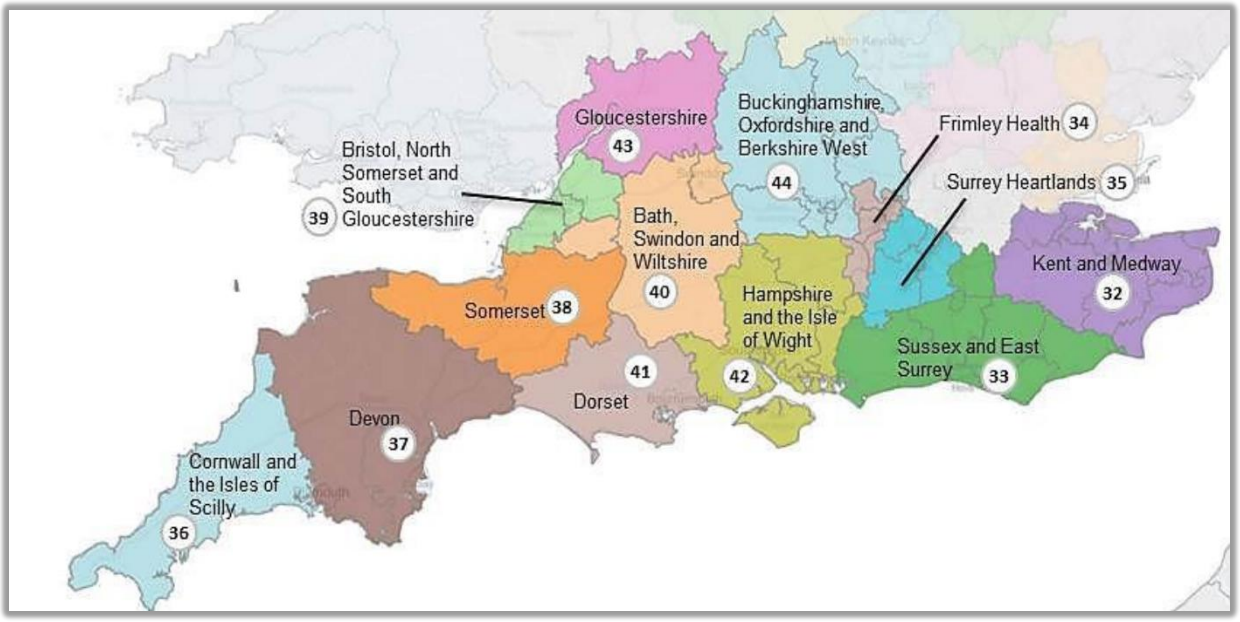
Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

Checkpoint submission - June 2016

KEY INFORMATION SUMMARY	
FOOTPRINT AREA: Bristol, North Somerset & South Gloucestershire (BNSSG)	**FOOTPRINT LEAD:** Robert Woolley, Chief Executive University Hospital Bristol FT
PARTNER ORGANISATIONS: **CCGS/COMMISSIONERS:** Bristol, South Gloucestershire and North Somerset CCGs, Bristol, NHS England **LOCAL AUTHORITIES:** South Gloucestershire, Bristol and North Somerset Local Authorities which includes the West of England Public Health Partnership **PROVIDERS:** Weston Area Health NHS Trust, North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, AWP Mental Health Trust, Sirona, Bristol Community Health, North Somerset Community Partnership, South Western Ambulance Service NHS Foundation Trust	
Version: 7.5	
Date: 30 June 2016	



Publication November 2016.

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Introduction

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

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

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

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

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

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

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

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

Chapter 1 – Case for Change

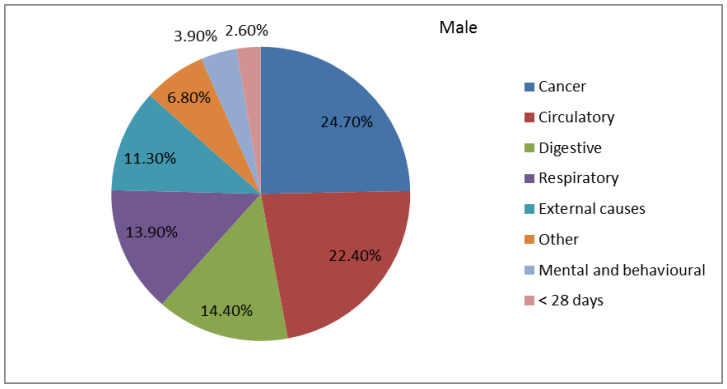
Our health and wellbeing gap:

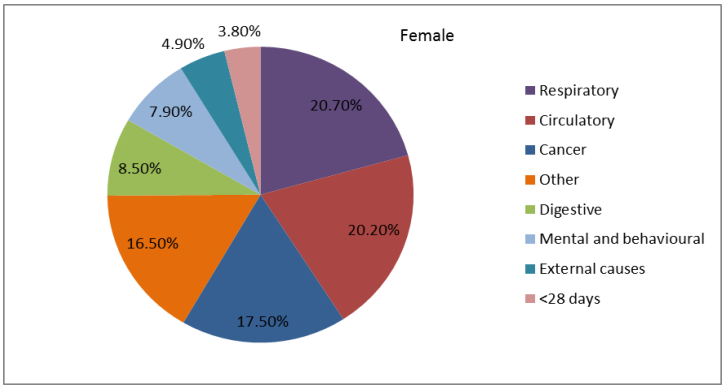
Our population is 968,314, with 17.5% (164,613) of the population living in the most deprived quintile areas of England (IMD, 2015). The population is projected to grow by 43,000 by 2021 with significant growth in both the under 15 and over 75 age groups.

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

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

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





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

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

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

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

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

Our care and quality gap:

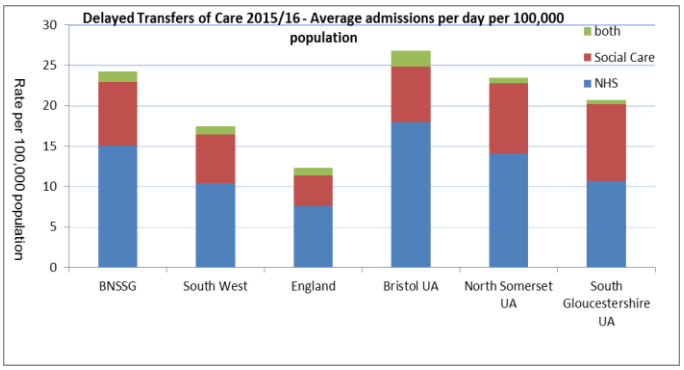
People who live in BNSSG and use our services tell us that they want integrated services closer to home; they don't want to have to negotiate organisational boundaries or have to repeat their story many times; they find it hard to understand how or where to access urgent care; and they don't understand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

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

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

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

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



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

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

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

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

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

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

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

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

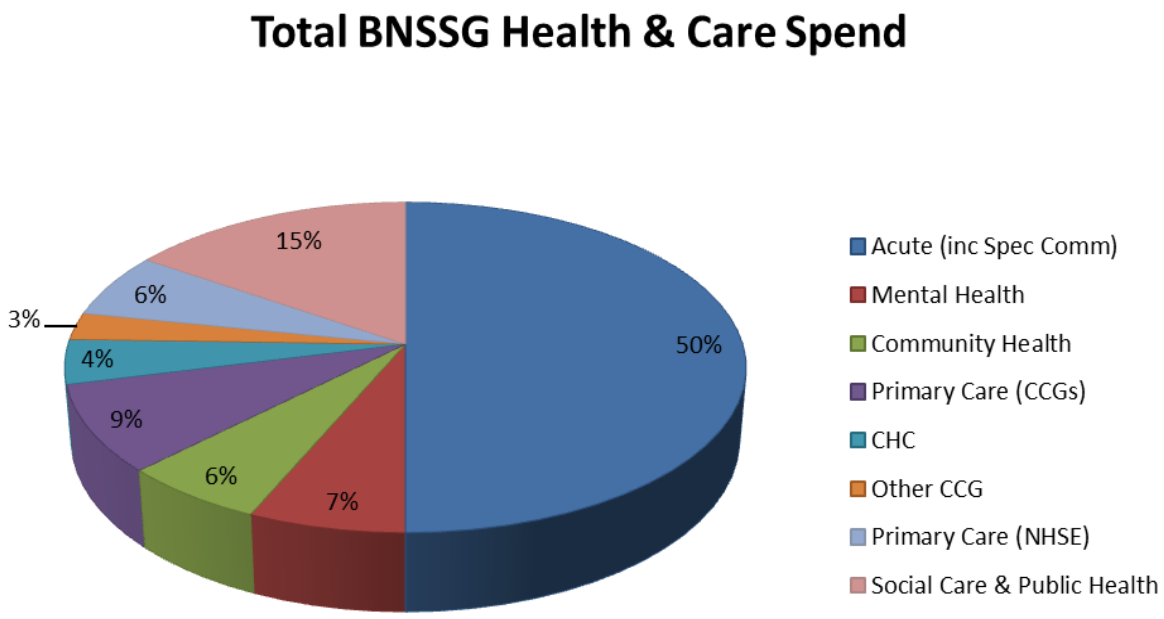
challenging, resulting in significant excess staff costs, under-utilised theatre capacity and a continuing risk to maintaining services.

Our Affordability Gap

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

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

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



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

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

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

Surplus / (Deficit)	2015/16 Actual £'m	2016/17 Plan £'m	2017/18 Plan £'m	2018/19 Plan £'m	2019/20 Plan £'m	2020/21 Plan £'m
Providers						
University Hospitals Bristol NHS FT (UHB)	3.5	14.2	6	5.7	5.9	7
North Bristol NHS Trust (NBT)	-51.6	-39.5	-39.5	-39.5	-39.5	-39.5
Weston Area Healthcare NHS Trust (WAHT)	-7	-3.2	-8.8	-9	-9.3	-9.6
Avon & Wiltshire Mental Health Partnership (AWP)	0.1	0.1	0.1	0.1	0.1	0
South Western Ambulance Service (SWAST)	0	0	0	0	0	0
Community Interest Providers	-0.2	-0.8	-0.6	1	0.8	0.5
Sub-total Providers	**-55.2**	**-29.2**	**-42.8**	**-41.6**	**-41.9**	**-41.5**
Commissioners						
Bristol CCG	5.7	-2.2	1.9	2	2.3	0
North Somerset CCG	-13.6	-13.7	-10	-7.2	-3.8	0
South Gloucestershire CCG	-9.3	-6.5	-7.2	-3	0	0
NHS England (Specialised Commissioning)	0	-0.5	0	0	0	0
NHS England (Mandated Primary Medical Care)	0	0	0	0	0	0
Sub-total Commissioners	**-17.2**	**-22.9**	**-15.3**	**-8.2**	**-1.5**	**0**
Total Organisational Financial Plans	**-72.4**	**-52.1**	**-58.1**	**-49.7**	**-43.4**	**-41.5**
Convert to 2020/21 "Do nothing"						
Remove sustainability funding assumed (UHB only)						-13
Remove CIP/QIPPS 2016/17 to 2020/21						-361
Total BNSSG "Do nothing" Position						**-415.5**

NB: The CCGs positions exclude Recovery of Annual Borrowing

This 20/21 position includes significant sustained deficits within NBT (£39.5m) and Weston (9.6m) reflecting specific drivers as follows:

NBT	**Weston**
Additional PFI costs £20m Impact of contractual levers CQUIN £1.5m Income shortfalls £10m Balance due to activity / emergency pressures £8m	£9.6m deficit mainly due to clinical sustainability issues

Summary

We have a clear shared understanding of the gaps in our system and their key drivers. Our agreed approach to addressing these issues and accommodating future growth in demand within available resources involves containing

and reducing costs individually and collectively, targeting productivity opportunities and transforming the way we plan, commission and deliver care over next 5 years. We need to invest in technology, self-care, prevention, and workforce to enable productivity initiatives. This is described in the next chapters.

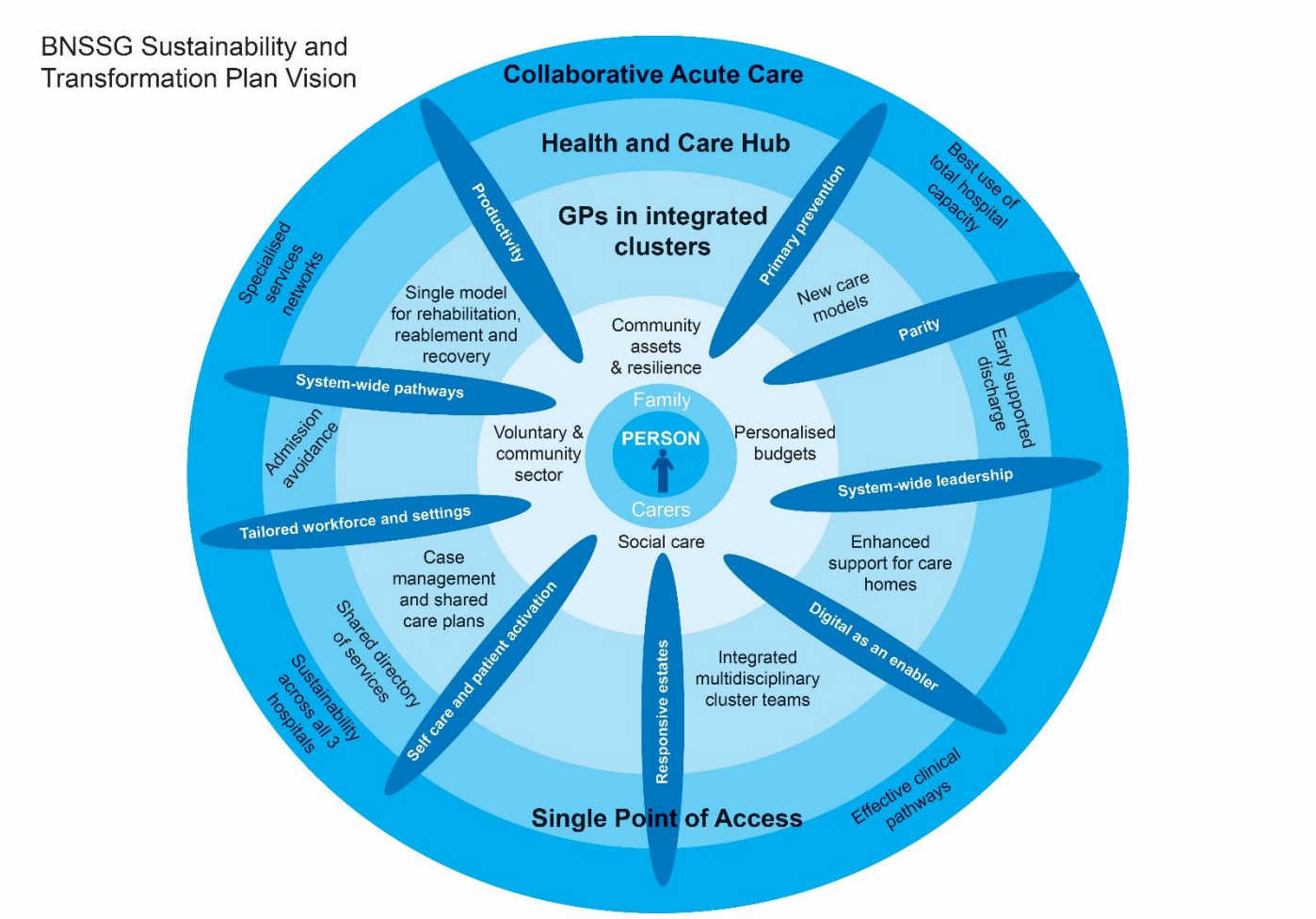
Chapter 2 – New Model of Care

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

Our current system is one in which hospital care is seen as the apex of the health and care system and people are seen as a collection of illnesses or problems usually dealt with separately.

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

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



We will deliver care consistently and at scale across our footprint as part of a fundamental change in the way we respond to demand. We will remain responsive to individuals and local communities and ensure appropriate care and support in the right place at the right time.

Disparities in care for physical and mental health conditions are everybody's business. Our model will ensure that parity is a golden thread running through the whole of health and social care provision. All forms of care will consider and value mental and physical health equally, so that people receive the treatment to which they have a right and will be supported effectively in their recovery. We will apply a 'parity test' to our services and developments and will challenge professional behaviours, attitudes and policies that stigmatise mental illness. Our staff will show the same respect for each other, wherever they provide health or social care or treatment.

Drivers of change in our new model of care

In order to deliver the change required we will need to behave differently. We have agreed that there are five key drivers that together will enable us to develop and implement our new model of care.

1. We will standardise and operate at scale:
   We need to standardise the care that is delivered across our system to reduce variation and reduce fragmentation. At the same time we need to work at scale. This means developing a single commissioning voice, increasing collaboration across our acute hospitals and operating at scale in primary and community care around defined populations.

2. We will develop system-wide pathways of care:
   We need to address the variation in pathways across our system. This means redesigning pathways from a population perspective in a way that is clinically led, includes prevention and self-care at all stages, and ensures consistent quality and access across our footprint.

3. We will develop a new relationship with the population:
   We need to simplify access to the health and care system for our population and deliver services predominantly in the community that appear seamless. At the same time we need to enable people to care for themselves. This means developing single points of access, multidisciplinary teams and a shift to prevention and early intervention.

4. We will develop new relationships between organisations and staff:
   We need to remove organisational boundaries that impede integrated working and support our staff to deliver better services. This means developing interoperable IT and HR systems, aligning resources with individual need and system efficiency rather than organisational priorities and promoting the health and wellbeing of our staff.

5. We will build on our existing digital work as a driver and enabler of cultural change:
   We need to use technology to drive a cultural change in the way we work. This means developing mobile working for staff, digital medical records, and solutions for self-care and prevention.

Our plans are articulated in more detail in the chapter below setting out how our drivers will deliver change in three key areas;

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

This approach is summarised on our Plan on a Page below. We believe this approach allows us to address the '10 questions' to achieve the 5 Year Forward vision and have summarised these below.

	Standardise and Operate at Scale	New Relationship with population	New Relationship with staff and organisations	Care pathways	Digital as a driver and enabler
Preventing ill health and reduce demand		X		X	X
Engage communities and staff	X	X	X	X	X
Support and improve general practice	X	X	X		X
Implement new models of care	X	X	X		X
Achieve and maintain performance against core standards	X			X	X
Achieve national clinical priorities by 2020		X		X	X
Improve quality and safety	X			X	X
Use technology to accelerate change		X	X		X
Develop the necessary workforce	X		X		X
Achieve and maintain financial balance	X	X	X	X	X

Our Plan on a page

Our case for change

Our health & well-being gap	Our care & quality gap	Our finance and efficiency gap
Premature mortality, the burden of disease and mental health conditions is increasing demand for health and care , with limited patient activation and continued inequalities	Unacceptable variation in care and quality outcomes and under investment in primary, preventative and community care resulting in fragmented, poorly integrated and complex system focused on acute care	increasing pressure on resources due to demographic changes, recruitment and retention issues , financial constraints and cost variations. Our "do nothing" gap will be £415m by 2020/21

What we will do differently

Standardise and operate at scale	Consistent pathways	A new relationship with our population	A new relationship with organisations and staff	A shift to digital

Our Service Model Focus

Prevention, Early Intervention & Self-Care	**Self-care and patient activation** will be implemented at scale with consistent delivery across our system	**Population focussed standardised pathways** to reduce variation, activate the population and increase proactive prevention	**Innovative care settings and digital reach** to enable self care and maximise use of all community assets	**Targeting and reducing health inequalities** with a focus on key at risk groups to make early impact
Integrated Primary & Community Care	**Stable and sustainable primary care at scale - cluster based primary care** to deliver a 7 day service model and facilitate delivery of the 10 high impact actions within the GP 5 Year Forward View	**Integrated cluster-based care and support** through one integrated model of care based on health and social care multi-disciplinary teams operating at scale, supporting primary care clusters and targeting support through population based, risk stratification.		**Health and Care Single Point of Access** to simplify and standardise emergency and urgent pathways
Acute Care Collaboration	**Specialist services & Networks** developed to consolidate and network Bristol hospitals for specialist services avoiding unnecessary travel for patients to more costly providers out of region.	**Effective Clinical Pathways** across our provider landscape to improve quality, reduce costs and variation with a focus in the short term on high volume and high-cost services.	**Best Use of Hospital** capacity to maximise bed productivity, achieve a sustainable level of acute occupancy and release capacity to reduce unit costs and secure sustainable delivery of constitutional standards.	**Sustainable acute services including Weston General Hospital** through collaboration and clinical networking.
Enabling the Change	**Leadership & Governance** to share and build capacity and capability, achieve balance between system priorities and benefits and individual organisations and manage risks	**Working together to develop our workforce and deliver productivity** collaborating to build new skills, reduce duplication and support collaborative working	**Engaging and communicating with our stakeholders**	**Making best use of our collective estate**	**Driving our Digital ambition** to fundamentally change how we work, doing things differently and working together differently.

The impact we will make

Our collaborative working and new models of care will enable us to develop and sustain appropriate capacity across all parts of health and care to ensure we can effectively and affordably respond to growing demand and achieve greater productivity and efficiency than working alone. Specific impacts we will deliver will include increasing the appropriateness and effectiveness of interventions in the right setting; reducing hospital admissions, readmissions and ED attendances; increasing resilience and capacity in primary care; achieving standardisation of pathways and processes that improves patient flow, reduces duplication, improves quality outcomes and increases efficiency and performance against standards; developing our staff to work in an integrated way with parity and trust across all teams; maximising use of our collective estate; and a digitally enabled system.

Through this plan we have the opportunity to reduce our affordability gap to £60m and we will continue to work to build evidence for achieving balance.

Chapter 3 –Delivering the New Model of Care

3.1 Integrated Primary and Community Care

In our new model, clusters of GP practices will be responsible for the health and wellbeing of their populations 7 days a week. They will be responsible for coordinating the mental and physical health and social care and support of populations, operating within larger multispecialty community providers, primary and acute care systems, or other appropriate models.

The required level of care for individuals and populations will be identified using risk stratification, and delivered through multidisciplinary working and integrated systems of care.

General practices - as key assets in their community - will support community resilience, link with community and voluntary sector groups, and support local people to stay as well and as healthy as possible. Clusters will vary in size depending on the requirements of their populations but will serve approximately 30 to 50 thousand people.

A range of different collaborative arrangements are already under discussion across BNSSG. At present, GP practices in South Gloucestershire are arranged into 6 clusters; North Somerset has 4 localities; and Bristol has 3 localities within which there are a number of emerging clusters.

The integrated model of primary and community care will enable:

- A sustainable 7 day model of primary care for BNSSG, facilitating delivery of the 10 high impact actions within the GP 5 Year Forward View
- Delivery of more specialist care in the community by moving whole elements of routine and urgent care out of hospital e.g. for those with long term conditions and frail older people
- Reduction of inappropriate use of hospital beds by a standardisation of systems across organisations and levels of care including delivery of community based routine care in place of traditional outpatients, urgent and planned admission avoidance support and supported discharge
- More efficient, integrated health and social, primary and community care through application of consistent best practice, use of digital solutions, joint estate options and integration and delivery at scale
- A holistic person-centred approach encompassing physical and mental health needs with social care and community support

The central theme is ‘person-centred, coordinated care’, bringing together services and health and social care professionals from across the health and care systems.

Transformation

The key elements of the new model for integrated primary and community care are:

1. Sustainable primary care at scale – cluster based primary care
2. Integrated cluster-based care and support
    a. Population based, risk stratified care and support – one integrated model of care based on health and social care multi-disciplinary teams operating at scale, supporting clusters
    b. Targeted support for those at risk of admission or following discharge or towards end of life, through case management or a virtual ward model and holistic care planning

   c. Rapid response for urgent care needs, consistent across BNSSG, including community based crisis support for those with mental health conditions preventing avoidable admissions
   d. One model of sustainable rehabilitation, reablement and recovery supporting a return to independent living and enabling use of personalised care budgets.
3. An integrated health and care single point of access (SPA)
   a. One single standard service provided across BNSSG, which is aligned to each acute hospital, to prevent admission and support early and effective discharge.

Sustainable primary care at scale – cluster based primary care

In order to deliver sustainable primary care 7 days a week, core primary care will become more multi-disciplinary. Work has already started across BNSSG, using the Prime Minister's Challenge Fund and the National Primary Care Home Initiative to test new ways of working. Options including direct access physiotherapy, clinical pharmacist pilots, integrated primary and community nursing, multi-disciplinary community teams, social prescribing and community navigators are being tested within BNSSG.

Greater use of technology to change the way care is provided will be facilitated by easier communication between primary and secondary care and by access to records held outside practices.

The recent decision to adopt a single voice for primary care providers within BNSSG provides a significant opportunity to help practices collaborate and consider how they will implement the GP five year forward view.

Integrated cluster-based care and support

a. BNSSG will jointly work on a population risk based approach, identifying the required levels of care and whether these can be delivered at an individual GP, cluster or integrated multi-disciplinary team (MDT) level. This will build on existing integrated models of care which support those with respiratory conditions; diabetes; frail older people and those living in care homes. Bringing mental health into the MDT approach means better access to appropriate advice and guidance.
b. A single model of enhanced care for residents in care homes will be developed working with care homes to improve staff clinical, management and leadership skills through training and supervision/support and to deliver new shared models of care e.g. enhanced community matron support to Extra Care Housing.
c. In consultation with the urgent and emergency care network, we have aligned our plans with the key priorities for the urgent and emergency care system. This includes the development of one health and care SPA, and also a multi-disciplinary approach to developing urgent primary and community care e.g. mental health, pharmacy, social care. This will facilitate direct referrals between services and is likely to include the ability to make direct bookings into primary care and community services such as Rapid Response from Emergency Department (ED) and 111 as part of joint front door arrangements as well as an increase in capacity in mental health crisis teams.
d. There has already been considerable work to align discharge pathways across BNSSG using a Discharge to Assess model. Models of reablement, rehabilitation and recovery are in place and capacity being brought on line across BNSSG. Further work will be done to ensure the capacity required is available those with dementia.
e. This approach provides a platform for patient education and activation, encouraging prevention through improved lifestyle choices, more self-care, more appropriate use of health services and choices which are both better for patients and families and can be delivered at reduced cost. Individualised commissioning, or personal health budgets, based on more meaningful conversations with patients and families will support this.

An Integrated Health and Care SPA

A Single Point of professional Access (24/7) with underpinning technology and information sharing, will be linked to all of our acute hospitals, connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

This will integrate as required with the proposed urgent and emergency care network integrated clinical hubs and will be underpinned by a shared directory of services to ensure consistency of approach and integration where this makes sense.

It will operate under single management and to common Standard Operating Procedures, staffed by care co-ordinators working with their cluster practices and hubs, with access to capacity including community beds across the system, and deploying in-reach clinical staff into hospitals.

The focus will be to ensure the most appropriate care in the community to prevent admission and facilitate discharge through:

Prevention of Admission

- Co-ordination of urgent care case management including improved responses for those presenting with mental health crises and dementia.
- A standard integrated offer to people presenting at ED at risk of admission or for whom an alternative to admission would be a better option, including ambulatory care.
- Co-location with Out of Hours service call-handlers and the supported self-care hub, and potentially with 111 and ambulance services.

Supported discharge

- Supporting wards to discharge simple and complex patients and enabling service users or their carers to arrange their own discharge so that no medically fit person need remain in a hospital bed for more than 24 hours.
- Maintaining links with practices during a hospital stay, with GPs as the main co-ordinator after discharge, supported by a single model of rehabilitation and reablement services.

Supported self-care

- Early intervention, prevention and supported self-care in primary and community settings e.g. supporting people using technology, motivating, coaching and activating people to self-care and improve their lifestyles or comply with their agreed care plan.

Non clinical interventions, signposting and community assets

- Delivering a social prescribing model to harness existing local resources in the community and voluntary sector e.g. reducing social isolation.

Impact

We expect this model to support delivery of care in more cost effective settings, in particular preventing future reliance on acute physical and mental health beds, but also to ensure more efficient and consistent delivery of care in primary and community settings. Specifically we expect the model to have the following impacts:

Activity / Initiative	Description	Impact	Alignment to Drivers of Change
Integrated cluster based care and support	More efficient primary and community care through delivery of integrated, digitally enabled working and greater reliance on alternatives such as social prescribing and self-care	An overall 15% avoidance of future primary and community contacts.	Relevant to all 5 drivers
	Coordinated care for those with long term conditions, multi-morbidity, frailty including dementia and for those who live in care homes and those with end of life care needs	An overall reduction in admissions of 30% and of ED attendances by year 3, modelled for very specific long term conditions or population groups e.g. those in care homes, reflecting Right Care approaches to maximising value across the pathway. Length of stay reductions are modelled within the Acute care workstream so not duplicated Elements of this reduction has been tested to a degree in a number of smaller scale QiPP initiatives and can be scaled up	Consistent pathways New relationship with population New relationship with staff and organisations
	Coordinated crisis support and care for those with mental health conditions including specific pathway work for those with personality disorders	2.5% reduction in admissions and free up capacity for increased demand to an equivalent value of £1m	Consistent pathways New relationship with population New relationship with staff and organisations
	Reduced outpatient attendances for defined cohort (first and follow up) by providing alternatives via cluster based MDT or through self-care, group delivery and digitally enabled care	Relevant specialties will have their first attendances reduced by 30% and their follow-ups will match national first to f/up ratios. The counter-balance will be approximately 1 in 3 of the reduced activity will require some form of community activity	Relevant to all 5 drivers
Health and care hub	An integrated BNSSG health and care hub at Hospital level	All modelled activity reductions are set out above in the Cluster-based care initiative to avoid double-count	Relevant to all 5 drivers
	More efficient utilisation of community beds by streamlining access and “type”	Reduction in length of stay to best for bed “type”. Releasing further beds to the system and a small saving	Relevant to all 5 drivers

3.2 Prevention, Early Intervention and Self-Care

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

The model is based on four principles:

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

Transformation

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

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

Impact

Our initial priorities are:

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

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

Our priorities are enabled by:

- an established patient-centred Bristol, North Somerset & South Gloucestershire health and care partnership approach
- the development of a new relationship with the public and the delivery of the shift of care from an acute setting to primary and secondary and self-care with a reduced dependency on beds and increased use of health and social care hubs and signposting
- wider definition of workforce to include for example voluntary sector, police, housing, pharmacy; and a non-differentiated workforce across BNSSG with common training and standards.
- digital platforms and technologies such as personal health records, telehealth and app development.

Priority	Impact	Methods to measure impact
Alcohol - reduce excessive alcohol consumption and associated burden on NHS and Local Authorities (LAs) and wider society	Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs by 2020/21 Reduce the burden on NHS, police and social care services from high volume service users Reduce the impact of parental alcohol misuse on children	Alcohol-related hospital admission (narrow measure): number of admissions (by CCG and LA) Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission (by CCG) For every 3 IBA interventions delivered 1 alcohol-related admission will be avoided[1] Ambulance call-out data
Falls - reduce fractures from repeat falls.	10% reduction in the number of injuries due to falls in people aged 65+ by 2020/21, through improved and more coordinated preventative services	Emergency admissions due to hip fractures in people aged 65+ per 100,000

[1] Public Health England

		Patients with fragility fracture and confirmed osteoporosis treated with bone-sparing agent Fracture liaison services can reduce risk of second fracture by up to 50%[2]
Diabetes – prevent cases of Type 2 diabetes and improve management of those with diabetes	Reduce the projected growth in incidence of diabetes Improve support for self-care in people with a diagnosis of diabetes Improve the treatment and care of people with diabetes	Uptake of the NHS Diabetes Prevention programme Incidence of diabetes
Supported self-care at scale	Reduction in emergency admissions of LTC group with above average risk of admission Develop training for health professionals and population Self care enabled via digital supports	22-32% reduction in emergency admissions of LTC group with above average risk of admission (25%)[3] Patient Activation Measure

Medium and long-term priorities

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

Activity / initiative	**Description**	**Impact**	**Alignment to Drivers of Change**
PATHWAYS			
Healthy lives	Obesity reduction, smoking cessation and continue work on alcohol harm reduction	Reduce related hospital admissions	Consistent pathways A new relationship with the population
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG and build on self-care work already underway*		
Primary prevention - adults	Dementia and stroke prevention	Consistent pathways across BNSSG with prevention integrated across pathway	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on atrial fibrillation and impact on stroke prevention & return on investment*		
Mental health - Children and young people	Provide appropriate support and services focusing on the emotional wellbeing and mental health of children and young people Work with schools, Children's Centres etc.	Consistent pathways across BNSSG with a strong focus on prevention and early intervention prior to any formal diagnosis	Relevant to all 5 drivers
Intervention	*Ensure services reflect need particularly for those sub-threshold in terms of clinical diagnosis.* *Ensure consistent offer across BNSSG and access to appropriately designed prevention and self-care initiative in appropriate settings – base on existing examples of good practice.* *Reduce attendances due to self-harm.*		

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

[3] BCH/Philips project

Secondary prevention - adults	Secondary prevention: atrial fibrillation, hypertension, hypercholesterolaemia, LTCs (multi-morbidities), cancer prevention via a range of health professionals	Ensure consistent pathways across BNSSG	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on evidence for return on investment for health and social care*		
Ambulatory care	Develop/build on prevention and self-care services	Reduce ED attendances and admissions.	Consistent pathways A shift to digital A new relationship with the population
Intervention	*For example develop/build on self-management for COPD; rapid response teams at home; EOLC*		
Sexual health	Focus on contraception and return on investment	Reduce associated costs of less effective contraception	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Increase take up of more effective contraception (LARC)*		
Health protection	Flu programme Antimicrobial resistance and link to self-care	Reduced primary and secondary care attendances	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Focus on potential to reduce:* *GP consultation rates for influenza-like illnesses; A&E attendances for respiratory conditions; Emergency admissions for confirmed influenza* *Impact of health and social care reduced capacity and performance due to staff absence; Antibiotic prescribing for secondary bacterial pneumonia (and resultant risk of a rise in antimicrobial resistance); Outbreaks in acute and community settings requiring special management arrangements; Parental leave to care for ill children; Excess winter mortality, particularly in identified at-risk groups.*		
WIDER DETERMINANTS OF HEALTH			
Reduce harm caused by social isolation	Provide adequate support for the frail elderly and reduce the harm caused by social isolation	Reduce ED attendances and admissions.	Consistent pathways A new relationship with the population
Intervention	*Ensure consistent support and signposting across BNSSG with a focus on evidence for return on investment, building on existing support services and social prescribing*		
Expand prevention activities within NHS providers	Create healthier environments in health and care providers and local employers.	Healthier workforce – positive impact on workforce retention	A new relationship with staff and organisations
Intervention	*Ensure consistent messaging conveyed to the workforce. Include link to enabling those with LTCs to work. Consistent approach to workplace health across BNSSG starting with health and care providers and broadening out to other employers*		
Inequalities	Take a BNSSG approach with a focus on inequalities within BNSSG rather than regional comparisons	Equal access to the right prevention/early intervention/self-care initiative in the right place at the right time	Relevant to all 5 drivers

Intervention	*For example review excess winter deaths and link to inequalities*		

3.3 Acute Care Collaboration

This part of our model is about the acute care system and not individual providers. The following principles for how we commission and deliver acute physical and mental health care have been agreed:

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

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

Reducing utilisation of acute hospital bed base

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

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

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

Transformation

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

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

3.3.1 Best use of hospital capacity

Within our system at the moment all of the hospitals operate at inefficient levels of bed occupancy for the majority of the year. During winter months elective cancellations are high. BNSSG has high hospital admission rates with inappropriate use for Ambulatory Care Sensitive conditions and End of Life care. The aim is to reduce bed occupancy to average 90% over the year and maximum 95% at times of peak demand.

Our key actions to address this will be to:

- Improve bed use through reduction in delayed discharges and achievement of upper quartile length of stay
- Work in partnership with primary, community and social care to improve assessment processes in acute and mental health hospitals to minimise delay to complex discharges
- Support development of capacity and capability of community services with delivery of hospital based services such as 'Hot clinics' and diagnostics so that patients are only in hospital beds when necessary
- Embed best practice in managing hospital patient flow in all providers
- Maximise ambulatory care pathways that avoid hospital admission in all health communities, sharing best practice between providers
- Develop high quality care 7 days per week sharing hospital resources and work force to provide a consistent offer whilst minimising additional investment
- Enhance partnership working between clinical staff and patients so that interventions are only undertaken when they will add value to an individual's quality of life. Share provider's experience in creating this culture change

3.3.2 Effective Clinical Pathways

The vision for the whole system is to make best use of hospital capacity and ensure that patients receive the right care first time. Although described here effective clinical pathways will need changes across the system and not just in hospital.

Highest impact pathways will be chosen from a review of Getting it Right First time (provider focus) and Right Care (commissioner focus) data as well as the Optimal Care tool developed by the CLAHRC-West. Pathway reviews will be guided by our newly established Clinical Cabinet and all new pathways will be evaluated to ensure elimination of unwarranted variation in practice and to avoid unintended consequences.

Urgent and Emergency Care

The paediatric major trauma centre is at University Hospitals Bristol and the Adult MTC is at North Bristol Trust. All of the acute Trusts in the foot print are members of the Severn Urgent and Emergency Care Network (SUECN). The network is developing a Delivery Plan that will support further development of the STP urgent services;

Our key actions will be to:

- Create a Clinical Cabinet and process to prioritise pathways for review and to ensure reviews are clinically led and involve clinicians from within hospitals, community and primary care, and public health
- Review the capacity, demand and cost profile of Trauma and Orthopaedic services to manage the increasing demand in a system that already has a back log of work and high reference costs
- Develop stroke pathways that provide the highest quality care in the hyper-acute setting and rapid discharge to an out of hospital rehabilitation environment at the earliest opportunity
- Avoid admission for end of life care where possible and provide early discharge to a place of the patients choice by enhancing care in the community
- Address the poor outcomes of diabetic care that result in increased amputation rates and other complications
- Maximise care in the community for patients with respiratory disease with pathways that reduce the seasonal increase in admissions in the winter
- Address the high cost and variation in hospital length of stay in cardiology

- Work with Mental Health providers, acute Trusts, community and primary care to make most appropriate use of acute mental health bed capacity and ensure patients receive physical and mental health care rapidly in the most appropriate setting, aiming for care close to home whenever appropriate, avoiding out of area placements.
- Focus work with Bristol Children's Hospital through the emergent Children's Community Health Partnership, to increase community based care and ensure that growing demand can be accommodated within current resources
- Review the infrastructure for Radiology and centralised Pathology to support rapid access for primary and community care, specialist services in hospitals 7 days a week and make best use of future opportunities for personalised medicine

3.3.3 Specialised Services

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

Our key actions will be:

- Support commissioner led review of specialist rehabilitation pathways focussed on neurosurgery, trauma, vascular and stroke patients
- Support continued development of the Operational Delivery Networks and a Cancer Alliance hosted by the acute Trusts to enhance their ability to deliver effective pathways
- Review clinical leadership and management oversight for the level 3 neonatal units in Bristol so that they meet the required designation standards within available resources
- Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services with a new provider partnership model including third sector members.

3.3.4 Weston Sustainability

The specific issues with the sustainability of services at Weston General Hospital are being addressed through a North Somerset Sustainability board within the auspices of the STP. The three acute Trusts in the STP together with commissioners are committed to working together to describe models that provide high quality care to residents of North Somerset maximising the value of available resources. The solutions will be aligned with the recommendations in 5 Year Forward view for smaller hospitals

Key actions and opportunities for the system in achieving a sustainable model at Weston are:

- Support the ongoing resilience of the emergency services ahead of winter 2016/17
- Work with the North Somerset Sustainability Board to identify future models of care during 2016/17
- Agree models to maximise use of the Weston hospital estate for example, operating theatre capacity to meet elective demand across BNSSG.

Impact

Activity / initiative	Description	Impact	Alignment to Drivers of Change
Best Use of Hospital Capacity	Reduce bed day demand and improve bed productivity through a reduction in delayed discharges and achievement of upper quartile LOS. Address the volume of patients currently experiencing a delayed discharge across our acute mental health bed base, resulting in out of area placements, to the potential value of up to £3.3m per year. Improved partnerships with primary, community and social care to improve assessment processes in hospitals, complex discharges, support increased assessment out of hospital and enhance community based capacity. Achieve reduction in admissions through development of self care and prevention and community / primary care based intervention, through driving a 'single front door', as part of the Urgent Care Network delivery plan, and enhancement and development of ambulatory care pathways. Development of 7 day services across the system.	Achievement of upper quartile LOS in top 3 impact areas (not linked to DTOC). 50% reduction in current level of patients in acute beds who are Medically Fit For Discharge (MFFD), which includes an 85% reduction in the number currently meeting the national DTOC definition Potential impact of bed day activity released in the region of 200-300 acute beds, including acute mental health beds. Reduction in out of area mental health placements. To the potential value of £3mReduction in admissions linked to self-care work stream and Urgent Care Network Delivery Plan. Sustainable delivery of access standards. Decreased use of outsourcing to independent sector for elective activity. 7 day coverage for emergency care. Increase in ambulatory care pathways	Standardise and operate at scale Consistent pathways A new relationship with our population
Effective Clinical Pathways	Year one focus on MSK/T&O pathways, building on BNSSG T&O Steering Group and supported by the Intensive Support Team (IST). Stroke Care –for acute stroke and minimum hospital stay during stroke rehabilitation. End of life care –Reducing unnecessary admission at this time and support early discharge to community care where possible. Diabetes –address our outcomes and reduce the cost of managing complications. Cardiology and Respiratory – further understand opportunity to manage demand with out of hospital solutions. Emergency paediatrics– Manage current high level of growth in demand. Radiology and Pathology diagnostic services – to support in and out of hospital care. Urgent Care Pathways – Develop sustainable in and out of hospital pathways, with the Urgent and Emergency Care Network.	30% reduction in excess costs relating to RCI in T&O, cardiology and respiratory. Reduced admissions and LOS for stroke. Increase in early discharge to community for patients in end of life care and reduction in admissions. Improved outcomes and reduction in admissions resulting from diabetes related complications. Reduction in variation between pathways across local providers, including LOS, operational performance and cost base. Reduction in current levels of growth in emergency paediatric at tendencies and admissions. With focus on UH Bristol and Bristol. Rapid access to diagnostics to enable community and primary care to manage patients at home and to enable efficient self-care and personalised medicine. Sustainable urgent and emergency care pathways, including a standardised front door.	Standardise and operate at scale Consistent pathways A new relationship with our population

Specialist Services and Networks	Year one focus to develop a single provider model for NICU in BNSSG High quality provider of specialist services for catchment ensuring patients are not travelling unnecessarily to alternative, more expensive, providers out of the region Provide leadership in clinical networks that support the sustainability of services in local providers. Address delays in repatriating patients to their referring provider or rehabilitation – 16/17 focus on delays in accessing Neuro and Spinal rehabilitation. Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services in BNSSG through a new CCHP provider partnership model. Focus on contributing to the developing Cancer Alliances, led by the Cancer Network, to provide effective cancer pathways that meet the national quality and access standards. Establish potential impact in terms patient volume, of commissioner stated intention to further evaluate the number and configuration of specialist units in the region	Development of single provider model for NICU. 10% reduction in patients treated out of area on specialised pathways. Only planned increase in BNSSG demand resulting from any change in configuration of specialist units in the region and support local providers to deliver 7 day services where required. Reduced delays in repatriation of patients on specialist pathways. Implementation of new integrated, partnership based community paediatric services (CCHP). Development of cancer alliances to improve quality and access. Reduction in bed days associated with delayed repatriation to referring provider or rehabilitation for patients on specialised pathways. NHSE modelled potential change in flows associated with consolidation of providers. Capacity developed accordingly to manage demand within available resources.	Standardise and operate at scale Consistent pathways A new relationship with our population
Sustainable services at Weston General Hospital	Priority focus on a solution for the short term sustainability of ED and developing an alternative model for the provision of emergency care. Phase 2 – Evaluation of full options and development of medium to long term plan for Weston Hospital, which secures a sustainable solution for acute services within North Somerset. Phase 3 implementation of full plan.	Clear plan in place ahead of winter 2016 to address the current sustainability issues associated with Weston ED and emergency care pathways. Medium to long term plan in place, which establishing the long term service profile of Weston General Hospital. New model in place.	Standardise and operate at scale Consistent pathways A new relationship with our population

Chapter 4 – Enabling Change

Enabling workstreams are described in detail in the annexes. The key points are:

Leadership and Governance

While we have good foundations in place through our established System Leadership Group, for working collaboratively in BNSSG, we know we need to invest time and leadership to deliver on our STP ambitions. In particular we need to establish mechanisms that support us to achieve balance between priorities and benefits for the whole system, while maintaining stability and meeting the requirements of individual partner organisations with whom final authority currently remains.

The Senior Responsible Officer (SRO) for the STP was agreed by the SLG and an SLG Executive Group was established with cross-sector representation to act as the programme steering group for the STP. Each STP workstream is led by a Chief Officer or equivalent from the System Leadership group as SRO. Budget pooling arrangements were agreed to fund capacity associated with development of the STP including the Project Management Office (PMO), modelling support and external consultancy.

Going forward we will draw on lessons learned from the development of the STP, from other footprints and vanguards and maintain the involvement of SLG members to ensure that pace is maintained and obstacles addressed. We will consider how we can redirect existing resource within organisations and in the system to minimise additional cost, reinforce collaborative working and provide credible leadership.

Engagement

Although no formal consultation has taken place a large number of partners and stakeholders have been involved in the development of our plan. Existing feedback from service users, carers and the public from across BNSSG has informed the development of the STP. This includes information from public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports. This has helped to ensure that our thinking is being shaped by the issues that the people who rely on our services have told us is important to them.

A joint working group has been set up by the 15 partner organisations (including health and LA partners) and a communication and engagement plan has been agreed in outline. An initial stakeholder mapping exercise has been undertaken in order to identify target audiences for communication and engagement and support the development and implementation of the STP. Subject to any feedback during July from the initial submission and agreement on the national timetable for further development, discussions with the three local Health Watch organisations and other stakeholder organisations, the working group will finalise arrangements for local engagement using existing patient, public and staff networks and fora over the next 5 years.

Workforce

Within BNSSG there is a system wide commitment for a more joined up, co-ordinated, digitally enabled and flexible workforce which delivers increased productivity and meets the changing health and social care needs of the local population. Each of the new models of care described in this STP rely on the requirement to have the right staff with

the right skills, values and behaviours in the right place at the right time to deliver respectful, compassionate and expert professional service.

As part of the on-going STP planning there will be a requirement to confirm the size and shape of the workforce particularly in the children and adolescent social care services, the Ambulance Service, the primary care sector and the voluntary sector – all of which have key enabling roles within the STP.

Workforce is identified as key to the implementation of our new model of care. This will require a flexible workforce focused on providing care out of hospital wherever possible, building centres of excellence and able to share core capabilities across organisations.

Workforce transformation takes time, involves complex stakeholder engagement and negotiation, lengthy redesign and delivery of training and it requires strong leadership to ensure that commitment (and therefore retention) is achieved across all services. We will build on our expertise and partnerships in research to develop OD and leadership capability to support us in this journey of change, continuing to work with AHSN and CLARH to achieve this. We will undertake further work to evidence the opportunity for collective efficiency impact from our workforce working differently in the new model of care. Our key areas of immediate focus will be:

- Improving Health and Wellbeing of workforce to reduce sickness, broaden skill sets and improve participation rates
- Analyse the potential for shared Recruiting and Training to support a reduction in temporary staff costs and drive down agency supported by shared bank.
- Explore collaboration on the National Apprenticeship Levy, e.g. a sector wide Apprenticeship provided collaboratively to optimise the national offer through sharing of training and mentoring and avoiding external training costs.
- Creating a Common Culture with more understanding and engagement across and between our teams
- Making every Contact Count by training for frontline staff in brief interventions around specific lifestyle issues such as alcohol and smoking.

Estates

A new approach to estates provision and coordination across the whole health and social care system is an essential component of ensuring that we can deliver our shared vision from a property base that is fit for purpose in terms of location, configuration and specification.

The 2004 Bristol Health Services Plan 10 year plan resulted in significant strategic estates investment. Building on this our priorities and action plan have been aligned to the drivers of change identified in this document, relevant national guidance, an overview of the current estate and know risks to sustainability**.**

Our draft estates strategy is flexible so that it can adapt as circumstances dictate and support the intended strategic approach to shifting the balance of care from hospital to community, primary, social and self-care.

Digital

We are in the midst of a digital revolution. In the last 20 years, the way we live our lives, support our recreation and leisure, read and share news, shop, bank and communicate have changed beyond all recognition.

We do not believe that our digital roadmap is about automating existing processes or making it go more quickly - rather it is an opportunity to change how we work fundamentally by doing things differently and working together differently. We have closely aligned the formation of the Local Digital Roadmap priorities with the key areas of the STP, as well as closely linking it to the national needs from the Local Digital Roadmap (Universal Capabilities) and the domains and work streams of the National Information Board.

The Local Digital Roadmap vision has been drawn from the Connecting Care Vision, whose core principles and ambitions remain relevant and applicable in describing a vision for the future in delivering change driven by a channel-shift to digital ways of working.

The ability to operate efficiently, share information and support people and develop society is now a **digital first** activity for most of the population and we aim to drive this attitude into all aspects of health and social care. We shall deliver this through our five key building blocks:

1. **Primary Care at scale** – focus on maximising digital across GP practices and Out of Hours services.
2. **Paperless by 2020** – Embedding digital records in acute, community, mental health and social care.
3. **Connecting Care** – Information sharing to include putting citizens at the heart of their 'personal health records'.
4. **The Information Engine** – fully utilising our electronic data to power our planning and delivery engine.
5. **Infrastructure and support** – ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism.

Chapter 5 – Addressing Our Affordability Challenge: Financial Analysis

We have carried out analysis to identify our key areas of opportunity for efficiencies and savings and undertaken initial modelling to estimate the impact of our actions on reducing demand through our new model of care, reducing variation and improving productivity and quality by working collaboratively. We will continue to develop the detail and confidence behind these assumptions and opportunities including risk assessment using normal processes both in terms of delivery and the impact on clinical services. However, we believe we have made significant progress in reaching a single system view of how to address our 20/21 "do nothing" affordability gap of £415.5m.

The assessed level of potential savings delivery and opportunities that reduce the affordability gap to £60.6m are show below:

Delivery	**Solution per Financial Excel submission**	**Status per Excel Submission**	**Providers £m**	**Commissioners £m**	**Total £m**
2016/17 identified schemes	Solution 1 & 3	b	(45.7)	Note 1 (44.3)	(90.0)
1% Business as usual savings	Solution 2 & 4	e	(54.8)	(10.0)	(64.8)
RCI Benchmarking/Carter (estimate)	Solution 5	d	(100.0)	0.0	(100.0)
Corporate costs/% reduction of 10%	Solution 6	d	(10.0)	(2.0)	(12.0)
Margin on net activity growth @ 10%	Solution 7	d	(7.0)	0.0	(7.0)
System Transformation savings (risk assessed at 50%)	Solution 8	d	0.0	(20.0)	(20.0)
Subtotal – Delivery			**(217.5)**	**(76.3)**	**(293.8)**
Sustainability & Transformation Funding			0.0	(61.0)	(61.0)
Unidentified			(25.7)	(35.0)	(60.6)
Total			**(243.2)**	**(172.3)**	**(415.5)**

Key: b = Detailed plans in place but not all elements or organisations; d = Savings estimate based on baseline modelling and the potential size of the prize; e= No detailed plans in place yet.

Note 1: 2016-17 QIPP schemes are predominantly identified

These opportunities can only be delivered by the BNSSG system working in a more coherent, coordinated and collaborative way and by individual organisations delivering on the 2016/17 identified schemes included in current organisational financial plans and their specific "business as usual" efficiency and cost reduction opportunities. Reference cost indices demonstrate significant variation in opportunity between organisations and there is clear commitment to secure these savings opportunities through rigorous cost containment at individual organisation level alongside the collective approaches outlined in the previous chapters.

Our plans are based on the following:

- The assumption that 1% savings can be delivered through normal organisational processes
- That we will be able to address the difficulties of converting opportunities for savings indicated through the Carter work on 'unwarranted variation'/ benchmarking into cash savings by working collectively to transform delivery of the outlying services rather than adopting a simple cost reduction approach, with a target of £100m

Based on 2014/15 Reference Cost Index data for relevant providers, our opportunity to reduce variation for speciality lines with actual cost over £100k where the RCI is over 100	**UHB**	**NBT**	**Weston**	**AWP**	**TOTAL**
As submitted to National Reference Cost	£443.0m	£472.0m	£95.0m	£177.0m	£1187.0m
Overall organisational RCI	98	113	108	128	
Excess costs for specialties over 100 RCI	£27.0m	£68.0m	£11.0m	£48.0m	£154.0m

- That we can realise real savings from corporate costs for the whole footprint (excluding NHS England) either from sharing services or organisational change with a conservative target of 10% assumed while we develop more detailed proposals.
- That a margin of 10% can be made on increased acute activity after allowing for an assumed reduction in acute demand from our system transformation schemes
- That some of the specific impacts from our new care model approach as identified in the chapters above, will deliver additional savings. We have modelled out some specific impacts at a 'first cut' level which indicates net savings of £39m and will continue to analyse and risk assess to build confidence in deliverability. Until this is completed a 50% risk assessment has been applied.
- Sustainability and Transformation funding of £61m has been notified by NHS England. This is in excess of the potential sustainability fund of £32m available in 2016/17. Whether this sustainability funding will be able to be applied towards organisations savings requirements remains unclear. Our access to the transformation element of this funding to pump prime the transition to new models and ways of working and invest in transformational enablers such as digital change, will equally require discussion.

The system transformation we have identified does not fully resolve our financial gap but is essential to ensure the projected level of demand in the footprint can be managed – in particular by ensuring patients do not access acute services where they do not need to and ensuring that scarce capacity in acute services (workforce and buildings) is used where it is needed. We will continue to build on the significant progress we have made in securing transparency and ownership of our challenge and understanding our opportunities to address our residual gap of £61m.

Conclusion - Our Way Forward

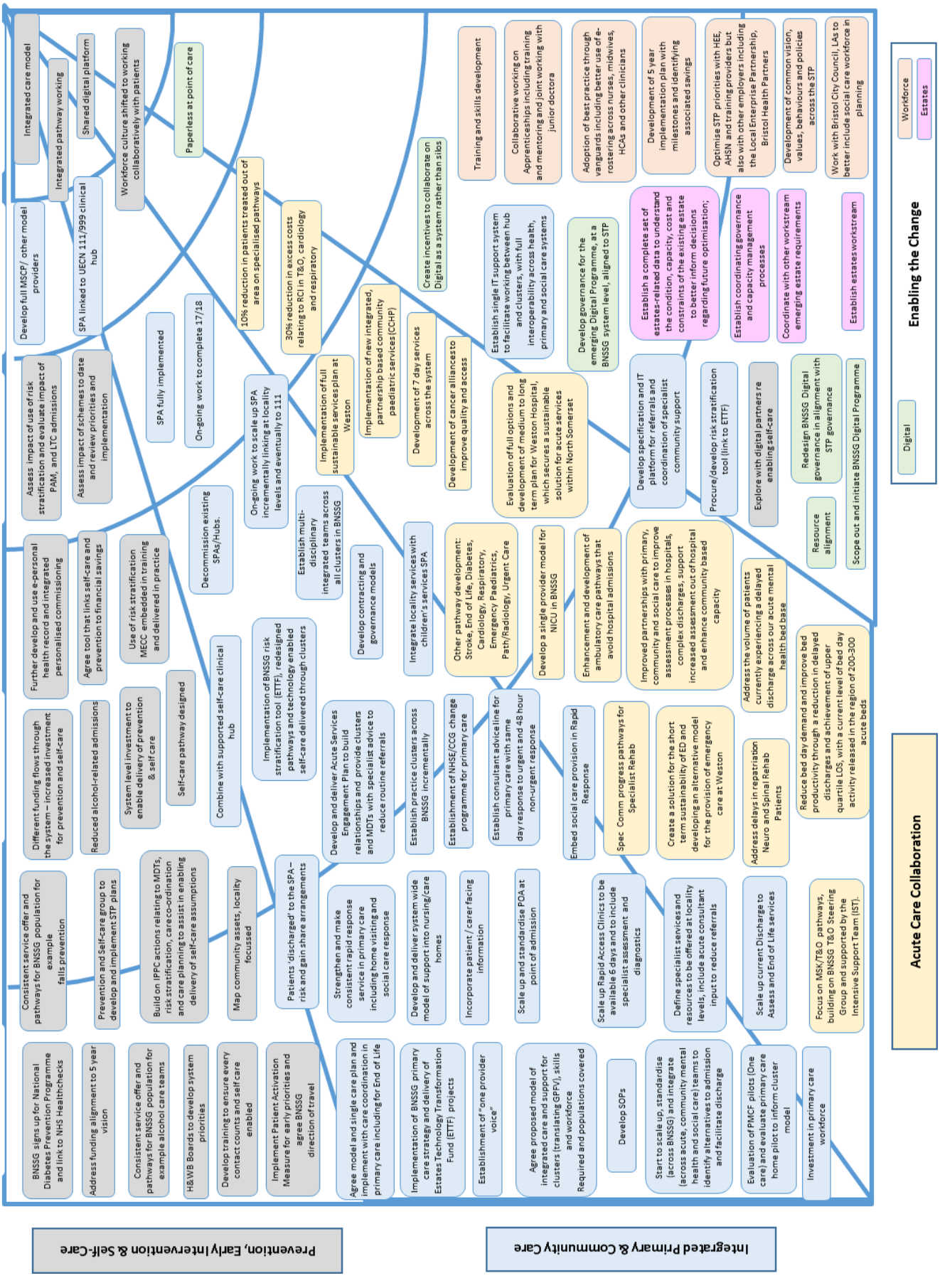
There are very significant challenges to be addressed in BNSSG now and into the future. Our plan has described the way we intend to approach them. If we are to be successful, we must first look to ourselves to ensure that we work together for our whole population and in the best interests of patients and service users rather than working in silos and within organisational boundaries. We have described the ways in which our behaviours need to change and be aligned in order that can provide the leadership needed to effect significant change across our teams and that we work openly together to share and manage risk.

We have started to identify specific actions for our model of care with a focus on securing early wins and scaling up existing, evidence-based approaches in 2016/17. This is set out in our transformation map below. We want to continue to work with our service users, staff and wider public in developing clear implementation plans around these actions.

Our immediate focus will be on continuing to work to build confidence and detail behind our modelling and affordability assessment, to build on this to address our £61m gap and to progress delivery against our existing 2016/17 savings plans.

We require support in this endeavour. Within the footprint we have unanimously agreed our system leadership going forward, committed to resourcing a dedicated Programme Director and PMO and to securing the requisite capacity and capability we need by pooling and realigning resources. In the wider system, we need a facilitative environment within which to work. If we are to behave as one system then we will need to consider the implications for how, over time, we can be treated as one system with incentives that align to system priorities rather than organisational priorities. We will want to access rapid learning from vanguard and success regimes to short-circuit our journey and discuss how we can access sustainability and transformation funds to lever early change.

T-Map


2016/17
2017/18
2018/19
2019/20
2020/21
Prevention, Early Intervention & Self-Care
Integrated Primary & Community Care
Acute Care Collaboration
Enabling the Change
Digital
Workforce
Estates
BNSSG signs up for National Diabetes Prevention Programme and link to NHS Healthchecks
Address funding alignment to 5 year vision
Consistent service offer and pathways for BNSSG population for example alcohol care teams
H&WB Boards to develop system priorities
Develop training to ensure every contact counts and self care enabled
Implement Patient Activation Measure for early priorities and agree BNSSG direction of travel
Consistent service offer and pathways for BNSSG population for example falls prevention
Prevention and Self-care group to develop and implement STP plans
Build on IPPC actions relating to MDTs, risk stratification, care co-ordination and care planning to assist in enabling delivery of self-care assumptions
Map community assets, locality focussed
Patients 'discharged' to the SPA – risk and gain share arrangements
Different funding flows through the system – increased investment for prevention and self-care
Reduced alcohol-related admissions
System level investment to enable delivery of prevention & self care
Self-care pathway designed
Combine with supported self-care clinical hub
Implementation of BNSSG risk stratification tool (ETTF), redesigned pathways and technology enabled self-care delivered through clusters
Develop and deliver Acute Services Engagement Plan to build relationships and provide clusters and MDTs with specialist advice to reduce routine referrals
Strengthen and make consistent rapid response service in primary care including home visiting and social care response
Develop and deliver system wide model of support into nursing/care homes
Incorporate patient / carer facing information
Scale up and standardise POA at point of admission
Establish practice clusters across BNSSG incrementally
Establishment of NHSE/CCG change programme for primary care
Establish consultant advicaline for primary care with same day response to urgent and 48 hour non-urgent response
Embed social care provision in Rapid Response
Spec Comm progress pathways for Specialist Rehab
Scale up Rapid Access Clinics to be available 6 days and to include specialist assessment and diagnostics
Define specialist services and resources to be offered at locality levels, include acute consultant input to reduce referrals
Scale up current Discharge to Assess and End of Life services
Focus on MSK/T&O pathways, building on BNSSG T&O Steering Group and supported by the Intensive Support Team (IST).
Further develop and use e-personal health record and integrated personalised commissioning
Agree tool that links self-care and prevention to financial savings
Use of risk stratification MECC embedded in training and delivered in practice
Decommission existing SPAs/Hubs.
Establish multi-disciplinary integrated teams across all clusters in BNSSG
Develop contracting and governance models
Integrate locality services with children's services SPA
Other pathway development: Stroke, End of Life, Diabetes, Cardiology, Respiratory, Emergency Paediatrics, Path/Radiology, Urgent Care
Develop a single provider model for NICU in BNSSG
Enhancement and development of ambulatory care pathways that avoid hospital admissions
Improved partnerships with primary, community and social care to improve assessment processes in hospitals, complex discharges, support increased assessment out of hospital and enhance community based capacity
Address the volume of patients currently experiencing a delayed discharge across our acute mental health bed base
Reduce bed day demand and improve bed productivity through a reduction in delayed discharges and achievement of upper quartile LOS, with a current level of bed day activity released in the region of 200-300 acute beds
Create a solution for the short term sustainability of ED and developing an alternative model for the provision of emergency care at Weston
Address delays in repatriation Neuro and Spinal Rehab Patients
Resource alignment
Assess impact of use of risk stratification and evaluate impact of PAM, and LTC admissions
Assess impact of schemes to date and review priorities and implementation
Develop full MSCP/ other model providers
Integrated pathway working
SPA linked to UECN 111/999 clinical hub
Integrated care model
Shared digital platform
Workforce culture shifted to working collaboratively with patients
Paperless at point of care
SPA fully implemented
On-going work to complete 17/18
10% reduction in patients treated out of area on specialised pathways
On-going work to scale up SPA incrementally linking at locality levels and eventually to 111
30% reduction in excess costs relating to RCI in T&O, cardiology and respiratory
Implementation of full sustainable services plan at Weston
Implementation of new integrated, partnership based community paediatric services (CCHP)
Development of 7 day services across the system
Development of cancer alliances to improve quality and access
Evaluation of full options and development of medium to long term plan for Weston Hospital, which secures a sustainable solution for acute services within North Somerset
Create incentives to collaborate on Digital as a system rather than silos
Establish single IT support system to facilitate working between hub and clusters, with full interoperability across health, primary and social care systems
Develop governance for the emerging Digital Programme, at a BNSSG system level, aligned to STP
Develop specification and IT platform for referrals and coordination of specialist community support
Procure/develop risk stratification tool (link to ETTF)
Explore with digital partners re enabling self-care
Redesign BNSSG Digital governance in alignment with STP governance
Scope out and initiate BNSSG Digital Programme
Establish a complete set of estates-related data to understand the condition, capacity, cost and constraints of the existing estate to better inform decisions regarding future optimisation;
Establish coordinating governance and capacity management processes
Coordinate with other workstream emerging estate requirements
Establish estates workstream
Training and skills development
Collaborative working on Apprenticeships including training and mentoring and joint working with junior doctors
Adoption of best practice through vanguards including better use of e-rostering across nurses, midwives, HCAs and other clinicians
Development of 5 year implementation plan with milestones and identifying associated savings
Optimise STP priorities with HEE, AHSN and training providers but also with other employers including the Local Enterprise Partnership, Bristol Health Partners
Development of common vision, values, behaviours and policies across the STP
Work with Bristol City Council, LAs to better include social care workforce in planning
Agree model and single care plan and implement with care coordination in primary care including for End of Life
Implementation of BNSSG primary care strategy and delivery of Estates Technology Transformation Fund (ETTF) projects
Establishment of "one provider voice"
Agree proposed model of integrated care and support for clusters (translating GPFV), skills and workforce Required and populations covered
Develop SOPs
Start to scale up, standardise (across BNSSG) and integrate (across acute, community mental health and social care) teams to identify alternatives to admission and facilitate discharge
Evaluation of PMCF pilots (One care) and evaluate primary care home pilot to inform cluster model
Investment in primary care workforce