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

Meeting of BNSSG ICB Board

Date: Thursday 3rd October 2024
Time: 12:30 – 15:30
Location: Virtual, via Microsoft Teams

Agenda Number:	6.1	
Title:	Healthier Together 2040	
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)	No
Purpose: Decision		
Key Points for Discussion:		

This paper provides a progress update on Healthier Together 2040 (HT2040) which has been established to set the long-term strategic plan for the Bristol, North Somerset and South Gloucestershire Integrated Care System.

In addition to this paper is a document which provides a summary of the progress so far, approach set out and the population cohorts that will be focused upon through this work.

This paper will outline:

1. Background and Assumptions behind HT2040
2. Progress so far, population cohorts identified and logic behind them
3. Impact and implications of focusing on one cohort at a time
4. What will happen next

Recommendations:	To approve the recommendation to progress onto the next phase of work – to develop Strategic Intentions for the Working Age Population with Multiple Long Term Conditions.

	To note: other population cohorts will be taken forward after this initial area of focus
Previously Considered By and feedback :	HT2040 Steering Group Directors of Public Health & Medical Director System Executive Group Integrated Care Partnership Board – 26 September. The Board endorsed the approach and recommended next step
Management of Declared Interest:	No conflicts of interest
Risk and Assurance:	The recommended decision set out in this paper moves Healthier Together 2040 into the next phase of delivery. It is at this stage that risks are exposed – these will be set out by the steering group and managed accordingly.
Financial / Resource Implications:	As above, the next phase of delivery will set out the potential financial impact. The current costs of the population cohorts identified have been set out in the paper below. The development of strategic intentions will enable a full assessment of health and wider costs and the opportunity to set objectives for the proportion of spend on planned, preventative integrated care in comparison to unplanned and unscheduled care.
Legal, Policy and Regulatory Requirements:	None identified
How does this reduce Health Inequalities:	The design of the approach for HT2040 builds in a focus on reducing health inequalities
How does this impact on Equality & diversity	An EIA will be undertaken for the cohorts as the next phase is initiated. A focus on population cohorts will enable increased focus on any equality and diversity issues or opportunities.
Patient and Public Involvement:	Public involvement will be initiated in the next phase. Two members of the public have been recruited into the Steering Group
Communications and Engagement:	Most communication to date has been through stakeholder groups. A communications plan has been developed and key narratives are in development.
Author(s):	Gemma Self – Programme Director
Sponsoring Director / Clinical Lead / Lay Member:	Sarah Truelove – Deputy Chief Executive and Chief Finance Officer

Agenda item: 6.1

Report title: Healthier Together 2040

Background

Healthier Together 2040 has been established to create a long-term strategic plan for the Bristol, North Somerset, and South Gloucestershire (BNSSG) Integrated Care System (ICS). Building on the system strategy published in 2023, it intends to be more than a written blueprint for the future set at a point in time; it represents a local approach and a dynamic process to shape health and care services and how they will adapt to current and future needs over time.

Why is Healthier Together 2040 needed?

Healthier Together 2040 will provide a clear vision of the future of health and care locally, designed to address evolving needs and ensure the system is equipped for the challenges ahead.

The plan will outline how the ICS will work toward a sustainable, equitable future for the health system while improving the overall health and wellbeing of the BNSSG population and reducing gaps in healthy life expectancy. By focusing on redesigning services for current population health issues, the project seeks to deliver medium term improvements in integrated services, whilst also seeking prevention opportunities to avoid future generations facing similar health challenges in the longer term.

Following the recent general election, a national focus on health being central to the new government's priorities[1] and with growing stability within the ICS infrastructure, the timing has become ideal to focus on the long-term future. The recent publication of the Independent Investigation of the NHS in England by Lord Darzi (September 2024[2]) reinforces the need for significant local redesign of the NHS. It recognises that the deterioration in the health of the public has contributed to the NHS's current state with still too great a proportion of NHS money spent in hospitals as well as many other areas of

[1] https://www.health.org.uk/publications/health-at-the-heart-of-government

[2] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

improvement. Healthier Together 2040 aligns to this national agenda and the subsequent national 10-year plan for the NHS will be a strategic context for this work and locally. Given progress so far, there is an intention to influence the national agenda as the 10-year plan is developed.

Healthier Together 2040 is an approach to work as a partnership to organise services around population cohorts needs with a focus on preventing people living in poor health for extended periods of time. This approach will gradually inform decisions on where services, buildings, and infrastructure should be optimally located within the system. It will enable the system to focus on innovation aligned to the key strategic objectives for a long-term sustainable system.

The initial phase of Healthier Together 2040 has reviewed national and local trends to shape what the BNSSG health and care system needs to address by 2040. Key insights from the national and local modelling highlight important considerations for the next 15 years:

- People will likely live for longer in poor health, experiencing multiple health conditions from a younger age. Nationally, people living with major illness is expected to increase by 37% in 2040 (Health Foundation, 2023[3]), this is corroborated by population modelling using local data.

- Individuals in more deprived areas will face these health challenges at a higher rate and at younger age, driven by unresolved inequalities and a collision of health and social factors. 80% of the increase in the number of working-age people living with major illness will be from more deprived areas (Health Foundation, 2024[4]).

- The working-age population is growing more slowly (4%) than the older population groups, presenting workforce and economic challenges (Health Foundation 2023).

- Many existing buildings, particularly in primary care, are no longer fit for purpose. With 95,000 new houses projected to be built, the population increase will drive

[3] https://www.health.org.uk/publications/health-in-2040

[4] https://www.health.org.uk/publications/health-inequalities-in-2040

further demand, particularly in more deprived areas of South Bristol and Weston area (HT2040 Analysis).

- Currently there is a concentration of health and care services in urban areas, where older people disproportionately live in more rural communities (CMO Report, 2023[5])
- A strong focus on general mental wellbeing is needed, especially for young people, working-age adults, and healthcare staff (Options 2040, 2024[6]).
- New technologies including AI, treatments and digital health solutions, along with climate change, political and economic instability and future pandemics present opportunities and threats. All require the health and care system to be more resilient, efficient, connected and innovating locally (Options 2040, 2024).

This analysis makes clear that the current health and care system must change to meet both current and future needs. A central design principle adopted by Healthier Together 2040 is that solutions to these interconnected issues revolve around people, their communities, the choices they make, and how the health and care system can best operate at the local level.

Delivery Plan

To date, Healthier Together 2040 has been focused on building momentum through discussions with stakeholders, analysing existing data, and identifying population groups that may require increasing levels of health and care in the future.

Embedded in the design approach is the concept that the project will sequentially focus on defined cohorts of the population to ensure in-depth codesign, enabling proof-of-concept to embed prevention at all levels, and use change resources most effectively. By focusing on groups of people and all the health, wellbeing and social needs surrounding them, we can bring organisations together to organise and deliver health and care differently. This will

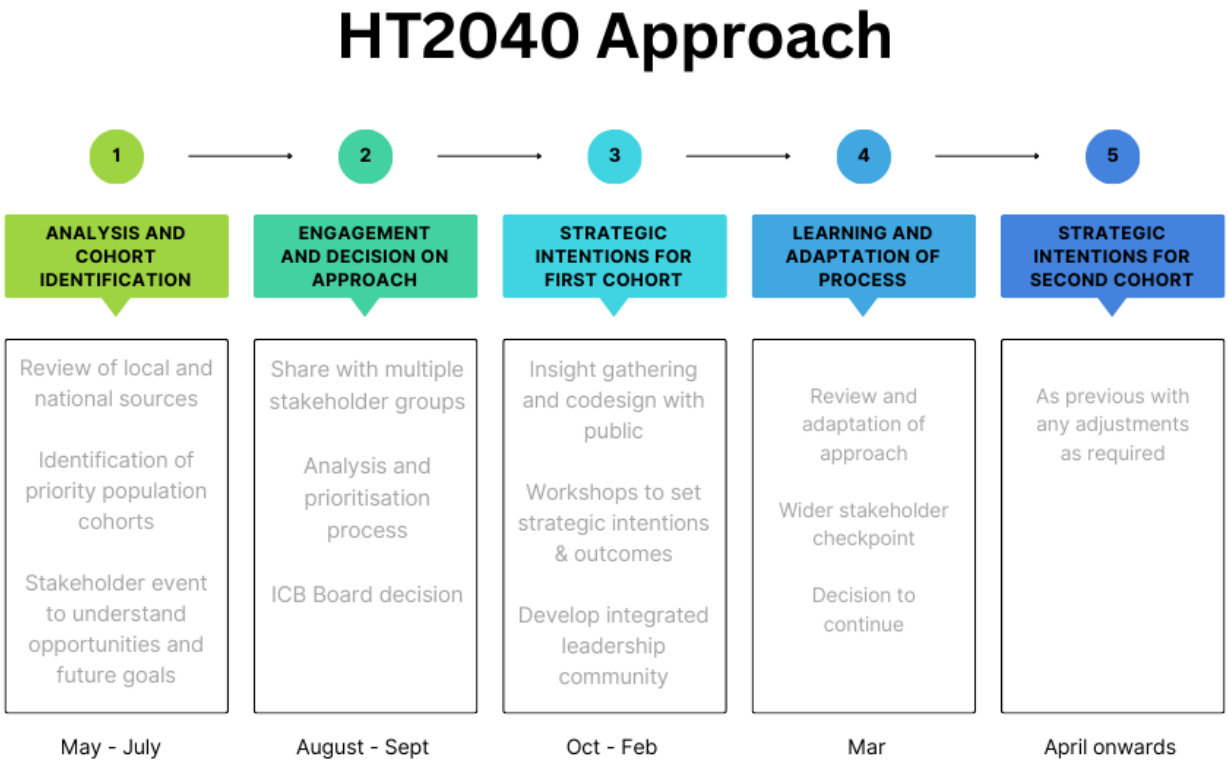
[5] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society

[6] https://options2040.co.uk/health-and-social-care-the-ideas/

fundamentally move to new care models wrapped around people in their communities and shifting resource to tackle the key drivers influencing current and future health needs.

Therefore, in the next phase, the project will go in depth into a single population cohort, developing a phased medium- and long-term set of Strategic Intentions based on linked health and care data, population insights, and expert knowledge.

The outline approach is set out below:



Population Cohorts Analysis

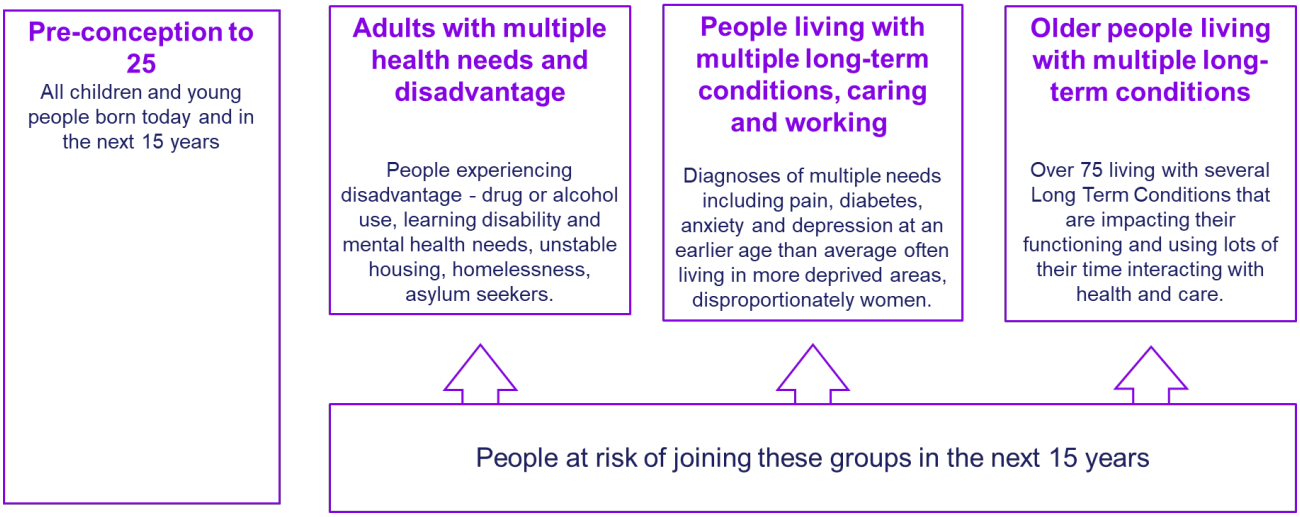
Central to the Healthier Together 2040 approach is the principle that a core purpose of the health and care system is to prevent the deterioration of health where it is possible and ethical to do so. There is an established tiered approach to prevention as set out in the table below.

	Who	Goal	Examples of General Actions
Tertiary Prevention	People living with established disease and complications of that disease	Minimise the impact of chronic disease	Specialist involvement to focus on preventable deterioration in health and maximise people's ability to live their lives how they wish.
Secondary Prevention	People living with disease	Minimise severity of clinical events, reduce likelihood of repeated events	Early diagnosis and supported self-management, peer support, mental health support, prompt care, prevention of onset of other associated conditions
Primary Prevention	People with health or social risk factors predisposing them to illness	Prevention of the onset of poor health	Smoking cessation, healthy weight management, health checks, peer support, immunisation
Primordial Prevention	Whole population	Reduce or eliminate risk factors for whole population	Housing, green space, transport, access to high quality food, education, mental wellbeing, physical activity, immunisation

The initial analysis phase sought to identify cohorts of the population who are currently experiencing poor outcomes, high users of multiple types of services, where there is an opportunity to prevent further deterioration of health and understand the risk factors to prevent future waves of people entering that cohort.

Health Foundation reports [3,4] demonstrate that for adults, an ageing population with increased multimorbidity or multiple conditions along with deprivation and social complexity is a critical health and social issue looking to 2040. Of all the evidence reviewed this was the clearest indication of impact on the sustainability of the health and care system. When

analysing the local linked data for people living with multiple health needs, experiencing poor outcomes, three key adult groups of the population emerged clearly, these are set out below. The fourth cohort focuses on Children and Young People currently in the broadest possible definition, as it is logical to include them in any long-term planning. These population cohorts are defined in the data at a moment in time and are mutually exclusive to enable planning and the creation of boundaries, however people can and will move between cohorts.



Further detail about each of these cohorts is currently being written up into a document that will be published in November. A summary of the key characteristics is set out in the table below.

Population cohort summary information

	Preconception to 25	Adults with multiple health needs and disadvantage	People living with multiple long-term conditions, caring and working	Older people living with multiple long-term conditions
Demographics	*Further segmentation will be necessary before any targeted population cohort work can be undertaken.* Data for 0-17yrs: 200,000, which is 21% of the whole BNSSG population. Ethnicity: mostly white (61%) but more varied composition compared with whole BNSSG - 72.5% white. Most CYP (90%) are in the healthiest segment of our population. National rate of referrals has increased by 11.7 per cent a year from around 40,000 a month in 2016 to almost 120,000 a month in 2024	Majority (94%) aged between 40-69yrs. 6% aged 20-39. Almost half in the 50-59 age group. 90% of cohort ethnicity is White, with other ethnicities evenly distributed. (BNSSG average 72.5% White) 93.6% of cohort have a current mental need on their on primary care record	80% are 50-69, very few under 40. More Female (57%) than male (43%) – sub cohort of women who are female, mothers and carers. Largest clustering of conditions is pain, anxiety/depression, T2 Diabetes & Hypertension Having chronic pain and anxiety/depression along with other conditions leads to conditions being less well managed (National) At the start of 2024, 2.8m people were economically inactive due to long-term sickness. 800,000 increase on pre-pandemic levels with most of the rise accounted for by mental health conditions Given demographic, high chance that these people	All over 70 with skew towards being female 3% of the BNSSG population overall Significant growth (from other cohorts and wider population) expected over time

			work in service/care/health roles	
Locations	Deprivation - mostly maps to BNSSG deprivation spread	Higher numbers in NS (+7%) and Bristol (+3%) and lower in South Glos (-10%) vs BNSSG Disproportionately living in more deprived areas with population concentrations in Weston, South Bristol and Lawrence Weston 38% this cohort live in areas classified as IMD 1 (most deprived) With a 23% in IMD 2. 61% total IMD 1&2	Widespread but with hotspots in deprived areas of South Bristol and Weston.	Widespread but with hotspots in deprived areas of South Bristol and Weston.
Outcomes are particularly poor and are expected to worsen	Disadvantage such as experienced by Children in Care and through ACEs. School absence rates increasing. Homelessness and poverty have increased locally especially in Bristol.	No expected improvement in health inequalities for working-age adults between 2019 and 2040	Having chronic pain and anxiety/depression along with other LTCs leads to conditions being less well managed Poor diabetes and worsening CVD outcomes Person with diabetes seen in primary care 30 times on average before a foot procedure.	6-month readmission rate between 35-45% 48% inpatient stays don't have an intervention Poor outcomes in the whole hospital care pathway through UEC, to admission and then discharge Significant health gap emerged in older people between those in IMD quintile 1 and IMD quintile 5.
Population scale	200,000 (0-17s)	3000 (although many unregistered/transient)	5200	35,000

Costs (currently only have NHS costs)	£81 million total £403,000 per 1000 population	£16.7 million total £5.5 million per 1000 population	£13.1 million total £2.5 million per 1000 population	£143.6 million total £4.1 million per 1000 population
Any current pressure in the system	Neurodiversity diagnosis demand and ongoing support CAHMS referrals	High users of all kinds of services (primary care, 999, urgent care, outpatients etc) High rates of cancelled and DNA outpatients – mostly mental health and crisis This cohort is 0.3% of BNSSG population and represents 4.5% of all high intensity users.	High use of primary care, secondary *and* community health Very high risk of future inpatient, ambulance and social care requirement	Major driver of ambulance conveyances Wait the longest to get off ambulances and for decision to admit Wait longest to get out of hospital

Recommendation

Throughout August and early September, further analysis and engagement with multiple stakeholder groups has been undertaken to enable a recommendation of one cohort to start as the area of focus for the next phase of work to this Board. The Steering Group is recommending **focusing upon the population cohort of people of working age living with multiple long-term conditions.**

The rationale for this recommendation is:

1. It enables the identification and embedding of integrated solutions for the people who will be frail in the next 10-15 years whilst understanding how to prevent the next waves of people being diagnosed with multiple long-term conditions at working age
2. Many of the root causes span family, community, economic, housing, employment and health solutions so provides an opportunity to test integrated and partnership-based approaches, shifting resources upstream and embedding primary and secondary prevention within communities.
3. Focusing here first sets this project firmly in the strategic position of tackling one of the key issues predicted for 2040 – multiple health and care needs driving increasing demand
4. With a cohort of 5200 people, it is a small enough cohort to enable development of a place level approach whilst also identifying the system-wide opportunities. Furthermore, the population at risk of becoming this cohort in the future is much greater, so understanding how to prevent future waves will have a wide population impact.
5. Currently predominantly managed as individual disease pathways and limited targeted integrated services with people's health needs mostly being held in primary care - opportunity to test person and community focused approached to living with multiple conditions.
6. Starting with a working age population, there is learning to help design primary and then secondary prevention interventions to slow ongoing deterioration of health considering workplaces and wider economy, childcare and families and women's

health agenda – making some traction in this cohort will set a real tone for how the system could operate in the future.

All other cohorts will have a focus after the first has been completed and the project team will return to the Board with learning from the first cohort and recommended next steps in Spring 2025. The rationale for not recommending the other cohorts to be taken as the first for in depth review and the setting of strategic intentions is:

1. **Complex older people** – there are multiple existing services and transformation activities already planned and being embedded such as Integrated Care at Home providing complexity. It may be that solutions for the working age population with multiple long-term conditions also apply to this population cohort and that will be considered at a later stage. Furthermore, given the nature of this project expecting to realise impact in the next three to 15 years, a focus on the current working age will aim to prevent future demand as they become complex older people of the future.
2. **Adults with multiple health needs and disadvantage** – Although being high cost and a sufficiently small group to test a concept with, much of their care coordination is held within specialist mental health, VCSE and local authorities. There is significant opportunity to improve integration, build in proactive opportunities and work more collaboratively for this population cohort. However, focusing on them first is less likely to test and shape the primary and community care models at scale, build confidence and test decision making.
3. **Children and young people** – currently without sub-segmentation of the population this cohort is too large to take forward this targeted approach beyond primordial and primary prevention. A segmentation methodology is already in development and this project will support that approach so that it can be focused upon next. There has already been some work to set out a strategic approach for this cohort with opportunity to support that and use similar methodologies.

Intended impact of focusing on this cohort

The whole approach for Healthier Together 2040 is purposefully collaborative, adaptive, and innovative. It will take steps to gradually test a movement towards organising the system around population cohorts, using the longer-term timeline to build confidence and test risk appetite. There are significant challenges to navigate, the first being a need to

direct increasing resource into a focus on redesigning how our system responds for this population cohort over the coming months, potentially redirected by slowing or pausing other workstreams. Through conversations to date there is appetite to do this, however it is a risk for the delivery of this project in a timeline that maintains the current pace.

Working on a longer time horizon, enables the project to direct attention to three to 15 years into the future, whilst identifying how to jigsaw into existing plans set out in the Joint Forward Plan. With all analysis pointing us in the direction that integrated redesign around population cohorts is the best approach to redesigning services for people multiple health and social needs, exploring this territory is a necessary strategic step.

Next Steps

Upon support of this recommendation by the ICB Board it will trigger a series of next steps which will lead to the delivery of a set of Strategic Intentions for this population cohort that will be brought back to the Board, along with learning from the process in Spring 2025.

1. **Detailed analysis to identify opportunities**

    - Involvement of the public and working with VCSE organisations to identify and gather insight from people in communities who are in cohort or have risk factors
    - Full evidence reviews to identify evidence-based solutions and prevention opportunities including development of theory of change for the cohort and review of best practice and case studies
    - In depth financial and contractual analysis – assessment of opportunities to shift resources upstream and slow growth of this cohort in the future
    - Place based analysis of impact and opportunities on infrastructure (buildings and digital) in line with the Infrastructure Strategy
    - Alignment to outcomes framework to develop a set of measures to monitor progress over time

2. **Build a community to lead the change**

Run a series of in-depth workshops using the Three Horizons model [7]to:

- Set out what the future could look like and define goals and outcome measures to track impact (H3)
- Identify current good practice and elements that need to change (H1)
- Identify and prioritise opportunities at place and system level to get to the future state (H2- and H2+)
- Identify key milestones for 3, 5, 10 and 15 years
- Create an integrated leadership team around the cohort which will take it forward into a delivery phase in the next financial year.

3. **All collated into a set of strategic intentions**

4. **Ready the transformation community** so that, once the Strategic Intentions are agreed the Discovery, Design and Delivery phases can progress. The ICB Board is also receiving a paper on the System Framework for Improvement, Transformation and Innovation in this meeting and that starts to set out the approach that will be taken forward to embed and deliver the initiatives that will be identified through as Strategic Intentions.

Conclusion

This paper provides a summary of the principles and ways of working of Healthier Together 2040, with work to date culminating in a recommendation for a population cohort to focus upon for the next stages of work. The Board is asked to consider and approve this recommendation, moving the project onto the next phase of work.

[7] https://www.h3uni.org/tutorial/three-horizons/

Going forward, the project will be going through a semi-structured process to identify the key opportunities and initiatives for this cohort and build a multi organisation leadership community to take forward the transformation required.

This will be led by the Steering Group which reports into the System Executive Group. The ICB Board will next be updated with the Strategic Intentions for this cohort, learning from the approach and definition of the requirements to take it into the Improvement, Innovation and Transformation phase.

1. Financial resource implications

The scope of this paper does not cover financial implications. It does however trigger focused work to understand the current cost of delivering care for the target cohort and then try to project forward future demand. That will enable an analysis of the split between the spend on proactive and preventative care and the spend on reactive and unplanned care. The aim is to set some goals to shift this balance over the course of time.

As part of HT2040, the pursuit of innovative funding approaches including outcomes-based payments and social impact investments is being scoped to enable new payment approaches to be embedded to address the impact current payment mechanisms hinder integration.

2. Legal implications

Currently no known legal implications

3. Risk implications

As the decision associated with this paper triggers the next phase of work, it also generates new risks which will be included in the Risk Register once scoped and developed with the steering group. These include:

1. Delivery impact is contingent on reducing other activities and aligning resource within the ICB and other partners around the HT2040 agenda and approach, with this growing and scaling over time
2. Delivery monitoring is contingent on use of linked health and care data to track shifts in service use. There are risks being managed around:
    a. Consent in using this data going forward to monitor changes in pathways
    b. Alignment with delivery of the Intelligence Centre
3. Managing across multiple organisations medium- and long-term strategies and how to manage increasing alignment.

4. How does this reduce health inequalities

The goal to reduce health inequalities is built into the approach set out above. Work to date has identified the key cohorts experiencing and expected to experience the poorest health and require increased levels of health and care involvement. The approach set out embeds the principle that focusing on improving health and care and preventing deterioration in health for those expected to have the greatest need, will improve the access to health and care services for all.

5. How does this impact on Equality and Diversity?

The decision about which population cohort to focus on first will then enable an in depth understanding of the Equality and Diversity impacts.

Focusing on smaller cohorts is a deliberate starting point to enable:

a) Codesign and improved understanding of issues
b) Understanding of the wider population at risk of entering this cohort
c) Understanding how this cohort's health might be maintained or improved to prevent further deterioration

As such it is expected that a much larger population will be impacted by this work as it starts to include people at risk and wider family members.

A full EQIA for this population cohort will be undertaken as one of the first next steps.

6. Consultation and Communication including Public Involvement

Public involvement in the form of user experience and user centred design is central to the approach set out in the next steps.

Two public representatives have been recruited to the Steering Group and they are starting in October

Involving the public through surveys, deliberative events and networks through the VCSE Alliance is planned in the initial phase to ensure accurate understanding of root causes and then enable strategic intentions to be set.

Members of the public will then be involved in the subsequent design and implementation phases.

Furthermore, with the need for wider public involvement driven by the national ten-year plan agenda, there will be opportunities to gain further understanding of more general experiences and expectations from the public when looking to the future.