Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

Appendix B1 – Plan on Page

***Please note this documented has been formatted to print on A3.**

Publication November 2016

Prevention, Early Intervention and Self Care

Making Every Contact Count (MECC) Project

Aim

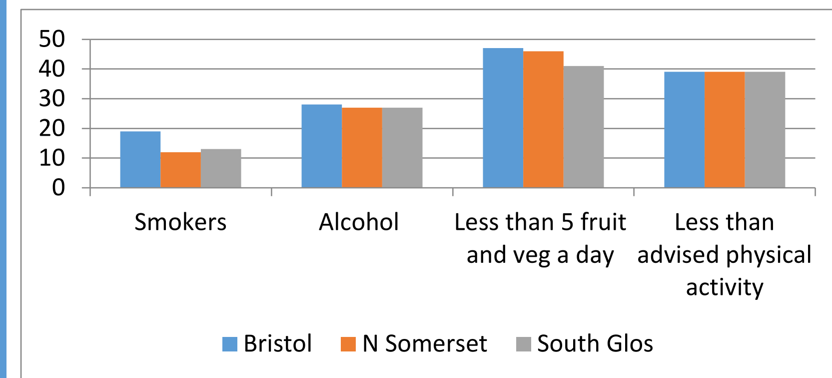
To champion a culture and environment of health improvement where health becomes everyone's business.

Current State

Unhealthy lifestyles are a significant contributor to premature death, disability, inequalities and NHS costs.
Almost 75% of premature mortality is due to 4 main diseases- cancers, cardiovascular disease, respiratory disease and liver disease. The main risk factors for these diseases are lifestyle related- smoking, poor diet, lack of physical activity and alcohol. These 4 lifestyles contribute to around 50% of premature death from these diseases alone.

Evidence from the JSNAs for BNSSG have shown that lifestyle behaviours are not equally distributed, and that socioeconomic status and lifestyles behaviours are clearly correlated with those from the most deprived backgrounds suffering the worst consequences.

Figure 1: Percentage of adults with unhealthy lifestyles in BNSSG.



Objectives

- To ensure that the prevention of poor physical and mental health becomes everyone's business within key provider organisations.
- To promote health and healthy lifestyles and wellbeing to all staff working with adult patients

Risks

- It is difficult to estimate the exact financial benefits from MECC at this stage
- The evidence base for outcomes from MECC programmes is still in its infancy.

Projects

- Making Every Contact Count (MECC) is an approach to behaviour change that utilises day to day interactions to support people in making positive changes to their physical and mental health and wellbeing.
- The project will ensure that each organisation has a 0.5 MECC co-ordinator in each of our main provider organisations for 12 months
- The role of the co-ordinators would be to work with senior leaders and workforce leads within their organisations to champion a culture and environment of health improvement where health becomes everyone's business.
- They will develop a sustainable MECC programme, rolling out MECC training to all frontline staff to ensure they have the skills and confidence to have opportunistic and sensitive conversations about healthy lifestyles and wellbeing.
- The co-ordinator will monitor and evaluate the impact of MECC and will, with partners across other providers, the local authorities and the South West region, ensure a consistent and system wide approach to MECC.
- They will be supported by MECC leads within local authorities and Public Health England and provided with tools, training and resources to support the delivery within their organisations.

Benefits

- Senior leaders will champion the importance of prevention across their organisations, building a culture and environment that supports health improvement
- Staff will be trained in the skills and will confidently and sensitively deliver brief healthy chats around smoking, diet, physical activity, alcohol and mental wellbeing to the patients they come into contact with and signpost patients to support where needed
- The lifestyles and health of the workforce and the patients they come into contact with will be improved and inequalities in health will be reduced.

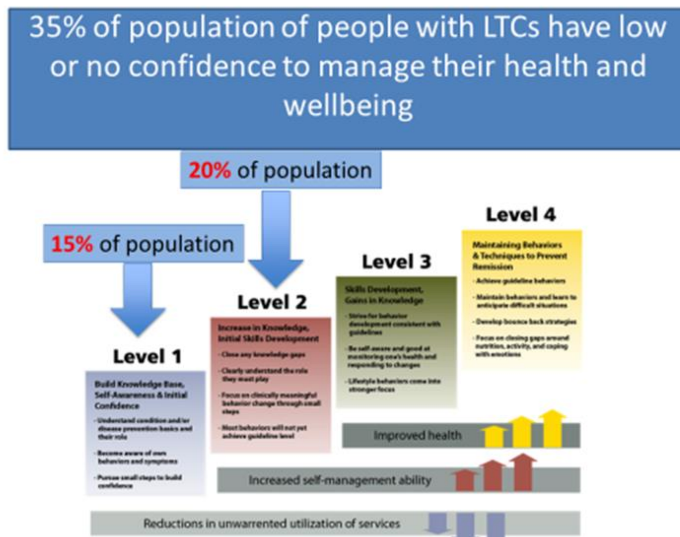
Self-Care and Social Prescribing

Aim

To deliver social prescribing, based on effective models of social prescribing and self-management at scale across BNSSG targeting the population at risk of emergency admission and ED attendance due to long term conditions.

Current State

There are currently a number of initiatives already in place that could be up-scaled across BNSSG - including Bristol Community Resource leads based in primary care, South Gloucestershire Community Connectors and Health Champions. The potential to self-care has been defined in terms of 'Patient Activation', which describes the knowledge, skills and confidence a person has in managing their own health and health care. It has been robustly demonstrated that levels of patient activation are related to most health behaviours, many clinical outcomes, health care costs and patient experiences.



Objectives

- to activate patients with Long Term Conditions to make their care more effective, increase wellbeing, and make better use of NHS resources
- To address low levels of patient activation; social isolation/loneliness and low activity levels
- To reduce avoidable emergency appointments and OP appointments
- To reduce DTOCs
- To reduce re-attendances within 30 days

Risks:

- It is difficult to estimate the exact financial benefits from social prescription at this stage

Project

This project will:

- Coordinate, align and upscale existing initiatives such as SG Community Connections, Health Champions and BCH Community Resource Leads to ensure equity of access across BNSSG
- Deliver using a cluster model of service delivery outlined in the IPCC workstream
- Develop links to MECC, Healthy Living Hubs, Healthy Living Pharmacies and Voluntary and Community Sector

Outcomes

- A range of interventions to enable self-care with a focus on social prescribing
- Upscaling of work shown to reduce demand on health and social care services across BNSSG
- A network of community health champions
- A network of peer led self-management groups

Supported Self-Care (Digital)

Aim

To improve people's ability and confidence to self-manage, through information, participating in a structured educational and monitoring programme, or by receiving and responding to text messages designed to support positive behaviours, co-ordinated through a clinically staffed, central 'hub'.

Current State

In the UK, 80% of GP consultations, 60% of days spent in hospital and two thirds of emergency admissions are related to long term conditions. However more than 80% of the care is undertaken by the patient or their carer. A small scale, eight month 'Champion' project in Bristol with one surgery and a total of 93 patients in three cohorts, tested how a range of people with varying health needs and preferences could be supported to better manage their conditions. While not designed as a statistically significant study, outcomes of the project showed a reduction in secondary care emergency attendances, admissions and out-patient appointments as well as reduced primary and community care contacts.

This local work is complemented by intelligence gained form a similar, larger scale service currently running in Liverpool which evidenced reductions in emergency admissions by a cohort of patients with LTCs of between 22- 32%.

Objectives

- to activate patients with Long Term Conditions to make their care more effective, increase wellbeing, and make better use of NHS resources
- To address low levels of patient activation; social isolation/loneliness and low activity levels
- To reduce avoidable emergency appointments and OP appointments
- To reduce DTOCs
- To reduce re-attendances within 30 days

Project

The project will deliver a range of interventions as part of a structured programme to enable self-care across BNSSG, focussing on those with Long Term Conditions at the highest risk of emergency admissions, using risk stratification, complex case management, traditional healthcare, information, education and signposting and, including the use of technology.

It will use the infrastructure and clinical workforce located in the Health and Care Single Point of Access (SPA) (see Integrated Primary and Community Care business case), from where patient alerts and data will be monitored and responded to, and technical and healthcare advice and support provided. The Health and Care SPA will work with GPs, case managers and other staff in the Multi-Disciplinary Teams (see Integrated Primary and Community Care business case) , including mental health staff, who will provide the hands-on care and treatment for patients on the programme.

Risks

- Full savings may not be realised
- Project has critical dependencies on other workstreams such as procurement of risk stratification and case finding tools, which may not be realised at speed required of the self-care programme
- Model and financial assumptions have not yet been fully described

Outcomes

- Improved clinical outcomes for patients
- Improved knowledge, skills and confidence to self-manage
- Improved quality of life and better experience for patients and carers
- Improved communication between care teams and breakdown of organisational silos
- Better care coordination
- Increased capacity through greater productivity and efficiency

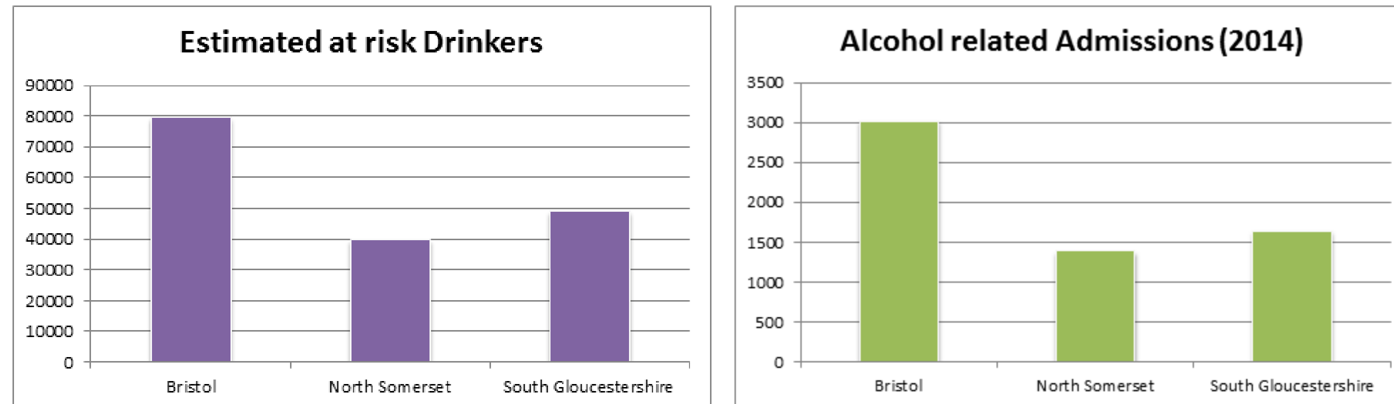
Alcohol Harm Reduction

Aim

To reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions.

Current State

Current provision of Alcohol Identification and Brief Advice (IBA) across Bristol, North Somerset and South Gloucestershire (BNSSG) is variable across primary, community and secondary care. It is estimated there are the following:-



Objectives

- to strengthen the provision of Alcohol IBA across Bristol, North Somerset and South Gloucestershire (BNSSG) to ensure a consistent approach to IBA commissioning
- to improve the links between primary, secondary and community care including the wider workforce eg pharmacists
- to contribute to Alcohol harm reduction, which is a key priority for the STP within the Prevention, Early Intervention and Self Care (PEISC) workstream
- to reduce alcohol related hospital admissions, re-admissions, length of stay and ambulance call outs as well as the reduction in the burden of excessive alcohol consumption on the NHS, police and social care from high volume service users
- to tackle the poor understanding of alcohol-related health risks among patients and health care professionals
- to develop a more proactive approach to the earlier identification of people with chronic liver disease
- to explore opportunities for alternative ways to deliver diagnostic tests

Risks

- Full savings will not be realised

Project: Alcohol IBA

The Alcohol Identification and Brief Advice (IBA) programme aims to reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions. The main objective is to tackle the poor understanding of alcohol-related health risks among patients and health care professionals using the following methods:

- Training of healthcare staff working in primary and secondary care settings (GP practices, hospital wards and community pharmacies)
- Increasing screening of patients (for example by use of the Audit-C scratch cards)
- Providing simple brief advice on alcohol consumption to cover potential harm and strategies to reduce alcohol intake
- Referral for specialist treatment where relevant

The two primary workstreams in this project are as follows:

- New primary care liver/alcohol pathway to identify those at risk of significant health and psychological issues caused by alcohol. The new liver/alcohol pathway seeks to standardise investigation and treatment of liver disease across the region and ensure equity of treatment. It would also ensure that liver referrals are appropriate and reduce hospital admissions and attendances for those in crisis by enabling earlier recognition and care planning of these high risk patients. Currently, more than one million liver function tests are requested a year, 70% of which are requested from primary care. Savings will also be obtained from a reduction in ultrasound scanning.
- Alternative pathways for diagnostics in primary care (for example testing for liver fibrosis using fibroscans) to identify those patients at highest risk of liver cirrhosis. This is expected to save significant resource in secondary care. The fibroscan service will be piloted in Bristol before the eventual roll out of the service across BNSSG.

Outcomes

- Consistent approach to Alcohol IBA provision across BNSSG
- Improved links between community, primary, secondary care and auxiliary healthcare professionals
- Reduced systems costs from avoidance of or reductions in alcohol related admissions, readmissions, Length of Stay and ambulance call outs
- Better understanding of alcohol related risks
- Earlier diagnosis of chronic liver disease and improved long term health outcomes

Integrated Primary and Community Care

Sustainable Primary Care Programme

Aim

- Sustainable, effective and accessible primary care
- Absorb the expected rise in demand by 2020/21 through new ways of working that include supported self-care, an MDT approach and deployment of non-clinical services.
- Make Primary Care a satisfying career choice

Current State

- Deficit of Clinical workforce availability to continue to provide care in its current form. Need to consider new models of care and meet increasing needs of the population
- Difficulties for patients in accessing primary care services
- GP estate is not fit for purpose in many cases given practice mergers and the percentage of work needing to move into an out of hospital setting current and this is causing system wide pressures.
- Variations in quality of care provision

Objectives

- Absorb the expected 12% rise in demand by 2020/21
- Management of patients as risk of admission in the community setting
- Delivery of primary and secondary prevention interventions
- Early identification and intervention to manage demand for both urgent and elective care
- Reduce variation of practice and improve consistency of outcomes by operating standardised policies, processes, procedures and documentation, including the digital record. Right care first time.
- Patient education, activation and involvement are in planning and delivery
- Reduce the need for patients and carers to repeatedly tell their story. This will be enabled through regular MDT meetings, health passports, close working relationships and enabling IT
- Promote and develop inter-professional team-working in order to achieve a multi-disciplinary service delivery
- GPs day de-cluttered so that they do what only they can do
- Move non-medical appointments from Primary Care to the voluntary / community sector, freeing high cost resource and capacity
- Maximise contribution of Community Pharmacy sector
- Maximise contribution of voluntary sector and other community assets
- Ensure the first care / treatment option offered is the most cost effective which delivers the identified health, care and wellbeing outcomes
- Provide training which is consistent across BNSSG, supporting the delivery of clinically effective intervention and care without variation
- Driving improvement through innovation and research
- Enable inter-professional collaboration and decision making by blurring organisational boundaries
- Ensure MDT workforce is appropriately skilled and trained to manage the local population's health, care and wellbeing needs
- Digital enablement to the above
- Buildings that enable the above
- An organised Primary care sector with a single provider voice

Risks

- Lack of a 'Primary Care ready' MDT workforce
- Current contracting arrangements
- Project management and business case development resource
- Expertise on new funding models
- Funding for transformation and investment in technology
- Baseline data for demand and activity across both community services and primary care

Projects

- A patient and their GP will be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This will occur in general practices which are recognised as places in each community, developing community resilience and supporting our citizens to stay as well and as healthy as possible.
- High quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home as well as general medical services.
- To be organised in different ways depending on local circumstances but based on a defined geographical patch, reflecting natural communities of 30-50k, within which they are responsible for the health and wellbeing of the population. The units (circa 18 across BNSSG) will be large enough to be organisationally resilient whilst hosting smaller clinical teams at a local level of different specialisms. They will form the basis for delivery of seven day services and enhanced primary care, including Mental Health.
- Local care organisations will work with similar organisations across the BNSSG system to provide a seamless service to patients through defining new community care pathways and sharing a common patient record.

General Practice Pilots

These pilots are underway and include:-

- Piloting mental health workers, physiotherapists and pharmacists to develop multi-disciplinary teams to support better patient access to services and GP workload
- Developing a 7 day access model in primary care across BNSSG
- Piloting use of web based technology for GP consultations and improving patient access to web based self-help information
- Improving telephone access through the review of telephony systems
- Reviewing back office functions and processes to improve practice efficiency

The GP sustainability and transformation of general practice programme will be responsible for reviewing the evaluations and business cases of the above pilots to understand whether these initiatives are something the system may wish to take a view on continuing or not in the longer term.

Temperature Check Project

This project aims to work with GPS across BNSSG to undertake a 'temperature check' of general practice in November 2016. This will put together data and understanding of the current system. The project will then meet with groups of practices to discuss their results from the temperate check, to have proactive discussions and develop a 'resilience and transformation plan for the local area' with go live on a number of initiatives from December 2016. This will also help inform the programme plan further for the GP sustainability and delivery programme.

Development of Primary Care Capacity

This project aims to maximise benefits of Clinical Pharmacy Pilot, spread of pilots relating to practice based physio, mental health nurses, IAPT, health trainers and introduce new partnerhsips with community pharmacies for both urgent care and LTC management. It will work closely with with 7 day working multidiciplinary work project and the development of the SPA project to ensure the work delivers a clear offer for patients and staff working within the system.

Benefits

- Improved health outcomes and reduced inequalities
- Reduce demand for secondary care services
- Reduce the number of consultations conducted by GPs by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Decrease the number of home visits, surgery visits and outpatient appoints by up to 15% through the use of home monitoring and remote consultation
- Reduced admission to care homes.

Health & Care Single Point of Access (Design and Technologies)

Aim

The aim of this project is to replace the current multiple points of access to health & social care for adults by establishing one BNSSG SPA for professionals (and possibly patients on care plans and their carers) to support admission avoidance and discharge to underpin the Urgent Care System to meet the aims, objectives, and outcomes outlined in the STP.

Current State

Currently the process of referring people to the most appropriate services in the community is not very easy to navigate and lacks consistency of approach, where the physical, mental and social health teams work quite separately.
Other issues with the current model include problems with technology and information sharing, inconsistent call handling timescales and processes (it can take anything from 5 minutes to 1.5hrs for a community referral to be processed, depending on the time of day), duplication of work and repeat assessments, inefficient use of clinical time (often spent trying to identify and then get through to the most appropriate person), fragmented and complex system, with no single call to access clinical advice, lack of consistency in accessing community services every day of the week and significant costs associated.

Objectives

- Provide a sustainable, high quality service that enables Bristol, North Somerset and South Gloucestershire population to receive the right care, in the right place, at the right time by providing seamless coordinated care;
- Design a service specification and model of care that meets the requirements of IPCC model in the STP and delivers the savings and benefits assumptions;
- To enable the appropriate, effective and timely sharing of relevant user data across and between providers;
- To improve clinical decision making through access to user records;
- Improve the co-ordination of services between primary, community, social and secondary care provision;
- Increase cost effectiveness by bringing functions together and working in a new way to achieve the economies of scale, which can be done by maximising the use of existing services in terms of workforce skill mix, knowledge and competencies;
- To provide a service that can respond to a user's needs early in the pathway, linking into services across the community without the need for repeated assessments and information at each stage;
- Assist in increasing the accessibility to right services based on need;
- Improve appropriateness and the quality of care provision as well as releasing clinical time;
- Improve pathways for high intensity users;
- Work with the providers of community beds and acute providers in relation to step-up and step-down provision;
- Deliver a rich set of information on unmet need, demand and capacity gaps and so contribute to workforce development by shaping/reshaping the workforce to meet user's needs and delivery of the urgent care model now and in the future;
- Reduce conveyances by linking the SWAST clinical desk function provided by the Ambulance Service with the BNSSG SPA to ensure patients are cared for in the most appropriate place (including at home or within the community), reducing the need for conveyances and emergency admission to hospital;
- To ensure changes to urgent care services in BNSSG are coordinated with the work led by the Severn Urgent & Emergency Care Network;
- Support delivery of cluster working & MDTs in the community.

Project

The project will:-

- To identify all current SPA services in BNSSG (pop. C900 000);
- To identify all SPA related projects and work streams in progress or planned across BNSSG, and their underpinning assumptions/benefits, delivery mechanisms, timeframes and membership;
- Establish a common service specification for a BNSSG SPA for adults, which takes into account current local services and all future aspirations;
- Develop an outline service model in response to the agreed output specification;
- Identify the required workforce and skills, whether they are currently in the system and where there are gaps;
- Identify the underpinning infrastructure likely to be required to deliver the functions (a strategic outline business case for capital has been submitted to NHS England as part of a call for applications under the Urgent Care Review recommendations. The £3 457 300 submitted was done at short notice and requires validation);
- Identify the membership and governance arrangements for this project;
- Review STP assumptions and work up a SPA activity model to inform an indicative cost (capital and revenue);
- Identify funding/resources across organisations which could be diverted to fund the BNSSG SPA;
- Profile the delivery of the SPA incrementally in line with the current STP Plan, which sees the SPA fully implemented in 2018/19;
- Develop a detailed implementation plan.
- Commission and implement the new service.

Risks

- There is a risk that we will not have sufficient capital to invest in establishing a SPA, including accommodation and technology solutions to enable the service to be established.
- There is a risk that the contract expiry dates across the BNSSG may not be aligned and may result in double or over paying for services.
- Conflicting local priorities and inability to agree on a service specification and scope among providers and commissioners.

Outcomes

- Reduction in emergency admissions
- Reduction in ED attendances
- Reduction in re-admissions
- Reduction in length of stay
- Reduction in excess bed days
- Reduction in conveyances
- Increase utilisation of Community Beds
- Increase telehealth usage
- Also several other qualitative benefits e.g. improved patient and service user's experience & outcomes by better coordinated care with a single contact, provision of alternatives to emergency admissions to avoid older people deteriorating during extended stays in hospital and with no need for repeat assessments

SPA Services Rapid Response

Aim

To deliver an expanded Rapid Response service accessed via the health and care hub, with support from the full multidisciplinary team this will include rapid access for diagnostics, prescribing of medication, urgent social care and nursing support, all community and primary care based.

Current State

The mounting pressures on Emergency Departments across the BNSSG geography illustrates the need to transition to a more sustainable model of care, which may involve caring for more patients in the community and preventing unnecessary deconditioning of patients.

Bristol, North Somerset and South Gloucestershire are also experiencing significant challenges in terms of demand for urgent care services. This is impacting on the quality of care and delivery of key performance targets and, most importantly, on patient experience and outcomes.

Nationally, Better Care has set out the need for services provided by health and social care to be better co-ordinated and integrated and concentrate on strengthening clinical triage and advice service to allow for smoother pathways for both clinicians and patients navigating the complex system.

Objectives

- Reduce the number of unnecessary non elective admissions to hospital.
- Reduce the number of readmissions to hospital
- Define equitable good quality 7 day services available on the basis of need
- Provide care that centres on patient needs with timely interventions.

Risks

- There is a risk that investment in diagnostic services and step up beds is reliant exclusively by disinvestment from the acute providers. The Primary and Community care providers are unable to assume that risk unless agreement can be reached.
- It is not possible to rain workforce and recruit to new roles to deliver new models of care
- Existing community services do not have the capacity to meet increasing demand. Lack of capacity could effect ability to achieve outcomes.

Projects

- To identify all current Rapid Response services in BNSSG (pop. C900 000);
- To identify all related projects and work streams in progress or planned across BNSSG, and their underpinning assumptions/benefits, delivery mechanisms, timeframes and membership;
- Develop an outline service model in response to the agreed output specification;
- Identify the required workforce and skills, whether they are currently in the system and where there are gaps;
- Identify the membership and governance arrangements for this project;
- Review STP assumptions and work up an activity model to inform an indicative cost (capital and revenue);
- Develop a detailed implementation plan.

Outcomes

Direct shift of appropriate activity from A&E

There are additional savings to be made in mental health, dementia, diabetes and respiratory emergency admissions.

Also qualitative benefits including:

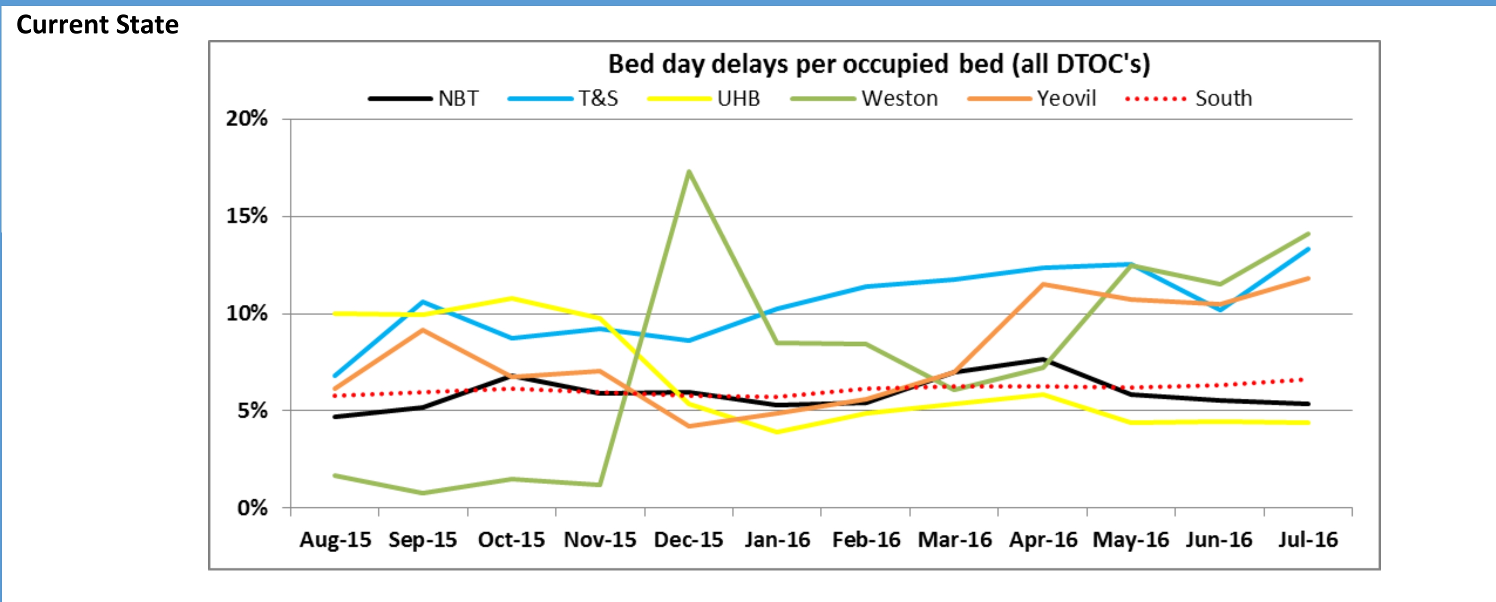
- Improved patient and service user's experience & outcomes by better coordinated care with a single contact, provision of alternatives to emergency admissions to avoid older people deteriorating during extended stays in hospital and with no need for repeat assessments;
- Immediate advice and basic treatment to enable the patient to remain in their home.
- For those experiencing a short term crisis immediate health intervention or support during breakdown of care.
- Improved system resilience by operating at larger scale across the three geographies resulting in improved use of services and the skills of all staff;
- ensuring a robust interface for emergency services, acute hospitals and primary care;
- Increased number of people being treated in their own home or closer to home in community facilities;
- Improved the effectiveness of health interventions and wellbeing and management of mental alongside physical health;
- Reduced duplication and fragmentation by standardising processes and criteria, reduced variation in access and referrals, integrated teams and development of trusted assessor roles and procedures;
- Closer working and understanding between the health and social care staff working together.

Health and Care Single Point of Access – Delayed Transfers of Care (Part A)

Aim

Requirement to have a consolidated plan to ensure that Delayed Transfer of Care (DTOC) levels are within 2.5-3.5% parameters & address longer term issues re bed utilisation, length of stay (LOS) and model of care for Frailty. To ensure that plans for community and primary care developments are aligned with wider BNSSG Transforming Care Plan (TCP) requirements.

Current State



Objectives

- To maximise opportunities for patients to go directly home to their usual place of residence, spending the shortest time possible within a hospital or inpatient setting.
- To standardise, simplify and reduce variation within our approach to discharge, maintaining configuration for individual patient need but simplifying and reducing processes, options and decision making at key points in the patient journey.
- To maintain and develop the current D2A pathways across BNSSG to ensure that DTOC levels are reliably and consistently within the national 2.5%- 3.5% parameters.
- One key element of addressing LOS and expanding the principles of D2A will be a restructuring of all therapy services to create a new flexible clinical and operational model. This model will include all current therapy resources distributed across health and social care to support early discharge and prevention of readmission.
- To reduce overall LOS within hospitals for all patients including 'simple' discharges with a target of approximately 200 beds across the local system.
- To ensure there is optimal use of current bedded assets footprint wide including South Bristol Community Hospital, North Somerset (Clevedon) Community Hospital, the proposed developments at Frenchay and Thornbury, other rehabilitation settings and D2A Pathways 1-3.This will include establishing what facilities will be required to support a sustained reduction in LOS across a broad range of patient pathways
- To integrate within the proposed locality/cluster and MDT models across BNSSG and supporting admission avoidance work and long term conditions management.
- To make optimal use of other related service elements such as long term residential care beds , homecare, voluntary sector services and also self-care/support for carers especially in the context of extreme pressure on social care budgets

Risks

- Resources, particularly workforce
- Ability and will of organisations to work collaboratively to develop new models of care and to share risks and benefits
- Work will be required to change patient and carer perception of the best setting for care, particularly during the post-acute phase.
- Transformation and development capacity within organisations to implement and embed the required changes
- Political and public attachment to current operational configuration, especially locality specific services

  Clinical 'buy in' to a significantly transformed model of care which will challenge current ways of working and organising our services.

Projects

Work to continue to reduce DTOC's to the 2.5/3.5% national target as part of a BNSSG-wide Discharge to Assess (D2A) programme.

Formalise the discharge to assess pathways provided by North Somerset
Work across BNSSG on flexible use of all (bedded) pathways based on need rather than GP registration.
Maximise the discharge to assess offer at the front door, including the inpatient assessment units
Embedding of trusted assessment across the patch is also key, and links to the business case submitted by the Local Authorities

Focus on simple / routine discharges and overall reductions in length of stay

A change is culture and understanding by staff and patients will be required to embed these new ways of working.
Individual pathways reviews will show areas of opportunity for length of stay reductions though increased use of MDT working and targeted application of the agreed operational standards for discharge. Known areas for development currently include stroke, MSK, neurology and medicine.
A review of end of life care pathways will be required and will link with the STP business cases related to frailty and end of life. This needs to include work on care home market management and quality assurance.
A focus on criteria-led discharge, earlier in the day discharges and weekend discharges, and routine use of discharge / transfer lounge facilities.
Utilising structured supported self-care programmes (see separate IPCC business case) to support earlier discharges for people with Long Term Conditions.
Utilising the expertise and information in the Health and Care Single Point of Access to facilitate early discharge to the right place, with the right support.

Transformation of secondary/primary/community care at scale

Scoping and provision of step up/ step down requirements across BNSSG.
Active case management through the STP proposal of Community MDTs (see separate IPCC business case)
Linked to this would be a transformation of the way therapies are delivered across the system.
Assertive discharge procedures would centre around the board round, which would become the hub and driving force of all discharges
Unbundling of tariff and other funding structures to support financial flows through the system would be required.
A focus on the requirements of mental health DTOC patients, including working with local authority colleagues on suitable housing options and the provision of care home beds for people with complex needs, such as advanced dementia.
A review of staffing ratios and use of bank and agency staffing would be needed, and reduction in use of non-substantive roles would be supported through unification of pathways / providers.
Standardisation of supplies would generate efficiencies and savings for example in community equipment, dressings etc.

In summary, there will be three broad strands to this work, as follows:

1) Simple Discharges– efficiency and productivity will be maximised through changes to internal flow within the hospital systems (including mental health). This element will be largely cost neutral / cost saving.
2) Complex Discharges– efficiency will be maximised through the at scale provision of discharge to assess pathways. For Bristol and South Gloucestershire provision currently matches demand (taking into account developments already underway to increase discharges across all pathways). As discussed, further work is required to understand the needs of North Somerset patients, though systems and processes can be shared easily which would simplify future implementation and aid alignment across the patch.
3) Early Supported Discharge – efficiency would be facilitated through the discharge of patients who, whilst still within tariff structures, can be safely cared for in a lower intensity (cost) setting. This would be a balance between a virtual ward type scenario and convalescence. Obvious examples include fractured neck of femur patients and people ready for stroke rehabilitation.

Outcomes

- Reduced risk of decompensation and loss of independence
- Positive patient stories & single, patient-focused assessments, joint decision making in out of hospital settings,
- A sustained and permanent shift activity from the acute sector to the primary and community sector community
- Flexible, people rather than estates based model that can flex with changes in demand, presentation and patient expectation
- Patients return home more quickly to their place of residence and reduced readmission rates
- Reduced hospital bed days and improved internal flow within hospital which will support the consistent delivery of NHS Constitutional standards.
- Better use of current and future workforce especially registered staff & sustainable and skill orientated work plans for staff
- Improved access to beds to support elective programme and fewer patient ward moves and outlying patients
- Assessment in out of hospital settings which provide a more accurate picture of patients' needs
- Decreased requirement for long term, high cost packages of care following successful periods of reablement at home

Health and Care Single Point of Access – Delayed Transfers of Care (Part B)

Aim

Partners within the STP collaborate to avoid admissions, reduce length of stay for patients, improve patient experience and improve the efficiency of patient flow/discharge processes. Improvements will be achieved through a more consistent, responsive and collaborative team approach to patient flow and hospital discharge at all the acute trusts in the STP area.

Current State

Average LOS are:

- 10.1 days unplanned/ 4 days planned at Bristol,
- 8.6 days unplanned/ 3.7 days planned a North Somerset,
- 8.8 days unplanned/ 3.3 days planned at South Gloucestershire.

The mapping exercise also found that:

- Each of the 3 areas has different weekend and bank holiday cover arrangements.
- Variable amounts of progress in the development of Discharge to Assess (D2A) pathways e.g. North Somerset has still not fully implemented D2A pathways 2 and 3.
- Different processes/paperwork are used for discharge by each of the 3 STP areas even though patients from each area are regularly treated in hospitals in all three areas.
- Different hospital social work models exist in the STP area e.g. with some social workers attached to wards and others operate a referral and allocation model.
- That delays in discharge sometimes occur because likely discharge complexity is not always identified at admission.

Objectives

- Avoid unnecessary admissions to hospital
- Improve patient flow after admission
- Ensure prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.
- Achieve a reduction in the LOS of at least one day for between 10% and 20% of all unplanned spells in hospital by patients aged over 65 in the BNSSG STP area and so save between £1m and £2m p.a.

Projects

Increase the Social Care staff presence within wards and within ED and Medical Assessment Units. The aims are to sign-post people to non-statutory support when it is appropriate to do so, facilitate a prompt and safe discharge process and expedite the assessment of patients as soon as they are "medically optimised".

Design a single and consistent 7 days a week Hospital Discharge process to operate in each of the 3 main acute hospitals in the BNSSG STP area. The aims are to eliminate waste and duplication, save staff time as they will not have to use different systems/processes depending on which area the patient is resident in, and ensure the patient experience is consistently good.

Consider options for, develop and pilot "Trusted Assessor" arrangements with a sample of large residential/nursing care homes. Aim is to establish if the pilot arrangements are justified by a reduction in discharge delays due to waiting for an assessment by a care provider.

Undertake an analysis of care/nursing home placements made on discharge from hospital by each of the 3 local authorities and CHC funded placements made by the 3 CCG's in the STP area. The aim is to establish whether there is a business case for a joint BNSSG STP area care home commissioning and brokerage service is justified.

Risks

- **Inability to recruit into the posts** – Posts may not appear attractive in particular into the evening posts and therefore it is possible that high quality staff may not be recruited.
- **A lack of available service provision outside of hospital for people to be discharged to** – This could still limit the impact of this work stream even if patient flow and hospital discharge processes are ideally designed and operate to their optimum.
- Different ICT systems at each hospital may make having 100% identical processes at each hospital difficult. A possible constraint is the extent to which local work arounds that preserve the same overall process at each hospital, but allow staff to use local ICT systems can be developed and will be allowed/supported by Corporate ICT colleagues.
- **A lack of available res/nursing places for people to be discharged to** – This could still limit the impact of this work stream i.e. even if "Trusted Assessment" was in place a delay in discharge could occur while a suitable vacancy was located.
- It is difficult to demonstrate why **c**hanges in admission numbers and LOS occur as they are multi-factorial i.e. isolating the "cause" and the "effect" will be difficult. Proving value for money maybe a challenge.
- A lack of available service provision outside of Hospital for people to be discharged to – This could limit the impact of the work streams even if patient flow and hospital discharge processes are ideally designed and operate to their optimum.
- Although a joint unit should be able to maximise placements that are close to patient's homes and lower the overall average price paid there is a risk that the lowest payer currently will have to pay higher prices.

Outcomes

- Give a financial payback of between 2.667 times and 5.333 times the level of the expenditure proposed.
- Contribute to the acute trusts maintaining patient flow through system and reduce occupied bed days and so ease capacity issues.
- Help to develop the knowledge of acute staff around social care, community health and community support through more contact with social care staff.
- Improve experience for patients with complex needs and achieve a far more consistent experience regardless of where they are treated.
- Support the achievement of the 4 hour target for Emergency Department.
- Support an increase in the numbers of safe evening discharges.

7 Day Multi-disciplinary Team Working

Aim

Our vision is for more care and support to be delivered in the community / primary care setting under the guidance of well-informed, highly skilled Multidisciplinary Teams (MDTs) at GP cluster level. This will improve efficiency, reduce duplication and improve patient experience.

Multidisciplinary teams (MDT) will underpin our new models of care and enable the delivery of the overall STP benefits.

Current State

MDTs are a key enabler for the delivery of the overall STP financial savings target. As an individual way of working, MDTs will create sufficient efficiencies to absorb the expected increase in demand of 12% by 20/21.

Objectives

- Be the expected and primary way of working across BNSSG, community and primary care
- Absorb the expected 12% rise in demand by 2020/21 through;
- Reduce GP appointments by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Reduce the cost of supporting those with Long Term Conditions by 7% through a People Powered Health approach
- Additional capacity of 1 visit per day for field-based workforce through provision and access to fully functioning mobile IT
- Reduce variation of practice and improve consistency of outcomes by operating standard BNSSG wide policies, processes, procedures and documentation (including care plan), using the Fundamental Standards to underpin delivery and monitoring
- Provide the best possible care and support for those with the most complex needs by drawing on the most appropriate MDT expertise and the available community resources
- Support people to remain well through self-care programmes and early intervention and prevention thus preventing or delaying future high cost intervention
- Plan for long-term health and wellbeing at a population and individual level with a focus on achieving personal goals and objectives
- Reduce the need for patients and carers to repeatedly tell their story. This will be enabled through regular MDT meetings, health passports, close working relationships and enabling IT
- To improve clinical decision making through inter-professional collaboration in MDTs
- Engage local people with the development of their local MDT and ensure their views help shape services and service configuration
- Promote and develop inter-professional team-working in order to achieve a multi-disciplinary service delivery
- Move non-medical appointments from Primary Care to the voluntary / community sector, freeing high cost resource and capacity
- Ensure the first care / treatment option offered is the most cost effective which delivers the identified health, care and wellbeing outcomes
- Provide training which is consistent across BNSSG, supporting the delivery of clinically effective intervention and care without variation
- Driving improvement through innovation and research
- Through accurate data and analytics, provide MDTs the information, in real time, which allows them to make the most informed decision possible during patient consultations
- Enable inter-professional collaboration and decision making by blurring organisational boundaries
- Ensure MDT workforce is appropriately skilled and trained to manage the local population's health, care and wellbeing needs.

Risks

- Current contracting arrangements
- Project management and business case development resource
- Expertise on new funding models
- Funding for transformation and investment in technology
- Baseline data for demand and activity across both community services and primary care

Projects

The project will work to developed a shared understanding of the current arrangements including financial, operational, IMT, Estate and Workforce, Patient and Staff feedback arrangements which are currently in place and then work up the detail of how a new MDT model could be implemented across BNSSG. This will link closely with the Sustainable Primary Care Model.

Operations

This element of the project would work through the operational detail of how any MDT team might operate including forms of multidisciplinary working; improved access to care through seven-day working; risk stratification, management of people with complex multi-morbidity, approach to care planning and standardising processes and pathways across BNSSG, integrated discharge; Integrated Personal Commissioning (IPC) and Personal Health Budgets (PHB); approach to working with care home residents and links with other project such as social prescribing and health and wellbeing services.

Funding Model

This element of the project will responsible for developing and understanding of the current financial flow and activity and then develop an understanding the financial impact of the model and funding flows which would be required to deliver the model

Governance

This element of the project will work though the clinical, organisational and information governance issues and develop solutions to support the implementation of the new model.

Workforce

The element of the project will work to gain an understanding of existing workforce, consider skill mix and new staffing models

Technology

This element of the project will gain an understanding of the IMT systems in use across the existing organisations and respond to the requirements coming out of the model to consider how to ensure staff have access patient information and link with the supported self care project which include remote monitoring etc

Outcomes

- Reduce the number of consultations conducted by GPs by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Reduce the cost of supporting those with Long Term Conditions by 7% through a People Powered Health approach.
- Decrease the number of home visits, surgery visits and outpatient appoints by up to 15% through the use of home monitoring and remote consultation
- Additional capacity of 1 visit per day for field-based workforce through provision and access to fully functioning mobile IT
- Reduced admission to care homes will create additional capacity in the system, removing a key block to effective system flow
- Gains in capacity within community services through diversion of activity, focused on early intervention and prevention, via social prescribing
- Increased care in the community / primary care (driven through upskilled GPs, development of specialist health care professional roles and rapid response) will reduce incidents of unrequired acute admission, incurring savings accordingly. This could be a cashable benefit if the bed base could be safe reduced accordingly. (Additional community resource would be required)
- Reshaped pathways will standardise the most clinically effective approaches and appropriate resources, driving down the overall cost of care
- Population profiling enables better decision making on intervention and support. This will enable the delivery of the right care to the right person at the right time, driving down the overall cost of care
- Reduced admission to care homes. This could be a cashable benefit if the bed base could be safely reduced accordingly. (Additional community resource would be required)

End of Life Care Services

Aim

To enable the consistency of service provision for End of Life Care Services across BNSSG, avoid unplanned admissions and to ensure that peoples wishes at end of life with respect to place of death are respected.

Current State

Current providers of End of Life Care Services across BNSSG include Bristol Community Health (BCH), North Somerset Community Partnership (NSCP) and Sirona Care & Health CIC (Sirona).

BCH are currently commissioned to run the Bristol Care Co-ordination Centre (BCCC) service. This service provides a single point of access for end of life care services, as well as signposting and some advisory functions. These services include: -

Palliative Care Home Support (PCHS) – This service is a nurse led service that provides personal and nursing care for patients who have a prognosis considered to be within last days/weeks of life, have a preference for care at home and have a preference for to die at home. BCH provide this service in Bristol (9am – 9pm) and South Gloucestershire (9am – 5pm) seven days a week.

Hospice at Home (HaH) - This service is a nurse-led service which provides night care, plus some day shifts, at home, for patients within their last few weeks of life.

Marie Curie Care (MCC) – This is coordinated by the BCCC service to provide overnight care at home for patients at end of life stage.

The BCCC service currently provides a 'funnel' system designed to capture all referrals to the above services (PCHS, HAH and MCC) with the aim of providing clinical triage, appropriate prioritisation of care and effective coordination.

NSCP are commissioned to provide the Care Co-ordination Centre and Palliative Care services for North Somerset patients.

Sirona are commissioned to provide an End of Life Care Co-ordination Centre service for South Gloucestershire patients.

Objectives

- Provide easily accessible, locally appropriate support for G.P's and hospitals, to prevent admission, expedite discharge and deliver peoples' wishes at the end of life.
- Provide information and guidance to service users and carers to support self- management and self-care, and support for GPs (and MDTs) in their roles as complex case managers.
- Improve co-ordination of care from both a patient and carers' perspective
- Achieve a % reduction on the 2015/16 rate of the number of non- final emergency admissions for people identified as at End of Life across BNSSG.
- Achieve a % reduction on the 2015/16 rate of patients dying in hospital for BNSSG.
- Increase the number of people that have had the opportunity to discuss and agree their preferences for their end of life care.

Projects

End of Life Care Co-ordination – A function within the Health and Care Single Point of Access (see separate business case) to co-ordinate the required End of Life Care service provision across BNSSG. This will be for health professionals, health and social care staff, patients and their families and carers across BNSSG. The service will take responsibility for coordinating the patient's care and services through existing providers.

Palliative Care Home Support (PCHS) – To provide a consistent PCHS service across BNSSG to patients from 9am to 9pm seven days a week all year round. This will include up to 3 visits a day to provide personal care and emotional support for patients who wish to be at home as they approach the end of their lives.

Improved working with the Hospice Sector – Through expanding equitable palliative care services across BNSSG and working in partnership with the Hospice sector, hospital emergency admissions will be reduced and patients are kept out of Hospital, if that is their wish.

Fast Track Nurse Assessor (FTNA) – To provide a consistent FTNA service across BNSSG to work with Acute Hospitals/Care Homes and relatives to ensure that patients who have been identified as approaching end of life are discharged as quickly as possible from Hospitals to Care Homes or their home in accordance with their wishes. This service could be operational seven days a week, 9 – 9, provided that discharges could be arranged from hospitals to care homes during these extended hours, and provided there was sufficient demand. Analysing this data will be part of the project.

Risks

- Current contract and staffing arrangements.
- Care and nursing home placement availability.

Outcomes

Financial Benefits

- Reduction in non-elective admissions and AvLoS: frailty, respiratory, End of Life and from care homes.
- A reduction to unplanned admissions to hospital during the last 12 months of life.

Non-Financial Benefits

- More people to achieve their preferred place of care at the end of their life by establishing an integrated care pathway that is recognised across all services.
- Equitable access to services and expertise.
- Provision of expert end of life advice, training and support to health and social care professionals.
- Ensure that most care and support at end of life is delivered locally, ensuring continuity of care, enabling shared decision making, and providing a whole person/multi-disciplinary approach. This will ensure the best outcomes and experience and achieve our goals of keeping people as well and independent as possible even as they age and develop long term conditions, and even at the end of life.

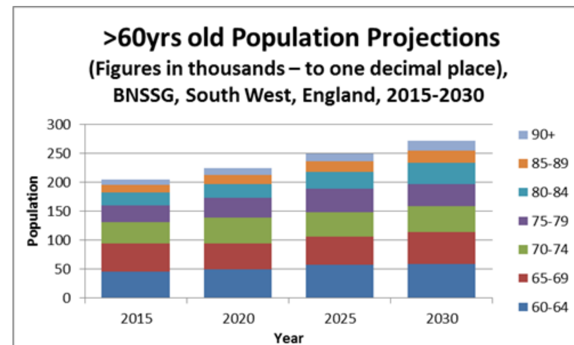
BNSSG Frailty Model of Care

Aim

To provide equity of care across BNSSG for our frail population.

Current State

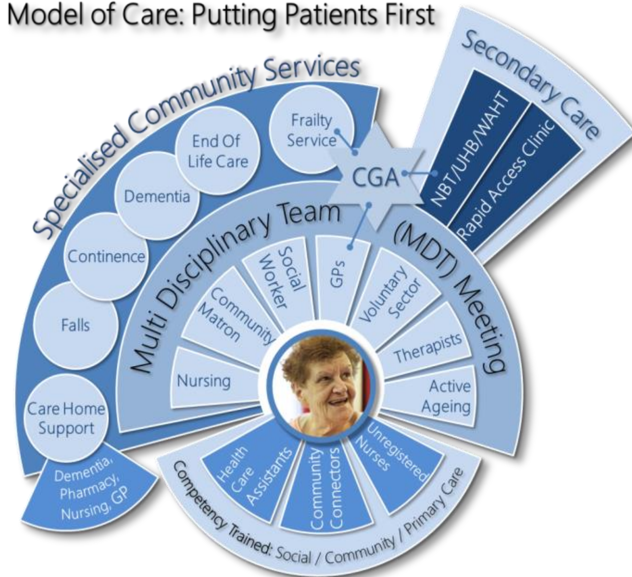
On average the frail population has a larger impact upon all health and social services, in comparison to those aged under 65 years. Across BNSSG the expected population growth for those over 60.



With the average length of stay with BNSSG acute services being 9.45 days for those >65, and an expected increase in this population (>60yr olds) by 32.68%. This can be approximated as an approximate additional 325 bed days per day, across BNSSG by 2030.

Objectives

The primary objective of this scheme is hospital admission avoidance through increasing the quality of care within the community. It focusses support towards Care Homes and aims to work collaboratively with our acute organisations to build upon trusted assessment and provide timely and appropriate access to expertise. This proposed model of care (below – Fig 1) will keep the patient at the centre of all services and undertake a holistic approach for the management of frailty across BNSSG.



Projects

1. **GP Based Multi-Disciplinary Team (MDT) meetings**.
2. **Falls including Multi-Factorial Risk Assessment, Community Based Falls Service, Strength and Balance Training, SWAST pathway people who do not need medical attention**
3. **Dementia Navigators/Advisors**
   Consistent model to be used across BNSSG, building upon current resourced posts from Alzheimer's Society and CCG. Subject to separate business case "Dementia Advisors (Post Diagnosis Support)
4. **Care Home Support**
   A bundle of carehome support has ensured a reduced rate of admissions within some localities in BNSSG. A standardisation of support is required across the BNSSG area.
5. **Competency training across BNSSG**. Upskilling our community teams (registered and no-registered nurses) in frailty care with the following topics
6. **A standardised frailty assessment within Primary Care**. Working upon the principles of completing a <TBD: comprehensive geriatric assessment (CGA)> within primary care. Ensuring GPs with specialist interest are equipped to adequately assess patients and that the wider system is able to act upon this information where required. This is to standardise and instigate the gold standard of care in the community and ensure the use of a common frailty indicator.
7. **Carer Support**. Supporting GP practices to support carers. Immediate identification of carers through Primary care offering double appointments, degree of flexibility. £40k for South Glos.
8. **End Of Life** – End of life care co-ordination centre (described under different business case)
9. **Rapid Access Admission Avoidance Clinics**. MDT with rapid access to diagnostics. The same model of care to be provided across BNSSG.
10. **A&E Front door**, Acute Trust based early senior assessment and access to CGA. [ref. A&E DB Streaming workstream] – please see urgent care project for more detail
11. **Acute Frailty Short stay units:** Standardised across BNSSG.

Risks

- Recruitment to specialist physio and nursing posts
- Nursing homes closing due workforce storage
- Nursing and care homes do not engage with the project

Outcomes

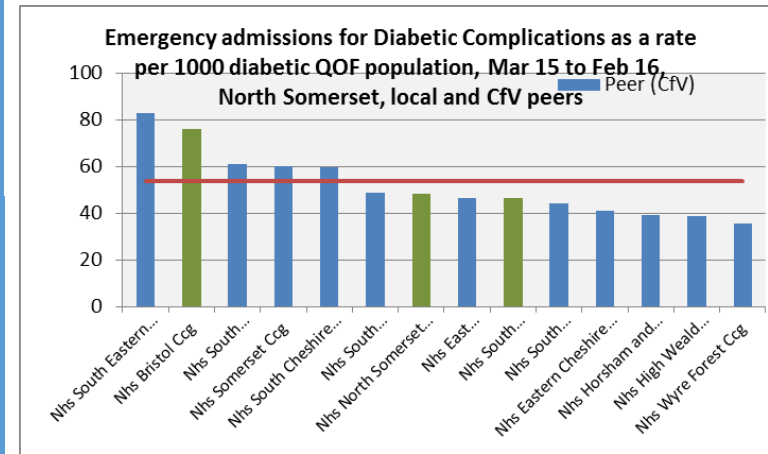
The CCGs recognised this is largely quality driven and the estimation on hospital admissions avoided is conservative. Each one of these directly stated financial benefits is stated within individual CCG business cases, but scope and build up across the BNSSG footprint is required.

Diabetes Programme

Aim

A new efficient model of delivery of diabetes care is proposed; a proactive, integrated, patient-centred service with "barrier-free" working between providers.
The reconfiguration would have an emphasis on delivering as much care as possible in the community setting with the use of care planning and robust, accessible support from specialist expertise.

Current State



The rise in diabetes prevalence between 14/15 and 15/16 across the patch is 4.26%

People with diabetes are also getting older and increasingly have other comorbidities which compound the complexity of caring for these people.

Objectives

- To provide a person with an individualised community diabetes service which is consistent, proven, and effective that optimise both access and sustainability of service.
- Decreased A+E attendances for all diabetes patients
- To decrease the number of lower limb amputations by proactive care planning and early diagnosis and integrated services that meet national and local guidance
- Improved number of patients achieving treatment targets in Hba1c, BP and cholesterol
- An increase in people offered a personalised care/self-management plan which empowers the patient to take an active role within their care.
- Improving the overall quality of diabetes care delivered in primary care
- Reducing variations in the delivery of diabetes care across GP practices
- Up-skilling of practices in delivering diabetes care
- On-going educational support for people, GPs and Practice Nurses
- The start of a reduction in the increase in type 2 diabetes within the lifetime of the programme and the years to come
- Less than 7% growth (current trend) in referrals to Diabetic Medicine (outpatients) by year 5
- Addressing existing health inequalities
- Improved patient and staff experience
- Improved compliance with NICE guidance (as clinically appropriate).
- Reduce the number of acute admissions and early discharge for people with diabetes and other related co morbidities
- Proactively manage patients in community settings when acute exacerbations of a co morbidity impact upon diabetes management.
- Increased uptake of retinal screening

Risks

- The main constraint is a financial one. As CCGs are required to deliver transformation change across the health economy, there is only so much money available within the envelope to deliver wide scale change. Significant investment is required to improve the service with the majority of savings only being realised after five years.
- Given the fact that the 3 CCGs have already introduced diabetes pathways, there may be a reluctance to change those already entrenched due to time and investment already undertaken
- Individual CCGs are not in a financial position to invest in new collaborative diabetes pathways.
- That individual CCGs do not have the resource or capacity to deliver the programme

Projects

Prevention

The programme will implement the national diabetes programme.

Primary Care

Reduction of variation in diabetes care across all GP Practices. Continued up-skilling of GPs and PNs with support from secondary care consultants and both secondary care and community DSNs and dietetics. Identification of diabetes complex patients within GP registers and promote the use of virtual wards with diabetes clinical specialists to ensure better patient outcomes.
Seek funding from the diabetes prevention programme and other educational funding available to improve identification and prevention of those patient who are viewed as pre-diabetes
Look into ways of delivering better personal care plans and how these could link into educational courses.
Seek ways of enhancing advice and guidance between GPs and diabetes specialists where needed.
For practices to follow NICE guidelines and improve coding where appropriate and submit data to the NDA on a yearly basis.
For GPs to follow enhanced guidelines on referring diabetes patients with lower limb complications to the podiatry/foot clinic.

Community Care

To increase diabetes care within the community by working with providers. To reduce diabetes care within secondary care. To promote patient diabetes education within the community and tailor education according to the needs of the community. To understand capacity versus demand and ensure patients referred to education are able to attend a course within a reasonable timeframe. To work with Local Authority/Public Health to identify where closer working could promote better ways of self-management and sign post patients appropriately to local services

Foot Care

To improve the current foot care service between primary care and the foot clinic provider. To enhance referral guidelines and up-skill GPs in understanding appropriate referral and where early intense intervention can reduce unnecessary lower limb amputations. To put into place capacity versus demand so that all patients that need an urgent 24hr consultation are seen within the service level agreement

Outcomes

- Reduced lower limb amputations (Service Specification and improved pathway)
- Enhanced GP and PN Diabetes education
- Increased patient education and uptake of courses
- Increasing diabetes care within the community whilst decreasing secondary care
- Practice review and standardised NICE guidance for yearly patient review
- Reduced number of complications leading to savings across primary, secondary and pharmacy
- Reduced secondary care costs (Surgery and OP)
- Reduced number of referrals to secondary care
- Reduced number of complications leading to savings across the health economy (including primary, secondary and pharmacy)
- Decreased patient treatment costs

BNSSG Respiratory Programme

Aim

The aim of the project is to establish standardised respiratory services across BNSSG that provide consistent, equitable, comprehensive, clinically and cost effective appropriate services for patients with a respiratory condition.

Current State

- Variation in practice
- Gaps in provision
- Discrepancy in estimated prevalence 'v' actual prevalence of COPD
- High emergency admission numbers
- Excess bed day figures
- Benchmarking results (in particular influenza and pneumonia admissions along with respiratory outpatients benchmark high and provide the best opportunity)
- 2016/17 onwards delivery requirements

Objectives

- Agree and implement an integrated approach to both acute and chronic respiratory disease management
- Improved early identification of COPD, self-management and intervention to improve wellbeing of patients with respiratory disease
- Enable multi-disciplinary assessment and treatment, providing seamless care for people with respiratory conditions
- To reduce non-elective admissions and outpatient appointments
- Ensure that for this cohort of patients' admission to hospital is minimised but when it does happen their length of stay is as short as possible
- Improve the patient experience. Maximising a patient's physical and psychological health through lifestyle advice and education on medication, exercise and breathlessness
- To upskill primary care services to ensure potential to support the patient population is maximised
- Ensuring medicines optimisation so the most cost effective therapy is provided at the right time without compromising care whilst reducing admissions e.g. step down programme to reduce pneumonia
- Agree performance measures

Projects

Prevention and Self Care

Education, Self Care, Vaccinations, Smoking cessation

Early Diagnosis

Primary care education, Education course alignment, Spirometry, FEV1 check, Case finding

Ongoing Management

Pulmonary Rehabilitation, Annual reviews, Meds review, O2 therapy, ICS transfer, Inhaler retrieval

Exacerbation Management

Rescue packs, HOT clinics, Pulmonary rehabilitation refresher

Inpatient Management

COPD Bundle, Education, Smoking status recording, Smoking cessation, Meds review, NRT provision, Pulmonary rehabilitation

Early Supported Discharge

Early Supported Discharge, Appropriate follow up, Self Care

Risks

- Inequality in provision of care for patients with respiratory conditions continues
- The number of undiagnosed patients has the potential to increase
- Admission rates continue to increase
- Disease progression rates have the potential to increase.
- This is an incredibly ambitious programme with a significant amount of work to be delivered within the current financial envelope. There are several unknowns and it is therefore very difficult to identify potential costs at this time.
- Variability in stages of progress and services available across BNSSG may hinder momentum of work for individual CCGs.
- Likely shift in activity between providers without processes in place for resource to follow this activity in a timely manner.

Outcomes

- Improved outcomes for patients with respiratory conditions
- Improved patient experience
- Improved prevention and early diagnosis of COPD
- Emphasis of care in the community and self care
- Patients will be consulted and have a better understanding of their condition which will facilitate self-care of their respiratory condition.
- Decreased A+E attendances
- Savings will be derived from the reduction of patients requiring hospital care. Admissions will be avoided and people will spend less time in hospital.
- Savings will be derived from the reduction of inappropriate use of Oxygen

Developing Personality Disorder Pathways for BNSSG with Avon and Wiltshire Partnership

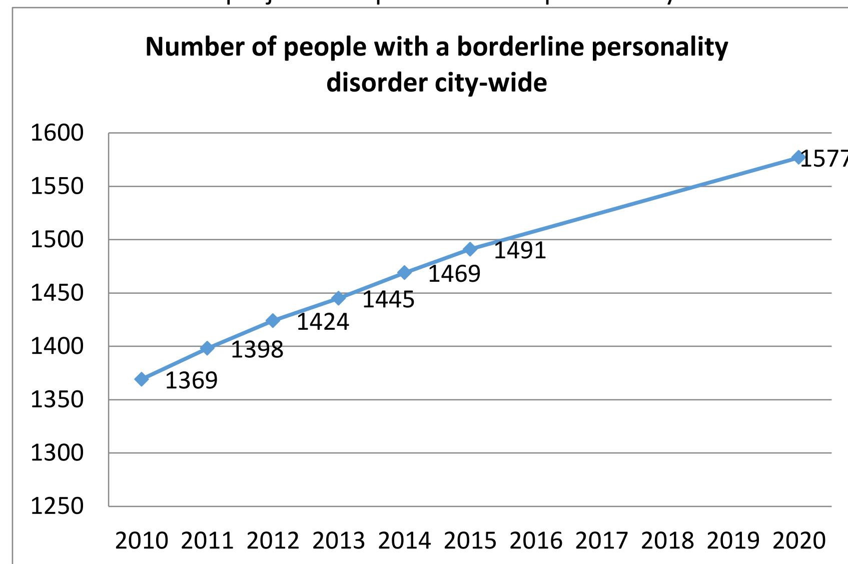
Aim

To scope and develop a personality disorders care pathway for BNSSG as part of the mental health work within the Sustainability and Transformation Plan.

Current State

Cost avoidance

- The JSNA projects the prevalence of personality disorders in Bristol will rise over the coming year as follows:



Source: PANSI; based on the report Adult psychiatric morbidity in England, 2007

In addition to this rising need Avon and Wiltshire Partnership have completed a skill mix review which indicates the caseloads for the Assessment and Recovery service (which currently care co-ordinates people with personality disorders) is operating at 25% above capacity. Whilst these two pieces of evidence are limited to Bristol but in discussion with neighbouring CCGs and AWP, the issues are similar. Unless a prevention focussed pathway is developed to ensure people with personality disorders get timely and effective treatment there will be we can project increased cost pressures on secondary care, crisis services and out of area placements.

Objectives

The aim of this business case is to ensure that across BNSSG people living with a personality disorder are supported to get timely and high quality support to help them stay well.

The objectives are:

- That professionals within the BNSSG System have access to training around personality disorders
- That there are specific interventions available within primary care to avoid people being unnecessarily referred to secondary services or to allow people to be supported to step down from secondary care
- That there is a clear pathway and interventions available within secondary care
- That there is intensive specialist personality disorder interventions available locally so people do not require out of area inpatient support or those who are already out of area can be repatriated.

Risks

- It has not yet been possible to scope the funding requirements of a specialist PD pathway across BNSSG but it is likely this will require an invest to save. Funding is therefore likely to be a constraint
- It is not possible to firmly cost projected savings from a PD pathway
- Developing closer collaborative working across provider and commissioners

Projects

Areas for scoping

The areas to be scoped across BNSSG are as follows. Scoping will include analysis of what is already in place across BNSSG and what needs to be developed:

Training & staff development

- Structured clinical management – supports MH professionals in care co-ordinating people with personality disorder. This will build on work already in place in North Somerset.
- Knowledge and Understanding Framework - training for professionals and non-professionals that explains personality disorders as a condition and identifies techniques for working with people with personality disorders

Enhance primary care support

- Mapping and evaluating and potentially expanding the STEPPS programme across BNSSG
- Consideration of how mental health professionals embedded in primary care could specifically support maintenance of people with PD in primary care

Early intervention

- Scoping a young people's service or early intervention for emerging personality disorders service to support prevention

Secondary care interventions

- Ensuring there is timely access to specialist interventions such as Dialectical Behavioural Therapy (DBT) across BNSSG

Intensive support service to prevent out of area placements

- Scoping an intensive support service that specifically acts as an alternative to or prevention of out of area placements

Once there is clear understanding of current state including patient experience, finance, activity and patient flows, reviewing the evidence base and best practices from other parts of the county we will work up a new service model and then work up the supporting financial model. A decision would then be taken to commission the new service and detailed implementation planning would then lead to a full implementation.

Outcomes

- People with personality disorder have been identified as being 50 times more likely to complete suicide than the general population and therefore an effective local pathway should support a reduction in the suicide rate across BNSSG which will support the five year forward view aspiration for a reduction in suicide rates across the country by 10% compared to 2016/17 rates
- People with personality disorder will be able to be effectively supported within primary care
- Staff across the mental health system will be able to support people with a PD more effectively through increased knowledge, understanding and improved attitudes following KUF training.

Acute Care Collaboration

MSK/T&O

Aim

The brief of the project is to evaluate, develop and implement a revised clinical pathway and service delivery model for MSK services, including acute Trauma and Orthopaedics within BNSSG.

Current State

- Reference Cost Index (RCI) analysis indicates that there are significant excess costs (£13.75m) within T&O in the three acute providers. High elective and non-elective length of stay across all three providers, with 12,730 beds days, or 34 beds opportunity across NBT and UH Bristol between current and upper quartile performance
- £7m Right Care opportunity across BNSSG CCGs
- RTT targets for Orthopaedics have not been sustainably achieved in BNSSG.

Objectives

- Agreement of outcomes which matter to patients
- Agreement of a vision and model for MSK/T&O services across BNSSG
- Ensure that MSK/T&O patients have a positive experience of care
- Improve productivity and efficiency of current service delivery model
- Address issues of sustainability, with a focus on matching capacity to demand across the service

Projects

MSK Clinical Pathways

This project will create a model of MSK care that will integrate and streamline the delivery of services, providing an aligned service for anyone who has an MSK condition. It will enable a greater proportion of patients to self-manage and have their care managed in a community setting. The review will include all MSK services including Core Physio, Enhanced Physio, Podiatry, Orthotics, Orthopaedics, Pain and Rheumatology Services. The first year the project will also seek to deliver some quick wins to reduce demand.

Elective Orthopaedics

This project will focus on the optimal distribution of services across the three acute providers and the independent sector, in order to maximise quality, productivity and efficiency and to realign capacity across the system to meet demand and sustainably deliver improved access for patients.
The project will seek to determine future demand and to develop the required capacity accordingly, in the most appropriate location.

Orthopaedics and Trauma Services

This project will consider how to deliver orthopaedics and trauma services. It will need to consider the interdependencies with other Major trauma services and the extent that it competes for resource with other services i.e. ED, theatres, beds, radiology and staffing.

The project will establish the optimal view of the specific volume and location of the capacity required to deliver the work in this health economy. It will also provide modelling of tariff and pathways that demonstrate a financially viable case mix and will include capacity in terms of theatres, beds and staffing.

Risks

- Failure to deliver RTT constitutional standards
- Poorer clinical outcomes as a consequence of extended waiting times
- Unaffordable clinical model
- Fragmentation of service provision

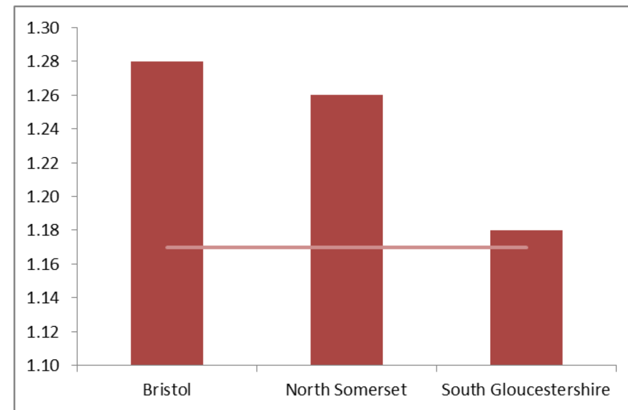
Outcomes

- Improved sustainability of existing services, including a significantly improved Reference Cost Index across all acute providers.
- Sustainable RTT performance across the providers driven by realignment of capacity, including best use of existing capacity to sustainably balance capacity and demand across the acute providers.
- Increase in proportion of NHS activity delivered in NHS organisations.
- Reduction in use of premium rate sessions to deliver elective activity.
- Sustainable and affordable workforce across all providers – to include a reduction in nursing and medical agency costs, through improved recruitment and retention.
- Reduction in acute Length of Stay across providers.
- Reduction in repatriation delays across the Trauma Network.
- Improvement in performance against fractured NOF Best Practice Tariff across the acute providers.

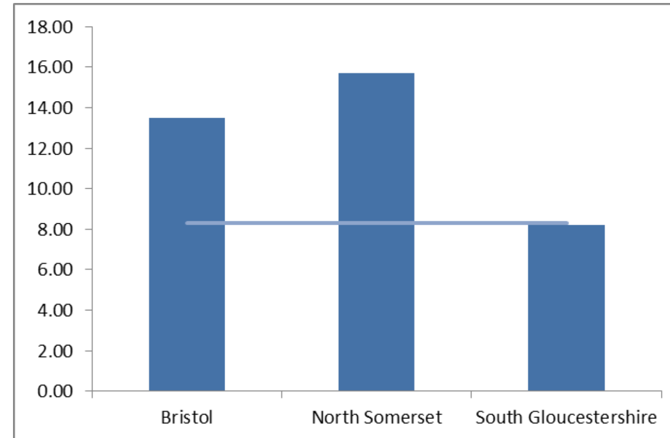
Stroke

Aim
The aim is improve quality, equity and sustainability for stroke care across BNSSG.

Current State
Ranges of benchmarking indicators have identified that Stroke Provision is an outlier when compared to our comparator CCGs. At present there is a plethora of stroke provision across the BNSSG footprint with many services and organisations, including tertiary services that provide stroke care with a variety of different specifications and facilities.



Meeting a benchmark of 75th percentile of similar CCG's might save approx. 30 lives per year.



Meeting a benchmark of 75th percentile of similar CCG's might lead to approx. 100 more patients going home after stroke each year.

Objectives

- Reduce mortality following a stroke
- Reduce the incidence of stroke
- Centralise stroke services
- Improve the quality of care for patients
- Provide an equitable service across the BNSSG footprint
- Ensure a financially sustainable service

Risks

- Finance risk - lack of available data from various sources to inform acute and rehabilitation work streams
- Operational risk - Capacity within programme management and reduced workforce to support projects and admin
- Operational risk - failure in agreement of organisations and adherence to timescales and transfer of bed capacity

Projects
There are three main projects following the patients care journey

Prevention and Primary Care
This project aims to reduce the incidence of stroke by reducing risk factors. The initial focus is to improve detection and treatments for patients with Atrial Fibrillation (AF) and hypertension, and timely attendance at seven day a week Transient Ischaemic Attack (TIA) clinics.

Acute Care
This project aims is to provide an excellent centralised seven day a week acute stroke service in a HASU with step down for those patients who have ongoing acute medical needs to an acute stroke unit(s) (ASU).

The Rehabilitation and Living with Stroke
This project aims consider how to provide out-of-acute hospital rehabilitation for all patients no longer in need of acute hospital care in their own homes or if necessary in bedded community facilities.

Outcomes
Quality
- Reduce mortality following stroke in BNSSG.
- Prevention of stroke leading to a reduction in incidence.
- Patients offered specialist stroke rehabilitation as close to home as possible.
- Reduce long term packages of care and placements.
- Improve care for patients living with stroke.
- Increased evidence of improved performance as measured by SSNAP.
- Conform to national and local drivers and best practice.

Equity
- Provide equitable stroke services across BNSSG.

Sustainability and Finance
- Increased effectiveness, efficiency and economy resulting from centralising stroke services.
- Reduce length of stay in acute hospitals.
- More effective use of scarce specialist workforce.

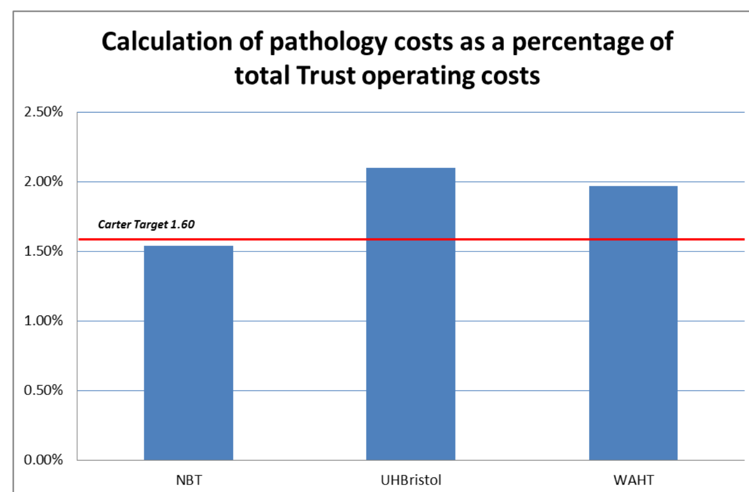
Pathology Programme

Aim

To create a maximally effective pathology service across BNSSG through enhanced networking and support between the three existing providers

Current State

We currently spend more on pathology as a percentage of the total trusts operating costs than the Carter Target at UHB and Weston Area Health Trust.



Objectives

- Ensure pathology services are configured to support delivery of safe and most cost effective clinical pathways
- Minimise cost per test of pathology services
- Maintain quality of pathology results at reduced cost
- Reduce or minimise growth of pathology testing by avoiding non-value add testing
- Drive cost effective clinical pathways through rapid adoption of new pathology testing as the evidence develops
- Ensure Weston has a sustainable pathology service
- Establish BNSSG pathology to enable early adoption of personalised medicine approach as they develop of the Genomic Project and Personalised medicine Strategy

Projects

Cellular Pathology

In May 2016 Cellular Pathology services were centralised at NBT.

Benefits Realisation from LIMS

There is already collaboration underway between providers and a shared LIMS system is currently being deployed. Work is currently underway to ensure this is used effectively across the healthcare system to maximise the benefits.

Transfer PHE to NBT automated bacteriology Lab

From November 2016 PHE bacteriology services will co-locate with NBT bacteriology services at NBT under an agreed collaboration, this will bring all bacteriology from both Bristol and Bath onto a new fully automated system going live early 2017. The remaining PHE services will move to the NBT site from spring 2017

Sustainable model of Weston Histopathology

This will be one element of the Weston Sustainability Model. We will feed in options into the wider Weston Project, in the right timescale to support their programme delivery.

Specialist Testing Review

We will review all the tests currently being sent out of area to identify if any of these could be delivered in BNSSG at a lower cost

Blood Sciences Review

We will consider if there are options for closer collaboration or consolidation of blood sciences services across providers

MES Re-procurement

The MES contract expires and with closer collaboration and consolidations service we will consider what equipment is now needed and what will be needed over the next contract period to deliver services

Demand Management

Reduce inappropriate or no value investigations, ensure repeat testing is correctly timed and promote testing where linked to decision points in care pathways.

Urgent Care Pathways

Develop plan for appropriate support for primary care to maximise care in the community speed urgent pathways

Clinical Service Change

Utilise current and new pathology tests to influence care pathways where reduced overall cost, delayed progression and/or better outcomes can be demonstrated.

Risks

- Individual organisational interest clashes with STP interest preventing maximum benefit being realised
- National storages in specialist staff impact the ability to deliver high quality services
- Excessive reductions in infrastructure reduce resilience resulting in service failure

Outcomes

- Ensure sustainable services with respect to cost and staffing
- Reduce cost per pathology test
- Minimise growth of pathology testing
- Enable access to specialist reporting where appropriate
- Share risks between providers to create resilience and reduce risks of service failure
- Support develop of new care pathways and drive beneficial changes resulting from new pathology testing
- Maintain sufficient resourcing to manage rapid technology change as genomics and personalised medicine develops

Weston Health

Aim

The overall purpose of the North Somerset Programme for Sustainable Services is to redesign and strengthen the Weston and North Somerset health & social care provision models so that they are:

- Fit for the future to meet the changing needs of local patients and communities
- Clinically safe. No proposals will be put forward that clinicians have not agreed are clinically safe and appropriate for the population. Any solution will also need to give assurance that recruitment and retention of the necessary clinical staff is feasible
- Financially sustainable in terms of North Somerset and the wider BNSSG systems, and also for the relevant parts of Somerset

Current State

- Waiting times for urgent and emergency care are not being met and there are high levels of bed occupancy within Weston General Hospital
- Between April-December 2015/2016 there were 27% more patients waiting for community packages to be in place before they could be discharged from Weston General than for the whole of 2013/14. This reflects the high degree of pressure on social care services
- A number of GP practices around the Weston area are under significant pressure
- The Care Quality Commission has highlighted a number of areas for improvement at Weston Area Health NHS Trust, including reducing the numbers of long term locum and agency doctors in certain specialities by ensuring that there are suitable numbers of permanent doctors in post
- A recommendation from the GMC was for the trust to continue to provide effective support, training and supervision to junior doctors. Overnight FY2 A&E doctors been withdrawn
- Both Weston Area Health NHS Trust and North Somerset CCG have recurrent financial deficits and the position is forecast to worsen significantly in a “do nothing” scenario

Objectives

We are currently in the second phase of a 3 phase programme:

- GE Finnamore (health consultancy) was commissioned in early 2016 to complete a review of all the previous assessments of the local system’s challenges
- The Programme for Sustainable Services is currently developing a set of options/ proposals based on the Finnamore’s work to put to the Sustainability Board. These will be drafted in December
- Once agreed by the Board's/ Governing Bodies of the organisations who make up the Sustainability Board, we will move into a phase of engagement, consultation and implementation

Risks

- A solution cannot be identified that both balances financially and meets the needs of a relatively geographically isolated population that is growing faster than the national average
- Limited programme management capability and capacity risks the proposals developed by December not being robust enough for engagement and consultation, thereby delaying the timetable for implementation
- Current - There is a risk that appropriate clinical staff cannot be attracted to work at the Weston site, both as part of a long-term solution but also in the meantime as proposals are consulted upon and then implemented
- Proposed - There is a risk that appropriate clinical staff cannot be attracted to work at the Weston site due to uncertainty as proposals are developed and consulted upon.

Projects

The purpose of the project is to consider the service configuration options which would allow Weston Area Health Trust to be clinically and financially viable. The process to find a solution is financially driven but clinically led. A Clinical Leadership Group has set up four expert clinical sub-groups to examine the key elements of the system and develop proposals for improving patient care and service pathways. The Expert Clinical sub-groups are made up of senior clinicians/ practitioners from all the service providers who are members of the Sustainability Board. The clinical groups are supported by groups for Analytics, Finance and Communications. Again, these enabling groups are drawn from the membership of the Sustainability Board

A full project for implementation would be developed following public consultation if change is substantial and therefore required In Phase 3 of the Programme. The length of time it takes to complete Phase 3 will depend on the nature and complexity of the changes being proposed. Although this work has its origins in the challenges faced by a single organisation, it is clear that the answer lies in a system solution. We need to make the best use of the vital capacity that the Weston site offers. The live issues that we are currently working on include:

- Leaders in the health and social care system are strongly in of retaining a 24-7 urgent/ emergency care service on the Weston site
- Redirection of elective work to optimise use of the facilities at Weston is likely to be a big part of ensuring the financial viability of the site
- Both University Hospitals Bristol and North Bristol trusts have expressed a commitment to closer working with and at Weston to help deliver the objectives in 1 and 2 above. We also continue to work closely with Taunton & Somerset FT
- Although increased use of Weston elective facilities could be part of the solution, we will still need to take significant costs out of the system to make this programme a success
- Ways to achieve this include reducing delays/pinch points in the patient’s journey as they pass from one health or care organisation to another. Another way is to get better at working together to avoid admissions to hospital in the first place, and when patients are admitted help them get home as soon as it is safe to do so
- Clinicians think that a major way to achieve these goals could be closer working between local community, acute and primary care services
- We have included the issue of commissioning sufficient numbers of community hospital beds in our system, given the closure for repairs of part of the Clevedon community hospital site

Outcomes

The Weston/ North Somerset system has been operating under a label of “not sustainable” for a number of years now, with all the attendant instability and uncertainty for staff and patients that this brings with it. There have been a number of previously unsuccessful attempts to reform the health economy over the past few years. The overarching aim of this programme is not to create the perfect system, but instead to remove the label of unsustainably by addressing the structural problems in the current configuration of services, thereby putting the health economy on a level playing field with our peers

- Safe and effective clinical services for the population served by Weston Area Health Trust and the population of North Somerset
- Models of care that are financially suitable and are likely to be able to recruit and retain the necessary clinical staff to deliver them
- Much closer working between acute, primary and community health and care systems – potentially supported by organisational integration as an enabler

Medicine Optimisation

Aim

The aim is to deliver transformational improvement in medicines optimisation in BNSSG. This will deliver cost savings, improve efficiencies, maximise benefits from medicines including cost avoidance, and improve patient outcomes.

Current State

More than £250m pa is spent on medicines in BNSSG; are we really making the most of this investment?
The following information is extracted from national data:

- Do patients take their medicines?
  - Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.
  - Ten days after starting a medicine, almost a third of patients are already non-adherent - of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent.
- How well do we use medicines?
  - A study conducted in care homes found that over two thirds of residents were exposed to one or more medication errors.
  - Over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.
  - In hospitals the General Medical Councils EQUIP study demonstrates a prescribing error rate of almost nine percent.
  - In general practice an estimated 1.7 million serious prescribing errors occurred in the NHS in 2010.
- Is the NHS getting best value from medicines?
  - In primary care in England around £300 million per year of medicines are wasted (this is likely to be a conservative estimate) of which £150 million is avoidable
  - At least 6% of emergency re-admissions are caused by avoidable adverse reactions to medicines
- Are patients getting the right medicines?
  - Analysis of the NHS Atlas of variation highlights unwarranted variations in the prescribing of some medicines across England.

Objectives

The Medicines Optimisation Transformation Programme incorporates a wide range of projects, all of which result in financial and patient benefit. Objectives include:

- Maximisation of biosimilar implementation
- Embedding of e-referral to Community Pharmacy
- Efficiency improvements in high cost drug delivery
- Reduce polypharmacy in care homes
- Implement BNSSG de-prescribing protocols
- Implement centralised dispensing of unlicensed medicines pilot
- Implementation of repeat prescription project
- Improve outcomes from RightCare
- Technology linkage regarding medicines data and information
- Acute service centralisation project efficiencies from Carter
- Centralisation of aseptic dispensing services

Risks

- Risk that the BNSSG Pharmacy services (and clinical colleagues) do not have the capacity or project management support to implement the identified projects.
- Risk that the cost avoidance savings from medicines optimisation (eg improved patient safety, reduced admissions, reduced length of stay) are not recognised as they are not readily measurable.
- Risk that the underlying financial impact of activity increases and the cost of new innovative medicines will mask the direct cost savings available and delivered.

Projects

Biosimilars

To work with medical teams (GI, Rheumatology, Dermatology) and patients to implement the more cost-effective biosimilar pharmaceutical products and manage the transfer to these drugs where clinically appropriate.

E-Referrals

To use available technology to transfer discharge information to community pharmacists to provide follow up care for patients taking complex medicines.

High Cost Drugs

To review the use of the most expensive drugs and ensure they are being used appropriately and consider if improvements could be made.

Polypharmacy (GP guidance & care homes)

To review medicines being taken by the frail elderly, particularly within the care home context, in order to ensure that all medicines are necessary and appropriate.

De-Prescribing

To identify and agree medicines that are considered to have no proven benefit and implement de-prescribing protocols.

Centralised unlicensed medicines dispensing project

To develop a project to manage all unlicensed medicines through a central hospital based service in order to avoid high commercial charges.

Repeat Prescriptions management service pilot

To manage repeat prescription services in order to avoid provision of unnecessary medicines and reduce wastage.

Implementing Right Care to reduce variation

To apply RightCare medicines data on variation to BNSSG to focus on areas for improvement and implement change.

Connecting Care

To develop utilisation of Connecting Care in the context of sharing information and data concerning medicines in order to improve efficiency.

Pharmacy Transformation Plan (Carter)

To implement changes through the acute Trusts' Hospital Pharmacy Transformation Programmes in order to improve service efficiency across BNSSG.

BNSSG aseptic pharmacy services

To plan a BNSSG wide aseptic dispensing services facility to meet strategic STP requirements.

Outcomes

The benefits include the following, (with the assessment in the Carter efficiencies, that for every £1 that is spent on medicines optimisation there is a £5 benefit to the NHS).

- Cost savings; eg Biosimilar implementation results in reduced medicines expenditure; better management of medicines results in reduced wastage
- Cost avoidance; eg Improved medicines optimisation results in reduced readmission rates and reduced length of stay
- Patient harm reduction; eg medicines safety improvements have a direct impact on avoidance of harm and therefore also result in cost avoidance
- Service efficiencies; eg service centralisation in order to focus attention on medicines optimisation

Urgent Care

Aim

To ensure the public get the rapid response to an urgent care need and get to the right service first time.

Current State

The national target is for 95% of people attending ED to be seen within 4 hours, the following table illustrates the current performance for NBT, UH Bristol and WHAT and therefore the need to make change within the BNNSG urgent care system

Trust	April 16	May 16	June 16	July 16	August 16
NBT	77.1%	76.2%	82.2%	80.1%	78.6%
UH Bristol	87.2%	91.7%	89%	89.3%	89.9%
WAHT	76.3%	89.4%	88.1%	84.6%	82%

Objectives

- To ensure the public know where to seek help when they have an urgent need
- To ensure a consistent response regardless of where a patient presents
- To ensure effective assessment and treatment are delivered in a timely way
- To reduce demand on A&E
- To reduce inappropriate presentations at A&E
- To ensure effective use of the whole urgent care system

Risks

- Complexity of a large programme to deliver
- Difficult to get agreement across 3 CCGs and all providers
- Improving urgent care services and informing the public about the changes may create 'provider induced demand' rather than reducing demand on urgent care

Projects

Alcohol care teams

The aim of this project is to introduce alcohol care teams in A&E to reduce admissions. Alcohol care teams will be part of multidisciplinary teams which combine clearly defined alcohol pathways with referrals to and from the community, a seven day service with particular focus on Friday, Saturday and Sunday

Urgent Care Pilot

The aim of the project is to establish a primary care led streaming hub and urgent care centre at the front door of the Bristol Royal Infirmary. The evaluation of this pilot will feed into the broader urgent care review.

Urgent Care Project

The aim of the project is to develop a comprehensive understanding of the urgent care system including whole range of providers including 111, pharmacy, GPs, mental health crisis teams, mental health sanctuary/crisis cafes, ambulance service, community optometrists, minor injury units, A&Es, social care duty teams etc. This will include understanding current patient flows, activity, finance and patient experience and the evidence base of what is effective and best practice from other parts of the county. The project will then work with stakeholders to develop the future model of care and ensure consultation with public before making a decision. This will be followed by detailed implementation planning before making the change to the new arrangements. In parallel with the main work programme quick wins will be identified and implemented where it is appropriate to do so.

Outcomes

- People will be treated in a service that matches the level of acuity for their condition
- Service users and carers will have an improved experience of urgent and emergency care that meets their needs in a more appropriate setting
- Providers will deliver against the 4 hour national target
- The cost of care will be reduced