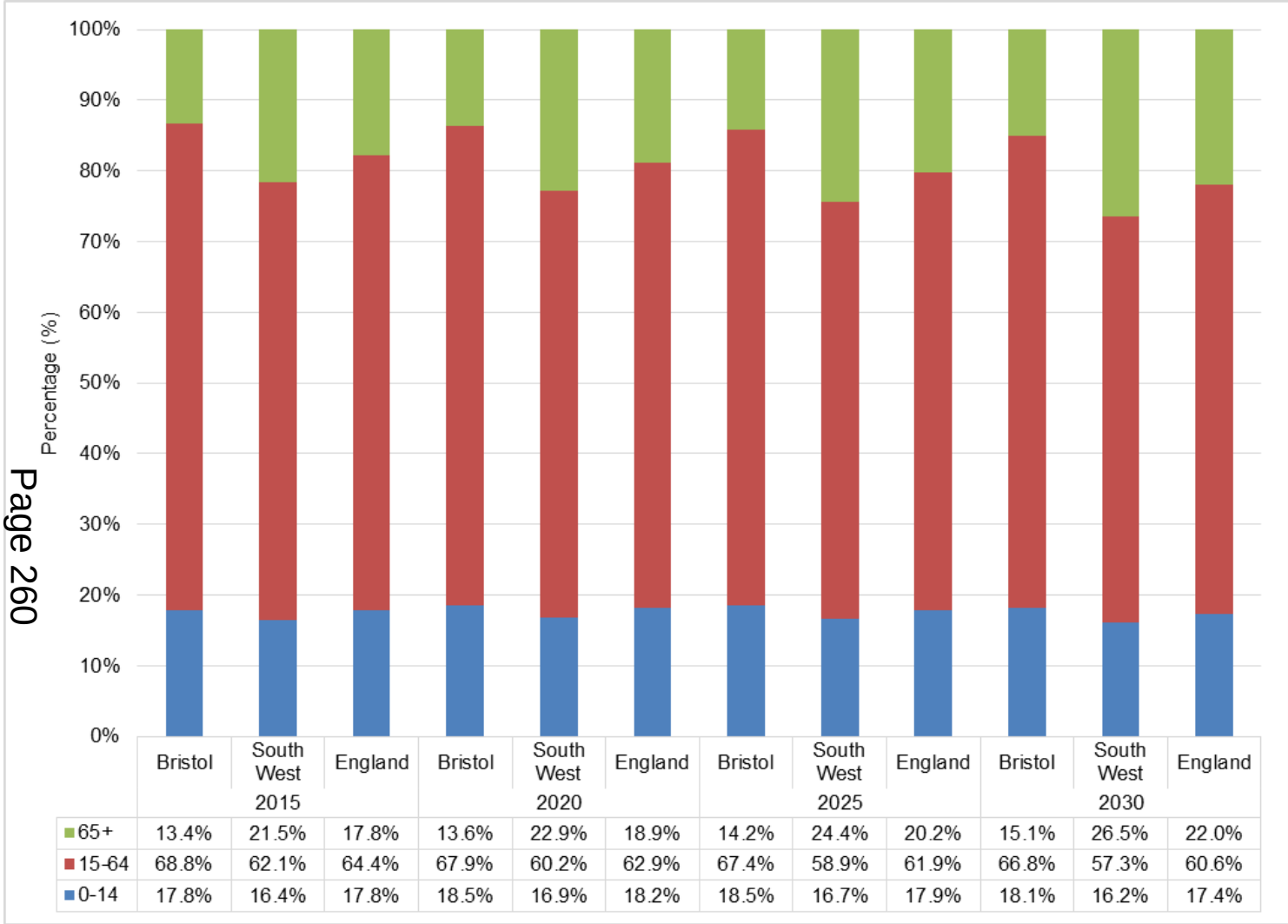
Information Details:	
Title	Bristol, North Somerset and South Gloucestershire Population Projections, benchmarked against South West and England
Broken Down By	Local Authority
Data Period	2015-2030
Unit	Numbers and Percentage Population Change
Age	All years in 5 year age groups
Data Source/s	Office for National Statistics, 2012
Indicator source	http://ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Projections

The table below shows the population projections for Bristol and the percentage change in each age band from 2015 to 2030. In comparison to the South West and England, the number of 0-4 year olds is set to increase by 6.39%, whereas it is reducing in the South West and England. Similarly those aged 45-49 are set to increase rather than reducing as the regional and national figures suggest. The increases in the elderly are not as large as the South West and England increases, however it is still increasing.

Table 1: Population Projections (Figures in thousands – to one decimal place), Bristol, South West, England, 2015-2030

Area	Age Grp	2015	2020	2025	2030	% Change from 2015	% Change from 2015 South West	% Change from 2015 England
Bristol	0-4	31	33	33	33	6.39	-0.36	-0.79
Bristol	5-9	27	29	30	30	13.16	6.31	5.08
Bristol	10-14	22	25	27	28	30.70	20.00	19.00
Bristol	15-19	26	25	29	31	19.92	10.60	11.59
Bristol	20-24	46	46	44	50	8.03	2.44	1.12
Bristol	25-29	44	45	44	42	-2.53	-6.05	-6.95
Bristol	30-34	39	42	43	42	7.42	3.09	0.99
Bristol	35-39	32	35	37	38	19.75	14.33	13.94
Bristol	40-44	28	29	31	33	19.13	1.80	6.18
Bristol	45-49	27	26	27	29	8.61	-11.89	-5.18
Bristol	50-54	26	26	25	25	-1.18	-17.41	-11.19
Bristol	55-59	22	24	24	24	8.80	2.98	7.05
Bristol	60-64	19	20	23	23	21.39	23.53	27.20
Bristol	65-69	18	17	18	21	15.00	12.04	16.48
Bristol	70-74	13	16	15	17	24.81	22.73	27.14
Bristol	75-79	11	12	14	14	28.04	35.70	31.85
Bristol	80-84	8	9	10	12	44.05	69.69	63.47
Bristol	85-89	6	6	6	7	30.36	61.16	57.69
Bristol	90+	4	4	5	6	61.11	92.68	100.51
Bristol	**All ages**	**446**	**467**	**486**	**504**	**13.14**	**10.04**	**10.06**

Figure 1: Population projections for Bristol, South West and England, by age categories, 2015-2030.



	Bristol	South West	England	Bristol	South West	England	Bristol	South West	England	Bristol	South West	England
	2015			2020			2025			2030		
65+	13.4%	21.5%	17.8%	13.6%	22.9%	18.9%	14.2%	24.4%	20.2%	15.1%	26.5%	22.0%
15-64	68.8%	62.1%	64.4%	67.9%	60.2%	62.9%	67.4%	58.9%	61.9%	66.8%	57.3%	60.6%
0-14	17.8%	16.4%	17.8%	18.5%	16.9%	18.2%	18.5%	16.7%	17.9%	18.1%	16.2%	17.4%

Figure 1 indicates that Bristol has a lower proportion of over 65s in comparison to the South West and England, which remains throughout the projections

Although the percentage of elderly is increasing in Bristol it is comparatively lower than the regional and national proportions, reaching 15.1% by 2030, in comparison to 26.5% in the South West and 22.0% in England.

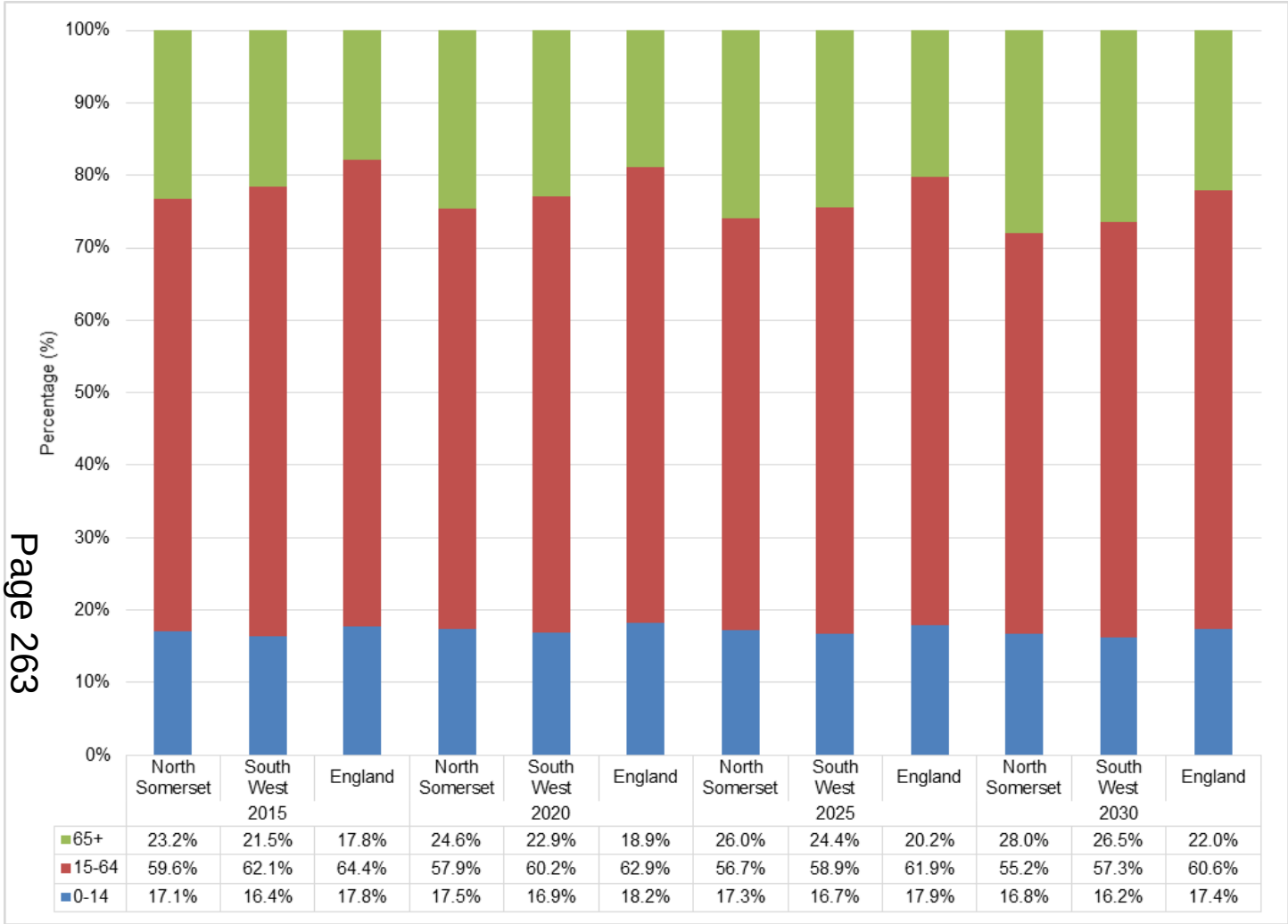
Similarly to Bristol, the table below shows that North Somerset's 0-4 population will increase, which is against the projections for the South West and England. There are comparatively larger increases in the elderly population in North Somerset in comparison to the regional and national projections, reaching 68,000

Table 2: Population Projections (Figures in thousands – to one decimal place), North Somerset, South West, England, 2015-2030

aged 65+ by 2030, which is a 36% increase from 2015, where the number was 50,000.

Area	Age Grp	2015	2020	2025	2030	% Change from 2015	% Change from 2015 South West	% Change from 2015 England
North Somerset	0-4	12	13	13	13	4.03	-0.36	-0.79
North Somerset	5-9	12	13	14	14	11.38	6.31	5.08
North Somerset	10-14	11	13	14	14	25.00	20.00	19.00
North Somerset	15-19	11	11	12	13	17.12	10.60	11.59
North Somerset	20-24	10	9	9	10	4.21	2.44	1.12
North Somerset	25-29	11	11	11	10	-2.83	-6.05	-6.95
North Somerset	30-34	11	12	12	12	6.19	3.09	0.99
North Somerset	35-39	12	13	14	14	17.65	14.33	13.94
North Somerset	40-44	14	13	14	15	5.80	1.80	6.18
North Somerset	45-49	16	14	13	15	-7.05	-11.89	-5.18
North Somerset	50-54	15	16	15	14	-10.46	-17.41	-11.19
North Somerset	55-59	14	16	16	15	9.63	2.98	7.05
North Somerset	60-64	13	14	16	17	27.91	23.53	27.20
North Somerset	65-69	15	13	14	16	10.20	12.04	16.48
North Somerset	70-74	12	14	13	14	18.97	22.73	27.14
North Somerset	75-79	9	11	14	12	39.08	35.70	31.85
North Somerset	80-84	7	8	10	12	79.10	69.69	63.47
North Somerset	85-89	4	5	6	8	79.07	61.16	57.69
North Somerset	90+	3	4	5	6	100.00	92.68	100.51
North Somerset	**All ages**	**210**	**221**	**232**	**242**	**14.83**	**10.04**	**10.06**

Figure 2: Population projections for North Somerset, South West and England, by age categories, 2015-2030.



	North Somerset	South West	England	North Somerset	South West	England	North Somerset	South West	England	North Somerset	South West	England
	2015			2020			2025			2030		
65+	23.2%	21.5%	17.8%	24.6%	22.9%	18.9%	26.0%	24.4%	20.2%	28.0%	26.5%	22.0%
15-64	59.6%	62.1%	64.4%	57.9%	60.2%	62.9%	56.7%	58.9%	61.9%	55.2%	57.3%	60.6%
0-14	17.1%	16.4%	17.8%	17.5%	16.9%	18.2%	17.3%	16.7%	17.9%	16.8%	16.2%	17.4%

Figure 2 indicates that North Somerset has a higher proportion of over 65s in comparison to the South West and England, which remains throughout the projections.

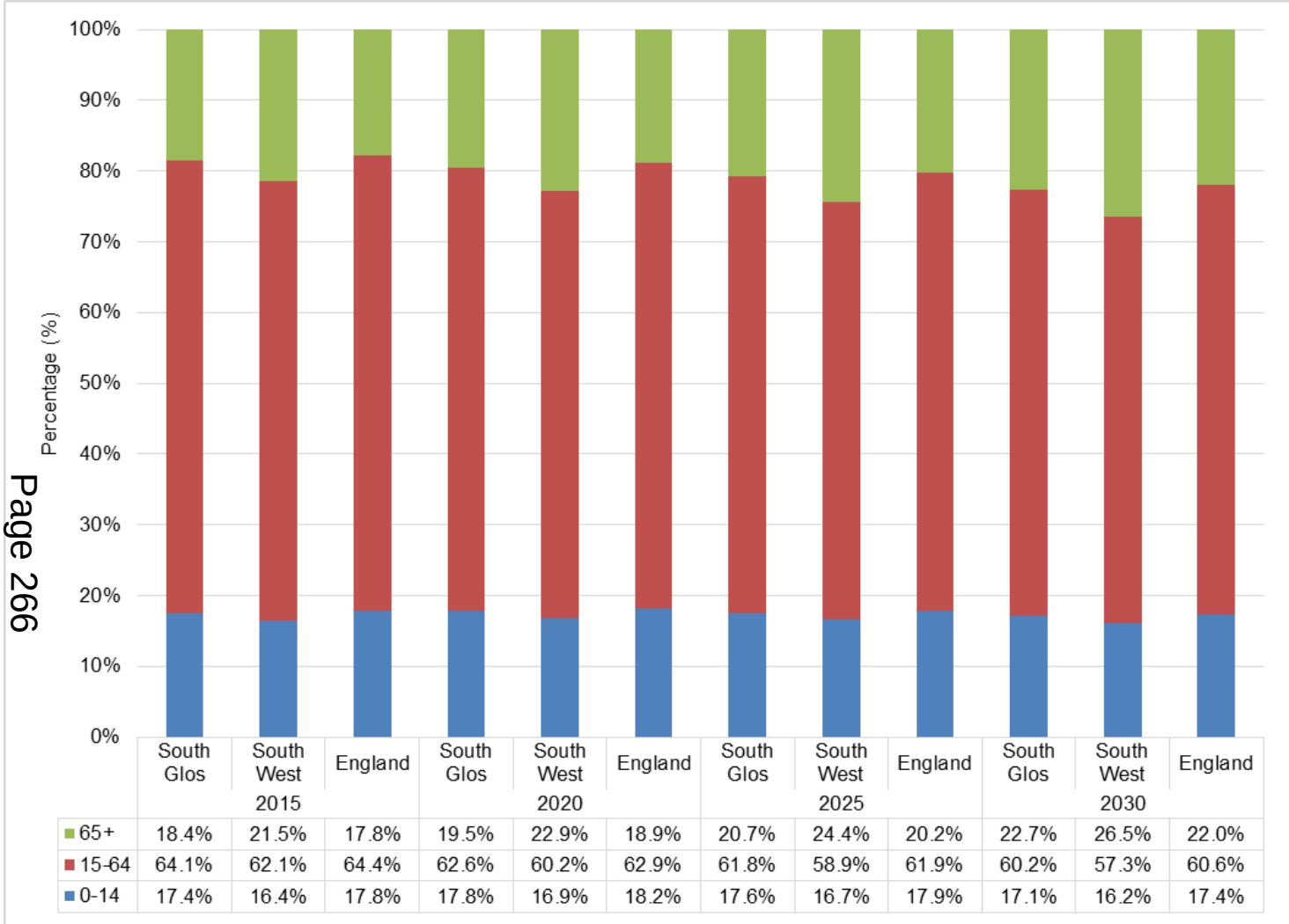
The percentage of elderly is increasing in North Somerset reaching 28% by 2030, in comparison to 26.5% in the South West and 22.0% in England.

Similarly to both North Somerset and Bristol, the table below shows that South Gloucestershire's 0-4 population will increase, which is against the projections for the South West and England. There are comparatively smaller increases in the 65-84 ages, however larger increases in the 85+ in South Gloucestershire in comparison to the regional and national projections, reaching 12,000 aged 85+ by 2030, which is a 100% increase from 2015, where the number was 6,000.

Table 3: Population Projections (Figures in thousands – to one decimal place), South Gloucestershire, South West, England, 2015-2030

Area	Age Grp	2015	2020	2025	2030	% Change from 2015	% Change from 2015 South West	% Change from 2015 England
South Gloucestershire	0-4	16	17	17	17	3.70	-0.36	-0.79
South Gloucestershire	5-9	17	17	18	18	6.63	6.31	5.08
South Gloucestershire	10-14	15	17	18	18	20.95	20.00	19.00
South Gloucestershire	15-19	17	16	18	19	8.82	10.60	11.59
South Gloucestershire	20-24	17	17	16	19	6.94	2.44	1.12
South Gloucestershire	25-29	16	17	17	16	0.63	-6.05	-6.95
South Gloucestershire	30-34	17	18	18	18	6.51	3.09	0.99
South Gloucestershire	35-39	17	18	19	19	14.88	14.33	13.94
South Gloucestershire	40-44	19	17	19	19	4.86	1.80	6.18
South Gloucestershire	45-49	21	19	18	19	-10.38	-11.89	-5.18
South Gloucestershire	50-54	21	21	19	18	-14.56	-17.41	-11.19
South Gloucestershire	55-59	17	20	20	18	9.70	2.98	7.05
South Gloucestershire	60-64	14	16	19	20	35.42	23.53	27.20
South Gloucestershire	65-69	15	14	15	19	22.52	12.04	16.48
South Gloucestershire	70-74	12	14	13	15	18.55	22.73	27.14
South Gloucestershire	75-79	10	11	13	12	29.47	35.70	31.85
South Gloucestershire	80-84	7	8	10	11	60.56	69.69	63.47
South Gloucestershire	85-89	4	5	6	7	82.50	61.16	57.69
South Gloucestershire	90+	2	3	4	5	126.09	92.68	100.51
South Gloucestershire	**All ages**	**273**	**285**	**296**	**306**	**11.93**	**10.04**	**10.06**

Figure 3: Population projections for South Gloucestershire, South West and England, by age categories, 2015-2030.



	South Glos	South West	England	South Glos	South West	England	South Glos	South West	England	South Glos	South West	England
	2015			2020			2025			2030		
65+	18.4%	21.5%	17.8%	19.5%	22.9%	18.9%	20.7%	24.4%	20.2%	22.7%	26.5%	22.0%
15-64	64.1%	62.1%	64.4%	62.6%	60.2%	62.9%	61.8%	58.9%	61.9%	60.2%	57.3%	60.6%
0-14	17.4%	16.4%	17.8%	17.8%	16.9%	18.2%	17.6%	16.7%	17.9%	17.1%	16.2%	17.4%

Figure 3 indicates that South Gloucestershire has a lower proportion of over 65s in comparison to the South West but similar to England, which remains throughout the projections.

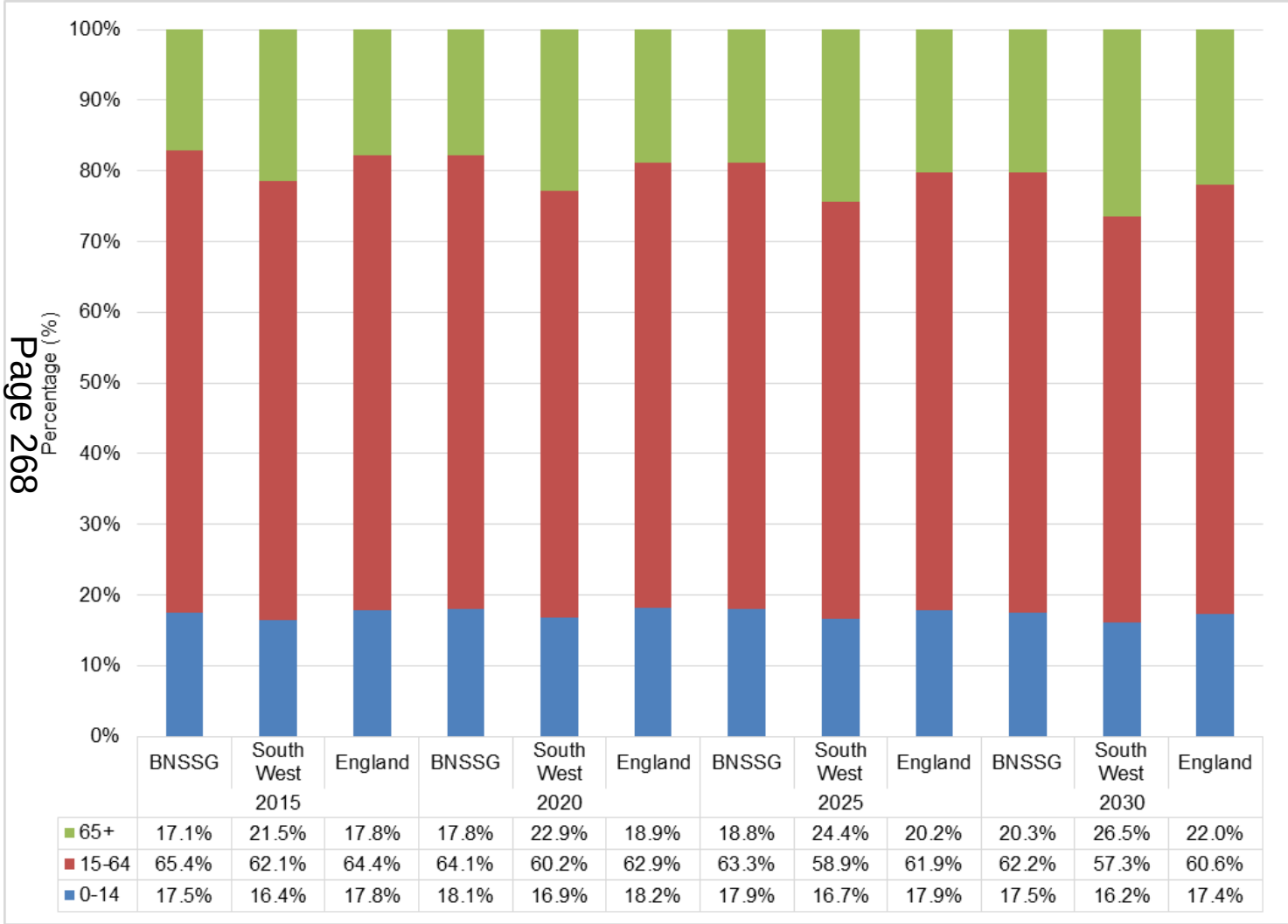
The percentage of elderly is increasing in South Gloucestershire at a similar rate to England, reaching 22.7% by 2030, in comparison to 26.5% in the South West and 22.0% in England.

Table 4: Population Projections (Figures in thousands – to one decimal place), BNSSG, South West, England, 2015-2030

Area	Age Grp	2015	2020	2025	2030	% Change from 2015	% Change from 2015 South West	% Change from 2015 England
BNSSG	0-4	60	62	63	63	5.18	-0.36	-0.79
BNSSG	5-9	56	59	61	62	10.81	6.31	5.08
BNSSG	10-14	48	55	58	60	26.32	20.00	19.00
BNSSG	15-19	54	52	59	63	15.87	10.60	11.59
BNSSG	20-24	73	73	69	78	7.27	2.44	1.12
BNSSG	25-29	70	73	72	69	-1.85	-6.05	-6.95
BNSSG	30-34	67	71	74	72	6.98	3.09	0.99
BNSSG	35-39	61	66	69	72	17.99	14.33	13.94
BNSSG	40-44	60	59	64	67	11.67	1.80	6.18
BNSSG	45-49	64	59	58	63	-1.57	-11.89	-5.18
BNSSG	50-54	61	62	58	57	-7.98	-17.41	-11.19
BNSSG	55-59	52	60	61	56	9.30	2.98	7.05
BNSSG	60-64	46	50	58	59	27.61	23.53	27.20
BNSSG	65-69	48	44	48	55	15.90	12.04	16.48
BNSSG	70-74	37	45	42	45	20.91	22.73	27.14
BNSSG	75-79	29	34	41	38	31.83	35.70	31.85
BNSSG	80-84	22	24	29	36	59.91	69.69	63.47
BNSSG	85-89	14	16	18	22	60.43	61.16	57.69
BNSSG	90+	9	11	13	17	90.91	92.68	100.51
BNSSG	**All ages**	**930**	**973**	**1,013**	**1,052**	**13.17**	**10.04**	**10.06**

The overall picture for Bristol, North Somerset and South Gloucestershire (BNSSG) shows the younger population (0-14) is increasing at a quicker rate than the South West and England. There is a substantial increase in the elderly population with 20.3% over 65 by 2030.

Figure 4: Population projections for BNSSG, South West and England, by age categories, 2015-2030.



	BNSSG	South West	England	BNSSG	South West	England	BNSSG	South West	England	BNSSG	South West	England
	2015			2020			2025			2030		
65+	17.1%	21.5%	17.8%	17.8%	22.9%	18.9%	18.8%	24.4%	20.2%	20.3%	26.5%	22.0%
15-64	65.4%	62.1%	64.4%	64.1%	60.2%	62.9%	63.3%	58.9%	61.9%	62.2%	57.3%	60.6%
0-14	17.5%	16.4%	17.8%	18.1%	16.9%	18.2%	17.9%	16.7%	17.9%	17.5%	16.2%	17.4%

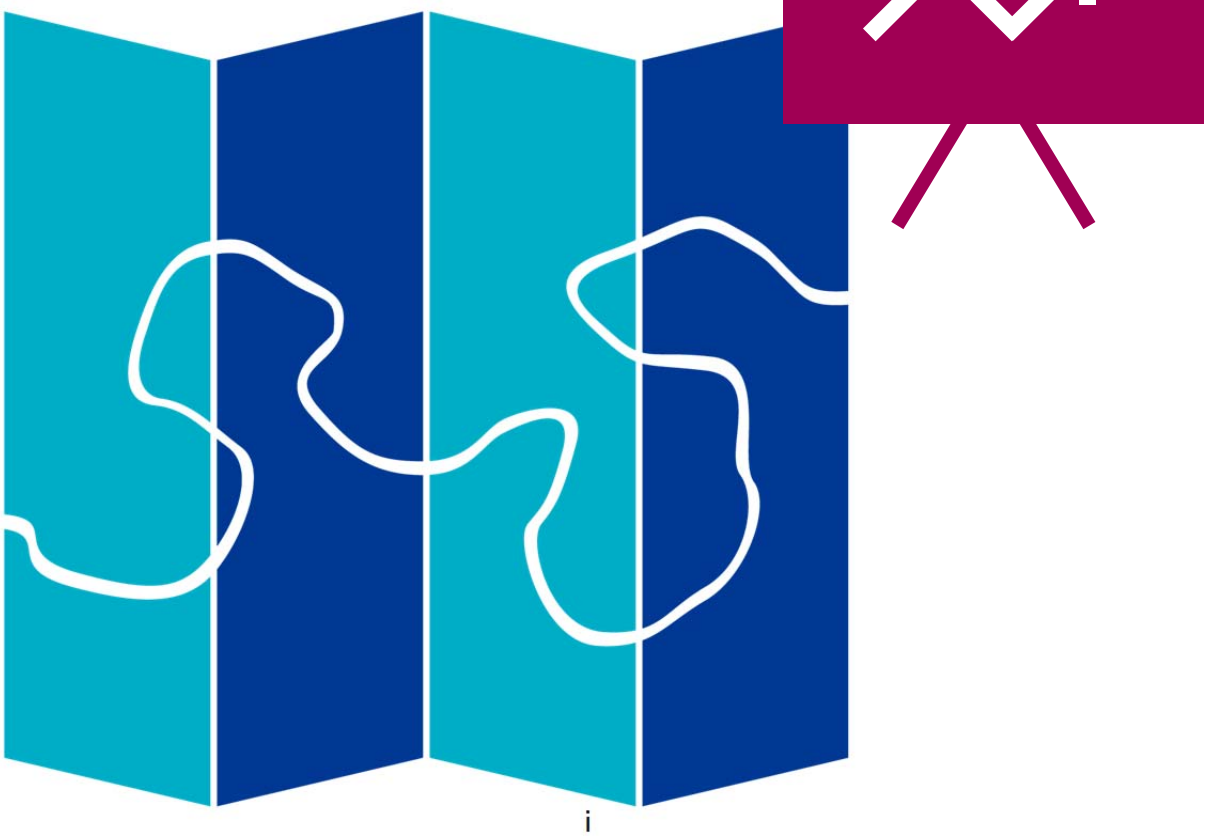
Figure 4 indicates that the average for BNSSG has a lower proportion of over 65s in comparison to the South West and similar to England, which remains throughout the projections.

The percentage of elderly is increasing across BNSSG at a similar rate to England, reaching 20.3% by 2030, in comparison to 26.5% in the South West and 22.0% in England. However, as seen from the previous figures there is variation among the different areas that make up BNSSG.

Our Digital Roadmap

Bristol, North Somerset and South Gloucestershire (BNSSG)

FIRST EDITION UPDATE -
OCTOBER UPDATE REPORT



Contents

1 Executive Summary

This is the Bristol, North Somerset and South Gloucestershire Local Digital Roadmap – *October Update Report*.

A significant change in the way we plan, organise and provide services is required if we are to continue to meet the health needs of our local population. We understand that technology has a key part to play in helping our region meet its financial challenges – as well as improving efficiency, enabling better care and quality, and closing the wellbeing gap.

We do not believe that our digital roadmap programme is simply about supporting 'the same stuff' being done more quickly, nor is it about purely automating antiquated paper processes and pathways. Rather it about changing how we work fundamentally, *doing things differently, and working together differently.*

> *Better use of data and technology has the power to improve health, transforming the quality and reducing the cost of health and care services. It can give patients and citizens more control over their health and wellbeing, empower carers, reduce the administrative burden for care professionals, and support the development of new medicines and treatments".*
>
> Personalised Health & Care 2020 – Using Data & technology to Transform Outcomes for Patients and Citizens – A Framework for Action

This report will –

- Provide a summary re-cap of our **STP alignment**
- Describe our **priority areas** - those that are critical for our progress – with a focus on work on-going on our leadership, governance, and the 'delivery vehicle'
- Provide **responses to the feedback** that we received to our First Edition (published in June)

We recognise that what we want to do and deliver is not going to be easy or straight-forward – but we have a common purpose to serve the one million people in Bristol, North Somerset and South Gloucestershire by meeting their needs for health care and social care.

Our common vision is that, by developing our digital programme, we will make a lasting contribution to the health, well-being and opportunity of our population. Our vision is matched by a commitment: to keep working together until we have made it a reality.

2 Document Purpose

The purpose of this document is to provide an update to NHS England on the Bristol, North Somerset and South Gloucestershire (BNSSG) *Local Digital Roadmap* (LDR).

This document contains –

- Background to the Local Digital Roadmap
- Summary of the NHS England Requirements and this October submission
- A summary re-cap of our STP alignment
- Areas that are critical for our progress – with a focus on work on-going on leadership, governance, and the 'delivery vehicle'
- A response to the feedback that we received to our June submission[1]

3 Background

The First Edition of our Local Digital Roadmap was submitted at the end of June, 2016.

That edition had previously been endorsed on 21 June 2016 by our *Connecting Care Programme Board* and again as part of the local Sustainability and Transformation Plan on 27 June 2016 by our *System Leadership Group*[2].

Our First Edition document still stands, as is, at this point in time – and will be part of this re-submission.

NHS England (NHSE) has recently requested a second iteration of our LDR plans, the purpose of which was to gain assurance that –

> *"All LDRs have initial momentum…[and] are activities defined for 16/17 considered reasonable for meeting the ambition locally defined for 16/17, in the context of the current baseline?*[3]*"*

[1] This is the feedback provided by the NHS England Local Team to the BNSSG LDR submitted in June 2016
[2] These groups both have members and delegated authority from all the partner organisations in our footprint.
[3] Email from Simon Hills, Head of Digital Technology (South), NHS England – 20/09/2016

3.1 NHS England Requirements

The core requirements of this October submission are listed below.

- It is to be submitted by Monday 31 October
- It should demonstrate clear alignment with STP priorities (if not already done)
- It must respond to feedback we received on our Local Digital Roadmap June 2016 submission
- It must demonstrate that we meet the 'core criteria' (formally known as investment readiness criteria)
- It must clearly articulate the system-wide interoperability and information sharing approach, and underlying business and technical capabilities that will deliver STP outcomes (if not already done)
- It should highlight priority activities critical to progress
- Ideally it should identify a further level of detail in the 16/17 activities (although this is *not mandatory* for the October submission)
- The documents requested by NHSE are listed below. In addition to these, our October submission will contain this report and a covering letter.

• Main *Local Digital Roadmap* Document	• *Core Criteria Checklist*
• Updated *Universal Capabilities Delivery Plan*	• *Checklist for Submission*
• *Information Sharing Approach*	• *Capability Deployment Schedule* and *Capability Trajectory* (re-submission of these documents is optional at this stage)

Table 1 - Required Submission to include

4 STP alignment

Our Bristol, North Somerset and South Gloucestershire's Sustainability and Transformation plans (STP) emerging thinking and vision is for a health and care system in which –

- Services are responsive to individual needs and relevant to local communities
- Appropriate care and support is available in the right place at the right time
- Parity is a golden thread running through the whole of health and social care provision for both mental and physical health needs
- There is a consistent approach to delivering care at scale

It recognises that a **significant change** in the way we plan, organise and provide services is required if we are to continue to meet the health needs of our local population[4]

There are **five key drivers** that will enable us to develop and implement a sustainable health and care system for our population. These are shown below.

Figure 1 - our 5 key drivers

[4] As our population ages the number of people requiring care for life changing diseases such as dementia and diabetes continues to rise, and our local combined financial position is projected to be £400 million in deficit within 5 years

Our original Local Digital Roadmap was commended for the fact that it had -

> **"Clear links with the STP which has ensured the vision, development and governance arrangements are well aligned"**

And

> "Shows delivery interdependencies between STP and LDR"

A more general point noted was that –

> "…subsequent iterations of STPs should set out those IT-critical projects which will facilitate service changes/wider transformation across the footprint".

Given this background, this report does not seek to materially change our June Local Digital Roadmap – but rather reaffirms the links between our STP and our LDR.

> *"The NHS will **simply not be able to provide high levels of service at an affordable cost without digitisation** and appropriate use of digital data at every level."*
>
> [The Wachter Review, Sept 2016]

- We see the BNSSG Digital Programme as one of the most significant drivers of cultural and operational service change in our system
- Our STP recognises that it can capitalise on the huge potential that digital transformation offers
- Our Local Digital Roadmap has and will feed inspiration, information and ideas to the other STP developments, whilst also providing the enabling technologies required to enable them to meet their objectives. This is a two-way symbiotic[5] flow – we are part of the same eco-system
- We share a leader – Robert Woolley, Chief Executive at University Hospitals Bristol NHS Foundation Trust, is both the Chair of the Connecting Care Programme Board, leading the development of this Local Digital Roadmap, and the nominated Sustainability and Transformation Plan Lead for BNSSG.

[5] Symbiosis - from Greek συμβίωσις "living together"

4.1 LDR and 'Centres of Global Digital Excellence' (GDE)

The objective of the CGDE programme is: "to create a digitally advanced health and care system that will eclipse the best in the rest of the world within 2 years."

Source: Letter to UH Bristol from Keith McNeill (National CCIO)

Since our June 2016 LDR submission, one of our acute trusts (University Hospitals Bristol NHS Foundation Trust - UHB) has been asked to apply for the status of a 'Centre of Global Digital Excellence Programme' (GDE). We recognise this as a once-in-a-lifetime opportunity to make a huge difference within the Trust and across BNSSG.

If we are successful, delivering GDE will be a joint effort between UHB, a small number of strategic suppliers and BNSSG LDR partners. At least half of the 'value' of GDE effort will be delivered across BNSSG through Connecting Care.

We see strong strategic alignment between our Local Digital Roadmap and the focus of the GDE.

Paperless 2020 –

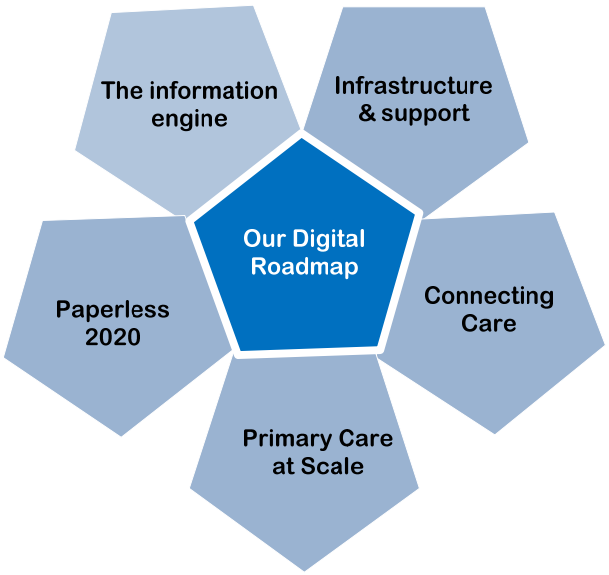
- Within UHB's hospitals GDE will ensure a focus on paper-light, then paper-free where possible
- Improved and faster communication and decision-making

Connecting Care –

- Integrated health and social care, building on the BNSSG-wide shared care record
- Clinical collaboration and work-flows across the care community
- Support for new cross care-community care pathways
- Eradication of paper and fax between carers and providers

The information engine –

- Population health management
- Activity and clinical reporting across the whole care community

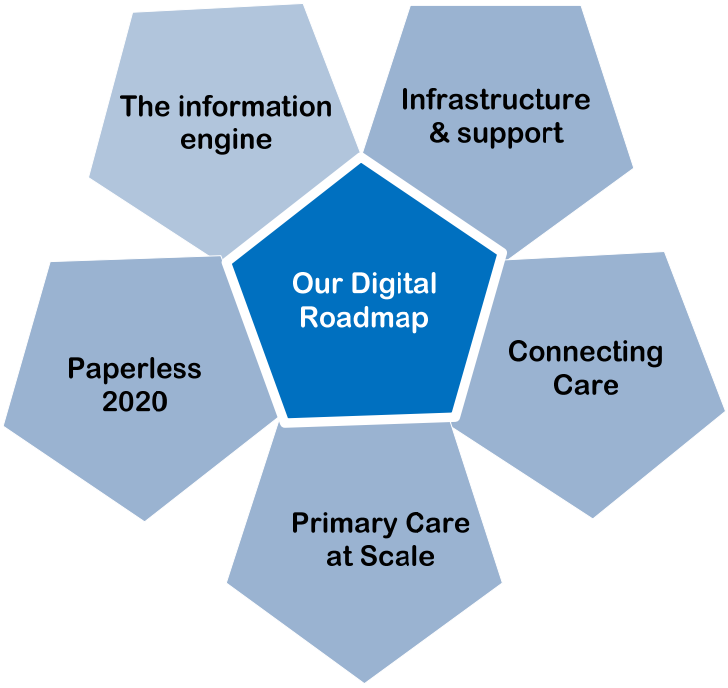


5 Our current focus

5.1 Leadership, governance, and the 'delivery vehicle'

The BNSSG LDR contains some elements of work that are already in train – and as such it is based on our strong track record of delivery. However, it also includes new ambitions. Our LDR consists of five major work programmes, as described in our LDR document and reiterated below –

- **Primary Care At Scale** – this programme focuses on maximising digital across GP practices and Out of Hours services. Supporting **primary and community care** reconfiguration, **new integrated team working** and maximising efficiency of practices through shared ways of using technology. This is also about how we can better support people and communities **out of hospital**



- **Paperless 2020** – Embedding and developing **fully digital records** within acute, community, mental health and social care settings. Enabling true electronic record keeping, and **sharing** of those records.

- **Connecting Care** – Developing and enhancing our existing **information sharing** from and to all parts of our system – on the back of more fully developed digital records. Improving **interoperability**. Enabling a 'shift' and putting **citizens** at the heart of their **'personal health records'**. Supporting the wellness of people and communities and out of hospital care

- **The Information Engine** – Fully utilising our electronic data and intelligence to power our planning and delivery engine. Devising new and innovative ways to use information – with a focus on integrated **population analytics** and **data driven decision** making.

- **Infrastructure & Support** - Ensuring we do all the above on a solid, efficient

infrastructure and delivery mechanism – how we organise our delivery, how can **consolidate and streamline**, how we can best run our digital services and how we work (**people, systems, locations & processes**).

5.1.1 Rationale

'Traditional system leadership' is often centred on building consensus about how risk is brokered around the health and social care community.

Digitally-enabled system leadership focuses on value – and is centred on how **opportunity** is brokered around the health and social care community. It creates **new kinds of value** through digital transformation and whilst offering the possibility of transformation and a more stable system overall, may be disruptive at the organisational level.

This is our challenge.

Working on the delivery of our LDR June submission fully brought to light the fact that much of the *collective and pan-organisational delivery*[6] we have done to date has been based on a 'voluntary partnership' and the effort of a small cohort of keen individuals.

The scope and scale of our ambitions within our LDR and beyond cannot be delivered and sustained using this model of a 'volunteer army'.

In addition, the STP/LDR offers the opportunity to move from traditional to digitally-enabled system leadership - but it has to do so in a context where organisational accountability remains the legal basis for activity. This poses a challenge which requires addressing.

As a consequence we have identified that the most critical area for us to progress at present is to firmly establish our on-going **leadership, governance and delivery vehicle.**

The successful delivery of our LDR and the exploitation of technology as an enabler of transformation rests on this.

5.1.2 Approach

We are currently in the midst of a focused intervention on the LDR to establish the appropriate leadership, governance and delivery 'vehicle' for the BNSSG LDR.

The outcome of this work will be –

- **Recommended leadership model**. Reflecting the clinical leadership from the *Wachter Review*[7] - but recognising the 'C' triangle (CEO, CCIO, CIO[8]) behind many successful

[6] In contrast with delivery that is focused within one organisation
[7] https://www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs

digitisation journeys. It will also include health *and* social care representation and it will be fully aligned to the proposed BNSSG STP leadership model

- **Recommendations and a clear description of a future governance model** that carries the responsibility and authority. It will be fully aligned to the proposed BNSSG STP governance model
- Recommendations and a clear description of options for how the work can be delivered – i.e. the most appropriate '**delivery vehicle(s)'**
- A clear set of key **guiding principles** for **behaviours / code of conduct** which will be used for all collective / co-produced work

> *"Collaborative leadership involves creating shared vision, purpose, outcomes and values across organisations by building trust, sharing influence and finding solutions when starting from different viewpoints or priorities".*
>
> [The Kings Fund]

This work is being delivered via workshops, a set of stakeholder interviews, and supported by a small working group.

A final workshop will be used to review and ratify final proposals and build an approach to sharing risk and accountability that creates win-win opportunities and agrees how digital transformation will be *sustainably created* in BNSSG.

Final decisions will be made and signed off by the current *System Leadership Group.*

5.1.3 Scrutiny

We will employ independent input & scrutiny of this work –

- External independent advice will be provided by the *Corsham Institute*[9] who have agreed to review our approach and our findings
- NHS England and / or NHS Digital will be asked to provide some external quality assurance
- Oversight within BNSSG will be provided by the current *Connecting Care Partnership Board* and the current *System Leadership Group*

[8] Chief Exec Officer, Chief Clinical Information Officer and Chief Information Officer
[9] Corsham Institute (Ci) provides an agnostic 'white-space' for Government, the Voluntary sector, Academia and Industry to come together to recognise the opportunities and challenges of the digital society, both culturally and as an economy. http://corshaminstitute.org/

5.2 Other priority activities

5.2.1 Aligning current programmes / LDR start-up

Once the over-arching leadership, governance and delivery 'vehicle' for the BNSSG LDR is established, one of our next steps will be to

- **Align** programmes that are already in train within the LDR / STP governance
- **Set up** programmes that are as yet embryonic

Two examples are listed below -

- **Primary Care At Scale** - The BNSSG 'OneCare[10] programme is dedicated to creating an integrated and effective approach to the delivery of primary care, providing seamless seven-day a week care to patients. Much of this programme is already 'in train'. However we recognise that there is primary care development work that is also being carried out by other organisations. Thus we will seek to ensure that all elements of work are *fully aligned with STP and LDR*.

In terms of our other programme areas, Paperless 2020 requires *alignment*, Connecting Care requires *alignment,* and Infrastructure and Support requires *set up.*

- **The Information Engine** – we have a wealth of resource and experience collectively in informatics analysis and in reporting. However, much of our 'analysis functions' are very much located within each individual partner organisation. This means that we are unable to fully leverage 'at scale' opportunities. Moving towards population health and care analytics necessitates a different approach. This 'new approach' is not yet fully in train – therefore this programme of work requires '*set up' within the STP and LDR governance model.*

[10] http://onecareconsortium.co.uk/

5.2.2 Key technical elements

Whilst all of our programmes within the BNSSG LDR programmes are vital to our success, we recognise that there are a handful of key areas which have the potential to radically transform and allow us to re-imagine health and care services in line with STP priorities. These key areas are listed below.

Key element in our LDR	Summary
CONNECTING CARE **Citizen / Patient Access - PHR**	Our STP recognises the need to maximise **self-care** opportunity. Clinicians are actively exploring ways in which care pathways might be adapted to allow **self-care via digital solutions.** We are keen to exploit technology support this agenda through – • IoT[11] linked devices to monitor and alert • Development of **PHR**[12] capability – we are already working with leading exponents e.g. University Hospital Southampton • We have bid for funding the 'ETTF process'[13] to initiate projects in this space.
CONNECTING CARE **Develop our information sharing – digital shared care record**	We are committed to extending the reach of our award winning 'Connecting Care' **interoperability** programme into new domains – i.e. fully developing our information sharing in our **digital shared care record**. Discussions and planning is well advanced in many areas including – • Mental health • Supporting homeless services • Complex patient care • Police services e.g. MASH & custody suites • Safeguarding e.g. children at risk of sexual exploitation
INFORMATION ENGINE **Population health & care**	BNSSG is lucky to have some of the most advanced thinking in the area of health analytics and research. Our priority is to bring this talent together under single

[11] The Internet of Things, (IoT), is the internetworking of physical devices, (connected devices / smart devices) —embedded with electronics, software, sensors, actuators, and network connectivity that enable these objects to collect and exchange data.
[12] PHR – Personal Health / Held Records
[13] The Estates and Technology Transformation Fund

Key element in our LDR	Summary
analytics	'Information Engine' programme utilising the expertise in commissioners, provider, university and other agencies. The bringing together of financial, operational and clinical outcome data centred around the citizen provides an opportunity for deriving **whole system intelligence** to support **population health** management, effective commissioning, outcome based contracting, planning, clinical surveillance, service re-design and research. This, in turn, should enable more **effective prioritisation and targeting of resources**, increased opportunities for joint initiatives, common solutions and shared expertise. A core goal of the BNSSG STP is to improve the integration of services around the patient, and whole systems intelligence is critical to this. This can be supported by refocusing analysis of service use and resources around the patient, rather than on services. We recognise that we may find some challenges in this work. For example there may be a tension for a local authority between the 'internal / One Council' agenda where social services departments will be engaged at a Council level looking across *all* their council services versus the needs to do the same / similar work with health partners locally. There will be a challenge in bridging these two overlapping agendas. It is therefore important that we have effective engagement, communication and governance with corporate programmes, and in fact see this as an opportunity rather than a risk, as it may open up greater possibilities and opportunities for early identification and intervention.
PAPERLESS 2020 **Developing our Mobile workforce**	BNSSG have a major ambition to ensure **mobile working** is maximised for community providers and becomes part of 'routine working'. There are major efficiency drivers for seeking to ensure mobile working.
PAPERLESS 2020 & CONNECTING CARE **Global Digital Exemplar**	One of our acute trusts (University Hospitals Bristol NHS Foundation Trust - UHB) has been asked to apply for the status of a 'Centre of Global Digital Excellence Programme' (**GDE**). UHB are keen to ensure this investment secures benefits inside the trust, but also extends into the wider community via the Connecting Care programme. BNSSG firmly believe the Global Digital Exemplars of the future

Key element in our LDR	Summary
	will not be individual organisations but instead 'city regions' displaying fully integrated digital health & care systems.
INFRASTRUCTURE & SUPPORT	BNSSG are keen to develop our plans to maximise the **'at scale'** delivery opportunity for **digital infrastructure and support.** We recognise the opportunity to increase efficiency through the consolidation of support services[14] is a very real one. (E.g. Between us, we have several well-established data centres and differing ways in which our core systems are maintained. There may be more prudent use of our **collective resources** and this is an area which we recognise we should review as part of this Digital Roadmap – and that we should consider some 'radical re-imagining' of how these services are provided.) This is an area which could support our STP well in terms of aims to support a healthier financial balance.
PRIMARY CARE AT SCALE & CONNECTING CARE **Maximising the touch points between our two most mature programmes**	BNSSG are lucky to benefit from one of the most advanced thinking GP groups in the country. The **'One Care' Consortium** have demonstrated the power of 'at scale' thinking for primary care. We are keen to continue to exploit this thinking through the development of further information sharing projects. Opportunities exist in a number of areas including end of life, document sharing, context launching of shared care records, care planning and Out of Hours services.

Table 2 – key areas

Figure 2 – A wall in Bristol

[14] People, processes, physical buildings and services

6 Our June LDR feedback

6.1 General Feedback

All LDR reviews were led by the Regional 'P&I team' working with the local office, national specialist advisors, NHS Digital, and the LGA. Panels were chaired by Cathy Francis - Regional P&I Director in July 2016.

There are a number of key themes which have emerged from the reviews of *all LDRs*, *both regionally and across the country.*

- In general LDRs were strong on the 'why', good on the 'what', but weaker on the 'how'
- There will need to be more focus on outcomes and how business processes will be transformed through technology to meet the Five Year Forward View aims
- There was an understanding of the need for alignment with the STP, but the priorities of the STP were not always clearly evident. (It was not always clear what the key LDR deliverables were that will make a big difference to the STP)
- There was a general lack of articulation as to how the elements of the LDR would lead to improved outcomes and benefits and how these would be measured
- In many cases governance arrangements were still being developed
- Interoperability/information sharing - there was a huge variety in detail about plans and benefits

6.2 BNSSG Feedback

The overall assessment of BNSSG LDR is

> **"Very positive, strong vision and leadership, building on success, strong engagement across the footprint."**

In summary –

> **"BNSSG LDR is well-structured and presented, covering national NIB domains, universal capabilities and local thinking. A key strength is the approach to data sharing using an IDCR (Integrated Digital Care Record) where there is a good description of the journey involved, the key elements already delivered, and the maturing of the approach based on lessons learned."**

It was also noted that we had –

- Demonstrated real willingness to take this agenda forward, understanding the benefits it will bring
- It was clear there had been strong endorsement from Boards across footprint
- Our LDR sets out system-wide challenges and what can / should be done to resolve them
- Overall a very strong roadmap with good alignment to STP
- Good Engagement with key providers – including social care – who made significant contributions in the LDR development process
- Our LDR elements that focused on interoperability were particularly strong – and it was noted that there is potential for us to share our lessons learnt to date on interoperability with other regions
- Whilst risks arising from technology appear to be well managed at an organisational level across the footprint, the ambition to manage risk at a footprint level – e.g. to develop a BNSSG-wide risk strategy/compliance standards – was commended

6.2.1 Recommendations

It was recommended that our next 'LDR iteration' should –

1) Include more links with the voluntary sector and prisoners and the justice system
2) Establish engagement with Health and Wellbeing Board
3) Include plans around patient and public feedback
4) On delivery – identify which individuals are going to drive this forward and ensure there is capacity to deliver – provide clear evidence that there is the capacity to lead and deliver
5) Explore the detail behind new ways of working with Mental Health
6) Was there anything specific on Western Area Health Trust support and the question was posed as to how this would be incorporated into plans
7) On Interoperability (which was particularly commended) two points of note were –
    - Our interest in enabling real-time access to data via greater use of open APIs – could be built on to articulate the architecture that is needed across care settings, and to clarify those capabilities that will need to be delivered at the locality level by a group of CCGs and those delivered by providers
    - Explore data flows between Summary Care Record (SCR) and Connecting Care
8) Explore how we support increased adoption of NHS number

9) Set out those IT-critical projects which will facilitate service changes/wider transformation across the footprint and firm up detail around delivery (the 'how' and 'when')

10) Identify our technical / digital priorities in advance of any funding announcements. (There are restricted funds that will likely be allocated to enable prioritised activity with a clear business case.)

11) Include more on about benefits / cost benefit analysis

6.3 Responses

Feedback	Response / Clarification
1) Links with the voluntary sector and prisoners and the justice system	**Commenced** Our Local Authorities are already doing a great deal, working with the voluntary sector. We recognise the need to improve the breadth and depth of engagement in this space within the context of our LDR. Notable progress has been made within Prison and Justice system with further developing conversations and plans with both prison health service and police. Opportunities (e.g. Connecting care for Police Custody Suites and Multi-agency Safe-guarding Hubs) have been identified and the work to develop plans is underway. Some progress has been made in the 3rd sector with specific agencies e.g. Connecting Care and the St Peter's Hospice, but further work to do to strengthen the links overall is recognised.
2) Establish engagement with Health and Wellbeing Board	**Complete / On-going** Actions undertaken to brief the STP leadership and the Better Care governance executive on the Local Digital Roadmap and its contribution to future Health and Wellbeing in BNSSG have been completed and are now part of an ongoing process. Our Sustainability and Transformation Plans (STPs) have been submitted / presented to our Local Health & Wellbeing Boards. (To date, this has been carried out in Bristol and South Gloucestershire - and will be followed on in North Somerset). Our STP clearly references our digital plans as critical "driver and enabler of cultural change" - however to date, our Local Digital Roadmap has not been submitted as a 'standalone' document to any of our local Health & Wellbeing Boards.

Feedback	Response / Clarification
3) Plans around patient and public feedback	**Commenced** There have been on-going regular meetings with *Healthwatch* as part of the Connecting Care programme since the programme's inception. Discussions with *Healthwatch* on how best to progress wider public and patient engagement as part of the LDR delivery have been initiated and well received. The 'Leadership, Governance and Delivery' review offer a further opportunity to ensure these are cemented into the future. Some of our planned projects will necessitate public / patients driving the agenda – e.g. in the citizen access / patient health records area
4) On delivery – identify which individuals are going to drive this forward and ensure there is capacity to deliver – provide clear evidence that there is the capacity to lead and deliver	**Commenced** This feedback is recognised and acknowledged. It is for this reason that the main thrust of our efforts at present are to complete the focused work on our Leadership, Governance and Delivery Vehicles(s) – see section 5.1.
5) Explore the detail behind new ways of working with Mental Health	**Commenced** We have made significant progress on the mental health & digital health agenda. A number of meetings across a vast range of service providers have led to tangible steps forward. These are evidenced by the creation of a new film describing the way in which digital programmes can and need to contribute to the care of mental ill homeless people. It is also evidenced by the invitation to digital leaders to engage with the BNSSG Mental Health 'Concordat group', the routine engagement of mental health CCIOs in digital programmes and the current Connecting Care governance, in the creation of this LDR and the financial investment secured from mental health organisations to support in-flight digital work.
6) Western Area Health Trust support (WAHT)	**Commenced** The support to WAHT has seen significant progress as levels of engagement rise.

Feedback	Response / Clarification
	This can be evidenced by WHAT's close engagement with the UHBT GDE programme, the Connecting Care presentations to WAHT CEO/Chair, the collective support to WAHT around their digital financing challenge and the support to WAHT to become the second organisation in BNSSG to join our XDS/ITK based document exchange.
7) On Interoperability - real-time access to data via greater use of open APIs And - data flows between Summary Care Record (SCR) and Connecting Care	**Commenced** BNSSG see themselves in the vanguard of the work on Open APIs. Our Connecting Care Programme is part of the national *Code4Health interoperability* 'network of networks' Board We are working alongside Endeavour, INTEROpen & NHS England/NHS Digital colleagues to derive this agenda nationally. We are seeking to exploit this agenda locally e.g. through the early adoption of technologies like GP Connect.
8) Set out those IT-critical projects which will facilitate service changes/wider transformation across the footprint and firm up detail around delivery (the 'how' and 'when')	**Commenced** Wherever possible we have outlined the delivery plan for the key projects within our 5 major programmes within our main Digital Roadmap. See section 5.2.2 of this document for a summary on the areas that we believe are particularly critical for success in supporting our STP. We expect further clarity in these areas to emerge during the next few months e.g. The Global Exemplar delivery plan is expected to be fully defined by Dec 2017. Our focus in the immediate term however remains ensuring we have the robust Leadership and Governance framework in place to deliver the LDR in the long term
9) Identify our technical / digital priorities in advance of any funding announcements	**Commenced** We have a number of technical priorities and have outlined these in section 5.2.2 of this document. Our number one priority remains interoperability, with a very clear focus on supporting the development of Personal Health Records
10) Include more on about benefits / cost benefit analysis	**Complete / On-going** Section 7.2 and 7.3 of our main Local Digital Roadmap contains full details of our benefits approach. We have published a full and detailed Benefits Report as part

Feedback	Response / Clarification
	of the initiation of the Connecting Care programme. We have followed that with some case-studies and focused 'deep dives' into particular areas (ranging from local authority teams to Acute trusts). Work to establish our 'benefits approach' has been completed and are now part of an ongoing process. We have recently done some work with NHS Digital on some benefit studies locally linked to our Connecting Care programme. We have also recently kicked off some work to carry out 'rollout' and a 'benefits evaluation' with the ambulance service and with 111. We recognise that there is still work to do to embed benefits realisation within local partner organisations. *We have also noted the recent 'Wachter Report' on this importance of patience with benefits! "While it is natural to seek a short-term financial return on investment (ROI) from health IT, experience has shown that the short-term ROI is more likely to come in the form of improvements in safety and quality than in raw financial terms. In fact, cost savings may take 10 years or more to emerge (the so-called 'productivity paradox' of IT), since the keys to these gains are improvements in the technology, reconfiguration of the workforce, local adaptation to digital technologies, and a reimagining of the work."*

Table 3 - Feedback Responses - Summary

6.4 Universal Capabilities

As part of the June 2016, all LDR footprints were required to submit their ambitions / plans for a series of 'Universal Capabilities'.

The 'Universal Capabilities' are listed below – alongside a note as to whether the level of detail or information within our submission fully met expectations.

There is an updated 'annexe' on which has more details for the 'Universal Capabilities' that did not fully meet expectations. (Other 'Universal Capabilities' remain unchanged – at this point in time). *See this 'annexe' for more details.*

To note is that where one of our 'Universal Capabilities' has been marked as being 'below expectation' this may be a result of the interpretation of our LDR content – rather than necessarily an accurate assessment of the work we have in train. We would therefore welcome an opportunity to discuss any of these areas with NHS England.

Universal Capabilities	Met expectation?
A - Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	YES
B - Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)	YES
C & J - Patients can access their GP record and Patients can book appointments and order repeat prescriptions from their GP practice	YES
D - GPs can refer electronically to secondary care	NO
E - GPs receive timely electronic discharge summaries from secondary care	YES
F - Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care	NO
G - Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	NO
H - Professionals across care settings made aware of end-of-life preference information	YES
I - GPs and community pharmacists can utilise electronic prescriptions	NO

Table 4 - 'Universal Capabilities'

7 Our information sharing approach

Information sharing is at the heart of our Local Digital Roadmap – and features strongly in three of the five elements of our LDR –

- Connecting Care
- Primary Care at Scale
- Paperless 2020

As well as being founded on an ethos of information sharing as a critical part of our LDR, we have also established concrete 'Information Sharing Agreements', which we review regularly (in line with NHS England Information Sharing Policy).

Our Information Sharing Approach is described in section 9.3 of our main Local Digital Roadmap (Edition 1) - this section makes explicit reference to information sharing agreements that are already in place across Bristol, North Somerset and South Gloucestershire.

We are intending to further develop our information sharing across our health and care community to support work on patient / citizen access (PHR) and our shared digital care record - and as such we consider that this work will be an on-going part of our LDR.

7.1 Latest updates

- As part of work on the Connecting Care programme, we invited the Information Commissioner (ICO) in to review our approach in July 2016. As a result of the visit, we received commendations on our Data Sharing Agreement and its appendices (which specified the legal gateways, security profile mapping and access control matrix).
- Our focus on information sharing to provide safe, quality care is exemplified in this link to our latest film https://www.youtube.com/watch?v=IDJpdIRA0zM&feature=youtu.be The film describes how and where our ambitions for information sharing can support our Homeless Health and Care services.

7.2 Interoperability

We have noted the recommendations in the recent '*Wachter Review Report*' [15]

> "Interoperability should be built in from the start. Local and regional efforts to promote interoperability and data sharing, which are beginning to bear fruit, should be built upon. National standards for interoperability should be developed and enforced, with an expectation of widespread interoperability of core data elements by 2020. In addition, the Advisory Group endorses giving patients full access to their electronic data, including clinician notes."

Our established Interoperability Programme (Connecting Care) within BNSSG is a mature, well established one and is a key part of our Local Digital Roadmap.

The emerging context of Sustainability and Transformation Plans (STPs) is one where they have been asked to outline their system-wide information sharing approaches – this is recognised by NHS England as forming a 'strong' hook in driving local and regional interoperability[16]. The NHS England diagram below illustrates this well.

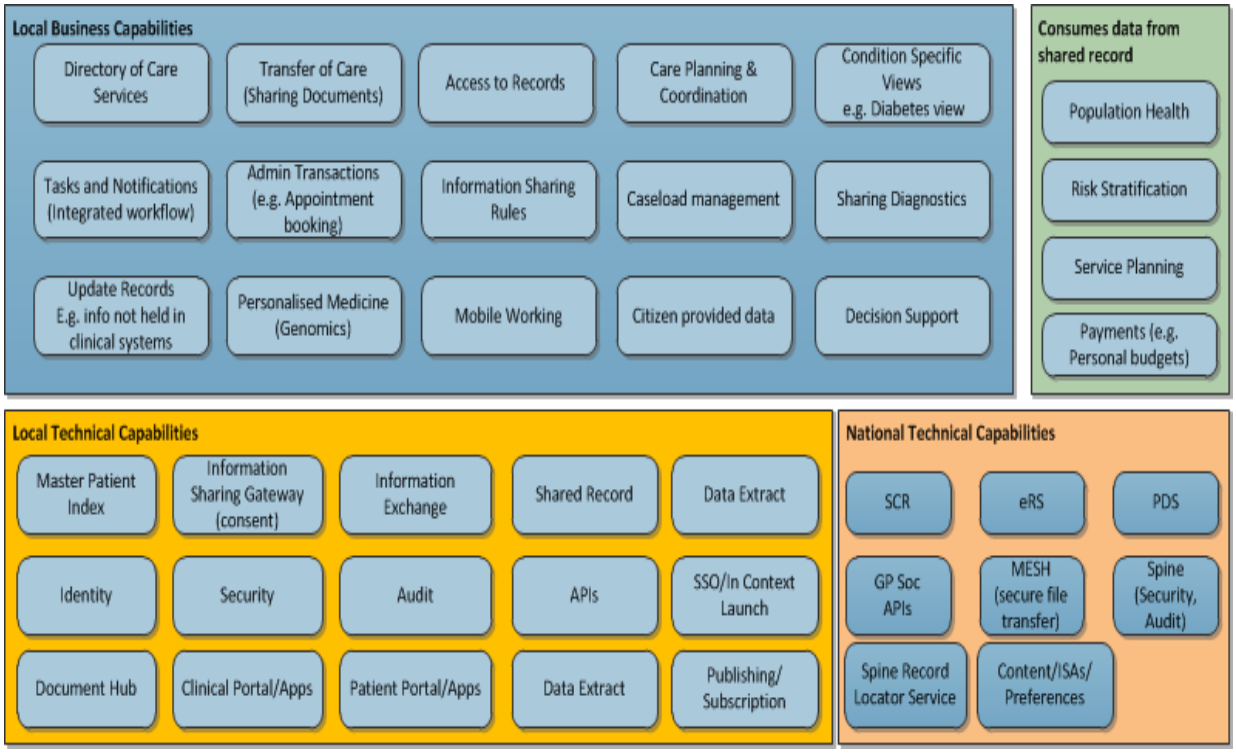


Figure 3 - NHSE 'Reference Architecture' to support integrated records

The Information Sharing Annexe which was part of our main Local Digital roadmap Report (Edition 1) remains valid (and has not been amended for this October update.)

[15] https://www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs/making-it-work-harnessing-the-power-of-health-information-technology-to-improve-care-in-england

[16] It is clear that the direction of travel is one where local and regional interoperability is encouraged and local drivers are triangulated with standards and priorities that will be delivered / driven nationally

8 End summary

This report has –

- Provided a summary re-cap of our **STP alignment**
- Described our **priority areas** - those that are critical for our progress – with a focus on work on-going on our leadership, governance, and the 'delivery vehicle'
- Provided **responses to the feedback** that we received to our First Edition (published in June)

This report complete with a series of annexes which include –

- A covering letter
- Our Main Local Digital Roadmap Document (June Edition)
- The Core Criteria Checklist (new)
- An updated Universal Capabilities Delivery Plan (new)
- A checklist for submission (no updates required)
- Details on our Information Sharing Approach
- Note that our Capability Deployment Schedule and Capability Trajectory have not been re-submitted [17]

"To those who wonder whether the NHS can afford an ambitious effort to digitise in today's environment of austerity and a myriad of ongoing challenges, we believe the answer is clear: ***the one thing that NHS cannot afford to do is to remain a largely non-digital system****.*

It is time to get on with IT."

[The Wachter Review, Sept 2016]

We recognise that we are ambitious and have much to do – but we welcome the challenge!

We welcome the opportunity to further discuss this report and any of our plans and feedback with NHS England.

"Tomorrow belongs to those who can hear it coming"

David Bowie

[17] Optional at this stage

9 About this document

9.1 Document details

Issued to NHSE on 31/10/2016

This document does not replace the First Edition (published at the end of June 2016). It provides an update on that document in relation to feedback from NHSE. **Please refer to the main document for all the complete details.**

9.2 Our digital footprint partners

The partners in our footprint are:

NHS Commissioners	Bristol CCG (Lead CCG) North Somerset CCG South Gloucestershire CCG NHS England
Local Authorities	Bristol City Council South Gloucestershire Council North Somerset Council
Providers	101 GP Practices (via three CCGs – now represented by 'One Care Consortium') North Bristol NHS Trust University Hospital Bristol NHS Foundation Trust Weston Area Health NHS Trust Bristol Community Partnership North Somerset Community Partnership Sirona Care and Health (South Gloucestershire) Avon & Wiltshire Mental Health Partnership NHS Trust South Western Ambulance Service NHS Foundation Trust One Care Consortium
Other organisations	West of England Academic Health Science Network NHS South, Central & West Commissioning Support Unit Bristol Health Partners

end