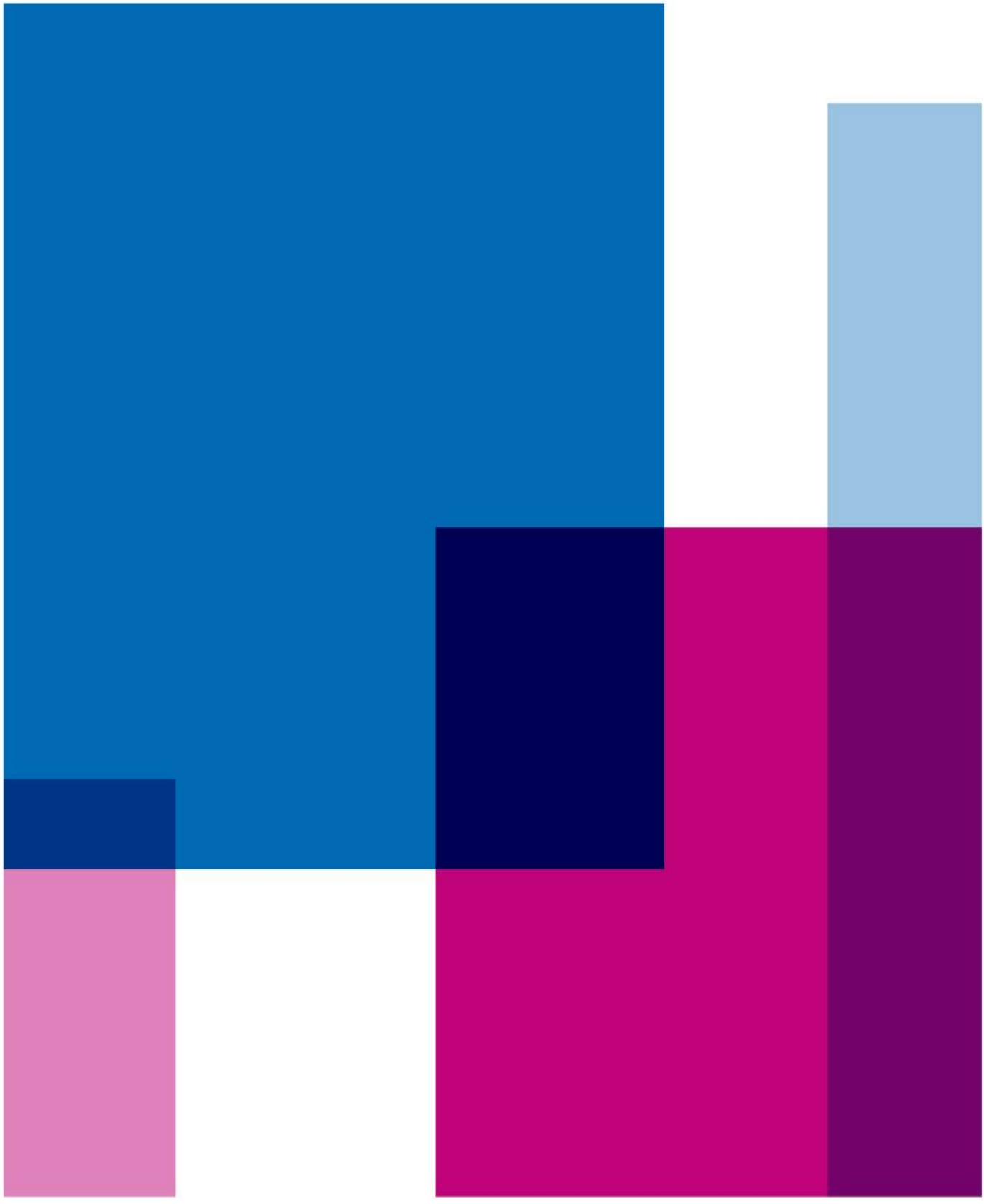
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of ICB Board

Date: Thursday 6th October 2022
Time: 9.30am
Location: Engineers House

Agenda Number :	5
Title:	Chief Executive Update – October 2022
Confidential Papers	**Commercially Sensitive**: No **Legally Sensitive**: No **Contains Patient Identifiable data**: No **Financially Sensitive**: No **Time Sensitive – not for public release at this time**: No **Other (Please state)**: Yes/No
Purpose: For Information	
Key Points for Discussion:	
The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives. The main areas of discussion this month are; • **Strategic Needs Assessment** • **ICB Organisational Structures** • **Winter Planning**	
Recommendations:	To note the current position with regards to the Strategic Needs Assessment and to socialise widely To note the current winter planning position To note the position on the ICB Operational Structures
Previously Considered By and feedback :	No other groups
Management of Declared Interest:	No declared interest

Chief Executive Briefing – October 2022



Shaping better health

Purpose

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The main areas of discussion this month are;

- **Strategic Needs Assessment**
- **ICB Organisational Structures**
- **Winter Planning**

Strategic Needs Assessment

The creation of the Integrated Care System provides a fabulous opportunity to improve outcomes for our population and to truly address health inequalities. A key part of the success of the system will be an effective shared strategy based on addressing the needs of our population. The collective partners of the ICB, through the Population Health and Inequalities steering group, have produced a joint population needs assessment known as 'Our Future Health' (Appendix A).

Our Future Health presents an overview of key health and wellbeing issues for our population and key opportunities for local interventions across all stages of life to maintain good health and wellbeing and reduce ill health for the residents of Bristol, North Somerset and South Gloucestershire (BNSSG) and reduce health inequalities. It considers the circumstances, environments and behaviours shaping our health now and in the future. Throughout this report, it talks about the building blocks of health.

We have the best chance of maintaining good health when the right building blocks are in place: nurturing family and community relationships; a safe environment with quality housing, places to exercise and clean air to breathe; good education; meaningful work; and freedom from discrimination. Clearly the ICB has a major role to impact on these areas.

This report has been developed from existing reports, routinely available data and local resources particularly our Local Authority Joint Strategic Needs Assessments and Population Health Management resources, and our developing system Outcomes Framework. It does not cover all health conditions and services.

What is presented are what we consider to be the major influences on health. Most of the information in this report is drawn from quantitative analysis of local data and from published research. The decisions on what to include were influenced by the authors' knowledge of what citizens and staff say about their experience of health and care in BNSSG. Feedback from citizens is being gathered through the Have Your Say campaign and will be published separately.

As Chief Executive I see this document as fundamental to developing the direction for the ICB and for the role of the Board. If we are to be successful in improving outcomes and closing the

inequality gaps, then we have to be clear about the challenges and the opportunities. I have pulled out a few key elements to illustrate.

Figure 1
Highlights –the health gap

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

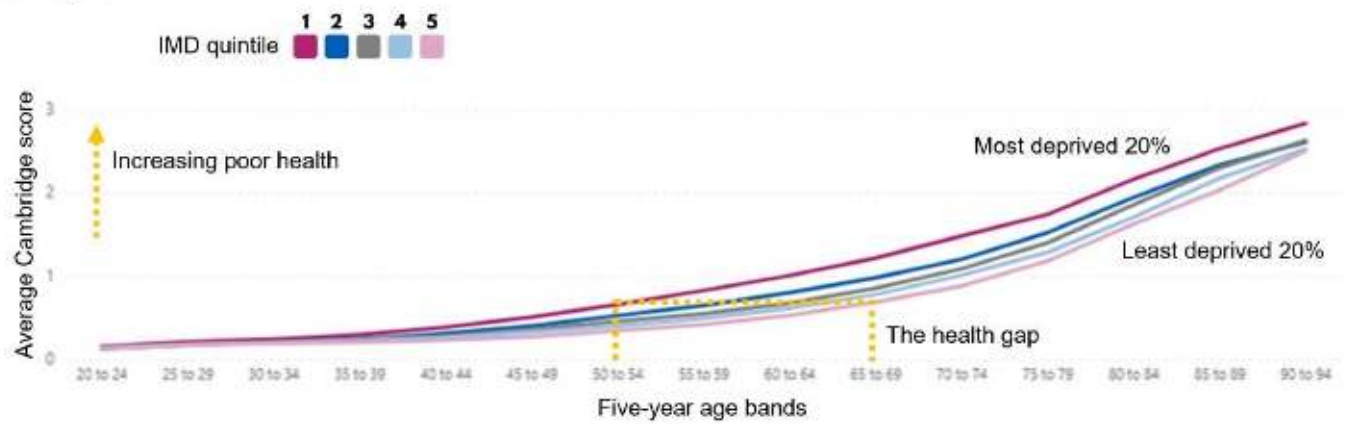


Figure 1 shows the relationship between age, poor health and deprivation. Poor health is illustrated using a multi morbidity index known as the Cambridge Score. There are a number key issues within the analysis.

Our deprived communities are, in health terms, 15 years 'older' than the least deprived by the age of 50. This challenges us to close the gap and help everyone age better, put another way, pull all the lines down but pull the top ones down faster. When you look behind this analysis a large part of what cuts lives short (e.g. heart disease, lung disease, cancer, mental health) are preventable and/or manageable and therefore we could argue that our job, as the ICB, is to drive prevention opportunities that can be realised over short, medium and long-term horizons.

Figure 2 presents similar information but in this case it is reflecting the factor of race as opposed to deprivation in relation to both age and poor health. Health disparities are a more complex picture, with other factors such as deprivation and language issues playing a part. However as can be seen from the graph the difference in health age is 20 years at the age of 50 between Bangladeshi and Chinese members of our community with a very steep rise in poorer health in all categories with Caribbean being exceptionally steep from the age of 60 onwards.

It could be argued that Figure 2 challenges us to think differently about how we engage with individual communities and how we ensure that both access to healthcare and the prevention agenda is tailored towards different communities in a variety ways.

Figure 2 -Racial disparities in health in BNSSG

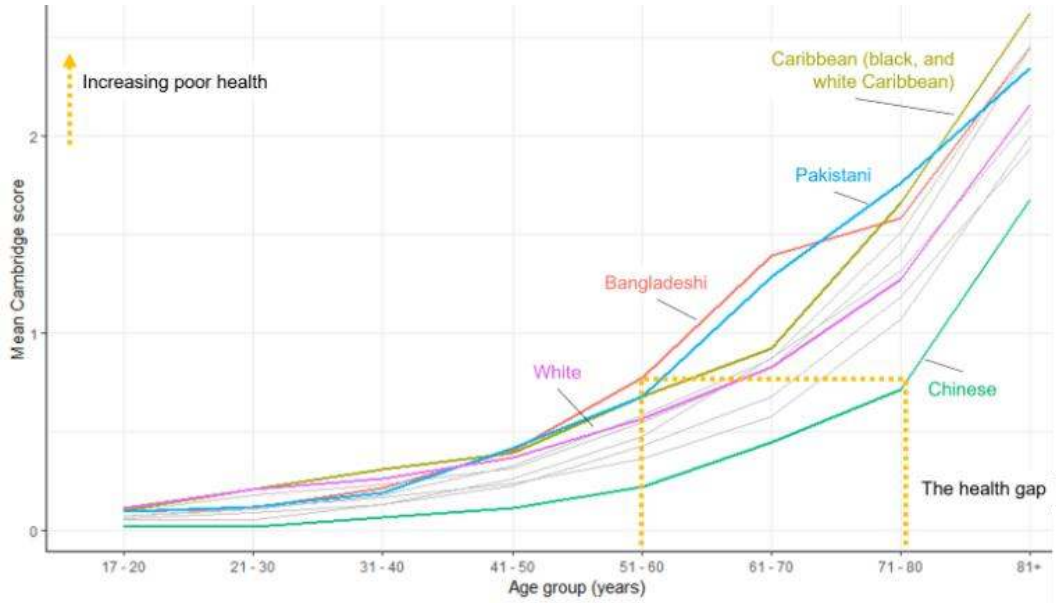


Figure 3 -Inequality is expensive

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

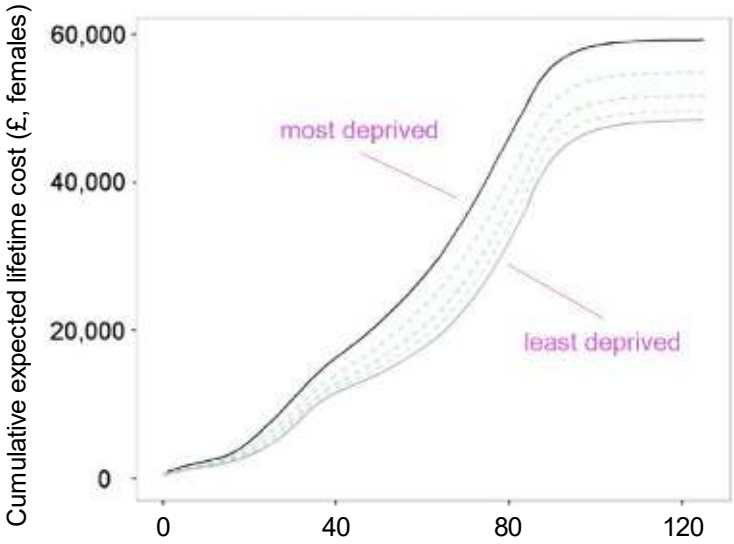
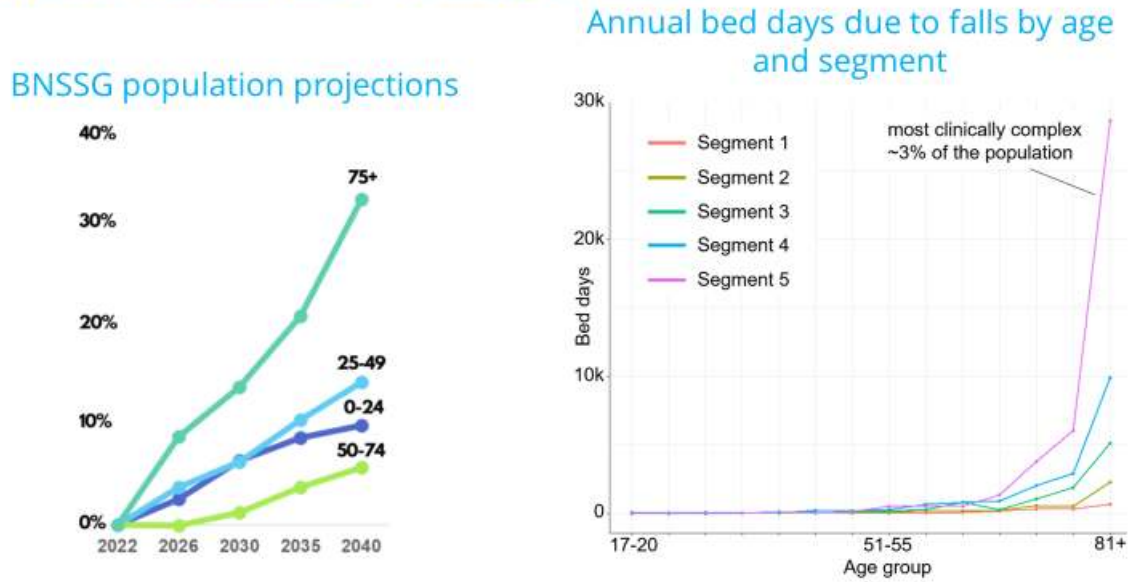


Figure 3 is based on a study to model cumulative lifetime costs of hospital usage - in England - for males and females, broken down by Index of Multiple Deprivation quintiles. Cost data were estimated in 2011/2012 but will be higher after adjusting for inflation. These estimates include the effect of reduced life expectancy among more deprived groups.

Average lifetime costs for women were approximately £48,000 for IMD5 (least deprived) and £59,000 for IMD1 (most deprived). Costs for males were £43,000 and £50,000 respectively. As shown in the graphs, there is an increase in costs for each IMD quintile between the least and most deprived.

Applying these estimates to the BNSSG population, the total cost of hospital episodes associated with deprivation in BNSSG could be estimated to be in the region of £100 million per year. It could be argued that this is an allocation of hospital resource to treat the downstream effects of largely preventable illness and therefore once again presenting a very strong argument for the ICB to refocus upstream.

Figure 4 Highlights – demographics



The final area I have chosen to highlight is presented in Figure 4 – Demographics. It could be argued that this is the population burning platform, and opportunity, in two graphs. BNSSG is growing older quickly, and the way we currently age and provide services for older complex people means this is unsustainable for services. This highlights the message that ‘how we age’ is a major strategic issue

There is a second powerful insight; what is happening to our oldest most complex people? It is highly doubtful that long hospital admissions are of value to them and there are alternative ways to meet their needs.

In summary the “Our Future Health” document presents both a challenge and a potential roadmap for the ICB to follow. The document will form a key part of the development of the ICS strategy alongside the outcome of the “Big Conversation” and the input from our partners and their people.

ICB Organisation Structures

As was presented at the September ICB Board meeting the Senior Executive appointments have been completed with the exception of the Chief People Officer. This role has been re-advertised and interviews are planned for the 22nd November.

In the meantime the Executive Team have been moving forward with the next stages of reorganisation. The team have now developed a proposed new operational structure, below executive level, and the details are in the process of being shared throughout the organisation. The changes have been designed on the basis of transitioning staff into new directorates and then transforming from within their new teams.

We have a timescale linked to different phases of the transition and transformation.

Phase 1 happens in October 2022. This is where we will talk to individuals and teams about transitioning work areas, which need to move into their new directorate.

Phase 1 transition will take place on 1 November 2022.

Phase 2 is from November to the end of December. This is where executives, in discussion with their teams redesign their structures (if necessary). Not all directorates will need to do this. We will also carry out an analysis of the new structures to decide on the best change management approach, which causes the least disruption to teams and individuals.

Phase 3 starts in January 2023 and extends to the end of February. During this period, we will engage with everyone about the new structures and carryout any formal change management consultation with affected staff.

Phase 4 is when we implement the transformation. We expect this to last from the beginning March to the end of April.

By the end of April, we are expecting the transformation to be completed, with only evolutionary changes remaining which can be accommodated naturally as we grow and mature as an organisation.

Winter Planning

This item is fully explored under agenda item 6. Winter Assurance Framework.

Healthier Together

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

OUR FUTURE HEALTH

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This report would not have been possible without the Joint Strategic Needs Assessments produced by our local authority public health teams in BNSSG.

We are grateful for the innovative work of the Population Health Management Delivery Group, who have pioneered the use of the Cambridge Multi-Morbidity Index and provided novel insight into our population's health.

We would like to thank the many colleagues from the Population Health Improvement Team and across the Integrated Care System who have reviewed and improved the final report.

”If you’re rich it doesn’t much matter where you live. If you’re poor it matters enormously where you live”.

Professor Sir Michael Marmot

Acronyms

ACE adverse childhood experiences. 8, 25

ACSC ambulatory care sensitive conditions. 40

AF Atrial Fibrillation. 7, 9, 35, 36

BNSSG Bristol, North Somerset and South Gloucestershire. 1, 7, 8, 10, 16–18, 20, 22, 25–27, 30–33, 35, 36, 40, 43, 44, 46

CMMI Cambridge Multi-Morbidity Index. 1, 14–16, 21

COPD chronic obstructive pulmonary disease. 7, 36

CVD cardiovascular disease. 9, 18, 35, 36

GP general practitioner. 1, 16

ICB Integrated Care Board. 1

ICP Integrated Care Partnership. 36

ICS Integrated Care System. 1, 22, 35

IHD ischaemic heart disease. 7

IMD Index of Multiple Deprivation. 14, 18–20, 25

JSNA Joint Strategic Needs Assessment. 1

LGBTQ+ Lesbian, Gay, Bisexual, Transgender, and Queer (or Questioning). 17

NEL non-elective admission. 40

ONS Office for National Statistics. 16

PHM Population Health Management. 1

SEND special educational needs and disabilities. 26

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1 The top line

1.1 The Answer

To save lives and improve health and wellbeing, our ICS strategy should focus on three things:

- **Prevention** at each stage of life and every step of a care pathway
- Designing for the **clustering** of risks and ill health within individual people, families and communities
- Reducing **inequalities**

1.2 The Problem

Lives in Bristol, North Somerset and South Gloucestershire (BNSSG) are being cut short. Gains in life expectancy across the UK have stalled for a decade [1]. Inequalities in outcomes are rife. In Weston-super-Mare (Central Ward) there are four times more early deaths per year compared to Nailsea (Golden Valley Ward).

People in BNSSG, particularly in the most deprived areas, are spending more of their lives in ill health. The leading causes of early deaths in our population are ischaemic heart disease (IHD), stroke, cancer (especially lung cancer) and chronic obstructive pulmonary disease (COPD). These are largely the result of unhealthy habits such as smoking, poor diet and inactivity, and treatable conditions such as high blood pressure and diabetes.

Much of this illness is preventable. Nearly half of all cancers and three quarters of COPD cases are preventable [2, 3]. Type 2 diabetes (90% of diabetes cases) - strongly linked with being overweight or obese - is preventable and now considered a reversible condition [4].

New local analysis shows the top most 'impactful' conditions on our day-to-day health are: anxiety and depression, painful conditions, diabetes, Atrial Fibrillation (AF) and COPD. These are all associated with higher rates of death and use of health services.

We have the best chance of maintaining good health when the right *building blocks* are in place: nurturing family and community relationships; a safe environment with quality housing, places to exercise and clean air to breathe; good education; meaningful work; and freedom from discrimination.

For many people in BNSSG, these building blocks of good health are missing. When blocks are missing or poorly maintained, this worsens peoples' social and job opportunities, their habits, and ultimately their health.

The connections between the building blocks and their effects on opportunities and healthy habits mean that poor health clusters within individual people, families and communities.

Families living in our more deprived areas may have to choose between food and heat this winter. This cost of living crisis is set to make this choice more likely [5, 6]. In turn these worries can lead to chronic stress which directly impacts health causing anxiety and depression, high blood pressure and poor immunity [7].

In order to cope with these stressors, smoking, problem drinking and drug taking become more common [8, 9, 10]. Children in these families are more likely to have adverse childhood experiences (ACE)s and trauma, such as parental drug use or abuse. These children in turn are more likely to develop unhealthy habits and have poor health in adulthood [11].

Because of the connections between the places and conditions in which people live, and their health habits, it is no surprise that health conditions cluster within people (multi-morbidity), families and communities.

Multi-morbidity is more common in our more deprived communities and starts at a younger age. People in our more deprived areas are spending more of their lives in ill health. The gap in health status with deprivation in BNSSG is clear from early adulthood and continues to widen to older age. Deprivation impacts across the life course on healthy habits, health outcomes and use of urgent and emergency care.

Our data show that high levels of multi-morbidity in combination with older age is the major driver of hospital admissions and other health service use. Our over 75-year-old population is projected to increase by over a third over the next 15-20 years. If we do not find ways to live in better health, the situation will become unmanageable for our health and care system.

Inequalities in health are not only bad for the individual but impact on families and on health and care services. We spend disproportionate resource treating the preventable health impacts of deprivation, in hospital, even accounting for shorter life expectancy in more deprived areas [12].

As well as worse health in deprived communities, differences in care processes are apparent. At each stage of a care pathway there is some ‘loss’ e.g. lack of awareness, treatment not being offered or accepted, difficulties in maintaining or completing a treatment programme; and these losses are worsened by deprivation.

Inequalities are not limited to differences by deprivation. Issues such as discrimination because of race, gender, disability or sexuality can make life even harder for some groups. In BNSSG, pregnant women from Black, Asian and minority groups, as well as those in more deprived areas are most likely to experience poor birth outcomes [13]. Uptake of vaccines for flu and COVID-19 are lower in our more deprived and in our more ethnic and linguistically diverse communities even after accounting for deprivation. A lack of trust in, and experience of services plays a big part in this [14].

1.3 The Opportunities

Actions to **strengthen building blocks for good health** – the ‘causes of the causes’ will have the biggest impact, over a long time-frame:

- We need to collaborate to mitigate the effects of deprivation and poverty. Learning from holistic approaches such as Sure Start, Supporting Families, Hope and the Red Cross Project in Weston-super-Mare, to co-design multi-agency services,

rooted in communities, around 'high need' people and families

We can go further with our **actions to address the habits impacting most on health** – smoking, poor diet and inactivity leading to obesity, and drug and alcohol use - and the living conditions that can lead to these:

- Implement and build on our tobacco control programme to go further in reducing smoking, ensuring there are **no gaps** in our services for those wanting help to quit
- Whole system approach to prevention of obesity in children and adults
- Develop a system plan for tackling drug and alcohol related harm

Opportunities for **prevention and early intervention in all services and every stage of care pathways** for key conditions need to be taken ensure that health and care services, and informal care support is sustainable:

- Develop and deliver plans to reduce health inequalities, including work on CORE20PLUS5
- Scale up the work of our cancer inequalities work to improve early cancer diagnosis
- Optimise identification and good management of risks for cardiovascular disease (CVD): Atrial Fibrillation (AF) , high blood pressure and cholesterol
- Preventing onset of diabetes in high risk individuals and reversing diabetes - take up of the National Diabetes Prevention Programme, Learn from BNSSG low calorie diet pilot to ensure everyone who needs to has a chance to reverse, or better manage their type 2 diabetes

Develop **system approaches to better manage key conditions** impacting most on health in our population:

- Transform the system approach to pain management to improve health and wellbeing
- Build mental wellbeing in our children and young people, and improve access to mental health support when needed, in line with NHS Long Term Plan ambitions

Ensure our **approach to addressing inequalities includes equitable access to and experience of services:**

- Work with communities and groups most affected to understand and address barriers to access and uptake of services and to build trust
- Ensure our health and care provision is equitable and meets the needs of all our communities - different people and communities will need different approaches and levels of resource to meet their needs

2 Introduction

Our Future Health presents an overview of key health and wellbeing issues for our population and key opportunities for local interventions across all stages of life to maintain good health and wellbeing and reduce ill health for the residents of Bristol, North Somerset and South Gloucestershire (BNSSG) and reduce health inequalities. It considers both the circumstances, environments and behaviours shaping our health now and in the future.

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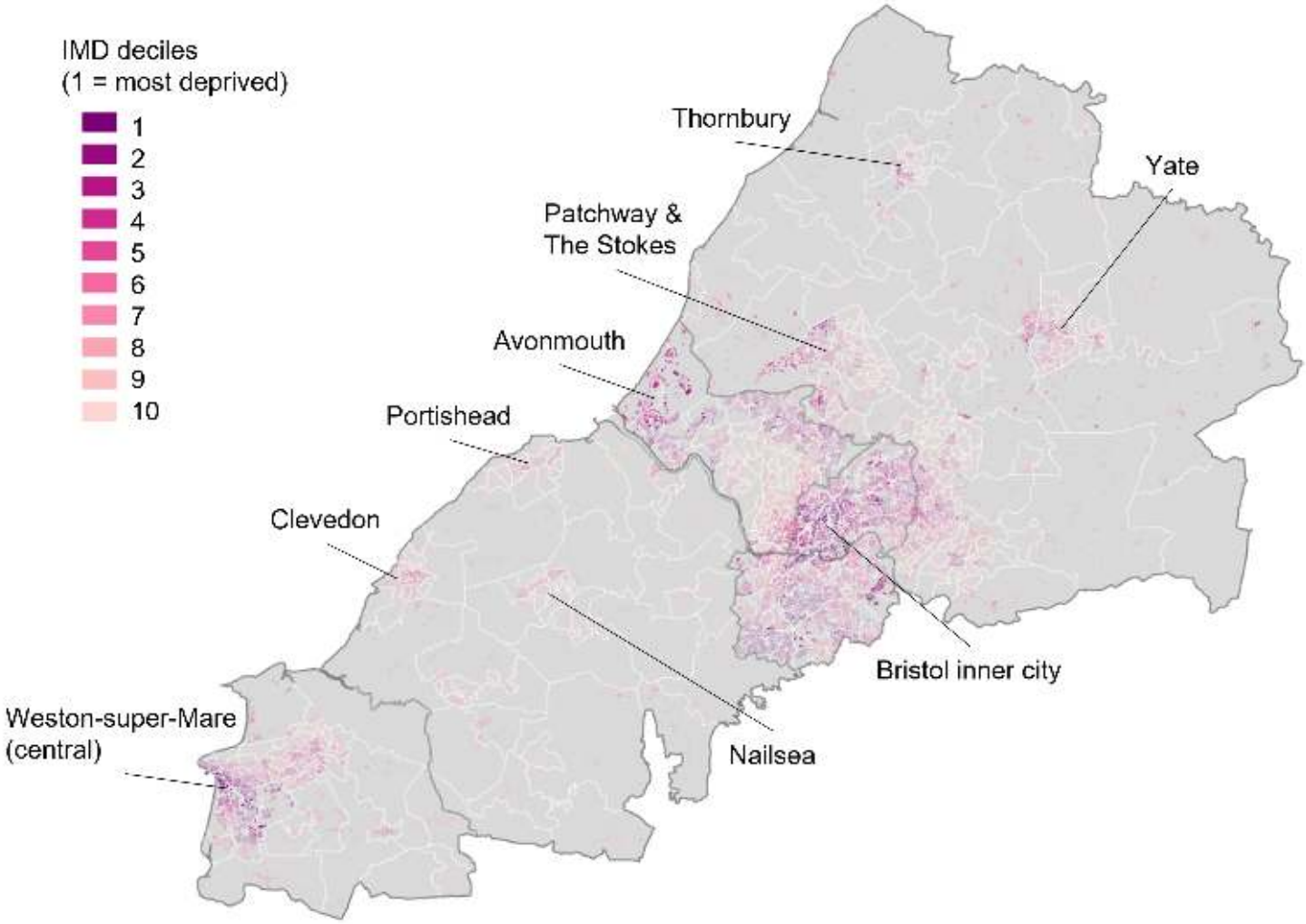
Figure 2.1: How deprivation clusters within BNSSG

This map and the choice of labels was designed to show the natural geography of our 'patch' - deprivation by Index of Multiple Deprivation (IMD) national deciles (1 = most deprived - darker shading), by lower super output areas (LSOAs). LSOAs (white outlines) contain on average 1,500 people. Shading indicates where people actually live (buildings). Locality borders in grey.[15]



3 The big picture

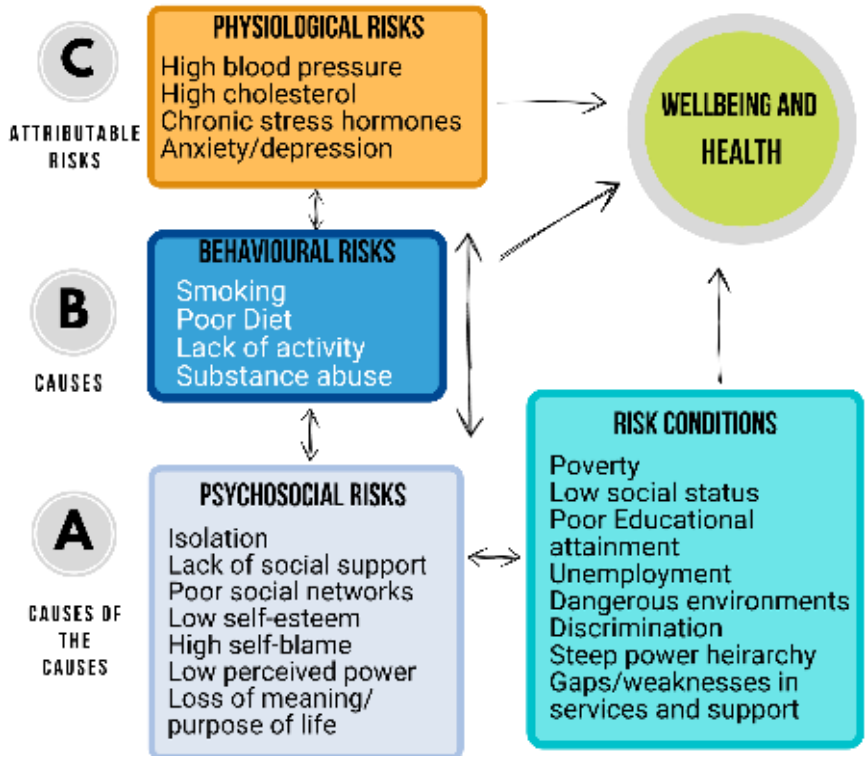
3.1 Overview

Our population speaks over 90 languages (English, Polish and Somali are the most common) and is spread over urban, rural and coastal communities.

Our population's health, and need for health and social care is largely the result of two main factors. The first is the development of ill-health as people grow older. The second is the effect of social and economic deprivation, which leads to the earlier onset of ill-health. Deprivation disproportionately affects minority ethnic communities. Issues such as discrimination because of race, gender, disability or sexuality worsens this further.

Our population is ageing, and the current economic situation means deprivation will deepen. To continue to meet the needs of our population we need to: help people to age well through prevention; improve the quality of care - especially proactive care; mitigate the effects of deprivation and eliminate discrimination.

Figure 3.1: The connections that shape our health and wellbeing[16]

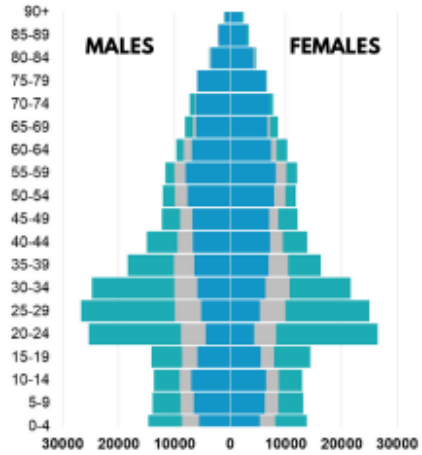


AROUND ONE MILLION PEOPLE LIVE ACROSS BNSSG

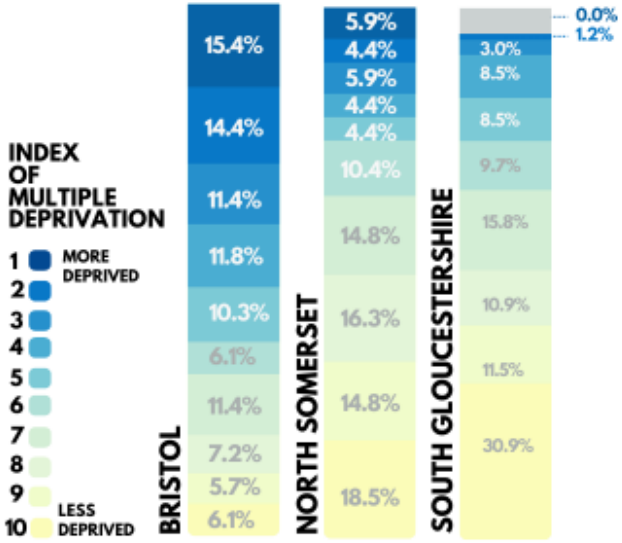
1 ICS
3 Places
6 Localities

THE POPULATION IN BRISTOL IS YOUNGER WITH AN AVERAGE AGE OF 30 COMPARED TO 46 IN NORTH SOMERSET AND 40 IN SOUTH GLOUCESTERSHIRE

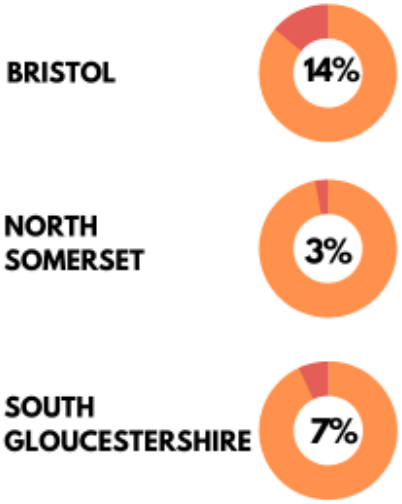
BRISTOL
NORTH SOMERSET
SOUTH GLOUCESTERSHIRE



THERE ARE WIDE VARIATIONS IN DEPRIVATION



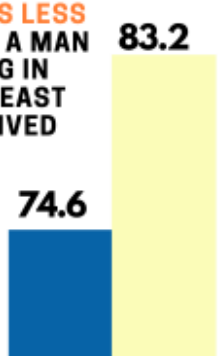
BLACK AND MINORITY ETHNIC GROUPS



THERE ARE LARGE DIFFERENCES IN LIFE EXPECTANCY BETWEEN THE MORE DEPRIVED AND LESS DEPRIVED AREAS

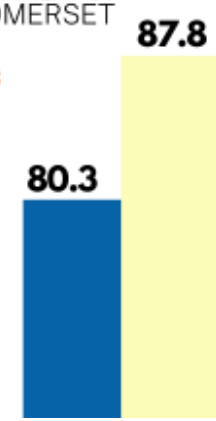
A MAN LIVING IN THE MOST DEPRIVED AREA OF BRISTOL

LIVES 9.9 YEARS LESS THAN A MAN LIVING IN THE LEAST DEPRIVED AREA



A WOMAN LIVING IN THE MOST DEPRIVED AREA OF NORTH SOMERSET

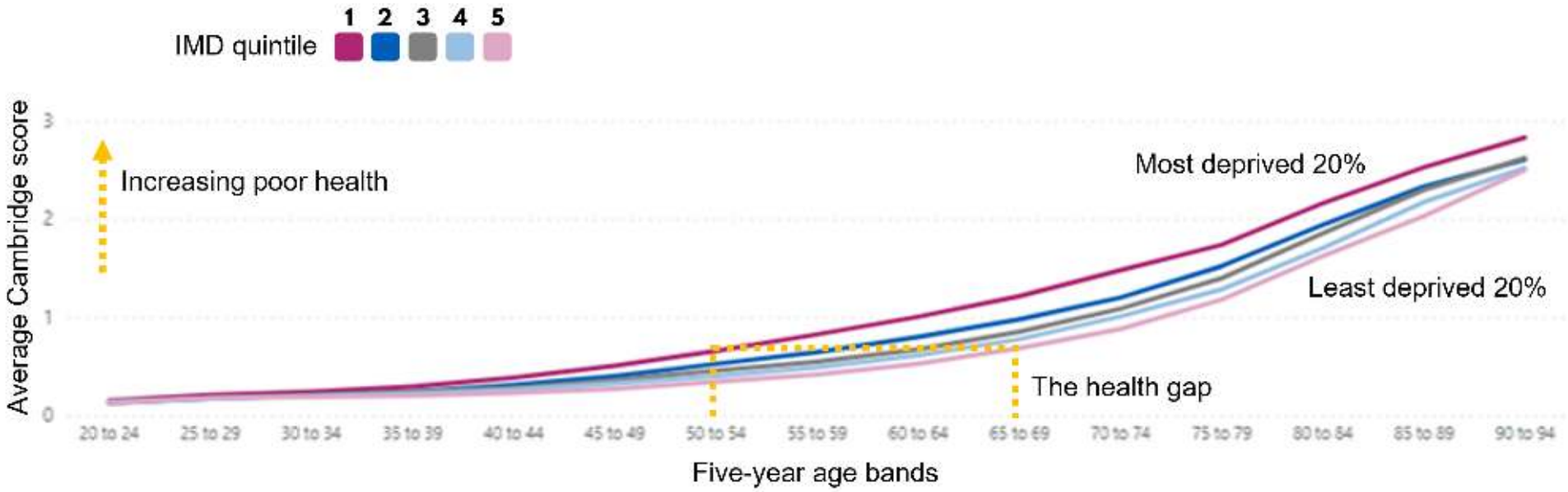
LIVES 7.9 YEARS LESS THAN A WOMAN LIVING IN THE LEAST DEPRIVED AREA



3.2 Our state of health

Figure 3.2: The life course health gap in BNSSG by deprivation

Health status is estimated using the Cambridge Multi-Morbidity Index (CMMI), based on diagnosed long-term illness in GP records [17]. Illness may be underestimated for certain groups, for example those with lower levels of engagement with general practice. This does not include data for people not registered with a BNSSG GP. Nor does it include all possible medical diagnoses. IMD1 = most deprived 20% nationally. [15]



This analysis (figure 3.2) and that shown in figure 3.4 show how diagnosed ill-health builds up in the population through peoples' lives, according to deprivation and ethnic groups respectively. They show how health gaps begin early in life and widen through to older age. The orange dotted lines show the 'health gap' by age. **People in the most deprived areas have the same level of ill-health in their *early 50's* as people in the least deprived areas in their *late 60's*. People with a Bangladeshi ethnicity experience the same level of health in their *50's* as do people with a Chinese ethnicity in their *70's*.**

These charts make it clear what the population health mission is. Simply put, we need to help people age well (pull the lines on the chart down), and improve the health of the worst outcomes, faster (narrow the gap).

Figure 3.3: The impacts on health through the life-course in BNSSG This 'tree plot' shows the conditions that have the greatest impact on the population, in four different age groups. The bigger the box within each of the four squares, the bigger the impact of that condition. Health impacts are based on the CMMI conditions, calculated as the prevalence of a condition multiplied by the 'weighting' for that condition. Weightings take into account risk of death and intensity of service use. This only includes people over 16 years old as the CMMI has only been validated in adults. We are developing a similar technique for understanding the population health need in children.[15]

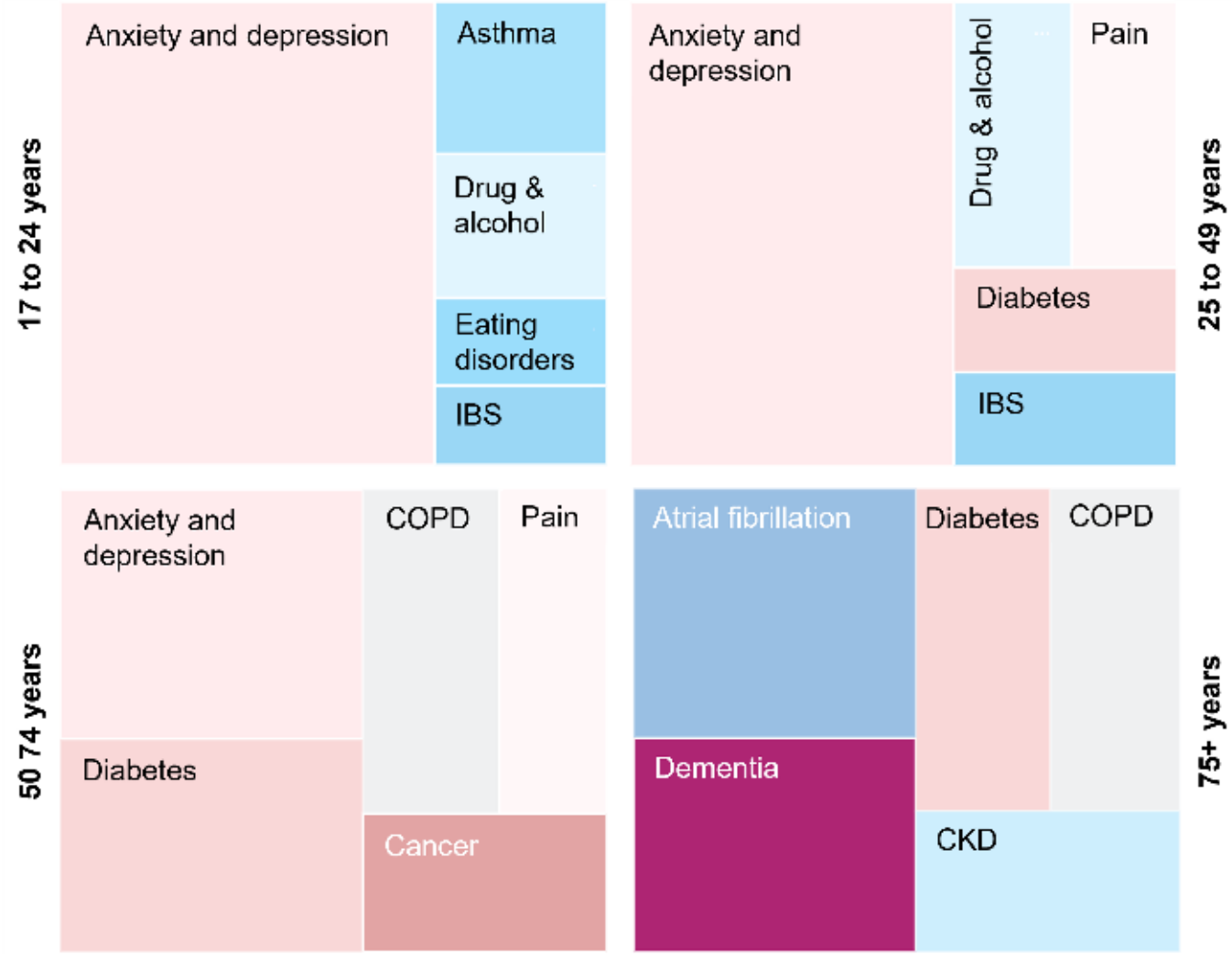
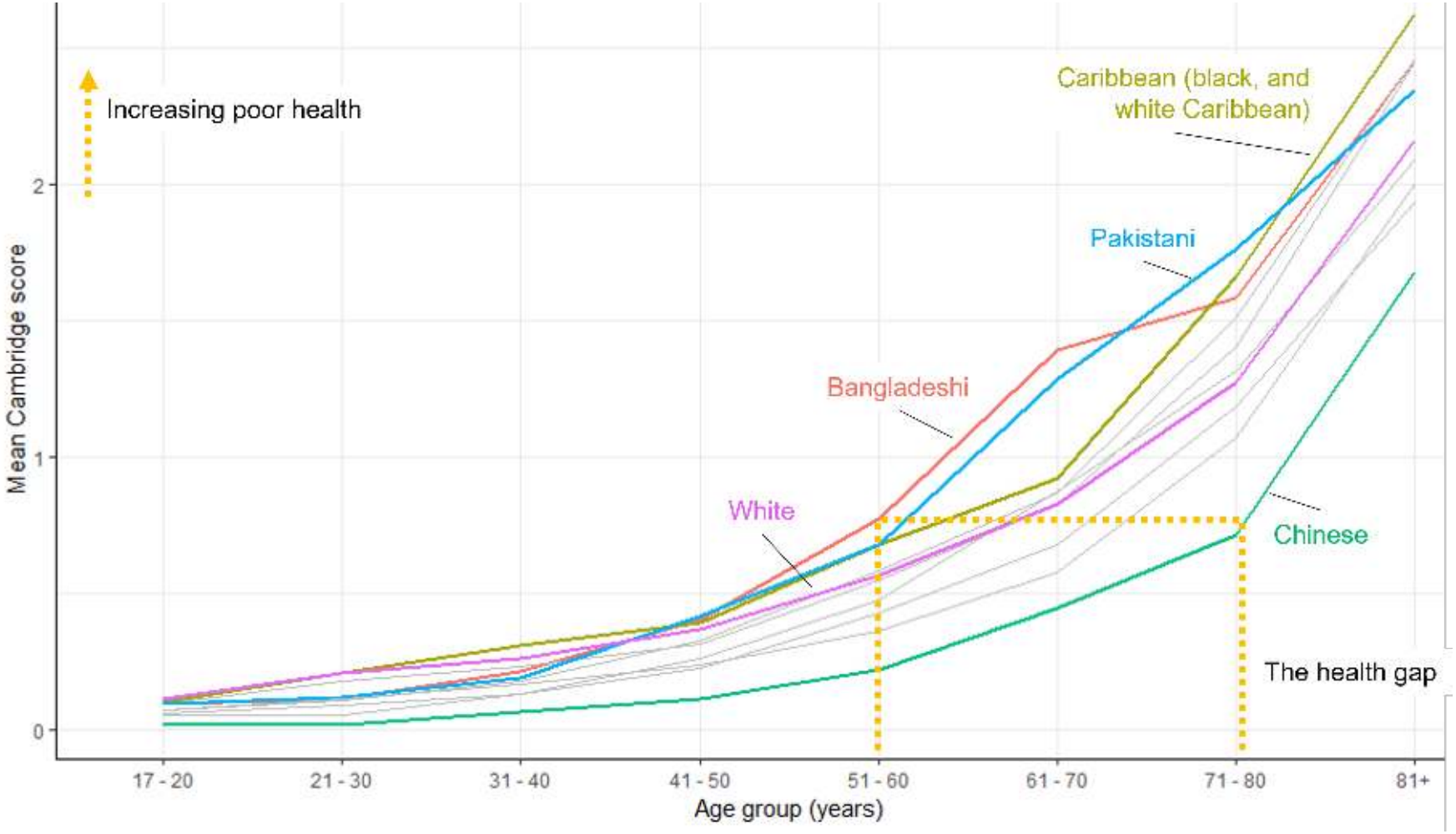


Figure 3.4: The health status of ethnic groups in BNSSG

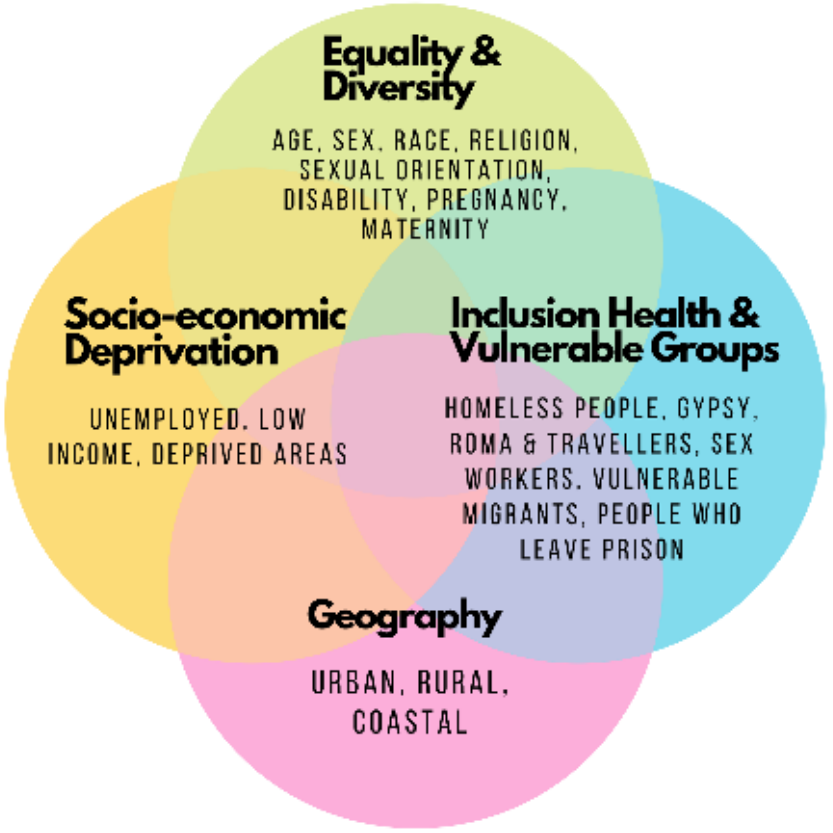
Health status was estimated using the Cambridge Multi-Morbidity Index (CMMI), based on diagnosed long-term illness in GP records. The White ethnic group (majority of the population) is shown in pink as the reference group. Top level census category groups are shown in grey (Asian or Asian British; Black, Black British, Caribbean or African; Mixed or multiple ethnic groups; other; and 'unknown'). Selected sub-groups are plotted where they stand-out from the main groups. Differences in health status may be real, but could also be explained by over- or under-diagnosis. Ethnicity recording in BNSSG is around 80% and for those missing, our analysis suggests the majority are likely to be healthier White people. This would have the effect of making the White group appear in poorer health. Estimates of minority ethnic group populations in BNSSG in the GP record are similar to Office for National Statistics (ONS) estimates. [15]



Health inequalities are seen across multiple domains, which often cluster (overlap) in people, families and communities. One way to make sense of this is to use the framework illustrated in the diagram on this page. Inclusion health groups are particularly vulnerable to poor health outcomes and there is often a lack of local data about their health. Some of the most significant inequalities that affect our population include:

- Discrimination has negative effects on both physical and mental health [18]
- The median age at death for people with learning disabilities is 59 years (compared with 80 years for men and 84 years for women, in BNSSG) [19]
- Half of all individuals who live in poverty live in a household where somebody is disabled [20]
- In 2019, Bristol had the fourth highest total number of deaths in homeless people amongst all Local Authorities. The average age of death for a homeless person is estimated around 45 years [21]
- Certain groups within society are disproportionately victims of crime, these include women, minority ethnic groups and people who identify as Lesbian, Gay, Bisexual, Transgender, and Queer (or Questioning) (LGBTQ+) [22, 23, 24, 25]

Figure 3.5: Dimensions of inequality in health [26]



3.2.1 Racial inequalities

- The pattern of health disparities in BNSSG is complicated (see figure 3.4) and the reasons for this are multiple and complex, involving discrimination, distrust of services, deprivation and language challenges [14]
- ”Ethnic minorities in Bristol experience greater disadvantage than in England and Wales in education and employment and this is particularly so for Black African people” [27]
- Poor experience of healthcare is more likely to be reported by minority ethnic groups [28, 14]
- In BNSSG, Bangladeshi, Caribbean and Pakistani people have especially poor health (diagnosed) in their middle to later years (see figure 3.4)
- People with a White ethnicity recorded have poorer health (diagnosed) than most groups in their early years, which could be a true finding, but there is some evidence this may be a bias finding due to younger and healthier White people not having their ethnicity recorded
- Gypsy Roma Travellers can have a life expectancy of 25 years less than the general population [26, 29, 30]
- Infant and maternal mortality and deaths from CVD and diabetes are higher among Black and South Asian groups nationally [28]
- Minority ethnic groups experience inequalities in access to ’improving access to psychological therapies’ and cognitive behavioural therapy and higher rates of compulsory admission to psychiatric wards, particularly for Black (including Mixed) and South Asian groups [14]

3.2.2 Life expectancy and what limits it

Figure 3.6: Stark differences in life expectancy within BNSSG

Life expectancy between IMD1 (most deprived) to IMD5, and males and females. Bristol (B), North Somerset (NS), South Gloucestershire (SG). Deprivation gap (years) shown above each pair of bars [31].

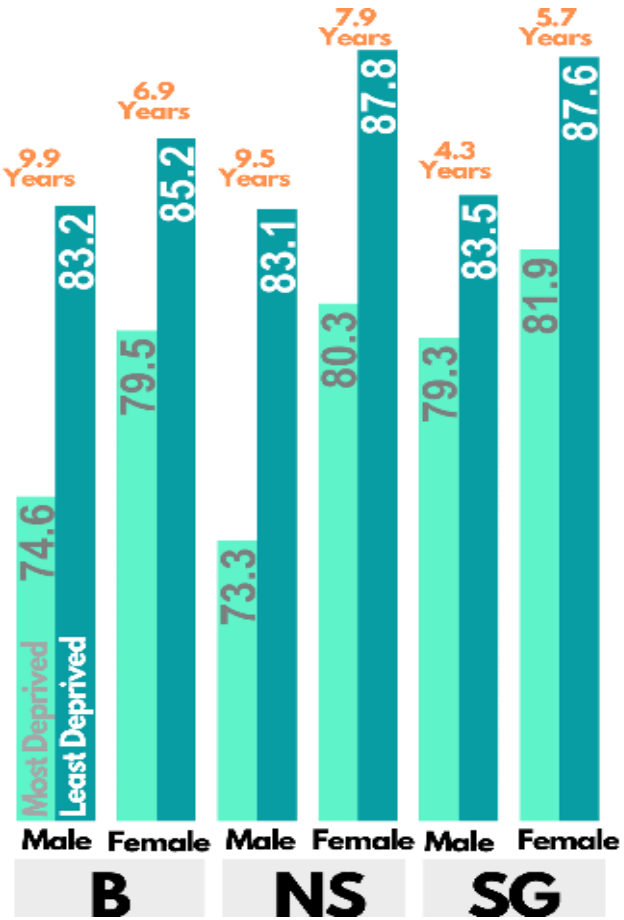


Figure 3.7: The life expectancy gap

Conditions contributing to the life expectancy gap (in years) in BNSSG between the most and least deprived areas (IMD quintiles)[32]

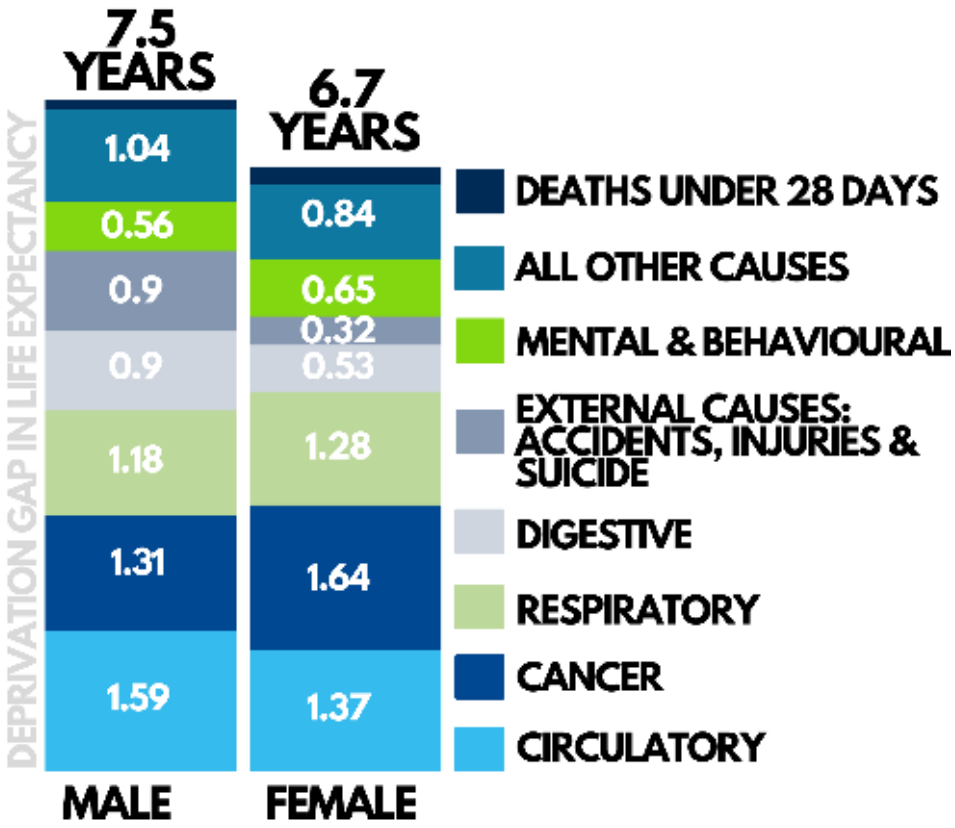
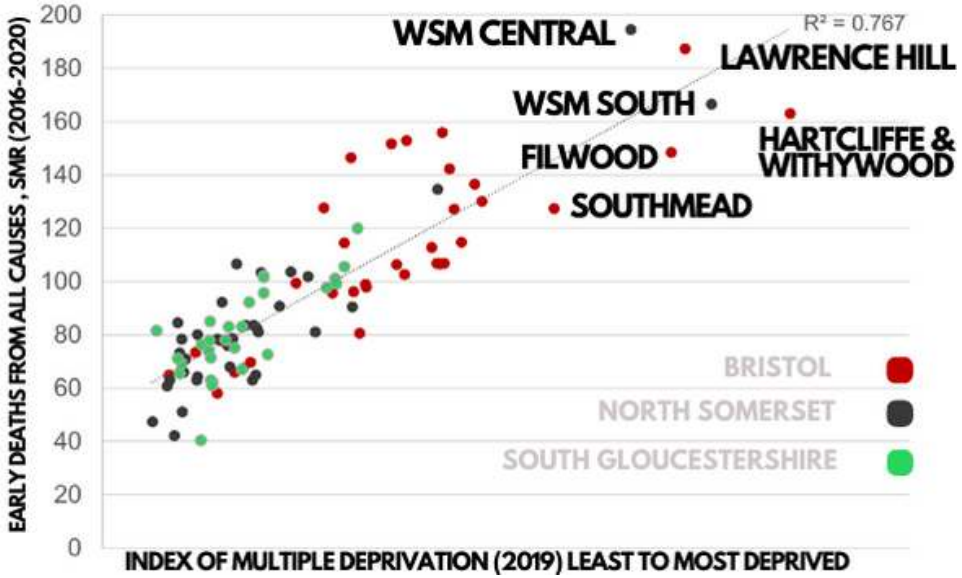


Figure 3.8: More lives are cut short in our more deprived communities

Early Deaths from All Causes in 2016-2020 by Deprivation (IMD2019)[33]



Most early deaths are due to cardiovascular disease, cancers (especially lung, colorectal and breast), respiratory diseases and liver disease. These conditions drive most of the life expectancy gap by deprivation and are often preventable.

Suicide is uncommon but a leading cause of *years of life lost* as it is more common in young people with more years ahead of them.

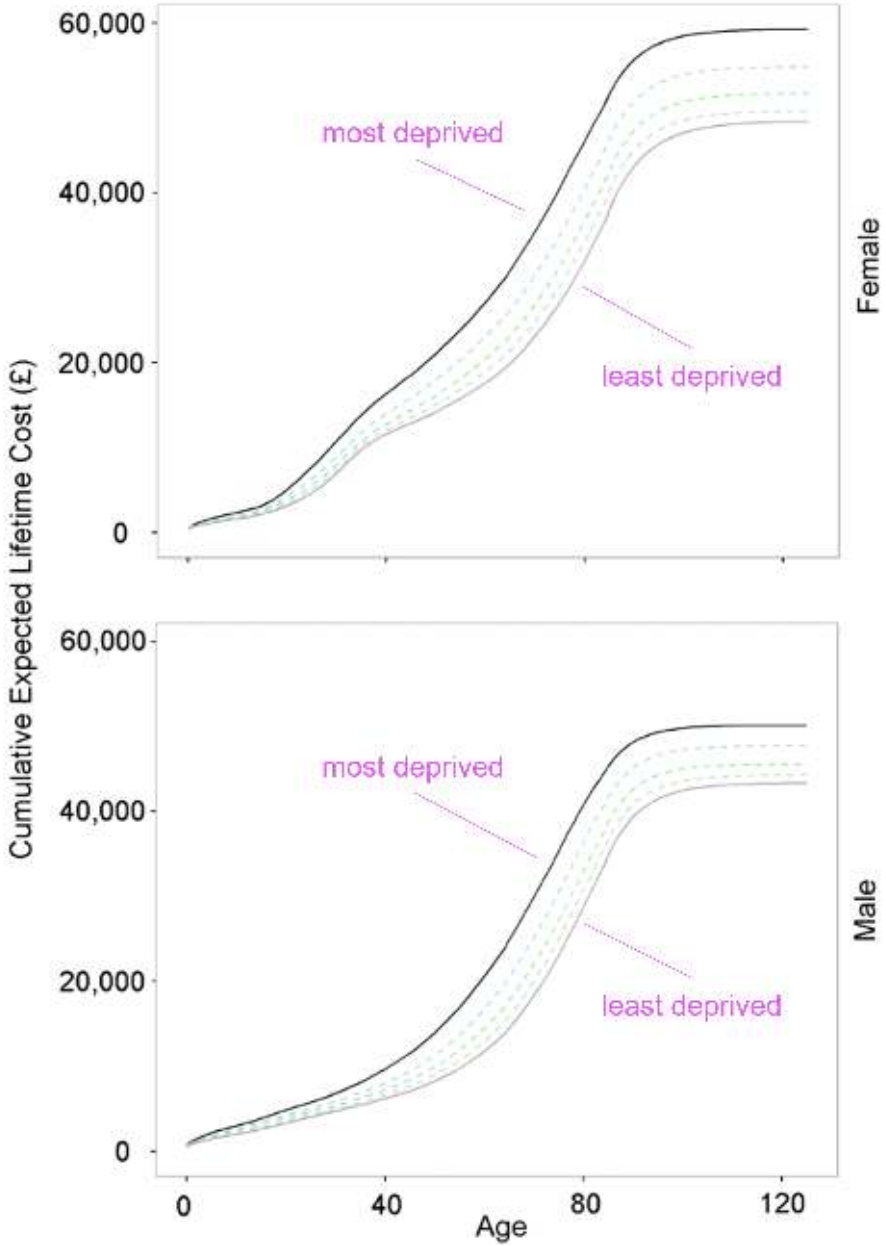
3.3 The cost of inequality

Figure 3.9 shows the result of a study to model cumulative lifetime costs of hospital usage - in England - for males and females, broken down by Index of Multiple Deprivation quintiles [12]. Cost data were estimated in 2011/2012 but may be higher after adjusting for inflation [34]. These estimates include the effect of reduced life expectancy among more deprived groups.

Average lifetime costs for women were approximately £48,000 for IMD5 (least deprived) and £59,000 for IMD1 (most deprived). Costs for males were £43,000 and £50,000 respectively. As shown in the graphs, there is an increase in costs for each IMD quintile between the least and most deprived.

Applying these estimates to the BNSSG population, the total cost of hospital episodes associated with deprivation in BNSSG is in the region of £100 million per year. In effect, this is an uncontrolled allocation of hospital resource to treat the downstream effects of largely preventable illness.

Figure 3.9: Inequality is expensive [12]



3.4 Demographic impacts

Figure 3.10: Over 75-year-olds is the fastest growing age-group in BNSSG

Projected population growth for BNSSG by age groups (0-24, 25-49, 50-74, 75+ years), from 2022 to 2040 [35]

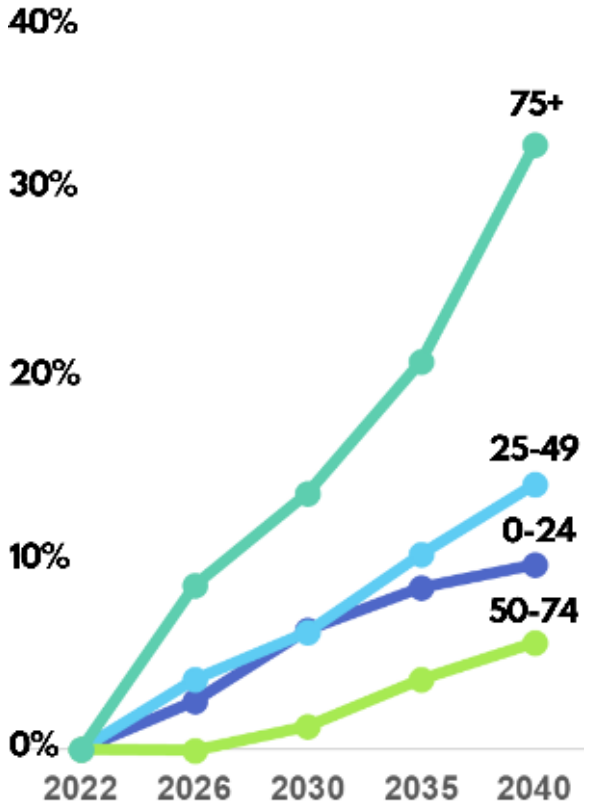
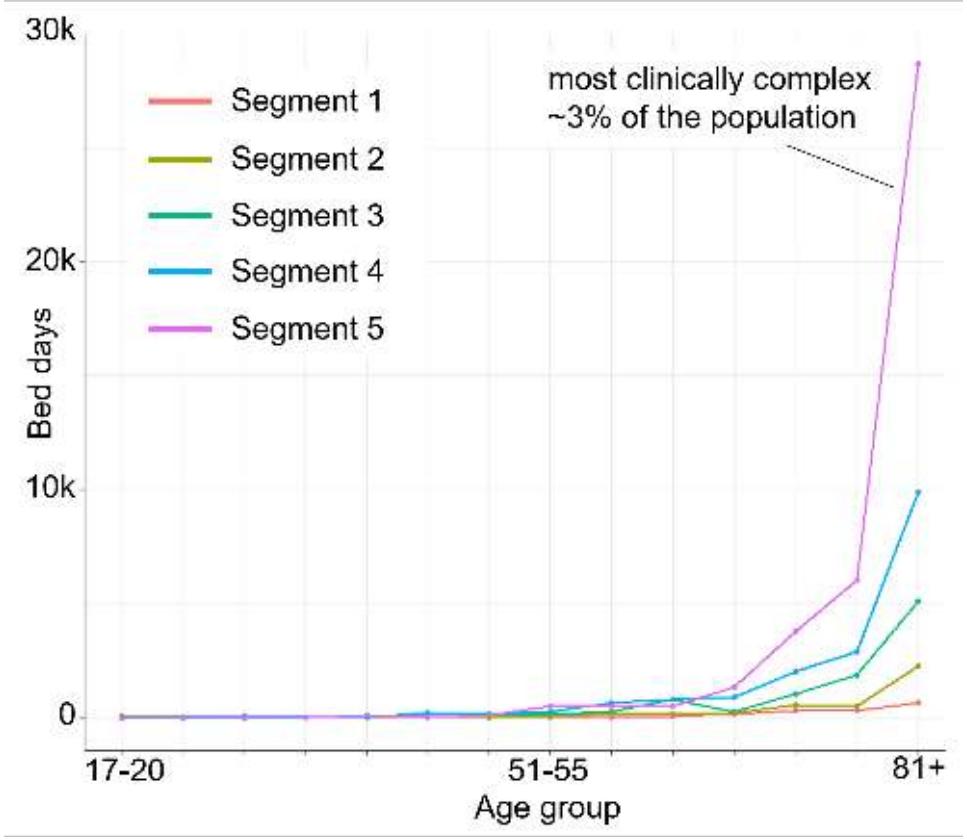


Figure 3.11: How we age has a bigger impact than simply getting older

BNSSG total annual bed days for admissions due to falls, by population segment and age band. Segments are defined by Cambridge Multi-Morbidity Index (CMMI) scores. Segment one is the 50% healthiest group of our adult population. Segment five is the most complex 3% group of adults. Segments two to four make up 24%, 13% and 7% of adults respectively. The total number of over 80-year-olds in each segment are: one - 2,752; two - 6,263; three - 8,425; four - 9,749; and five - 10,930.[15]



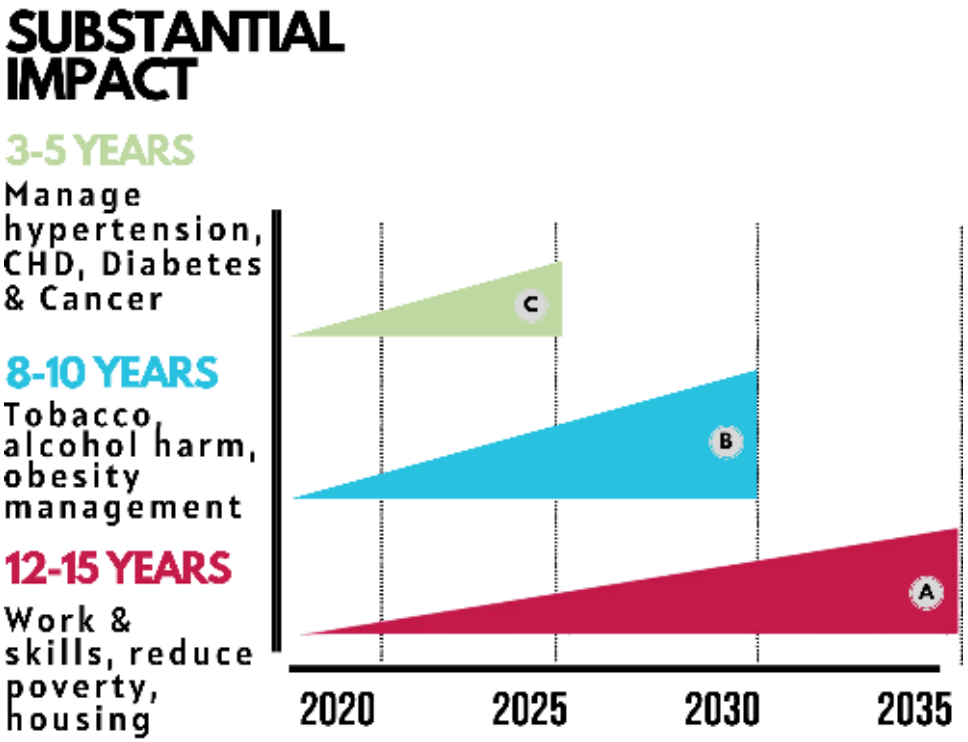
The message from our analysis of the health of the BNSSG population is stark. It is not age, but ill-health that is the dominant determinant of demand for non-elective care within our system.

Figure 3.11 shows non-elective admissions for falls to demonstrate the effect of varying levels of health (segments one to five) on hospital bed day use. These data show that nearly 30,000 bed days are used per year for admissions due to falls for the 10,000 people over 80 years old in segment five (greatest ill-health). Despite similarly sized populations, people over 80 years old in segments four and three use just 10,000 and 5,000 bed days respectively. Our population is set to age rapidly (figure 3.10), and while health status is more important than age when it comes to service use, we know that *growing older* is associated with an increased prevalence of diagnosed illness (figures 3.2 and 3.4). However, many older people within our population are in very good health. As shown earlier, much of the burden of ill-health is preventable and manageable. Taking the opportunity to help people age well is essential for the future of our population's health and the sustainability of their services.

3.5 The big opportunity

Our first big opportunity is in *what* we do. We have to improve our prevention effort. This is the only realistic way to substantially improve the health of the population - especially the most disadvantaged groups - and ensure the sustainability of our services. This is a moment to align our improvement work on the things that are having the current biggest impact on peoples' lives. Our second big opportunity is in *how* we work together as partners to do this work. Many of our challenges can be more effectively tackled together, not least as we are now collectively responsible for how we allocate our resources. This might involve providing services at scale across the ICS. It might mean joining up high volume and critical functions like prescribing that affect multiple partners across the system. It has to be different to what we do now.

Figure 3.12: Impact timelines [16]



”Our children are our future and one of the basic responsibilities is to care for them in the best and most compassionate manner possible”

Nelson Mandela

4 Starting well

Adverse Childhood Experiences (ACEs) and Trauma

The first 1,001 days of a child's life are when the foundations of the brain are built. Positive experiences during this time with the people who care for us lead to secure attachments which support healthy development.

ACEs cause significant harm from exposure to traumatic and stressful events in childhood. This increases the risk of smoking, drug and alcohol misuse and involvement in crime.

Constant exposure to high levels of stress can directly affect brain and body development. This can place individuals at a higher risk of things like cancer, heart disease and poor mental health.

We can support strong foundations for child development through holistic services such as family hubs/Sure Start and 'Supporting Families' initiatives.

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women smoke at the time of delivery across BNSSG

4.1 Building blocks for future health and wellbeing

Childhood experiences of **trauma and ACEs** have long term impacts on physical and mental health. ACEs cluster in those living in more deprived areas – experience of 4 or more ACEs is 3 times more common in the most deprived areas compared to the least deprived [36].

Poverty affecting children is a major driver of future inequality in health. The 25,000 children in BNSSG growing up in poverty are more likely to experience health problems from birth and to accumulate physical and mental ill health throughout life. Children eligible for free school meals are more likely to be lower educational achievers. [37, 38].

Higher levels of **education** are associated with better health. Measures of school readiness at age five show a 20-25% gap between the most and least deprived areas in BNSSG in the percentage of children ready for school. Some children from Black and Minority ethnic groups and those with special educational needs and disabilities are more likely to be lower educational achievers [38, 27, 39].

Fixed Period Exclusions are increasing. Keeping children in education is important for achievement but also to protect mental health, confidence and self-esteem. There are many reasons for these poorer outcomes, one of which is the way that organisations, policies and ways of working have been designed, consciously or unconsciously to benefit one group over others.[18]

4.2 Healthy habits

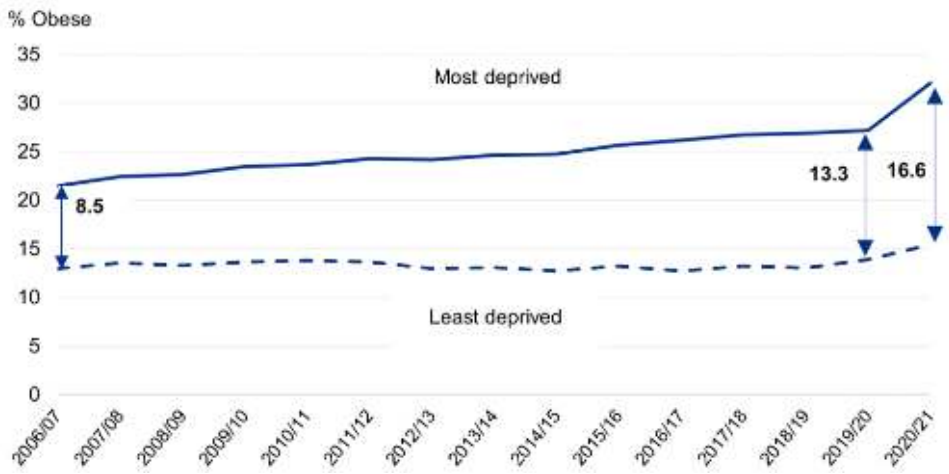
Smoking in pregnancy is strongly linked with deprivation, and is the main modifiable risk factor for poor pregnancy outcomes such as low birth weight, stillbirth, and premature birth. Exposure to smoke at home increases a child's risk of illness such as respiratory diseases and infections [40]. Currently, 11.8% of pregnant women in IMD1 (most deprived) areas smoke at the time of delivery, compared with 6.6% in IMD5 (least deprived) areas.

Local pathways to support pregnant women to quit have been developed, and rates are slowly coming down. Offering support beyond pregnancy – to the first 1,001 days, and to household partners who smoke, would strengthen support for women and reduce childhood exposure to smoke.

Smoking among children and young people: There are an estimated 14,700 children and young people aged 16-25 who smoke. Children are more likely to take up smoking if they live with smokers. The best way to reduce smoking among young people is to reduce smoking in the world around them. When the age of sale for tobacco was increased from 16 to 18 in 2007, it led to a 30% reduction in smoking prevalence for 16 and 17 year olds in England [41, 42, 43].

Healthy weight among children: Prevention and treatment of childhood obesity has become a major public health challenge. There are around 2,260 children in BNSSG either overweight or obese. Obesity rates are higher in some of our Black and Minority ethnic groups and in children living in the poorest areas. The consequences are a greater chance of being obese as an adult, with an increased risk of developing health conditions such as diabetes, cancer, heart disease.

Figure 4.1: Childhood Obesity is major public health issue [44]



Nationally, tooth decay is the leading cause of hospital admissions among 5-9 year olds [45]. The rate of admission to hospital for extraction of decayed teeth is higher in Bristol than the national average, and significantly higher in the most deprived wards.

Across BNSSG there are high rates of hospital admissions linked to **alcohol and to drug misuse**; these are higher than the England average in all three local authority areas. Over a year, there were 245 admissions related to alcohol and 455 for drug use in young people. Drug misuse in young people increases risk of poor mental health and is linked to adverse experiences and behaviours including truancy, school exclusion, homelessness, time in care and offending.

4.3 Mental health

Hospital admissions for mental health conditions and for self-harm in children and young people are significantly higher than the England average in each of the local authority areas, with around 1,320 self harm admissions in BNSSG a year.

In South Gloucestershire, over half young people reported they are worried about their appearance, about being discriminated against and their mental health [46]. In Bristol, children with low wellbeing scores were highest in young carers, children with Free School Meal status, children with disability, long-term illness, special educational needs and disabilities (SEND) or Learning Disabilities and those living in single parent families [47]. Eating disorders rank in the top five most impactful conditions among 17-25 year olds in BNSSG. Nationally, it is estimated that the prevalence of eating disorders is around 8% of the overall population. The numbers of children and young people in treatment for eating disorders in BNSSG has increased from 107 in 2017-18 to 367 in 2021-22 [48]. Compared with White British children, Black children are 10 times more likely to referred to children's mental health services via social services, rather than through their GP [14]. Psychosis is in the top five most impactful conditions affecting young Black people in inner-city Bristol.

4.4 Health and care services

Preconception care at the earliest stage for women planning pregnancy is important to support the adoption of healthy habits such as a good diet, taking folic acid supplements and stopping smoking.

Access to **antenatal care** at an early stage supports women to have a healthy pregnancy, including though support for healthy living, screening, vaccinations, and preparation for the birth and for contraception after the birth [49, 50].

Not everyone's experience of pregnancy and birth is equal. A recent Maternity Health equity Audit [13] across BNSSG showed that

- Black, Asian and Mixed Ethnicity women, women living in more deprived areas, and women under 20 or over 40 years are most likely to experience poor birth outcomes
- Women under 20 were most likely to have children with low birth weight and premature births
- Women over 40 were more likely to have cesarean sections and admissions to Neonatal Intensive Care Units
- Black women had the poorest outcomes across all areas, including higher rates of prematurity, low birth weight, and neonatal intensive care admissions

Protecting the health of children and young people through vaccination is an important health intervention. Measles, Mumps and Rubella vaccination is given in 2 doses. Vaccination coverage is similar for South Gloucestershire and North Somerset but Bristol is below the target for England at 88.6%. As a system, there are opportunities to reduce inequalities and tackle low uptake of vaccination, especially for children and young people, but also across the whole life course [51, 52].

Supporting young families through programmes such as Start for Life, and the Supporting Families programme help establish foundations for family-based good health across wider issues like housing and employment, relationships, parenting, as well as health. The new Family Hubs programme builds on Sure Start and will be further developed locally, with a focus on integrating services for families. Research by the Institute for Fiscal Studies identified that Sure Start centres contributed to the prevention of hospital admissions for children. Opening just one centre for every thousand children prevents 5,500 hospital admissions of 11-year-olds each year. Reduction in hospitalisation was greatest in the most deprived areas and reduced the inequality gap in hospital admissions between rich and poor areas by half [53, 54]

4.5 Opportunities

- The teenage pregnancy reduction programme in the UK is used as a model for best practice across the world - we can do the same for reducing childhood obesity
- Address the inequalities in access, experience and outcomes in maternity care
- Build mental health and wellbeing among children and young people
- Further develop family approaches to support health and wellbeing of young families, and integrate services around them
- Reduce impact of tobacco smoke on babies and children through family/household-based support for quitting and promotion of smoke-free homes, and a **no gaps** approach in-line with the Ottawa Model for Smoking Cessation
- Address poor housing and fuel poverty (detailed in chapter 6)
- Implement the recommendations in the Ethnic Inequalities in Healthcare report [14]

“There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they’re falling in”

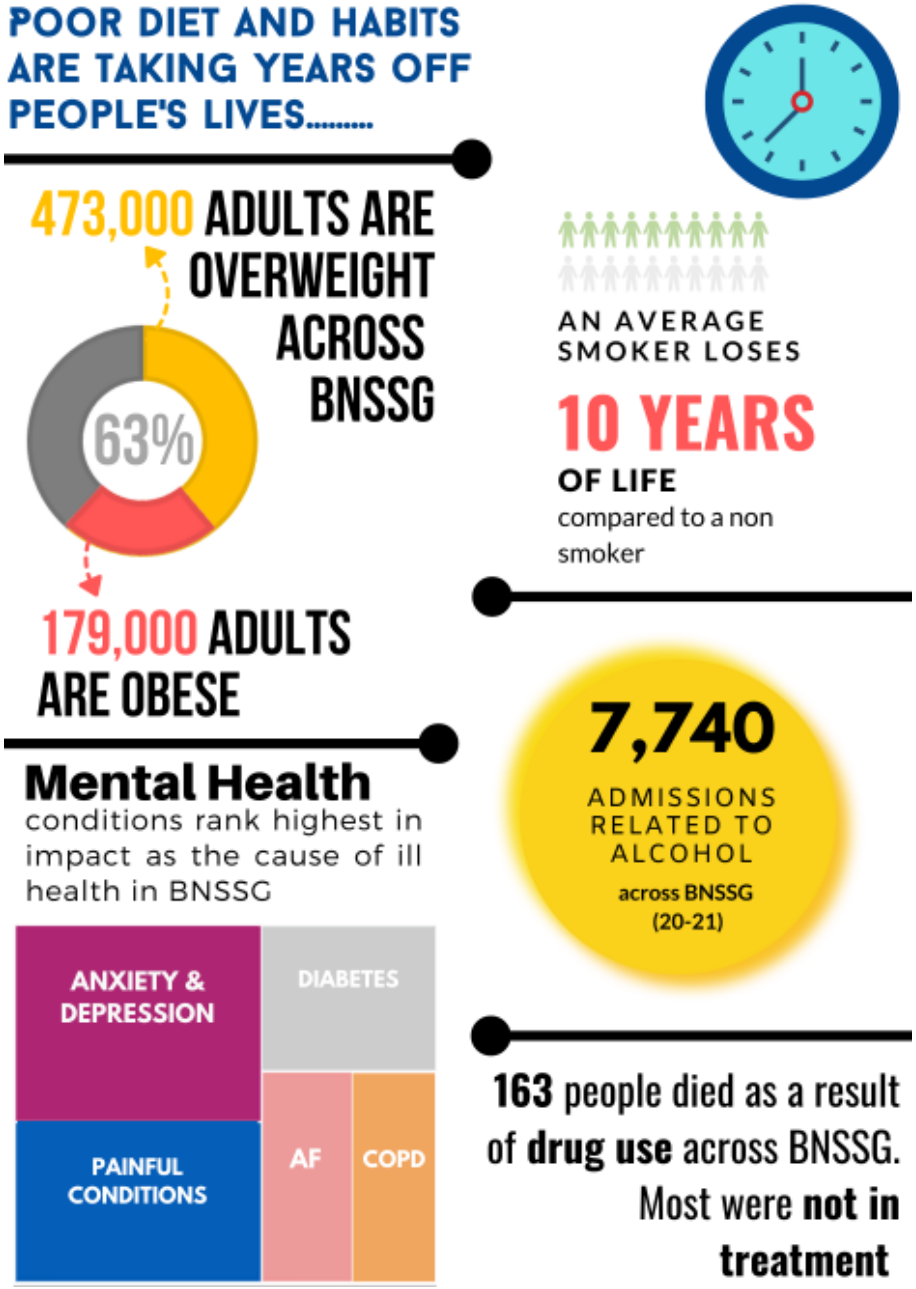
Desmond Tutu

5 | Living well

Employment and Housing

Two of the key things we need to live well are jobs with fair pay and secure housing. Having both of these things can help to mitigate and lift people out of poverty support health and wellbeing, and reduce stress.

Chronic stress directly impacts health in multiple ways by causing anxiety, depression, high blood pressure and poorer immunity, making us more vulnerable to infection and disease. It can also lead to people engaging in harmful behaviours to manage the stress in their lives such as smoking, lack of exercise or eating a poor diet. Improved mental health is associated with a range of positive outcomes including healthier and longer lives, better educational achievement and improved employment rates.



5.1 Building blocks for health and wellbeing

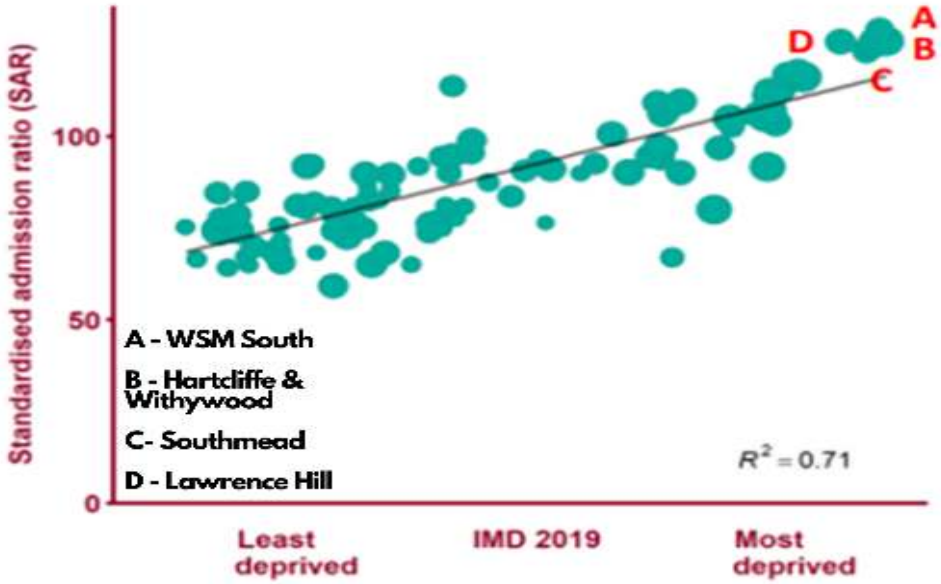
Our health, and health-related behaviours and habits are strongly influenced by the families, homes, communities and circumstances we live in and work in. Improving population health and preventing ill health requires effort to address both behaviours and the wider social, economic and environmental drivers of these.

Poverty is a key determinant of poor health. It intersects and exacerbates other forms of inequality. The current cost-of-living crisis will worsen the situation, and those already on low incomes will be disproportionately affected. The cost-of-living crisis will also affect organisations and businesses, and the voluntary and community sector is anticipated to be particularly affected. These organisations may be the ones working to support people with the impacts of the cost-of-living crisis [6, 5].

Twice as many people die prematurely from preventable causes in the poorest areas. Many of the factors that contribute to poorer health and wellbeing cluster in more disadvantaged individuals, families and communities.

Figure 5.1: Emergency hospital admissions are highest in areas of high deprivation

All causes, all ages, standardised admission ratio, 2016/17 - 20/21 [55]



Stable employment is an important determinant of good health outcomes; unemployment has adverse effects on wellbeing and is a key driver of poverty. Employment rates across BNSSG are in line with or above the national average, but the proportion of young people 16-17 years not in education, employment or training is higher.

Good housing helps protect our mental and physical health and helps us live well. Poor housing is associated with higher risk of cardiovascular disease and respiratory diseases, depression, anxiety and injuries [56]. Around 50% of properties in Bristol are owner-occupied, indicative of high levels of rental property and potential housing insecurity.

Homelessness is associated with severe poverty, and with poor health, education and social outcomes, particularly for children. Homelessness is not just people living on the street, this can include people who are living in temporary accommodation with family or friends or who are at risk of becoming homeless [57]. In 2018, Bristol had the fourth highest total number of deaths in homeless people amongst all Local Authorities [21].

Fear of or effects of crime, domestic violence, unstable housing and drug and alcohol use impacts on day-to-day life and physical and mental health. Positive feelings about where we live can create **strong, inclusive communities**. Strong communities are more likely to have higher social and civic participation, lower crime, and improved health of residents [58].

Approximately 15% of the BNSSG population is from a minority ethnic group and over 90 languages are spoken. **Racial disparities** in health are evident and complex. Pakistani, Bangladeshi and Caribbean ethnic groups have a generally higher levels of diagnosed ill-health (see figure 3.4). This is consistent with what is observed at national level [28].

Structural inequality marginalises or excludes minority ethnic groups e.g. in housing, employment or the criminal justice system, which in turn affects health. There is also evidence that racism and discrimination, both exposure to discrimination and the threat of exposure to discrimination, negatively impact on physical and mental health[18].

5.2 Healthy habits

The principal conditions causing early deaths (and more so among the most deprived) share some common risk factors or habits: smoking, poor diet, obesity, lack of physical activity and harmful alcohol use.

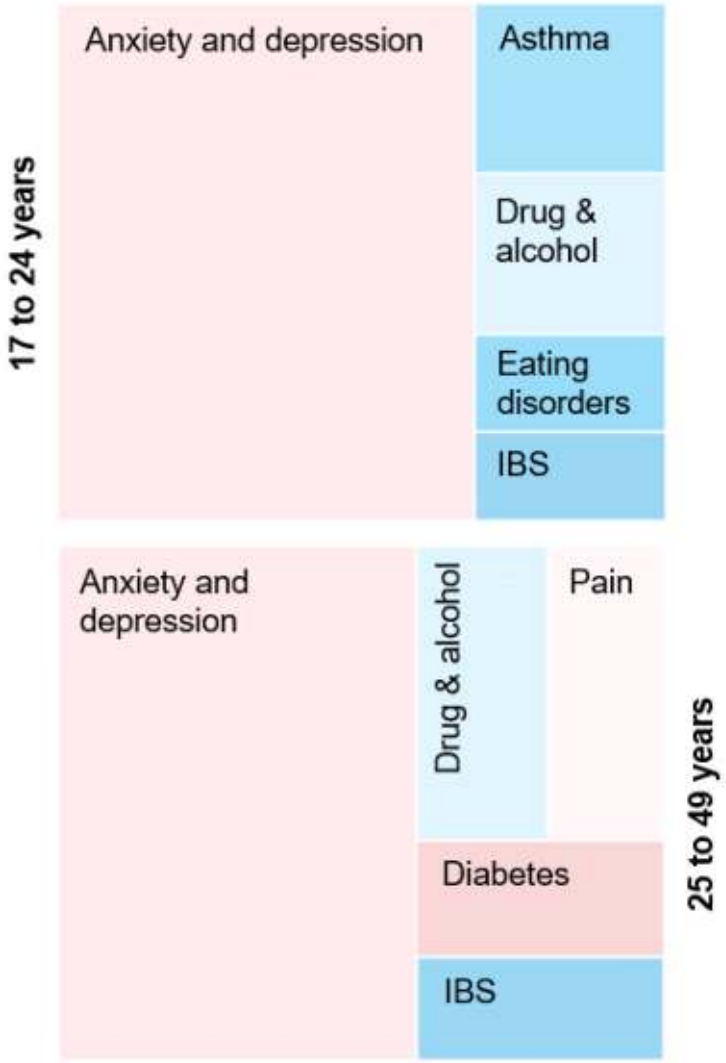
Unhealthy habits are not evenly distributed – people in more deprived groups are five times as likely to have three or four of these risk factors than those in less deprived groups [59].

Obesity is reported as the biggest risk factor for disability in BNSSG. It is the second leading cause of preventable cancers, and a major risk factor for type 2 diabetes, and for cardiovascular diseases. Around 90% of adults with type 2 diabetes are overweight or obese. Obesity prevalence is highest in more deprived areas. Diabetes is a key risk factor for cardiovascular disease.

Unhealthy weight is a complex issue; diet and physical activity levels are affected by our behaviour, environment, biology, and our society and culture. To address this complexity, we need a ‘whole systems approach’ – involving collective action across local authorities, NHS, education settings, food businesses, leisure sport providers, workplaces and communities, to deliver long-term change.

Alcohol dependency has the second largest impact upon the health of people aged 18 to 49 across BNSSG, after anxiety and depression.

Figure 5.2: The most impactful conditions for people aged 18-49 are mental health, drug and alcohol, and painful conditions [15]



Emergency hospital admissions for alcohol related harm are increasing, particularly in females. Admissions are highest in Bristol and North Somerset, and higher than the national average. These also link closely to areas with high deprivation.

Smoking is the primary driver of the gap in life expectancy between rich and poor. It accounts for more years of life lost than any other modifiable risk factor. It is the leading cause of preventable cancers; overweight and obesity is the second leading cause [2].

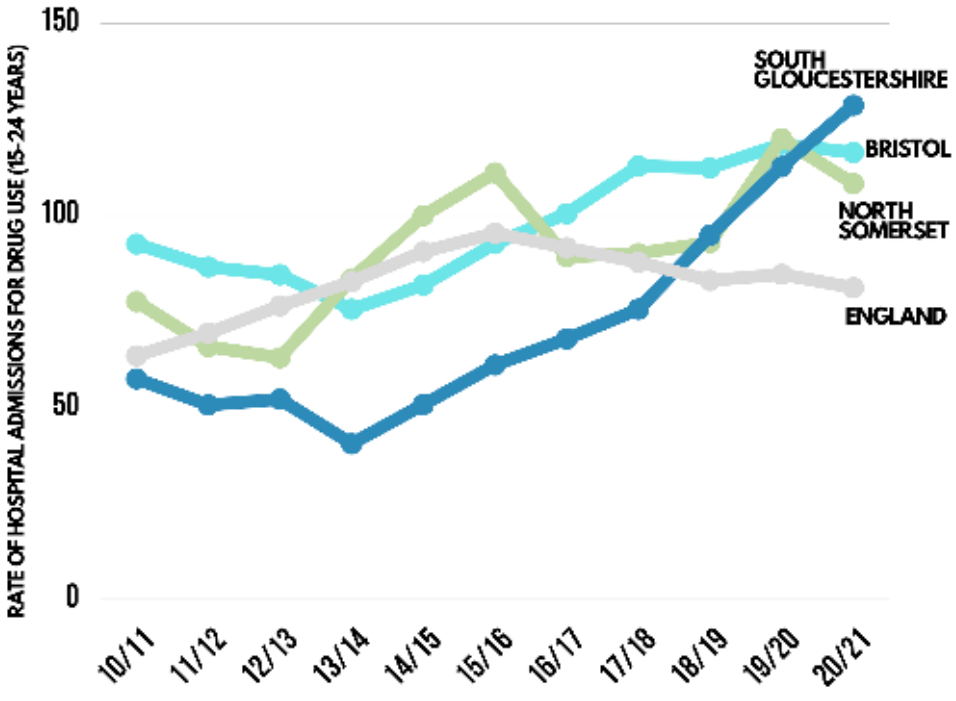
An estimated 111,000 people smoke across BNSSG - over one in ten people.

The smoking rate has fallen over the last decade but it is starting to increase once again in more socioeconomically deprived populations. Smoking is increasingly concentrated in more deprived areas - people in more deprived areas are more likely to smoke and less likely to quit. Smoking is higher among adults with a long term mental health condition. Smokers see their GP 35% more than non-smokers [43]

Stop smoking services are highly cost effective. Being encouraged by a health professional is one of the most important motivational factors, so asking at every opportunity is important. It is never too late to stop – stopping smoking at any time has considerable health benefits over the short and long term. In one year of stopping smoking, a persons risk of a heart attack is halved compared to a smoker and within ten years, the risk of death from lung cancer is halved [43, 60, 61].

Drug and alcohol use impact is increasing. Hospital admissions for drug use amongst 15-24 year olds are higher than the national average and are increasing especially in South Gloucestershire. Hospital admissions for alcohol in under 18's are higher than the England average, across the three local authority areas.

Figure 5.3: Hospital Admissions for drug use in young people in South Gloucestershire shows a worrying trend [62]



The number of people dying from a drug related deaths is high in Bristol and increasing. This represents the tip of the iceberg – drug and alcohol misuse impacts heavily on families and communities.

5.3 Health Impacts

Mental health conditions are one of the biggest contributors to years lived with disability in BNSSG. Anxiety/depression is the most impactful condition on health of the adult under 50 population in BNSSG, followed by alcohol dependency.

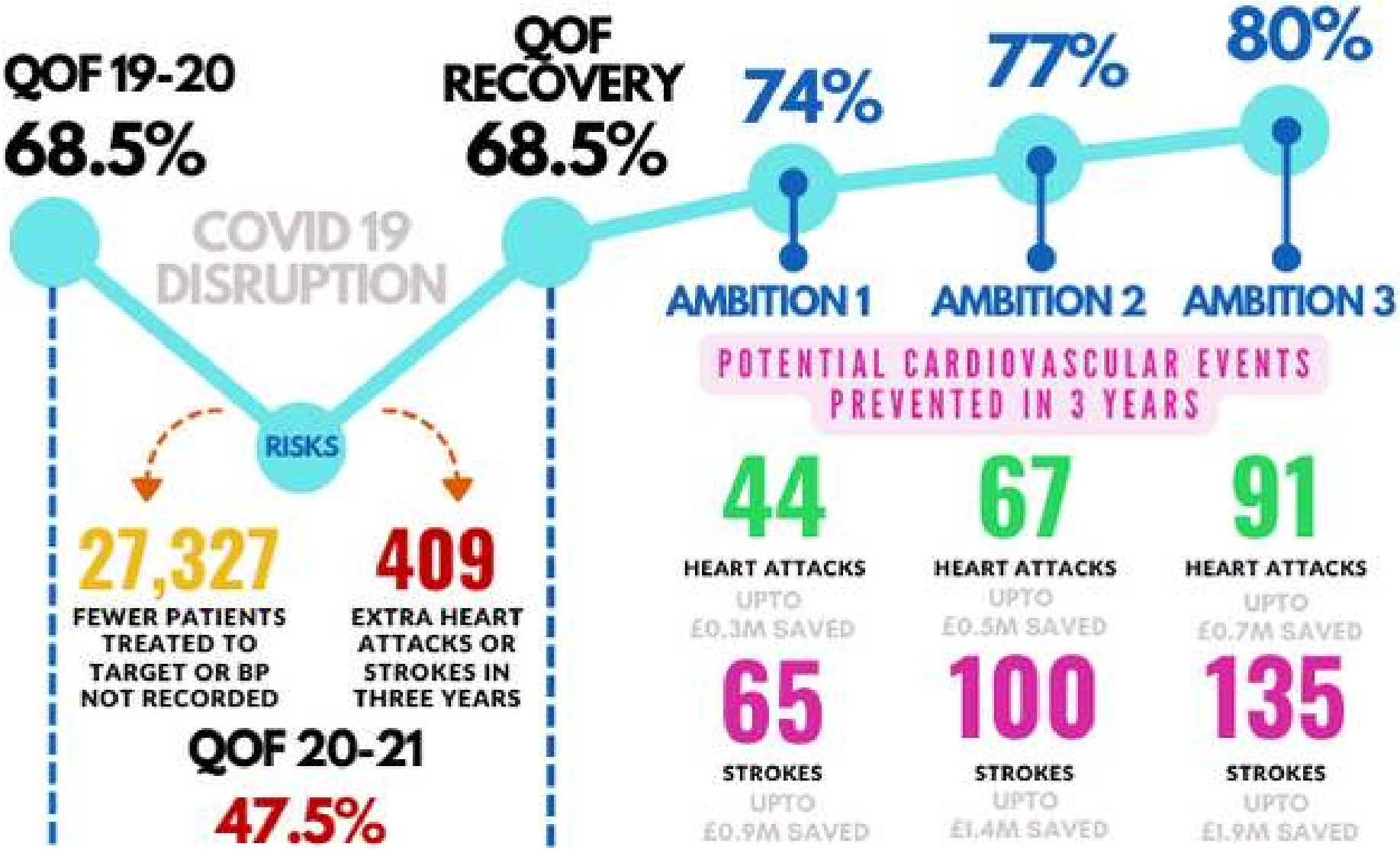
Suicide is our second biggest cause of years of life lost, after heart disease.

Self harm is a particular issue for all 3 local authorities and results in large and rising numbers of emergency hospital admissions. There were 1320 emergency admissions for self-harm in 15-24 year olds across BNSSG in 2020-21. This accounted for 40% of all emergency admissions for self-harm during this time period.

Painful conditions are in the top five most impactful conditions in BNSSG across the life course but particularly among the older, over 50s population. There is significant overlap with mental health issues especially anxiety and depression, and this is unlikely to be resolved through more prescribing or faster access to procedures. Painful musculo-skeletal conditions such as low back pain are one of the leading causes of sickness absence.

Figure 5.4: The size of the hypertension prize

Blood pressure optimisation to prevent heart attacks and strokes in BNSSG at scale [63]



5.4 Prevention, screening and early intervention services

5.4.1 Identifying and reducing cardiovascular risk

Heart disease alone is the top cause of years of lost life in BNSSG.

NHS Health Checks are offered five-yearly to 40-74 year olds, to identify and manage risk of **cardiovascular disease (CVD)** and related conditions, and support management of lifestyle risks (eg weight, smoking), high blood pressure and raised cholesterol levels.

The national ambition (10 year cardiovascular disease ambitions for England) is by 2029 that 75% of 40-74 year olds to have received a formal CVD risk assessment and cholesterol measurement within the previous 5 years. Rates in BNSSG (and nationally) are well below this ambition, and new ways to deliver NHS Health Checks in parts of BNSSG are needed.

The Size of the Prize resource [63] for ICSs shows for BNSSG the potential for real ambition in preventing heart attacks and strokes at scale in a short time frame - three years - by optimising the management of high blood pressure.

This represents a big opportunity, not least in reducing acute care, discharge and social care pressures through reduced strokes.

To reach the target of 80% of people with high blood pressure diagnosed, we need to find/record an estimated 37,000 people with high blood pressure across BNSSG.

For treatment, around 15,000 additional patients in BNSSG need to be managed to target levels in order to meet the national ambition of 80% treated to target.

For **atrial fibrillation**, the national ambition is for 90% of patients with Atrial Fibrillation (AF) who are known to be at high risk of a stroke to be adequately anticoagulated by 2029. In BNSSG, the opportunity is 650 more patients to be adequately anticoagulated.

5.4.2 Cancer Screening

Cancers are the second biggest contributor to the gap in life expectancy across BNSSG. It is estimated nearly 50% of cancers are preventable through supporting people to live healthier lives [2]. This includes avoiding smoking, maintaining healthy weight, reducing harmful alcohol consumption, eating healthily and staying safe in the sun.

Bowel cancer screening coverage is significantly lower in Bristol than the national average, as is breast cancer screening.

Nationally there are marked differences in screening coverage by deprivation. There is wide variation in cancer screening rates across BNSSG at primary care network level, and by deprivation and for those with a Learning Disability.

The percentage of cancers diagnosed at stage 1 or stage 2 was in line with the national average of 55% in 2019 for Bristol and North Somerset, and higher in South Gloucestershire. The national ambition is that by 2028, 75% of cancers will be diagnosed at stage 1 or 2, and early cancer diagnosis is one of the five clinical areas for current focus on reducing inequalities.

A new programme of targeted lung checks is starting in BNSSG following successful pilots elsewhere in England.

5.4.3 Diabetes Prevention

Nationally, the Diabetes Prevention Programme has shown evidence of significant reductions in new cases of **type 2 diabetes** amongst those at risk. Increased uptake is needed among deprived, and minority ethnic groups. A recent randomised control trial showed that almost half of people with type 2 diabetes who received primary care-led weight management had non-diabetic sugar levels [4].

5.4.4 COPD admission prevention

Respiratory diseases are significant drivers of acute hospital activity and show a strong gradient with deprivation in BNSSG. Chronic obstructive pulmonary disease COPD is a key clinical area of focus to address inequalities in health outcomes, particularly through vaccinations (COVID, pneumococcal and flu) to reduce infective exacerbations of COPD and emergency admissions.

5.5 Opportunities

- Identify system-wide opportunities to mitigate the impacts of poverty, deprivation and the rising cost-of-living on health
- Develop a 'no gaps', whole-system programme for prevention and reduction of excess weight and obesity across the ICP and with wider partners including education, businesses, workplaces and communities
- Develop a system-wide programme to reduce alcohol-related harms to health. This could include identification and brief advice, alcohol teams in hospitals and implementation of Alcohol Treatment Guidance for dependent drinkers – use of medication to stop drinking can save lives
- Ensure system-wide commitment to a tobacco control programme with no gaps in support for those wanting to quit
- Build mental health and wellbeing, and access to therapies and support where needed, especially in children and young people
- Go further with identification and optimal management of CVD risks especially AF, blood pressure and cholesterol
- Strengthen earlier diagnosis of cancer
- Prioritise prevention and reversal of type 2 diabetes in those with already raised blood sugar levels
- Go further with vaccination coverage in those with existing long term conditions especially COPD
- Transform the system approach to pain management to reduce the impact of painful conditions on health and wellbeing and unplanned service use

”Ageing is inevitable, but how we age is not”

PHE consensus on healthy ageing

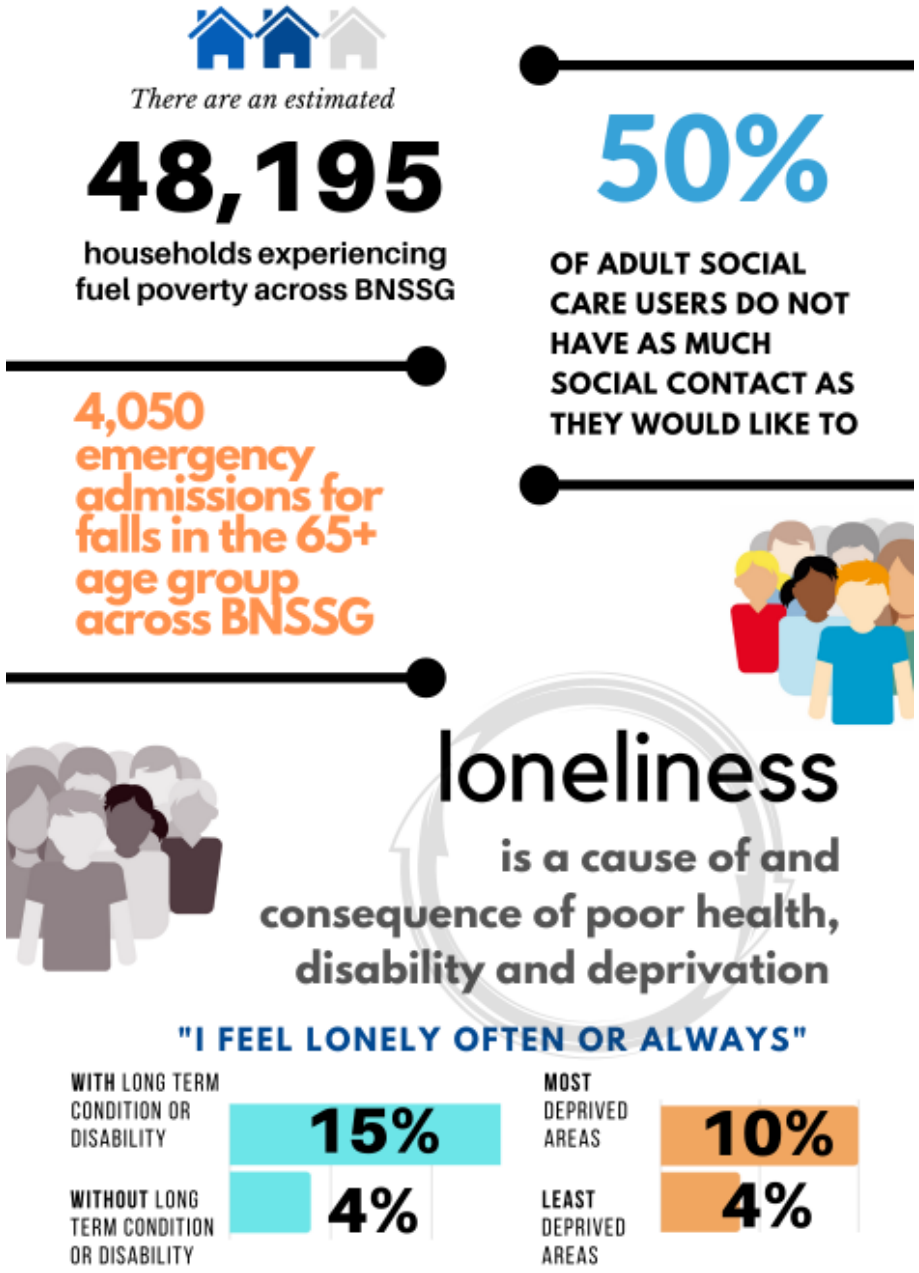
6 | Ageing Well

Warm Homes

Cold, damp and poorly ventilated homes are bad for everyone, throughout the entire life course. They can be linked to a higher risk of CVD and respiratory diseases, injuries, depression and anxiety. Local analysis has shown cold homes are linked to to increased hospital admissions for COPD and CVD. These homes are also in some of the most deprived areas.

The current economic crisis has seen fuel bills increase dramatically. The individuals who will experience this most severely include the older population, who spend a lot of time in their homes.

Warm homes are important for health and wellbeing. All three local authorities have partnerships with energy companies to provide free local advice, training, referrals and support for households experiencing fuel poverty.



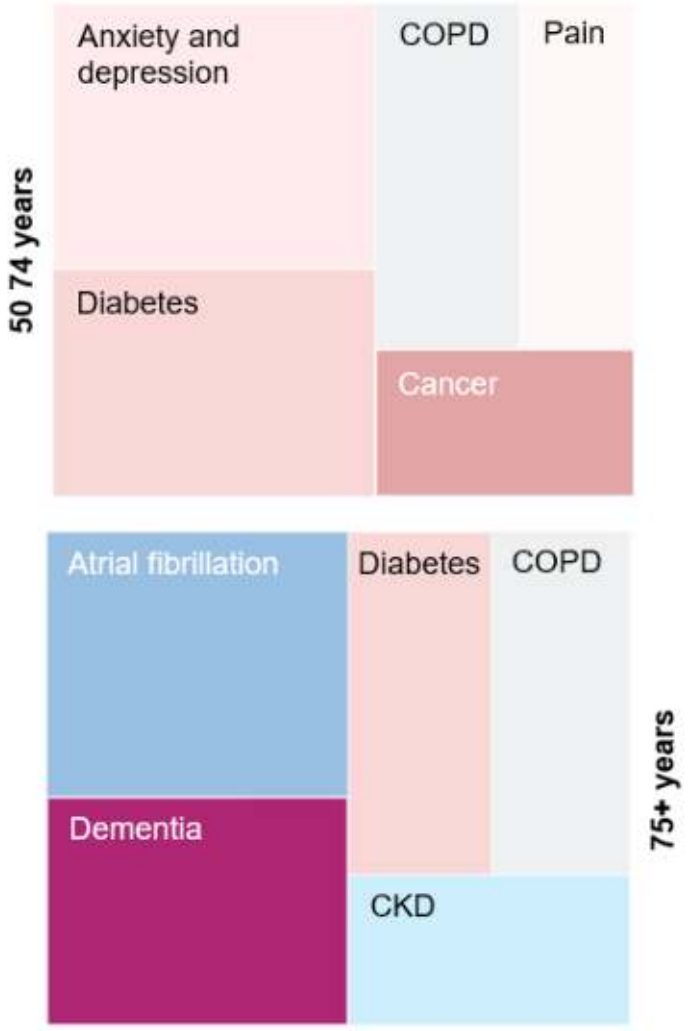
6.1 Building blocks for future health and wellbeing

The older a person is, the more likely they are to experience chronic diseases and disabilities. Multi-morbidity, the clustering of health conditions in an individual, becomes commoner as we age. Increases in life expectancy over recent decades have not been matched by increases in healthy life expectancy – we are living more of our lives in ill health. People in more deprived groups and certain ethnic groups experience poor health at a younger age, and have higher levels of multi-morbidity (see figures 3.2 and 3.4).

Good housing is an important building block for older people, for maintaining health and keeping safe. Whilst local authorities have a key role in housing, front line workers can take opportunities to signpost or facilitate adaptions and repairs to maintain safe homes. Older people are particularly at risk from **inadequately heated homes**, which is of particular concern as energy prices rise substantially. Low temperatures increase the risk of heart attacks and strokes in an older person, exacerbate lung conditions and arthritis, worsen mental health and contribute to loneliness. Home insulation programmes can reduce hospital admissions by around 11% - more for respiratory and cardiac conditions [64].

Social connections are good for protecting mental health and wellbeing, and reducing cognitive decline; they also help protect our physical health. National data shows that loneliness increases the likelihood of early death by 26% [65]. Poor health contributes to reduced opportunities for social interaction.

Figure 6.1: High impact conditions in over 50-year-olds[15]



6.2 Healthy habits

Keeping active has protective benefits throughout the life course and this should not stop in older age. Staying active can help people to maintain their independence, improve strength and balance, and have positive benefits for mental health, social and emotional wellbeing.
Fear of **falling** contributes to social isolation, reducing quality of life and increasing the need for care and support services. The rate of emergency hospital admissions for falls among over 65s in Bristol is significantly higher than the national average.

6.3 Multi-morbidity and complex health needs

When conditions cluster in an individual they often exacerbate each other e.g. depression can impact on eating, which can exacerbate diabetes and in turn worsen mental wellbeing. The most common clusters of three conditions in deprived areas in BNSSG are combinations of hypertension, depression/anxiety, diabetes and painful conditions. Figures 3.2, 3.4 and 3.11 shows the accumulation within the population, and the dramatic effect this has on service use.
As much as 25% of all non-elective admission (NEL) admissions for people in segment five (the 3% of the population with the highest level of multi-morbidity) are for ambulatory care sensitive conditions (ACSC) conditions where effective community care and case management can help prevent the need for hospital admission.

6.4 Protecting Health

Vaccinations are important for protecting individual health and also health services, which can be overwhelmed during the winter months. Vaccination is particularly important for at-risk populations i.e. people aged 65 and over, those who have weaker immune systems and those with certain medical conditions who may experience a higher risk of hospital admission. Vaccination provides the best protection against severe disease and hospitalisation and ultimately saves lives.
Flu vaccination coverage among over 65s is 85% in North Somerset, 83% in South Gloucestershire and 81% in Bristol, against a national ambition of 85% [66].

6.5 Opportunities

- Identify opportunities across the partnership to mitigate impacts of fuel poverty on health
- Plan for the expected substantial increase in the over 75 population of BNSSG, with integrated, multi-agency services and approaches to manage multi-morbidity and complex health needs
- Take a systematic approach to advanced care planning and proactive care - especially in older people with the highest level of multi-morbidity
- Maintain a stronger focus on prevention in to older age, particularly keeping active and staying connected
- Identify local opportunities for mitigating the health impacts of fuel poverty on older people ahead of this winter
- Take a systematic and integrated approach to the community management management of ambulatory care sensitive conditions, including the developing *hospital at home* programme

“By encountering death many thousands of times, I have come to a view that there is usually little to fear and much to prepare for”

Kathryn Mannix, With the End in Mind

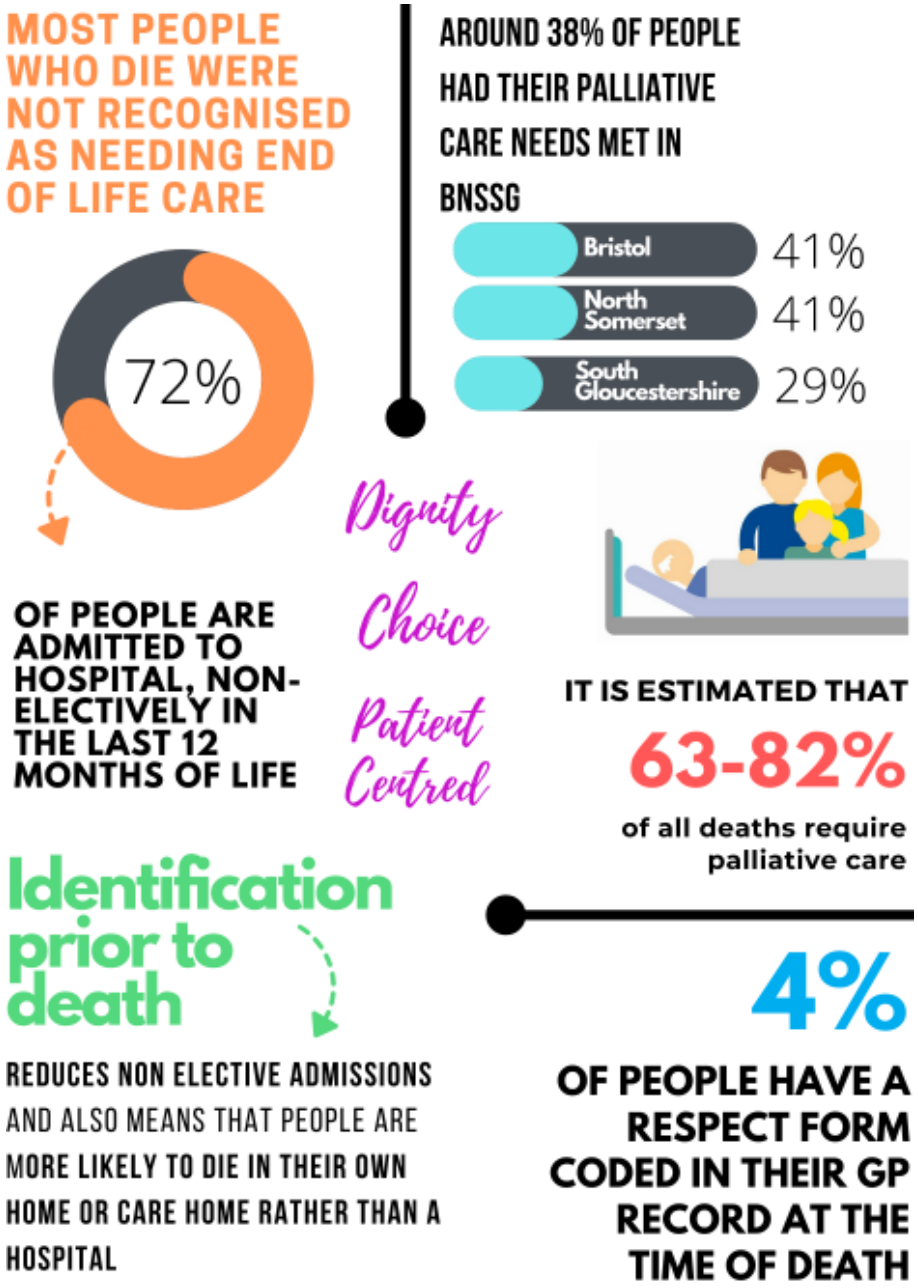
7 | Dying well

Isla's story

Isla's brain did not develop as it should before she was born. She was frequently admitted to hospital and was well known to Lifetime (Sirona service for children with life-limiting conditions), Charlton Farm Children's Hospice, and teams at the Bristol Children's Hospital.

When Isla's care became palliative, her family's wish was for her to die at home but her care team concluded this was not possible. Isla's symptoms needed expert help that was not available in the community. She received excellent care and died at Charlton farm, but this was not her family's preferred choice.

Our ICS can improve personalised care for children and adults at the end of life. Improved integrated, community-based palliative care would improve choice for people and families, improve quality of care and minimise disruption to people's lives through unwanted hospital admissions.



7.1 Building blocks for dignity in dying

- Terminal illness can lead to poverty for the individual/family, due to loss of earnings, and the additional costs as a result of their condition [20]
- Fuel poverty, leading to cold homes, worsens breathlessness and pain symptoms at the end of life
- It is estimated that on average, the cost for an individual living with a terminal illness is an additional £12,000-£16,000 per year [67]
- ”The triple challenge of high housing and heating costs, unsuitable or insecure housing, and inadequate support from the benefits system means that for too many, a death at home is a difficult experience - and, for many, unachievable” [20]
- Inequalities in access to hospice care affect: the ’oldest old’, minority ethnic group, inclusion health groups, people in deprived or rural areas, and those with non-cancer illness [68, 69]

7.2 Adults

- Only a quarter of people who die in BNSSG are on GP palliative care registers (low compared to England average)
- Just 3.6% of people who died in BNSSG had a ReSPECT form coded in their GP record. ReSPECT creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices
- 72% of people experience non-elective admissions to hospital in the last 12 months of life
- Around a quarter of people who die in BNSSG, and are on a GP palliative care register, experience a non-elective admission in their last 30 days of life. For people who were not on a register, half experienced an admission
- 74% of people who die and are on a GP palliative care register in BNSSG die at home or in a care home, compared with only 45% of people not on a palliative care register
- Over half (55%) of people in BNSSG die at home or in a care home

7.3 Children and young people

- In the last three years just five out of the 102 children and young people who died in BNSSG, died at home
- A clinical review of cases estimated half of those children could have been offered the option of end of life care at home
- Nationally, 58% of admissions to paediatric intensive care units are for children with Life Limiting Conditions
- More Children and Young People are living for longer with more complex needs - estimated at 66 per 10,000 currently and projected to rise to 80 per 10,000 by 2030
- Palliative and end of life care services for children are fragmented

7.4 Opportunities

- There are substantial potential benefits to individuals, families and services from recognising when people are dying or nearly the end of their lives, and planning for it

- Communicating people's advance plans and decisions is vital for good end of life care. BNSSG already uses the ReSPECT process across the system and version two of the digital ReSPECT form (ReSPECT Plus) is being implemented. We can build on this to be excellent communicating advanced care plans as an ICS
- Older more complex people and those at the end of life may benefit from better conversations when it comes to deciding about hospital admission, which may not always be in their best interests. BNSSG can support the Admission Reflection Tool project aiming to improve conversations at the point of considering hospital admissions
- Providing options for children and adults for palliative care, including improved and joined up integrated services at home, improves choice, dignity and quality of care
- Implementation of the recommendations in NICE NG6 (Excess winter deaths and illness and the health risks associated with cold homes), including home energy efficiency can improve quality of life in a cost-effective manner, especially people at or approaching the end of life

Glossary

ambulatory care sensitive conditions ACSCs are conditions for which effective management and treatment should prevent admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness.. 3, 40

Atrial Fibrillation Atrial fibrillation (AF) is a common abnormal heart rhythm (arrhythmia). It causes your heart to beat abnormally, which might feel like your heart is fluttering. Untreated AF can increase the risk of stroke, heart failure and other heart-related problems.. 3, 7, 9, 35

building blocks We have the best chance of maintaining good health when the right building blocks are in place: nurturing family and community relationships; a safe environment with quality housing, places to exercise and clean air to breathe; good education; meaningful work; and freedom from discrimination. For many people in BNSSG, these building blocks of good health are missing. When blocks are missing or poorly maintained, this worsens peoples' social and job opportunities, their habits, and ultimately their health. The connections between the building blocks and their effects on opportunities and healthy habits mean that poor health clusters within individual people, families and communities.. 7, 10

cardiovascular disease Cardiovascular disease is a general term for conditions affecting the heart or blood vessels.The conditions commonly associated with CVD are ischaemic heart disease, stroke, peripheral artery disease and aortic disease.. 3, 9, 19, 30, 31, 35

chronic obstructive pulmonary disease Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It includes emphysema and chronic bronchitis. COPD is a common condition that mainly affects middle-aged or older adults who have smoked.. 3, 7

chronic stress Stress is our body's response to pressure. Many different situations or life events can cause stress. It is often triggered when we experience something new, unexpected or that threatens our sense of self, or when we feel we have little control over a situation. Sometimes, this stress response can be useful: it can help us push through fear or pain so we can run a marathon or deliver a speech, for example. Our stress hormones will usually go back to normal quickly once the stressful event is over, and there won't be any lasting effects. However, too much stress can cause negative effects. It can leave us in a permanent stage of fight or flight, leaving us overwhelmed or unable to cope. Long term, this can affect our physical and mental health.. 8

complex health needs This describes people who have high levels of multi-morbidity. In general we use this term in BNSSG to refer to the 10% of the population with the highest levels of multi-morbidity.. 40

deprivation The damaging lack of material benefits considered to be basic necessities in a society.. 8, 11, 12, 14, 25, 32, 35, 36

deprived See also: Deprivation. The damaging lack of material benefits considered to be basic necessities in a society.. 7, 8, 25–27, 31, 32, 35, 39, 40, 43

discrimination Discrimination has been defined as a set of "policies, practices, and behaviours that perpetuate inequities between socially-defined groups".. 7, 8, 12, 17, 31

health equity Health equity means that everyone has a fair and just opportunity to be as healthy as possible.. 27

holistic Holistic care is about treating the whole of something or someone and not just a part. Instead of looking at separate long term conditions and treating them separately, it means looking at how the long term conditions might affect one another and treating the patient rather than the condition.. 8

hypertension High blood pressure, or hypertension rarely has noticeable symptoms, but if untreated it increases your risk of serious problems such as heart attacks and strokes. If your blood pressure is too high, it puts extra strain on your blood vessels, heart and other organs, such as the brain, kidneys and eyes.. 40

Index of Multiple Deprivation The Indices of Deprivation are a unique measure of relative deprivation at a small local area level (Lower-layer Super Output Areas) across England. The Indices provide a set of relative measures of deprivation based on seven different domains, or facets, of deprivation: income, employment, education, skills and training, health and disability, crime, barriers to housing and services, and living environment.. 3, 11, 20

inequalities Inequalities in health are differences in outcomes that are unfair, unjust and avoidable.. 7–9, 35

ischaemic heart disease This refers to the disease process atherosclerosis, which causes narrowing of the blood vessels supplying the heart muscle. This results in impaired blood flow to the heart muscle causing symptoms including chest pain (angina) and shortness of breath. This disease process can ultimately result in a heart attack.. 3, 7

Joint Strategic Needs Assessment The process and resources through which local authorities, the NHS, service users and the third sector research and agree a comprehensive local picture of health and wellbeing needs.. 10

life course Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, a life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.. 8, 33, 40

life expectancy The average total lifespan of a person before death. Lifespan – i.e. the average number of years of life – is usually measured by life expectancy at birth.. 7, 8, 18, 19, 32, 35, 39

Life Limiting Conditions Incurable conditions that will shorten a person's life, though they may continue to live active lives for many years. There is a wide range of life-limiting illnesses, including heart failure, lung disease, neurological conditions, such as Parkinson's and Multiple Sclerosis, and cancer that is no longer responding to treatment intended to cure.. 43

minority ethnic group We have used this term to refer to all ethnic groups except the white British group. Ethnic minorities include white minorities, such as Gypsy, Roma and Irish Traveller groups.. 16–18, 25, 31, 35, 43

multi-morbidity Multi-morbidity means living with two or more chronic illnesses. For example, a person could have diabetes, heart disease and depression.. 8, 39, 40

NHS Long Term Plan The NHS Long Term Plan is the priorities for the NHS for the next 10 years.. 9

painful conditions Painful conditions refers to people who are prescribed regular pain medication (four or more in a year) for their condition. This definition is designed to include a range of people, including those with: long-term back and joint pains, abdominal pain and other pain syndromes.. 7, 36, 40

palliative care The active, holistic care of people who use services who have advanced progressive illness. The goal of palliative care is to achieve the best quality of life for people who use services and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with other treatments.. 43, 44

population health Population health is one of our core strategic aims for integrated care systems (ICSs); to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population, with a specific focus on the wider determinants of health (things like housing, employment, education).. 14, 15, 30

Population Health Management Population Health Management is the use of joined up data sets to provide new insights into peoples' health and the health service, and track outcomes.. 10

prevalence The proportion of a condition or characteristic within the population at any given time, e.g. 1% of people have rheumatoid arthritis.. 22

racial disparities Racial disparity means a condition where one racial group systemically and disproportionately experiences worse outcomes in comparison to another racial group or groups. Racial disparities may occur in a range of areas, including but not limited to education, employment, wealth, policing, criminal justice, health, transportation, housing, and homelessness.. 31

ReSPECT The ReSPECT process aims to develop a shared understanding between the healthcare professional and the patient of their condition, the outcomes the patient values and those they fear and then how treatments and interventions, such as cardiopulmonary resuscitation (CPR) fit into this. It supports the important principle of personalised care.. 43

respiratory diseases Respiratory disease affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease). Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death.. 19, 25, 30, 36

special educational needs and disabilities A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support.. 4, 25, 26

structural inequality It is a system that creates conditions where one category of people have an unequal status in relation to another category of people. This is systematically rooted in the normal operations of social institutions such as education, employment, laws an regulations and healthcare.. 31

Supporting Families Supporting Families helps thousands of families across England to get the help they need to address multiple disadvantages through a whole family approach, delivered by key-workers, working for local authorities and their partners.. 8, 27

Sure Start The aim of Sure Start is to work with parents and preschool children to promote the physical, intellectual, social, and emotional development of children—particularly those who are disadvantaged. The idea is to ensure that the children who have been in Sure Start programmes are ready to thrive when they get to school.. 8, 27

type 2 diabetes A condition characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin properly. Type 2 diabetes develops most often in middle-aged and older adults but can appear in young people.. 7, 9, 31, 35, 36

vaccination coverage Proportion of the population who have received a vaccination. i.e. 85% of people aged over 65 years received a flu vaccination. 27, 36, 40

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