

## Appendix B2 Additional Programme Narrative

### Prevention, Early Intervention and Self-Care

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

The model is based on four principles:

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

### Transformation

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

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

### Impact

Our initial priorities are:

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

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

Our priorities are enabled by:

- an established patient-centred Bristol, North Somerset & South Gloucestershire health and care partnership approach
- the development of a new relationship with the public and the delivery of the shift of care from an acute setting to primary and secondary and self-care with a reduced dependency on beds and increased use of health and social care hubs and signposting

- wider definition of workforce to include for example voluntary sector, police, housing, pharmacy; and a non-differentiated workforce across BNSSG with common training and standards.
- digital platforms and technologies such as personal health records, telehealth and app development.

Priority	Impact	Methods to measure impact
Alcohol - reduce excessive alcohol consumption and associated burden on NHS and Local Authorities (LAs) and wider society	<p>Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs by 2020/21</p> <p>Reduce the burden on NHS, police and social care services from high volume service users</p> <p>Reduce the impact of parental alcohol misuse on children</p>	<p><a href="#">Alcohol-related hospital admission (narrow measure): number of admissions</a> (by CCG and LA)</p> <p><a href="#">Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission</a> (by CCG)</p> <p>For every 3 IBA interventions delivered 1 alcohol-related admission will be avoided<sup>1</sup></p> <p>Ambulance call-out data</p>
Falls - reduce fractures from repeat falls.	<p>10% reduction in the number of injuries due to falls in people aged 65+ by 2020/21, through improved and more coordinated preventative services</p>	<p><a href="#">Emergency admissions due to hip fractures in people aged 65+ per 100,000</a></p> <p><a href="#">Patients with fragility fracture and confirmed osteoporosis treated with bone-sparing agent</a></p> <p>Fracture liaison services can reduce risk of second fracture by up to 50%<sup>2</sup></p>
Diabetes – prevent cases of Type 2 diabetes and improve management of those with diabetes	<p>Reduce the projected growth in incidence of diabetes</p> <p>Improve support for self-care in people with a diagnosis of diabetes</p> <p>Improve the treatment and care of people with diabetes</p>	<p>Uptake of the NHS Diabetes Prevention programme</p> <p><a href="#">Incidence</a> of diabetes</p>

<sup>1</sup> Public Health England

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

Supported self-care at scale	Reduction in emergency admissions of Long Term Conditions (LTC) group with above average risk of admission  Develop training for health professionals and population  Self care enabled via digital supports	22-32% reduction in emergency admissions of LTC group with above average risk of admission (25%) <sup>3</sup>  Patient Activation Measure
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### Medium and long-term priorities

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

Activity / initiative	Description	Impact	Alignment to Drivers of Change
PATHWAYS			
Healthy lives	Obesity reduction, smoking cessation and continue work on alcohol harm reduction	Reduce related hospital admissions	Consistent pathways  A new relationship with the population
<i>Intervention</i>	<i>Ensure evidence based pathways and interventions consistently applied across BNSSG and build on self-care work already underway</i>		
Primary prevention - adults	Dementia and stroke prevention	Consistent pathways across BNSSG with prevention integrated across pathway	Relevant to all 5 drivers
<i>Intervention</i>	<i>Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on atrial fibrillation and impact on stroke prevention &amp; return on investment</i>		

<sup>3</sup> BCH/Philips project

Mental health - Children and young people	Provide appropriate support and services focusing on the emotional wellbeing and mental health of children and young people  Work with schools, Children's Centres etc.	Consistent pathways across BNSSG with a strong focus on prevention and early intervention prior to any formal diagnosis	Relevant to all 5 drivers
<i>Intervention</i>	<i>Ensure services reflect need particularly for those sub-threshold in terms of clinical diagnosis.</i>  <i>Ensure consistent offer across BNSSG and access to appropriately designed prevention and self-care initiative in appropriate settings – base on existing examples of good practice.</i>  <i>Reduce attendances due to self-harm.</i>		
Secondary prevention - adults	Secondary prevention: atrial fibrillation, hypertension, hypercholesterolaemia, LTCs (multi-morbidities), cancer prevention via a range of health professionals	Ensure consistent pathways across BNSSG	Relevant to all 5 drivers
<i>Intervention</i>	<i>Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on evidence for return on investment for health and social care</i>		
Ambulatory care	Develop/build on prevention and self-care services	Reduce ED attendances and admissions.	Consistent pathways  A shift to digital  A new relationship with the population
<i>Intervention</i>	<i>For example develop/build on self-management for COPD; rapid response teams at home; End of Life Care</i>		
Sexual health	Focus on contraception and return on investment	Reduce associated costs of less effective contraception	Standardise and operate at scale  A new relationship with the population  A new relationship with staff and organisations
<i>Intervention</i>	<i>Increase take up of more effective contraception (LARC)</i>		

Health protection	Flu programme Antimicrobial resistance and link to self-care	Reduced primary and secondary care attendances	Standardise and operate at scale  A new relationship with the population  A new relationship with staff and organisations
<i>Intervention</i>	<i>Focus on potential to reduce:</i>  <i>GP consultation rates for influenza-like illnesses; A&amp;E attendances for respiratory conditions; Emergency admissions for confirmed influenza</i>  <i>Impact of health and social care reduced capacity and performance due to staff absence; Antibiotic prescribing for secondary bacterial pneumonia (and resultant risk of a rise in antimicrobial resistance); Outbreaks in acute and community settings requiring special management arrangements; Parental leave to care for ill children; Excess winter mortality, particularly in identified at-risk groups.</i>		
<b>WIDER DETERMINANTS OF HEALTH</b>			
Reduce harm caused by social isolation	Provide adequate support for the frail elderly and reduce the harm caused by social isolation	Reduce ED attendances and admissions.	Consistent pathways  A new relationship with the population
<i>Intervention</i>	<i>Ensure consistent support and signposting across BNSSG with a focus on evidence for return on investment, building on existing support services and social prescribing</i>		
Expand prevention activities within NHS providers	Create healthier environments in health and care providers and local employers.	Healthier workforce – positive impact on workforce retention	A new relationship with staff and organisations
<i>Intervention</i>	<i>Ensure consistent messaging conveyed to the workforce. Include link to enabling those with LTCs to work. Consistent approach to workplace health across BNSSG starting with health and care providers and broadening out to other employers</i>		

Inequalities	Take a BNSSG approach with a focus on inequalities within BNSSG rather than regional comparisons	Equal access to the right prevention/early intervention/self-care initiative in the right place at the right time	Relevant to all 5 drivers
Intervention	<i>For example review excess winter deaths and link to inequalities</i>		

1. Agreement that PEISC stakeholder group is overseen by WoE PH Partnership and that the STP and prevention is a new workstream within this partnership. This will ensure close working and allocation of BNSSG DsPH and PH Consultants as appropriate to STP-related work.

2. As agreed at WoE PH Partnership business cases submitted to the STP/CCG commissioning process are based on the initial priorities as above but MECC and health protection also included in this first tranche:

- Alcohol harm reduction
- Falls
- Diabetes
- Self-care at scale
- Making Every Contact Count
- Health protection (flu vaccination and AMR).

Alongside the above first tranche of business cases from this workstream we have submitted an overarching PEISC covering business case that highlights the need for dedicated funding for prevention in order to deliver not only the immediate priorities but to also deliver the medium/long term priorities and support those cross-cutting pathway focused workstreams currently under review (diabetes, MSK, stroke) and other pathways reviewed going forward as agreed by the Clinical Cabinet and prioritisation forum – dedicated investment is required if the system is to reduce demand on the health and social care system that it cannot support in the future.

Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years. It is proposed that rather than being reliant on individual business cases submission that a resource/fund is identified for prevention to enable delivery of STP prevention, early intervention and self-care priorities and cross-cutting pathway reviews across the three STP workstreams.

## Integrated Primary and Community care

IPCC programme has agreed the delivery structure, developed the overarching PID and relevant terms of reference for the proposed programme board and strategy and design group. The programme board has met twice and the steering group has not yet met but the focus has been on testing with key stakeholders the elements of the model and the development of project briefs in support of the overall target impacts previously set out in the June submission.

There has been significant engagement across commissioners and providers to consider at a high level the component parts of the model. This has involved recognising the different starting points across BNSSG in each of the areas, understanding the shared BNSSG blueprint or end point for the model and considering the high level milestones to achieve this. Encouragingly, there has been a very high degree of consensus for each area and a good platform has been developed for moving this forward into project delivery.

There have been the beginnings of greater engagement with mental health colleagues and a testing of where mental health needs to be integrated into the overall model and where it needs to be specifically represented a particular pathway or model.

Given the degree of engagement that has been required to date to develop this consensus, the normal timeline associated with understanding properly the evidence base, engaging with clinicians developing complex transformation and the lack of resources specifically allocated to this work, the following represents the progress to date in developing the impacts further:

- We are unlikely to shift the numbers in this iteration for this element of the model and therefore these remain as high level targets based on high level evidence.
- activity and finance impacts remain group for the whole model but could be disaggregated if useful with efficiency benefits hanging off the model and specific numbers for avoided admissions etc hanging off the pathways which would enable incorporating any cross over with ACC or prevention (e.g., diabetes pathways)
- we note the email in which the risk rating on IPCC projects was lifted so we are now theoretically aiming at maximum saving
- individual business cases may have better, more accurate costing models to get underneath the 40% re-provision assumption but it is unlikely
- the next stage will be to resource and deliver the required project work to develop the granularity required and in some cases this will take a considerable level of engagement based on the suggested programmes of work.

The key impacts modelled for the IPCC workstream were:

The impacts of the integrated, cluster based teams on:

- Admissions and;
- Outpatients and associated follow-ups for key conditions/patient groups.

This was also tested against national evidence as outlined in background information and to a degree local experience where that existed.

A further potential efficiency impact from new ways of working (including diverting activity away from primary care e.g. social prescribing) on future projected activity was worked up, including:

- Impact on primary care and community care contacts and;
- Community beds efficiency improvements.

The SPA and any other elements of the new IPCC model were considered to be wrapped up in (or enablers to) the above – and therefore no additional impacts were calculated for these.

The acute care collaboration workstream similarly has 40% re-provision which might be regarded as potential investment within IPCC and needs clarifying, attributed to:

- Reductions in bed days (elective and non-elective)
- MH reduction in admissions and LOS

## General Practice Sustainability and Transformation Delivery Programme

### Sustainable primary care, what is the problem we are trying to fix

Primary care continues to be the foundation on which healthcare has been provided since the inception of the NHS in 1948. We know that high-quality primary and community services is the key that unlocks the potential for preventative, proactive management of patients, reducing the need for acute and bed-based care, and addressing many of the health inequalities that exist across our population. However, there are significant challenges being faced by primary care and General Practice in particular. The growing workload and need to manage increasing numbers of patients with multiple and complex health needs, coupled with the uncertainty of future workforce, means we need to radically rethink the model of General Practice if we are to make it sustainable beyond the current decade.

The current state of play in primary care across BNSSG:

- With practice mergers and the percentage of work needing to move into an out of hospital setting current GP estate is not fit for purpose in many cases and this is causing system wide pressures.
- The biggest issue facing all contractor groups is the availability of the clinical workforce to continue to provide primary care in its current form leading us to consider new models of care.
- We know from feedback from Healthwatch, MPs and patients there are problems getting access to primary care services in some parts of our patch, – this challenge will continue as we have seen the number of patients making contact about waits to see their GP and dentists growing.

Our top five challenges are:

1. Urgent action is needed to tackle significant variations in quality.
2. Challenges including an increasing workload; an expanding population; people living longer and with increased care needs.
3. We need to see significant changes to the numbers, skills and roles in the workforce that are needed across our primary care system.
4. We need to get better at educating our systems about pharmacies and other resources to divert large numbers of patients from GP surgeries and service such as A&E.
5. We recognise the problems facing primary care cannot be solved by silo working and wish to see pharmacy being considered as part of the solution.



We must collectively across the system ensure that our primary care colleagues possess the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our population and we set out within this section our plans to support this more suitable future both in general practice. With the issue of key policy documents such as the 'General Practice Forward View' a burning platform like never before places emphasis on a programme of rapid transformation that drives quality and sustainability.

It is clear that general practices in BNSSG are under strain and are bearing the brunt of pressures to meet increasing and changing health needs. Our vision for general practice is that it operates without borders, and in partnership with the wider health and care system. 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.

We think that new models of general practice can in the main only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations which we are already seeing happen across the SW, with 40 general practices merging with others already over the course of the previous 12 months to create larger and more resilient providers. This really gives rise to us turning our heads and focusing effort into re-energising primary care and GPs in the main to sustaining an area of our system that provides a service for over 80% of our population not simply the most costly 2%..

We have created a BNSSG wide primary care strategy, initially focussing on general practice. This sets a clear direction of travel towards integrated service delivery by local care organisations covering a geographical footprint with small enough teams to retain the GP practices' very personal relationship with patients and a sense of continuity of care, whilst being large enough to assure long term sustainability and capacity to meet the demands of the wider system. We want to see these primary care at scale organisations providing 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. They will be organised in different ways depending on local circumstances but will be based on a defined geographical patch, reflecting natural communities, within which they are responsible for the health and wellbeing of the population. They will be large enough to be organisationally resilient whilst hosting smaller clinical teams at a local level of different specialisms. 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.

As mentioned above we are currently working across BNSSG to define the GP localities. North Somerset and South Gloucestershire CCGs are more advanced in their configurations than Bristol. During October and November Bristol CCG are working with their GP members and Governing body to move this conversation on, the GP localities will be built around the following principles:

1. Based on population health needs, with weighted populations of circa 30-50k;
2. Demarcated geographical footprints;
3. Will provide a platform for delivery of GP Forward View, including seven day access;
4. Will provide a platform for delivery of mental health and integrated community services;
5. Will provide a basis for commissioning of enhanced primary care services.

These footprints will be the basis for the planning and delivery of services, irrespective of who owns or operationally runs a general practice. If a GP practice sits across a border in it will be expected to organise delivery of care according to the needs of the population within that defined geography.

In BNSSG the CCGs, working in collaboration with NHS England South (South West) are supporting a number of initiatives which will deliver a sustained transformation of primary care via the funding a three year programme which facilitates the coming together of various organisations and arm's length bodies to support local areas to sustain general practice not just for tomorrow but for the coming years. New roles in primary care will be critical to its sustainability and this programme of work will focus its efforts on exploring this concept in more detail to build a programme of delivery including community education provider

networks. We will also work with providers to explore more efficient ways of working across clinical, management and administrative functions by sharing expertise and resource throughout the SW, which will strengthen the capacity of practices to develop new services out of hospital. We recognise that greater integrated working particularly in primary care could yield significant benefits in terms of efficiency effectiveness and patient outcomes.

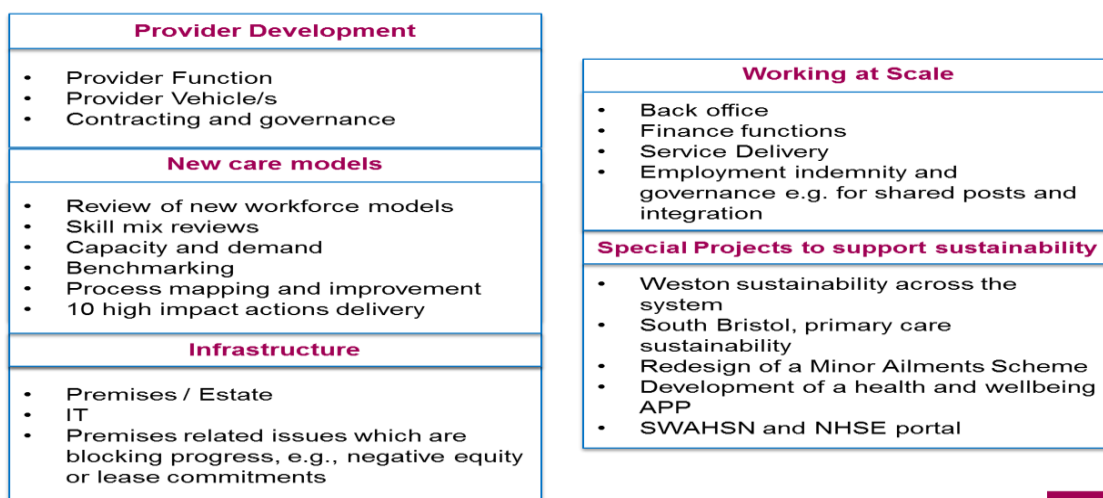
The way general practice is organised will need to change; this applies to the standard GP contract timing 0800am-18.30pm and out of hours. This programme will also take a view on organising care and delivery of the GP access fund for 16/17 and 17/18. Already across BNSSG new and innovative access to general practice pilots have been established by One Care Consortium who nationally obtained £9.6m of new monies via the GP Access Fund.

This money has been used over the previous three years to pilot new ways of working including:

- Piloting mental health workers, physiotherapists and pharmacists to develop multi-disciplinary teams to support better patient access to services and GP workload;
- Developing a seven-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.

The immediate priorities for action and oversight of the GP sustainability and transformation delivery board are:



#GPforwardview

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### Temperate check of general practice

Across BNSSG in November commissioners will undertake a ‘temperate check’ of general practice throughout November, this will also include the bringing together of denoted ‘resilience areas’ via the national £40 resilience of general practice fund launched as part of the GP Forward View announcements recently. The resilience areas will be brought together 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. This will also help inform the programme plan further for the GP sustainability and delivery programme.

The temperate check will collect the following data (per practice) via a web tool:

- Number of appointments available for the week (by professional working at the practice);
- Demand for appointments for the week (by professional working at the practice);
- What the gap is between capacity and demand;
- What happens to the patients when demand is reached;
- How much of the demand (by Health Care Practitioner) could have been delivered by another member of the team or moved to self-care.

## Developing System indicators - helping STP's understand what is going on in primary care

- Number of GP practices
- Number of potentially vulnerable GP practices: (looking for downward trend) \*
- % GP practices working in a formal collaboration (looking for upward trend) \*
- % vulnerable GP practices working towards sustainable solution (looking for upward trend and any that are not named and identified as a key risk)\*
- Workforce (from national return) -number (? and %) practices with combined clinical staffing numbers/1000 practice population (think this is probably more useful than no of GP's) below national average (looking for downward trend)\*(AHSN)
- Workforce (from national return) % clinical staff >age 55 (potential risk identifier)\*(AHSN)
- No and % of practices with CQC requires improvement rating (risk identifier/looking for downward trend)\*\*
- No and % of practices with CQC inadequate rating (risk identifier/looking for downward trend)\*\*
- No and % of practices identified for GPOS review (Risk identifier/Looking for downward trend) \*\*
- No and % of practices >6 GPHLI > 6 outliers (Risk identifier/Looking for downward trend) \*\*
- No and % of practices with application for list closure in last 6 months (Risk identifier/Looking for downward trend)\*\*
- No and % of practices with QOF score<80% (Risk identifier/Looking for downward trend) \*
- No and % GP practices with referral rate increasing by (?) >5% (System outcome indicator/Looking for downward trend)\*\*\*
- No and % GP practices with referral rate reducing by (?) >5% (System outcome indicator/Looking for downward trend)\*\*\*
- No and % GP practices with unplanned admission rate increasing by (?) >5% (System outcome indicator/Looking for downward trend)\*\*\*
- No and % GP practices with unplanned admission rate reducing by (?) >5% (System outcome indicator/Looking for downward trend)\*\*\*

Source of data: \* - PMO \*\* - NHSE Primary Care contracting team \*\*\* - CCG/STP

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## Estates and technology transformation funding (ETTP)

In 2015 NHS England released details of a 'Primary Care Infrastructure Fund' which is a four year £1billion investment programme to accelerate improvements in GP premises and infrastructure like Information Technology. CCGs in BNSSG are currently in the process of finishing their 'strategic estates plans' to inform the release of monies attached to any strategic priorities identified. This is creating opportunities for collaborative work between providers and local communities to identify the best way of utilising/developing existing infrastructure.

## Technology

- Technology is a key enabler for delivery of a transformed and sustained primary care and currently we are not doing enough to really bring the NHS into the modern era via use of modern methods of technology.
- There is a BNSSG Digital Road Map and IT strategy for BSG and NS CCGs. These need to be aligned to this piece of work to ensure focus is in the agreed areas to enable achievement of key priorities.
- The ETPP process is a potential source of funding, that could fund some of the areas to move at pace, however although CCGs will work together with Avon IM&T Consortium to put bids forward that are a priority to the system, there is no guarantee that bids will be successful .
- Summary Care Record (SCR) is in the process of roll out to community pharmacy its introduction will be of particular benefit to the South West where there is a high population of visitors and this introduction will support greater safety in the delivery of emergency supplies and in general dispensing. It is recognised however to realise our ambition of fully integrating community pharmacy with practices read write access to patient records will be necessary and all of this looks set to support General Practice sustainability.

## Estates

### How we will improve General Practice Infrastructure in 2016/17

- Premises play an important role in the delivery of healthcare historically, GP premises have not been developed at the same pace as modern General Practice and Primary Care. Some premises are barely fit for purpose, lacking facilities for disabled patients, have no additional capacity or are poorly located.
- Where development has occurred much of it has been excellent-however, there has not been enough development, and the growth in demand means that the developments don't have the necessary capacity to deal with the increased number of patients and additional service requirements.
- GP premises could be ideally placed within their communities to develop as hubs, coordinating care across health and social provision. The identification of the needs of the community should drive the development of premises within the broader locality setting, rather than the responsibility resting with contractors alone.
- If premises were located on the basis of population need and were centres for wellbeing, they could contribute significantly to addressing the inequalities in health outcome however due to lack of land and lack of capital and revenue costs we are constrained slightly by what the future could look like for delivery of out of hospital care in BNSSG.
- We are also aware of low occupancy rates of some existing buildings with potentially high patient access in community pharmacy that could further support the wider system in its estate utilisation and ongoing estate issues.

### What the programme aims to deliver

1. Baseline capacity, demand audit of all BNSSG practices
2. A resilience plan for each area
3. A training needs analysis to support delivery of a new workforce model across primary care supported by partners Health Education England (HEE), Wessex Academic Health Science Network (WAHSN) and South West Academic Health Science Network
4. Test different organisational forms across the spectrum from informal collaborations through to formalised new business models
5. Testing of new models of care and services configurations
6. Create a more sustainable and resilient primary care through eradication of contractual silos especially across Pharmacy and General Practice
7. Development and testing of new roles in Primary Care
8. A range of case studies which can support delivery in other areas of the SW

9. Roll out across general practice of the 10 high impact actions.

**With the above in mind the general practice sustainability and transformation delivery programme will discuss and formulate answers too:**

- How we will reduce variations in quality.
- How we will make significant changes to the numbers, skills and roles in the workforce that are needed across our primary care system working with partners such as HEE and AHSNs.
- Education of patients – how we do this better to divert large numbers of patients from GP surgeries.
- Provider Development – how we work with providers to explore more efficient ways of working across clinical, management and administrative functions by sharing expertise and resource throughout the network, which will strengthen the capacity of practices to develop new services out of hospital.
- Where areas in the UK have explored and adopted social prescribing to support a reduction in demand on GP appointments – (in Rotherham for example 21% of A&E and use of GP appointments reduced by introducing a social prescriber to the PC team.
- To explore and develop the idea of care coordination in primary care.

**Provider voice** – moving to one provider “voice” to represent for General Practice providers across BNSSG was established in the summer of 2016 with One Care being asked by all member practices to act as its provider voice at the BNSSG systems leaders group.

## Acute Care Collaboration (ACC)

The STP foot print has agreed a series of principles as part of our model of care, which is about the acute care system and not individual providers. These principles were outlined in the 30<sup>th</sup> June checkpoint submission and can be summarised as follows;

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

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

*Reducing utilisation of acute hospital bed base*

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

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

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

### Building on Principles to Establish New Ways of Working

Notable progress has been made in developing the outline principles above into the consideration of new ways of working. University Hospitals Bristol, North Bristol Trust and Weston Area Health Trust have agreed that working together to improve services and pathways for patients is a primary aim of the STP ACC workstream. We want to ensure we deliver the most effective and efficient configuration of services for patients, by collectively using the resources at our disposal.

BNSSG has already delivered a very ambitious change plan over the period 2005-15 which saw major service transformation, including the transfer of services between UH Bristol and NBT to consolidate services in the right place together with a new PFI at Southmead and a new Community hospital in South Bristol. We have delivered big change to the benefit of patients and commissioners on a wide range of services such as trauma outcomes, children's services, the vascular network model, urology, breast, ENT, head & neck and pathology. They were well

considered/planned and executed changes which also make us fit for the new NHS England South specialised commissioning proposals around Major Trauma Centres and Cancer alliances.

Therefore, the BNSSG system has a strong track record of working together to achieve significant change and - through the Sustainability Transformation Planning process - we intend to develop closer working at a range of different levels, such as specialties, clinical support services and corporate support services

We want to build on this track record of success through continuing to develop our ways of working together. In practice this means there needs to be a consistent emphasis on those working within the acute sector thinking and working on a system basis, to design service configurations that meet the needs of local populations in an equitable, high quality and efficient way. This will importantly include clinical teams joining up to deliver pathways of care, irrespective of location or organisation.

This could lead to more standardisation across three or more sites, or it could be differentiated/ graduated between sites as circumstances require. In some cases we may supplement this model by agreeing joint appointments and changes to referral flows and case mix. We would also like in some cases to see these new networks extend into primary and community care; for example in respiratory, diabetes and cardiology.

We do not want to see services constrained by the buildings that they have historically been delivered in. Naturally we will engage and consult with all staff to ensure that this work is done in an appropriate and constructive way. We believe that services should be driven by what makes sense clinically, rather than by what has grown up historically. We want form to be shaped by function, rather than the other way round. We understand that we may have to consider changing or challenging some payment approaches and funding flows to support delivery of a model that makes best clinical sense rather than allow this to be a major constraint to change. Consideration will be given to alternative models of joint working and learning will be sought from the 13 Acute Care Collaboration Vanguard who are at various stages of developing and implementing alternative models of working.

It is acknowledged that Acute Care Collaboration Vanguard are designed to spread excellence in hospital services and management across multiple geographies and that some of these approaches could present significant benefits and opportunities for the acute sector within BNSSG.

It is understood that three of the key approaches being taken within the Vanguard are;

1. Excellently-performing individual NHS hospitals able to form NHS Foundation Groups to raise standards across a chain of hospitals (a model of hospital 'chains').
2. Individual clinical services at local District General Hospitals being run on site by specialists from regional centers of excellence, where a smaller trust draws in expertise from larger and surrounding trusts through a mixture of both networking and franchises.
3. Forming 'accountable clinical networks' integrating care across District General Hospitals and teaching hospitals for key services, including cancer and mental health.

It is acknowledged that these are just three of the approaches being explored nationally and the BNSSG leadership will develop learning from the Acute Care Collaboration vanguard to develop new arrangements between hospitals for staff, services and resources to improve the quality of care provided to patients, the clinical viability of smaller hospitals, and the productivity of each participating hospital.

## Transformational Change - Themes to projects

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

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

Emphasis is now being placed on building on the actions outlined in the previous submission, to develop these themes into specific and deliverable projects. Each project has been selected as a priority based on the scale of opportunity and potential to impact on reducing our known gaps in Care and Quality, Finance and Efficiency and Health and Wellbeing.

It is well understood that the acute care asset base in BNSSG is expensive, with city centre estates and state of the art modern hospital facilities contributing to a higher cost base. Improved productivity is therefore a key focus of the developing projects, with specific emphasis placed on the need to maximise the use of acute facilities through improved productivity at all levels, reducing costs, duplication and variation where possible and potentially reconfiguring or redistributing services between the three acute providers, using the principles outlined above, if this provides greater opportunity for services to develop and thrive. The new and developing ways of collaborative working are providing a new framework in which models for the provision of services in BNSSG can develop with the common and shared agenda of improving pathways for our patients.

Common principles for acute care services have been agreed and are jointly owned by the system. The approach taken in developing these principles and themes into action is to start by establishing a smaller number of high impact projects to both realised 'quick wins' in closing the gaps, but also to establish and build confidence in new ways of working and collaborating as a system.

The phase one priority projects identified are;

1. Stroke pathways
2. Trauma and Orthopaedic and Musculoskeletal services
3. Pathology consolidation
4. Medicines optimisation
5. Corporate services consolidation
6. Weston sustainability

It is recognised that the following five areas are also clear priorities within BNSSG. There is significant work and energy across the system already focussed on improving services in these areas, however, the role of the STP and Acute Care Collaboration work stream will be to harness this existing energy to provide a point of focus to maximise the benefits afforded by a whole system view and to provide joint leadership where required.

1. Mental Health – Personality Disorders
2. Acute mental health beds and out of area placements
3. Developing Specialised Services and Networks
4. Urgent and Emergency Care – Including Urgent Care Network
5. Cancer – Development of Cancer Alliances



Projects are also developing within the workstream in the following areas and will be scoped and implemented using the same common principles as the phase one projects;

1. Cardiology
2. Neonatal Intensive Care
3. Interventional Radiology
4. Optimising outpatients

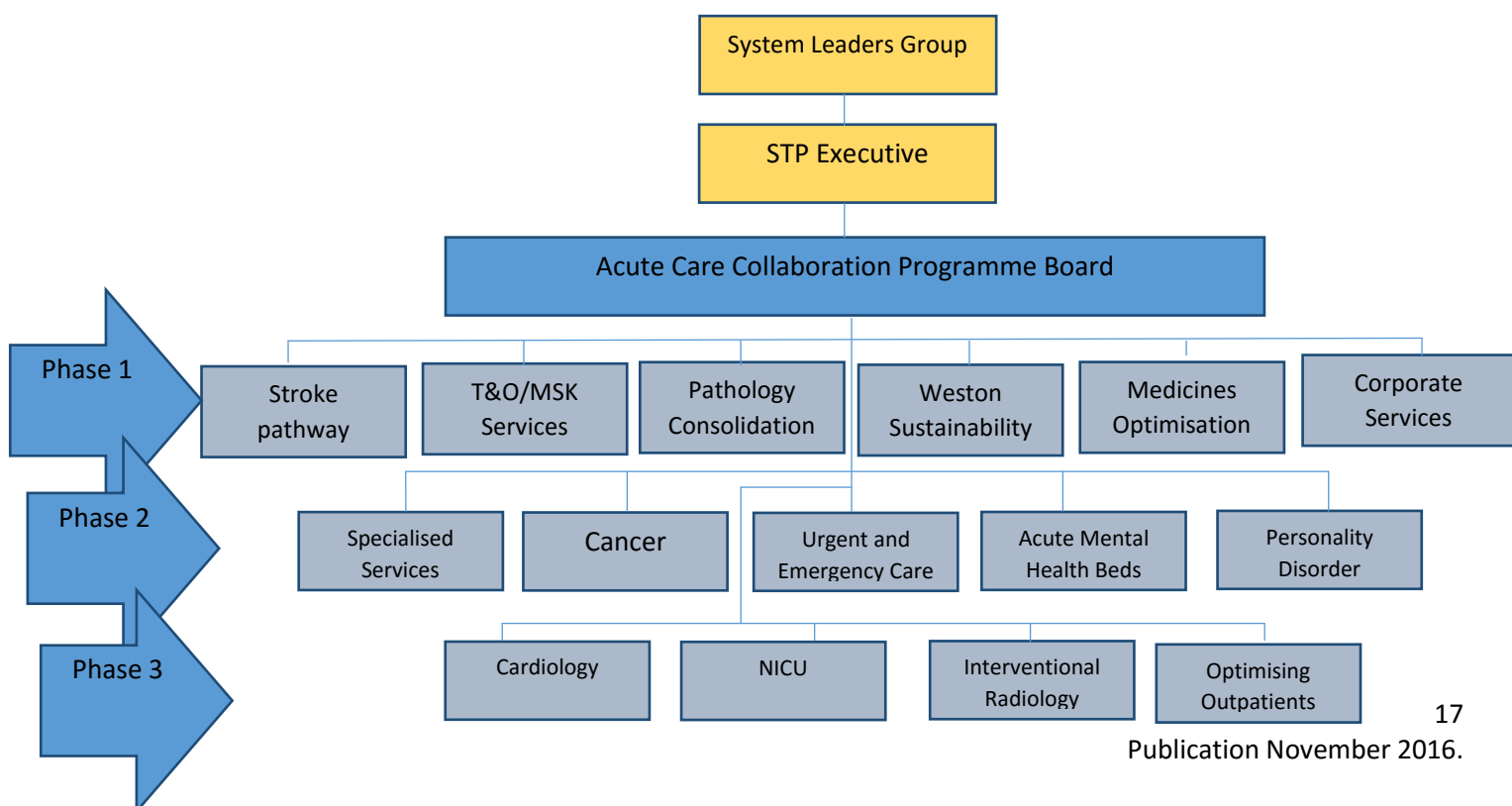
In addition, there are a number of projects developing in the other two STP model of care workstreams which are key enablers to improving utilisation within the acute sector and importantly to ensuring that only the patients who require treatment in an acute setting are in hospital. These projects include specialty pathway work in respiratory, diabetes and the frail elderly, as well as reducing delayed transfers of care, primary care sustainability and self-care initiatives. The role of digital will also be fundamental to realising innovations in the acute sector, with UH Bristol recently being identified as a National Digital Exemplar presenting further opportunity to maximise the benefit over the next five year period.

**Acute Care Collaboration – Governance, Delivery and Impact**

There has been a clear focus on the rapid development of the phase one projects outlined above. These are all now at the stage of having produced a project initiation document, or outline business case, outlining the high level milestones and delivery plans, including how each of these projects contribute to the overall planned impacts on the systems. Leadership teams have been established and project teams are being mobilised, ensuring plans for stakeholder engagement as required.

The Acute Care Collaboration work stream project structure is outlined below, with multidisciplinary, senior membership from across the system holding to account the delivery of each of the projects.

**STP Acute Care Collaboration – Proposed Structure**



The table below outlines the proposed membership and required roles within the ACC programme and each of the constituent project groups.

It is proposed that each of these roles hold clear accountability and responsibilities and that each of the key roles for delivery are appointed to, or allocated as dedicated roles. This would include Programme and Project management roles (recommended at least 0.5-1wte for the ACC programme manager role and 0.5 wte for each of the projects, with supporting administration, depending on scale of project). These may come from existing roles from within the organisations in the system, or through realigning those already engaged in delivering work in these areas. It is recommended however, that by allocating specific roles, there will be the capacity to deliver the scale of change required and post holders will be clear on the requirements of the role and accountability for delivery.

Consideration needs to be given to BI, finance, communications and workforce capacity to undertake roles and clinical time may need to be freed up through allocating Pas to dedicate to specific stages of the projects.

**ACC Programme Board Membership**

- Chair – SRO
- Programme Manager
- Administration
- Medical Directors – All Acute
- Directors of Strategy – All Acute
- Leads/SROs for each project
- Finance Lead
- Estate Lead
- Digital Lead
- Workforce Lead
- Commissioning Lead (CCG)
- Specialised Commissioning Lead
- Community Care Lead
- Mental Health Lead
- Communications Lead
- Local Authority Lead

**Project Groups (minimum)**

- Chair – SRO
- Project Manager
- Administration
- Clinical Leads
- Operational/Business Leads
- Finance Lead
- BI Lead
- Estate link (as required)
- Digital link (as required)
- Workforce link(as required)
- Communications link
- Representation from key stakeholders, to include Commissioning, Acute, Community Care, Mental Health, Authority as required.

### **Specialised Services STP Plans**

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

The key actions within the STP plans, which may have a consequence for specialised commissioned pathways are as follows:

- Support commissioner led review of specialist rehabilitation pathways focussed on neurosurgery, trauma, vascular and stroke patients (largely NBT based).
- Support continued development of the Operational Delivery Networks and a Cancer Alliance hosted by the acute Trusts to enhance their ability to deliver effective pathways.
- Review clinical leadership and management oversight for the level 3 neonatal units (NICU) in Bristol so that they meet the required designation standards within available resources.
- Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services with a new provider partnership model including third sector members.
- Review the capacity, demand and cost profile of Trauma and Orthopaedic services to manage the increasing demand in a system that already has a back log of work and high reference costs
- Develop stroke pathways that provide the highest quality care in the hyper-acute setting and rapid discharge to an out of hospital rehabilitation environment at the earliest opportunity
- Address the poor outcomes of diabetic care that result in increased amputation rates and other complications
- Maximise care in the community for patients with respiratory disease with pathways that reduce the seasonal increase in admissions in the winter
- Address the high cost and variation in hospital length of stay in cardiology
- Work with Mental Health providers, acute Trusts, community and primary care to make most appropriate use of acute mental health bed capacity and ensure patients receive physical and mental health care rapidly in the most appropriate setting, aiming for care close to home whenever appropriate, avoiding out of area placements.
- 10% reduction in patients treated out of area (specifically at London Trusts at a higher MFF) on specialised pathways.

### **UH Bristol Potential Plans (Not covered above)**

- **Clinical Genetics** – discussions with Taunton and Somerset NHS Foundation Trust regarding transfer of Clinical Genetics activity to UH Bristol.
- **Genomics** – Potential future changes to commissioning following 2 year project.
- **Paediatric Emergency activity** – significantly high recent growth levels.
- **Adult oncology and haematology** – significantly high recent growth levels.
- **Neonatal Surgery** – National review to be conducted, may impact on other units ability to deliver activity if standards not met, resulting in increased flow of activity to UH Bristol.
- **Thyroid surgery** – Potential redistribution of activity between NBT and UH Bristol (Head and Neck activity).
- **HPB surgery** – Potential transfer of RUH patients currently going to Basingstoke for surgery, to UH Bristol.

- **Congenital Heart Disease** – Impact of recent designation exercise. May see impact of increased flows from other providers.
- **PICU** – Associated impact of any increase in CHD activity, but also potential growth to meet current standards, not associated with CHD.
- **SRT** – Delivery of impacts of recent tender.
- **Intestinal Failure** – Tender.
- **Complex Cancer Surgery** – Thoracic, HPB, OG, Colorectal, H&N, Gynae. Need to understand potential changes in demand and patient flows across region associated with Specialised Commissioning STP briefing.