Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Healthier Together

Five Year System Plan

Interim Submission

Version: 25
27 September 2019

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1. Introduction

Introduction

This document is the interim submission from the Bristol, North Somerset and South Gloucestershire system (known as Healthier Together) to articulate our local implementation of the national Long Term Plan. It outlines how Healthier Together will deliver the requirements set out within the Long Term Plan, whilst also identifying and demonstrating how the system will evolve to address the needs of the current and future local population.

Our primary focus is on identifying and meeting the needs of our population and optimising the value we achieve from every pound spent. To do this we will use:

- Population Health Management
- Our Citizen's Panel
- The principles and processes we have put in place

Producing a long term plan gives us an opportunity to articulate a clear strategy for the future. The majority of transformation activities described within this plan have already been in development or in delivery and many of the core elements set out within the Long Term Plan were part of the strategy for the system. In developing our five year system plan we have focussed on a longer delivery timeline, better defined outcomes and developed a small number of newer elements.

This interim submission provides an overview of work undertaken to date to develop our Five Year System Plan. The November submission will include further detail, increasingly aligned assumptions and phased implementation.

Healthier Together: Now to 2024

- Bristol, North Somerset and South Gloucestershire (BNSSG) is striving to deliver compassionate and technically excellent care for a population with complex needs.
- We need to deliver effective care for a diverse population with different challenges, including in our urban centres, our seaside towns, rural areas and some particularly deprived communities.
- Our ambition in redesigning the system is to support not just the physical and mental health of people, but also the broader wellbeing of our population.

Our Model of Care

- At its heart, our plan entails a significant shift in our philosophy. We want to move from a model focused on treating the consequences of ill health to a model of proactive, anticipatory care. We will do this by using our data more intelligently and listening better to our population.
- All of this requires a greater focus on integrated community-based care services delivered within local neighbourhoods. It also requires a move away from largely medical approaches to supporting people with complex needs to social models where medicine plays an important role. This could be delivered by 'in community' providers working as Integrated Care Partnerships.
- Specialists in our hospitals have a hugely important role in this new system, ensuring that the integrated community based system is able to deliver safe, effective care closer to people's homes.
- Our hospitals are increasingly working in a network to improve performance across specialist services, including through sharing staff, bringing together rotas, benchmarking performance and participating in collaboratives to reduce unwarranted variation in treatment and outcomes.
- We will continue to develop centres of excellence for certain specialised services, including genomics

Financial sustainability

- If we deliver these changes to the organisation of services, coupled with the targeted initiatives we describe below, we expect to reduce the growth in numbers of people attending hospital who we could support better in community based services. This will allow us to re-balance resources, reduce demand and ensure financial balance.
- Our longer term ambition is to go further, achieving a substantive reduction in the use of specialist hospital services as we develop our community-based model. Over time, we want to achieve a significant shift in how we use our resources from reactive to proactive and anticipatory care.

Workforce

- To redesign the workforce we need new roles, different combined skill sets, new ways of working, better use of volunteers and third sector
- We know that we need to attract new people and retain our current staff to have sufficient resource to deliver our plans. To achieve this our ambition is to make our health and care system the best place to work by improving career pathways, flexible working and training opportunities together.
- Many staff live within our region and we want to enable them to be healthy and well through a range offers to improve physical and mental wellbeing.
- We are already working with our local schools to attract the next generation from all backgrounds into health and care roles. We are using technology to attract and facilitate new recruits into health and social care.

Working together as a single team

- We have already made real progress in developing partnership working and joint oversight and decision-making for our system through our partnership board and cross-system work programmes.
- But our ambition now is to work as a fully integrated local system: one team, with one budget, one set of priorities, one dashboard to monitor our performance and shared accountabilities.
- We will need to make further changes to do so, including to our payment systems and contracting so we can work flexibly together and move resources where they are needed.
- We will continue to build on the partnership between health and the three local authorities and as we develop our integrated care system, so that we can pool resources and work together to improve health and wellbeing in our communities.

We are developing a framework for our 5-year plan that reflects local and national priorities and strategies…

Ambitions

Improve Population Health and reduce gap in healthy life expectancy

Systematic delivery of value-based care

Shift to personalised, integrated, proactive and preventive care

Rebalance resources

Our Population

Local needs

Outcomes focus

Targeted interventions

Architecture

Strengthen primary care

Build integrated care partnerships at a locality level – including building healthier communities

Network acute care, deliver consistent standards and integrate access to specialist care closer to home

Develop further our specialist services to lead regionally, nationally and internationally

Priority Care Programmes

- Children and Families
- Mental Health
- Frailty and dementia
- Diabetes
- Respiratory
- LD and Autism
- Cancer
- CVD
- Stroke
- End of Life

Key Enablers

- Digital
- Workforce
- Estates

Delivery Plans

Roadmap for delivery

Activity Plan

Financial Plan

Workforce Plan

We have agreed design principles to guide our approach

Focusing on population, people and place – focusing on population health and wellbeing, identifying the outcomes that matter to people and understanding place from a resident's perspective

Targeting interventions to address inequality – tailoring approaches to address variation and under/over representation, and to take account of geography and cultural diversity

Addressing wider determinants of health and inequalities – working in partnership to give children the best possible start in life; improve education and employment outcomes; and contribute to inclusive growth

Reducing our impact on the environment – assessing the environmental impact of developments; reducing our carbon footprint and promoting better air quality

Investing in localities and neighbourhoods and in community capacity building to support health and wellbeing – devolving accountability and decision making as close to the community as possible

Applying data, intelligence and resources in a value based approach to understand population health, focus on outcomes that matter to people and ensure best possible use of all our resources

Identifying what matters to people – measuring outcomes, promoting independence and personalising care

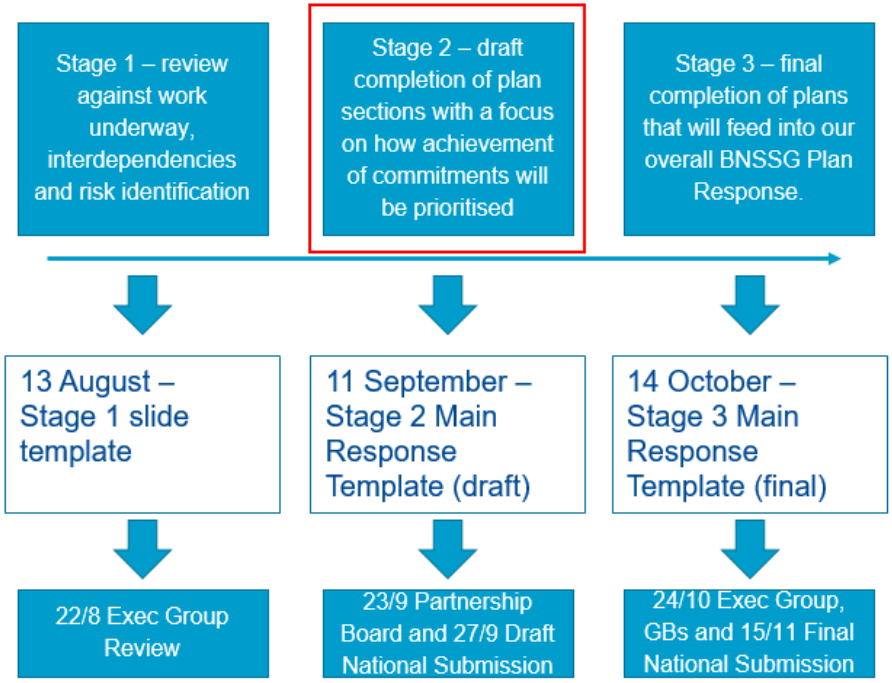
Focusing on hearts and minds to drive change – facilitating cultural shift, embracing innovation and adopting best practice

Evidencing committed ownership of all partners – agreeing credible plans and timelines for delivery and embedding them in our organisational plans

...and established a three stage planning process

The interim submission draws from the Stage 2 process. Top down modelling assumptions have been used to inform the interim submission. Work is continuing to model the impact of the transformation plans. This second stage of the process, used to inform this submission provided a key focus on:

- Describing the **outcomes** that we want to achieve for our population.
- **Prioritising** which aspects of the LTP we want to deliver soonest and which are longer term deliverables for the latter years of the five year planning window.
- Ensuring **interdependencies** across work areas are understood and being acted upon.
- Assessing the **impact** of the delivery plans in terms of finance, activity, performance and workforce.



Population Health & Value are at the heart of our approach

Value Based Healthcare is being used as an organising principle to guide the way we plan, commission and evaluate our services. Our plan seeks to ensure that we maximise health and care outcomes that matter to people and the whole population, within our given resources. This approach to **population health** also aims to reduce unwarranted variation and health inequalities in deprivation or groups such as those with learning disabilities or severe mental illness. Doing this will mean ensuring that we:

- Measure and improve outcomes **that matter to people**
- Deliver quality care for the **people who will benefit**; avoiding the overuse as much as the underuse of interventions
- Allocate our resources across the system enabling us to achieve the **best possible outcomes** we can for our population

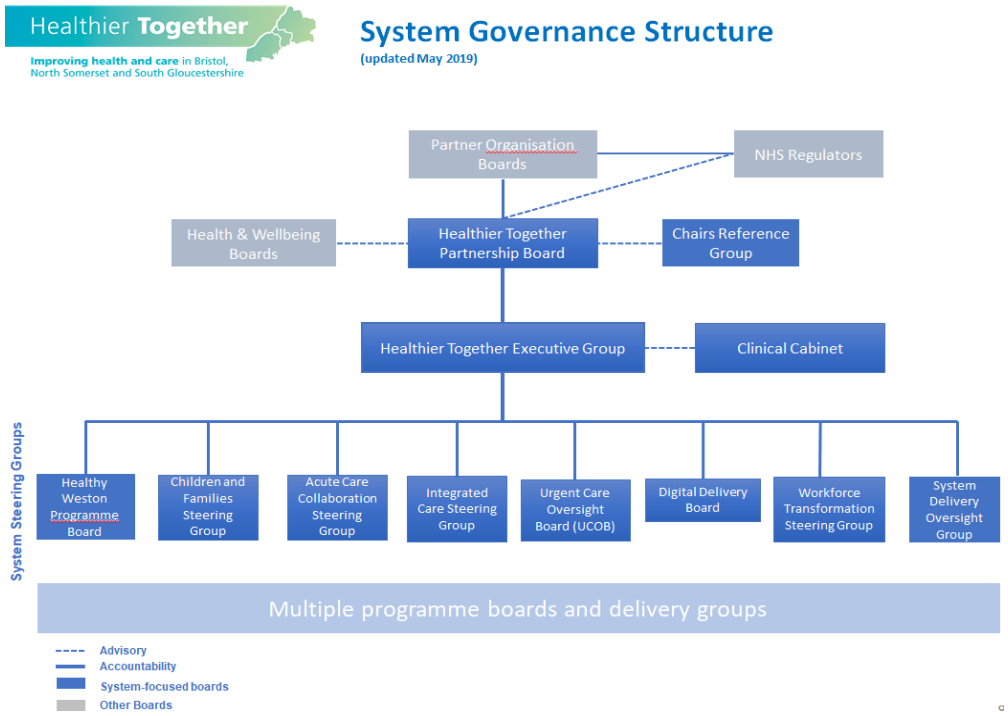
A key enabler of this approach is **'Population Health Management'**, which aims to improve population health by data-driven planning, delivery and evaluation of care. We have built a linked data-set which contains person records from general practice, secondary care, mental health and community care. Our progress has been recognised nationally and we have started on Wave 2 of the national PHM Development Programme. We have used our data-set to establish:

- 300-400% growth in the highest cost (over 77-years) section of the population within the next 15 years, compared with small relative increases in the rest of the population.
- The most intense 1% users of urgent and emergency care use as many resources as the other 99%.

10 organisations form our system and we work closely with local Healthwatch and the VCSE

From April 2020, our system will comprise of ten partner organisations:

- Avon & Wiltshire Partnership NHS Foundation Trust
- BNSSG CCG
- Bristol City Council
- North Bristol NHS Trust
- North Somerset Council
- One Care
- Sirona care & health
- South Gloucestershire Council
- South West Ambulance Services Foundation Trust
- UH Bristol NHS Foundation Trust



All organisations form part of the system's governance structure, with a Partnership Board comprising chairs, chief executives and elected members leading the system.

We have already achieved a lot in building our system

Since 2016, our health and care system has come together under the banner of Healthier Together with a shared purpose of improving health and care for the people living in our communities.

Over the past three years, the system has matured and delivered some key achievements:

- **2018** - Merging of three CCGs into a single CCG
- **2018** - Creating six localities: bringing together primary care to work at scale and integrating services with community services and social care
- **2018** - Developing an Integrated Care Bureau across the system bringing together all acute, community and social care teams
- **2018/2019** - Multiple partners collaborating to develop a sustainable services solution for the Weston locality. Public consultation on proposals for Weston took place in 2019.
- **2019** - Single community provider from April 2020 – 10 year contract with VCSE delivery element
- **2019** – Significant process in Population Health Management with a full linked dataset; nationally recognised by participation in national Population Health Management accelerator
- **2020** – Potential UHBristol and Weston Area Health Trust Merger

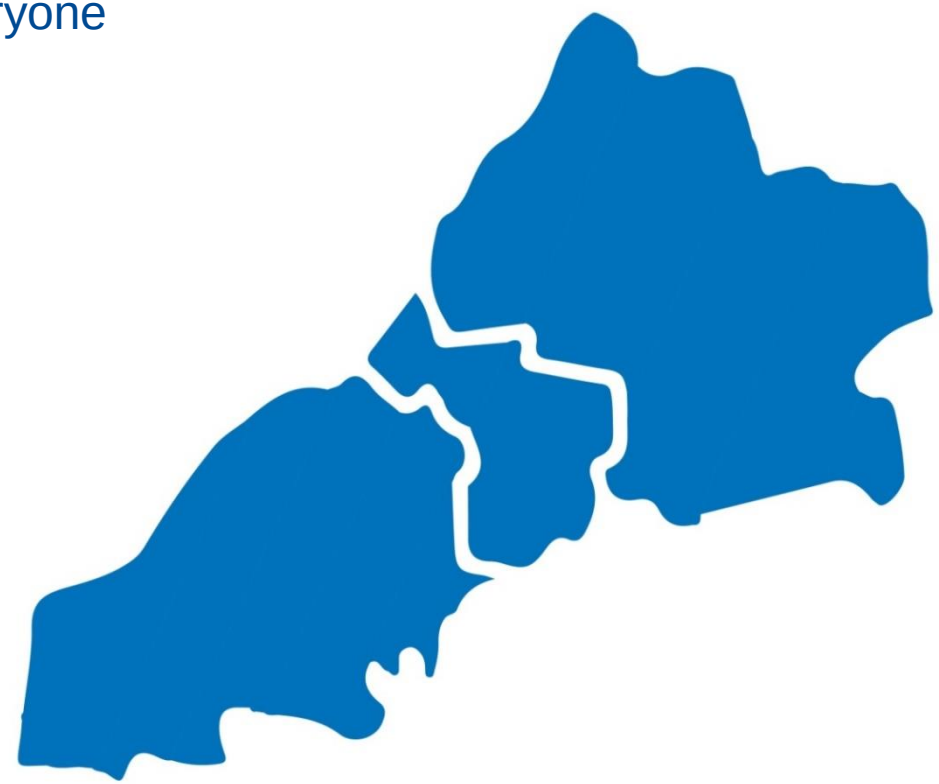
2. Our Population & Outcomes

Our five year plan will focus on improving health and wellbeing for our populations

Vision - healthy, fulfilled lives for everyone

Goals

- Reduce inequalities in healthy life expectancy
- Release and reallocate resources from low value to high value activity
- Optimise people's independence
- Ensure our system deliver compassionate and high quality care
- Build a healthy and fulfilled workforce



Our starting point is to understand our populations better….

This is all driven by our approach to population health & population health management

Taking a population health approach means that we are collectively responsible for improving the physical and mental health outcomes and wellbeing of the people of Bristol, North Somerset and South Gloucestershire, while reducing health inequalities.

In doing so this approach guides us to prevent ill health, deliver quality health and care services and impact on the wider determinants of health. We believe this will only be achieved though working as a health and care community, which includes our patients and public.

A key enabler of our value based population health approach is the Population Health Management (PHM) programme, which aims to improve population health by data-driven planning, delivery and evaluation of care. Operationally this has involved the construction of a linked dataset across primary, secondary, community and mental health care, which is then used to facilitate analysis of a single longitudinal person record to enable more sophisticated intervention planning.

Through our involvement on Wave Two of the National Population Health Management development programme, we expect to expand our capability to broaden the breadth and depth of the linked dataset and over time bring together our data and intelligence assets to enable our system to deliver better value for our population.

We are already working with our frailty programme to improve the modelling of integrated locality hubs, urgent and emergency care where we have identified that 1% of users of those services use 50% of resource and are comprised of a frail and multimorbid cohort, and developing a targeted approach to improving the early diagnosis of cancers.

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We know that we need to address the wider determinants of health to improve health and have a sustainable system. We can address these as a partnership.

46% **of Bristol secondary school leavers are not achieving five GCSEs grade A*-C including mathematics and English**

North Somerset 42%; South Gloucestershire 43%

27% **of children across BNSSG are not considered to have achieved a good level of development at the end of reception.**

5.1% **of mortality in Bristol and South Gloucestershire is attributable to air pollution**

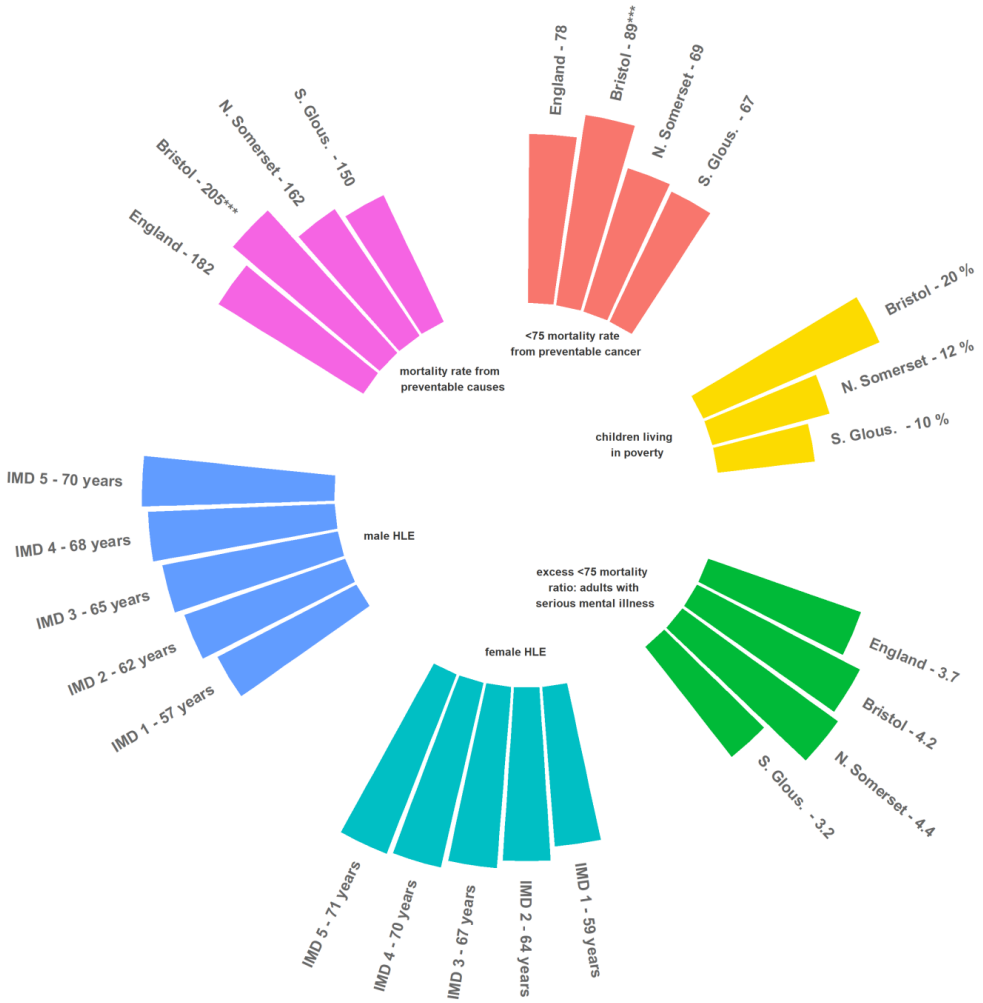
North Somerset 4.3%

21% **of people aged 16-64 in North Somerset are unemployed**

Bristol 22%; South Gloucestershire 21%

We also know that health inequalities play a large part in the demand for health and care services

The inequalities in health outcomes that we observe in the system are the result of the current state of the wider determinants of health, how people manage their own health and the function of the health system.



Guidance Notes

HLE: Healthy Life Expectancy.

IMD 1: most deprived population quintile by index of multiple deprivation.

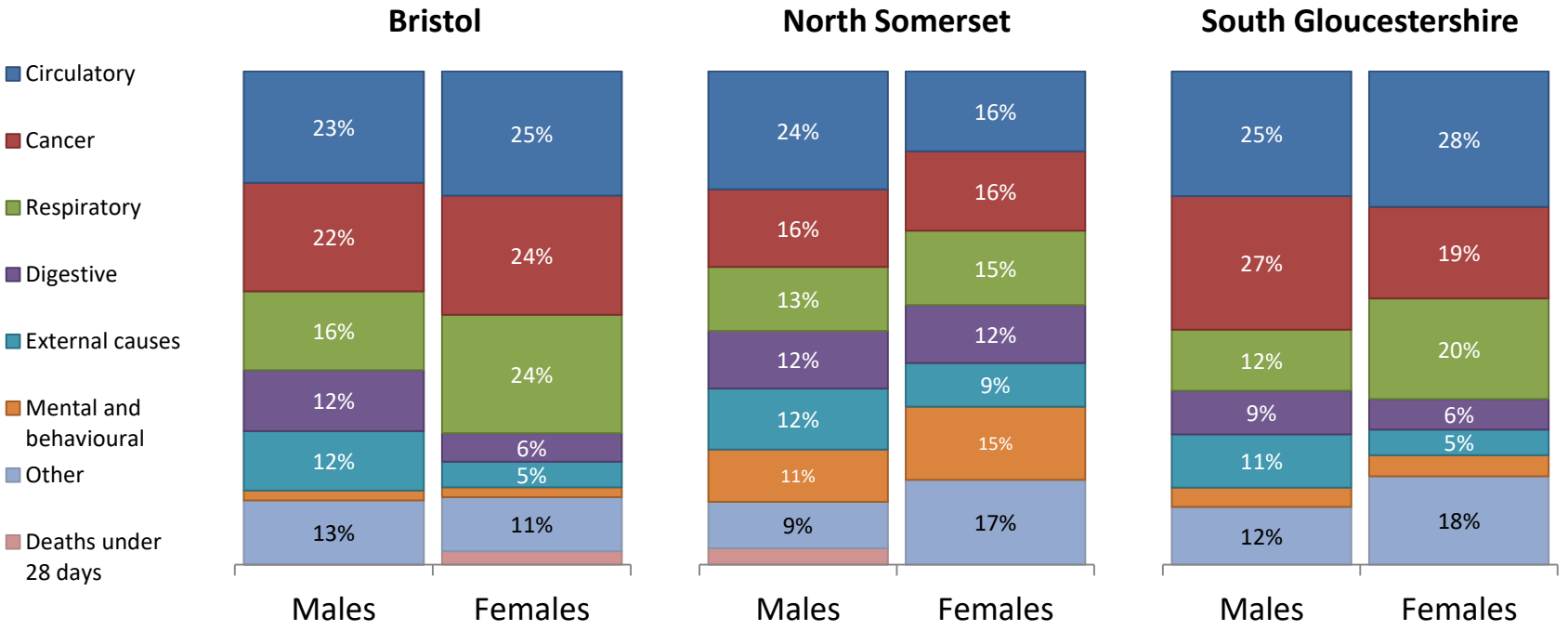
Excess <75 mortality ratio is the number of times greater than the background population.

Mortality rates are directly standardised per 100,000 population.

Outliers with statistically significant differences from the England average are denoted ***.

Our approaches to reducing inequalities are determined through local insight about population health

This insight is generated through local engagement with communities and stakeholders, as well as data from population health management to enable us as a system to develop a common understanding of the complex causes and costs of health inequalities and what we can do to address them. We will use national tools and guidance such as such as the PHE Place-based approaches for reducing health inequalities to support us in this work.

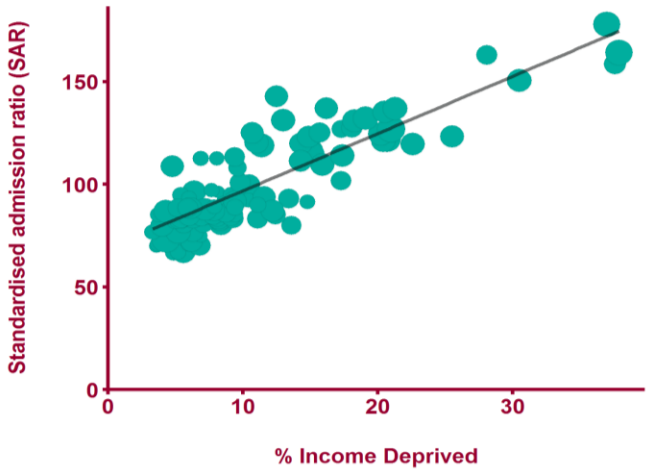


between most deprived quintile and least deprived quintile, 2015-17

Health inequalities are not only bad for the people who experience them, but there is a strong correlation between deprivation and demand on the health system, and in particular the acute system

Across a range of indicator conditions, health inequalities have a significant impact on acute hospital activity.

Alcohol related harm



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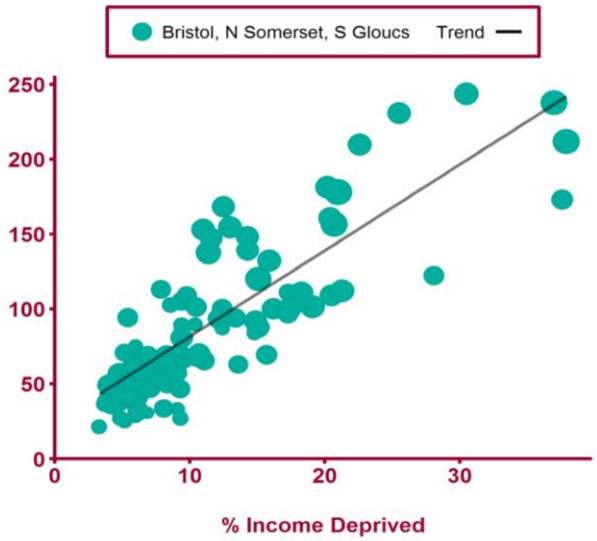
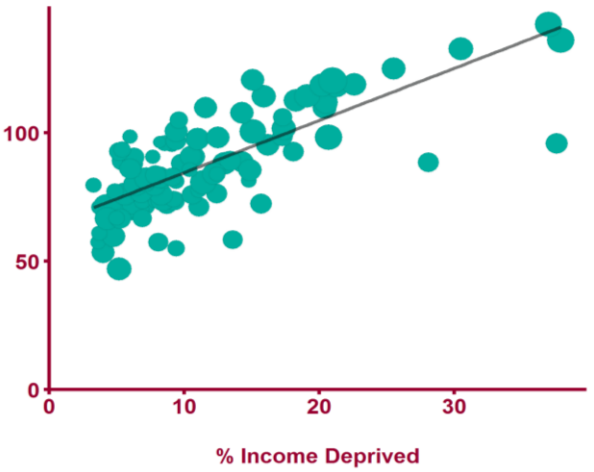


Coronary Heart Disease



We know that people living with mental health problems, learning disabilities and/or autism have poorer access and outcomes

Bristol autistic spectrum service for adults
292 people waiting, average wait 8 months

Autistic Spectrum Diagnosis Pathway for children and young people
463 people waiting (January 2019)

Child and adolescent mental health services
660 children waiting for access (December 2018)

Improving access to psychological therapies (IAPT)
Estimated by September 2019 there will be 3400-3840 people waiting for their second treatment

Completeness of the GP learning disability register (BNSSG prevalence 1.7%, England prevalence 1.5%)
0.46% of population on a register (6th/11 CCG peers; 104/195 in England)

Proportion of people with a learning disability on the GP register receiving an annual health check
51.9% (5th/11 CCG peers; 72/195 in England)

Self-harm
2,200 emergency admissions annually, predominantly females and Bristol more than other areas

In line with the global Value Based Healthcare movement we are taking a value based approach to population health

For us this means following three core principles:

- Firstly it means that the outcomes we are trying to improve are outcomes that matter to people and our population. We need to understand and respond to these outcomes from the level of the clinic to the board room.
- Secondly it means delivering quality, cost-effective services based on the best available evidence to the people who will benefit; avoiding both under and overuse of healthcare.
- Thirdly it means taking both a ‘bottom up’ and ‘top down’ approach to analysing and planning the allocation of resources across our system in order to achieve the greatest overall benefit.

Healthier Together has developed a Value Programme, working with the Aneurin Bevan University Health Board and Professor Sir Muir Gray’s Oxford Centre for Triple Value Healthcare. Although in the early stages we have trained a clinically led, cross-system multidisciplinary group of 25 leaders, worked with programmes to develop whole system outcome sets in co-production with people with lived experience, and we are engaged in a procurement process to secure a digital platform to enable our system partners to systematically measure patient reported outcomes measures.

During the next phase of work we will be defining our ambitions for improving outcomes and how we will measure progress

We have started a discussion, working with our Directors of Public Health, on what overarching outcomes our system will direct its efforts at achieving. These outcomes will be ones that can only be achieved using the efforts of all partners, the community's assets and individual people.

We'll be working with public health, wider local authority and other partners over the next few weeks to finalise a set of outcomes

Our overarching aim is to:

Improve the overall health of everyone in BNSSG and improve the health of the poorest fastest

Outcomes we will monitor include:

- Healthy life expectancy
- Premature mortality
- Mental health and wellbeing
- Educational attainment
- Inequalities in outcomes

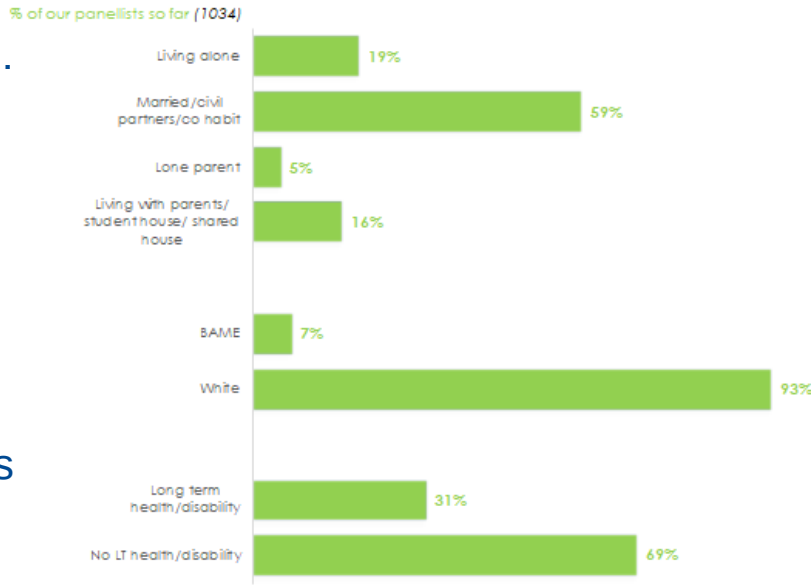
We are also having meaningful conversations with our population to understand their needs and wants further

In 2018, we established the Healthier Together Citizen's Panel. Our vision is to have a detailed understanding of the needs and wants of the population of BNSSG, and use this insight to connect to the behavioural insights gained through Population Health Management to ensure we have a thorough understanding of the key drivers which lead to the behaviour we observe.

This will allow us to make more sophisticated and effective decisions on how we allocate resource and plan services.

The Citizen's Panel has completed 3 waves of research. We have recruited a total of 1,034 panellists, carefully calibrating our recruitment to ensure that we have a panel which is robust and representative of the population we serve.

We will continue to explore key areas of focus from our 5 year system plan using the full panel, and are also conducting deliberative research with smaller subgroups within our population to ensure that our plans are developed through meaningful conversations with our



These insights are already shaping our decisions

73% of BNSSG residents report that they are **feeling healthy**

65% of BNSSG residents currently **feel in control** of their lives

Only **62%** of BNSSG residents currently **feel happy**

If BNSSG residents were in control of the health and care budget, 28% of it would be split equally between adult and children's mental health

They would split a further 30% of the budget equally between hospital care and General Practice

The remaining 42% of the budget would be shared relatively equally between services for older people, learning disabilities, end of life care, children's social care and adult social care

11% of BNSSG residents report that they have had an outpatient or clinic appointment that they considered to be a waste of their time

13% of BNSSG residents report that they have had surgery or treatment that they later regretted (or know someone who has)

Between one half and two thirds of BNSSG residents would travel (up to 3 hours on average) to receive specialist care with better results, rather than stay close to home

Healthier Together

…and over the last year we have involved the public in developing plans through a number of engagement activities

Nov '18	Apr '19	May	June	July	August	Sept	Oct	Nov	Dec
'Your Story' event 85 members of the public, VCSE and Councillors	**Healthwatch** research with ~650 people				**Call for evidence** ~40 submissions from public, VCSE, academics		Deliberative research with ~20 members of the public	Community engagement roadshow	
			Staff engagement with ~150 people across the partnership capturing 400-450 individual pieces of feedback				**17th Oct** Conference targeting public, NEDs, Councillor, VCSE, lay reps, ~200 people	Public Launch	
Healthier Together Citizens' Panel – three surveys with representative sample of the population (1,000 citizens)									
							Joint HOSC		

Ongoing Activities

- Healthier Together Citizens' Panel
- Engagement supporting bespoke pieces of work and programme areas, such as Healthy Weston, Adult Community Services Procurement
- Updates included as part of routine discussions with MPs

3. Model of Care

At its heart, our plan reflects a significant shift in our thinking on the most important features of the care we want to be provided for our population

Proactive and anticipatory care	We want to move from a system that reacts after people become ill or their conditions worsen to a system which is much more proactive and anticipatory: using population health and other methods to monitor people's health and wellbeing to help them remain healthy and independent; and intervening much more quickly to prevent an emerging condition from worsening.
Importance of relationships	In our system, health and care staff have much stronger relationships with individuals and families they support. We want core groups of health and care staff to maintain sustained relationships with people, so they understand their life circumstances, coordinate support that meets people's individual needs, and can influence how they live their lives.
Integrated working between General Practitioners and specialists	We will shift from a model of healthcare where we regularly send people out to specialist clinics for specific treatments to a more generalist model, where core teams of staff who know their patients deliver a broad range of care. This will mean that some specialists will spend more time supporting generalists in delivering their services, allowing them in turn to give greater attention to people who most need specialist support.
Medical and non-medical support	We want to move from a system that focuses on health to a system that delivers whole person care, addressing both health and social aspects of people's problems. For example, provide holistic care for people whose health problems are bound up with social problems.
An asset-based approach	We want to move to a model of much greater partnership working between health and care services and individuals and communities, so we pool our resources and work together to improve health and wellbeing.

Prevention is at the heart of our model of care. We want to help people stay healthy, happy and independent for as long as possible.

In order to achieve this we will deliver personalised care based on ‘what matters’ to people and their individual strengths and needs.

We will achieve this in a number of ways:

- Taking a population health and prevention approach, ensuring that opportunities for primary prevention are taken across all our programmes and pathways, and delivering as well as delivering targeted prevention plans to address lifestyle risk factors and the wider determinants of health.
- Taking a value approach, ensuring that individuals are supported to make decisions about their treatment that are right for them.
- Developing the workforce to enable them to identify the knowledge, skills and confidence people have to take action to improve their health and manage their own health and care including ensuring all organisations within the system have a Making Every Contact Count plan.
- Primary care working together with the voluntary and community sector to develop a network social prescribing link workers across BNSSG able to connect people to community service and groups for practical support.
- Developing a new focus on friends, families and carers working with the voluntary, community and social enterprise sector in support of our communities through our Building Healthier Communities programme.

We already have a plan for targeted prevention across the whole system

Reducing Tobacco Use

- Implement the BNSSG Smokefree Pregnancy Pathway.
- Deliver health visitor stop smoking training and associated patient/family information pilot in Bristol.
- Ensure each trust within BNSSG has a director-led, smokefree committee with an action plan.
- Support Health Optimisation pilot to include smoking cessation referral as part of hip and knee pathway.
- Review smokefree status of inpatient mental health facilities locally. Smoking cessation to be offered to all staff and patients who smoke.

Reducing Obesity Prevalence

- All organisations to commit to NHS Healthy Weight Declaration.
- Maximise opportunities to improve health outcomes via the Pre-op pathway.

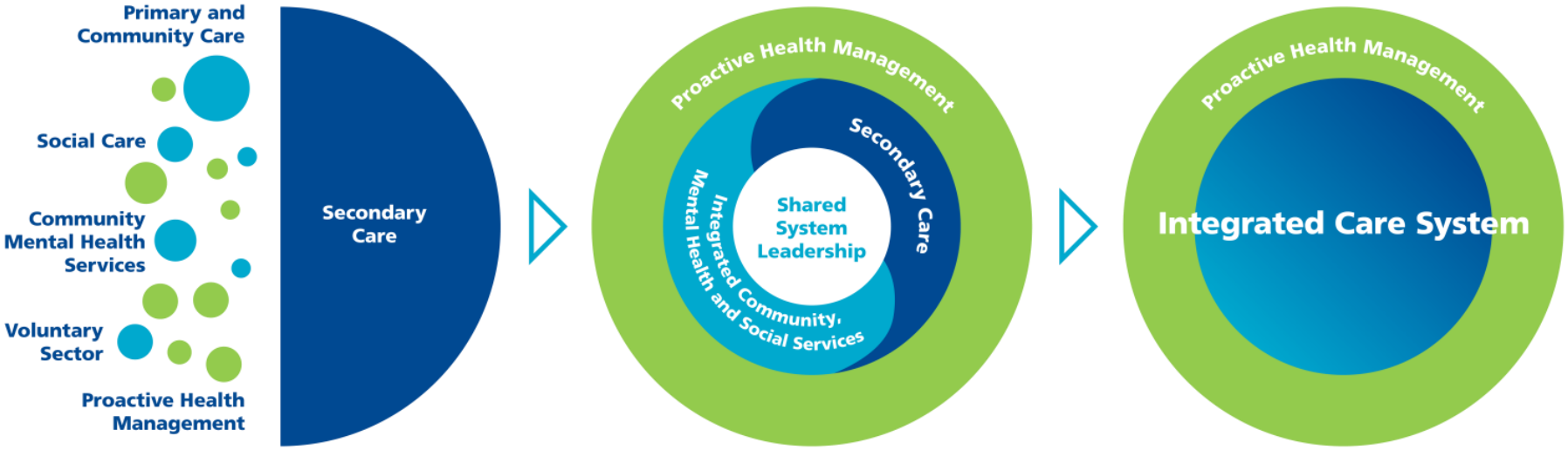
Reducing Alcohol Consumption

- Establish and/or optimise alcohol care teams in district general hospitals.
- Provide alcohol Identification and Brief Advice in primary and secondary care settings.
- Establish Alcohol Assertive Outreach Teams (AAOT) to reduce repeat users of hospital and other services such as police and social services.
- Establish clear care pathways to ensure sustained engagement with high volume service users.
- Ensure alcohol treatment systems provide prompt access for parents who are identified as harmful/dependent drinkers with agreed pathways between services.

Improving Mental Wellbeing

- Development of evidence-based pilots to integrate socio-economic responses in primary and secondary care linked to and embedded in IAPT, social prescribing and peer support and delivered through localities.
- The development and delivery of a joint communications plan to promote positive mental health using a viral change model.
- Develop a BNSSG wide mental health training programme.
- Support local schools to take a whole-school approach to improving mental health.
- Work with communities to build social connectedness.

The foundation of our strategy is to build integrated care partnerships at locality level...



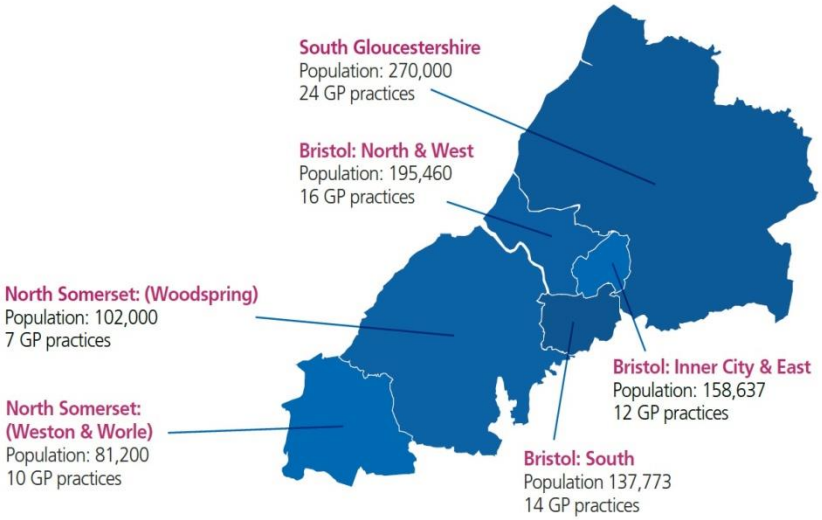
We are making good progress in joining up a fragmented system of care and in promoting proactive population health management. Our work largely anticipated some of the detail in the Long Term Plan. Our progress in delivering an integrated model of care and networking acute care has enabled us to make significant steps forward to become an Integrated Care System.

We have six localities in BNSSG, each with a population between 100,000 and 250,000

The formation of localities (and latterly PCNs) has allowed a more joined up and coherent conversation between Primary Care and the rest of the system since 2018. For example, this can be seen in the work progressing on frailty, same day urgent care and mental health. We have already made significant progress, with localities in place and working together to deliver primary care at scale for extended hours.

Each locality has evolving to become an Integrated Care Partnership (ICPs) formed of organisations driving transformation for their population including social care and voluntary sector partners.

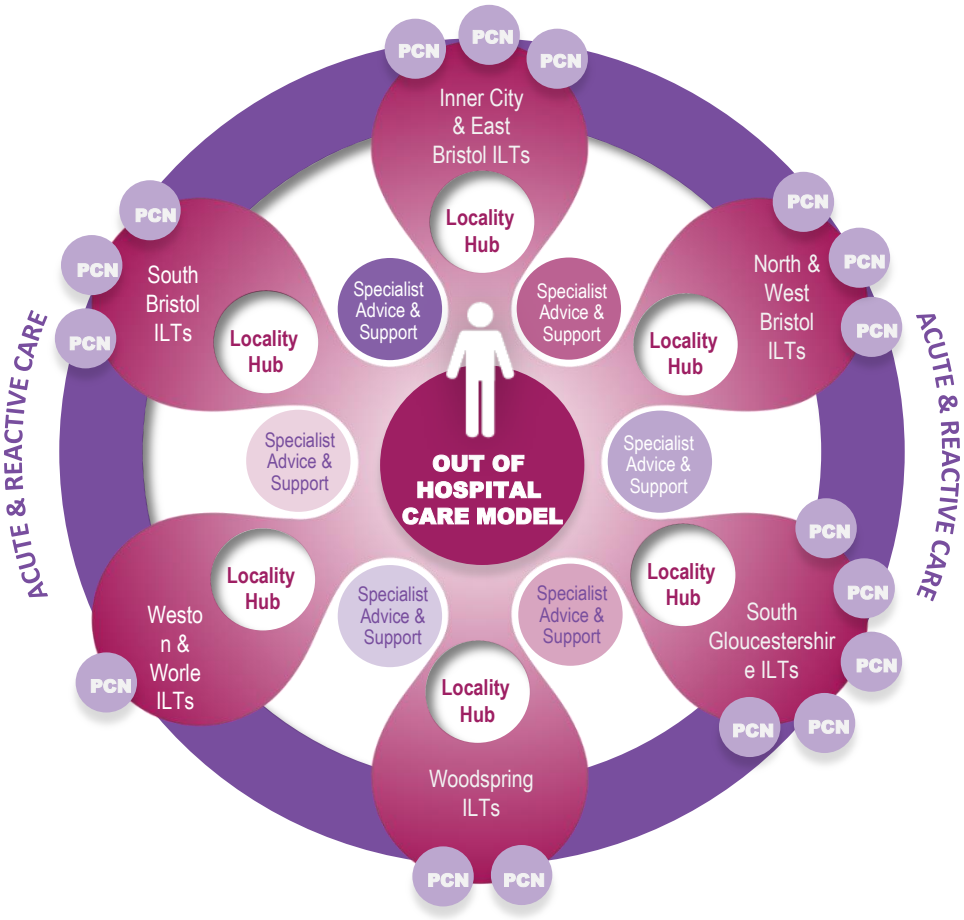
In addition to coordinating services, these teams will build strong relationships with people in their care through both traditional medical services and support to address the social issues causing underlying ill health.



Our new single BNSSG wide community services model is designed to accelerate progress towards fully integrated localities as a key enabler of ICPs

These teams will be able to focus more on prevention and proactive, anticipatory care, providing continuity of care for people with varying needs.

They will expand the range of services available from core teams in the community, reducing the need to refer people to new services when they are most vulnerable and the need for specialist referrals, reliance on emergency and crisis services and avoidable admission of people to hospital in-patient wards in acute or mental health hospitals.



Specialist care and support will be integrated within localities and hospital services will be delivered through networks…

We will increasingly use the specialist staff in our hospitals to support the locality teams, in addition to caring directly for their patients, so that generalist teams can deliver technically excellent as well as holistic care to people with more severe health conditions. These changes will reduce the number of people attending urgent care and specialist hospital services who could be better supported in the community, allowing hospital consultants to give direct care to people who most need their support.

One example of closer integration is the proposed model for outpatient services. This model is based on enhanced links between named specialists and locality teams who will work together in a virtual integrated team to support more delivery of care out of hospital, fewer deteriorations of care, ability to manage higher acuity locally and reduce duplication and low value activities for patients and staff.

Our hospitals will work together in a network to improve the quality of all our general hospital services through sharing scarce resources such as particular consultants, working together to benchmark performance and on improvement projects. We will deliver exceptional quality and outcomes through consistent and aligned services. We will reduce cost through better use of estate and reduced service duplication. We will improve clinical sustainability and the experience of our staff by working as one network

Collaborating for excellence specialist hospital services - making best use of specialist skills and facilities

Our hospitals will continue to develop as regional, national and international centres of excellence delivering highly specialist services for people across the south west of England, building on the progress we have already made in cancer treatment, cardiac surgery and paediatrics amongst others.

Our 5-year plan will set out our ambitions for further development and expansion of some of our most specialist services, working in partnership with our local Universities in promoting research, innovation and education.

We will agree our plans with NHSE Specialised Commissioners so that this work is aligned at a regional and national level. the South West and beyond.

Genomics is an example of the potential opportunities in BNSSG. We have one of only seven genomics laboratory hubs in the country, a genomics medicines service and whole genome sequencing and we want to continue to be at the forefront of supporting more personalised medicine for patients with cancer and rare diseases.

Digital transformation offers an opportunity for us to make these changes within the context of limited workforce supply

We will build on our significant progress to date on delivering digitally enabled health and care in the next five years. Our Connecting Care integrated digital care record has been in use across all partners since 2013 and is paving the way for delivering digital innovation as a partnership by 2024.

- Digital information captured at the point of care
- Reliable and prompt communication between staff through integrated digital records and messaging systems
- People will be able to access and interact with their records
- Automation of low value transactions such as booking appointments, ordering prescriptions and receiving test results
- Digitally enabled health and social care including assistive technology that builds on our asset-based model
- 24/7 access to advice, guidance and support across different services
- Involvement of the public and staff in developing digital systems and applications

connecting care

4. Long Term Plan Commitments

Developing Core Programme Plans

We have received rich material from our Healthier Together Steering Groups and their respective Programmes as part of the local BNSSG process to develop our response to the LTP. Stage 2 of the process has been completed and Stage 3 is underway.

The final Five Year System Plan submission will present clear ‘plans on a page’ for the core programme areas. This section will ensure the aims, outcomes and interventions are well articulated along with specific impacts of plans such as in terms of activity, workforce and finance. As part of the Stage 2 submissions there is a clear distinction between those areas focusing on changing infrastructure e.g. outpatients, integrated models and locality development, estates and workforce, and those focused on care pathways or population groups e.g. diabetes, LD & autism, frailty. The latter group is here proposed as our core programmes and the plans on a page to be included will be:

- End of Life
- Frailty and dementia
- SDUC
- Diabetes
- Respiratory
- Mental Health
- LD and Autism
- Urgent and Emergency Care
- Medicines Optimisation
- MSK
- Cancer
- CVD
- Ophthalmology
- Stroke
- Children and Families
- Maternity
- Locality plans

See Appendix 1 for current programme status

Headline metrics set out in the Long Term Plan

So far 33 metrics have been defined nationally to measure and monitor quantifiable progress delivering LTP ambitions. These cover a sub-set of all the LTP aspirations.

The LTP submission requires provision of numeric plans against each of these metrics, to show our planned progress from 2019/20 to 2023/24.

In BNSSG we have allocated these metrics to system-wide Steering Groups through which interim plans have been worked up and are being submitted to the Strategic Data Collection Service as part of this interim submission.

We have undertaken self-assessment of progress in developing plans against these metrics. A summary is provided in Appendix 3.

The guiding principle has been to reflect the status of our narrative and delivery plans at this point. They show the realistic delivery case.

During the Phase 3 process these plans will evolve inline with the development of Steering Group delivery plans. The wider process includes consideration of these delivery ambitions in the context of the whole plan, to balance relative priority and resource or investment decisions.

Quantified metric plans will be updated for the final November submission.

The LTP metrics, in addition to the NHS Oversight Framework, local LTP outcome measures and other existing reporting will be built into local ICS governance reporting.

5. Example plans on a page

Plan on a page – Integrated Frailty Service

Finance (tbc)	Activity (tbc)	Workforce (tbc)

Outcomes

- Improved patient experience of care
- Increase in (health related) quality of life
- Increase in preferred place of death
- Reduced emergency admissions & attendances
- Decrease in emergency bed days
- Increase in time spent at home
- Preventing or delaying the development of moderate and severe frailty
- Increase in carers feeling supported in their role
- Increase in staff satisfaction
- Decrease in falls

Key Metrics

- No. of care plans completed
- No. of CGAs completed by hub and ED-based MDTs
- No. of MDT reviews completed
- No. of medication reviews
- No. of patients with completed RESPECT forms
- No. of Carers accessing support services
- No. of care plans including carers support elements
- Patient survey results
- Staff survey results
- No. of patients accessing each service

Delivery Plan and Milestones

- High quality, locality-based navigation services in place for all frail individuals, and those at risk of becoming frail, with access to health, care, and social prescription interventions.
- Consistent, practice-level MDT case reviews for moderately frail individuals across all localities.
- 3 x community frailty services based at locality hubs for comprehensive geriatric assessment by a specialist MDT.
- 3 x frailty day assessment units at locality hubs with access to diagnostics, step up beds, complex supported discharge and emergency care practitioner home visits, for severely frail individuals.
- Specialist frailty MDT in all three EDs to support admission avoidance, with access to community and short stay services.
- Pathways developed for accessing services (including IUC and SWAST) and 'pulling' patients from acute spells using the ICB.
- All frailty services underpinned by a consistent approach to care planning and data sharing, population health analytics-informed risk stratification, and holistic assessment.

2019/20	2020/21	2021/22	2022/23	2023/24
Phase A – In-year delivery and 20/21 investment business Case • **In Year delivery of elements of Model of Care by localities and acutes including practice MDTs & Weston hub.** • **Development of strategic then investment cases for 20/21, in conjunction with CSP mobilisation.**	**Phase B – Delivery of full IFS** • **Delivery of investment business case through existing contracts, including new community provider.** • **Implementation of first phase of infrastructure requirements, e.g. estates sharing, data sharing agreements.** • **Business cases and planning for any major capital projects required.** **Phase C – Agreement of commissioning approach** • **Agreement of commissioning approach, including integrated contract for 2021/22.** • **Agreement of activity and resource shifts with providers.** • **Negotiation of integrated contract arrangements**	**Phase D - Delivery of IFS through integrated contract** • **Introduction of integrated contract arrangements.** • **Monitoring of outcomes and additional benefits predicted from integrated contract.** • **Implementation of longer term infrastructure requirements that are major capital projects e.g. estates reconfiguration.**	**Ongoing service delivery, evaluation, and optimisation.**	**Ongoing service delivery, evaluation, and optimisation.**

Plan on a page - Outpatients

Finance (tbc)	Activity (tbc)	Workforce (tbc)

Outcomes

- Redesign services to avoid up to a third of face-to-face outpatient visits
- Achieve interoperability of data and systems including digitising appointments and prescriptions
- Establish a digital NHS 'front door' through the NHS App will provide advice, check symptoms and connect people with healthcare professionals.

Key Metrics

- Reduce traditional F2F appts by 33% (18/19 baseline)
- All patients can book online or through an app
- Contain growth, releasing £15m savings to system
- Achieve peer median new:FU rates
- DNA rate reduced to 25% of 18/19 level
- Reduced the DNA rate gap between most & least deprived by 50%
- 100% of services using enhanced patient experience measures (e.g. F&F +/- PREMS)
- 50% of pathways using digital systematic PROM to design and deliver services

Delivery Plan and Milestones

Everybody requiring specialist input receives quality care, that meets the outcomes that matter to them in a way that makes best use of resources

- Traditional F2F OP are no longer the default option:
  - Clinicians are easily connected across the system, reducing the need for F2F attends – A&G, named link consultants
  - New technology solutions reduce the need for F2F appointments
  - Low value FUs are removed – remote monitoring of LTCs, FU protocols
- More people are managed locally in integrated community services:
  - New models of care trialled in urology and ophthalmology
  - Integrated community model becomes the default model of provision with named linked consultants
- Clinic resources are fully utilised:
  - Roll out on the day outcomes / test booking
  - Enable patient directed booking / re-scheduling
  - Technology driven appointment reminders

2019/20	2020/21	2021/22	2022/23	2023/24
• **Respiratory redesign through Elective Care Transformation Programme** • **Referral mgt 100% coverage** • **Finalise digital specification & procurement** • **25% specialties through Real-Time efficiency prog.** • **Linked consultants in at least 1 specialty**	• **Urology & ophthalmology models of care begin** • **MSK tests shared decision making** • **At least 1 service routinely capturing PROMS & PREMS** • **Increase non-F2F to 10%** • **At least 1 LTC service using PROMS to replace routine FU**	• **Roll-out wave 2 of integrated model of care** • **PIFU is 1st choice for all appropriate specialties** • **Communication solution rolled out (e.g. cons – GP)** • **25% services using PROMS to design services**	• **Implement online appt booking** • **75% specialties through Real-Time efficiency prog.** • **Embedding use of apps to manage LTC patients** • **Roll out wave 3 of integrated model of care**	• **Roll out wave 4 of integrated model of care** • **Waiting time standards achieved** • **50% services using PROMS & PREMS** • **33% shift of activity away from traditional F2F**

Plan on a page - Embedding Digital Practice

Finance (tbc)	Activity (tbc)	Workforce (tbc)

Outcomes

- Improve productivity of practitioners by enabling digital access to records wherever required
- Reduce unwarranted variation by using decision support and artificial intelligence (AI)
- Improve care planning for our population by using predictive techniques
- Improve efficiency and outcomes digitally capturing data once during care

Key Metrics

- Number/% of residents whose care record is accessible in muiltiple settings
- Number of digital outpatient appointments
- Number of remote e-consultations
- Number of e-prescriptions made
- Number of digital care plans
- % of people identified via electronic frailty index
- % of staff in the community with access to mobile devices and digital services
- Number of people with LD or autism who have a digital flag on their record
- Reduce average turnover from 14.1% to 12.1%

Delivery Plan and Milestones

- **Convergence of acute EPRs:** UHB (complete), Weston (by Sept 2020), NBT (Nov 2021)
- **Alignment of acute systems:** UHB (ongoing), Weston and NBT (2020-2023)
- **Children's Community Health Services EPR:** started and subject to funding will complete in 2021
- **Digitalisation of ICB:** subject to funding will complete in 2022
- **Real time image sharing:** building on existing systems and to link in with LHCR (2019-21)
- **System wide messaging system:** rollout of Careflow within and between organisations by 2023
- **System wide digital maternity service:** development and rollout between 2019 and 2021
- **System wide e-prescribing:** development and rollout between 2019 and 2023
- **Collaborative use of care plans:** explore as part of LHCR development by 2020
- **Remote collection of PROMS:** system wide rollout by 2020
- **Joint procurement strategy:** ensure new digital applications and systems support interoperability by 2021
- **System wide approach to e-consultations:** develop approach and systems across settings 2020-2022
- **System wide decision support tools:** develop plan and rollout across settings 2020-2024

2019/20	2020/21	2021/22	2022/23	2023/24
• **Collaborative use of care plans** • **Remote collection of PROMs**	• **Acute EPR convergence** • **Children's community health services EPR** • **Real time image sharing** • **System wide digital maternity service** • **Joint procurement strategy**	• **Digitalisation of ICB** • **System wide approach to e-consultations**	• **Acute systems aligned** • **System wide e-prescribing** • **System wide rollout of Careflow**	• **System wide decision support tools**

Plan on a page - Workforce

Finance (tbc)	Activity (tbc)	Workforce (tbc)

Outcomes

- Improve staff engagement
- Improve staff retention by 2%
- Improve on BME representation
- Increase the number of placements
- Reduced sickness absence
- Increased supply pipeline for registered nursing
- Effective integrated workforce models

Key Metrics

- Reduce average turnover from 14.1% to 12.1%
- Reduce average sickness from 4.5% to 3.5%
- Increase staff engagement scores by 5% over 5 years
- Increase % of staff recommending the NHS as a place to work
- Reduce agency costs – 30% by year 5
- Increased diversity (National targets for WRES & disability issued in 2019)
- 100% of apprenticeship levy spent by year 5
- 20% increase in placements

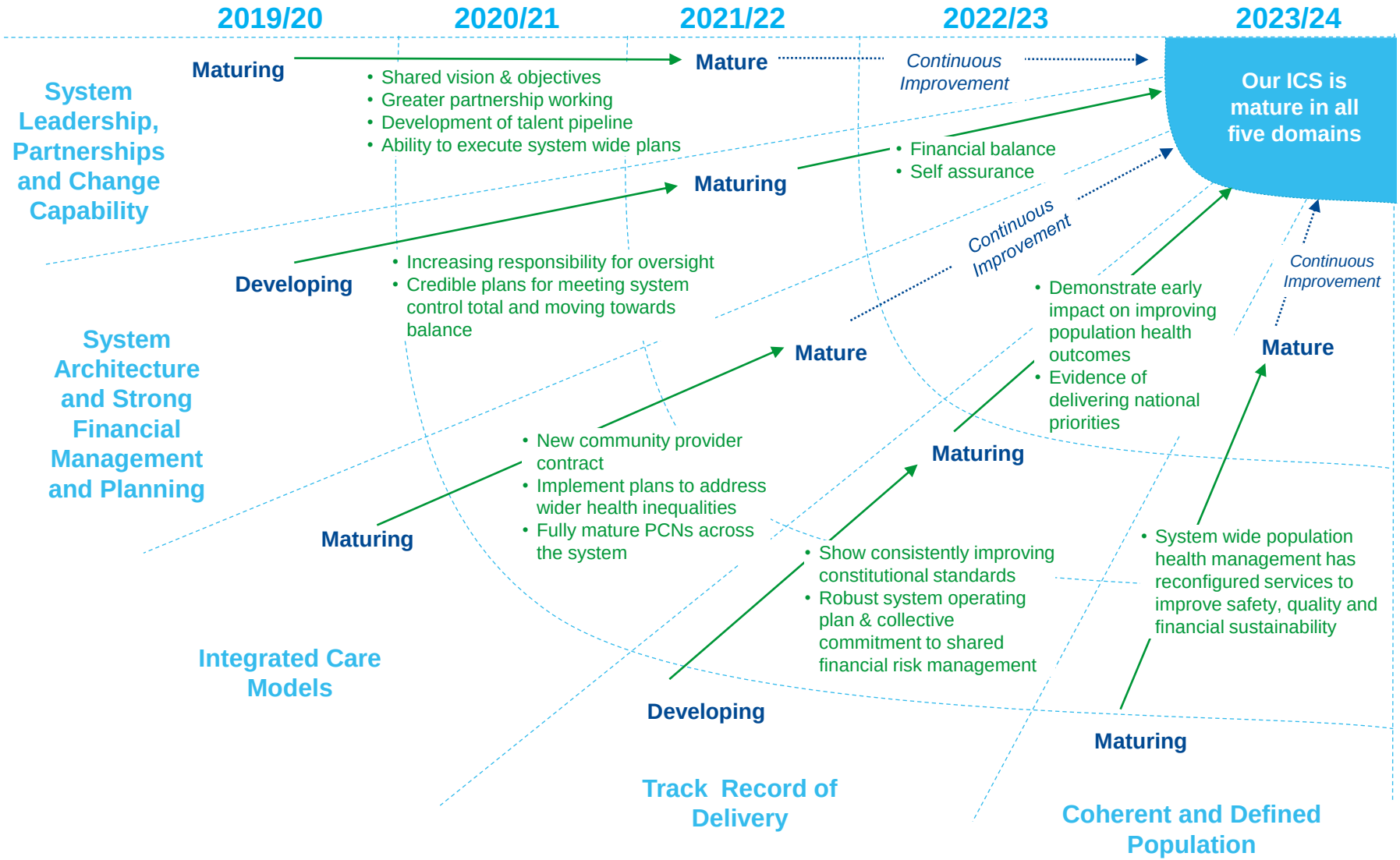
Delivery Plan and Milestones

- **Making the NHS the best place to work:** Improve the "BNSSG Offer", through innovative and flexible workforce models. Attract and retain staff through our pan BNSSG career pathways embedded into recruitment and appraisal, attracting a more diverse workforce through our work with schools.
- **Improving our leadership culture:** Deliver, evaluate and extend our System OD and leadership programme. Develop and maintain our talent pipeline with a focus on developing a diverse leadership pool for the future
- **Releasing time to care:** A single system wide bank and rostering system. Jointly procure a single learning management system to reduce duplication and support skills passporting.
- **Addressing Urgent Workforce Shortages**: Maximise our workforce supply through increased placements, a common approach to return to practice, and work together to address nurse vacancies as a system.
- **Delivering 21st century care - workforce redesign and optimising skills**: BNSSG Learning Academy delivering an integrated learning approach for staff, with cross system, high quality learning placements at undergraduate and postgraduate level. Workforce development for PCNs developing and facilitating peer groups networks, and a voluntary workforce model across community and primary care. Supporting PCNs through sharing apprenticeship levy .

2019/20	2020/21	2021/22	2022/23	2023/24
• **Learning Academy to deliver consistent approach to optimising skills** • **Apprenticeship strategy and levy sharing** • **System OD programme** • **Primary care nurse preceptorships** • **Action Learning Sets for PCN roles - Social prescribers, Paramedics, Pharmacists and Nurses**	• **Improve the BNSSG Offer for staff in health and care, embedded career framework** • **A BNSSG voluntary staffing protocol tested in community and localities** • **Registered nurse strategy**	• **A common bank across community and primary care** • **A single learning record, passporting skills across providers** • **Jointly procure a single learning management system**	• **Tiered occupational health and well being support for staff** • **New roles emerging from training eg nursing associate, advanced clinical practitioner, physicians associate, primary care paramedic.**	• **A single bank and rostering system across BNSSG** • **Develop recognition scheme across STP to recognise and reward positive, compassionate and improvement focused leadership** • **Pan BNSSG talent schemes promoting diversity**

6. BNSSG's path to maturing as an Integrated Care System (ICS)

BNSSG is on the path to be an ICS by 2021



How we want to work together

Rather than working as separate organisations with individual priorities, we know as commissioners and health and care providers that we need to work as a single system to deliver significant transformation.

The most important opportunities for improvement in the health and wellbeing of our population exist across traditional organisational boundaries, in how services within different organisations work together.

We will only be able to exploit these opportunities if we work together as a partnership with a clear vision for the local system and trusting relationships.

Principles for joint working

- Our partnership has already agreed a set of principles for how we want to work together in future, including: providing collective leadership for the system, developing a vision we all share for system transformation, working together and with service users to redesign services, using our workforce more flexibly, sharing information and sharing risk.

Our Partnership Board

- We have established a Partnership Board which brings together the key leaders in our system representing their individual organisations. The Partnership Board is responsible for setting strategic direction. It provides oversight for all system and a forum to make decisions together as Partners which are related to the progress of the Partnership. Healthwatch are also represented on the Partnership Board.

Local authority and health services

- Representatives from our local authorities sit on our Partnership Board and play an active role in decision-making. However, we believe that there are opportunities we have not yet exploited for closer joint working at a strategic level as well as in the design and operation of services.
- We are using the development of our plan to explore these opportunities, for example how we can integrate care at a place level.

Delivery workstreams

- Senior leaders from our CCG and providers are overseeing a number of workstreams through five steering groups which bring together staff from across our system to deliver aspects of the plan. These include workstreams to improve population health and wellbeing, develop our new community model, develop how our hospital services work together, and develop our shared workforce, digital technology, estates and other infrastructure.

Collective decision-making

- We are developing our arrangements for joint decision-making for the entire system through our partnership board and steering groups for workstreams. Our current model is to seek consensus wherever possible for decisions affecting the whole system. As we refine our plan, the principles and priorities in it should provide a framework for joint decision-making.

One system with one budget

- Our objective is to move increasingly to a system where we have a single budget, staff and other resources that we deploy as flexibly as possible and one dashboard to tell us if we are heading in the right direction. We are developing our thinking on how we will make decisions on resource allocation, using savings and managing overspends.

Role of the commissioner

- The role of the CCG is changing rapidly and we need to formalise the new arrangements. For example the CCG is now using it's resource to bring together our shared vision and acting as a convenor and consensus builder in a complex system.

Aligning funding to the future state

- We are considering the changes we need to make to payments and contracting so that we can work as a single system. We need to address features of our payment system and to the nature of our contracts that prevent services working flexibly together to exploit improvement opportunities.

7. Planning Assumptions

Long Term Plan Financial Expectations

('Taxpayers' investment will be used to maximum effect')

This means meeting five tests:

1. The NHS (including providers) will return to financial balance;
    - All NHS organisations are in balance by 2023/24
    - Changes to payment arrangements, such as the update to the Market Forces Formula, and reforming the payment system
    - 2019/20 will be a transitional year, with one-year, rebased control totals
    - Further financial reforms after 2019/20 – new ICS accountability performance framework to assess financial performance and a new Financial Recovery Fund and 'turnaround' process, so that on a phased basis over the next five years not only the NHS as a whole, but also the trust sector, local systems and individual organisations progressively return to financial balance.
2. The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care.
3. The NHS will reduce the growth in demand for care through better integration and prevention;
4. The NHS will reduce variation across the health system;
5. The NHS will make better use of capital investment and its existing assets to drive transformation.

Financial principles agreed by DoFs to support development of the LTP

1. We will act in the best interests of our patients and population; and will create financial flows and incentives to promote this
2. Our decisions will be based on the costs and benefits at a system level; and we will resolve the impact of that for organisations
3. We will maximise new resources into our system
4. We will minimise the flow of resources out of our system
5. We will cease activities that shift only financial problems between organisations within the system
6. We will minimise the cost of growth and other new activities
7. We will commit system resources to our highest system priorities (funding, people etc…)
8. We will be open and transparent regarding our financial risk & opportunities
9. The system will review and agree the growth levels across the system
10. We will strive to be the best finance function to support our system priorities

Financial planning parameters agreed by DoFs and signed off by Executive Group to support planning

Area	Parameters
Financial Recovery Funding/ sustainability funding	£51,092k in 2019/20. National guidance about the future of this funding is still in development. There remains a recurrent allocation of £2bn throughout the period. Currently the system requires £33m to deliver a balanced plan.
Specialist Commissioning	This is assumed to be in line with the letters sent by Geoff Shone, Regional Director of Finance NHS England Direct Commissioning. Reconciliation of these letters back to the national allocation table generates a £132m investment fund for specialised services which is currently still being held at a national level for new drugs, devices and procedures. Further update anticipated.
Capital	No assumptions made to date, this will clearly be a dependency and further guidance is expected soon, this will be an area for further work to be completed by steering groups during stage 3.
Training	No specific assumptions made.
Debt Repayment	Assumed none required within the period.
Delegated Commissioning	As per separate allocation.
Mental Health	Growth assumed as per mental health investment standard.
Primary and Community (Including CHC)	Growth as per primary and community investment standard.
Contingency	0.5% as per current business rules and a further 1% to deliver CCG surplus as required.
Invest to save resource	0.5% set aside to fund transformation at a system level that may not be covered by a specific allocation where the payback may take more than one year.
Baseline position	This is based on information provided by each of the NHS regulated providers and the CCG. This gives the system an opening deficit position of £79.6m. Further in year risk is emerging which could deteriorate this position to £100m deficit. The model assumes other providers are in recurrent balance.
Acute Growth	Assumed to reduce by 50% from recent historic levels of growth which has been 3.5%(with a higher level of growth in urgent care offset by planned care). This takes it to 1.75%, roughly 0.5% above population growth.

Workforce Planning

- We have agreed some consistent planning assumptions with regard to activity growth:
  - For acute NHS providers, activity growth would have been 3.5% in a “do nothing” scenario, to be reduced to 1.75%
  - Mental health workforce demand is expected to increase in line with the Mental Health Investment Standard
  - Primary and community activity is expected to increase to 3.6% and 3.2% respectively
- We have a robust 5 year workforce programme, to deliver on the Interim NHS People Plan requirements, agreed at our Workforce Transformation Steering Board, which will deliver significant reductions in turnover, sickness and nurse agency, and these have been built into our workforce planning assumptions
- Our workforce plan also assumes workforce redesign including, nursing associates, advanced clinical practitioners, social prescribers and physicians associates
- Our internal workforce modelling indicates that our workforce programme will have a significant impact on supply and that we will successfully increase the size of our workforce over the next five years
- However, it is likely that there will continue to be a gap between workforce supply and demand in some areas unless we have a more radical reduction in demand, combined with models of care which use far fewer registered nurses and other shortage professions

8. Rebalancing resources to achieve financial sustainability

Progress to date on achieving financial sustainability

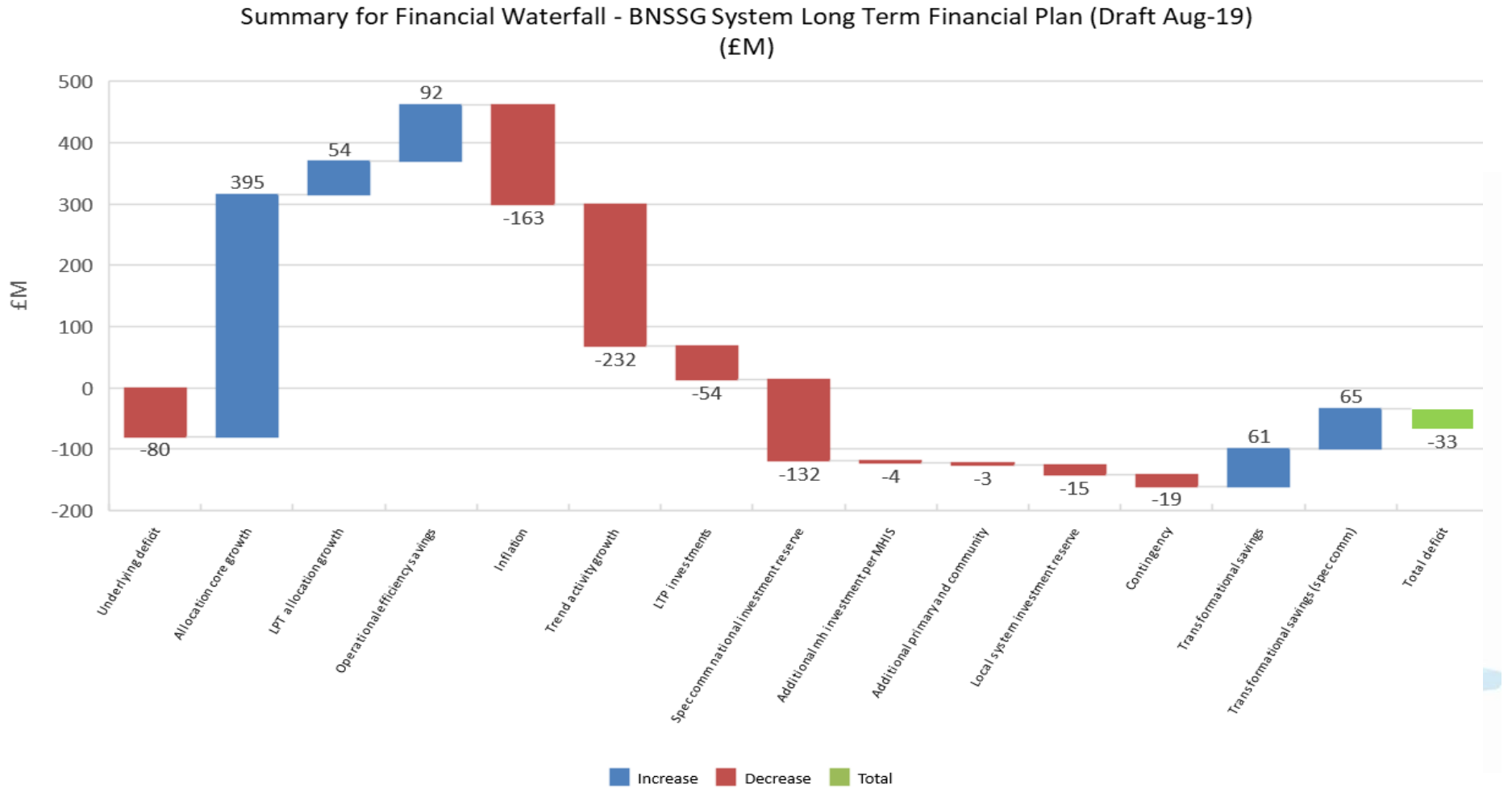
- Good progress has been made in developing the financial plans that underpin the LTP response
- The plans currently reduce the deficit by 50% by the end of the period

Work still to be completed:

- Deep dive review of provider efficiency plans
- Ensure more clarity on transformation resources available to support delivery
- Ensure the steering group plans are specific and quantified to give confidence of delivery
- Further work on alignment, particularly between CCG and NBT and all providers with specialist commissioning
- Contract options to align incentives to deliver the plan
- Capital requirements to deliver the revised models of care need to be developed

We are developing plans to reduce the BNSSG system deficit to £33m by the end of 2023/24

Summary planning assumptions



Financial Assumptions

- Requires adjustment for in year cost pressures
- Assumes residual deficit will be covered by provider support (FRF)
- Assumes additional activity will be provided at tariff cost
- Further discussion required around utilisation of Spec Comm indicative national reserve
- Contingency includes requirement for CCG to make 1% surplus
- Additional costs not reflected above will increase the transformational savings requirement

Summary for Financial Waterfall - BNSSG System Long Term Financial Plan (Draft August 2019)	£m
Underlying deficit	-80
Allocation core growth	395
LPT allocation growth	54
Operational efficiency savings	92
Inflation	-163
Trend activity growth	-232
LTP investments	-54
Spec comm national investment reserve	-132
Additional mh investment per MHIS	-4
Additional primary and community	-3
Local system investment reserve	-15
Contingency	-19
Transformational savings	61
Transformational savings (spec comm)	65
Total deficit	-33

Recovery Trajectories

	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m
CCG	-12	-16.7	-6.6	3.4	11.3
AWP	-2.8	-5.9	-5.8	-5.5	-5.2
NBT	-29.9	-31.4	-25.1	-21.3	-19.4
Weston	-16.8	-23.0	-25.3	-26.8	-28.4
UHBT	2.6	7.0	7.6	7.8	8.0
System	-58.9	-69.9	-55.2	-42.4	-33.7
System Target	To be advised by Regional NHS E/I				
Current gap					

Issues to be resolved

- Availability of the workforce
- Ability to deliver the national efficiency requirement plus the 0.5% stretch in Weston due to the unsustainability of the organisations in a stand alone capacity.
- Understanding of how we will deliver the affordable level of acute growth between all organisations (Current misalignment of £23m)
- Lack of information about availability of transformation funding for BNSSG
- Specialist commissioning misalignment
- Consistency of approach to 19/20 financial risks

Mitigations

- Detailed review of the bottom up planning between organisations
- Stage 3 work with steering groups to quantify system plans could remove strategic misalignment with NBT, further discussions to be held prior to interim submission
- Merger of Weston Area Health Trust with UHBristol NHS Foundation Trust
- Application of Financial Recovery Funding
- National transformation funds
- Further work with specialist commissioning to integrate plans into the work of the steering groups
- Further review of the workforce plans to test deliverability

Financial History of BNSSG

	16/17 Outturn £m	17/18 Outturn £m	18/19 Outturn £m	19/20 Plan £m
UHBT	2.9	0.9	4.5	2.6
NBT	(43.9)	(32.0)	(34.4)	(30.4)
Weston	(8.9)	(14.6)	(17.5)	(13.1)
AWP (55%)	(5.1)	(5.7)	(2.1)	(2.8)
CCG	(37.8)	(35.0)	(10.0)	(12.0)
System deficit	**(92.8)**	**(86.4)**	**(59.5)**	**(55.7)**
Savings delivered	**76.0**	**101.0**	**89.1**	**93.7**

Structural deficit issues

The previous page shows how the system has improved the financial position over the last 4 years. BNSSG is now trying to address the structural deficit issues of >£65m. These are by their nature harder to address and take a longer timeframe. Changes set out in the BNSSG Long Term Plan should reduce this deficit significantly by 2023/24.

Some of the key drivers of this structural deficit are:

- PFI & LIFTCo cost premium above NHS cost of capital
  - Southmead £20m excess costs split between NBT and CCG
  - South Bristol Community Hospital £4.5m funded by CCG
  - AWP £3m
- Sub- scale DGH subject to public consultation drives deficit in excess of £15m – split between Weston and CCG
- Long term workforce challenges – Weston (recruitment and retention challenges due to continued service uncertainty) and AWP (supply of Registered Mental Health Nurses)
- Strong AQP market locally – drives very low waiting times for certain procedures. Benchmark above average for independent market spend and waiting list numbers have reduced during 18/19.
- CCG 2.04% under target allocation £25m in 19/20; 1.42% under target £21m by 23/24
- Presence of 2 tertiary providers drives increased cost of DGH services

Opportunities to reduce growing pressures on hospital services

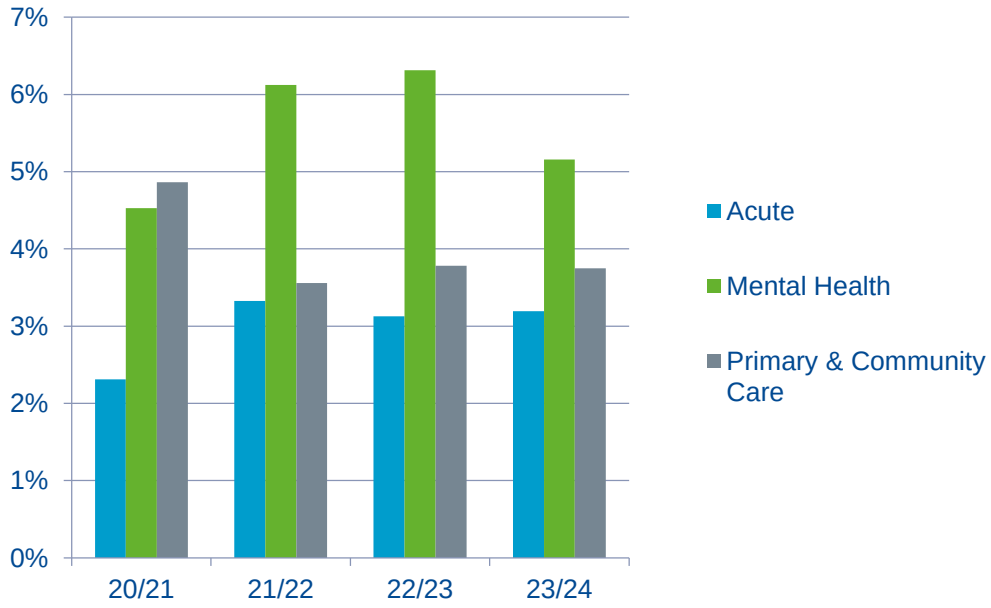
We have identified a total opportunity of £55million over the next five years by improving health and care in these areas. This has been broken down and allocated to our key system steering groups.

Growth Reduction Targets for period to Mar 2024	Steering group	Do nothing growth (£000s)	Rightcare opportunity (£000s)	BNSSG LTP Target (£000s)	What does this mean?
Cancers & Tumours	ACC	£609	£4,690		
Circulation Problems	ACC	£4,226	£3,685	£3,685	Hold acute growth to 0.5% per year
Endocrine, Nutritional and Metabolic Problems	ICSG	£647	£820		
Frailty	ICSG	£13,909		£10,000	Hold acute growth to 1% per year
Gastro Intestinal System Problems		£5,259	£3,403		
Genito Urinary System Disorders		£5,505	£1,712		
Neurological System Problems		£1,730	£3,722		
Respiratory System Problems	ICSG	£2,556	£4,936	£2,556	No growth in acute activity
Trauma And Orthopaedics	ACC	£11,335	£8,242	£8,577	Hold acute growth to 1% per year
SDEC in the community	ISCG	£18,899		£10,000	Reduce acute growth in non -elective admissions by 50% to include rightcare opportunities in neuro and Genito urinary system disorders
MH	MH			£5,000	Up to £1.8m potential opportunity in ED attendances relating to people who are experiencing mental ill health. See separate worksheet.
Outpatients	ACC			£15,000	Reduce 30% outpatients using digital solutions and specialist advice to integrated localities
		£64,676		**£54,818**	

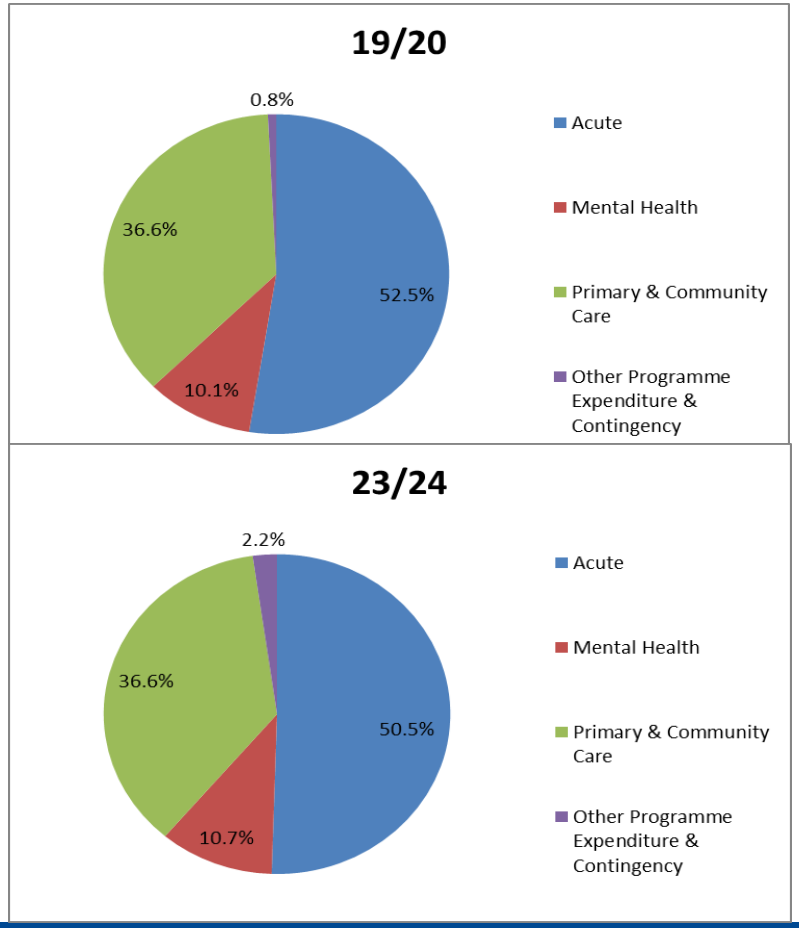
Increasing capacity in Primary and Community Care and Mental Health

BNSSG will increase investment in Primary & Community Care and Mental Health each year to support improvements in population health and to reduce growing pressures on hospital services

Boosting investment in out of hospital care each year



Reducing growth in acute care



Healthier Together

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

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Appendices

1. Gap Analysis of Programme Level Five Year Plans
2. Financial Plan by Partner (NHS Organisations only)
3. Progress against LTP Metrics
4. Example of Locality Insights

Healthier Together

Appendix 1 – Gap Analysis of Programme Level Five Year Plans

Following Stage 2 of the process the Healthier Together team completed a review of the submissions and provided feedback to Steering Groups and their Programmes . The following slides present an overarching, point in time, RAG rated summary of progress against the different aspects of the programme plans submissions.

Summary of Programme Plan Status

LTP Submission 2 Completion Checklist - 19th September 2019

	Integrated Care									
	Overarching- Intergrated Localities (Sirona)	Diabetes	EOLC	Frailty	Locality Model of Care B(NW)	Locality Model of Care B(South)	Locality Model of Care B(ICE)	Locality Model of Care (Sglos)	Locality Model of Care (W+W)	Locality Model of Care Woodspring
Template received?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Template Completion										
Outcomes *people, clinical outcomes, population level outcomes*	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Incomplete	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed
Measuring Success *Key indicators*	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed
Context and case for change *why doing?*	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed
Developing Plans: Linking Outcomes and Interventions *How going to do it?*	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed
Key Deliverables Timescales	Incomplete	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed
Impacts on Activity, Finance and Workforce spreadsheet completion	Incomplete	Complete - Further clarif needed	Incomplete	Complete - Further clarif needed	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete
Resourcing	Incomplete	Complete - Further clarif needed	Complete - No Concerns	Incomplete	Complete - No Concerns	Incomplete	Complete - Further clarif needed	Incomplete	Incomplete	Incomplete
Opportunities for co-production/co-design inc engagement	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete
Risks and Issues spreadsheet completion	Incomplete	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Incomplete	Incomplete	Incomplete	Complete - Further clarif needed	Complete - Further clarif needed

Summary of Programme Plan Status

LTP Submission 2 Completion Checklist - 19th September 2019

	Integrated Care				Acute Care Collaborative				
	SDUC	**Primary Care Networks**	**Prevention**	**Respiratory**	**MSK**	**Short Waits for Planned Care**	**Stroke (Acute & Rehab Services)**	**Cancer**	**CVD**
Template received?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Template Completion									In development
Outcomes *people, clinical outcomes, population level outcomes*	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	
Measuring Success *Key indicators*	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	
Context and case for change *why doing?*	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	
Developing Plans: Linking Outcomes and Interventions *How going to do it?*	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	
Key Deliverables Timescales	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	
Impacts on Activity, Finance and Workforce spreadsheet completion	Complete - Further clarif needed	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	
Resourcing	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	
Opportunities for co-production/co-design inc engagement	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	
Risks and Issues spreadsheet completion	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	

Summary of Programme Plan Status

LTP Submission 2 Completion Checklist - 19th September 2019

	Acute Care Collaborative				Urgent Care	Workforce	Digital			
	Meds Opt	**Meds Opt Antimicrobial Resistance**	**Outpatients**	**Ophthalmology**	**UEC**	**Workforce**	**Embedding Digital Practice**	**Patient Facing Digital**	**Population Health**	**Shared Care Records**
Template received?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Template Completion			In development							
Outcomes *people, clinical outcomes, population level outcomes*	Complete - No Concerns	Complete - Further clarif needed		Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns
Measuring Success *Key indicators*	Complete - No Concerns	Complete - No Concerns		Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns
Context and case for change *why doing?*	Complete - No Concerns	Complete - Further clarif needed		Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed
Developing Plans: Linking Outcomes and Interventions *How going to do it?*	Complete - No Concerns	Complete - No Concerns		Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed
Key Deliverables Timescales	Complete - Further clarif needed	Complete - Further clarif needed		Complete - Further clarif needed	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Incomplete
Impacts on Activity, Finance and Workforce spreadsheet completion	Complete - Further clarif needed	Incomplete		Incomplete	Incomplete	n/a	n/a	n/a	n/a	n/a
Resourcing	Complete - Further clarif needed	Complete - Further clarif needed		Complete - Further clarif needed	Incomplete	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns
Opportunities for co-production/co-design inc engagement	Complete - Further clarif needed	Complete - No Concerns		Complete - Further clarif needed	Incomplete	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns
Risks and Issues spreadsheet completion	Complete - No Concerns	Complete - Further clarif needed		Complete - Further clarif needed	Incomplete	Complete - No Concerns	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed

Summary of Programme Plan Status

LTP Submission 2 Completion Checklist - 19th September 2019

	Childrens & Families		Mental Health	
	Childrens & Families	**Maternity**	**Mental Health**	**LD and Autism**
Template received?	Yes	Yes	Yes	Yes
Template Completion				
Outcomes *people, clinical outcomes, population level outcomes*	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns
Measuring Success *Key indicators*	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns
Context and case for change *why doing?*	Complete - Further clarif needed	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed
Developing Plans: Linking Outcomes and Interventions *How going to do it?*	Complete - Further clarif needed	Complete - No Concerns	Complete - Further clarif needed	Complete - Further clarif needed
Key Deliverables Timescales	Complete - Further clarif needed	Complete - Further clarif needed	Complete - Further clarif needed	Incomplete
Impacts on Activity, Finance and Workforce spreadsheet completion	Incomplete	Incomplete	Incomplete	Incomplete
Resourcing	Incomplete	Complete - No Concerns	Complete - Further clarif needed	Complete - No Concerns
Opportunities for co-production/co-design inc engagement	Incomplete	Complete - No Concerns	Complete - No Concerns	Incomplete
Risks and Issues spreadsheet completion	Incomplete	Complete - No Concerns	Complete - No Concerns	Complete - Further clarif needed

Appendix 2 – Financial Plan by Partner (NHS Organisations only)

BNSSG CCG

BNSSG CCG is planning to achieve a surplus by 2022/23 and to hold a 0.5% contingency. Key planning assumptions include achievement of £5m prescribing savings from 2020/21 to offset historic NCSO cost and £55m of Acute activity growth being mitigated through transformation

		Plan	Forecast Outturn	Plan	Plan	Plan	Plan
	Units	2019/20	2019/20	2020/21	2021/22	2022/23	2023/24
Commissioner Summary							
Commissioner Allocations	£000s	1,396,688	1,396,688	1,454,935	1,499,129	1,561,471	1,623,537
Commissioner Expenditure	£000s	(1,408,688)	(1,408,688)	(1,471,557)	(1,505,822)	(1,558,061)	(1,612,234)
Underspend / (Deficit) excluding CSF	**£000s**	(12,000)	(12,000)	(16,622)	(6,693)	3,410	11,303

UH Bristol NHS Foundation Trust

UHBT shows delivery of financial surplus in each year of plan. Workforce growth and CCG income growth broadly in line with system planning assumptions . Higher specialised income growth assumed. Average annual provider efficiency assumptions of circa 2%

		Plan	Forecast Outturn	Plan		Plan	Plan
	Units	2019/20	2019/20	2020/21	2021/22	2022/23	2023/24
Provider Summary							
Provider Income	£000s	722,991	726,336	740,955	759,032	783,109	805,232
Provider Expenditure	£000s	(710,176)	(712,812)	(733,292)	(750,782)	(774,626)	(796,516)
Provider Surplus / (Deficit) excludir	**£000s**	2,593	2,593	7,018	7,603	7,837	8,035
Total Provider Workforce	WTEs	8,959	8,896	9,067	9,232	9,426	9,519

North Bristol NHS Trust

NBT shows an improvement in the financial position during from 2021/22 onwards but this is based on a level of growth in activity and income that is higher than the system and CCG assumptions. It also includes provider efficiency of 4% per year

		Plan	Forecast Outturn	Plan		Plan	Plan
	Units	2019/20	2019/20	2020/21	2021/22	2022/23	2023/24
Provider Summary							
Provider Income	£000s	636,555	636,554	639,229	665,047	690,299	717,367
Provider Expenditure	£000s	(641,474)	(641,473)	(670,596)	(690,126)	(711,655)	(736,742)
Provider Surplus / (Deficit) excludir	**£000s**	(29,886)	(29,886)	(31,367)	(25,079)	(21,356)	(19,375)
Provider Surplus / (Deficit) includin	**£000s**	(4,919)	(4,919)	(31,367)	(25,079)	(21,356)	(19,375)
Total Provider Workforce	WTEs	8,134	8,134	8,251	8,357	8,470	8,599

Avon and Wiltshire Partnership NHS Trust

AWP position shows a deterioration of the financial position in 2020/21 – figures reflect 55% of Trust total which is the BNSSG system share. Income assumption for BNSSG assumes % share of LPT transformation funding

		Plan	Forecast Outturn	Plan		Plan	Plan
	Units	2019/20	2019/20	2020/21	2021/22	2022/23	2023/24
Provider Summary							
Provider Income	£000s	131,292	133,702	134,519	139,580	145,356	150,119
Provider Expenditure	£000s	(131,292)	(133,702)	(140,459)	(145,330)	(150,818)	(155,324)
Provider Surplus / (Deficit) excludir	**£000s**	(2,764)	(2,764)	(5,940)	(5,750)	(5,462)	(5,205)
Provider Surplus / (Deficit) includin	**£000s**	-	-	(5,940)	(5,750)	(5,462)	(5,205)
Total Provider Workforce	WTEs	2,269	2,312	2,356	2,390	2,448	2,481

Weston Area Health Trust

Weston submission shows a deterioration in financial position. .

		Plan	Forecast Outturn	Plan		Plan	Plan
	Units	2019/20	2019/20	2020/21	2021/22	2022/23	2023/24
Provider Summary							
Provider Income	£000s	113,536	111,936	97,050	99,080	100,857	102,686
Provider Expenditure	£000s	(122,076)	(124,086)	(120,037)	(124,340)	(127,697)	(131,105)
Provider Surplus / (Deficit) excludir	**£000s**	(13,140)	(16,750)	(22,987)	(25,260)	(26,840)	(28,419)
Provider Surplus / (Deficit) includin	**£000s**	(8,540)	(12,150)	(22,987)	(25,260)	(26,840)	(28,419)
Total Provider Workforce	WTEs	1,665	1,665	1,606	1,611	1,621	1,633

Appendix 3: Progress against LTP Metrics

Appendix

Long Term Plan Metrics - Local Status Stocktake as at Friday 27th September

Tab / Organisation	Healthier Together Programme	ID	Measure	Local assessment of position against national ambition
Cancer Alliance	Acute Care Collaboration	E.P.1	One Year Survival from Cancer	Plans received from Cancer Alliance
Cancer Alliance	Acute Care Collaboration	E.P.2	Proportion of cancers diagnosed at stages 1 or 2	Plans received from Cancer Alliance meet national expectation Dependancy on diagnostics not aligned with system plans
System	Acute Care Collaboration	E.S.1	Proportion of patients directly admitted to a stroke unit within 4 hours of clock start	Achieves the national ambition a year late due to depenancy on service reconfiguration
System	Acute Care Collaboration	E.S.2	Percentage of applicable patients who are assessed at 6 months	Achieves the national ambition a year late due to depenancy on service reconfiguration
LMS	Children and Families	E.Q.1	Stillbirth rate	Plan meets the national ambition
LMS	Children and Families	E.Q.2	Neonatal mortality rate	Plan meets the national ambition
LMS	Children and Families	E.Q.3	Percentage of women placed on a continuity of care pathway at booking appointment	Plan meets the national ambition
System	Children and Families	E.Q.4	Brain Injury Rate	Plan meets the national ambition
CCG	Digital	E.D.16	Proportion of the population with access to online consultations	Plan meets the national ambition
CCG	Digital	E.D.20	Citizen facing tools: Proportion of the population registered to use NHSApp	Plan meets the national ambition
CCG	Digital	E.D.21	Cyber Security	Plan meets the national ambition
Provider	Digital	E.D.21	Cyber Security	Plan meets the national ambition
NBT/UHB/ Weston	Urgent Care	E.M.25	Length of stay for patients in hospital for over 21 days	Meet national ambition a year late & seek to continually improve

System	Integrated care	E.M.24	Delayed Transfers of Care	Meet national ambition a year late & maintain for last 2 years
CCG	Integrated care	E.N.1	Personal Health Budgets	Significant imrpovement planned but finishes the period still some way off national share
CCG	Integrated Care	E.N.2	Social Prescribing Referrals	Plan meets the national ambition
System	Integrated care	E.N.3	Personalised Care and Support Planning	Plan meets the national ambition
System	Integrated care	E.R.1	Number of people supported through the NHS Diabetes Prevention programme	Explicit national ambition unclear, cautious view on that basis
System	Mental Health	E.A.3	IAPT roll-out	New contract delivers improvement to year 3, but without having been tested, contractual discussion & possible investment can not plan year 4 & 5 improvement
System	Mental Health	E.H.13	People with severe mental illness receiving a full annual physical health check and follow up interventions	Primary Care & Mental Health Strategies underpin delivery. Numbers to be worked through.
System	Mental Health	E.H.17	Number of people accessing Individual Placement and Support (IPS)	One contract reflected in numbers so far. Other provider to be added & future plans in discussion.
System	Mental Health	E.H.19	Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illness	Awaiting national pilot findings. No local plans yet being formed.
CCG	Mental Health	E.H.9	Improve access to Children and Young People's Mental Health Services (CYPMH)	Service invested in in 19/20, impact to be tested. Potential to address via consolidation of service across BNSSG.
CCG	Mental Health	E.H.15	Perinatal Mental Health: Number of women accessing specialist perinatal mental health service	Reviewing current contract delivery. Seeking further progress during phase 3.
CCG	Mental Health	E.H.18	EIP Services achieving Level 3 NICE concordance	Seeking to develop plan in phase 3

CCG	Mental Health	E.H.20	Coverage of 24/7 crisis provision for children and young people (CYP) that combine crisis assessment, brief response and intensive home treatment functions. Key: Fully comprehensive service: 1 Partially comprehensive service: 0.5 No comprehensive service: 0 No data available: -	Partial geographic coverage in Br & SG, no service in Weston. Partial coverage of technical service requirements.
CCG	Mental Health	E.K.1a	Reliance on inpatient care for people with a learning disability and/or autism - adults - CCG Commissioned	Plan meets the national ambition.
CCG	Mental Health	E.K.1b	Reliance on inpatient care for people with a learning disability and/or autism - adults - Spec Com commissioned	Plan meets the national ambition.
CCG	Mental Health	E.K.3	Learning Disability Registers and Annual Health Checks delivered by GPs	Seeking to develop plan in phase 3
AWP	Mental Health	E.H.12	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Plan meets the national ambition.
NBT/UHB/ Weston	Mental Health	E.H.16	Mental Health Liaison services within general hospitals meeting the “core 24” service standard	Seeking to develop plan in phase 3
TCP	Mental Health	E.K.1c	Reliance on inpatient care for people with a learning disability and/or autism - for both care commissioned by CCGs and NHS England for children	Plan meets the national ambition.
Not applicable	Urgent Care	E.M.23	Ambulance Conveyance to ED	

Key

- Plan meets national ambition
- Risks to achieving national ambition or development of plans still in progress
- Plans do not meet national ambition

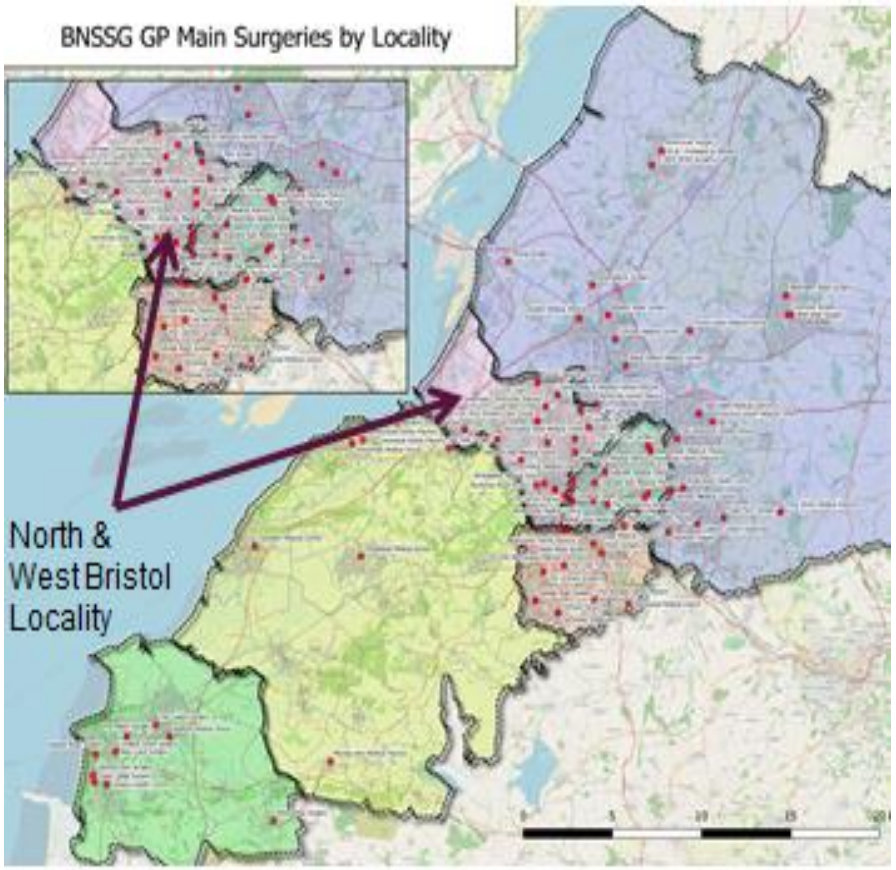
Appendix 4: Example of a Locality's insights into it's population

North & West BRISTOL

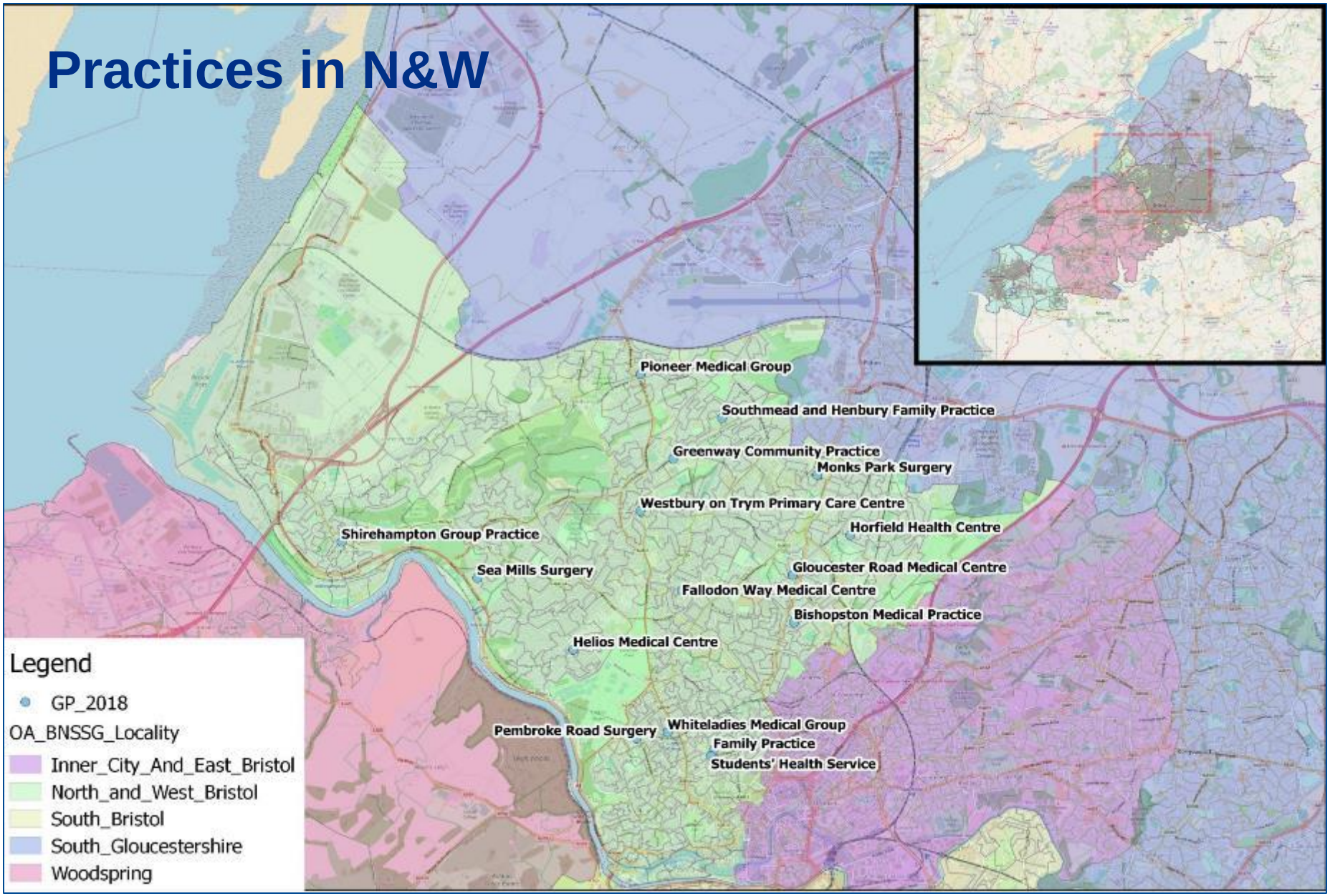
Part 1:
Locality Introduction and Informatics

North & West Bristol Locality

- 195,245 patient population
- 15 (16) GP Practices
- 4 Primary Care Networks

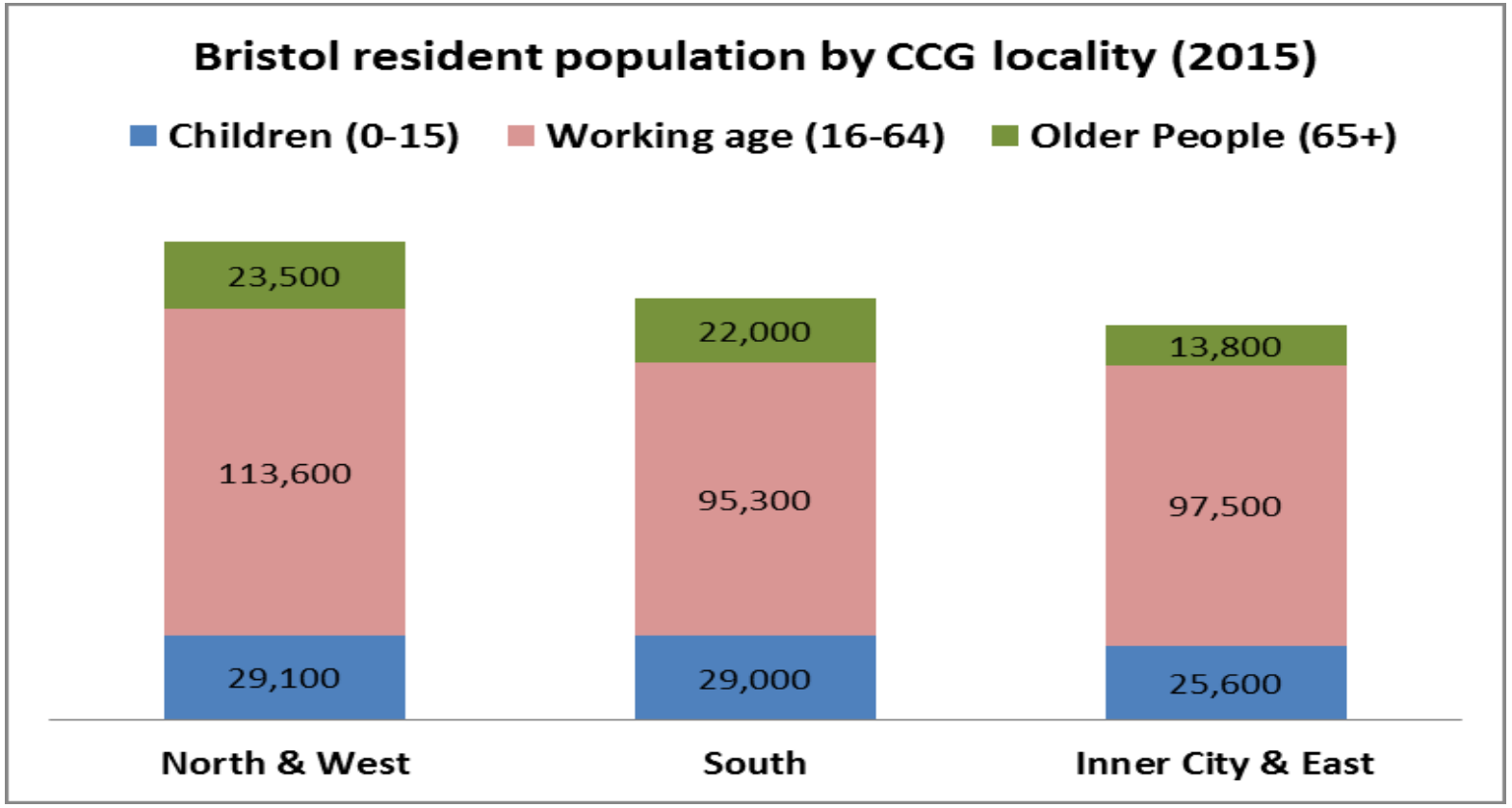


Practices in N&W



North & West (N&W) locality has four clusters which together serve approximately 195,000 people – this is the largest, by population, of the three Bristol localities. There are 16 GP practices that provide primary care for people in Lockleaze,Southmead, Henbury, Lawrence Weston, Avonmouth, Horfield, Henleaze, Bishopston, Stoke Bishop, Clifton and Redland. This locality covers some of the least deprived parts of Bristol, but also some of the most deprived.

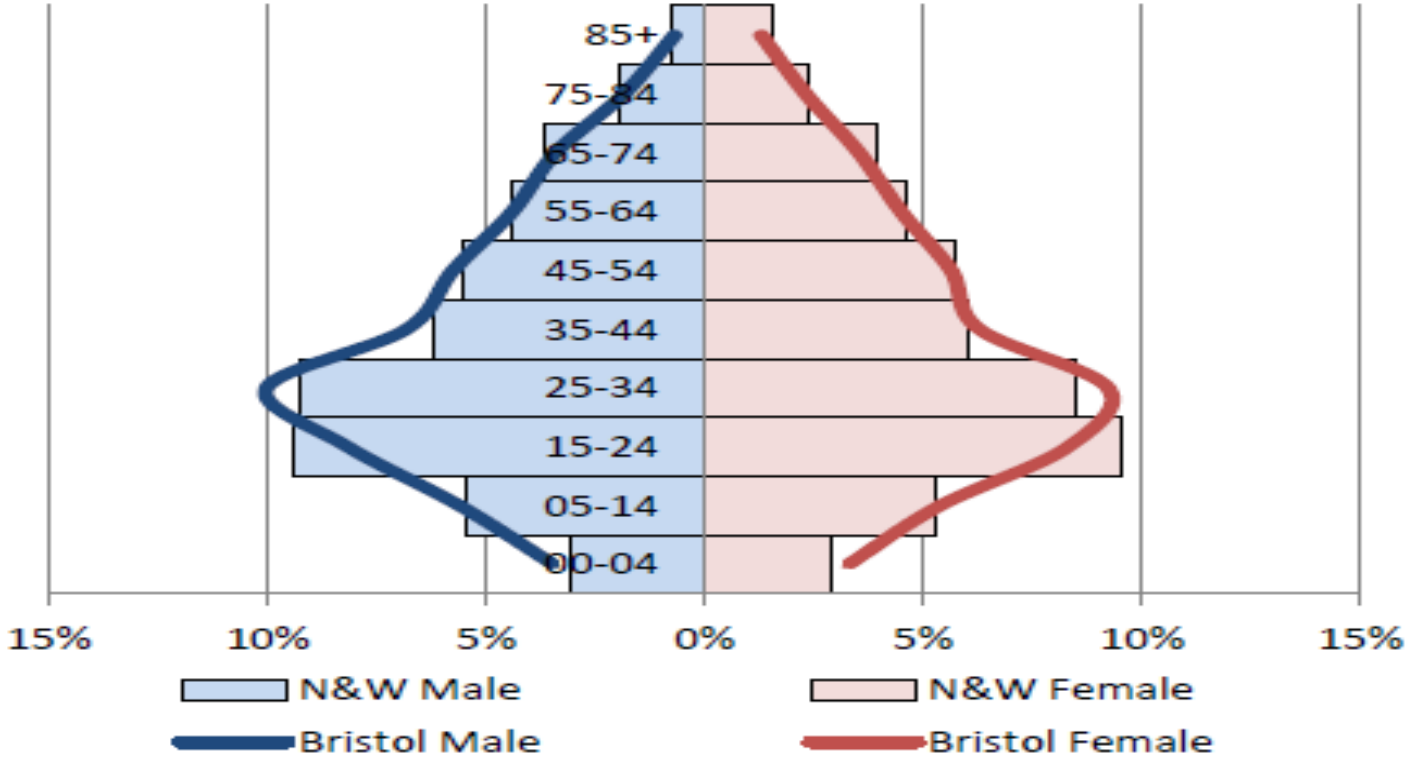
Demographics - comparative



Source: JSNA Bristol 2016-17

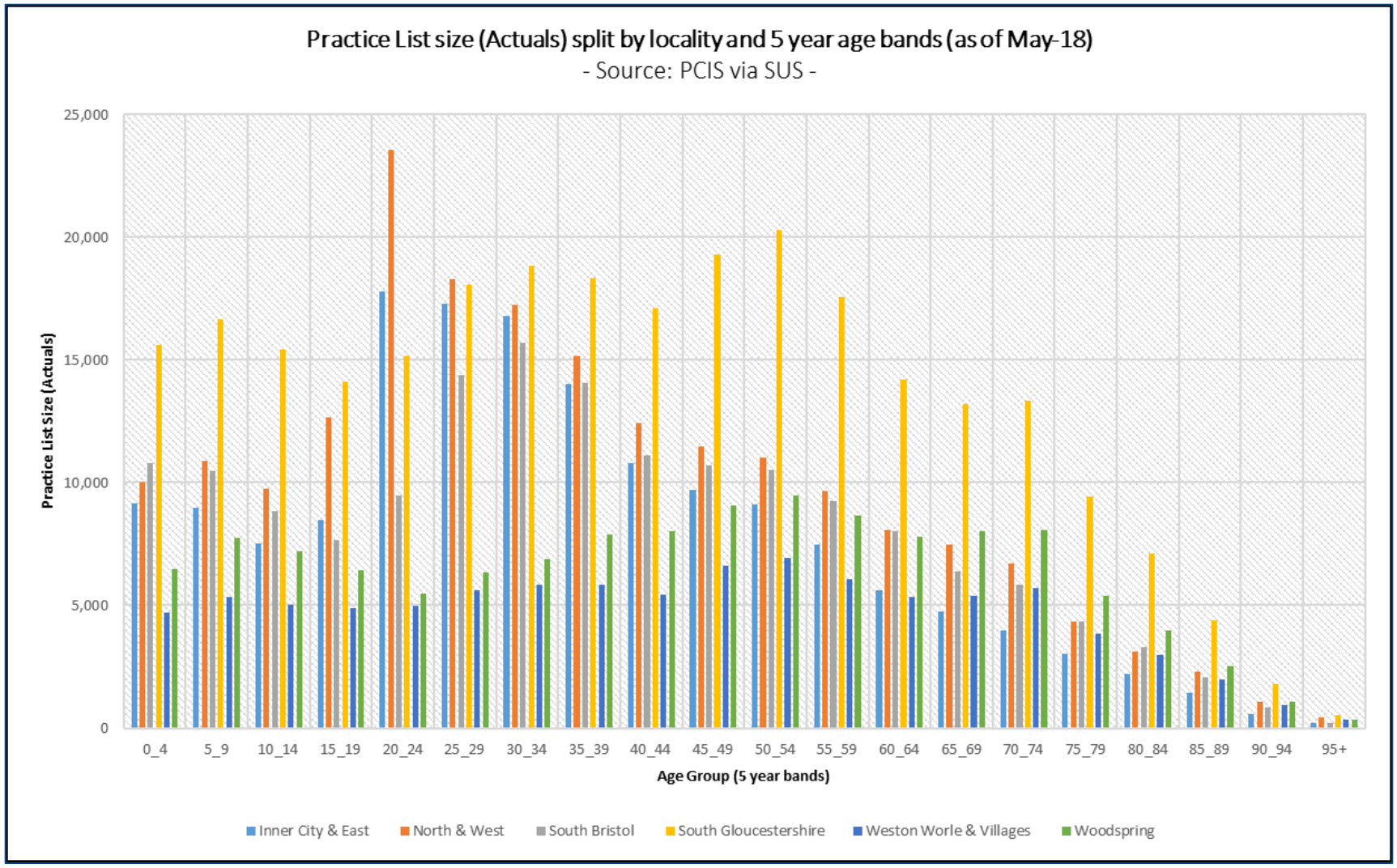
Demographics

N&W Bristol and Bristol Population Pyramid by age and gender, mid-2016 population estimates



Source: ONS 2016 mid-year population estimates

A large proportion of the N&W population is young adults



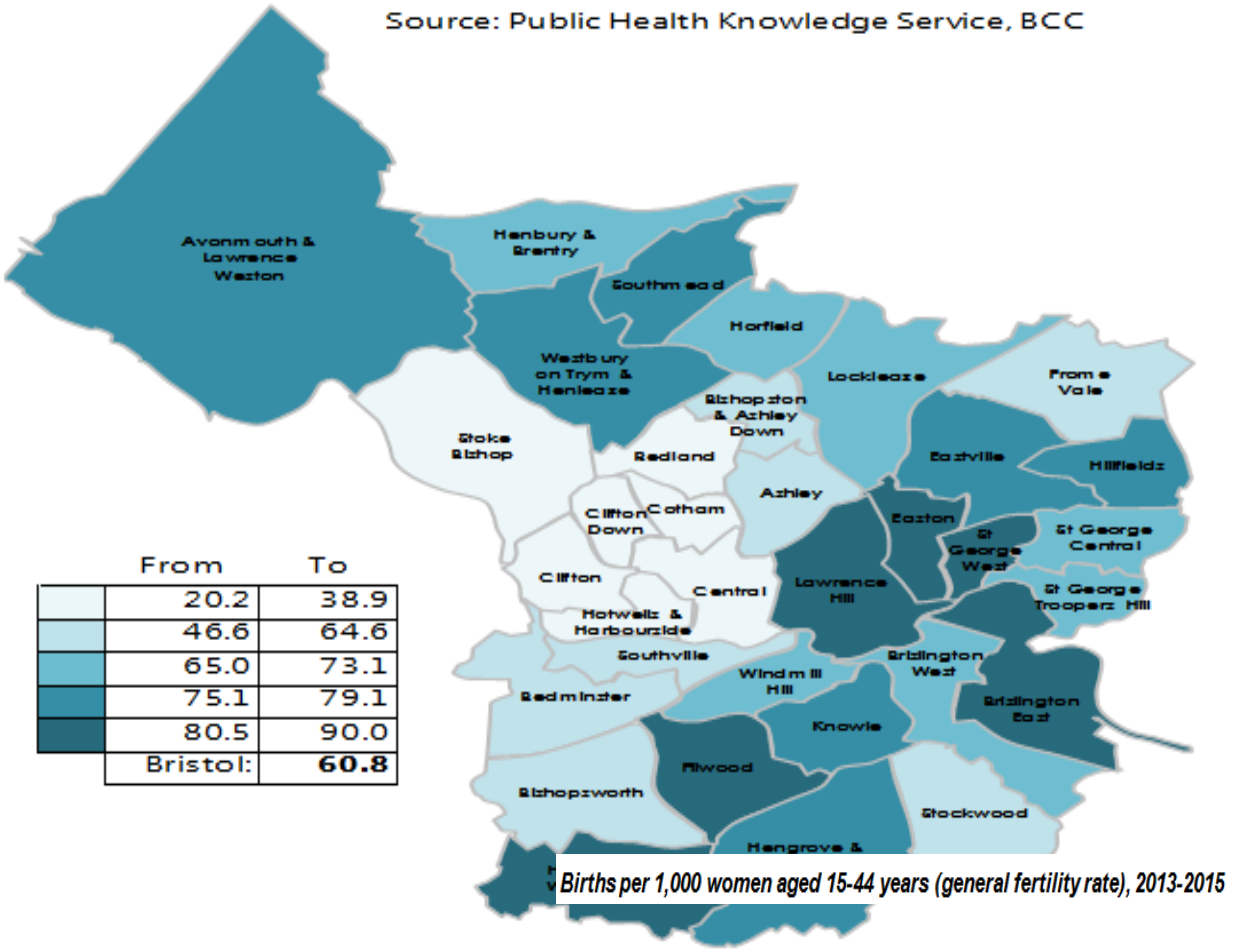
N&W has the largest overall practice list size of the three Bristol localities. There is a large spike in the number of 20-24 year olds living here – they account for 30.8% of the total number of 20-24 year olds living in BNSSG. This may be due to the location of the campuses of the University of Bristol and UWE.

Birth Rates by 2016 wards (2011 census)

- Avonmouth & Lawrence Weston, Southmead and Westbury on Trym & Henleaze have the **highest birth rate** in N&W.

- The inner wards such as Redland, Clifton and Stoke Bishop have some of the **lowest birth rates in Bristol.**

Source: Public Health Knowledge Service, BCC



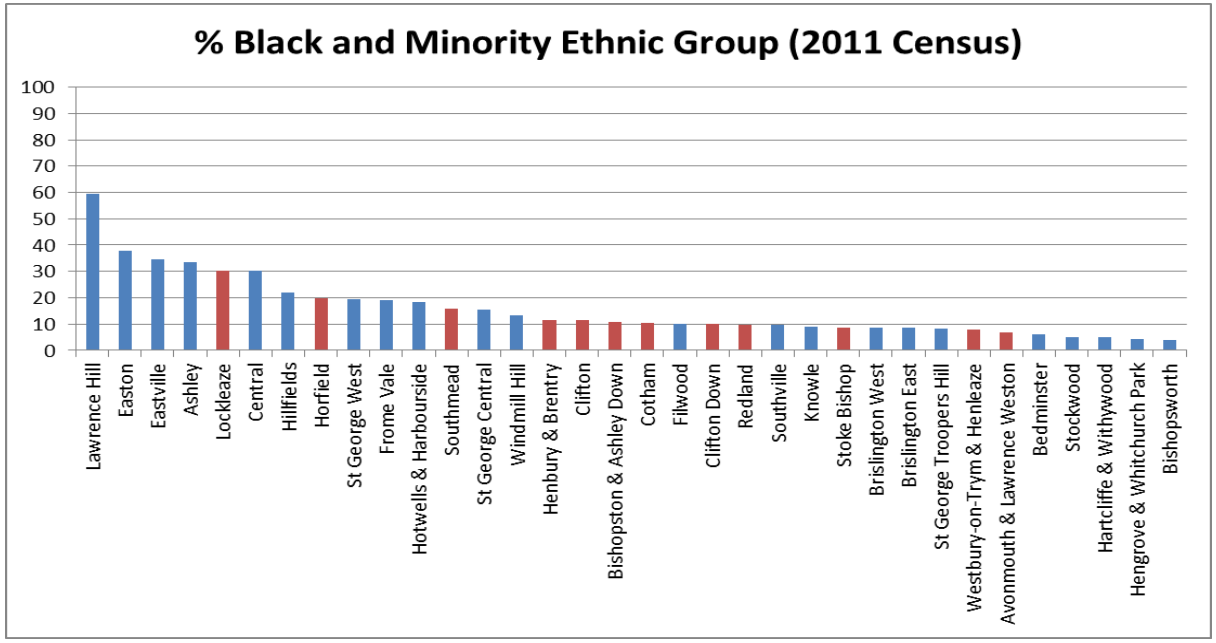
From	To
20.2	38.9
46.6	64.6
65.0	73.1
75.1	79.1
80.5	90.0
Bristol:	**60.8**

Births per 1,000 women aged 15-44 years (general fertility rate), 2013-2015

Source: opendata Bristol, 2011 census by 2016 wards)

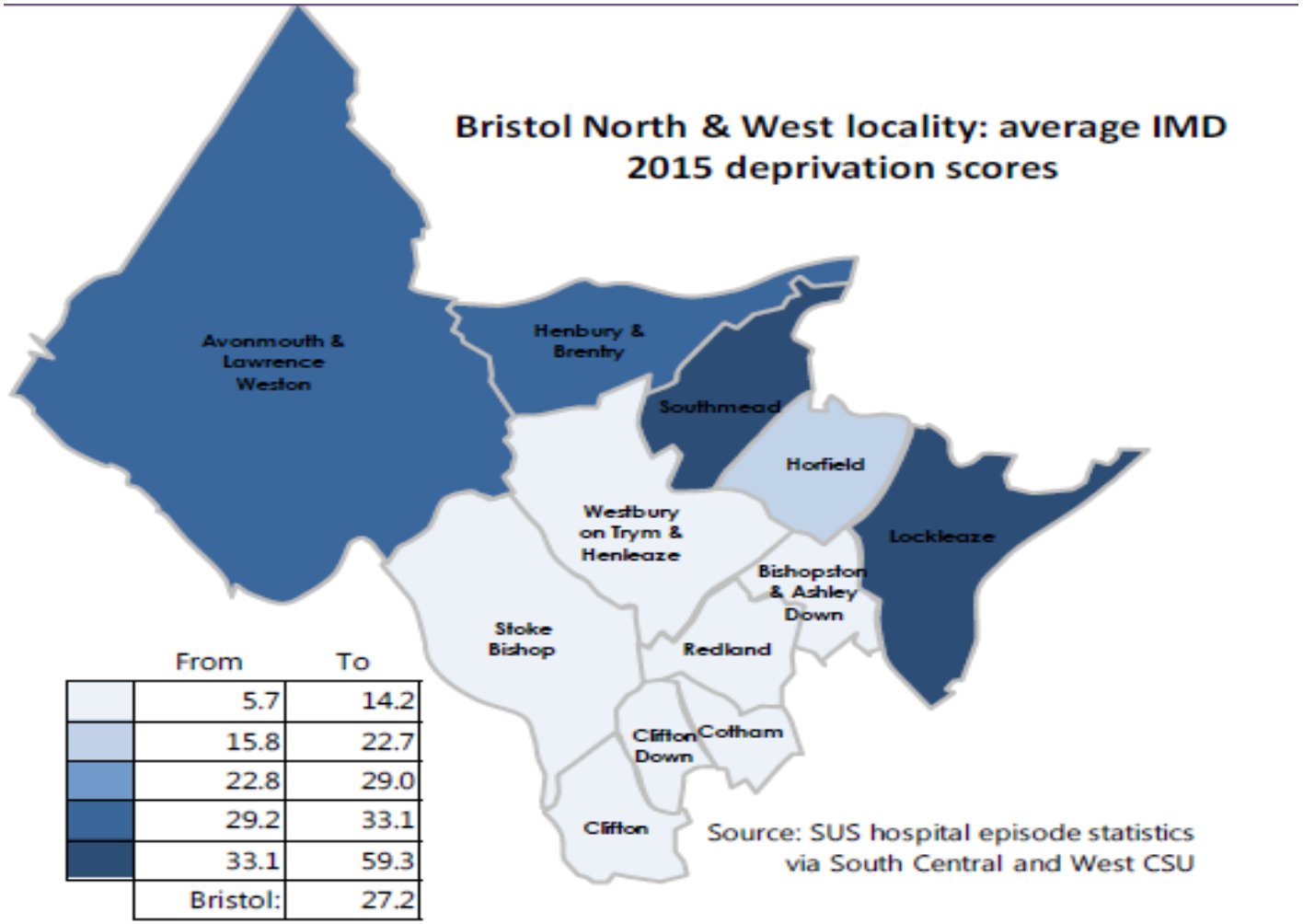
Ethnic Background - Black & Minority Ethnic Group

- North & West **have lower proportions** of the population from BME groups than the Bristol average.
- 22% of Bristol's population are non-white British and by locality this is 38% ICE, **18% N&W** and 12% in South



Source: opendata Bristol, 2011 census by 2016 wards)

Significant inequalities in deprivation exist in N&W



	From	To
	5.7	14.2
	15.8	22.7
	22.8	29.0
	29.2	33.1
	33.1	59.3
	Bristol:	27.2

Source: JSNA Bristol 2016-17

Significant inequalities in deprivation exist in N&W

- Indices of deprivation correlate strongly with the social determinants of health.
- Southmead and Lockleaze are the two **most deprived** wards in N&W, followed by Avonmouth & Lawrence Weston and Henbury & Brentry.
- However, the inner wards of N&W (Stoke Bishop, Westbury on Trym & Henleaze, Bishopston & Ashley Down, Redland, Cotham, Clifton Down and Clifton) are some of the **least deprived** wards in Bristol.

Source: JSNA Bristol 2016-17

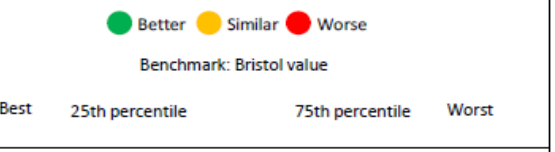
Significant inequalities in deprivation exist in N&W

- Parts of Avonmouth & Lawrence Weston, Henbury & Brentry, Southmead and Lockleaze are some of the most deprived 10% in England.

- Outer N&W has the second highest proportion of **children** living in income deprived households in Bristol – 28% in 2014.

Source: JSNA Bristol 2016-17

Locality outcomes



Indicator	Period	% / Rate			Bristol		
		N&W Inner	N&W Outer	Bristol	Best	Range	Worst
Life Expectancy at Birth - FEMALES	2015 - 2017	85.5	81.9	82.7	93.5		78.8
Life Expectancy at Birth - MALES	2015 - 2017	82.0	78.3	78.7	85.1		74.4
Percentage of children measured that were overweight or very overweight - Reception year (4/5 year-olds)	2014/15 -2016/17	16.7%	26.5%	23.4%	12.9%		32.8%
Percentage of children measured that were overweight or very overweight - Year 6 (10/11 year-olds)	2014/15 -2016/17	20.6%	37.2%	34.5%	17.4%		43.3%
Percentage of children living in low income families	2015	4.3%	20.7%	17.7%	1.8%		36.9%
Rate of hospital admissions caused by unintentional and deliberate INJURIES in children aged 0-4 years per 10,000 resident population	2017/18	102.7	145.3	137.9	52.0		186.7
Rate of hospital admissions caused by unintentional and deliberate INJURIES in children aged 0-14 years per 10,000 resident population	2017/18	81.8	115.4	110.0	66.2		153.2
Emergency hospital admissions as a result of SELF-HARM in children and young people aged 10-24, rate per 10,000	2015/16 - 2017/18	33.7	70.4	58.8	15.9		156.0
Emergency hospital admissions for ROAD TRAFFIC ACCIDENTS (all ages) - rate per 100,000 population	2015/16 - 2017/18	88.4	103.4	106.4	64.5		157.0
Emergency admissions for ASTHMA, rate per 100,000	2015/16 - 2017/18	53.2	176.5	122.2	19.5		218.7
ALCOHOL related admissions to hospital (narrow), rate per 100,000	2015/16 - 2017/18	548.0	787.4	764.6	469.5		1,345.4
SMOKING attributable admissions to hospital, rate per 100,000	2015/16 - 2017/18	1,232.0	2,179.0	1,901.1	955.1		3,543.0
Emergency hospital admissions for CARDIOVASCULAR DISEASES (CVD), rate per 100,000	2015/16 - 2017/18	747.0	1,064.0	972.0	653.0		1,359.0
Emergency hospital admissions for CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), rate per 100,000	2015/16 - 2017/18	121.4	386.7	349.8	82.3		813.7
Emergency admissions due to FALLS injuries, patients aged 65+, rate per 100,000.	2015/16 - 2017/18	2,396.9	2,767.0	2,664.3	1,680.9		3,838.5
Years of life lost due to ALCOHOL-related conditions mortality, rate per 100,000	2015 - 2017	455.7	613.3	754.2	357.9		2,313.4
Years of life lost due to SMOKING attributable conditions mortality, rate per 100,000	2015 - 2017	481.0	1,057.7	893.3	265.8		1,911.9
Years of life lost due to CARDIOVASCULAR DISEASES (CVD) mortality, rate per 100,000	2015 - 2017	528.4	1,084.6	926.8	276.1		1,807.1
Years of life lost due to CANCER mortality, rate per 100,000	2015 - 2017	1,266.9	1,837.2	1,756.1	1,108.2		3,031.8
Income Deprivation Affecting Older People Index (IDAOPI) % older people aged 60+	2015	9.4%	22.2%	19.8%	7.0%		49.1%
Percentage of people living in 20% most deprived LSOAs in Bristol	2015	0.0%	23.7%	19.8%	0.0%		84.6%
Percentage of households in Fuel Poverty	2015	15.0%	11.2%	12.9%	8.8%		20.1%

Data sources: ONS Mid-year Population Estimates for 2016; Primary Care Mortality Database - Registered Deaths 2015-2017; 2011 Census via NOMIS; English Indices of Deprivation 2015 - Department for Communities and Local Government; HM Revenue & Customs: Personal tax credits: Children in low-income families local measure 2015; Department for Business, Energy & Industrial Strategy: Sub-regional Fuel Poverty, England 2017'; SUS hospital admissions data