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 and Wellbeing Board

1 March 2023

Sebastian Habibi: Healthier Together Programme Director

Introduction

Purpose

1. **Integrated Care System strategy development**
   a. To brief the Board on the BNSSG Strategic Framework and supporting evidence, published in December 2022
   b. To update the Board on the current work in progress to further develop the ICS strategy

2. **Joint Forward Plan**
   a. To brief the Board on the purpose of the Joint Forward Plan, highlight key requirements from legislation and guidance; and, to set out the process and timeline
   b. To signpost plans to publish the draft Joint Forward Plan by 31 March and to consult with the Board during in April-May
   c. Recommendation – That the Board agrees to hold a development session in April/May to facilitate engagement on the draft Joint Forward Plan

Contents

- **Strategic Framework:** Slides 3-6
  - Supporting evidence: Appendix 1 (Slides 21-31)
- **Strategy development current work in progress**
  - Developing our approach to strategy: Slides 8-10
  - Prioritisation: Slides 11-13
  - Strategy Development next steps and timeline: Slide 14
  - Example Priority Outcome Proposals: Appendix 2 (Slides 32-25)
- **Joint Forward Plan:** Slides 16-20

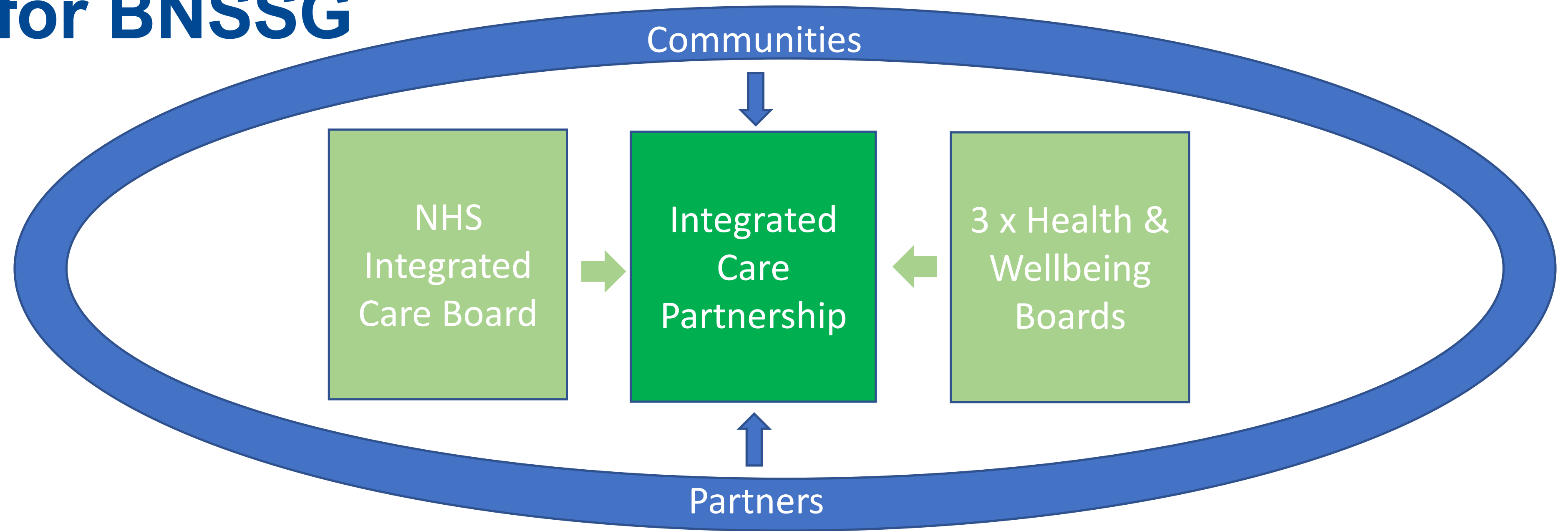
Healthier Together

Strategic Framework

Healthier
Together

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

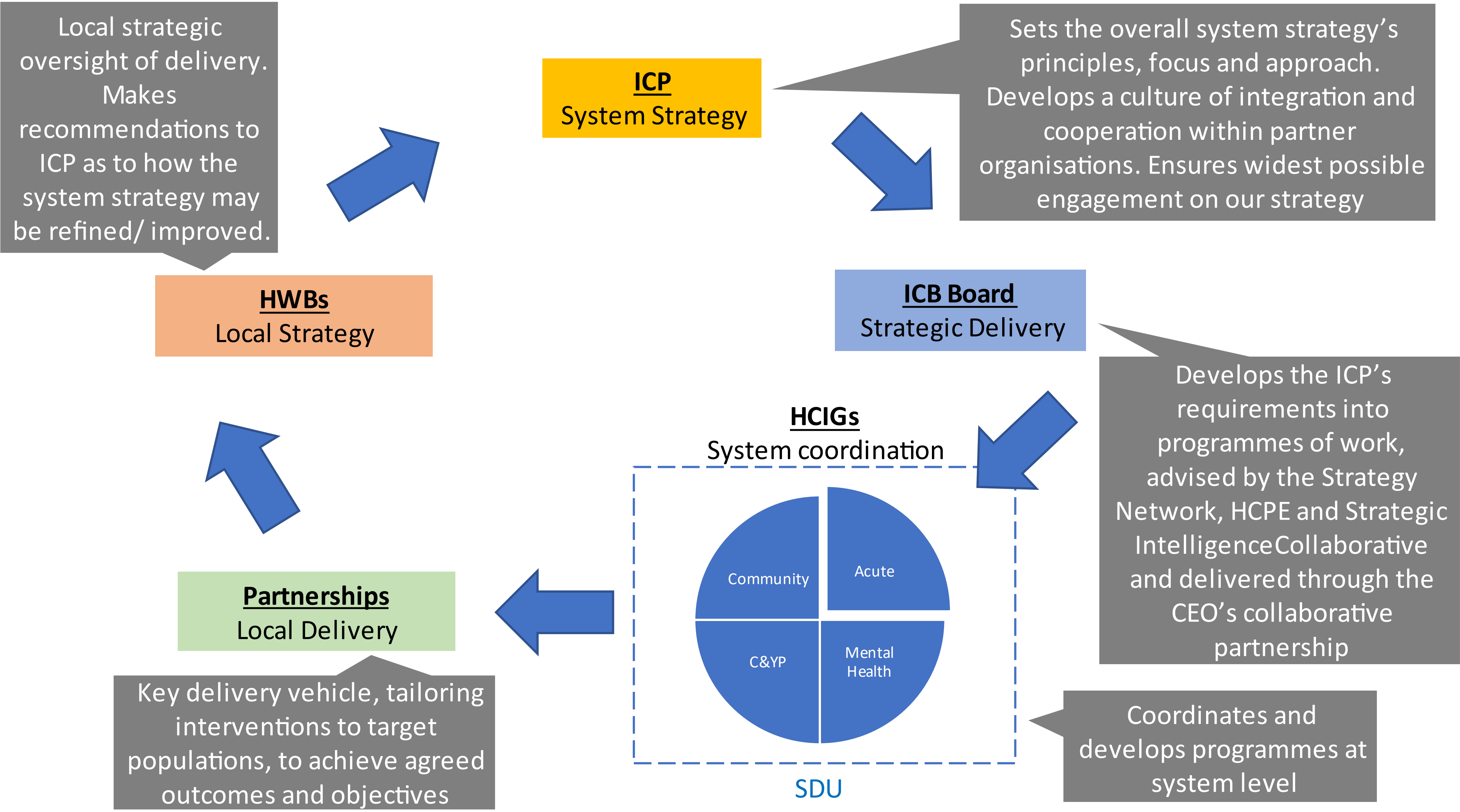
The Integrated Care Partnership is a committee of the 3 Local Authorities and the NHS Integrated Care Board within BNSSG



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**

The Integrated Care Partnership operates within a system of governance



Strategy development progress to date

- Integrated Care Partnership agreed a Strategic Framework in December 22
  - Underpinned by supporting documents:
    - Our Future Health: strategic needs assessment (Annex 1)
    - Have Your Say: public engagement thematic analysis (Annex 2)
    - Summary of Locality Partnership Priorities (Annex 3)
    - ICS Green Plan (Annex 4)
    - Strategy alignment analysis (Annex 5)
- Bulit around the 4 aims of the ICS, within a life-course approach
- Next step is to prioritise a small number of strategic objectives

BNSSG Strategic framework on a page

MISSION

HEALTHIER TOGETHER BY WORKING TOGETHER

VISION

People enjoying healthy and productive lives, supported by a fully integrated health and care system – providing personalised support close to home for everyone who needs it.

OUR 4 AIMS

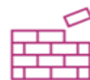
Improve outcomes in population health and healthcare

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

An asset-based approach to community development

OUTCOMES
Everything we do as a system will have measurable outcomes

PRIORITISATION
Focus on areas where we can have the biggest impact

BALANCE
We will balance multiple needs and expectations in our system.

REALISM
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

Strategy development

Current work in progress

Healthier Together

How might we “do” strategy in BNSSG ICS?*

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.

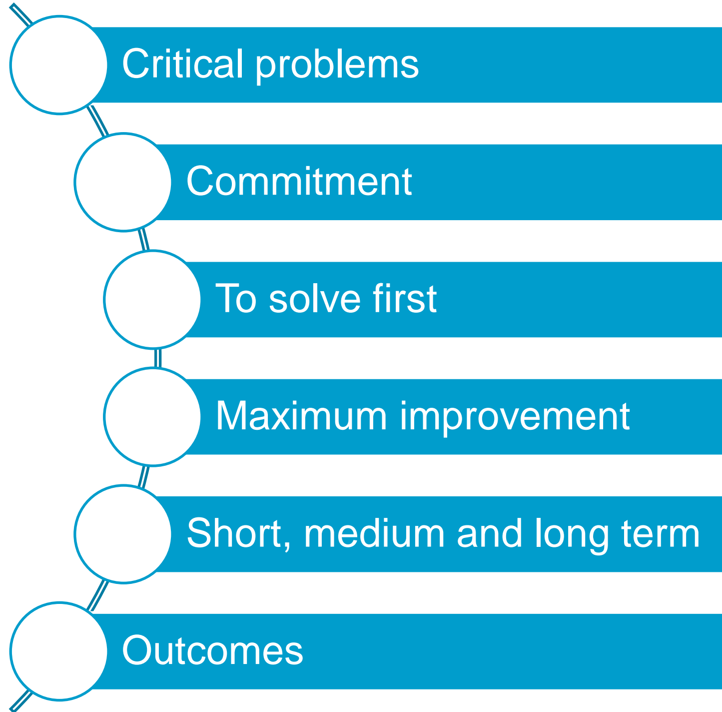
2. A **guiding policy** for dealing with the challenge. This is an overall approach chosen to cope with or overcome the obstacles identified in the diagnosis. Channels action in a certain direction, without defining exactly what should be done.

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.

* Three illustrative examples are set out in Appendix 2

Healthier Together

Working definition of an ICS strategic objective:



In short:

*The **critical challenges or opportunities that we commit to addressing collectively**, because we believe that this will **achieve the biggest improvements in outcomes or mitigate the biggest risks/issues** that would stop us improving outcomes.*

In more detail:

*The **problems** that we endeavour to **solve first** to deliver **maximum improvement in outcomes***:

- **Initial diagnosis has identified these problems as shared critical challenges** that if addressed through an effective partnership approach, would lead to step-change improvements in outcomes **or mitigate the biggest risks/issues** stopping us improving outcomes
- **Further diagnosis** has determined the **root causes** of these problems
- An initial **feasibility assessment** has demonstrated **credible opportunities for solutions** and the **potential improvements in outcomes**
- **Solutions will depend on strategic change**, rather than operational improvements alone
- **SMART objectives** have been identified and a **guiding policy** is being developed
- The ICS Partners expect to commit to taking **coordinated action** in line with the guiding policy
- **Incremental measures of progress** will be identified and **aligned to the Outcomes Framework**

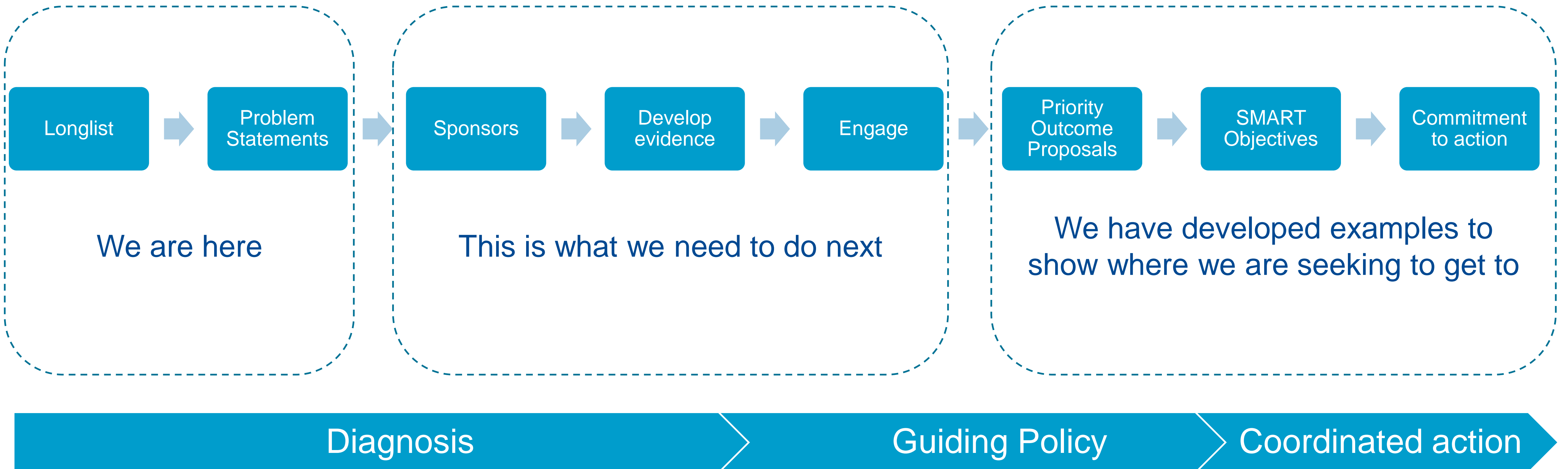
Healthier Together

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	We will lower the burden of infectious disease in all population groups
	RES4	We will reduce the proportion of people in BNSSG who smoke
	RES5	We will improve self-reported mental wellbeing
	RES6	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

Purpose of the strategy prioritisation process

- To facilitate decisions...
- That move us on from a Longlist of opportunities and challenges…
- By building consensus on why we should focus on a small number of pivotal objectives…
- So that we commit to action to improve outcomes…



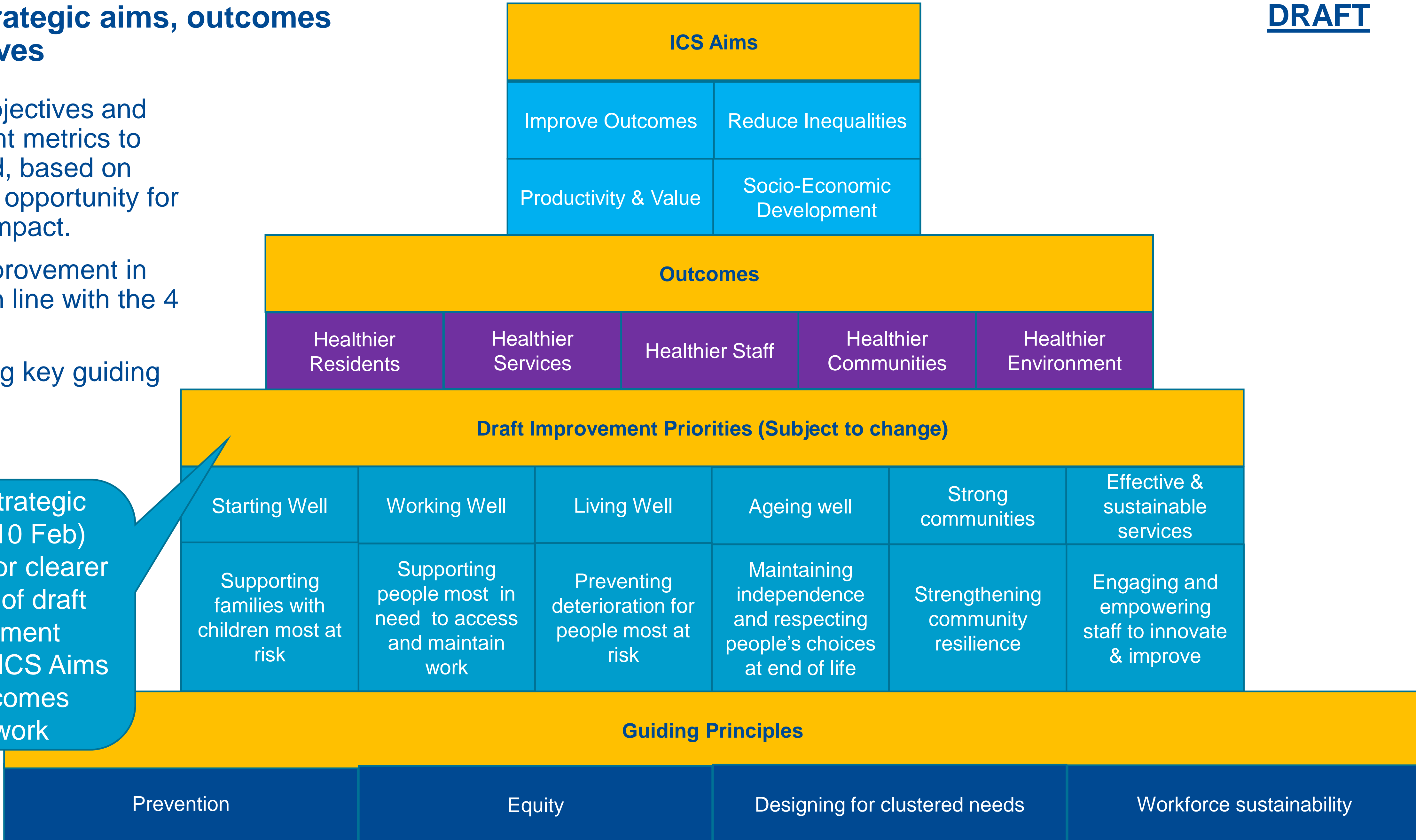
Developing the Longlist: progress to date

- Longlist of >200 issues collated by ICB Strategy team in Autumn 2022
  - Sources: Strategic Needs Assessment; Have Your Say; Locality Priorities; Health & Wellbeing Strategies; NHS Operational Plans; Partnership Day
- Consolidated into a list of c45 opportunities, issues and risks:
- Translated into c41 draft problem statements (ongoing)
- A small number of improvement priorities to be identified for developing strength based solutions

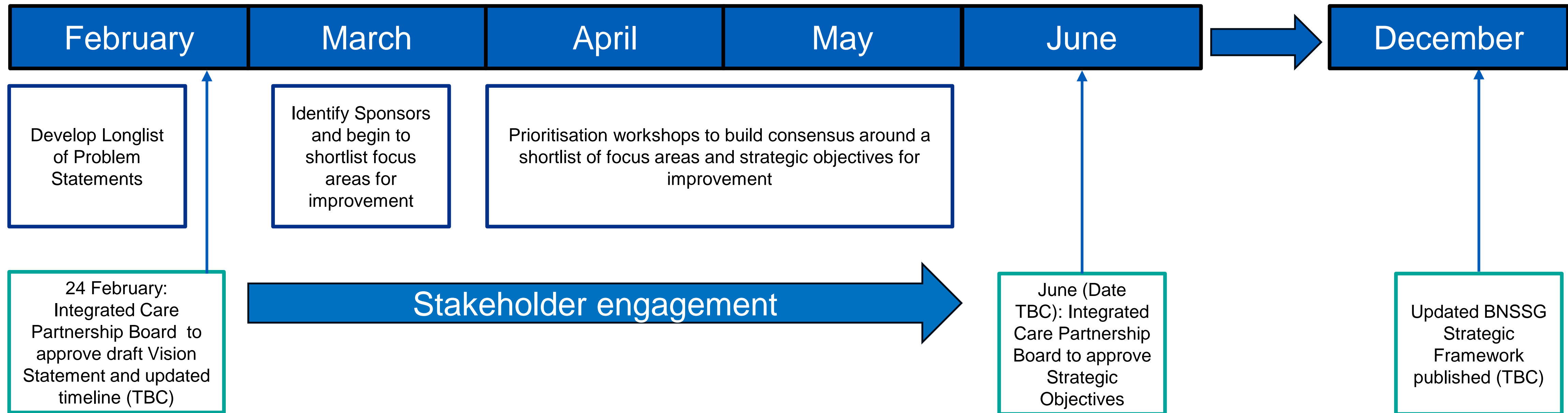
Aligning strategic aims, outcomes and objectives

DRAFT

- Strategic objectives and improvement metrics to be identified, based on evidence of opportunity for maximum impact.
- To drive improvement in outcomes in line with the 4 ICS aims
- And applying key guiding principles



Strategy development next steps – draft timeline*



* Timeline subject to approval by Integrated Care Partnership Board

Healthier Together

Joint Forward Plan

Healthier Together

Purpose of the Joint Forward Plan (JFP

To describe how the ICB and provider trusts intend to meet the physical and mental health needs of the population through arranging and/or providing NHS services, supported by local authority and VCSE partners

Address the four core purposes of ICS:

1. Improving outcomes in population health and healthcare
2. Tackling inequalities in outcomes, experience and access
3. Enhancing productivity and value for money
4. Helping the NHS support broader social and economic development

Delivery of universal NHS commitments:

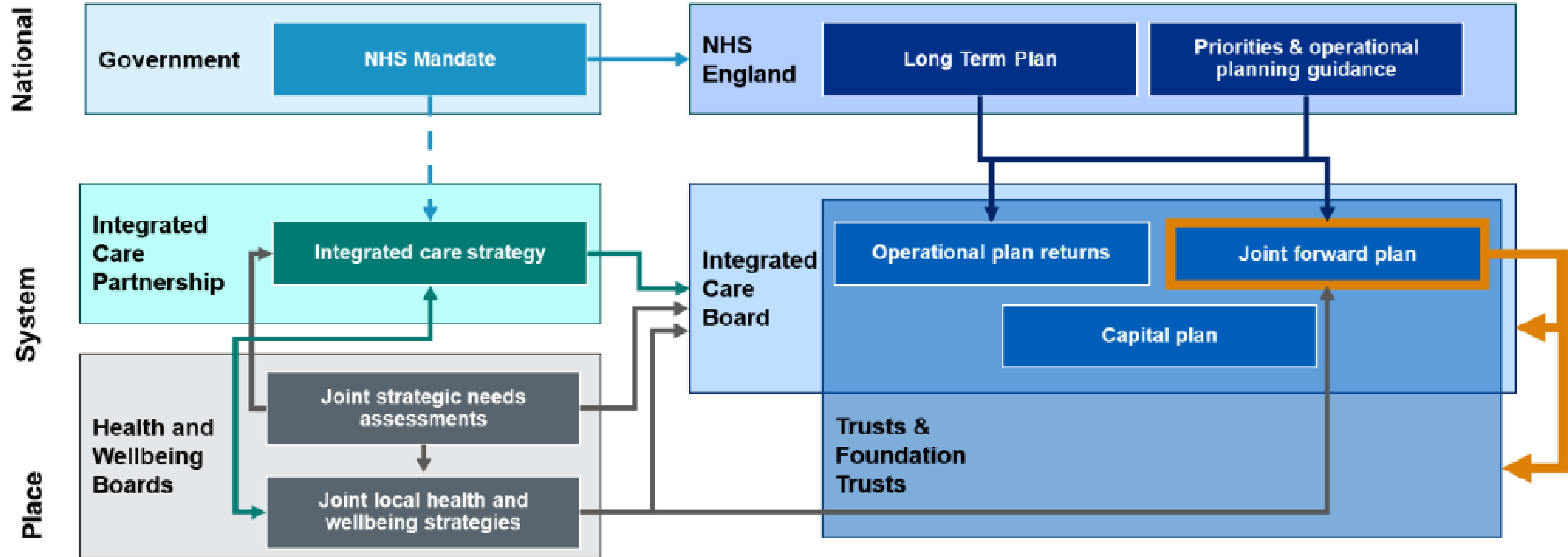
1. Long Term plan
2. Annual NHS Priorities
3. Operational planning guidance

Meet Legal Requirements:

1. Public Sector Equality Duty
2. Section 149 of the Equality Act 2010
3. NHS Act 2006

National guidance encourages systems to use the JFP to develop a shared delivery plan for the ICS Integrated Care strategy (developed by the ICP) and the Joint Local Health & Wellbeing Strategies (developed by HWBs)

Legislative Framework – relationship with other strategies and plans



Healthier Together

BNSSG approach to development of the 2023 JFP

1. Draw from the ICS Strategic Framework, NHS Operational Planning, Health and Wellbeing Board Strategies, ICS Decision-Making Framework and other existing plans and strategies

2. 2022/23 is a transitional year. Our operational plans reflect nationally mandated priorities and the continuation of programmes that were initiated prior to establishment of the new ICS in July.

3. As our Strategy evolves, and our approaches to delivering in partnership become more embedded, then the business cycle will be more synchronised between our Strategy and operational plans.

4. We will develop a standard approach for consultation on the annual review required before the start of each financial year.

Proposed structure for BNSSG JFP

Background

- Who are we?
- Our purpose and vision
- Our Strategic Framework
- Our Population Needs
- How are we working together
- How are we delivering together

Reflecting the Strategic Framework content

Joint Forward Plan

- What is the JFP?
- How the JFP will be further developed and delivered
- How we will know if we are succeeding (Outcomes framework)

Plain English requirements reflecting mandate

Our Plan

- To improve the lives of our children - Inc Safeguarding
- To improve the lives of people in our communities – inc Personalised Care
- To improve the lives of people with MH, LD &A
- To improve our acute healthcare services – inc Maternity
- To meet net zero target

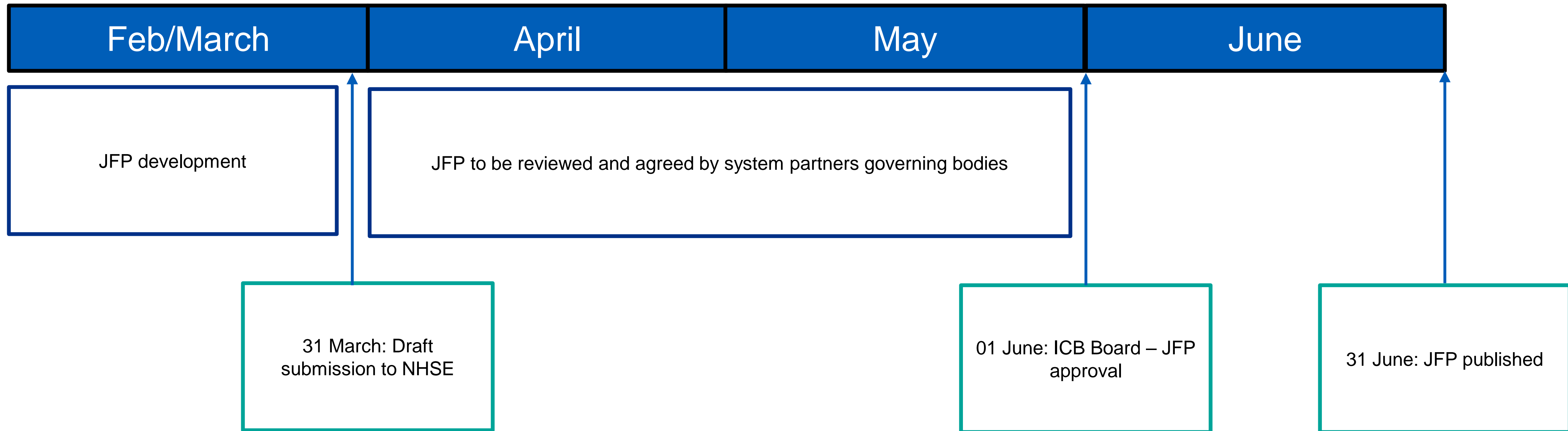
Reflecting existing programmes under each of the Improvement Groups structure

Our enablers

- Workforce
- Digital
- Estates
- Finance & Procurement
- Population Health Management
- Health and Care Professional Leadership

Reflecting other frameworks, strategies and national requirements

2023 Joint Forward Plan Timeline



The Integrated Care Partnership and three Health and Wellbeing Boards must be consulted on the draft Joint Forward Plan.

Healthier Together

Appendix 1:

Strategic Framework supporting evidence – key findings from Discovery Phase

Have Your Say – public engagement thematic analysis

Our Future Health – strategic needs assessment

Healthier Together

"Have Your Say"

Summary of key findings

What keeps you healthy, happy and well?

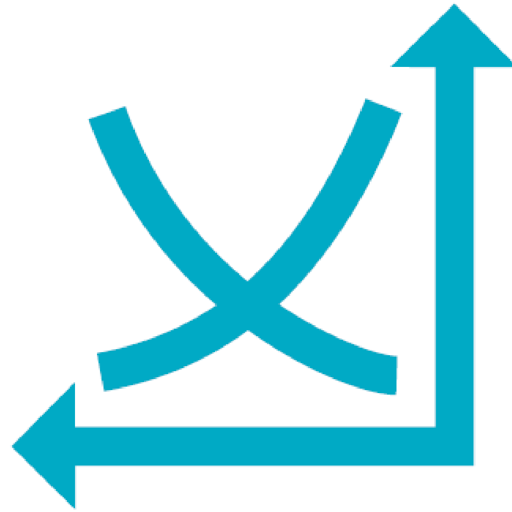
Results as of 31 August following interim analysis of first 1,100 survey responses. Each question was a 'free text' answer so respondents could say as much or as little as they wanted. These answers were then 'coded' to understand the 'topic areas' they mentioned. Because people could say as many things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

Healthier Together

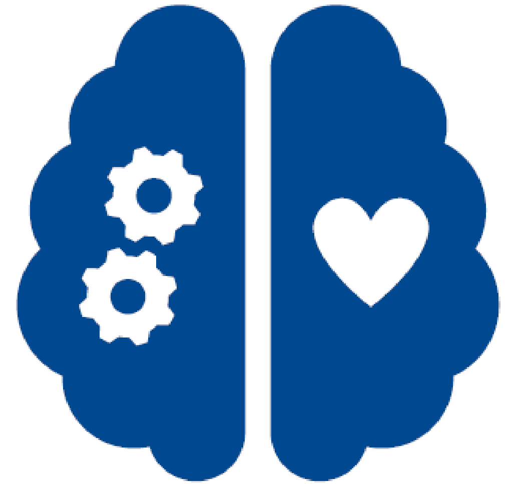
Improving health and care in Bristol, North Somerset and South Gloucestershire

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

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'.

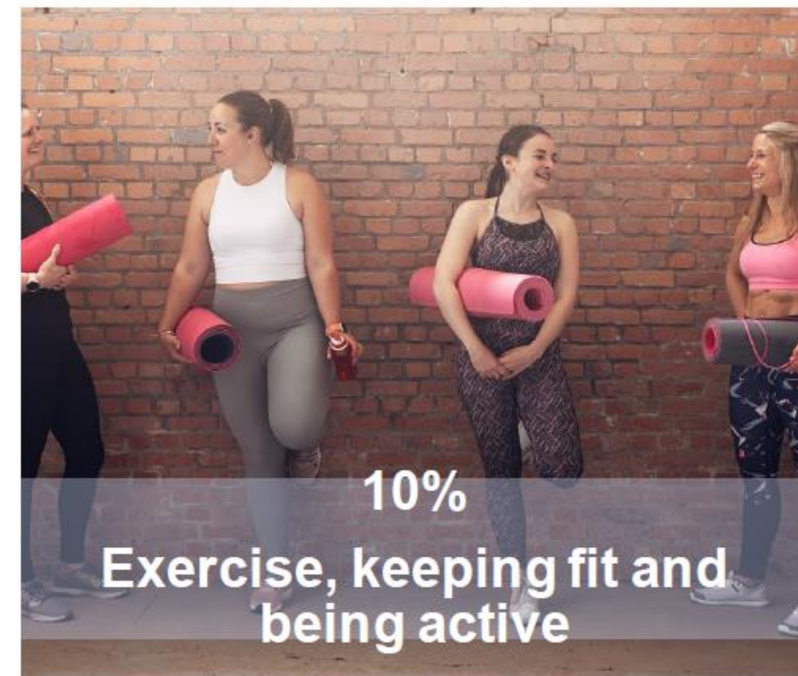
Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

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

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'.

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

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



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'.

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

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.

Healthier Together

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.

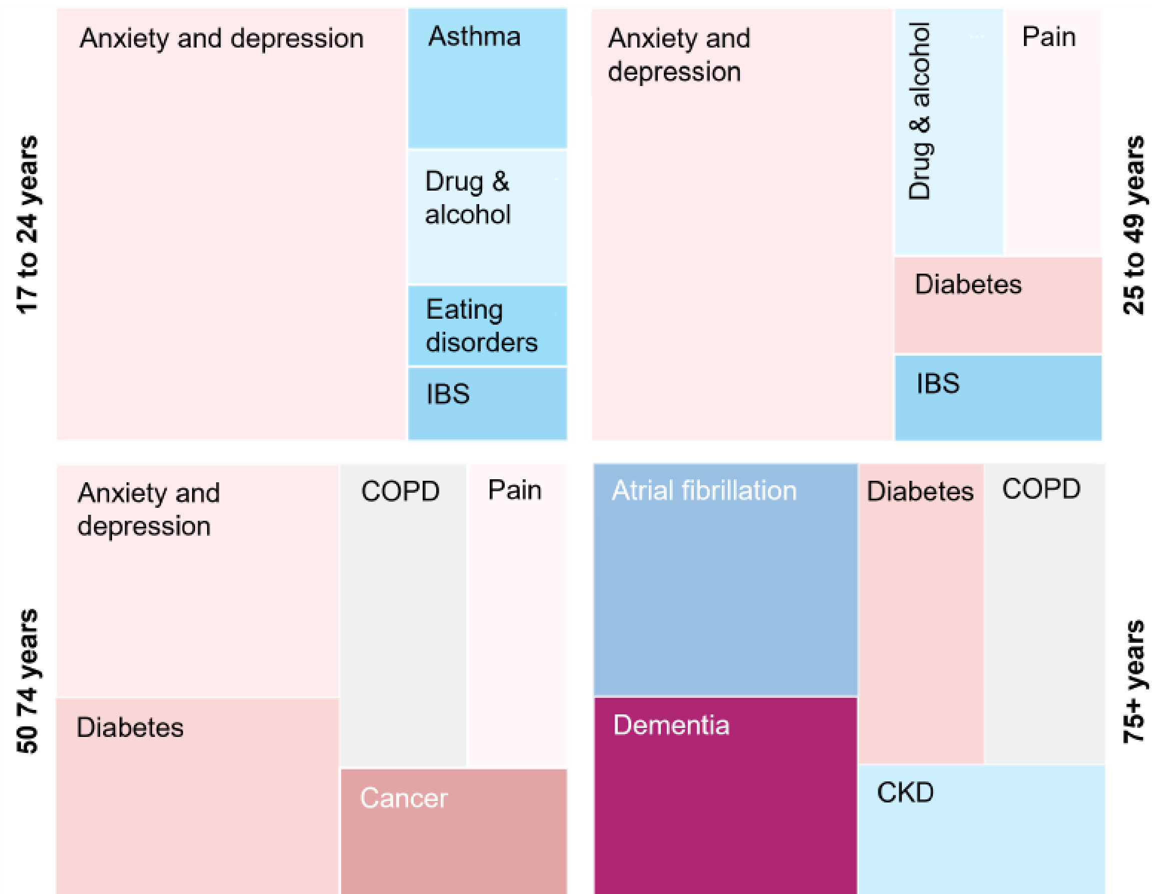
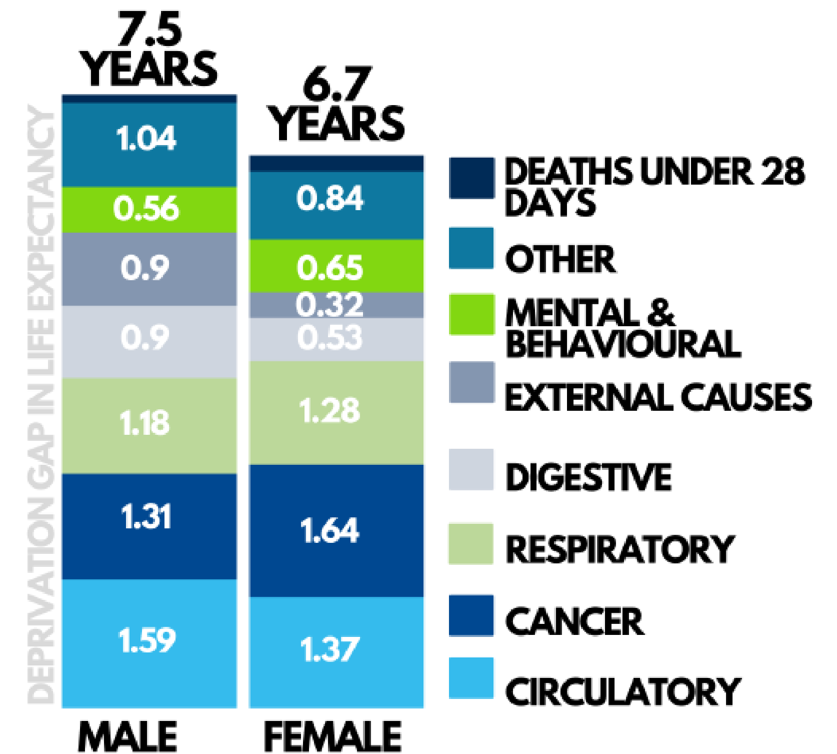


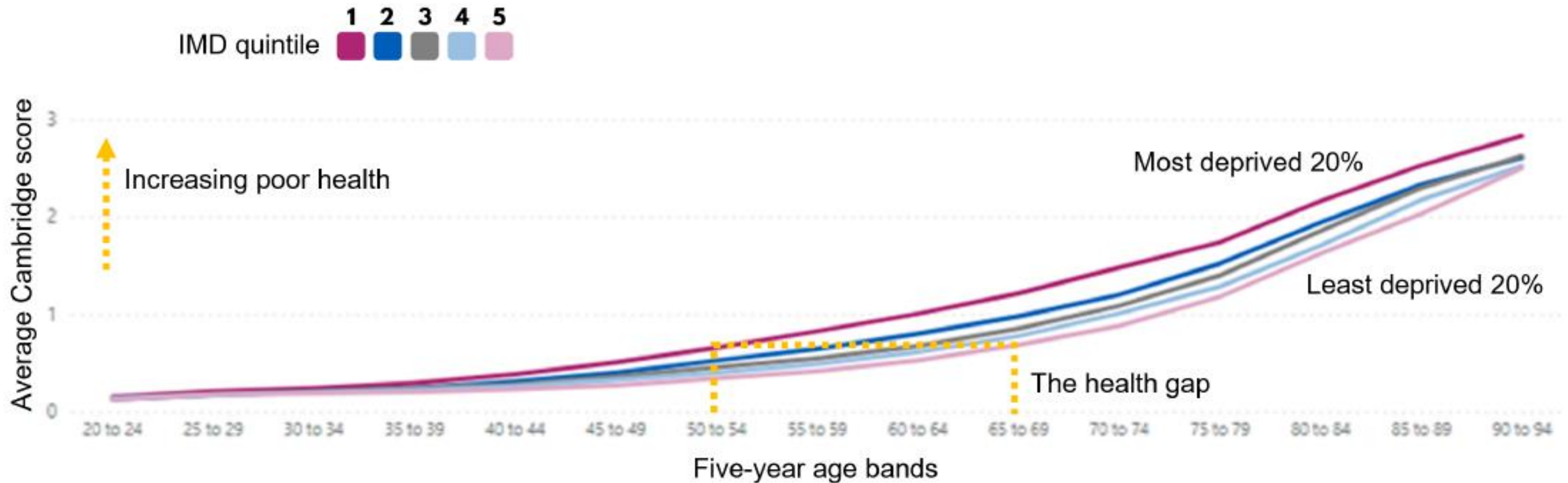
Figure 3.8: The life expectancy gap

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



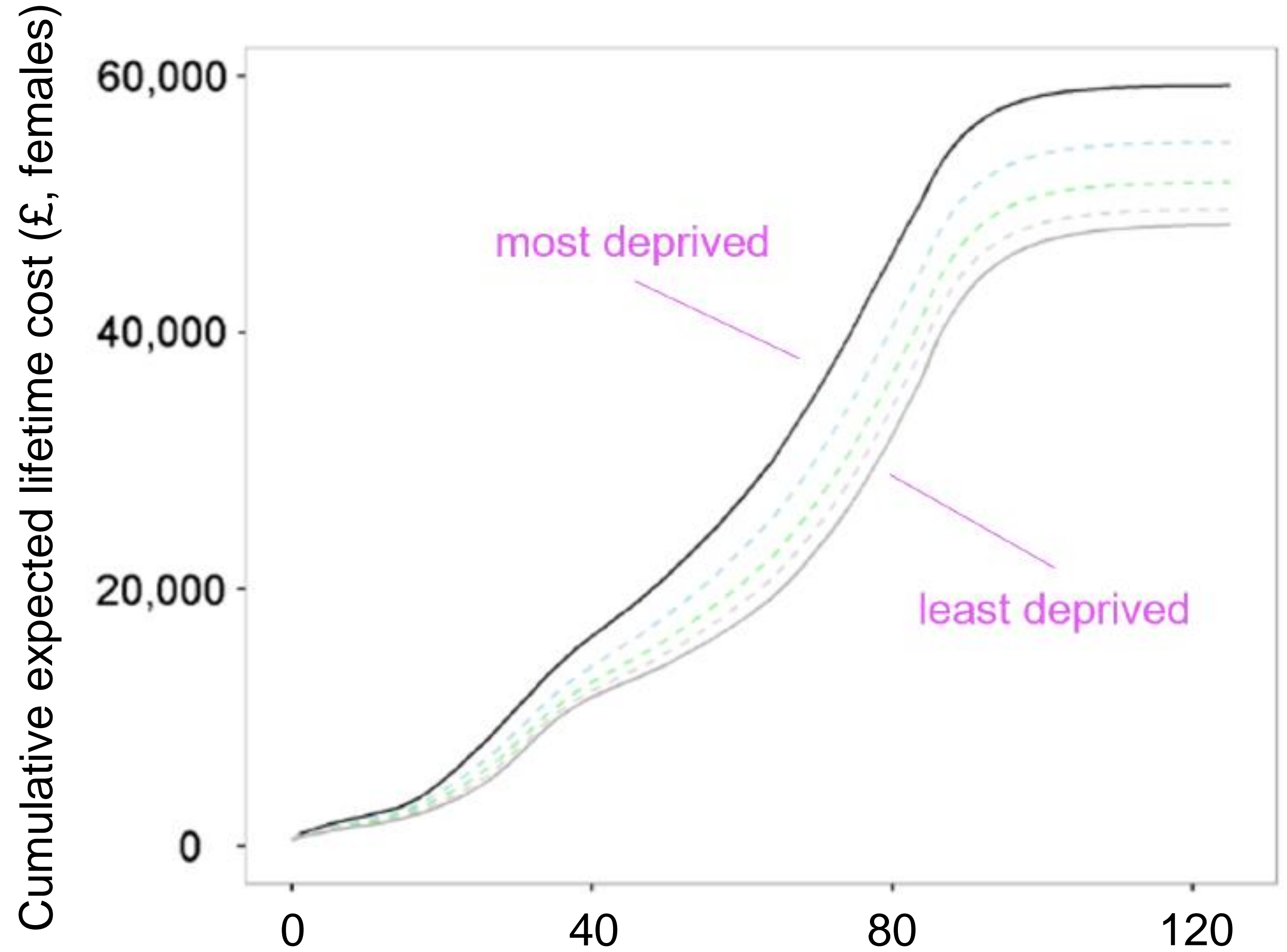
The population health mission

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



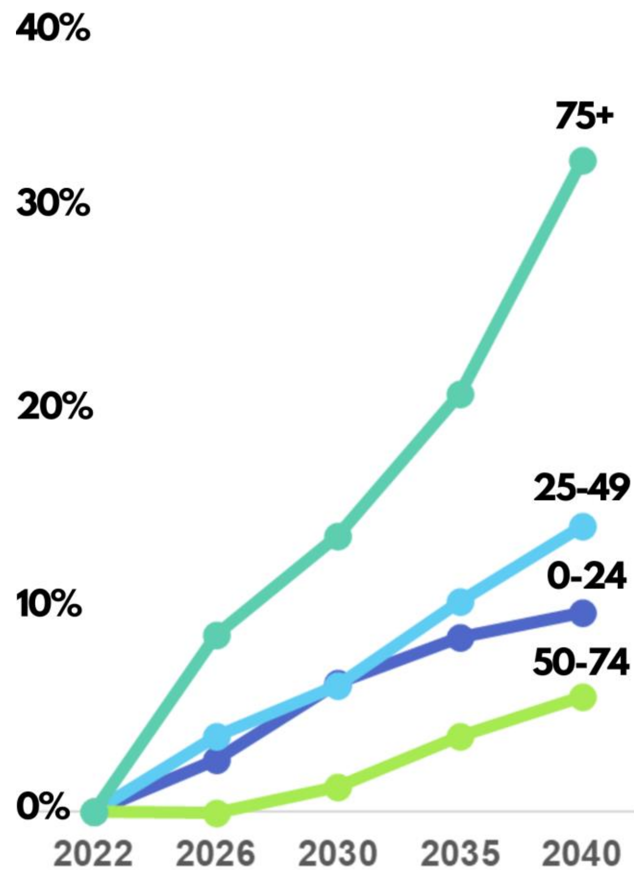
Inequality is expensive

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.

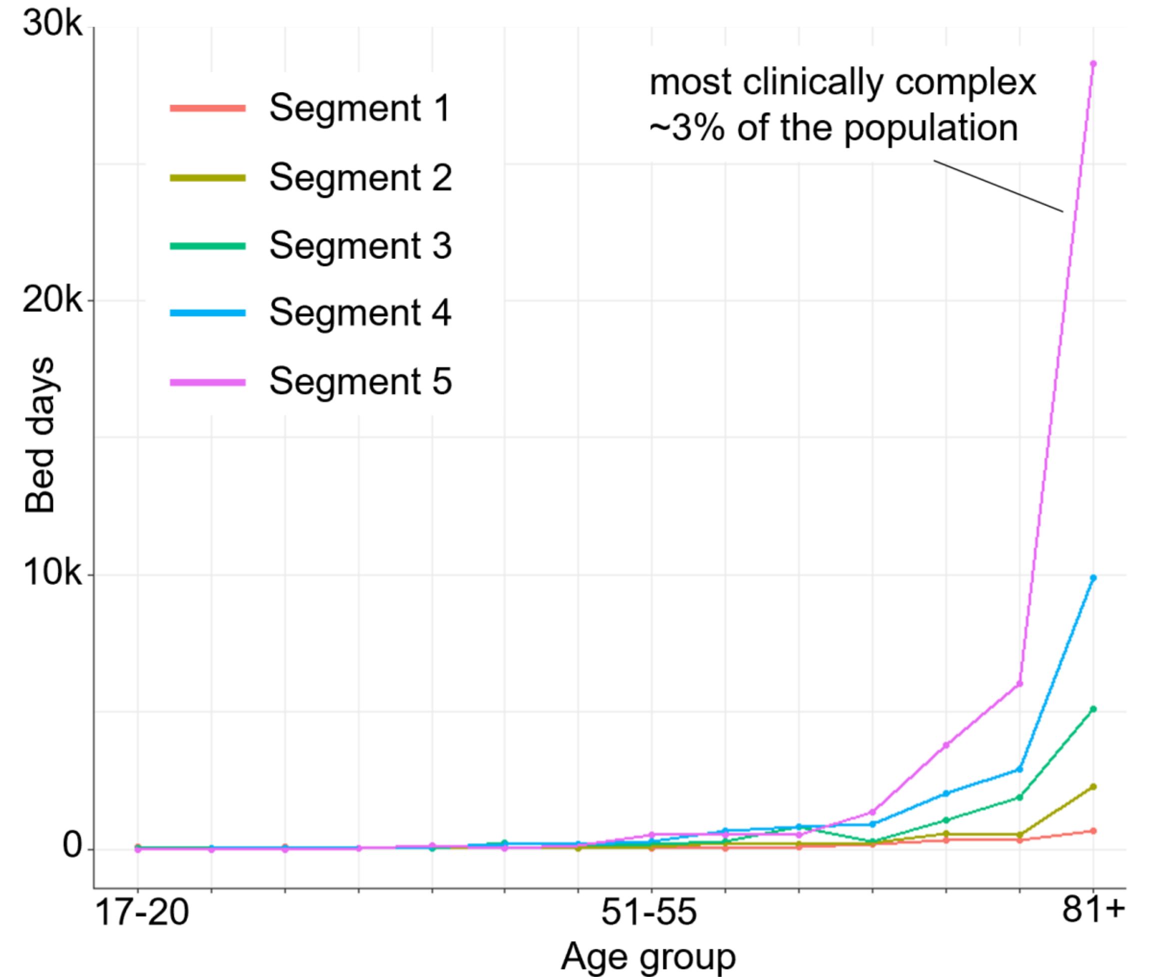


The population health problem

BNSSG population projections



Annual bed days due to falls by age and segment



Appendix 2

1st draft examples of Priority Outcome Proposals for strategic change (Jan 2023)

1. Ageing Population
2. Chronic Pain
3. Children & Young People with Autism

Healthier Together

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

1) Problem statement	2) Guiding Policy	3) Coherent Actions	Linked outcomes
Chronic pain The UK prevalence of chronic pain (present >3months) is ~43% and increases with age as predisposing comorbidities such as obesity, arthritis, diabetes mellitus and malignancy become more common. The commonest causes are back pain and osteoarthritis of the hips and knees, which together account for >65% of those suffering from chronic pain. A subset of those individuals, conservatively estimated at 10-15%, have disabling chronic pain that significantly interferes with their activities of daily living and is associated with poor health outcomes and inequalities and unsustainable growth in health and social care costs. Chronic pain also limits social and economic activity. • Chronic pain has the second highest impact on poor health in BNSSG after anxiety/depression (greater than diabetes) and has the highest impact in the over 50s, especially in areas of deprivation. Weston-Super-Mare is a 'town in pain' across all adult ages • There is significant overlap between chronic pain and mental health issues, especially anxiety and depression, and also with drug and alcohol dependency • When conditions cluster in an individual they often exacerbate each other. The most common clusters of three conditions in deprived areas in BNSSG are combinations of hypertension, depression/anxiety, diabetes and chronic pain • Healthcare costs are c5 times greater for people living with chronic pain for 12 months (c£3.485m vs c£0.719m per 1,000 population). Utilisation is increased across all locations and treatment modalities. • Painful musculoskeletal conditions such as low back pain and joint arthritis are some of the leading causes of sickness absence.	**Shift left** Develop integrated community support to improve outcomes and reduce avoidable costs **Support the whole person, address the causes of pain and prevent complications** Identify where people experiencing chronic pain are living with other conditions that may be exacerbating each other. Facilitate access to support to meet the whole person's needs. **Deliver local community-based pain management programmes much earlier in the pain pathway which address the causes of pain alongside symptoms.** There is increasing data that individuals with protected characteristics are under-represented across all pain treatment modalities. Work in partnership and engage with VCSEs, primary, community and specialist pain providers to improve equity of access and to reduce the impact of chronic pain on people's ability to work.	**Access:** provide information in multiple languages and distribute through a broad range of channels. Enable people to access support through multiple access points e.g. Pharmacies, VCSE organisations, Employers and Employment Agencies. Roll-out community-based pain management clinics at scale– based on findings from the BNSSG pilot(s). **Prevention:** support people to address lifestyle and/or other risk factors that may be causing and/or exacerbating chronic pain. **Clustered needs:** use data to proactively target pain management programmes to those people living with chronic pain, and other associated conditions, who are most in need and will benefit the most. **Integrated support for mental and physical health:** facilitate access to support for people living with chronic pain that may also need help with anxiety and/or depression **Inequalities:** use population health data to identify and target groups and work with community organisations to improve equity of access **Employment:** work in partnership with employers and Trade Unions to support staff to minimise the impact of chronic pain on their ability to work. Provide dedicated support for health and care staff **Workforce:** community-based workforce will need to be developed. Will require investment in training by psychologists for community staff and volunteers (e.g. for VCSE).	**POP1:** We will increase population healthy life expectancy across BNSSG and narrow the gap between different population groups **POP5:** We will improve everyone's mental wellbeing **SER8:** We will increase the proportion of people who report that they are able to access the services they need, when they need them **SER9:** We will increase the proportion of people who report that their health and care is delivered through joined up services **STA11:** We will reduce sickness absence rates across all our Healthier Together partner organisations

1) Problem statement	2) Guiding Policy	3) Coherent Actions	Linked outcomes
Children & Young People with Autism Our commissioned Autism assessment pathway is not delivering assessments in a timely manner leading to un-met needs with extensive impact, huge frustration and anger for families, poor working experience for clinicians and a large backlog of accepted referrals **Demand data** 2792 c&yp accepted and on waiting list for assessment. 1638 referrals waiting to receive outcome of triage. Referrals being received at approx. 130/month 40 assessment appointments available per month Pathway completely overwhelmed – many referrals deemed non-urgent means some c&yp and their families will wait years for assessment	Move system (and society) from being focused on diagnosis to being focused on meeting needs - “needs led” approach Reshape a support and assessment pathway that includes diagnosis but as a later option rather than a first thought Deal with current backlog Identify for assessment those c&yp who are urgent priority cases Signpost c&yp who are not triaged for assessment to other support	**Data:** consistent methodology to identify those with emerging neurodiverse needs **Strengths based approach**: system to jointly develop and embrace a “needs led” approach as has been successfully trialled in other parts of the country **Community support:** development of services and support that focus on anticipating need, meeting needs in most appropriate place rather than a diagnosis and crisis-driven model. 15 grant funded “needs led” services that are delivering support within the community to yp& families on waiting list. Local parent carer forums commissioned to provide face to face and virtual neurodiverse workshops 2021-2024 Keyworker team developed, recruited and operational, working with LD&A young people at point of crisis **Practical support**: working with c&yp and their families as neurodiverse challenges emerge. The User Experience autism diagnosis project will result in 4 digital support platforms later this year	**RES 5:** We will improve everyone's mental wellbeing **RES 6:** We will give the next generation the best opportunity to be healthy and well **SER 7:** We will increase the proportion of our residents who report that they are able to find information about health and care services easily **SER 8:** We will increase the proportion of our residents who report that they are able to access the services they need, when they need them **SER 9:** We will increase the proportion of our residents who report that their health and care is delivered through joined up services **STA12:** We will improve self-reported health and wellbeing amongst our staff

Healthier Together