Healthier Together

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

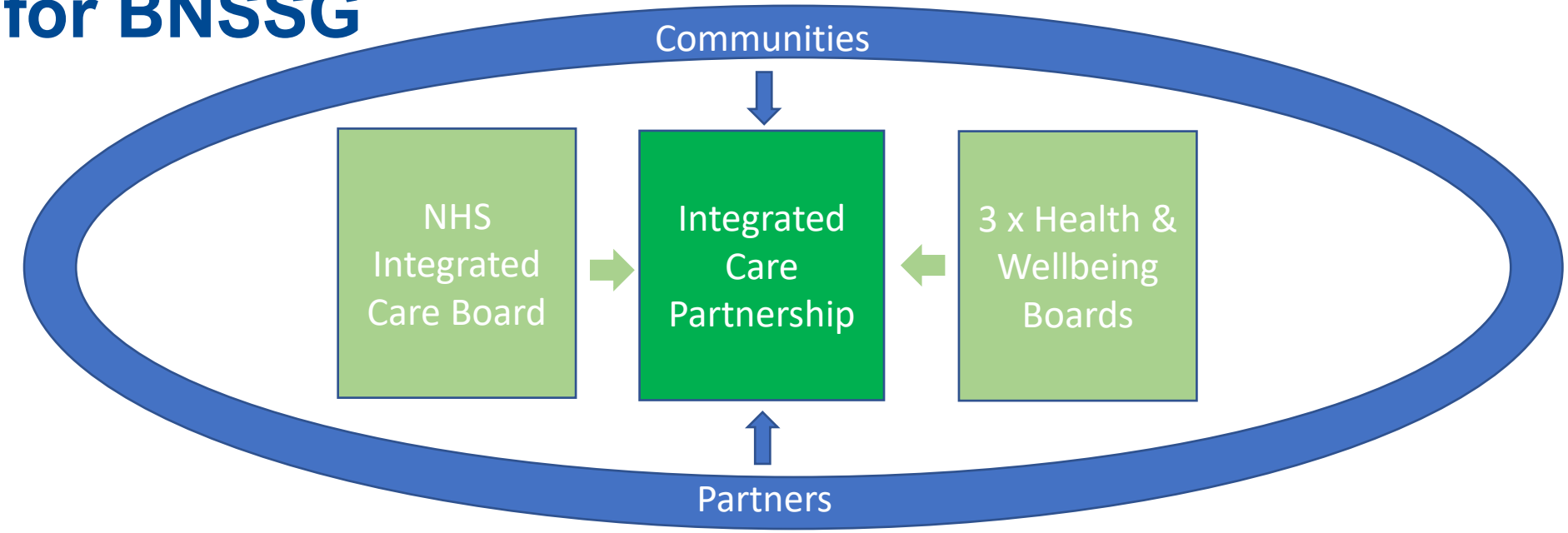
Developing an Integrated Care Strategy for Bristol, North Somerset and South Gloucestershire (BNSSG)

North Somerset Health Oversight Panel – 16 February 2023

Sebastian Habibi, Programme Director, BNSSG ICB

An Integrated Care Partnership is developing an integrated care strategy for BNSSG

The Integrated Care Partnership is a committee of the 3 Local Authorities and the NHS Integrated Care Board within BNSSG



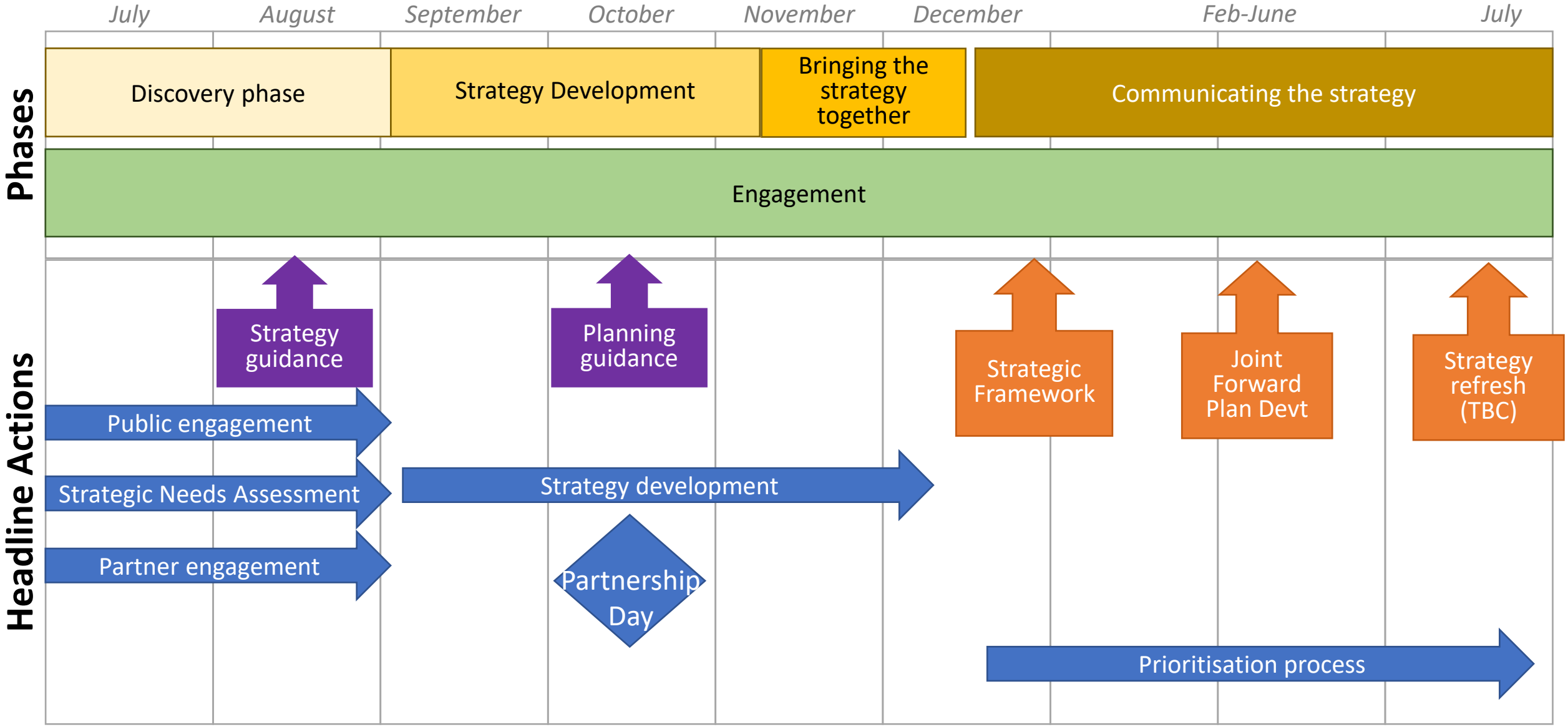
The purpose of the strategy is to guide decisions and action on:

1. **Improving outcomes** in population health and healthcare
2. **Tackling inequalities** in outcomes, experience and access
3. Enhancing **productivity and value for money**
4. Contributing to broader **social and economic development**

Current position

- Integrated Care Partnership agreed a Strategic Framework in December 22
- Bulit around the 4 aims of the ICS, within a life-course approach
- Next step is to prioritise a small number of strategic goals

Timeline: 2022-2023



BNSSG Strategic framework on a page

MISSION

HEALTHIER TOGETHER BY WORKING TOGETHER

VISION

We will establish a fully integrated health and care system that enables people to live healthy lives ensuring that personalised care is delivered close to home for everyone who needs it

OUR 4 AIMS

- *Improve outcomes in population health and healthcare*
- *Tackle inequalities in outcomes, experience and access*
- *Enhance productivity and value for money*
- *Help the NHS support broader social and economic development.*

OUR APPROACH TO THOSE AIMS

- Build on the work of the HWBs and Localities
- Building community led partnerships
- Seeing 'risk' from the view of the person not the organisation
- A new relationship with the VCSE
- Being brave and innovative
- Design led by the Clinician/practitioner, user or carer together
- Seeing the whole person/issue
- Using our power to support the local community

OUTCOMES	PRIORITISATION	BALANCE	REALISM
Everything we do as a system will have measurable outcomes	Focus on areas where we can have the biggest impact	We will balance multiple needs and expectations in our system.	This will be grounded in what is achievable and deliverable

LIFECOURSE FRAMEWORK

We will make this an 'all-age' strategy with interventions at all stages of the life course

START WELL – LIVE WELL – AGE WELL – DIE WELL

WHAT WE MUST DO

- High quality services in all care settings
- Financial sustainability and taxpayer value
- People empowered to control their own health
- Sustainable, motivated, valued workforce

Improvement opportunities and cross cutting issues highlighted in the Strategic Framework (Dec 2022)

Starting Well

- Supporting children and young people who are beginning life in economic hardship; live with anxiety or depression or with risk factors for poor mental wellbeing; experiencing trauma, excluded from school, are in care or
- care leavers;
- Enabling healthy weight

Living Well

- Enabling people to be healthy and well and preventing the onset of illness;
- Supporting people living with long-term mental and physical health
- Supporting people during important transitional stages of life (e.g. pregnancy)

Ageing Well

- Enabling people to age well and be independent;
- Supporting older people living with multiple conditions
- Proactively supporting older people admitted to hospital to get home as soon as possible

Dying Well

- Treating people as individuals, with dignity and respect; supporting
- People to be without pain and other symptoms near the end of life,
- Supporting people to die where they wish;
- Supporting carers

Prevention

Inequalities

Clustered needs

Workforce sustainability

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How we will measure success: BNSSG Outcomes Framework

The health of our population will be improved through a focus on…	Code	Our Outcomes
The health of our RESIDENTS	RES1	We will increase population healthy life expectancy across BNSSG and narrow the gap between different population groups
	RES2	We will reduce early deaths from preventable causes - cardiovascular and respiratory conditions, liver disease and cancers - in the communities which currently have the poorest outcomes
	RES3	
	RES4	We will lower the burden of infectious disease in all population groups
	RES5	We will reduce the proportion of people in BNSSG who smoke
	RES6	We will improve self-reported mental wellbeing
		We will increase the proportion of children who achieve a good level of education attainment
The health of our SERVICES	SER7	We will increase the proportion of our residents who report that they are able to find information about health and care services easily
	SER8	We will increase the proportion of our residents who report that they are able to access the services they need, when they need them
	SER9	We will increase the proportion of our residents who report that their health and care is delivered through joined up services
The health of our STAFF	STA10	We will increase the proportion of our health and care staff who report being able to deliver high value care
	STA11	We will reduce sickness absence rates across all our Healthier Together partner organisations
	STA12	We will improve self-reported health and wellbeing amongst our staff
	STA13	We will improve Equality and Diversity workforce measures in all Healthier Together Partner organisations
The health of our COMMUNITIES	COM14	We will reduce the number and proportion of people living in fuel poverty
	COM15	We will reduce the number of people living in poor housing conditions
	COM16	We will reduce levels of domestic violence and abuse
	COM17	We will reduce levels of child poverty
	COM18	We will increase the number of our residents describing their community as a healthy, safe, and positive place to live
The health and wellbeing of our ENVIRONMENT	ENV19	We will increase the proportion of energy used by the estates of our Healthier Together partner organisations from renewable sources
	ENV20	We will reduce the total carbon footprint generated through travel of patients using our services
	ENV21	We will increase use of active travel, public transport and other sustainable transport by our staff, service users and communities

How might we “do” strategy?

1. A **diagnosis** that defines or explains the nature of the challenge. A good diagnosis simplifies the often overwhelming complexity of reality by identifying certain aspects of the situation as critical.

2. A **guiding policy** for dealing with the challenge. This is an overall approach chosen to cope with or overcome the obstacles identified in the diagnosis. Channels action in a certain direction, without defining exactly what should be done.

3. A set of **coherent actions** that are designed to carry out the guiding policy. Theses are steps that are coordinated with one another to work together in accomplishing the guiding policy.

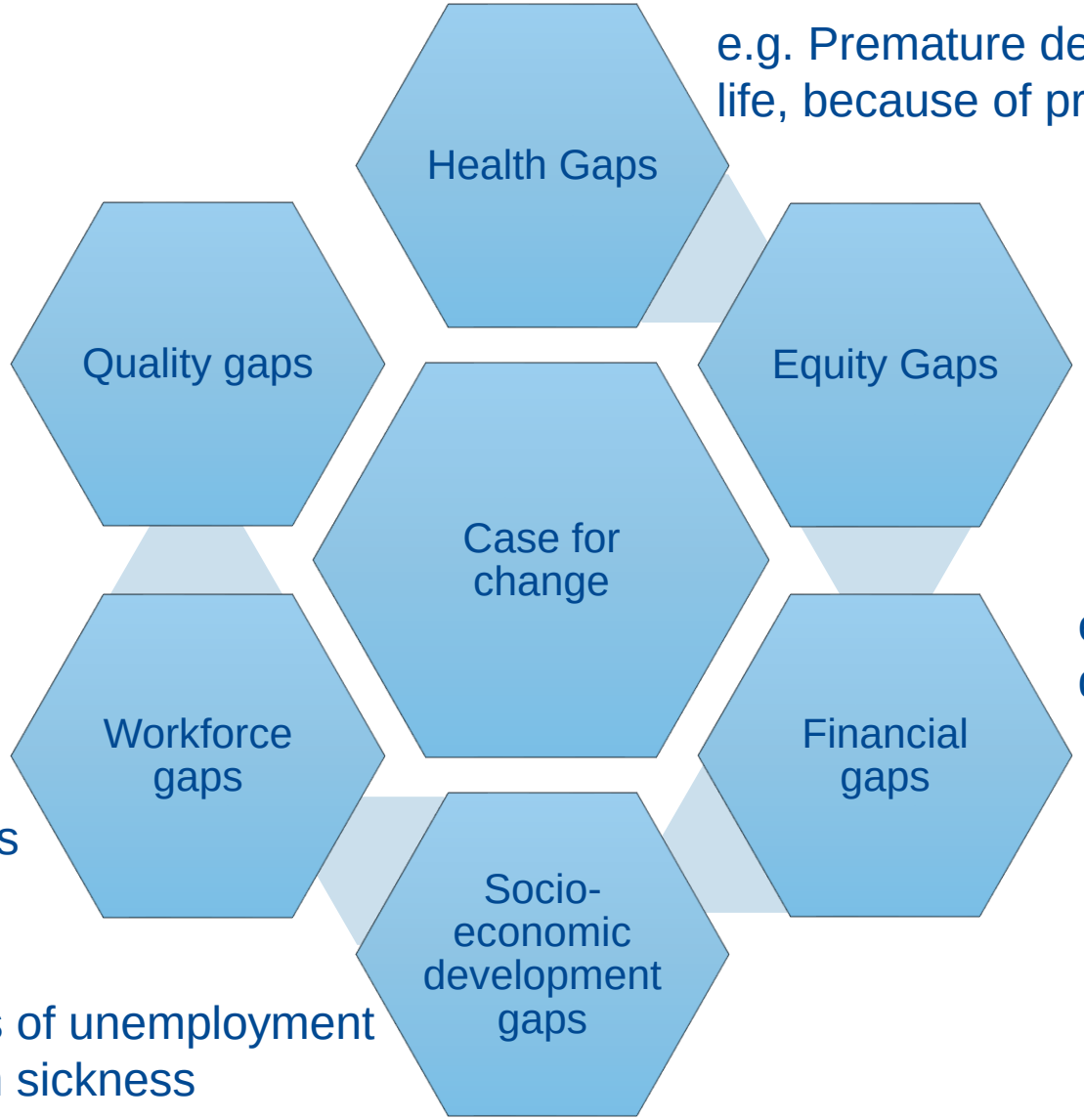
Illustrative example of what this could look like for BNSSG

1)Problem statement	2) Guiding Policy	3) Coherent Actions	Linked outcomes
Ageing population Our unplanned care system is not delivering optimal outcomes for frail elderly residents The >75 population is forecast to grow by ~10% in the next 4 years and by ~35% by 2040. An increasing proportion of this group have multi morbidities. Our current unplanned care system is likely to be overwhelmed by demand if we continue to wait for frail/ elderly people to need hospitalisation before responding.	**Anticipate, co-ordinate and divert** Identify those at highest risk of deterioration/ hospitalisation and intervene systematically, proactively and comprehensively. Coordinate care to ensure complex needs are addressed through personalised, patient-centred provision. A single coherent, defined pathway for people as they age and reach the end of their life.	**Data:** BNSSG core Segments 4 and 5 identify the 10% most co-morbid people in our population, with highest risk of unplanned hospitalisation for Ambulatory Care Sensitive conditions **Strengths based approach**: VCSE lead on proactive support in the community to help people stay well (e.g. falls prevention). Community health workers recruited from the places where need is most concentrated **Planning care packages:** Development of proactive interventions and care packages that anticipate need and sustain independence for people for longer **Enhanced support for care homes** Consistent, multi-disciplinary support to care homes, including advanced care planning, medication reviews, staff education and technology enabled care **Psychological and practical support**: working with individuals and their families as they age and approach the end of their life; to help them understand their options and plan based on what is important to them	**POP2:** We will reduce early deaths from preventable causes in the communities which currently have the poorest outcomes **SER9:** We will increase the proportion of people who report that their health and care is delivered through joined up services **STA13:** We will improve Equality and Diversity workforce measures in all *Healthier Together* Partner organisations

Appendix:

Discovery Phase – key findings

Emerging Case for Change



e.g. Premature deaths and lower quality of life, because of preventable diseases

e.g. 10-15 year Deprivation Gap in healthy life expectancy by age 50

e.g. Poor performance on ambulance handover and cancer treatment delays

e.g. c£76m underlying deficit in the BNSSG NHS

e.g. 16-20% vacancy rates

e.g. Rising rates of unemployment due to long term sickness

“Have Your Say”

Summary of key findings

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What keeps you healthy, happy and well?

35%
Healthy eating

21%
Access to nature and the outdoors

48%
Active and healthy lifestyle

59%
Relationships and social interaction

Results as of 31 August following interim analysis of first 1,100 survey responses. Each question was a 'free text' answer so respondents could say as much or as little as they wanted. These answers were then 'coded' to understand the 'topic areas' they mentioned. Because people could say as many things as they wanted, the percentages below will not add up to 100. The percentages represent the number of people who mentioned these 'topic areas'.

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What gets in the way of you staying happy, healthy and well?

30%
Work-life balance

26%
Cost of living and financial concerns

19%
Mental health concerns

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What do you think you need more of, either now or in the future, to stay happy, healthy and well?

16%
Access to primary care services

18%
Improved work-life balance

17%
Healthy mindset

13%
Cost of living/financial stability

13%
Active lifestyle

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What would you prioritise to ensure a happy and healthy population in BNSSG?

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Our Future Health

- Built up from what is already known using existing JSNA Products, H&WBB Reports, System Outcomes Framework and Population Health Management resources.
- Part of the initial stage of system wide strategy development.
- High level synthesis to get across key messages for the system.
- Opportunities to deliver at scale > not to replace work done at place level.

Health impacts

Figure 3.3: The impacts on health through the life-course in BNSSG Health impacts are based on Cambridge score categories, calculated as the prevalence of a condition multiplied by the 'weighting' for that condition. Weightings take into account risk of death and intensity of service use.

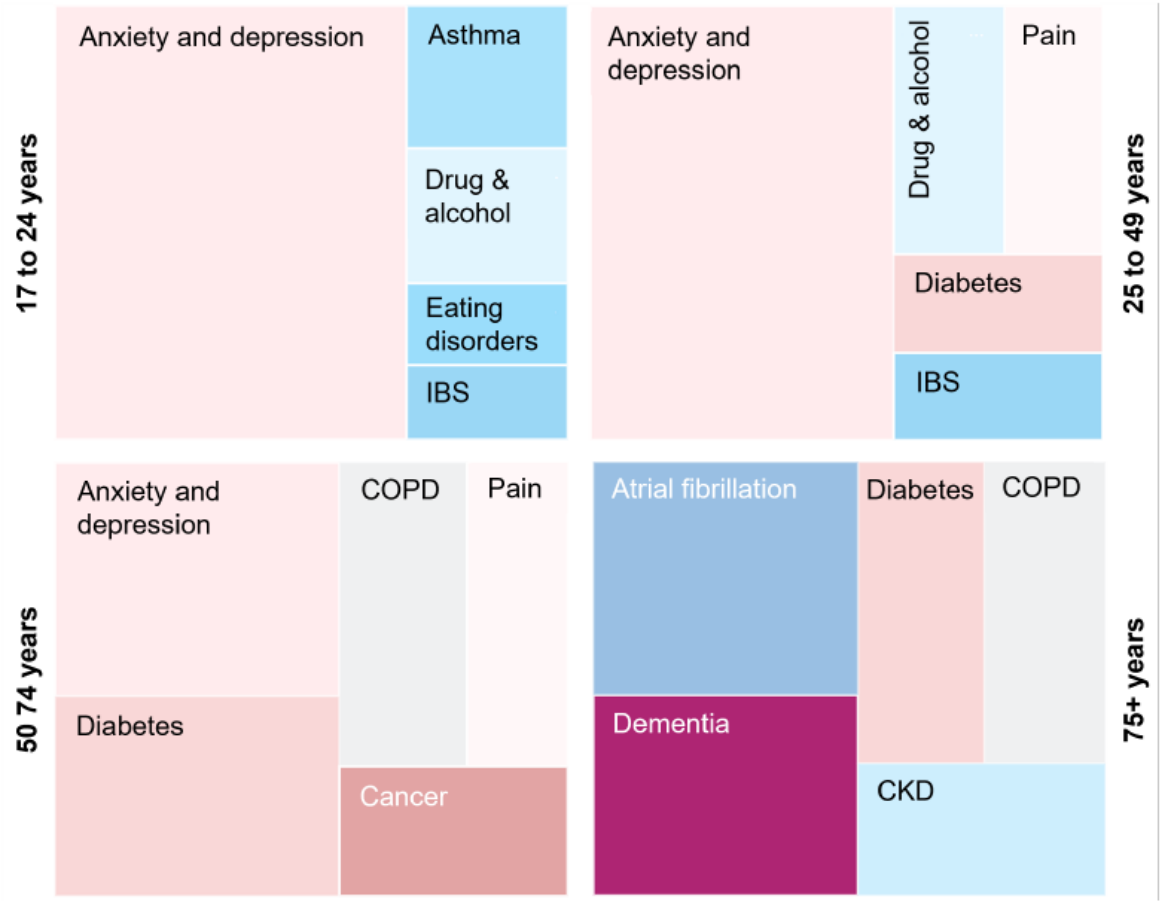
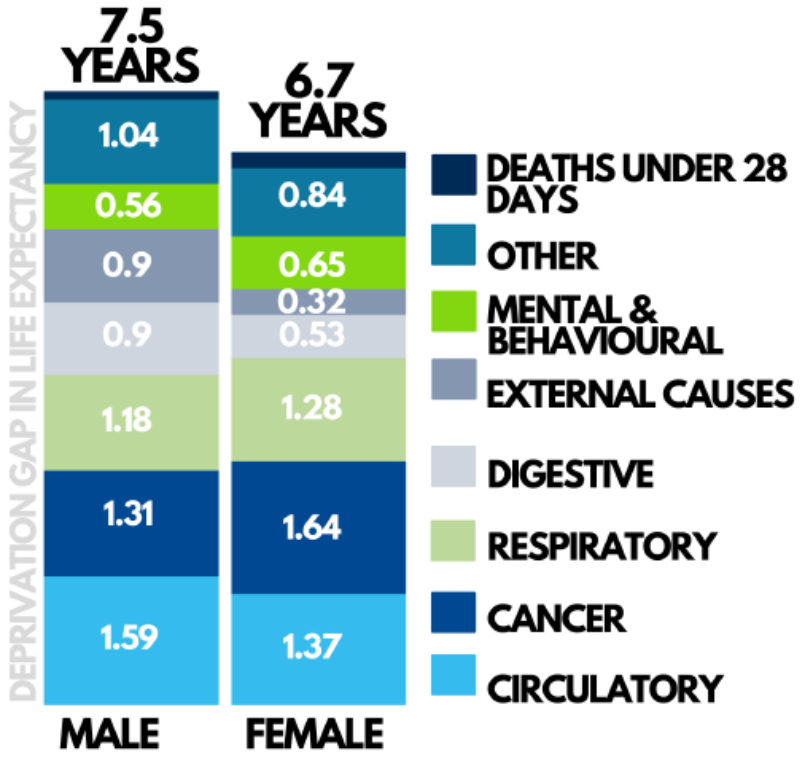


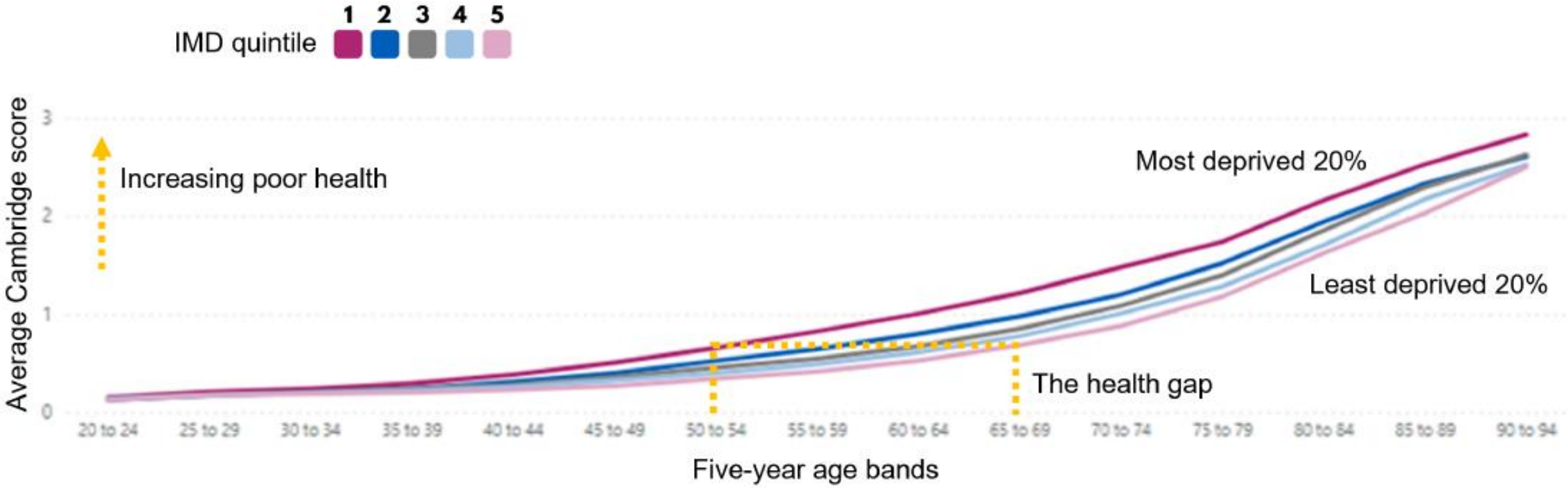
Figure 3.8: The life expectancy gap

Conditions contributing to the life expectancy gap (in years) in BNSSG between the most and least deprived.



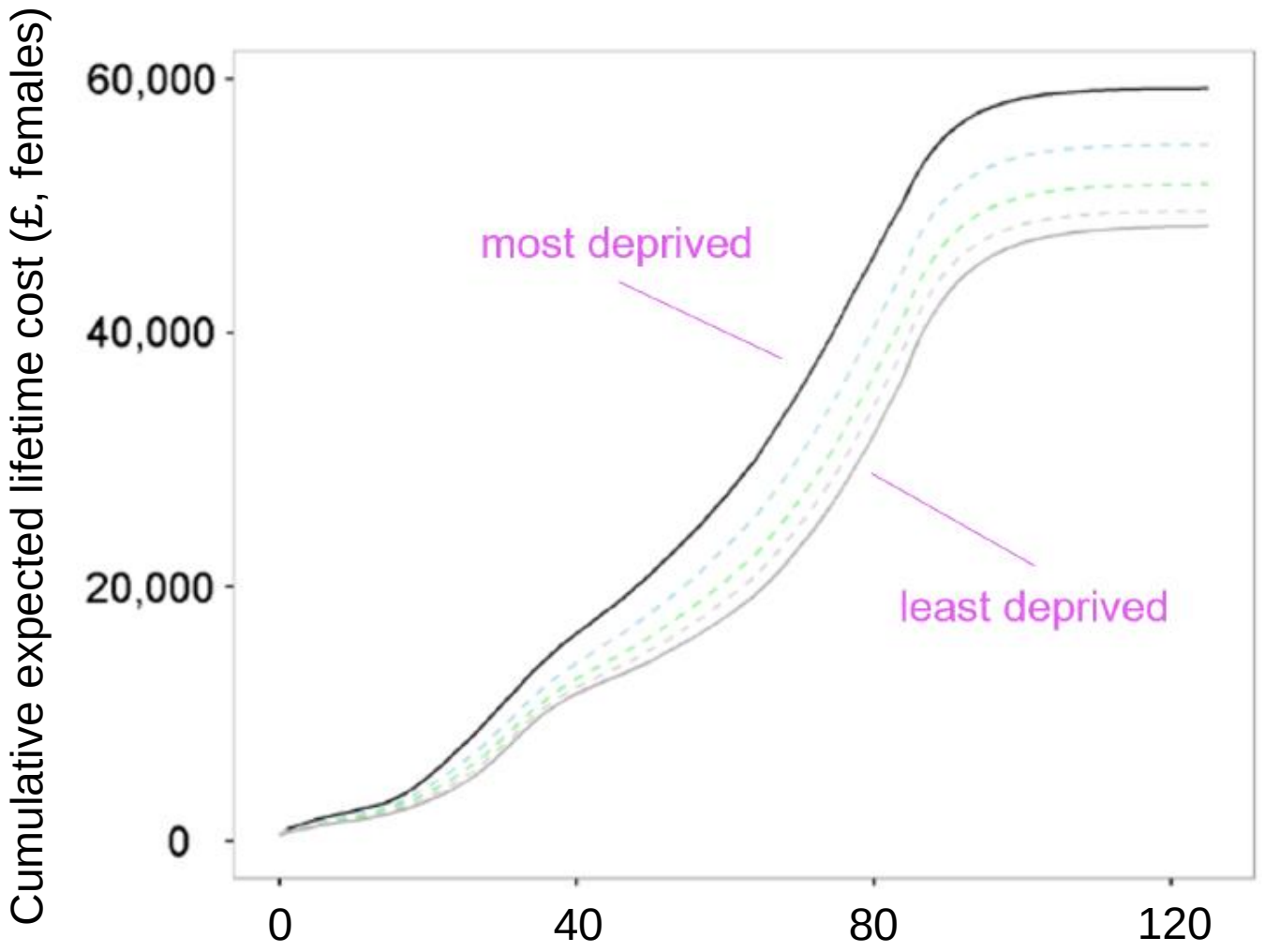
The population health mission

Drivers: poverty, discrimination, childhood trauma → poor mental health, drugs, alcohol, smoking, poor diet → pain, diabetes, COPD, cancer, heart disease, dementia



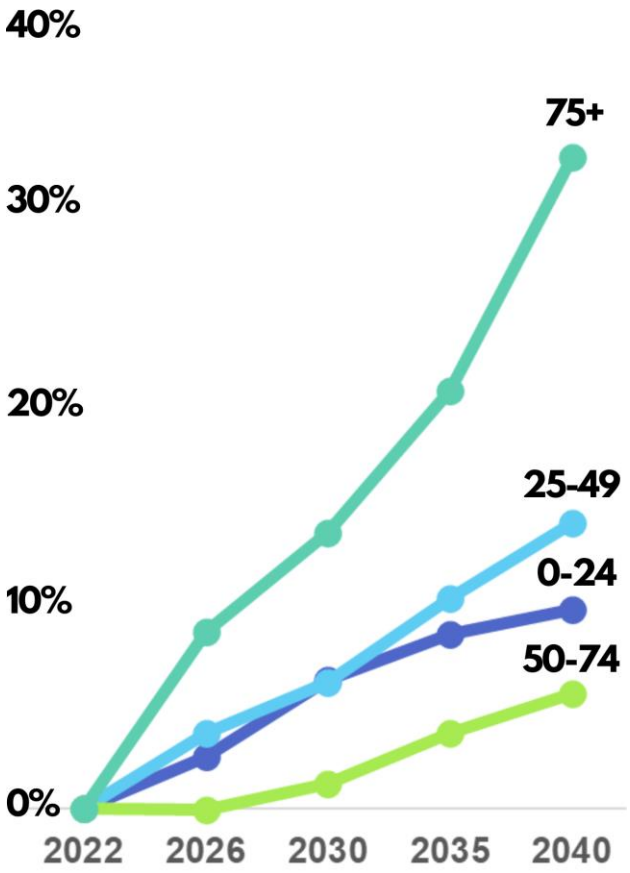
Inequality is expensive

Applying these estimates to the BNSSG population, the total cost of hospital episodes associated with deprivation in BNSSG is in the region of £100 million per year.

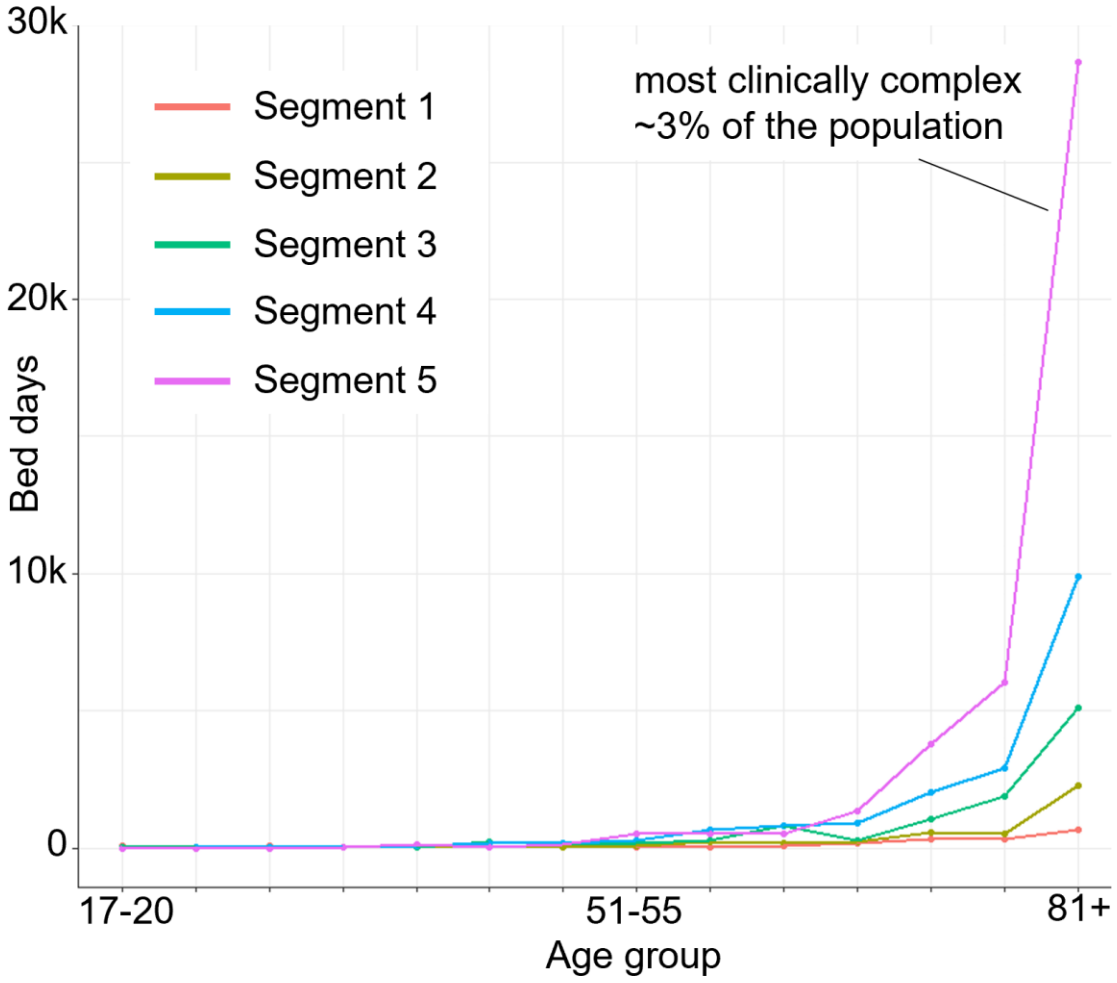


The population health problem

BNSSG population projections



Annual bed days due to falls by age and segment



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Questions?

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