



Developing a
Sustainability and
Transformation Plan

Bristol, North Somerset, South
Gloucestershire working together.



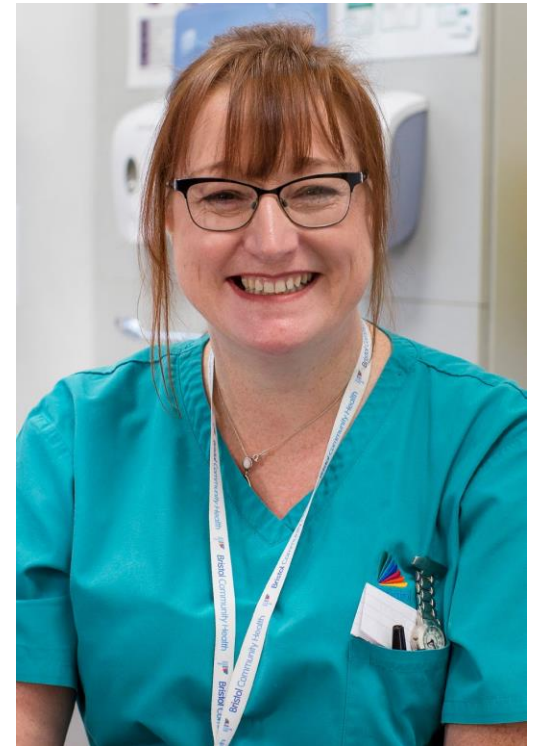
A NEW APPROACH

Sustainability and transformation plans are a new approach to planning health and care services across England over the next 5 years.

Local organisations will work together to develop a shared understanding of the challenges and agree joint plans for addressing them.

Principal aims

- Improve the health and wellbeing of local people
- Improve the quality of local health and care services
- Deliver financial stability in order to be able to continue to meet local health needs



THE CASE FOR CHANGE

- Growing and aging population
 - Avoidable illness
 - Pressure on services
 - Organisation of services
 - Financial balance
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WHAT PEOPLE TELL US MATTERS TO THEM

- Understandable information and help navigating the 'system'
 - Having needs assessed multiple times can be frustrating and distressing
 - Care plans arranged around the needs of the individual
 - Families and carers also central to successful care
 - People value locally accessible services and improved access to primary care
 - Transport issues, especially for those living in rural areas and people with disabilities
 - People's experience of discharge from hospital is not consistently good
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OUR VISION

A health and care system for Bristol, North Somerset and South Gloucestershire 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
- People are partners in their care
- Mental health is given equal priority to physical health in the way local services are planned and delivered
- There is consistency in the way both hospital and community services work so patients and staff know what to expect and how to use services



OUR VISION

Our areas of focus

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



PREVENTION, EARLY INTERVENTION AND SELF CARE

We know that people's lifestyle choices can have a big impact on their health.

Smoking and being overweight increases the risk of many major diseases such as cancer, COPD, stroke and heart attacks.

We need to make it as easy as possible for people who are health literate to self-serve and provide more support to those who may need help in making changes.



INTEGRATED PRIMARY AND COMMUNITY CARE

A whole-person approach for everyone accessing community and primary care services.

Completely different interface from traditional arrangements in which the GP is almost always the first point of contact.

A dynamic new integrated approach with a multi-disciplinary team extending beyond health professionals.

Also encompassing social care workers, volunteers, counsellors and others.

Able to support a variety of issues and manage whole-person problems – housing, money, loneliness, anxiety and depression, physical conditions.

A focus on improving and maintaining health and wellbeing.



ACUTE CARE COLLABORATION

If people need to go to hospital we need to make sure we provide services in a logical and efficient way.

Many services have evolved over time in response to the needs of patients but the journey often does not make sense to them.

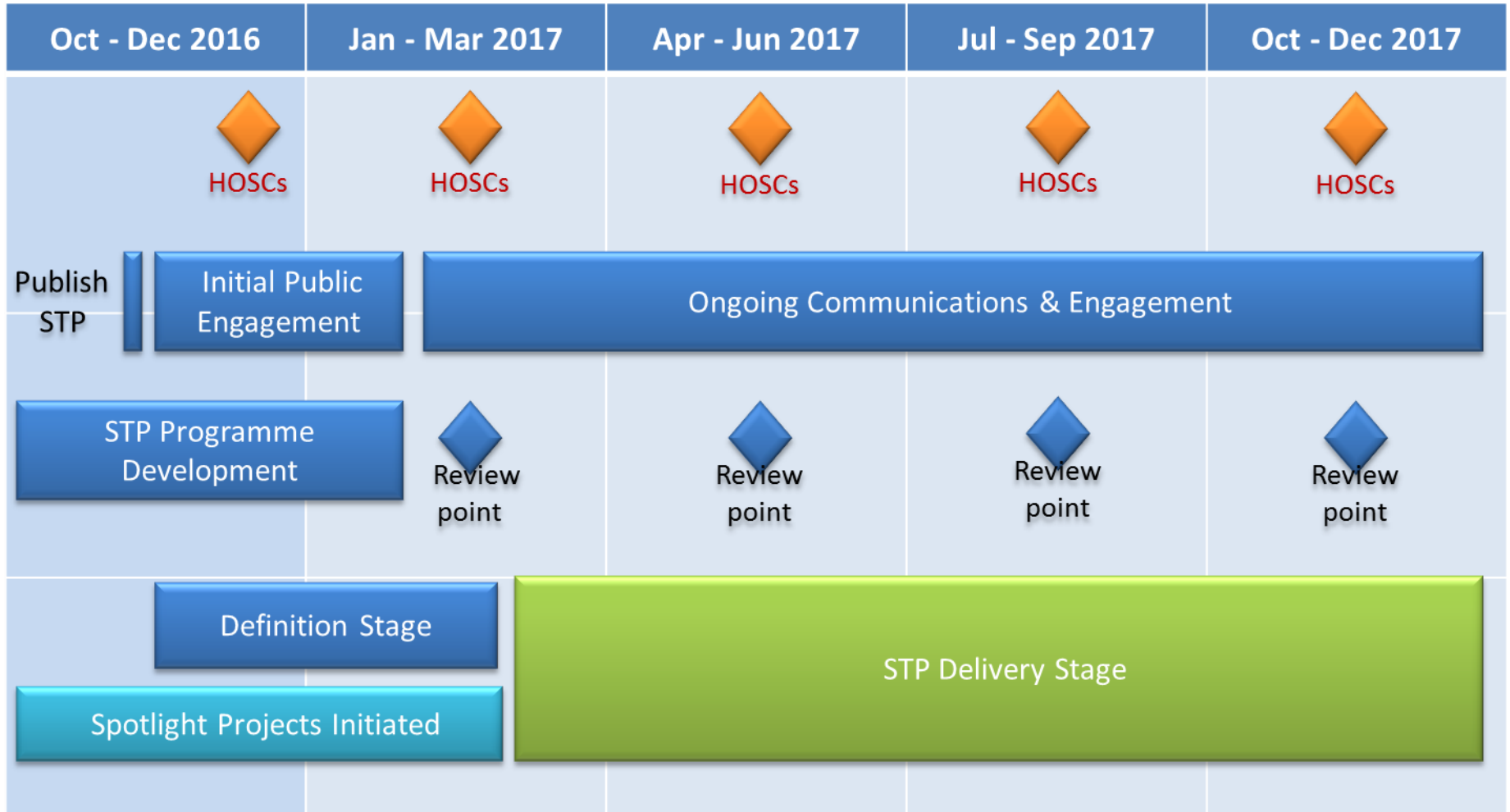
We need to take a step back and design services around patients, not around organisational structures.

It is right to expect patients to travel for specialist care but we should provide regular, routine services close to where people live.



SUSTAINABILITY & TRANSFORMATION PLAN

NEXT STEPS



The BNSSG local authorities

Established BNSSG Local Authorities Planning Group

- Meeting regularly, to ensure effective and coordinated contribution to STP process and outcomes.
- We are working together, across all STP work streams, on short and long term priorities

Exploring and developing opportunities for collaboration

- Adult social care workforce development: joint efforts to develop social care capacity and integrated teams; 7 day working
- Integrated discharge services/processes: working to support older people's urgent care system
- Care pathway opportunities: e.g. shared working to develop stroke prevention
- Single point of access: a shared understanding
- Shared commissioning where possible, e.g. community equipment

Working towards a single BNSSG health and social care integration plan

- A joint approach to Better Care across BNSSG
- Joint Director of Public Health network and joint Public Health Commissioning

